NAPCRG 52nd Annual Meeting — Abstracts of Completed Research 2024.

Submission Id: 6542

Title

Risks and Needs: Lessons Learned from Assessing Patients' Willingness to Receive Help for Social Risks in Primary Care

Priority 1 (Research Category)

Social determinants and vulnerable populations

Presenters

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Abstract

Context: In May 2023, Mayo Clinic implemented a revised screening tool to assess social determinants of health (SDOH) for its patients. Objective: To assess the impact of a question on need for assistance with social risk factors identified through routine screening. Study Design and Analysis: Descriptive analysis of secondary data. Setting or Dataset: Secondary data on social needs screening and referral generated through Epic. Population Studied: 13 urban and rural primary care practices located across Mayo Clinic sites in Minnesota, Wisconsin, and Florida. Intervention/Instrument: The intervention includes a short survey to determine patients' needs with respect to transportation, food insecurity, financial difficulty related to utility payments, and housing. The final question asked patients, who have at least one risk factor, if they would like assistance with their need(s). Outcome Measures: social risk factors, whether patients wanted assistance with their risk factors, and measures related to connection to community resources. Results: Between May 2023 and December 2023, 821 patients seen across Mayo Clinic sites in Minnesota, Wisconsin, and Florida representing 13 urban and rural primary care departments reported that they had at least one of the four risks on the screening tool; however, of those, more than half of patients declined assistance (56%, n=486). Of those patients with at least one need who also requested assistance (44%, n=375), 247 episodes were closed/completed, 68 are at various points in the referral process, and 60 have been identified with at least one risk factor and are being contacted by staff for referral consent . Conclusions: Findings from the implementation period indicate that additional work is required to optimize workflows to ensure that no patients are overlooked and to validate that they have received support from the community resource to which they are referred. For example, even though patients are asked when and how they (portal, text, phone call) want to be contacted for follow-up, it is often difficult, time consuming and sometimes not possible to connect with patients about assistance. As a next step, we will seek to understand the barriers to

connecting patients with resources, including those who are found to have a positive screen but who decline assistance.