The Social Determinants Of Health Nursing Knowledge and Needs Assessment Survey

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RUSH

Rush's Vision for Social Determinants of Health (SDoH)

Rush's vision is to be a healthcare system in which all patients' essential resource needs are addressed as a **standard** part of quality care. We believe that **identifying** the non-medical needs of our patients and **providing resources** (through shared and tracked referrals) will help us to **understand and address** our patients' needs better.

We believe that this will also help patients to **connect** more deeply with their health care providers and teams, and enable them to work towards a **better quality of life**. Through highlighting and closing care gaps, Rush will ultimately **impact health outcomes** such as ambulatory quality metrics (eCQMs), readmissions, and patient satisfaction (to name a few).

Key Definitions

Health Inequity

Socioeconomic differences in health - that is, health differences "which are unnecessary and avoidable but are also considered unfair and unjust."

Equity in Health

Everyone has a fair opportunity to attain their full health potential.

Social Determinants of Health

Conditions in which people are born, grow, live, work, and age (WHO)

IHI, 2018

Health Equity

Health equity means that everyone has a fair and just opportunity to be healthy.

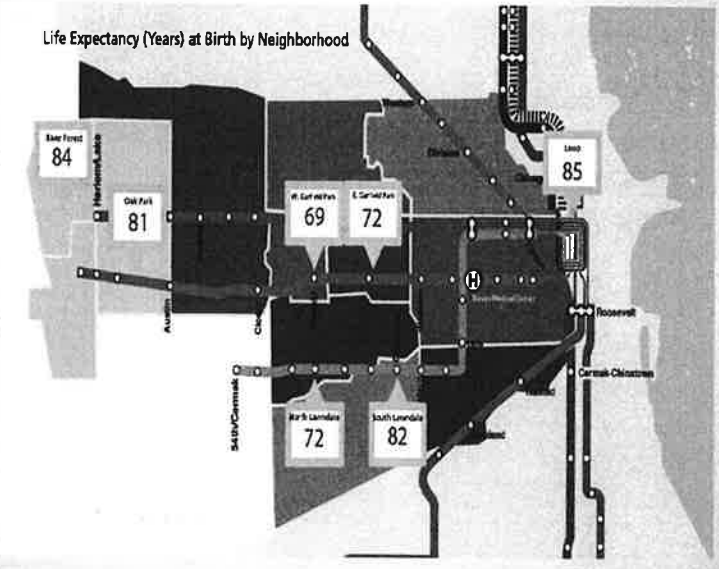
This requires removing obstacles to health such as poverty and discrimination while creating access to good jobs with fair pay, quality education and housing, safe environments, and quality health care.

County Health Rankings, 2018

Increased Interest

- High health care expenditures - poorer health outcomes.
- Medical care is insufficient for ensuring better health.
- New payment models prompting interest.
- Health care systems have vital role to play in achieving health equity.

There is a major gap in life expectancy between the West Side and the Loop, reflecting high levels of hardship and disease in West Side communities



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How Can Academic Medical Centers and Teaching Hospitals Address the Social Determinants of Health?

Malika Fair, MD, MPH and Taniecea Arceneaux, PhD | Association of American Medical Colleges (AAMC)

Social Determinants of Health are the conditions in which people are born, grow up, live, work, age, and receive health care.[1] Academic medical centers and teaching hospitals are uniquely positioned to address these factors to have a powerful impact on the health of communities.

Basic Necessities	• The availability of basic necessities such as healthy food and clean water is vital for the health of communities. • For example, decreased rates of obesity and increased life expectancy can be partly attributed to better nutrition.[2]	**Gundersen Lutheran Health System** has been committed to the health of its communities by working with local restaurants, convenience stores, and other retailers to offer healthy food choices to its community.[3]
Built Environment	• Health is determined in large part by the safety and supports available in homes and neighborhoods. • Inadequate housing, dangerous streets, and blighted neighborhoods all have a negative impact on health.[2]	As a prominent institution within a city challenged with crime, extreme poverty, and poor living conditions, **Henry Ford Health System** has partnered with several institutions to improve local neighborhoods and develop safe and affordable housing for the residents of Detroit.[3]
Education	• Educational opportunity is significantly related to good health outcomes. • People with more educational opportunities have better jobs, more affluence, greater health, and improved quality of life.[2]	**Johns Hopkins University**, in collaboration with Morgan State University, has developed a new public school in one of the poorest neighborhoods in East Baltimore. The school, named Henderson-Hopkins, is part of a major redevelopment project that includes new science and technology buildings, a park, retail development, and mixed-income housing.[4]
Community	• Social connectedness and a sense of community is directly related to achieving good health. • For instance, it has been shown that social cohesion is associated with lower mortality rates.[2]	**Florida International University** has developed the Green Family Foundation NeighborhoodHELP™ (Health Education Learning Program), which exposes students to the delivery of health care from a family and community perspective that will shape the way they interact with patients for the rest of their careers.[5]
Economic Stability	• Economic factors play an important role in the health of communities. • The unemployment rate, for example, has a great impact on issues such as domestic violence, substance abuse, depression, and physical illness.[2]	**University Hospitals** recently launched *The UH Difference: Vision 2010*, which aimed to include as many local minority- and female-owned businesses as possible, to direct as much spending as possible toward local businesses, and to produce lasting change in Northeast Ohio.[4]

References

[1]Healthy People 2020. http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39

[2]*Addressing Social Determinants of Health and Development*. The Community Tool Box. http://ctb.ku.edu/en/table-of-contents/analyze/analyze-community-problems-and-solutions/social-determinants-of-health/main

[3]Zuckerman, David. 2013. *Hospitals Building Healthier Communities: Embracing the Anchor Mission.*

[4]*Reading, Writing and Renewal (the Urban Kind)*, NY Times. http://www.nytimes.com/2014/03/18/arts/design/reading-writing-and-renewal-the-urban-kind.html

[5]Florida International University. http://medicine.fiu.edu/education/md/curriculum/service-learning/neighborhoodhelp/

Evolving Role for Nursing

- Traditionally taught to apply holistic lens
- Integration of SDoH new opportunity
- Compliments the Rush Health Equity Strategic Plan
- Demonstrated patient need

Purpose

- Assess nurses knowledge, level of comfort and behaviors relative to the social determinants of health.
- Provide data to inform staff education and enhance nursing's contribution to the overall strategic plan

Design

- Descriptive study
- Redcap online survey method tool
- IRB reviewed
- Invitational letter send by each CNO at three sites
- Interested parties directed to password protected link to Survey

Social Determinants of Health Survey

- 71 item Social Determinants of Health Survey
- Adapted with permission from Persaud (53) items)
- Added more SDoH items
- Open ended items to reflect internal and external community initiatives
- One multiple choice item on related barriers
- Identification of needed resources for nursing engagement

Survey Items

- How confident are you? (SDoH)
- How likely are you to ask?(SDoH)
- How knowledgeable are you? (SDoH)
- How knowledgeable about internal and external community efforts?
- How often do you ask patients?
- Awareness of their social needs, barriers to addressing needs.

Demographics

- Of those responding (n=421)

Primary Role

(RN1) 35 (7.8%)

(RN 2) 264 (58.7%)

(RN 3) 55 (2.2%)
Leaders 65 (21.3%)

Demographics

- Less than 2 years 47(10.9)%
- 2-10 years 161(35.8%)
- 11-20 years 94 (20.9%)
- Greater than 20 years 130 (28.9%)
- BSN 276(61.8%)
- MSN/PhD/DNP 139 (31%)

How confident are you in your ability to discuss the SDoH with Patients?

Social Determinant of Health	Frequency
Access to Nutritious Foods	
• Not at all/Slightly	138(28.6%)
• Very/Extremely	165(36.9%)
Access to Care	
• Not at all/Slightly	93(20.7%)
• Very/Extremely	198(41.5%)
Access to A Primary Care Provider	
• Not at all/Slightly	**79(17.9%)**
• Very/Extremely	**206(47.5%)**
Civic Participation	197(44.0%)
• Not at all/Slightly	129(25.6%)
• Very/Extremely	
Crime and Violence	168(37.5%)
• Not at all/Slightly	120(26.7%)
• Very/Extremely	
Discrimination	161(35.9%)
• Not at all/Slightly	136(30.3%)
• Very/Extremely	
Employment Status	129(28.8%)
• Not at all/Slightly	142(31.7%)
• Very/Extremely	
Environmental Conditions	136(25.8%)
• Not at all/Slightly	159(35.4%)
• Very/Extremely	
Health Literacy	86(19.2%)
• Not at all/Slightly	185(41.3%)
• Very/Extremely	

How confident are you in your ability to discuss the SDoH with patients?

Housing Situation	156(34.8%)
• Not at all/Slightly	138(30.8%)
• Very/Extremely	
Income	225(50.3%)
• Not at all/Slightly	92(20.6%)
• Very/Extremely	
Interpersonal Violence	168(63.7%)
• Not at all/Slightly	123(27.4%)
• Very/Extremely	
Level of Education	129(28.8%)
• Not at all/Slightly	148(33.0%)
• Very/Extremely	
Social Support Network	114(25.8%)
• Not at all/Slightly	173(38.7%)
• Very/Extremely	
Transportation Needs	107(25.0%)
• Not at all/Slightly	187 (41.7%)
• Very/Extremely	
Utilities	176(39.9%)
• Not at all/Slightly	123(27.9%)
• Very/Extremely	

How likely are you to ask about the SDoH?

Social Determinant of Health	Frequency
Access to Nutritious Foods	
• Not at all/Slightly	202 (45.4%)
• Very/Extremely	106(23.8%)
Access to Care	
• Not at all/Slightly	106(26.0%)
• Very/Extremely	170(38.1)%
Access to A Primary Care Provider	
• Not at all/Slightly	107(24.1%)
• Very/Extremely	285(64.2%)
Civic Participation	
• Not at all/Slightly	292(65.6%)
• Very/Extremely	62(13.9%)
Crime and Violence	
• Not at all/Slightly	235(51.8%)
• Very/Extremely	83(18.5%)
Employment Status	
• Not at all/Slightly	179(40.1%)
• Very/Extremely	137(30.6%)
Environmental Conditions	
• Not at all/Slightly	167(37.4%)
• Very/Extremely	130(29.3%)
Health Literacy	
• Not at all/Slightly	143(31.9%)
• Very/Extremely	156 (34.9%)

How likely are you to ask about the SDoH?

Housing Situation	
• Not at all/Slightly	144(32.2%)
• Very/Extremely	157(60.2%)
Income	
• Not at all/Slightly	292(65.2%)
• Very/Extremely	64(14.3%)
Interpersonal Violence	179(50.3%)
• Not at all/Slightly	125(28.1%)
• Very/Extremely	
Level of Education	194(43.4%)
• Not at all/Slightly	113(25.3%)
• Very/Extremely	
Social Support Network	
• Not at all/Slightly	114(25.3%)
• Very/Extremely	182(40.7%)
Transportation Needs	113 (37.5%)
• Not at all/Slightly	180(40.3%)
• Very/Extremely	
Utilities	227(51.3%)
• Not at all/Slightly	98 (22.2%)
• Very/Extremely	

How knowledgeable are you regarding the SDoH?

Social Determinant of Health	Frequency
Access to Nutritious Foods	
• Not at all/Slightly	145(32.4%)
• Very/Extremely	116(26.0%)
Access to Care	
• Not at all/Slightly	115(25.8%)
• Very/Extremely	129(28.9%)
Access to A Primary Care Provider	
• Not at all/Slightly	108(24.4%)
• Very/Extremely	136(30.7%)
Civic Participation	
• Not at all/Slightly	221(49.6%)
• Very/Extremely	73(16.4%)
Crime and Violence	
• Not at all/Slightly	183(41.0%)
• Very/Extremely	93(20.8%)
Discrimination	
• Not at all/Slightly	158(35.5%)
• Very/Extremely	99.2(23.1%)
Employment Status	
• Not at all/Slightly	165(37.0%)
• Very/Extremely	106(23.8%)
Environmental Conditions	
• Not at all/Slightly	149(33.5%)
• Very/Extremely	116(26.0%)
Health Literacy	
• Not at all/Slightly	136(25.2%)

How knowledgeable are you regarding the SDoH?

Housing Situation	
• Not at all/Slightly	176 (39.4%)
• Very/Extremely	97 (21.8%)
Income	
• Not at all/Slightly	186 (41.8%)
• Very/Extremely	100 (22.5%)
Interpersonal Violence	
• Not at all/Slightly	77 (39.6%)
• Very/Extremely	98 (22%)
Level of Education	167(28.6%)
• Not at all/Slightly	127(28.6%)
• Very/Extremely	
Social Support Network	142 (31.9%)
• Not at all/Slightly	124 (27.9%)
• Very/Extremely	
Transportation Needs	45(10.2%)
• Not at all/Slightly	117(26.6%)
• Very/Extremely	
Utilities	190 (44.0%)
• Not at all/Slightly	87 (20.1%)
• Very/Extremely	

How Knowledgeable about Community Internal Efforts and SDoH?

	Not at all	Slightly	Very	Extremely
Conducting social determinants of health screening for patients in the emergency room and primary care clinics?	162(36.8%)	133(30.2%)	33(7.5%)	11(2.5%)
Integrating NOWPOW referral resource service into EPIC	269(60.7%)	102(23.0%)	17(3.8%)	6(1.4%)
Creating the Food Surplus Program to assist communities in addressing food insecurity	195(44.5%)	111(25.3%)	41(9.4%)	13(3.0%)
Establishing the "Food as Medicine" initiative for patients.	240(54.4%)	116(26.3%)	16(3.6%)	4(.9%)

How often do you ask patients about the SDoH?

Social Determinant of Health	Frequency
Access to Nutritious Foods	
• Not at all/Slightly	202 (45.4%)
• Very/Extremely	106 (23.8%)
Access to Care	
• Not at all/Slightly	106 (26.0%)
• Very/Extremely	170 (38.1)%
Access to A Primary Care Provider	
• Not at all/Slightly	107 (24.1%)
• Very/Extremely	285 (64.2%)
Civic Participation	
• Not at all/Slightly	292 (65.6%)
• Very/Extremely	62 (13.9%)
Crime and Violence	
• Not at all/Slightly	235 (51.8%)
• Very/Extremely	83 (18.5%)
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• Not at all/Slightly	179 (40.1%)
• Very/Extremely	137 (30.6%)
Environmental Conditions	
• Not at all/Slightly	167 (37.4%)
• Very/Extremely	130 (29.3%)
Health Literacy	
• Not at all/Slightly	143 (31.9%)
• Very/Extremely	156 (34.9%)

How Often Do You Ask Patients About the SDoH?

Housing Situation • Not at all/Slightly • Very/Extremely	 144(32.2%) 157(60.2%)
Income • Not at all/Slightly • Very/Extremely	 292(65.2%) 64(14.3%)
Interpersonal Violence • Not at all/Slightly • Very/Extremely	179(50.3%) 125(28.1%)
Level of Education • Not at all/Slightly • Very/Extremely	194(43.4%) 113(25.3%)
Social Support Network • Not at all/Slightly • Very/Extremely	 114(25.3%) 182(40.7%)
Transportation Needs • Not at all/Slightly • Very/Extremely	113 (37.5%) 180(40.3%)
Utilities • Not at all/Slightly • Very/Extremely	227(51.3%) 98 (22.2%)

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Knowledge and Comfort SDOH

Very	Not at All	Somewhat	Very
How knowledgeable are you on the social and economic issues that affect the patients that you care for face?	49(11.1%)	298(67.4%)	95(21.5%)
How comfortable do you feel raising and discussing issues related to the social determinates of health with patients during care?	73(16.6%)	270(61.2%)	98(22.2%)
How knowledgeable do you feel advising patients about local resources to help their identified social needs?	158(35.5%)	237(53.3%)	50(11.2%)

What are the barriers to addressing issues with patients in your care? Check all that apply

it takes too much time	120(26.7)
I'm uncomfortable asking this type of information	113 (25.1%)
I think my patients would be uncomfortable if I asked	166(36.9%)
I don't know how to address the issues if they are present	180(40.0%)
I don't think my patients have these types of issues	16(3.6%)
I don't think these are important issues	1(.2%)
Nurses should not be involved in these types of issues	20(4.4%)
I believe that social work handles these types of issues	197(43.8%)
I believe that case management handles these types of issues	185(41.1%)
There are other people in the organization who address these issues	91(20.2)%

RUSH

Addressing SDoH Needs

SDoH Need	Intervention
Primary Care and Insurance	• Transitional Care Program (TCP) and CommunityHealth
Utilities	• Community and Economic Development Association (CEDA) of Cook County
Housing*	• Better Health Through Housing pilot w/Center for Housing and Health (CHH) • Coordinated Entry System (Future State)
Food Insecurity	• Top Box (employees) • Food is Medicine Program/Greater Chicago Food Depository (inpatient) • Food Surplus (community)
Transportation*	• MCOs (First Transit); PACE; • Lyft Partnership

*Involves referral to Social Work services

Comments

- Additional education most requested (SDOH, SW, types of insurance)
- Resource Listing
- 24 hour social worker
- Workshop on how to address patients without offending beyond a check box
- Clear expectations on how an when to ask these questions
- Discomfort with addressing these issues night shift

IMPLICATIONS

- Expand Screening for the SDoH
- Create a nursing agenda around the social determinants of health using the Nurse Health Equity Council
- Educate to address nursing needs and support
- Sustain critical interdisciplinary partnerships
- Capture the patient experience
- Support student projects (WYNN, SANCHEZ)
- Identify outcome measures

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