Implementation of SDOH Screening in Patients with Diabetes: Cook Children's Endocrinology Clinic

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BACKGROUND

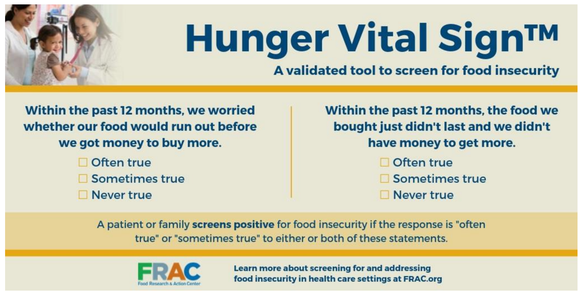
Social determinants of health (SDOH) and conditions in which children are born, grow, and live affect children's health and contribute to health disparities. Studies have shown that inequities in living, working, and environmental conditions have a direct effect on factors related to diabetes control. The Cook Children's Endocrinology clinic did not have a formal process for screening for SDOH in patients with Type 1 diabetes prior to this project.

OBJECTIVE

The objective of this project was to implement SDOH screening, specifically for food insecurity, in the Cook Children's Endocrinology Diabetes program. We aimed to screen 50% of patients over a 6 month period.

METHODS

We created a multidisciplinary team that decided on utilizing the Hunger Vital Sign™ questionnaire. Caregivers of patients arriving for an appointment type "Established Diabetic" with specific pre-selected providers were given a paper questionnaire with the two Hunger Vital Sign™ questions at check-in.



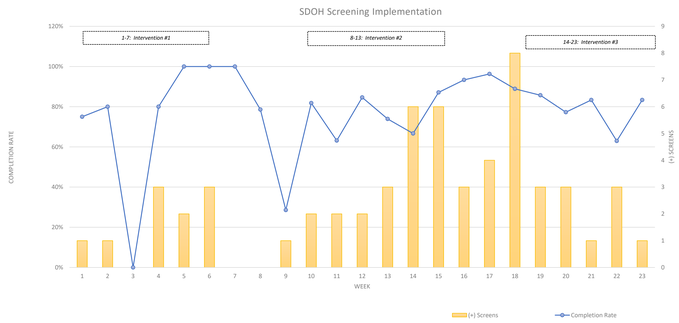
The following interventions were tested in PDSA cycles:

1. Provided survey to selected caregivers
2. Provided survey both in English and Spanish caregiver completed survey in preferred language and asked why caregivers may have chosen not to complete survey.
3. Included a statement to assure the caregiver that responses to the survey would be confidential

We connected all positive screens to available resources.

RESULTS

Before the implementation of the survey, there was no screening data regarding food insecurity. Following interventions, the survey completion rate increased from 0% to 85% over 6 months.



During our initial PDSA cycle, 89% of the 38 eligible caregivers completed the survey. Following this cycle we wanted to know if these results would remain the same if we expanded the survey to more patients and included the questionnaire in Spanish. We also wondered why those who didn't return it chose not to respond.

During PDSA Cycle 2 our sample size increased to 87 caregivers, but only 71% of those returned a completed screening survey. During this cycle we wondered if caregivers were choosing not to complete it due to confidentiality concerns and potential implications of admitting to food insecurity.

In PDSA Cycle 3 we added a statement indicating that responses to the survey would remain confidential. We also increased our eligible patient population to 215 potential caregivers. During this cycle 83% of caregivers returned a completed survey.

Twenty-one percent of returned screenings were positive, and these caregivers were connected to food resources.

CONCLUSIONS

Implementing a formal screening process using a validated tool allowed the discovery of patients with food insecurities. We were able to connect these caregivers to resources, and in turn, meet a need that may have interfered with adequate diabetes management. Offering SDOH screening in both English and Spanish languages, and assuring patients/caregivers that responses remain confidential helped increase the completion rate. These results support the need for expansion of screening to all patients with Type 1 diabetes in the Cook Children's health care system. Questions to consider for the future include the level of confidentiality allowed to remain for caregiver responses with the implementation of the Cure Act, and how well utilized are the resources provided to those with food insecurities.

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