Health-Related Social Needs

Confronting Food, Housing, and Transportation Barriers

Providing ready access to medical care when people need it is only one component of health equity. To help everyone live their healthiest life, we need to understand barriers to good health people may face outside the doctor's office, and work with community partners to address them.

Starting Point: Providers Trained to Treat Symptoms, Not Social Needs

Three health-related social needs (HRSN) have long been known to have a strong impact on how healthy a person is.

- **Access to nutritious food** supports a healthy diet
- **Stable housing** is essential to physical and mental well-being
- **Affordable, reliable transportation** is needed to reach schools, jobs, shopping, and medical appointments

People in groups traditionally underserved by health systems often lack one or more of these needs, which contributes to inequity. But doctors, nurses, and other health care providers haven't traditionally discussed them with patients. They are trained to assess a person's symptoms in the moment, diagnose their condition, and provide medical treatment if needed.

Answering the Community's Call

The latest health equity measures and standards from both the federal government and national accreditation organizations call on health systems to collect and address health-related social information on patients.

This call is magnified by local data and insights, including those collected by Common Ground Health, that shine a light on health inequities across the Finger Lakes region. For example, the highest rates of food insecurity (20% or higher) are found in zip codes within the cities of Rochester and Elmira.

*"Every data point we collect regarding health and equity narrates the story of a neighbor in our region facing unnecessary barriers to living a fuller, more abundant life," said **Wade Norwood**, CEO of Common Ground Health. "That's why it is so important that our community's health systems link data to actions that address these barriers to care and aim towards prevention."*

Asking About Social Needs as Part of Medical Visits

In 2021, our Health Equity & Anti-Racism Technology (HEART) Program began an effort to standardize the collection and discrete documentation of health-related social needs in eRecord, the electronic medical record URMC uses to track the care and treatment of each patient.

Care managers, nurses, and social workers began asking patients a standard set of questions about their access to food, housing, and transportation—also known as Social Determinants of Health (SDoH)—regularly during office visits and hospital stays. Since 2022, patients who electronically check in for an appointment are asked to provide this information in MyChart.

% of Active Patients Screened for SDoH

Year	%
2020	0.30%
2023	28%
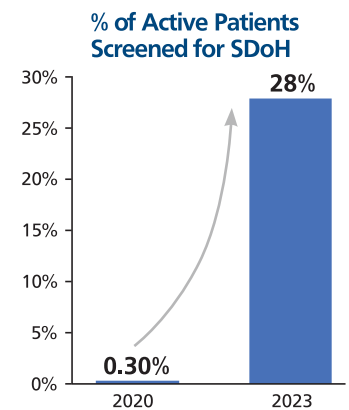
*"Collaboration is the cornerstone of transforming this effort from a lofty goal to part of our everyday operations," said **Sarah Carpino, RN, MSBA**, medical informatics manager and HEART program manager. "Successfully standardizing our SDoH collection was fueled by collaborations between both our Informatics and Information Systems Division teams, clinical and operational leaders, and, most importantly, our patients. It's important that our patients trust us to share this important information about their daily lives so we can work together to ensure their needs are met."*

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Spotlight: Embedded Health Home Provides Care Management

Let's say a patient's SDoH responses show they're at risk for experiencing food insecurity—then what? The HEART Program has worked with clinical teams to link patients to internal and community resources, many of which are listed within eRecord.

The Embedded & Perinatal Health Home provides an internal care management resource for patients with chronic illness and unmet social needs. The Health Home Program is a New York State Medicaid service model that works with patients referred by ambulatory or inpatient care teams. Since the program's creation in 2016, Embedded Health Home care managers have helped hundreds of patients meet personal goals, resulting in many being twice as likely to attend scheduled appointments while enrolled in the program.

"A key part of providing equitable health care is meeting patients where they're at in their respective journeys," said **Kathy Parrinello,** *Strong Memorial Hospital chief operating officer. "Our Embedded and Perinatal Health Home team plays an integral role in helping our patients get both health care and the social support services they need to be their best, healthiest selves."*

Questions about the Embedded & Perinatal Health Home? Email the team.
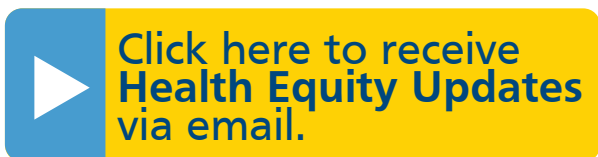
What's Next: Strengthening Work with Community Partners

URMC plans to continue screening patients for social needs, and strengthening our collaborations with community partners to help patients address barriers to good health. Current partners include:

- Foodlink, which helps people address food insecurity
- Finger Lakes' 211/Life Line links people to a range of services available from government and non-profit agencies
- DePaul, Catholic Charities Family and Community Services, and the YWCA collectively provide supportive housing and related services for people experiencing housing insecurity

*Editor's Note: The terms "health-related social needs" and "social determinants of health" are sometimes used interchangeably. When referring to individual patient's needs, we use the phrase "health-related social needs (HRSN)." When discussing our broader patient population, we use "social determinants of health (SDoH)."

▶ Click here to receive **Health Equity Updates** via email.

HOW YOU CAN HELP…
If you have ideas for other community partnerships to address health-related social needs, please email HEPSOProgramOffice@URMC.Rochester.edu.

About Health Equity Updates

Faculty and staff members across URMC are working to reduce health inequities through research, education, and improved access to care. These updates provide snapshots of our work with community partners toward the ultimate goal of equal life expectancy for all.

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