Novant Health Community Health Worker Program:

Engaging health care extenders in management of those at risk and post stroke

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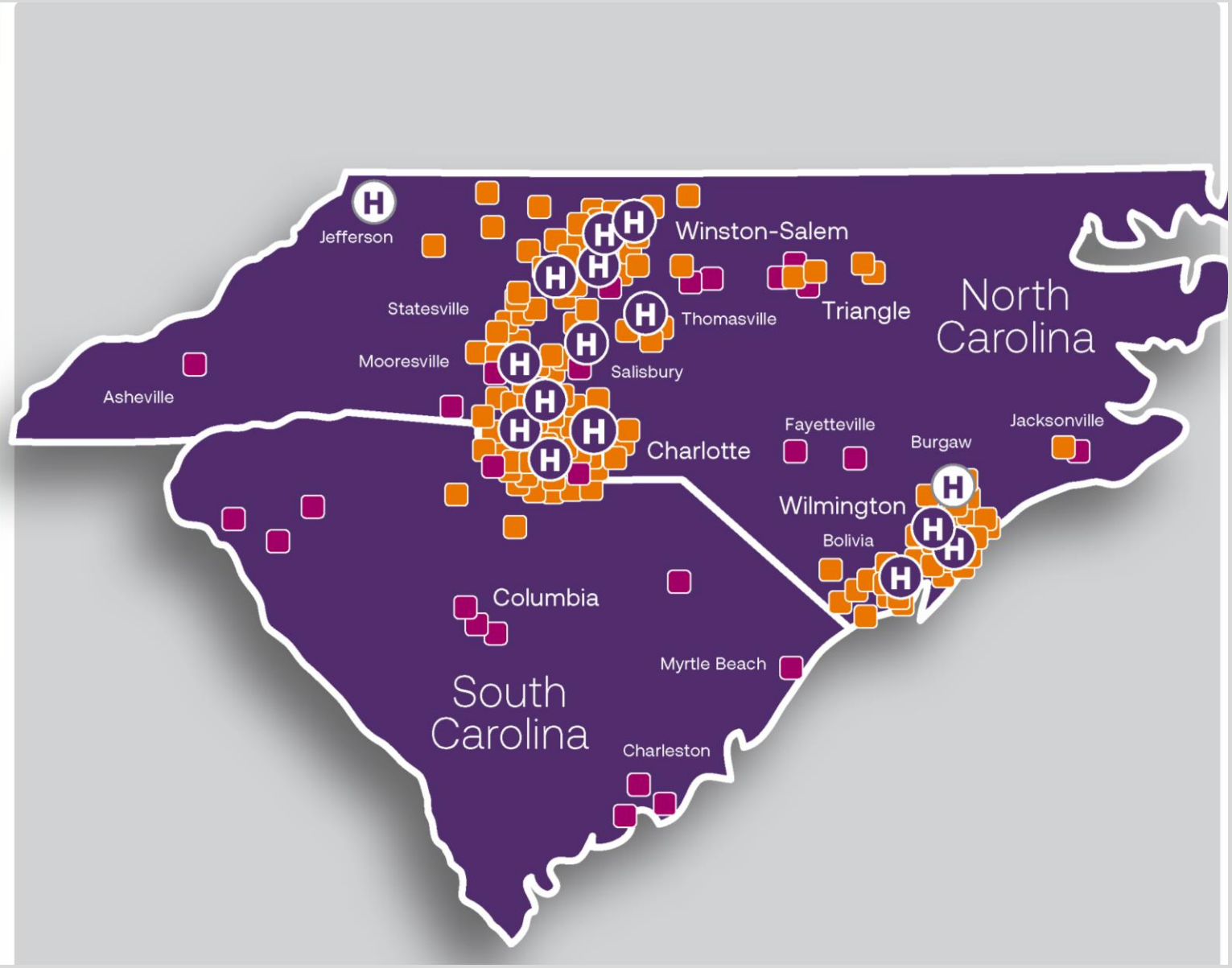
- Medical Centers
- Managed Medical Center
- Physician offices
- Imaging centers



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Our Cause

We create a healthier future and bring remarkable experiences to life.

Discover.

We consistently seek to innovate, courageously transform ourselves and find new ways to add value for our patients, communities and one another.

Empower.

We provide one another, our patients, families and communities with the resources and environment to create shared accountability and action.

Thrive.

We demonstrate equity, empathy, safety and quality to help each other, and our communities, grow and succeed.

Together.

We work as a trusted team with our unique perspectives, life experiences and expertise to bring remarkable to life in every interaction.
We all belong.

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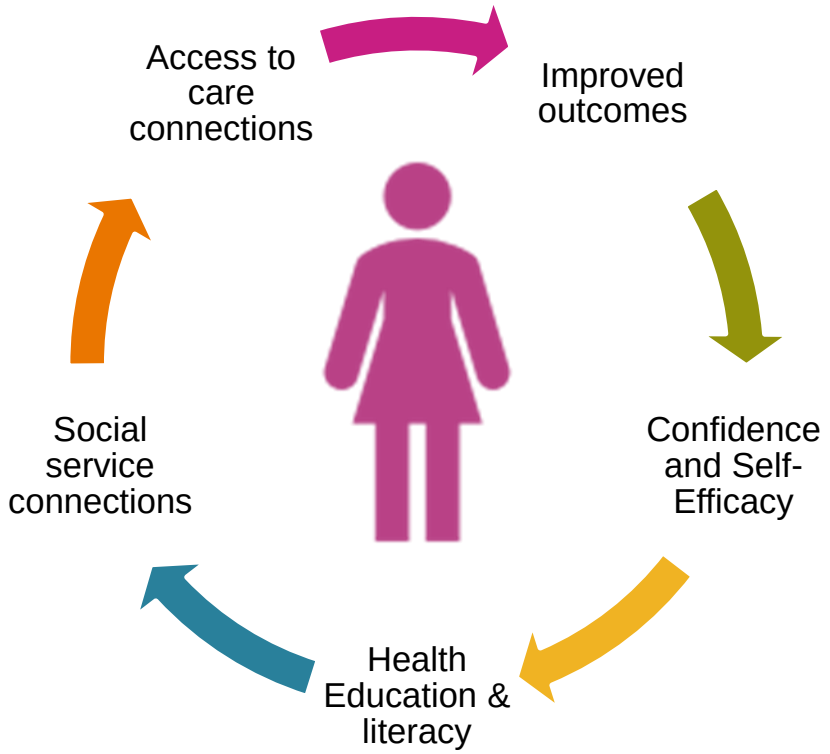
CHW Program Overview: Highlights

CHWs are efficient and effective, reducing unnecessary costs and utilization by connecting our most vulnerable, most complex patients to health and social services. This promotes effective utilization of resources across the continuum and improve the patients' health, upward mobility, and quality of care.

- **Members of Office of Health Equity & Community Health**
- **Connecting with patients outside our four walls**
- **Investing time to change behavior**
- **Providing quality, culturally competent care**
- **Aligned with system facility effectiveness & mortality and care coordination work teams affecting quality metrics**



CHW program overview: models & roles

Acute-embedded:
ED & Institute Support to reduce readmissions and utilization in alignment with quality goals

Community-based:
Community based organization support to provide access to care and social services

Ambulatory-embedded:
Support to reduce readmission/ED use and address root causes at access/equity clinics and with virtual care

2018:

2019:

2020:

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Financial sustainability

- Grant funding to begin and innovate
- Demonstration of impact in alignment with system goals to demonstrate ROI
- Payor partnerships and legislative advocacy
- Future reimbursement opportunities through CMS

CHWs with NC Rep. Amber Baker during CHW Legislative Advocacy Day

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CHW Program Overview: Key Performance Indicators

- Improved health: improved PHQ9 scores and medication adherence
- Improved system efficiency and effectiveness: reduced ED and IP utilization Improved experience: increase in perceived quality, coordination and access to care
- Improved social determinants: decrease in unmet social needs, increase in confidence to improve health

Select examples include:

Reducing ED utilization*	33% decrease in ED utilization
Reducing readmissions**	75% decrease in the first 30 days of intervention among high-risk COPD patients at RMC and PMC.
Improved ED throughput*	CHWs reduce ED visits by 2.5 visits per patient per year. With a possible annual case load of up to 80 patients, this means reducing wait time and opening space for 200 ED patients.
Long-term change in utilization***	30% ED utilization reduction holds steady a year after graduation from the program; overall system utilization (acute and ambulatory) is reduced 2%.
Improved mental health and chronic disease management*	41% of patients demonstrate improved medication adherence; patients' PHQ9 scores reduce by 21% on average.

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Engagement along the care contiuum

Prevention

- **BE FAST Training**
- **Health Screening events**
- **Personal self awareness for team members**
- **Social work intern program**
- **Blood pressure cuff distribution**

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Workflow

Referrals

- Via EPIC Amb Referral to Community Health Worker
- Social work students
- External referral from community partner
- Direct referrals to support team members (documented in ServiceNow platform)

CHW Team Lead manages work queue weekly and assigns cases based on acuity and CHW caseload opening (max caseload 16)

Assigned CHW contacts patient by phone (3 attempts) or via MyChart to schedule initial visit

CHW meets with patient weekly or bi-weekly based on acuity or provides telephonic support to patient regarding needs

Engaged for 30-45 days on avg however time frame of engagement is driven by need

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What does a good referral look like?

- Patient with needs related to social determinants of health (food, housing, access to care, transportation, interpersonal violence)
- Need assessment of patient home environment
- Patient distrusting of medical system and CHW can facilitate communication
- Patient in need of culturally appropriate informal counseling and guidance on health behaviors
- Patient needs help navigating social service systems
- Patient socially isolated
- Patient with significant number of no shows to primary care clinic
- Suspect patient has low health literacy
- Patient with English as a second language
- Patient needs assistance in enrollment in public benefits
- Patient in need of education on advance care planning/notary of HCPOA
- Patient with multiple chronic conditions and in need of motivational interviewing to assist with health goals (diabetes, hypertension, COPD)
- Patient has under treated behavioral health needs
- Suspicion of polypharmacy
- Support for undocumented patients

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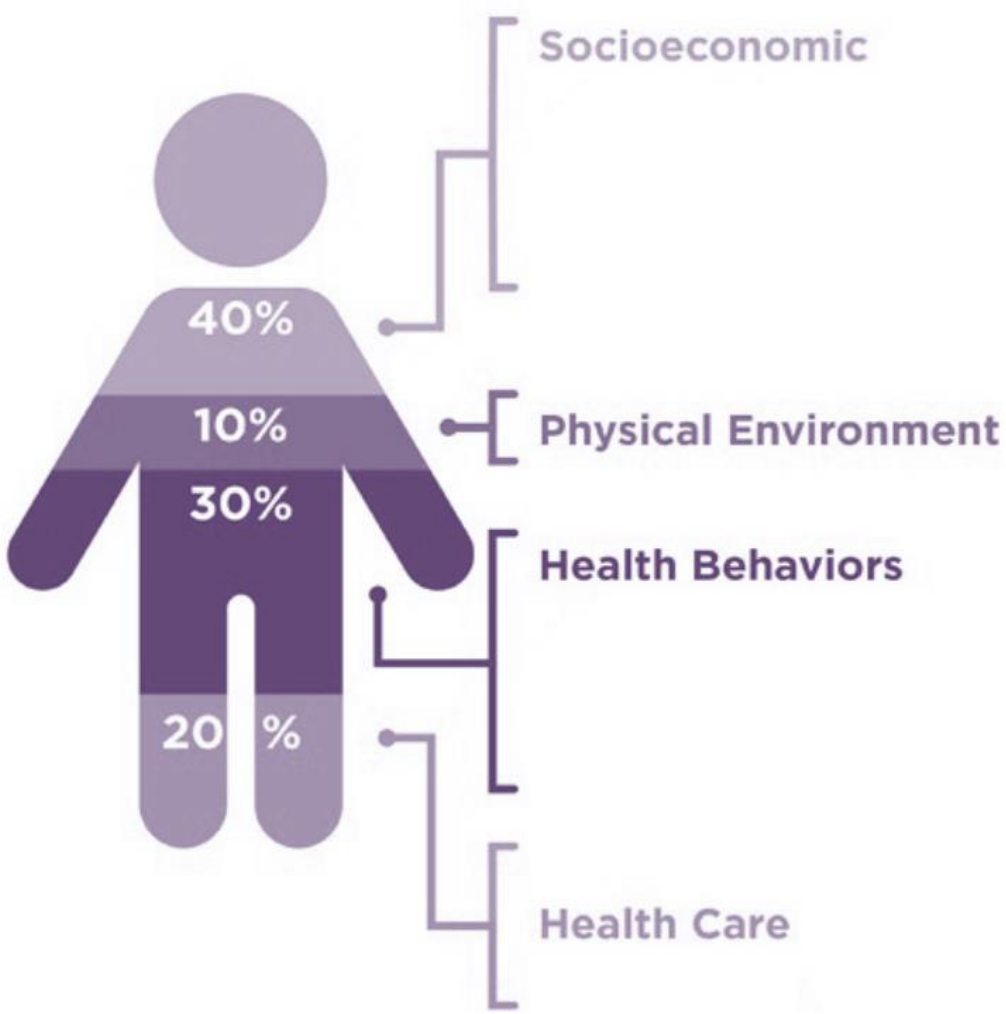
Post Discharge



Addressing social determinants of health is a critical part of providing remarkable healthcare because **80% of a person's health is attributable to social, physical and health factors outside of clinical care.**

- **Home visits**
- **Advocacy at doctor's visits**
- **Communication with multidisciplinary team**
- **Removing barriers related to SDOH**

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

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Patient Story

Jasmine was referred to work with patient Mrs. A after her recent stroke. This patient was a 65-year-old female that lived alone in a senior living community, and had no family supports in this area.

Patient had severe aphasia due to stroke and was in need of device for communication. Patient also had no access to transportation and needed an advocate for medical visits.

Jasmine worked with patient to secure CAP services, follow up on disability application, and DART transportation. She attended doctor's visit with patient and was able to ensure that patient got order for DME equipment needed for communication authorized by insurance. Most importantly, she helped the patient see that her life wasn't over due to the stroke, and she could continue to have meaningful connections with her community.

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Questions?

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Thank you

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