Community Health Workers

Integrating Clinical and Community into Team Based Patient Care

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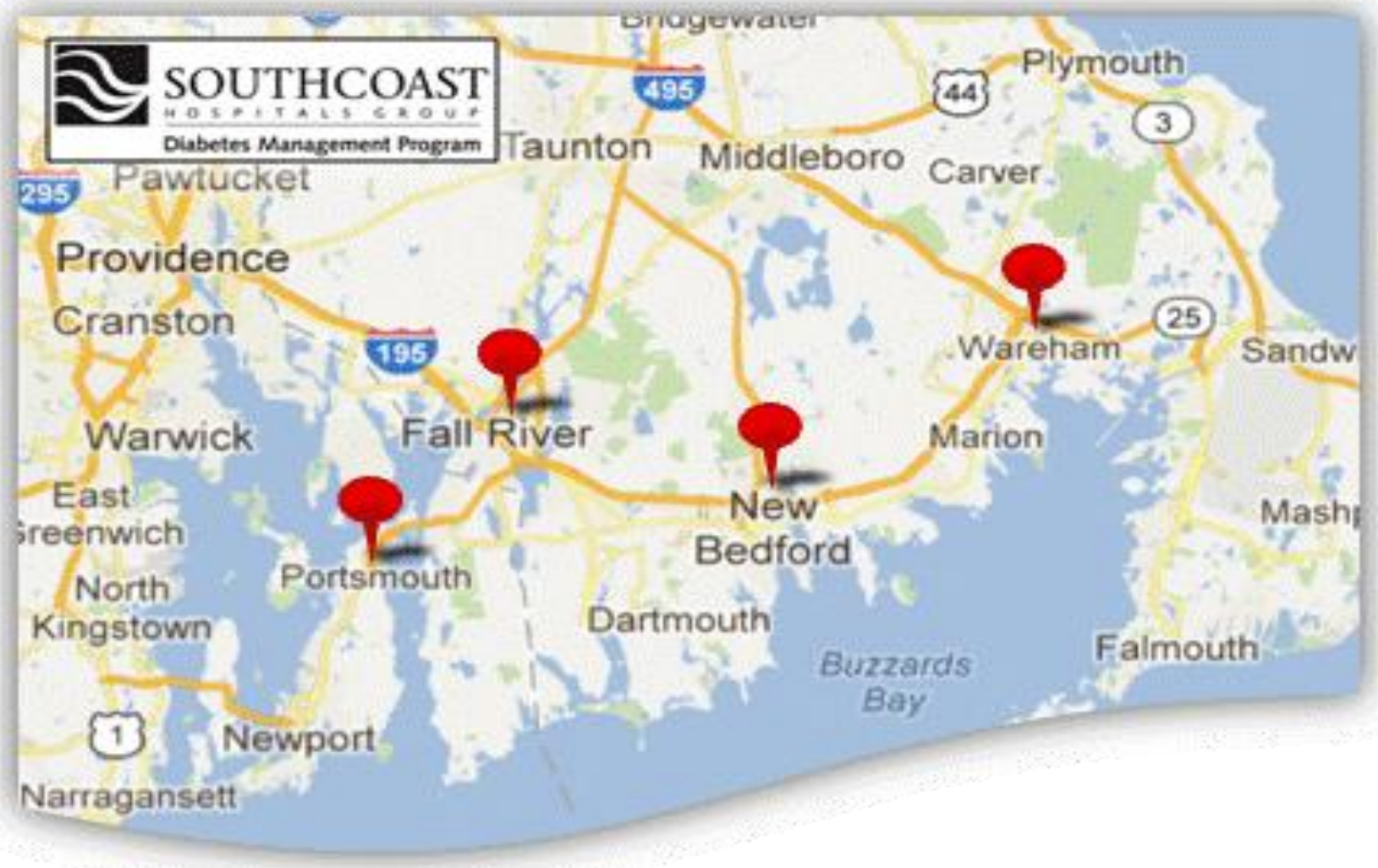
Jennifer Pritchard, RN, MHA, CPHQ, CDE
Director, Diabetes Management
Southcoast Health

Objectives

Create a new model of care for primary care

Incorporate CHWs into a team based approach for patient care to improve diabetes management

Transforming Communities:
CHWs Improving the Health of Our Region



Program Development

- Literature review for best practice
- Site visits and interviews
- Define priorities
- Care delivery model
  - Patient recruitment process
  - Communication
  - Documentation
- Education program
- Resources
- Metrics & Data Collection

Define priorities

Improve

- Patient self-management
- Medication management
- Patient attendance at DSME*
- Patient experience

Reduce

- “No shows” to DSME, PCP appointments
- ED visits, preventable hospital admissions/readmissions
- Total Medical Expense (TME) to the health system

Create

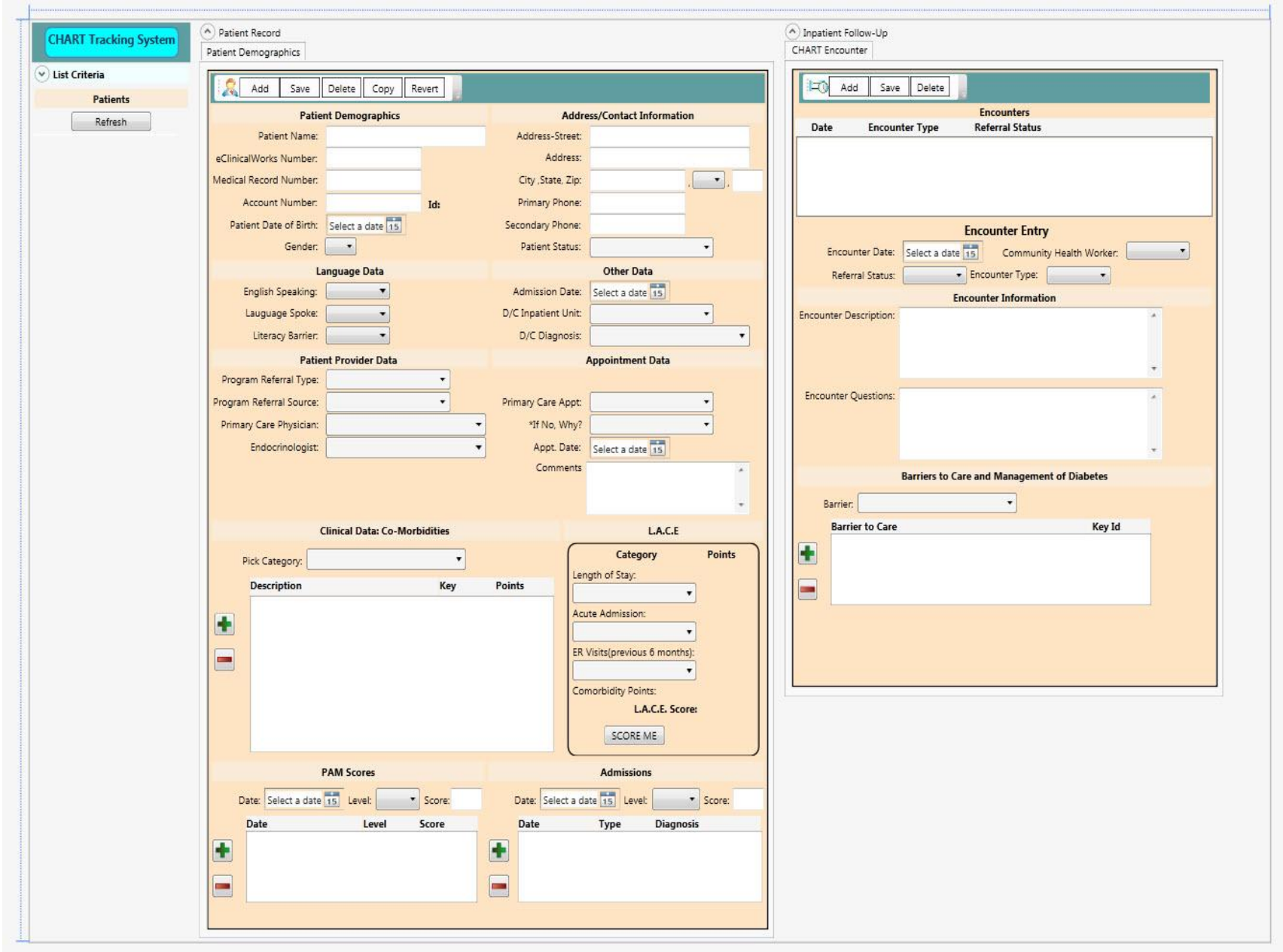
- Awareness of the value of CHWs as part of a care team
- Physician champions to advocate for the role of CHWs in our health system.

*DSME= Diabetes Self Management Education

CHW Process for Patient Recruitment/Communication

- Patient selection criteria
  - A1c ≥ 8%, medically and socially complex
- Provider referral form
- Documentation
- Database
- Communication process
- Integration of technology (e.g. iPads, iPhones)
- Bi-weekly meetings with providers
- Monthly meetings with CHWs and CDEs

Database and Documentation



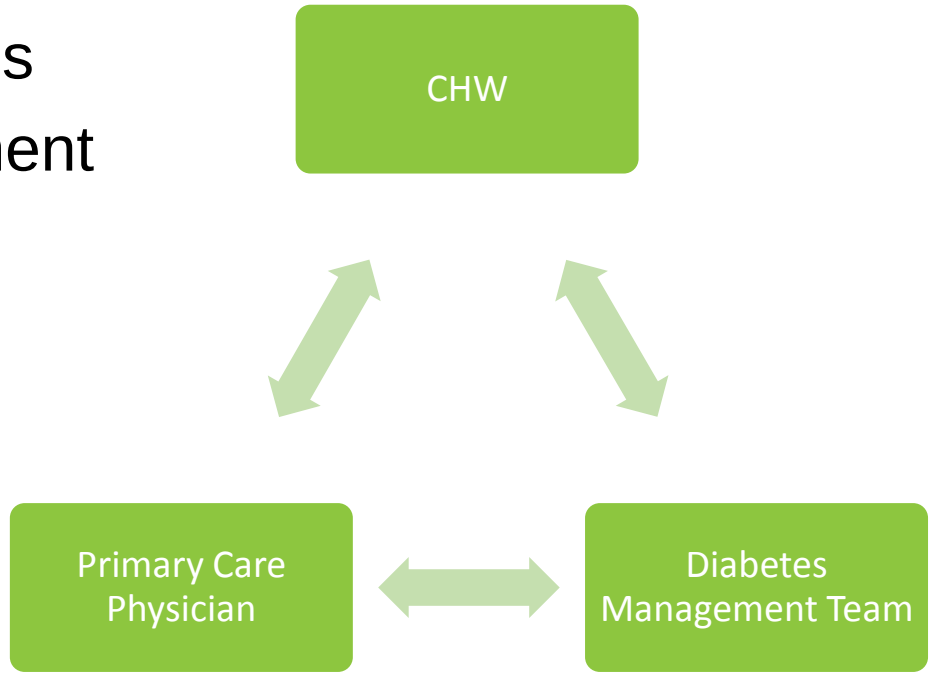
Education Program and Resources

- CHW Training Curriculum based upon the *Core Competencies Massachusetts Board of Certification of Community Health Workers*
- Added 50 hours of diabetes specific education that included:
    - Peer Leader Education by the *International Diabetes Federation.*
    - Motivational interviewing, coaching techniques and role play
    - Southcoast Health's DSME program
    - SC Policy and procedures related to PHI and security issues
- Created a tool box of resources for patient education

CHW Projects: Models of Care

1. Blue Cross Blue Shield of Massachusetts Demonstration Project (05/2013 to present)

- Triad of care for diabetes
- Regular case management meetings with providers
- Ongoing



CHW Projects: Models of Care

2. CHART *: Improving Patient Engagement and Satisfaction through Skilled Navigation and Community Health Worker Support 02/2014-10/2014

- Located on-site at multi-practice primary care facility
- Diabetes Nurse Navigator
- Warm Handoff
- CHW identified and implemented creative strategies to overcome barriers to care
- iPads for teaching and coordination of clinical care*

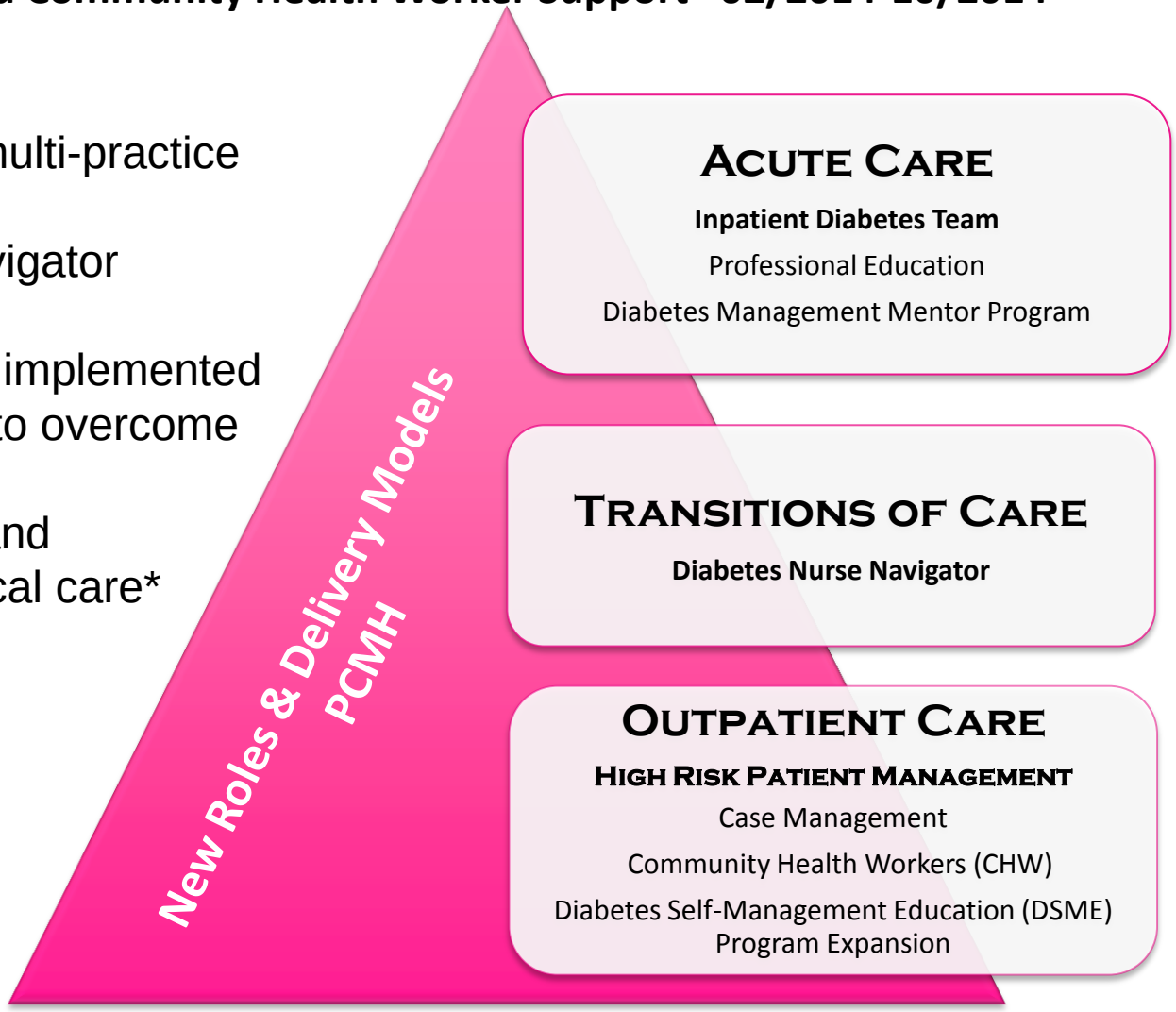
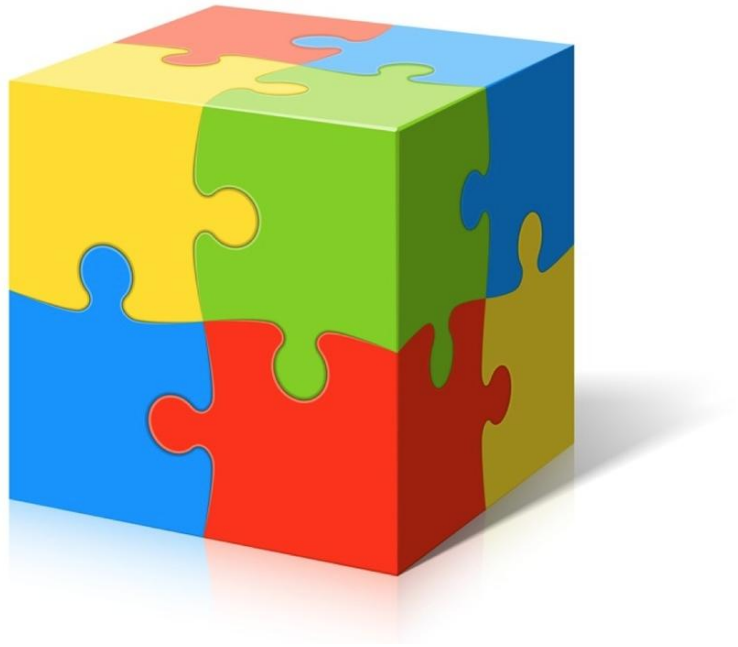


CHART Phase 1: Funded by the Commonwealth of Massachusetts, Health Policy Commission 2014

CHART: Community Hospital Acceleration, Revitalization and Transformation

Strong Foundation for the Future

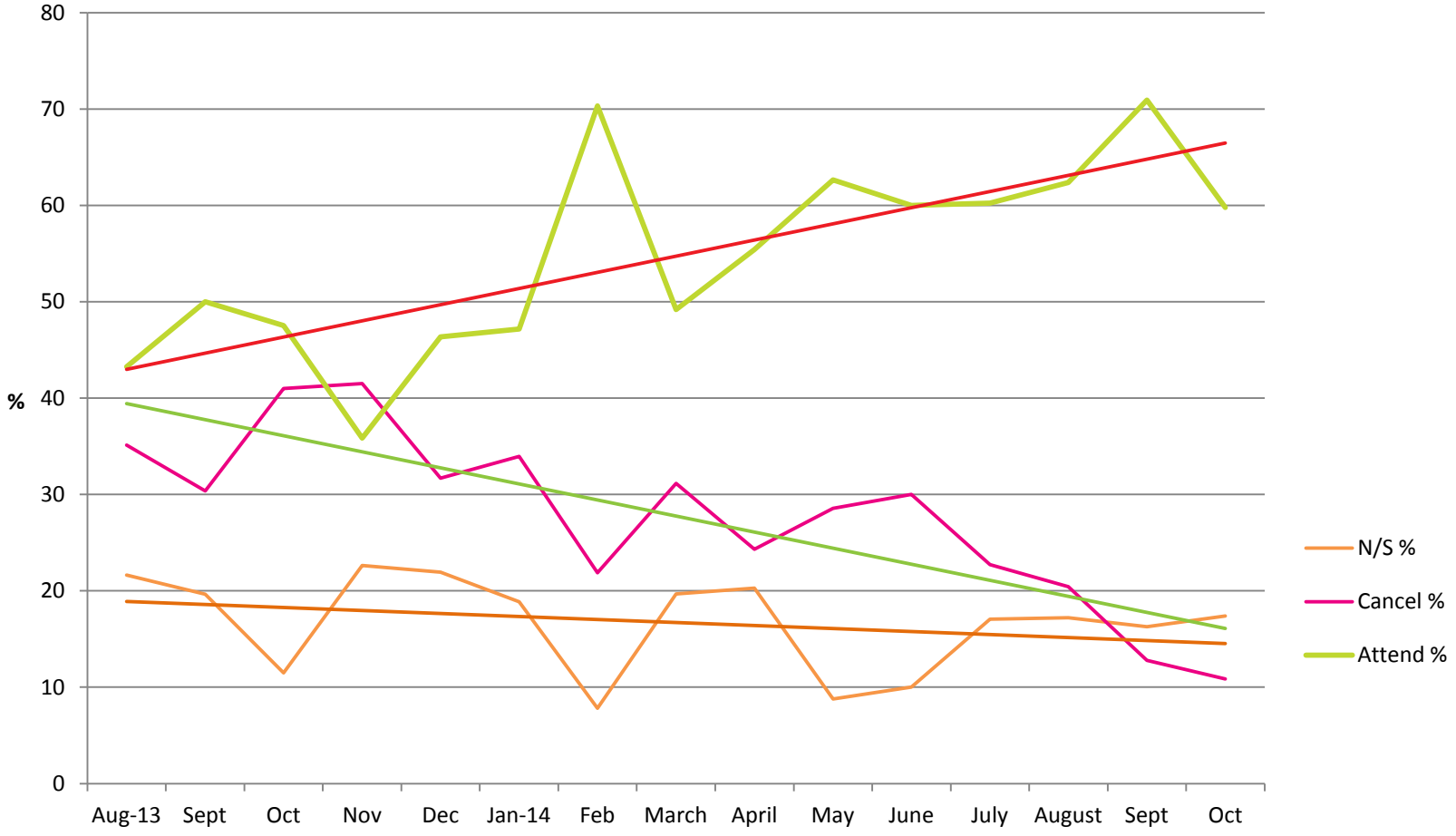
- Each project has contributed to the success of the next.
- Work is progressive
- We have applied lessons learned and continue to move forward.



Results: What We Measured

- Patient Activation Measure (PAM) Scores
- Patient satisfaction
- Post-acute discharge follow-up appointment with PCP
- Patient refusal rate of service
- Service Intensity (CHW)
- Provider and **patient satisfaction**
- **No show rates for ambulatory diabetes management**
- Clinical measures
  - **A1C**
  - Hypertension
  - Cholesterol
  - Weight

Percent of No Show, Cancel and Attend for Diabetes Education (Rosebrook) Aug 13 to Oct 14



Numerator: The number of no show, cancel and attend appointments

Denominator: The total number of available appointments

Target: No show < 25% Baseline: No Show ~ 50%

Totals: No Show 226 Cancel 386 Attend 738 Booked Appts 1361

Patient Satisfaction

"It was helpful to have a CHW as part of my team."

- 80% strongly agree
- 20% somewhat agree

"In general, I learned something new about my diabetes."

- 80% strongly agree
- 20% somewhat agree

Clinical Outcomes

Excellent clinical results (CHART):

- Average A1c decrease who received DSME: 2.4% (14 patients had pre and post A1c)
  - Range of decrease: 0.5% to 6.6%
- CHW Intervention only: Initial 13.2%
  Follow-up 7.6%
- Greatest decrease in A1c with both CDE and CHW intervention.
  - Range of decrease: 3.1% to 6.6%
- Within 6 months: 41% of patients achieved an A1c $\leq$ 8% (n=19 patients)
- Six patients who experienced an increase in A1c had neither CDE nor CHW intervention

Results: What We Have Learned

- Face to face interaction is highly successful to engage patients in self-care (89% engagement) enhanced with provider participation
- Multiple touch points (average 7-10) for engagement
- Successful in eliciting information from patients, critical to the clinical care plan
- Translated medical treatments, simplified and culturally relevant
- Clinical outcomes may take a year or more to be realized

Results: What We Have Learned (con't)

- Support/encouragement in home environment
- Facilitated shared decision making
- Developed unique, innovative and creative patient specific strategies
- Provided education of clinical staff regarding root causes for "non-adherence" to treatment
- CHWs need access to clinical supervision to define boundaries of care and when to seek professional help

Challenges: Moving forward

- Sustainability of model
- Team based care--new
- Reimbursement
- Discharge criteria
- Reporting clinical information to providers
- Over “medicalization” of CHW role
- Demonstration of value to healthcare

Diabetes Team (CHART)

Missing: Robin Zora, RN, MS, CDE, CDOE
Cathy Bowers, RN, RD, CDE
CHW: Valentina Martinez and Ana Silva

Southcoast® Health

For more information contact:

Jennifer Pritchard, RN, MHA, CDE®, CPHQ
Director, Diabetes Management
Southcoast Health
pritchardj@southcoast.org