Conducting A Gap Analysis Of Current Practice Of Addressing Social Determinants Of Health In A Primary Care Setting: A Quality Improvement Project

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Background & Significance

- **Social determinants of health** (**SDOH**) are the places and conditions in which people are born, live, learn, work, and play, affecting a wide range of health risks and health outcomes (WHO, 2008)
- Striking differences in health status are evident in poorer communities; poorest of the poor demonstrate higher levels of illness and mortality.
- Direct impact of SDOH on health outcomes:
  - **Blood Glucose**
    - Those who are continuously insured tend to have lower baseline HgBA1C.(Li et al, 2016)
    - Glycemic control demonstrated to have an inverse relationship with education and social support. (Walker, Smalls, & Egede, 2015)
    - Glycemic control demonstrated to have a positive correlation with employment status and neighborhood (Li et al, 2016)
  - **Blood Pressure**
    - Strong positive association between hypertension and poverty (Kolat et al 2019)
    - Interventions aimed at SDOH in combination with standard management demonstrated better BP control (McClintock & Bogner, 2017)
- Despite growing emphasis of the impact of social determinants on health and health outcomes, currently, there is no routine approach to the assessment and management of SDOH.

Aims & Objectives

Aims

- To address SDOH and improve screening in the primary care setting

Objectives

- To assess current SDOH screening, if any
- To develop a toolkit to help providers in ambulatory care integrate best evidence for screening SDOH into routine practices
- To create a guide for available community resources.

Methodology

- **Design** Quality improvement project
- **Theoretical Framework** Plan-Do-Study-Act cycles
- **Sample** Convenience sample -- 10 providers (8 MD/DOs, 2 nurse practitioners) employed in ambulatory care services
- **Setting** an integrated health care system providing services to military veterans in NJ
- **Intervention** De novo survey (12 question, Likert style) administered over 4-week period with gap analysis comparing current practice with evidence to create practice recommendations and develop SDOH toolkit

Clinical Question

Are there differences between evidence-based and current practice of screening for SDOH in a primary care setting?

Results

Frequency of Screening

Social Determinant	*Housing (N, %)*	*Employment (N, %)*	*Food Insecurity (N, %)*	*Social Support (N, %)*	*Exposure to Crime and Violence (N, %)*	*Transportation (N, %)*
I never ask.	*0, 0%*	*1, 10%*	*0, 0%*	*0, 0%*	*1, 10%*	*1, 10%*
I ask only new patients at an initial visit.	*1, 10%*	*1, 10%*	*0, 0%*	*1, 10%*	*1, 10%*	*0, 0%*
I ask all patients once a year (at a health maintenance visit).	*1, 10%*	*2, 20%*	*2, 20%*	*2, 20%*	*3, 30%*	*2, 20%*
I ask all patients once a year (at a health maintenance visit) and periodically as needed.	*5, 50%*	*5, 50%*	*6, 60%*	*5, 50%*	*1, 10%*	*3, 30%*
I ask only patients at risk on an as needed basis.	*3, 30%*	*1, 10%*	*2, 20%*	*2, 20%*	*4, 40%*	*4, 40%*

SDOH Toolkit

Things to Consider

What?	How?	Who?	Where?	When?
What are we doing? Social Determinant of Health Screening implementation	*How will we gather the data?* Select a standardized Social Determinant of Health Screening tool from available tools (CMS AHC-HRSN, PRAPARE tool, EveryONE Project screening tool)	*Who will administer the screening tool?* – Non-clinical staff – Medical assistant – Nurse – Provider	*Where will be utilize the screening tool?* – In the waiting room – In the provider's office	*When during the visit will we administer the screening tool?* – Before the visit – During the visit *How frequently do we administer the tool?* – New patients – New patients + annually – New patients + quarterly – New patients + bi-annually

Available Standardized Social Determinant of Health Screening Tools

Currently, there is no preferred screening tool recommended for social determinants of health. There are three available:

OPTION 1	Centers for Medicare and Medicaid Services' Accountable Health Commmunities Health-Related Social Needs Screening tool (AHC-HRSN): 10 question self-assessment addressing housing instability, food insecurity, transportation needs, utility needs, and interpersonal safety.
OPTION 2	National Association of Community Health Centers Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool: 5 demographic questions + 15 core questions assessing housing, employment, education, security, transportation, social integration and stress, which can be administered by staff (clinical or non-clinical) or can be self-adminsitered.
OPTION 3	American Academy of Family Physicians EveryONE Project screening tool: 11 question assessment tool addressing housing, food, transportation, utilities personal safety, and the need for assistance, which can be adminsitered by staff (clincial or non-clinical) or can be self-administered.

(NOT SHOWN: EXISTING LOCAL RESOURCES TO ADDRESS IDENTIFIED SOCIAL NEEDS)

Discussion

- Prior to this project, the facility had no standardized, routine practice for the screening and referral of SDOH.
- Frequency of screening proved to be sporadic with rates for routine screening varying from 10 to 60%.
- The select domain(s) screened also varied by provider.
- Screening primarily was done without the use of standardized screening tools.
- Most providers were unaware of local community resources to which screened patients can be immediately referred.
- Based on the identified gaps in practice, a toolkit was developed that included workflow considerations, recommended standardized SDOH screening tools, and a list of local public services that address specific SDOH.

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Implications

- Evidence supports that increased screening increases identification of social needs as well as intervention on social needs improves health outcomes.
- Identification of social needs enables the provider to assist the patient in connecting with community resources to allow for increased compliance with treatment plans.
- The results of this project support the body of literature substantiating the need for routine screening of SDOH in primary care.
- Future scholarship could potentially focus on the effect of standardized screening such as rates of identified patients with social needs, rates of referrals to resources, and rates of resolved social needs. Future scholarship may also evaluate the effect of screening on clinically important outcomes such as decreased morbidity and mortality.

Sustainability

- VANJHCS is an ideal setting to develop and implement standardized SDOH screening into routine practice due to its integrated system and service of an indigenous population
- Potentially screening practices could be shared to other facilities in the Veterans Integrated Service Network (VISN) and subsequently to other VA facilities across the nation

Dissemination

Abstract for this project has been submitted by Rutgers for application to ENRS 2021 conference.

References

- American Academy of Family Physicians. (2020). Assessment and action. Retrieved from https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project/eop-tools/assessment-action.html#screen
- Centers for Medicare and Medicaid Services. (2019). The accountable health communities health-related social needs screening tool. Retrieved from https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf
- National Association of Community Health Centers. (2019). About the PRAPARE assessment tool.
- Kolak, M., Chua, R., Kamber, I., Tung, E. L., Besser, S., Anyanwu, E., . . . Tabit, C. (2019). Social determinants of health and clinical hypertension and diabetes prevalence on Chicago's south side. *Journal of the American College of Cardiology, 73*(9), 1824-1824. doi:10.1016/S0735-1097(19)32430-1
- Li, V., McBurnie, M. A., Simon, M., Crawford, P., Leo, M., Rachman, F., . . . Chang Weir, R. (2016). Impact of Social Determinants of Health on Patients with Complex Diabetes Who Are Served by National Safety-Net Health Centers. *Journal of the American Board of Family Medicine : JABFM, 29*(3), 356. doi:10.3122/jabfm.2016.03.150226
- McClintock, H., & Bogner, H. (2017). Incorporating Patients' Social Determinants of Health into Hypertension and Depression Care: A Pilot Randomized Controlled Trial. *Community Mental Health Journal, 53*(6), 703-710. doi:10.1007/s10597-017-0131-x
- Walker, R. J., Smalls, B. L., & Egede, L. E. (2015). Social determinants of health in adults with type 2 diabetes—Contribution of mutable and immutable factors. *Diabetes Research and Clinical Practice, 110*(2), 193-201. doi:10.1016/j.diabres.2015.09.007
- World Health Organization. (2008). Closing the gap in a generation : health equity through action on the social determinants of health : Commission on Social Determinants of Health final report.