Addressing the Social Determinants of Health

Ethical Considerations

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Objectives

- Define ethical considerations in CM and apply to Social Determinants of Health issues
- Explore the Importance of SDoH & Impact of Proactive Identification
  - Review Evidence Based Tools to aid in better identification and documentation
  - Review Evidence Based Programs in place to address SDoH needs
- Discuss the importance of patient's perspective
- Apply ethical decision making and CCMC Code of Professional Conduct to CM scenarios with an eye to SDOH.

Ethical Considerations

- **Autonomy**
- **Beneficence**
- **Fidelity**
- **Justice**
- **Non-Malfeasance**

Definitions

- Autonomy: Patient holds the right and freedom to select and initiate his or her own treatment and course of action and taking control for his or her health
  - fostering the patient's independence and self-determination.
- Beneficence: The obligation and duty to promote good, to further and support a patient's legitimate interests and decisions, and to actively prevent or remove harm
  - share with the patient risks associated with a particular treatment option.

- Fidelity/ Veracity: The act of telling the truth.

- Justice: Maintaining what is right and fair and making decisions that are good for the patient.

- Nonmaleficence: Refraining from doing harm to others emphasizing quality care outcomes.

Code of Conduct for Case Managers

What are the core principles underlying the Code?

- Principle 1: place the public interest above their own at all times.
- Principle 2: respect the rights and inherent dignity of all of their clients.
- Principle 3: always maintain objectivity in their relationships with clients.
- Principle 4: act with integrity and fidelity with clients and others.
- Principle 5: maintain their competency at a level that ensures their clients will receive the highest quality of service.

CCMC, 2015

Why so important?

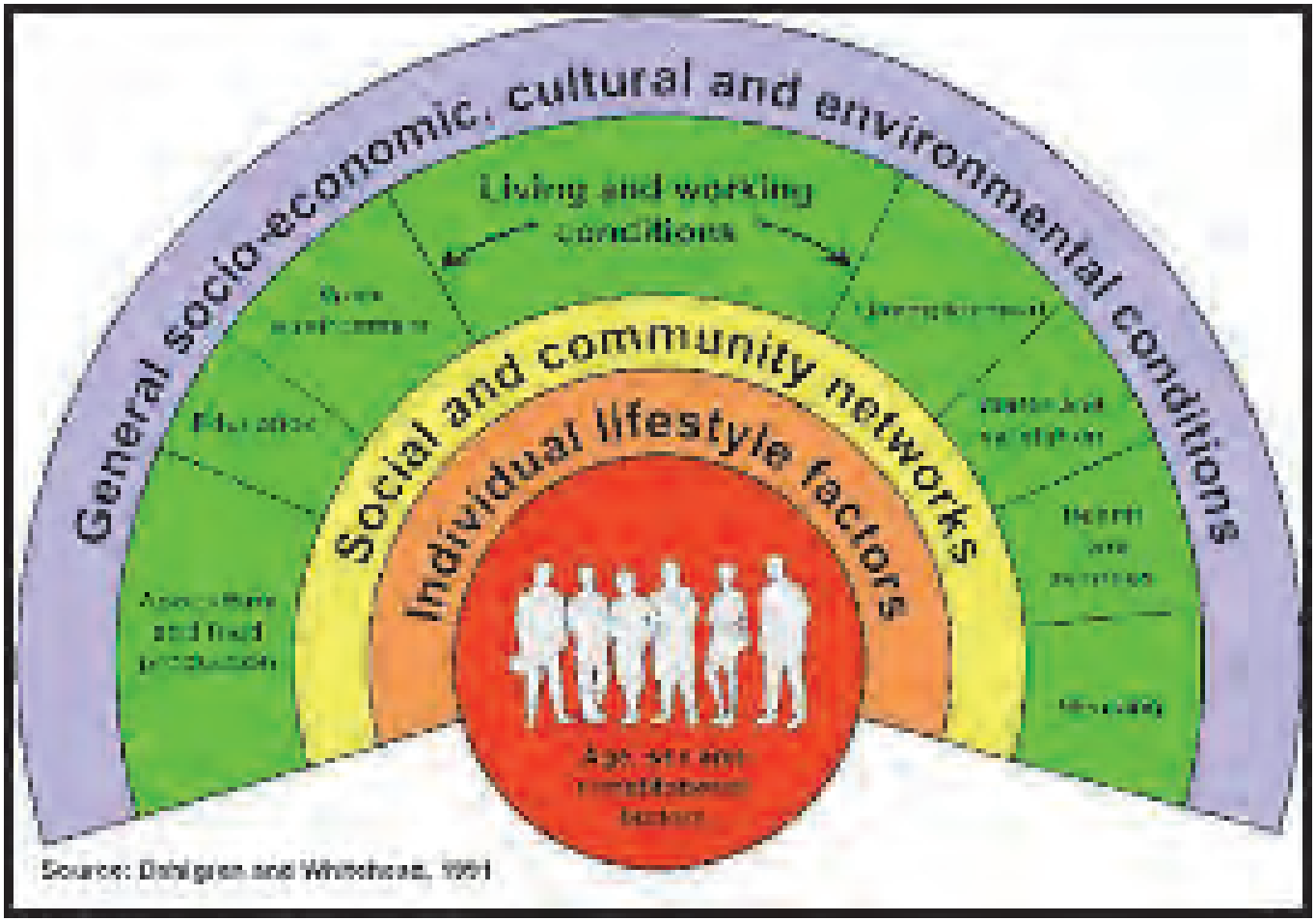
- Understanding the underlying values and principles of Case Management is important in resolving ethical dilemmas
  - end of life issues
  - experimental treatments
  - refusal of care
  - other reason.
- based on the belief that Case Management is a means for
  - improving client health, wellness and autonomy
  - through advocacy, communication, education
  - identification of service resources and service facilitation.

Advocacy

- Patient advocacy is an important part of case management
  - promotes beneficence, justice and autonomy for clients
  - Advocacy especially aims to foster the client's independence.
- Also involves
  - educating clients about their rights, healthcare and human services, resources, and benefits
  - facilitating appropriate and informed decision making
    - includes considerations for the client's values, beliefs and interests.


SOCIAL
DETERMINANTS
OF HEALTH

Primary Determinants of Health



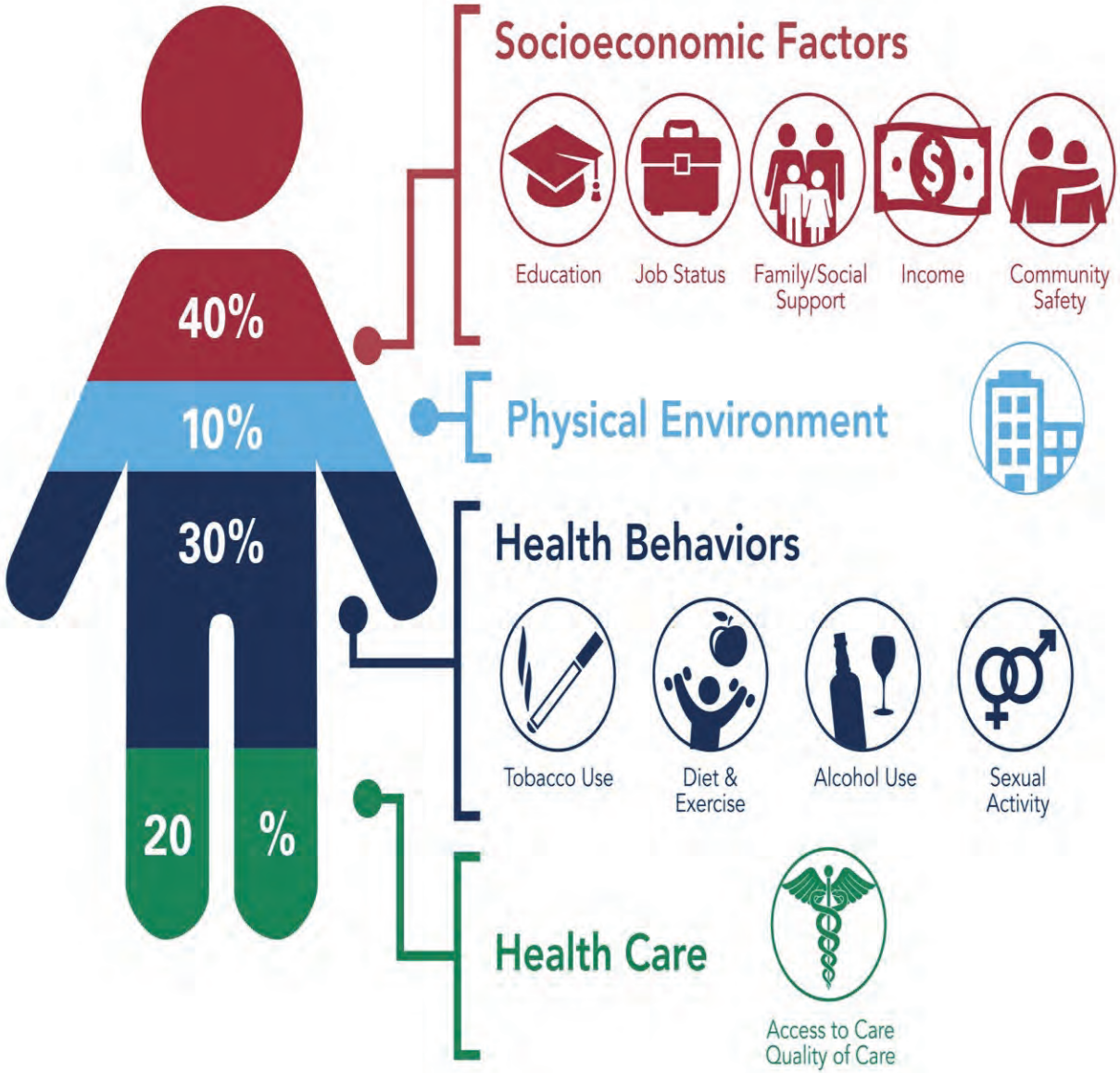
- Social Determinants of Healthcare (SDoH)
  - Patient Perspective
    - Stress, vulnerability, anxiety, health challenged, can lead to premature death
  - Case Manager Perspective
    - Emphasis on population health, medication and treatment adherence, readmission rates & overall costs of care

STATISTICS

- 86% of current healthcare spending is related to chronic conditions
- $1.7 trillion spent on 5% of patients associated with SDoH
  - $35 million in excess care costs
  - $10 billion in illness related lost productivity
  - $200 billion related to premature deaths
  - $26 billion on readmissions
  - Uncompensated care costs???

IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual's health regardless of age, race, or ethnicity.



SDOH Impact

- **20 percent** of a person's health and well-being is related to **access to care** and **quality of services**
- The **physical environment**, **social determinants** and **behavioral factors** drive **80 percent** of health outcomes

Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.

Comparison of Definitions

Health Disparities	Health Inequities	Health Equity	SDOH
Differences in the incidence and prevalence of health conditions and health status between groups based on: •Race/ethnicity •Socioeconomic status •Sexual orientation •Gender •Disability status •Geographic location •Combination of these	Systematic and unjust distribution of social, economic, and environmental conditions needed for health. •Unequal access to quality education, healthcare, housing, transportation, other resources (e.g., grocery stores, car seats) •Unequal employment opportunities and pay/income •Discrimination based upon social status/other factors	The opportunity for everyone to attain his or her full health potential. No one is disadvantaged from achieving this potential because of his or her social position or other socially determined circumstance. •Equal access to quality education, healthcare, housing, transportation, other resources •Equitable pay/income •Equal opportunity for employment •Absence of discrimination based upon social status/other factors	Life-enhancing resources whose distribution across populations effectively determines length and quality of life. •Food supply •Housing •Economic relationships •Social relationships •Transportation •Education •Health Care

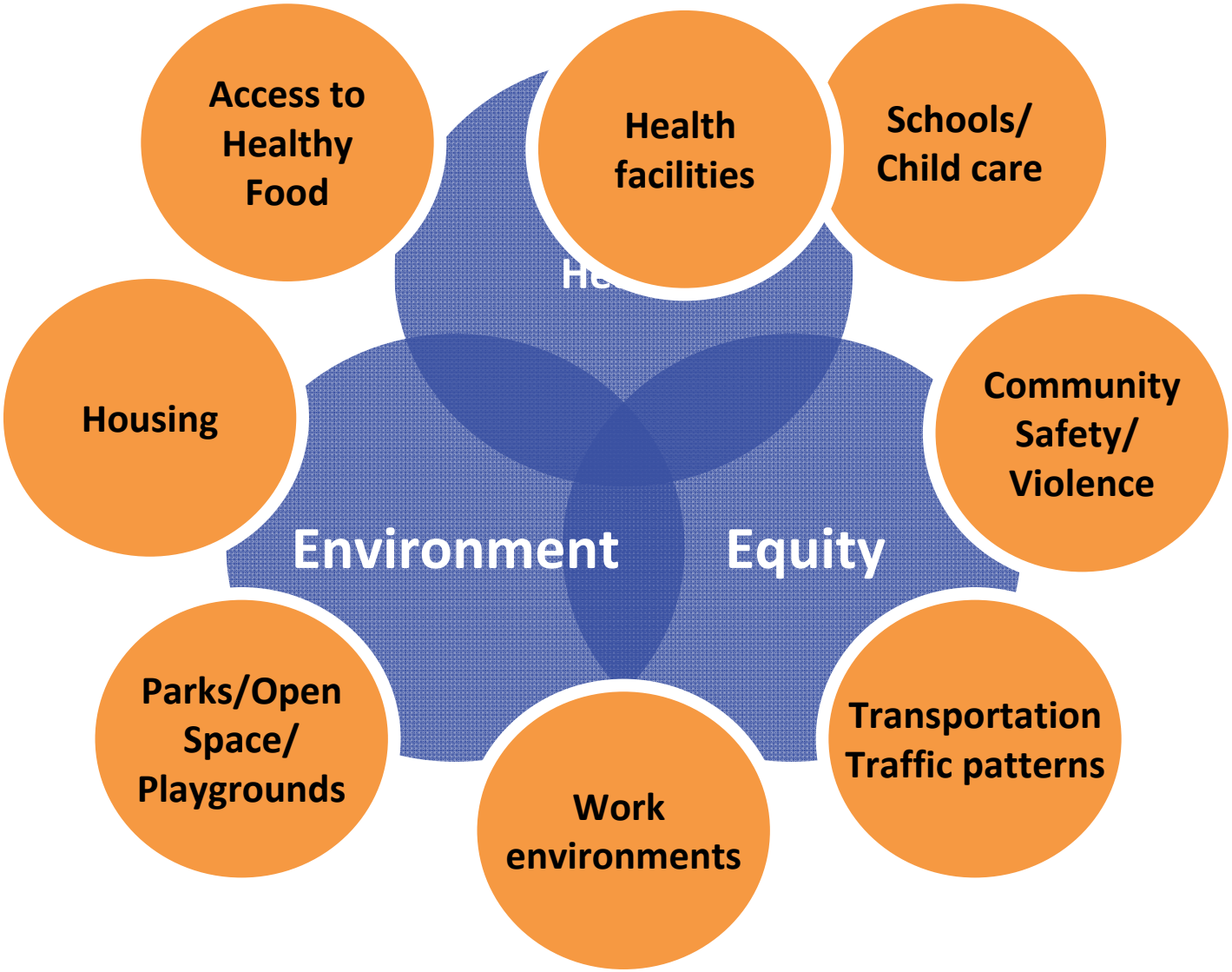
Social Determinants of Health

Life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education and health care, *whose distribution across populations* effectively determines length and quality of life.

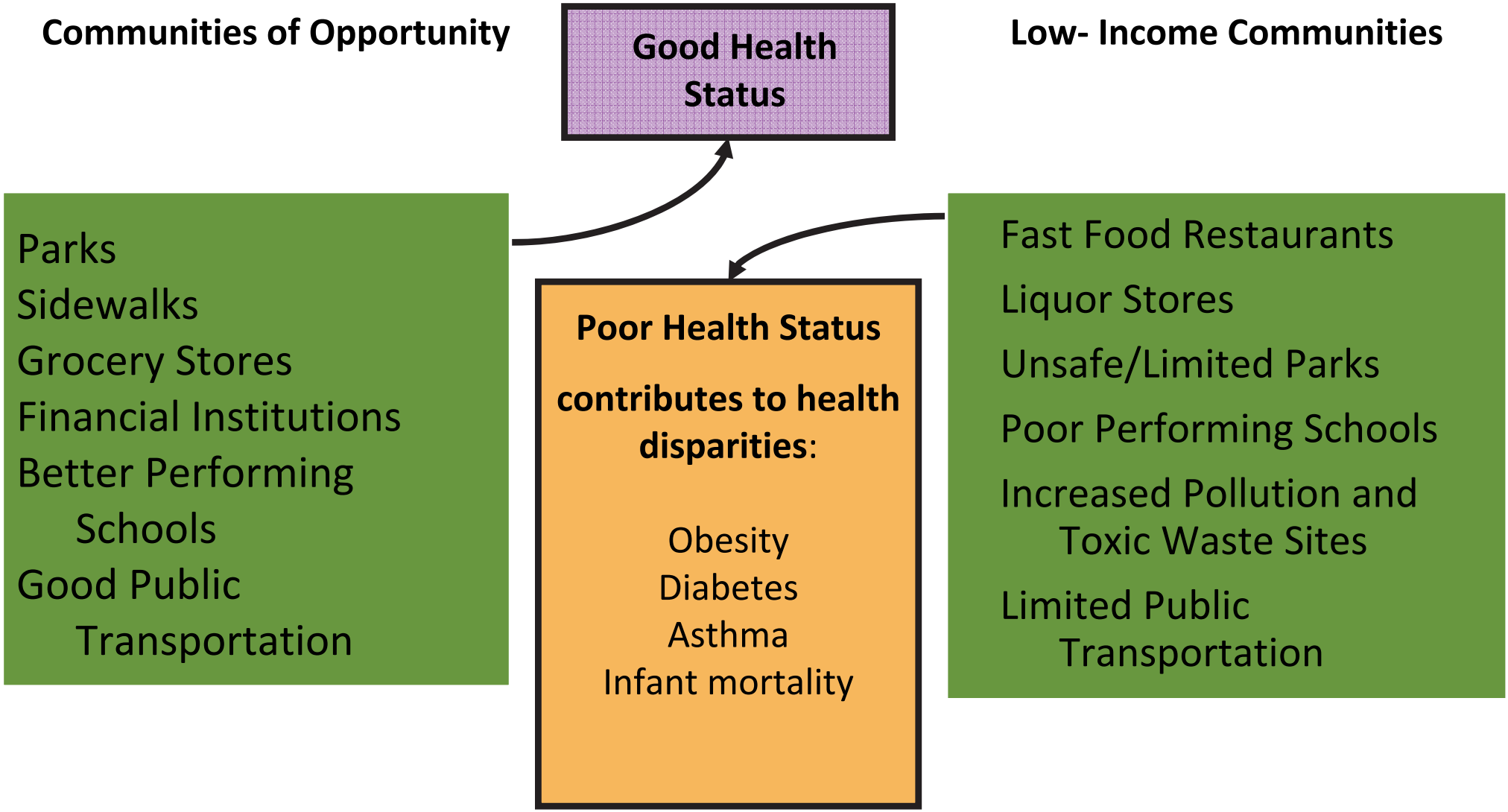
Social Determinants of Health

- Access to health care
- Access to resources
- Education
- Employment
- Environment
- Income/Poverty
- Insurance Coverage
- Housing
- Racism/Discrimination
- Segregation
- Transportation

Intersection of Health, Place & Equity

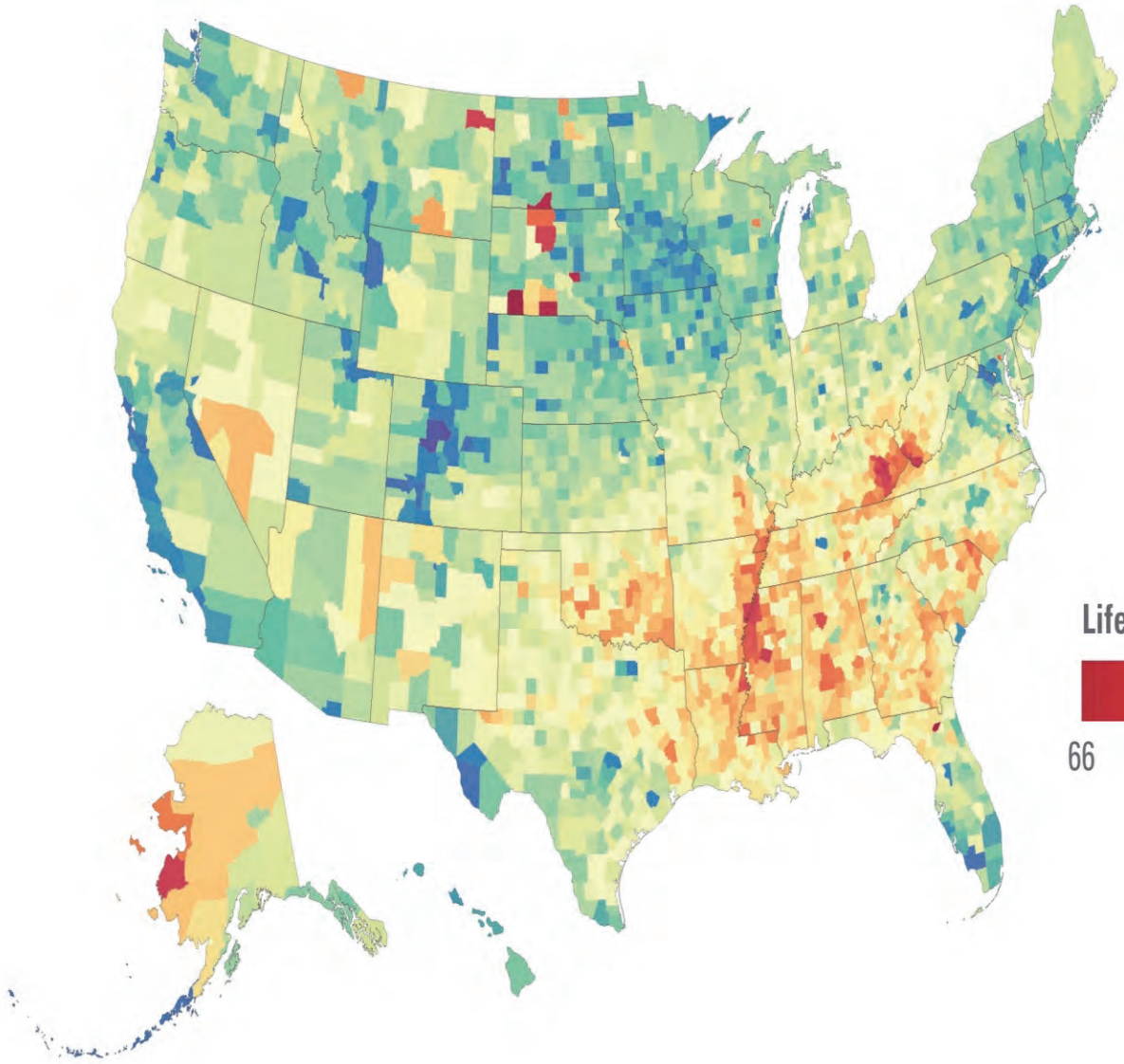


Place Matters



PLACE MATTERS

Where we live can determine how well we live and is a significant factor of life expectancy.



Life expectancy at birth (years):

66 69 72 75 78 81 84 87

American Hospital Association™

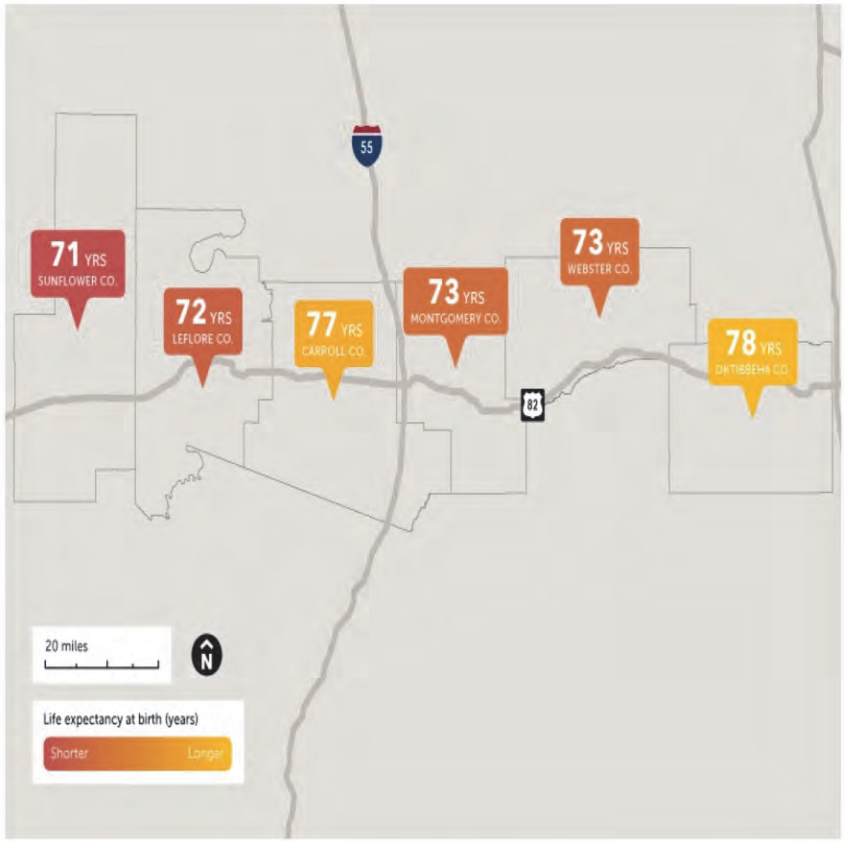
Advancing Health in America

Source: Institute for Health Metrics and Evaluation, University of Washington, 2014

ZIP CODE MATTERS

Your zip code – where you actually live – also influences health.

Chicago, Illinois



Mississippi

Short Distances To Large Gaps In Health

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Source: Reprinted with permission from the VCU Center on Society and Health.

CCMC Ethics Check- In

- PRINCIPLE 2: Board-Certified Case Managers (CCMs) will respect the rights and inherent dignity of all of their clients.
  - Health equity vs health disparity; doesn't everyone have the right to equal treatment?
- PRINCIPLE 3: Board-Certified Case Managers (CCMs) will always maintain objectivity in their relationships with clients.
  - How does the professional case manager maintain objectivity in providing care ?
- PRINCIPLE 4: Board-Certified Case Managers (CCMs) will act with integrity and fidelity with clients and others.
  - Reviewing the data, how can the professional case manager ensure that every client receives the best care we can provide and the most transparent communication we can offer?

Distribution of U.S. Population by Race/Ethnicity 2000 and 2050

Total = 419.9 million **Total = 282.1 million**

NOTES: Data do not include residents of Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Marina Islands. “Other” category includes American Indian/Alaska Native, Native Hawaiian or Other Pacific Islander, and individuals reporting “Two or more races.” African-American, Asian, and Other categories jointly double-count 1% (2000) and 2% (2050) of the population that is of these races and Hispanic; thus, totals may not add to 100%.
SOURCE: Kaiser Family Foundation, based on http://www.census.gov/population/www/projections/popproj.html, U.S. Census Bureau, 2004, US Interim Projections by Age, Sex, Race, and Hispanic Origin.

Cancer Screening Rates by Race/Ethnicity* 2003

- **Breast Cancer (Mammography)**
- **Cervical Cancer (Pap Test)**
- **Colon and Rectum Cancer (Fecal Occult Blood Test)**

- NOTES: * Data for American Indians/Alaska Natives and Native Hawaiians/Pacific Islanders do not meet the criteria for statistical reliability, data quality or confidentiality. Age-adjusted percentages of women 40 and older who reported a mammography within the past 2 years, women 18 and older who reported a pap test within the past 3 years, and adults 50 and older (male and female) who reported a fecal occult blood test within the past 2 years.
- SOURCE: Kaiser Family Foundation, based on the National Healthcare Disparities Report, 2005, available at: http://www.ahrq.gov/qual/nhdr05/index.html, using data from the Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Examples of Health Disparities

Diabetes	As of 2007, Native Americans and Alaska Natives (17%), African Americans (12%), and Hispanics/Latinos (10%) were all significantly more likely to have been diagnosed with diabetes compared to their White counterparts (7%).[1]
Heart Disease	In 2000, rates of death from diseases of the heart were 29 percent higher among African American adults than among white adults, and death rates from stroke were 40 percent higher.[2]
Infant Mortality	In 2002, Sudden Infant Death Syndrome (SIDS) deaths among American Indian and Alaska Natives was 2.3 times the rate for non-Hispanic white mothers.[3]

References: [1]CDC (2008), [2]NCHS (2002), [3]NICHD (2007)

IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual's health regardless of age, race, or ethnicity.

Economic Stabilty:
- » Employment
- » Income
- » Expenses
- » Debt
- » Medical Bills
- » Support

Neighborhood & Physical Environment:
- » Housing
- » Transportation
- » Safety
- » Parks
- » Playgrounds
- » Walkability

Education:
- » Literacy
- » Language
- » Higher Education
- » Vocational Training
- » Early Childhood Education

Food:
- » Hunger
- » Access to Healthy Options

Community & Social Context:
- » Social Integration
- » Community Engagement
- » Support Systems
- » Discrimination

Health Care Systems:
- » Health Coverage
- » Provider Availability
- » Provider Linguistic & Cultural Competency
- » Quality of Care

Health Outcomes:

» Mortality » Life Expectancy » Health Care Expenditures » Health Status » Functional Limitations

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Source: Adapted from Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. November 2015.

Discussion: Social Determinants of Health

- How are resources (e.g., food, housing, local businesses, transportation, health care services) distributed within your community?
- How does this compare to surrounding communities?
- What are the relationships among social determinants, cultural and psychological?

Six Ways to Talk about Social Determinants of Health

- Health starts – long before illness – in our homes, schools, and jobs.
- All Americans should have the opportunity to make the choices that allow them to live a long, healthy life, regardless of their income, education or ethnic background.
- Your neighborhood or job shouldn't be hazardous to your health.
- Your opportunity for health starts long before you need medical care.
- The opportunity for health begins in our families, neighborhoods, schools, and jobs.

Robert Wood Johnson Foundation

EVIDENCE BASED INTERVENTIONS

- National Projects (Theory)
- Tools
- SDoH Interventions in Action

Evolution of Healthy People

Target Year	1990	2000	2010	2020
Overarching Goals	• Decrease mortality: infants–adults • Increase independence among older adults	• Increase span of healthy life • Reduce health disparities • Achieve access to preventive services for all	• Increase quality and years of healthy life • Eliminate health disparities	• Attain high-quality, longer lives free of preventable disease • Achieve health equity; eliminate disparities • Create social and physical environments that promote good health • Promote quality of life, healthy development, healthy behaviors across life stages
# Topic Areas	15	22	28	42
# Objectives/ Measures	226	312	1,000	~1,200

Healthy People 2020
SDOH Conceptual Model and Priority Issues

Neighborhood/Built Environment:
- Quality of housing
- Crime and violence
- Environmental conditions
- Access to healthy foods

Education:
- High school graduation rates
- Enrollment in higher education
- Early childhood education/development
- Language/literacy

Economic Stability:
- Poverty
- Employment
- Housing stability
- Food insecurity

Health and Health Care:
- Access to health services
- Access to primary care
- Health literacy

Social and Community Context:
- Social cohesion
- Perceptions of discrimination and equity
- Civic participation
- Incarceration/institutionalization

Health People 2030

- Healthy People 2030 is the fifth edition of Healthy People. It aims at new challenges and builds on lessons learned from its first 4 decades.
- The initiative began in 1979, when Surgeon General Julius Richmond issued a landmark report entitled, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*.
- This report focused on reducing preventable death and injury. It included ambitious, quantifiable objectives to achieve national health promotion and disease prevention goals for the United States within a 10-year period (by 1990).
- The report was followed in later decades by the release of updated, 10-year Healthy People goals and objectives (*Healthy People 2000*, *Healthy People 2010*, and *Healthy People 2020*).

Healthy People 2030
Overarching Goals

- Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death.
- **Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all**.
- **Create social, physical, and economic environments that promote attaining full potential for health and well-being for all**.
- Promote healthy development, healthy behaviors and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

https://www.healthypeople.gov/2020/About-Healthy-People/Development-Healthy-People-2030/Framework

Health People 2030
Plan of Action

- Set national goals and measurable objectives to guide evidence-based policies, programs and other actions to improve health and well-being.
- Provide data that is accurate, timely, accessible, and can drive targeted actions to address regions and populations with poor health or at high risk for poor health in the future.
- Foster impact through public and private efforts to improve health and well-being for people of all ages and the communities in which they live.
- Provide tools for the public, programs, policy makers and others to evaluate progress toward improving health and well-being.
- Share and support the implementation of evidence-based programs and policies that are replicable, scalable and sustainable.
- Report biennially on progress throughout the decade from 2020 to 2030.
- Stimulate research and innovation toward meeting Healthy People 2030 goals and highlight critical research, data, and evaluation needs.
- Facilitate development and availability of affordable means of health promotion, disease prevention, and treatment.

https://www.healthypeople.gov/2020/About-Healthy-People/Development-Healthy-People-2030/Framework

POTENTIAL NEXT STEPS

If a hospital or health system wants to move forward on their journey to address the social determinants, some examples of next steps include:

1. Know and engage with the community
2. Gather data
3. Develop organizational/internal engagement strategies
4. Integrate social determinants in strategic/financial plans
5. Explore funding options
6. Establish measurement strategies and evaluation tools

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Real-Life Examples

- The EveryONE Project
- Coordinating Transitions (CT)
- Transforming Complex Care (TCC)
- ProMedica
- Advocate ACO Nutrition Program
- University of Illinois Housing Project
- MedStar/Denver Health Transportation Projects
- Mount Sinai Hospital/Sinai Health Urban Health Institute CHW Program
- West Suburban Medical Center “Food As Medicine” Program

- The EveryONE Project
  - Asks the question “Why treat people and send them back to the conditions that made them sick in the first place?”
    - American Academy of Family Physicians
    - Assessment toolkit developed (handout)
- Coordinating Transitions (CT)
  - Integrated SDoH into practice workflow using existing EMR/HIE and electronic data
    - Includes a Patient Centered Assessment Method (PCAM) that scores and standardizes identification of social problems that place individual for risk of hospitalization
    - Contributed to decreased ED use (over 700 visits) and hospital admission rates (over 80 admissions) over 2 year study period
- Transforming Complex Care (TCC)
  - Multistate initiative under Robert Wood Johnson grant
    - Uses “PRAPARE” tool or home grown screening tool
    - Focus on data collection, electronic implementation

- Advocate ACO Nutrition Program
  - 2 initiatives
    - High risk patients (malnutrition) receive oral nutritional supplement within 2 days of admission
    - Enrolled in post acute program: nutrition education, follow up calls, coupons and oral nutritional supplementation
      - Total savings $4.8 million, decreased readmission rates
- West Suburban Medical Center “Eat & Be Well Medical Pantry”
  - Collaboration with Temple Jeremiah, Great Chicago Food Depository
  - Patients receive a Rx from the pantry, operated once a week
  - Lean meats, fresh produce
  - Follow up with MD in 6 weeks to renew Rx
  - Started in 2017, continues to operate today
- ProMedica
  - 332 sites of care, 4.7 M encounters, 13 hospitals and 323,000 lives
  - Toledo, OH project :“Food Pharmacy”
  - HCP writes a referral and identified patients visit and pick up supplemental health food supply
    - 57,224 patients screened in 2016/ 2243 screened positive/1100 became food pharmacy clients
    - ED usage dropped 3%, readmission rates dropped 53%, primary care visits increased 4%
- Multisite Transportation Projects
  - Team with Uber/Lyft (MedStar, Denver Health)
  - Mobile treatment facilities (Calvert Health, MD)

- University of Illinois Housing Project
  - 200 chronically homeless in 10th-decile for patient cost
  - Partnered with Center for Housing and Health
    - "Better Health Through Housing" 2015
  - Identification and assessment in ED
    - Continually homeless x 1 yr+ or 4 +episodes of homelessness within 3 year period.
  - Move to "bridge unit" (transitional housing) and work with CM for long term housing solutions
  - ED use decreased by 35%, increased clinic use, healthcare costs dropped 42% initially and most recent results show 61% reduction
- Mount Sinai Hospital/Sinai Health Urban Health Institute CHW Program
  - Use of Community Health Workers for post-acute home visits
  - Started with asthma in 2011, CHW sent to identify triggers to exacerbations (environmental, behavioral, etc)
  - Year 1 reduced asthma ED visits by 74=3% and hospitalization by 75%

Case Study

- Dave and Bob are both 53 years old.
  - DM, HTN, High Cholesterol and COPD
- Dave: Master's degree, fully employed, has health insurance, lives with spouse and family, can afford deductibles and co-payments. Is connected with PCP.

- Bob: HS graduate, occasionally employed, lives alone. Has health insurance sporadically (when employed) but cannot afford deductibles/copayments, difficulty paying rent and buys processed foods in single servings. Uses ED as primary care.

Identify non-medical factors that may impact outcomes

CCMC Ethics Check In

- PRINCIPLE 2: Board-Certified Case Managers (CCMs) will respect the rights and inherent dignity of all of their clients.
  - Health equity vs health disparity; national, state and local interventions to help meet the needs of our clients. What do you have in your backyard?

- PRINCIPLE 3: Board-Certified Case Managers (CCMs) will always maintain objectivity in their relationships with clients.
  - How does the professional case manager make the resources available equitably?

Readmissions Statistics

- 1 out of 5 Medicare patients are readmitted within 30 days (19.8%), with 34% readmitted within 90 days
- 50.2% did not have PCP visit within their immediate 30 day post-hospitalization period

West Suburban Medical Center "Point of View" Project

- Facility Readmissions,2018-2019
- Project started in July 2018, concluded August, 2019
- Uses survey tool developed internally, based on "PRAPARE" tool (used in OP settings)

Survey

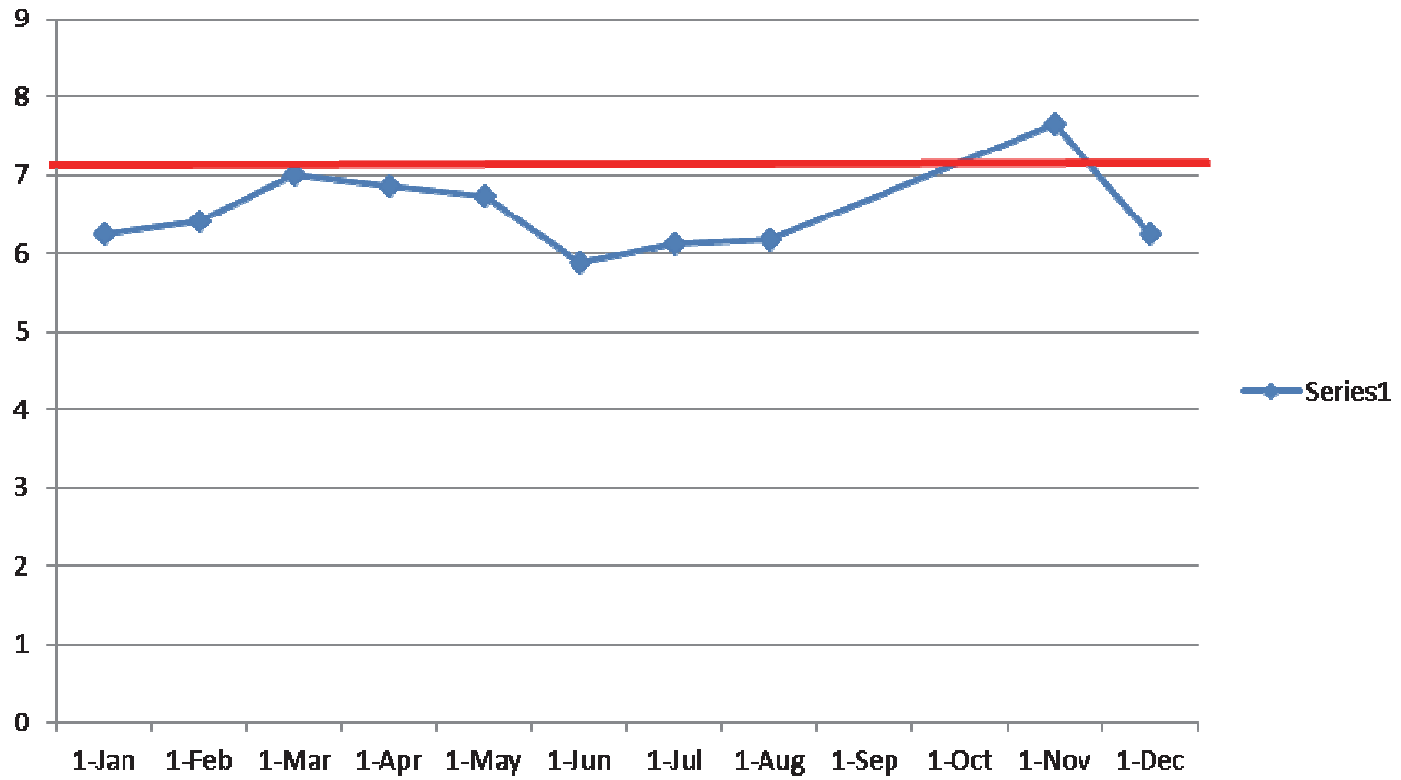
- SW staff, during initial assessment, add the 10 question POV tool for all patients identified as 30 day readmission (regardless of diagnosis)
- SW well equipped to discuss any + findings and do more in depth assessment

Health Confidence

- Health Confidence Tool added in October, 2018
- Goal Score is 7/10

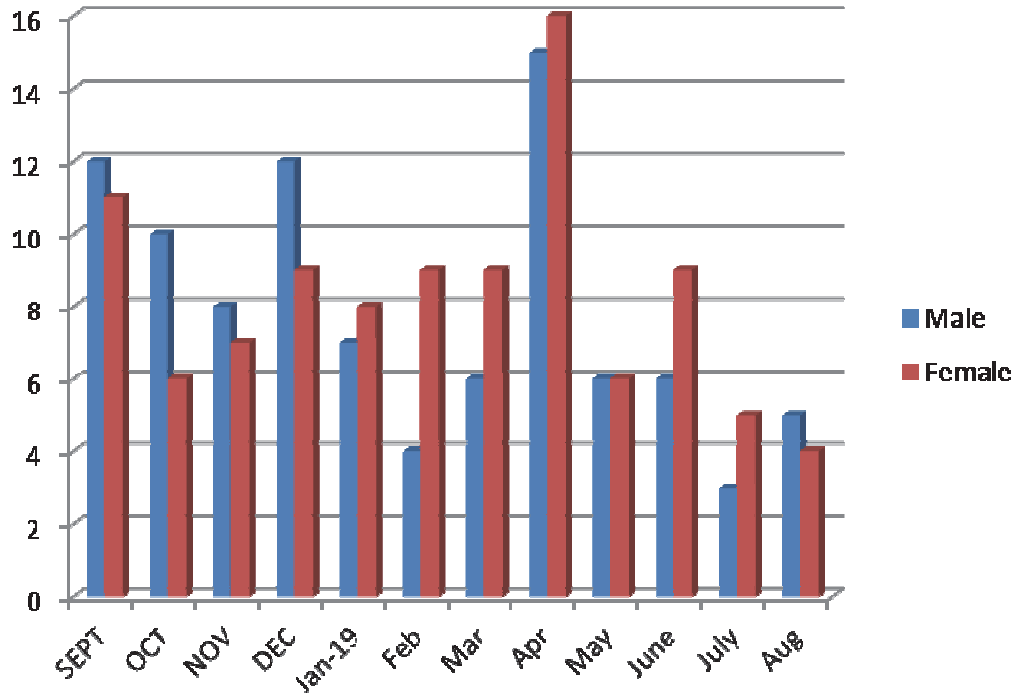
Health Confidence Results

Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19
7.66	6.25	6.25	6.4	7	6.85	6.73	5.88	6.125	6.18

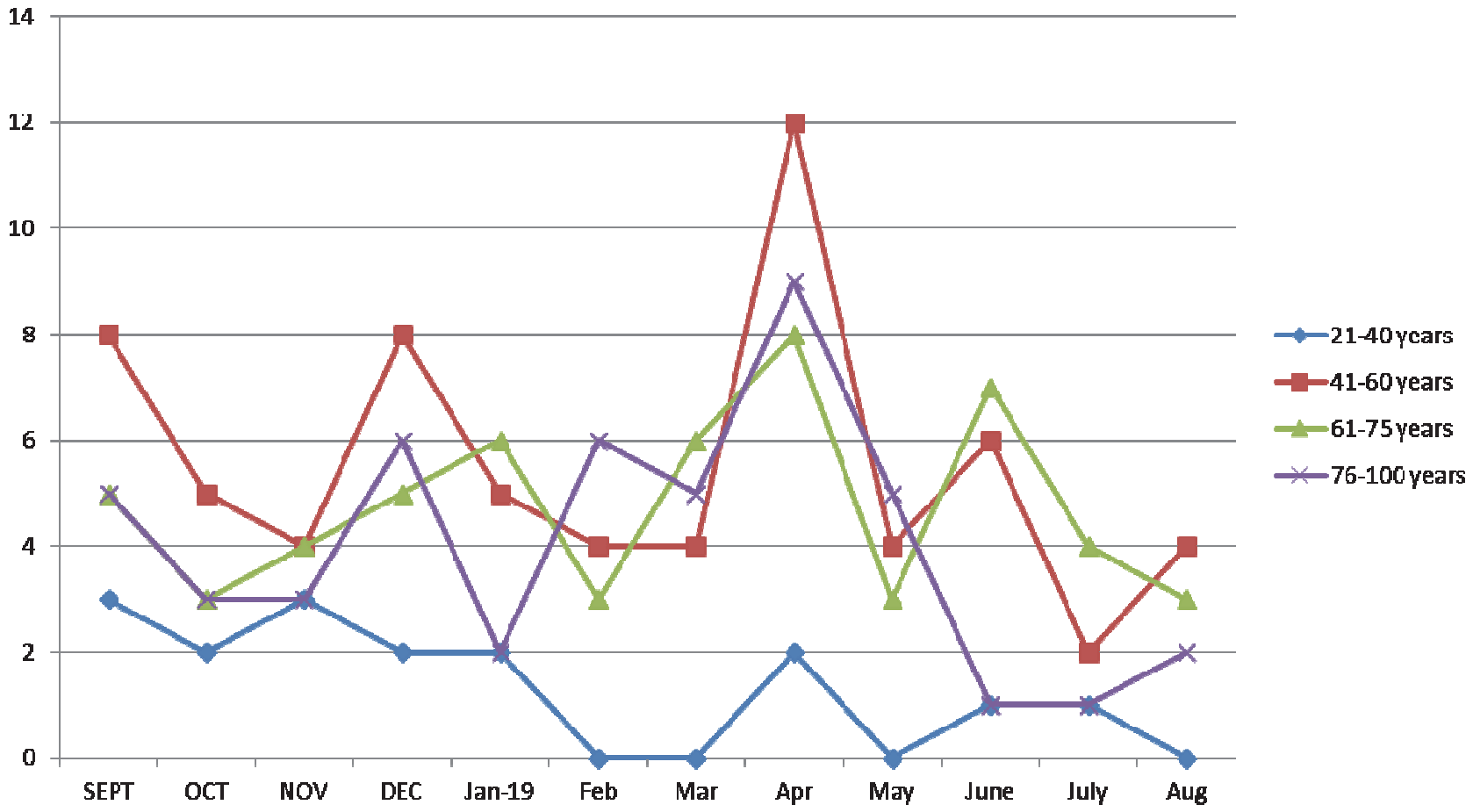


RESULTS

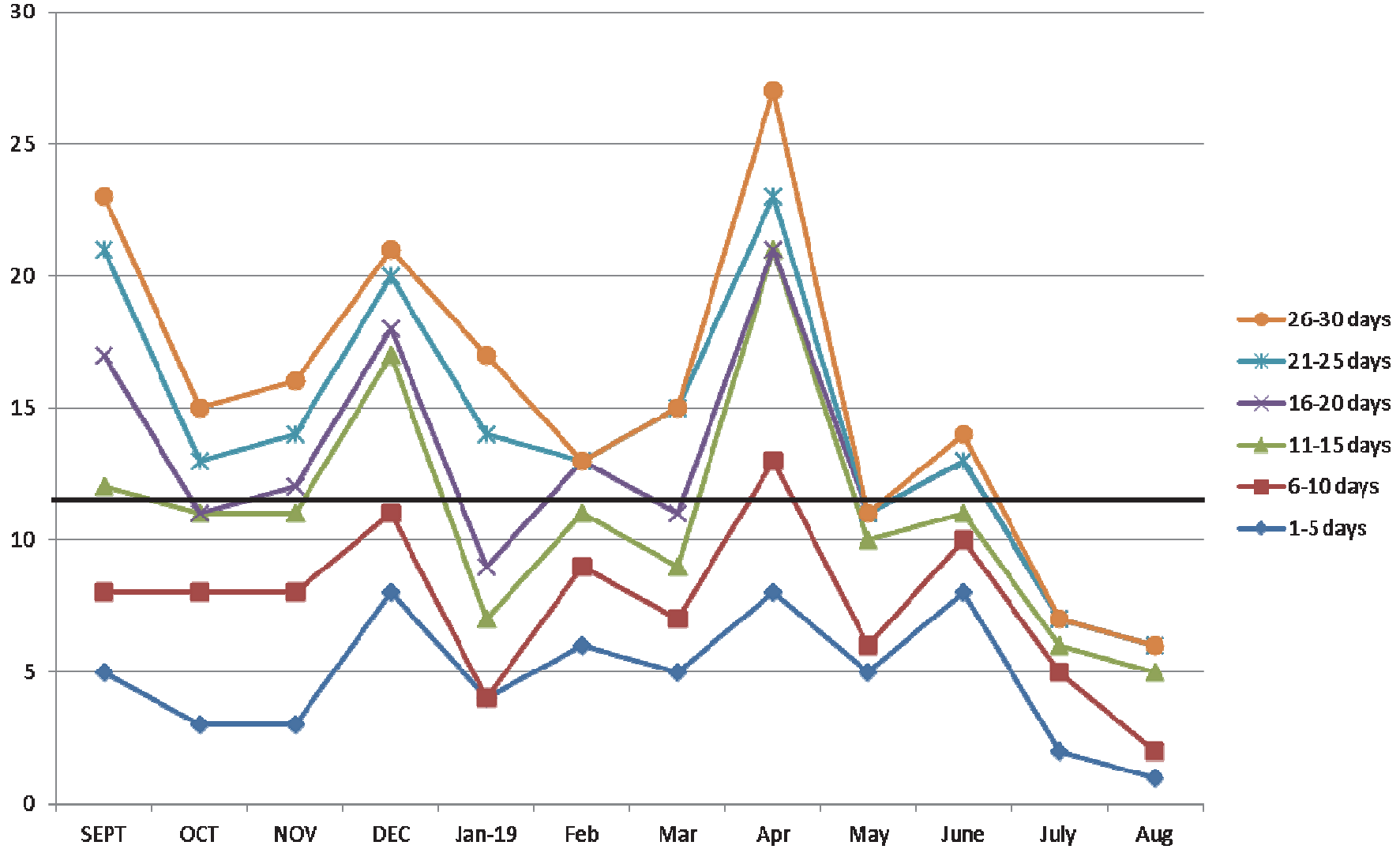
- Surveyed readmitted patients during this period upon each readmission
  - 193 surveys
    - Male: 94 48.70%
    - Female: 99 51.20%



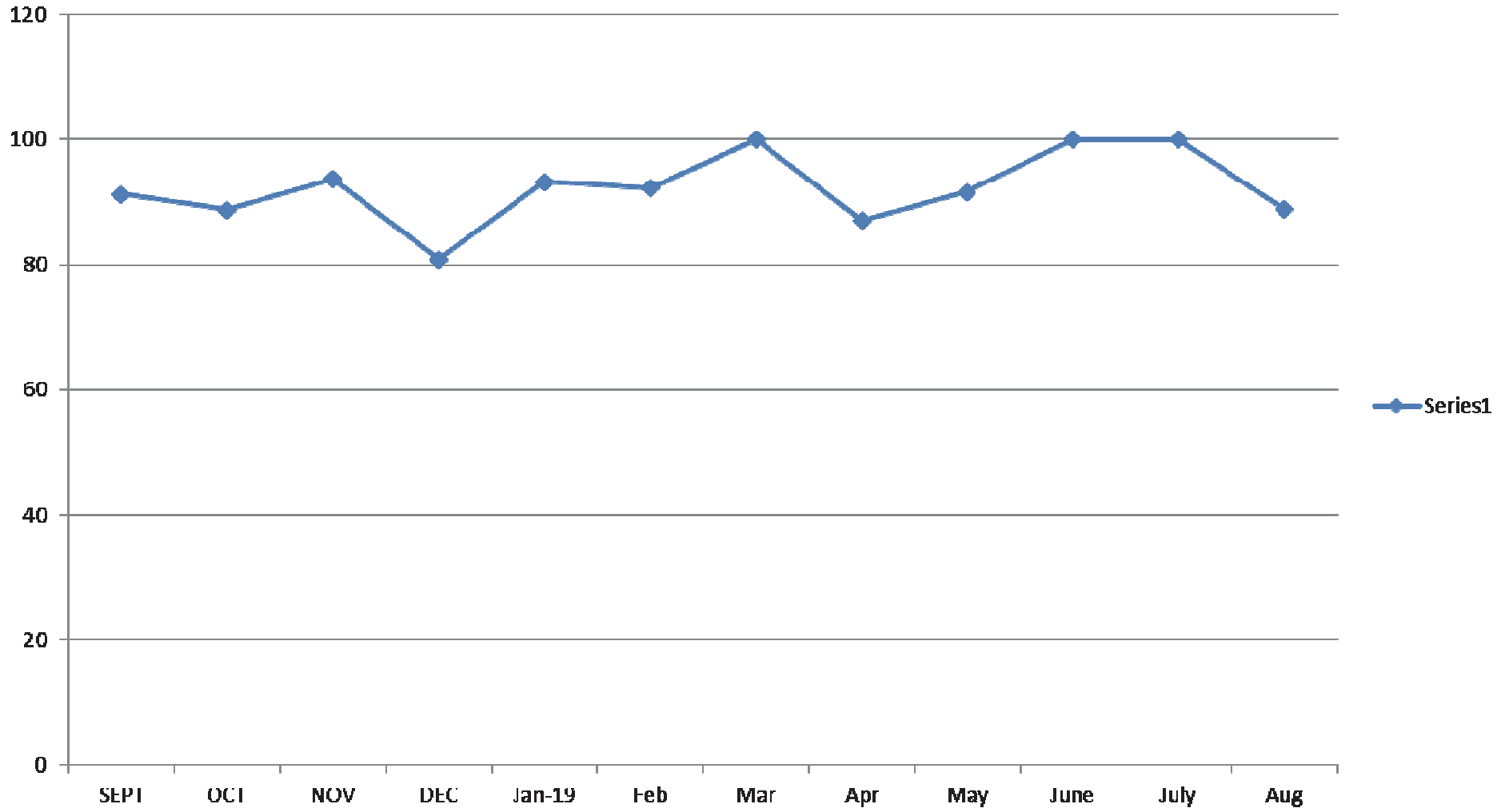
Age Distribution



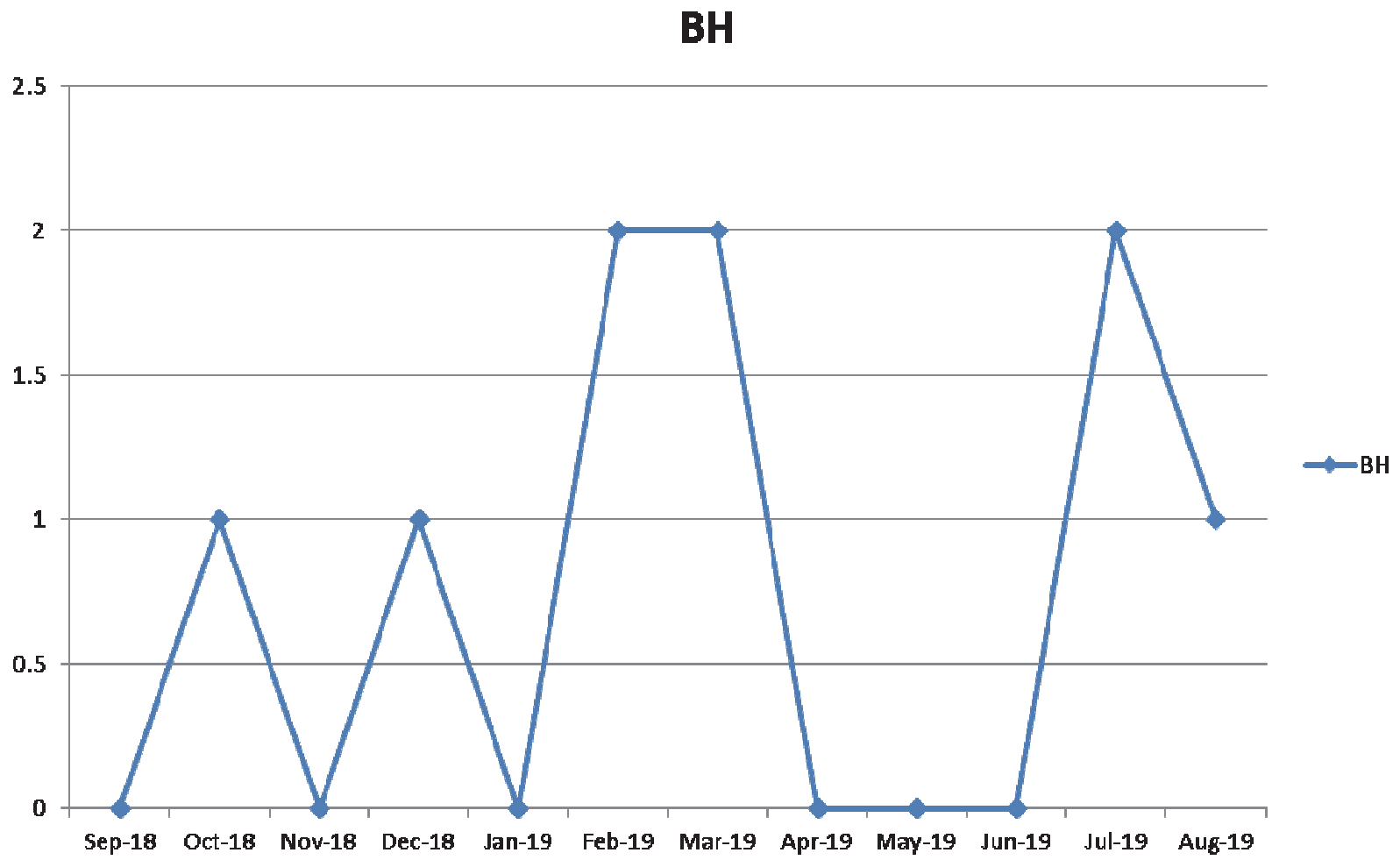
Time to Readmission



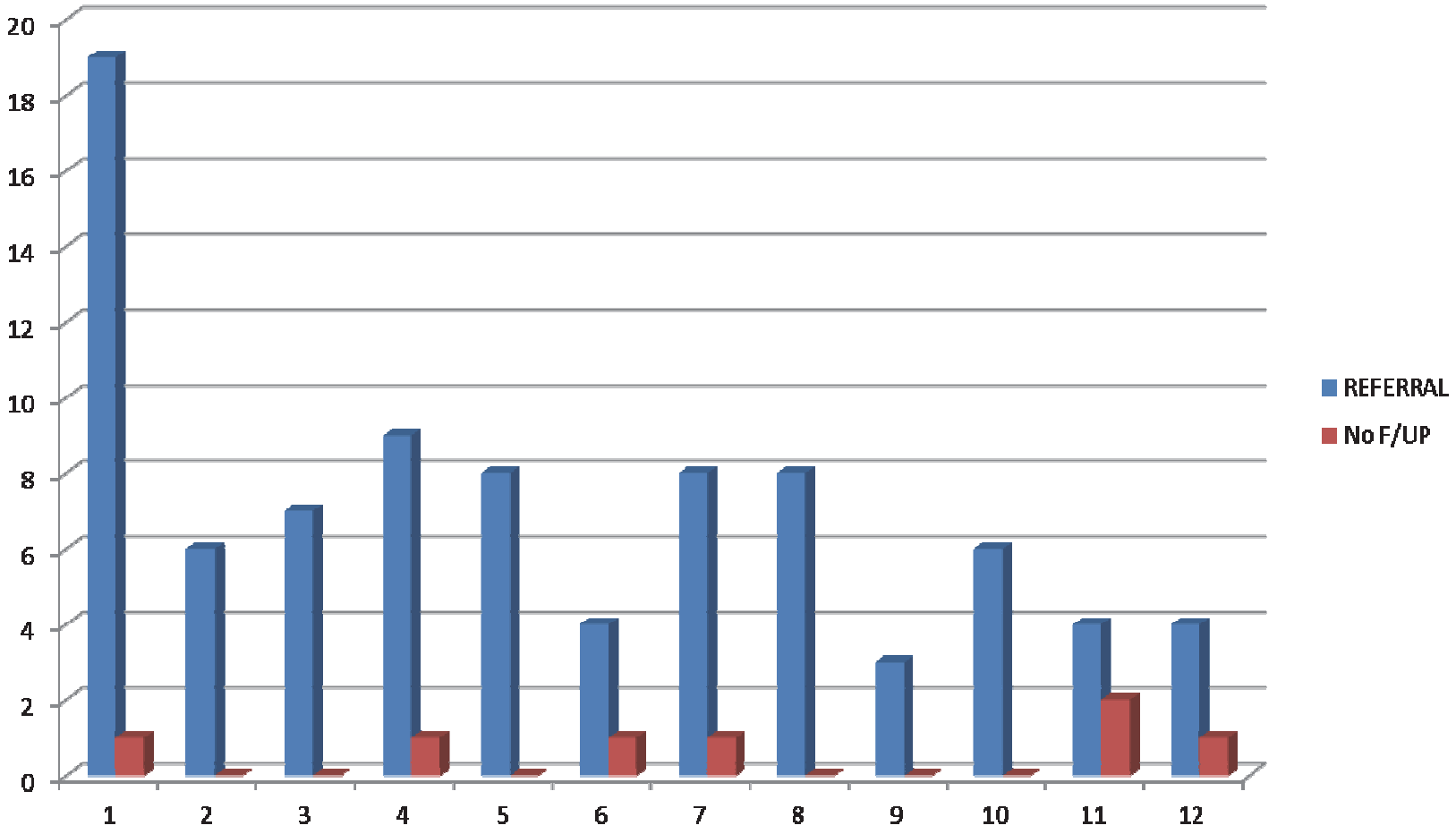
DC Destination: Home or HHC



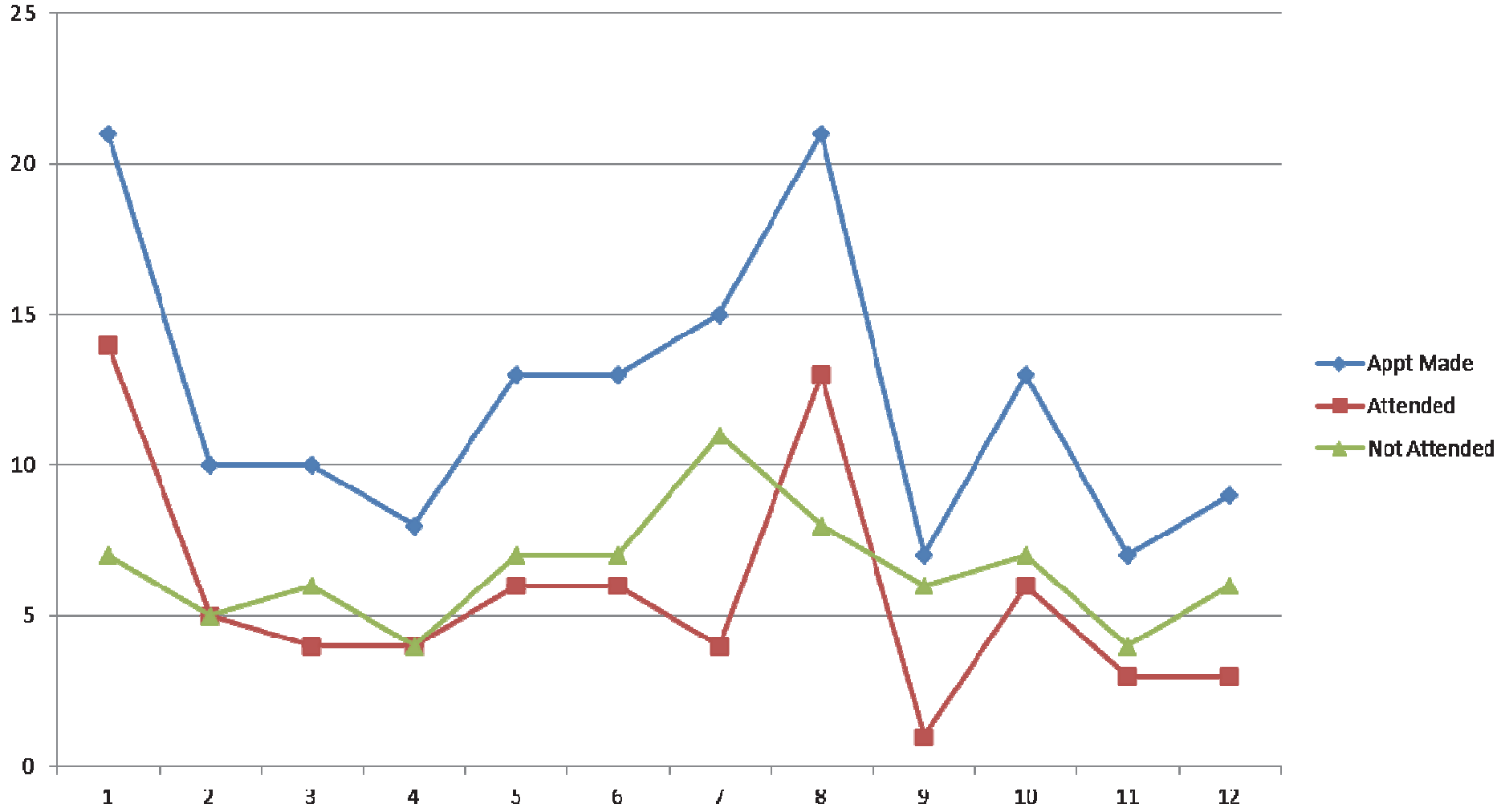
Behavioral Health Impact



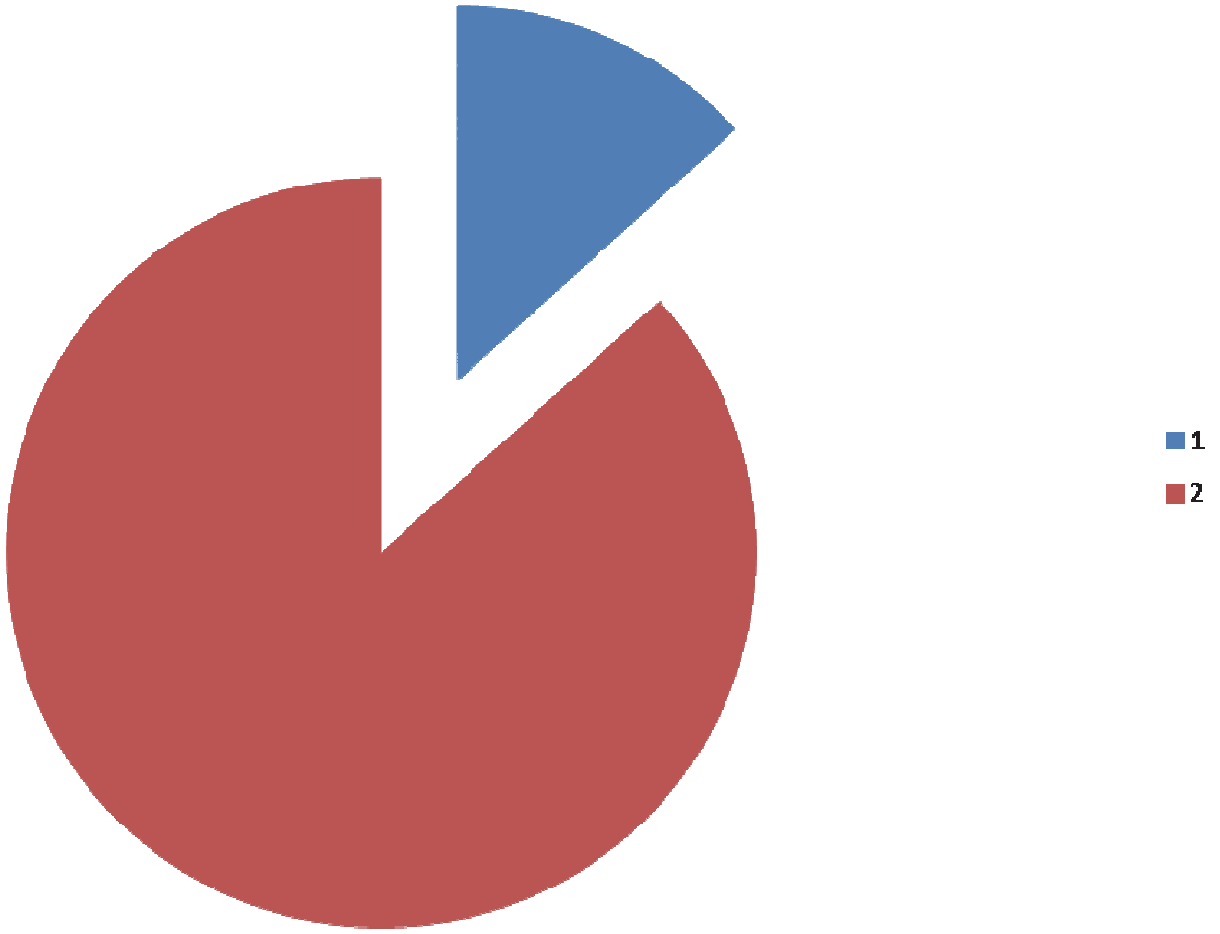
Post Acute Services



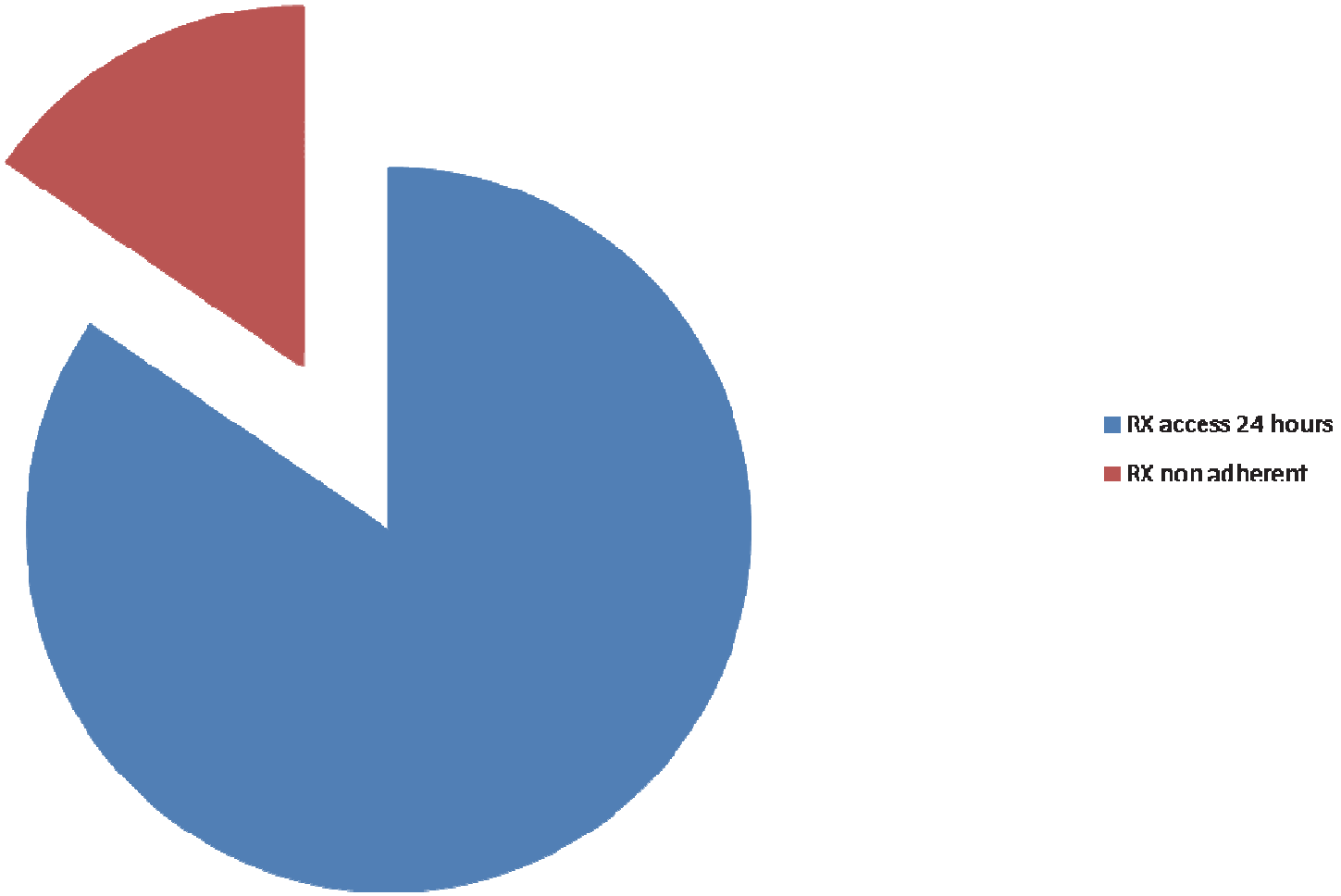
Follow Up Appointment



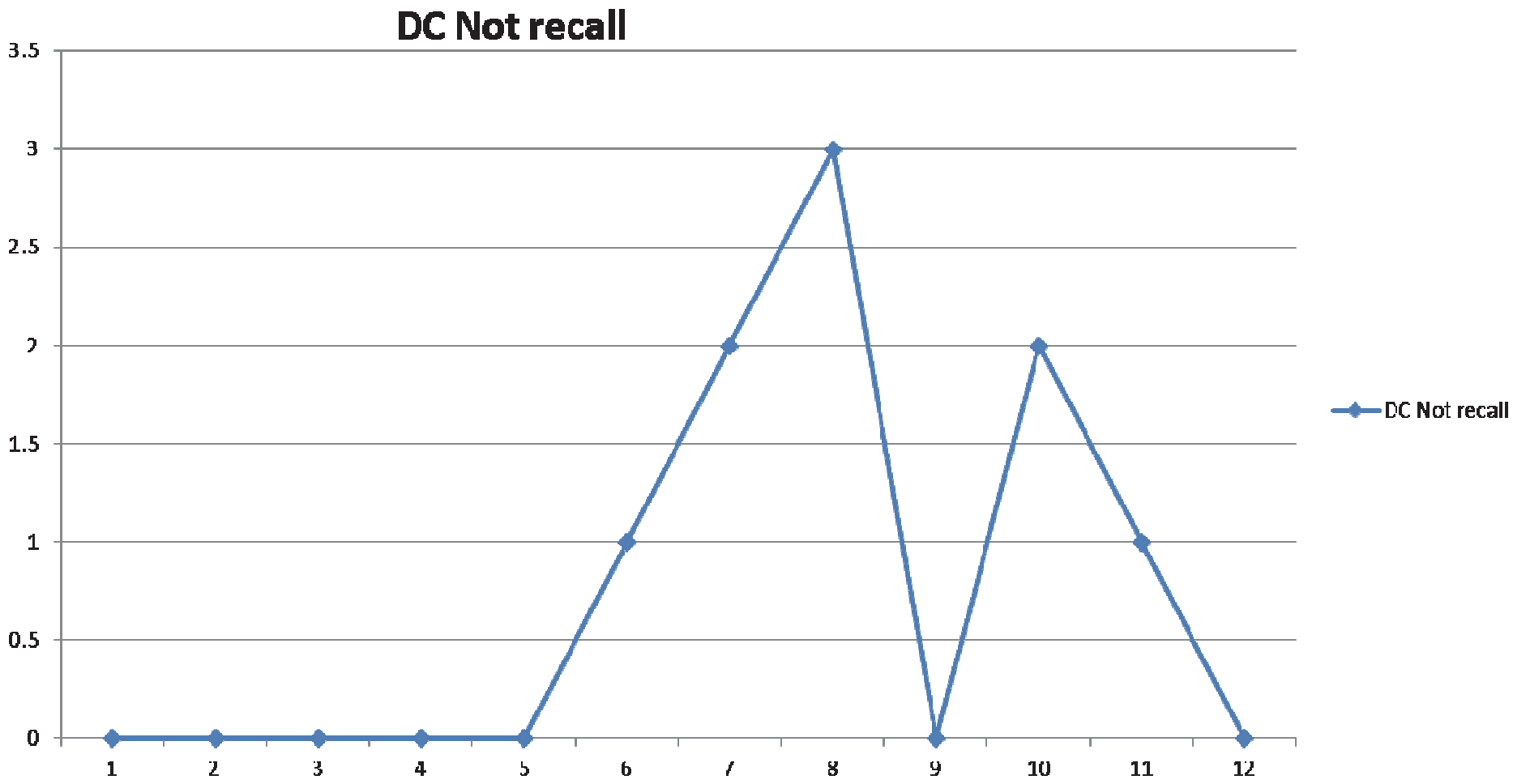
MD Contact Prior to ER Presentation



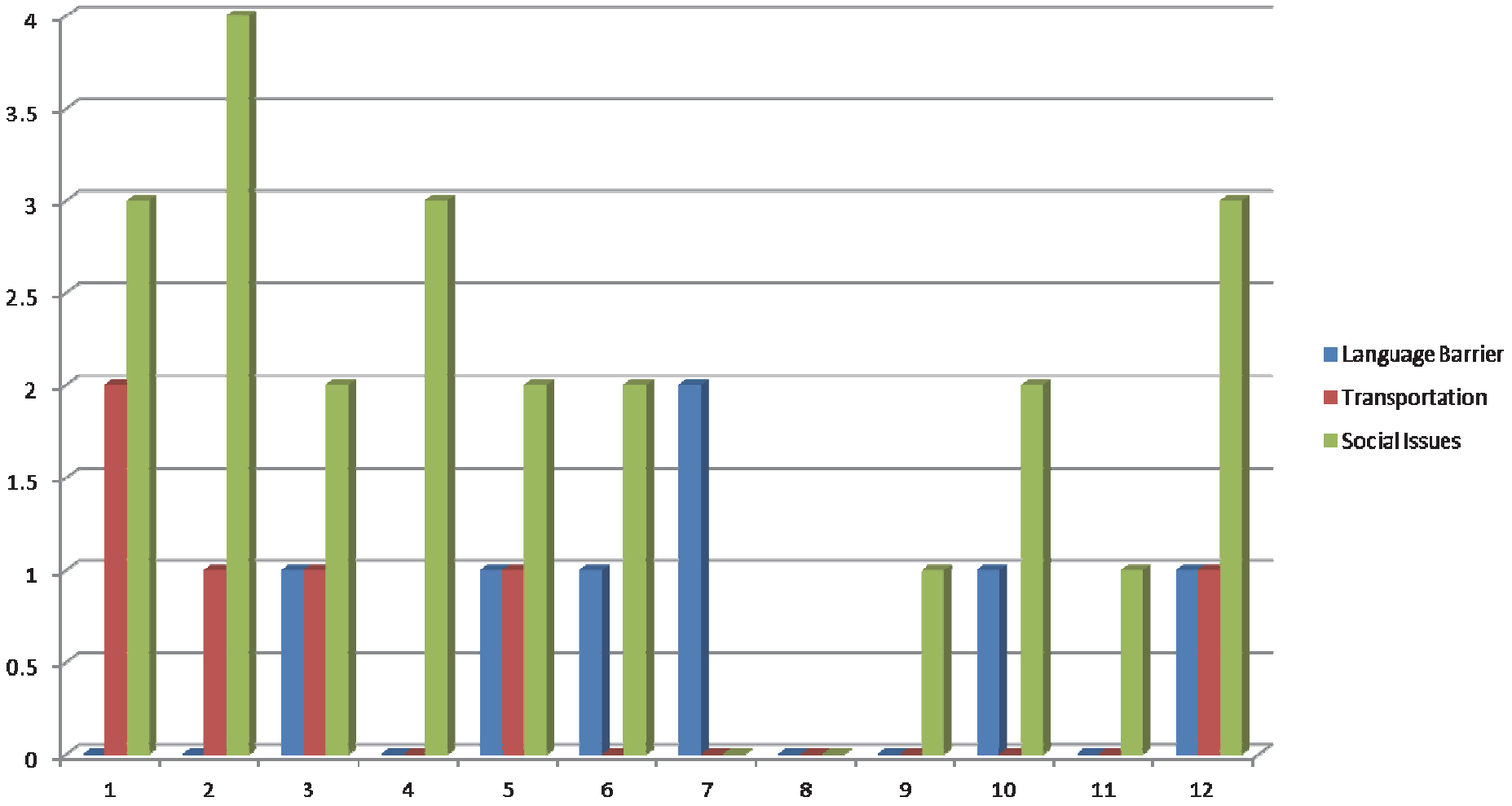
Rx Access/ Adherence



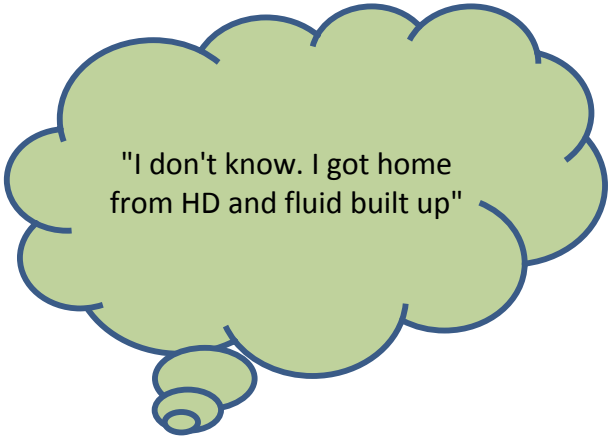
Recall DC Instructions?

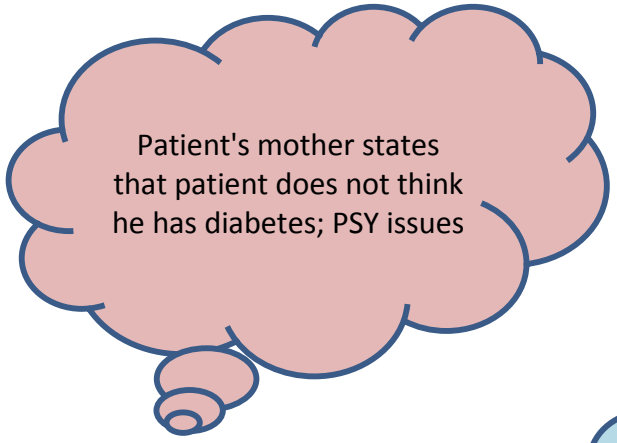


Other Social Issues Identified

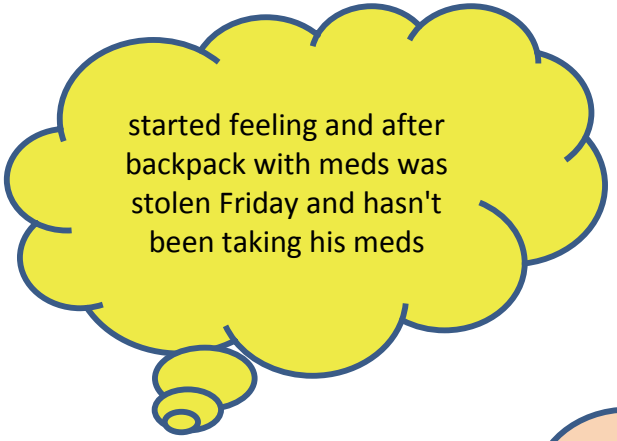


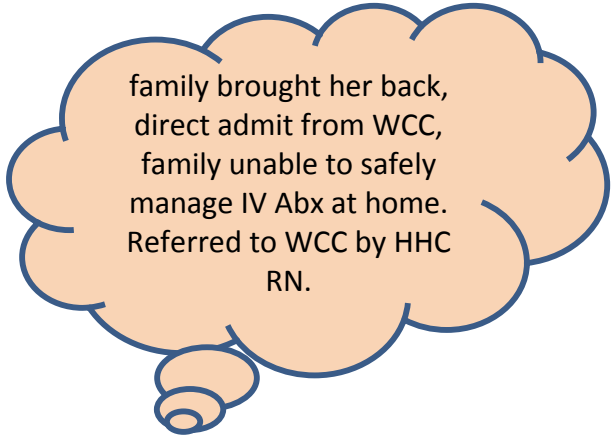

came in for HD chair setup; left AMA due to leaving verbally abusive relationship and "needed some air"

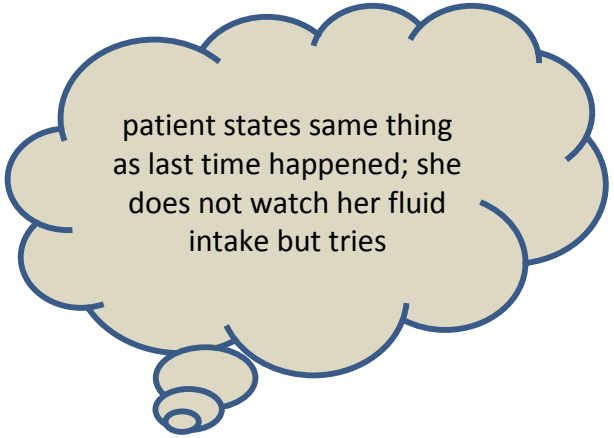

"I don't know. I got home from HD and fluid built up"


Patient's mother states that patient does not think he has diabetes; PSY issues


Patient reports "being unsure"


started feeling and after backpack with meds was stolen Friday and hasn't been taking his meds


family brought her back, direct admit from WCC, family unable to safely manage IV Abx at home. Referred to WCC by HHC RN.


patient states same thing as last time happened; she does not watch her fluid intake but tries

Project Evaluation

- Numbers don’t necessarily tell the whole story
- Patient perspective is important
- The impact of Social Determinants of Health varies from area to area
  - Know your area(s) and their issues
- The core concern should always be what does the patient need to be successful

CCMC Ethics Check In

- PRINCIPLE 2: Board-Certified Case Managers (CCMs) will respect the rights and inherent dignity of all of their clients.
  - Patient perspective: is it important or can we fix things for everyone with one-size-fits-all solution?

- PRINCIPLE 3: Board-Certified Case Managers (CCMs) will always maintain objectivity in their relationships with clients.
  - Identify your own implicit biases, stereotypes that impact your decision making and do the work to resolve these so you can maintain your objectivity.

SOCIAL DETERMINANTS IN ACTION

Case Study A

- Meet William. William came to our hospital with an infected wound on this foot, but in truth, his troubles were greater than what was presented.
- When I first met William, he was an affable, but guarded patient. He was willing to answer questions, but only to a certain point, when he started to be evasive. The next time I went to speak with him, he was in full blown withdrawal from his heroin addiction. During his admission, his discharge concerns continue to mount.
- He was homeless, uninsured, without an income, without family or other social supports, and without a primary care physician all of these issues making it difficult to obtain the medical care he needed to heal his infected foot. He needed antibiotics, a substance abuse program, a clean place to change his dressings, follow up at wound care clinic , a primary care physician, and lastly, transportation to all his appointments.

What Can You Do for William?

- Identify issues
- Prioritize issue
- Solve issues

- PRINCIPLE 2: Board-Certified Case Managers (CCMs) will respect the rights and inherent dignity of all of their clients.
- PRINCIPLE 3: Board-Certified Case Managers (CCMs) will always maintain objectivity in their relationships with clients.
- PRINCIPLE 4: Board-Certified Case Managers (CCMs) will act with integrity and fidelity with clients and others.

William's Story, continued

- After meeting with him a few times, William was agreeable to try a Suboxone program for his heroin use issues. One of the hospitals affiliated clinics had such a program and could enroll him in it. His hospital physician was also on staff with the same clinic and was willing to continue to see William as an outpatient even with his current financial status.
- Financial counselors were contacted and they, with William, began his application for Medicaid. We were also able to find him temporary, but transitional, shelter at a facility that worked with the homeless who needed medical care . William now had a place to live for a while, where he could care for his foot in clean environment. A call to the wound care clinic was made and after some advocating, they were willing to see William, knowing his insurance had not been yet approved. They would monitor the healing of his foot ulcer. The hospital's medication program was able to provide the patient with his antibiotics and the nursing floor at discharge provided him with extra dressing changes until he could go to the wound care clinic. The hospital provided bus passes for William to get to all his appointments.
- I met with William about two to three times a week to check in with him and to provide the needed bus passes. About 4 weeks into the situation, I saw William and he stated he was doing well. He was still attending the substance abuse program and remained abstinent. He was continuing with the wound care clinic and his foot was doing much better and was well on the way to being healed. I offered him some more bus passes for transport but he declined stating he didn't need them. How was he to get to his appointments? He smiled at me stated, I got a job! He had started a new job the previous week and was getting his first paycheck that day. He was grateful for all we had done, but didn't want to continue to take what he didn't need. He turned gave me a huge hug and went off to work.

- I heard from William about three months later. He was still substance free, the wound was healed and he was still working. He had found an apartment and was making headway with rebuilding relationships. The stars and planets had aligned and he was following their path. This is what case managers and social workers do. We give the push in the right direction for others to have their needs fulfilled.

Case Study B

- Wanda is age 64 and lives alone in a two-level home which her deceased father built. She lives in a rural, poor community with few resources. She has lived in her home for 40 years and is very emotionally connected to her home. She can present at times as overwhelmed, confused, helpless and tearful.
- She has three children, two siblings and extended family, but they are not involved or available. Wanda's brother recently passed away suddenly and dramatically. Wanda has a primary care physician who she respects and feels an emotional bond and connectiveness due to their similar cultural background, interests and values.
- Wanda has Chronic Obstructive Pulmonary Disease (COPD), Diabetes, along with a progressive medical ailment which has her mostly using a power wheelchair. She is on continuous oxygen. Wanda can seem to present with some memory / cognitive impairment issues.
- She appears to have some significant executive skills impairment related to managing her finances and paying her bills. Wanda's monthly fixed income is around $1,200. Wanda has very little money in the bank. Wanda's electricity was nearly turned off until she made a phone payment aided by the social worker. She also had to make a payment, again aided by the social worker, to the phone company after she realized she could no longer make outbound calls.
- Her monthly water bill is typically $15 month. However, she has had a water leak causing her water bill to become increasingly exorbitant. Her first water bill after leak began was $150 and continues increasing by an increment of around $50 month. Therefore, the second month water bill after the leak was $200/mth, third month is $250/mth. Repair is estimated between $4000-7000.

What Can You Do for Wanda?

- Identify issues
- Prioritize issue
- Solve issues

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Wanda's Story, continued

Wanda &SW have worked together to ensure that her phone & electricity are not disconnected; confirmed with electric company that she has a "limiter" function on her electric meter which would provide voltage enough to operate her oxygen machine should her electric be disconnected

We have informed water company related to Wanda's various vulnerabilities and dangerous situation which could occur if Wanda's water bill should be suddenly turned off

Wanda and SW consulted with plumbing company to figure out repair issue and cost. Several bids were obtained and repairs were completed by a company found through local senior citizen's coop, willing to negotiate and take payment plan. Repairs were completed for $1500.

Wanda has been able to access needed handicapped transportation.

Wanda's primary care physician (PCP) has been updated related to her status. PCP hadn't been aware of the severity of some of Wanda's psycho-social needs

Adult Protective Services (APS) has been able to get involved in an effort to help member resolve some of her crisis issues to ensure her safety and to enhance her independence

Wanda has expressed interest in stair-lift, in home help, financial assistance and emotional support. Wanda and SW are continuing to outreach local community-based agencies, such as Office on Aging, churches, disability and diseased centric organizations and others.

Conclusion

- SDoH issues can be ethical issues
  - Health equity issues, health disparities have huge impact on individual's health status
- Access to all kinds of services is critical to quality/ quantity of life
- Addressing SDoH impacting client's acute and ongoing health/lifestyle is necessary to promoting engagement, empowerment
- Think outside the box. Know what's available around you.
  - Don't be afraid to "what if" and create a solution.
- Patient perspective/feedback is key. "One size" does not fit all.
  - Be patient centered in your approach.

Questions???

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