Navigator Tool: Linking Patient Preferences and Needs to Programs

Bree Holtz, PhD
bree.holtz@va.gov
Ann Arbor VA Healthcare System

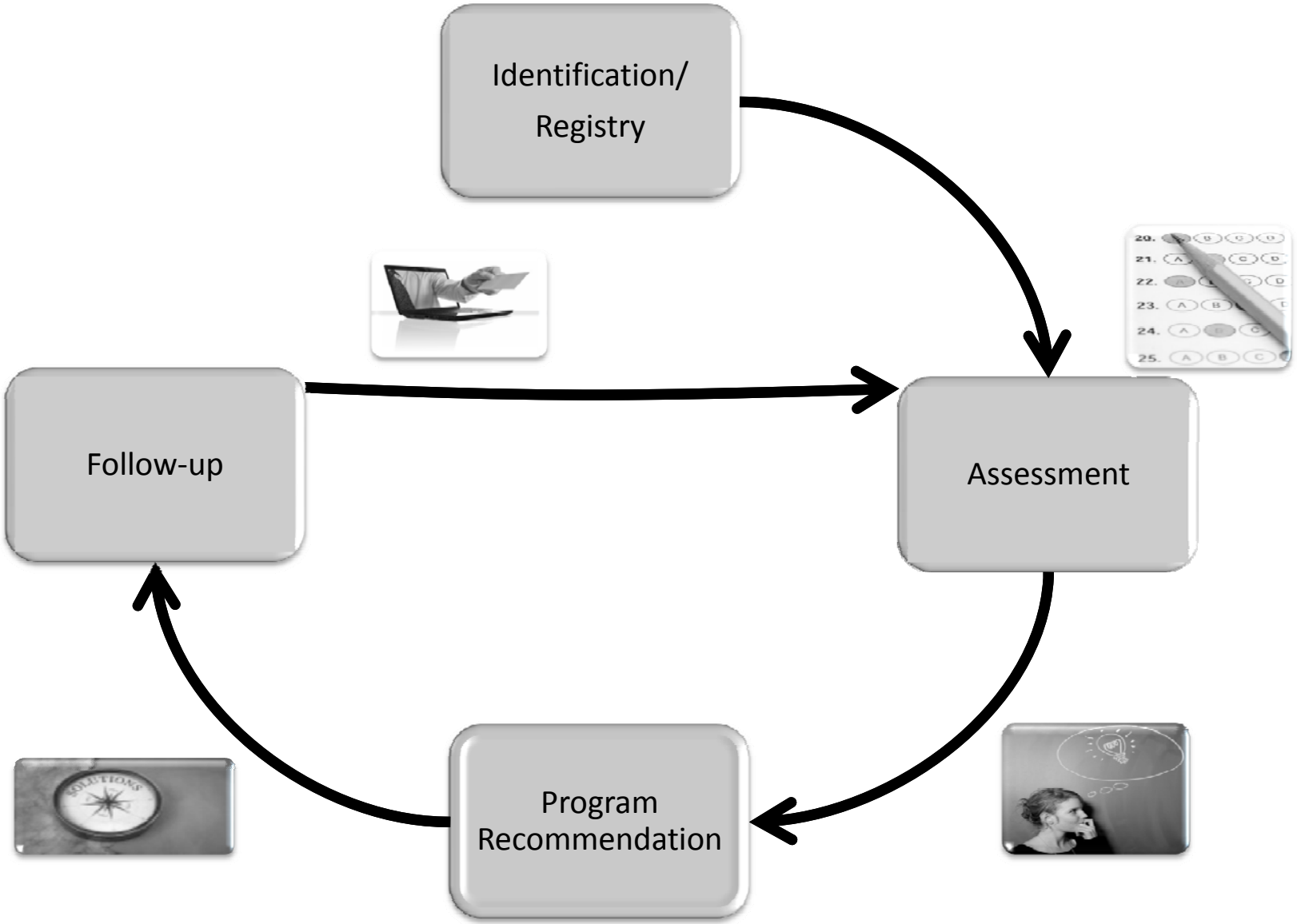
Past Literature

- Previous Navigation:
  - Cancer Care & Pediatrics
  - Who has been the Navigator
  - Outcomes
- PACT: Navigation
  - Shifted paradigm
  - Improve patients' access to services
  - Engage in shared decision making

Navigator in PACT - Objectives

- Patient-centered care
- Non-traditional care options
- Care coordination
- Match patients to programs based on their needs and preferences

The Navigator Tool



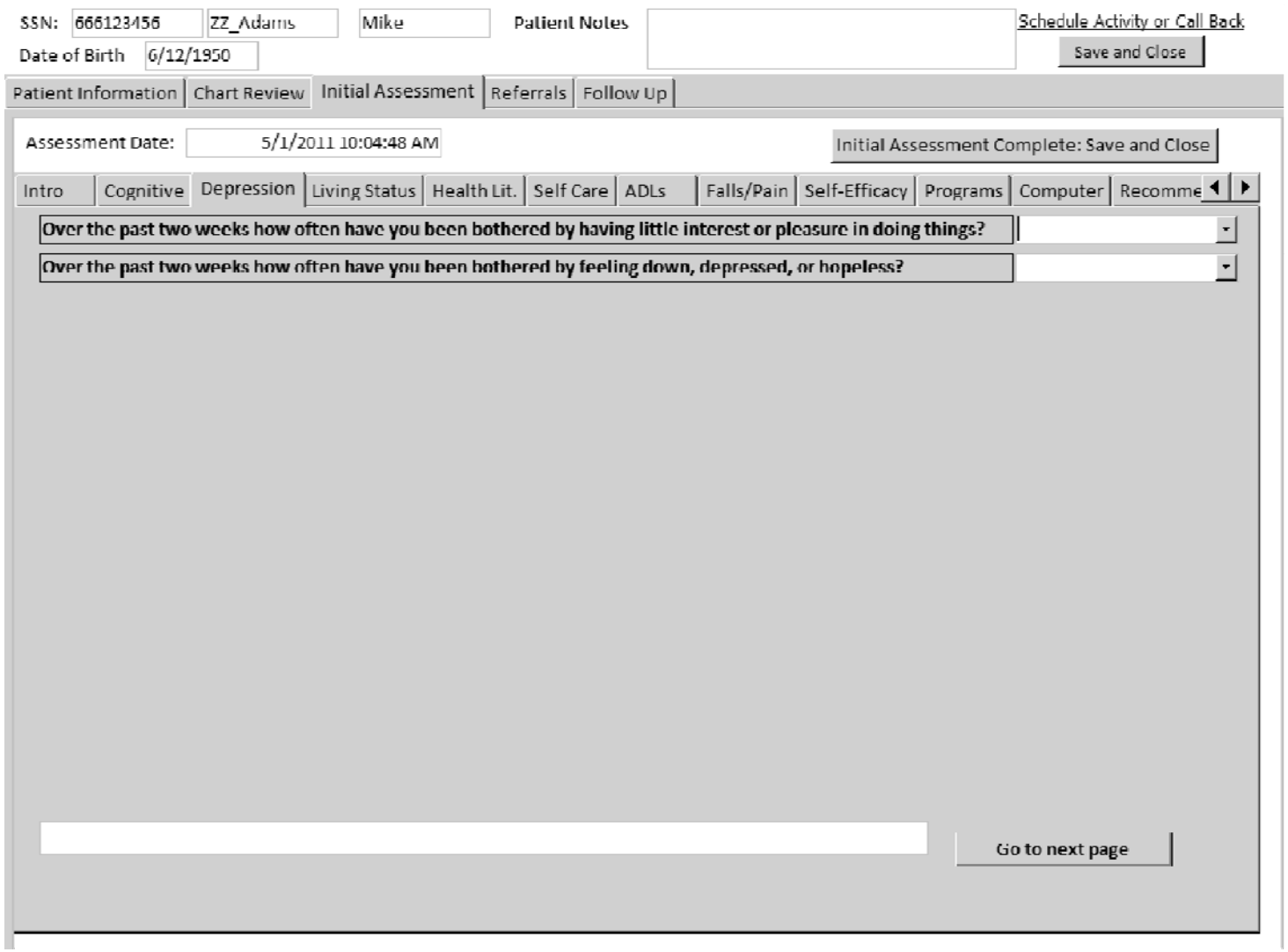
The Navigator Tool

Not a “case management” tool

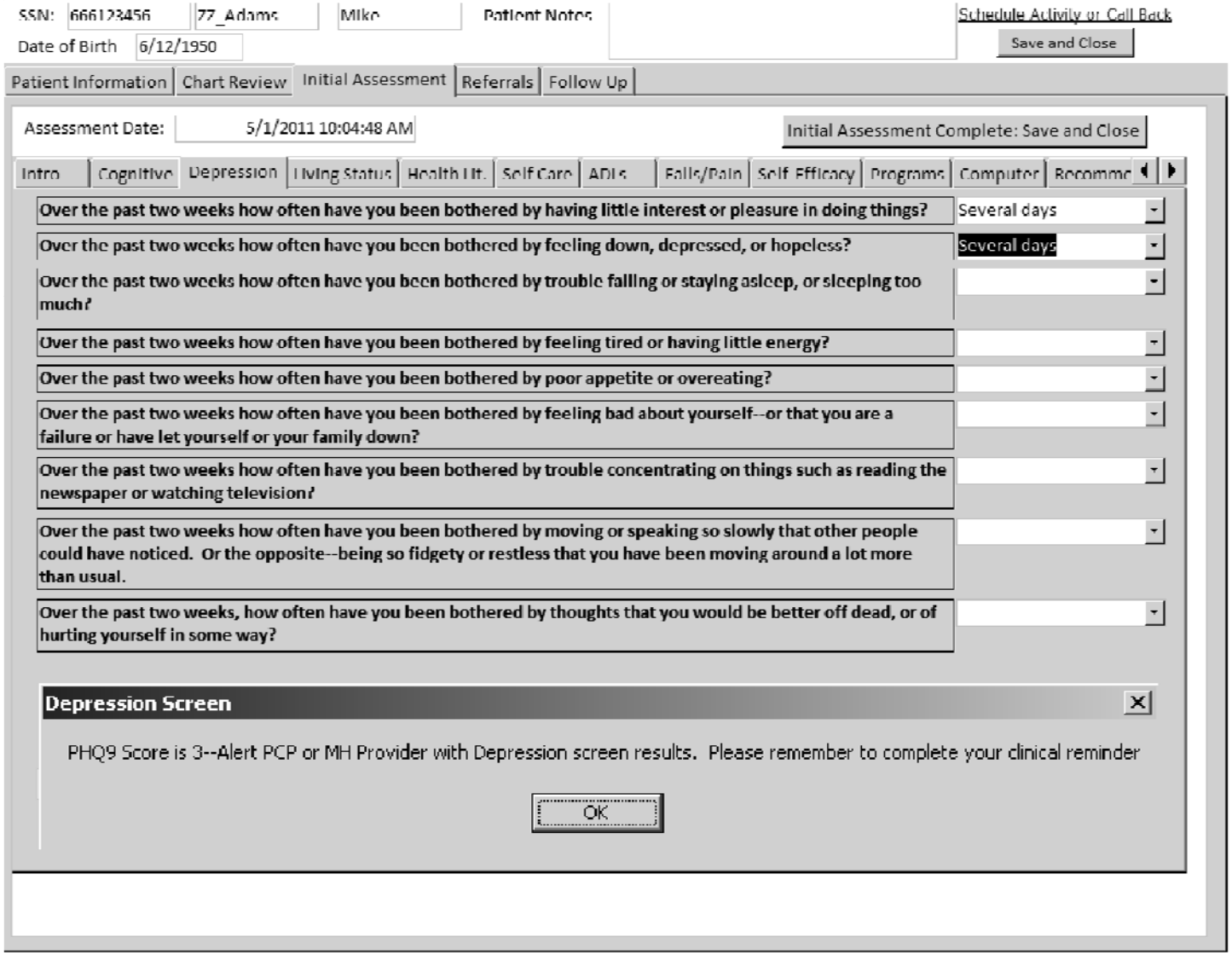
Domains

- (Chart review)
- General Patient Information
- Cognitive Questions*
- Depression
- Living Situation
- Social Support
- Literacy*
- Tobacco Use
- Alcohol Use
- Medication Adherence
- Self-Care Management Adherence
- Frailty
- Pain
- Self-Efficacy
- Fall Risk*
- Transportation
- Technology Use
- Health Priorities/Preferences*

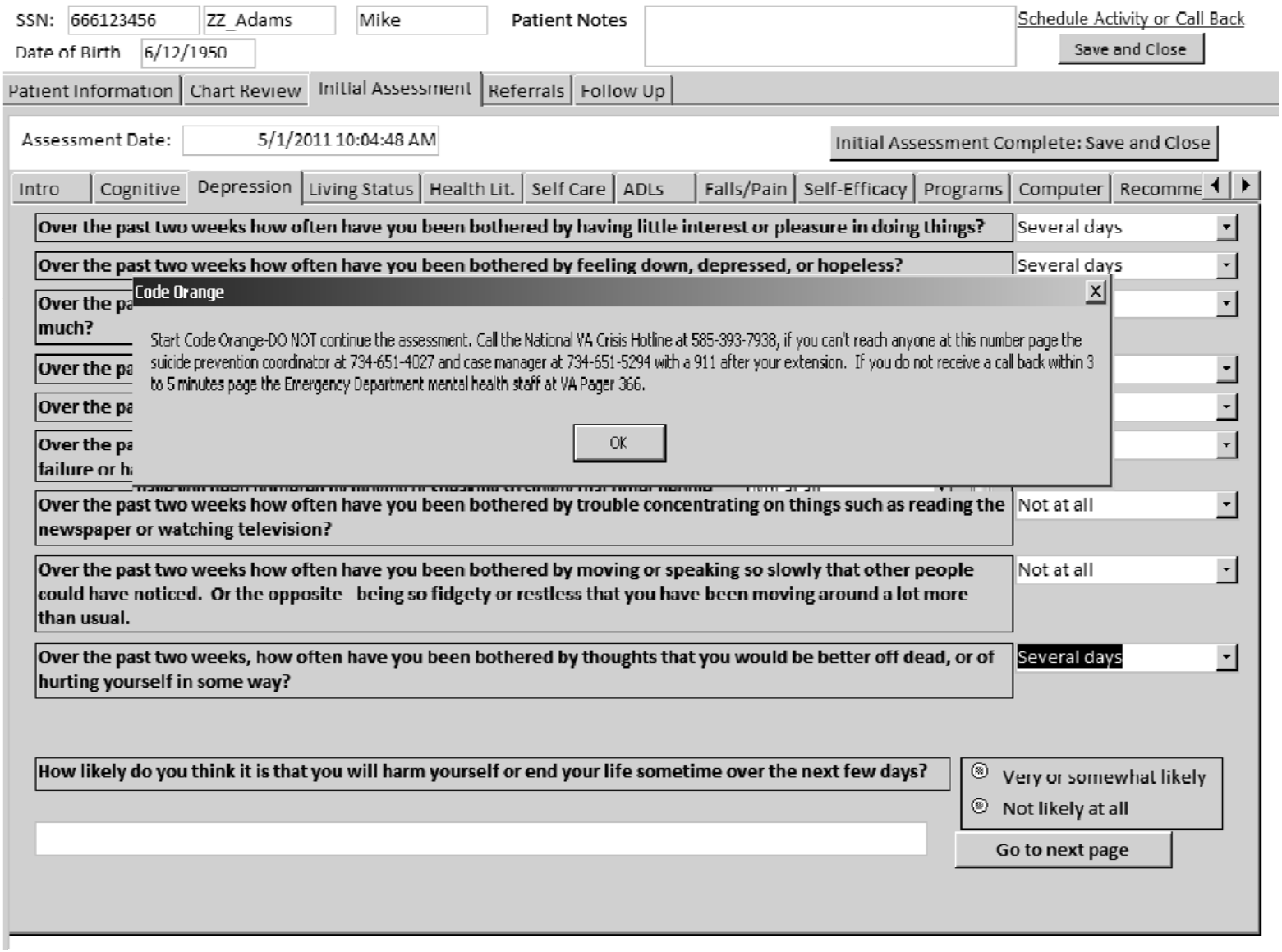
Initial Assessment – Depression



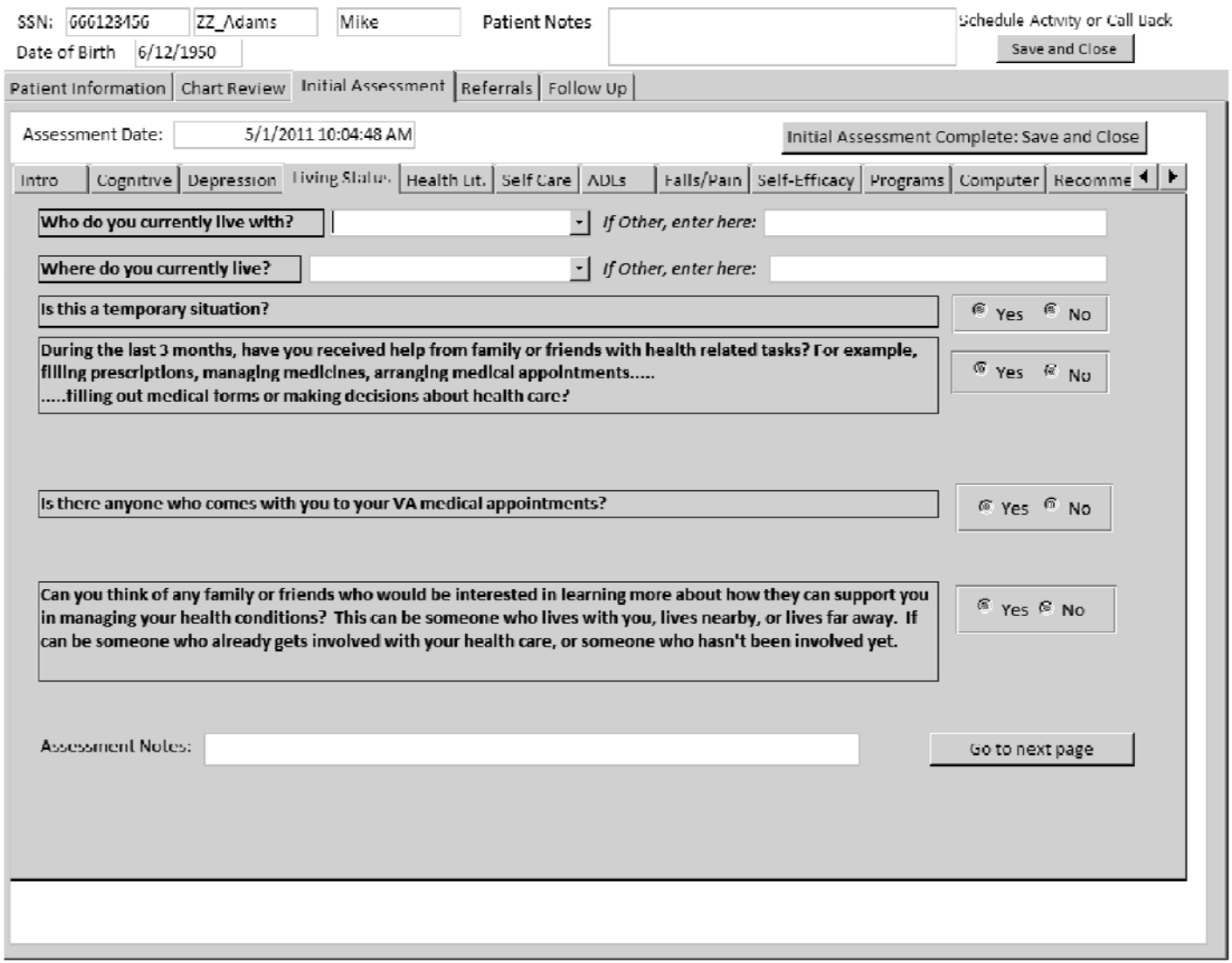
Initial Assessment - Depression



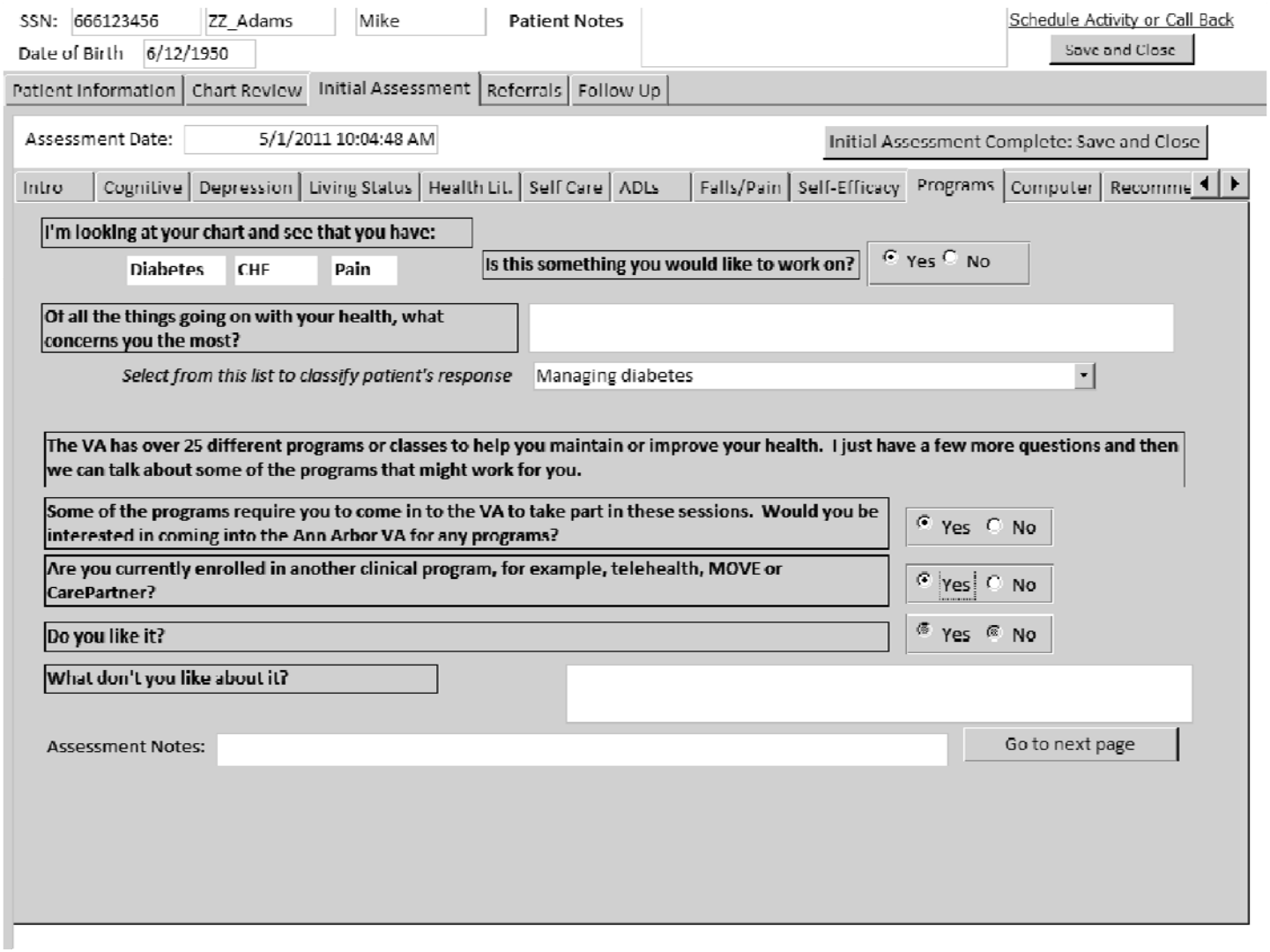
Initial Assessment - Depression



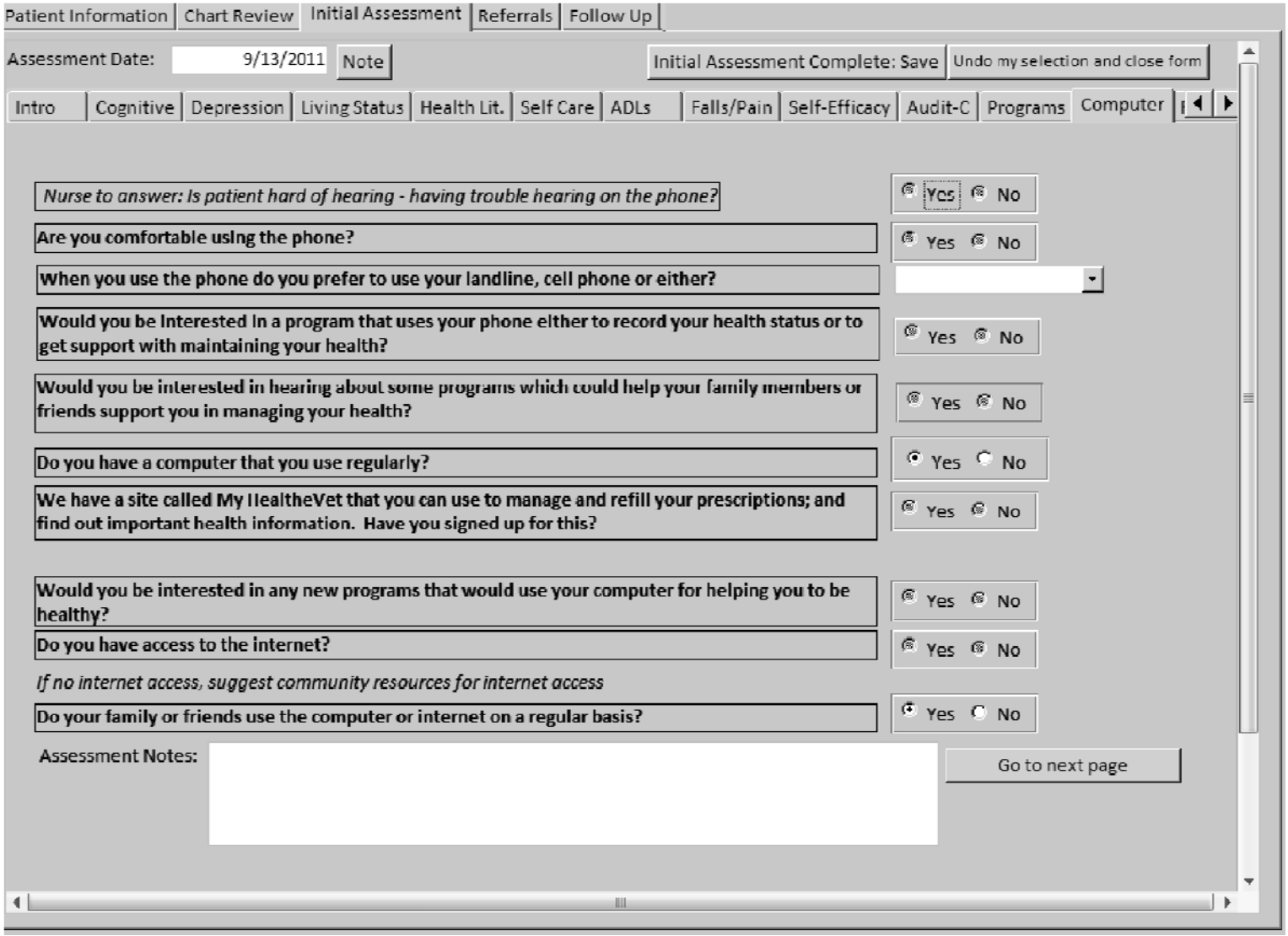
Initial Assess – Living Situation



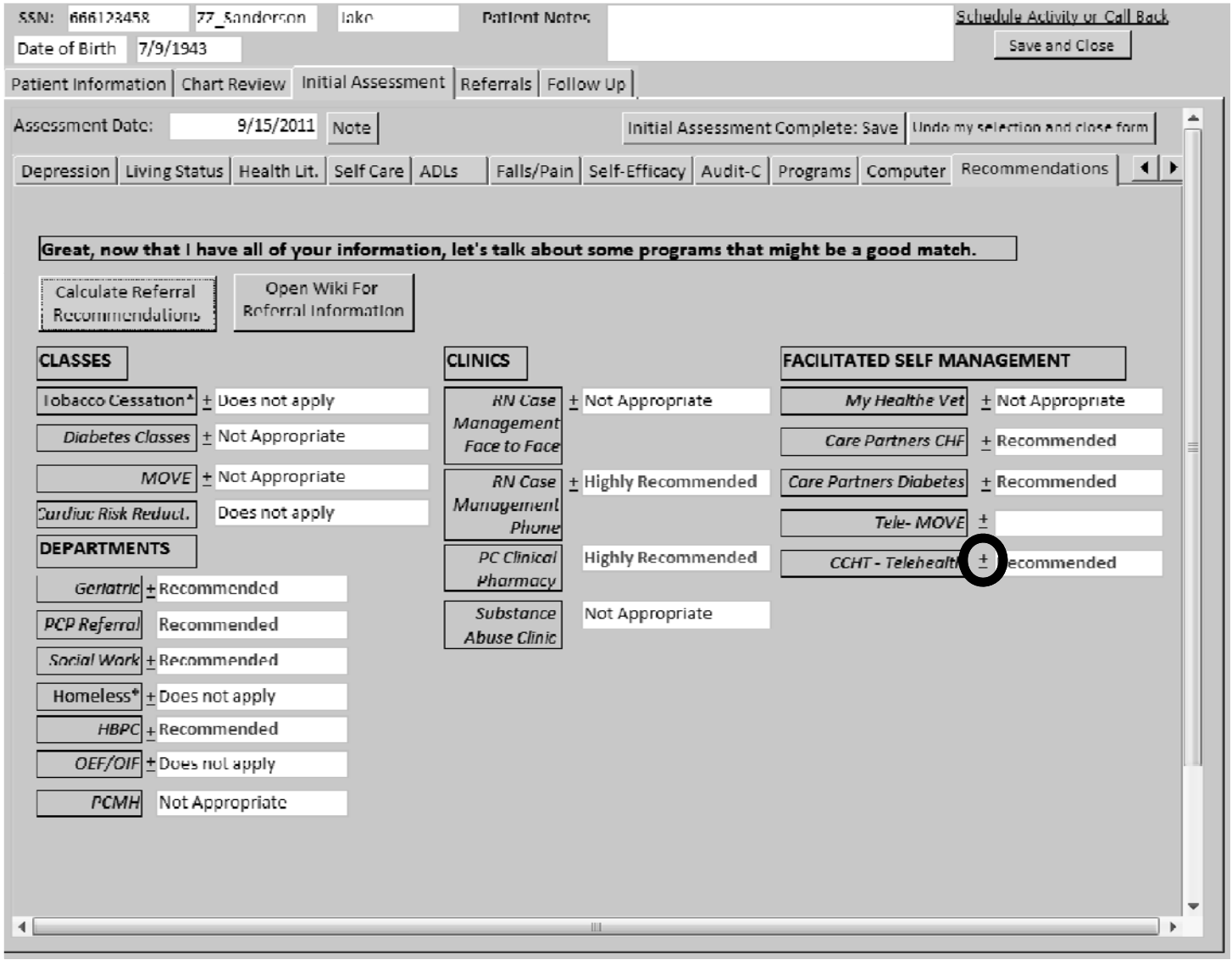
Initial Assessment – Health Priorities



Initial Assessment – Technology Use

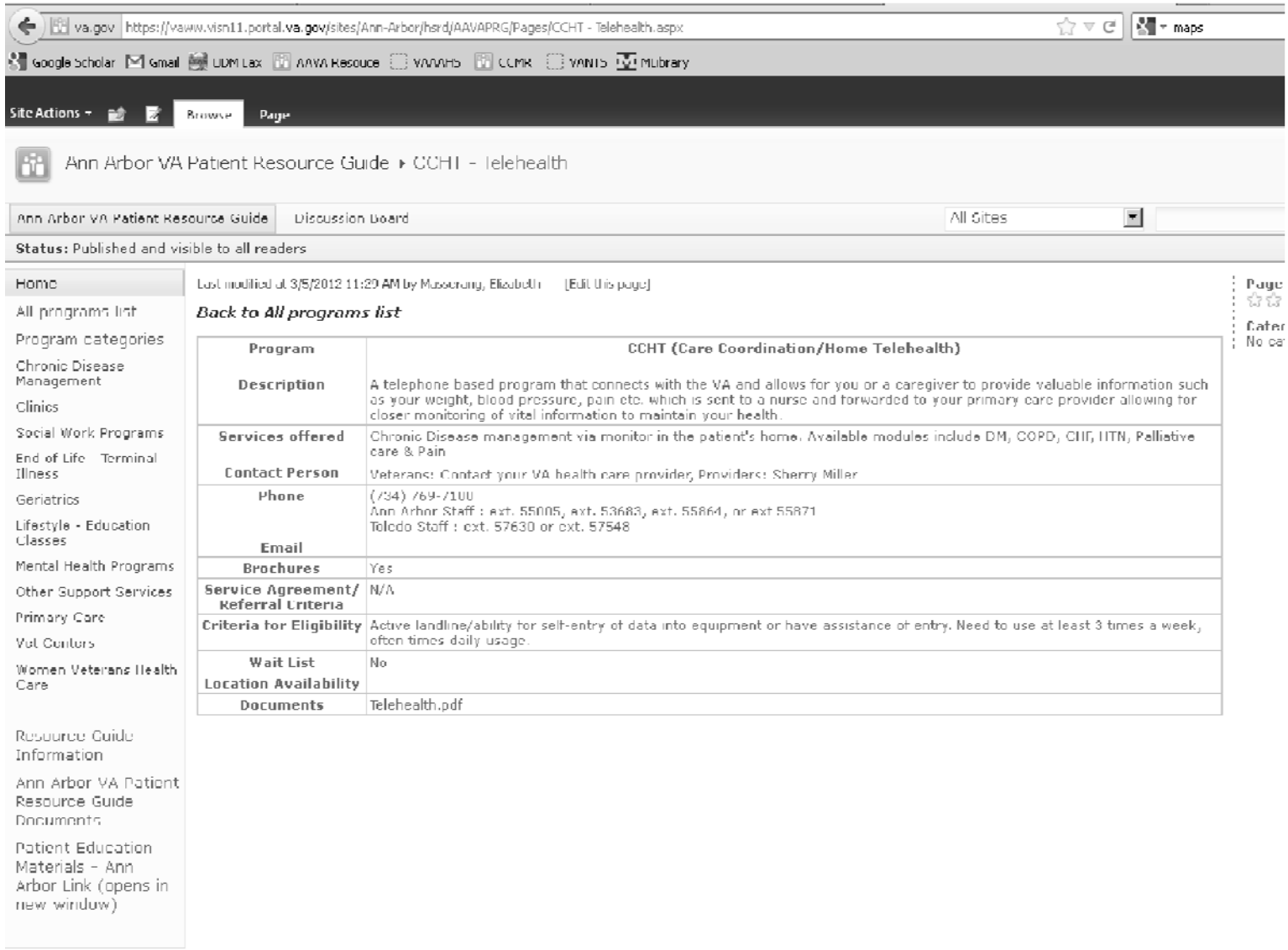


Initial Assessment – Program Recommendation



Resource Guide

https://vaww.visn11.portal.va.gov/sites/Ann-Arbor/hsrd/AAVAPRG/Pages/Home.aspx



What is the Home Telehealth Program?

The Home Telehealth program helps to manage depression, diabetes, congestive heart failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), hypertension, chronic pain, cancer, and weight management. After a short training session at the VA, you can complete sessions from home using a home phone, cell phone, or internet connection. Information you enter, such as: your blood pressure readings, weight, or even your blood sugar readings are reviewed by our staff and if needed, changes in your treatment can be made before your next visit.

How do I find out if the Home Telehealth Program is right for me?

If you are interested, check the items below that apply to you and show this form to your healthcare provider.

- ☐ Do you have a working phone and electricity?
- ☐ Are you willing to enter information 5 times week?
- ☐ Do you have diabetes, heart failure, COPD, hypertension, depression, chronic pain or receive palliative care?
- ☐ Do you live alone?
- ☐ Are 75 or older (you can be younger and still participate)?
- ☐ Have had two or more hospitalization in the past year?
- ☐ Have had ten or more clinic visits in the past year?
- ☐ Have had two or more ER visits in the past year?
- ☐ Do you need help with preparing meals, housework, shopping, bathing, or dressing?
- ☐ Do you need a cane, walker, or scooter to move around?
- ☐ Do you have trouble remembering to take medications?

VA Ann Arbor Healthcare System
Home Telehealth Program
2215 Fuller Road -Ann Arbor, MI 48105
(734) 769-7100
Ann Arbor Staff : ext. 55005, ext. 53683, ext. 55864, or ext 55871
Toledo Staff : ext. 57630 or ext. 57548

HOME TELEHEALTH PROGRAM

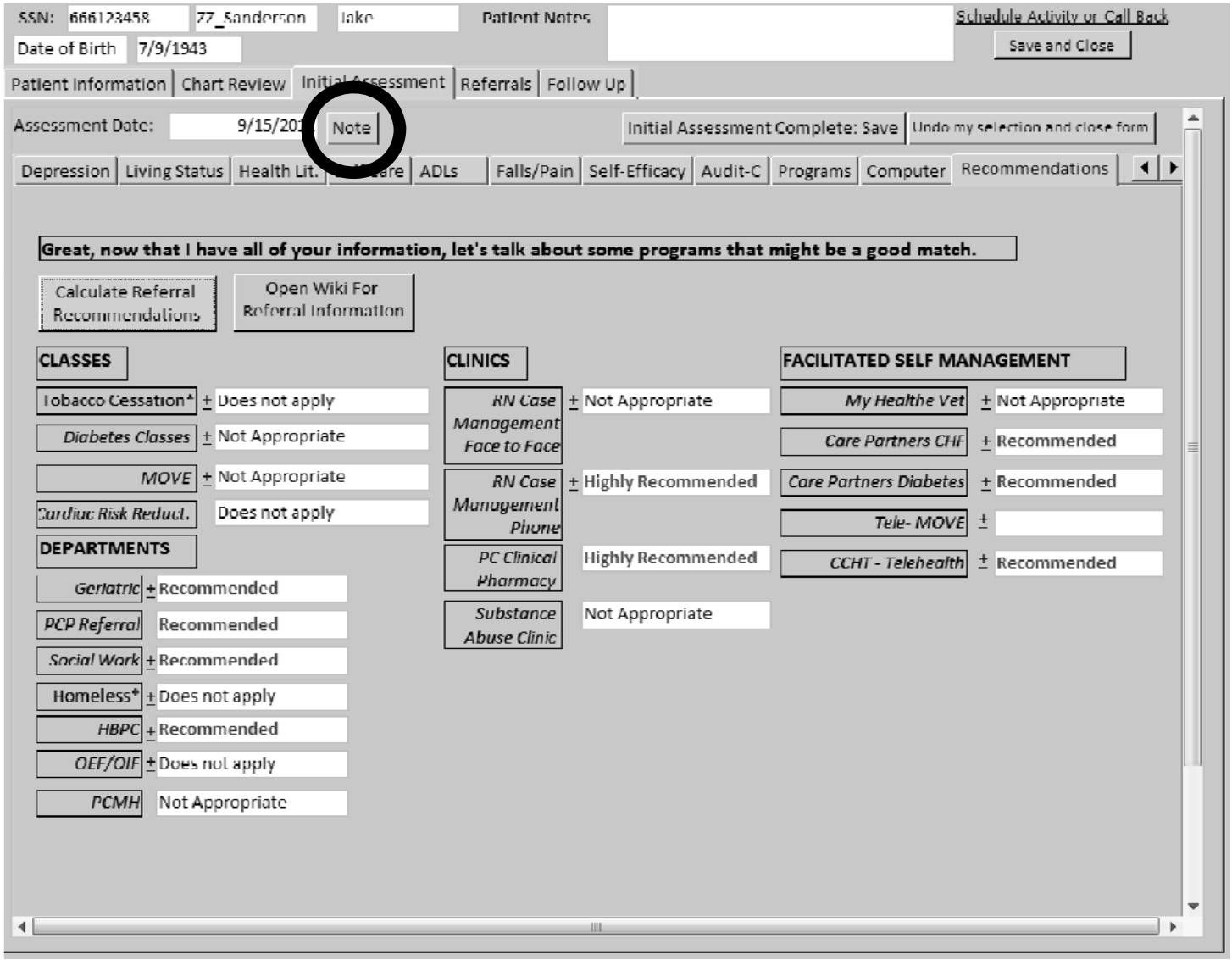
Telehealth

Our mission at the VA is to provide the right care, in the right place, at the right time.

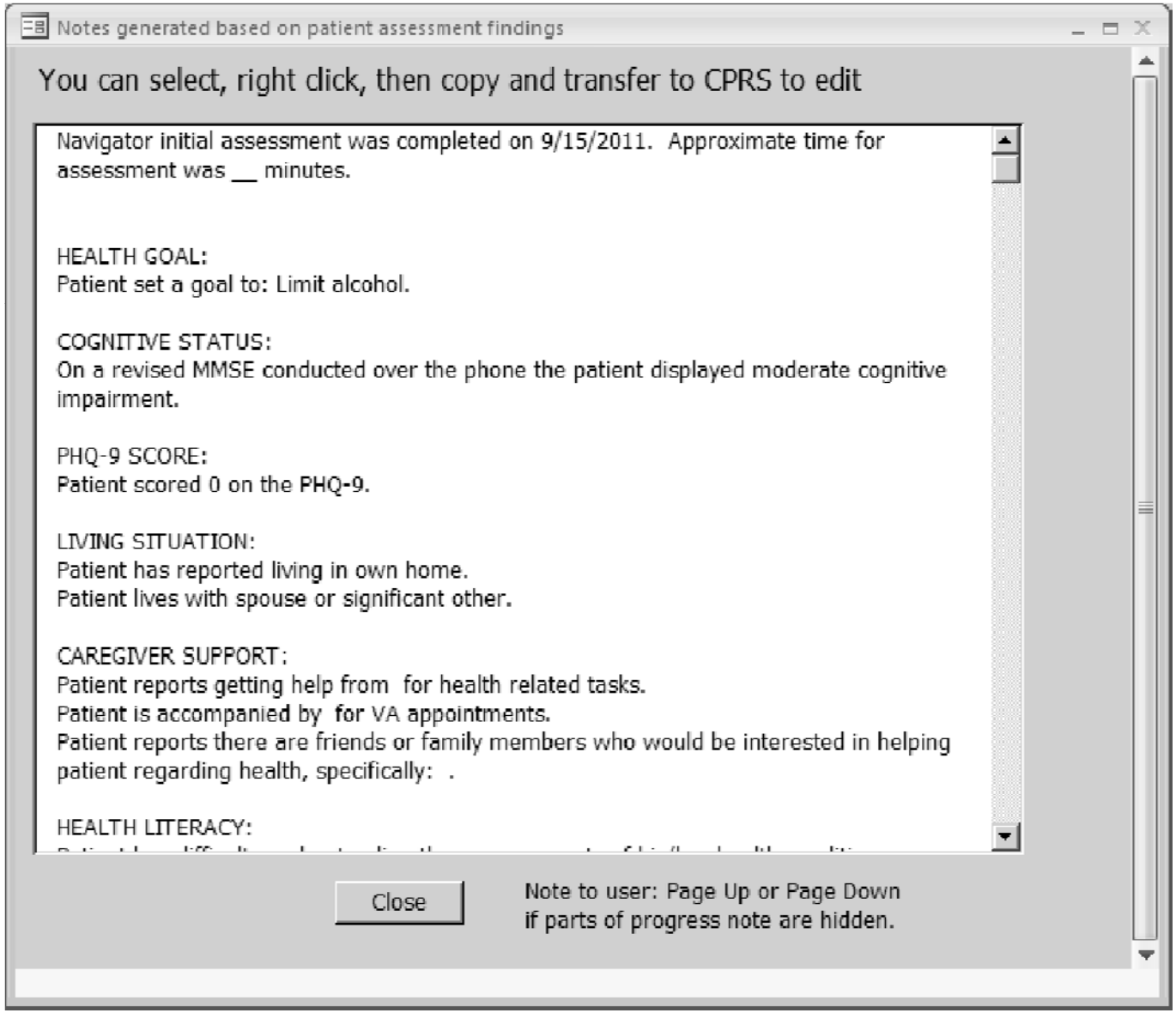
VA Ann Arbor Healthcare System

Ann Arbor • Flint • Jackson • Toledo

Initial Assessment – Program Recommendation



Note


Notes generated based on patient assessment findings
You can select, right click, then copy and transfer to CPRS to edit
Navigator initial assessment was completed on 9/15/2011. Approximate time for assessment was __ minutes.
HEALTH GOAL:
Patient set a goal to: Limit alcohol.
COGNITIVE STATUS:
On a revised MMSE conducted over the phone the patient displayed moderate cognitive impairment.
PHQ-9 SCORE:
Patient scored 0 on the PHQ-9.
LIVING SITUATION:
Patient has reported living in own home.
Patient lives with spouse or significant other.
CAREGIVER SUPPORT:
Patient reports getting help from for health related tasks.
Patient is accompanied by for VA appointments.
Patient reports there are friends or family members who would be interested in helping patient regarding health, specifically: .
HEALTH LITERACY:
Close
Note to user: Page Up or Page Down if parts of progress note are hidden.

Patient Characteristics

- Average patient is a 67 year old male
- Cognitively healthy (93%)
- Is not depressed (only asked the PHQ-2)
- Live with spouse or SO (56%)
- Has someone come to appointment with him (50%)
- Drives (73%)

Patient Characteristics

- Would rather not come to the VA for programs (74%)
- Comfortable using the phone (83%)
- Has a computer that he uses regularly (51%)
  - Has access to the internet (63%)

Program Referrals

Technology-Based Programs:
167 Patient Referrals
My Healthe*V*et (24%)
Tele-RN Case Management (16%)
CCHT (13%)
TeleMove (11%)
CarePartners (10%)

Enhanced Care:
168 Patient Referrals
RN Case Management (12%)
MOVE (11%)
CVD Risk Reduction (8%)
Diabetes Classes (4%)
PCMH (4%)

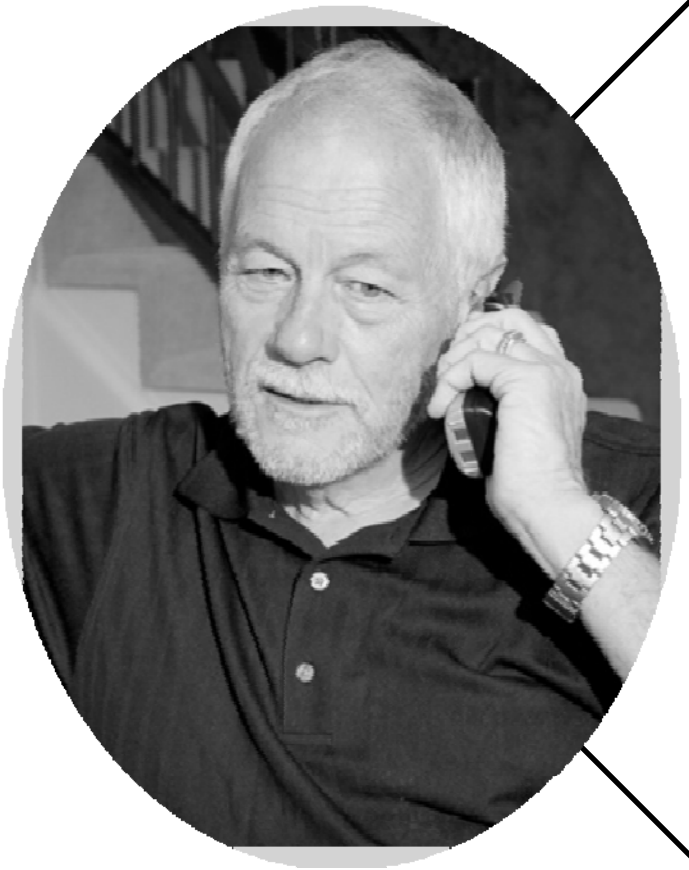
Initial Navigator Assessment N=358

Traditional Care:
93 Patient Referrals
Social Work (18%)
Primary Care Provider (11%)
Pharmacist (3%)
Geriatrics (1%)

Refused a Program:
69 Patients

Patient choice
Education and follow-up is provided

The Navigator System:
A Patient Story of Prevention

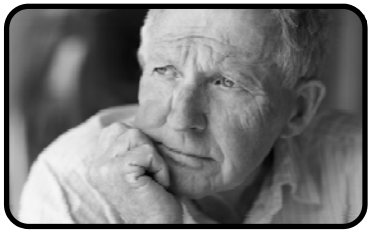


62 yr old male Veteran was referred to social work due to financial issues; his home was in foreclosure. He had no plans as to what to do.

"Thank you for all your help. I got names of agencies that are helping me keep my house; I didn't think anyone cared."

Patient Feedback

“It’s nice that the VA cares enough to ask these questions”



“I am not concerned about my diabetes; I’m more concerned about my wife’s cancer”

“It’s nice that a nurse would take the time out and call me”

“I didn’t know you had different things I can do”

Implementation Challenges

- Stand-alone system
- Teamlet formation
- Space

Nurse Feedback

The Navigator may open up more clinic time for patients

This will help prevent re-admissions, urgent care visits, and walk-ups

Older Veterans use technology more than I thought

The Navigator will help patients to not fall through the cracks

Navigator Development Team

Wendy Morrish, Diane Hooker, Jenny Davis, Liz Masserang, Molly Harrod, Jess Ott, Sarah Krein & Bree Holtz

Questions: bree.holtz@va.gov

Using Peer Mentors to Improve Diabetic Outcomes

Using Peer Mentors to Improve Diabetic Outcomes

Judith A. Long, MD

Funding:
CHERP Pilot Grant Long (PI)
NIA Roybal Center 1P30AG034546 Volpp (PI)
NIDDK R01 DK087874-01 Long (PI)

CHERP
CENTER FOR HEALTH EQUITY RESEARCH AND PROMOTION
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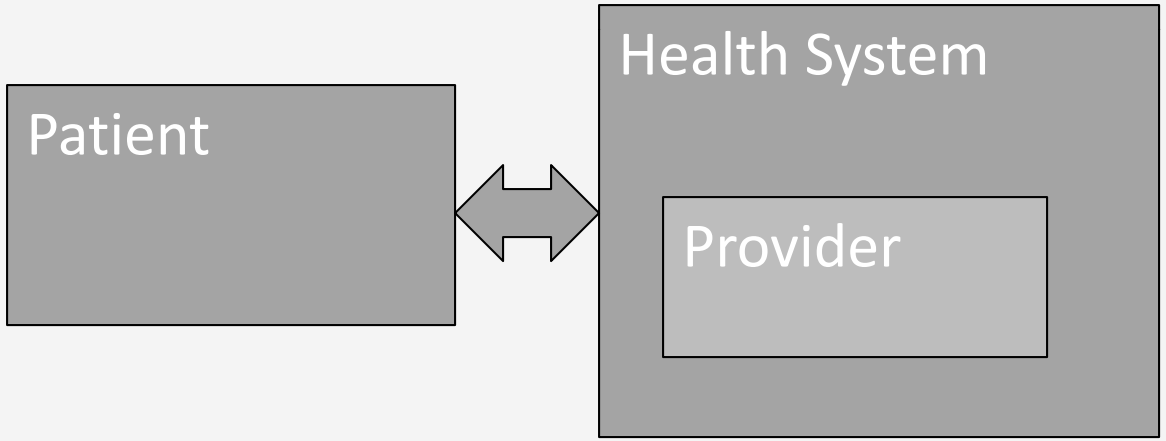
Perelman School of Medicine
UNIVERSITY of PENNSYLVANIA

Diabetes Care and Outcomes

- What are we good at?
  - Improving processes
    - Checking blood tests (Hba1c, LDL)
    - Ordering appropriate care – retinal exams
    - Performing office based care – diabetic foot exams
- What are we bad at?
  - Improving intermediate and long term clinical outcomes
    - e.g. improving HbA1c, avoiding micro-vascular complications
    - Especially for low income and minority populations

Life

Family/friends
Socio-economic factors
Cultural factors
Neighborhood environment
Community support
Access to care
Policy …



Hours awake per year ≈ 6,000: Hours with providers per year ≈ 3 (max)
Need interventions that follow a patient out of the health care system

Peer Intervention Models

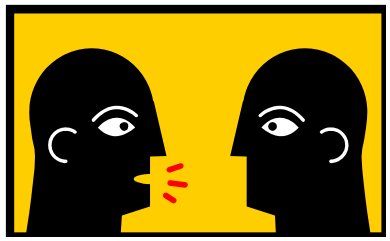
- Group-based self-management
  - Involves professional support
  - Usually conducted within the confines of the health care system
- Peer community health workers/Peer health navigators
  - Peers are semi-professionals and usually salaried
- Peer coaches or mentors
  - Most flexible and informal
  - Can occur anywhere

Heisler. *Fam Pract* 2010;27 (suppl 1): i23-i32
Webel et al. *AJPH* 2010;100247-253

Peer Mentors

- Usually have same culture, language, and disease process
- Often from the same community
- Innately culturally sensitive

- Modes of delivery
  - Face-to-face
  - Telephone based
  - Web and e-mail based



Heisler. *Fam Pract* 2010;27 (suppl 1): i23-i32
Webel et al. *AJPH* 2010;100247-253

Peer Mentoring and Financial Incentives to Improve Glucose Control in African American Veterans. A Randomized, Controlled Trial

Judith A. Long, MD
Erica Jahnle
Diane M. Richardson, PhD
George Loewenstein, PhD
Kevin Volpp, MD, PhD

Ann Intern Med March 2012

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Design

- 6 month long, randomized controlled trial
- Participants
  - African American, veterans, 50-70 years old
  - Enrollees: persistent poor DM control
    - Last two HbA1c > 8% with last measure being within 3 months of enrollment
  - Mentors: currently in good DM control
    - HbA1c of > 8% in the past 3 years and an HbA1c ≤ 7.5% within 3 months of enrollment

Procedures: All Enrollees

- HbA1c drawn at enrollment and 6-month
- Notified of baseline and final HbA1c and provided with ADA and VA recommendations for HbA1c targets
- Monthly calls assessing for hypoglycemic symptoms and serious adverse events
- $25 to enroll and $25 to complete final HbA1c

Intervention Procedures

Mentor Arm

- Matched to mentor by gender and age (+/- 10 years)
- Mentors:
  - 1 hour one-on-one training with RA
  - Provided with mentee's phone number
  - Called monthly to reinforce training
  - $20 per month if talked at least 4 times in month

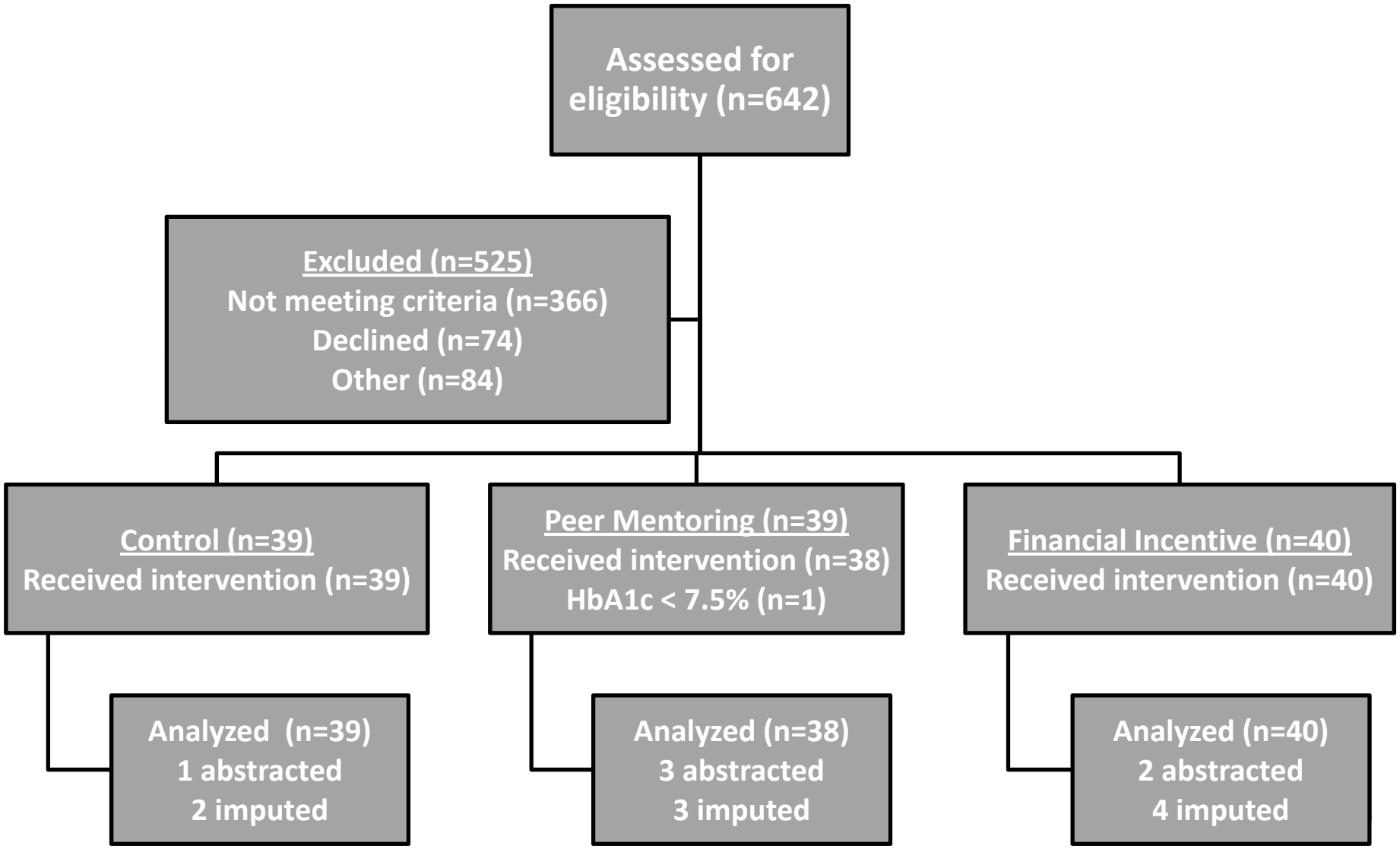
Incentive Arm

- Lump sum for achieving goal at 6 months : $100 for 1 point improvement, $200 for 2 point improvement or HbA1c of 6.5%

Analysis

- Intention-to-treat
- Main outcome: change in HbA1c
- Missing follow-up:
  - If an HbA1c was found in the medical record around time for follow-up (+/- 4 weeks), used record HbA1c
  - If no HbA1c in the medical record used multiple imputation

Study Flow Diagram



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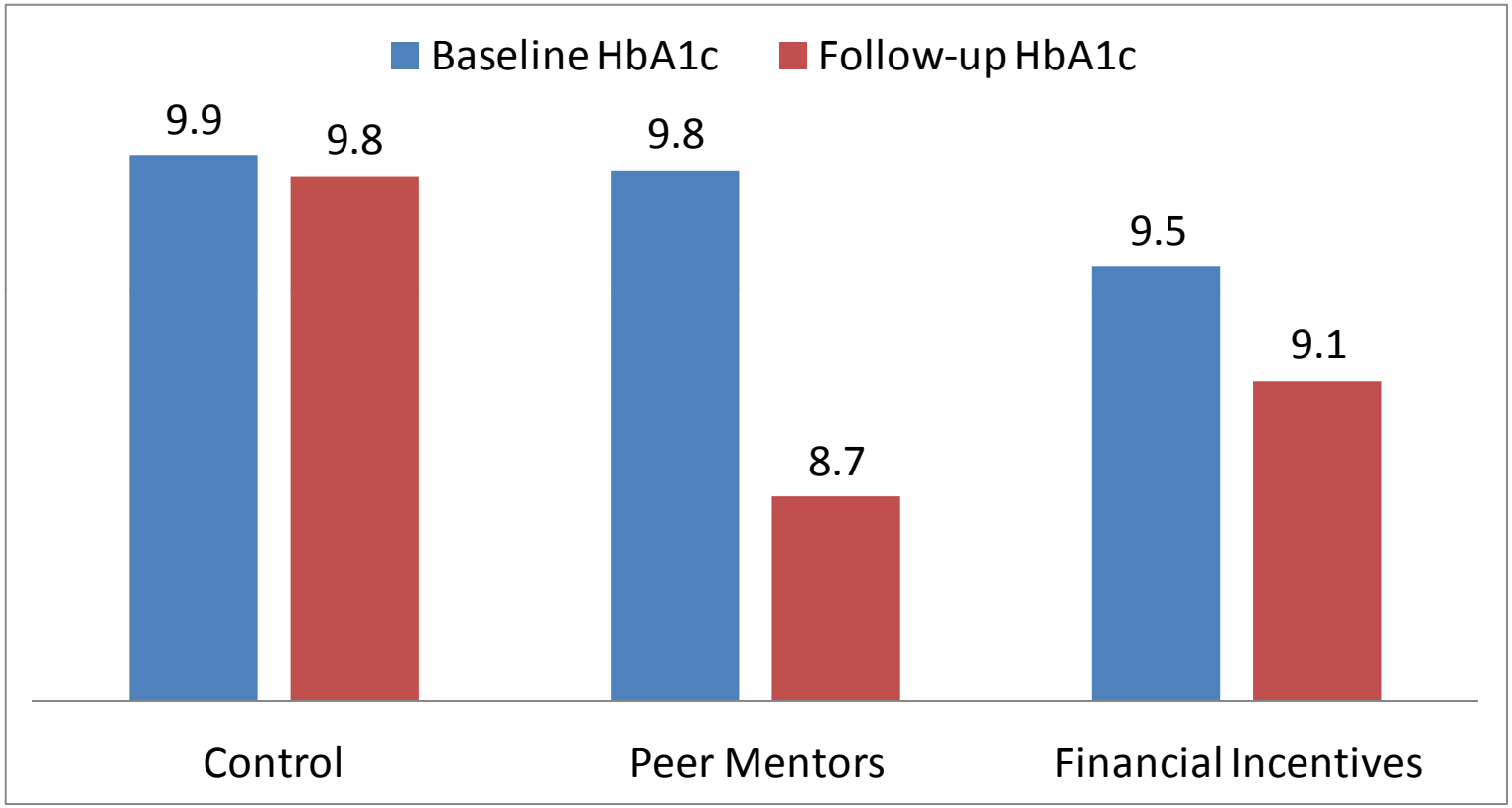
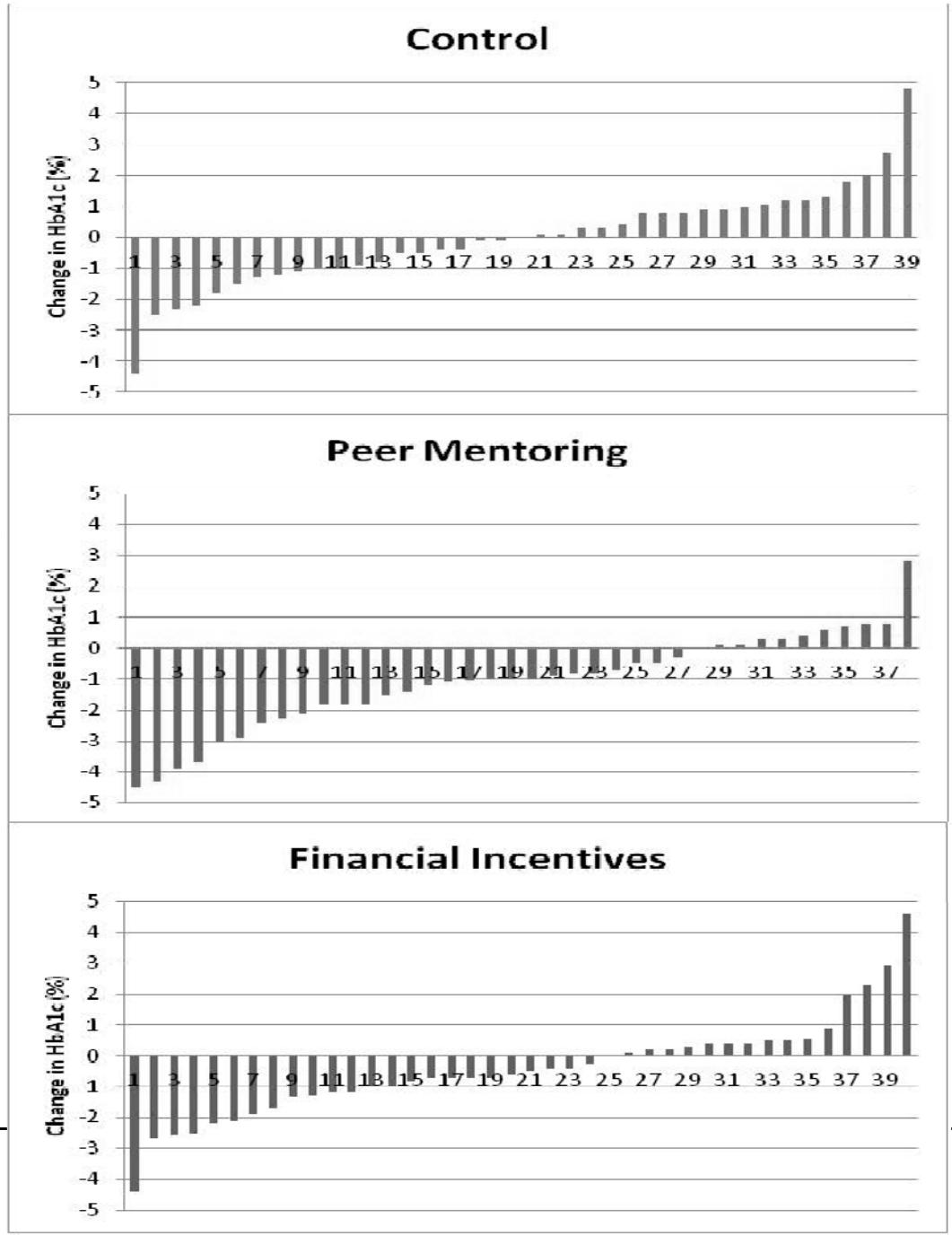
Participant Characteristics

	Arm 1 Control (39)	Arm 2 Mentoring (38)	Arm 3 Incentives (40)
Mean Age, (SD)	59.8 (4.4)	58.8 (5.1)	59.1 (4.9)
Education <12, %	64.1	68.4	50.0
Married, %	46	58	38
On Insulin, %	71.8	71.1	62.5
Diabetes >10 years, %	66.7	55.3	52.3
Any DM Co-morbidity, %	92.3	81.6	97.5
Smoker Current, %	33.3	47.4	27.5
All healthcare at VA, %	74.4	73.7	72.5
Good Adherence, %	66.7	78.9	80.0
Mean Baseline HbA1c, (SD)	9.9 (1.6)	9.8 (1.8)	9.5 (1.2)
Mean Days Between Tests, (SD)	185 (11)	195 (15)	185 (13)

Pre and Post HbA1c





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Mean Change in HbA1c Level

Mean Change	Usual Care	Peer Mentoring	P Value	Financial Incentive	P Value
From Baseline (95% CI)	-0.01 (-0.52 to 0.51)	-1.08 (-1.62 to -0.41)		-0.46 (-1.02 to 0.10)	
Relative to Control (95% CI)*		-1.07 (-1.84 to -0.31)	0.006	-0.45 (-1.23 to 0.32)	0.25

*Covariates: baseline HbA1c, marital status, insulin use, diabetic comorbid conditions, duration of diabetes, self-reported adherence

Adverse Events

	Usual Care	Peer Mentoring	Financial Incentive
Deaths	0	0	0
Serious Hypoglycemic Events	1	0	1
Minor Hypoglycemic Events/Month			
0, n (%)	142 (71)	107 (61)	121 (64)
1-3, n (%)	28 (19)	52 (30)	51 (27)
>3, n (%)	21 (10)	15 (9)	16 (9)

- All events unexpected
- No enrollees removed from study due to adverse events

Qualitative Feedback re Peer Mentors

Mentees

- Important that the mentor had diabetes (26/28)
- Appreciated the support (14/28), education (9/28)
- Trouble getting in touch (4/28), lack of compatibility (3/28)
- Wished for a face-to-face introduction (8/28)

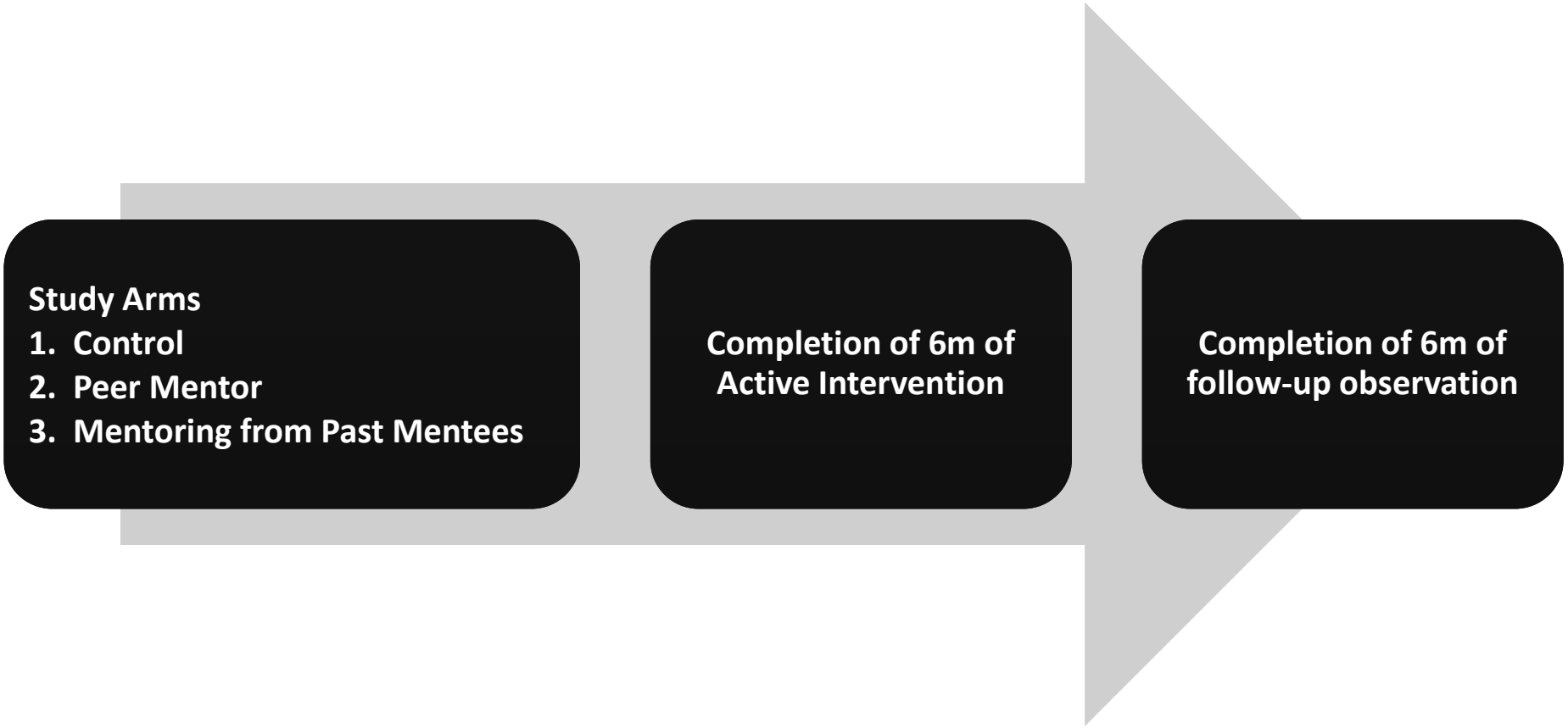
Mentors

- Appreciated helping others (12/24)
- Thought it important previously been out of control (15/24)
- Trouble scheduling (5/24), disinterested mentees (5/24)
- Wished for a face-to-face introduction (15/24)

Limitations

- One race study
- One institution study
- Financial incentives given in lump sum – did not really provide immediate reward for delayed benefit
- Can not determine if the effects will persist

PACT Peer Mentor Study



Conclusions

- Peer mentors had a strong effect in improving glucose control in a population with persistently poor control
- The peer mentor training was extremely short and straight forward – making the intervention very appealing
- Peer mentoring may be a powerful tool to reducing disparities in glucose control and improving clinical outcomes in minority populations
- One size is unlikely to fit all – using navigators may be one way to best fit patients and program together

Thank You

- jalong@mail.med.upenn.edu
- Questions