Leveraging Social Determinants of Health Screening to Improve Health Disparities in Primary Care Settings

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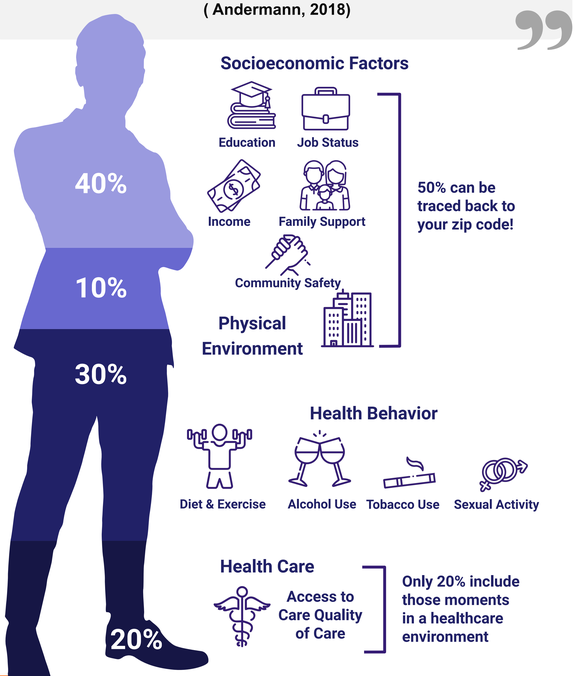
1 Background

(SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (WHO, 2017).

- SDOH data-driven insights are the key to bridging inequity in access to healthcare across our communities and establishing coordinated interventions outside of clinical care to deliver the right care, to the right patient, in the right context, at the right time.
- If the patient's SDOH factors are recognized by the primary care provider, and used to help inform their care, the patient is more likely to adhere to their health treatment plan. Social determinants of health are among the most influential factors that influence health outcomes.

Did you know...that 80% of what makes up someone's health is determined by what happens outside of the hospital and health clinic? Of the 80%, the largest segment is made up of the "Social Determinants of Health" or "Socioeconomic Factors"

(Andermann, 2018)



2 Purpose/Research Question

The purpose of this Quality Improvement (QI) Project was to identify social needs among patients who attended a semi-rural specialty primary care clinic using the PRAPARE SDOH screening questionnaire and implement a referral process to make appropriate referrals using a resource database.

3 Method

Setting:

- Semi rural specialty primary care clinic in Southern Maryland; data collection X 14 weeks

Sample:

- A random sample of 100 patients was approached to fill the PRAPARE screening tool.

Intervention:

- DNP student and clinic staff administered SDOH screening tool.
- Adapted PRAPARE Screening tool (NACHC, 2019) was integrated into the daily schedule with other intake forms

Population:

- Mixed population: Medicaid, Medicare, Private pay for service (>18 years of age); and self referral

Procedures:

- The PRAPARE Screening tool was administered by clinic staff before patient saw the provider
- Flyers about SDOH resources were given after screening to increase awareness of available resources to patients

Implementation Plan/Instruments

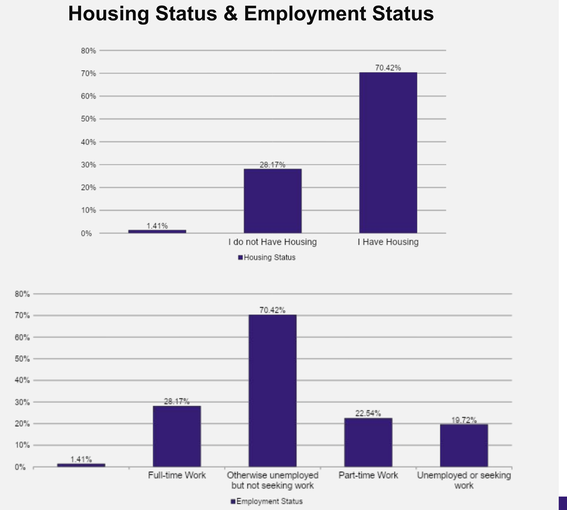
- The PRAPARE standardized SDOH screening tool was used to screen patients of SDOH while seeking care at the clinic.

Data Analysis

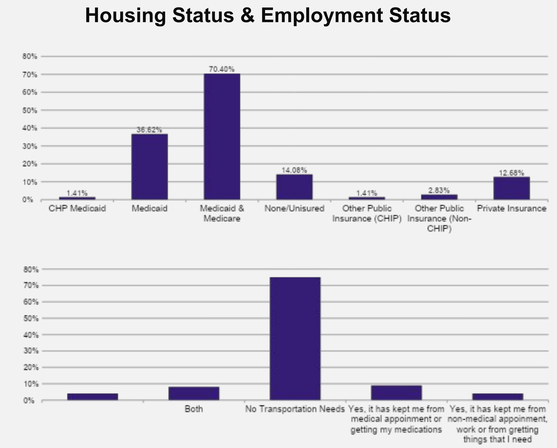
- The PRAPARE screening tool responses were entered into Excel spreadsheets at which time the data was double checked for accuracy, and missing data identified and managed.
- Data was analyzed using mathematical, statistical, or computational algorithms

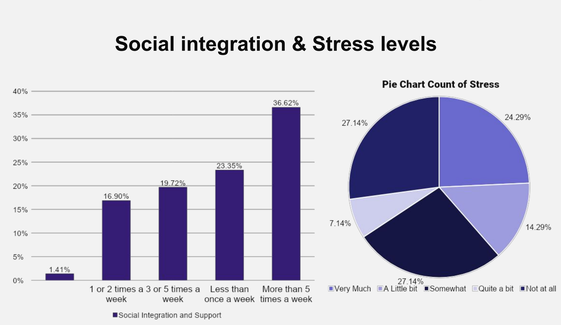
PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

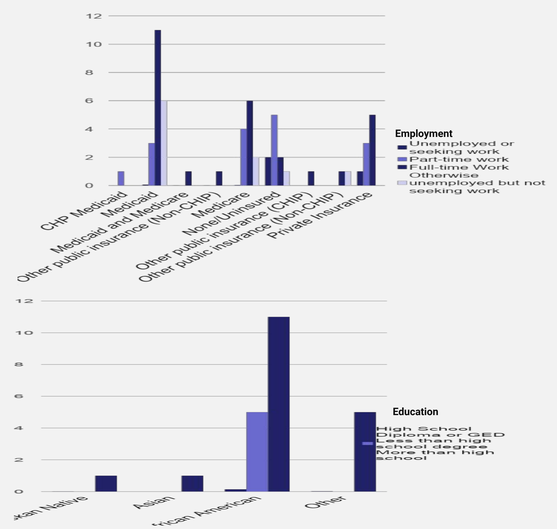
4 Results



4 Results







4 Results

- Among the total number of 71 valid respondents, the Whites (43%) are higher than most of other categories followed closely by Black or African American (42%)
- Among 71 patient respondents, more than 77% of patients were comfortable speaking English whereas 22% of patients preferred other languages than English.

5 Conclusio

- Social determinants have a major impact on health outcomes-especially for the most vulnerable populations. SDOH such as a patient's education, income level, stress and environment must be considered when providing treatment and care.
- 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.

Limitations:

- Self-reported data and the use of a convenience sample recruited from a single clinic in a small urban area. A reginal or nationally representative sample would be helpful in future studies.

Implications:

- Every patient, practice, and community is different. There is
- not a one-size-fits-all approach to addressing social needs.
- Through routine screening for social determinants of health, precision medicine will develop treatment plans that consider not only a person's genetic make-up, but also their social environment.

Next Steps:

- Recommendation to measure long term goals and impacts of SDOH on health outcomes on specific chronic illness such as diabetes , CKD, HTN.
- It will be necessary to conduct further studies to examine the impact of administering questionnaires on the clinic workflow and integration into the electronic health record.
- Explore the possibility of disseminating these findings to other primary care clinics and underserved communities to further narrow the gap on health disparities and increase positive health outcomes

REFERENCES

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