Addressing Psycho-Social Barriers in a Vulnerable Community

Objectives:

- Identify challenges, opportunities, and impact on population health
- Discuss methods within Christian Hospital to address patient social needs through clinical and community-based interventions
- Identify strategies to address community challenges
- Understand the top 5 psychosocial needs, which are not identified by the hospital

Demographics: 2013 Community Health Needs Assessment

<table>
<thead>
<tr>
<th>North St. Louis County</th>
<th>St. Louis County</th>
</tr>
</thead>
<tbody>
<tr>
<td>249,807 (2009 census)</td>
<td>992,412 (2009 census)</td>
</tr>
<tr>
<td>Household Median Income</td>
<td>Household Median Income</td>
</tr>
<tr>
<td>$44,919</td>
<td>$57,502</td>
</tr>
<tr>
<td>Unemployment</td>
<td>Unemployment</td>
</tr>
<tr>
<td>13%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Race</td>
<td>Race</td>
</tr>
<tr>
<td>45% African American</td>
<td>20% African American</td>
</tr>
<tr>
<td>53% Caucasian</td>
<td>76% Caucasian</td>
</tr>
<tr>
<td>Education (25+ w/o H.S. Diploma)</td>
<td>Education (25+ w/o H.S. Diploma)</td>
</tr>
<tr>
<td>19%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>Uninsured</td>
</tr>
<tr>
<td>14%</td>
<td>9.3%</td>
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</tbody>
</table>
Demographics: 2013 Community Health Needs Assessment

<table>
<thead>
<tr>
<th>North St. Louis County</th>
<th>St. Louis County</th>
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</thead>
<tbody>
<tr>
<td>Fair-poor health status</td>
<td>Fair-poor health status</td>
</tr>
<tr>
<td>18%</td>
<td>10%</td>
</tr>
<tr>
<td>ED visits for ACS/100,000</td>
<td>ED visits for ACS/100,000</td>
</tr>
<tr>
<td>5,149</td>
<td>2,523</td>
</tr>
<tr>
<td>Hospital admissions ACS/100,000</td>
<td>Hospital admissions ACS/100,000</td>
</tr>
<tr>
<td>2,903</td>
<td>1,947</td>
</tr>
<tr>
<td>Sedentary Lifestyle</td>
<td>Sedentary Lifestyle</td>
</tr>
<tr>
<td>29%</td>
<td>22%</td>
</tr>
<tr>
<td>Obesity</td>
<td>Obesity</td>
</tr>
<tr>
<td>38%</td>
<td>27%</td>
</tr>
</tbody>
</table>

St. Louis County Psycho-Social Barriers

- High unemployment rate
  - lack of access to affordable health care
- No Medicaid expansion
- Civil Unrest
- Limited access to mental health services
- Health Literacy

How has Christian Hospital Responded to these psycho-social barriers?
Group Discussion

- 69 y.o male – African American
  - Widower
- DM, paraplegia, CHF (EF 20%), HTN, BPH, chronic foley nephrostomy tube, home O2
- Homeowner: Caregiver-Son
  - Unemployed
  - Recreational drug user
  - Multiple children
- Finances: Receiving disability only
- Wheel chair bound

Group Discussion

- Recommendations:
  - Skilled nursing placement
    - Son refused
  - Home health
    - Son refused
  - Visiting physician
    - Son refused
  - Given 3 new prescriptions
    - Unable to pick up until next day
- 3rd readmission within month

Group Discussion

WHAT ARE THE PATIENTS DISCHARGE NEEDS?
Discharge Needs

• Home health
• Post discharge medication
• Medication reconciliation
• Provider follow up appointments
• Identification of primary care giver
• Palliative care
• Disposition
• Emergency backup plan

Group Discussion

WHAT SHOULD BE COMMUNICATED TO ENSURE A SUCCESSFUL HANDOFF?

Communication With Handoff

• Social barriers
• Compliance challenges
• Needed resources
• Psychosocial status
• Disposition
• Caregiver status
• Educational needs
• Needed resources
### Group Discussion

**WHAT CONCERNS ARE IDENTIFIABLE BASED ON HIS HISTORY AND PSYCHOSOCIAL ECONOMIC BARRIERS?**

### Concerns

- Compliance
- Caregiver support
- Education
- Lack of financial resources

### Group Discussions

**WHAT ARE THE PSYCHOSOCIAL COMPONENTS THAT SHOULD BE IDENTIFIED PRIOR TO DISCHARGE?**
**Psychosocial Components**

- Lack of caregiver support
- Financial Resources
- Disease knowledge and education
  - Patient & family
- Community Resources
  - Transportation
  - Medication assistance
  - DME
  - ADLs
  - Behavioral health

**Group Discussions**

**WHAT ASSESSMENT TOOLS SHOULD BE UTILIZED PRIOR TO DISCHARGE?**

**Assessment Tools**

- LACE Assessment
- Psychosocial assessment
- Fall risk assessment
- Pain assessment
- Mini-mental Exam
Group Discussion

WHAT COMMUNITY PROGRAMS
COULD YOU REFER THE PATIENT TO?

Community Resources

- Federally Qualified Health Centers
- Behavioral Health
- Meals on Wheels
- WIC
- Department of Health and Senior Services
- Mideast Area Agency on Aging
- TTW/MIH
- Pharmacy delivery services

- Congestive Heart Failure (CHF) Resistance Prevention Program
- Diabetes Prevention Program
Mission

Execute seamless transitions across the healthcare continuum through patient empowerment and collaboration.

Goal of the Program

Reduce readmissions rates for patients that are Medicare 65 or older with a discharge diagnosis of CHF, MI, Pneumonia, COPD, Diabetes, and Hip and Knee Replacements.
Transition To Wellness

Expected Outcomes

• Reduce hospital readmission rates
• Improve connections with primary care physician/other community providers
• Promote patient well-being and self-management of health
• Strengthen relationships with rehabilitation and extended care facilities.
• COLLABORATION IS KEY!

CHAP-Mobile Integrated Healthcare

Enjoying Life By Improving Health

Community Needs

Not meeting patient needs  Lack of attention to promoting health  Too many people lack health coverage & care
Connection to community resources  Educating patients on managing conditions  Lack of on-going medical support
Mobile Integrated Health Care

Advanced Practice Paramedic
– Re-defining the role of the Paramedic to better support the community.

- Weight checks
- Well Child
- Vital Sign screenings
- Cholesterol screens
- Routine follow up/12 leads
- Blood Sugar checks
- Set up CPAP
- Managing Surgical drains
- IV Catheter change
- Tx minor injuries
- Wound Care
- Suture removal
- Ultrasounds
- Patient History
- Lab Specimen Collection
- Lab Specimen Testing (I-STAT)
- Post Stroke Assessment
- Chronic Disease Management (COPD, diabetes, CHF)
- Weight checks
- Well Child
- Vital Sign screenings
- Cholesterol screens
- Routine follow up/12 leads
- Blood Sugar checks
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Collaboration

- Patient and Caregiver
- ACO
- Social Workers and Case Managers
- Primary Care Physicians
- Home Healthcare and Community Agencies

CHAP-Mobile Integrated Healthcare

- Enrollment
  - 8-12 weeks - dedicated APP & preventative visits
  - Initial visit
    - Baseline vitals
    - Numerous assessments
    - Medication reconciliation
  - Develop care plan
  - Collaboration with ALL medical contacts
  - Navigation to local resources
    - Home health, PT/OT, case management, social work, SCP,
      meals on wheels, United Way, behavioral health, SNF, dental
  - Assistance with daily needs
    - Transportation, utilities, housing, finance, advocacy

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Outcomes

Navigation
- Successfully navigated over 7,700 patients
- Connected over 170 patients to medical homes

Enrollment
- Increased overall health
- Increased quality of life

Enjoying Life by Improving Health

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