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**

1. **Patient checks-in at counter**
   - Greeter checks status/shows pt to assessment tablet
   - Greeter enters patient’s MRN & selects language

2. **Patient enters name, answers 20 behavioral & SDOH questions**
   - Patient views SDOH or health ed video
   - Patient requests more information/connection to services

3. **Patient receives information via text/email/print**
   - Data transmitted to EHR/server
   - Viewed by clinician on EHR/tablet/paper
   - Alert to CHW/Health Plan

4. **Patient called back for visit**
   - Use of SDOH information (4 min)
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

<table>
<thead>
<tr>
<th>Category</th>
<th>N=296</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>273</td>
<td>92%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;45</td>
<td>281</td>
<td>95%</td>
</tr>
<tr>
<td>&gt;65</td>
<td>162</td>
<td>55%</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>167</td>
<td>49%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school or less</td>
<td>171</td>
<td>58%</td>
</tr>
</tbody>
</table>
### High Loneliness

\[ n=37 \text{ (13%)} \]

<table>
<thead>
<tr>
<th>How often do you feel isolated from others?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hardly ever</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How often do you feel left out?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hardly ever</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How often do you feel you lack companionship?</th>
</tr>
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<tbody>
<tr>
<td>1. Hardly ever</td>
</tr>
</tbody>
</table>
Work status

- Full time: 9% (N=All), 5% (N=Lonely)
- Part time: 7% (N=All), 8% (N=Lonely)
- Homemaker: 1% (N=All), 3% (N=Lonely)
- Disabled: 49% (N=All), 35% (N=Lonely)
- Retired: 14% (N=All), 35% (N=Lonely)
- School: 1% (N=All), 0% (N=Lonely)
- Unemployed: 8% (N=All), 19% (N=Lonely)
- Not answer: 1% (N=All), 0% (N=Lonely)
- Other: 2% (N=All), 3% (N=Lonely)

Legend: N=All, N=Lonely
Housing & Financial Stress

- **No housing, or losing housing**: 15% (N=All), 32% (N=Lonely)
- **Environmental issues (rats, mold)**: 18% (N=All), 27% (N=Lonely)
- **Yes, hard to make ends meet**: 38% (N=All), 57% (N=Lonely)
Transportation

Transportation Issues

- Yes, problem for medical: 23% for N=All, 35% for N=Lonely
- Yes, problem for other: 5% for N=All, 16% for N=Lonely

N=All  N=Lonely
Food Insecurity

- Not enough to eat: 20%
- Worried food give out: 46%
- Food didn't last: 41%
- Not eat whole day in past 12 months: 30%
- Not eat whole day in past 4 weeks: 16%

N=All  N=Lonely
Safety & Well-being

- Concerns about safety: 30%
- Physically hurt: 14%
- Threatened: 11%
- Physically hit: 4%
- Stress: 70%
- Down: 57%
- Hopeless: 65%

N=All  N=Lonely
Advanced Social Determinants

<table>
<thead>
<tr>
<th>Question</th>
<th>Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your race?</td>
<td>Black or African American</td>
</tr>
<tr>
<td>Are you of Hispanic or Latinx origin or descent?</td>
<td>No</td>
</tr>
<tr>
<td>What is the highest grade of school that you have completed?</td>
<td>High school graduate or GED</td>
</tr>
<tr>
<td>What is your employment status?</td>
<td>Retired</td>
</tr>
</tbody>
</table>

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 time?

- 1 place

- 2 portions

- 3 portions

- 4 portions

- 5 or more portions

How often do you feel that you lack companionship?

- Hardly ever

- Sometimes

- Often

How often do you feel isolated from others?

- Hardly ever

- Sometimes

- Often

Do you ever have problems making ends meet at the end of the month?

- Yes

- No

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

- Somewhat hard

- Very hard

- Extremely hard

What is your housing situation today?

- I have a home

- I don’t have a home

Think about the place you live. Do you have problems with any of the following (check all that apply)?

- No problems

- Sometimes

- Hardly ever

- Often

- Very often

Which of the following describes the amount of food your household has to eat?

- Enough to eat

- Sometimes not enough

- Often too little

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

- Sometimes

- Often true

You indicated you have had some concerns about access to healthy food and / or feeling lonely. Would you be interested in learning about some great local resources to maybe help you?

- Yes

- No

Would you like PatientToc to send this information to you by text or email?

- Text message

- Email
Auto-Connect to Social Services

SDOH referral (Loneliness & Food Insecurity Only) N=297

- Offered auto-referral: 46% (n=136)
- Accepted auto-referral: 42% (n=57)
- Requested text: 86% (n=49)
- Requested email: 16% (n=9)
- Provided cell: 78% (n=44)
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
Percent of total respondent who worried about food insecurity
Percent of total respondent with medical transportation barriers
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