



SESSION A: A COMMUNITY OUTREACH AND PATIENT EMPOWERMENT PROGRAM (COPE) PROGRAM



CHR Policy Summit II, September 2016

Chinle Service Unit, Diabetes Program

Miranda Williams, Diabetes Program Coordinator

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STARTING POINT WITH COPE IN 2011:

- In 2011, CSU Division of Public Health began a collaboration with the COPE project and the Diabetes team was asked to take the lead for CSU
- COPE: Community Outreach Patient Empowerment
 - Funded by HHS grant
 - Partners: Brigham and Women's Hospital, Boston; Navajo Area IHS and CHRs
 - Gallup, Shiprock, Fort Defiance, Chinle, Crownpoint

INITIAL KEY PARTICIPANTS

- COPE
 - Sonya Shin, MD
 - Christine Hamann
- CSU
 - Stephen Flynn, MD
 - Elvira Martin, Director of CHR program
 - Alta White, Senior CHR, Chinle
 - Diabetes team: Miranda Williams, Krista Haven
 - Clinical Application Coordinator: Nick Bird
 - CHRs, PHNs, and diabetes coaches

A COPE PROGRAM IN NAVAJO NATION

COPE Objectives

- Enhance Navajo Nation CHR program by providing additional resources, training & support
- Improve outcomes of individuals living with uncontrolled chronic conditions

COPE Activities

- Health education and health promotion training for CHRs
- Patient self-management teaching materials for CHRs to use in homes
- Increase linkages between clinic and community teams



CSU COMMUNITY HEALTH REPRESENTATIVES IN 2011

- Initially 16 CHRs serving 17 chapters
- Certified Nurse Assistants and First Responders
- Solicit their own clients in each community based on certain high risk criteria (e.g., elderly, frail, chronic disease, lack of social support), no referral mechanism from clinic providers
 - Few referrals directly from Providers
 - Some referrals from Public Health Nurses
- Home visits documented on a paper CHR-PCC form, not entered into the medical record; some visit data entered into RPMS
- No formal communication between CHRs and clinic teams

CSU COMMUNITY HEALTH REPRESENTATIVES IN 2011



INITIAL INVOLVEMENT WITH COPE: HEALTH EDUCATION & HEALTH PROMOTION TRAINING

- Monthly 3 hour teaching sessions at CSU
- Taught by CSU Medical Doctors, diabetes program (Improvement Specialist, Clinical Consultant, Health Coaches), Public Health Nursing, others
- Use COPE flipcharts
- COPE personnel did Motivational Interviewing workshops
- CHRs enroll clients into COPE program and begin using the flipcharts on home visits

INCREASING PATIENT SELF-MANAGEMENT



Patient Teaching Materials

Flipcharts (per CHR request)

- Culturally appropriate
- Visual imagery
- Client-centered approach with Motivational Interviewing and Goal Setting Techniques

Initial Intake*

Diabetes Basics

**Wellness & Change: Navajo
Wellness Model***

Know My Numbers (A1c, BGL)

Blood Pressure Basics

All About Cholesterol

Know My meds

All About Insulin

Healthy Eating*

Healthy Portions*

Keeping Active*

Caring for My Feet (DM)

**Healthy Emotions: coping with
stress***

**Taking My Medications: improving
adherence***

**Avoiding complications of
diabetes**

Alcohol & My Health*

My Appointments & Doctors*

Caring for the caregiver*

We've come this far*

**Protecting Ourselves: HIV & other
STDs***

Checking My Blood Sugars

Eating in*

Eating out*

Preventing Diabetes *

Pre-Diabetes & My Health

Joints & safety*

Common mental health problems*

Common substance use issues*

We Made It!*

Great expectations: Pregnancy

**What every man should know
about his health***

**What every woman should know
about her health***

Infants & newborns*

**What all teens should know about
their health ***

Common problems of the brain

**Common problems of the kidneys
& urine**

Common breathing problems

**Common problems of the
digestive system**

Common problems of the heart

Tuberculosis

Hepatitis C

HIV Basics

TOPICS FOR COPE MODULES

GETTING CHRS ONTO ELECTRONIC HEALTH RECORD: INCREASE LINKAGES BETWEEN CLINIC AND COMMUNITY TEAMS

- Meetings with IRM, CHRs, providers, Clinical Applications Coordinator & Medical Records
- Developed a template in Electronic Health Record (E.H.R.) to replace paper PCC
- Identified coding issues
- Trained 3 CHRs for a pilot project

Click Check Box to Begin

Patient's Community:
COTTONWOOD

Location of Visit:

Chinle

Home Visits:

Home (808189)

Senior Centers:

Senior Centers

Head Start:

Head Start

Schools:

Chinle Schools

Chapter House Visits:

Chinle Chapter Houses

Health Facilities:

Chinle Health Facilities

Tsaille

Pinon

SUBJECTIVE INFORMATION: (Include Patient's complaint)

OBJECTIVE DATA:

ASSESSMENT-PCC PURPOSE OF VISIT

Problem 1:

Communicable Diseases Measles

Service Provided: Health Education Time: 10 mins

Chronic Diseases

Service Provided: Time: mins

Digestive

Service Provided: Time: mins

Ear

Service Provided: Time: mins

Behavioral Health

Service Provided: Time: mins

* Indicates a Required Field

RESULTS OF LINKING CHRS ONTO EHR

- Initial results: 3 CHRs were successful in entering notes in HER
- Notes reviewed by physician and found helpful
- Discovered difficulty with importing vital signs into notes
- Medical Records concerns about coding errors due to different coding systems
- Trained CHR on coding for joint visits with PHNs
- Double documentation for CHR – still had to document in CHR software in RPMS to get visit credit as well as in EHR
- Scaled up and provided 3 hour training session for all Chinle CHRs
- Guidelines developed (“cheat sheet”) for documenting in E.H.R.
- COPE purchased laptops for CHRs so they can use from remote wireless sites
- Determined need for CHR referral template

DEVELOPED REFERRAL TEMPLATE IN EHR

- Developed referral template for clinic providers to make direct referrals to CHRs in the EHR
- Improved the process to distribute the referral to the appropriate CHR
- Used an introductory statement about the role of CHRs to guide appropriate referrals
- Defined in free text reason for referral

Template: CHR Consult Request Template



Community Health Representatives (CHR) are paraprofessionals who regularly make home visits in their community to provide support, education, and monitoring for clients with chronic medical conditions, disabilities and/or lack of family support. They can take vital signs and do basic assessments, but cannot administer medications.

Examples of Services that CHR's can provide:

Health Education including self management support

Patient Care including monitoring vital signs, pulse oximetry, and home glucose testing

Making regular contact with a patient with a known health problem or disability

Assisting with scheduling appointments and transportation

Diagnosis:

Services Requested:

Patient Phone:

123 456 789 (home)/NONE (office)

Location of home:

012 01 04: NHA HSE 1234

* Indicates a Required Field

Preview

OK

Cancel

CLINIC PHYSICIAN PERSPECTIVE ON WORKING WITH CHRS

- Eager, enthusiastic learners interested in advancing their knowledge and skills to help their clients
- Patient and family centered care in the community
- Source of important information about patients
- Assets in area of self-management support
- Linkage with clinic system would provide tremendous resource for managing patients with chronic disease

LESSONS LEARNED

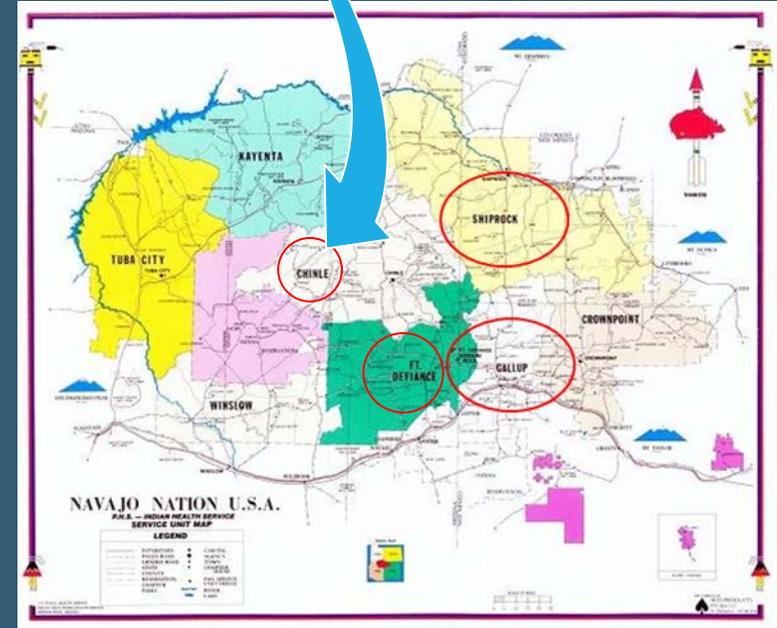
- Have your most functional team lead the charge
 - In our case, it was the diabetes team
 - Include provider(s)
 - Include CAC
- Slow process; expect obstacles – it's never over
- Get all stakeholders involved and keep them informed – especially PHNs and Med Records
- Get buy-in early and often from CHRs

Examples of IPC Innovations:

Chinle:

- COPE steering committee
- Monthly regional “outreach” meetings (Chinle, Pinon, Tsaile)
- Training schedule & COPE materials accessible to trainers on shared drive
- Algorithms for referral, including eligibility for COPE versus other related projects (e.g. Healthy Heart)
- Pregnancy-DM intervention

LINKAGE WITH
CARE TEAM



NEXT STEPS

- Continue ongoing trainings with CHRs to support E.H.R. documentation
- Ongoing education to providers on CHRs and COPE

Improving Relations and Access to EHR

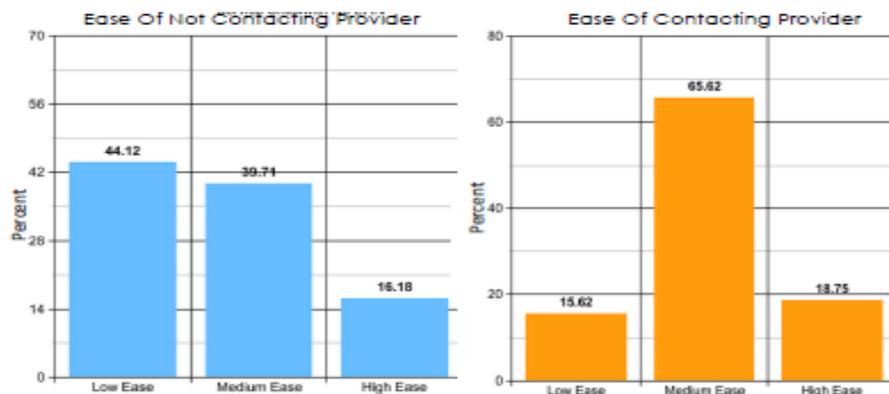
The Electronic Health Record (EHR) is a digital patient record system used throughout Indian Health Services and many 638 tribal facilities.

Before COPE began working with the program, Community Health Representatives (CHRs) did not have access to the EHR, relying primarily on Public Health Nurses (PHN) to obtain any health information about their clients. Now, 2 out of 8 CHR service units have access to their clients' data directly through the EHR system.



Ease Of Contacting A Provider In Service Units With And Without EHR

CHRs with access to EHR reported greater ability to contact providers about patient issues ($p < 0.05$) compared to CHRs without access



Recommendations



EHR access for CHRs should be strongly considered for all service unit teams because:

- 1) Improves the referral process from clinic providers to CHRs (i.e., more direct, streamline, increase total numbers of referrals).
- 2) Improves communication & collaboration between CHRs & clinical providers.
- 3) Provides patients with more holistic & integrated care.

What Do The CHR's Say?

CHRs with access to patient health records:

- Strongly agree that communication & teamwork had improved since EHR access (44%).
- Felt the patient referral process from providers to CHRs improved since using EHR (41%).
- Feel that EHR access to client information had direct positive implications on their client's health.

"I think we have **better communication** with the doctors, now with the EHR. I met a lot more doctors, they say, 'You're so and so,' and we email **each other.**"

- Female CHR

What Do Providers Say?

Where CHRs had gained access to EHRs, providers thought:

- There was greater integration among CHRs & clinical teams compared with those that did not have access to EHR.
- Providers were able to recognize CHRs as part of their clients' care team.
- Providers felt that EHR connection to CHRs encouraged them to make referrals to CHRs.
- EHR access for CHRs has been seen as positive & desired.

"Getting those little **EHR notifications**, I think it's really **helpful**... so, I think getting some sort of feedback about what interventions are performed with the patient, how their doing, things like that really **encourage** the providers **to continue** to refer."

- Provider

THANK YOU!
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