Community Health Workers and Reducing Disparities in Diabetes: Lessons Learned From the Front Lines of Care

Monday, June 17\textsuperscript{th}, 2013
12:00 – 1:00 pm ET

Sponsored by The Merck Company Foundation
Welcome and Introductions

Panel:

Belinda Nelson, PhD, Research Investigator, National Program Office, Alliance to Reduce Disparities in Diabetes (Moderator)

Christine A. Snead, RN, CPHQ, Nurse Manager, Care Coordination, Baylor Physician Services, Baylor Health Care System

Magdalena Lopez, Community Health Worker, HealthTexas Provider Network, Baylor Health Care System

James Walton, DO, MBA, President and CEO, Genesis Physicians Group, Former Vice President Network Performance, Baylor Quality Alliance, Baylor Health Care System
Community Health Workers:
Filling a Care Gap
Establishing the Role at Your Health System

Christine Snead, RN
Baylor Health Care System
Figure 17: Projected Increase of Diabetes Cases by Race/Ethnicity, Texas

Texas Projected Diabetes Cases, 2000 - 2040

- Hispanic (Prevalence = 12.3%)
- Black, non-Hispanic (Prevalence = 12.9%)
- White, non-Hispanic (Prevalence = 8.5%)
- TOTAL (Prevalence = 10.3%)

Program Population Demographics

Ethnicity
- White
- African American
- Hispanic
- Other

Primary Language
- English
- Spanish
- Other

Data for participants enrolled in DEP Year One from September 2009 through March 2013. N = 747. Sites are charitable clinics in Dallas County.
Program Population Demographics

Data for participants enrolled in DEP Year One from September 2009 through March 2013. N = 747. Sites are charitable clinics in Dallas County.
Why Community Health Workers?

**Problem**

- Gap in diabetes education services for uninsured
- Traditional diabetes education doesn’t address other barriers to effective self-management*
  - Health literacy
  - Financial barriers
  - Language
  - Mistrust of the health system

**Solution?**

- Trusted peer*
  - Helps patients navigate medical, behavioral, and social services
  - Provides culturally appropriate and accessible health education and information
- Lower cost intervention
- CHW certification through Texas Department of Health Services

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CoDE™: CHW-led, Culturally Tailored Diabetes Self-Management Support

- Single site intervention
- Promising results: statistically significant improvement in A1c
- Could this be scaled to other primary care practices with similar patient demographics?
Merck Foundation funding and the Alliance to Reduce Disparities in Diabetes…

DIABETES EQUITY PROJECT!!

5 CHARITABLE CLINIC SITES IN DALLAS COUNTY
CHW Recruitment

• CHW job code created. Requirements include:
  – High school diploma
  – Fluent in Spanish
  – Medical Assistant preferred

• Recruited via
  – Baylor website
  – Local workforce development site
  – Charitable clinic network
CHW Interviews

- Existing CHW and program manager conducted behavioral interviews
- Ranked candidates on behavioral traits
  - Compassion
  - Communication
  - Self-motivation
  - Capacity to learn
  - Integrity
  - Teamwork
  - Quality
CHW Training

- Texas State Health Services Community Health Worker Certification
  - 160 hour skills based program or 1,000 hours
  - 20 hours continuing education/2 years
- Core Competencies
  - Communication and interpersonal skills
  - Service coordination skills
  - Capacity building skills
  - Advocacy skills
  - Organizational skills
  - Knowledge base (communities and disease)
Other CHW Training Resources

- State of Texas CHW Curriculum Information: www.dshs.state.tx.us/mch/chw


- Temple University
Role Based Initial Training

• **Diabetes Knowledge**
  - American Association of Diabetes Educator Level 1 certification (web based)
  - Local Certified Diabetes Educator led self-management classes
  - Diabetes Knowledge Pre/Post Test

• Clinical skills competency training
• Protocol/Job Scope
• EMR/Diabetes Registry
• Shadow other health care team members
Ongoing Training

- Continuing education (15 - 20 hours/year)
  - Motivational interviewing
  - Diabetes and comorbidities
  - Compassion fatigue
- Patient Visit Coaching
  - Competency Assessments
- CHW continuing education
  - 20 hours/2 years
**Defined Protocol Increases Comfort with New Health Care Role**

### Diabetes Health Promotion Scheduled Visits* (Adapted from CoDE™)

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<th>Activity</th>
<th>1 (day 1)</th>
<th>3 (30-45 days)</th>
<th>4 (3 months)</th>
<th>5 (6 months)</th>
<th>6 (9 months)</th>
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Community Care Navigation: Hospital to PCP

CHW receives referrals from hospital social work

Visits patient in hospital

Schedules new PCP appointment and delivers clinical and social information

Confirms appointment attended, reconnects with patient if appointment is missed
CHW Program Facilitators

- Successful evidence-based pilot
- Certification/standardized training
- Centralized program management
- Organizational Commitment
- Funding
- Low cost intervention
Lessons Learned

• Unique CHW/Patient relationship is the cornerstone of the intervention
  - Identification of cultural and other barriers
  - Need direct communication with providers

• CHW competency is a must have
  - Training
  - Clearly defined protocols and procedures
  - Clearly defined scope

• EMR access facilitates model acceptance and effectiveness

• Registry facilitates outcome tracking and communication

• Relationships, relationships, relationships
Integrating CHWs into Baylor Health Care System

Career Path Development:

2005

1 CHW CoDE

2 CHWs CoDE Charitable Program Enrollment

9 CHWs Diabetes Equity Project Community Care Navigation

20 CHWs Diabetes Equity Project Community Care Navigation Care Connect DHWI Diabetes Elder House Calls

32 CHWs Chronic Disease Education Community Care Navigation Care Connect DHWI Elder House Calls

2013

CHW 1

CHW 2
Thank You!
The Community Health Worker as an Integral Member of the Health Care Team

Magdalena Lopez, CMA, CHW
CitySquare Clinic
What is my role as a CHW?

- Build trust with patients
- Connect patients to resources
- Educate patients about diabetes and healthy behaviors
  - Help patients to set measurable, achievable goals
- Help patients communicate with their provider
- Inform provider’s treatment plan for patient
My Workflow

• Typical Day
  – 8 patient visits
  – 4 telephone outreach follow up calls
  – 1 inbound call from patient with questions

• Communication with Primary Care Provider
  – Mostly standard diabetes pathway documentation in EMR
  – 3 urgent situations requiring phone note or in-person conversation with PCP

• Team Meetings
  – Biweekly CHW team meeting/conference call
  – Monthly clinic team meeting
  – Monthly rounding with clinic manager and program manager
Patient Visit: Part 1

• Clinical Measures
  – Glucose readings
  – Vital signs
  – Visual foot exam
  – Depression screen

• Refer red flags to PCP
Patient Visit: Part 2

- Self-management training
  - AADE-7 behaviors
- Identify Barriers
  - Navigation support
- Refer concerns to Social Worker
- Follow up
  - Schedule next appt
  - Encourage to call with concerns
CHW Responsibilities

- Diabetes education
  - Assess barriers
  - Follow-up
  - Clinical measures

CHW Model

PCP Responsibilities

- Have confidence in CHW
- Verbalize support
- Shadow CHW, review protocol
- Be available

Patient Responsibilities

- Comply with lifestyle modifications & med mgmt
  - Participate in intervention
  - Share info about health status

Have confidence in CHW
- Verbalize support
- Shadow CHW, review protocol
- Be available

Comply with lifestyle modifications & med mgmt
- Participate in intervention
- Share info about health status
Communication with Providers

- Speak to provider for red flags
- Phone note for non-urgent requests
- EMR documentation for normal visits
- Quarterly outcomes report shared with providers
What Facilitated Provider Acceptance?

- **Embed in the clinic**
  “When the CHW was offsite, it was low value to me because I didn’t know what was going on or who she was. When she moved onsite, all of a sudden, she was part of the team. We are discussing patients together when the red flags happen.”

- **Patient feedback**
  “I started to see the effect of what she was having when I spoke to the patients. I would see her reports, I would see the level of knowledge growing and then I started to rely more on her… it was a relationship that we built over time.”

- **Structured program clearly defining CHW scope**
  “We shouldn’t put the CHW in situations where they feel they need to make clinical decisions. That’s our job.”

* Twelve qualitative interviews conducted by BHCS Director of Health Sciences Research Funding, 2012
Patient Feedback: Qualitative Interviews

- Relaxed, safe environment
- Frequent contact
- Relatable and accessible when there are issues

“With the DHP, you can be part of the conversation in deciding your health.”

“I know I can always call my DHP.”

“She tells me the truth. I believe she’s honest about things. I feel I can get open with her because she’s the kind of person who will listen to what you’re going to say.”

* Twelve qualitative interviews conducted by BHCS Director of Health Sciences Research Funding, 2012.*
Changing to team culture takes leadership

“At first the medical director didn’t think I should be here. There hasn’t been a model like the CHWs. The Certified Diabetes Educators (CDE) thought we were taking their jobs. The director of the clinic had a big meeting about roles, what the process would be. Roles and processes were defined for everyone. The patient would see the physician, then the CHW if they had diabetes, then the CDE.”

CHW team support is important

“They are moral support. We vent and help each other out. They are like a support group.”

Patient relationships are fulfilling

“Before I worked with patients in a group setting. It was not personal. I did not have a relationship with the patients. Here you have a relationship with the patients. They want to tell you everything. I enjoy it.”

Stress/compassion fatigue

“I love my job but when they tell sad stories it breaks your heart. Sometimes it can be very stressful.”

* Five qualitative interviews conducted by BHCS Director of Health Sciences Research Funding, 2011.
Tips for Integrating into Health Care Team

- Streamline clinic workflow
  - Scheduling CHW appointment immediately prior to PCP appointment
  - Offloads clinical measures from clinic Medical Assistant to CHW
  - Identifies barriers and red flags before PCP sees patient
  - Communicate within EMR
- Frequently communicate with providers, clinic manager, and program manager
- Go to program manager with concerns
- Learn from other CHWs at team meetings
Magdalena Lopez, CMA, CHW
Diabetes Health Promoter
maqdalena.lopez@baylorhealth.edu

Christine Snead, RN
Nurse Manager, Care Coordination
christine.snead@baylorhealth.edu
Diabetes Equity Project - Dallas

Goal: To optimize primary care for “at-risk” diabetic patients (i.e. IOM’s Triple Aim)

Tactics:
- Embed Community Health Workers within PCMH
- Train & Manage CHWs – Diabetes Health Promoters
- Leverage Software for data capture/communication
- Adapt Community Diabetes Education Program (CoDE™)
- Connect to Community Health Network
Improvement of Disease Control

- 4+ Years – 1,200 Diabetic Patients
  - 89% Racial/Ethnic Minorities
  - HgbA1c “Good Control” – 49% of Population
    - Average at Initiation = 32%
  - HgbA1c “Poor Control” – 17% of Population
    - Average at Initiation = 38%
- Avg. HgbA1c after 24 mo. = 7.2%
  - Average at Initiation = 8.4%

*HgbA1c “Good Control” = <7%; HgbA1c “Poor Control” = >9%
Improvement of Disease Control (9/30/12)

- 4+ Years – 1,200 Diabetic Patients
  - 79% Racial/Ethnic Minorities
  - HgbA1c "Good Control" – 47.5% of Population
    - Average at Initiation = 32%
  - HgbA1c "Poor Control" – 15.9% of Population
    - Average at Initiation = 38%
- Avg. HgbA1c after 24 mo. = 7.2%
  - Average at Initiation = 8.4%

*HgbA1c “Good Control” = <7%; HgbA1c “Poor Control” = >9%
Reduction in Downstream Costs

- Decreased ED & IP Utilization/Costs after program completion

Increase in Patient Satisfaction

- >98% Top Box Satisfaction during program

Table 1: ED Utilization Measures

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Three Lessons Learned

• Professional Development of CHWs
  – Commitment to transforming the PCP Care Team
    • Connecting Patients & Medical Home

• Dedicated Care Coordination Software
  – Optimizing communication across the team
    • Capture behavioral, social and clinical data – Reporting

• Manage productivity, quality & satisfaction
  – Nurse management - centralized training, team-building and troubleshooting
Thank You!

Jim Walton, DO, MBA
President/CEO Genesis Physicians Group
jim.walton@genesisdocs.org
Office: 214-419-0047
Questions?

Please enter your questions in the chat box on the lower right of your screen.

For questions after the webinar, please contact Belinda Nelson at belindan@umich.edu