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
Krista Haven, Diabetes Improvement Specialist
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
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
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
TOPICS FOR COPE MODULES

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
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
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 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
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 CHRs 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)/1234567890 (office)

**Location of Home:**

012 01 04: ABC ROAD 1234
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
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 (CHR)s 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 (<0.05) compared to CHRIs without access.

Recommendations

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

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

What Do The CHR’s Say?

CHRIs 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 CHRIs improved since using EHR (41%).
- Feel that EHR access to client information had clear 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 CHRIs had gained access to EHRs, providers thought:

- There was greater integration among CHRIs & clinical teams compared with those that did not have access to EHR.
- Providers able to recognize CHRIs as part of their clients’ care team.
- Providers felt that EHR connection to CHRIs encouraged them to make referrals to CHRIs.
- EHR access for CHRIs 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 they are doing, things like that really encourage the providers to continue to refer.”

- Provider
THANK YOU!
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