

Addressing Social Determinants of Health through Screening and Resource Referrals

Submitted by: Ascension

Bronze Winner, Planning Stage

Category: Reaching the Patients in Need

Overview

Serious illness outcomes reflect pre-existing racial and ethnic disparities in healthcare access and quality in our communities. Minority populations are more likely to receive unhelpful aggressive care at end of life (EOL), more likely to receive care requiring care transitions, less likely to complete advance directives, and less likely to enroll in hospice. The factors that contribute to disparities in EOL care are complex, and include health system issues, care provider considerations, policy considerations, and cultural issues.

Social determinants of health (SDOH) are closely linked to health outcomes among populations historically exposed to health care disparities, and present actionable targets for enterprises committed to improving care for all people living with serious illness. We will address the SDOH barriers that community members with serious illness face through the implementation of a systematic SDOH screening and resource referral process to address basic and unmet needs of the most vulnerable populations.

Impact

The scope and significance of health care disparities among the seriously ill population in the United States (U.S) will only grow. The U.S. Census Bureau estimates that by 2030, all 73 million baby boomers will be at least age 65 – that's over 10,000 baby boomers a day crossing this age threshold. Given our constantly evolving healthcare environment and the aging of the baby boomer population, there is an even more urgent need to address the SDOH barriers. The WHO defines SDOH as the "conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels". The complexities in care and quality of life for the seriously ill population is further compounded when difficult decisions about their health need to be made, such as going to a follow up appointment or paying for medications, when the basic needs of access to nutritious foods or safe housing are unaddressed. These barriers are deepened at the end of life with people from minority groups in the US being more likely to die in a hospital setting and have more intensive treatments at the end-of-life compared to white Americans.

Through the development of a complex multi-level effort, we hope to address the growing healthcare disparities that minority and vulnerable populations across our nation are facing. Given the interdisciplinary structure, the palliative care team offers a unique vantage point and skill set to identify and address SDOH barriers. In review of specialized palliative care delivery models, it was found that there was inadequate evidence to recommend any

single approach to palliative care over others. A purely medical approach to EOL care may not address barriers to uptake in underserved communities, such as lack of trust in the health care system, perceived discrimination, and limited knowledge regarding options. An effective model designed to explicitly address SDOH in addition to medical aspects may provide care that better meets the needs of both palliative care patients and caregivers.

Our solution has the potential to have a significant impact on population health outcomes by offering an systematic SDOH screening tool and resource referral process, coupled with an in depth qualitative and quantitative assessment of the patient population currently accessing specialty-level palliative care services with the goal to shed light on the healthcare experience for minority populations. The literature suggests that substantial evidence supports improved health outcomes and reduced health care spending related to interventions that addressed housing, nutrition, income support, and care coordination and community outreach needs.

As a new initiative, we are confident and committed that this project will achieve its solution. Ascension is the leading non-profit and Catholic health systems in the U.S. we know we have the capacity to tackle SDOH barriers among our patient populations. This intervention will directly impact the patients seen by the palliative care specialty service lines by offering an in-depth wraparound approach to SDOH needs.

Evidence-Base

Following the Plan, Do, Check, Act (PDCA) method, we will use continuous quality improvement and learning every step of the way in our implementation and expansion of the SDOH screening and resource referral tool. First, we will implement routine SDOH screening with the existing palliative care social work workforce, and collect user experience data. Second, we will track utilization data and identify top SDOH needs among the palliative care patient population such as food, housing, legal, and medication assistance.

Next, we will assess baseline palliative care patient population demographic data to understand current access to services based on age, gender, race/ethnicity, and setting of care. This information will then be compared to system-wide demographic data to understand the specific needs or barriers accessing palliative care among minority groups.

While the quantitative data will provide information related to gaps in healthcare access, we need to contextualize the data with patient focus groups to delve deeper into the healthcare experience for minority populations with serious illness and their caregivers. Focus group topics to explore include: preferences in engagement of advance care planning, such as telephonic, telehealth, group sessions, one on one with a trained lay facilitator, a healthcare professional, or with a physician. The key themes will then be used to help inform future decisions related to training employees and community members in the benefits of palliative care and how to access services. These findings will be undertaken in each ministry, with recognition that both resources and gaps in resources are likely to be “local”. Likewise, we anticipate that cultural issues that determine local or regional trust in the healthcare system and willingness to access available resources may be highly variable.

We hope to gain new insights and knowledge in understanding the diverse needs and expectation of minority populations with a serious illness as well as leverage the key skills of palliative care social workers in identifying

SDOH needs among a larger scope of the patient population through the use of standardized SDOH screening tool and access to a large online database of community based resources.

Furthermore, in the initial pre-planning development effort of the initiative, we received unilateral consensus among our palliative care steering committee members and executive leadership to pursue addressing this topic. Furthermore, with access to the tools and technologies available to implement the model we are confident we will yield results as the support for investment in time and attention to palliative care and health equity is a system wide strategic priority.

Feasibility

Ascension Medical Group is already in the implementation stages of an SDOH screening initiative targeting 425 primary care practices to offers an annual SDOH assessment to their patient population in the domains of employment and income, education, food, utilities, healthcare, transportation, housing/shelter, social connection, and interpersonal violence. We are encouraged and inspired by the current SDOH initiative at Ascension and are focused on bringing a standardized SDOH screening process to our palliative care teams.

By leveraging the existing SDOH infrastructure and partnering with the Ascension Medical Group clinical and quality operations teams we can accelerate our efforts to expand SDOH screening to the patient population receiving palliative care services.

The SDOH screening tool has 10 standardized questions that have been vetted through clinical leadership groups across multiple markets. An emphasis on understanding the unique SDOH needs, gaps, and barriers of patients facing serious illness will not only help to inform care, but also ensures earlier access to necessary basic needs to improve quality of life and reduce suffering.

The first key tactic for integration of the SDOH initiative in palliative care is to: Ensure access to the screening tool in the inpatient and outpatient Electronic Health Record (EHR) platforms. Next, we will focus on a phased implementation of the SDOH tool among our palliative care teams through training on the use and importance of the SDOH tool. Measurable objectives surrounding the volume of providers trained in the SDOH tool, number of palliative care patients screened, and top basic needs identified will be captured throughout the process. At the same time, we will also assess demographic data through our ongoing dashboard development process with our clinical informatics team to shine a light on the populations in greatest need as well as overall potential gaps in access based on race and ethnicity. With support from our patient and family engagement team, we will form a few small virtual focus groups to meet over a secure platform to learn more about the healthcare experience for minority populations specifically those facing a serious illness through a semi-structured interview process.

Moreover, Ascension understands that screening for SDOH needs is not enough to impact the health disparities facing our community. We must take this a step further and offer a comprehensive community referral process. Through the system- wide adoption of the Aunt Bertha platform in combination with the licensed clinical social

workers we will be able to provide our palliative care patients facing additional stress and strain with a free online social services search engine in addition to the wraparound assistance from our clinical social workers. This tool will help connect people in need to programs in their community that are tailored to their needs and location with the option for electronic referrals.

Scalability

The SDOH initiative has the potential to be expanded from solely a primary care intervention to service lines across the care continuum. Palliative care is interested in leading the way by further piloting the use of an SDOH screening tool as well as resource referral process. Based on the responses from the palliative care team members utilizing the tools and the patient and family experience, there is opportunity to adapt the process based on learnings. Specifically, learning key needs or gaps faced by the seriously ill population on a macro level as well as understanding whether our services are providing adequate interventions based on qualitative focus groups with vulnerable and minority populations. In consideration of scalability and growth of the model, we are sensitive to the time commitment of front line clinicians and operational leadership to ensure a successful and smooth expansion. Furthermore, we are aware of possible escalating internal costs associated with data collection and analysis. The collaboration with key community-based organizations and partners will ensure the most impact.

We hope to not only scale the intervention but also expand knowledge and best practices in the field by testing the success of an SDOH screening and referral process across multiple palliative care sites of care such as inpatient, outpatient, virtually, and in the home setting. We particularly think that our palliative care services offered virtually and in the home and community-based setting have an advantage of assessing and addressing needs such as safety in the home environment, health literacy, financial needs, and access to nutritious food. This work has strong executive physician and operational leadership support as the work aligns with our mission, vision, and strategic direction. Through the holistic, culturally competent, and compassionate care palliative care teams provide, we are pleased to be able to integrate an SDOH screening and referral process in our palliative care workflow. With the underlying demographic assessment and focus group sessions, we hope to make great improvements in offering person and family centered care that cares for the whole person--physically, socially, emotionally, and spiritually. Focusing on these SDOH and health care disparity needs will also go a long way in improving earlier access to palliative care and improving the end of life experience for all.

Sustainability

As a new initiative, we are confident and committed that this project will achieve its solution. Ascension is the leading non-profit and Catholic health systems in the U.S., providing over \$2.4 billion in care for persons living in poverty and other community benefit programs, 14.8 million physician office and clinic visits, and 1.6 million equivalent discharges. Our palliative care services span 12 states, with 54 inpatient locations, 19 outpatient clinics, and 2 community-based models of care. With over 200 palliative care specialty level staff (physicians, advanced practice providers, social workers, nurses, and chaplains) we know we have the capacity to tackle SDOH barriers among our patient populations.

By leveraging existing technology and tools within our healthcare system additional startup funding within the palliative care budget was not necessary to implement this initiative. As the implementation continues, we expect to rely more heavily on information technology and analytics support, which has a cost. Furthermore, this solution will improve quality of life for patients and caregivers facing the stress and symptoms of serious illness. In each Ascension ministry, our goal is to assist patients and caregivers to address basic needs. We will also gather qualitative and quantitative data on the healthcare experience for people historically subject to healthcare disparity to understand gaps in access to high quality palliative care. Furthermore, by assessing racial and ethnic demographic utilization in palliative care services and engaging in small focus groups with minority patient populations facing serious illness we hope our findings and recommendations will have a broad population based impact that can help inform our national diversity and inclusion group ABIDE (Appreciation - Belongingness - Inclusivity - Diversity - Equity). Group for wider employee level dissemination among our 160,000 associates and 9,000 employed providers.

As with any new initiative, there are potential threats or risk to the project implementation. For instance, we know competing priorities may exist with which groups are able to integrate this new screening and referral process first. Second, we are aware of the challenges we will face in integrating the tool across multiple EHR platforms and are aware of the change management process that will be involved with offering a new tool to the palliative care clinical workflow.

Regardless of the difficulties that we may encounter throughout this implementation process, we are committed to improving the quality of life of the patients that we serve and hope that the SDOH initiative will offer a more holistic approach to patient care by assessing the person in their environment. The interdisciplinary team structure of palliative care makes it uniquely situated to address not only the SDOH screening process but also support the patient population with appropriate interventions through interprofessional collaborative practice. Even including the use of nontraditional roles to support this work, such as medical assistants, nursing assistants, community health workers, or home healthcare aides to focus efforts on SDOH screening may improve outcomes for the palliative care population.

Project Team

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About the Challenge

The John A. Hartford Foundation Tipping Point Challenge is a national competition to catalyze the spread of skills, ideas, and solutions that will improve health care delivery for all people living with a serious illness. It is sponsored by the [Center to Advance Palliative Care](#) and [The John A. Hartford Foundation](#).

For more information, visit tippingpointchallenge.capc.org.