Lunch & Learn

Tuesday, February 15th, 2022 | 12:00 PM

- Welcome!
- Daily Newsletters
-

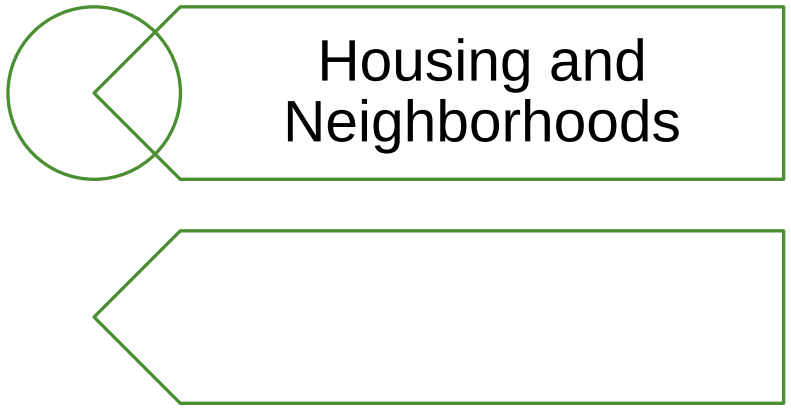
Objectives

1. Define social determinants of health
2. Discuss the downstream social determinants of health and the interventions used to address them in the delivery of care in patient with heart failure

What Are Social Determinants of Health (SDOH)?

Conditions in which people are

Social Determinants of Health Components



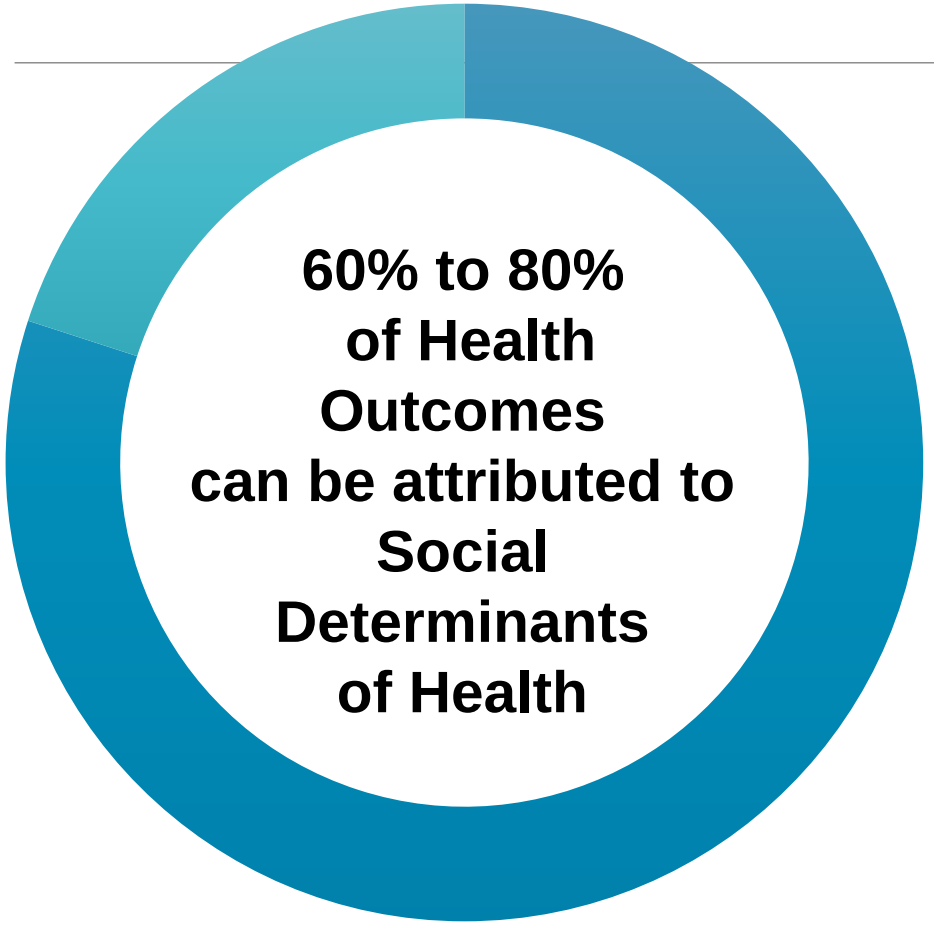
Upstream

- Use policies and laws to address community conditions and social environment

Midstream

- Address individual social needs
- Utilize screening questions to address needs

Social Determinants of Health and Their Impact



Physical Health
- Access to Care
- Functional Status
- Quality of Life

Behavioral Health
- Depression, Anxiety

Social Health
- Isolation, Community Participation
- Financial Burden

Sterling, M et al. Journal of the American Heart Association. Social Determinants of Health and 90-Day Mortality After Hospitalization for Heart Failure in the REGARDS Study, Volume: 9, Issue: 9, DOI: (10.1161/JAHA.119.014836)
World Health Organization. 2020.

Heart Failure and Social Determinants of Health

Heart failure is expected to increase in incidence with direct medical costs increasing from $21 to $69.8 billion by 2030.

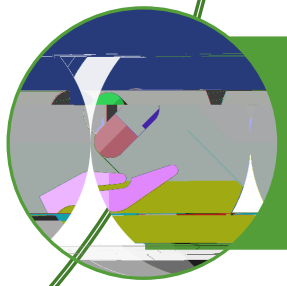
Patients who experience the unfortunate consequences of social determinants of health may have poorer health outcomes.

Important transitions of care are challenging for the underser trans999 137.6266 Tm(Important transitions of care are)TjEMC (t)3.

Social Determinants of Health

Access to Care

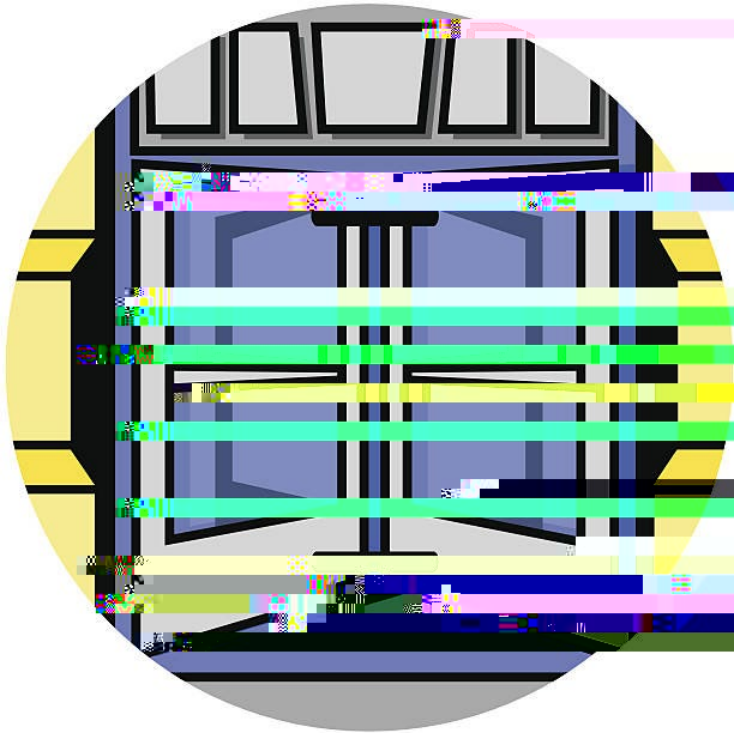
Food Insecurity



Access to Medication

What Happens when Patients with Heart Failure don’t have Access to Care?

- Insufficient follow-up for heart failure treatment
- Uninsured use the Emergency Department for routine care
- Frequent Readmissions



Khan, Muhammad Shahzeb, et al. Trends in 30- and 90-Day Readmission Rates for Heart Failure. *Circulation. Heart Failure*, 2021.
Psotka MA et al. The hospital readmissions reduction program: nationwide perspectives and recommendations: a JACC: heart failure position paper. JACC Heart Fail. 2020.

Access to Care

Create a program to care for underserved patients

Heart Failure Transitional Care Services for Adults (HRTSA) Clinic

- Nurse-led clinic
- Interprofessional team: Nursing (Administration, NPs, CNL, RN, CMA, Office Support), Social Work, Medicine (Collaborating Physician and Psychiatrist),

Mr. J

59 yr old African American

Presents to HRTSA for evaluation and management of heart failure.

Past medical revealed a history of hypertension (HTN), chronic kidney disease, crack-cocaine use, and recent stroke without residual weakness or speech abnormalities.

Medical record review indicated the patient had four documented emergency department visits and hospital readmissions within the past six months. Most recently, the patient reports that he was hospitalized with chest pain, shortness of breath, and elevated blood pressure after missing several weeks of prescribed medications. **He stated, "I didn't take my meds because I wasn't sure which ones were important enough to buy first and when to take each one."**

He reports becoming dyspneic when walking 10 feet to the mailbox, whereas he was previously able to walk 2 blocks before having to stop to rest due to shortness of breath. He denied current chest pain or palpitations. He does not exercise. He does not adhere to dietary or fluid restrictions.

Mr. J

The patient is currently unemployed.

He reports that his prior home was bulldozed, and that he is living with a sister and does not have stable housing.

He is uninsured.

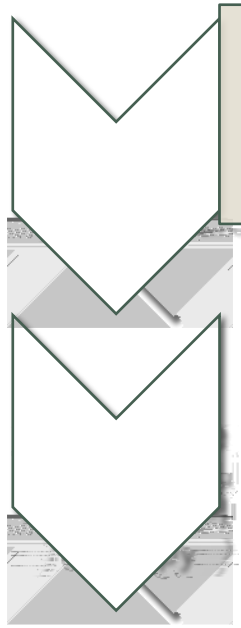
Reports current tobacco use and occasional crack-cocaine use.

Depression and anxiety screenings were low.

Health literacy screening scored “inadequate.”

Patient screened food insecure.

Interventions to Address Access to Care: 3 Care Bundles



- **Meet Patient in Hospital before Discharge**
- **Clinic calls to remind of appointment, Automated text reminder of appointment**
- **Offer home visit if within 30-mile radius of hospital (suspended during COVID)**
- **Interprofessional Team Appointment Begin to establish a trusting relationship**

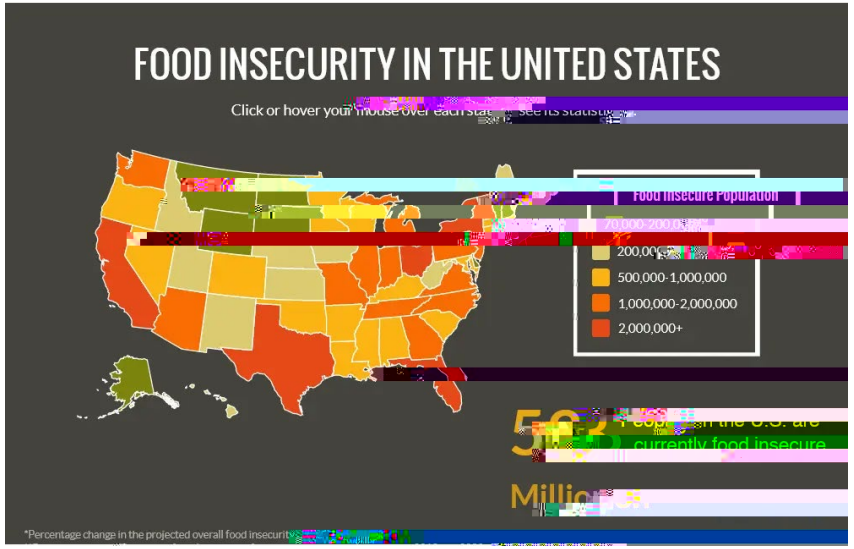
Food Insecurity

An economic and social condition characterized by limited or uncertain access to adequate food

COVID-19 pandemic has impacted food insecurity

Estimates of 40 to 54 million people are food insecure in the U.S.

Feeding America projects 42 million or 1 in 8 households are food insecure; Racial disparities exist



Interventions to Address Food Insecurity

Meal Vouchers

Provide a healthy meal at Support Group meetings

Partner with Local Food Bank
(Community Food Bank of Central Alabama

Access to Medication

Guideline directed medical therapy with titration to maintenance dose is a goal of the HRTSA Clinic.

Many patients are faced with difficult decisions when it comes to deciding between medications and food, medications and bills, medications and basic needs.

Access to medication can impact survival, quality of life, and readmission rates.

Cainzos-Achirica M et al., Int J Cardiology, 2019; White-Williams et al., Circulation, 2020

Interventions to Address Access To Medication

Education

- Medication Reconciliation
- Medicine Action Plans
- Pill boxes
- Prescriptions
- Refills

Transportation

- Bus Passes
- Bus Route
- Free Parking

Assistance Programs

- Free/Low Cost Coupons
- Medication Assistance Programs

Pharmaceutical Assistance Programs and Dispensary of Hope

- **Pharmaceutical Assistance Programs (PAPs)**
  - Company programs that provide medications to those who qualify:
    - –Income limits vary, ranging from 200% FPL-400%FPL
    - –No or limited insurance coverage
  -

Dispensary of Hope (DOH)

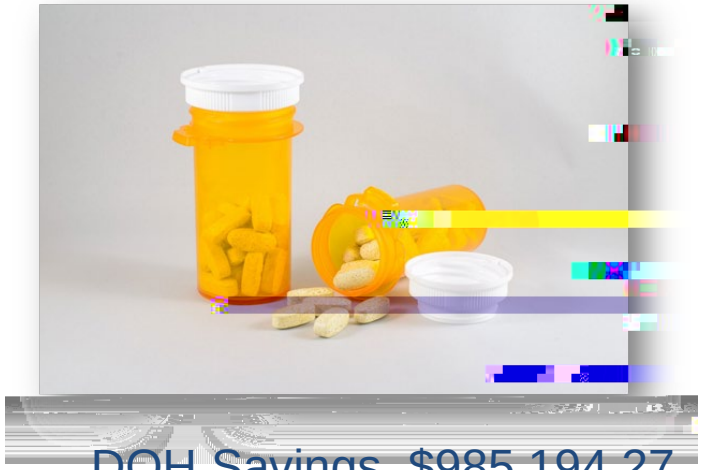
The Dispensary of Hope (DOH) delivers critical medicine – free of cost – to the people who need it the most but cannot afford it.

DOH is a charitable medication distributor dedicated to providing pharmacies and safety-net clinics with reliable access to vital medication – generously donated by pharmaceutical manufacturers.

Must be at or below 300% of Federal Poverty Guidelines.

Partnered with our Ambulatory Pharmacy to implement.

- Annual dues
- Medication storage must be in separate area
- DOH Formulary



DOH Savings $985,194.27
May 2019 to October 2021

Focused Interventions to Address Social Determinants of Health

Housing

Collaborate with Local Organizations (One Roof, Shelters, Housing Authority) to provide stable housing

Safe Environment

Behavioral Health

Women.lC.63997m6nh

Mr. J

With the social workers' assistance, he was able to apply and be approved for Supplemental Security Income (SSI), therefore gaining monthly income to secure more stable housing.

Behavioral health addressed his tobacco and cocaine dependence and medication along with regular counseling was instituted to mitigate the effects of triggers and address barriers to quitting substance use.

He was also able to establish care with a counselor.

He was seen both by clinic physical therapy students, and enrolled in cardiac rehabilitation, which he completed.

No ED visits and admissions in the last 12 months.

He was able to resume regular fishing, a favorite pastime, and reported sustained NYHA class II symptoms, an improvement from his initial visit.

Take Aways

- An interprofessional collaborative practice can be a successful model in caring for an underserved heart failure population.
- Addressing social determinants of health can lead to improved heart failure outcomes.
- Reducing hospital readmissions can lead to significant cost avoidance in the underserved heart failure population.
- Patient engagement in their self-care is a critical component of reducing hospitalizations.