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 the patient over the phone or in the room, Nurse or MA assists in completion, or patient declines.

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)

Plan
QI team determined to pilot social health needs screening tool for one week at ECU Family Medicine – Geriatric Module.

Do
ECU FM Geriatric module medical staff administered screening tool to patients for one month (including pilot week).

Act
Determined that due to COVID-19, many of the NCCARE360 resources in patient home counties were unavailable. Therefore, we developed an information packet for patients in need.

Study
Weekly review of completed screeners to identify areas of greatest social health needs and/or correlations among geriatric patient and unidentified social health needs.

RESULTS/OUTCOMES

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<th>Week</th>
<th>Dates</th>
<th>Total Screens</th>
<th>Negative</th>
<th>Positive</th>
<th>Incomplete</th>
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- Indicated Need(s), By Type

- 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
We would like to acknowledge the ECU Family Medicine Geriatric Module Staff in their hard work and dedication to this project and to the social health needs of their patients.

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