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SOUTH DAKOTA HEALTHCARE

SUCCESS STORY

Increasing Healthcare Referrals for Better Choices, Better Health® South Dakota

Summary

Developing a sustainable system for Better Choices, Better Health® South Dakota (BCBH-SD) referrals has helped to form clinical-community linkages with our healthcare systems. This process allows providers to support their patients by providing resources that help them become more confident about their role in condition management and improved quality of life.

Self-management programs are evidence-based, and research shows that workshop participants have better health (41% improvement in moderate physical activity), better care practices (12% improvement in medication compliance), and have better value for their healthcare costs (32% reduction in Emergency Care).

Impact

Referrals can save dollars! Studies show a $350 estimated per person annual net savings in healthcare costs for those who participated in chronic disease self-management education programs like BCBH-SD.

Challenges

BCBH-SD currently offers a suite of self-management education programs and is working to create a referral hub for multiple programs, most recently linking with the *Walk With Ease and Fit and Strong!* exercise and fall prevention programs.

Referrals are needed to support program sustainability. The majority of our most highly attended workshops had participants who were referred by their provider. To implement a sustainable referral process we have addressed barriers related to capacity, data sharing, and navigating referral method options (EMR, fax, phone, etc.).

Key Components

BCBH-SD is led by SDSU Extension in partnership with the SD Departments of Human Services and Health. It is supported by key stakeholders and a statewide Advisory Council. BCBH-SD has included designing a sustainable referral process as a key priority in their 2019-2021 BCBH-SD Strategic Plan.

To advance a provider referral network for BCBH-SD, SDSU Extension partnered with Avera St. Benedict (ASB) Health Center in Parkston, SD to establish a shared Community Referral and Wellness Coach (CRWC) position to manage BCBH-SD workshop referrals and registrations, generate customized reports using the BCBH-SD Workshop Wizard software, and provide individualized wellness coaching for program participants. The CRWC position also serves as a member of ASB's Coordinated Care Team.

Implementing a referral policy provides the capacity to not only identify patients who have a chronic condition, but also remind providers to refer these patients to BCBH-SD. The referral process increases the likelihood that healthcare providers will consistently assess patient's chronic disease(s) and advise and/or refer these patients to evidence-based programs and resources.

Results

To date, BCBH-SD has achieved many successes:

- 79 formal provider referrals received
- 433 active referrals received
- 68% completion rate by workshop participants
- 9 current health systems are actively implementing a referral process to one or more of the BCBH Suite of Programs. (Note: This number reflects each of the large health systems (Avera, Sanford, etc.) as one implementing body.)

Target Audience: Health systems and providers. A referral may also come from those who work closely with patients and clients in other dimensions of their health management such as dental team, health coach, pharmacist, any therapy, social worker, and public health or faith community nurse. Participants may also self-refer because they have an interest in learning skills to help them gain the confidence they need to better manage their health and increase their quality of life.

Lessons: You must develop a thorough plan for implementation of a large project such as this. It requires patience and steady persistence from all parties involved as they determine their gain.

Timeline

Initial conversations and plans to create the BCBH-SD referral coordinator position began almost two years in advance of its reality in the summer of 2017. Confirming funds, creating the scope of work to meet the BCBH-SD program needs, and developing a partnership with ASB to share the cost of the position took over a year to complete. In addition, planning on how to best generate referrals in a safe, HIPPA compliant manner took much research and planning. The CRWC position posted in late 2018, with the CRWC starting in her position April 2019.

Evidence Based Interventions

Triple Aim Framework: describes an approach to optimizing health system performance that simultaneously pursues three dimensions, which we call the "Triple Aim":

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

Healthcare organizations are looking for programs that meet the Triple Aim goals. By utilizing the CDSME model, it is anticipated that BCBH-SD workshop participants will experience improvement in all of these areas, further solidifying the need for strong health system partnerships that will drive BCBH-SD to scale.[1]

Social Determinants of Health Model: the **Health in All Policies framework** is regarded as a best practice for improving population health outcomes by national public health organizations. Adoption of a "collaborative approach to improving the health of all people by incorporating health, equity, and sustainability considerations into decision-making across sectors and policy areas" helps BCBH-SD to meaningfully improve the health of South Dakotans.[2]

NEXT STEPS

South Dakota State University was 1 out of 11 grantees awarded the ACL 2019-2022 Empowering Older Adults and Adults with Disabilities through CDSME Programs financed by the Prevention and Public Health Fund grant program to advance and sustain BCBH-SD. Those funds will support an additional BCBH-SD referral coordinator position in partnership with a health system. This collaboration can be a model for other organizations seeking to establish a position that can be mutually financed.

> *"Our partnership with BCBH-SD helped us to implement the strategies identified for our ACO. We utilized our Chronic Care Management team to meet with those patients with high health needs and refer them to appropriate evidence-based programs. This is critical as we look forward to tracking outcomes."*
>
> - Rita Blasius,
> Avera St Benedict CEO

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1. Ory, M. G., Ahn, S., Jiang, L., et al. (2013). Successes of a National Study of the Chronic Disease Management Program: Meeting the Triple Aim of Health Care Reform. Med Care, 992-8. Retrieved February 21, 2017. http://www.ihi.org/engage/initiatives/TripleAim/Pages/default.aspx

2. Health in All Policies. American Public Health Association. 2018. https://www.apha.org/topics-and-issues/health-in-all-policies

Published: February 2020