The Heart of Community Health

BALTIMORE
Medical SYSTEM

BMS Care and Community Health Worker Model

"Building Healthy Communities"

November 15,2010

BMS History with Public Housing

- BMS Outreach staff has a relationship of over 10 years providing health education, principally in Breast Health and Tobacco Use Prevention and Cessation, and access to care to Baltimore City residents of Public Housing
- Interest in reducing health disparities has led to the development of programs using the Community Health Worker model

Community Health Workers
Unique Characteristics & Function

- Lay educators drawn from communities where patients live
- Patients share information with CHWs which they do not reveal to health professionals
- CHWs are trained to listen to patients' specific needs and respond with useful education and links to health/social services.
- CHWs report findings to health professionals that would otherwise remain unknown; detect barriers to following care plan under the supervision of RN and share with clinical team.

Three Powerful Tools

Three powerful tools were combined :

- **Grass roots outreach**
  - Health workers from the neighborhoods
  - Health workers with similar life/cultural experiences
- **-- Culturally competent disease management**
  - Focus on life style and behavior changes
- **--Patient Education**
  - Promotion of healthy lifestyle and self-care management in culturally sensitive ways

"Health for Life" Measurable Indicators

Diagnostic Indicators	Measure	Guidelines
Hypertension	Blood Pressure	High normal: 130–139and/or85–89 [1]
Diabetes	Hemoglobin A1C	HA1C <7% [2]
Obesity	BMI	BMI <27 [3]
Hyperlipidemia	LDL	LDL-C <100 mg/dL [2]

Resources:

Mancia, G, et al. 2007. Guidelines for the management of arterial hypertension: The Task Force for the Management of Arterial Hypertension of the European Society of Hypertension (ESH) and of the European Society of Cardiology (ESC). Eur Heart J 2007 Jun;28(12):1462-536. [1]

AACE Diabetes Mellitus Clinical Practice Guidelines Task Force. AACE diabetes mellitus guidelines. Hypertension management. Endocr Pract 2007 May-Jun;13(Suppl 1):35-40. [2]

www.cdc.org [3]

"Health for Life" Clinical Outcomes

Outcomes for 450 out of 832 patients served.

Clinical Indicators	Outcomes
Hypertension	60% are at goal for BP 130/80 or < (most recent BP)
Diabetes	35% had HgB A1C < or = to 7.0% 55% showed a decrease in their Hgb A1C
Obesity	56 % had a reduction in BMI
Hyperlipidemia	49% LDL below 100 59% LDL moved in a positive direction

- **Reportable outcomes not collected for remaining 382 patients.**

"Health for Life"
Non-clinical Assessment and Interventions

Assessments	Interventions
Many patients live alone.	CHWs gave Medical Alert necklaces to over 50% of the patients served.
Many patients do not have access to an ophthalmologist.	CHWs linked over 200 uninsured diabetic patient to free dilated retinal eye exams at the Wilmer Eye Institute.
Many patients are not comfortable with education at their homes.	RN and CHWs held 85 group education classes at locations in the communities served. 658 patients and family members were reached.
Many patients needed follow-up to understand the provider's orders.	CHWs made calls and visits until the patient understood the doctor's goals for his or her disease management under the direction of RN.

Lessons Learned

- **Establish trust** with patients first and foremost; personal and face-to-face relationships are worth the time they take to create.
- **Develop methods to reestablish relationships** with patients who drop out.
- **Use data collection methods** that make data analysis easy and accurate.
- **Improve integration of CHWs with clinical team;** build a close working relationship with RNs, MAs, and other health center personnel.

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