Geriatric Health Disparity Screening: A Quality Improvement Project at ECU Family Medicine

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BACKGROUND

A study of geriatric social complexity factors (low-income, food insecurity, limited transportation, etc.) found that 54% of respondents live with at least one social complexity and 4% have greater than five. Around 5.7% among this group experience food insecurity, while this number is 10% higher among minorities and those with mental illness (Steiner et al., 2018). Potential threats to Social Security may further increase the economic vulnerability of this population in upcoming years (Cooper & Gould, 2013). NCCARE360 is the first state-wide solution to improve upon gaps in patient healthcare disparities. It is designed to help healthcare providers coordinate care to address various patient needs, including housing, food assistance, personal safety, etc. Our study works to connect patients in the ECU Family Medicine Geriatric Module with the resources they need.

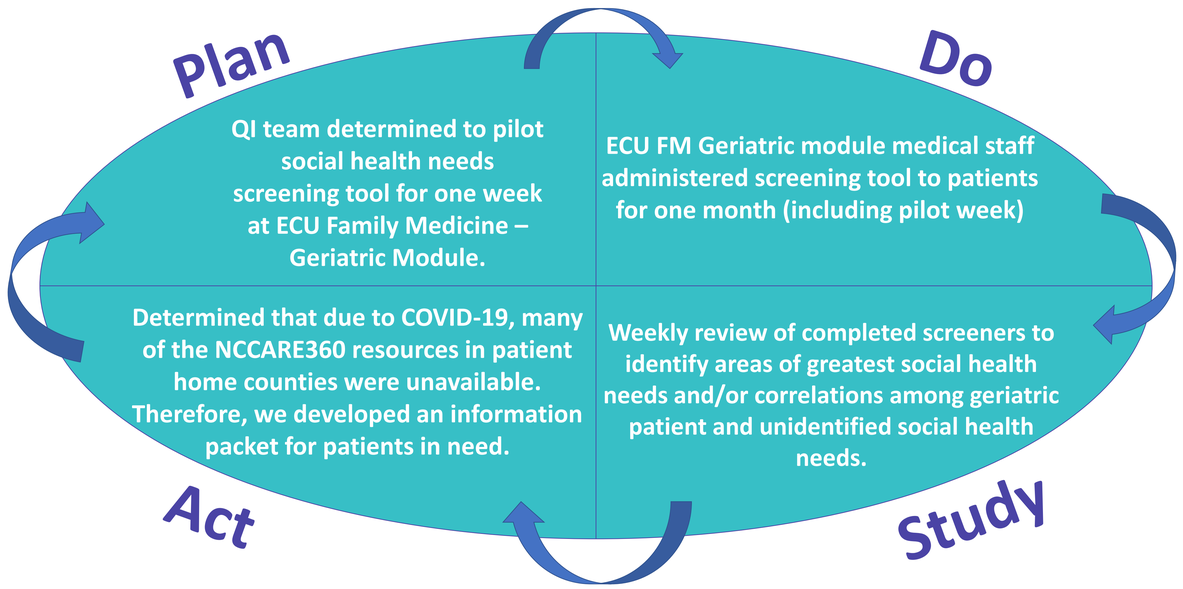
PROJECT AIM

- **Global Aim:** To increase systematic identification of social health needs in the geriatric population of follow-up patients at ECU Family Medicine Center's Geriatric Module.
- **Specific Aim:** To increase the number of referrals made to on-site social worker and pharmacist at ECU Family Medicine Center by May 2021.

PROJECT DESIGN/STRATEGY

1. Patient checks in ECU FM Geriatric module.
2. Patient is given study screener. Nurse or MA explains the screener.
    a) Is the screener completed? (Y/N)
3. If Y: Nurse or MA sees if screener is positive.
4. If N: Patient is given additional time in the room, Nurse or MA assists in completion, or patient declines.
5. If Screener is Positive: Nurse or MA obtains consent to refer the patient to social work or pharmacy depending on the questions that were positive.
6. Social Work or pharmacy will follow-up with the patient over the phone or in-person depending on patient needs.
7. All screener data sent to QI team for analysis.

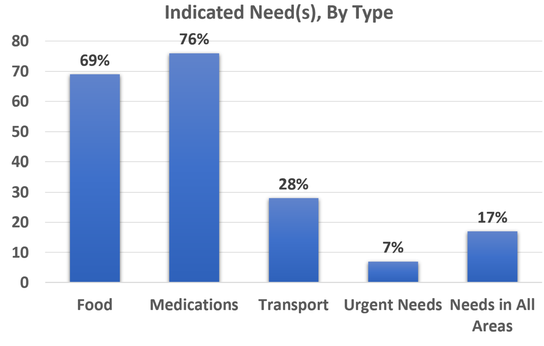
CHANGES MADE (PDSA CYCLES)



RESULTS/OUTCOMES

Weekly Tracking

Week	Dates	Total Screens	Negative	Positive	Incomplete	Declined
Pilot	11/9 - 11/13	17	8	7	0	2
Week 1	11/30 - 12/4	26	20	6	0	0
Week 2	12/7 - 12/11	29	20	7	2	0
Week 3	12/11 - 12/15	8	6	2	0	0
Week 4	12/14 -12/18	15	8	7	0	0
Week 5	1/4 - 1/8	25	20	4	1	0
Week 6	1/11 - 1/15	11	7	3	1	0



- During the pilot period of the screening system, the clinic had **17** geriatric patients complete the screener, with **seven** identifying at least one social need.
- Following the pilot period, an additional **114** patients were screened, with **29** identifying at least one social need.
- Of the **29** patients who identified as having a social need, **69%** identified a food insecurity, **76%** identified difficulty with medications, **28%** identified difficulty with transport, and **17%** had needs in all 3 areas. **7%** indicated urgent needs.
- Unfortunately, **four** patients were unable to complete their screener; solutions will be identified to help patients complete the screener.

LESSONS LEARNED

- Utilizing a standardized screening tool to identify social health needs increases awareness of social determinants of health that may complicate chronic health conditions and/or treatment compliance
- Implementing standardized screening increases the number of referrals placed to community partners through NCCARE360 and narrows the pre-existing gap between health and community systems of care
- This standardized screening system is feasible, effective, and has increased the quality of person-centered care at ECU Family Medicine Center's Geriatric Module

NEXT STEPS

- Encourage increased awareness of social needs during patient visits, to improve utilization of in-house social work, pharmacy and NCCARE360 system by all medical providers and staff on the Geriatric Module.
- Continue collecting demographic data on the Eastern NC geriatric population to serve as a resource for future study/intervention.
- Develop informational resource packets for patients in need. Packets will be specific to the patient's home county. This is meant to address deficits due to COVID-19 closures.

ACKNOWLEDGEMENTS

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