



Social Prescribing at the Jackson Free Clinic

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INTRODUCTION

- The Social Health Clinic was established at the Jackson Free Clinic (JFC) to connect patients to community resources, address social and economic barriers to health, and improve overall health outcomes.
- One study found that socioeconomic factors, health behaviors, and environment attribute to 47%, 34%, and 3% of a patient's overall health, respectively, compared to the 16% from clinical care alone.¹
- A social prescribing protocol was implemented in August 2022.
- Social prescribing is a means of enabling healthcare providers to refer patients to community resources in an official capacity by utilizing electronic health records with ICD-10 codes and social diagnoses.
- Social prescribing emphasizes how social determinants affect health outcomes and helps fill the gaps by ensuring patients get connected to community resources that can improve their overall health and well-being.²

AIM

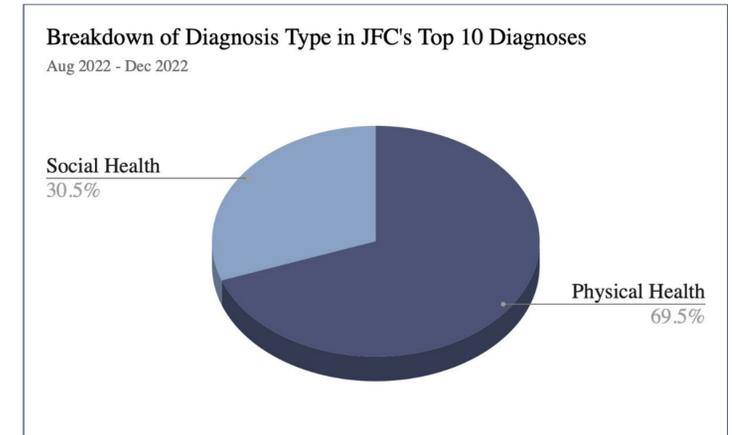
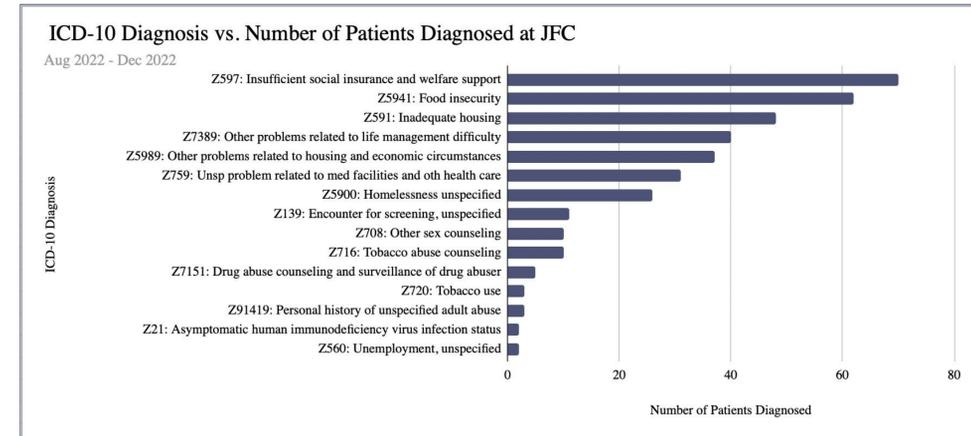
- Analyze social prescribing data to determine the most common social needs among patients at the JFC.
- Provide information specific to JFC patients that can be used to develop community partnerships to address these social needs.

METHODS

- At the JFC, patients who elect to speak to a Social Health Clinic volunteer are screened under the eleven following categories: general health and hygiene, sexual health, medications, houselessness, financial resources strain, food insecurity, transportation, unemployment, substance dependence, safety/intimate partner violence, and government programs.
- Each of the social determinants above were pre-assigned to a corresponding diagnosis and ICD-10 code available in the Athena EMR.
- Based on patient responses, social diagnoses are made, patient encounters are recorded, and relevant community resources are discussed with the patient.
- Six months after social prescribing implementation, data were analyzed to determine which social diagnoses had been made the most often among the JFC patient population.

RESULTS

- **Social Health Clinic Patient Visits:** From August-December 2022, the Social Health Clinic operated 19 times and saw a total of 124 patients. 360 unique social diagnoses were made during this time period.
- **Most Common Social Diagnoses:** The most common social diagnosis was “insufficient social insurance and welfare support” (which includes access to medications and government housing), with 70 patients being diagnosed. “Food insecurity” was next, with 62 patients diagnosed, followed by “inadequate housing,” with 48 patients diagnosed, and “other problems related to life management difficulty” (which includes access to hygiene products and glasses), with 40 patients diagnosed. These top 4 social diagnoses are in the top 10 clinic diagnoses at JFC.
- **Least Common Social Diagnoses:** The least common social diagnoses were “personal history of unspecified adult abuse” and “tobacco use,” with 4 diagnoses each, and “unemployment, unspecified” and “asymptomatic HIV infection status,” with 2 diagnoses each.



CONCLUSION

- The 4 most common social diagnoses are in the top 10 clinic diagnoses as a whole, indicating that social needs are a major barrier to health among the JFC patient population.
- A large percentage of patients at JFC lack access to (or cannot afford) basic items such as food and medications, indicating the urgency to foster relationships with community partners who can help address these needs.
- Many patients show interest in government programs such as Medicare and Medicaid but need assistance with enrollment, highlighting the need to investigate the barriers to enrollment and ways to facilitate success.
- Patients are least interested in resources related to domestic violence, tobacco cessation, HIV, and unemployment, suggesting that patients are either less affected/concerned by these factors or are unwilling to speak of them.
- More long-term data collection is needed to continue to assess the social needs of patients at JFC.

REFERENCES

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