Culver Cares: Primary Care Screening for Social Determinants of Health

The Hoekelman Center

Francis Coyne MD and Andrew Peckham MD

Culver Medical Group

Rob Fortuna MD, Andy Aligne MD MPH

PROJECT SUMMARY:

Our project's aim is to increase the health of the patients we serve by addressing social determinants of health (SDH) systematically. Specifically, our project will implement an evidence-based screening tool (WECARE, Garg et al.) during health maintenance visits with adults and children.

BACKGROUND:

- Social determinants of health are the settings in which people are born, grow older, work, and live in addition to the wider social forces that shape these conditions.
- 91% of MDs reported that screening for SDH is important, but only 11-18% routinely screened. (Garg et al., Clin. Ped., 2009)
- 1/3 of patients with one or more social need received no screening for needs in the prior 12 months. 70% reported a need for at least one referral and 49% had at least one unmet referral (Fleegler et al., Pediatrics, 2007)
- A recent study by Garg et al. demonstrated that using the WE CARE screening and referral system to screen families for SDH at well child checks led to increased enrollment in a community resource (39% vs 29%). (Garg et al., Pediatrics, 2015)

GOALS:

1. Institute a self-reported screening tool for social determinants of health, adapted from the WE CARE study, at Culver Medical Group (CMG) for patients of all ages.
2. Create an easy-to-use system of community-resource referral.
3. Promote health amongst our patients and increase access to known community resources.
4. Incorporate social determinants of health into the daily practice of our residents and to increase resident awareness of their patients' social contexts.

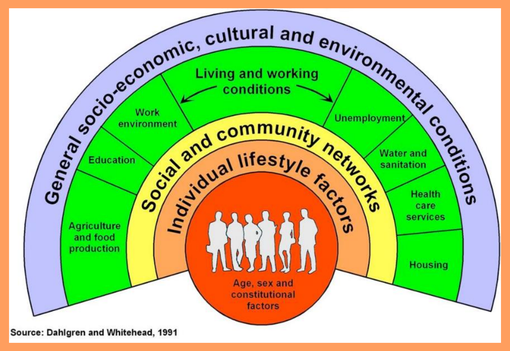
OBJECTIVES:

Primary Measurable Outcome:

- Number of referrals to community resources.

Other Objectives:

- Patient satisfaction with screening.
- Ways to improve our screening process from a patient's perspective.
- Ask "Why do patients not ask for help when they identify a need?" to improve our in-office screening and referral.



METHODS:

Screening tool: Handed out at check in.

- Food insecurity
- Heat/energy insecurity
- Child care
- Unemployment

Referral database: Packets available to providers in each encounter room.

- Sources: 211, CMG social workers.
- Contact each CBO to ensure availability of resources.

Implementation

- 3 month pilot screening of residents' patients March-May 2017.

Patient experience and outcomes

- Phone follow up 1 week (reminder) and 1 month after pilot run.
- Did the patient connect with a community resource?
- Did the patient appreciate our office screening for a need?

RESULTS:

61.4% (81/135) of our patients reported at least one need.

Social determinant	Need present	Asked for help
Food insecurity	24.7% (20/81)	45% (9/20)
Heat insecurity	42% (34/81)	47% (16/34)
Day care	25.9% (21/81)	66.6% (14/21)
Employment	64.1% (52/81)	17.3% (9/52)

61.9% (82/134) gave us permission to call them to follow up on the survey.

24.7% (20/81) of patients were successfully provided referral materials in our office.

RESULTS CONTINUED:

Of those who were referred in our office (n=20), there were five new connections to CBOs (two occurring in one patient):

- Dept of social services
- Utility aid
- Child care
- Food pantry x2

No patients who were mailed a packet connected with a CBO.

Why do patients say no?

Response	% (N=51)
Lacked time	17.65 (N=9)
Embarrassed or ashamed	1.96 (N=1)
Expected problem to resolve soon	35.29 (N=18)
Thought doctor's office could not help	1.96 (N=1)
Did not understand survey	9.80 (N=5)
Other	33.33 (N=17)

How can we improve?

Response	% (N=53)
Asking Directly	15.09 (N=8)
Not having Children in Room	9.43 (N=5)
Providing resources anonymously	1.89 (N=1)
Confidence in resources available	5.66 (N=3)
Understanding what resources are available	20.75 (N=11)
Other	47.17 (N=25)

FUTURE DIRECTIONS:

- Continued screening after pilot with optimized referral process.
- Collaborate with other healthcare providers/offices for a streamlined and centralized screening and referral process.
- Use of iPads for screening with intergration into our electronic health record

Mission Statement: ***"Connecting, advocating, researching, and educating in our communities to do what works for health".***