Health Equity in Action

Health Partners: Reducing Health Disparities Via Sustained Referral

Ariana Tyler, BS
October 12, 2017

North Country HealthCare
Northern Arizona Area Health Education Center (NAHEC)

The first patient of the day…

- Ms. Smith is a 67 year old female with multiple medical problems. However, she often doesn't make it to her appointments. She is nauseated and dizzy today.

- She tells her doctor that she…
  - Hasn't been taking her insulin because it is too expensive – ran out a few days ago
  - Hasn't been checking her blood sugar levels at home because she ran out of strips
  - Has been taking her blood pressure meds, but today BP is high at 168/92
  - Lives with her son who is trying to help her get disability so she can pay for her meds. He can sometimes borrow a car to drive her to appointments

How should the doctor approach this patient?

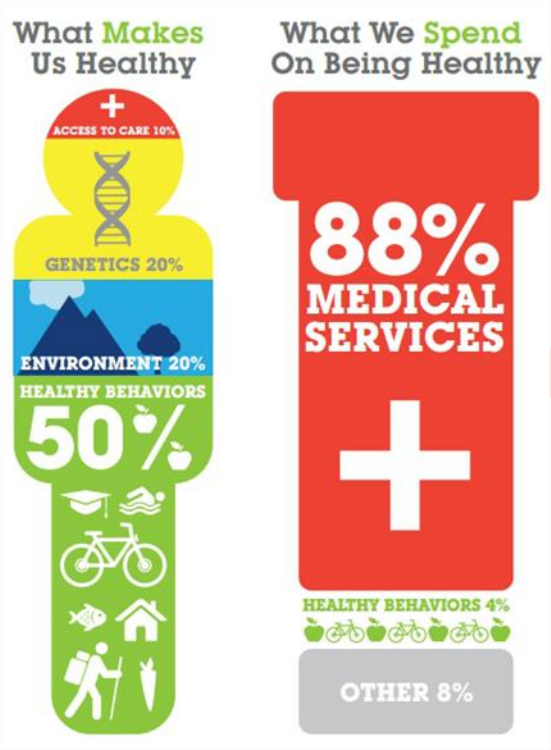
A. Tell her that the dizziness and nausea is due to poor blood sugar control

B. Tell the patient how important it is to check her sugars and give her a script for strips

C. Get upset at the patient for not following directions

D. Realize that she probably is trying her best but feel powerless to do anything

So, what's going on?



- Social stressors are believed to be the *largest* predictor of health outcomes.
- Access to medical care alone can only reduce premature mortality by about 10%
- The other 90% is made up of social determinants including housing, income, transportation, and social standing.

Source: Bipartisan Policy Center. Data from Boston Foundation and New England Healthcare Institute

McGinnis, et al, *Health Affairs*, 2002

North Country HealthCare and Health Partners

How healthcare systems can aid in the reduction of social determinants

North Country HealthCare

- Non-profit Community Health Center (FQHC)
- Mission: To provide accessible, affordable, comprehensive, quality primary healthcare in an atmosphere of respect, dignity, and cultural sensitivity. The health and well-being of patients and community alike are promoted through direct services, training/education, outreach, and advocacy.
- Northern Arizona Area Health Education Center (NAHEC)- one of 5 AHECs in AZ

NAHEC
Northern Arizona
Area Health Education Center

NORTH COUNTRY
HealthCare

Health Partners- The Basics

- Program designed by Shipra Bansal, MD. Put in place 2 years ago
- The goal of the program is to reduce the impact of the social determinants of health on North Country's underserved and under/uninsured populations

The Logistics

- Students from Northern Arizona University (biomed, public health) staff the Health Partners desk from 9am-5pm Monday-Friday.
  - Interviewed and hand-picked for the program each semester after applying
- Clients can walk-in or be referred by a provider
- Participate in a full intake process with the Health Partners
- Health Partner gives referral based on 1-2 priority areas
- Sustained Referral

The Intake

- Students are trained to ask questions specific to the clients situation
- Some of the interview prompt areas we advise our Health Partners to use:
  - Health Specific Information, such as insurance status, ability to pay for needed medications
  - Economic Situation, such as means of transport, employment, access to food
  - Social Networks, such as family or friends in town, social supports

The Database

- The Health Partners database is a comprehensive referral resource
- Housed in a GoogleSheet, making it easily accessible and free
- Over 400 resources

- https://docs.google.com/spreadsheets/d/1TTV10KkyTx3sopq_Ka2GaqEhUsnzcyHO4e0Bs3LQQfA/edit?usp=sharing

Student Benefits

- Experience interacting 1-1 with clients in a healthcare setting
- Weekly class meetings give more information and depth to the experience
- Earn course credit at NAU
- Opportunity to meet community members from different organizations and make connections beyond the internship

NORTHERN ARIZONA UNIVERSITY

Back to Ms. Smith

- Ms. Smith is referred to the Health Partners desk for medication assistance
  - Unreliable transportation
    - *provides a taxi voucher so the patient doesn't have to depend on her son for getting to her next appointment. He verifies Ms. Smith's next appointment with her*
  - Unable to pay for insulin
    - *Identifies a free insulin program. Helps Ms. Smith apply. He informs her of any supporting documents she will need and offers to help with obtaining those*
  - Not checking sugars
    - *Connects patient to the diabetic program to get diabetic strips until her insurance status can be optimized*

Ms. Smith

- Ms. Smith also reports she has a hard time seeing the markings on the syringe and is afraid she'll give herself the wrong dose
  - Connects patient to the Lion's club for an eye exam and glasses, for only $10
- The intern lets her know he will call her in a week to see how she is doing

The Data

- In the past 2 years, Health Partners has had over 1,200 patient referrals
  - Major referral areas include housing, transportation, and vision
- Students have also reported an increased understanding of the social determinants of health

Expanding Our Reach- Health Connections

- Health Connections is an expansion of the Health Partners model to other agencies in town
  - Currently in the pilot phase, training will occur within the next month
- We will be tracking usage closely in order to determine effectiveness and ease of use

Evellean / shutterstock.com

Success Stories

- Patient was camping out in the woods in an RV with her family (husband and 2 kids). As Winter was approaching this was getting to be increasingly difficult. She has a history of chronic infection, one of her children was diagnosed with asthma, and the other would also commonly become ill. During nighttime it would get so cold to the point where they had to burn propane for heat on a stove in the RV. She came into the HP office and we were able to get her an Angel Fund request for around $600 dollars for the first month of rent and utilities at a local RV park. She and her husband both made low wages and it would have taken a long time for them to save up the money to pay these fees. Once they moved into the RV park they had access to electricity and water and were given a head start to get their lives and health back in order.

Success Stories

- This client came in February, struggling to find a new home. He was renting a space in a friend’s driveway and living in his parked RV when the friend told him he would be moving, so the client would need to move his RV. The RV was parked for over 2 years with a dead battery and no keys, which the client could not afford to replace. I directed him to St. Vincent De Paul where they wrote him a $200 check for a locksmith to come out and make him a new ignition and keys. His friend also allowed him to park his RV for free for the last month before he moved, so the client was able to buy a new battery! Within 4 weeks he was able to get his RV running and move into a neighbor's yard with his RV. The new living situation is “100 times better” as he put it. He is now focusing on his silver smith business to create his own income. He also has began living a healthier lifestyle with absolutely no more alcohol! He is incredibly grateful for Health Partners and says he would have given up on everything if he wasn't able to find help from us and St. Vincent De Paul.

Questions?

Thank you!

Ariana Tyler

atyler@nchcaz.org 928.522.9862