Patient Centered Dental Care: Screening for Social Determinants of Health at Bernstein Dental Clinic
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PROJECT GOALS

Greenville, NC currently has a 32.1% poverty rate and 21% of the population (82,560 individuals) reports food insecurity. By adapting a medical care management program to the James D. Bernstein Dental clinic, our project worked to take advantage of every healthcare interaction to offer patients the opportunity to link to community resources and ensure better overall health outcomes.

Project Goals:
• Screen patients for most common Social Determinants of Health
• Connect patients who screen positive to local resources
• Continue following up with patients to ensure health goals are met

RESULTS

Provided 218 hours of Community Service
• Screened 489 patients at the Bernstein Dental Clinic
• Connected 40 patients to local resources
• 11 patients reported meeting their set health goal
• Trained 18 staff members at the Bernstein Dental Clinic

Language breakdown:
English (49.12%)
Spanish (50.88%)

Screen Breakdown:
Positive Screens (50.44%)
Negative Screens (49.56%)

Resource Breakdown

HAVE YOU BEEN UNABLE TO GET FOOD WHEN NEEDED?

No, 83.02%
Yes, 16.48%

STRESS LEVELS AMONG PATIENTS

No answer 11%
Very Much 8%
Quite a bit 7%
Somewhat 13%
A little bit 25%
Not at all 32%

SUSTAINABILITY

Our sustainability plan has focused on:
• Training Bernstein staff (especially dental assistants and receptionists) by holding "lunch and learns" to teach them about our project
• Engage community partners to understand the goal of our project and stay connected with our site. We also hope to incorporate ideas from other fellows and possibly connect projects to ensure a stable patient population.
• Continue to encourage Bernstein Case Managers involved with the Dental clinic and working with patients to meet health goals

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SCREENING AND SERVICES

PRAPARE
Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences

1. SCREENING: PRAPARE Survey
• Analyzes multiple social determinants of health
• Already being used in Bernstein Medical Center
• Already coded into the clinic’s Electronic Health Record to document with patient’s health records

2. CONNECTING TO RESOURCES
• Determine which patients screen positive for each resource
• Contact patients to determine current status and desire for referral to Bernstein social workers
• Ensure patients have been successfully connected to local resource
• Follow up with patient after 1 month