SOCIAL DETERMINANTS OF HEALTH AND THEIR IMPACT ON ESTABLISHING HEART FAILURE CARE IN A CLINIC FOR THE UNDERSERVED

Poster #

Stephen Clarkson, M.D., MSPH, University of Alabama at Birmingham

Megan Nordberg, MPH, Jessica Williams, Ph.D., Connie White-Williams, RN, Ph.D., Andrea Cherrington, M.D., MPH

Background

- Heart failure (HF) is a chronic and progressive disease that requires supporting patients across the continuum of care to avoid adverse outcomes.
- Adverse social determinants of health (SDOH) impact incident HF, ability to access care, HF readmissions, and mortality.
- The Heart FailuRe Transitional Care Services for Adults (HRTSA) Clinic at UAB provides inter-professional care to uninsured or underinsured adults with a diagnosis of HF.
- When patients attend the HRTSA Clinic, there is a demonstrated reduction in readmissions, however, prior work demonstrates some are unable to attend clinic.

Theoretical Framework

- There is evidence demonstrating an association between adverse SDOH and poor HF outcomes; however, evidence is lacking on how best to practically apply this information in the context of care transitions.
- For Aim 1: We utilized the Healthy People 2030 framework for SDOH to organize and characterize the individual and community-level SDOH. This includes five domains: economic stability, education access, healthcare access, neighborhood environment, and social context.
- For Aim 2: The interview guide is developed utilizing the Health Belief Model to understand a person's belief in the personal threat of HF and effectiveness of the intervention on the likelihood that the person will be able to successfully transition to outpatient care.

Project Aims

Aim 1: To determine the prevalence of SDOH among a sample of patients referred to the HRTSA clinic and examine associations between individual and community-level SDOH and subsequent clinic attendance.

Aim 2: To identify patient-specific barriers and facilitators to successful linkage into care during an inpatient hospital admission for heart failure.

Study Design

Aim 1:

- All patients referred to the UAB HRTSA Clinic from December 2014-January 2022 with completed data will be included in this analysis.
- Individual level SDOH will be analyzed based on data from the electronic health record.
- The social vulnerability index (SVI) and area deprivation index (ADI) will be used to assess community-level SDOH.
- Patients will be stratified by whether they were seen in clinic, engaged (attended two consecutive appts), or unengaged (attended at lease one visit).

Aim 2:

- Patients admitted to UAB Hospital and referred to the HRTSA Clinic for outpatient follow-up will be interviewed.
- Interviews will include open-ended questions regarding thoughts and beliefs about HF and to understand barriers and facilitators to successfully linking to care following hospitalizations for HF.

Outcomes

SVI Themes	Engaged (n=193)	Unengaged (n=434)	p-value
SES	0.73±0.26	0.68±0.26	0.035
Household Characteristics	0.65±0.28	0.62±0.26	0.187
Racial & Ethnic Minority Status	0.71±0.32	0.63±0.32	0.004
Housing Type & Transportation	0.55±0.27	0.52±0.26	0.347
Overall	0.70±0.26	0.65±0.25	0.047

Transportation was a commonly cited barrier to attending clinic: "...they don't have no transportation. Then too, you got people they don't know how to catch the bus. Like me, I never caught the bus. I done been on the bus probably one time in my life" (P4).

Key Messages

- Patients engaged with the clinic had higher vulnerability in SES, household characteristics, and racial and ethnic minority themes, suggesting the clinic is effectively engaging this vulnerable population.
- Individual level measures of social risk are still undergoing abstraction from the medical record.
- Initial interviews demonstrate improving patient access to and confidence in methods of transportation could help more patients attend clinic regularly.

Community Impact

Key Partners: We have partnered with the UAB HRTSA Clinic, which serves underserved patients with HF, providing them with access to a multidisciplinary interprofessional care team clinic model that also addresses SDOH needs.

Public Health & Societal Impact: Community & Public Health Potential Benefits

- Health care accessibility: Expand access to health care by implementing relevant interventions
- Health care delivery: Provide support to patients who have difficulty establishing care due to various individual and community barriers
- Health education resources: Improve patient understanding of services available to them through informational resources

References

SUPPORTED BY NIMHD AWARD #P50MD017338

Contact Stephen Clarkson, M.D., MSPH, University of Alabama at Birmingham (UAB), sclarkson@uabmc.edu

forgeaheadcenter.com