Healthcare's New Workforce

How Non-Clinical Care Team Members Improve Access, Experience, and Outcomes

With an ongoing transition to value-based care payment models, engaging patients and understanding the full scope of their health is more important than ever. There is limited research assessing the scalability of behavior change in the patient population if patients are relying solely on clinical care for structure. However, there is a sufficient body of evidence[1] demonstrating that engaging patients in their care leads to better health outcomes and increased mortality.

An extensive review[2] of patient behavior assessed the projection of improving health-seeking behavior among patients in conjunction with their monitoring status in developed and underdeveloped countries. The study found that regardless of location, in order for patients to receive the best healthcare, collaborative work among medical disciplines is necessary.

Additionally, when addressing behavior change, the study recommended providers spend more time asking carefully-designed, open-ended questions about medication concerns, beliefs, understandings, and behaviors. Placing emphasis on a "range of patient treatment behaviors including sharing beliefs and expectations, asking questions, adhering to regimens, using home monitoring devices, keeping appointments, identifying and reporting side effects and drug-taking problems, and other valuable forms of communication" is necessary for modern care.

While that would be ideal, it's also important to be realistic. Approximately 56% of physicians[3] spend less than 16 minutes with their patients each visit, with 5% spending less than 9 minutes of time with patients during visits. In 2016, the CDC reported 277 doctor's visits for every 100 people, averaging out to 2.7 visits per year per person. On average, patients are spending less than an hour with their physician each year, and provider time is spread thin due to an influx of administrative and bureaucratic tasks placed upon them. How can we successfully merge the needs for more patient interaction with the systemic limitations that currently exist within the healthcare system?

Recommendations for providers in changing health behaviors

Open-ended questions

Address beliefs & expectations

Collaborative care team work

THE EVOLUTION OF NON-CLINICAL CARE FUNCTIONS

Non-clinical care provides a unique benefit to the healthcare system. Generally speaking, nonclinical care is accessible and can be less intimidating than the clinical experience. The premise of this sector of healthcare workers is that they provide supplementary care focused on behavior change, resource acquisition, and barrier assessment. Some common examples of non-clinical care workers include case managers, nurse navigators, community health workers, and health coaches.

Case Managers

Case management is "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services" used to comprehensively meet patient needs through communication and resource integration, such as medication management, self-care support, and advocacy[4]. By coordinating care both within the healthcare system and the community, case managers work to improve patient wellness and autonomy.

Due to the relative length of existence and abundance of case managers, there are many studies that analyze the effectiveness of the profession at large. In a 2012 systematic review[5], 5 of 7 studies reported significant improvements in psychological wellbeing among an aged community, while 3 out of 3 studies reported consistent improvement in unmet service needs. However, there is some evidence with mixed reviews on overall impact. In an analysis[6] studying nursing home admission prevention, while there were no statistically significant overall effects, case management helped in specific cases.

Non-clinical care practitioner responsibilities include:

- Care coordination services
- Increased time for personalized communication
- Barrier assessments
- Resources to address Social Determinants of Health
- Accountability in day-to-day life

Nurse Navigators

A nurse navigator is "a medical professional whose clinical expertise and training guides patients and their caregivers to make informed decisions", collaborating with a clinical team to provide direct patient care and comprehensive coordination of care for patients to eliminate barriers to timely care[7]. Nurse navigators are almost exclusively found in the cancer treatment setting, but there are many definitions of the role, which are entirely dependent upon the organization in which the nurse navigators are housed.

The ultimate goal behind the nurse navigation position is facilitating benefits for both patients and healthcare providers. For patients, nurse navigators can help improve access to care, increase quality of care, and create a more seamless navigation through the healthcare system (Rasulnia, 2017). For the healthcare providers, nurse navigation complements value-based care. Through a team-based approach, they can save time for clinicians and reduce costs of care (Rasulnia, 2017).

Community Health Workers

Community health workers (CHW)[8] promote access to services, provide health education, support care delivery, and promote advocacy. With such a broad definition, it is unsurprising that there are many different job titles associated with the role. This ever-expanding scope complicates analyses surrounding the work of CHWs particularly as the CHW labor force continues to grow within the US[9].

Due to the hyper-localized nature of CHWs, a relationship is built with the community in order for the CHW to act as an intermediary between those in the community that need services and local organizations that can provide those health and social services. This follows the integrated care approach, improving "the quality and cultural competence of service delivery. Some studies suggest that there is insufficient CHW outcomes data. While the profession increases in popularity for its ability to improve health outcomes[10], little evidence suggests well-defined methods for identifying this workforce, partially due to the different job titles and responsibilities.

Health Coaches

Health coaches are empathetic, non-clinical coaches who collaborate with patients, their healthcare providers, and other resources to ensure that patients adhere to healthcare plans and follow evidence-based protocols to improve their health outcomes. In recent years, the term "health coach" has become popularized by large-scale online exercise programs or multi-level nutrition marketing efforts. In their true and valid sense, health coaches come from a diverse range of backgrounds, with a bachelor's degree, master's degree, or certification in a healthcare-related field, such as kinesiologist, registered dietitian, or masters of public health graduate. Goals associated with a health coaching position include: 1) enhancing patient satisfaction; 2) facilitating access to care; 3) increasing timely diagnosis and treatment; 4) and improving health outcomes and quality of life.

As chronic disease management is heavily reliant on daily behaviors, the focus on sustainable behavior change by health coaches yields significant improvements[11] in the lives of patients with chronic conditions. For example, a cancer

Where Coaching Meets Navigation

Pack Health has expanded upon the concept of a health coach by creating the Health Advisor (HA). Health Advisors are also:

01 Highly Credentialed

Health Advisors maintain extensive credentialing requirements, including HIPAA, IRB, C-SSRS and Care Escalation Protocols, DPP, FSW, and NBC-HWC.

02 Relationship Driven

Health Advisors form a relationship based around social support, which is essential for behavior change, through weekly engagement.

03 Structure for Data

Health Advisors collect weekly metrics from each member that allows accurate data to supplement member engagement strategies.

04 Digital Empathy

By using Digital Empathy strategies, Health Advisors leverage technology to reduce barriers, coordinate care, and provide highly personalized resources for each member.

management study observed improvements across certain outcomes after 12 weeks. Patients undergoing the Pack Health navigation program perceived pain decreased by 15%, prescreens for depression decreased by 10%, and recommended 7-9 hours of sleep each night increased by 11%. Additionally, patients indicated strong satisfaction for the program (Srivastava, Burton, Lewis, Patel, & Rasulnia, 2018).

A 2016 Johns Hopkins study reported that

250,000 deaths

were attributed to medical error each year.

(Source)

WHERE NON-CLINICAL CARE COMES IN

Incorporating non-clinical care into a care team poses several benefits to the patient and the clinical team. One of the most prominent and pressing benefits would be the potential impact on patient safety. The leading cause of medical malpractice lawsuits are related to misdiagnoses or failure to diagnose. However, it is important to note that the study explains that most of the errors are caused by "systemic problems, including poorly coordinated care, fragmented insurance networks, the absence or underuse of safety nets, and other protocols" rather than poor physician training.

Encourage patients to seek care when they *actually need it*

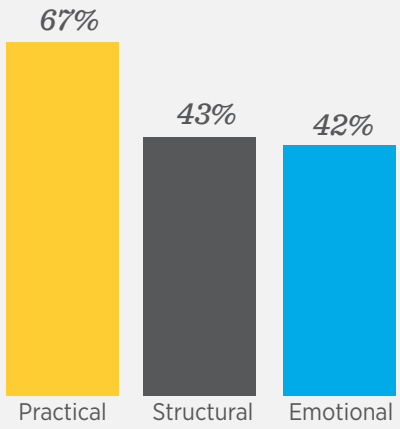
- **1 in 5 adults** get annual physicals[12]
- **50% of patients avoid care** due to barriers such as time, inconvenient clinic hours, or transportation issues
- Non-clinical care can offer personalized support to **reduce barriers and improve care access.**
- **Add more capacity for patient engagement** into treatment plans to deliver holistic solutions

Encourage patients to seek care when they actually need it: Many patients continue to check in with their physician to ensure they are staying in good health, while others wait to pay a visit to their doctor until they're really sick. It is widely reported that those who avoid medical care are more likely to have worse health outcomes, so why do patients continue to avoid care? A 2015 Journal of General Internal Medicine study[13] found 50% of patients avoided care due to access related barriers.

Where Non-Clinical Care Comes In: Research has found that most patients recognize the importance of follow-up care appointments[14], such as screenings or post-care check ups, but do not always attend these visits due to issues such as transportation barriers or low health literacy. Experts recommend reducing barriers to help patients access care more effectively. Solutions include providing digital health options to reduce geographical barriers to care access, improving patient education opportunities, and offering personalized support to address Social Determinants of Health. Non-clinical care team members have more capacity to reach patients in these ways, and can translate that information to providers, leading to a more comprehensive treatment plan for the patient.

Increase adherence to medication and lifestyle prescription

- Rates of nonadherence have been reported as high as **50-80%.**
- Patients with **higher activation for behavior change** had providers who provided problem solving support or emphasized patient ownership.
- **Practical support had higher impact on medication adherence** than emotional or structural support.



Reduce costs related to readmissions

- **27%** of 30-day readmissions could have been prevented
- The average readmission costs across diagnoses is **$14,400 per readmission.**
- Health coaching participants reduced readmission rates by **8% in the first 30 days of the program**.

Increase adherence: Adherence challenges to lifestyle and medication prescription can be exhausting for clinical providers. Rates of non-adherence[15] to recommended lifestyle changes and medications have been reported as high as 50-80%. What strategies need to be put in place to increase patient activation levels? A 2016 study[16] studied the approaches used by primary care clinicians who had patients with high activation levels for behavior change and found that clinicians whose patients had relatively large activation increases reported using 5 key strategies to support patient behavior change (mean = 3.9 strategies): emphasizing patient ownership, partnering with patients, identifying small steps, scheduling frequent follow-up visits to cheer successes and problem solve, and showing caring and concern for patients. Clinicians whose patients had lesser change activation were far less likely to describe using these approaches (mean = 1.3).

Where Non-Clinical Care Comes In: Pack Health members report the most frequent barriers to medication adherence as forgetting (31%), side effects of medication (27%), and time (25%). A systematic review of 50 studies assessing the impact of different social support strategies found that practical support (67%), or support related to practical activities, such as medication reminders, had the most significant impact on improving medication adherence, compared to structural (43%) or emotional support (42%). Providing patients with more opportunities for practical support, such as health coaching integration into follow-up care plans or employee wellness provides opportunities to close care gaps that lead to medication non-adherence.

Reduce costs related to hospital readmissions: A 2016 study reviewed 1000 patients who had been readmitted to the hospital within the following 30 days and found that approximately 27% of readmissions were preventable. The top reasons for readmission included emergency department decision making, inability to keep appointments after discharge, premature discharge from the hospital, and patient lack of awareness of whom to contact after discharge. The average readmission cost across diagnoses is $14,400[18]. Each year, roughly 2 million patients are readmitted into the hospital[19]. This costs Medicare $27 billion, of which $17 billion is spent on potentially avoidable readmissions.

About 88% of hospitals screen patients for social needs. Using data to understand the root cause of why a patient returns to the hospital after discharge is essential to preventing hospital readmissions.
(Deloitte, 2017)

Where Non-Clinical Care Comes In: A 2016 study[20] found that COPD patients who participated in health coaching had significantly lower rates of hospital readmissions, with readmission being reduced by 7.5% in the first 30 days and by 11% at 3 and 6 months post-discharge. Additionally, a 2019 study[21] assessed the pre and post effects of a nurse navigation program on patients who had been admitted for a heart attack. The study found that those who had been treated for a heart attack before the program began had a readmission rate of 6.3% and fell to 3.7% for the patients who participated in the nurse navigation program. Furthermore, patients' rates of follow-up for appointments made prior to discharge increased from 78% to 96%.

NON-CLINICAL SUPPORT AUGMENTS CLINICAL CARE

Nonclinical support is an accessible, comprehensive strategy to supplement clinical care and enhance a patient's healthcare experience. The literature is clear in the understanding that patient engagement and accountability is essential to improving patient health outcomes, reducing readmissions, and improving health behaviors. By empowering and preparing patients to arrive at clinical appointments with the questions they need answered, patients can begin to hold themselves accountable and are more adherent to clinical care plans. Incorporating non-clinical support options can help create a continuum of care by reducing patient barriers, increasing the frequency of patient engagement, and helping patients become a partner in their own care.

Digital health coaching provides a unique edge for employers, health systems, and care by creating structure for practical support in a location-agnostic fashion. At Pack Health, we take digital health coaching a step further by using technology to leverage the human to human connection with in-house Health Advisors. Health Advisors complement clinical care providers by enhancing and maintaining patient activation through a minimum of five direct touch points each week. Additionally, Health Advisors prepare our members to be their own best advocate in a clinical care setting by working through barriers, helping set members up for success, and working to ensure members serve as an active partner in their own care. By identifying more opportunities for engagement within the patient care spectrum, we can begin to incorporate more targeted, data-driven strategies to deliver holistic value-based care.