

Screening for Social Determinants of Health in a Pediatric Primary Care Clinic

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Oregon Health & Science University School of Nursing

Submitted to: Sharon Norman - Chair

This paper is submitted in partial fulfillment of the requirements for
the Doctor of Nursing Practice degree.

Abstract

Social determinants of health (SDOH) have far-reaching impacts on health, well-being, quality of life, and are the root cause of child health inequity in the United States. The American Academy of Pediatrics recommends standardized screening to assess for social determinants of health at all patient encounters. The aim of this quality improvement (QI) project is to both increase the number of children being screened for SDOH and improve adherence to screening. This QI project took place in a non-profit pediatric primary care clinic that provides care for children two- weeks to 18 years of age. The Institute for Healthcare Improvement's Plan, Do, Study, Act (PDSA) tool was used to accelerate change in small scale cycles. Screening for SDOH was performed at the 2-week well check using a tool that consisted of seven questions, to address SDOH domains. This QI project utilized this screening tool and expanded the age group for each subsequent PDSA cycle screening. Each PDSA cycle observed adherence to screening with the addition of each new age group. There was a median screening rate of 66% with a mean of 63%, and the population being screened broadened to include five additional age groups. The screening identified 617 positive domains, of which 48% indicated difficulty paying for necessities, 22% identified food insecurity, 19% trouble paying for housing, 7% lack of transportation, and 4% identified a time without shelter. For each positive domain a corresponding resource was provide and a social work consultation was offered.

Introduction

Problem Description

Social determinants of health (SDOH) are environmental conditions under which people are born, live, work, and interact, that directly affect their health and quality of life (Office of

Disease and Prevention and Health Promotion [ODPHP], 2020). SDOH can have detrimental effects on a child and increases their risk for worse health outcomes including negative physical health, impaired socioemotional development and decrease in educational achievement (Council on Community Pediatrics [CCP], 2016). These social and environmental conditions that impact health help to explain why some Americans are healthier than others. The Office of Disease Prevention and Health Promotion sets a 10-year plan for addressing the nation's most critical public health priorities called the Healthy People initiative. The Healthy People 2020 initiative specifically focused attention on SDOH with a goal of creating social and physical environments that promote good health for all. Healthy People 2020 organized the SDOH into five widely recognized categories: 1. Economic stability, 2. Education, 3. Social and Community Context, 4. Health and Healthcare, and 5. Neighborhood and Built Environment (ODPHP, 2020). Similarly, at a local level, the Oregon Health Authority (OHA) provides a health report on the State of Oregon every five years. The latest report produced in 2018, focuses on SDOH and the impact on the health and wellness of Oregonians. The report breaks down major SDOH categories that parallel the Healthy People 2020 initiative including poverty, food insecurity, and affordable housing.

Poverty is a major predictor of poor health, with those below the federal poverty line experiencing higher rates of chronic disease and early death (Berman et al., 2018). Nationally, 43% of children under 18 live in low-income households. This crisis is evident at our state level, where 17% of Oregon children live at or below the federal poverty level (Berman et al., 2018; Oregon Health Authority [OHA], 2018). It is important to recognize that poverty and food insecurity exist in tandem with one another. One in five impoverished Oregon children are also food insecure with little to no access to food that is vital to their growth and development (OHA,

2018). Compared with children who are food secure, those who struggle with food insecurity have an increased risk of chronic health diseases and rates of hospitalization (Markowitz et al., 2022).

Food insecurity and poverty are exacerbated by lack of affordable housing. The most recent Oregon health report from 2018 revealed one in three Oregon households pay more than half of their income towards rent, leaving them vulnerable to unmet needs. With such a tremendous portion of income going towards housing, other necessities such as food, healthcare, and transportation are sacrificed (OHA, 2018). Neighborhoods that are affordable only compound food insecurity where low-income neighborhoods have 30% less supermarkets than high income neighborhoods and are felt to be less safe for walking, making it more difficult to access food (Walker et al., 2010).

The demographic where this QI project was conducted serves as a safety net clinic. Safety net clinics are sites that provide health care opportunities for those who would otherwise have barriers to accessing quality health services, including lack of coverage, geographic isolation, language, mental illness and homelessness (Oregon Health Authority, 2023). This clinic serves an average of 4,000 children annually, with 80% either insured by Medicaid or uninsured. Resources are frequently given out and these include shelf stable food bags for children experiencing food insecurity, and vital necessities for safety like car seats, cribs, and gun lock boxes. Prior to this QI project, the clinic was screening for SDOH but exclusively at 2-week well child visits. The clinic did not have a formal data collection process to capture the volume of patients who screened positively and required resources at those visits.

Available Knowledge

The American Academy of Pediatrics (AAP) recommends standardized screening tools be implemented to assess for SDOH among children to help recognize and address associated risks (Sokol et al., 2019). Screening for SDOH can help to identify children in need of preventative health services, learning opportunities, and socioemotional support earlier than if screening was not performed. More importantly, screening for SDOH helps to improve the clinical care decisions made by providers based on the needs of the child identified through screening (CCP, 2016; LaForge et al., 2018). Based on this knowledge, many pediatric primary care offices have started screening for SDOH but unfortunately, many barriers remain that make screening less effective. In a 2019 systematic review, Sokol et al., (2019) reviewed 17 different SDOH screening tools implemented in pediatric primary care. From their review, they found language and reading level to be a major obstacle to the accuracy and reliability of screening. They further explained that to understand the screening questions the screening tool needs to: 1. Be in the patient's native language and 2. Have an appropriate literacy level for comprehension. In their review, Sokol et al., (2019) found only three of the seven SDOH screening tools were required to be supplied at an appropriate reading level for low-literacy populations, but many were at least offered in additional languages other than English.

In a similar case study, researchers analyzed six institutions that implemented SDOH screening and found systematic barriers that impede positively identifying children who need resources. LaForge et al., (2018) found that workflow associated with adding SDOH screening to their practice was a common difficulty across all six institutions. While various methods (electronic health record [EHR] or paper) were used across the institutions to conduct the screening, consuming staff time and minimizing burden was a concern throughout. Collecting

data on paper and transferring it to the EHR takes time, as does developing and maintaining EHR tools. Additionally, every positive screen requires intervention and each of the six institutions were concerned about their ability to address these positive screens due to lack of staff and local resources. An accurate list of available resources in the community will require standardized practices for obtaining community information and staff time to gather and maintain the information (LaForge et al., 2018).

In both studies, Sokol et al., (2019) and LaForge et al., (2018) found that more research is needed to determine the best way to integrate SDOH screening into pediatric primary care and to understand the efficacy of referrals and interventions that are provided based on positive screens. There is lack of available knowledge on the impact of screening for SDOH in pediatrics and how screening may contribute to positive health outcomes.

Rationale

This QI project was conducted with guidance from the Institute for Healthcare Improvement (IHI) and utilized the Model for Improvement (MFI). The MFI is a tool used by organizations to accelerate change in small scale cycles. These cycles include four fundamental categories: Plan, Do, Study, Act (PDSA) (Institute for Healthcare Improvement [IHI], 2020). The primary care clinic where this QI project was conducted started the process of change by introducing screening for SDOH at two-week well child check appointments. By implementing the SDOH screening at two-week appointments, the clinic completed the first PDSA cycle. After creating a cause-and-effect diagram it was identified that this clinic did not have a standard process to review and analyze the changes they implemented. Using the MFI, the first PDSA cycle was studied, and a second cycle was initiated based on those results. This helped to achieve our aim by creating a standardized process for studying changes and better understanding if those

changes helped to progress toward our goal to both broaden and increase SDOH screening in the clinic.

Specific Aims

This QI project aimed to increase the number of children being screened for SDOH and improve adherence to screening in a non-profit primary care clinic in Portland, Oregon. This was done by expanding the clinic's previous SDOH screening, which occurred only at 2-week well child visits, to all annual visits for all ages and reviewing screening adherence rates with each PDSA cycle. The goal was to achieve a screening adherence rate of 98% and broaden screening to all annual visits in the clinic by December of 2022.

Methods

Context

The primary care clinic utilized for this QI project is in the inner city of Portland, Oregon. The clinic cares for children aged two weeks to 18 years and provides 4,000 visits annually, both well child exams and sick visits. Their patient population is approximately 72% Medicaid, 9% uninsured, and the remainder with private insurance. The clinic is equipped with a 24-hour nurse advice line with triage nursing available in the clinic 5 days a week. Staff in this clinic includes: eight providers, 17 registered nurses, three medical assistants, three social workers, and one behavioral health clinician.

This clinic started screening for SDOH in March of 2022, limiting the screening to only 2-week well child appointments. Resources in the form of informational sheets for each of the screening topics were created to provide for any positive screen. The resource sheets required families to reach out and follow-up independently to obtain the resources provided. Social work

was consulted for any family who screened positively in three or more of the SDOH domains, and on an as needed basis for any family who requested to meet with them. The clinic is supported by a larger foundation who donates food bags for patients and their families who screen positively for food insecurity. There are 10 shelf stable food bags provided each month for distribution, in addition to fresh food bags given out once a month on a first come, first served basis.

Intervention

The first PDSA cycle was completed by the primary care clinic prior to the start of this QI project, with screening for SDOH exclusively at 2-week well child visits. The workflow created by the clinic included the nurse or medical assistant assigned to the patient providing the SDOH screening, as shown in Appendix E, for parent completion. Once completed, the staff member entered the result into the EHR. For the patients who screened positively in three or more SDOH domains (Food, Housing, Finances, or Transportation), social work was automatically notified to meet with the family and provide resources with face-to-face counseling. For positive screens in less than three domains, the staff member assigned to that patient provided appropriate resource handouts and social work reached out via telephone at a later date for follow-up. In addition to these interventions, shelf stable food bags donated to the clinic were provided when a child screened positively for food insecurity.

The second PDSA cycle was the start of this QI project. Using the same screening tool and process created by the clinic, cycle 2 reviewed the previous adherence rate to screening from the onset of cycle 1 in March 2022 to June 2022 when cycle 2 began. Cycle 2 was also the first

expansion of the population being screened with the addition of screening at 4- year well child exams in addition to the pre-established screening at 2-week exams. The clinic staff asked for 3 months dedicated to screening with this additional age group before launching cycle 3.

Subsequent cycles continued to mirror PDSA cycle 2 by reviewing adherence and adding additional age groups when the clinic felt prepared for the change. This QI project produced 3 PDSA cycles, for a total of 4 cycles including the initial PDSA cycle independently conducted by the clinic. Throughout the course of the PDSA cycles, staff were reminded at daily huddles on the screening process and which ages were being screened, and data was presented at monthly staff meetings to encourage staff and stress the importance of identifying SDOH.

Study of Interventions

The study of these interventions included the utilization of the EHR to review screening adherence. Screening adherence was calculated using the EHR to identify the number of children eligible for screening and how many of those same children did not receive screening. Adherence rates were calculated monthly, the data was divided by age group and reviewed prior to each new PDSA cycle. An initial goal of 98% adherence rate was initially set at the start of the project. The EHR was also used to identify the number of positive screens and the percentage of positive screens in each SDOH domain. Additionally, this project aimed to broaden screening, this was tracked by observing how many age groups were added to the screening process over the course of data collection.

Measures

The primary outcome measure for this project was the adherence to screening during data collection from March 2022 to December 2022. Secondary outcome measures are the number of age groups screened, number of positive screens, and percentage of each positive SDOH domain.

There were numerous balancing measures with the implementation of this project. These included increased staff burden on medical assistants and nurses who provided and documented the screening, decreased patient satisfaction related to the sensitivity of the screening questions, and potential burnout for social workers who meet with families who screen positively or request further assistance. These balancing measures were not formally assessed as they were outside the scope of this QI project.

Data Analysis

This improvement project was implemented over six months between June 2022 and December 2022. The collected data included retrospective information from March 2022-June 2022 from PDSA cycle 1 that was implemented prior to this QI project. This data was collected by the author with support from clinic staff. Data was documented monthly in an Excel spreadsheet and displayed in both a run chart and pie chart. Screening adherence rates, age groups being screened, and the number of positive domains identified with screening were tracked.

Ethical Considerations

Ethical considerations for this QI project included maintaining anonymity of data collected from patients and staff. The SDOH screening questions required patients to divulge sensitive information and it was imperative that this be de-identified to maintain their privacy. The author of this QI project reports no conflict of interest and both institutions invested in this

project deemed this project as not research (Institution 1 Study #FWA00001280; Institution 2 Study# 00024791). The participating clinical sites gave consent to the project by signing a letter of support. All staff at the clinic were informed of the project during staff meetings and by email.

Results

PDSA cycle 1 included retrospective clinic data collected from March 2022- June 2022 when screening was completed by the clinic only at 2-week well child exams. This data showed screening adherence started at 22% in March 2022, then prior to the initiation of cycle 2 in June 2022, had increased to 66%. Cycle 2 was the initiation of the QI project and increased the population being screened to include 4-year well exams, per the clinic's request this cycle was maintained for three months before the next cycle was started. Cycle 2 had the highest screening adherence throughout the entirety of the QI project with 83.5% of eligible children being screened in July. This spike in screening adherence was likely due to the lower volumes of children in the summer months and the additional staff meeting reminder that was given in June at the beginning of cycle 2. Cycle 3 was initiated in September of 2022 with the addition of screening at 5-year exams. At this point in the project, the population given the opportunity to screen were children at their 2-week, 4-year, and 5-year well child exams. In September 2022, adherence was 69%, an overall improvement from 66% at the start of cycle 2. Following the 5-year age addition, in October 2022 the clinic was given a grant for a community health worker (CHW) whose primary job was to manage the positive SDOH screens. The addition of this CHW allowed the clinic an essential resource to help social work manage the workload associated with positive SDOH screens. With the CHW resource, the clinic felt ready to add more age groups to the SDOH screening. October 2022 was the final PDSA cycle in this QI project and included the simultaneous addition of the CHW and addition of children at 1-3 year well visits to be screened.

Over the course of data collection there was a median screening of 66% with a mean of 57%, and the population being screened broadened to include 5 additional age groups. Throughout the entirety of the QI project there were a total of 905 opportunities to screen for SDOH and 454 of those children received screening, an average of 50%.

A total of 617 responses were obtained from the SDOH screening tools, many families identifying difficulty in more than one of the SDOH domains. Of the 617 responses, 48% indicated difficulty paying for necessities, 22% identified food insecurity, 19% trouble paying for housing, 7% lack of transportation, and 4% identified a time without shelter.

Discussion

Summary

This DNP project sought to expand the number of children being screened for SDOH, increase adherence to screening and identify resources needed in an outpatient safety net primary care clinic, between June 2022 and December 2022. It aimed to achieve the AAP recommendation for the implementation of standardized screening tools to assess for SDOH among children to help recognize and address associated risks (Sokol et al., 2019). The desired outcome of this intervention was to increase the detection rate of children in need of resources and identify children in need of preventative health services, learning opportunities, and socioemotional support earlier than if screening was not performed (CCP, 2016). Using the Model for Improvement, we were able to plan PDSA cycles that allowed for continuous modification and adaptation of the screening process (IHI, 2020). Screening adherence, extension of the population being screened, and number of positive SDOH screens all increased

significantly over the course of this project, resulting in improved identification of children at risk for complications associated with SDOH and providing them with resources.

Limitations

There were many contributing factors throughout this QI project that created limitations. The clinic where this project took place had an incredibly high staff turnover rate from June-December 2022 when this project was being conducted. The clinic further suffered many leadership changes during this time, creating a disruption in the clinic's flow and knowledge on ongoing projects. The high turnover rate made it difficult to keep the continuity of the SDOH screening process and allowed for gaps in the screening process to occur. Additionally, there was a "triple-demic" of influenza, COVID, and Respiratory Syncytial Virus that affected the entire country starting in October of 2022 and lasting through December 2022. At this time, the clinic was inundated with sick visits and cancelled 75% of well visits to function as an urgent care and keep children out of the over-run hospitals. With the cancellation of well child visits, SDOH screening was not being done and the few children who were eligible missed the screening likely due to clinic constraints during this stressful time.

The generalizability of this project may be limited as it was tailored to a specific clinic, however, the interventions described could potentially be utilized with variations and different workflows that could make it feasible in other primary care clinics.

Conclusion

SDOH can have detrimental effects on a child and increases their risk for worse health outcomes including negative physical health, impaired socioemotional development and decrease in educational achievement (CCP, 2016). In this quality improvement project, a screening tool

for SDOH captured a high incidence of positive screens, identifying children in need of resources. These results support the need for primary care clinics to develop standardized screening to document and mitigate this public health problem.

With this clinic only screening age 2-week through 5 years, the project should be continued with additional PDSA cycles until all age groups up to 18 years are being screened annually at their well child exams. The clinic should continue to monitor the screening adherence rate and remind staff of the process and the impact that screening makes. Additionally, an evaluation of barriers, both individual and systemic, should be considered with strategies to address those barriers.

References

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Appendix A

Project Timeline

SDOH Screening Project Timeline

Jordyn Rao

OHSU School of Nursing

703 A/B

	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Finalize project design and approach (703A)	X										
Complete IRB determination or approval (703A)		X									
PDSA Cycle 1 (703B)			X								
PDSA Cycle 2 (703B)						X					
PDSA Cycle 3 (703B)								X			
Final data analysis (703B)										X	
Write sections 13-17 of final paper (703B)										X	
Prepare for project dissemination (703B)											X

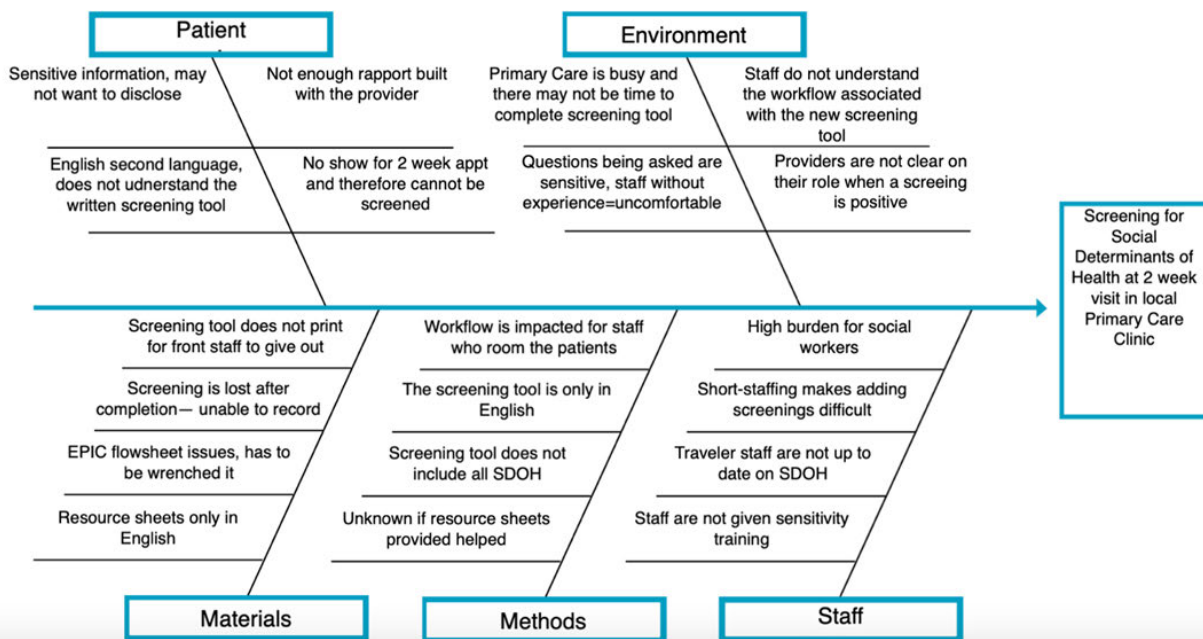
Appendix B

Cause and Effect Diagram

Template: Cause and Effect Diagram

Team: Local Primary Care Clinic Project: Identifying Social Determinants of Health

- 1) Input the effect you'd like to influence.
- 2) Input categories of causes for the effect (or keep the classic five).
- 3) Input causes within each category.



Appendix C

Letter of Support from Site

Dear Jordyn Rao,

This letter confirms that I, Christian Huber allow Jordyn Rao (OHSU Doctor of Nursing Practice Student) access to complete his/her DNP Final Project at our clinical site. The project will take place from approximately 5/18/2022 to 5/18/2023.

This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor and clinical liaison (if applicable):

- **Project Site(s):**
Randall Children's Clinic
2800 N Vancouver Ave. Suite 165
Portland, OR 97227
- **Project Plan: Use the following guidance to describe your project in a brief paragraph.**
 - **Identified Clinical Problem:** Annual Social Determinants of Health (SDOH) screening at well child visit is not optimized at Randall Children's Clinic.
 - **Rationale:** Working to increase the number of families being screened annually will ensure families who screen positive are being provided the resources they need. Missed SDOH screenings leave high risk families who would otherwise screen positively without these vital resources.
 - **Specific Aims:** 98% of SDOH screenings will be completed at Randall Children's Clinic, with resources provided to those who screen positively.
 - **Methods/Interventions/Measures:** Utilizing the electronic health record, all well-child checks requiring SDOH screening will be reviewed and data on the percentage of parents who were not screened will be collected. Missed screenings will be reviewed and interviews with clinic staff will be conducted to understand why the screening was missed. Global trends that cause missed screenings will be evaluated to understand what intervention is needed. Once the most beneficial intervention is identified, it will be implanted in the clinic to improve the percentage of screenings. 1 month following the implementation, data will be collected to observe if the intervention influenced the number of SDOH screenings. Screening for SDOH will begin with 2-week well child visits and progress as the clinic feels ready.
 - **Data Management:** Data will be collected using EPIC, which is password protected. Collected data will be de-identified so all patient information is protected.
 - **Site(s) Support:** Randall Children's Clinic supports the project in the following ways: provide the clinic in its entirety to collect information, authorizes all site employees who are agreeable to participate, provide all information via EPIC for data collection, identify all patients who may be included (all 2-week well child visits to start and all additional well child visits as the project expands).

During the project implementation and evaluation, Jordyn Rao will provide regular updates and communicate any necessary changes to the DNP Project Preceptor.

Our organization looks forward to working with this student to complete their DNP project. If we have any concerns related to this project, we will contact Jordyn Rao and Sharon Norman (student's DNP Project Chairperson).

Regards,

Christian Huber RN, BSN, MBA
Manager | Randall Children's Pediatric Services | Randall Children's Hospital
2801 N. Gantenbein | Portland, OR 97227 | work 503-413-3286, cell 503-830-9968 | Chhuber@lils.org

Appendix D

IRB Application/Determination

Determination of Research or QI/EBP

Instructions: Answer YES or NO to each of the following statements:

	YES	NO
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	X	
The specific aim is to improve performance on a specific service or program and is a part of usual care . ALL participants will receive standard of care.	X	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does NOT develop paradigms or uses untested methods or new untested standards.	X	
The project does NOT follow a research design that tests a hypothesis, includes randomization or has comparison or control groups. The project does NOT follow a protocol that overrides clinical decision-making.	X	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does NOT seek to test an intervention that is beyond current science and experience.	X	
This project does NOT depend on the voluntary participation of colleagues, students and/or patients (e.g. the methods of the project do not involve soliciting or recruiting participants).	X	
If there is an intent to publish, or a possibility of publishing your work, you and your supervising faculty are comfortable with the following statement: <i>“This project was undertaken as an evidence-based practice or quality improvement project at X hospital and as such was not formally supervised by the Institutional Review Board.”</i>	X	

If the answer to **ALL** of these items is yes, the project can be considered an evidence-based or quality improvement activity that does NOT meet the definition of research. IRB review may not

be required (final determination is made by IRB in review of the Statement of Mutual Agreement). If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

Statement of Mutual Agreement

Student name:	Jordyn Rao
University:	Oregon Health and Science University
Degree (i.e., MSN, DNP, PhD, etc.)	DNP
University project advisor name and email:	Sharon Norman
Legacy Site where project will occur:	Randall Children's Clinic
Unit/area(s) involved:	Randall Children's Clinic
Legacy preceptor (if applicable):	Brad Olson, MD & Christian Huber
Legacy IRB determination required by University (y/n)?	Y
Title of project:	Increasing Social Determinants of Health Screening and Intervention in the Pediatric Primary Care Clinic
Project description and objectives:	<p>This pediatric primary care clinic is screening for Social Determinants of Health as part of a system-wide population health initiative. The first PDSA cycle involved selecting the screening tool and developing the process for SDOH screening and the resources needed should a family screen positively. During the first PDSA cycle, the clinic chose the smaller sample population of two-week well child checks to trial the SDOH screening process. If a family screens positively at the two-week check, resources for their specific need are provided. If they screen positively in 3 or more of the screening categories, a social worker is consulted to meet with the family.</p> <p>The primary objective of this QI project is to expand the established SDOH screening to all annual visits beyond the 2-week well child visit. The aim of this QI project is to screen at least 98% of the clinic population by December of 2022. This will be done by drilling down the root cause of any missed screenings up to this point by conducting employee interviews, reviewing workflows, and</p>

	identifying any care gaps prior to expanding the screening to further age groups. Electronic health records will be utilized to identify patients who require SDOH screening and analyze the percentage of screenings missed.
List all data to be collected (or attach data collection form):	Data collection form attached
Does this project require staff time or involvement (if yes please explain):	<p>Yes, as part of their standard work.</p> <p>MA's and RN's currently provide families the SDOH screening tool and transcribe the information into the electronic health record. The provider then reviews the information in the electronic health record and the social worker is consulted on an as needed basis, or if a family scores positively in 3 or more categories of the SDOH screening.</p> <p>The MA's and RN's will be involved more intricately in this QI project by helping to identify the root cause for missed screenings and explaining workflows.</p>
Does this project include a potentially sensitive or vulnerable population or topic	Yes, this project involves pediatric patients and sensitive topics such as housing, financial, and food insecurity
Anticipated start date:	06/13/2022
Anticipated end date:	05/01/2023
On-site activities (please list):	<ol style="list-style-type: none"> 1. Data collection from the electronic health record 2. Working with staff for education and alterations in screening process 3. Conduct multiple PDSA cycles to increase number of screenings based on data collected

Terms and Conditions (please initial), I agree to the following:

Any Protected Health Information (PHI) (<https://www.hipaa.com/hipaa-protected-health-information-what-does-phi-include/>) collected as part of the project outlined above will only be viewed and stored on a Legacy-secured computer or network. If PHI is required to be used outside of Legacy, please contact Cindy Bianchini .

No data, except what is listed above, will be collected and shared. If additional data collection is required, please contact Cindy Bianchini .

X Any external publication or presentation of this project (beyond university stated above) will be approved by the hospital CNO

X Following completion of this project, a final report will be send to the unit manager and Cindy Bianchini, including all tools developed and data collected during completion of the project

05/19/2022

Student

E- Signature

Date

Christian Huber RN, BSN, MBA
 Manager | Randall Children's Pediatric Services | Randall Children's Hospital
 2801 N. Gantenbein | Portland, OR 97227 | work 503-413-3286, cell 503-830-9968 | Chhuber@lhs.org

Legacy unit manager/director

Signature

Date

05/19/2022

Please return this completed form to Cindy Bianchini by email (EM 3072).

or directly



IRB MEMO

Research Integrity Office

3181 SW Sam Jackson Park Road - L106RI
Portland, OR 97239-3098
(503)494-7887 irb@ohsu.edu

NOT HUMAN RESEARCH

August 19, 2022

Dear Investigator:

On 8/19/2022, the IRB reviewed the following submission:

Title of Study:	Increasing Social Determinants of Health Screening in Pediatric Primary Care: A Quality Improvement Project
Investigator:	Sharon Norman
IRB ID:	STUDY00024791
Funding:	None

The IRB determined that the proposed activity is not research involving human subjects. IRB review and approval is not required.

Certain changes to the research plan may affect this determination. Contact the IRB Office if your project changes and you have questions regarding the need for IRB oversight.

If this project involves the collection, use, or disclosure of Protected Health Information (PHI), you must comply with all applicable requirements under HIPAA. See the [HIPAA and Research website](#) and the [Information Privacy and Security website](#) for more information.

Sincerely,

The OHSU IRB Office



Legacy Research Institute
1225 N.E. Second Ave.
Portland, OR 97232
503.413.2491 phone
503.413.4942 fax

LEGACY HEALTH INSTITUTIONAL REVIEW BOARD

NOTICE OF IRB ACTION

Protocol: <i>Increasing Social Determinants of Health Screening and Intervention in the Pediatric Primary Care Clinic</i>	
Principal Investigator: Jordyn Rao, RN	Board Action: EXEMPT QI DETERMINATION
SUBMISSION TYPE: QI EXEMPTION Submitted 5-26-22	Date of Board Action: 6-3-22
Sponsor:	Study Risk Level: Minimal Risk/Exempt
Site(s): RCH	Jurisdiction: OCR
IRB Tracking Number: 2033	

SUBMITTED DOCUMENTS REVIEWED

- ✓ Legacy Statement of Mutual Agreement Form 5-25-22
- ✓ Investigator's CV
- ✓ Study Staff Training Information: CITI
- ✓ Other: SDOH Screening Tool, Staff Questionnaire

REVIEW

REVIEW TYPE	IRB ACTION
<ul style="list-style-type: none"> ✓ Initial Review ✓ Exemption Review ✓ QI Review 	<ul style="list-style-type: none"> ✓ Exempt from IRB Review determination

ADDITIONAL FINDINGS AND REQUIREMENTS FOR THIS STUDY

- ✓ Continuing Review Frequency: None
- ✓ The study is minimal risk.
- ✓ Legacy site management must be apprised of the study and the Board's action.

APPROVAL IS GRANTED SUBJECT TO THE FOLLOWING

1. Conduct the research in accordance with the protocol, applicable laws and regulations, Legacy policies, and the principles of research ethics as set forth in the Belmont Report.

2. Unless consent has been waived, conduct the informed consent process without coercion or undue influence, and provide the potential subject sufficient opportunity to consider whether or not to participate.
3. Use only the most current consent form bearing the Legacy Health IRB "APPROVED" stamp.
4. Provide non-English speaking subjects with a certified translation of the approved consent form in the subject's first language. The translation must be approved by Legacy Health IRB.
5. Obtain pre-approval from Legacy IRB for changes in research.
6. Obtain pre-approval from Legacy IRB for planned deviations and changes in research activity.
7. Report all deviations, violations, adverse events in a timely manner and submit corrective actions.
8. Report all unanticipated problems in a timely manner and submit plans to resolve such problems.
9. Provide reports to Legacy IRB concerning the progress of the research, when requested.
10. Ensure that prior to performing study-related duties, each member of the research study team has had training in the protection of human subjects appropriate to the processes required in the approved protocol.
11. Retain all IRB documentation at study site.

IRB ACTION SIGNATURE

BY LEGACY IRB OFFICE – EXEMPT – QI – DATE: 6-3-22

Paul Newton JD CIP – LEGACY IRB ADMINISTRATOR

6-3-22

Paul Newton JD CIP
Legacy IRB Administrator

DATE

IRB CONTACT

If you have questions or concerns or wish to ask the IRB to reconsider its action, please contact **Paul Newton, JD, CIP, Research Regulatory Specialist Sr.** at

If you have questions regarding the administrative procedures for your study, please contact **Valerie Stallings, IRB Administrative Assistant** at

IRB INFORMATION

Shaban Demirel, PhD, VP of Research, Legacy Institutional Official, Legacy Research Institute

Legacy IRB: FWA00001280
 REG: #1 (Good Sam): 00000677
 REG: #2 (Emanuel): 00000678
 LRI IRB (LRI): 00011999

END OF IRB ACTION DOCUMENT

Appendix E

Staff Questionnaire

Social Needs Screening Tool

These questions are about needs that can affect your health. We have resources that may be of help to you. Please answer the following:

FINANCIAL

1. How hard is it to pay for the basic food, housing, medical care and heating?
- Very hard
 - Hard
 - Somewhat hard
 - Not very hard
 - Not hard at all

HOUSING

2. In the past 12 months, was there a time when you were not able to pay the mortgage or rent on time?
- Yes
 - No
3. In the past 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?
- Yes
 - No

TRANSPORTATION

4. In the last year, has lack of transportation kept you from medical appointments or from getting medications?
- Yes
 - No

FOOD

5. Within the past 12 months, were you worried that your family's food (including formula) would run out before you got the money to buy more?
- Never true
 - Sometimes true
 - Often true

ASSISTANCE

6. Please mark if you would like help with any of the following:
- Financial Support
 - Housing
 - Transportation
 - Food
 - Safety
7. Would you like a member of our care team to contact you?
- Yes
 - No
8. Anything else that you would like to share?