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Screening and Referring Patients for Food and Housing Insecurity:

Findings from a Survey of Michigan Physicians

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Background

- Patients' social needs, such as food and housing insecurity, have negative consequences for their health and can be a barrier to treatment.
- An important strategy for improving patients' health outcomes and reducing health disparities is addressing patients' social needs.
- There has been a push to equip and encourage health care professionals, including physicians, to identify patients' social needs and connect them to needed social services.
- A key component of MDHHS's strategy to achieve health equity is to build the capacity and infrastructure for health care and social care organizations to communicate and collaborate to address patients' social needs.

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Purpose

1. Are Michigan physicians screening their patients for food and housing insecurity?

2. Do Michigan physicians know where to refer patients for food and housing insecurity?

3. What can be done to increase Michigan physicians' ability to identify patients' food and housing needs and connect patients to resources?

About the data

In April and May of 2021, CHRT surveyed 2,188 Michigan physicians

- Physicians were identified through the Licensing and Regulatory Affairs (LARA) dataset of licensed physicians in Michigan
- 8% response rate

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Physicians were asked…

Below is a list of non-medical issues that some patients experience.

Please indicate if *you or any other staff in your practice* routinely screen your patients for any of these issues.

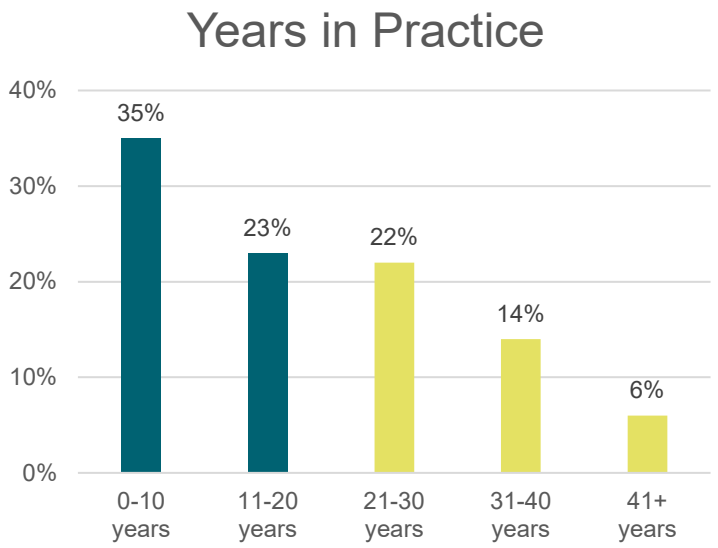
Please indicate if *you or a member of your care team* know where you would refer your patients to get assistance in addressing those needs.

- Lack of access to adequate food and nutrition
- Inadequate or unsafe housing and homelessness
- Lack of transportation
- Unemployment / Underemployment
- Lack of health literacy
- Social isolation / loneliness
- Domestic or relationship violence
- Concerns about being able to afford the treatment you prescribe
- Traumatic life experiences

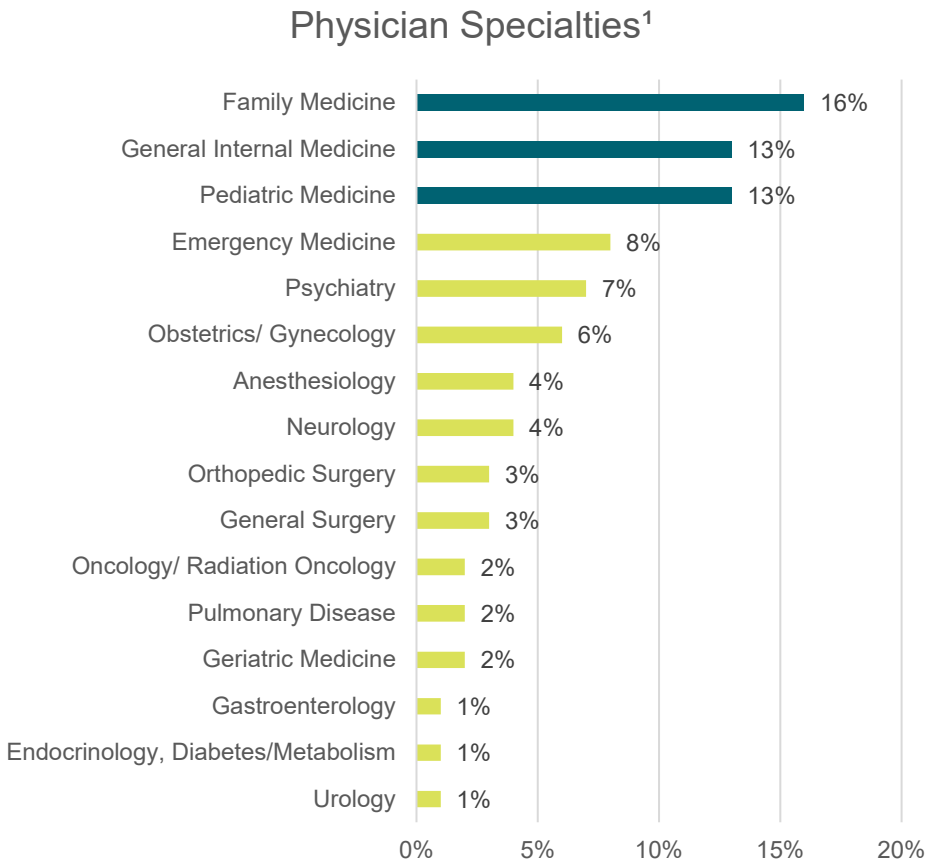
What tools or resources would help you in collecting or sharing this kind of information to better meet your patients' needs?

Physician Characteristics

The 3 most commonly reported specialties include family medicine, general internal medicine, and pediatric medicine.



58% of the respondents had been practicing for 20 or fewer years.

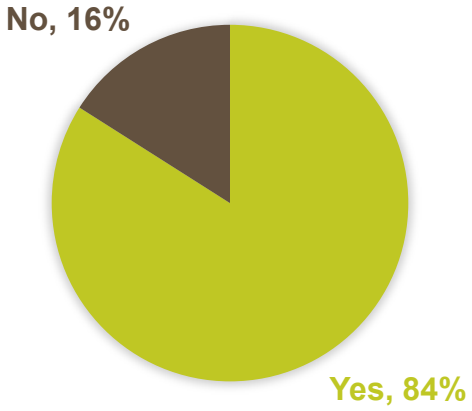


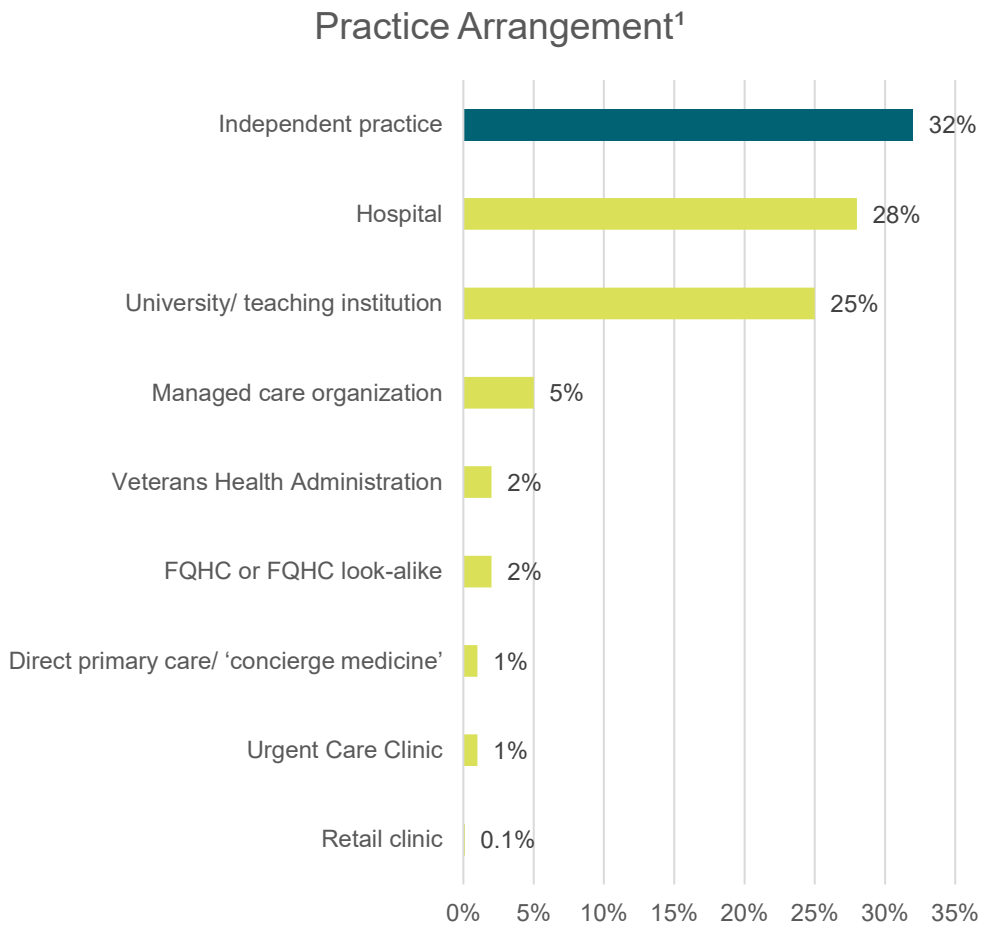
¹Physicians could select more than one specialty, so these categories are not mutually exclusive.

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Physician Characteristics

84% of the respondents reported being part of a Physician Organization (PO) or Physician Hospital Organization (PHO)





About a third of the respondents were in an independent practice.

[1]Physicians could select more than one type of practice arrangement, so these categories are not mutually exclusive.

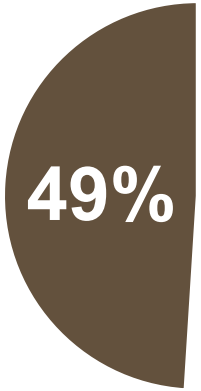
Are physicians and their care teams routinely screening patients for food and housing insecurity?

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Are physicians and their care teams routinely screening patients for food and housing insecurity?



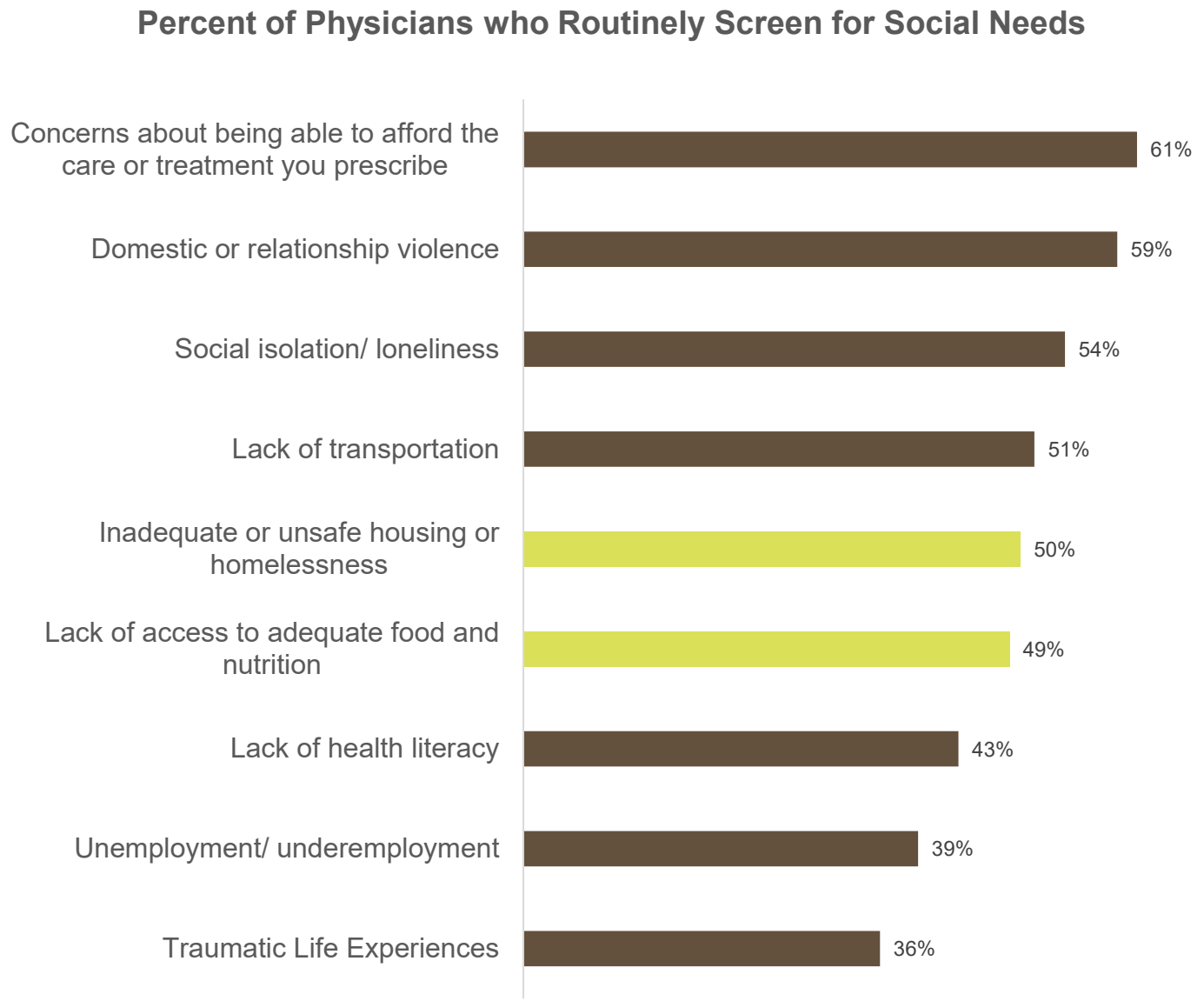
routinely screen for inadequate or unsafe housing or homelessness



routinely screen for lack of access to adequate food or nutrition

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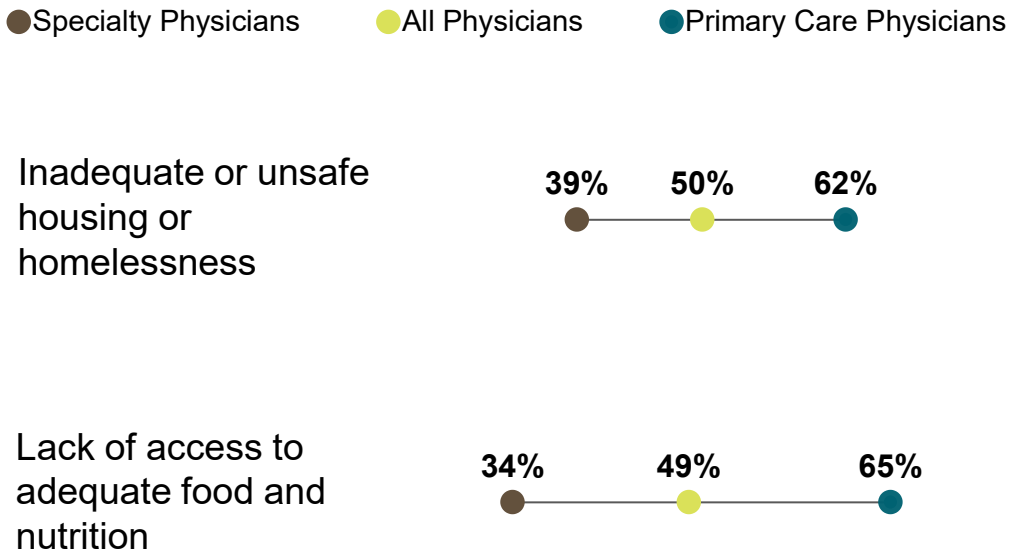
How does that compare to other social needs?



Which physicians are screening for food and housing insecurity?

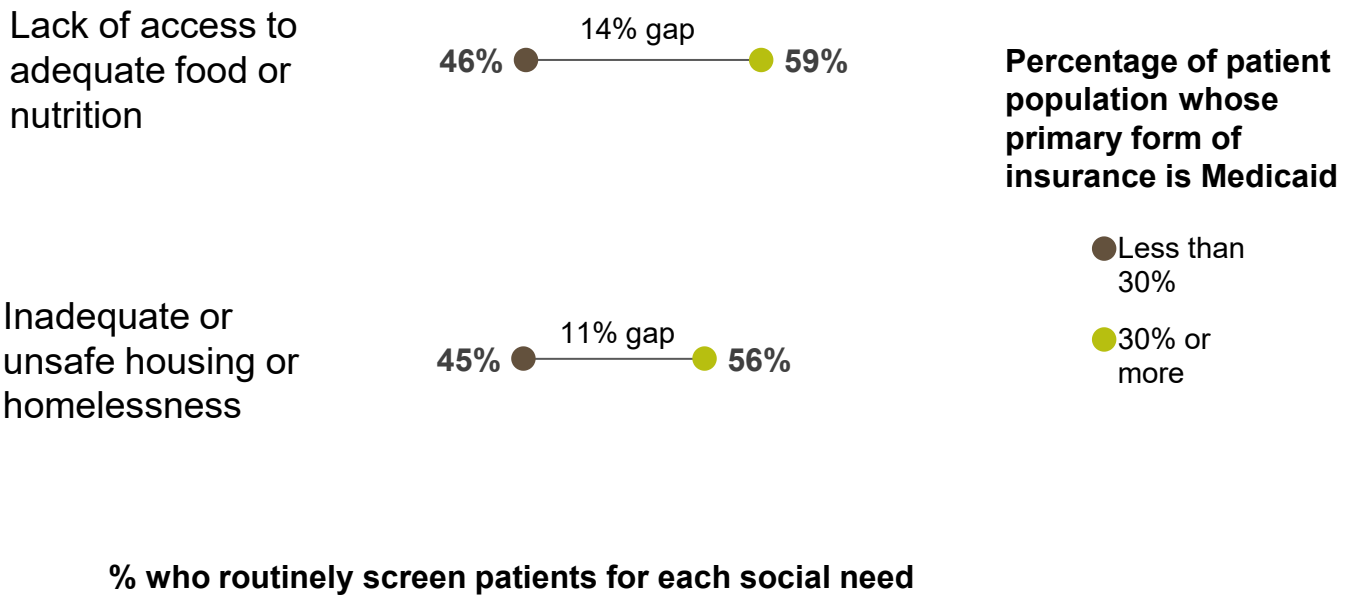
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Primary care physicians are more likely to screen for food and housing insecurity



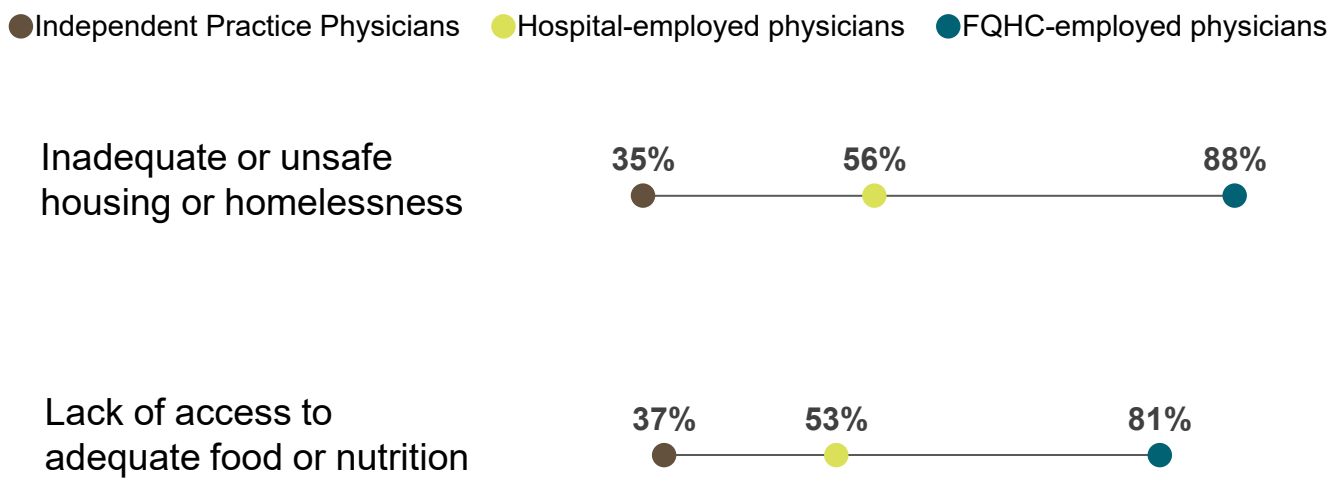
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Physicians who serve a larger share of Medicaid patients are more likely to screen for food and housing insecurity.



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FQHC-employed physicians are more likely to screen for food and housing insecurity

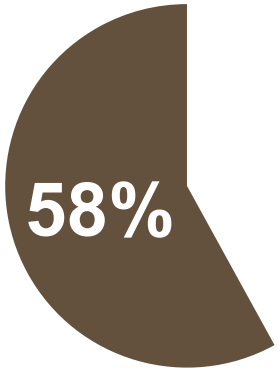


% who routinely screen patients for each social determinant of health need

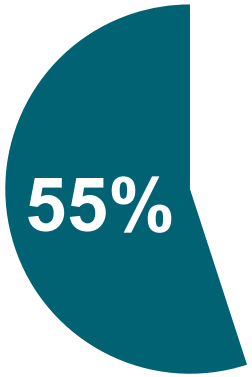
Do physicians and their care teams know where to refer patients for food and housing insecurity?

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Do physicians and their care teams know where to refer patients for food and housing insecurity?



know where to refer for lack of access to adequate food or nutrition

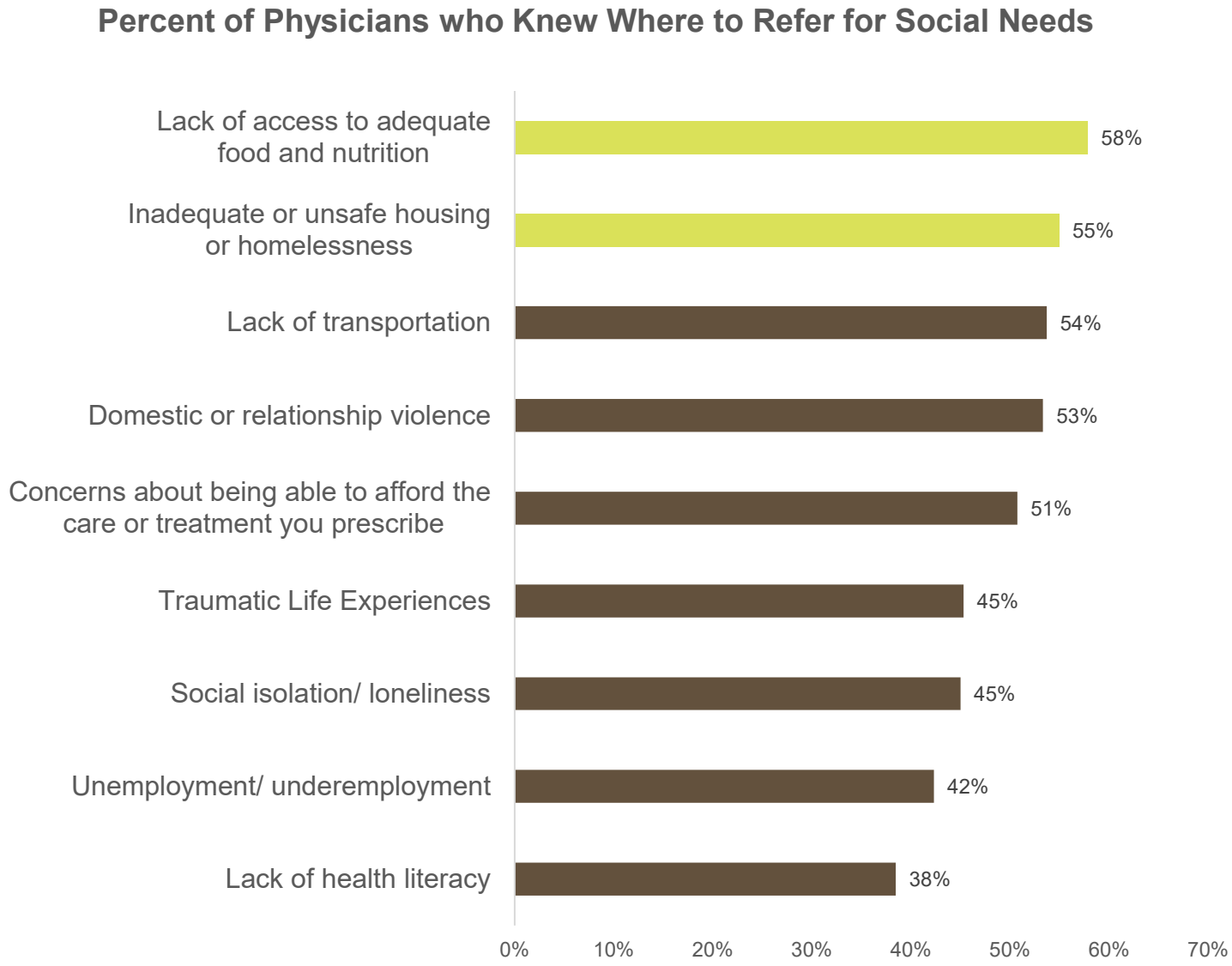


know where to refer for inadequate or unsafe housing or homelessness

*No significant differences in referral knowledge between primary care and specialty physicians, by practice arrangement, nor by share of Medicaid patients.

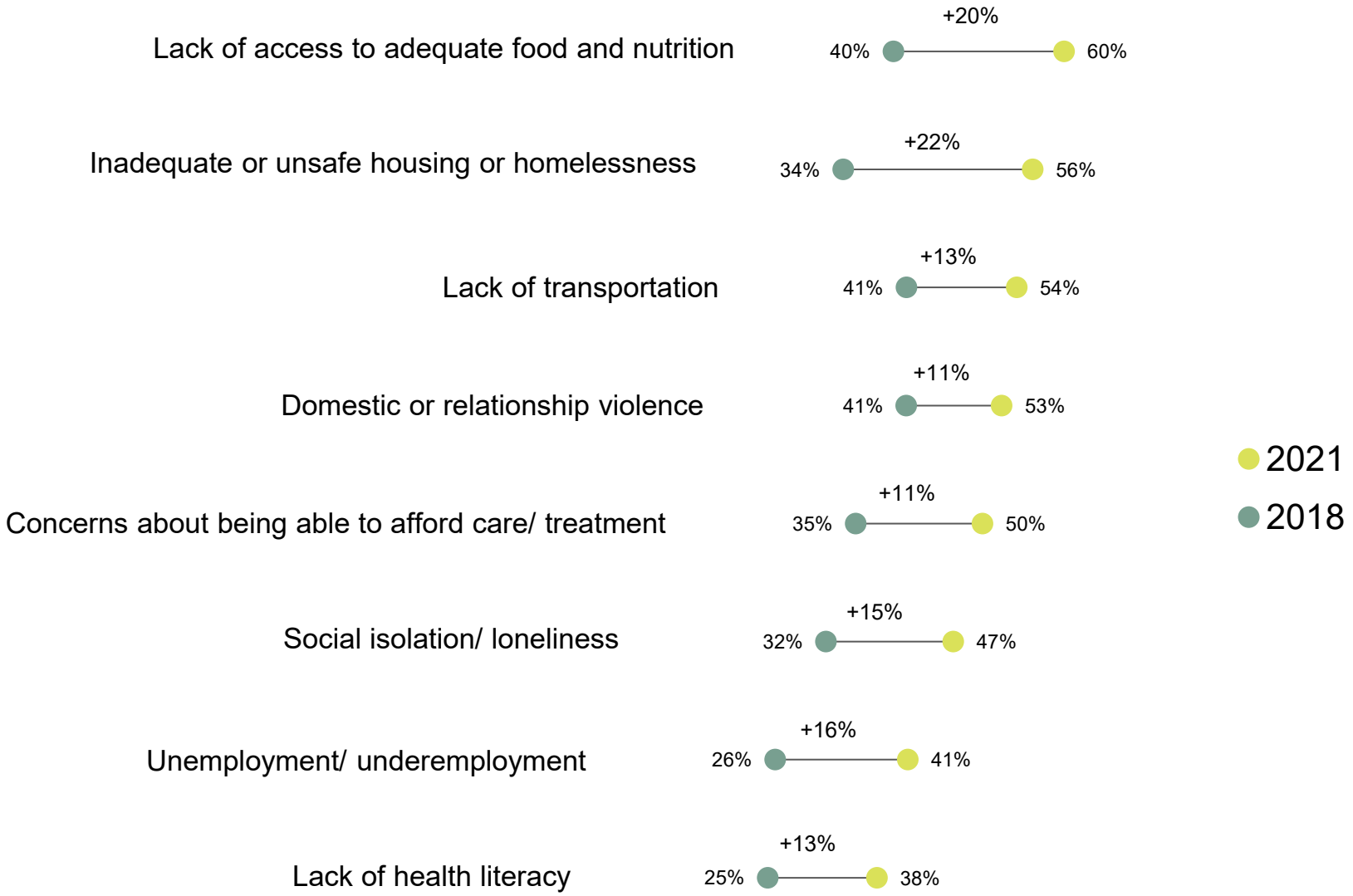
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How does that compare to other social needs?



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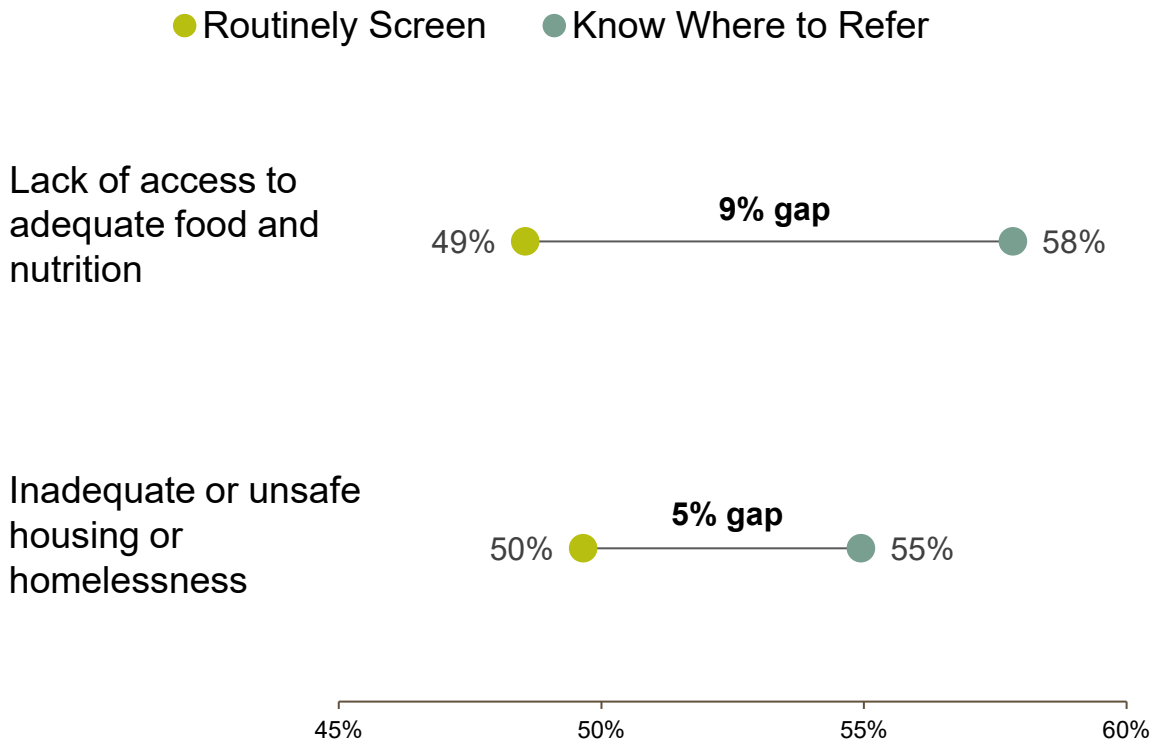
Primary care physicians' knowledge of where to refer patients for food and housing insecurity increased from 2018 to 2021.



% of primary care physicians who know where to refer patients for social determinant of health needs

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Physicians were more likely to know where to refer than to routinely screen for food and housing insecurity



Overall, what is this data telling us?

- A notable share of physicians report that they and/or their care team screen and know where to refer patients for food and housing insecurity
- We've seen promising growth in referral knowledge over time
- Important gaps remain

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What do physicians think would improve screening and referrals for food and housing insecurity?

Top 5 recommendations:

1. Support from care team / adequate staffing
2. Referral resources / resource lists
3. Screening tools
4. Support and expand community-based organizations, services, and resources
5. Technology to facilitate collection and sharing of SDOH data

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Support from care team / adequate staffing

Other staff are more equipped to address social needs given training and familiarity with community resources

- “Having a social worker (or trained MA) gather this information to present to me would be helpful, as they could make the proper assessment and have access to the resources to provide patients and families.”

To relieve time pressures for physicians

- “Time is a major factor in screening and screening well for these conditions. The ability to have social work embedded would help greatly.”

Easy to access / embedded in the organization / on-site

- “Easier Social worker access. We are not primary care so this is not on site in our clinic.”
- “Social work in the office is desperately needed.”

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Support from care team / adequate staffing - Barriers

Staffing shortages

- “We do have case managers who are actively reaching out to patients and their families, linking with community resources. Unfortunately, Covid has impacted our staffing and we have been understaffed in all areas from reception staff to providers, putting incredible stress on the available staff.”

Sufficient funding / reimbursement for support staff

- “Had a case manager to address these but her funding dried up.”
- “We need social workers with reimbursed services in 100% of clinics”

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Centralized resource guide

- “Centralized online location for resources covering multiple categories, searchable by zip code.”

Materials to share with patients with information about local resources

Routinely updated resource lists

- “Access to an up-to-date data base of organizations addressing these issues would help - more than googling for the local information since the internet has lots of outdated information.”
- “The facilities present prior to COVID are no longer available. A list of local resources for the various issues above would be excellent tool.”

What information would be helpful to include in the resource lists?

- Description of resource
- Requirements/ criteria for receiving services
  - “A compilation of resources for our county and the requirements to receive them. I don’t have time to research during a visit.”

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Screening tools

"Standardized" screening tool

"Quick," "easy," "simple," "concise" screening tools

- "Quick, easy screening tools that I and my staff can use to assess."
- "Easier screeners that don't delay the visit."

"Validated" screening tools

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Support and expand community-based organizations, services, and resources

Expand capacity of community organizations / services to help patients

- “More social supports in general, the sad thing is that while I know where to refer people, I also know that those resources are limited and often do not provide what families need.”
- “More local resources!!”

Geographic gaps

- “I have no idea where to refer people who have inadequate shelter or transportation. We live in a rural area with few resources for this.”

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Technology to facilitate collection and sharing of SDOH data

SDOH screening tool integrated, or better integrated into EHR

- “Consistent integration of validated screening tools within the EMR.”
- “The electronic medical records are not very adaptable to the specific questions within our communities and in our specialty.”

SDOH data stored in EHR in easily accessible location to facilitate access to and sharing of data

- “Info placed in EMR for quick easy access.”
- “A common medical record communicating with all the stakeholders of health care.”

SDOH screening integrated into patient portal

- “Digital videos and questionnaires that can be push through the patient portal to the patient for viewing and filling out forms.”

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What is the value of collecting this information?

How is the data being used?

- “We neither are given the time nor the resources to help patients with these conditions. We are strapped for time and almost "avoid" screening for these conditions and if we stumble on these issues, we do not have the resources or the information to address these issues.”
- “It would be useful if we reviewed the data we collect.”
- “I think we collect the information. The trick is what to do with it.”
- “Majority of screening is performed either by patient registration or nursing. Providers are generally unaware of the results.”
- “A minimum feedback and/or update…about patients that I transfer to them. It is the NORM rather than exception to NOT receive any feedback or follow up on the patients we transfer.”

What can be done to increase physicians' ability to identify patients' food and housing needs and connect them resources?

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Recommendations

Staff care teams so that they are equipped to screen and refer patients for food and housing needs

- Invest in workforce development, including the training of Community Health Workers

Increase physician awareness of existing referral resources

- Ex. Michigan 211

Increase awareness of existing, validated screening tools for food and housing needs

- Ex. Accountable Health Communities; AAFP Social Needs Screening Tool; PRAPARE; Safe Environment for Every Kid (SEEK)

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Recommendations

Create incentives for care teams to collect and act on social needs information

- Ex. New HEDIS measure on Social Need Screening and Intervention (SNS)

Improve mechanisms for sharing social needs data between primary physicians, specialty care physicians, and community-based organizations

- Health Information Exchanges (HIEs) and Community Information Exchanges (CIEs)

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Recommendations

Adequately support and compensate Community-Based Organizations (CBOs) so that they have the capacity to…

- address the needs of referred patients
- participate in Community Information Exchanges

Independent practice physicians may require additional support to implement routine screenings.

- Ex. technological support, legal, and staff support

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Discussion Questions

- How should we staff care teams so that they are equipped to screen and refer patients for food and housing needs, particularly in light of workforce shortages?
- What can health plans do to encourage physicians and their care teams to screen for food and housing insecurity?
- What is needed to support the capacity of Community-Based Organizations to respond to referrals?
- What is needed to support the capacity of independent practice physicians to implement social needs screenings?

Physicians screen patients for social needs: what happens next? Survey, analysis, and policy recommendations



June 30, 2022

Check out the full brief at:

https://chrt.org/publication/physicians-social-needs-referrals/

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