***Embedding the Social Determinants of Health in Patient Medical Home***

***Wave I PCN Community of Practice***

Physicians know that people with fewer resources have poorer health. Hospitalization rates are significantly higher for those in the lowest versus the highest income quintile, particularly for issues such as mental health, ambulatory care services, COPD and diabetes. Wave 1 PCN communities have taken a big step towards addressing the social determinants of health (SDH) by advancing the Patient Medical Home (PMH), leveraging the opportunity within PCN funding to support physicians to implement new practice patterns, and introducing new nursing and allied staff who are often best positioned to directly address the SDH within the clinical setting.

Health equity is a complex, value-laden issue that is applied differently according to the attitudes, beliefs and experiences of individual practitioners. As a group, you are united in the desire to provide the best possible patient care for everyone in your practice. As early adopters of PMH/PCN, you have a lot to learn from each other as you break new ground towards health equity. We hope that communicating with each other, having access to a wide range of resources, and accessing the support of [www.EmbedSDH.ca](http://www.EmbedSDH.ca) will help you navigate this complex and worthwhile journey.

GOAL of *E͎m͎b͎e͎d͎S͎D͎H͎:*

“To empower family physicians to address the social determinants of health.”

Patient Medical Home and Primary Care Networks aims to transform BC’s health system, by offering an integrated health system that makes it feasible to provide care that takes into account patients' living conditions. With multidisciplinary teams, [panel management](http://www.gpscbc.ca/what-we-do/patient-medical-homes/panel-management) providing patient data to inform and plan proactive care; and [physician networks](http://www.gpscbc.ca/what-we-do/patient-medical-homes/physician-networks) linking practices with each other, continuous and comprehensive patient care is possible.

The multi-disciplinary approach of PMH will better address the needs of patients with the most complex needs, reducing repeat visits to health care providers and freeing up physician time. The end result of equity-oriented care is better care for patients, along with more patients attached to physicians.

What does this mean for your community and the physicians within it? An opportunity to meaningfully impact patient care and the satisfaction of every member of the clinical team.

VISION of *E͎m͎b͎e͎d͎S͎D͎H͎:*

“To meaningfully impact patient care and physician satisfaction.”

Why a Community of Practice?

Many organizations and professionals have been working towards health equity for decades and a significant amount of knowledge and research is available to inform practice. The Community of Practice will help link you to those resources and expertise, and help you learn from each other as you overcome various challenges along the way. As some of you may feel you are lone voices in this endeavour, you will also gain support and strength from your colleagues.

How will the Community of Practice work?

We plan to hold monthly calls/meetings to connect you with each other. This will be your chance to raise issues you are dealing with, share helpful resources you have found and hear from like-minded colleagues. Summaries of the calls will be sent to all participants of the CoP for those unable to attend and to provide a record of experiences and resources.

Who will Participate in the Community of Practice?

We envision membership to begin with Physician Leaders within Divisions with a passion for the SDH, and Divisions Executive Directors, staff and contractors supporting the PCN change work (In [www.EmbedSDH.ca](http://www.EmbedSDH.ca) we call these people “PMH Facilitators”. As Teams are built on the ground, we anticipate the Community of Practice to grow, with more physicians in practice, and the nursing and allied staff that are employed to work with them, as a result of new PCN funds.

Support/Resources

*EmbedSDH.ca* is a website designed for busy family physicians, by busy family physicians. It provides enough information for you and your colleagues to confidently bring physician leadership to this work without overwhelming you with detail. EmbedSDH.ca also provides highly detailed information on leading practices in SDH, primarily for the use of the PMH Facilitators/PSCs.

PMH Facilitators/PSCs in your community, and the new team members you will gain as a result of the implementation of the PMH, will be part of every step of this journey. These change management resources enable you to bring physician leadership to these ideas, without taking attention away from the ever-present clinical requirements of your busy practice.

*Divisions Support* – At the provincial level, several staff and consultants are available to support your efforts:

* [Dr. Lee MacKay](http://www.gpscbc.ca/who-we-are/committee-members), Family Physician, Board member – KBDFP, and Committee Member, GPSC. Lee is a champion of SDH-based care and has provided numerous Grand Rounds on the subject.
* [Andrew Earnshaw](C:\\Users\\Andrew Earnshaw\\AppData\\Local\\Packages\\Microsoft.MicrosoftEdge_8wekyb3d8bbwe\\TempState\\Downloads\\Link to bio), ED of Kootenay Boundary Division of Family Practice. Andrew & Lee brought the Poverty Intervention Tool to BC and he plays a lead role in advancing SDH-based practice.
* Terry Brock, Regional Liaison, Divisions of Family Practice. Terry will provide day-to-day support to CoP participants, helping to navigate the challenges of re-orienting practices.
* [Diana Daghofer](http://wellspring.pressfolios.com/), consultant in the social determinants of health. Diana helped create EmbedSDH.ca and will support participants with resources in SDH care.

Prior to the first meeting

Before our first meeting, you may want to review your practice’s readiness to provide equity-oriented practice. For example:

* Have you identified the clinics who will be part of your PCN?
* When will your new staff be joining the team?
* Do you have a good sense of your community profile with regard to SES?
* Do you have a good sense of services available in the community? Have you established relationships/partnerships with service providers?

Going Forward

These are questions you may want to think about as you plan next steps:

* Have you discussed the upcoming changes in practice with existing staff? Patients?
* How many of the 8 Primary Care Network Core Attributes does your practice currently meet?
* Do you have a plan to meet the remainder?
* Have you identified priorities among your SES-challenged patients (housing, employment, adequate food, etc.)?
* How do you plan to discuss living conditions with patients (Poverty Intervention Tool/ACEs)?
  + Who will administer the tools?
  + Where will the interviews take place?
  + How will the information be entered and tracked on patient records?