Community Clinical Linkages

Tanner Health System

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TANNER HEALTH SYSTEM

Tanner Community Health Needs Assessment (CHNA) 2016-2019

- Access to Care
- Chronic Disease Prevention and Management
- Behavioral Health
- Health Education & Literacy

Health Rankings 2016

Carroll Co.	Haralson Co.	Heard Co.
58th health outcomes	95th health outcomes	60th health outcomes
60th health factors	55th health factors	66th health factors
56th health behaviors	37th health behaviors	63rd health behaviors
70th social& economic factors	92nd social & economic factors	53rd social & economic factors
145th physical environment	116th physical environment	89th physical environment

FOCUSING ON GREATER IMPACT:

Community Engagement & Capacity

Policy, System & Environmental

Priority Population

- African American Health through Faith-based Organizations
- Faith in Health Expansion

Community - Clinical Linkages

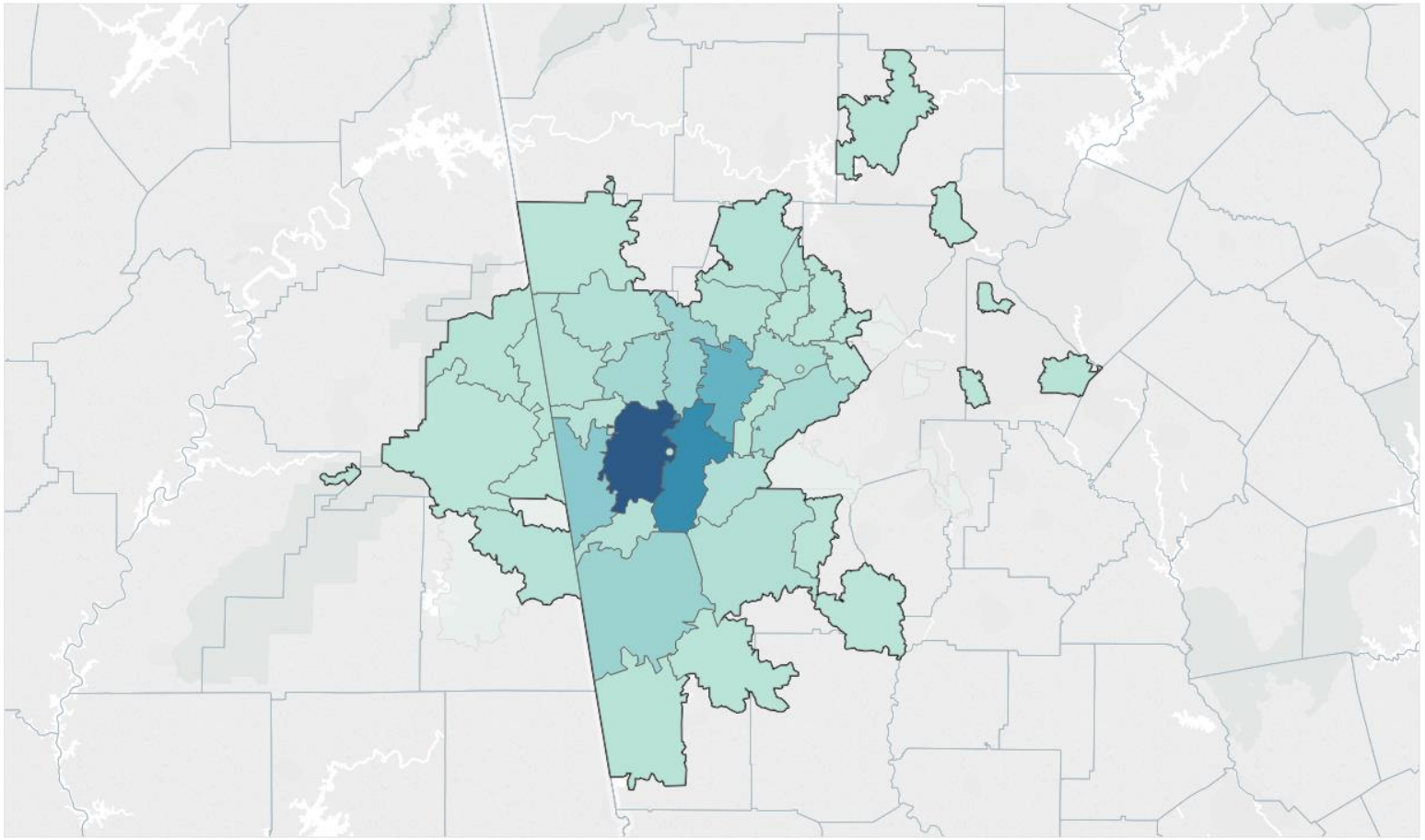
- Physician Referral + Patient Engagement
- Community Involvement
- GHLW communication loop of patient outcomes to clinics

A Sustainable Evidence -Based Model

- Reduce Health Disparities
- Increase Access
- Increase Patient Self-Management
- Increase Community Involvement
- Increase health literacy

Demographics

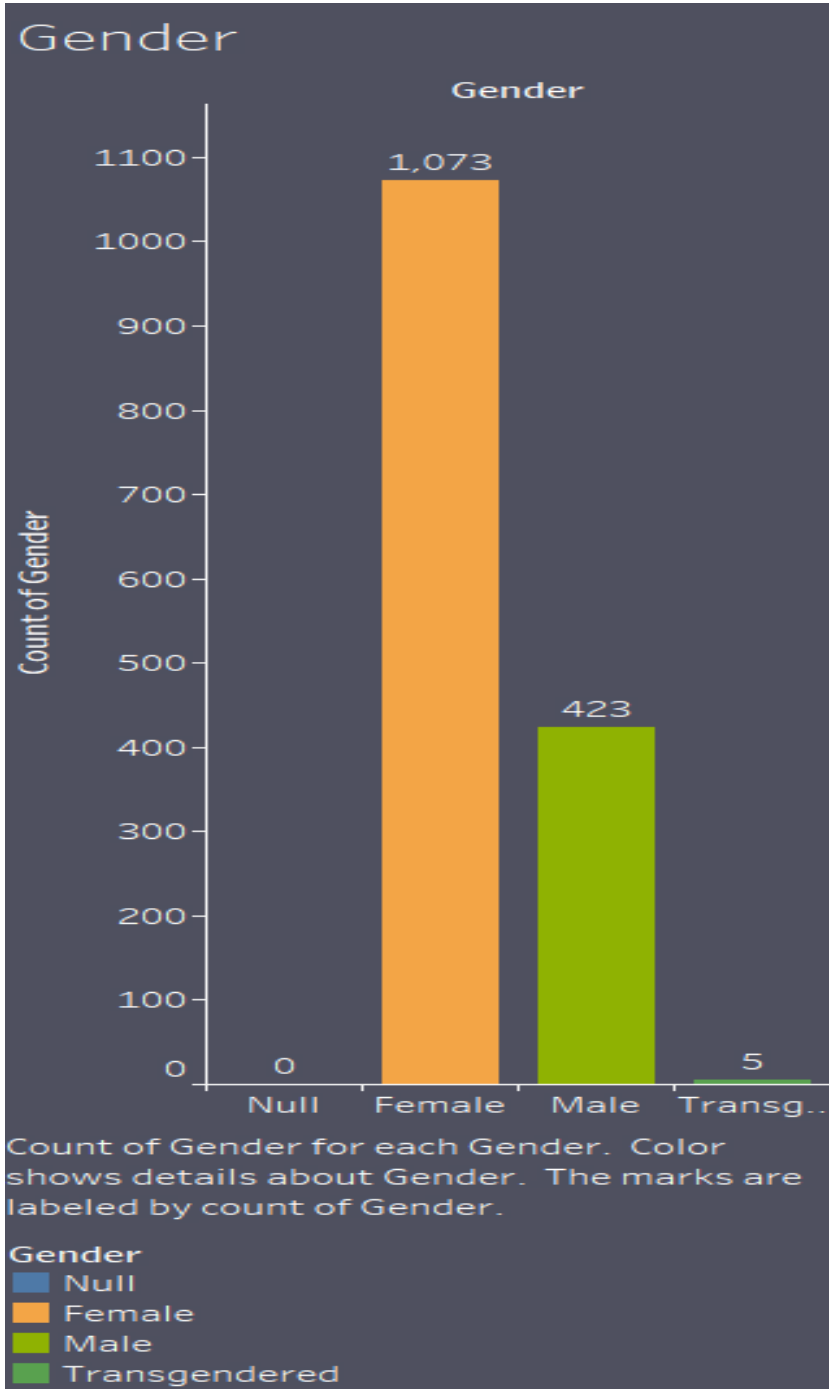
Zip Code



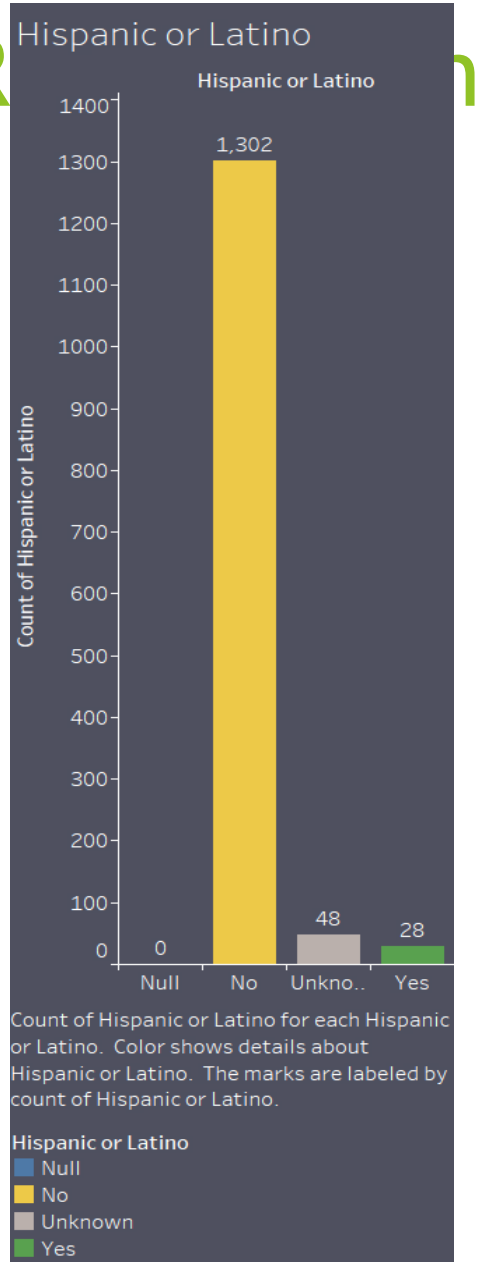
Map based on Longitude (generated) and Latitude (generated). Color shows count of Zip Code. Details are shown for Zip Code. The data is filtered on Class Name (Participant Class Information (Community Health Database V.3_be)), which keeps 12 of 12 members. The view is filtered on Zip Code and count of Zip Code. The Zip Code filter keeps 50 of 58 members. The count of Zip Code filter keeps all values.

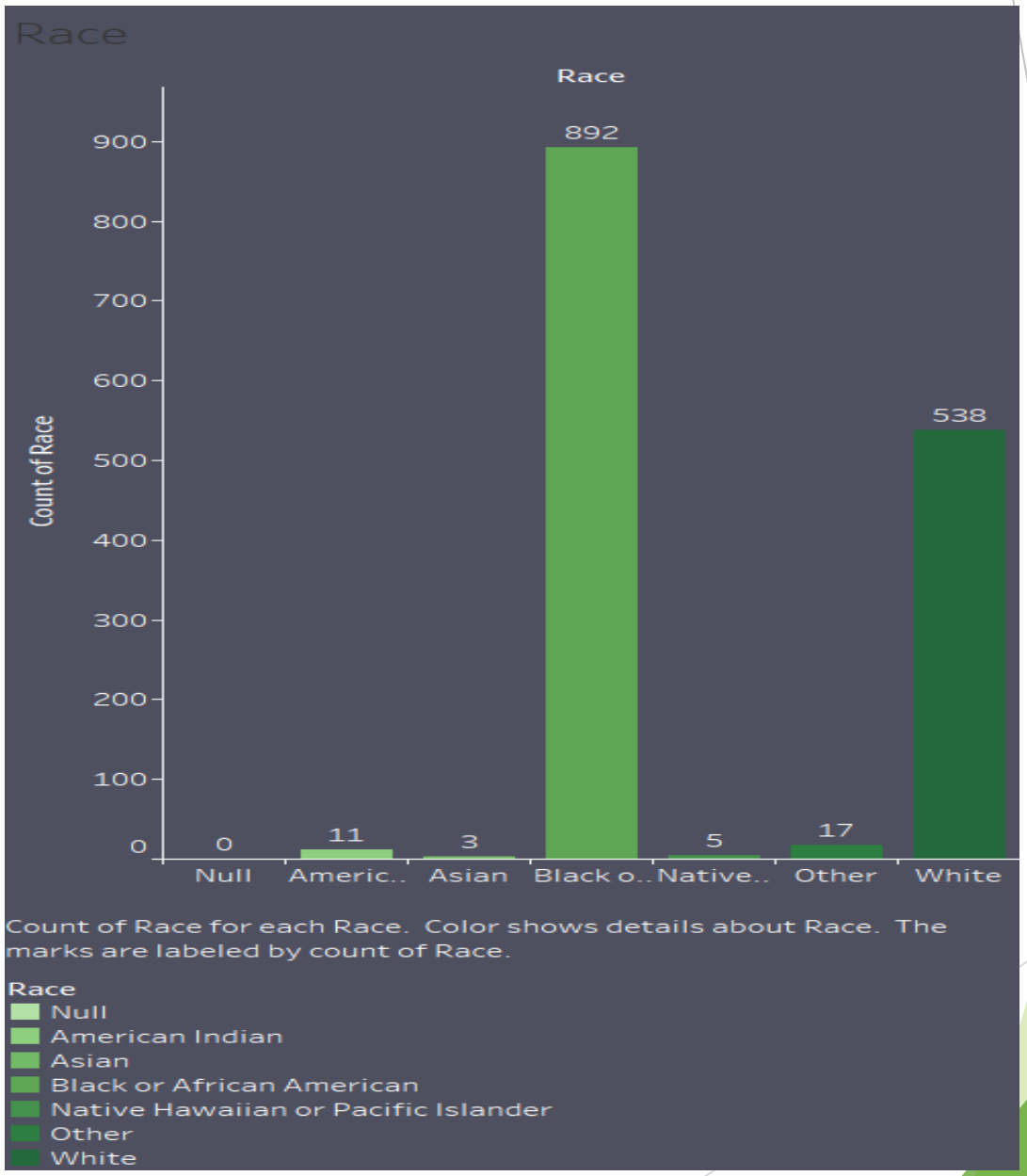
Count of Zip Code

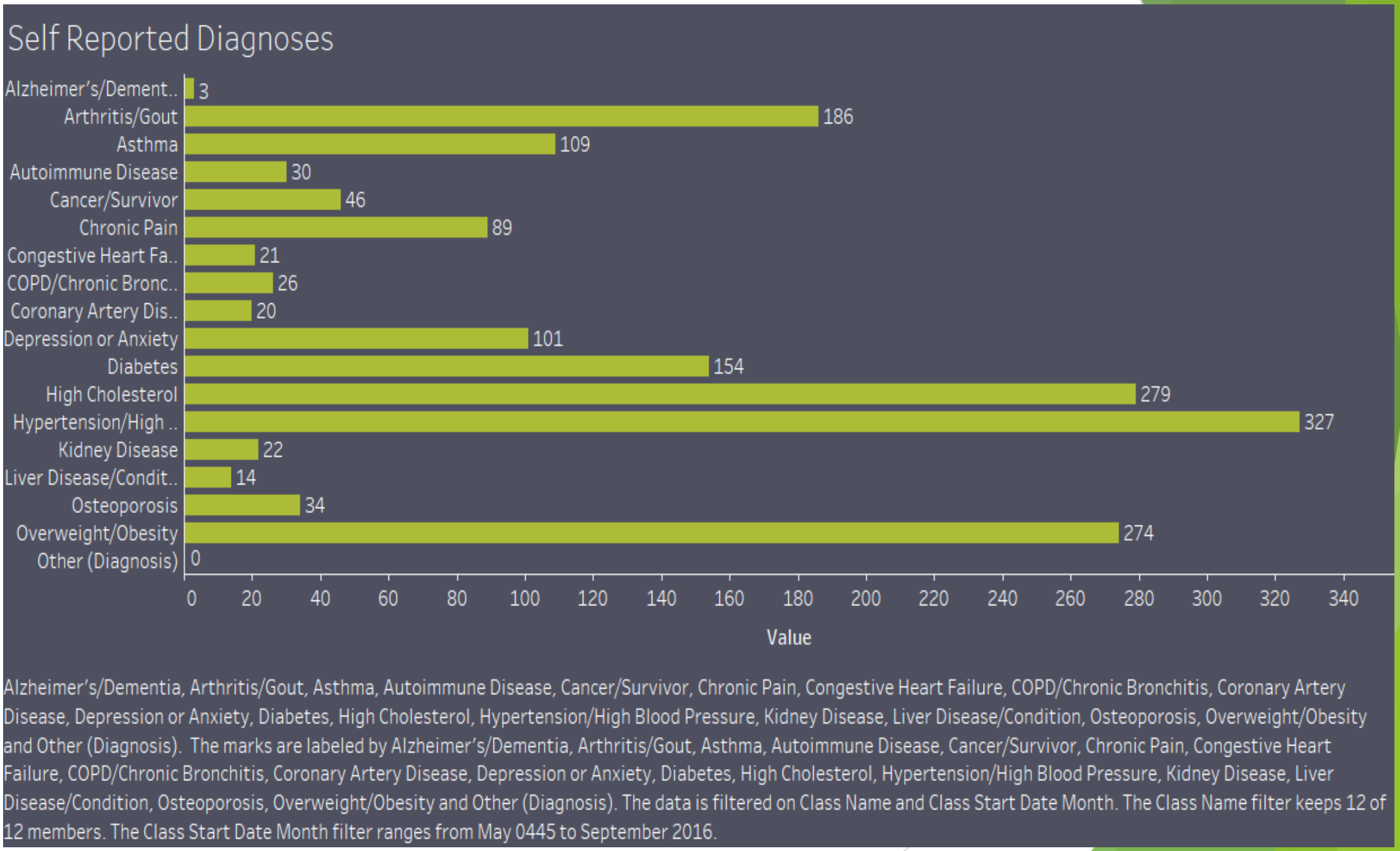
1 473


Gender
Gender
1100
1000
900
800
700
600
500
400
300
200
100
0
Count of Gender
1,073
423
0
5
Null
Female
Male
Transg..
Count of Gender for each Gender. Color shows details about Gender. The marks are labeled by count of Gender.
Gender
Null
Female
Male
Transgendered

R nicity


Hispanic or Latino
Hispanic or Latino
Count of Hispanic or Latino
1400
1300
1200
1100
1000
900
800
700
600
500
400
300
200
100
0
0
1,302
48
28
Null
No
Unkno..
Yes
Count of Hispanic or Latino for each Hispanic or Latino. Color shows details about Hispanic or Latino. The marks are labeled by count of Hispanic or Latino.
Hispanic or Latino
Null
No
Unknown
Yes


Race
Race
Count of Race
900
800
700
600
500
400
300
200
100
0
0
11
3
892
5
17
538
Null
Americ..
Asian
Black o..
Native..
Other
White
Count of Race for each Race. Color shows details about Race. The marks are labeled by count of Race.
Race
Null
American Indian
Asian
Black or African American
Native Hawaiian or Pacific Islander
Other
White


Self Reported Diagnoses
Alzheimer's/Dement..
Arthritis/Gout
Asthma
Autoimmune Disease
Cancer/Survivor
Chronic Pain
Congestive Heart Fa..
COPD/Chronic Bronc..
Coronary Artery Dis..
Depression or Anxiety
Diabetes
High Cholesterol
Hypertension/High ..
Kidney Disease
Liver Disease/Condit..
Osteoporosis
Overweight/Obesity
Other (Diagnosis)
3
186
109
30
46
89
21
26
20
101
154
279
327
22
14
34
274
0
0 20 40 60 80 100 120 140 160 180 200 220 240 260 280 300 320 340
Value
Alzheimer's/Dementia, Arthritis/Gout, Asthma, Autoimmune Disease, Cancer/Survivor, Chronic Pain, Congestive Heart Failure, COPD/Chronic Bronchitis, Coronary Artery Disease, Depression or Anxiety, Diabetes, High Cholesterol, Hypertension/High Blood Pressure, Kidney Disease, Liver Disease/Condition, Osteoporosis, Overweight/Obesity and Other (Diagnosis). The marks are labeled by Alzheimer's/Dementia, Arthritis/Gout, Asthma, Autoimmune Disease, Cancer/Survivor, Chronic Pain, Congestive Heart Failure, COPD/Chronic Bronchitis, Coronary Artery Disease, Depression or Anxiety, Diabetes, High Cholesterol, Hypertension/High Blood Pressure, Kidney Disease, Liver Disease/Condition, Osteoporosis, Overweight/Obesity and Other (Diagnosis). The data is filtered on Class Name and Class Start Date Month. The Class Name filter keeps 12 of 12 members. The Class Start Date Month filter ranges from May 0445 to September 2016.

Community Interventions

- Education on the 5 evidence-based programs offered for patient referrals
  - Diabetes Prevention Program (DPP)- CDC- Tanner GHLW has full recognition
  - Chronic disease self-management (CDMP)- Stanford University
  - Diabetes self-management (DSMP)- Stanford University- Tanner is accredited through AADE
  - FreshStart (FS)- American Cancer Society
  - Kids N Fitness ©- Los Angels Children's Hospital *(not part of evaluation study)

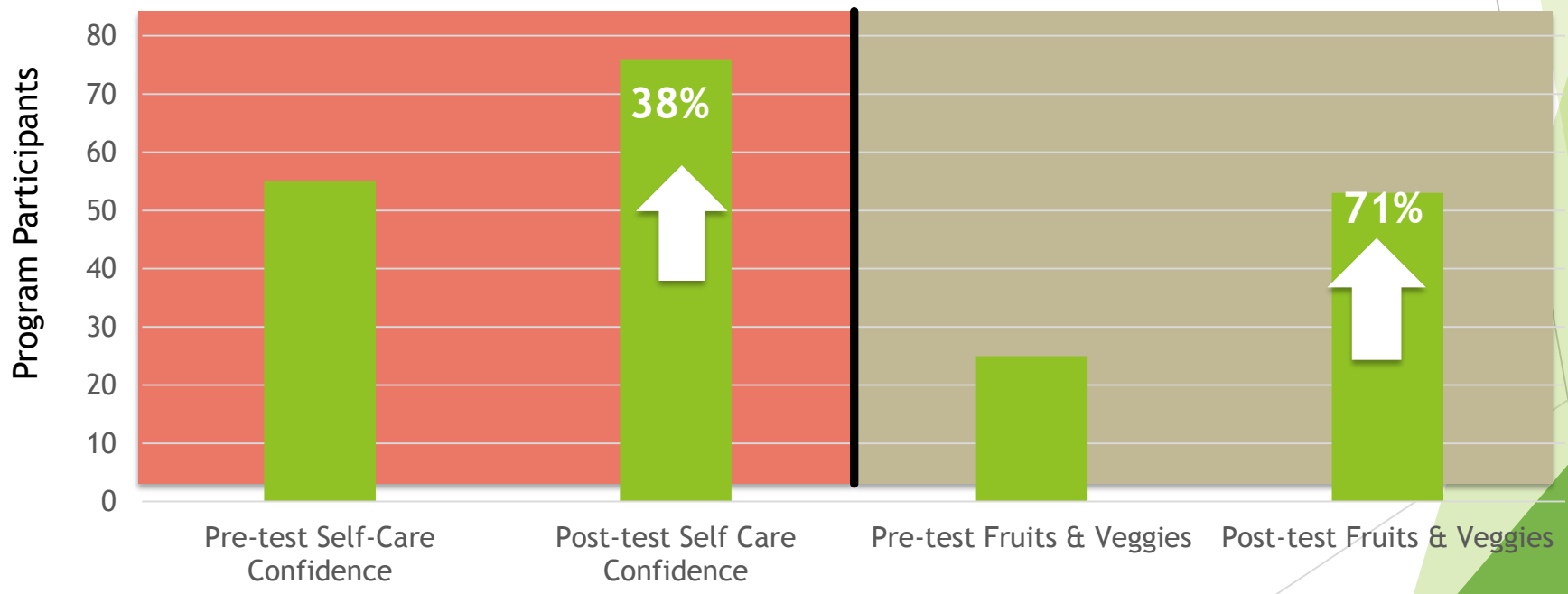
EB Class Objectives

- 1) techniques for problems such as: frustration, fatigue, pain and isolation,
- 2) physical activity for maintaining and improving strength, flexibility, and endurance,
- 3) appropriate use of prescribed medications,
- 4) communicating effectively with family, friends, and health professionals,
- 5) nutrition,
- 6) decision making related to health,
- 7) how to evaluate new treatment options
- 8) develop coping skills to combat the psychological and physical side effects of smoking cessation
- 9) lifestyle change
- 10) weight loss

Health Behavior Change:

CDSMP & DSMP

- 261 Patients enrolled: Feb 1, 2015 through March 1, 2017
- 73.5% completion rate (192 patients)



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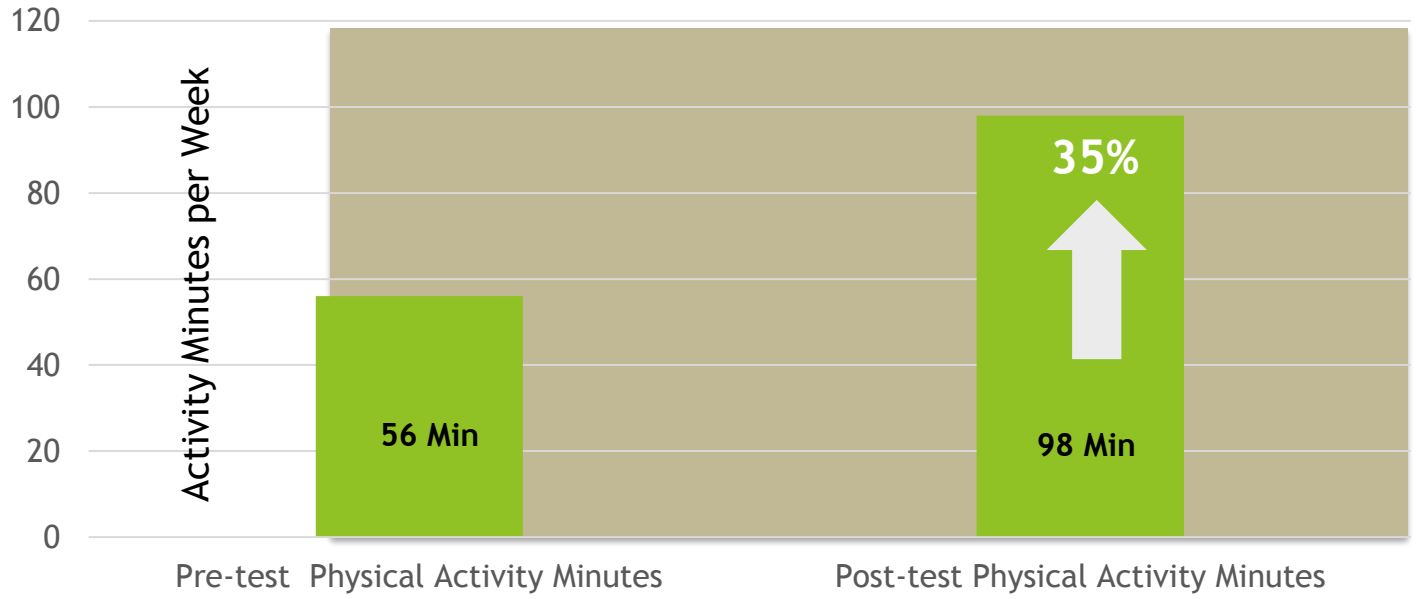
FRESHSTART

- 94 Patients enrolled: Jan 1, 2016 through Dec 31,16
- 51% completion rate (46 patients)
  - No significant increase in coping with cravings confidence level noted for data collection period

Health Behavior Change:

DIABETES PREVENTION PROGRAM (DPP)

- 104 Patients enrolled: Jan 1, 2016 through Dec 31, 2016
- 30% completion rate (73 patients)



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COST AVOIDANCE:

DPP - 2016

- Average Annual cost of patient with Diabetes $ 13,700
- Amount directly attributed to Diabetes $ **7,900**

2016 Course Completion		Annual Medical Cost of Diabetes		Annual Cost Avoidance
73	X	$7,900	=	$ 576,700

*2011 CDC study demonstrated 34% decrease in diabetes dx for at least 10 years following class completion

vs.

18% for patients only on metformin compared to placebo.

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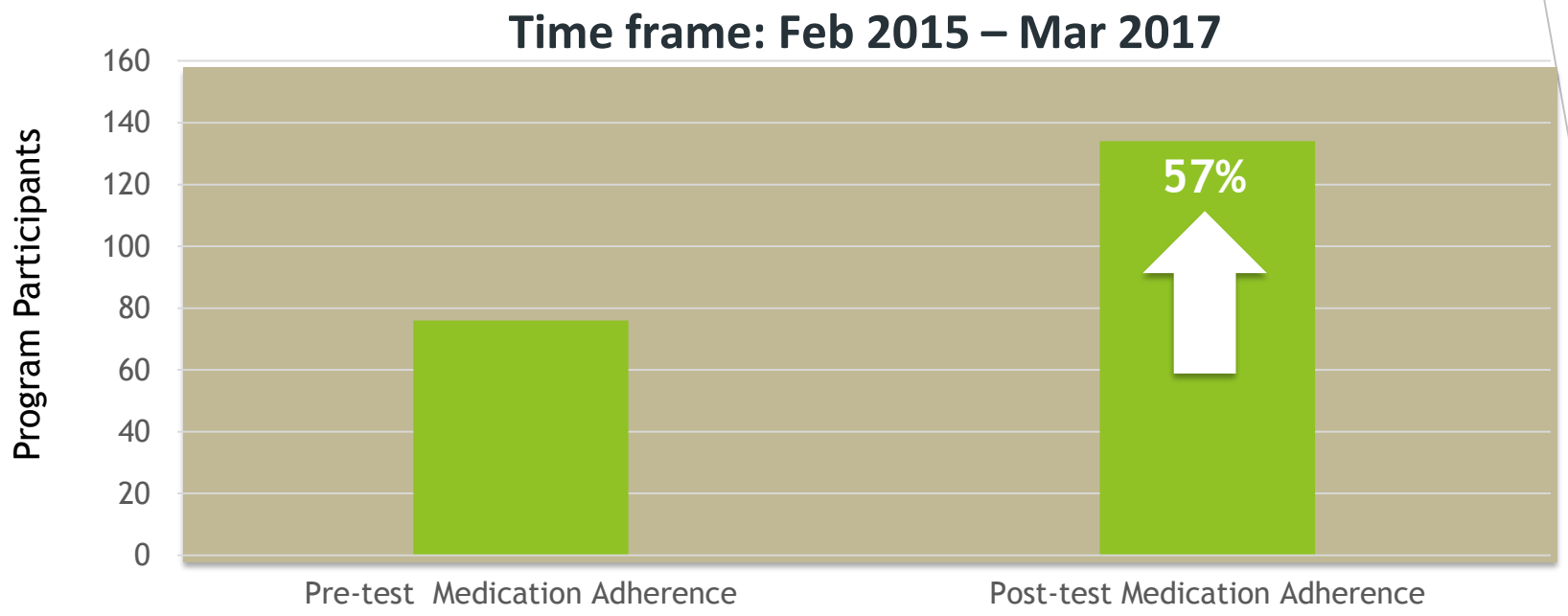
COST SAVINGS & REDUCED HEALTHCARE UTILIZATION:

CDSMP & DSMP



Patients Completing Program		Reduced HC Util per pt/per yr		Total HC Util Cost Savings (2 yrs)
192	X	$714	=	$ 274,176

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Tanner Community Clinical Linkages Actual Use Evaluation

- Single intervention
- AHRQ clinical-community relationship evaluation roadmap
  - Information Technology
  - Infrastructure
  - Clinical training
  - Referral process

Evaluation Questions

- Are the components of CCL referral process implemented as proposed?
- What portion of eligible patients are referred to community resources by clinics receiving intervention versus those not receiving intervention?
- Are the patients who were referred to community programs healthier compared to patients in the control clinics?
- Study Participants:
  - Adults 21+
  - At risk of diabetes
  - Diagnosed with a chronic condition
  - 2 Intervention clinics
  - 2 Delayed-control clinics**
  - Physician referral- vs. self-referral

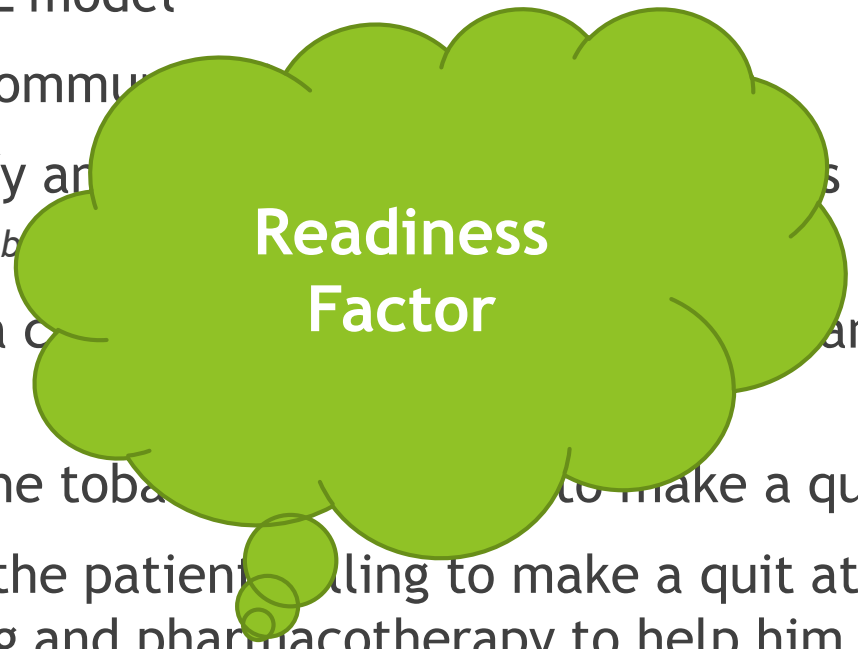
Study clinics were all person-centered medical homes and part of Tanner Health System

Study Details

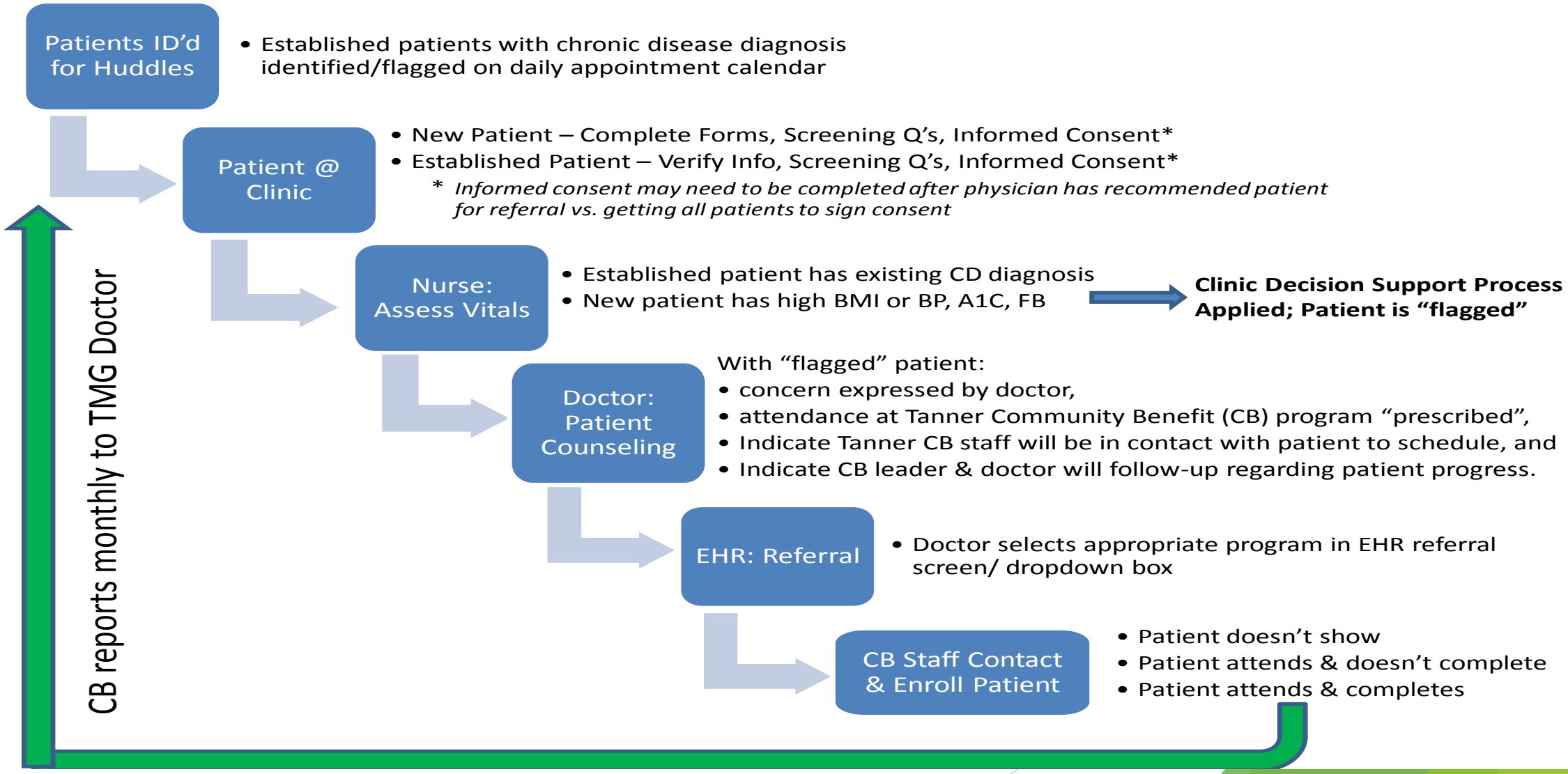
- Estimate effects of community programs on health outcomes using reduced-form and instrumental variable methods
- **H_ict=B_0+B_1{TX}_ct+B_2X_ict+a_i+t_T+e_ict**
- Two-stage model
  - Stage 1 estimates the effect of clinic being in the treatment group in given time period and probability of individual patients being referred
  - Stage 2 estimates the effect of patient referral on health outcome capturing causal effect of the referral

Clinicians

- Consistent training of physicians, nurse managers, clinical staff and office managers in CCL model
- Use of 5 A's in commu
  - **Ask** - Identify ar s for every patient at every visit. *(This can b*
  - **Advise** - In a c anner, urge every tobacco user to quit.
  - **Assess** - Is the toba ke a quit attempt at this time?
  - **Assist** - For the patient ling to make a quit attempt, use education programming and pharmacotherapy to help him or her quit.
  - **Arrange** - Schedule follow-up contact, in person or by telephone, preferably within the first week after the quit date.

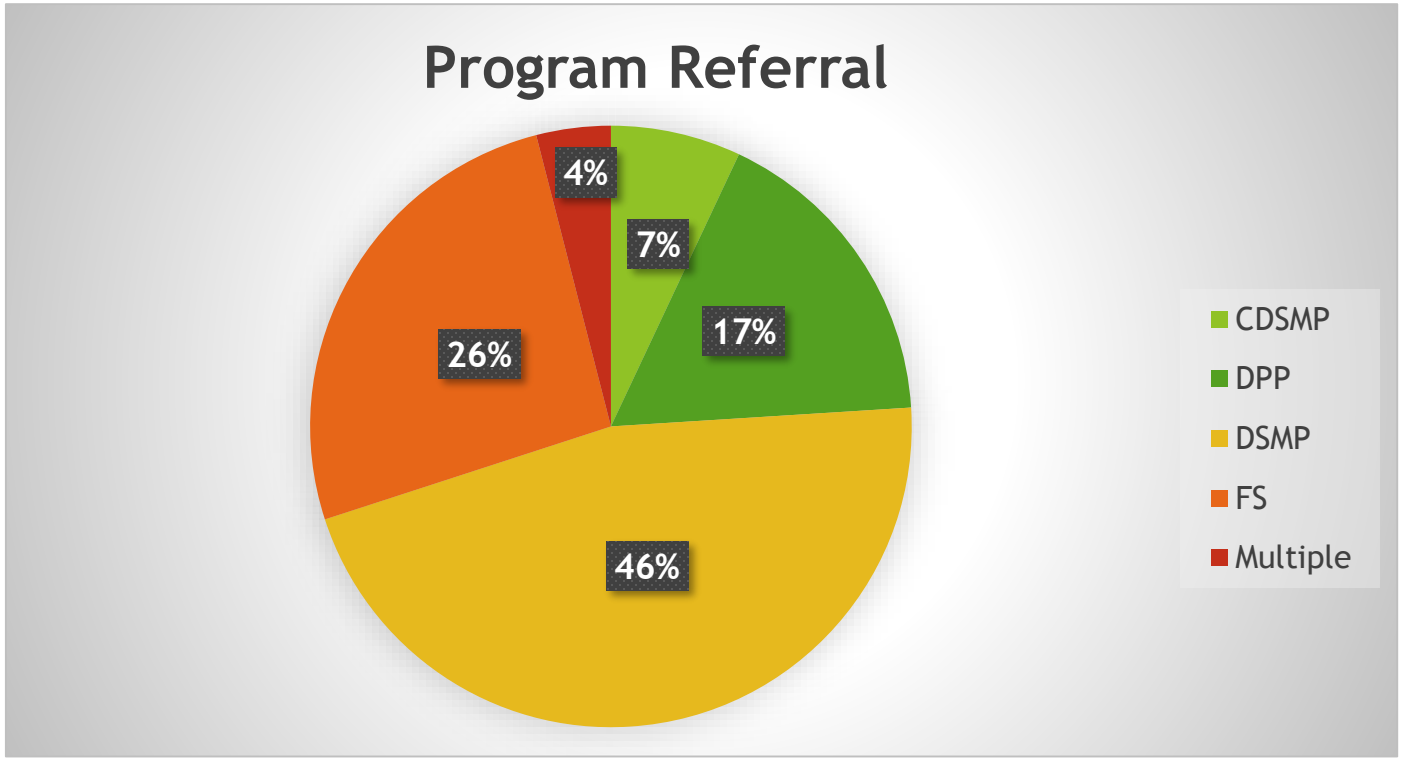


Tanner Community Clinical Linkages (CCL) Project:
Patient Flow Chart to Enhance Chronic Disease (CD) Management



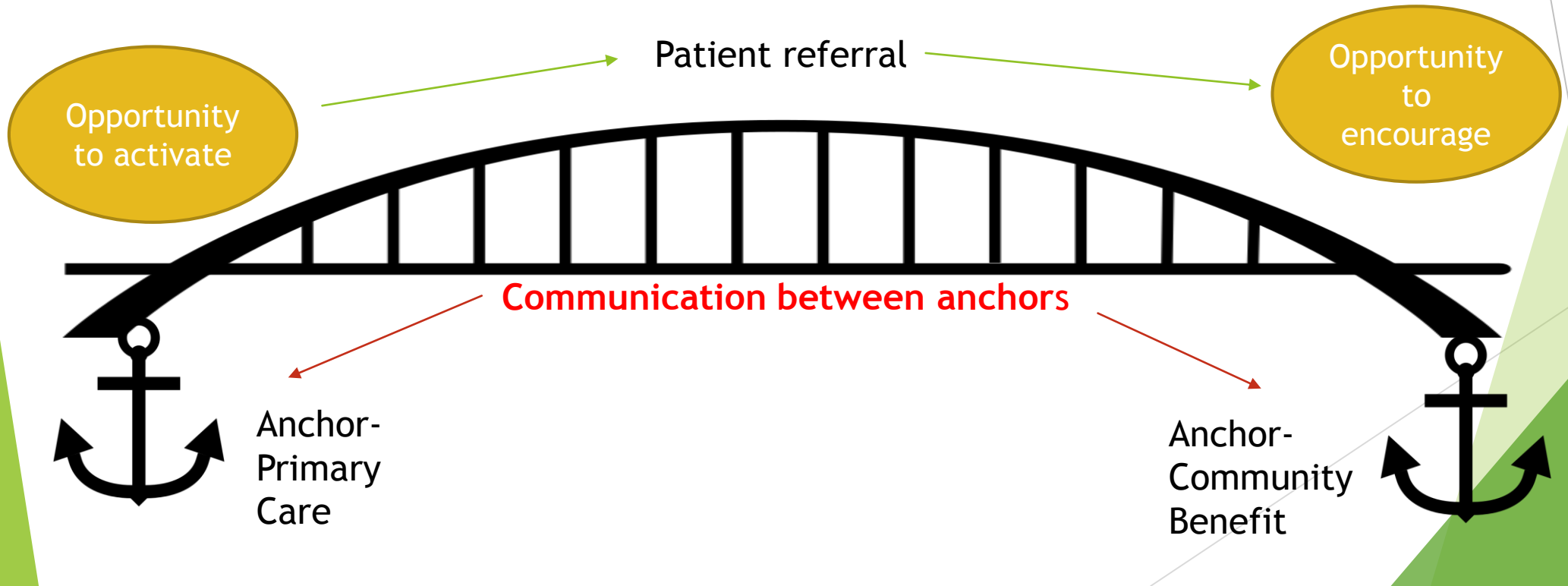
Referral Data

- Physicians are referring patients predominantly to Diabetes self-management program and FreshStart



Connecting Strategies

- Point of access
- Identification of community resources
- Evidence-based programming
- Educate and patient engagement



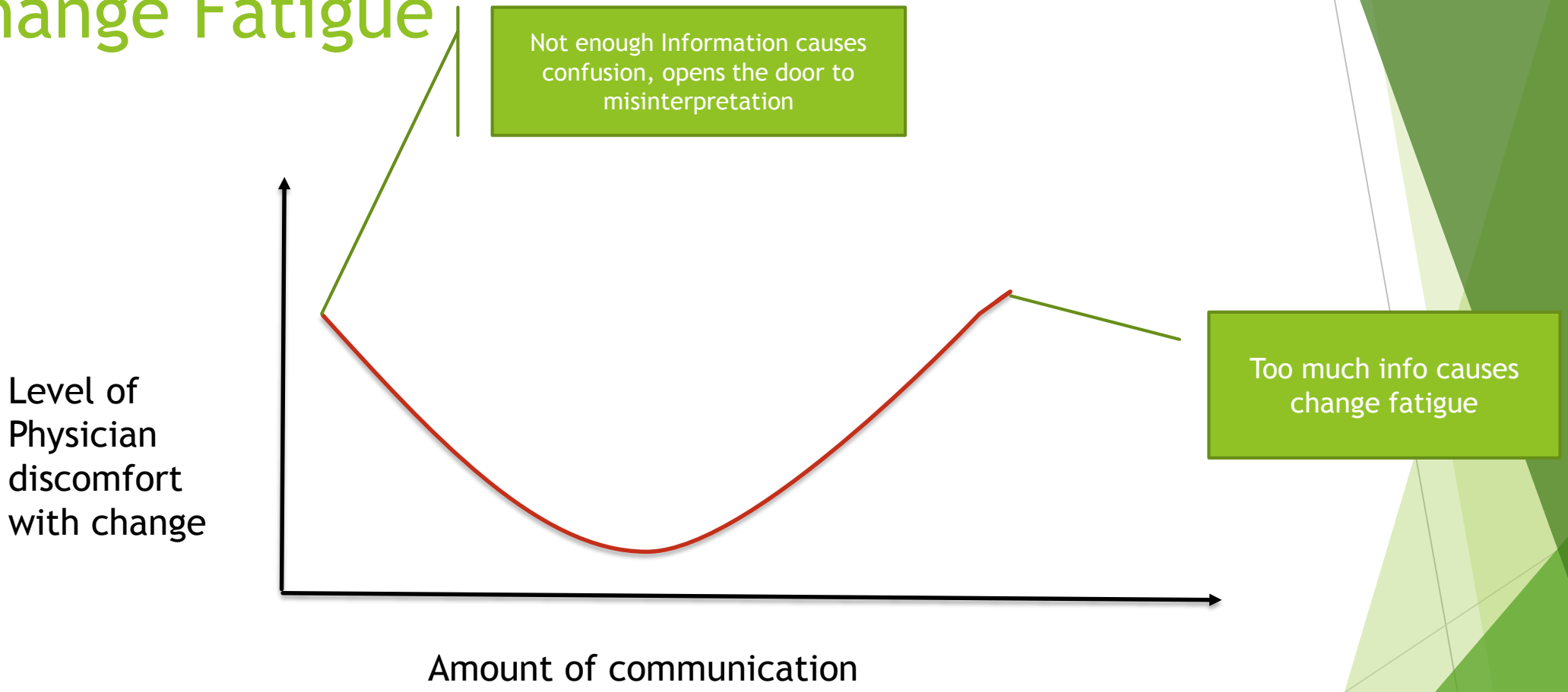
Evaluation Findings:

- Older adults (age 58+) tend to be more confident they have the tools to take care of and make decisions about their health.
- Females are less confident than male respondents about tasks and activities they need to do to manage their health condition and reduce their need to see a doctor
- Chronic condition pool of patients referred: hypertension, obesity, high cholesterol, pre-diabetes/diabetes, arthritis/gout, depression/anxiety
- Of evaluation cohort, 45.9% were referred by their physician directly and 53.9% were self-referrals
- Female physicians were more than twice as likely to refer patients to evidence-based programs than their male counterparts.

Barriers Noted:

- Medical model stigma toward community health programs
- Physician participation in key informant interviews was minimal
- Engagement varied among physicians and clinics
- Nurses were the gatekeepers to referrals and referral reminders for physicians
- Lack of ease of access to A1C and other clinical indicator data (chart reviews)
- 24 month process to create a referral order in the EHR
- Patients not wanting to enroll in classes upon contact by Community Benefit dept. of Tanner
- Rural area, could not offer classes in all areas on dates/ times requested

Another Barrier: Communication and Change Fatigue



Success Story Video

- https://www.dropbox.com/s/loih6sk6je9dz0k/GHLW_Strickland2.2.mov?dl=0

Pt. who became an instructor for chronic disease self-management. Learned how to talk with physician and insisted on a colonoscopy due to symptoms in spite of physician recommendation. As a result found a polyp that would have possibly turned cancerous by 2019 when the pt. was next scheduled for procedure.

Pt. and wife attend Diabetes Self-management ss. As a result changed lifestyle cutting out soda habit, becoming more physically active and successfully reduced his blood sugar levels.

ian lost
vith otl

DPP participant before taking the class ate fast food almost everyday and no physical activity. Through the class lost 32 lbs. and now
meals and wa

Patient with a
Tanner quit smoki
participated in GHLW weight loss challenge and lost 56 lbs total over 2 years of challenges, took DPP and began walking on the trail joined Move it Mondays through GHLW and is now member of the West GA Track Club, runs 5K and 10K races a just completed a half marathon.

Pt struggling with Type II diabetes for 30 years learns through diabetes self-management class to change eating habits and lose weight. Now has blood sugar under control and has been able to decrease medications per his physician.

Advancing Health

WITH COMMUNITY
BEYOND MEASURE.

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