NHPCO Project ECHO 2023

Equity Where It Matters

Topic: Exploring Lived Experiences to Address Social Determinants of Health in End-of-life Care

Date: March 16, 2023

NHPCO Project ECHO Team

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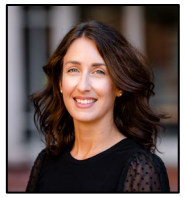

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Disclosures

Disclosure

The planners and faculty disclose that they have no financial relationships with any commercial interest.

Data Collection

In order to support the growth of the ECHO® movement, Project ECHO® collects participation data for each ECHO® program. Data allows Project ECHO® to measure, analyze, and report on the movement's reach. Data is used in reports, on maps and visualizations, for research, for communications and surveys, for data quality assurance activities, and for decision-making related to new initiatives.

Evaluation

You will be receiving an email with a link to complete a short survey about this session. Please complete the survey within 48 hours. We ask all participants to take the survey as it will help us to improve future sessions.

Ground Rules and Video Teleconferencing Etiquette

- This is an all share-all learn format; judging is not appropriate
- Respect one another – it is ok to disagree but please do so respectfully
- Participants – introduce yourself prior to speaking
- One person speaks at a time
- Disregard rank/status
- Remain on mute unless speaking and eliminate or reduce environmental distractions to improve sound/video quality
- Use video whenever possible; make eye contact with the camera when you are speaking
- **Do not disclose protected health information (PHI) or personally identifiable information (PII)**

Today's Agenda

- Introduction of Faculty – NHPCO Team
- Didactic Presentation – Faculty
- Case Study Presentation – Faculty
- Discussion – Session Participants, Faculty, and NHPCO Team
- Key Takeaways – Faculty and NHPCO Team
- Closing Remarks – NHPCO Team

Session Faculty

Keith T. Everett, MBA, MHA, CPHQ, CSSBB,
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Didactic Presentation

Social Determinants of Health (SDoH)

The **conditions** in the environments where people are born, live, learn, work, play, worship, and age that **affect** a **wide range of health, functioning, and quality-of-life outcomes and risks**.

SDoH Domains

HEALTHCARE ACCESS & QUALITY

Access to healthcare is not equal, and people's financial and physical access to healthcare, as well as their understanding of health services and their health, is a major social determinant of health. This includes access to primary care, access to specialty care, health insurance coverage, and health literacy. Health literacy is especially salient as a non-medical social factor

ECONOMIC STABILITY

people's income, socioeconomic status, and cost of living, with factors such as poverty, unemployment or underemployment, food insecurity, and housing instability negatively impacting health..

EDUCATION ACCESS & QUALITY

Influences health and well-being. Education factors include early childhood education and development, graduating from high school, receiving higher education, and even English knowledge and literacy.

SOCIAL & COMMUNITY CONTEXT

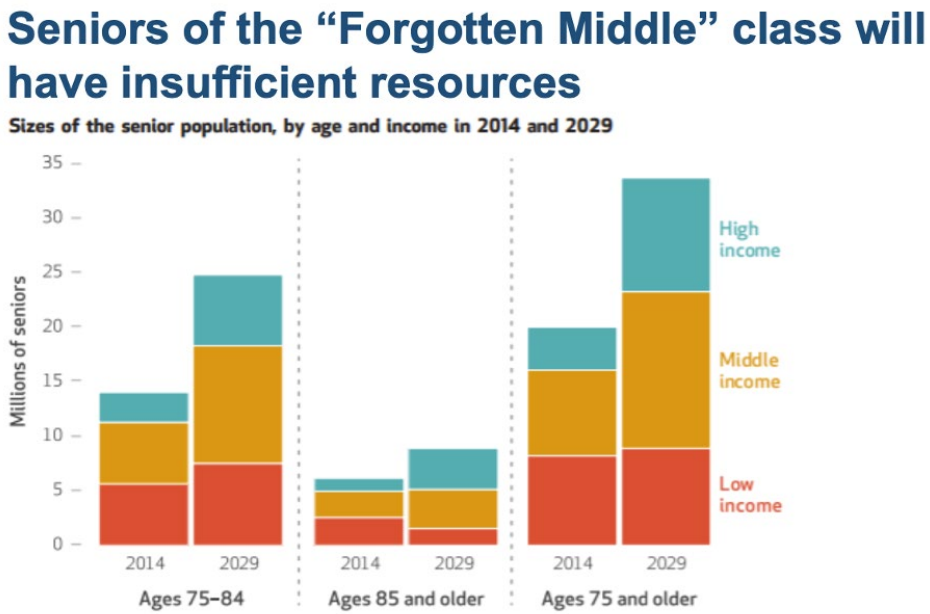
covering the contexts in which people live, study, work, and relax. The sense of belonging to a community, workplace conditions, and discrimination or racism all impact people's health..

NEIGHBORHOOD & BUILT ENVIRONMENT

affect health outcomes through quality of housing, access to transportation, access to healthy foods and clean water, air quality inside and outside, and the impact of crime and violence on people who live in the area.

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.
https://health.gov/healthypeople/priority-areas/social-determinants-health

Emerging Trends



The Future Ain't What it Used to Be: Key Trends and Challenges for an Aging Population, Nancy Leamond, AARP Chief Advocacy and Engagement Officer, 2022

Interesting Facts

- The Office of Disease Prevention and Health Promotion notes, that social determinants of health **affect nearly everyone** in one way or another.

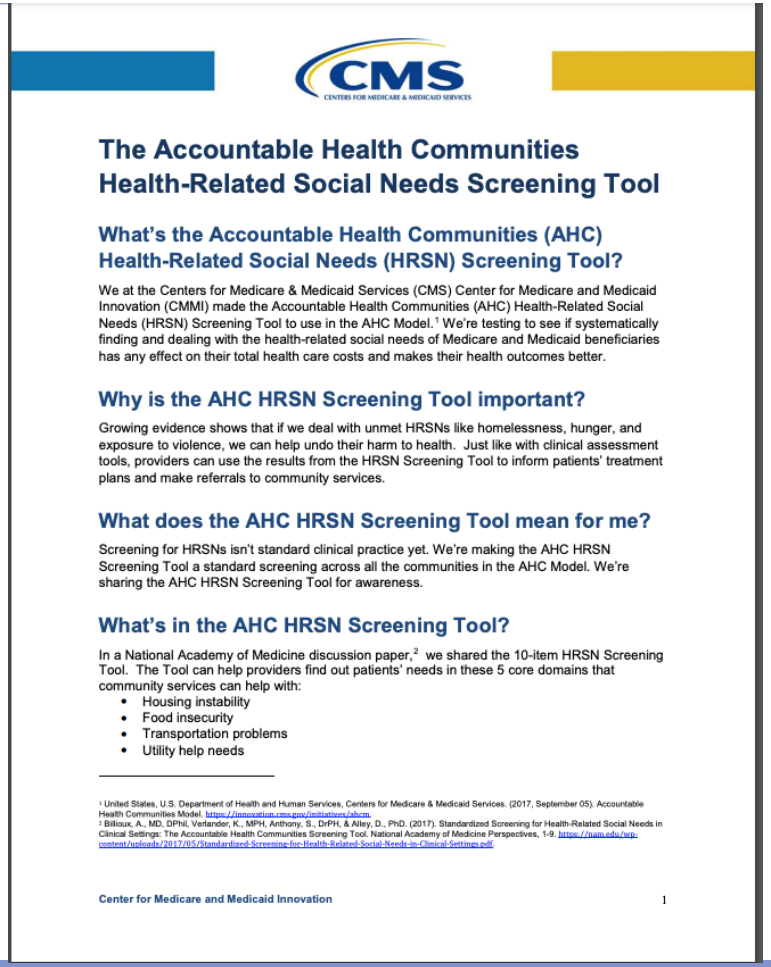
- Institute of Medicine (2003), inadequate health **insurance coverage is one of the largest barriers to health care access**, and the unequal distribution of coverage **contributes to disparities in health**.

- Berkman, Sheridan, Donahue, Halpern, Crotty, 2011 noted in their Annuals of Internal Medicine article Personal health literacy is a social risk, one associated with **worse health care and health outcomes**. When individuals have **limited personal health literacy,** they are at **higher risk of misunderstanding information that is important to achieving and maintaining health or losing their way in the fragmented health care system.**

- In 1999, in the American College of Physicians – American Society of Internal Medicine highlights that disparities in access to primary care exist, and **many people face barriers that decrease access to services and increase the risk of poor health outcomes**.

Barriers to Identifying SDoH

- Screening is avoided because organizations don't have the resources to address the risks they would uncover.
- Screening is avoided because there's always something more immediate, urgent, and higher risk right now that needs to be addressed in the short clinical visit time.
- Screening is occurring, but finding more SDOH needs than the health system or payer is equipped to deal with through a shortage of resources, bandwidth, or care coordination ability.
- The lack of a single dataset on SDOH interventions provided through disparate care partners makes it difficult to prove interventions are effective and save money.



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

The Accountable Health Communities Health-Related Social Needs Screening Tool

What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

We at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model.[1] We're testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

Why is the AHC HRSN Screening Tool important?

Growing evidence shows that if we deal with unmet HRSNs like homelessness, hunger, and exposure to violence, we can help undo their harm to health. Just like with clinical assessment tools, providers can use the results from the HRSN Screening Tool to inform patients' treatment plans and make referrals to community services.

What does the AHC HRSN Screening Tool mean for me?

Screening for HRSNs isn't standard clinical practice yet. We're making the AHC HRSN Screening Tool a standard screening across all the communities in the AHC Model. We're sharing the AHC HRSN Screening Tool for awareness.

What's in the AHC HRSN Screening Tool?

In a National Academy of Medicine discussion paper,[2] we shared the 10-item HRSN Screening Tool. The Tool can help providers find out patients' needs in these 5 core domains that community services can help with:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs

[1] United States, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2017, September 05). Accountable Health Communities Model. https://innovation.cms.gov/initiatives/ahcm.
[2] Billioux, A., MD, DPhil, Verlander, K., MPH, Anthony, S., DrPH, & Alley, D., PhD. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. National Academy of Medicine Perspectives, 1-9. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf.

Center for Medicare and Medicaid Innovation 1

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Case Study Presentation: Slipping Between the Cracks

Situation

63 year old male after recent visit to the emergency room and subsequent admission, was diagnosed with amyotrophic lateral sclerosis ten months after experiencing a number of symptoms to include muscle twitching, cramps, and spasticity in both arms and hands.

Background

- Patient reports that he has no family, has never been married and has no children. He lives alone in a small, private residence, with the support of local friends.
- The home has been modified with a ceiling lift system, allowing the patient to be moved between the two bedrooms and the bathroom with the assistance of his friends, who also leave pureed meals and snacks for the patient daily.
- Patient does not have access to private or public transportation due to his disability
- Patient unable to afford COBRA premiums, causing his health insurance to lapse.
- Patient's only source of income is online gambling that is used to pay for utilities, groceries, other household expenses and medications

Assessment

- Using a combined initial/comprehensive assessment, the nurse assessed the patient on the day of admission. The comprehensive assessment and plan of care for this patient were completed within 5 days of admission.
- Patient appears well-cared for and has access to meals and snacks throughout the day.
- Patient reports that friends transfer from his bed to wheelchair in the morning and from his wheelchair to bed in the evening. A ceiling mounted lift is used for his transfer. Ceiling mounted lift tracks are present in the bedrooms, hall and bathroom of the home.
- Patient's backdoor remains unlocked at all times. Dog barks to alarm patient when someone enters the house.
- Patient is homebound and unable to visit neurologist or primary care provider.
- Patient has little to no access to information and support of disease process, advance directives and powers of attorney.
- Patient has no payer source for healthcare and often does not have prescribed medications.
- Patient is an atheist and declines spiritual counselor services.

Outcome(s)

- The social worker made a scheduled visit to the patient's home within seven (7) days of admission. During the visit, the social worker provided verbal and written education regarding:
  - ALS Association of Texas
  - Advance directives
  - Need for a legal representative
  - SNAP, Medicaid and Social Security Disability programs
- The spiritual counselor called the patient to offer services and to pray with the patient.
- The RN made scheduled visits twice a week to assess the patient, including a medication assessment.
- When making a second visit to the patient's home, the social worker found the patient sitting in his wheelchair. He was unresponsive with no signs of life. 9-1-1 was called and, upon their arrival initiated CPR and transported the patient to the hospital.
- Per the patient's autopsy report, the patient's cause of death was myocardial infarction.

Discussion and Recommendations

Discussion

- Did we miss anything during the initial assessment?
- Did the patient truly understand their diagnosis?
- What wasn't addressed and what opportunities where missed?
- Where there any other key opportunities missed?
- Was there one question that could have led to patient having a better understanding of their situation?
- Did we take for granted the patients "support system"?
- Did we take for granted the patients "appearance" upon assessment?
- Would a SDoH Survey been appropriate for this patient?

Recommendations & Key Takeaways

- Develop relationships with community health partners that can provide supportive resources for patients
- Social determinants of health affect nearly everyone in one way or another, complete SDoH Survey regardless if resources are limited
- Be proactive in your organizations approach to SDoH
- Work hard and strive for health equity by identifying your patients SDoH needs and connecting them to the appropriate resources sooner to improve outcomes.
- Consider care coordination as a valuable tool for your organization

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Session Evaluation and Certificate of Completion

- Your feedback is valuable as we plan upcoming sessions!
  - Please complete the Project ECHO Session Evaluation

- Project ECHO sessions are not accredited for continuing education, but we are able to offer a confirmation of completion for each session. To receive confirmation of completion, please complete the following within 10 days of each session using the links found on the Project ECHO webpage.
  - *Project ECHO Session Evaluation*
  - *Project ECHO Post-Session Knowledge Check*

NHPCO Health Equity Certificate

- Would you like to demonstrate your commitment to delivering culturally competent care across the continuum of serious illness in an equitable, inclusive, and person-centered manner?
  - NHPCO is pleased to offer a Health Equity Certificate for individuals who participate in at least 17 sessions in the *Equity Where It Matters* series

- To receive participate in the Health Equity Certificate, please complete the following within 10 days of each session using the links found on the Project ECHO webpage.
  - *Project ECHO Session Evaluation*
  - *Project ECHO Post-Session Knowledge Check*

Upcoming Sessions

Date: April 6, 2023

Topic: Caring Through Interpersonal Conflict

Date: April 20, 2023

Topic: Policy and Advocacy: Addressing Discrimination at the Bedside

Additional Information

NHPCO Project ECHO webpage:

https://www.nhpco.org/regulatory-and-quality/quality/projectecho/

NHPCO Project ECHO session recordings and Key Takeaways:

https://www.nhpco.org/regulatory-and-quality/quality/projectecho/2023-project-echo-session-recordings/

NHPCO Project ECHO Registration Link:

https://nhpco.zoom.us/meeting/register/tZEsfu-trz4oGtQeKFw41UElYNwjSli8QCBF

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