MADRAS MEDICAL GROUP

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There is strong evidence that deficits in basic needs such as food security, housing, transportation, and safety from violence have an adverse effect on the health of individuals and populations. There is less evidence that screening for these social determinants of health improves outcomes in places where there are limited or no resources to address the needs when identified. Additionally, the primary care clinic has no resources to address these social needs other than referring patients on to other organizations in the community who can help. For these reasons, it is not appropriate to delegate screening for social determinants of health to the primary care clinic.

Madras Medical Group has been part of a three-year research project through the Oregon Rural Practice Research Network studying the effect on patients and the clinic of screening all Medicaid- and Medicare-eligible patients for social needs using a tablet-based screening program. Patients who screen positive for social needs are given a list of available community resources. Patients with needs in two or more areas and at least one ER visit in the last year are referred to navigation through the 2-1-1 system to connect them with local community resources in a more intentional way. What we have learned from this project is that resources are sorely lacking in our community for social deficits. While we can provide the list of local food banks, only patients eligible for SNAP benefits ever truly address their food insecurity. Unless patients are also mentally ill, there is no available housing assistance in the community. Unless patients are Medicaid eligible, there is no free or low-cost public transportation in Jefferson County, and then only for medical visits. Other than a single women's shelter, there are no significant resources for patients dealing with domestic or other violence. A project that adds five to ten minutes to each office visit and considerable uncompensated staff time seems to make very little positive impact in the lives of our patients. As a result, patients choose not to participate in subsequent screenings.

Social needs must be addressed at the community level, not at the primary care clinic. The CCO measure should include assessment at the community level both for needs and resources. The state and community must then dedicate resources to address these needs in ways that decrease social deficits over time. The primary care clinic has neither the resources to add yet another screening nor the ability to effectively reduce social deficits when identified. OHA, the CCO, or private insurers confirm eligibility every year. Adding a screening for social determinants to this process would add little burden to the CCO or insurer. Patients could be referred directly to community resources. However, any process will only be as effective as the resources available in the community to help individuals address their social deficits when identified.

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