RN/CHW Care Team Model for Infectious Disease Treatment: From Research to Practice

February 23rd 1:00-2:30pm EST

NATIONAL NURSE-LED CARE CONSORTIUM
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Agenda

01.	Introduction	Introduction of NTTAP Program
02.	CHW/RN Model	Dr. Nyamathi, Dr. Salem and Emily Van Cise: Discussion of research and model with Q+A
03.	Implementation of CHW/RN Model	Jeneen Skinner and Dorothy Scott: Camden Coalition's implementation model with Q+A

National Nurse-Led Care Consortium (NNCC)

The National Nurse-Led Care Consortium (NNCC) is a membership organization that supports nurse-led care and nurses at the front lines of care.

NNCC provides expertise to support comprehensive, community-based primary care.

- Policy research and advocacy
- Technical assistance and education support
- Direct, nurse-led healthcare services

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Learning Objectives

By the end of this webinar, participants will be able to:

1. Discuss foundational components of the CHW/RN care team model as implemented in community health care settings
2. Recognize how the Nurse-Led CHW team may lead to patient engagement and retention for infectious disease treatment including HCV.
3. Identify cost savings, return on investment, and treatment benefits in the CHW/RN model.

UCI University of California, Irvine

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DOWNTOWN WOMEN'S CENTER

NATIONAL NURSE-LED CARE CONSORTIUM

Developing and Implementing Nurse-Led/Community Health Worker Teams as a Model of Care for Underserved Communities Locally and Globally

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The presenters have no relevant financial relationships with any commercial interests to disclose.

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Presentation Outline

- Part I: Characteristics of Community Health Workers, Training, and Fidelity Monitoring
- Part II: Nurse-Led/CHW Model To Improve Medication Adherence among Homeless Adults Diagnosed with LTBI
- Part III: ASHA LIFE - Improving Health and Nutrition of Rural Indian Women Living with HIV
- Part IV: How the Downtown Women's Center Integrated Community Health Workers to Ensure Sustainability

Part I: Community Health Worker Roles, Training, & Fidelity

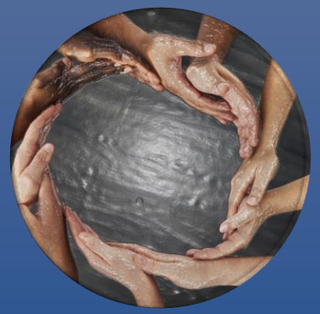
Benissa E. Salem, PhD, RN, MSN, PHN, CNL

NIH/NIMHD R21-MD012696, R21MD013580
NIH/NIDA R01DA027213, R34DA035409

UCLA School of Nursing

Characteristics of Community Health Workers[1]

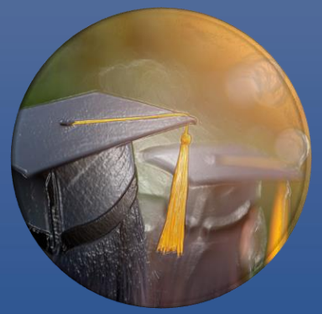
CHWs live in the community they serve



CHWs are selected by that community

CHWs are accountable to the community they work within

CHWs receive short and defined training

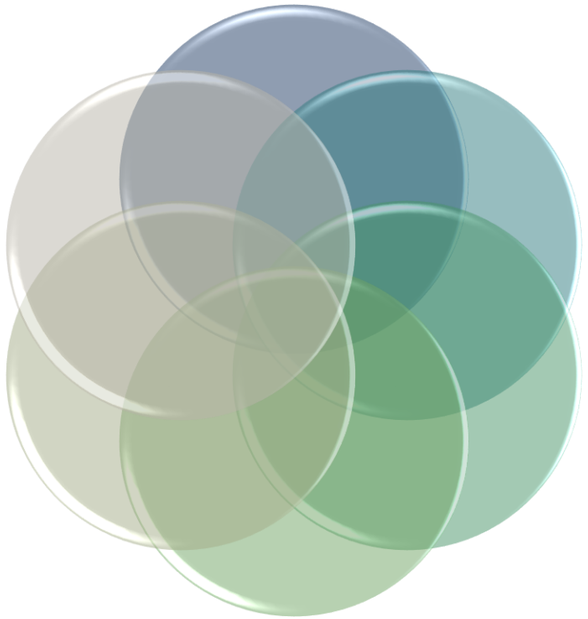


CHWs are not necessarily attached to any formal institution

A Vital Role - Characteristics of Community Health Workers[2,3]

Cultural mediation

Building individual and community capacity and providing direct services



Informal counseling and social support

Assuring people get the services they need

Providing culturally appropriate health education

Advocating for individual and community needs

Community Health Workers Outcomes[3]

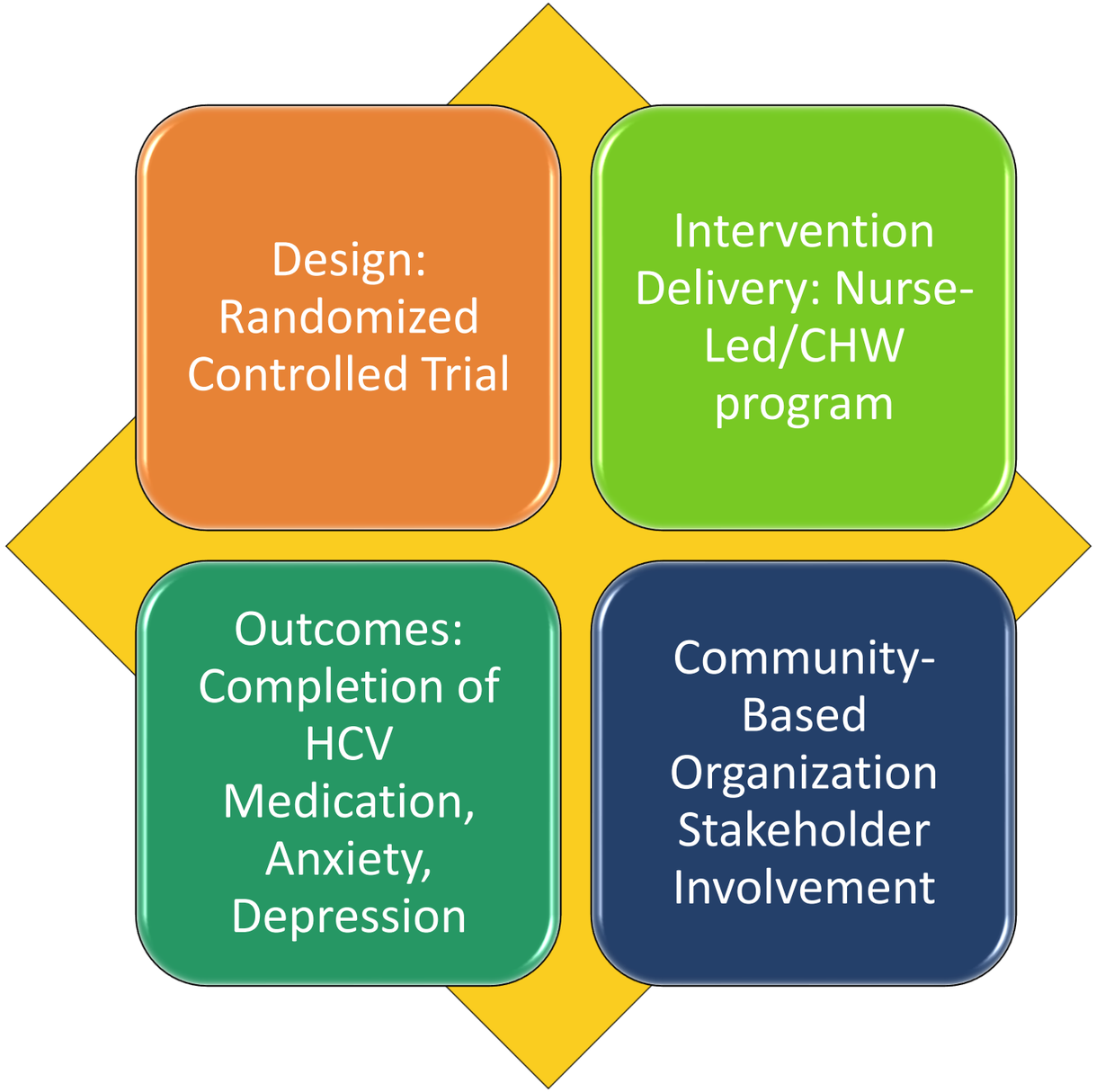
Decreasing Healthcare Costs

Increasing Healthcare Access

Strengthening local economy

Strengthening Family and Community

“I am HCV Free” Intervention Versus Clinic-Based Standard of Care



Training and Supervision of Community Health Workers

Competency Checklist - Example

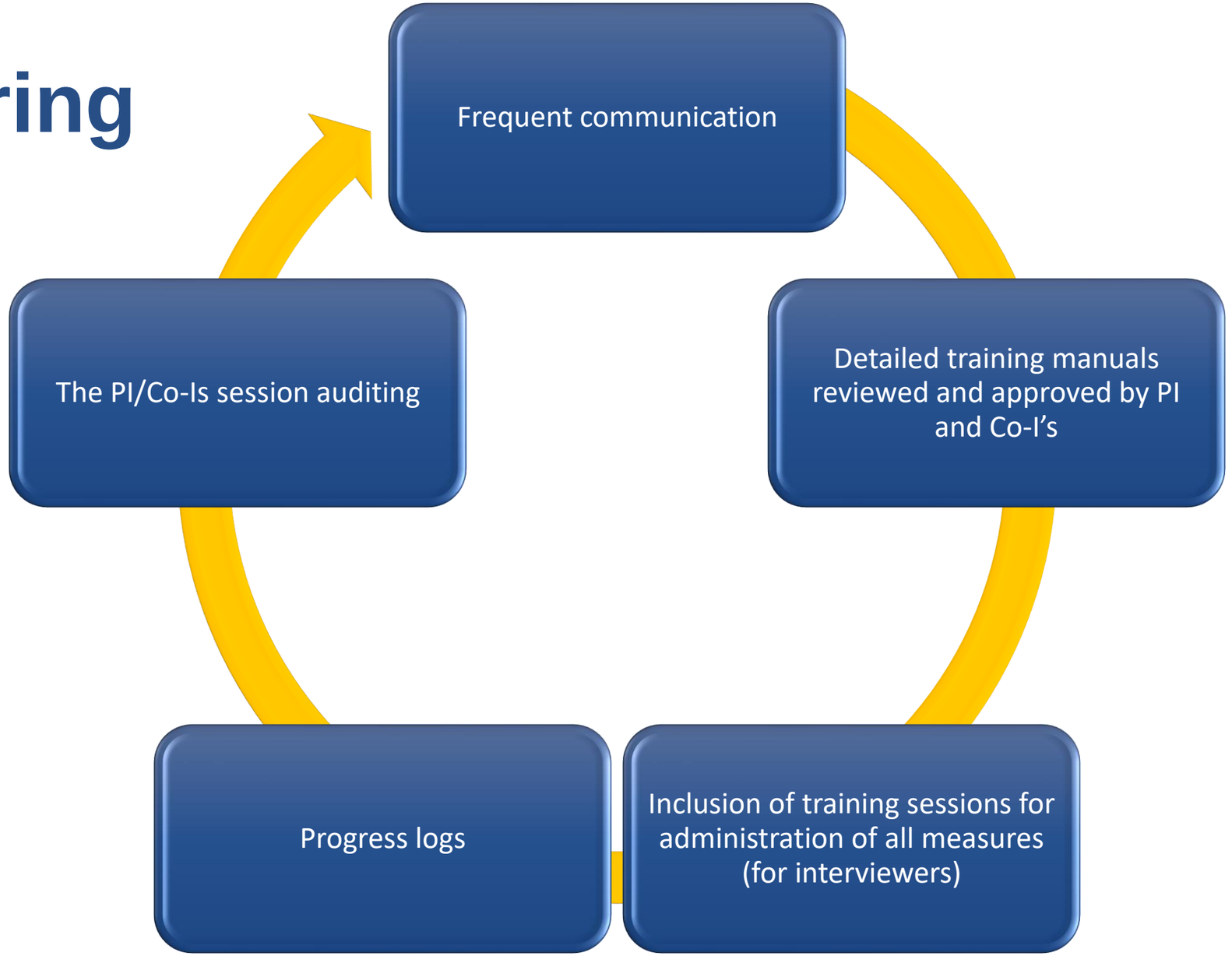
	Excellent	Good	Okay	Needs Improvement	Request to Observe or Discuss Again		Date Observed	Signature
1. Scope of Work & Participant Flow Chart	4	3	2	1	Yes	No		
2. Recruitment and Screening	4	3	2	1	Yes	No		
3. Script for information session at research site	4	3	2	1	Yes	No		
4. Script for information session at performance site	4	3	2	1	Yes	No		
5. Information session script	4	3	2	1	Yes	No		
6. Two-month follow-up flyer	4	3	2	1	Yes	No		
7. Five-Month follow-up flyer	4	3	2	1	Yes	No		
8. Screening Consent	4	3	2	1	Yes	No		
9. Eligibility criteria	4	3	2	1	Yes	No		
10. Laboratory tests	4	3	2	1	Yes	No		
11. Informed consent	4	3	2	1	Yes	No		
12. Locator guide	4	3	2	1	Yes	No		
13. Photo face sheet	4	3	2	1	Yes	No		
14. Enrollment and Mavyret prescription	4	3	2	1	Yes	No		
15. Baseline questionnaire administration	4	3	2	1	Yes	No		
16. Two Month Questionnaire Administration	4	3	2	1	Yes	No		
17. Five Month Questionnaire Administration	4	3	2	1	Yes	No		
18. Urinalysis	4	3	2	1	Yes	No		
19. Mavyret medication pick-up	4	3	2	1	Yes	No		
20. Mavyret medication transport	4	3	2	1	Yes	No		
21. Mavyret medication delivery and pick- up to RN & documentation	4	3	2	1	Yes	No		
22. Mavyret dispensing environment	4	3	2	1	Yes	No		
23. Mavyret dispensing process	4	3	2	1	Yes	No		

Competency Scoring

Scoring Instructions: The following is the scale used to compute the overall evaluation score. A score of **75% (138 points/184 points)** is needed to **pass overall.**

Percentage	Evaluation Grade
97-100	A+
94-96	A
90-93	A-
87-89	B+
84-86	B
80-83	B-
77-79	C+
74-75	C
70-73	C-

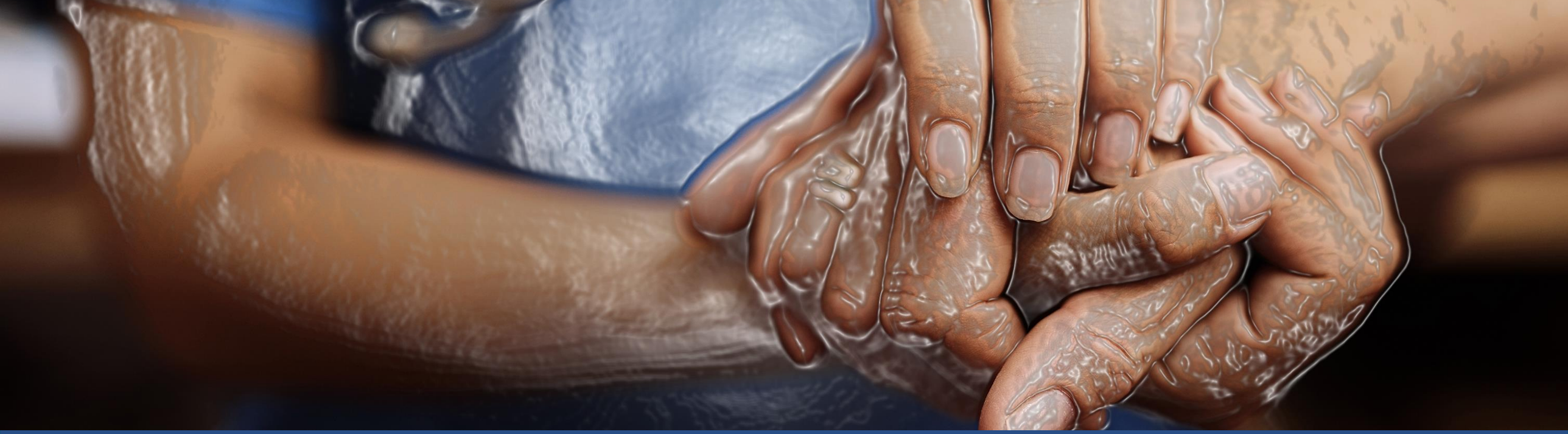
Fidelity Monitoring



Nurse-Led/Community Health Worker Studies

Exemplars

Citation	Design	Results	Conclusions
Nyamathi et al 2016[4,5]	• RCT (N=600)	• When compared to baseline, all three groups made progress on key health-related outcomes during the 12-month intervention period; further, 84.5 % of all participants eligible for hepatitis A/B vaccination completed their vaccine series.	• All three intervention strategies were found to be comparable in achieving a high rate of vaccine completion, which over time will likely produce tremendous savings to the public health system.
Nyamathi et al 2017[6]	• RCT (N=414)	• Regardless of group assignment, significant and clinically relevant reductions were observed in stimulant use over time, and sex with multiple partners	• Culturally sensitive approaches are needed to successfully reduce drug use and risky sexual activities among gay and bisexual populations.
Nyamathi et al 2017[7]	• RCT (N=130)	• The effect of DBT-CM on reducing recidivism was greater among those who expressed a desire for help (risk ratio [RR] = 0.40; 95% confidence interval [CI] = [0.16, 1.00]; p = .050) and among homeless female ex-offenders (HFOs) who were younger (<50 years of age; RR = 0.46; 95% CI = [0.19, 1.11]; p = .085) and participants with Desire for Help score > 35 (Model 3; RR = 0.40; 95% CI = [0.16, 1.00]; p = .050).	• Findings from this pilot study suggest that the DBT-CM intervention may be effective in reducing reincarceration rates among some HFOs during reentry.
Salem et al 2017[8]	• Pilot RCT (N=32)	• While program differences were not statistically significant with the main outcome variables, medium-to-large effect sizes were found in favor of the HP program as it relates to physical and overall frailty, as well as, any drug use, alcohol use, and drug dependency.	• Strengthen the HP program to optimize all domains of frailty (e.g., physical, psychological, and social) and substance use for P/FHW.



Part II: Nurse-Led/CHW Model To Improve Medication Adherence among Homeless Adults Diagnosed with LTBI

Adey Nyamathi, Donald Morisky, Benissa E. Salem, Sanghyuk Shin

NIH/NIMHD R21-MD012696

UCI University of California, Irvine

Background & Significance

- Globally, TB is one of the top 10 causes of death; affecting over 10 million people
- In California, the rate of TB is more than twice the national case rate[9].
- TB is a disease of poverty as it disproportionately affects impoverished communities[10,11].
- In the US, homeless persons have a 10-fold increase in TB as compared to the general population[10,11].

Methods

DESIGN & PURPOSE

Single-Arm Longitudinal Design. Compared a tailored RN/CHW intervention to a historical control[12] of 3HP conducted in a homeless clinic setting.

SAMPLE SIZE

N=466 homeless adults screened; 50 were enrolled.

Delivering an LTBI Intervention: Focus Groups[13]

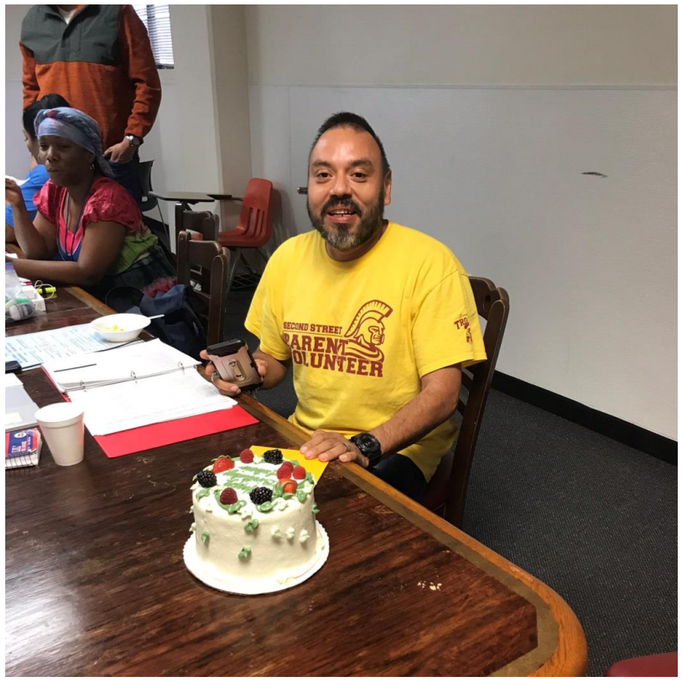
Facilitators

- Characteristics of research staff (i.e., gender, ethnicity language proficiency)
- Familiarity with PEH
- Internalizing Intervention content
- Providing Incentives
- Receiving Comprehensive services
- Staying connected and engaged

Barriers

- Lack of respect
- Lack of education on LTBI medication side effects
- LTBI as a stigmatized disease
- Transient population

Nurse-Led, Community Health Worker Team Delivering LTB Medication to People Experiencing Homelessness



Results[14,15]

- Most participants completed 3HP treatment (**92%; n=49; 65%)** historical control comparison.
- Significant **decreases in any drug use** (p=.004), **amphetamine use** (p = .029), **marijuana use** (p=.001) and **methamphetamine use** (p = .031) at 6-month follow-up.
- Neither drug use, depression, nor anxiety were associated with 3HP LTBI treatment completion.
- Follow-up at three and six months was **94% and 88%**, respectively.

Part III: ASHA LIFE - Improving Health and Nutrition of Rural Indian Women Living with HIV

Adey Nyamathi, Sanjeev Sinha, Maria Ekstrand, Sanghyuk Shin, Catherine Carpenter

NIH/NIMH R01-098729

UCI University of California, Irvine

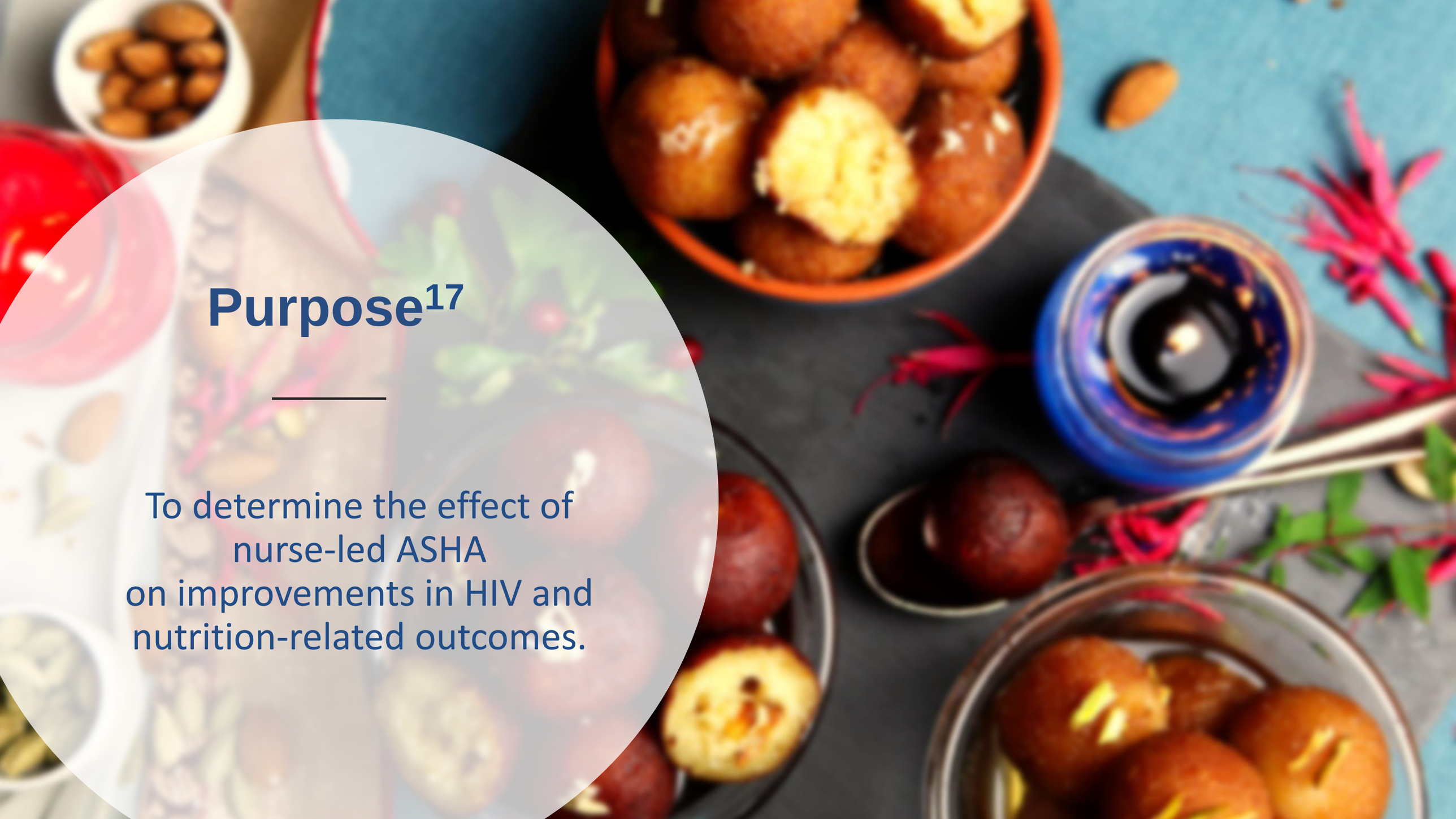
Background & Significance

Over 2.3 million people are living with HIV/AIDS in India

One third are women of childbearing age

Women first learn about being HIV infected when they are pregnant


STOP AIDS TALK AIDS



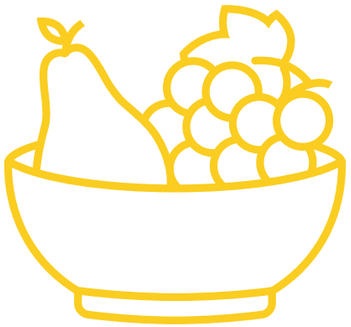
Purpose[17]

To determine the effect of
nurse-led ASHA
on improvements in HIV and
nutrition-related outcomes.

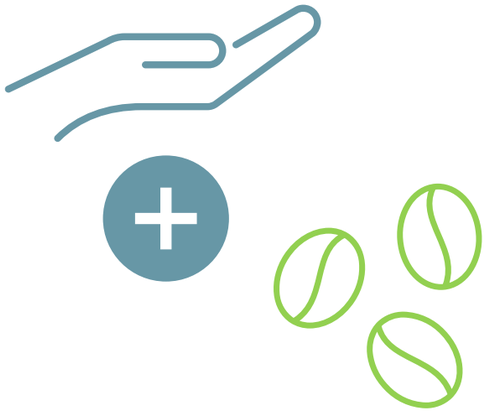
2 x 2 Factorial Design[16,17]

600 women were randomized into one of 4 arms

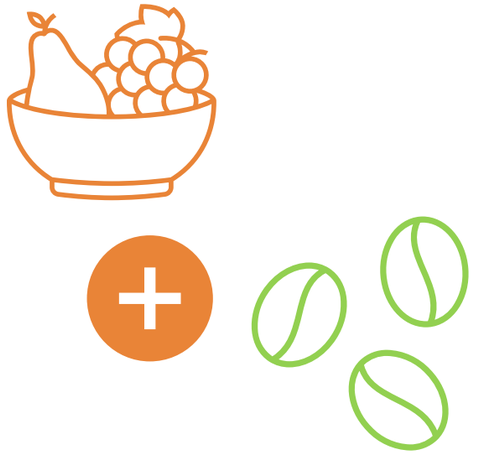
Asha support alone



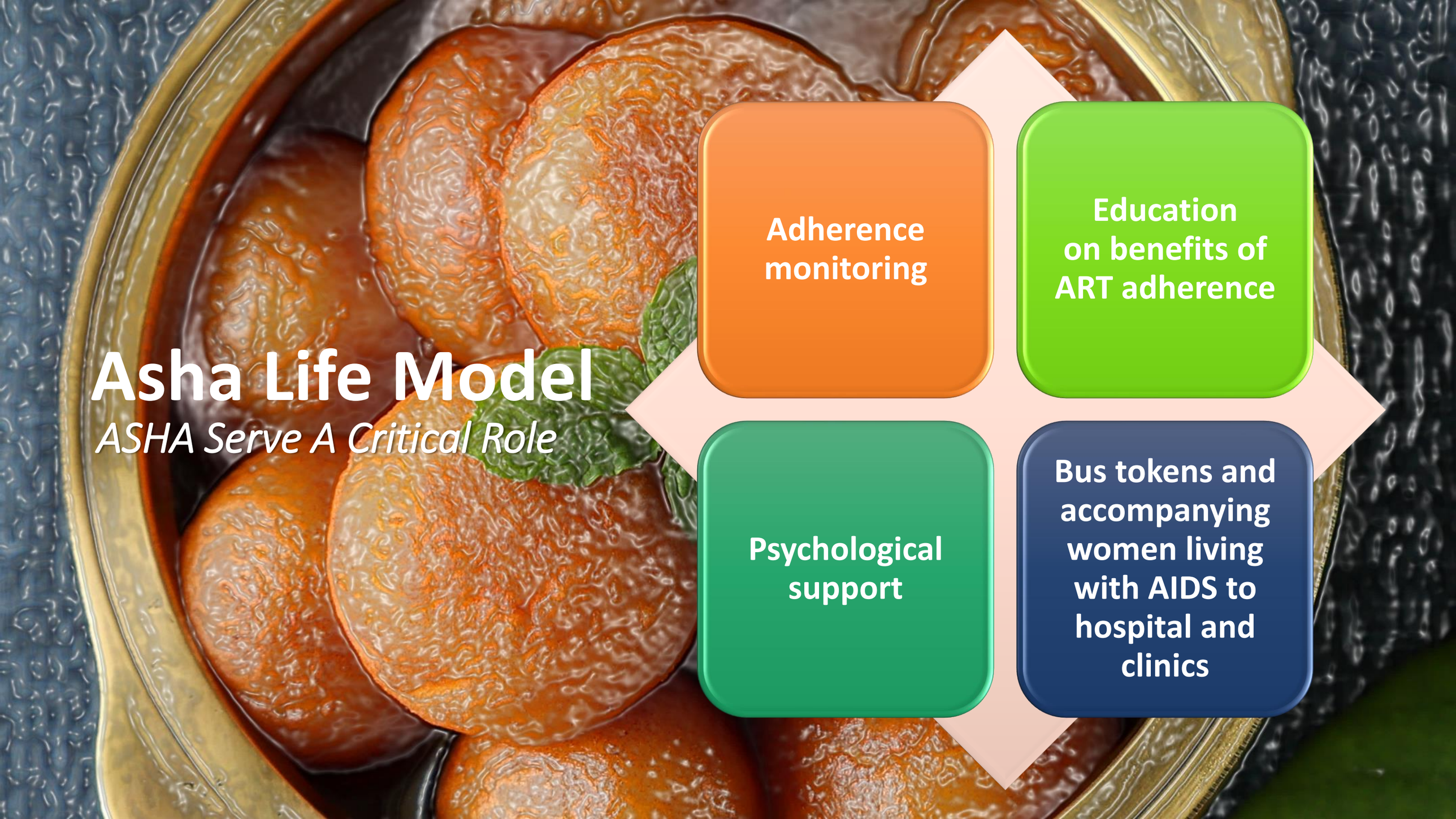
Asha support + nutrition education



Asha support + food supplementation



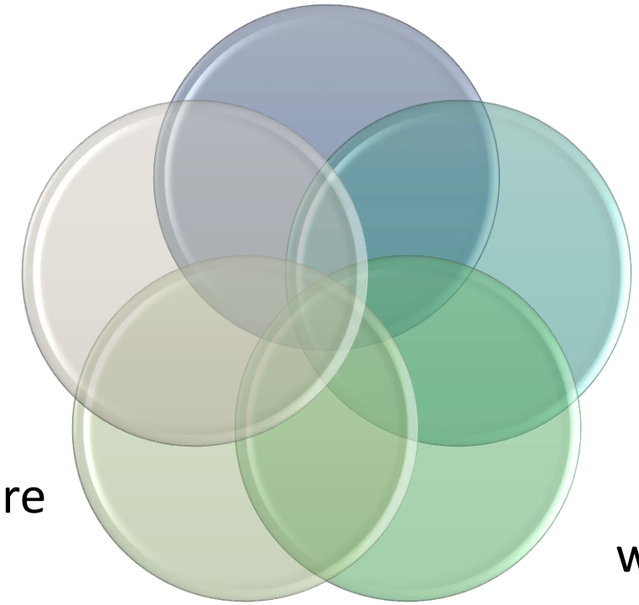
Asha support + nutrition education + food supplementation


Asha Life Model
ASHA Serve A Critical Role
Adherence monitoring
Education on benefits of ART adherence
Psychological support
Bus tokens and accompanying women living with AIDS to hospital and clinics

ASHA Selection & Training

Recruited from villages like the participants

Each of four groups received program-specific training and Life-Skills



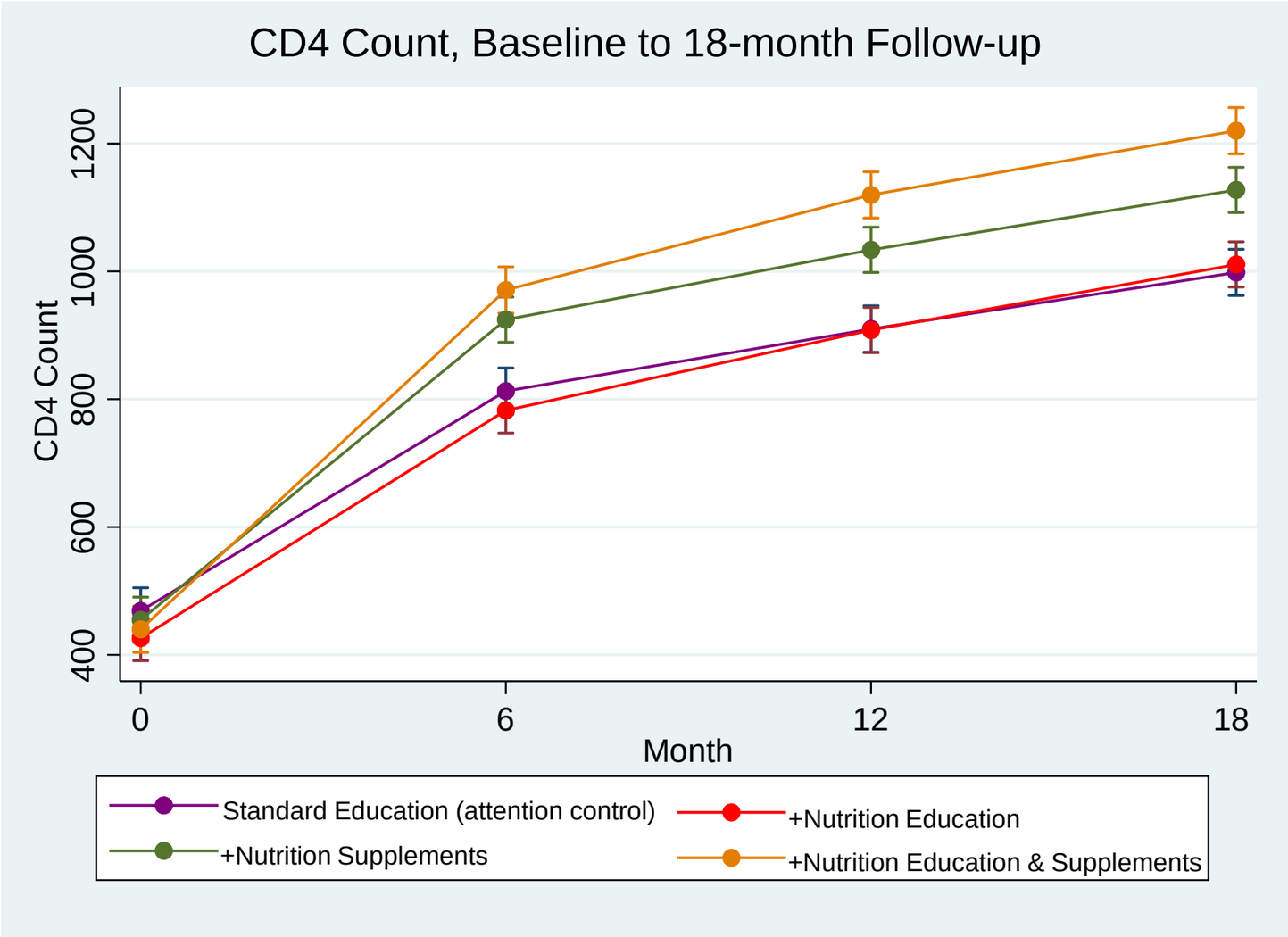
Age between 20-50 and interested in caring for women living with HIV

Four ASHA were assigned to each of the four groups

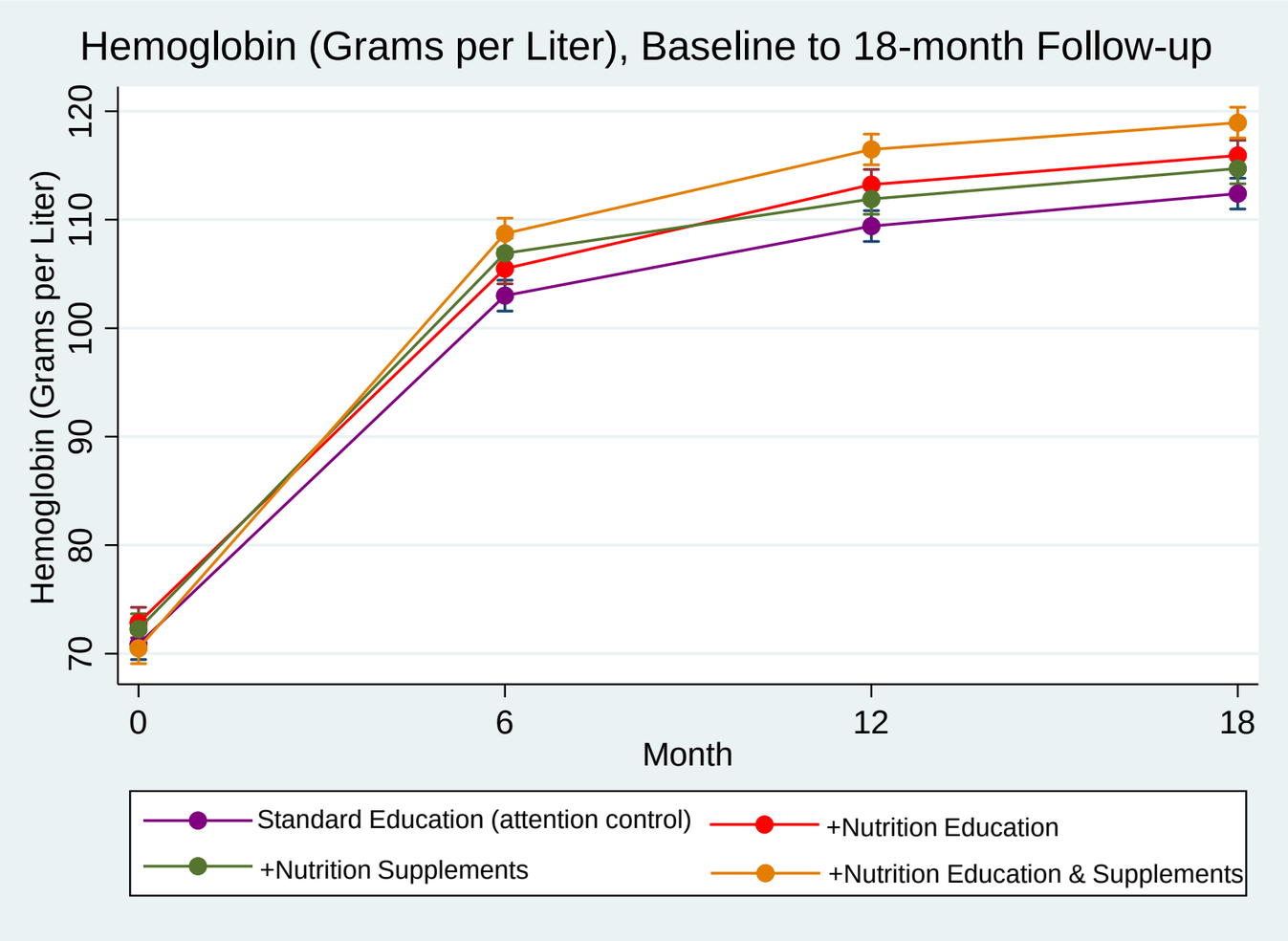
Sixteen ASHA were rigorously trained by investigators


NELLORE, INDIA

CD4 Count, Baseline to 18-Month Follow-Up[16]



Hemoglobin (Grams per Liter), Baseline to 18-Month Follow-Up[16,17]



Part IV: How the Downtown Women's Center Integrated Community Health Workers to Support Sustainability

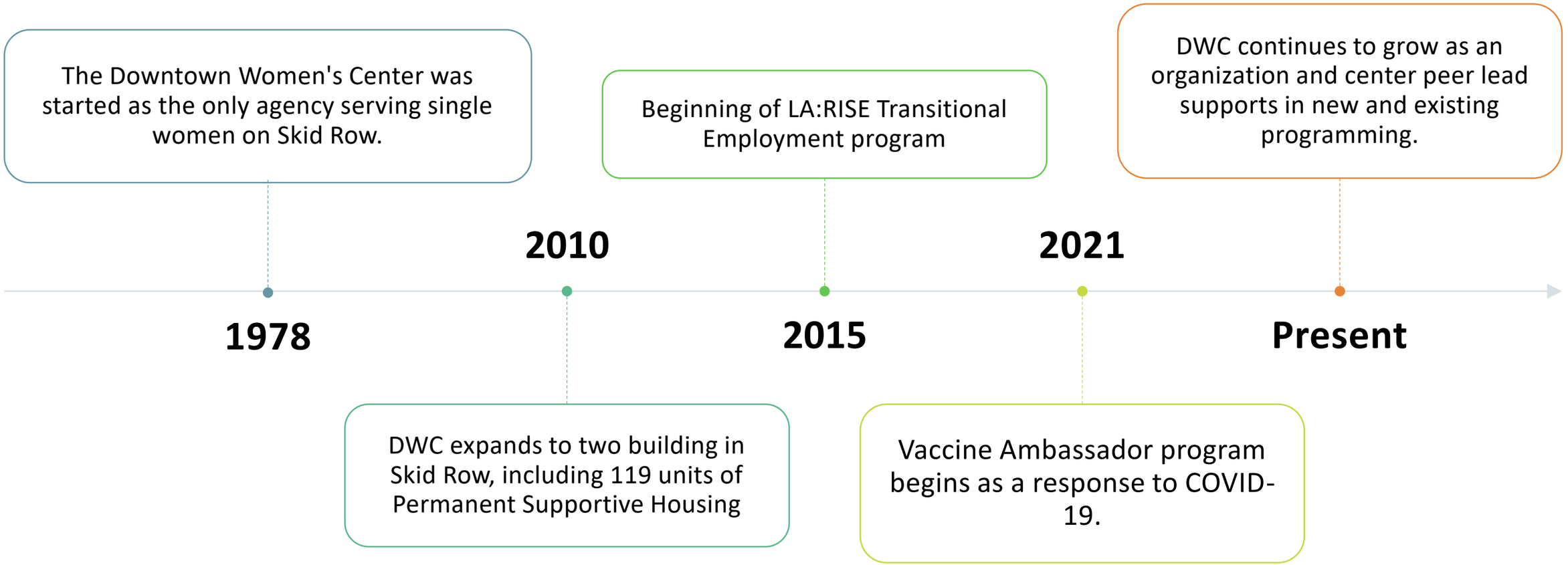
Emily Van Cise, MA

DOWNTOWN WOMEN'S CENTER

Mission & Vision[18]

The Downtown Women's Center (DWC) is the only organization in Los Angeles focused exclusively on serving and empowering women experiencing homelessness and formerly homeless women.

History of the Downtown Women's Center



Peer-Led Opportunities at DWC

Peer Leaders

- Unpaid participants
- Support Day Center, Health, and Permanent Supportive Housing Services

Vaccine Ambassadors

- Partnership with DHS to provide COVID vaccines, education, and outreach.
- Transitional employees with lived experience of homelessness.

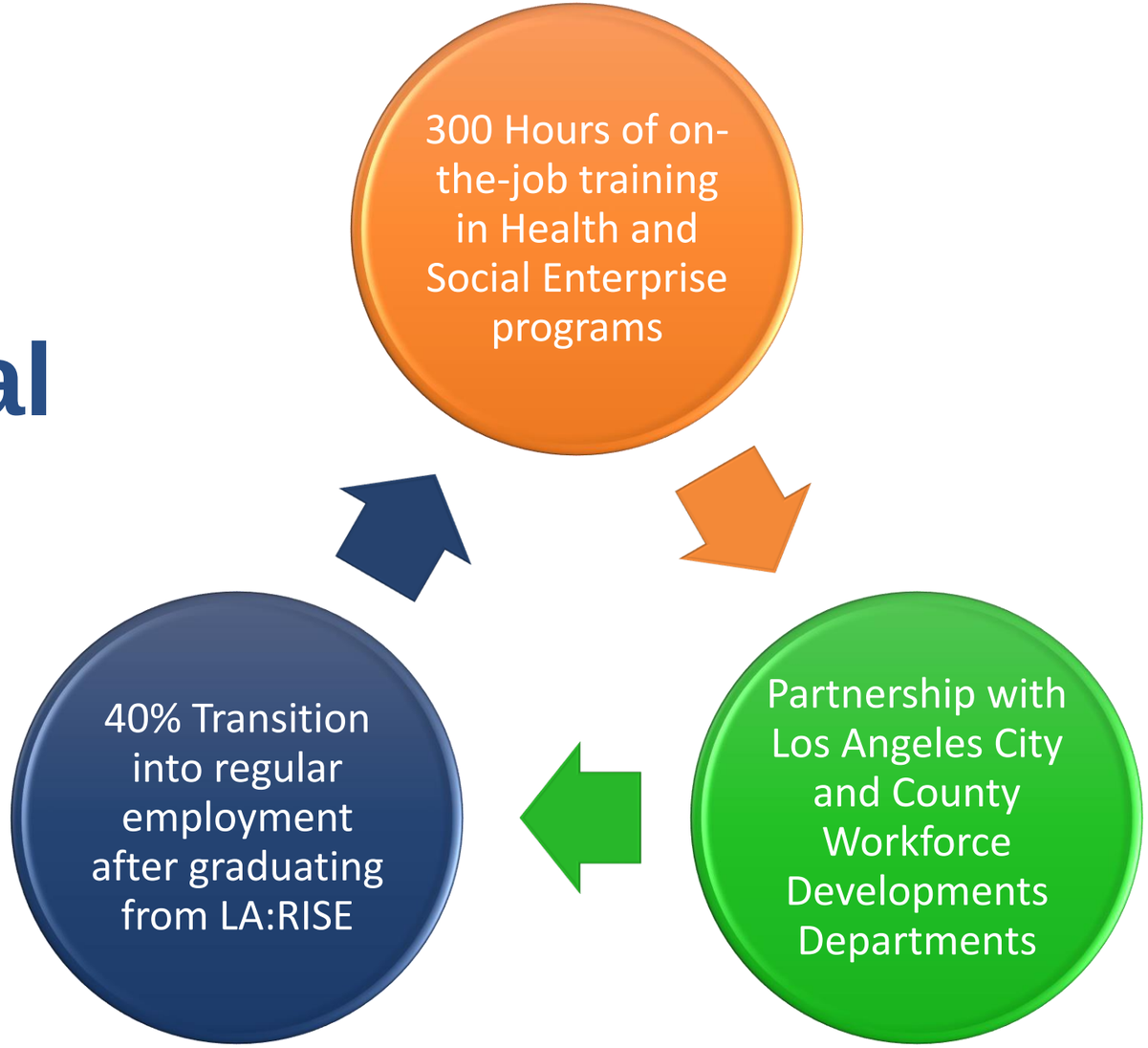
Transitional CHWs

- 300 Hours of on-the-job training
- No change in access to services
- Provide Street Outreach and Onsite Workshops

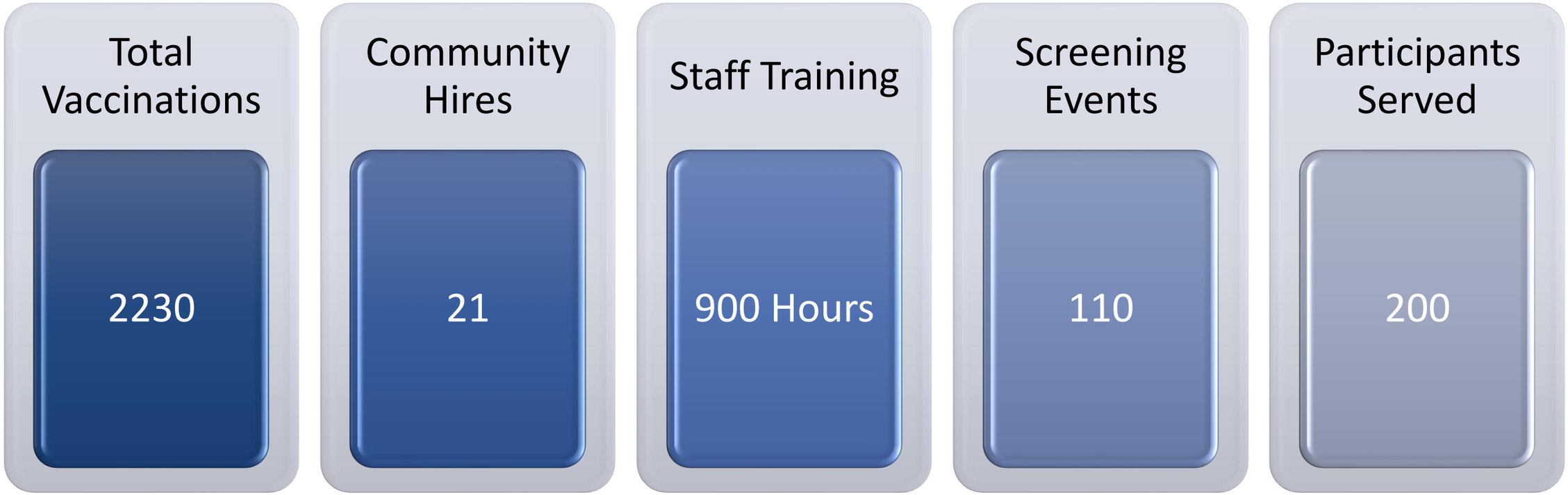
Peer Specialist

- Regular, full-time staff
- Focused on harm reduction and access to community health resources

LA: RISE - Transitional Employment



DWC Successes



Lessons Learned

Specialized Trainings

- Trauma-Informed Care
- Boundaries
- Crisis Intervention

Boundaries

- Understanding change in role from community member to community health worker

THANK YOU

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Camden Coalition
Subject Matter Experts

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Dorothy Scott

Community Health Worker
Care Management Initiatives,
Camden Coalition-Housing First

NNCC-Webinar
February 23, 2022

Camden Coalition
of Healthcare Providers

The National Center
for Complex Health & Social Needs

Camden Coalition

About Us

The Camden Coalition of Healthcare Providers is a multidisciplinary, community-based nonprofit working to improve care for people with complex health and social needs in the city of Camden, New Jersey, and across the country. We develop and test care management models and redesign systems in partnership with consumers, community members, health systems, community-based organizations, government agencies, payers, and more, with the goal of achieving person-centered, equitable care.

As one of New Jersey's four Regional Health Hubs, we work with regional partners, New Jersey's Medicaid office, and other state agencies to expand data sharing and collaboration between organizations so that patients across South Jersey experience seamless, whole-person care.

Camden Core Model

We use data to identify eligible patients, most often through our Camden Coalition Health Information Exchange, using criteria that measure considerable medical and social complexity. We then meet patients in-person, usually at the hospital bedside, to enroll them in the intervention. Once participants are enrolled, an interprofessional team of nurses, social workers, and community health workers visits them in the community, helps reconcile their medications, accompanies them to doctor's visits, and links them to social and legal services.

Our COACH practice guides our team in building authentic healing relationships that build patients' self-efficacy. We work with each individual to create a customized care plan, centered on their own goals and wishes, that helps them realize their highest level of health and well-being.

Triage Criteria

Utilization Pattern: 2-4 inpatient admissions within the past 6 months
Age: 18-80
Insurance Coverage: any patient with NJ Medicaid or dually eligible
Geographic Target Area: City of Camden and surrounding ZIP codes
Inclusion Criteria:
-2 or more chronic conditions
-2 or more barriers which can include:
polypharmacy
lack of social support at home or in the community
Housing instability
active substance use
physical disabilities (e.g., hearing or visual impairment
difficulty accessing services (e.g., language barrier, limited mobility)
significant mental health conditions (e.g., schizophrenia, bipolar disorder

Triage Criteria

Exclusion Criteria are any of the following:

-living in a nursing home or assisted living facility (because these patients receive all of their care at their facility)
-dementia or Alzheimer's
-receiving intensive care management services from another agency
-primary reason for the current admission is:
-cancer diagnosis (because the cancer diagnosis will drive most of the patient's hospital visits)
-planned surgical procedure (e.g., bariatric surgery)
-acute conditions without other complicating factors (e.g., appendicitis)
-due to the complications of a progressive disease that has limited treatment (e.g., multiple sclerosis or ALS, because the progressive chronic disease will drive most of the patient's hospital visits)
-for mental health only with no comorbid conditions (e.g., schizophrenia, suicidal ideation

Teaming

Interprofessional team that consists of the following:

Medical Director
Associate Director
Triage Specialist
RN/CHW Dyad
LPN/CHW Dyad
Social Workers
Housing Specialists
Medical Legal Partnership

COACH

We learned that our patients seemed to do better when they developed what we call "authentic healing relationships" with our Care Team — a secure, genuine, and continuous partnership between the Care Team Member and the patient. Our knowledge of the techniques and practices that worked best with patients, including authentic healing relationships evolved into what we now call COACH.

This five-part framework trains staff to problem-solve with patients to effectively manage their chronic health conditions and reduce preventable hospital admissions. Once the Care Teams were routinely practicing COACH, we worked with researchers from PolicyLab at the Children's Hospital of Philadelphia to develop a COACH manual that outlines the approach and standardizes how we use it with our patients.

COACH

COACH Stands for:

COACH is our framework for building authentic healing relationships with patients that empower them to take control of their health. COACH stands for:

Connect tasks with vision and priorities
Observe the normal routine
Assume a coaching style
Create a backwards plan
Highlight progress with data

Care-planning

Creating a Care-plan

The **Camden Coalition's 16 care domains** are the areas in which we work on behalf of our patients. Patients set their own goals as part of the Camden Core Model, and we use the care domains to help organize the work that needs to be done.

- Addiction
- Advocacy and activism
- Benefits and entitlements
- Education and employment connection
- Family, personal, and peer support
- Food and nutrition support
- Health maintenance, management, and promotion
- Housing and environment
- Identification support
- Legal assistance
- Medication and medical supplies
- Mental health support
- Provider relationship building
- Reproductive health
- Transportation support
- Patient-specific wildcard (i.e., patients' unique needs that do not fit neatly into any of the other categories)

Camden Core Model: Goals

- **Pre- Graduation Goals**
  - Medication Reconciliation by Core Team nurses
  - Establish relationship with PCP/other providers
  - Routinely attends appointments
  - Is knowledgeable / better able to identify and work towards goals

- **Graduation Goal**
  - Completion of self-identified goals identified through use of COACH/care-plan cards
  - Warm hand-off to PCP and/or partner agencies who can continue to off medical and social support

Camden Core Model: Goals

- **Post-graduation Goals**
  - confidence in navigating medical, behavioral health, and social needs
  - Improved quality of life

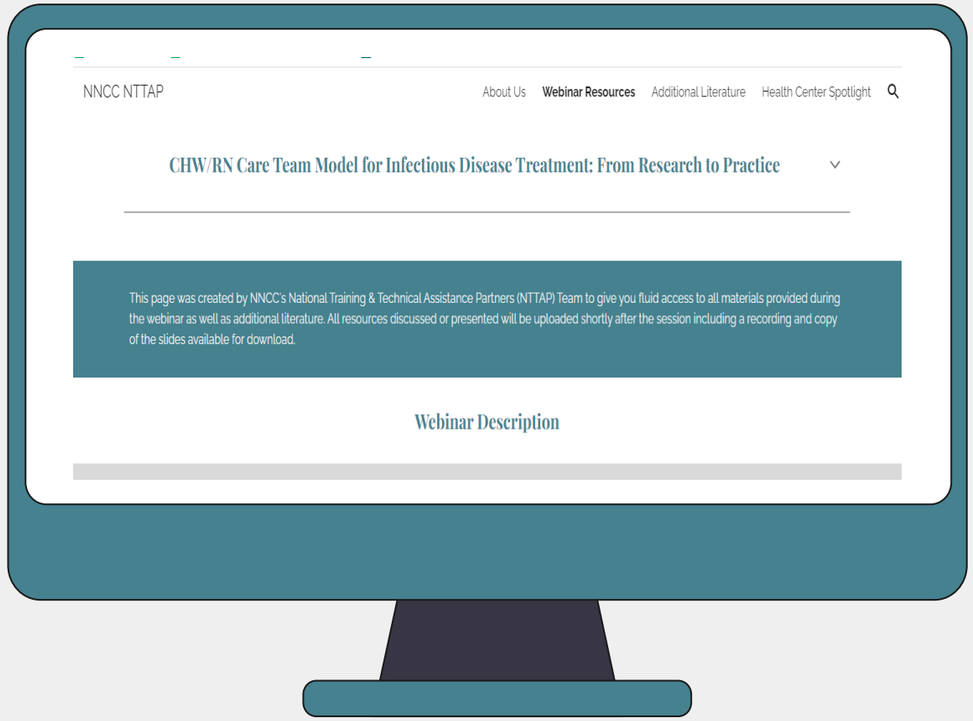
Community Experience

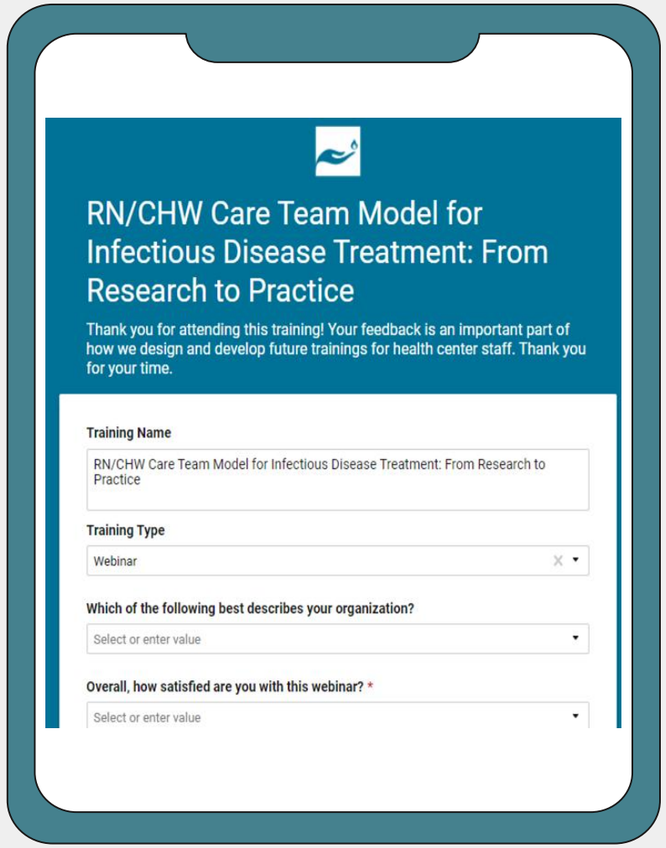
Thank you!

Q+A

Google Site

https://sites.google.com/view/rn-chw-careteam/webinar-resources





Evaluation Survey & CEs

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Thank You!

If you have any further questions or concerns please reach out to Senior Program Manager, Matt Beierschmitt at mbeierschmitt@phmc.org.

Please follow us on LinkedIn for updates on future trainings.

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