Why should primary care address SDHs?

- Improve individual health outcomes
- Improve population health
- Create novel avenues for research

Aim statement (How good? For whom? By when?)

By April 30, 2015, all patients who have seen behavioral health providers in clinic will have their relevant social determinants of health (SDHs) and the provider action(s) documented in a standard electronic health record location.

Changes tested

The team tested using a dot-phrase in different locations in patients’ medical records to streamline screening for and documentation of SDHs. (A dot-phrase is pre-written text that can be inserted into the patient chart with a click.)

Methodology

I utilized the complete IHI Model for Improvement to lead this project, including a project charter, Ishikawa diagram of root causes, 7 PDSA cycles, and run charts for our process and outcomes measures.

After revisions identified in cycle 1, the dot-phrase looked like this:

Draft Social Determinants of Health dot-phrase – cycle 2
[Auto-insert provider name, date of note]

Patient indicates presence of the following social determinants of health:
(Provider: Delete those that do not apply)

Financial / Employment status and / or meaningful work

Action:

Years of schooling / literacy

Action:

History of abuse / trauma / loss

Action:

Transportation

Action:

Nutrition / food security

Action:

Social connections / isolation

Action:

Results

Next steps

I will continue this project as my MPH internship, beginning summer 2015. Our team will 1) conduct a listening campaign with community members; and 2) create a new community health worker role at the clinic, to meet these needs.

By improving the clinic’s awareness and tracking of SDHs in their population, we have paved the way for a new kind of population health intervention for this clinic, conceived and carried out outside the clinic walls by the community itself.

References:


Incorporate "off-script" action into Cycle 2

Cycle 1

- Plan
- Do
- Study

Social worker tests dot-phrase with one patient

Screened for SDHs with 5 patients rather than one

Cycle 2

- Plan
- Do
- Study

Social worker tests dot-phrase to screen for SDHs with one patient

Team meeting to check goals, scope, feedback format for cycles 3 and beyond

Learning

Through this screening process, we have identified patients at Richmond Clinic have unmet SDH needs impacting their health outcomes.

- By improving the clinic’s awareness and tracking of SDHs in their population, we have paved the way for a new kind of population health intervention for this clinic, conceived and carried out outside the clinic walls by the community itself.

References: