BC3:
Bruner Community Care Connection

Data Driven Community Health Worker Intervention to Address High Utilizers of Acute Care Services

Saint Joseph HOSPITAL | SCL Health

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Bruner Community Care Connection (BC3)

We are…

Changing the care experience for high complexity patients

We are accomplishing this by…

leveraging a Community Health Worker (CHW) led multidisciplinary care team to meet these patients where they are and delivery intense clinical and social support.

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Thank you:

- SCL Health Innovation Challenge
- Care managers, Behavioral Health
- Clinic leadership
- Mike Matergia, MD
- Katherine Klein, MD, Tyler Jones, MD, Craig Erickson, MD, Emily Rand MD
- Huy Ly, MD
- Kevin Kuoni, Project Manager
- Our patients!

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Genesis of BC3

Influenced by:

- Camden Coalition
- Bridges 2 Care

https://vimeo.com/135509566

(Camden Coalition 4 Key Principles)

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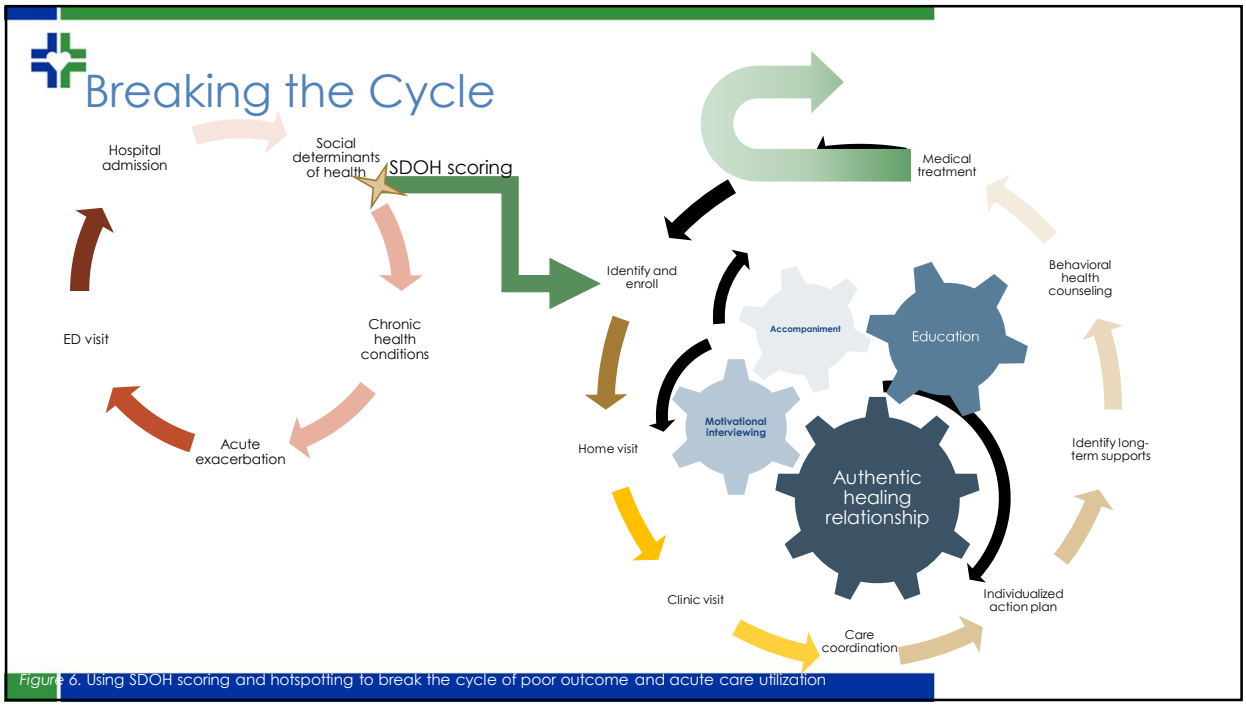

Figure 6. Using SDOH scoring and hotspotting to break the cycle of poor outcome and acute care utilization

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Meet Patients Where They Are

Who on the Care Team is right for this work? What will make this successful?

https://vimeo.com/151831828

(Camden Coalition: The Importance of Home Visits)

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CHW Profile

Jeanette Aparicio

Key Characteristics

- Experience working with complex patients including homeless populations
- Talented in developing connections and relationships with patients
- Served as an Action Plan Advisor
- Experience facilitating psychosocial rehabilitation groups
- Trained in motivational interviewing and trauma-informed care
- Motivated, professional, and dedicated

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Is the patient ready for change?

https://vimeo.com/151833231

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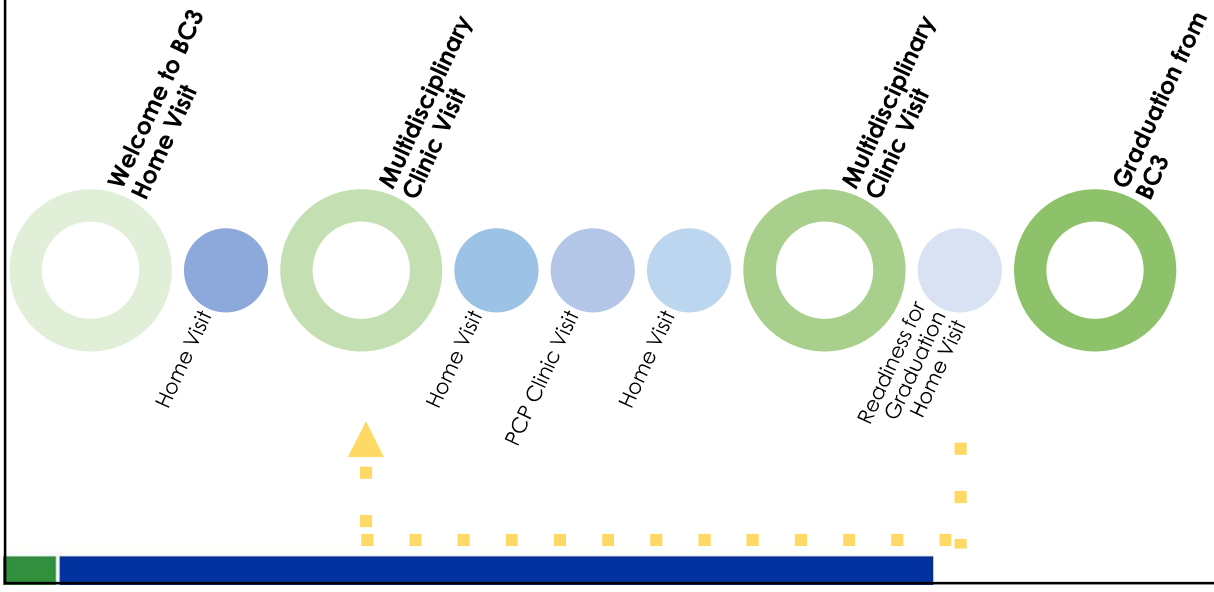
Intervention Timeline



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What is an Action Plan?

- Patient's perception of needs (physical, mental, etc.)
- Goal-setting
- SMART criteria
- Input from clinical team (multidisciplinary team meetings)
- Connecting with resources

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Process Indicators (as of 10-13-2019)

Enrolled
33

Active
17

Graduated **3**

Total Touches **220**

(with CHW)

Multidisciplinary Visits **10 (5%)**

Home Visits (66%) **145**

Accompaniment* **33 (15%)**

*** accompaniment = to join patient in visit for specialty service or social support agency**

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Meet Susan

- 69 year old female
- Diagnosed with heart failure, chronic kidney disease, and in remission from non-Hodgkin's lymphoma
- 6 ED visits in the past six months
- Lives alone with no family support
- One of the early enrollees into the intervention

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The Patient Experience

Gwendolyn

- 62 year old female
- Diagnosed with diabetes, hepatitis C, and chronic heart failure, and cataracts

Jesse

- 84 year old male
- Diagnosed with congestive heart failure, COPD, chronic kidney disease, and cataracts

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Feedback - Community Health Worker

- “I am a witness to the positive impact this program has made on patients' lives.”
- “I have been able to get an in-depth look at the patient's home life, noting the challenges they face and how these challenges impact their physical and mental health.”
- “I work with the patient on developing a plan to help them overcome their obstacles to a better life.”

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Feedback - Independent External Evaluator

"In listening to patients I have heard stories of how the program:

- decreases stress in their lives
- builds a broader social network
- addresses barriers such as transportation
- helps them communicate with their physicians
- pushes them to achieve their goals"

"Overall, it is clear that the program is improving the patients' self-efficacy"

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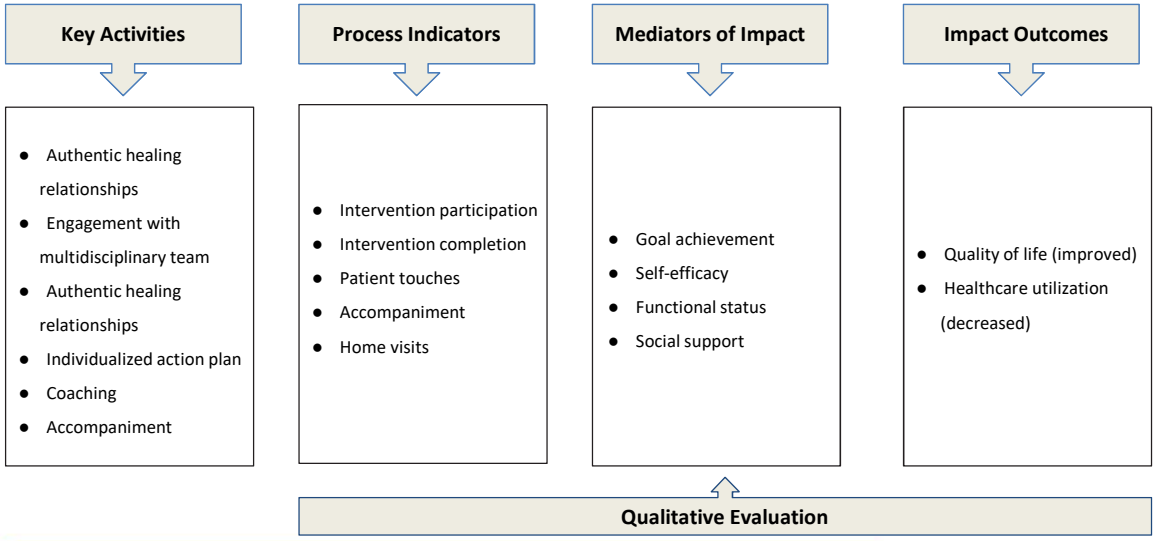
Evaluation Framework



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Demographics

- **15** medical problems per patient (mean)
  - 32% diabetes
  - 43% mental health (including substance use disorder)
  - 25% Cardiovascular Disease
- ED charges (in previous 12 months)
- Hospital Admissions (in previous 12 months)

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Process Indicators

- **33** touches per patient (mean)
- **13** home visits per patient (mean)

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Goal Achievement (Mediator of Impact)

- In collaboration with CHW and multidisciplinary team, patients identify (on average) **2 goals**
- **100%** of patients have achieved at least 1 goal

Sample Goals Achieved by Patients

1. Securing transportation resources
2. Learning coping skills
3. Improved mobility
4. Healed open wounds
5. Underwent cataract surgery

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Feedback - Providers

"(The group visit) helped identify ways that our integrated services could collaborate together to help with patient goals and to identify any barriers to care. Jeanette formed a close bond with the patient which helped with patient engagement and trust in her care team."

"I have a patient who was nearing the graduation portion of the process. She was so happy and excited about some of the strides she had made with her family and Jeanette that she cried with a smile on her face when she learned she was going to graduate. She was extremely grateful for all the program did for her, especially Jeanette."

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Lessons learned

- Finding the right person(s) for the CHW role essential
- Enrolling patients in the project took more time and effort than anticipated
- Initial neural network algorithm design was ultimately supplanted by provider nomination
- Research arm of study took some time to get up and running
- Sustainable funding is key to this work

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Successes

- We ultimately did find the right person for the CHW role
- We have been able to enroll patients in the project who were identified via provider nomination
- Research arm of the study is ongoing and we hope to have some data to present in the near future
- We have met a lot of collaborators through this work who also care about the health of our community

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Questions?

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