Utilization of Social Determinants of Health Screening Tool in a Primary Care Setting

OKLAHOMA STATE UNIVERSITY
CENTER FOR HEALTH SCIENCES
Family Medicine Department and Health Access Network

Chris Guinn, DO, MPH, PGY-2; Jing Zhang, DO, PGY-1 Faculty Advisors: Regina Lewis, DO; Glennda Tiller, DO, Med Contributors: Casey Bledsoe, MS, LPN; Heather Longshore

BACKGROUND

Social determinants of health (SDOH), are broadly comprised of the influences impacting the health of populations. According to Healthy People 2020, "our health is also determined, in part, by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships."[3] Social determinants, Stigma, Discrimination and Bias in Healthcare combine and lead to Healthcare Disparities. Family Medicine physicians are in a unique, frontline position affording them the opportunity to address and account for these determinants as they relate to our patient populations.

We have performed a quality improvement project which employs a SDOH screening tool readily available in the clinic system EMR. In addition to utilizing this screening tool, we provided patients with identified areas of concern resources to assist with these determinants.

AIM STATEMENT

Primary Aim: To improve collection of social determinants of health data in an underserved Family Medicine ambulatory clinic cohort.

Secondary Aim: To act upon identified areas of concern via provision of resource lists and/or referral to the Health Access Network (HAN).

METHODS

- Adult patients were provided with a paper screening tool which matched the EMR screen. The determinants included were food insecurity, housing stability, financial strain, transportation and stress. Intimate partner violence was also screened.
- The answers were input into the EMR social determinants section in the history tab by nursing staff. The information was then reviewed by the physician.
- Areas of concern would highlight red, indicating high risk, yellow, indicating medium risk, or green, indicating low risk.

METHODS CONTINUED

- The criteria for inclusion of referral to the HAN was one high risk area or 2 medium risk areas. If the patient had one medium risk area, they would be provided with an area-specific resource list.
- The lists were available in the EMR and were added to the After Visit Summary (AVS). Patients would be provided with these lists if they declined HAN referral as well.
- All patients who received a referral would be contacted by the HAN. They would be offered case management services, referred to case management through their insurance, or mailed additional resources.
- The physician would be notified of the result through a message in the EMR.

RESULTS

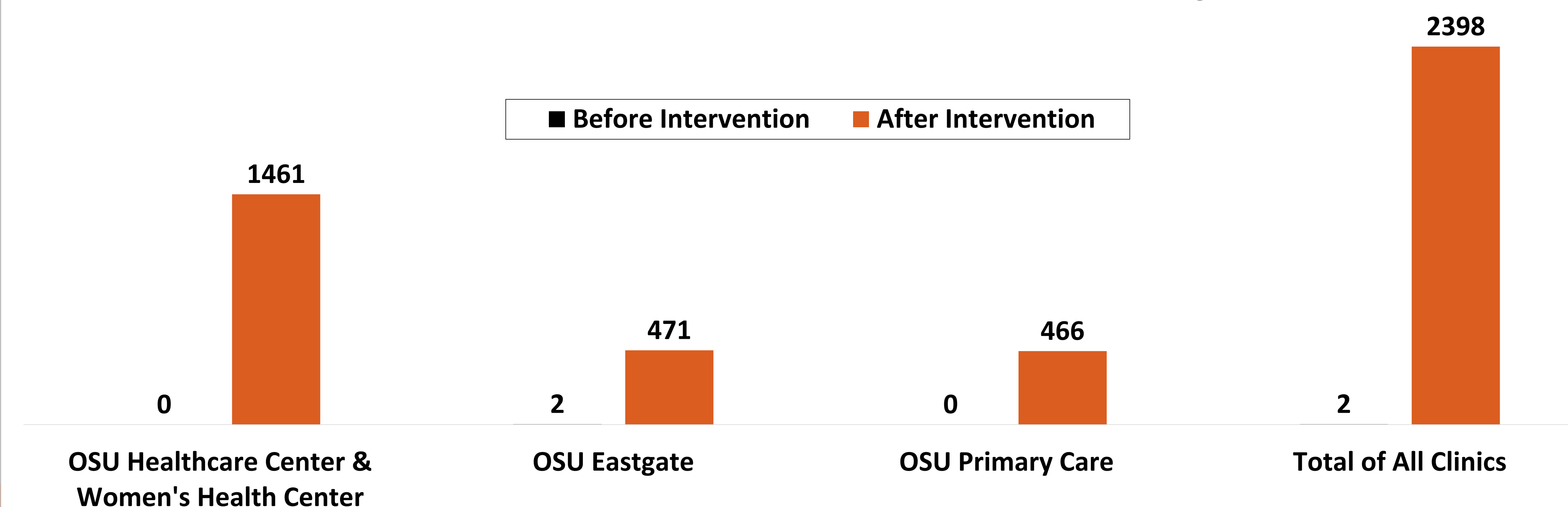

Chart 1. Illustrates the number of social determinants of health screens completed in the EMR at each clinic site and the total during the 3-month data collection period, comparing before and after required screens began.

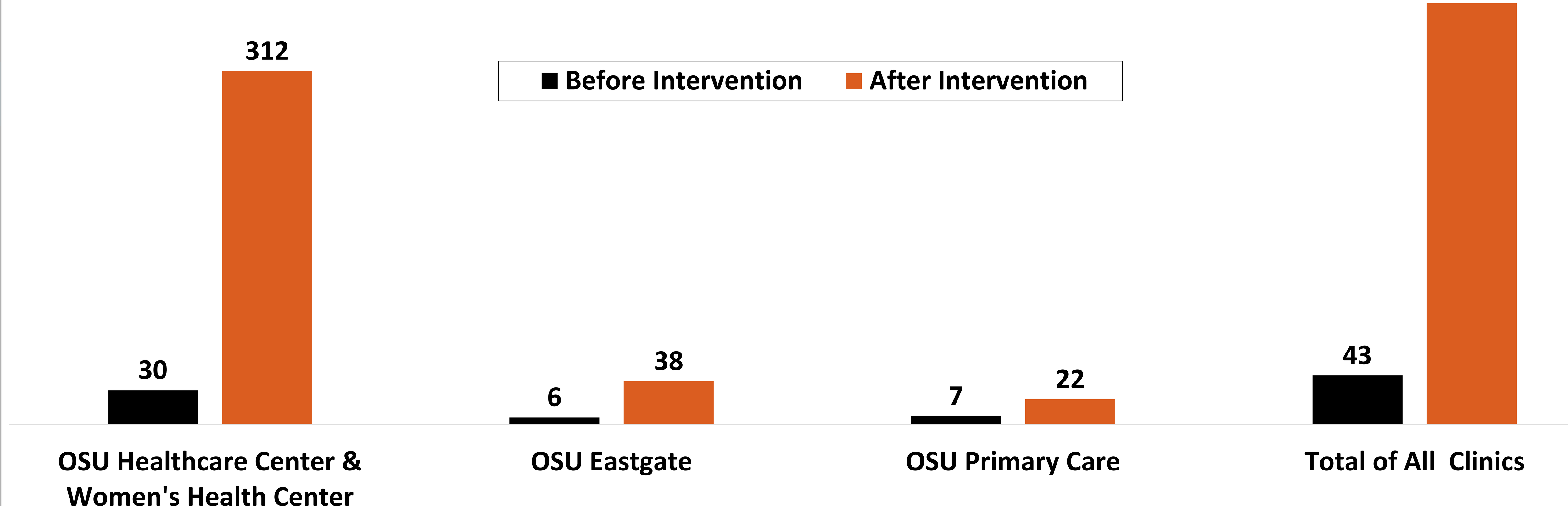

Chart 2. Illustrates the number of referrals placed to the Health Access Network during the 3 months before and the 3 months after the required screenings began.

CONCLUSIONS

Prior to the implementation of the project, only 2 SDOH screens were completed. After implementation of required screening, 2,398 patients were assessed in a 3-month span.

Additionally, all clinics consistently increased their number of referrals to the HAN after the execution of the SDOH screening tool was required. OSU Healthcare Center & Women's Health Center increased HAN referral placement by 1040%. OSU Eastgate increased HAN referral placement by 633%. OSU Primary Care increased HAN referral by 314%. The department increased HAN referrals by 865%.

Based on the data, it is reasonable to infer that OSU-CHS Family Medicine's efforts have directly led to a significant increase in the number of patients whose social determinants are being addressed.

IMPROVEMENTS AND NEXT STEPS

- The extraordinary value of this project has allowed it to continue past the experimental period. OSU-CHS Family Medicine intends to continue yearly screening.
- There is intention of expanding this screening to include the department's pediatric population.
- There is significant community interest in employing a similar screening tool in other clinics who utilize HAN services.
- In the future, we hope to track the number of patients who received case management services and explore outcomes of provision of services.

REFERENCES

1. *Implementation and Action Toolkit - NACHC.* https://www.nachc.org/wp-content/uploads/2019/04/NACHC_PRAPARE_Full-Toolkit.pdf
2. Weir, R.C., Proser, M., Jester, M., Li, V., Hood-Ronick, C.M., & Gurewich, D. (2020). Collecting Social Determinants of Health Data in the Clinical Setting: Findings from National PRAPARE Implementation. *Journal of Health Care for the Poor and Underserved 31*(2), 1018-1035. doi:10.1353/hpu.2020.0075.
3. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

ACKNOWLEDGEMENTS

We would like to thank the hardworking staff of the Health Access Network who gave strong support for this project. We want to thank the OSU-CHS Family Medicine residents, PSRs and nurses; without their participation this could not have been possible.