Concurrent Session #3

Advantages, Limitations, and Key Themes for Integrating Community Health Workers in a Large Healthcare Delivery System for Diabetes Management Among Vulnerable Populations – Qualitative Findings

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Learning Objectives

- To understand the value in recognizing and addressing health-related social needs when managing diabetes
- To identify determinants of implementation of a community health worker-led intervention in an integrated health care system
- To understand the value and importance seen by health system leaders in collaborating with community partners to provide culturally sensitive care and navigation services to diverse patient populations
- To identify factors that establish an effective partnership between community health workers and clinical care teams to support patients with poorly controlled diabetes

Agenda

- Introduction/Purpose
- Setting
- Study Criteria
- Qualitative Methods
- Results
- Discussion
- Limitations

Acknowledgements

Introduction

- Racial/ethnic and socioeconomic disparities in diabetes prevalence and management continue to persist [1-7]
- Unmet basic needs interfere with optimal diabetes self-management [1-7]
- There is increasing evidence that community health workers (CHW) can play an essential role in chronic disease management and address unmet basic needs [8-11]

Purpose

- *Bridge to Health/Puente a la Salud* is a 2-year pilot study funded by NIDDK to examine the feasibility and preliminary effectiveness of a CHW-led intervention to provide diabetes self-management support and address unmet basic needs via navigation to resources vs. a navigation to resources intervention only among racial/ethnic minority and low-income patients with uncontrolled diabetes

- Assess determinants of implementing a CHW-led intervention in a large, integrated health system by conducting qualitative interviews with senior health system leaders, health system Patient Navigators, and CHWs

Setting

Bridge to Health Research Study Team (KPNW-CHR)

KPNW Pop Health & Care Continuum Team

Project Access NOW

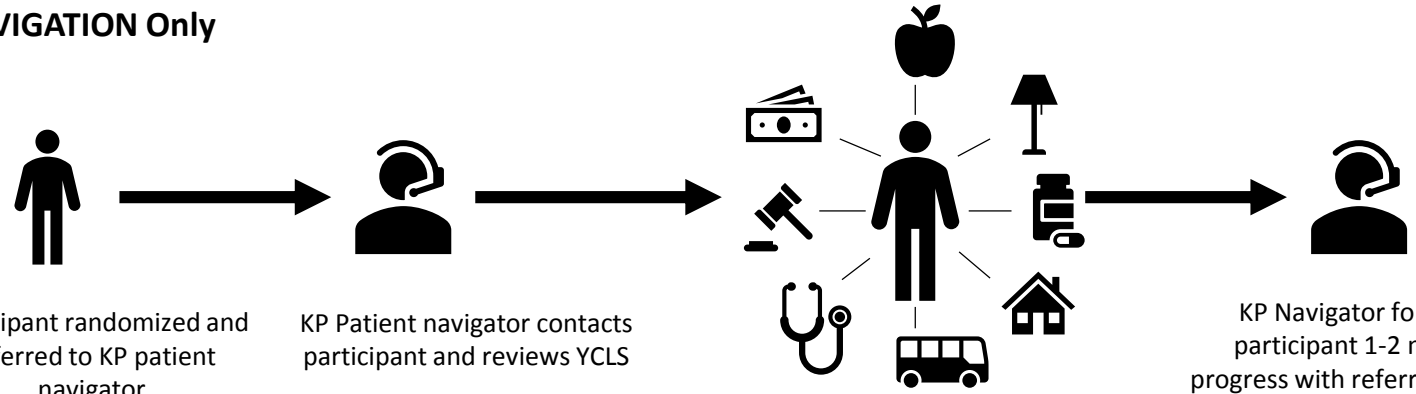
Asian Family Center/IRCO, Latino Network, Familias en Acción, Impact NW, NW Family Services, POIC, Volunteers of America, el Program Hispano

Patient Study Criteria

- Active member of KPNW
- Ages 18 years or older
- Black, Latino, or Medicaid recipient of any racial/ethnic background
- English or Spanish as preferred language
- Diagnosis of Type 2 diabetes
- A1C ≥ 8 on or after January 2017
- At screening endorsed 1 or more unmet basic needs using a 9-item social needs screener, Your Current Life Situation (YCLS)
- Agree to study participation for a 6-month period

Bridge to Health/ Puente a la Salud Intervention Arms

NAVIGATION Only



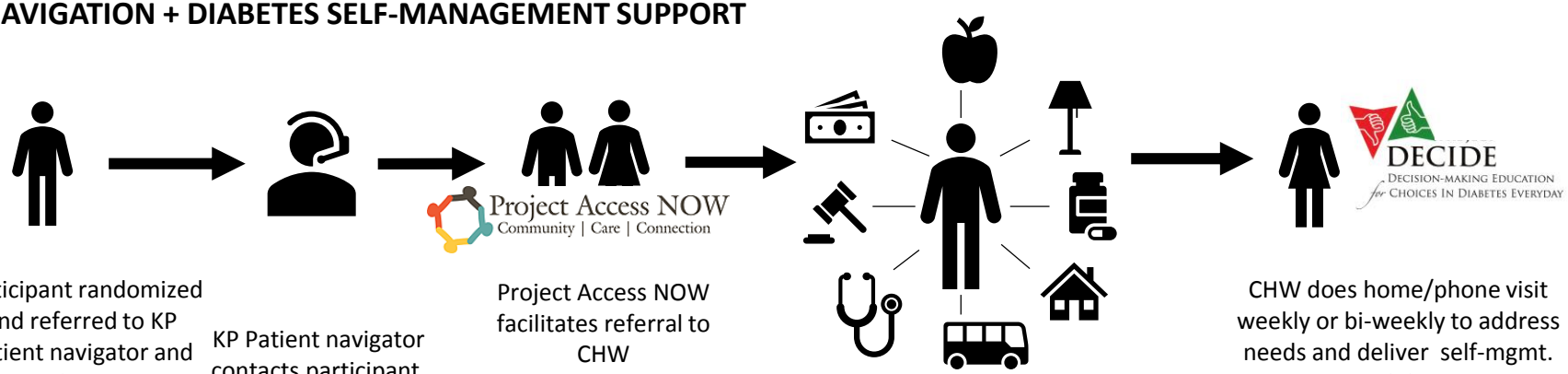
Participant randomized and referred to KP patient navigator

KP Patient navigator contacts participant and reviews YCLS

KP Navigator connects participant to medical and social services

KP Navigator follows-up with participant 1-2 more times on progress with referrals over 6- month period

NAVIGATION + DIABETES SELF-MANAGEMENT SUPPORT



Participant randomized and referred to KP patient navigator and CHW

KP Patient navigator contacts participant, reviews YCLS, connects participant to medical and social services

Project Access NOW facilitates referral to CHW

KP Navigator and CHW work in tandem to connect participant to medical and social services

CHW does home/phone visit weekly or bi-weekly to address needs and deliver self-mgmt. training

- Decision-making Education for Choices In Diabetes Everyday (DECIDE) [12]

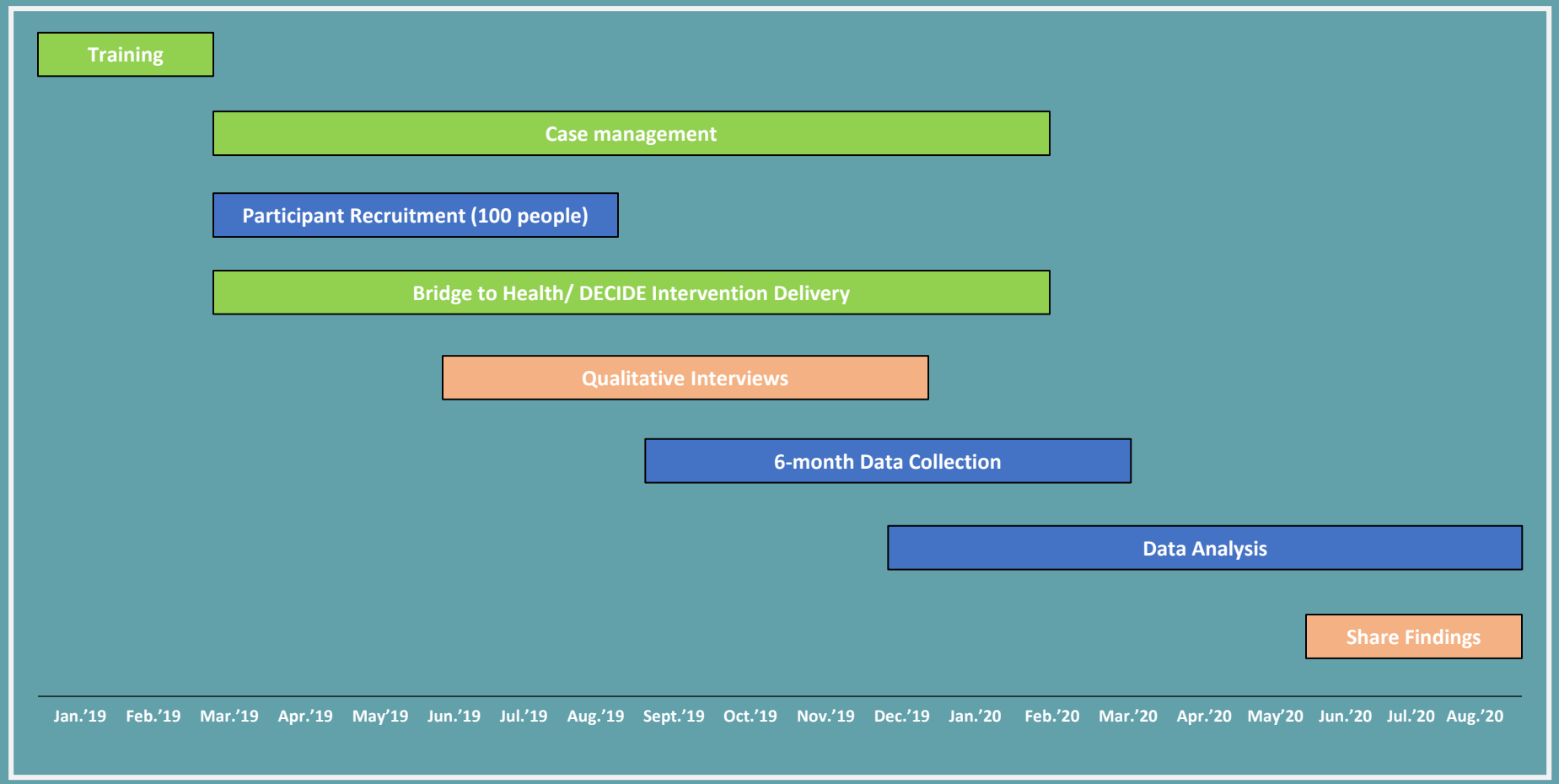
  * Uses problem-solving training as evidence-based behavior change skills to identify and manage barriers to diabetes self-management

- Approved by the ADA for diabetes self-management support

- For the study, CHWs completed a 20-hour training to facilitate the nine sessions with participants

DECIDE

Bridge to Health/Puente a la Salud Timeline



Activities CHW Directly Involved In

Activities CHR will Lead

Collaborative Activities

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Methods

Interviewees

* *Health System Leaders*

* *CHWs & Patient Navigators*

Qualitative Analysis

Interviews/focus groups were audio-recorded, transcribed, and coded using Dedoose software

Thematic analysis was applied to transcripts to identify key themes and reporting patterns regarding advantages, limitations, and sustainability factors

Results

Health System Leader Interviews (n=8)

Advantages for Integrating CHWs in health care setting

- Delivering culturally-competent care
- Partnering with clinical care team
- Health system partnering with community-based organizations
- Responsive to organization's priorities

Health System Leader Interviews (n=8)

Advantages for Integrating CHWs in health care setting

"I think it's a real opportunity to take a look at our population, you know, measure different bench marks and successes, change up the model a little bit to see how much of an impact we're making on our member's quality metrics and, ultimately, quality of life."

"So, there is more work than possibly we have within our four walls. So we really need to take advantage of what is happening out in the community. And we know that the population like the ones that we are looking at…they are more comfortable using some of the community resources versus what we have to offer here. Plus it…Again, you know, we don't need to do everything within KP. So, let's take advantage of…and work with everyone because it's not just Kaiser, but it's all organizations that and really struggle with this."

Results

Health System Leader Interviews (n=8)

Sustainability Factors for CHW-led Intervention

- Clear patient outcomes
- Return on financial investment
- Clear expectations on integrating with clinical care team
- Pilot complementing existing diabetes programs
- Organizational cultural change
- Prioritization of this work

Health System Leader Interviews (n=8)

Sustainability Factors for CHW-led Intervention

"So I would have to, I think know more about what are the specific outcomes. And we'd have to know …how do we attribute improvement? And I think that can often be difficult for care management programs to pinpoint so that you actually have a return on your investment. So we'd really need to understand what is the outcome of this intervention. And then, of the good work that's happening, are there ways we can incorporate that into the larger community-based work that we're doing?"

"In an ideal world, it would be wonderful if the CHWs had some form of documentation in the health record. ….that in and of itself can contribute to the communication between primary care provider, pharmacist, diabetes case manager if there is one, you know and CHW. If the CHW's notes are in there as well, everybody's sort of operating under the same care plan or with the same understanding. And they're ensuring that they're not giving conflicting information."

Results

CHW Focus Group (n=6)

Sustainability Factors for CHW-led intervention

- Support from supervisors
- Continued diabetes management education
- Team building with the Patient Navigators
- Clear expectations on roles and responsibilities
- Unrestricted resources for providing patient support

CHW Focus Group (n=6)

Sustainability Factors for CHW-led Intervention

“I feel like in order to be successful it's having really good communication with the Navigators, that way it keeps me balancing them with the resources and DECIDE. Or have one person where they can go to for resources and DECIDE.”

“Continued support, as we do with our supervisions. Continued resources around diabetes. And just continued communication. And even though we're not a team, but we are team, so continued team building.”

Results

Patient Navigator Focus Group (n=7)

Sustainability Factors for CHW-led intervention

- Establishing roles and responsibilities to avoid duplication of navigation services for patient
- Communication between the navigators and CHWs regarding patient referrals
- Develop documentation that can be accessible and updated by both parties
- Create a tracking system for managing patient status regarding community resource referrals

Patient Navigator Focus Group (n=7)

Sustainability Factors for CHW-led Intervention

"I would love to be able to review a list of patients that were referred to a navigator. I don't know if the interventions that needed to happen within these patients really happened. So you received a referral to follow-up on a patient. And then if they needed…one touch transportation it's no longer needed. You know, how do we keep that running log of, oh, that was a Bridge To Health patient."

"…She could say, okay, you're working with [Name] from Northwest Family Services. You're working with these three patients. Let's huddle, you know, twice a month and just touch bases on where we are with these patients and how we're doing. Because I have done that kind of organically with a patient in a…home admission that [Name] and I were meeting with through…I think it was Reach In, and that was really helpful. And so I think, you know, something like that we could do again. Just to make sure that we were covering all bases and not duplicating efforts."

Discussion

- There was consistent enthusiasm for the culturally competent care CHWs were able to provide patients
- Integrating CHWs in a large healthcare delivery system will require organizational readiness and alignment with the organization's priorities
- A cultural change within the healthcare delivery system is needed to recognize the value in community partnerships
- Sustaining this type of program will require clearly defined roles among the Patient Navigators and CHWs or having staff that encompass both roles within their position
- Enabling the clinical care team to partner with CHWs for optimal patient care and management

Limitations

- Interview clinical care team (physicians, nurses, diabetes manager) on the value of incorporating CHWs in their workflow
- Conduct interviews with health system leaders at study start-up and at the end of intervention to note any changes in clinical or operational value of CHW-involvement
- Measure readiness of health system to implement this program from health system leaders

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Citations

1. Spanakis EK, Golden SH. Race/ethnic difference in diabetes and diabetic complications. *Curr Diab Rep.* 2013;13(6):814-823.
2. Gucciardi E, Vahabi M, Norris N, Del Monte JP, Farnum C. The Intersection between Food Insecurity and Diabetes: A Review. *Current nutrition reports.* 2014;3(4):324-332.
3. Heerman WJ, Wallston KA, Osborn CY, et al. Food insecurity is associated with diabetes self-care behaviours and glycaemic control. *Diabet Med.* 2016;33(6):844-850.
4. Mayer VL, McDonough K, Seligman H, Mitra N, Long JA. Food insecurity, coping strategies and glucose control in low-income patients with diabetes. *Public Health Nutr.* 2016;19(6):1103-1111.
5. Leung CW, Epel ES, Ritchie LD, Crawford PB, Laraia BA. Food insecurity is inversely associated with diet quality of lower-income adults. *J Acad Nutr Diet.* 2014;114(12):1943-1953.e1942.
6. Billimek J, Sorkin DH. Food insecurity, processes of care, and self-reported medication underuse in patients with type 2 diabetes: results from the California Health Interview Survey. *Health Serv Res.* 2012;47(6):2159-2168.
7. Knight CK, Probst JC, Liese AD, Sercye E, Jones SJ. Household food insecurity and medication "scrimping" among US adults with diabetes. *Prev Med.* 2016;83:41-45.
8.Loskutova NY, Tsai AG, Fisher EB, et al. Patient Navigators Connecting Patients to Community Resources to Improve Diabetes Outcomes. *J Am Board Fam Med.* 2016;29(1):78-89.
9. Horny M, Glover W, Gupte G, Saraswat A, Vimalananda V, Rosenzweig J. Patient navigation to improve diabetes outpatient care at a safety-net hospital: a retrospective cohort study. *BMC Health Serv Res.* 2017;17(1):759.
10. Enard KR, Ganelin DM. Reducing preventable emergency department utilization and costs by using community health workers as patient navigators. *J Healthc Manag.* 2013;58(6):412-427; discussion 428.
11. Valaitis RK, Carter N, Lam A, Nicholl J, Feather J, Cleghorn L. Implementation and maintenance of patient navigation programs linking primary care with community-based health and social services: a scoping literature review. *BMC Health Serv Res.* 2017;17(1):116.
12. Fitzpatrick SL, Golden SH, Stewart K, et al. Effect of DECIDE (Decision-making Education for Choices In Diabetes Everyday) Program Delivery Modalities on Clinical and Behavioral Outcomes in Urban African Americans With Type 2 Diabetes: A Randomized Trial. *Diabetes Care.* 2016;39(12):2149-2157.