Social Determinants of Health Screening in a Suburban Primary Care Setting

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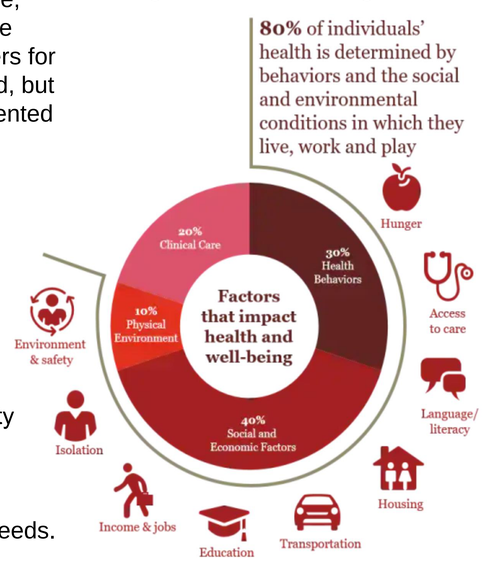
Problem Statement

- **Social determinants of health (SDOH) screening** is recommended by the World Health Organization, the Institute of Medicine, the Centers for Disease Control, and the Centers for Medicare and Medicaid, but it is not widely implemented in primary care (Gottlieb et al., 2017)
- 80% of surveyed providers did not feel confident in meeting patients' social needs (Andermann, 2018).
- 14,138 families in Prince George's County live in poverty; high unemployment rates suggest a high level of unmet social needs.
- COVID-19 has caused increased unemployment and financially unstable markets; social needs are expected to increase.

Figure 1. SDOH Categories



Project Purpose & Goals

Quality Improvement (QI) Project: To identify and address social needs among Medicare patients by implementing an electronic *Health Leads* SDOH screening questionnaire, and by training office staff on how to make appropriate referrals using a resource database.

Short Term Goals:

- 100% of fee-for-service Medicare beneficiaries will be screened during in-office or telehealth visits
- 100% of patients that screen positive will receive a referral for social resources.

Long Term Goals:

- 100% of patients at the practice will receive appropriate social needs support via community agencies as indicated.

Methods

Pre-intervention: Patient self-identification of SDOH concerns

Intervention:

- Medical assistants (MAs) conducted SDOH screens and made referrals prior visit with provider;
- Adapted *Health Leads* questionnaire integrated into the electronic health record (EHR) to promote sustainability (Berkowitz et al., 2016)

Setting/Duration: Suburban primary care group practice; data collection X 15 weeks

Population:

- Medicare fee-for-service (> 65 years of age or disabled); and
- Medicaid dual eligible

Tactics:

- Staff training using the Gradual Release of Responsibility ("I Do, We Do, You Do") Framework (for competence/fidelity);
- Flyers about SDOH screening to increase patient awareness;
- Weekly data reports to provide staff feedback.

Figure 2. Adapted *Health Leads* Questionnaire in EHR (Yes/No/NA)

1.	Are you worried that in the next 2 months, you may not have stable housing?
2.	In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?
3.	In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?
4.	In the last 12 months, have you needed to see a doctor or pick up medications, but could not because of cost?
5.	In the last 12 months, has unreliable transportation kept you from keeping appointments, going to work, or getting things needed for daily living?
6.	Do you ever need help reading medical materials given to you?
7.	Do you often feel that you lack companionship?
8.	Are you ever concerned for your safety in your apartment building or house?
9.	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight
10.	If you checked YES to any boxes above, would you like to receive assistance with any of these needs?
11.	Are you currently receiving assistance or benefits to address any of the concerns above?

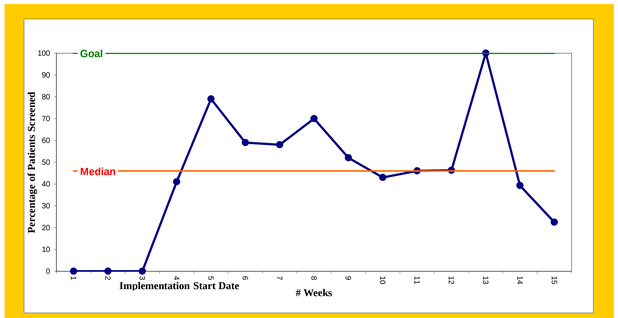
Office Use Only:

12.	Referral to at least one social resource given
13.	Is patient on an SDOH care plan?

Results

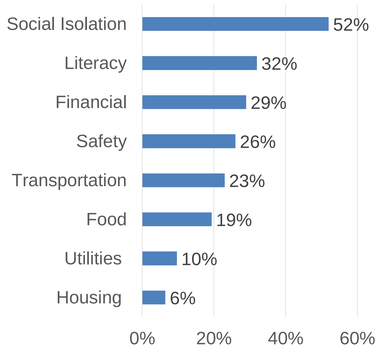
- **Screening:** 96.25% of patients (n=231) agreed to be screened for SDOH needs; 13.42% (n=31) reported at least one SDOH need; 48.39% (n=15) reported multiple social needs.
- **Referrals:** All patients screening positive (100%) received referral resources.
- **Identification of SDOH Need:** Not associated with gender (p=0.714), age (p=0.061) or Medicaid dual eligibility (p=0.708). Significantly associated with race. Of the four racial groups, 36.36% of patients who identified as "Other" race had one or more SDOH needs (n=4 of 11); followed by 16.25% of Caucasians (n=13 of 80); 12.77% of African Americans (n=12 of 94); and 4.35% of Asians (n=2 of 46); X^2 (df=3, N=231) =8.828, p= 0.032.
- **Telehealth vs In-Person Visits:** Patients were more likely to report SDOH needs during in-person visits (17.22%) compared to telehealth visits (6.25%); X^2 (df=1, N=231) = 5.4148, p = 0.020.

Figure 3. Percentage of Medicare Patients Screened Weekly



Note: Last two weeks of implementation was affected by staff shortages due to COVID-19

Figure 4. Identified SDOH Needs



Discussion

- **Facilitators:** The Maryland Primary Care Program designated this primary care practice as an Advanced Practice for their efforts to implement SDOH screening.
- **Barriers:** Staff were challenged at times to fit the screening and referral process into their workflow on busy days.
- **Limitations:** Lack of 90-day follow-up call data to determine whether patients with positive SDOH screens had been successfully linked to community resources. No conclusions about which race had highest need can be drawn.

Conclusions

Implications:

- Patients were willing to be screened for SDOH, and anecdotally, they appreciated the resources provided.
- Identification of SDOH needs more likely during in-office vs. telehealth visits.
- Point-of-care screening for SDOH during a health care provider visit is feasible and can increase detection of SDOH needs and referrals to community resources.
- SDOH screening by trusted providers in convenient locations where patients frequently visit helps to decrease stigma, improve access to services, reduce inequities, and improve health outcomes

Future Development

- Implement screening tool in other practice locations
- Measure long term goals and impacts of SDOH on health outcomes

References

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