Community Clinical Linkages

Tanner Health System

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Tanner Community Health Needs Assessment (CHNA) 2016-2019

- Access to Care
- Chronic Disease Prevention and Management
- Behavioral Health
- Health Education & Literacy
## Health Rankings 2016

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<th>Carroll Co.</th>
<th>Haralson Co.</th>
<th>Heard Co.</th>
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<tbody>
<tr>
<td>Health Outcomes</td>
<td>58&lt;sup&gt;th&lt;/sup&gt;</td>
<td>95&lt;sup&gt;th&lt;/sup&gt;</td>
<td>60&lt;sup&gt;th&lt;/sup&gt;</td>
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<td>Health Factors</td>
<td>60&lt;sup&gt;th&lt;/sup&gt;</td>
<td>55&lt;sup&gt;th&lt;/sup&gt;</td>
<td>66&lt;sup&gt;th&lt;/sup&gt;</td>
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<td>Health Behaviors</td>
<td>56&lt;sup&gt;th&lt;/sup&gt;</td>
<td>37&lt;sup&gt;th&lt;/sup&gt;</td>
<td>63&lt;sup&gt;rd&lt;/sup&gt;</td>
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<td>Social &amp; Economic Factors</td>
<td>70&lt;sup&gt;th&lt;/sup&gt;</td>
<td>92&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>53&lt;sup&gt;rd&lt;/sup&gt;</td>
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<td>Physical Environment</td>
<td>145&lt;sup&gt;th&lt;/sup&gt;</td>
<td>116&lt;sup&gt;th&lt;/sup&gt;</td>
<td>89&lt;sup&gt;th&lt;/sup&gt;</td>
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FOCUSBING 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
Count of Gender for each Gender. Color shows details about Gender. The marks are labeled by count of Gender.
Race & Ethnicity

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.

Race

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/Dementia: 13
- Arthritis/Gout: 30
- Asthma: 46
- Autoimmune Disease: 89
- Cancer/Survivor: 21
- Chronic Pain: 26
- Congestive Heart Failure: 20
- COPD/Chronic Bronchitis: 101
- Coronary Artery Disease: 154
- Depression or Anxiety: 327
- Diabetes: 279
- High Cholesterol: 274
- Hypertension/High Blood Pressure: 0
- Kidney Disease: 0
- Liver Disease/Condition: 0
- Osteoporosis: 0
- Overweight/Obesity: 0
- Other (Diagnosis): 0

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)
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)
**COST AVOIDANCE:**
**DPP - 2016**

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

<table>
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<tr>
<th>2016 Course Completion</th>
<th>Annual Medical Cost of Diabetes</th>
<th>Annual Cost Avoidance</th>
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<tr>
<td>73</td>
<td>$7,900</td>
<td>$576,700</td>
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*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.
COST SAVINGS & REDUCED HEALTHCARE UTILIZATION:
CDSMP & DSMP

Time frame: Feb 2015 – Mar 2017

Patients Completing
Program
192

Reduced HC
Util per pt/per yr
$714

Total HC Util Cost
Savings (2 yrs)
$274,176

$714 / per pt / per yr = $274,176 (savings 2 yrs)
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 communication with patients
  - **Ask** - Identify and document tobacco use status for every patient at every visit. *(This can be done by the nurse.)*
  - **Advise** - In a clear, strong, and personalized manner, urge every tobacco user to quit.
  - **Assess** - Is the tobacco user willing to make a quit attempt at this time?
  - **Assist** - For the patient willing 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

**Patients ID’d for Huddles**
- Established patients with chronic disease diagnosis identified/flagged on daily appointment calendar

**Patient @ Clinic**
- New Patient – Complete Forms, Screening Q’s, Informed Consent*
- Established Patient – Verify Info, Screening Q’s, Informed Consent*
  * Informed consent may need to be completed after physician has recommended patient for referral vs. getting all patients to sign consent

**Nurse: Assess Vitals**
- Established patient has existing CD diagnosis
- New patient has high BMI or BP, A1C, FB

**Doctor: Patient Counseling**
- With “flagged” patient:
  - concern expressed by doctor,
  - attendance at Tanner Community Benefit (CB) program “prescribed”,
  - Indicate Tanner CB staff will be in contact with patient to schedule, and
  - Indicate CB leader & doctor will follow-up regarding patient progress.

**EHR: Referral**
- Doctor selects appropriate program in EHR referral screen/dropdown box

**CB Staff Contact & Enroll Patient**
- Patient doesn’t show
- Patient attends & doesn’t complete
- Patient attends & completes

CB reports monthly to TMG Doctor
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

Not enough Information causes confusion, opens the door to misinterpretation

Too much info causes change fatigue

Level of Physician discomfort with change

Amount of communication
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.

Patient with artery stent from Tanner quit smoking, 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 and just completed a half marathon.

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

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.