Integration of a Social Needs Program into an Urban Student Run Free Clinic

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Introduction

The Cass Clinic is a student run free clinic affiliated with Wayne State University School of Medicine (WSUSOM) that provides primary care for the underserved, underrepresented population of Detroit, MI. The patients served experience a high incidence of chronic health conditions accompanied by social determinants of health such as poverty, homelessness, and food insecurity which can complicate their health care if not adequately addressed.

Research studies and public health entities, such as the CDC[1], have provided ample evidence on the negative impact of the social determinants of health. Therefore, to provide holistic health care that focuses on both the social and medical aspects of primary care, a social needs program was integrated into Cass Clinic to address various social determinants of health.

Methods

A social needs screening modality was incorporated into a medical encounter triage form. Two AAFP social needs screening questions were selected as social needs triage questions in order to identify patients who may benefit from social needs services:

- Are you worried that your food would run out before you got money to buy more?
  - Patients were able to select one of the following: Often true, Sometimes true, Never true
- Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?
  - Patients were able to select one of the following: Yes, No, Sometimes

After triage and examination by medical students, patients are referred to trained social needs personnel. Patient intervention after social needs encounter was recorded in an EMR system.
Qualitative data was collected by retrospective chart review in which social needs patient encounters were filtered and reviewed. The following information was collected from each social needs and clinical patient encounter:

- Chief complaint (for clinical and social visits)
- Medical diagnoses
- New or returning patient visit
- Resources given

Methods

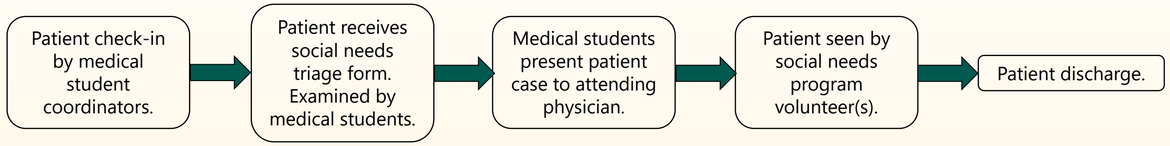

Figure 1. Clinic flow after integration of social needs program. Prior to the implementation of the social needs program, patients did not receive a triage form with social needs questions, nor were they seen by a social needs program volunteer.

Results

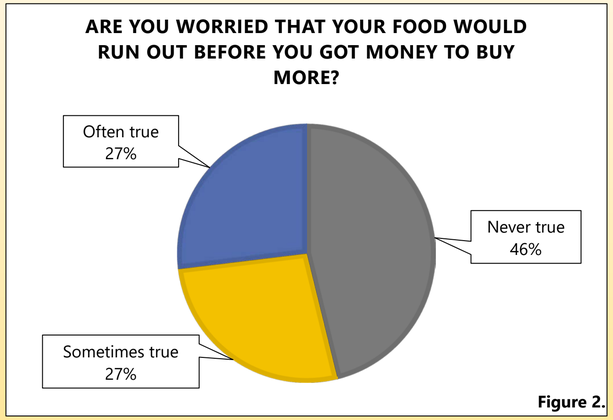

Figure 2.

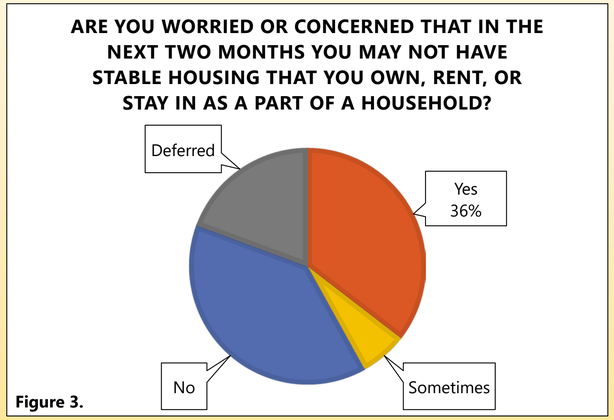

Figure 3.

31 patients were surveyed using the social needs triage form:

Figure 2. 54% of patents reported concern regarding food insecurity at least some of the time.

Figure 3. 42% of patients reported concern regarding housing insecurity at least some of the time.

9 patients were seen by the social needs program:

Figure 4. All patient visits with social needs addressed a variety of social determinants of health, such as food, transportation, housing, and clothing needs.
On average, patients requested assistance with 2.22 resources in the same visit.

Resources included as "other": Insurance information, hygiene kits, outside clinic referral.

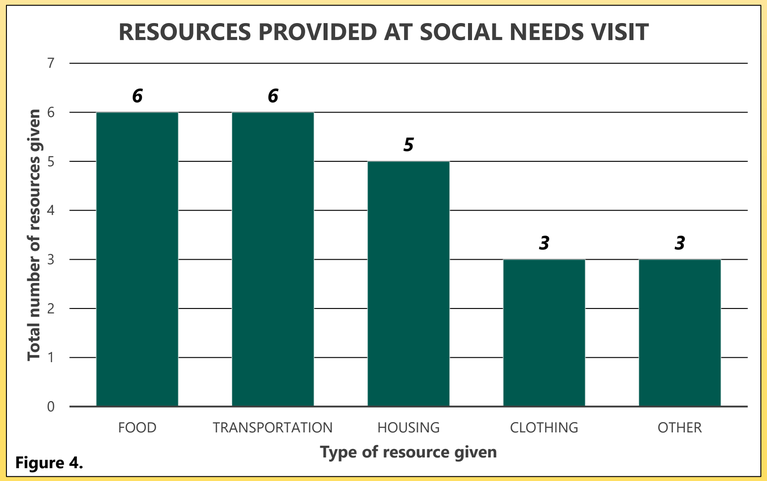

Figure 4.

Discussion

This initiative was achievable to implement with limited challenges. Although patient visits were inherently longer due to the addition of the social needs program, all patients that were seen by the social needs program received about 2 resources or interventions on average that addressed some to all of their presenting concerns.

Of all patients surveyed (n=31), 58% reported concern at least some of the time with their current food and/or housing situation but not all patients that reported concern were seen by the social needs program for various reasons that were not directly studied. However, some patients verbally expressed disinterest in assistance due to long wait times or other personal or logistical concerns.

In order to provide holistic healthcare to underserved, underrepresented populations, social determinants of health should be screened for and addressed if necessary. Furthermore, addressing various social barriers to medical care may assist in the long-term treatment of chronic medical conditions.

Future Implications

With long-term patient follow up, further studies of the integration of the social needs program could compare the effect of managing chronic health conditions such as hypertension and/or diabetes when patients who are considered underserved receive both medical and social needs assistance versus receiving medical management only. Additionally, patient perspectives of the quality of health care received at Cass Clinic before and after the implementation of the social needs program can be studied.

Considering patient concerns, future studies could also study methods that may improve the efficiency of the social needs program or clinical encounter to increase the number of patients willing to utilize the program.

References

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