From Research to Practice

Building an Effective, Sustainable CHW Program

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Our mission is to improve health in high-risk populations through the effective use of CHWs
Penn Center for Community Health Workers

- Replicability: Design, test and refine IMPaCT model of care
- Sustainability: ROI of $1.80:$1; care for 1,700 patients/year
- Adaptability: all diseases, in/outpatient
- Dissemination: Support to more than 600 organizations
Designing IMPaCT
Learning from patients
## Designing the program

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Intervention</th>
<th>Trait</th>
<th>Skill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients want to be heard and do not want</td>
<td>CHW conducts open-ended, strengths-based interview</td>
<td>-Nonjudgmental</td>
<td>Qualitative Interviewing</td>
</tr>
<tr>
<td>to feel judged</td>
<td></td>
<td>-Listens &gt; talks</td>
<td></td>
</tr>
</tbody>
</table>

Qualitative Interviewing
<table>
<thead>
<tr>
<th>Category</th>
<th>Patient Summary</th>
<th>Goal</th>
<th>Tailored Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial</td>
<td>62 year-old socially isolated woman hospitalized for panic attacks and chest pain.</td>
<td>Find a fun social activity</td>
<td>CHW went with patient to local recreation center. She felt “at home” and plans to go back.</td>
</tr>
<tr>
<td>Resource</td>
<td>53 year-old with schizophrenia who lives in a boarding home that will close in two weeks.</td>
<td>Find housing</td>
<td>CHW worked with patient and family to move him into another community boarding home.</td>
</tr>
<tr>
<td>Navigation</td>
<td>46 year-old patient with hypertension who could not afford $65 co-pay for discharge medications</td>
<td>Get low-cost prescriptions</td>
<td>CHW and patient asked hospitalist to prescribe generics with no co-pay</td>
</tr>
</tbody>
</table>
What we’ve learned
Historic pitfalls of CHW programs

- Turnover, variability
- Lack of infrastructure
- Disease-specific
- Not integrated
- Low-quality evidence

Kangovi, Grande, Trinh-Shevrin *NEJM* 2015
Photo Credit: Quora.com
IMPaCT

- Hiring protocols
- Standardized program
- Patient-centered
- Integrated with clinicians
- Scientifically proven
How it works
Target patients
Target patients

Set goals
Target patients

Set goals

Support
Target patients

Set goals

Support

Connect
Target patients
Set goals
Support
Connect

Measure outcomes
Target patients
Set goals
Support
Connect
Measure outcomes

Infrastructure
Target patients
Set goals
Support
Connect
Measure outcomes

Supervision

IMPACT Workforce Chart
Target patients
Set goals
Support
Connect
Measure outcomes

Manuals
# 3163 Patient Name
PCP: Dr. Smith 220-765-2047
Root Cause: Patient is lonely after husband's death

<table>
<thead>
<tr>
<th>Technology</th>
<th>Needs Not Filled</th>
<th>Followup Appt Not Completed</th>
<th>Home Care Not Completed</th>
</tr>
</thead>
</table>

**Roadmap 1**
Change insurance:
- Next Steps: Chw and pt will pick the Penn plan she wants this week
- Resolved: Yes

**Roadmap 2**
Make PCP appt and pt to attend
- Next Steps: Chw and pt will call new pcp and schedule appt by 9/29
- Chw will put appt on calendars and outlook
- Chw will make reminder call and attend if available
- Resolved: No

**Roadmap 3**
Get transportation for appt
- Next Steps: Chw and pt will call logistics to schedule rides for pt appt by 9/29 and ask logistics to fax form over to pcp
- Chw will follow-up with pcp at appt to make sure it is faxed back to logistics
- Chw will confirm with logistics that fax was received
- Resolved: No

**Roadmap 4**
Submit HFA modification
- Next Steps: Already completed
- Resolved: Yes

**Roadmap 5**
Invite pt to healthy living support group
- Next Steps: Chw will pick up file by 9/29
- Chw will talk to pt about healthy living group on 9/29
- If interested, chw will let PM know to add pt to list by 9/29
- Chw will also maintain as a reminder by 9/29
- Resolved: No

**Roadmap 6**
Have HomeLife Health for homecare come out to pt
- Next Steps: Chw will call pt on 9/29 to set up home health care and talk to hr about helping to ease transition with a new nurse
- Chw will call pt to make sure nurse came out by 10/1
- Resolved: No

Target patients
Set goals
Support
Connect
Measure outcomes
Community health workers are “symbolic of the highest standards of patient advocacy and the best our health system offers its patients.”

- Randi Jackson, Penn Presbyterian Medical Center Chief Service Care Coordinator
Results
Improved care, improved health and lower cost

Randomized Controlled Trial (n=446)

Kangovi et al, JAMA Internal Medicine 2014.
Sharing our learning
IMPaCT Partnership Program

- Launch quickly
- Scale efficiently
- Avoid “reinventing the wheel”
- Achieve financial sustainability
- Evaluate and continuously improve
Thank you!

http://chw.upenn.edu/