A Retrospective Review and Survey of Factors Related to Successful Engagement in a Multi-Visit Patient Clinic Program

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Lewis Katz School of Medicine
Center for Urban Bioethics

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Introduction

The Multi-Visit Patient (MVP) Clinic at Temple University Hospital was established in February 2020 as a community health worker-driven transitional care program to reduce hospital readmissions. In the clinic, community health workers provide care alongside our physicians to offer services including transportation to-and-from appointments, nutritious food, and access to social work (Shah Pandya et al. 2022). Patients "graduate" from the program when they are determined to have adequate outpatient follow-up in other healthcare settings. The program has seen impressive success thus far. In just the first nine months of clinic establishment, we saw a 48% reduction in inpatient admissions and a 42% reduction in emergency department visits for MVP Clinic patients (Sturgis 2022), revealing the positive impact of the program.

This study was designed to assess the factors related to successful patient engagement, with the aim of determining which patient populations require more targeted social support in the MVP clinic. A retrospective review was conducted using the social determinants of health screen embedded in Temple University Hospital's medical record platform. Social determinants of health data was compared between "graduated" patients (n=104) and those lost to follow-up (n=35). Successfully-engaged patients also participated in a survey (n=87). By exploring these factors, we hoped that further quality improvement initiatives could better target patients at the highest risk of loss to follow-up, increasing their rates of success within the program.

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Social Determinant	n (% Graduates)	n (% LTF)	p-value
Household Supply Needs	32 (39.51)	11 (57.89)	0.1985
Employment-Related Needs	4 (4.94)	3 (15.00)	0.1374
Housing Insecurity	25 (24.27)	10 (29.41)	0.6506
Food Insecurity	28 (27.18)	8 (23.53)	0.8230
Transportation Insecurity	57 (58.76)	16 (51.61)	0.5352
Utilities	20 (21.98)	8 (25.00)	0.8072
Financial Insecurity	27 (30.34)	7 (30.43)	1.0000
Safety	4 (4.49)	1 (3.13)	1.0000
PCP-Related Needs	56 (53.85)	16 (45.71)	0.4390
Insurance-Related Needs	15 (14.42)	2 (5.71)	0.2387

Table 1. Social determinants of health for patients who graduated and were lost to follow-up. LTF = lost to follow-up. PCP = primary care provider.

Survey Question	Survey Responses (Yes)
Recent Primary Care Visit	64.15%
Ability to Make Primary Care Appointments	78.16%
Home Internet Access	70.11%
Telephone Access	98.85%
Social Support	79.31%

Table 2. Survey responses for patients who had at least two documented MVP Clinic visits, including those who had graduated and could be reached via telephone.

Conclusions

The urban community surrounding Temple University Hospital faces many challenges that confer unique vulnerability to the hospital readmissions cycle. The Multi-Visit Patient Clinic was established to provide a bridge between inpatient and outpatient care. This study aimed to identify how to best engage patients who are most likely to be lost to MVP clinic follow-up by comparing social determinants between patients lost to care and those who have had success with our program.

Analysis of results revealed no significant differences in social determinant characteristics between patients who are lost to follow-up and those who achieve success with our program. Our results may have been influenced by factors related to study design including small sample size, a limited study period, and the introduction of human error through manual chart review. The reliance on a snapshot of data from a frequently-updated patient tracker may have also led to difficulty in identifying distinguishing features between the two patient groups.

This study did not identify any specific population that should be intentionally targeted for community health worker intervention. For this reason, our providers should continue to tailor their services to individual patient needs. We suspect that factors related to patient success with the program may be non-quantifiable, and future studies should be designed to further elicit how social determinants may affect patient interactions with the healthcare system.

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Prison Health and the Bioethical Challenges Facing Patients Who Are Incarcerated

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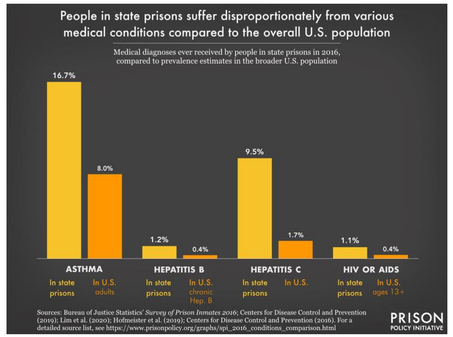
Introduction

- There are more than two million people currently incarcerated in the U.S.
- People in prison experience many health disparities, including higher rates of chronic conditions, infectious diseases, mental illnesses, and substance use disorders compared to the general population
- People in prison have a constitutional right to health care, however, this is often violated



Prison Health News

- Prison Health News (PHN) is a non-profit organization that strives to lift the voices, experience, and expertise of people who are currently and formerly incarcerated
- PHN is the only resource that responds to requests for health and advocacy information from people in prisons and jails everywhere in the U.S.
- Common topics include new diagnoses, medication adverse effects, access to health care, and co-pays

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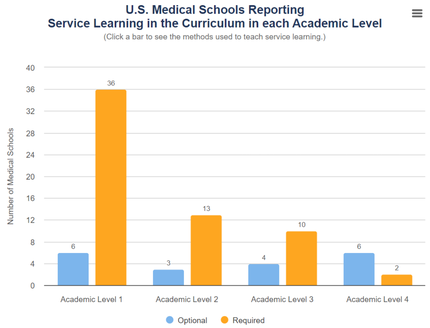
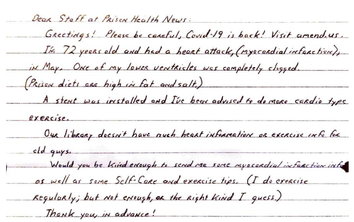
A Gap in Medical Education

- There are limited opportunities for medical students to learn about prison health in medical education
- Service-learning offers a potential solution to close this gap, however, it is not prioritized by the LCME
- Service-learning programs are not standardized across medical schools and represent a patchwork of efforts
- Service-learning fosters transferable skills, facilitates longitudinal relationships with the community, and empowers students



A Novel Service-Learning Program

- Pilot program with 21 first-year medical students who responded to health and advocacy questions in collaboration with PHN
- Students gained experience sourcing reputable information, writing for a lay audience, practicing empathetic communication, and adapting solutions to the constraints of the prison system
- Students reported increased knowledge of the barriers to prison health care and a greater desire to advocate for underserved communities upon program completion



Dear Staff at Prison Health News:

Greetings! Please be careful, Covid-19 is back! Visit amend.us.

I'm 72 years old and had a heart attack (myocardial infarction) in May. One of my major vessels was completely clogged. (Prison diets are high in fat and salt).

A stent was installed and I've been advised to do some cardio type exercise.

Our library doesn't have much heart information or exercise info for old guys.

Would you be kind enough to send me some myocardial infarction info as well as some Self-Care and exercise tips. (I do exercise regularly, but not enough, on the right kind I guess)

Thank you in advance!

Conclusions

- People in prison experience many health disparities and challenges in accessing their right to health care
- There are limited opportunities for medical students to learn about prison health
- LKSOM's novel prison health service-learning program offers a potential solution for students to learn from and advocate for people in prison
- Being able to care for diverse patient populations is crucially important for all medical students

Future Directions

- In recent years, greater attention has been placed on the social determinants of health within medical school curricula
- We argue for the inclusion of prison health in discussions and teaching on the social determinants of health across all medical schools

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Opinion

Why medical students should learn about prison health

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The Role of the Urban Academic Medical Center in Addressing Food Justice: From Farm to Families and Beyond

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Introduction

- Studies of fruit and vegetable prescription programs reveal that consistent participation results in health improvements among patients with diet-related chronic disease.
- These programs aim to disrupt environmental barriers to obtaining produce while at the same time leverage clinical providers' encouragement of healthy eating habits.

Farm to Families (F2F)

- Brings subsidized boxes of organic produce weekly from Lancaster farms directly to families in North Philadelphia.
- Increases people's capacity for health by fostering access to healthy foods and by allowing greater food choice that isn't solely dependent on cost.
- Embraces the philosophy of Food is Medicine and allows health care providers to write prescriptions for fresh food at low- or no-cost for patients.

Objective: We sought to understand patient practices and characteristics in influencing consistent, long-term participation in Temple University's F2F fruit and vegetable prescription program.

Methods

- From June to August 2021, I conducted 13 semi-structured interviews and 7 photovoice interviews with F2F participants. Patients enrolled ≥ 3 months were eligible to participate.
- The interview guide was developed by authors with expertise in internal medicine, nutrition, social work, and urban bioethics.
- Using the principles of grounded theory, we (JEC, ST, and PR) independently coded the transcripts to identify recurrent themes, selecting comments that served as examples of each theme.
- The study team met with the PI (SJH) to assess the level of concordance regarding themes and their supporting comments and discuss emerging or new themes.
- Related themes were consolidated and then separated into four categories that emerged from patterns within the data.
- Participants completed questionnaires on food insecurity, food shopping, cooking, and household kitchen items.
- Patient characteristics: Median age 65 years old; women (85%); SNAP participation (62%); Black/AA (92%)

Results

Qualitative Data

Themes	Representative Quotes
Relationship Between Food and Health 	*"I changed my diet. And the vegetables really helped—instead of eating a lot of nonsense. And I started learning how to cook the vegetables. And then it started coming down—my A1C started coming down."* *"I finally accepted the fact that if I wanted to have better quality and not far more chronic ailments […] I decided I had to start doing something […] Like this is the first foot forward and I will be stepping off in a new direction with food."* *"No, I'll never give up [F2F]. Because it's a healthy lifestyle initiative. And it is well-balanced, and it supports everything my doctor was teaching me through the lifestyle balance program. And it's [an] easier, more efficient way to get fruits and vegetables into your life. So I'll never quit."*
Valued Easy Access to Quality Fresh Produce	*"I would go to the market, but [the fruits and vegetables] weren't fresh all the time. Sometimes it was just poor quality. And that would make me buy the canned fruit instead of the fresh […] The quality is not good enough for the prices they want you to pay for [fresh vegetables]."* *"Well, [F2F] has changed the quality of the vegetables and fruit that I eat. Like, for instance, last week […] the green granny apples […] all the apples are good, but I never bothered buying them [at the grocery store] because I didn't like the way they look."*
Excitement and Curiosity 	*"Well, you know, food is a very important part of all of our lives, I think […] it's just an insatiable curiosity about what I could make next, what I can do next. I surprise myself all the time."* *"But at the moment, I think that [F2F] give[s] a selection, they give you the option of trying something different. They give it to you fresh, they bring it to your door […] Some of the things I never heard of before but that's okay. Expand my knowledge and taste buds."* *"What I like about F2F, I got vegetables I never knew before, never knew existed, you know. I got introduced to a lot of different vegetables – I didn't know squash came in so many different ways. […] So the wonderful other thing is that with Google, you know you can find out how to cook anything. […] I go on Google and see what they say about it, how did they say [to] prepare [it] and then I'll put my own little spin on it, you know, how I like things, and 'voila.'"*
Sharing Food With Community Members	*"So if I get any vegetables I don't understand, I go to the Korean [neighbors]. Because the majority – some of them is Korean vegetables. And we share. I've always been like that, you know?"* *"There sometimes, I don't want to call this a problem, but sometimes I have too much. That really freaks me out because my neighbor – she sometimes takes like – you know, if I have an abundance of something or something I don't need. But usually I have to take to friends […] if it's something I just will not eat."*

Beyond F2F

These four themes highlight important reasons, beyond food access, that may be leveraged in future efforts to promote consistent, long-term engagement in food prescription programs. F2F considers the obligations of an urban academic health system in providing food access to its patients and community. How we as Urban Bioethicists and clinicians choose to approach food insecurity determines our capacity to challenge the status quo and reconstruct the narratives that have perpetuated this issue for far too long. Food prescription programs, while both vital and necessary, are just one step in achieving food justice.

I gratefully acknowledge the study team, Dr. Sharon Herring, Professor Providenza Rocco, Dr. Brian Tuohy, and Shreya Thakur

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Ethical Considerations in Goals of Care for Patients with Polysubstance Use and Medical Complications in the Era of Xylazine

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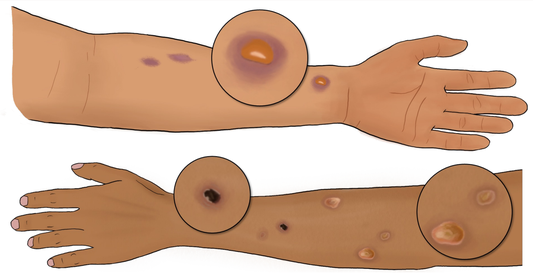

Introduction

Fentanyl and other high-potency synthetic opioids play a significant role in overdose deaths, hospitalizations, and medical complications related to drug use.

Xylazine has been present in the Philadelphia drug supply since 2006[1] and its prevalence has rapidly increased. Of fentanyl samples tested in Philadelphia, 91% contained xylazine.[2] Xylazine stimulates alpha-2 adrenergic receptors in the central nervous system and induces sedation and analgesia. When combined with opioids, it creates a synergistic toxic effect in humans. People with polysubstance use disorder (PSUD) who use fentanyl and xylazine describe worse withdrawal symptoms compared to when using fentanyl alone.[3]

The presence of xylazine in the drug supply is associated with serious wounds in this patient population, which are present even in the absence of injection use behaviors. These wounds often result in erosion of skin, soft tissue, tendons, and bone, leading to significant morbidity.

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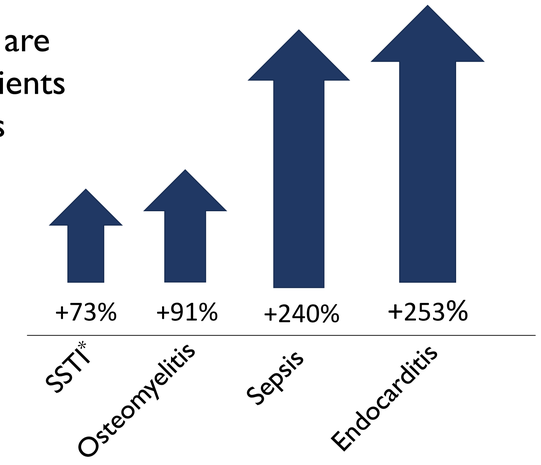
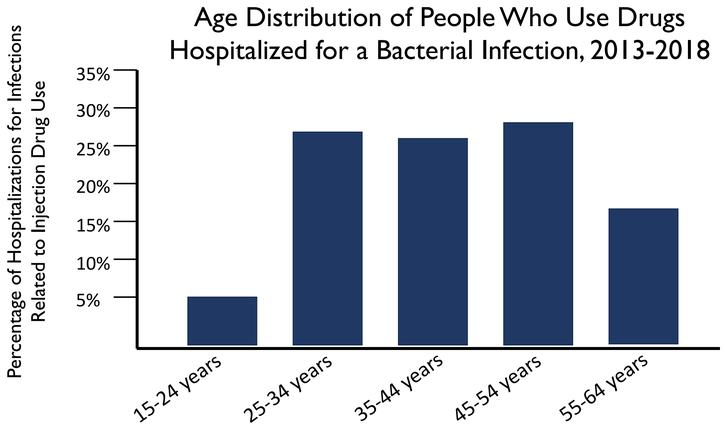
* Skin and Soft Tissue Infections

Hospitalizations are increasing in patients who inject drugs

Arrows reflect the percent change in hospitalizations according to diagnosis in patients who inject drugs between 2013-2018.[2]



Patients who injected drugs were more likely to develop complicated medical diagnoses such as septic embolism, endocarditis, cellulitis, and/or osteomyelitis and were 16 times more likely to develop an invasive MRSA infection than those who use drugs via another route.[6]



More than half of people hospitalized in Philadelphia for bacterial infections related to drug use were between 25 - 44 years old.[2]

Ethical considerations

Preserving autonomy

This patient population faces a variety of barriers to health care such as lack of transportation, unstable housing, loss of insurance, psychosocial stressors, and withdrawal symptoms.[5] An inability to access care is generally due to the barriers and stigma that patients face rather than their inability to care for themselves or make their healthcare decisions. Health care providers ought to understand the nuances of these challenges for patients while continuing to protect the autonomy that these patients maintain.

Initiating Goals of Care Conversations

Given that many patients with PSUD are young with no comorbidities, many of them have never discussed their goals while hospitalized or documented advance directives. The following are suggested topics to explore when caring for these patients.

- Pain management
- Withdrawal symptoms
- Initiating or continuing medication for opioid use disorder (MOUD)
- Communication between team members
- Code status
- Current treatment recommendations

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Racial Disparities in Primary Open Angle Glaucoma Research Studies Among Black and Hispanic Participants: A Critical Review of Studies Used to Inform Current Screening Guidelines

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Introduction

Glaucoma is the second leading cause of vision loss worldwide after cataracts. Primary open angle glaucoma (POAG) is the most common form of glaucoma in the United States and is the leading cause of blindness in African Americans. The estimated disease prevalence of POAG worldwide in 2014 was 64.3 million, with prevalence projected to increase to 70.6 million in 2020 and 111.8 million by 2040. POAG disproportionately affects Black and Hispanic patients. Although this is the case, there are no current primary care screening guidelines for this condition per the United States Preventative Services Task Force (USPSTF). The USPSTF cites that there is insufficient evidence to assess the benefits and harms of screening based on a systematic review. POAG is not entirely understood, and screening protocols are not yet optimized. However, a systematic review was performed in 2021 highlighting disparities in research participation race among POAG clinical trials. This is problematic because the literature largely informs current screening guidelines and understanding of the disease. No similar study has yet been performed assessing disparities among nonclinical trial-based studies. This study sought to address this.

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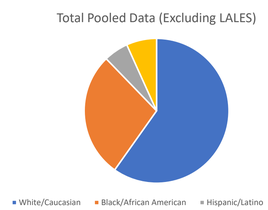
Methods

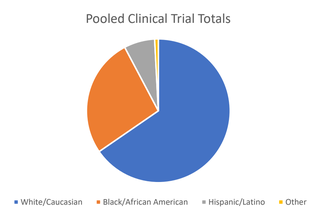
A rapid scoping review of the literature was performed with a particular focus on demographic data. Data was sourced from the included studies used in the systematic review performed in 2022 to inform the current USPSTF guidelines. Data collection consisted of the compilation of demographic data from each of the studies and subsequent analysis according to subgroup corresponding to study type.

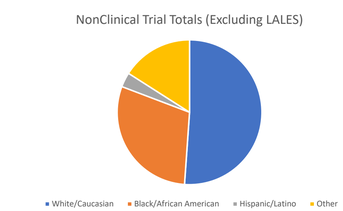
Results

16 studies were ultimately included in the analysis, from which a total pooled sample of 16659 participants was obtained. An outlier study, the Los Angeles Latino Eye Study (LALES), was identified and excluded from the analysis. The results are as follows:

- Participant demographics across all study types
  - 60.0% White, 28.0% Black, and 5.5% Hispanic. 6.7% Other
- Participant demographics in POAG Clinical Trials
  - 65.4% White, 26.9% Black, 6.9% Hispanic, 0.8% Other
- Participant demographics among nonclinical trials
  - 51.1% White, 29.7% Black, 3.3% Hispanic, 16.0% Other







Discussion and Bioethical Considerations

The results of this study corroborate previous findings of the disparities which exist in research participation among Black and Latino individuals in clinical trials, as well as highlight that this disparity in research participation persists across all types of POAG studies, including nonclinical trial-based studies.

Scientific evidence and research comprise a critical aspect of consideration when formulating screening protocol. However, bioethics allows us to critically evaluate the arguments for and against population-health level POAG screening from a patient-centric perspective that prioritizes health equity. The principle of justice is perhaps the most salient to consider here. It is difficult to evaluate given that the implications of screening are not fully elucidated because there is a need for additional studies that more accurately represent the diverse, urban populations which are present throughout the United States. Given that screening protocols are heavily informed by the currently available POAG literature and that disparities exist across the current literature, a recommendation to withhold screening may be considered to violate the principle of justice.

Key Takeaway

There is an ongoing need for equitable efforts in POAG research across all studies. Through this, recommendations for screening may be properly elucidated to inform more equitable care and identification of this disease.

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Getting Well: Expanding Tools to Treat Opioid Use Disorder In the Hospital

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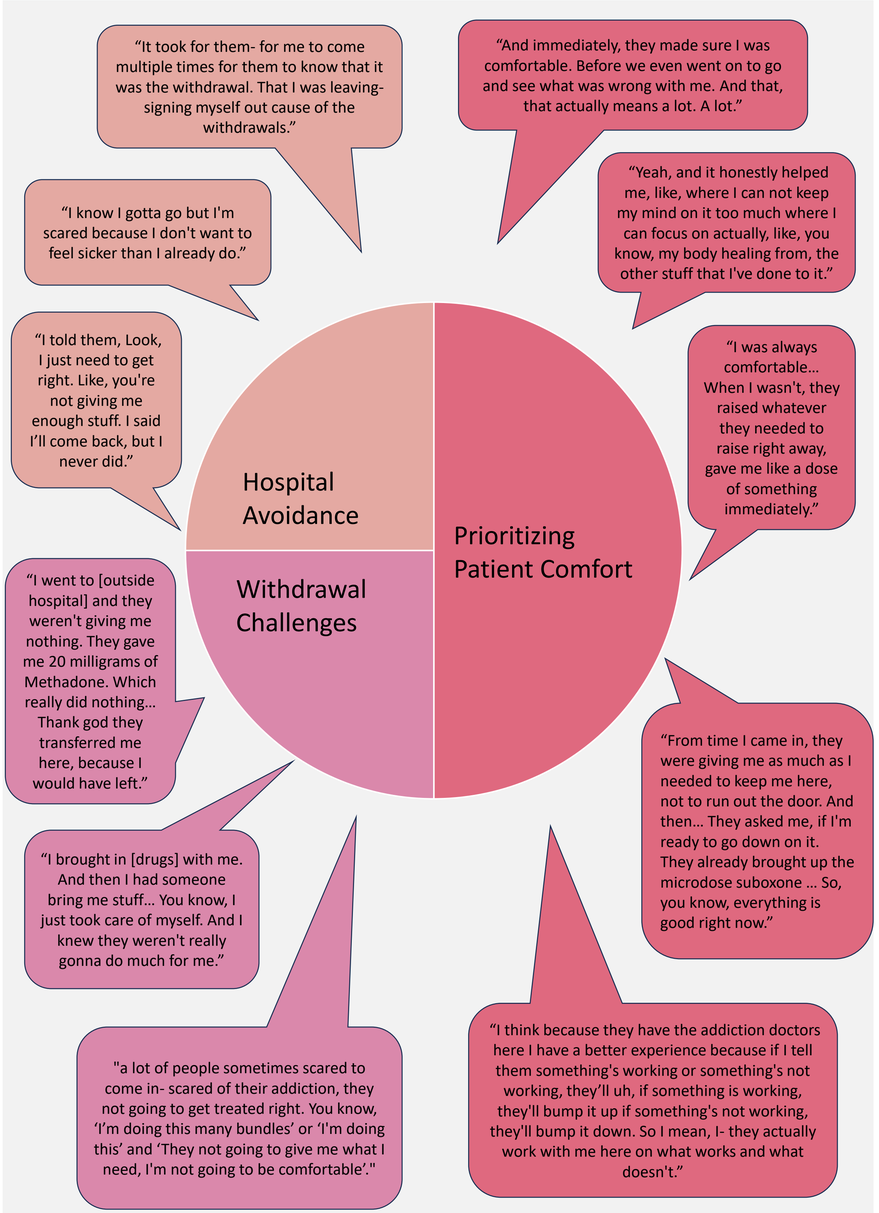
Introduction

- Patients with opioid use disorder (OUD) often leave the hospital before the completion of medical therapy due to inadequate treatment of withdrawal and pain.
- Guidance for the inpatient management of opioid withdrawal is the initiation of methadone or buprenorphine. Both are highly effective for reducing use and decreasing mortality. However, with highly potent synthetic opioids dominating the street supply, these medications can be less effective in stabilizing pain and withdrawal early in the hospitalization.
- One approach involves **expanding the array of opioid medications available to hospitalized patients with OUD to include both long and short-acting formulations.** This may be accomplished by giving patients a fixed, basal dose of long-acting opioids, and supplementing with bolus dosing of short acting, as needed opioids throughout the day. These medications can be rapidly titrated to signs and symptoms of opioid withdrawal.
- The advantage is the ability to start at high and therapeutic doses to rapidly control withdrawal symptoms and maintain patient comfort in order to facilitate completion of their hospital stay as well as transition to MOUD.
- There is limited data on the patient-reported outcomes and perspectives of such an approach.

Methods

- Semi-structured interviews with 15 English-speaking patients hospitalized with OUD at a tertiary care hospital.
- All patients were treated by an addiction medicine consultation team with long-acting opioids for at least three days.
- Interviews were transcribed, coded, and analyzed for themes.

Themes



Conclusions

- The current standards of care for hospitalized patients with OUD are inadequate, resulting in brief and inefficient inpatient admissions.
- Our existing tools, buprenorphine and methadone, are safe and highly effective, but with the rising potency of opioids patients can benefit from supplementation with higher dose long and short-acting opioid agonist medications in the early period of hospitalization.
- This approach serves to stabilize acute withdrawal symptoms, facilitate continued hospitalization as indicated, and ultimately function as a bridge to evidence-based MOUD.
- This expansion of the toolbox to treat patients with OUD gives providers the flexibility to respond to patient needs, promotes patient-centered care, and minimizes barriers to effective hospital-based care.

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