Integrating Peer Support into the Primary Care Team: Public and Private Models of Integration

Manuela McDonough, National Council of La Raza

Lizette Martinez, Peers for Progress

Justin Nash, Brown University and Memorial Hospital of RI

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Patrick Tang, Peers for Progress

PATIENT-CENTERED PRIMARY CARE:
AT THE HEART OF VALUE AND QUALITY

INTEGRATING PEER SUPPORT INTO THE PRIMARY CARE TEAM

Patrick Yao Tang, MPH

Peers for Progress

American Academy of Family Physicians Foundation

PCPCC Fall Conference
November 13, 2014
Washington, D.C.

INTEGRATING PEER SUPPORT INTO THE PRIMARY CARE TEAM

Peers for Progress
Peer Support Around the World
A Program of the American Academy of Family Physicians Foundation

AMERICAN ACADEMY OF FAMILY PHYSICIANS FOUNDATION

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TransforMED℠

TALKING POINTS

- Evidence for Peer Support (PS)
- PCMH Key Features and PS Utilities
- Models of PCMH-PS Integration
- Lessons for Implementation

SOCIAL RELATIONSHIPS & HEALTH

SOCIAL RELATIONSHIPS & HEALTH

- Social support is a fundamental need for health and well-being
- A key factor in motivating behavior change and maintenance
- Support from “someone like me” is trusted and valued

WHO PROVIDES PS

- *Community health workers*
- *Promotores de salud*
- *Peer health coaches*
- *Lay health advisors*
- *Sponsors*
- *Volunteers*
- *Friends*

4 KEY FUNCTIONS

PEER SUPPORT WORKS

Harnesses **inter**personal relationships to activate **intra**personal change

- Feasible across settings and populations
- Reaches, engages, retains intended populations, including “hardly reached”
- Effective across clinical and QoL outcomes
- Especially effective among high-risk groups

PATIENTS LIKE IT

- Access: convenient, responsive, timely
- Ease of communication: non-directive, non-judgmental, culturally competent
- Security: reduce unknowns, emotional support, someone that's there for them
- More than health: solving concrete problems in patient's lives

PROVIDERS BENEFIT

- Encourages appropriate utilization of health care resources
- Improves patient-provider relationships
- “The doctor helps me decide what to do, the peer supporter helps me figure out how to do it.”
- Growing evidence of cost-effectiveness

NCQA PCMH Standards

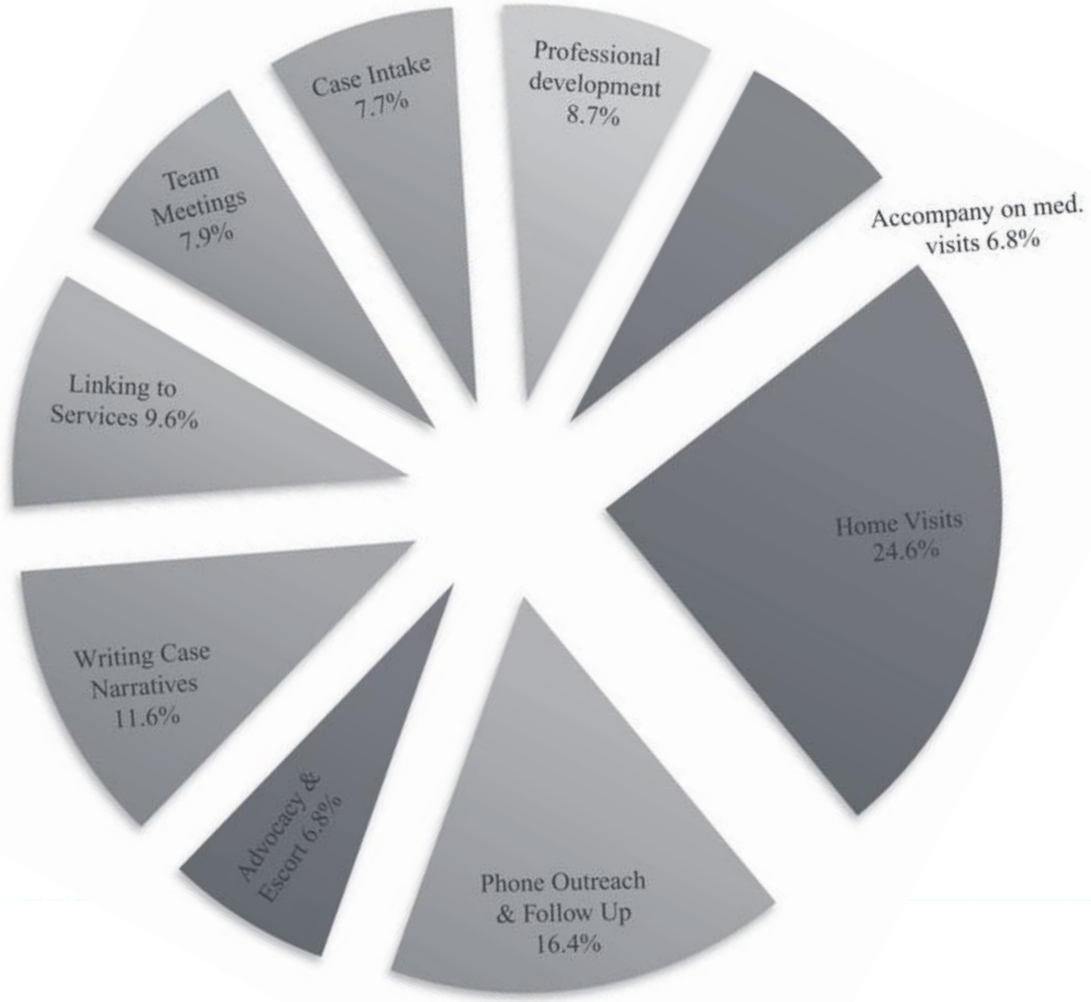
Patient-Centered Access	1A: Patient-Centered Appointment Access
Team-Based Care	2A: Continuity 2C: Culturally and Linguistically Appropriate Services 2D: The Care Team
Population Health Management	3A: Patient Information 3C: Comprehensive Health Assessment
Care Management and Support	4B: Care Planning and Self-Care Support 4C: Medication Management 4E: Support Self-Care and Shared Decision-Making
Care Coordination and Care Transitions	5B: Referral Tracking and Follow-Up 5C: Coordinate Care Transitions
Performance Measurement and Quality Improvement	6C: Measure Patient/Family Experience

PERSON-CENTEREDNESS

- Patient choice and empowerment
- Shared decision making
- Culturally sensitive
- Care personalized to the individual


Social Worker
Pharmacist
Nurse
Patient
Care Manager
Physician
Peer Supporter

TIME ALLOCATION BY TASK



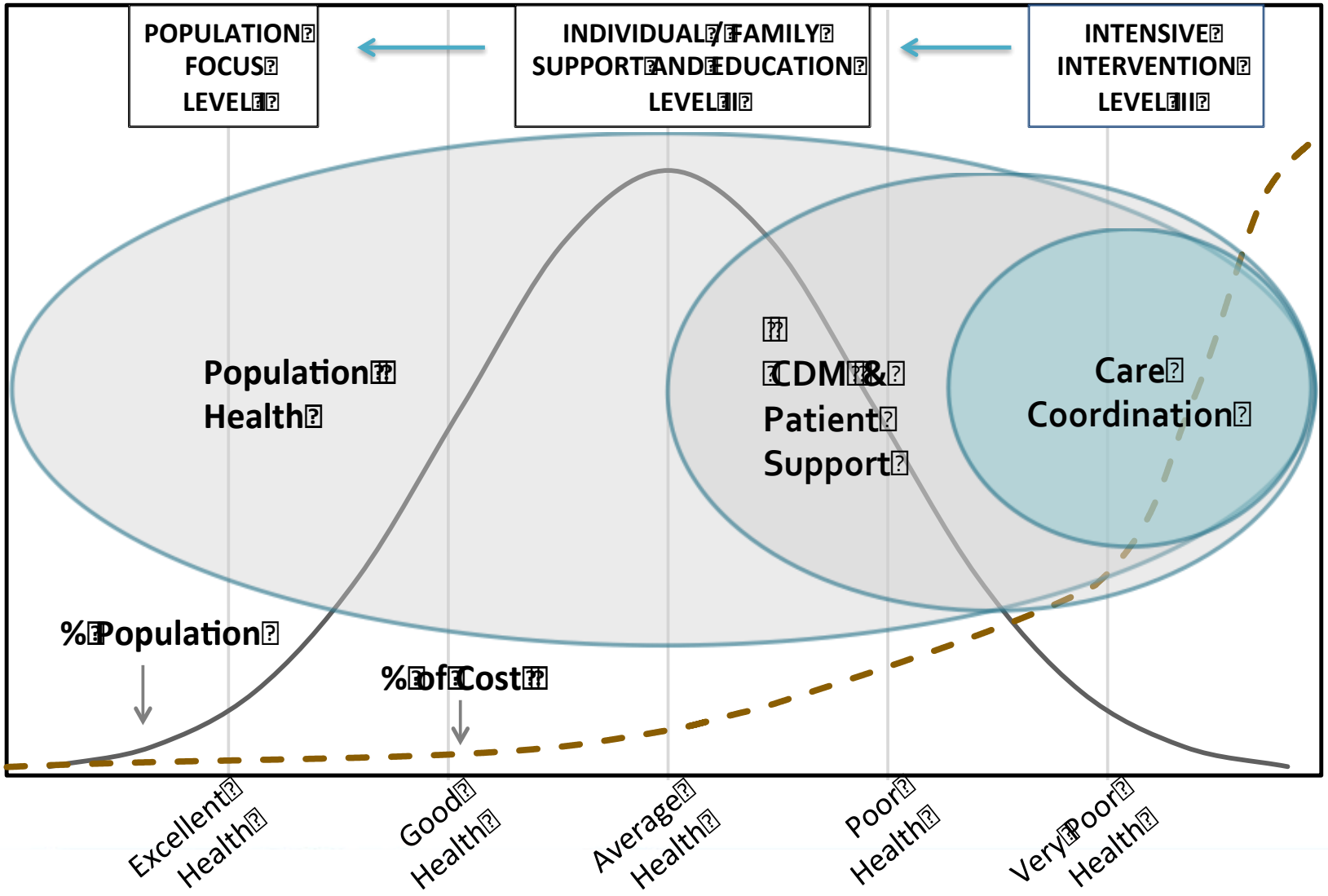
Findley et al. 2014

POINT OF CARE AND BEYOND

- Health care in the clinic and the community
- Support across the lifespan and chronic disease progression
- More touches, higher quality touches

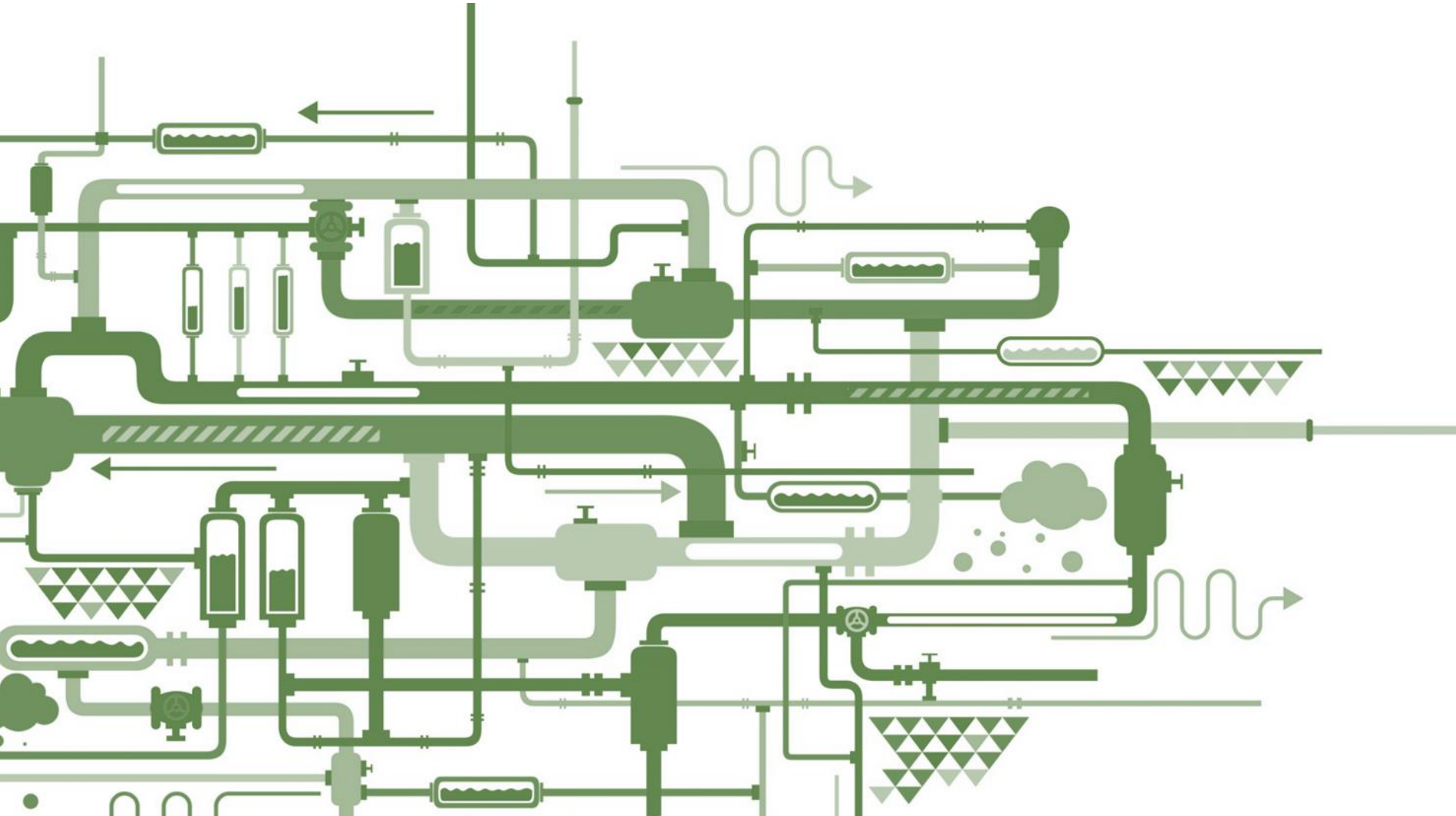
PROACTIVE POPULATION MANAGEMENT

- Risk Stratification
- Tool to identify gaps, such as registry or EMR
- Extends support to the right people at the right time



Kaufman A, Alfero C, et al. University of New Mexico & HMS – Center for Health Innovation

MODEL OF INTEGRATION



MODEL OF INTEGRATION

ALIVIO MEDICAL CENTER
An Active Presence for a Strong Community

- FQHC in Chicago, IL
- Serving 3,700 Latino adults with Type 2 diabetes

MI SALUD ES PRIMERO

MY HEALTH COMES FIRST

- 1 Program Manager
- 1 Program Coordinator / Training Supervisor
- 8 Compañeros en Salud / CHWs
- Primarily telephone contact
- Available onsite at the clinic

3,700 PATIENTS WITH DIABETES

High Need Group	Regular Care Group
• HbA1c > 8%, Psychosocial Distress, Physician's Referral • 471 of the 3,700 • Bi-weekly contacts for 12 weeks • Monthly contact for 6 months until no longer meet criteria for High Need or until progress has stabilized • Quarterly thereafter	• Quarterly contacts, encourage clinical care and use of resources (e.g., group classes) and self-management • Transition to High Need as needed

Diabetes Self-Management (DSM) Services at Alivio	Regular Care	High Need
Overall DSM program/services at Alivio *Everybody receives same services and messages about diabetes*	X	X
Compañeros en Salud Community Events *Increase diabetes awareness, promote screening, diagnosis, and referral*	X	X
Primary care PCMH clinical health services *Quarterly visits, care plan*	X	X
CES as a resource *Encourage use of community resources (healthy food, physical activity, etc.)*	X	X
Open events / drop-in activities *Health fairs, weekly info table in clinic lobby*	X	X
Diabetes self-management education *Group or individual*	X	X
Support groups *Bi-weekly, monthly*	X	X
Individual, intensive support for DSM		X

AN ORGANIZATIONAL HOME

- PCMH provides structure and support that enables compañeros to focus on their unique role
- Health care providers provide essential supervision and backup of compañeros
- Compañeros highly effective at community outreach and engaging new patients

ADDITIONAL READING

Findley S, Matos S, Hicks A, et al. (2014). Community Health Worker Integration Into the Health Care Team Accomplishes the Triple Aim in a Patient-Centered Medical Home: A Bronx Tale. J Ambul Care Manage, Jan-Mar;37(1):82-91. [Abstract]

Matiz LA, Peretz PJ, Jacotin PG, et al. (2014). The Impact of Integrating Community Health Workers Into the Patient-Centered Medical Home. J Prim Care Community Health, Oct;5(4):271-4. [Abstract]

Volkmann K & Castañares T. (2011). Clinical Community Health Workers: Linchpin of the Medical Home. J Ambul Care Manage, Jul-Sep;34(3):221-33. [Abstract]

Wennerstrom A, Bui T, Harden-Barrios J, Price-Haywood EG. (2014). Integrating Community Health Workers Into a Patient-Centered Medical Home to Support Disease Self-Management Among Vietnamese Americans: Lessons Learned. Health Promot Pract, Aug 19. [Abstract]

Zahn D, Matos S, Findley S, and Hicks A. (2012). Making the Connection: The Role of Community Health Workers in Health Homes. NYS Health Foundation, September 2012. [Abstract]


Lessons for integrating peer support and primary care
ABC

LESSONS LEARNED

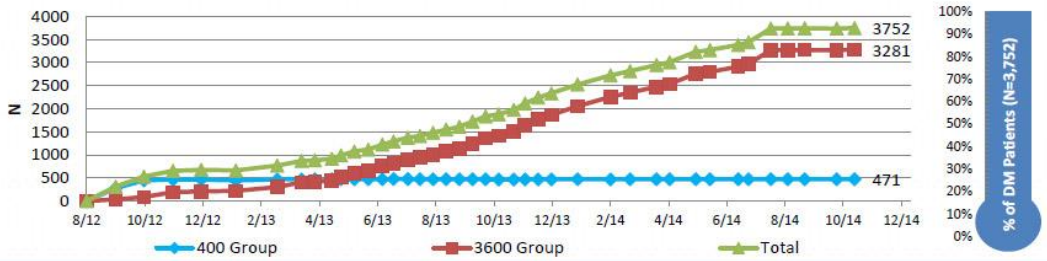
- Cross-training for continuity
- Regular training to reinforce concepts
- Define measures of success early
- Consistent measurement for QI

PROGRAM MONITORING

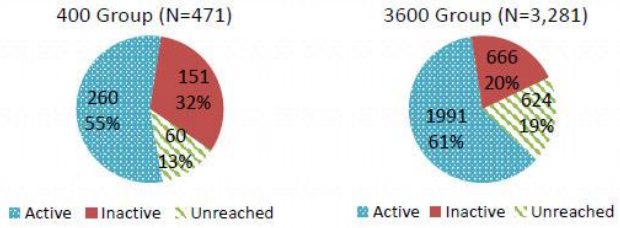
October 30, 2014 | ALIVIO MEDICAL CENTER | ¡Mi Salud es Primero!

Peers for Progress Chicago Program Monitoring Report

Total Number of Patients by Group



Active Status by Group at Last Contact



No Further Contact (N=857)	N (%)
No longer patient	510 (60%)
Moved	38 (4%)
Unable to reach	101 (12%)
Refused emphatically	43 (5%)
Deceased	36 (4%)
Multiple reasons	23 (3%)
Other	106 (12%)

Intensity of Contacts: 400 Group and 400-Actives

	400 All N (%)	400 Actives N
High intensity (bi-weekly)	2 (1)	0
Moderate intensity (monthly)	77 (20)	46
Low intensity (quarterly)	309 (80)	214

Intensity of Contacts: 3600 Group and 36-Actives

	3600 All N (%)	3600 Actives N
High intensity (bi-weekly)	10 (0)	9
Moderate intensity (monthly)	18 (1)	16
Low intensity (quarterly)	2209 (99)	1777

Monthly Total Number of Successful Contacts

LEADERSHIP AND ORGANIZATIONAL COMMITMENT

- Influential champion in the medical leadership
- Administrative commitment to the model
- Reinforce attitudes by demonstrating improved outcomes and lower costs

SECURING PROVIDER BUY-IN

- Involve providers in the program planning and training process
- Develop clear scope of work so staff understand roles
- Build team relationships to enhance mutual respect and understanding

FINANCING

- Value-based payment models
- Shared savings, bundled payment, capitation – predicated on care coordination, efficiency, and quality
- Wellness trusts
- Affordable Care Act provisions


Peers For Progress |
peersforprogress.org
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Peer Support Around the World
A Program of the American Academy of Family Physicians Foundation
Accelerating Best Practices In
Peer Support Around the World
WHAT WE DO
Who We Are
Learn About Peer Support
Promote Peer Support
Get Connected
Take Action
Tools & Training
News & Events
National Peer Support Network
A Learning Community of Peer Support
Our global network of peer support organizations is always growing
>JOIN THE GLOBAL NETWORK
FROM THE BLOG
Comparing Diabetes Support in 3 Countries
Clayton Vellicer, MPH Our website has frequently promoted peer support and community health worker programs around...
READ MORE >
Relationship Styles to Enhance Mental Health Peer Support
Jewels Rhode, MPH student Research has shown that the development of meaningful relationships is an essential part...
READ MORE >
HEADLINES & FEATURES
Upcoming Webinars in November
Three upcoming webinars for those interested in diabetes care. Diabetes Management: Peer Support, Patient-Centered...
READ MORE >
October Newsletter: From Planning to Action
How do you encourage people to take action to move peer support programs forward? For us, it means educating people,...
READ MORE >
SCIENTIFIC EVIDENCE
A Lay Arthritis Self-Management Program in Hong Kong
Clin Rheumatol. 2014 Oct 8. [Pubmed Abstract] A pilot evaluation of Arthritis Self-Management Program by lay leaders...
READ MORE >
Impact of Integrating CHWs into the Patient-Centered Medical Home
J Prim Care Community Health. 2014 Oct;5(4):271-4. [Pubmed Abstract] The impact of integrating community health...
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PATIENT-CENTERED PRIMARY CARE:
AT THE HEART OF VALUE AND QUALITY

¡Mi Salud es Primero!

PROGRAMA DE DIABETES

Lizette Martinez
Alivio Medical Center
Compañeros en Salud
Community Health Worker

Alivio Medical Center
An Active Presence for a Strong Community

Project Description

¡Mi Salud es Primero!
PROGRAMA DE DIABETES

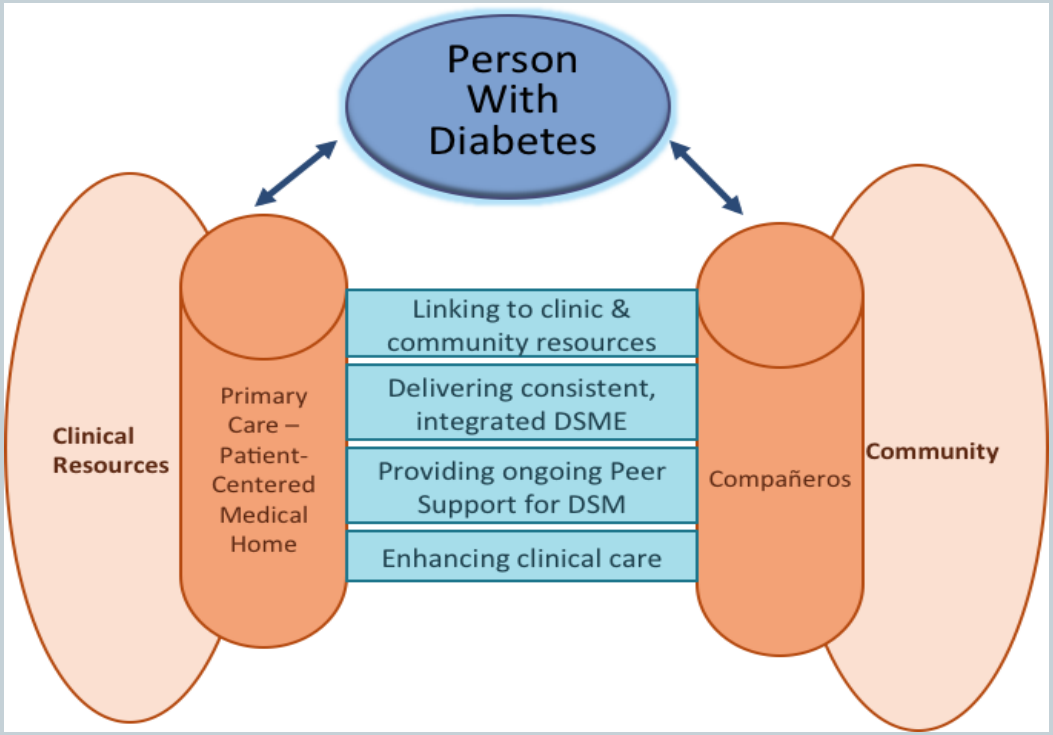
Diabetes Self Management Support (DSME)

- Engage low income minorities to improve self-mgmt (med adherence, PA, healthy diet, glucose monitoring) and other key outcomes in diabetes (A1c, BP, BMI, etc.)
- Assistance in daily management
- Social and emotional support
- Linkage to care
- Ongoing support, extended over time

The DSME Team

MY HEALTH COMES FIRST TEAM

- Manager, Coordinator and 8 Diabetes Health Educators



Health educators received ongoing training

- Diabetes Self-Management Education
- Risk Reduction and Prevention of Diabetes complications
- Motivational interviewing
- Problem Solving
- First aid in Mental Health
- Affordable Care Act.

Peers Support Focus

- Listening
- Encouraging
- Guidance

Successes

"in my 17 years of being a diabetic, I've never reached 100's.....not even 95 fasting!"

" I learn how to eat and I'm teaching my neighbor about what I've learned"

"If I would've known taking insulin would help me feel so much better I would've started sooner"

Successes

- Working as a Team within the DSME program
- Help pt obtain MD appts, eye referrals, glucometers and strips, medication assistance, community resources
- Providers received updates on their patients
- Support Group
- Diabetes Self Management Education classes
- One-to one interactions
- Setting small goals

Challenges

- Gain trust from our patients, especially the most resistant patients
- Gain the trust of the providers and clinical staff
- Breaking Silos among Departments and staff
- Balancing the case load of patients

Lessons Learned

- Patient contacts should be flexible, nondirective but also focused on at least 1 of the 7 key DSM behaviors
- Support/supervision/training of CHWs/CES/peer supporters must ongoing and consistent
- Allow for CHWs/CES/peer supporters to learn from and support each other

Mi Salud es Primero
Programa de Diabetes

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PATIENT-CENTERED PRIMARY CARE:
AT THE HEART OF VALUE AND QUALITY

Developing peer support on a behavioral health team in a PCMH

Justin M. Nash, PhD; Judy DePue, EdD; Daniel Evans, PhD; Marisa Sklar, MS

Brown University and Memorial Hospital of Rhode Island

PATIENT CENTERED PRIMARY CARE COLLABORATIVE

WASHINGTON DC

THURSDAY, NOVEMBER 20

NATIONAL PEER SUPPORT
Collaborative Learning Network

Peers for Progress
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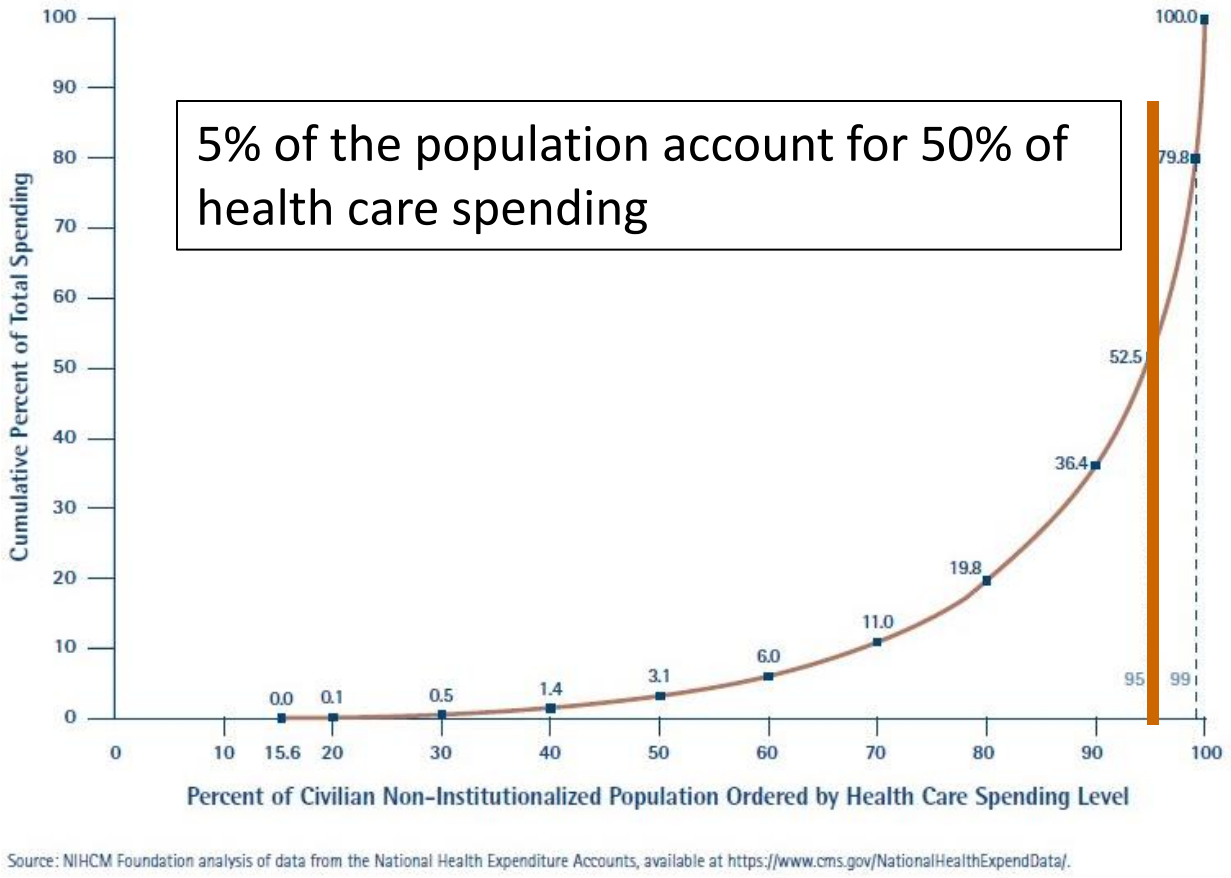
Concentration of health care spending



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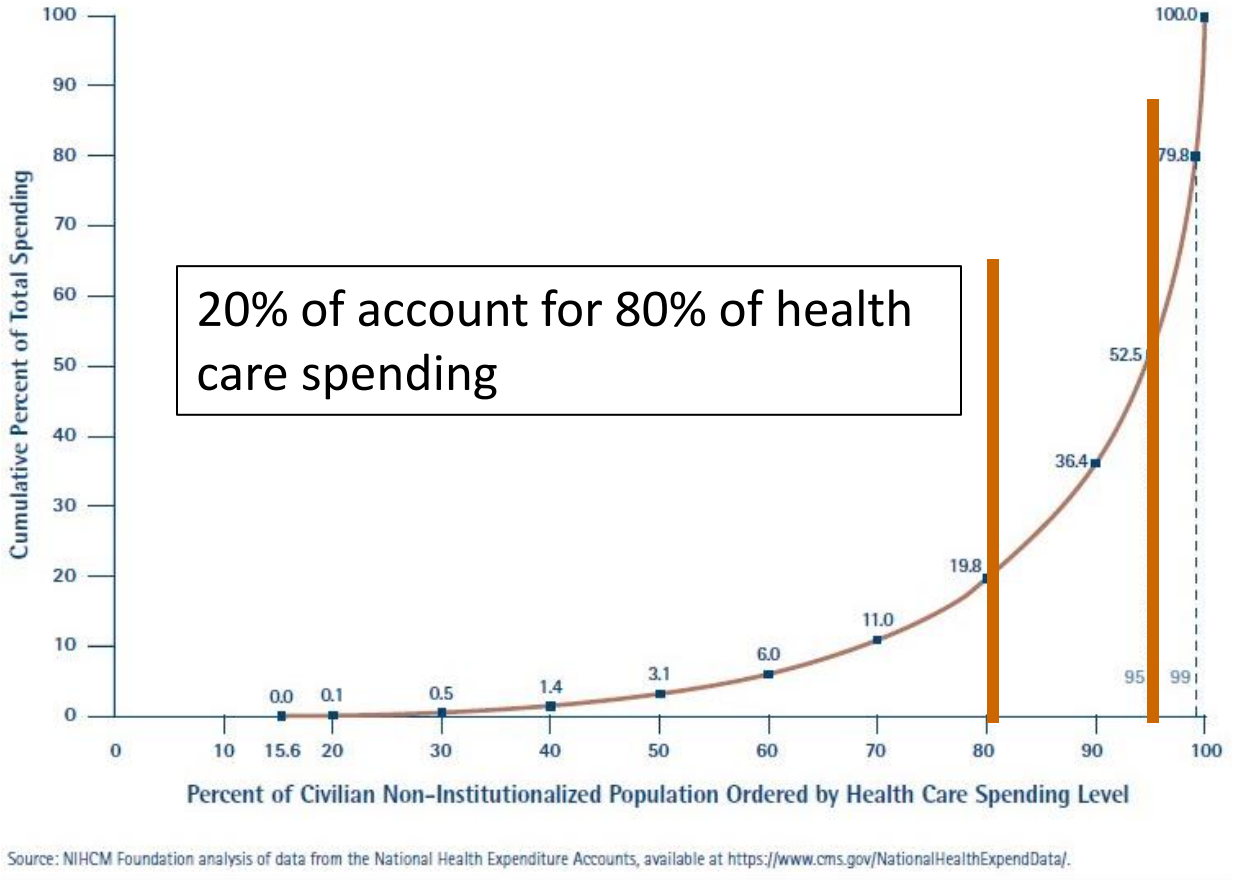
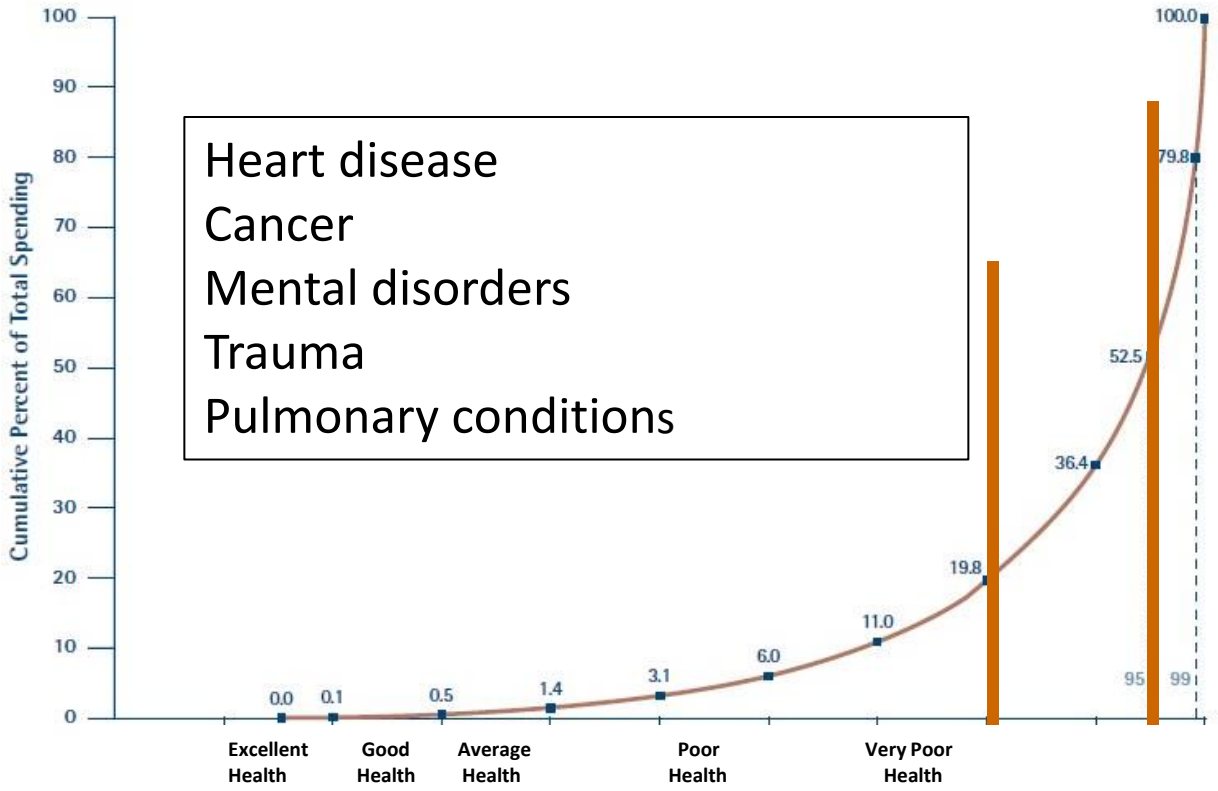
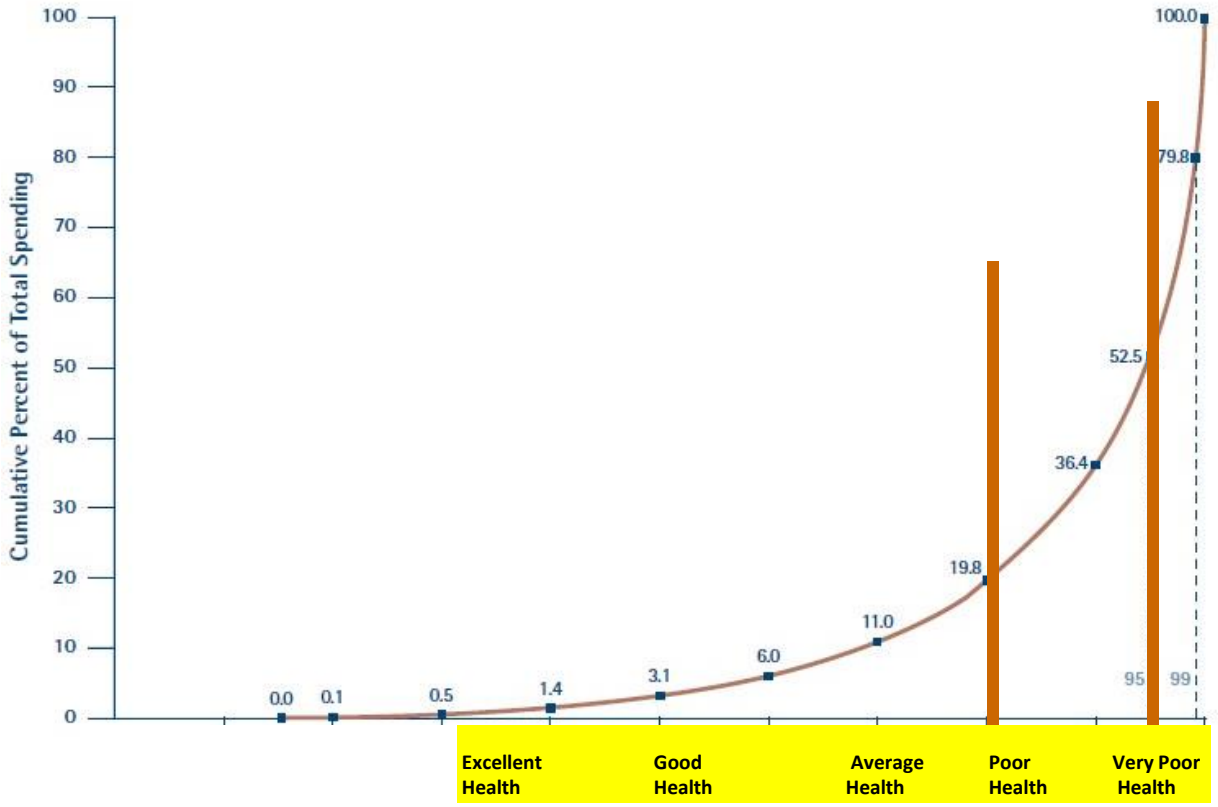


Health conditions that account for cost



Source: NIHCM Foundation analysis of data from the National Health Expenditure Accounts, available at https://www.cms.gov/NationalHealthExpendData/.

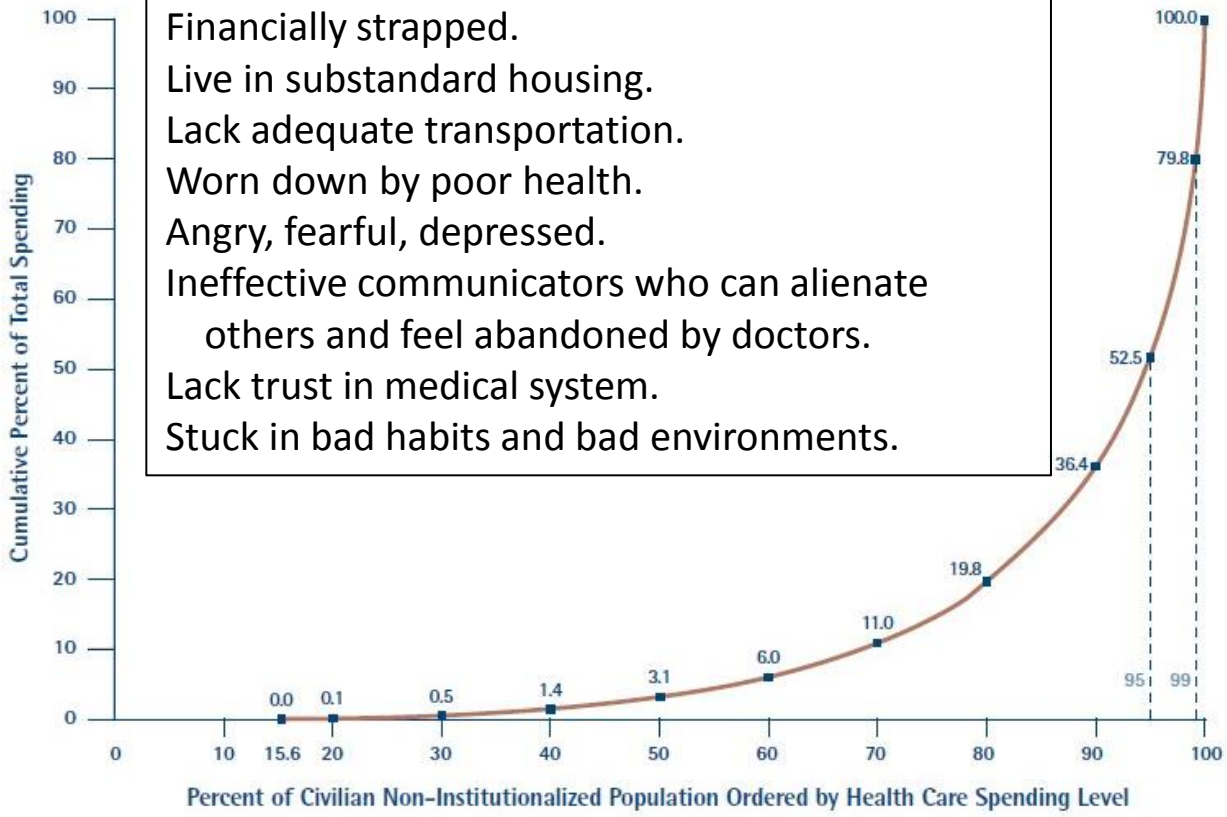
Health conditions related to cost



Source: NIHCM Foundation analysis of data from the National Health Expenditure Accounts, available at https://www.cms.gov/NationalHealthExpendData/.

What else characterizes those in poor health

Financially strapped.
Live in substandard housing.
Lack adequate transportation.
Worn down by poor health.
Angry, fearful, depressed.
Ineffective communicators who can alienate others and feel abandoned by doctors.
Lack trust in medical system.
Stuck in bad habits and bad environments.



Source: NIHCM Foundation analysis of data from the National Health Expenditure Accounts, available at https://www.cms.gov/NationalHealthExpendData/.

Objectives of behavioral health integration in primary care

- Improve health and patient experience while reducing costs
- Impact behavioral health, including serious mental illness
- Impact chronic disease through prevention and management

The Family Care Center

- NCQA Level 3 PCMH
- Hospital-based, academic teaching practice that provides training to Brown University medical students, family medicine residents, and psychology residents
- 13 faculty + 39 residents; 27 exam rooms
- Serves 12,500 active patients → 30,000 visits annually
- Diverse socioeconomic, ethnic, and racial patient population; 32% identify as Latino and 12% as Black

Ongoing challenges that are informing further behavioral health integration

- Patients who are not seeking service are not having needs addressed
- Brief visit with individual behavioral health clinician has limited impact given complexity of psychosocial and medical problems
- No mechanism to easily connect patients to needed community resources
- Medications do not address the social determinants affecting health
- Limits to population management: Behavioral health metrics like the PHQ-9 not routinely administered and recorded

Principles guiding further integration of behavioral health in Family Care Center

- Physicians, nurses, and medical staff manage and will continue to manage the bulk of behavioral health care
- Focus is on impacting population of patients within and across the practice
- Quality improvement process and use of Electronic Medical Record and other technology to guide approach
- A *system* of care is needed
- Care is *team*-based
- Complex patients require connecting to resources in community including specialty behavioral health and other community agencies

Enhancing team-based and population-based care

- Team case conference at end of open access clinics to collaboratively develop plan for patients and connect with community resources
- Create a multidisciplinary team to provide virtual consultations to physicians in their management of patients
- Develop patient registry and quality improvement process to identify patients in need and track treatment progress
- Incorporate peers from the community to serve in a support role for patients in the practice

Project

The aim is to create a model of peer support for behavioral health in diabetes patients that targets the combination of depression (or other mental health issues) and diabetes in primary care.

Eight patients will be identified, trained, and serve on the behavioral health team as peer supporters .

Patients will be supported by peers in their management of both depression (or other mental health issue) and diabetes.

Selection of peers

Inclusion

- Live in community
- Type 1 or type 2 diabetes that was diagnosed at least 1 year prior
- Diagnosis of depression and/or anxiety is preferred, but not required
- History of successfully coping with diabetes
- Personal qualities that are well-suited for the role of peer supporter (i.e. personable, nonjudgmental, good listener and communicator)

Exclusion criteria

- Substance misuse (AUDIT≥8 and/or DUDIT>8 (for men) >6 (for women))
- Serious mental illness (i.e. Bipolar disorder, psychotic disorder, suicidal)

Selection of patients

Inclusion

- Live in community
- Type 2 diabetes (HbA1c ≥8 in the past year)
- Evidence of psychosocial distress, defined as
  - Elevated diabetes-related distress (mean DDS>3) and one or both of:
    - Diagnosis in the medical record of depression (PHQ-9≥10)
    - Diagnosis in the medical record of anxiety (GAD-7≥10)

Exclusion:

- Substance misuse (AUDIT≥16 and/or DUDIT>8 (for men) >6 (for women))
- Serious mental illness (i.e. Bipolar disorder, psychotic disorder, suicidal, inpatient past 6 months)

Peer/patient meetings and scope of peer role

Monthly in person meetings in the primary care clinic and weekly phone contact

Scope of role includes

- Provide support through active listening, discussing concerns
- Serve as coping models for patients in self-management
- Connect the patient to community resources

Scope of role does not include

- Role as treatment providers, extenders of clinicians, or agents of the clinic
- Answering medical questions or providing medical advice
- Advising patients on depression or other behavioral health issue
- Helping with urgent behavioral health or medical issues

Training and supervision of peers

Training focuses on support skills

- Understanding the peer supporter role and the primary care setting
- Understanding depression, diabetes, and self-management
- Communication skills including reflective listening
- Healthy coping skills with diabetes
- Understanding social support

Supervision in groups

- Twice monthly team meetings with behavioral health and medical provider
- Individual phone and in person meetings as needed

Indicators of program sustainability

Practice support of incorporating patients as peers

Ability to recruit and retain peers and patients

Ability to train peers sufficiently in role

Frequency and quality of contact

- Patients with peers
- Peers with supervisors
- Patients and peers with primary care professionals

Indicators of program sustainability

Satisfaction, helpfulness, and impact of the program

- For patients, peers, and primary care professionals

Impact on peers and patients

- Connection of patients and peers to community resources
- Self-management of diabetes (peers and patients)
- Self-management of depression or other behavioral health issue
- Symptom measures (PHQ-9, Diabetes Distress Inventory)

Acknowledgements

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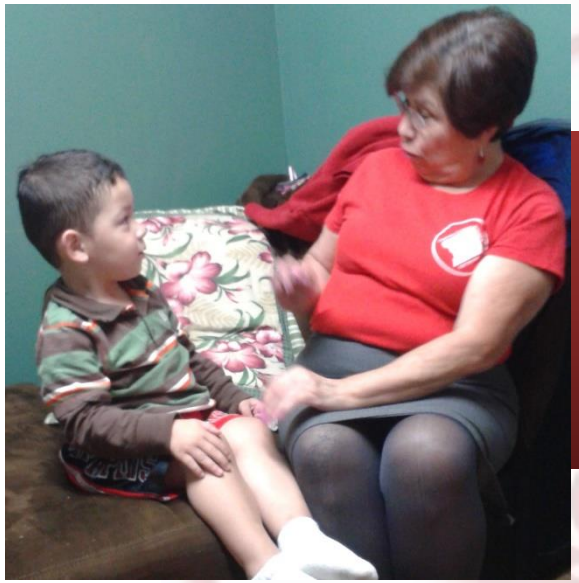
CAPITAL CLINICAL INTEGRATED NETWORK



COMMUNITY HEALTH WORKERS WITHIN THE HEALTHCARE SETTING

GINA PISTULKA, PHD, MPH, RN, APHN-BC
CHIEF NURSING OFFICER
PCPCC CONFERENCE, NOVEMBER 13, 2014

CMS Innovation

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Goals & Objectives

Funded by the Center for Medicare and Medicaid Services Innovation to Create an Integrated Care Coordination and Care Delivery System

- Improve access and coordination of care within the healthcare system within the District of Columbia. (key linkages, partnerships, technology)
- Improve the health of the CCIN participant population (HEDIS Measures)
- Reduce healthcare costs incurred by CCIN participants over 3 years

Our Partners and Subscribers

CURRENT PARTNERS

- Bread for the City
- La Clinica del Pueblo
- Mary's Center
- So Others Might Eat
- Providence Hospital
- Children's National Medical Center
- Unity Health Care
- Community of Hope
- AmeriHealth DC
- Trusted
- DC Primary Care Association
- DC Healthcare Finance
- Medical Mall
- Core Service Agencies (Green Door, Life Stride, Mary's Center)

Who We Serve

Target Population

- Medicaid and Medicare recipients in the DC area (including parts of Maryland) selected based on *Cost of Care, Health Behavior* leading to *Utilization* of key cost drivers and a wide array of complex *Health Conditions*
  - Covering all 8 Wards
  - Four languages: English, Spanish, Amharic, French

Population Characteristics

- Approximately 2500 enrolled to date
- 39% of participants have hypertension
- 17% of participants have diabetes
- 25% of participants have asthma
- 25% of participants report more than 2 ER visits in past year, prior to enrollment
- 22% of participants are poorly compliant with medications at enrollment

CCIN Core Model

90-day behavior change intervention focusing on community-based care coordination and chronic illness management for residents in the District of Columbia.

- **Community Health Worker**:
  - Functions as the health system educator, navigator and care connector for enrolled participants.
  - Coaches to support behavior change related to improved health. Teach participants to advocate for themselves and how to better communicate with care providers.
- **RN Care Coordinator**:
  - Provides clinical oversight for case management, CHW guidance and supervision, as well as training.
  - RNs utilize their knowledge of pharmacology, pathophysiology, patient care and a deep understanding of the health care system to lead teams of CHWs and help ensure a quality intervention for each enrolled participant.
  - Provide participants with advanced health education, medication adherence support and education, and triage via telehealth and in-person consults.
- **Technology**:
  - Electronic Care Coordination system tailored for CCIN
  - CHWs equipped with mobile devices (laptops, mobile phones, jetpacks, antennas)
  - Rolling out telehealth component
  - Leading the development and launch of the Capital Partners in Care Health Information Exchange

Impacting the Triple Aim

CCIN uses a high-touch, high-tech behavior change intervention to address the TRIPLE AIM of healthcare reform:

IMPROVE THE HEALTHCARE EXPERIENCE, IMPROVE HEALTHCARE OUTCOMES, AND REDUCE COST

Mentor/Coach

· Supports development of tangible skills to promote health and illness management

· Uses common social work approaches: Motivational Interviewing, strength-based approach, and praise to empower participants

Modeling Participant Engagement

· Encourages and teaches participants how to prepare for clinical care team visits, be proactive and able to advocate for their needs and quality services

· Supports clarification of chronic illness management recommendations and practices

Impacting the Triple Aim

Cultural and Language Brokering

· Makes knowledge understandable to a participant, teaching the culture and inner-workings of the health care system

· Advocates for language or literacy needs

· Supports necessary communication between Primary Care Provider and Specialty Providers

System Navigator and Care Connector

· Connects participants to the appropriate level of care to match the level of need

· Assists with finding transportation services

· Finds mental health and substance abuse treatment resources

Hospital As Partner

- Emergency Department
  - Educates on appropriate use of ED
  - Connects to primary care
  - Supports the reduction of barriers to engaging in one's health and with health home.
- Transitional Care
  - Provides community-based follow up for people who are recently discharged
  - Provides support in ensuring the post-discharge appointment is made and attended
  - Ensures prescriptions are filled
  - Works with the RNCC on complex cases

Community Health Centers/Ambulatory Care as Partners

- Patient-Centered Medical Home
  - Acts as a community extension of the care team
  - Supports clinical care plan
  - Assists in patient engagement/re-engagement
- Private Practice
  - Provides care coordination service arm in the community
  - Targets higher cost, more complex patients
- TeleHealth
  - Supports Primary Care
    - Post-ED visit: visual assessment and prescription management or assistance (CHW led)
    - Physical: using Otoscope, stethoscope (RN/LPN led)
  - Supports Mental Health
    - Regular appointments, attendance individual or group counseling

Outcomes to Date

- 100% of participants receive a care plan at their first visit, goals focus on Health Care Utilization and patient identified needs
- 98.3% of participants are visited within 2 weeks of enrollment, the majority in under 1 week
- 72.7% of participants complete the 90 days of the program
- 100% of participants report that CCIN has made a positive impact on their health
- 99% of participants would recommend CCIN to a friend or relative
- 92% of participants attend their scheduled PCP appointment

Estimated Cost Savings

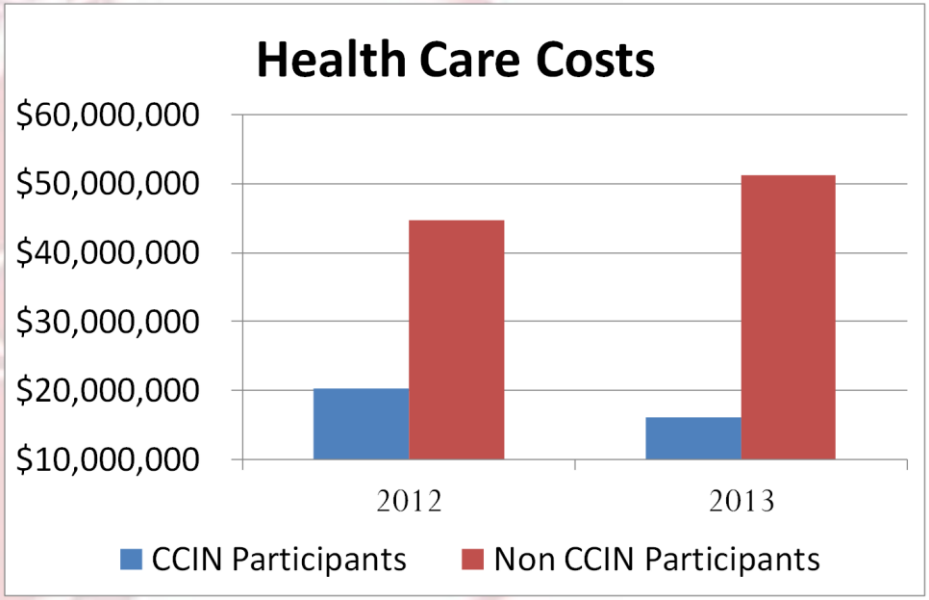
Utilization Change and Cost Comparison:

CCIN Enrolled CY2012 vs. CY2013 (n=1871)

*Decrease in ED visits, in-patient hospitalization, ambulance usage

*Decrease utilization 3.4%

*Estimated $4.2 million reduction (20.6% reduction)



Non-CCIN Enrolled Medicaid CY2012 vs CY2013 (n=1871)

*Increase utilization 23.5%

*Spending increase of $6.5 million (14.7% increase)

Lessons Learned

- Demonstrate value
  - Quantitative data
  - Success stories
- Develop partnerships at every level in the organization
- Work within an entity's workflow
- Consider models that work for the setting: centralized vs inbedding CHWs
- Engage providers to improve recruitment and outcomes
- Communication and collaborative decision-making are important (Board, Subscriber Committee, Technology Committee)
- Provide an opportunity for Participant feedback

Thank you!

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Integrating Peer Support into the Primary Care Team: Public and Private Models of Integration

Manuela McDonough, National Council of La Raza

Lizette Martinez, Peers for Progress

Justin Nash, Brown University and Memorial Hospital of RI

Gina Pistulka, Capital Clinical Integrated Network

Patrick Tang, Peers for Progress

PATIENT-CENTERED PRIMARY CARE:
AT THE HEART OF VALUE AND QUALITY