Taking Social Medicine From Free Time to Prime Time: Screening for Social Determinants of Health in a Large Urban Primary Care Practice

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Statement of Problem

- Chronic disease prevalence is rising, disproportionately affecting people of color on the West and South Sides of Chicago
- Social determinants of health (SDoH) impact chronic disease prevalence through access and adherence to care
- SDoH present dual health and social justice issues.
- Rush is committed to reducing health inequity, but does not systemically ask patients about social & structural determinants of health

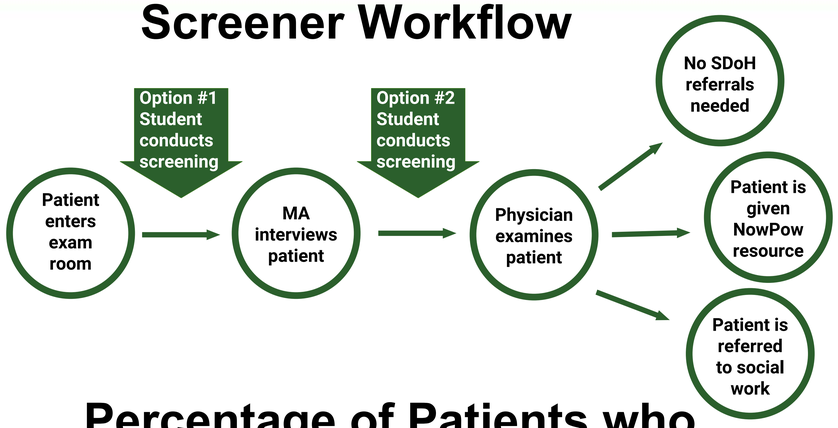
Objectives of Intervention

- Determine the feasibility of implementing a SDoH screener in a large, urban primary care practice
- Pilot connecting patients who screen positive for SDoH needs with resources specific to their needs and location through a community database, NowPow
- Pilot referring positively-screened patients for SDoH assistance to in-house social work services
- Develop a standardized method to screen patients for SDoH and referring positively-screened patients to appropriate resources

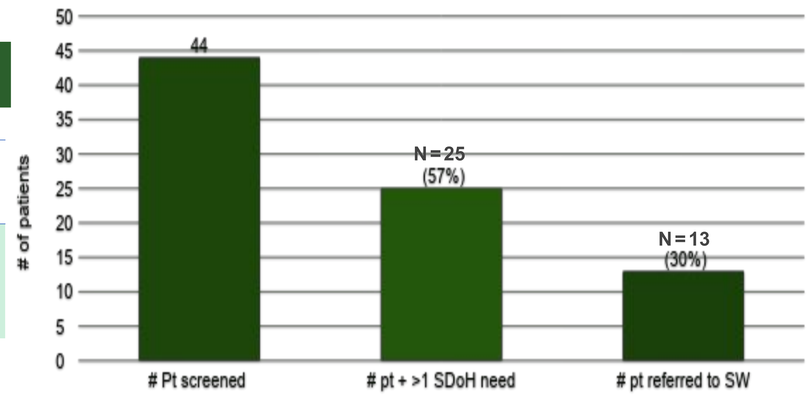
Description of Intervention

- Standardized screener was developed by Rush collaborators
- Questions focused on food insecurity, housing, transportation, utilities, primary care, and insurance
- Screener was linked to community resource database and integrated into Epic; screener results saved to patients' records
- Medical students screened patients in the exam room
- If SDoH needs were identified, patient received printout of local resources using community resource database (NowPow)
- Patients screening positive for housing or transportation, or 2+ needs were referred to social work

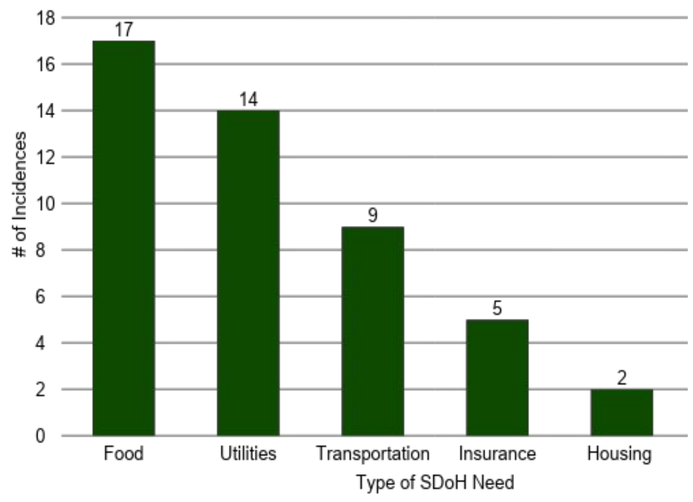
Screener Workflow



Percentage of Patients who Screened Positive



Types of SDoH Needs Reported in Positively Screened Patients



Findings

- 44 patients were screened at RUI prior to seeing the physician
- Screening took on average 7 minutes per person and was completed during times the patient was otherwise waiting
- Longer screening times often involved provision of resources
- High rates of positive screens and patients eligible for social work show the value of screening
- Ability to conduct the screenings quickly and during waiting times indicate the feasibility of integrating screening process into clinical workflow

Key Lessons for Dissemination

- SDoH screening by medical students in the primary care setting is feasible, but the number of patients screened is limited by students' time
- SDoH screening can be conducted at various points in workflow to accommodate variations in medical settings, providers' schedules
- Social work follow-up is crucial for patients screening positive for multiple SDoH
- A community resource database such as NowPow streamlines referrals
- Clinical & Non-clinical individuals can screen for SDoH

Next Steps

- Quantify number of patients referred to resources who successfully utilized them
- Assess reasons patients did or did not access resources
- Pilot self-administered, iPad screening in Rush University Family Practice
- Develop student led training in SDoH screening for new medical students
- Implement SDoH screening at Rush student volunteer sites
- Streamline workflow and data collection in Epic
- Streamline screening data from emergency department
- Add new full-time social work position to RUI to account for positive SDoH screens
- Analyze relationship between unaddressed SDoH in patient population and emergency room visits