Screening for Social Health Needs: A Quality Improvement Project at ECU Family Medicine

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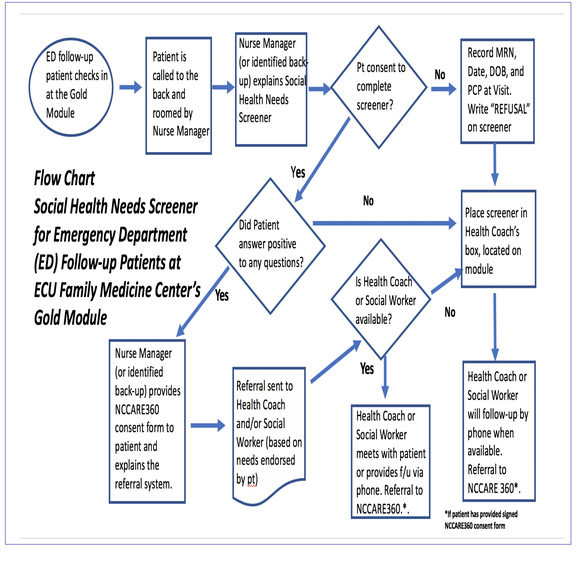
BACKGROUND

Despite evidence demonstrating the strong relationship between social determinants and health outcomes, the most effective approach to screening for social health needs in the clinical setting remains unclear. Studies have demonstrated a significant number of unmet social health needs among patients who frequently utilize the emergency department (ED). One study found that up to 25% of ED visits by homeless individuals could have been prevented if food or shelter was available by other means. NCCARE360 is the proposed state-wide solution to narrowing this care gap and is designed to coordinate care by addressing various patient needs, including housing, food assistance, personal safety, and other social determinants of health. NCCARE360 is intended to be implemented in every NC county by the end of 2020.

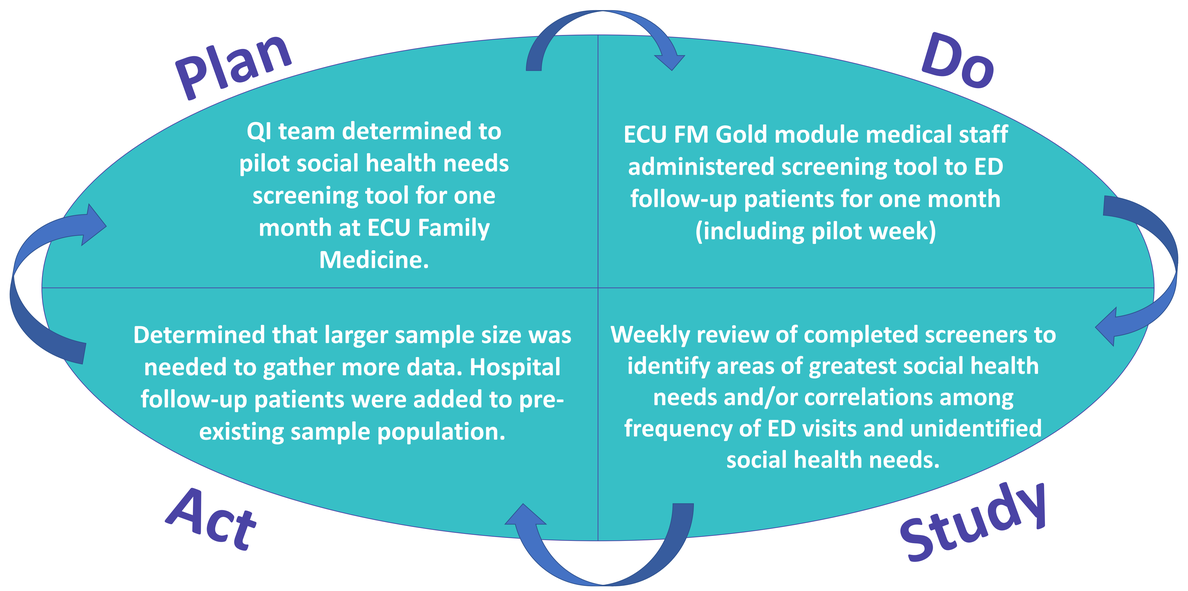
PROJECT AIM

Identify the unmet social health needs of ED and hospital follow-up patients at ECU Family Medicine Center, utilizing a standardized, self-administered social health needs screener in order to increase the number of referrals and rendered patient services through NCCARE360 by May 2020.

PROJECT DESIGN/STRATEGY



CHANGES MADE (PDSA CYCLES)

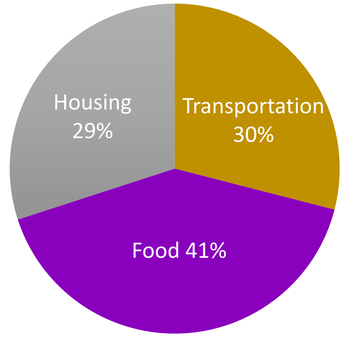


RESULTS/OUTCOMES

Weekly Tracking

Week	Dates	Total Screens	Negative	Positive	No-Shows	Missed
Pilot	11/4 – 11/8	8	5	3	3	0
Week 1	11/11 – 11/15	4	2	2	2	0
Week 2	11/18 – 11/22	1	0	1	0	1
Week 3	11/25 – 11/29	0	0	0	1	0
Week 4	12/2 – 12/6	3	2	0	0	0
Week 5	12/9 – 12/13	2	2	0	0	2
Week 6	12/16 – 12/20	0	0	0	2	5
Week 7	12/23 – 12/27	0	0	0	0	3
Week 8	12/30 – 1/3	0	0	0	0	5
Week 9	1/6 – 1/10	2	1	1	N/A	N/A
Total		**19**	**12**	**7**	**8**	**16**

Indicated Need(s), By Type



- During the pilot period of the screening system, the clinic saw **eight** ED follow-up patients, with **three** identifying at least one social need.
- Proceeding the pilot period, an additional **eleven** patients were identified, with **four** identifying at least one social need.
- Of the **seven** patients who identified as having a social need, **41%** identified a food insecurity, **30%** identified difficulty with transportation, and **29%** identified difficulty with housing.
- Unfortunately, **sixteen** patients were missed; solutions will be identified to reduce rate of missed patients.

LESSONS LEARNED

- Utilizing a standardized screening tool to identify social health needs increases awareness of non-medical drivers of health that could be complicating chronic health conditions and/or treatment compliance
- Implementing standardized screening increases the number of referrals placed to community partners through NCCARE360 and narrows the pre-existing gap between health and community systems of care
- This standardized screening system is feasible, effective, and has increased the quality of person-centered wraparound care at ECU Family Medicine Center's Gold Module

NEXT STEPS

- Encourage increased community agency utilization of NCCARE360 system by all medical providers and staff on the Gold Module
- Help educate community partners on how to utilize and respond to the referrals made through the NCCARE360 system
- Expand screening population to patients with 2 or more ED visits within the last 12 months
- Provide a framework for other primary care clinics who currently lack a standardized screening and referral system for patients with unmet social health needs.

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