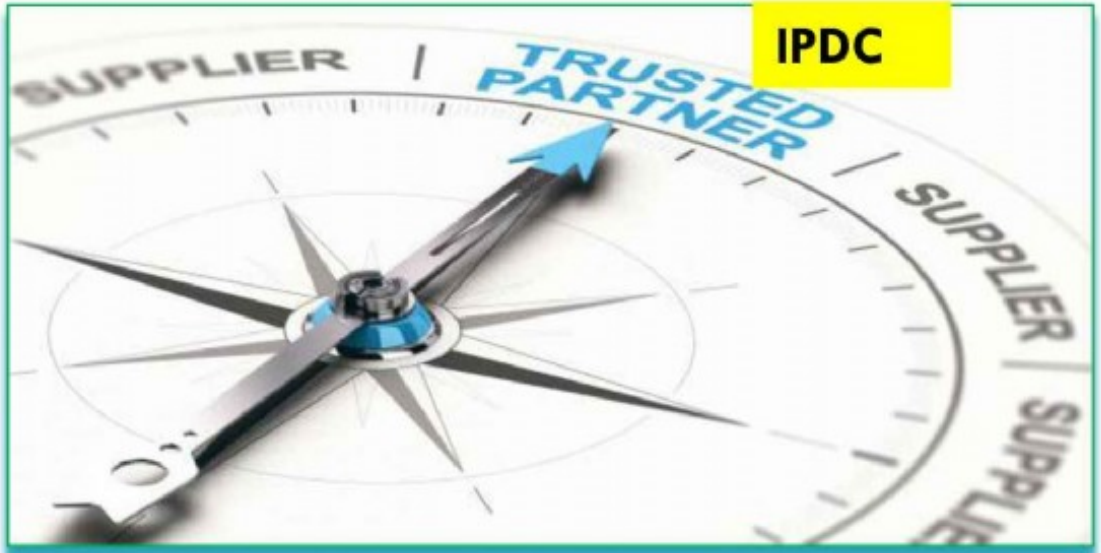
CHW/P



Where CHW/P are Valued Partners in the Care Team

International Pre-Diabetes Center Inc.

Diabetes Self-Management & Prevention Education

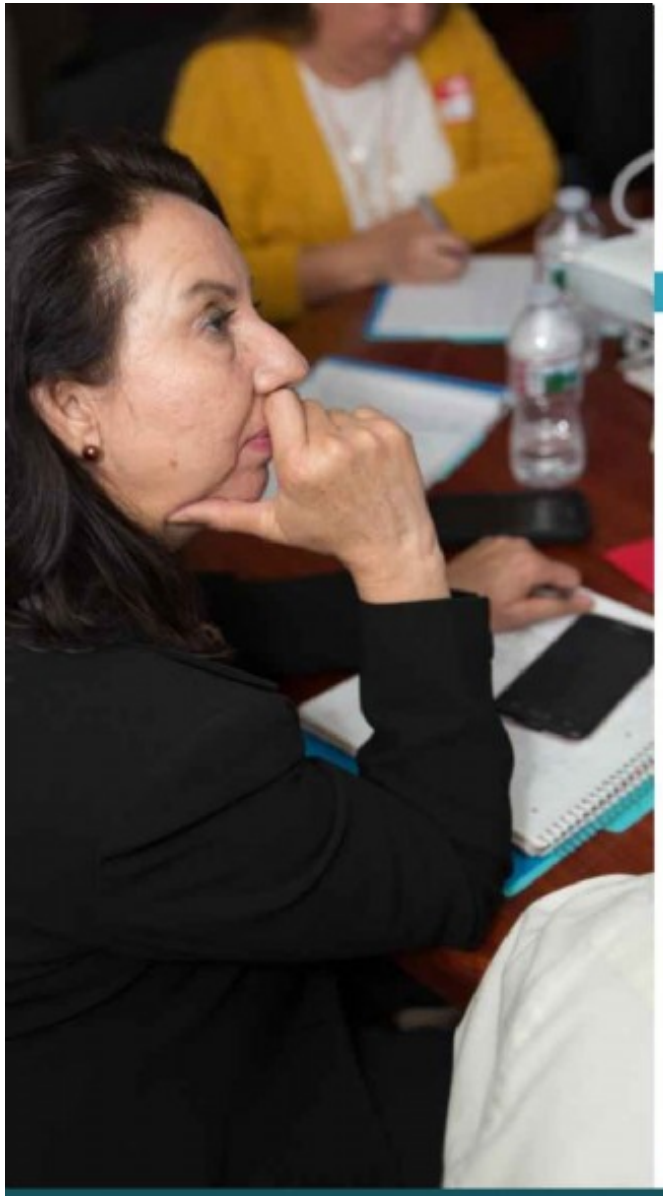
Our Mission Aligns with the Mission of Community Partners:

To close gaps for the disproportionate disparities that exists for chronic disease among high-risk minority and vulnerable population. We achieve our Mission:

1. **By Increasing access to Qualified Programs,** and Trained Staff (implementing evidence based, qualified/accredited Programs and Services that are reimbursable).
2. **By Utilizing a Community Health Worker/Promotores (CHW/P) Model that includes CHW/P as members of the Team to improve health Outcomes and decrease health care costs.**

IPDC CHW/P: Program Features

- Defines Learning Goals at the Outset
- Outlines Time Frames for Activities
- Incorporates Genuine Collaborations with the Community
- Includes Evaluation and Outcomes Measures
- Participates in Continuous Quality Improvement Plan
- Contributes to Program Improvement and Sustainability
- Identifies Best Practices, Challenges, and Barriers to Care
- Supports the Development of a Service-Learning Community-of Practice and Best-Practice CHW Tool-Kit



Value of CHW

- Build trust with patients and their families
- Provide encouragement with skills building for chronic disease management and prevention
- Ongoing follow-up, and support with: motivational interviewing and personalized patient goal-setting
- Facilitate “S-M-A-R-T” goals, coordinate primary care services including provider appointments
- Act as a patient advocate and liaison between the patient/family, to improve communication and engagement with primary care providers and team
- Provides support and navigates patients to community resources for positively screened unmet needs

How Does the CHW/P Model Work?

- **By removing barriers** and closing gaps in need for social un-met needs (with Outreach and Support)
- **By figuring out "how"** the service management and health management systems are all connected (to daily life and developing problem solving skills)
- **Learning** the Skills to do it!
- **Knowing that small rewards** linked to small steps in accomplishments and accountabilities are keys to success

Hands on Learning

- **Shadowing**: To Identify Work Flows

- Learn how to: **Incorporate SDOH Information** Into Individualized Care Plan

- Learn Effective Patient Engagement Techniques

Physician Team Leader Can Benefit From CHW SDoH Information .

CHW Training: Participants Receive

Resources:

National Programs

LA County 211 Data Community Resources

- Participants receive hands-on approach and direct on the job engagement
- Build trust and confidence
- Assess for Impact of Training
- Twice Monthly Group Reflection and opportunities for Improvement


Participant Peer Support: Meet Twice Monthly

Available Resources

- Face to face, hands-on experience with teams: thinking about complex health care issues, participant engagement and building relationships
- Collaborations with Communities: focus on community and community issues with the coalition
- Evaluation: for change in participant's attitudes and/or perceptions

CHW Resources Continued

- Opportunities for Evaluation and Outcomes Measure and Shared Data
- Participate in Continuous Quality Improvement Plan
- Contribute to Community Program Improvement and Sustainability
- Develop CHW Policies and Procedures

Lived Experience

- Thinking about complex health care issues and using real life experience
- Focusing on community and community issues
- Evaluation: for change in participant's attitudes and/or perceptions

CHW Supported Activities

ACTIVITIES:

- Apply knowledge of social factors: incorporate into care plan
- Design a Care Plan in collaboration with patient and care team
- Identify - How to: individualize patient care within population care management
- Participate in patient-centered, multi-sector team-approach to care
- Improve communication among the care team

International Pre-Diabetes Center Inc.

Diabetes Self-Management & Prevention Education

Educate Families: Delivering a Childhood Obesity Prevention Program Approved by the Centers for Disease Control and Prevention (CDC)

CHWs Support: Cultural Eating Habits:

What Are You Supposed To Eat ?

Patients almost always Ask:

- What to Eat?
- How to Prepare It?
- "Show Me Where I Can Find It"
- "At home I want to set a better example for my family, I want to learn how to, prepare and shop for the right foods"
- "Are there workshops that show how to prepare it?
- I would love to taste samples"

CHW Support Continued

- Assistance in setting up community health programs
- Educating shelter staff in support of the homeless in DSMES
- Screening for: SDOH, Diabetes (PAID5)
- Shadowing:
  - High Risk Patient Screening,
  - Assessment and DSMES,
  - FQHC Mobile Clinic and
  - DSMES: Schools and
    Homeless-shelters: for families with children

Other CHW: Community Support

- Hone Participants' skills, meet the needs of Communities, including FQHC's and Safety Net Clinics
- Provide additional Support and Training (Learning to speak English, Computer Skills) to achieve employment

Increase Engagement of Participants with Health Systems: Close Gaps in Need.
THRIVE

CHW/P Applicant: Selection

Community

Service Learning

Participation

- Based on interest in the topic/subject
- Previous relevant experience
- Availability to participate in activities
- Willingness to participate and support multi-disciplinary care team

CHW/P : Learning Opportunities

- Participants learn first hand the importance of individualized self-care
- Participants use their training and built skills to give back to their communities
- In so doing, improve their quality of life

Critical Thinking Problem Solving

CHW/P

We facilitate learning first hand: that some patients In our community are:

- Unemployed, Underemployed, and are living in poverty
- Poorly educated, (with less than high school education)
- Utilize Emergency Department and hospital services, for routine diabetes maintenance care
- Don't have access to appropriate foods and nutrition and
- Live in neighborhoods where lack of safety impairs physical activity.
- Experience daily, competing, non-health-related barriers and challenges to self-care

Community Problem Solving

Support Partnerships and Programs

- **Effective Partnerships:**
- Warm hand off
- Community support to increase patient engagement
- Improved health outcomes for high risk vulnerable populations
- **Responsiveness** to Identified Community Needs

Effective IPDC Partnerships

Align Organizational Mission

KAISER PERMANENTE®

- To improve the health of our members and the communities we serve.

AstraZeneca

- To create a meaningful difference In the lives of the patients we serve

IPDC International Pre-Diabetes Center Inc.
Diabetes Self-Management & Prevention Education

- To close gaps in disparities for patients & communities we serve

The Partnership Founded the Center That Serves the Community

DCRC

DIABETES COMMUNITY Resource Center

Mission: Close gaps For Disproportionate Disparities Among High-risk Population

DSMES Community-Based
Accessible Services
Qualified, Program
Culturally-Adapted

Service Learning: Aligned
- with Learning Objectives,
- Existing Programs
- Research New Services

Achieved through Community Partnerships:
IPDC
Kaiser Permanente
Community Stakeholders
AZ, CHW

Centered in Community Needs Assessment,
Multi-sector Approach, and
Community Health Worker Model

"Hands On" Community Engagement,
Skills Building and Long Term Community Projects: Including: Design, Implementation, Evaluation (Research)

KDBH: Patient Screening, Referral & Engagement

Know Diabetes By Heart

1. Patient seeks Medical Care.

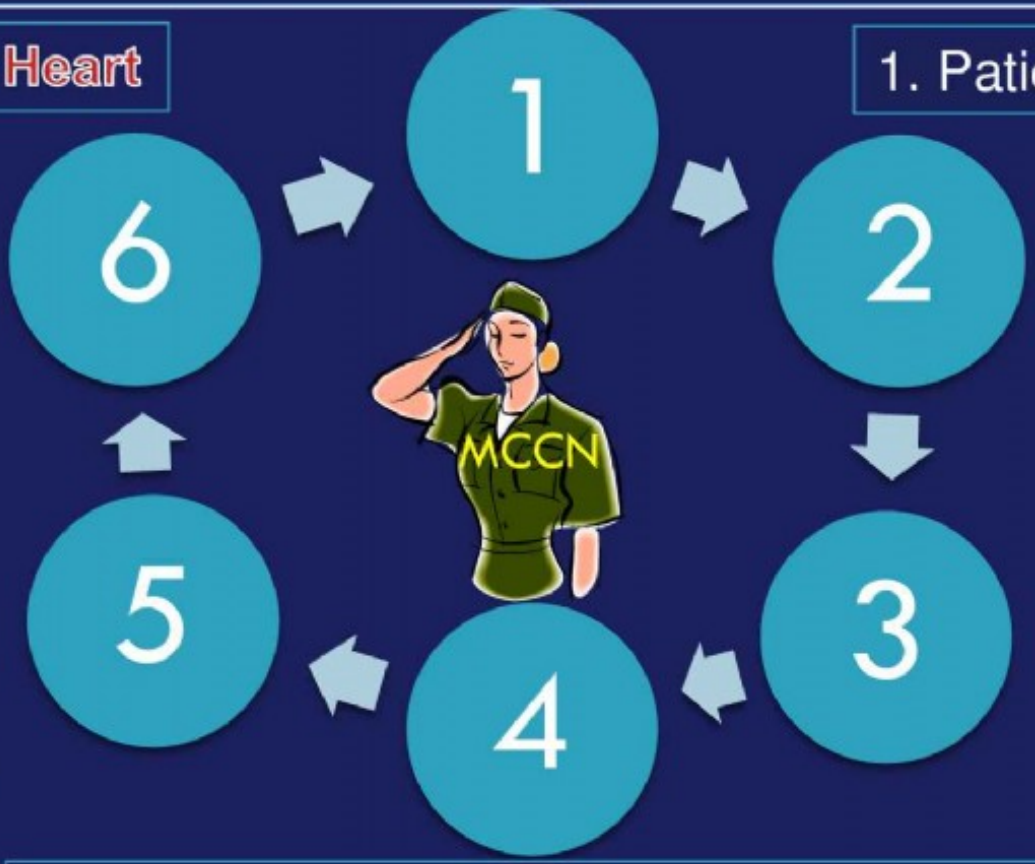
2. Patient screened for Diabetes

3. Patient receives referral for DSMES

4. Patient receives Assessment, Screening, Services and Support for **DSMES**

5. IPDC Health Navigator follow-up Data Collection

6. Navigator provides update to care team



American Diabetes Association®

American Heart Association®

CHW Model: Know Diabetes By Heart (KDBH)

AIM:

Multiple Stakeholders and Partnerships working in Concert

Improve Community Health

- **Resources:** National Alliance Partnerships Funded by ADA and AHA Community Learning Initiatives: **in which learning informs the Service and the Service informs the Learning**

Establish Work-Flow – FQHCs

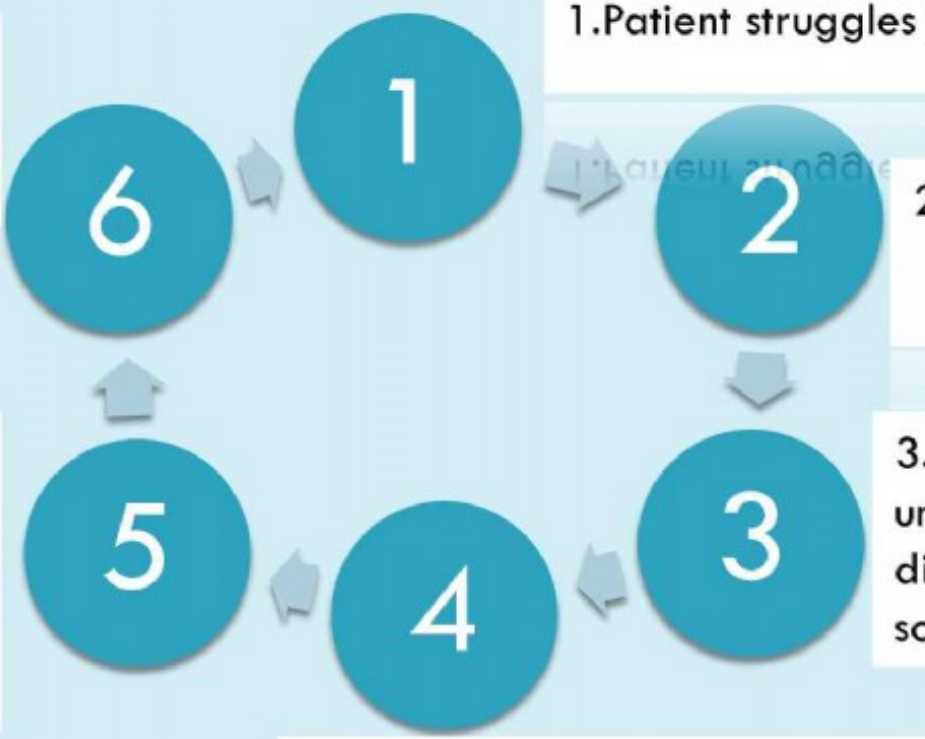
- Screening, Referral and Engagement
- Increase Awareness CVD risks linked to Diabetes

CHW Best Practices

Develop Service Learning-Skills

- **How To**: Develop Community-based, Data-Driven, Programs/ Services: to **Address Complex Needs**
- Develop Effective **Cultural Competence**
- Effective **Patient Engagement** in Self-Care Behaviors
- **Patient Support and Empowerment** to Achieve Patient Desired Goals and Health Outcomes
- Advocate for Patient's Health, Health Coaching and Peer Support
- **Sustainable Programs that Decrease Health Care Costs**

Work-Flow: CHW-Model - Outreach



1.Patient struggles to achieve blood glucose control

2. Provider Referral to DCRC for patient individualized Care

3. Patient receives screening for un-met social needs; Assessment in diabetes knowledge, and problem solving skills;

4. Patient is linked to Community Navigator (CN)
CN provides outreach, services, and support for un-met needs.

5. CN facilitates and coordinates care; advocates for community resources, follow-up with patient

6. CN provides update to care team

CHWs Develop Competence

ACTIVITIES:

- Apply knowledge of social factors: incorporate into care plan to improve outcomes
- Design and develop an Individualized Employment Plan in collaboration with participants and care team
- Identify - How to: individualize Participant Plan to meet their needs
- On the Job Employment (OJE) training may include: participate in patient-centered, multi-sector team-approach to care and community outreach
- Improve communication among the care team

Sustainability: Triple Bottom-line

1.Social Responsibility & Community Needs

What is the Right Thing to Do?

2.Value to Members Burden of Diabetes

3.Health Equity Vulnerable Populations

HIGHLIGHTS

Learning Opportunities - Pearls

1. Partner and Collaborate with Communities
2. Use Community Needs Assessment
3. Prioritize Problems and Challenges
4. Brainstorm Solutions
5. Align Interventions to Specific Needs
6. Share Data, Lessons Learned
7. Use Knowledge to Solve New Problem

Results: Screening/ Outreach

GOALS: Utilizing a Screening APP

1. **Screen for Social Stressors (SDoH)**
2. **Diabetes Emotional Distress (PAID 5)**
3. **Provide Community Outreach for Un-met Needs**

# Screened For SDoH =211	**# identified with positive Screens =45/211 =(21%)**	
SDoH	**# With Unmet Need**	**# that Received Resources**
1. Food Insecurity	12/45 (27%)	12 (100%)
2. Housing (Assistance with application/ Resource Location)	27/45 (60%)	27 (100%)
3. Transportation	5/45 (11%)	5 (100%)

Results: Impact On Cost Avoidance

STUDY	A1c	COSTS	DCRC Project: to Date
Claims Data	**Decrease** of **1% in A1c**	Cost Savings of **$960 to patients** (when Compared to no reduction in A1c)	**= $120,000/ 125 patients** (250 patients = $240,000) Target is 250 patients with A1c, decrease of 1 %
Managed Care Data	A1c above 7%	**Increase the costs of care by $1, 540 per patient**	**= $77,000/ 50 patients** (available labs < 7.0) (Target 150/pt = $231,000)
KP/Northern Cal		**$3, 500 higher cost of care each complex patient**	**= $960,000/ 261 patients** (current enrollment)
ED Visits (NIH Data)		Cost Per Visit (Average) $1,500	**= $51,000**/ 34 pts Target 100 pts = $150,000
Hospitalizations (KP-Region Estimate)		3 days LOS and $3,600/ Day (for **8 patients**) and decrease of 11 hospitalizations	**= $119,000/ 8 patients** Target is 50 patients (Estimated @ $744,000)

PROGRAM: DOES IT WORK?

PATIENT CASE- R.R.

6/18/17
Age: 53
Hispanic, Male
A1C: 12.3

BEFORE

AFTER

2/18/18
(9 months later)
A1C: 6.4

IPDC CHW/P: Service Learning Center

Go Back

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