Implementing a Social Determinants of Health Screening Program

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Objectives

• Understand the components of screening for social determinants of health in an ambulatory adult population

• Learn how the NowPow platform can be leveraged to provide community resources to patients in need

• Understand the challenges involved in social determinants screening and learn strategies to ensure success
Background

- Most healthcare systems recognize and invest in quality improvement initiatives, and it is important that SDoH be considered part of that work.

- Data is extremely important in working in this space:
  - Cannot correct behaviors or trends if we are unaware of them.
  - Implicit bias and institutional racism are deeply rooted.
  - Important that we de-personalize findings and focus on quality of care.

- Include gender, race, insurance status with quality dashboards / statistics.
**Neighborhoods** between Rush University Medical Center and Rush Oak Park have some of the **highest** levels of economic hardship, **lowest** life expectancy and **highest** unemployment rates in the region.
Social Determinants of Health 101 for Health Care: Five Plus Five

80% of Payers Aim to Address Social Determinants of Health

Payers are focusing on addressing the social determinants of health, expanding value-based reimbursement, and improving consumer engagement in the near future.
“Social determinants of health have taken center stage in recent health policy discussions because of the growing focus on global payment, accountable care organizations, and other initiatives focusing on improving population health.”

- Yale Global Health Leadership Institute
Infrastructure

- Responsible for day-to-day SDoH operations and implementation

- Responsible for overarching SDoH strategy and leadership

- Responsible for representing SDoH to Diversity and Health Equity Leadership

- Responsible for representing SDoH to Senior Leader team
Infrastructure

• Essential that plans align with existing strategic priorities / focus areas

• Identify clinical areas of need and implement SDoH screening as one of many tools aimed at improving performance

• Ensure a clinical and operational leader for this work as it will be considered an added burden at the outset

• After a pilot has taken place, there the return on investment will become more apparent
Rush partnered with the leadership of West Side ConnectED collaborative to implement a Social Determinant of Health Screening Tool.

Rush’s brief social determinant screening tool asks patients about:

- Housing
- Transportation
- Food Security
- Utilities
- Primary Care / Insurance
<table>
<thead>
<tr>
<th>Section</th>
<th>Question Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Do you have a doctor (primary care physician) or nurse that you see regularly?</td>
</tr>
<tr>
<td></td>
<td>Yes  No  Decline to answer</td>
</tr>
<tr>
<td>Insurance</td>
<td>Do you have health insurance or a medical card?</td>
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<tr>
<td></td>
<td>Yes  No  Decline to answer</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>Are you worried that your food will run out before you have money to buy more?</td>
</tr>
<tr>
<td></td>
<td>Yes  No  Decline to answer</td>
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<tr>
<td>Food Insecurity</td>
<td>In the last twelve months, have you run out of food that you bought and didn’t have money to buy more?</td>
</tr>
<tr>
<td></td>
<td>Yes  No  Decline to answer</td>
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<tr>
<td>Utilities</td>
<td>In the last two months, have you had difficulty paying your electric, gas or water bill?</td>
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<tr>
<td></td>
<td>Yes  No  Decline to answer</td>
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<tr>
<td>Transportation</td>
<td>Do you have a hard time finding transportation to and from your medical appointments?</td>
</tr>
<tr>
<td></td>
<td>Yes  No  Decline to answer</td>
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<tr>
<td>Housing Instability</td>
<td>Do you currently have a place to stay/live?</td>
</tr>
<tr>
<td></td>
<td>Yes  No  Decline to answer</td>
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<tr>
<td>Housing Instability</td>
<td>In the next two months, will you have a place to stay/live?</td>
</tr>
<tr>
<td></td>
<td>Yes  No  Decline to answer</td>
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</tbody>
</table>
### Screening Questions - Social Determinant Screener Questions

**Time taken:** 1218

**Values By**

#### Food Insecurity
- **Within the last 2 months has the food you bought run out and you didn’t have money to get more**

#### Utilities
- **Have you ever had difficulties in paying your utilities/home energy bills (i.e. gas, electric, etc.)**
- **Has your safety or health been affected by potential interruptions of utility services**

**Connect with food assistance resources**

**Connect with utilities resources**
Workflow

1. SDoH Screening records on flowsheet (Epic organization)

2. Patient demographics guide referral information:
   - Patient’s address or zip code
   - Problem List
   - Flowsheet responses indicating need

3. NowPow recommendations made available

4. Resources saved and filed to record as social work note type
   - Patient is provided resources in after-visit summary
   - Resources / contact information available through patient portal as well
Screening Opportunities

• Beyond primary care screening, other centralized opportunities for screening and intervention exist:

1. Scheduling appointment with access center / patient navigator
2. Outreach following missed appointments
3. Patients enrolled in disease-specific panels that include care management
4. Via iPad or mobile device at check-in or during wait (lobby, exam room)
5. Medical student participation in screening (in-person or by phone)
http://www.nowpow.com/
## Referrals

<table>
<thead>
<tr>
<th>Service</th>
<th>Referral Sent</th>
<th>Contacted</th>
<th>Apppt Scheduled</th>
<th>Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child daycare centers</td>
<td>05/12/2017</td>
<td>Not Contacted</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Community re-entry services</td>
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<td>05/12/2017</td>
<td>05/19/2017</td>
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<tr>
<td>Medical expense assistance</td>
<td>05/05/2017</td>
<td>05/08/2017</td>
<td>05/16/2017</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Patient Contact**
- CI: (773) 555-0103
- RudyAlvardo@500batchfile.com

**Referral Organization**
- Community Connections

**Referral Contact**
- Joseph Collins
  - (773) 893-9393 ext. 123
  - joe.collins@comm...

**Apppt Reminder**
- Send Reminder

**Referral Note**
- This client has a difficult work schedule and needs options for early morning and evening classes.
Plan-Do-Study-Act

• PDSA completed to understand workflow in primary care settings across different providers / practice styles

• Initial 50 patients screened:
  • Average 3 minutes per screening (before or after visit)
  • 33% screened positive for one or more need
  • Food insecurity was most frequent need (25% of screened patients)

• Among patients with (+) SDoH needs:
  • 65% were on hypertension registry
  • 30% were on CAD registry
  • 30% fell in highest quartile cost (internal charges) for Rush system
1st year Medical Student Workflow
Testimonials

“I don’t need any of those resources and I am an exception because Rush is a teaching hospital, it’s nice to have questions like these.”

“I love it, not only because I have a need, but also because my background is in behavioral health and I think Rush is doing well to service patients in this way.”

“I am very grateful for screening, I have only $3 dollars in my bank account after paying bills.”
Challenges

• Multiple challenges that continue today:

1. Clinician engagement ("not in scope of my care")

2. Support staff burn-out ---> “not my job” and/or “not enough time”

3. Requires social work engagement for greater SDoH needs ($$ investment)

4. Operational challenges ---> “where and when and what’s the ROI”

5. Closing the loop on referrals requires personnel to follow cases if not fully integrated with EHR

6. Preferred social work resources may not be part of NowPow
Challenges (yes, there are more)

1. Some screenings took a very long time

2. A lot of down-time between patients (i.e. patient navigator doing screenings)

2. Interpreter sometimes needed for screenings

3. Patient preference to answer sensitive questions with doctor only

4. Adequate training for all staff participating in screening
You won’t know if you don’t ask!