


Featured Health Care Equity Topic Area:






Assess Health-Related Social Needs

Related Joint Commission Requirement:

Standard LD.04.03.08, EP 2

About

Cook County Health (CCH) is one of the largest public health systems in the United States, providing a range of health services to its patients, health plan members and the larger community. Since the founding of the original Cook County Hospital in 1834, CCH has been committed to serving the health care needs of the residents of Cook County. Through the health system and the health plan, CCH serves more than 600,000 unique individual patients annually. CCH remains at the forefront of new therapies and innovations in health care while never neglecting those in need. It continues to maintain a strong commitment to the health care needs of Cook County's underserved population, while also offering a full range of specialized medical services for all segments of the community. Cook County Health strives to bring real issues to light, create a forum for conversation, and provide solutions to impact change.

Cook County Health	
	Chicago, Illinois
	Academic Medical Center
	Safety Net Hospital
	450 Beds (Stroger) / 48 Beds (Provident)
	Nonprofit

Mission

Cook County Health's mission is to establish universal access to the world's best care and health services for all Cook County residents, regardless of the ability to pay, so all may live their healthiest life. CCH seeks to create partnerships with other health providers and communities to enhance the health of the public and advocates for policies that promote the physical, mental, and social well-being of the people of Cook County.

Setting the Stage for Change

CCH provides care to a population with a high prevalence of health-related social needs (HRSNs), including housing, food, and transportation insecurity. In 2018, 80% of people using Chicago's emergency shelters or outreach services had a CCH patient record. CCH needed a system that was evidence-based and flexible, so that the same tools could be used across populations and at different sites. Using in-house resources, care coordination software was developed – Care Management Information System (CMIS).

Taking Action

Selecting Social Domains for Screening. Social domains for screening are selected by community feedback, based on what resources are available if someone screens positive for a social need. There are over 20 evidence-based screening tools used to screen for domains including domestic violence, food insecurity, and substance abuse. All patients seen at CCH primary care sites, emergency departments, and inpatient units are screened for HRSNs and care coordination is provided to those who screen positive. If someone screens positive in a particular domain, it leads to a more detailed screening.

Positive Screenings. Patients who screen positive for food insecurity are referred to system-based resources including fresh groceries that are delivered by truck to community health centers. Patients with legal needs that may impact their health, but cannot be addressed directly, are referred to Legal Aid Chicago. CCH's housing programs serve patients experiencing homelessness who are identified by a data-driven method that targets observable characteristics, rather than point-of-care screening. CCH continuously evaluates the resources allocated to patients enabling them to expand collaborative partnerships to address patient needs.

Improved Access for Disability-Eligible Patients. CCH identified a pattern where disability-eligible patients didn't know they could access benefits. In response, CCH formed a partnership with Legal Aid Chicago and formed a Medical Legal Partnership (MLP), made possible through a BUILD Health Challenge grant. This effort brought several organizations and stakeholders together – Legal Aid Chicago, Chicago Department of Public Health, CCH's leaders, care coordinators, providers, and researchers. Following a community-based needs assessment in 2017, MLP services were directed to CCH's complex care programs where care coordinators screen patients by telephone and direct interactions in hospitals and Cook County Central Bond Court. Program success led to sustainable funding of the MLP program.

“We have to get patients at their portal of entry....that might be a visit to see a specialist, it might be a primary care visit, it might be a visit to the emergency department, but it's an opportunity to touch base with patients and find where they are and begin to discuss some of the needs that they may have.” – Dr. Claudia Fegan

Challenges Encountered

Differing Needs Across Teams. Building the most efficient platform for multidisciplinary teams with differing needs, resources, staffing, and workflows was a significant challenge.

Limited Agility. The previous system was static and inflexible and CCH needed agility in its care coordination software with the ability to evolve over time and help anticipate trends such as the COVID-19 pandemic.

Duplicative Efforts in Assessment Data Entry. CCH providers had limited time to discuss and develop patient care plans due to the additional time required to enter assessment information into the electronic health record (EHR) that had previously been entered by other multidisciplinary team members.

Volume of Need. A large volume of patient needs makes it difficult to balance work as a medical provider and addressing other social needs as they are identified.

Scarcity of Resources. Resources available do not fully meet population’s needs. Often there are no immediate fixes to an identified HRSN, such as housing insecurity. Sustainably funding the growth of these programs is an ongoing challenge.

Screeener Discomfort. Partly out of a sense of powerlessness to help, some screeners feel uncomfortable when asking about HRSNs.

Solutions

- **Integration of Software and Screening Process.** CCH’s integration of the care coordination software and screening process made it possible for physicians to see screening domains and easily pull into notes without having to repeat the screening. This saves time and allows for more time to discuss issues with patients and develop follow-up plans. HRSN screening populates automatically on the problem list and stays in the list for future encounters. Teams can create and use their own task list to prioritize patient follow-up.
- **Development of Collaborative Partnerships.** Launching HRSN screening organization-wide was a huge undertaking made possible by the efforts of collaborative, multidisciplinary teams with a shared vision and passion for community health. Under leaders who recognized the impact of HRSNs on health, CCH has developed community partnerships and programs designed to address a variety of social needs. Examples include Housing Forward (aims to end homelessness), Greater Chicago Food Depository, and the Nutrition Education Program for Women, Infant and Children (WIC).

Lessons Learned

- **Leverage Partnerships.** Community partnerships need to not only be developed, but they also need to be leveraged. Identify unique areas of opportunity in your community that align with the needs of your patient population. Seize available opportunities in your community, rather than trying to build something that is not wanted or needed.
- **Your Community has a Voice.** Recognize the importance of bidirectional communication that your community has a voice. Connect and partner with local organizations with a shared vision.
- **Start Small and Build Support.** It is crucial to have support from both leadership and those on the front-line. Know that it won’t be easy, but momentum will build with perseverance.
- **Focus on the Data.** The work begins with screening for HRSNs and connecting patients with community resources. However, if outcomes don’t change, you need to look deeper. By keeping an eye on the data, you become better at anticipating trends and demands.
- **Make Staff Aware of Available Resources.** Making sure that staff are aware of available community resources empowers them to meet patients’ identified needs and reduces feelings of helplessness when conducting HRSN screening.

Check out the Joint Commission’s Health Care Equity Accreditation Resource Center
Assess Health-Related Social Needs

Access sample scripts for sensitive conversations, screening tools, and more