Good&HEALTHY
SOUTH DAKOTA HEALTHCARE

SUCCESS STORY

Risk Comes with Not Knowing: Using Health Guides to Address Social Drivers of Health for Patients Living with Hypertension, Diabetes, and Hyperlipidemia.

Summary

Risking-risk patients are different from high-risk patients. Despite lower acute utilization, rising-risk patients often need to present for healthcare for care and intervention for symptom resolution and continuity of care. Nonclinical roles improve trust and satisfaction of rising-risk patients by addressing individual barriers to care. Nonclinical roles improve health outcomes by addressing Social Drivers of Health (SDoH). Demographics (marital status, living situation, and outstanding balances) are linked to gaps in care on a higher level.

Challenges/Barriers

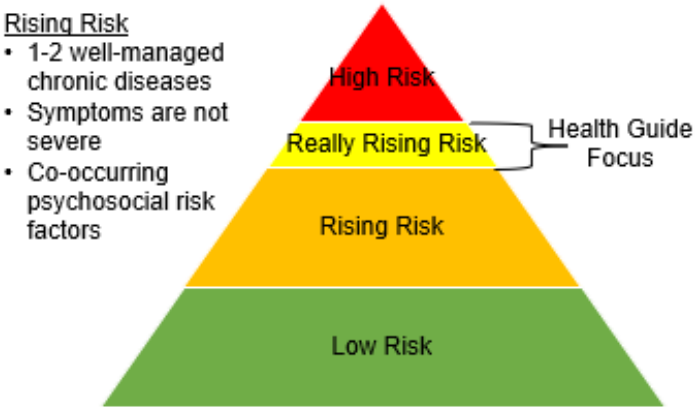
Care management strategies and resources are heavily focused on high-risk patients we anticipate seeing in our emergency rooms and in our hospital beds. We anticipate these patients not showing up for appointments and not adhering to their plan of care. The extent of time and intervention placed on a high-risk patient population result in a rising-risk patient population being underserved. Being out of sight can mean being out of mind. Without time, attention, and intervention, a rising-risk patient population can escalate to high-risk. A rising-risk patient population is defined as 1-2 well-managed chronic diseases, symptoms not severe, and with co-occurring psychosocial risk factors. We understand SDoH can impact 70-80% of our patient's health outcomes. We know it does not take clinical staff to close the loop on community resources, but it does take time, energy, and a whole lot of patience. We also know there is shame, anxiety and frustration that come with tackling these needs. With current nursing shortages, it becomes imperative we allow our nurses to work to the top of their licensure and serve in the moment to meet the needs of our patients. Much of the time, we have nurses providing services which do not require their expertise. This has been a dissatisfier for our nurses over time.

Solutions

We need to explore ways to impact an already vulnerable patient population (rising risk) with the goal of preventing from becoming further at risk. We know there is value to being proactive rather than always having to be so reactive in our efforts. We introduced the health guide as a non-clinical supporting role within our care management structure to focus on the risk-risk patient population. The health guide is a trustworthy insider to Sanford Health with vast knowledge of a complex healthcare system and a vast awareness of community resources and networking relationships focusing on gaps in care. To make sure we were focusing on a risking-risk patient population, we created a patient registry excluding high and low-risk patient populations, we added the ability to filter for chronic conditions (Diabetes, Hypertension, and Hyperlipidemia), for acute and clinical utilization, as well as key SDoH. We focused on gaps in care identified as no primary care provider, history of no shows or cancellations, recent acute encounter, appointment(s) not scheduled, identified break-down in communication, lack of adherence, open orders, and insurance questions or barriers.

Results

What we understood by listening to our patients was they experience a lack of trust within healthcare, they do not feel heard, and they do not feel like a partner in their care. We standardized a Trust and Satisfaction questionnaire mirroring that of the patient's voice to not trusting healthcare, not feeling heard, and not feeling like a partner in their care complemented by questions linked to emotional, financial, and physical wellbeing. 82-89% of our patients have reported an increase from their initial scoring per category.



Patient Risk Escalation. Adapted by Advisory Board-Population Health Advisor (2017). Addressing the Needs of Your Rising Risk Patients.

Using a report or a referral where a patient has cardiovascular and HTN diagnoses along with a noted missed refill of their antihypertensive, health guides made outreach to confirm medication adherence (does a patient have their medication, are they in need of a medication or a refill, are they taking their medication as prescribed, are they not taking their medication for any reason). *Eleven patients have needed medication assistance of which we have partnered with a pharmacy and our Sanford Foundation to provide financial support to obtain or improve access to necessary medications. We have been able to increase medication supply for antihypertensives from a 30, 60, or 90-day supply to a 100-day supply for patients who have this benefit available to them reducing the number of copays and as support for medication adherence strategy. Providers have welcomed the communication and acted on the requests.*

We recognized the top five SDoH impacting hypertension management as housing and economic circumstances, food insecurities, transportation needs, unemployment, and financial insecurities. connect patients with appropriate internal and external resources to complement their plan of care. Our top five referral resources have been *Sanford Financial Assistance, Lyft Rides, Medication Assistance through Sanford Pharmacy and Sanford Foundation, Food Pantry, and local utility resources (electricity).*

The ability to identify SDoH within our rising risk patient population has allowed reengagement or increased engagement between the patient and the clinician. We were able to address seventy-four transportation barriers allowing for patients to make it to their scheduled appointments which otherwise would not have occurred. Twenty-five food baskets obtained for those patients with insecurities. Ten patients have a roof over their head working through the challenges of housing instability. We continue to make it a first step to address outstanding balances at Sanford. This has proven to be the first best step to building a relationship with a patient to unveil what else may be standing in the way to receiving the care they need and to obtain optimal health and wellbeing.

Future Decisions

Short Term Goals:

- Increase Trust and Satisfaction Scores-By listening and acting on patient needs and/or concerns
- Complete SDoH Questionnaires-By having intentional and purposeful conversations

Long Term Goals:

- Positively impact acute and clinical utilization-By engaging/reengaging patients, empowering them to use their voices, advancing their self-management skills through understanding the importance of communicating with the right person, at the right time, for the right reason.
  - Reduction in Inpatient Admissions
  - Reduction in Emergency room visits
  - Reduction in Walk-In Visits
  - Reduction in No-shows
- Positivity impact clinical outcomes by addressing SDOH and reducing barriers to care.
  - HTN
  - PHQ
  - A1C

Get Involved

The first step to making a difference in someone's care is asking the difficult questions. We tell ourselves patients may feel hurt or offended if we inquire about SDOH understanding patients experience shame. We must break through the fear and expectation of ourselves linked to; "if I ask, I will have to, or it will be expected that I do something about it". Knowing and understanding unique patient situations allows for the opportunity to create an optimal plan of care. Rather than looking at the picture of overwhelming needs, what is it that we can do today, or this week as the next best step for streamlining care.

Taking time to explore and educate oneself on internal and external resources will always be beneficial use of one's time. It is not all about the awareness of resources, but also the networking that goes along with it. Never underestimate the depth of the team you create as a care team member.

Invest in non-clinical roles as frontline resources to positively impact patients and nursing staff for sustainable long-term strategy.

Lessons Learned

Our biggest barrier is successful initial outreach with patients. Many outreach attempts go unanswered, and patients can be suspicious of the reason for the call. Calls may go unanswered due to a busy daily schedule or practices of not answering a call if you are not familiar with a number. Overcoming patients' previous healthcare experiences and narratives have been difficult. We provide our Health Guides with training and education on universal reliability and relationship skills to create more efficient relationship building. Communication skills such as warmly greeting others, communicating positive intent, explaining the health guide role, listening with empathy and intention to take ownership of actions, and offering opportunities to collaborate and ask questions; has built the trust of our patients. Patient barriers encountered have been lack of access to transportation, financial stressors, fragmented care, and services. By addressing access to reliable transportation options and utilizing local services and resources (211, Findhelp, etc.), patients can increase their ability to cover the cost of medication and healthcare services.

Testimonials

"Your time and attention last week meant so much. If you hadn't stepped in, I wouldn't have gotten the care I needed in the moment, and probably would have just not been seen. I'm feeling so much better." ---Patient

"If it hadn't been for you, I wouldn't be sleeping with a roof over my head tonight. Thank you for all you've done supporting the coordination for my move". ---Patient

"I appreciate all that you are doing for our patient. I can tell you have a strong relationship that has been a benefit for our plan of care". ---Provider

"I met with our mutual patient yesterday for his annual. I know he has had challenges lately, but he was optimistic and in a good mood despite these challenges. You played a large part in that, and I wanted to say thank you. He talks very highly of you and is incredibly thankful for the support you have given him. Thank you for all your help." ---Community Partner

Timeline

The official start date for our project was 1/16/24 jumping in on the last two quarters for the grant. We received a continuation of grant funding for this next year starting July 1st, 2024.

Next Steps and Other Info.

As we venture into the1st quarter for a new grant funding, we look forwarding to sharing additional data on the impact to acute and clinical utilization (inpatient, ED, walk-Ins, no shows) and clinical outcomes (HTN, PHQ, A1C) for those patients partnering with health guides. We currently have just under 6 months of data. Our outcome data for utilization and clinical outcomes is linked to a 6-month pre and post calculation.

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