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.

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

- 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
- 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.

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); X² (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%); X² (df=1, N=231) = 5.4148, p = 0.020.

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

- 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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