Integrating SDOH Screening & Follow-up in small practices

Lyndee Knox, PhD, Kevin Thomas, MD

"There is mounting evidence to suggest that SDOH influence health outcomes more than medical care.."

AAFP

Florence Western

Patients: 4,000+

Clinicians:
PA (1 FTE)
MD (1.5 FTE)

EHR:
Office Ally

Demographics:

Black	70%
Latino	25%
White or other	5%

Payer mix:

MediCal	40%
Medicare	40%
Other	20%

Screening approaches considered

- Universal 
- Targeted
- Hybrid –Universal pre-screen + Targeted follow-up (multi-gated)

Why universal screening?

"You can't tell by looking at a patient if they are struggling to put food on the table or pay rent."

Alicia Cohen, M.D., M.Sc.

http://labblog.uofmhealth.org/rounds/why-screening-for-social-determinants-of-health-helps-doctors-provide-better-care

Also from Workflow perspective

- Simpler – everyone gets an SDOH screener

Selecting a screener

NACHC PRAPARE

Health Begins SDOH screener

WHO SDOH items

A mix of several 

(NAM 12 social & behavioral factors for EHRs)

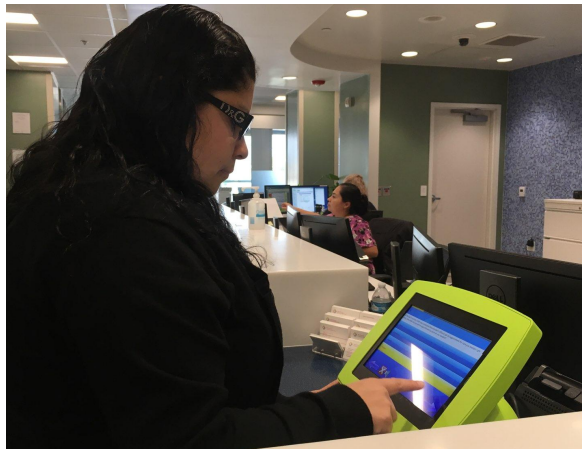
Why a mix of screeners?

Wanted items that supported real **action**

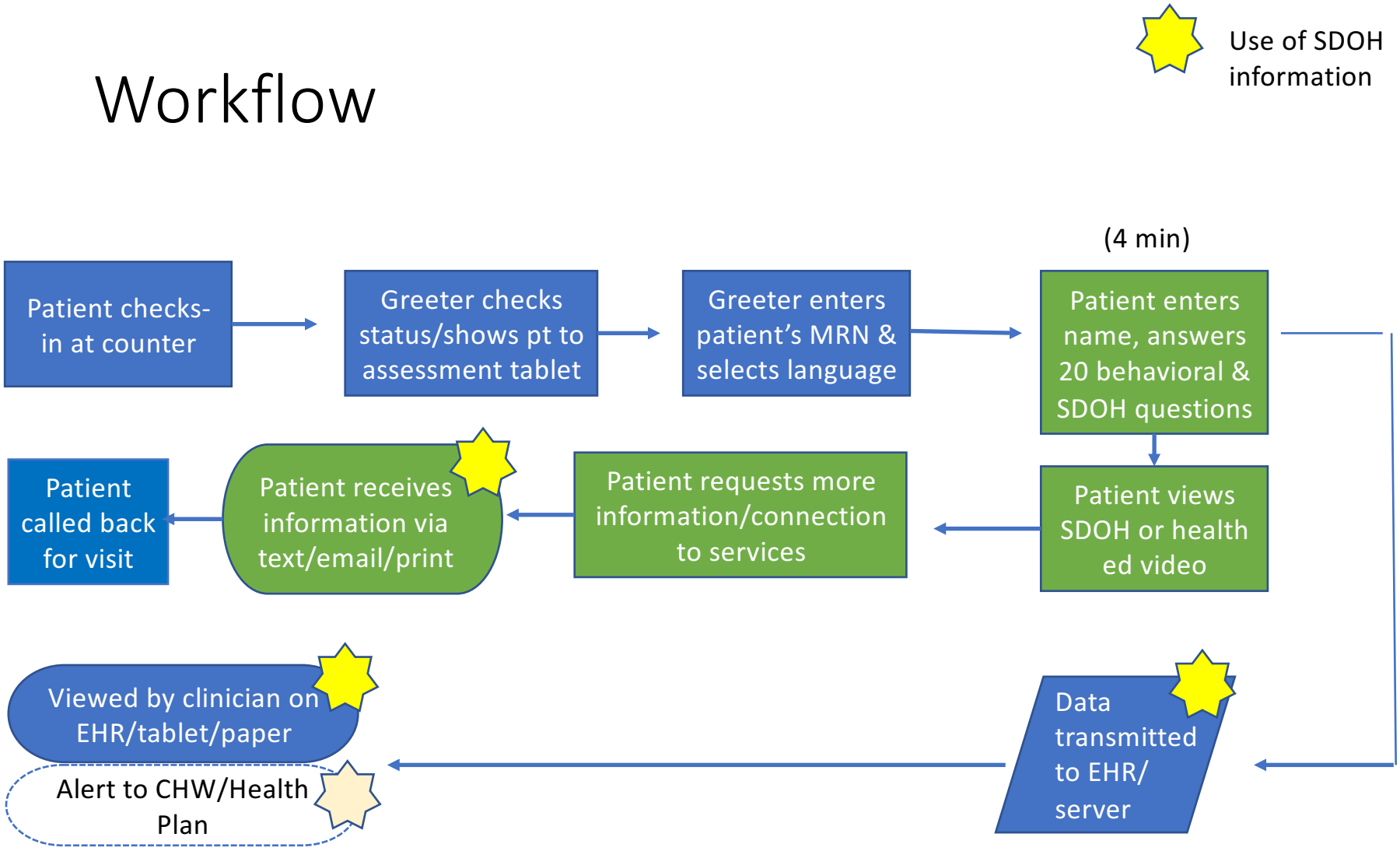
Wanted to **include “loneliness”** as a determinant

Methods of conducting screenings

- Old fashioned pen & paper
- Entry into EHR template (interview by CMA)
- Patient entry into standard EHR portal/Kiosk
- Specialized IT solution for low-literacy



Workflow


Use of SDOH information
(4 min)
Patient checks-in at counter
Greeter checks status/shows pt to assessment tablet
Greeter enters patient's MRN & selects language
Patient enters name, answers 20 behavioral & SDOH questions
Patient views SDOH or health ed video
Patient requests more information/connection to services
Patient receives information via text/email/print
Patient called back for visit
Data transmitted to EHR/ server
Viewed by clinician on EHR/tablet/paper
Alert to CHW/Health Plan

Survey completion

- Number invited = 417
- Number declining = 20
- **Rate of refusal =5%**

- Total surveys started = 397
- Total surveys completed = 346
- **Completion rate = 87%**

- Total surveys =397 (Jan-June)

Demographics

	N=296	%
Race		
Black	273	92%
Age		
>45	281	95%
>65	162	55%
Sex		
Male	167	49%
Education		
High school or less	171	58%

High Loneliness

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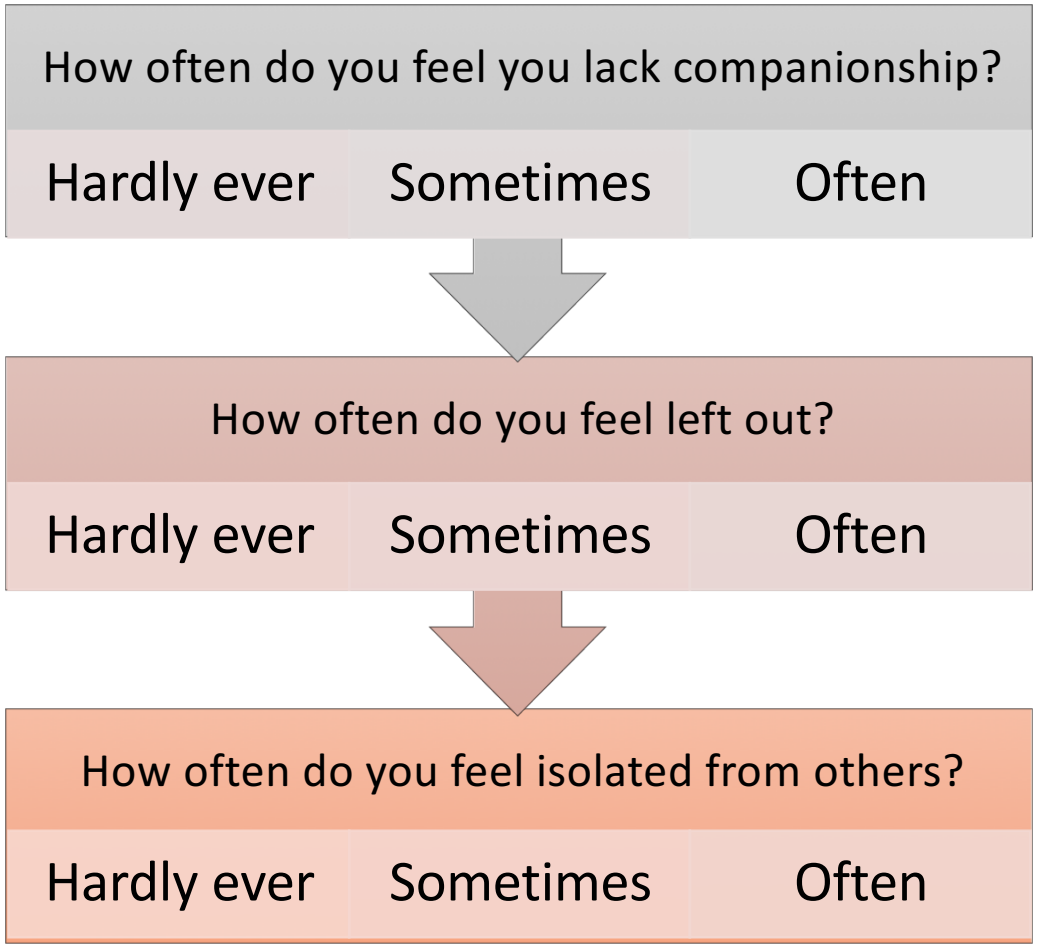
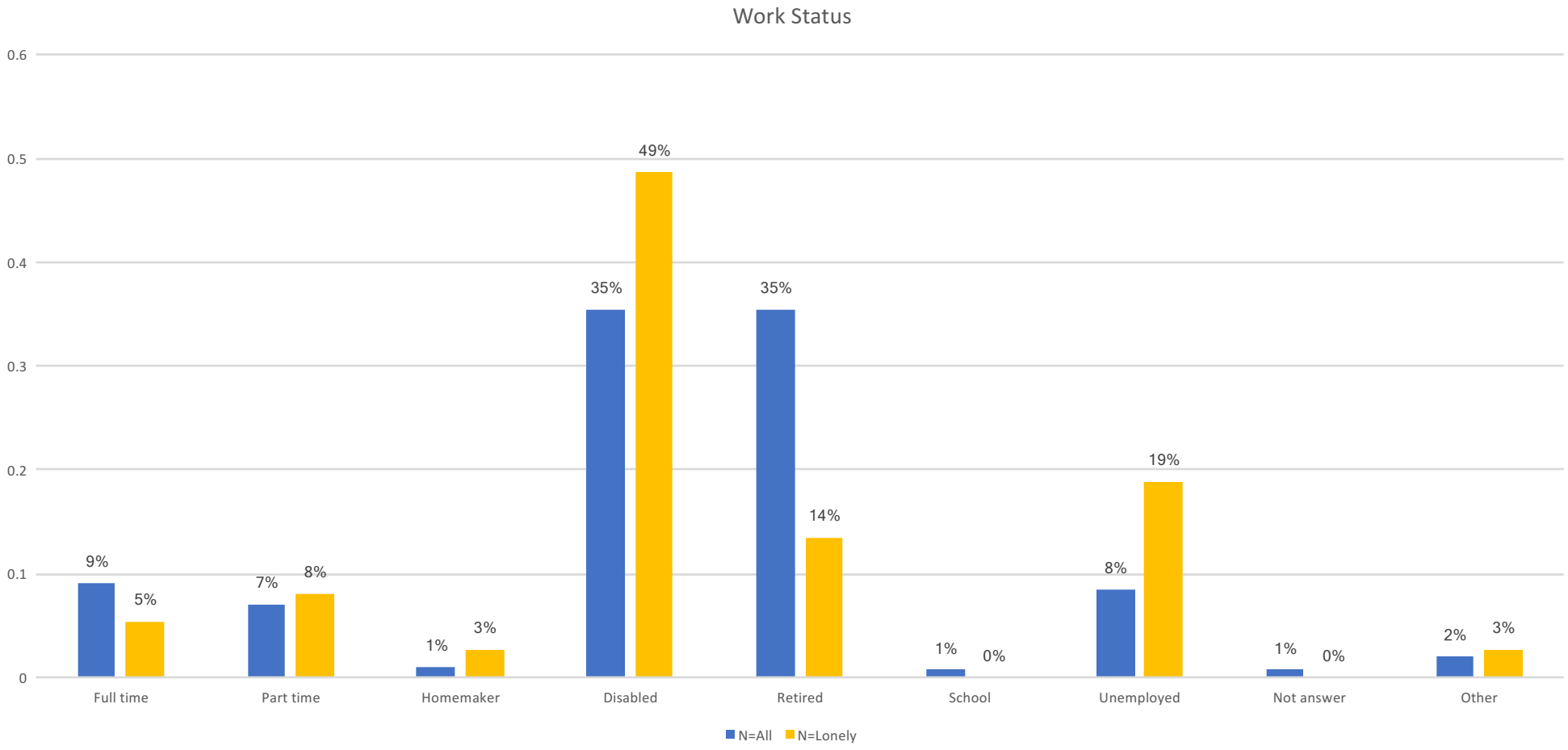
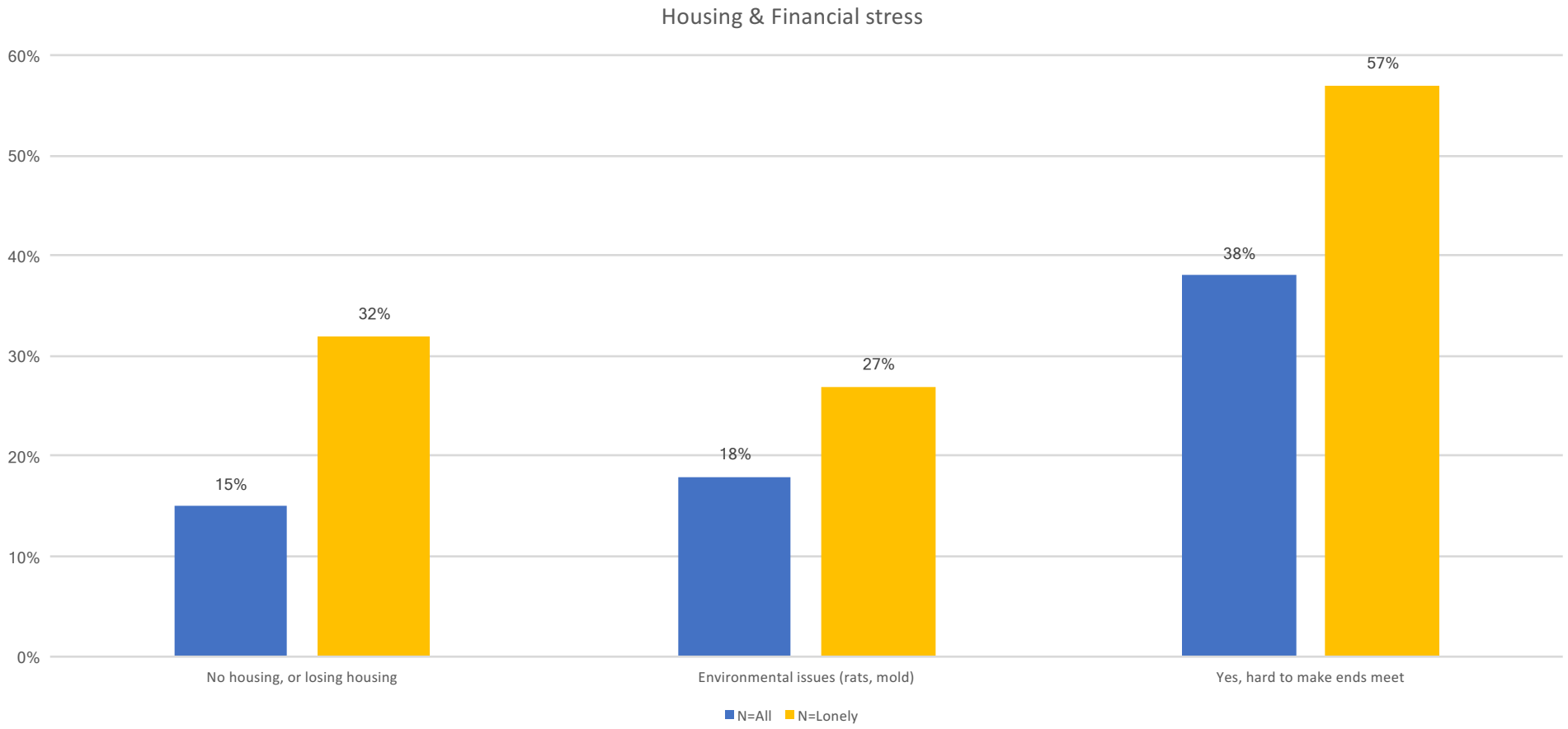
n=37 (13%)



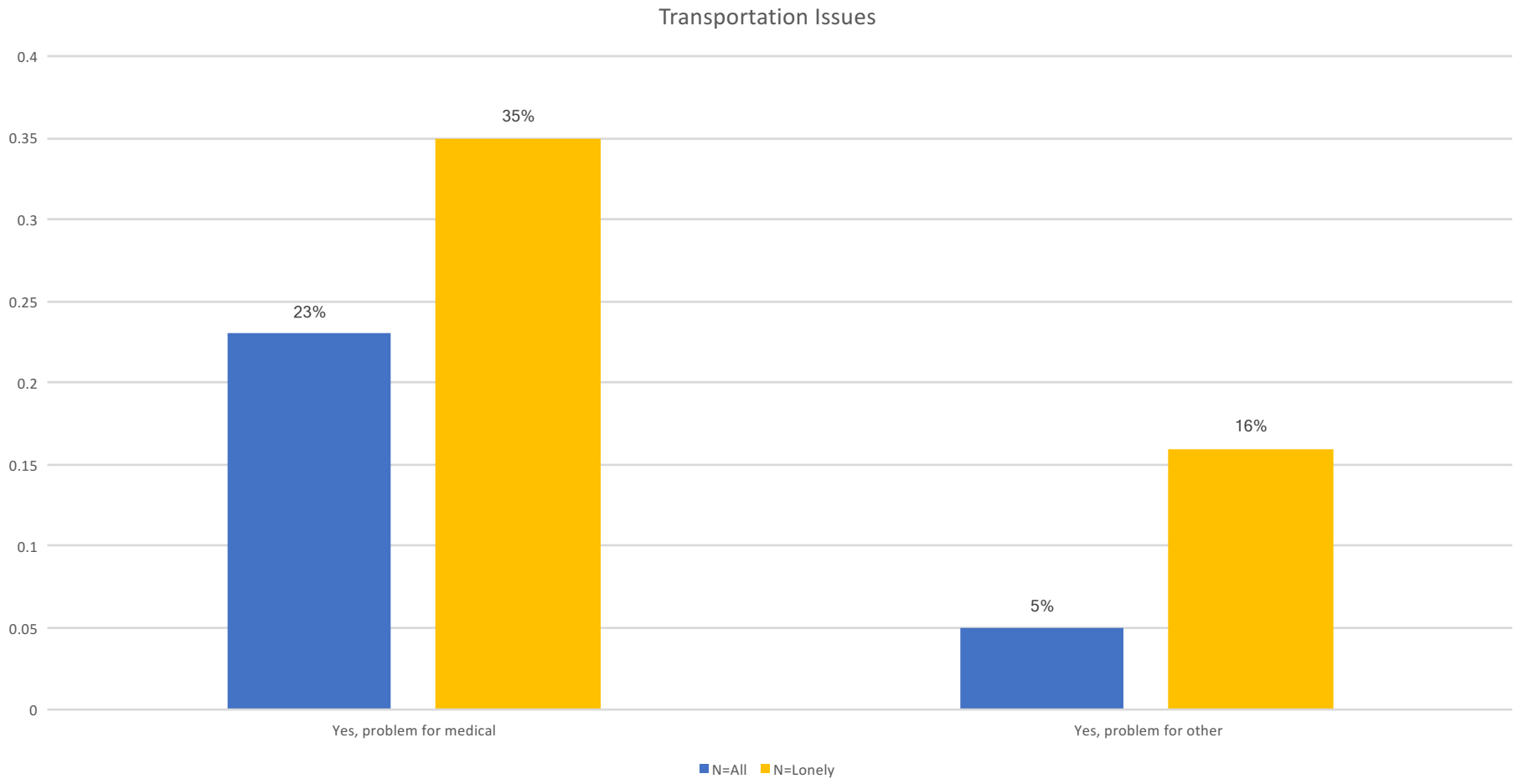
Work status


Work Status
0.6
0.5
0.4
0.3
0.2
0.1
0
9%
5%
7%
8%
1%
3%
35%
49%
35%
14%
1%
0%
8%
19%
1%
0%
2%
3%
Full time
Part time
Homemaker
Disabled
Retired
School
Unemployed
Not answer
Other
N=All
N=Lonely

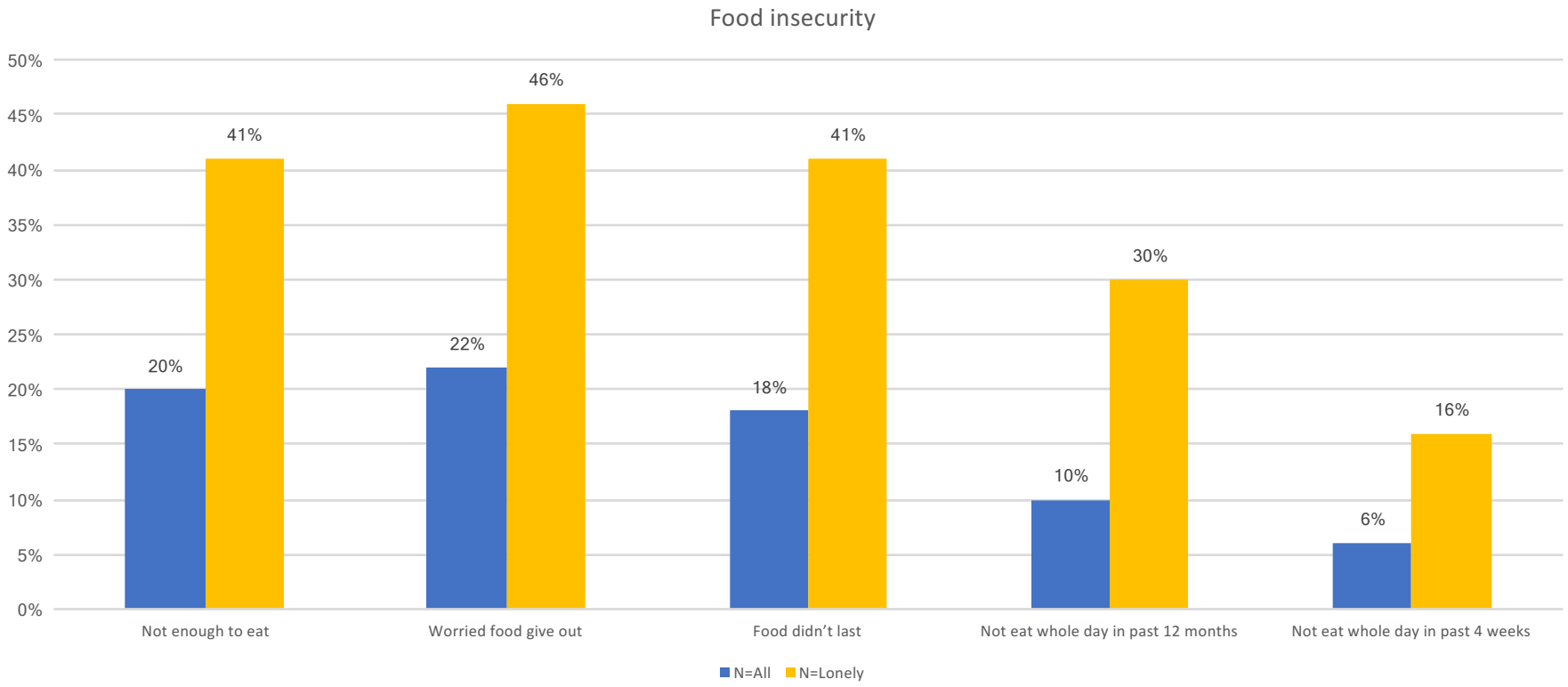
Housing & Financial Stress



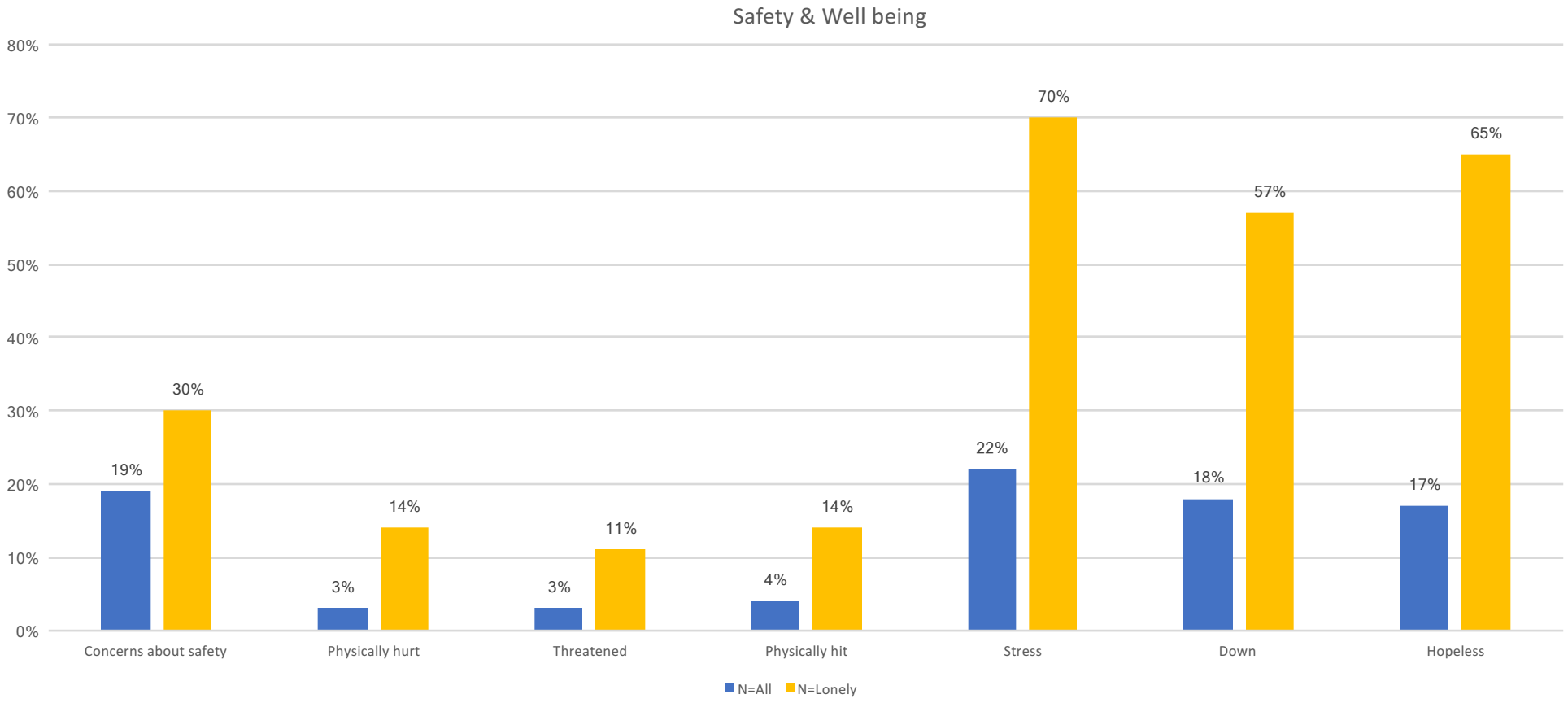
Transportation



Food Insecurity



Safety & Well-being



From Patient Report → Action

Patientoc

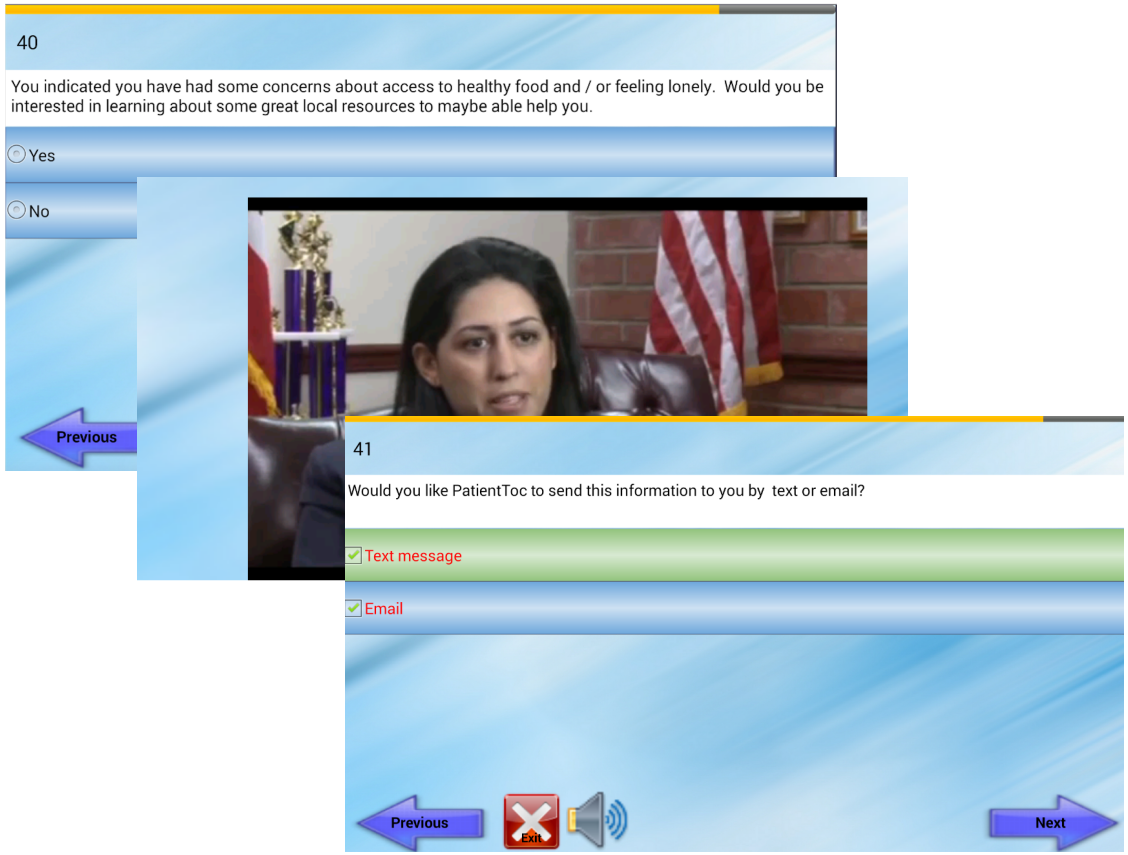
Advanced Social Determinant Sample Report -Generic

Date of Report: 10/6/2017

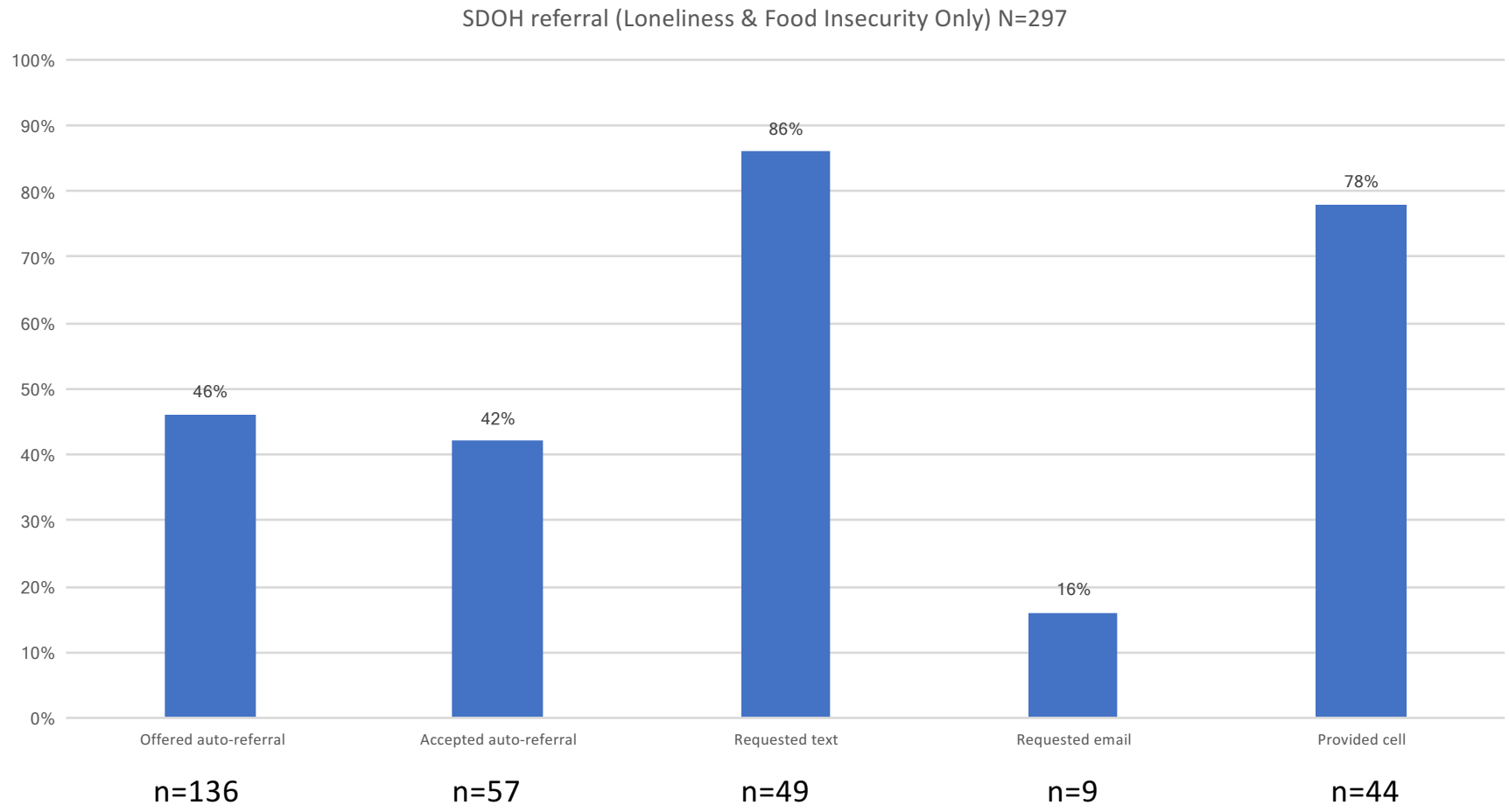
Language administered in:

Advanced Social Determinants

Question	Answers
What is your race? Mark one or more.	☑ Black or African American
Are you of Hispanic or Latino origin or descent?	☑ No
What is the highest grade or level of school that you have completed?	☑ High school graduate or GED
What is your employment status?	☑ Retired
Please tell us about your other employment status	
On average, how many days per week do you engage in moderate to strenuous exercise (like walking fast, running, jogging, dancing, swimming, biking or other activities that cause a light or heavy sweat)?	☑ 0 times per week
On average, how many minutes do you engage in exercise at this level?	
How many pieces of fruit, of any sort, do you eat on a typical day?	☑ 1 piece
How many portions of vegetables, excluding potatoes, do you eat on a typical day?	☑ 2 portions
How often do you feel that you lack companionship?	☑ Hardly ever
How often do you feel left out?	☑ Hardly ever
How often do you feel isolated from others?	☑ Hardly ever
Do you ever have problems making ends meet at the end of the month?	☑ Yes
How hard is it for you to pay for the very basics like food, housing, medical care, and heating?	☑ Somewhat hard
What is your housing situation today?	☑ I have housing
Think about the place you live. Do you have problems with any of the following (check all that apply)	☑ No problems
Which of the following describes the amount of food your household has to eat?	☑ Enough to eat
Within the past 12 months we worried that our food would run out before we got money to buy more. Is this statement often, sometimes or never true for your household?	☑ Never true

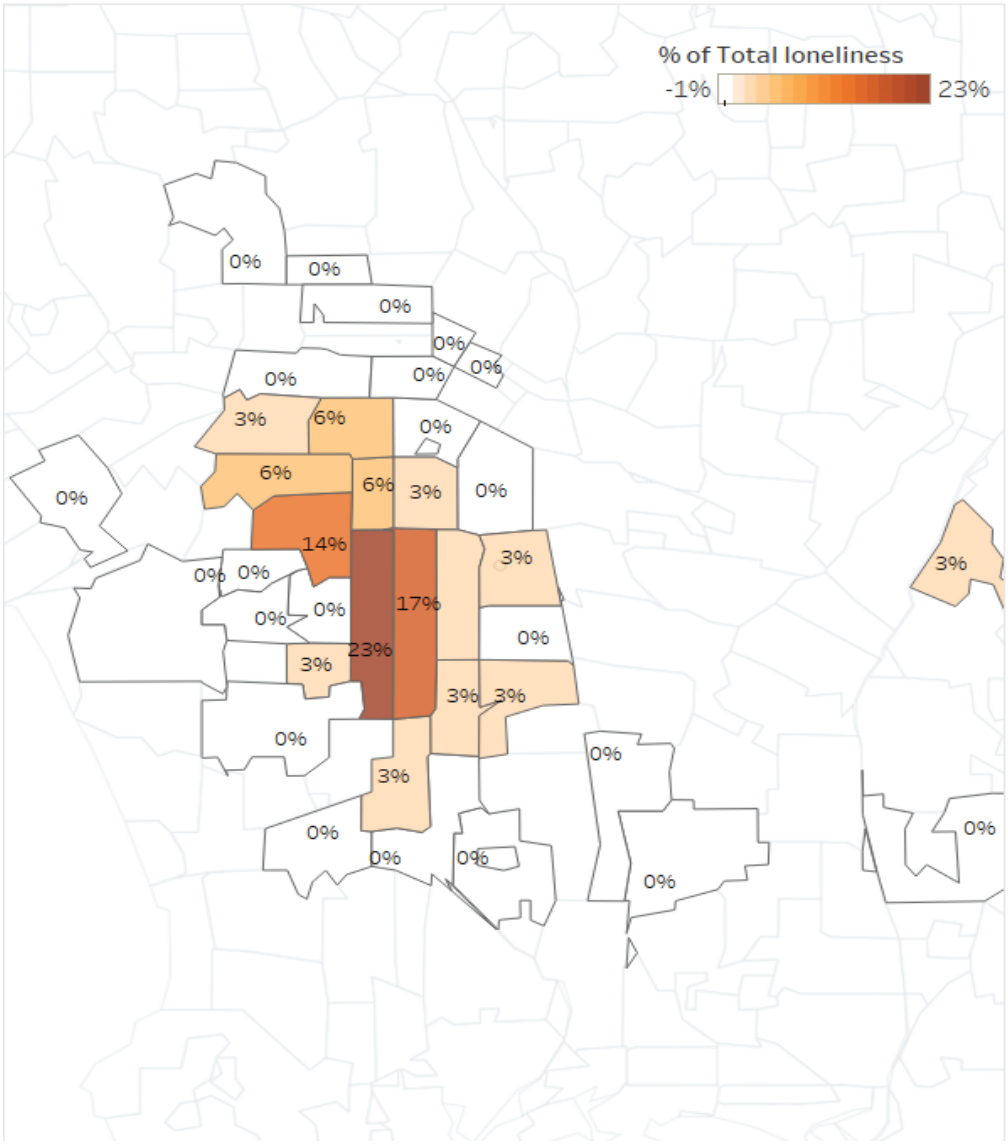


Auto-Connect to Social Services



Hot spotting SDOH data

- Patients came from 47 zip codes
- To inform service planning and outreach activities
- Also possibly to help with risk-stratification



Percent of total respondent that reported 6 or higher on the Loneliness score

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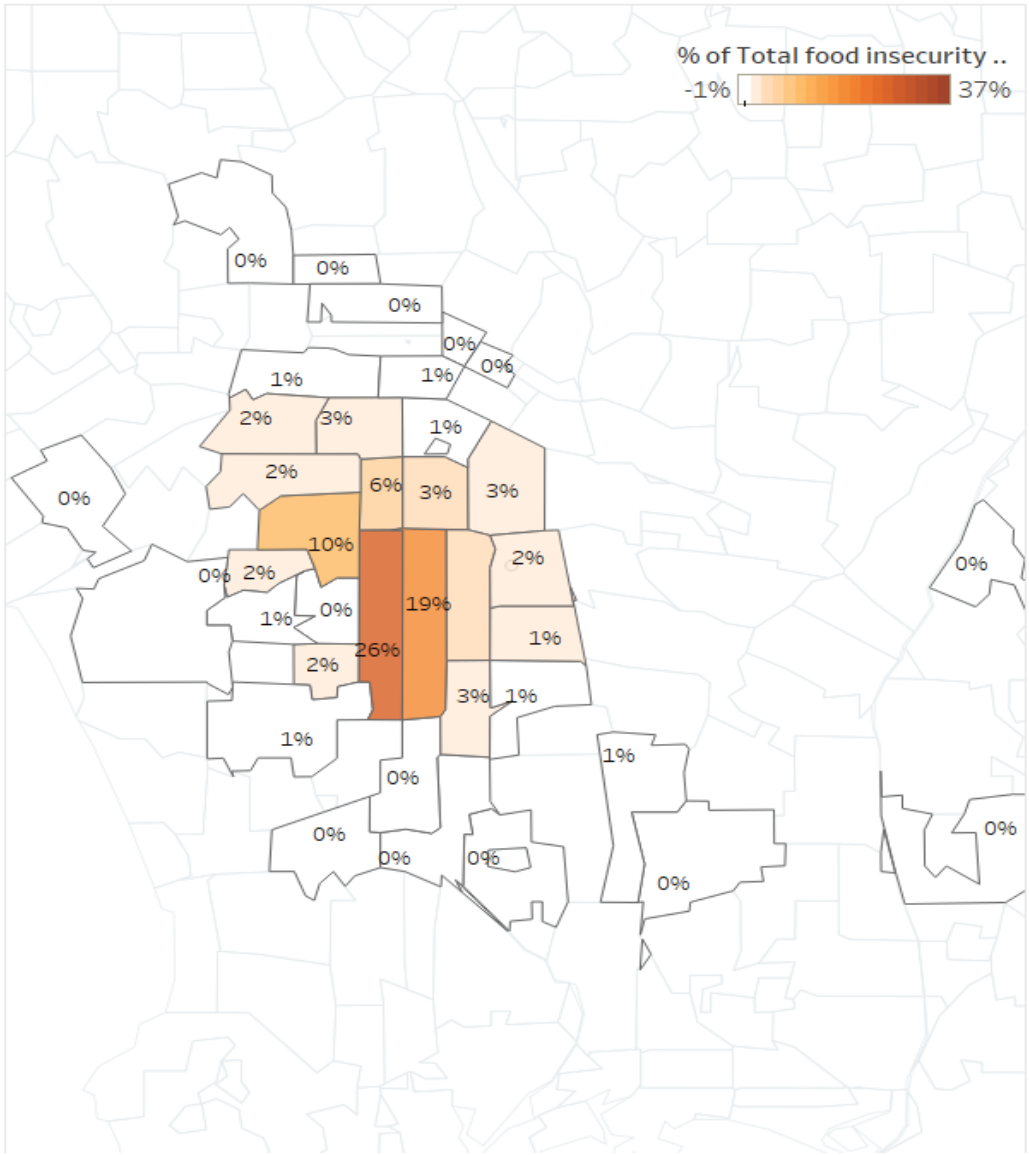

Percent of total respondent who worried about food insecurity

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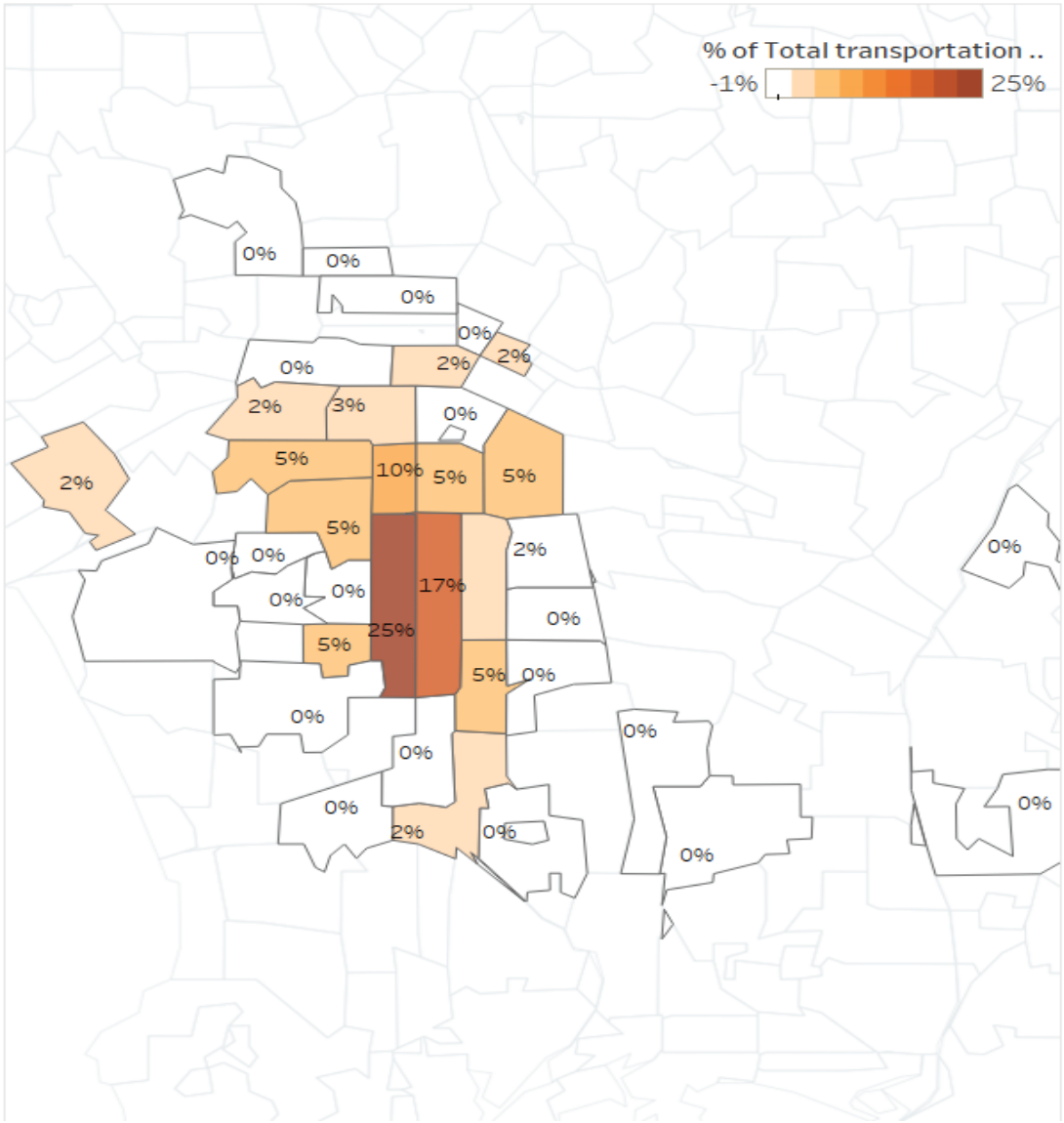

Percent of total respondent with medical transportation barriers

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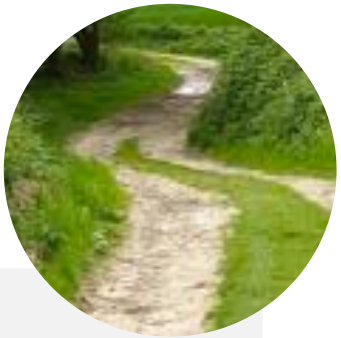
Next steps



1

EXPAND automated connections to services

(*HEUDIA* – also developed w/ a PBRN)

2

Incorporate use of SDOH in care

- *Training/capacity building resources:*
  - *Health Begins*
  - *Health Leads*

3

Engage health plan care managers at Time of Care to address SDOH

4

OFFER “TELE-DETERMINANT” VISITS