Social Determinants of Health Screening in a Suburban Primary Care Setting

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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.

Methods

Pre-intervention: Patient self-identification of SDOH concerns

Intervention:
- Medical assistants (MAs) conducted SDHQ 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;
- 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 SDHQ needs; 13.42% (n=31) reported at least one SDHQ need; 48.39% (n=15) reported multiple social needs.
- Referrals: All patients screening positive (100%) received referral resources.
- Identification of SDHQ 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 SDHQ 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 SDHQ 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 SDHQ 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 SDHQ 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 SDHQ, and anecdotally, they appreciated the resources provided.
- Identification of SDHQ needs more likely during in-office vs. telehealth visits.
- Point-of-care screening for SDHQ during a health care provider visit is feasible and can increase detection of SDHQ needs and referrals to community resources.
- SDHQ 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

References


Acknowledgments

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- Dr. Rita Pabla (Primary Care Provider);
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Figures:

- Figure 1. SDHQ Categories
- Figure 2. Adapted Health Leads Questionnaire in EHR (Yes/No/NA)
- Figure 3. Percentage of Medicare Patients Screened Weekly
- Figure 4. Identified SDHQ Needs

Table:

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