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Compassionate Care: Assessing and Addressing the Social Needs of Our Patients

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Recommended Citation

Wardian, Jana L. PhD and Benton, Brooke, "Compassionate Care: Assessing and Addressing the Social Needs of Our Patients" (2023). *Posters and Presentations: Hospital Medicine*. 3.
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Compassionate Care: Assessing and Addressing the Social Needs of Our Patients

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Social Determinants of Health in America

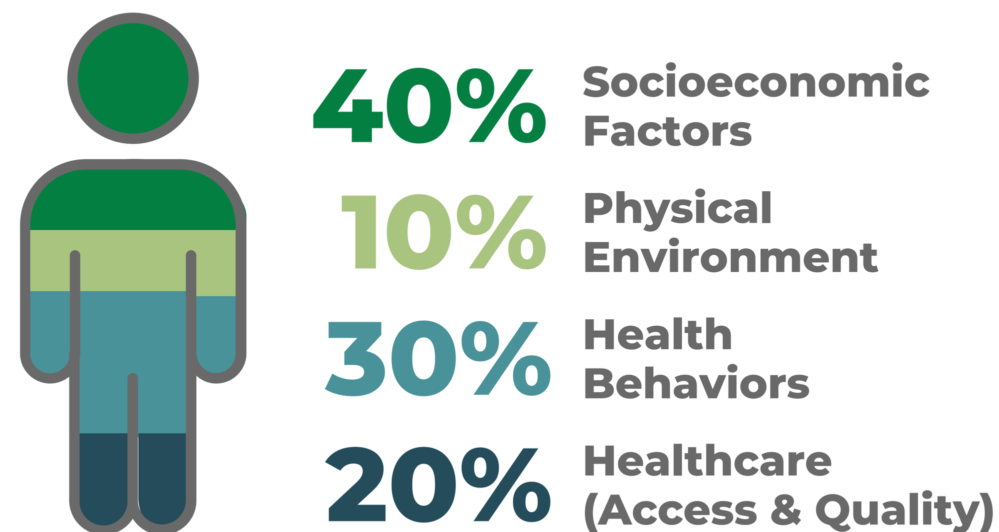
"Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." [1] Risk factors include unsafe living conditions, food insecurity, poverty, low education levels, lack of social support, poor access to healthcare

Disparities

- In 2019, 37.1 million American households spent 30% to 50% of their income on housing, creating stressors in paying for utilities, food, and healthcare [1]
- Lack of reliable transportation can prevent patients from accessing health care, obtaining healthy food, and sustaining employment
- Challenges in accessing healthy food

SDOH impacts patient care [2]

- Healthcare only influences 20% of patients' health
- Health behaviors contribute about 30% and are influenced by SDOH
- The remaining 50% can be attributed directly to SDOH



Training Clinicians on SDOH

Staff attended a one hour training by a social worker who researches SDOH

- Learned the value of compassionate care
- How to find resources for patients
- Followed by half hour "Ask the Social Worker" sessions to address questions

Screening Tool to Assess for SDOH

Patients were asked, "In the last 30 days, how many days have you experienced challenges with..."

Food
Having enough food to eat or having money to buy food

Utilities
Risk of electric, gas, oil, or water getting turned off

Housing
Lack of a stable place to live

Transportation
Lack of reliable transportation to get to medical appointments, work, meetings, places for daily living

Neighborhood Safety
Feeling safe in your home

If a patient screens positive for any of these SDOH issues, the clinician provides resources. These questions are asked at the beginning of the program and then reassessed every 90 days (about three months).

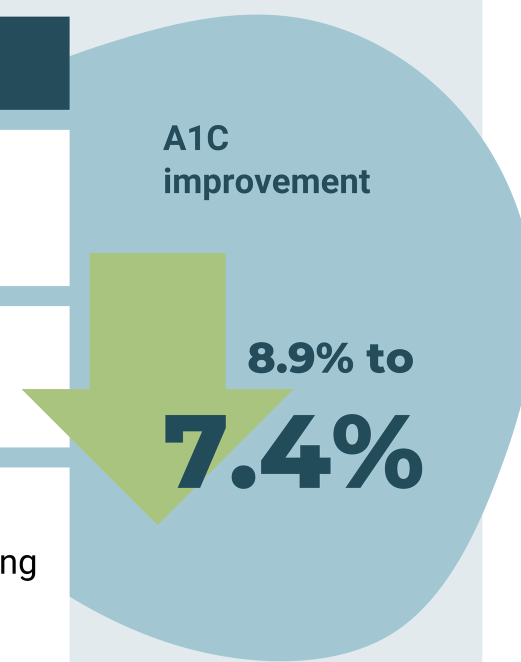
Patient story – Meet Ama

Ama* has been living with Type 2 Diabetes for 15 years. Now living in the United States, she is originally from West Africa. Although she is able to speak English, she does not read or write in her non-native language. She participated in the Cecelia Health Diabetes Education Program for six months.

Diabetes background

- Medications: Glipizide 5mg QD, Metformin 1000mg QD, Lantus 12u BID
- Blood Glucose Range: 40 to 200 mg/dL
- Gaps in Care: Open gaps for annual dilated eye exam, A1C, and primary care provider (PCP)

SDOH barriers identified	Resources provided	Results
Food insecurity: Experiencing hypoglycemia due to not having enough food	Supplemental Nutrition Assistance Program (SNAP) & West African Family Services	Hypoglycemia improved with food resource provided
Transportation: Challenges getting to doctor appointments	Medical appointment transportation services through personal health insurance	Closed all gaps in care with transportation resource provided
Financial: Difficulty paying for medications	NeedyMeds.org	Able to obtain all medications with financial resource provided, resulting in hyperglycemia improvement (blood glucose back in range)

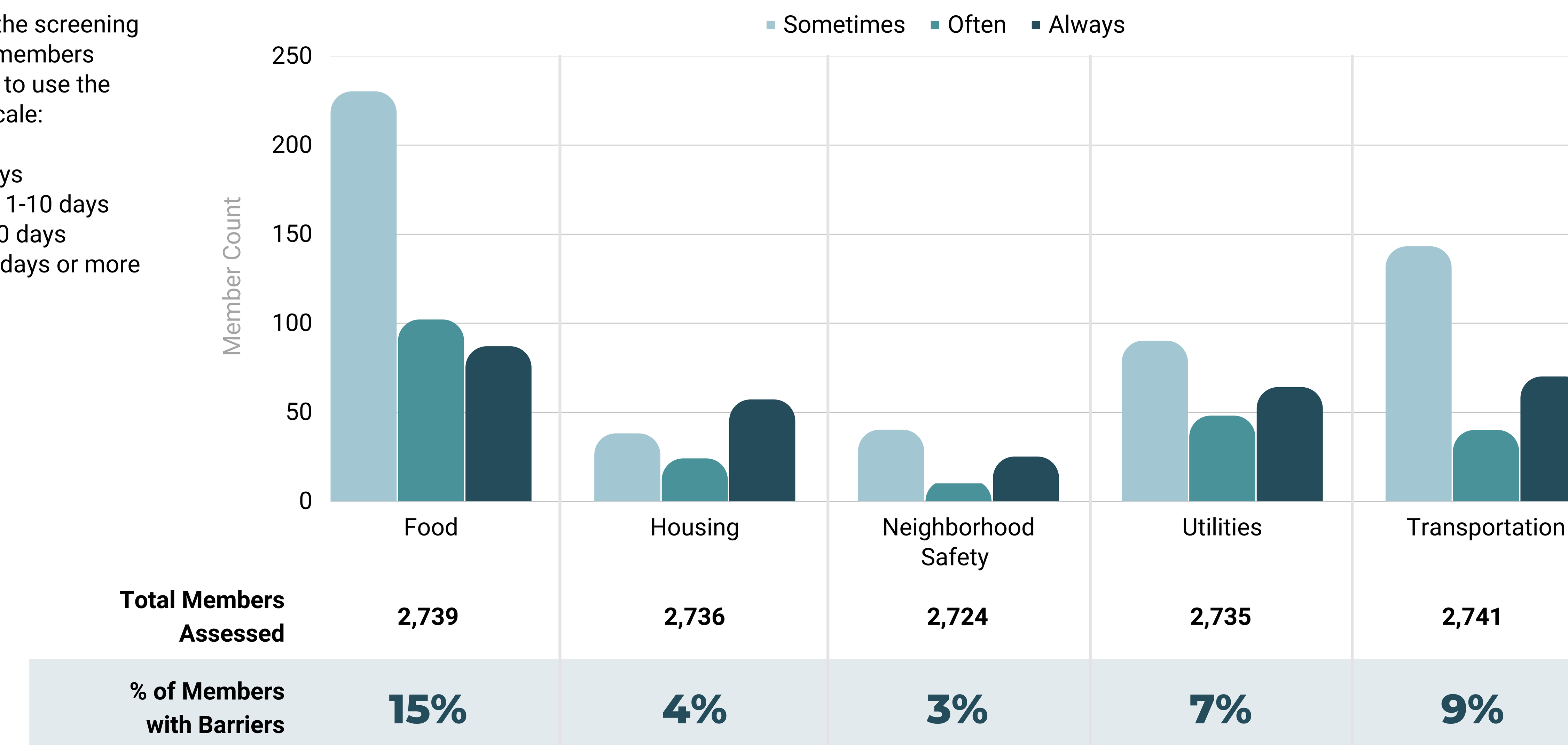


I can't thank you enough for taking the time to help me with all of these problems I am having. **Nobody has ever taken the time to care about me like that.**

Results from SDOH Screening Tool

To answer the screening questions, members were asked to use the following scale:

Never: 0 days
Sometimes 1-10 days
Often: 11-20 days
Always: 21 days or more



	Food	Housing	Neighborhood Safety	Utilities	Transportation
Total Members Assessed	2,739	2,736	2,724	2,735	2,741
% of Members with Barriers	15%	4%	3%	7%	9%

Resources for Addressing SDOH

National & local resources
Find Help (social care network)
https://www.findhelp.org/

Food & nutrition
Feeding America (local food banks)
https://www.feedingamerica.org/find-your-local-foodbank

Commodity Supplemental Food Program
https://www.fns.usda.gov/csfp/commodity-supplemental-food-program

Supplemental Nutrition Assistance Program (SNAP)
https://www.fns.usda.gov/snap/recipient/eligibility

Housing
Public Housing Agency
https://www.hud.gov/program_offices/public_indian_housing/pha/contacts

Safety at home
Area Agency on Aging (for older adults)
https://eldercare.acl.gov/Public/About/Aging_Network/AAA.aspx

National Domestic Violence Hotline: 1-800-799-SAFE (7233)

Transportation
Find Help
https://www.findhelp.org/

Health plan may have additional resources for healthcare appointments

Utilities
Find Help
https://www.findhelp.org/

Medication
NeedyMeds
https://www.needymeds.org/

Many pharma companies have rebates and/or assistance programs (search by company name)

Scan this QR code to access all SDOH links

References

1. Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved June 23, 2022 from https://health.gov/healthypeople/objectives-and-data/social-determinants-health
2. Institute for Clinical Systems Improvement (ICSI). 2014. Going Beyond Clinical Walls: Solving Complex Problems. Retrieved June 23, 2022 from https://www.icsi.org/wp-content/uploads/2019/08/1.SolvingComplexProblems_BeyondClinicalWalls.pdf

**Real patient story, but member name and likeness have been changed.*