**PRINT-OSF Launches 'Screen and Connect' to Identify Patients with Social Risks**

When a patient recently came into an OSF HealthCare rural health care clinic with stomach issues, it turns out, there was a lot more going on than just a simple stomach ache.

Physician Assistant Mandy Robinson learned from a new screening tool that the patient was at high risk for financial, housing and food insecurity.

"He didn't have refrigeration and he had eaten a piece of meat that he knew was probably spoiled but he was so hungry and because he didn't have any other food in the house he chose to eat it and became ill," she explained.

Under a new primary care digital screening program for social determinants of health**,** patients use iPads and are screening for ten areas of social needs including food insecurity, financial support, housing, transportation, and intimate partner violence among others. Social Determinants of Health are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. In this case, Robinson says the care team manager helped the patient avoid that kind of dilemma in the future.

"The care manager spoke to the power company on his behalf and we were also able to get him resources on food pantries in the area so we were able to help with that. I believe he also has an appointment to get his hearing aid test." Robinson added, "So it's definitely a process when we get into the lives of these patients but every step we take is a positive outcome for them."

Robinson was skeptical at first of the ***Screen and Connect*** pilot. She worried about having to address all of a patient's needs, clinical and non-clinical, during the average 15 to 20-minute appointment.

But, Robinson says when care managers know of non-clinical conditions they can handle patient referrals to community resources. She only gets involved when patients really need to be convinced to receive help or when she's so concerned about a patient's welfare that she personally follows up. Robinson often finds those who she sees have multiple unmet needs and they're relieved to know someone can coordinate help for them outside of the medical office.

"Once they realize that we care about them beyond their lab numbers that they're more likely to open up to us and come to us with needs that maybe they're not sure who to go to but they know at least, we're a good starting point, Robinson shared.

The OSF Innovation team worked with OSF Medical Group doctors and other care team members during the pilot in a rural community to come up with a screening tool and work-flow that would make it easy to access data and know more about the challenges their patients face in achieving better health.

OSF Innovation rolled out the ***Screen and Connect*** tool three months ago and recently hit a milestone on November 5, 2019 when the 1,000th patient was screened. Dr. Sarah Stewart de Ramirez, vice president and chief medical for OSF Innovation, says the idea was to treat social determinants of health like a vital sign. The team was empowered through a design process utilizing multiple tests of change to optimize the solution for providers and patients. Providers desired an approach which informed their interactions but didn't take up their patient-provider time with screening questions, or create delays in getting patients to rooms.

They also didn't want the long delays typically experienced by paper surveys or asynchronous screening, where patients screen at one time, and results are later tabulated and only inform subsequent referrals to social work etc. On the other hand, patients wanted privacy to share their information and decide if they felt comfortable talking about it so they didn't want to be called ahead of time or even asked face-to-face. The resulting process was able to use digital screening to achieve the privacy requirements of patients, and the real time need of providers to address social needs as they were identified.

Knowing many older patients use iPads to connect with their kids and grandchildren, using them seemed like a great approach.

According to Stewart de Ramirez, “For discrete assessment of all ten domains of the social determinants of health, iPads were used with every patient, every time they came into the clinic. The responses populated those social needs on food insecurity, housing, transportation. As they answered those questions in real time, that information would be available to the clinician before the patient was even in the room.”

Stewart de Ramirez believes that OSF HealthCare is a leader of screening patients by using a digital tool that can provide social vulnerability information as soon as a patient enters it in the waiting room so the social risk indicators can better inform "whole person care" during the patient's appointment.

“Instead of just asking about medications related to heart failure, medications related to their diabetes, instead of just talking about the clinical needs, they could now expand to whole person needs and be able to think about what else needs to be addressed to optimize the whole health of that individual and their family.” according to Stewart de Ramirez

The iPad screening tool takes patients an average of two-and-a-half minutes to complete and most patients have been willing to fill out the quick screening assessment, sometimes with the help of a medical office assistant. Nearly 40% of patients screened as having at least one social risk and nearly 25% have two to three social challenges that need to be addressed. While most health care leaders believed transportation would be the number one challenge in rural areas, food insecurity has been the leading concern of patients who screened high risk, accounting for nearly one third of patients with a factor influencing their health outside of the medical office.

Sarah Overton, chief nursing officer for OSF Multi Specialty Services says results so far have prompted care teams to consider alternative approaches with some patients.

“It really makes them stop and think when they’re going to prescribe a medication or treatment, if it’s really the best solution for that patient,” she said. “Perhaps there’s a cheaper alternative or there are some resources they can connect them with that really will allow them to achieve those goals of great care overall and a great health outcome for them.”

Overton believes nurses in particular, who often serve as care managers referring patients to community resources, are finding their jobs fulfilling and patients are feeling our Mission, to serve with the greatest care and love.

“Nothing is more gratifying as a nurse or physician than hearing how maybe something little that you did in that experience changed that patient’s overall perspective and outcome and really listened to them and cared for them in a way that probably they weren’t anticipating when they came in for their medical need.”

Stewart de Ramirez says ***Screen and Connect*** has already revealed that in the bread basket of America, which feeds the world, as many as half of patients are food insecure and that’s a challenge OSF HealthCare and community partners will have to tackle collectively. She also says a community care network will need expanded digital tools to allow two-way communication in which community partners can also refer individuals to OSF for medical care and, with patients’ permission, allow information-sharing among agencies for a coordinated approach to “whole person care.”