Heart Failure Awareness Week

Lunch & Learn
Tuesday, February 15th, 2022
Social Determinants of Health & Heart Failure: Lessons from the Field

American Heart Association.

Heart Failure Awareness Week!

- Welcome!
- Daily Newsletters
- Lunch & Learns Monday-Friday 12pm CST
- Join HFSA and other heart failure-focused organizations on Twitter at 11am CST on Wednesday, February 16 for a lively discussion on heart failure. The purpose of the chat is to provide healthcare providers and heart failure patients with an overview on the status of heart failure and to discuss ways to improve quality of care and expand heart failure awareness. Follow hashtag #HFChat2022
- Recordings
- Slides & Attachments
- Submit questions through the question panel

Social Determinants of Health and Heart Failure: Lessons from the Field

American Heart Association
February 15, 2022

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I have no disclosures.

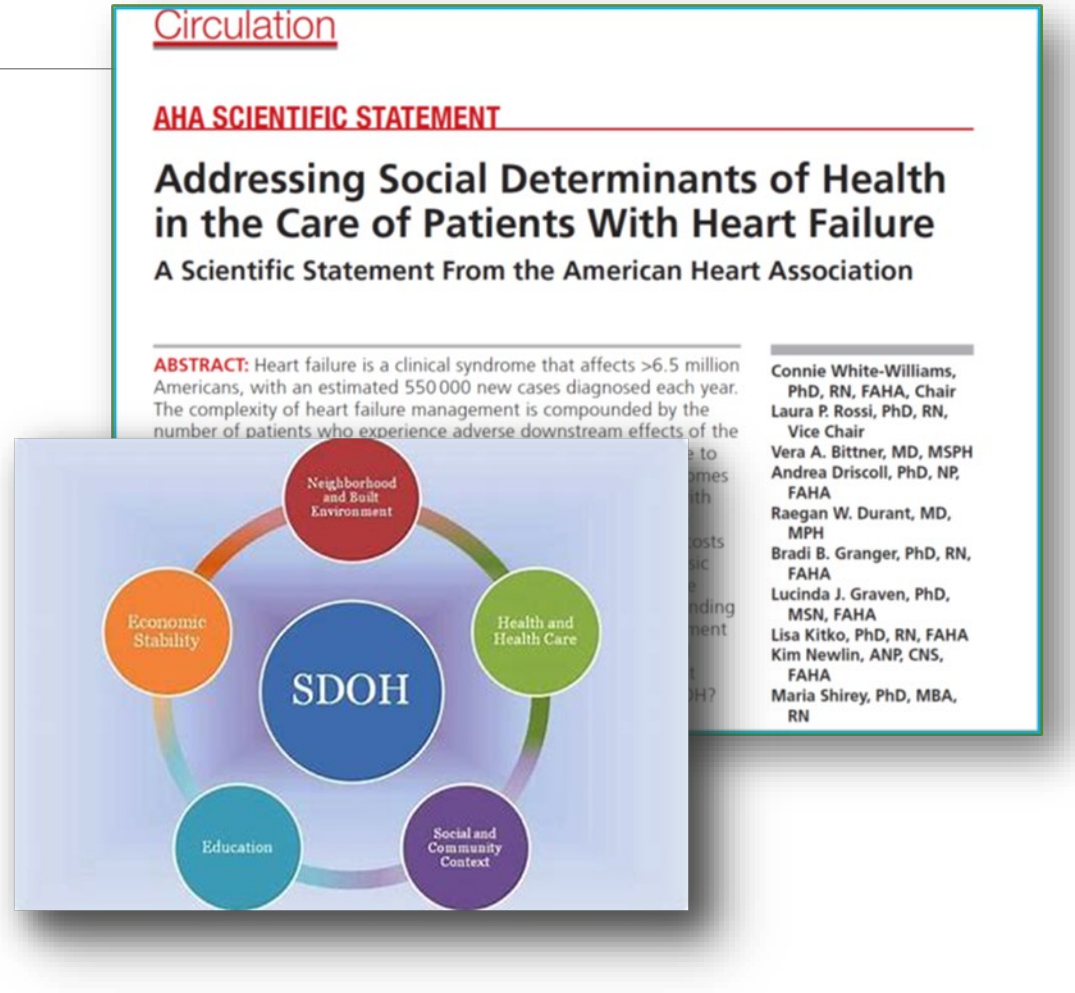
Objectives

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 born, grow, work, live, and age…and the wider set of systems that shape conditions of daily life.

(WHO)



World Health Organization. 2020.

Social Determinants of Health Components

Housing and Neighborhoods

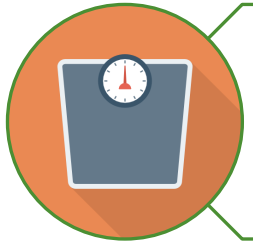
Education

Socioeconomic Position

Transportation

Food Insecurity

Access to Medication



Access to Care

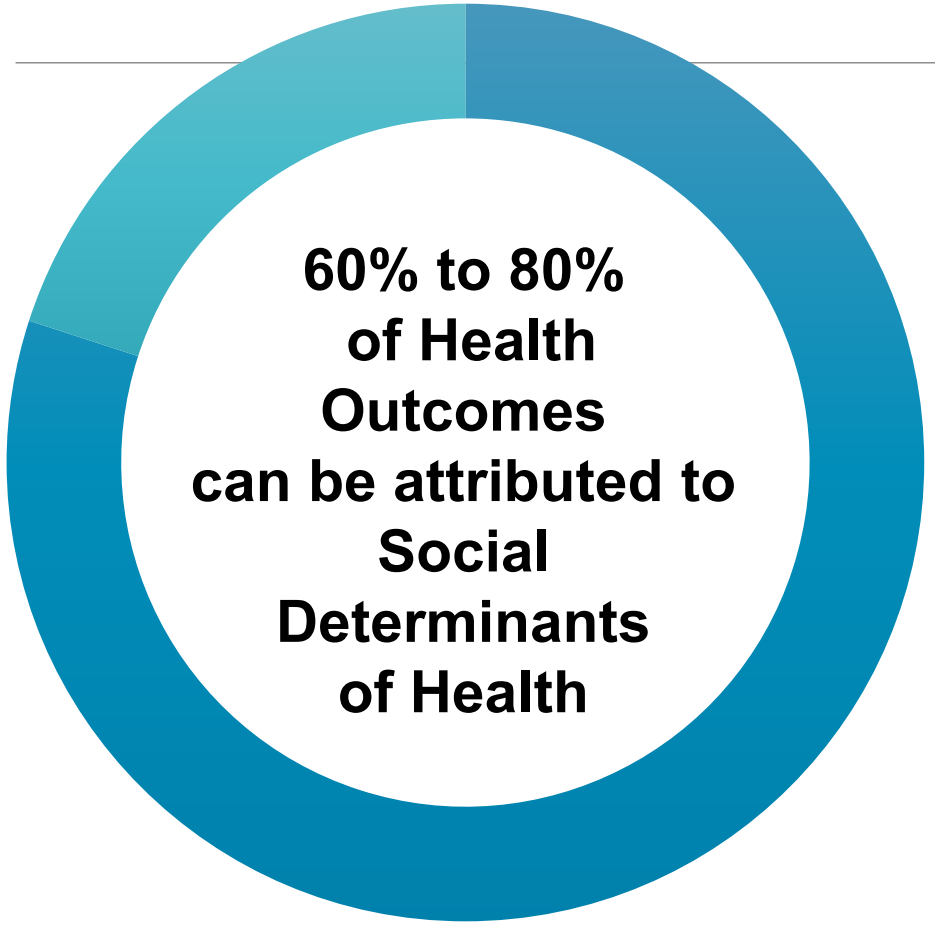
Social Determinants of Health and Their Impact

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

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

Downstream
- trickle-down effects of the unaddressed upstream and midstream variables seen in the clinical setting

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

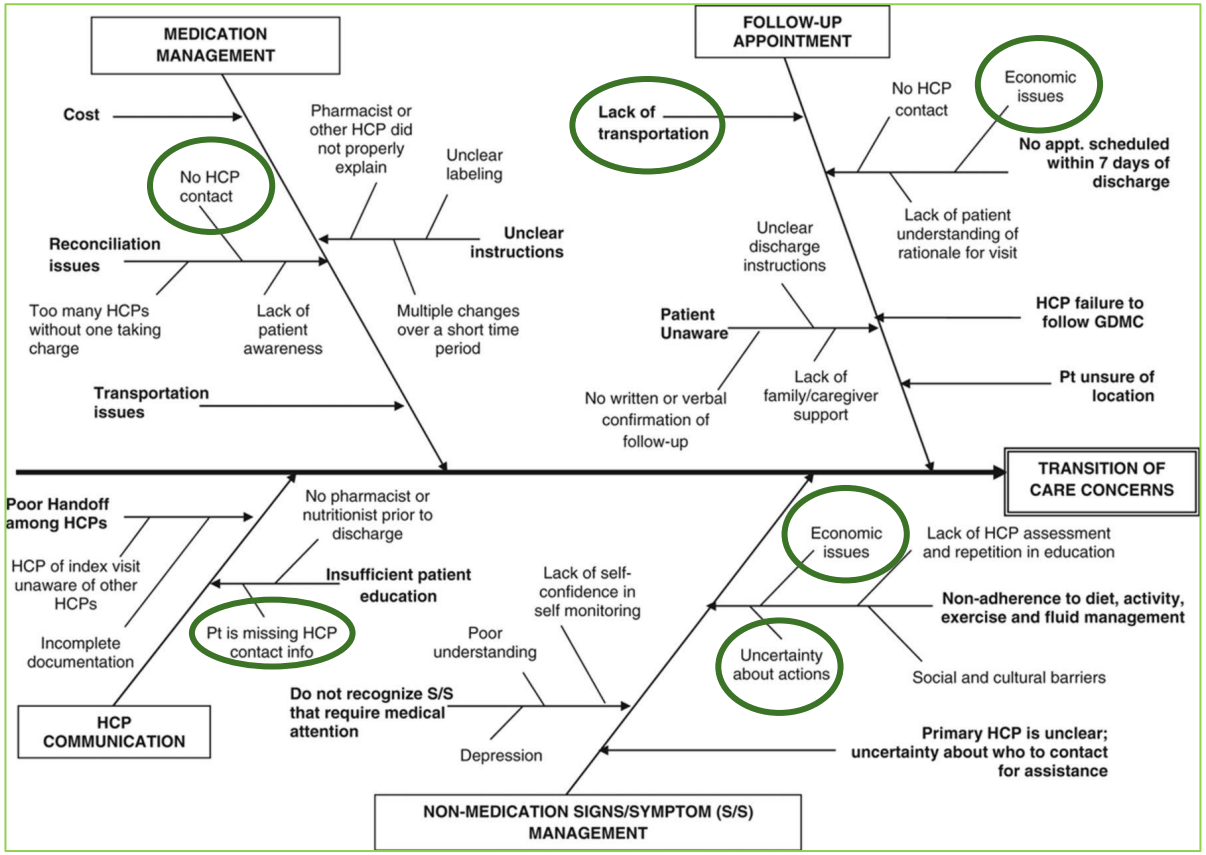
Sterling, M et al. Journal of the American Heart Association. Social Determinants of Health and 90-Day Mortality After Hospitalization for Heart Failure in the REGARDS Study, Volume: 9, Issue: 9, DOI: (10.1161/JAHA.119.014836)
World Health Organization. 2020.

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 underserved.



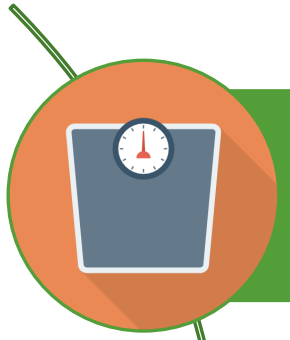
Albert NM, et al. *Circulation Heart Fail.* 2015;8:384-409

Maddox T, Januzzi J, Allen L…Youmans Q. *Journal of the American College of Cardiology*, 2021

Virani, Salim S., et al. Heart Disease and Stroke Statistics-2021 Update: A Report from the American Heart Association. *Circulation*, 2021.

White-Williams C, Rossi LP, Bittner VA, Driscoll A, Durant RW, Granger BB, Graven LJ, Kitko L, Newlin K, Shirey M.; *Circulation*. 2020

Social Determinants of Health



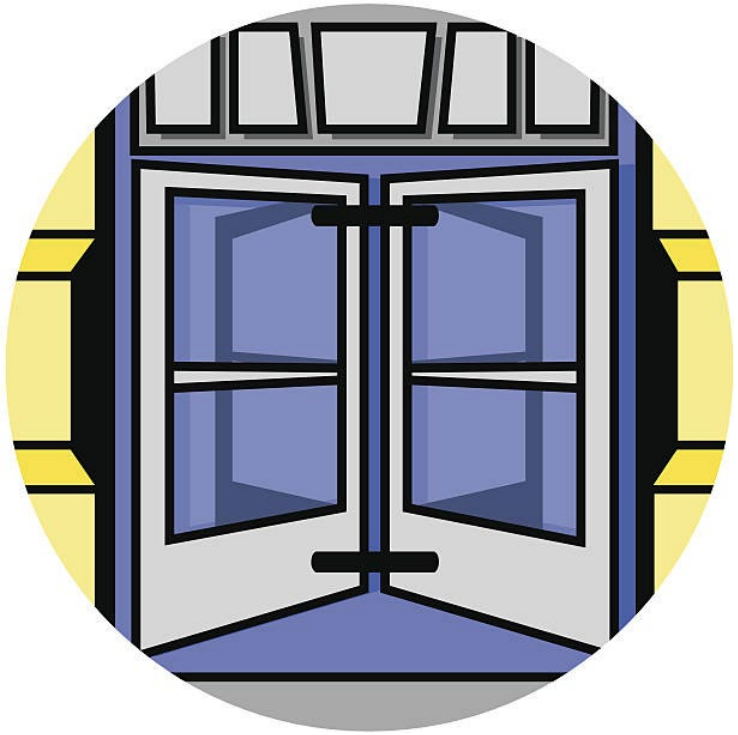
Access to Care

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



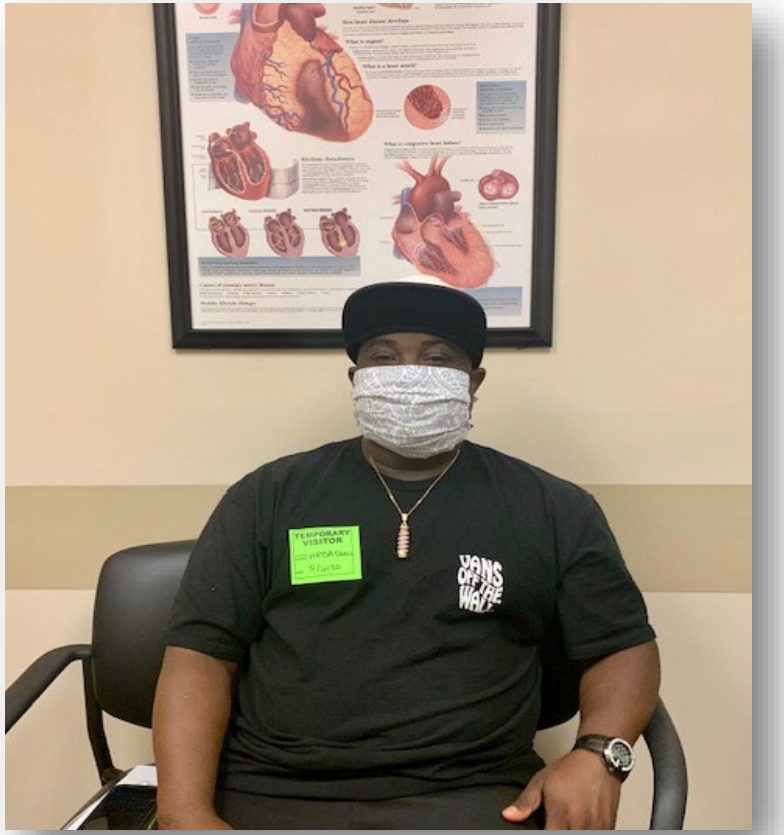
Khan, Muhammad Shahzeb, et al. Trends in 30- and 90-Day Readmission Rates for Heart Failure. *Circulation. Heart Failure*, 2021.
Psotka MA et al. The hospital readmissions reduction program: nationwide perspectives and recommendations: a JACC: heart failure position paper. JACC Heart Fail. 2020.

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), Pharmacy, Health Professions, Public Health
- Guideline Directed Medical Therapy
- Address social determinants of health



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

Transitional Care

- **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**

Guideline Directed Medical Therapy

- **Do not Bill for services**
- **Extensive SDOH Assessment**
- **Access to Medication programs**
- **Medication Education**
- **Heart Failure Self Care**

Patient Activation

- **Clinic calls and Automated Text messages to remind of appointment**
- **Continue to establish a trusting relationship**
- **Provide resources for self care (Scales, BP cuffs, Pillboxes)**
- **Continue GDMT and SDOH Interventions (housing, environment, financial stability)**
- **Offer Behavioral Health, Peer Support if needed**

White-Williams C,et al. An interprofessional collaborative practice can reduce heart failure hospital readmissions and costs in an underserved population. *J Card Fail*. 2021

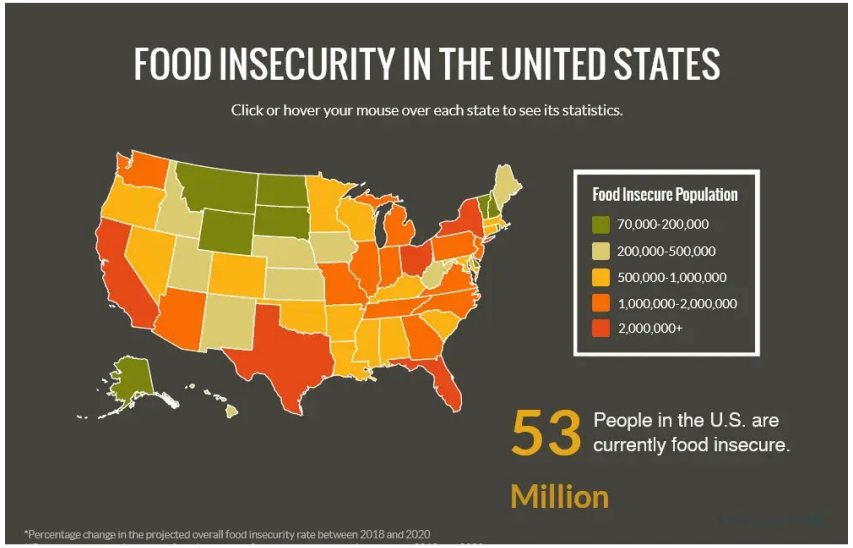
Food Insecurity

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



https://www.feedingamerica.org/sites/default/files/2021-03/National%20Projections%20Brief_3.9.2021_0.pdf

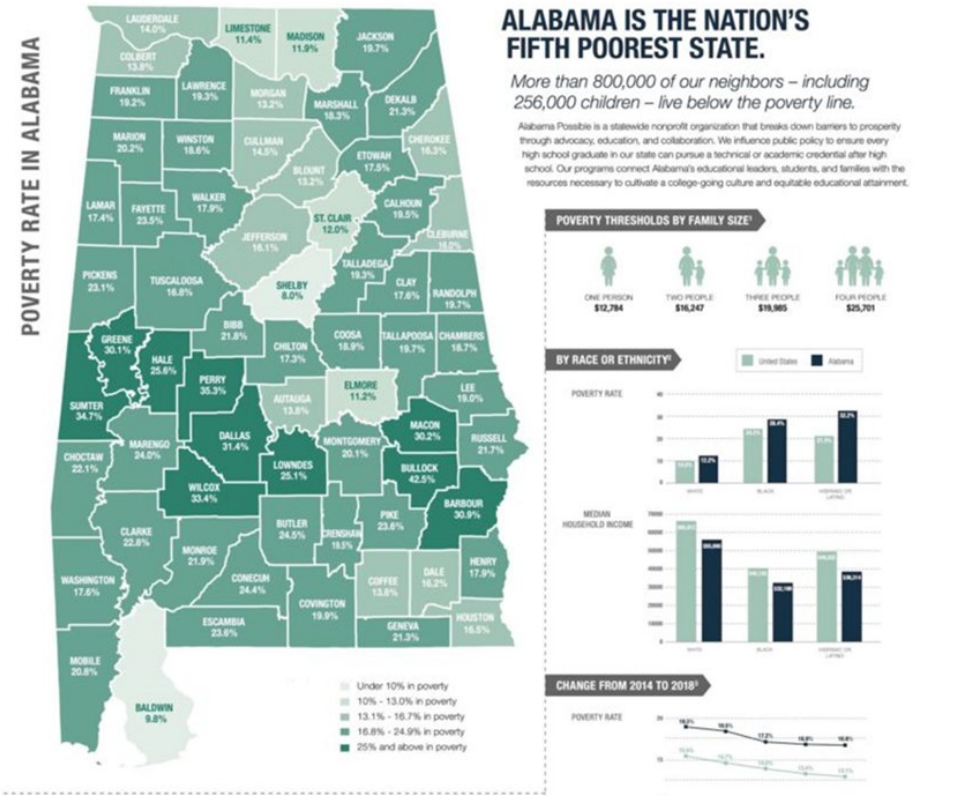
Addressing SDOH: Food Insecurity

In Alabama, 19.2 percent of the state's population is food insecure

In the HRTSA clinic, over 58% of the patients are food insecure

Screening every patient with validated 2-item screener

- Within the past 12 months, we worried whether our food would run out before we got money to buy more.
- Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.



https://www.welfareinfo.org/poverty-rate/alabama/jefferson-county
http://alabamapossible.org/2019/07/25/2019-poverty-data-sheet-800000-alabamians-live-below-poverty-threshold/

Clarkson EB, et al. Food link: A partnership providing healthy foods to food insecure patients. *Progress in Community Health Partnerships: Research, Education, and Action.* 2021.

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 and UAB's Benevolent Fund)

For every patient who screens food insecure, a bag of dry goods (pasta, rice, beans, low sodium sauce) and a bag of seasonal fresh produce (vegetables, fruit) are distributed.

Clarkson EB, et al. Food link: A partnership providing healthy foods to food insecure patients. *Progress in Community Health Partnerships: Research, Education, and Action.* 2021.

What Happens when Patients with Heart Failure are Food Insecure?

Those who are food insecurity are more likely to report rationing their medications, skip doses, or not take the full dose in order to make their medication last longer.

May use the Emergency Department for Meals

Frequent Readmissions

Berkowitz SA, et al. Treat or eat: food insecurity, cost-related medication underuse, and unmet needs. *Am J Med*. 2014.
Berkowitz SA, et al. Trends in food insecurity for adults with cardiometabolic disease in the United States: 2005-2012. *PLoS One*. 2017.

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
  - Where to start: Needymeds.org
- **Dedicated Position to assist Social Work with applications**

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

Social Determinants of Health

Socioeconomic Position

Housing and Environment

Education

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's Shelters
- **Transportation**
  - Bus passes
  - Free parking

Education

- Assess Health Literacy
- Educational Material
- Assist to Help Attain GED
- Assist Navigating the Healthcare System

Behavioral Health

- SON Behavioral Health Integration grant
- Peer Support Program
- PMHNP

Mr. J

Set him up with the DOH Pharmacy where he can obtain his medications for no cost.

Schedule a medication visit with the patient every two weeks to assist him in filling his pillboxes with teach back verification.

Provide education and medication action list with dosage and times.

Provide the patient access to immediate food resources and state benefit programs.

Counsel patient using a non-judgmental approach that focuses on the benefits of smoking cessation, options for support services and pharmacologic assistance, and how to identify triggers.

Offer Peer Support and Behavioral Health.

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.

THANK YOU!

For questions or more information: please contact your local AHA Quality Improvement Manager OR reach out via the below link: https://www.heart.org/en/professional/quality-improvement/contact-your-local-get-with-the-guidelines-representative

Registration for tomorrow's Lunch & Learn on Certification: At the Heart of Heart Failure Care can be completed by clicking here.

American Heart Association.