An interprofessional community-based approach to address social determinants of health in high-risk, high-cost patients

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Introduction

“Super-utilizers” refers to a small section of the population that accounts for a large portion of emergency room visits and puts a heavy burden on hospital services. This research project evaluates the impact that community-based interventions have on these high-risk, high-cost patients. This serves to increase value utilization of preventative care and decrease emergency department visits.

Background

In 2011, 1,000 patients made up the top 1% of those who used emergency department and hospital services, which accounted for 39,000 visits, and an average of $375 million per year. 5% of Americans account for 50% of all US healthcare spending. The Camden Coalition of Healthcare Providers (CCHP) is an organization that seeks to improve the quality and accessibility of healthcare by reconnecting patients to their primary care physician and decrease high utilization of emergency departments.

Goal

To connect interprofessional teams of health care students to socially complex persons as determined by the CCHP Hot-spotting criteria. This is a team-based approach to determine priority problems and design effective interventions that empower the patient to establish and maintain a healthy lifestyle.

Methods

The University at Buffalo has adopted the Camden Coalition model and established their own intensive interdisciplinary team of nursing, medical, pharmacy, and social work students to work with complex patients with social determinants of health in order to achieve higher value utilization by increasing primary care visits and decreasing emergency department visits. This program is on a volunteer basis in affiliation with Erie County Medical Center.

Social Determinants of Health

- **Health Literacy**
- **Access Challenges**
- **Economic Leverage**
- **Social & Cultural Context**
- **Economic Resources & Challenges**

Problems Identified

- Poor health literacy
- Limited access to care
- Inadequate social support
- Needed community resources
- Economic challenges

Solutions

- Bus cards for transportation
- Assistance with forms for identification cards and medical alert bracelets
- Setting up appointments
- Assisting with job applications
- Education for maintenance of chronic disease processes
- Accompanying to doctors’ appointments
- Obtaining necessary medical equipment
- Scheduling follow up visits as needed

Case Study

- Middle-aged minority male
- 3 chronic diseases
- Lives with sibling
- 4 social determinants of health
  - health literacy
  - access to health care
  - access to technology
  - access to transportation
- 4 priority problems identified with Camden Coalition’s “Backward Planning” model
- 4 priority problems – RESOLVED
- 4 home-visits completed with patient
- 2 primary-care visits at the ECMC Family Health Clinic
- 0 emergency department visits

Implications

- Team-based, interdisciplinary approach is ideal for patients with complex health problems.
- Motivational interviewing to facilitate communication with patients allows for them to be more active and empowered in their care.
- Follow up and transitional care from hospital to home setting is critical and allows a smoother transition and continuity of care.
- Care coordination facilitates optimal care by promoting communication between different disciplines with care targeted to the patient.

Conclusion

This unique experience has provided us the chance to collaborate on an interdisciplinary team, complete home visits as student nurses, and dive into the care management critical to our career development and patient-centered care.

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