DRAFT: Connecticut SIM Clinical and Community Integration Program Technical Support and Grant Funding

Focus Area: Health Equity Improvement Program

Program Definition and Objective: The objective of the Health Equity Improvement (HEI) program is to identify and close equity gaps experienced by patients. Practice Transformation Taskforce (PTTF) has developed standards for a community focused program to address identified equity gaps. The community approach recognizes the role social and cultural factors can play in contributing to gaps in care and seeks to address those issues. The PTTF has identified the use of Community Health Workers and the formation of clinical-community linkages to crucial social services as, at a minimum, the key capabilities needed to address equity gaps.

Patients experiencing health equity gaps are defined as those belonging to a specific subset of patients who are experiencing a disparity in care demonstrated through a differences in treatment patterns and/or health outcomes. The community focused equity gap intervention will be designed around x,y,z population subsets (TBD) experiencing gaps in clinical outcomes aligned with the CT SIM quality score card (provisionally, this may include diabetes, asthma, and hypertension). Health equity gaps often arise from language and health literacy barriers, challenges with the cultural competency of providers, and cultural gaps in methods of patient education. This presents a particular challenge amongst patients who have more complex chronic illnesses that often contain lifestyle components as part of the treatment. A wealth of research suggests that Community Health Workers (CHWs) can successfully address the gaps in care patients experience and improve overall outcomes (Perez-Escamilla R, 2014) (Institute for Clinical and Economic Review, 2013). Similar to the role a CHW plays as a member of a multidisciplinary team, the CHW addressing health equity gaps will:

- Support the individual to address psychosocial barriers to care through identifying and connecting the patient to needed social and behavioral support and act as a representative of those needs within the clinical setting
- In the short-term, work with the patient to establish clinical and non-clinical care goals and support them in meeting those goals
- Through the more intensive process of working with the patient to address equity gaps, improve overall patient engagement to support longer-term self-care management

While the role of CHWs to address equity gaps is similar to the role played on a multidisciplinary care team it also differs in several key ways:

- The CHW training will be focused on providing disease specific training, health promotion, education and peer support
- The knowledge base of community resources and established community resource relationships will differ as they will likely need to be more disease state specific and/or geared toward addressing cultural needs
- The CHW does not need to be part of a multidisciplinary team, but should have frequent and formal interactions with or be part of the primary care team

In addition to the CHW the Advanced Network/FQHC should develop formal relationships with 1-2 community organizations that will support addressing the needs of their target population.

Program Standards:

A. Establish analytic method to identify equity gaps (as defined by the PTTF) within the Advanced Network/FQHC attributed population to determine who is eligible for the Health Equity Improvement Program

B. Draft and implement process to deploy Community Health Workers to practices to work with patients experiencing equity gaps

C. Define role of Community Health Worker and necessary training protocols

D. Develop a needs assessment that evaluates the patients clinical, social, and behavioral needs with emphasis on social and behavioral barriers contributing to equity gaps

E. Draft and implement a process for administering the needs assessment

F. Develop a standardized care plan for CHW to complete for each patient

G. Draft and implement policies for Community Health Worker integration into primary care team and oversight of CHW work by primary care practice

H. Draft and implement guidelines for Community Health Worker interaction with patient

I. Draft and implement process for tracking patient progress on the care plan and making that information available to the primary care team

J. Develop and execute relationships with housing, economic, and nutrition/food security assistance organizations for the Community Health Worker to draw on to execute the care plan

K. Draft and implement guidelines for connecting patients with other community resources with which the Advanced Network/FQHC does not have formal linkages

L. Develop program evaluation parameters and capabilities to be reviewed and updated on an annual basis

M. Develop or identify criteria to identify when patient can be discontinued from Health Equity Improvement Program

Implementation Approach

A. Establish analytic method to identify equity gaps (as defined by the PTTF) within the Advanced Network/FQHC attributed population to determine who is eligible for the Community Focused Equity Gap intervention [Design Group 3]

- Describe method of analysis [TBD – level of specificity]
    - Should stratify attributed patients by race and evaluate differences in diabetes, asthma, HTN, LDL screening, and Colorectal screening
    - Confirm base rate is large enough to reliably demonstrate a significant difference
- Identify data source(s) for analysis

- Generate list of attributed patients who are eligible for the Community Focused Equity Gap Intervention and will be targeted for enrollment
- If applicable, generate list of eligible patients at least every _____ months

B. Draft and implement process to deploy Community Health Workers to practices to work with patients experiencing equity gaps

- AN/FQHC should establish a relationship/agreement with a Community Health Worker organization with CHWs trained in the specified clinical area identified for intervention
- Determine reasonable caseload per CHW and process to assign CHWs to patients

C. Define role of Community Health Worker and necessary training protocols

- **CHWs training protocol should require specific training in the disease state of the equity gap being addressed and result in _____certification**
- The CHW job description should include, at a minimum, the following key responsibilities (Health Management Associates, 2012; NCQA, 2015):
  - Staying up to date on key educational topics relevant to their patient population
  - Maintaining relationships with key community resources
  - Pro-actively reaching out to the patient to assess ongoing needs and promote continuity of care to improve health outcomes
  - Represent the social and behavioral needs of the patient in the clinical setting and surface any barriers the patient is experiencing preventing him/her from achieving improved health status
- The CHW should have, at a minimum, the following background (Health Management Associates, 2012; Perez-Escamilla R, 2014):
  - Representative in some manner of the patient population they are supporting (e.g.; culturally, geographically, clinical profile, etc.)

D. Develop a needs assessment that evaluates the patient's social and behavioral needs with an emphasis on social and behavioral barriers leading to equity gaps (Perez-Escamilla R, 2014) (NCQA, 2015)

- The needs assessment should focus on behavioral and social (in particular cultural and language needs) needs that are impacting the clinical area in which the AN/FQHC has identified equity gaps
- The behavioral assessment should cover mental health, substance abuse, and trauma that may be impacting the patient's ability to achieve better health outcomes
- The social needs assessment should cover family/social/cultural characteristics, communication needs (including language needs), behaviors affecting health, assessment of health literacy, and barriers to care

E. Draft and implement a process for administering the needs assessment

- The needs assessment should be conducted in the patient's home (Perez-Escamilla R, 2014)
- The assessment should be made available by electronic means to the patient's primary care team (Health Management Associates, 2012)

F. Develop a standardized care plan for CHW to complete for each patient

- The care plan should map to the behavioral and social needs/barriers to care identified in the needs assessment
- The care plan should contain:_____

G. Draft and implement policies and procedures that define how CHWs will function within the primary care team and otherwise integrate their roles into the primary care work flows (Honigfeld L, 2012)

- CHWs will report to _____
- CHWs will participate in meetings with primary care team to discuss challenges/barriers patients are experiencing and to identify potential solutions
- Establish how frequently CHW will meet with primary care team
- Topics covered on the agenda should include:_____
- CHWs will be responsible for collecting and tracking _____ data for the primary care practice

H. Draft and implement guidelines for Community Health Worker interaction with patient

- Establish the minimum number of interactions the CHW should have with the patient
- Define a timeline for which interactions between the CHW and the patient should occur and in what setting the CHW will interact with the patient

I. Draft and implement process for tracking patient progress on the care plan and making that information available to the primary care team

- Define standardized set of information to document on care plan during each patient interaction
- Establish timeframe within which CHW should update the care plan and create a progress note for the patient after every interaction
- CHWs should be responsible for collecting and tracking patient data (i.e.; progress note, updates to care plan, newly identified challenges/barriers) related to the care plan for the primary care practice
- Develop capabilities for care plan to be accessible to the primary care team

- Develop capabilities for the CHW to routinely communicate key information captured through patient interactions with the primary care team in between formal team meetings (e.g.; direct messaging)

J. Develop and execute relationships with housing, economic, and nutrition/food security assistance organizations for the Community Health Worker to draw on to execute the care plan

- To be discussed by design group 2

K. Draft and implement guidelines for connecting patients with other community resources with which the Advanced Network/FQHC does not have formal linkages (Health Management Associates, 2012) (NCQA, 2015) **[Will be Addressed by Design Group 2]**

- CHWs should maintain a list of relevant community resources for the patient population they are serving
- CHW is responsible for initiating the patient link to the needed resource and following up to ensure the patient received the necessary assistance
- Referrals made and successfully completed should be tracked in the care plan

L. Develop program evaluation parameters and capabilities to be reviewed and updated on an annual basis [Will be Addressed by Design Group 3]

- Develop process metrics reflective of process design that at a minimum include:
  - # of enrollees out of total eligible patients (% enrolled)
  - # of care plans completed for enrolled patients (% care plan completed)
  - # of in person visits with CHW/# of CHW hours
- Develop outcome metrics reflective of program objectives that at a minimum should include relevant metrics aligned with quality score card:
  - Health Equity Gap Design Group measures
- Establish process to share performance with program participants and develop process to utilize performance outcomes to inform ongoing performance improvement efforts

M. Develop or identify criteria to identify when patient can be discontinued from Health Equity Improvement Program

- Develop or identify evaluation tool that assess patient readiness for care self-management (e.g.; Client Perceptions of Coordination Questionnaire – CPCQ) (Coalition, 2015)

References

Coalition, C. (2015, April 20). Camden Coalition Care Management Initiative. (Chartis, Interviewer)

Health Management Associates. (2012). *Making the Connection: The Role of Community Health Workers in Health Homes.* n/a: New York State Health Foundation.

Honigfeld L, D. P. (2012). *Care Coordination: Improving Children's Access to Health Services.* n/a: Child Health and Development Institute of Connecticut.

Institute for Clinical and Economic Review. (2013). *Community Health Workers: A Review of Program Evolution, Evidence on Effectiveness and Value, and Status of Workforce Development in New England.* n/a: n/a.

NCQA. (2015, June 30). *NCQA*. Retrieved from PCMH 2011-2014 2014 Crosswalk: http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH/PCMH2011PCMH2014Crosswalk.aspx

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