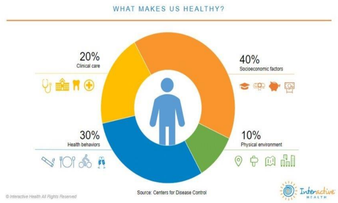
Evolution of Englewood Health's Social Needs Program

Christine Young, MSN, RN, Michelle Baksh Population Health

Background



Approximately 20% of an individual's overall health is determined in the clinical care setting while the remaining 80% are influenced by social determinants of health

Social determinants of health (SDOH) are the nonmedical factors that influence health outcomes.They include conditions in which people are born, grow, work, live, and age.

Objective

- Implementation of measures to address nonclinical 80% of patient's health within a clinical care setting to facilitate holistic comprehensive patient care.
  - Identify patients requiring social needs
  - Address patients' needs through resources
  - Ensure 100% of patient health is being overseen and managed

Impact on Health

- Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include but are not limited to:
  - Safe housing, transportation, and neighborhoods
  - Education, job opportunities, and income
  - Access to nutritious foods and physical activity opportunities
  - Discrimination and violence
  - Polluted air and water
  - Language and literacy skills

Growth Over Time

2017
- Comprehensive Primary Care Plus (CPC+) begin operations

2018
- Our goal was to select a standardized screening tool. We chose to use the AAFP Social Needs Screening Tool and embedded it within our EMR.

2019
- We started using the tool to screen the High-Risk patients within our Primary Care Division. We primarily began with inquiring about food insecurity.

2020 (COVID)
- Highlighted disparity in food security. We expanded our screening; screening for Food Insecurity began within the ED, inpatient units and by the Diabetes Educators.

2021
- Created partnership ships with food based community organizations

2022
- The screening tool was revamped to include questions from the PREPARE tool adding domains such as Health Literacy and Social Connections.

2023
- Brought with it the development of our county resource lists and system wide screening of all domains using Social Needs Flowsheet within Epic.

January 2024
- Began with the SDOH MyChart Questionairre being included in the E-Check-in process. This increased screening tremendously. home.

July 2024
- Find Help platform introduced. Platform allows for patients to be connected to local resources by searching according to their zipcodes.

Current
- Screening across the system. Leveraging MyChart to lessen administrative burden on staff and increasing autonomy/privacy for patients. Through Find Help connecting patients to local resources according to their zipcode.

Current Stats and Conclusion

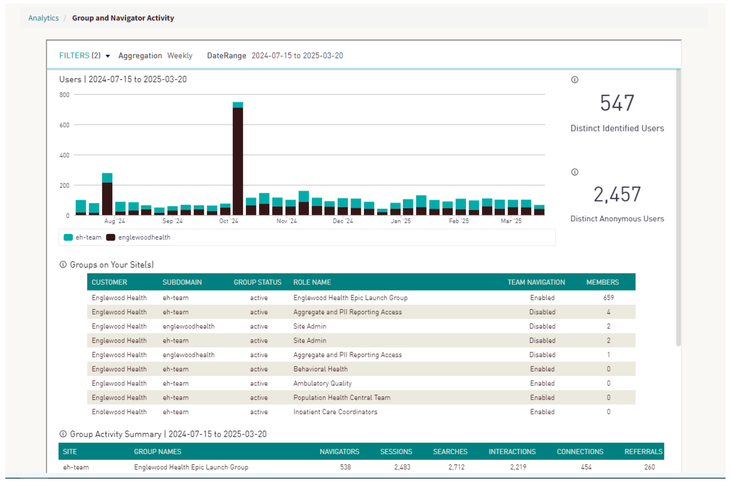
- To date, 138,000 unique patients were screened (across Health system)
- 7,600 patient needs identified and counting
- CONCLUSION: At Englewood Health, year over year, we have increased the number of patients screened for Social Needs and simultaneously increased connection to resources.

MyChart

- 38,500 patients have screening questionnaire completed from home through MyChart
- Through the screening process, valuable resource connections were established
- As seen in the table, for 2024 there has been significant growth across the SDOH domains

Requested Assistance	AMB	EH	ED	Total
EHPN R SDOH ASSISTANCE CHILDCARE	7			
HEALTH LITERACY	1,551	293	2	1,846
FOOD	1,099	140	4	1,243
HOUSING	831	140	5	976
TRANSPORTATION	824	120	1	945
UTILITY	679	77	2	758
FINANCIAL	563	87	5	655
SOCIAL	486	72	2	560
EMOTIONAL SAFE	314	40	2	356
PHYSICALLY SAFE	257	30	2	289

Find Help



Current Find Help usage. Identified Users are Englewood Health Staff and Anonymous Users are people using the public facing Englewood Health Find Help site.

Sources

https://acrobat.adobe.com/id/urn:aaid:sc:VA6C2:137a12ad-85c9-44a7-88da-4ec0db21ed7b

ENGLEWOOD HEALTH