DNP Project Final Paper

Marcia Morgan Parker, MSN, RN

Chamberlain College of Nursing

NR709: DNP Project and Practicum IV

March 2017

Abstract

Underserved populations, racial and ethnic minorities are at significant risk for poor outcomes due to social determinants such as culture, language needs, health beliefs and socioeconomic status. These factors increase their risk for hospital high utilization. The PICOT question is "Does educating nurses, regarding developing RN and community health workers (CHW) teams to conduct home visits on a set schedule, reduce 30-day hospital readmission rates and non-urgent emergency room visits of Asian patients who have a chronic disease(s) and receive services from Xincon Home Healthcare Services?" The project took place at Tha home care agency in New York City that services patients throughout all of it are five boroughs, Nassau and Suffolk Counties. The agency's census at the time of the study was 964 Asian patients, which accounts for 83% of its' total population. The results of the study did not produce the expected results of the intervention group having a less readmission and ED visit rates. Instead, it showed that there is no difference in the reduction rate in 30-day hospital readmission rates and unplanned ED visits between the participants that are in the intervention group and those who receive usual care. Based on the outcome of the study, there is a need for further research regarding the RN/CHW integrated delivery model and chronic disease management in a home health care setting.

DNP Project Final Paper

Underserved populations such as racial and ethnic minorities are at significant risk for poor health outcomes due to barriers to care which includes but is not limited to culture, language, health beliefs system, and socioeconomic status. These issues have been cited by The Center for Medicare and Medicaid Services as major factors that influence an increase in hospital readmission rates for Medicaid recipients (CMS, 2012b).

The purpose of this project was to determine if the use of the Registered Nurse combined with Community Health Worker (CHW) visits is effective in reducing 30-day hospital readmission rates and non-urgency emergency department visits of Asian patients from a home care agency. Shah, Thomas, Elliot-Bynum, Thomas, Allen LaPointe, Calhoun, Thomas, Mathews, Califf and Peterson (2013), defines CHW as lay workers who are recruited from their individual communities, trained as support healthcare staff to deliver services to the people in their communities. The CHW is familiar with the culture, language, and resources within their communities.

Significance of the Practice Problem

Chronic disease such as diabetes that has a high morbidity and mortality ratio affects 30-50% of Asians more than their white counterparts (Lee, Brancati & Yeh, 2011). Clough, Lee, & Chae, (2013) stated that the number of Asians in the United States grew by 43% from 2005 to 2010, making it the fastest growing racial and ethnic population in the US. But with this rapid growth, there is a related cultural and language barrier as these immigrants are relocating from various parts of Asia, each with its' own specific language and cultural needs (Clough, Lee & Chae, 2013). These issues increase this population risk of being underserved and with barriers to healthcare. For providers to meet the established goals of The Affordable Care Act of 2010,

which is to increase access to service, improve population health outcomes, provide preventative

services, reduce health care costs, reduce healthcare inequalities, provide safe quality care,

reduce hospital 30-day readmission rate and non-urgent emergency room visits the US healthcare

system must undergo a restructure. Measures must be implemented to foster an increase in

patient-family ties, patient engagement and disease self-management. Per Findley, Matos, Hicks,

Campbell, Moore and Diaz (2012) the CHW is that individual who can help healthcare

organizations and professional practice meet the goals of the ACA and improve population

health outcomes. In a randomized clinical trial that was done among Asians at John Hopkins

University in 2013 regarding the effectiveness of CHW in increasing Hepatitis B vaccination rate

among individual that were unprotected (n=232), the results were that the group that had the

CHW intervention adhered to the completion of the three (3) vaccine series at a rate of 51%

versus 15%. This is significant as 10% of Asian Americans are infected with Hepatitis B as

compared to 0.1% whites in the United States and the Asian population of the entire US census is

expected to increase from 5% in 2010 to 11% in 2050 (Juon, Strong, Kim, Park, & Lee (2016).

With such a high rate of infection of Hepatitis B, there is a related disparity for liver cancer.

Barriers to health care are not uncommon among Asian Americans, a population in whom

chronic disease such as mental health, diabetes, HIV/AIDS, tuberculosis, COPD and

cardiovascular disease is prevalent (Sorkin & Ngo-Metzger (2014). Chronic disease management

is one of the driving forces that increase hospital 30-day readmission rates and non-urgent

emergency department visits due to the high morbidity and corresponding mortality ratio

assigned to them (Hines, Barrett, Jiang & Steiner, 2014). Burns, Galbraith, Ross-Degnan and

Balaban (2014) study recommended that additional pilot study need to be conducted regarding

the significance of CHW as an effective strategy in helping to reduce hospital 30-day and non-

urgent ED visit rates. In other roles where the CHW was added to the team led by the RN, the results proved that an integrated RN/CHW is an effective strategy to manage chronic diseases (Allen, Dennison-Himmelfarb, Szanton, Hill, Levine, D....& Anderson, 2011; DePue, Dunsiger, Seiden, Blume, Rosen, Goldstein.... & McGarvey, 2013). Considering the determinants that increase an individuals' vulnerability to poor health outcomes and the risks for being underserved, it is, therefore, important the home care agency servicing Asian populations implement measures to reduce their population risk level and to improve population outcome. As healthcare providers, home care may not be able to control an individuals' socioeconomic status, culture and neither their language but there are measures such as RN/CHW care model that if used, can improve the overall health of patients' and improve their access to necessary services.

PICOT Question

Does educating nurses, regarding developing RN and community health workers (CHW) teams to conduct home visits on a set schedule, reduce 30-day hospital readmission rates and non-urgent emergency room visits of Asian patients who have a chronic disease(s) and receive services from Xincon Home Healthcare Services?

This intervention of registered nurse and community health worker combined as a team making scheduled home visits was applied while Registered nurse visits only as usual care served as the comparison. A reduction in 30-day hospital readmission rate was expected. Data that was measured by reviewing clinical records, patient self-reported satisfaction, medication adherence, no reported emergency room visits or hospitalization. The intervention was applied and measured over an eight (8) week period.

The use of CHW in improving health outcomes in racial and ethnic populations is an evidenced-based practice that is effective in improving health outcomes (IOM, 2003). In the past

CHW visits were combined with nurse practitioners, midwives, pharmacists, physicians, as peer counselors, community liaisons from the hospital in-patient setting before discharge to community health providers such as physician practice, health homes, clinics and home care providers. DePue, Dunsiger, Seiden, Blume, Rosen, Goldstein,.. McGravey, 2013; Burns, Galbraith, Ross-Degnan and Balaban (2014), stated that when RN/CHW visits are provided at regularly scheduled intervals in the home during the care transition period or following an emergency department visit, it reduces unplanned 30-day hospital readmission and non-urgent ED visits. A SWOT analysis (Table 1) was performed to examine the benefits, limitations, identify and to understand the key factors in implementing the RN/CHW as an intervention in reducing hospital readmission rates and non-urgent emergency rates for Asian patients with chronic disease in a New York City home care agency.

There were only a few risks and unintended consequences related to this intervention which was related to mistrust and a fear of violation of their confidentiality. It was important for the patients to accept the CHW as a valuable member of the care team whom they can trust will ensure their privacy and confidentiality into their homes. As such, information regarding their rights and informed consent to voluntarily participate in the study was provided verbally and in writing in both English and their preferred language. As a participant in the study, the patient was advised of their right to withdraw at any time without fear of reprisal or retaliation. The home care agency's code of ethics and policy regarding participation in a research study was also be made available to them in writing.

Per Strachan, Kallander, ten Asbroek, Kirkwood, Meek, Benton and Hill (2012), to foster retention of community health workers (CHW) and to facilitate program success, CHW must have a genuine interest in the issues affecting their communities and demonstrate a willingness to

share their knowledge. The selection criteria of CHW was based proof on prior experience as a volunteer a and commitment to helping others. Workers were required to speak both Cantonese and Mandarin since these are the two main languages spoken by most of the patients in the agency. Also, a commitment to be available for two (2) weeks CHW training (See Appendix E for CHW training curriculum outline) and the entire duration of the project was necessary. The use of the office's outreach staff and non-clinical coordinators who have already established a relationship with the nursing staff were trained as CHW to minimize the risk of poor rapport and or relationship. The CHW recruits were referred by at least one member of the administrative staff plus a member of the clinical team. To dispel their fears of the nursing staff, who were concerned that they might be replaced by unlicensed assistive personnel, the RNs were trained on the role of the CHW in health care as members of the care team. The CHW job description and responsibilities were clearly defined as well as their scope of practice. The nurses were trained on the CHW training curriculum as train-the-trainers to enable them to be able to teach future CHW training classes. The training fostered their buy-in of the RN/CHW intervention program.

The number of newly admitted patients to the agency during the intervention period varied, which affect the number of available participants for the study. The lack of an adequate sample size may have affected generalization.

Feasibility

This problem is significant with the practice site as the United States healthcare system is under restructure and is moving towards a value-based payment (VBP) structure. The project was feasible since the study was implemented and its' outcome measured within an eight (8) week period.

Theoretical Framework

Madeleine Leininger's theory states that different cultures have different health needs based on their health belief system, values and health behavior (Abdulrehman, Woith, Jenkins, Kossman & Hunte, 2016). The theorist examined the patient as a member of a larger group (the family and community) and promotes the development of a comprehensive care plan which as the patient as the central focus and for being treated a whole individual. The integration of this theory helps in reducing healthcare disparities, fostering relationship-based care and trust, and influencing an increase in rapport and an awareness of one's biases. Communication is enhanced as care is coordinated and centered around the patients assessed needs and preferences. Additionally, with the patient as a valued individual who has an input in his/her care, it promotes autonomy and self-management. The CHW who is recruited from the community and understands the language and cultural needs of the patient. The worker is knowledgeable about community resources, family dynamics and therefore is better able to collaborate and work together with to reduce 30-day hospital readmission rates and non-urgent emergency room visits.

Meeting the language and cultural needs of the patient are necessary to deliver culture-specific care and to communicate effectively with the patients and or their families. Many of the older Asian population would rather not utilize and communicate via a language line, and so it is important to have staff who can speak directly to them (E. Chen, personal communication, September 1, 2016). The uses of an RN/CW care model where at least one member of the team speaks the patients' language minimizes the need for a language line. At the home care agency, not all the RNs speak or understand an Asian language, and as such, patient education and assisting them in accessing resources may be limited. The CHW can collaborate with the RN in developing a culture-specific care plan with the patient at the center of it all.

Madeleine Leininger's' transcultural theory enables the agency to provide care that positively influences and promote optimal care outcome, at the same time respect and acknowledge the patient's culture and health belief systems. As such, Leininger's Transcultural theory facilitates the provision of patient-centered care and allows for patient-centered driven care by the RN/CHW (Saha, Beach, & Cooper, 2008) whose care outcome may be dependent on another variable that coexists in his life.

Synthesis of the Literature

A subject search of 30-day readmission, Medicaid, transitional care, community health worker, health reform, Asians, home care was performed on the following databases of Google Scholar, Cochrane, EBSCO, CINAHL to select the literature needed for evidence synthesis. Only original articles within the past five years have been chosen and those that were relevant to the use of CHW, Medicaid recipients and Asian patients over the age of 65 years. There was no literature available for review on the utilization of an RN educating the CHW.

Burns, Galbraith, Ross-Degnan and Balaban (2014), indicated that the use of CHW could have a positive impact on the delivery of culture-specific care. Because a CHW is recruited directly from the patients' community, the individual understands all the hidden idiosyncrasies that an outsider such as a nurse is unable to access. A nurse who is conducting home visits without the assistance of a CHW may have trouble getting to the root of the issues affecting the delivery of care because of a lack of awareness of socio-cultural issues that exists and that are embedded in the fabric of the community. The use of CHWs who are trained as a support to the registered professional nurse is an efficient and cost-effective way to support nursing service, improve access to care, and increase population health outcomes (Kangovi, Mitra, Grande, White, McCollum, Sellman, Shannon & Long, 2014). The CHW, when is added to the RN home

care team, can become the eyes and ears of the RN and provide ongoing feedback to the RN. Without the CHW, valuable information regarding factors that may be contributing to poor health outcomes will go unnoticed and left unaddressed. They can assist the RN in developing patient-centered goals and treatment plans that embody the patient as a whole individual.

The Asian population is medically underserved because of the barriers that exist that are related to language, culture, and health belief systems (Clough, Lee & Chae, 2013). Compared to their white counterparts, the Asian population is at significant risk for chronic disease (Miyoung, Kim, Kim & Han (2014). According to Allen, Dennison-Himmelfarb, Szanton, Hill, Levine, D....and Anderson (2011) and Miyong, Kim, Kim and Han (2014), the use of an RN led team of RN/CHW model of care is an effective way of managing chronic disease and promoting self-management. Chronic disease management has significant implications for the United States healthcare system because of the exorbitant financial impact it has on the nations' healthcare costs (IHI, 2009). Additionally, there is a disparity with chronic disease and its' impact on racial and ethnic minorities. In fact, Asians are 30-50% at risk of developing type 2 diabetes in comparison to non-Hispanic whites (Lee, Brancati & Yeh, 2011). The prevention of chronic disease among vulnerable populations is paramount to controlling healthcare climbing cost, in reducing vulnerabilities and diminishing healthcare disparities that exist in our society (IHI, 2009). It is, therefore, important that strategies that are feasible, sustainable, and improves health outcomes. The intervention of CHW is cost effective per Kim, Choi, Nieman, Joo, Lin, Gitlin, and Han (2016). It is an evidenced-based quality improvement strategy, which when combined with professional visits can significantly bridge the widening gap that exists today in healthcare disparities.

Although the use of lay workers as support to professional staff has been in use in the public health industry for many years, the success of RN/CHW interventions is strongly dependent on buy-in from providers and frontline staff (Mobula, Okoye, Ebony Bouware, Carson, Marstellar & Cooper, 2014). Additionally, the selection criteria used for the recruitment and training of CHW may pose threats to the use of RN/CHW as an intervention because if the right worker is not selected there can be negative outcomes related to lack of communication, knowledge, and motivation. In order minimize this threat it is important that the CHW who are recruited to work with the professional nurse be knowledgeable and committed regarding their role. They need to be mentored and supervised continuously (Lopes, Cabral, & de Sousa, 2014), to ensure competency and possession of a skill set that that applies to their responsibilities. The CHW needed to be accountable and empowered as members of the health care team with the RN as the designated team lead.

The RN/CHW model plays a vital role in care transition, care management and collaboration (Vetter, Bristow & Ahrens (2004). Together they can act as an adjunct to the provision of primary care service in preventative service not only in adults and geriatric patients but also in various settings and disease groups. In a pediatric asthma study, Woods, Bhaumik, Sommer, Ziniel, Kessler, Chan, Wilkinson, Sesma, Burack, Klements, Queenin, Dickerson, and Nethersole (2012), RN/CHW model resulted in 60% reduction in emergency department visits, hospitalization rate, time missed from school, and work for the parents. There was also an improvement in the limitations in this group. Despite the gamut of information that exists about reducing 30-day readmission rates and non-urgent emergency room visits; there remains minimal research from home care organizations regarding their efforts to minimize 30-day hospital readmissions.

Additionally, most of the evidence that was found regarding hospital 30-day readmissions had no data that was specific for non-urgent emergency room visits. Non-urgent emergency room visits are of clinical and financial significance due to over utilization. The use of ED increased by 20% from 2005-2010, which resulted in an increased cost of $18.8 million as stated by the New England Healthcare Institute (2010) in its' citation of Nawar, Niska, and Xu (2005). The ACA, 2010 called for improvement in primary care service, improvement in preventative care and as such, overutilization of ED visits needs to be fully addressed in the redesign of the US healthcare system. The other weakness in the literature review was that there was limited information available in regard to the Asian population, 30-day readmission and non-urgent visits. The literature that was examined primarily pooled all racial and ethnic minority groups' together.

Recommendation

Thirty-day hospital readmission rates and non-urgent emergency room visits require the immediate attention of all healthcare providers and systems. However, the use of CHW in most states is not reimbursable. It is also recommended that the utilization of the CHW in home care be deemed billable by the Centers for Medicare and Medicaid Services to help foster an increase in the use of this workforce category by hospitals and community-based programs. Also, home care agencies need to engage in research that examines measures that are effective in reducing unplanned 30-day hospital readmission rates, non-urgent emergency room visits and across the various ethnic groups and or sub-groups within the Asian population.

Standardization of CHW training and continuing education within the context of cultural groups, vulnerable populations and disease management groups is further recommended to foster consistency, continuity and to enhance the CHW skill competency. The suggestion is for the use

of an RN led RN/CHW model to be used as the foundation for CHW implementation. Such a model will facilitate supervision, mentoring and the delivery of safe quality care within the context of the patent-centered care that has been developed by the registered nurse (Burns, Galbraith, Ross-Degnan, D., & Balaban, (2014). Despite the drawbacks, there is strong evidence to support the use of an RN/CHW team as a cost-effective way to improve population health outcomes in vulnerable populations. Evidence suggests that the RN/CHW team collectively increases patient engagement, fosters disease self-management, reduces 30-day hospital readmission rates, non-urgent emergency room visits improves access to service and improve population health outcome in the targeted Asian population. However, more importantly, it is essential in home care that registered nurses who speak the language and understands the culture are assigned to these patients.

Project Setting

The setting for this project change is a home care agency in New York City. The agency is licensed to provide skilled and paraprofessional services throughout the five (5) boroughs of New York City, Nassau and Suffolk Counties. Asian patients over 65 years of age with Medicaid as their primary insurance make up eighty-three percent of the total population. They have been noted to have multiple chronic diseases. The agency contracts with several Medicaid Managed Long Term Care (MLTC) insurance companies to provide home care services. The home care agency has approximately 1200 patients with a nurse to patient ratio of 1:50 (E. Chen, personal communication September 1, 2016). All nursing staff is registered nurses (RNs) of which 25% hold a BSN and the others are AAS degree level nurses, and forty percent of the nursing staff is Asians (E. Chen, personal communication, September 1, 2016). There is currently no community

health worker on staff. The administrative leadership staff consists of a chief executive officer (CEO), an administrator, a director of patient services (DPS) and a chief financial officer (CFO).

Organizational Need

The need for the project was driven by the restructure of the US healthcare system and the need to incorporate models of care that reduce re-hospitalization, reduce healthcare expenditure, to improve patient engagement and population health outcomes. Additionally, the home care agency participates in value-based purchasing services where financial incentives and disincentives are linked to organizations' performance in improving care outcome. The reduction of 30-day readmission rate and non-urgent emergency room visits are performance measures for the organization. The home care agency currently has a 30-day hospitalization, and non-urgent emergency room visit rate of approximately 15% (E. Chen, personal communication, September 1, 2016), which she stated is related to language and cultural barriers, health beliefs and a lack of follow-up with primary care visits.

Stakeholders

The key players are the leadership team, nurses and community health workers (CHWs). Buy-in from the leadership team, the Chief Executive Officer; Administrator and Chief Financial Officer were necessary to ensure that an adequate budget was available to fund the program. The nursing staff time off was required for the nurses to participate in the train-the-trainer, CHW training curriculum, their functions and how the CHW influence care outcome as members of the care team. It was important for the nurse to understand that the CHW as peer support workers and as community liaisons. They reinforce health education that has been provided by nurses, serve as a support to nursing staff and assist patients in navigating the healthcare system. The CHW role was incorporated in the care plan that was developed by the nursing staff. The

registered nurses supervised the worker, acted as a mentor and coordinated interdisciplinary case conferences based on the feedback from the CHW. As a member of the healthcare team, the CHW understands the language, culture, and idiosyncrasies of their individual communities but they need to understand their scope of practice and be motivated to make a difference in the community as it relates to community health issues.

Other members of the organization that was affected are the agency's coordinating staff. Some of these staff were removed from their daily roles to be trained as CHW needed to act as a replacement when their co-workers were in the field. Also, they had the additional responsibilities for tracking hospitalization, discharges, and communicating this information to RN/CHW team. Without the ongoing support of the information technology (IT) department, the generation of clinical and scheduling reports would have been difficult. IT was needed to grant the CHW access to document the results of all visits conducted and their outcome. Finally, the finance department kept the program abreast of all expenditure and finance.

Organizational Support

Organizational support was very necessary for this program success. The organization made a verbal commitment to the continuation of the program due to the increased use of CHW as peer support workers, their role in improving care and financial outcomes. The use of CHW in the states' Delivery System Restructure Incentive Payment (DSRIP) program in managing chronic diseases has solidified their commitment. All departments (clinical, human resources, administrative and finance) will be involved in the project based on their respective role in the organization. The home care organization will fund all staffs (RN and CHW) salaries and fringe benefits, phone calls made by the CHW, travel expenses and refreshments for conferences and that which will be served at the presentation of the project. The cost of the consulting statistician

will be responsible for data analysis of the raw data collected will be the only cost incurred by this writer.

Sustainability

The measurement of milestones over a period is necessary to demonstrate sustainability for this project. The results can then be used to obtain increase financial incentives from managed care organizations whose members the agency services. The agency is financially viable and can offset the burden of CHW training and salaries, RN time and commitment to be trained on the role of CHWs and in serving as mentors. The agency has adequate nursing staff that will facilitate staffing restructure for RN training, CHWs mentoring and case conferencing, as such, client services will not be interrupted.

Project Vision, Mission, and Objectives

Vision

The vision was to facilitate an improvement in population health outcome among Asians.

Mission

The mission was to utilize a combined visit of registered nurse and community health workers on a set schedule throughout the transition period to reduce 30-dayhospital readmission rates and non-urgent emergency department visits.

This writer's vision and mission were in alignment with that of the home care agency from which the participants were recruited. The agency also wants to ensure financial stability and viability so that they can continue to provide needed care and expand services to the populations that it services based on market demands.

Short term objectives

The short-term aims of this study were to reduce 30-day hospital readmission rates and non-urgent hospital emergency room visits as evidenced by a 40% reduction over an eight-week period of the number of non-urgent emergency department visits as well as re-hospitalization within 30 days of hospital discharge.

Long term objectives

The agency's objectives over a three (3) year period were to achieve a progressive decline in 30-day hospital readmission rates and non-urgent ED visits to less than 25% of their current rate of 15.4%. By year one a 25% decline from the current rate of 15.4%, 35% reduction by year 2 and a 45% reduction by year 3. A 45% reduction by the third year would significantly surpass the New York State's goal of 25% over a 5-year period from 2015-2020 (OneCity, 2016).

The agency's existing performance improvement program utilized the PDSA (Plan, Do, Study, Act) as the framework for its' continuous quality improvement model. This four-step process would allow them to strategically plan for a change or predict a change, and implement a plan that could be phased in over a specified time frame. Studying the results of the intervention, and then making the decision to act would standardize the process and make it a part of the agency's operational process. This writer's project used the same process to facilitate alignment with the organizations' current process. During the study phase of this project, the results of the data collected were continuously evaluated to ensure that the intervention was being administered as planned. The data that was collected throughout this project will help to determine what factors influence readmission rates. It can also be used to show if there are inter-

relationships between the various variables. Lastly, it demonstrated the impact that an RN/CHW visit has on the overall care outcome for this population.

The implementation of the RN/CHW project facilitates the application of a pilot program that is related to 30-day hospital readmission rates and non-urgent ED visits. All data can be collected monthly, analyzed and reported quarterly at the agency's quarterly quality improvement meetings. The new data results can then be used to request funding for the program, and it can also be used to validate a long-term commitment for RN/CHW visits as a part of the agency's operational procedure. It can also be used to recruit and retain bilingual speaking nurses.

Project Description

Sample

The study data is based on data that is gathered from Asian patients who were recently discharged from an inpatient stay at the hospital and or emergency department and are patients of the home care agency. The participants were 65 years of age or older and had at least one (1) chronic disease. The length of stay as an in-patient or in the emergency room department was not considered as variables in the measuring of the outcomes; however, the number of days' post-discharge were. The other variables in this project were age, gender, and a chronic disease diagnosis.

The project was submitted to Chamberlain's IRB, and the proposal received approval. No oversight by the IRB is required as the board indicated that the proposal did not meet the criteria for human subjects. Xincon Home Health Care did not require IRB approval and a letter was received from them regarding same.

A convenience sampling of participants (n=38) was taken from among the 964 Asian patients at the home care agency. Before enrolling in the study, each participant was required to sign a consent form indicating their voluntary agreement to participate in the study. The informed consent fully discloses the research nature, process and the participants' involvement in the study. Information was provided verbally and in writing. The consent was provided in English and in the participants' language of choice, to facilitate full disclosure and understanding. There were two (2) groups (control and an intervention group). There were 18 participants in the group that received usual care and 19 in the RN/CHW intervention group. The admission rates between the two groups were then compared. A 50% readmission rate was expected for the control, assuming a 10% rate for the intervention group. A descriptive analysis was performed as there was an insufficient number of 30-day readmissions and non-urgent ED visit to perform parametric or non-parametric statistical analysis.

Inclusion Criteria:

- All Asian patients admitted to home care who were recently discharged from an in-patient stay or emergency department visit

- Patients with discharge time frame less than seven days from referral to the study

Exclusion criteria:

- Patients discharged over seven days from an inpatient hospitalization or emergency department visit upon referral to the study

- Non-Asian patients

- Patients younger than 18 years old

- Private pay patients

- Medicare only patients

Each participant was assigned randomly to the study group using an alternate method of assignment based on informed consent and patient choices.

Data Collection

At the time of the research, the agency was not a member of the state's Regional Health Information Organization (RHIO), an electronic medical record system that provides information such as clinical data or alerts regarding hospitalization and or emergency department visits. They are unable to receive real-time information on admission, discharge, receive clinical notifications or to predict patients risk of an event or outcomes, and so the agency relies on self-reports. However, at the time the study was implemented the agency had initiated conversation with Healthix, an RHIO and is planning on utilizing this system by the end of the second quarter of 2017. The clinical reports that are available through that system will enable the home care agency to generate reports on their patients' admission to acute care facilities and ED visits after this project ended. It was, therefore, necessary to rely on manual data collection and record audits.

The following data collection tools were used: Readmission Data Analysis, Readmission Review Tool, Patient Satisfaction Surveys, and Clinical Record Review Tool (Appendix D). The information that was collected includes patient demographic information such as date of birth, race and ethnicity, language, primary diagnoses, hospital admission and discharge dates, emergency department admission and discharge dates and the reasons for hospital re-admission or emergency room visits. The clinical information gathered includes information regarding their course of the treatment, grounds for admission / or ED visit, and discharge information. Information was also collected on patients' functional and social status. All the forms were straightforward and easy to use. Both the RN and CHW utilize the same forms to collect data.

Also, the data that was gathered provided insight regarding adherence with treatment plans. The use of the patient satisfaction surveys provide self-reports about the outcome of the participants' engagement and satisfaction with the delivery of care by RN/CHW team. Data was collected with each RN/CHW encounter; they were reviewed and evaluated weekly for accuracy.

Instrument/Tools

Participants received via Survey Monkey a patient satisfaction survey within one week of the initiation of RN/CHW collaborative visit intervention, again at week 4 and within 24 hours of completion. Subject responses are de-identified. The questions in the patient satisfaction survey were adapted from CAHPS ® survey instruments, the Clinician & Group Survey that is available in the public domain. The psychometrics test for CAHPS ® Clinician and Group Survey reflects reliability, Cronbach's $\alpha \geq 0.70$and a global range validity at 0.4 -0.76 (Dyer, Sorra, Smith, Cleary & Hays, 2012).

The Readmission Review Tool, Readmission Data Analysis Tool, and Clinical Record Review Worksheets were adapted from the STAAR initiative approach by the Institute for Health Improvement (IHI) and will be used to review all hospital readmission and non-urgent ED visits that occur during the intervention. All tools are available in the public domain and therefore do not require permission to use or reprint. Literature review does not indicate any information on the reliability and validity of the STAAR Readmission tools. Per Bradley, Brewster, and Curry (2015), the STAAR initiative is the first of its' kind to implement process and outcome measures across the care continuum to reduce 30-day all-cause readmission. In the first two (2) years of its' implementation in the states of Massachusetts, Washington, and Michigan the multivariable analysis results reflected that STAAR hospitals were more likely to

implement multiple strategies that effectively reduce 30-day readmission according to Bradley, Sipsma, Curry, Mehrotra, Horwitz and Krumholz (2013).

The STAAR initiative tools (See Appendix B) have been tested for reliability and validity. What are the reliability and validity statistical scores? They have been adopted in four (4) states and are being used to measure Medicaid readmission. The tools have been recommended to be used as a guide in reducing Medicaid 30-day readmission and non-urgent ED visits by AHRQ.

The readmission review tool, clinical record review, and readmission risk tool have both been tested and are deemed valid and reliable. The forms were recommended as part of the State Action Avoidable Rehospitalizations initiatives that was developed by the Commonwealth Fund to reduce 30-day rehospitalizations and adopted to be used by four (4) states in the four-year initiative (IHI, 2009). The readmission review tool is recommended by AHRQ (2009) as a guide to be used in reducing Medicaid readmissions and as such is deemed valid and reliable. Although they are not specifically developed for the home care setting these forms may be utilized in a variety of setting such as case management, hospital, and cross-continuum teams. These forms are available in the public domain and do not need permission for re-use. The database Excel Spreadsheet that was created by the Statistician for this project and is based on best practice guidelines. All PHI is identified.

The model of care is comprised of RN/CHW visits with the RN as team lead. The following serves to outline the implementation process:

Week 1—Initial Assessment Visits

Twenty-four hours' post-acute care discharge from the hospital or the emergency room, the CHW telephoned the participants to introduce him /herself and to explain the purpose of the

visit which was to ensure that the participant had everything that is needed to remain safely at home. The CHW also introduced the RN as the team lead responsible for providing skilled care, supervising the CHW and overall care of the participant. The RN/CHW worked collaboratively with the RN as the leader of the team and ensured the delivery of high-quality care. Together they worked with the participant to prevent re-hospitalization and minimize the need for non-urgent ED visits.

The worker then scheduled a face to face appointment to see the participant alone the next day alone so that a preliminary environmental assessment to complete a cultural assessment. The CHW assessed the environment and identified any social issues that either was affecting care delivery or had the potential to do so. The CHW first home visit was made 24-48 hours post initial contact. During the visit, the worker reviewed the discharge information that was provided to the participant, and he/she forwarded a copy of the discharge papers found at home to the RN. The CHW ensured that all necessary prescriptions per discharge summary were filled at the pharmacy before the RN's visit. The CHW reviewed the medication profile and availability of currently prescribed medications. The worker assessed the participants' knowledge and adherence to the prescribed medication regimen. They helped the participant in scheduling a follow up an appointment with the PCP.

Within 72 hours after the CHW visit, the RN conducted an initial visit with the CHW and developed a care plan based on clinical data (from the hospital) and findings from the CHW prior environment, cultural and medication management assessment. The RN solicits input from the CHW, participant/family to ensure that a collaborative care plan is developed to meet the participants' specific need. The care plan development of will focus on providing culture-

specific education, medication management, environmental needs, the identification of any necessary community resources and follow-up care.

Week 2—CHW face to face visits

The purpose of this visit was to reinforce information that has been provided by the RN and to work with the participants in meeting their goals. The CHW checked if all services that are in the discharge plans -home health aide service, skilled service, durable medical equipment has started and the participants' level of satisfaction with the delivery of care. Problem solving and guidance were done to ensure optimal utilization of available resources.

Week 3---RN/CHW visits

RN/CHW combined visit was made to assess clinical needs, to determine the level of family involvement in the delivery of care will be evaluated, motivate and reinforce education. The CHW assisted the participant in scheduling appointments with health care and community-based providers and worked towards facilitating increase communication between the participant and providers.

Week 4, 5---CHW face to face visit

To reinforce information that was provided by PCP during aftercare, coach and support participants ensure that medications are refilled and that medical appointments adhered. Additionally, the CHW will assist participants in identifying relevant community resources that may be instrumental in improving outcomes (health, social, behavioral health). The CHW reports to the RN all outcomes from the PCP visits and any barriers to care that are identified. Case conferencing with RN/PCP and other disciplines may be requested and arranged by the nurse based on feedback from the CHW.

Week 6---CHW conducts telephonic visit

The purpose of this visit is to follow up with participants' progress towards goals and determine family involvement. The CHW provided telephonic coaching, behavioral health counseling and referral to community resources as deemed necessary.

Week 7—CHW face to face visit

To reinforce education, motivate the participant and determine their progress towards participant specific goals. The CHW will follow up with patients to determine if all scheduled appointments are kept and checks to see if appointments are made for any upcoming visits with the appropriate provider.

Week 8--Combined RN/CHW visit

This visit is made to evaluate outcome, patients progress towards their individual goals, and plans have been made for any remaining needs. Week visit 8 is the last of the eight scheduled visits in the study; it is a joint RN/CHW visit.

At each weekly step of the quality improvement intervention program, all activities, patient encounter, and outcomes are logged by the staff. This writer was responsible for continuously reviewing all data that have been collected to ensure that the intervention is applied as directed and that the appropriate information is being logged.

As the project leader, this writer took full responsibility for the project planning, implementation, and evaluation. She ensured adherence to the project's time scheduled period (Appendix C - Project Schedule), the budget (Table 1), and maintained the integrity of the data collection (Appendix D—Data Collection Tools). Train-the-trainer of RNs on the CHW curriculum, RN/CHW orientation w completed by the project leader. Also, she served as support to the RN/CHW team.

Project Evaluation and Analysis

Summative Evaluation

To determine if the intervention of RN/CHW combined visits on a set frequency has made a significant impact on readmission rates in the Asian population a 40% reduction in admission /non-urgent emergency room visits is required. Each participants' clinical record, home health aide schedules, nurse visit notes were reviewed, as they helped to identify missed visits or gaps in the schedule which served as an indicator of an event occurring during that period which may have gone unreported to the agency staff. Data was also collected on the participants clinical, functional, social and environmental status. All participants were interviewed, regarding their perceived reasons for hospitalization or ED visit, their medical condition and the information from this self-report will also be gathered, reviewed, and compared against the hospital/ED discharge summaries. Data collection and examination of that data occurred weekly throughout the eight weeks of the study. Staff retraining on the tools and the process were performed as deemed necessary.

Formative Evaluation

Throughout the study, there were weekly contacts with scheduling staff and the RN/CHW teams for visit verification and to answer any questions that may have arose. A log of all visits made was documented and verified by this writer. A continuous clinical record review was conducted weekly throughout the duration of the project to determine the adequacy of care provided and the process outcome; data collected on an Excel Spreadsheet database. The charts of the participants who had a hospital stay or had an unplanned visit to the ED were reviewed. The Readmission Review Tool, the Readmission Data tool and clinical records worksheets from the Institute for Healthcare Improvement (IHI) were used chart reviews.

Data Analysis

As seen in Table 3, there were not enough re-admissions after 30 days in 2016 and 2017 to do a parametric or no parametric test to answer the PICOT question. Therefore, a descriptive analysis of the results was done, and it showed that there is no significance between the RN/CHW intervention group and the group that received usual care. The graph in Figure 1, it shows a comparison of the 30-day readmission results in 2016, 2017 and that between the intervention and the group that received usual care. There was one (1) re-admission in 2016 which was 33.33% of the Asian admitted to the home care between January and March. In 2017, there was zero percent (0%) 30-day re-admissions for the participants that were in the study during that same period (January through March). The number of re-admissions after 30 days did decline from 1 (33.33%) to 0 (0%) from 2016 to 2017 (Figure 1). The readmission rate for the intervention group and the group that received usual care was 0% for each of them. Upon analyzing the data for the unplanned ED visit, the results showed that in 2016 the non-urgent ED visit rate of 8.00% while in 2017, the rate dropped to 5.60% (Figure 1). The major theme that arose from the data that was collected can be seen in Figure 2. This graph depicts that the three top chronic disease groups across both the intervention and usual care group are diabetes (16.20%), hypertension(16.20%) and osteoarthritis (16.20%). A further breakdown of these disease groups among the intervention and the usual care group reflects that in diabetes was the driving disease group of 22.22% in the usual care and 10.53% in the participants that received the RN/CHW intervention. There were 11.11% of participants in the usual care group that had hypertension as a diagnosis in comparison to 16% in the intervention group. The third disease group that emerged is osteoarthritis, and there was minimal significance in the percentage diagnosed with this disease between the usual care (16.66%) and the intervention group (16%).

A further look at Table 2 that displays the there were an almost equal number of males and females that participated in the study which facilitates generalization among genders. Although 100% of the participants are Asian, there was a significantly higher number of participants of Chinese ethnicity (94.44%). The participants who are of Chinese ethnicity identified Mandarin (44.4%) and Cantonese (38.9%) as their primary languages. All the CHW spoke both Mandarin and Cantonese; they all scored a 3 and above on a language proficiency assessment test that all staff is required to take by the agency before they are allowed to interpret. A minimum score of 3 out five is considered as proficient. There were three (3) registered nurses and 66.66% (2) was of Asian decent and 50% (1) was proficient in Mandarin and Cantonese; the other spoke Korean. The third nurse was of Hispanic decent. The study did not address if the there was any significance in the results or care based on the nurse's language. However, based on the patient satisfaction survey that was administered, over 75% of the participants verbalized the desire to have nurses and staff in general who spoke their primary language. Demographics shows that all participants are over age 65 years and the average age of 78 years; $30.55\% \geq 90$ years, $25\% \geq 80$ years, $36.11\% \geq 70$ years, $8.3\% \geq 65$ years. Since a multivariate analysis was not done, there is no data and or evidence to determine any impact if any that age, gender, and diagnosis had on the outcome and or the ability to predict risk categories for 30-day hospital readmission and non-urgent ED visit rates. The PICOT and the length of time for this study did not make this analysis feasible.

Further investigation shows that all the individuals who were recruited for the research (n=38) and the total number whom analysis was completed for (n=36), all are members of a Medicaid Managed Long Term Care Program (MLTC) where they receive care management services. The care manager is responsible for coordinating all services and collaborates with the

various community-based programs to deliver care. Each member is contacted by their care

manager, who is either a Registered Nurse or a Social Worker at a minimum of once per month.

The care manager acts as the liaison and is a central part of the participants care. Care

management is an evidenced-based program that has been proven to be effective in improving

care coordination, communication, collaboration and an overall improvement in care outcome; it

has significant implications for managing chronic disease (AHRQ, 2015). As the common

denominator in the participants cares delivery model, this author believes that care management

may have acted as a restraining force in achieving the significance in the RN/CHW as

anticipated. Although the participants all were elderly with one or more chronic disease(s) and

had a need for culture-specific care, their care management program is perhaps keeping them

healthier nd is acting as a stabilizing entity in managing their care and keeping them healthier. It

should also be known that these participants are assigned to professional care managers who

speak their primary language.

Further research is warranted to address the significance that care management may have

on 30-day hospital readmission rates and non-urgent ED visits. Also, it is recommended that

additional studies using the RN/CHW intervention be done but with an application to a specific

disease group who demonstrates poor disease control. Since comprehensive diabetes

management and hypertension management are listed as indicators for Healthcare Effectiveness

Data and Information Set (HEDIS) 2017, a quality metrix among insurance companies, it is

recommended that the Agency consider one or both disease for future study. By doing this, the

parameters for uncontrolled diabetes (A1C > 9.0 mg/dl) and uncontrolled hypertension parameter

of blood pressure > 150/90 that are used by HEDIS may be used as eligibility criteria.

Implications for Healthcare and Nursing

The use of CHW in addition to regular visits by RNs helps to address the social, cultural determinants of health in underserved populations. As individuals who understand the idiosyncrasies and societal issues affecting population health in the communities that they service, the CHW can assist the RN in identifying the participant's needs. They collaborate with the registered nurse in implementing culture-specific care plans that transform individual and population health outcomes. The CHW act as a bridge between the community, the nurse, and the healthcare organization. They can assist patients in navigating the system and can understand the patient from that of a liaison who understands the community health needs. The use of the CHW on the care team providing RN/CHW visits facilitates the alignment of a partnership between health care providers and the community. The RN/CHW care model increases collaboration between the healthcare agency and community-based organizations. It helps to improve communication, and its patient-centered model facilitates relationship-base care, team building, and trust.

It is also imperative that patients be treated by nurses who understand their culture and can communicate effectively with them in their language of choice. It reduces the language barrier, and it improves patient satisfaction with nursing care, it improves care outcome and that of the community. Having professionals who speak a patients language as the primary care provider facilitates the provision of culture-specific care that Leininger admonishes. Nurses who can understand and communicate with their patients; they are less apt to feeling stressed and emotionally drained which are some of the issues that language and cultural barriers poses. Additionally, it improves nurse satisfaction as it allows the nurse to feel empowered in

knowledge transfer and outcome with them seeing the difference that their care and teaching makes. It facilitates nurse retention.

It is also a more financially viable solution and can be successfully used in underserved communities where there may be a shortage of healthcare providers. It promote disease education, self-management eliminates the need to have multiple providers in the clients' home.

<div align="center">**Plans for Dissemination**</div>

Internal Dissemination

All the key stakeholders, staff and care managers from the organization's affiliate care management company are invited to the final presentation of the project. The presentation is expected to be held in the facility's conference room. This writer also anticipates that there is staff who may join via a conference line. An oral presentation will be done with the use of a power point presentation via a projector will be used to present the final findings. Additionally, a copy of the presentation will be shared via email with staff that is unable to attend the live presentation and webinar.

External Dissemination

The Home Healthcare-NOW and the Home Health Nurse journals are ideal for the publication for the scholarly project as homecare nurses nationwide have access to them; these are both peer review interprofessional journals for home health and hospice clinicians. Only original articles may be submitted for publication, and they are required to be considered by a panel comprising of the Editor in Chief and members of the review committee before being published. There is a limit of 2000-5000 words, and the manuscript must be written using AP 6th edition guidelines, 12 -point font and double-spaced. All requirements for the submission of a manuscript are clearly outlined on the organization's webpage.

The transcultural nursing conference takes place in New Orleans from October 18-21, 2017, and so this writer plans to submit her abstract for consideration. The objectives of the conference are in alignment with this writers' project. They include the relationship between transcultural nursing and social determinants of health best practices in assessing community health needs, and lastly, nursing theories that address diverse population. There is a limit of 600 words for this abstract, and the deadline is April 15, 2017.

The New York State Association of Health Care Providers (NYSAHCP) will be used for external dissemination of the project findings. It is chosen as this is the major association of homecare and hospice organizations throughout New York State and conferences are held biennial which would facilitate this writer's presentation. The NYSAHCP advocates and lobbies for changes within the home care industry; it serves as the voice for providers, support, and advocates for standardization in practice. It also distributes newsletters on a continuous basis throughout the year to its' members. NYSHCAP also has political action committee at both state and federal levels.

Lastly, this writer plans to submit the project to the doctorate of nursing practice (DNP) for publishing in its repository. The DNP repository serves as a resource for other students, it enhances learning and promotes outcome; it fosters professional development and facilitates recognition for this writer and Chamberlain College of Nursing.

Conclusion

The RN/CHW intervention is an evidence-based model that facilitates the provision of culture-specific care. This integrated model promotes chronic disease self-management and it empowers patients as it facilitates the patients' autonomy. It is effective in the primary care, transition of care programs and community-based organizations. The RN/CHW delivery model

facilitates the delivery of care based on culture, language, and the patients' community. It brings

the care back to the community and is an effective way of reducing 30-day hospital readmission

rates and unplanned emergency department visits.

References

Abdulrehman, M. S., Woith, W., Jenkins, S., Kossman, S. & Hunte, G.L. (2016). Reflections on native ethnography by a nurse researcher. *Global Qualitative Nursing Research*, *3*, 1-13. doi: 10.1177/2333393616641825

Agency for Healthcare Research and Quality (AHRQ) (2015). Care management implications for medical practice, health policy, and health services research. Agency for Healthcare Research and Quality, Rockville, MD. Retrieved from http://www.ahrq.gov/professionals/prevention-chronic care/improve/coordination/caremanagement/index.html.

Agency for Healthcare Research and Quality (2014). Tool 2: Readmission review tool. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitgguide/medread-tool2.html

Agency for Healthcare Research and Quality (2014). Tool 9: Readmission risk tool. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitgguide/medread-tool9.html

Bradley, E. H., Sipsma, H., Curry, L., Mehrotra, D., Horwitz, L. I., & Krumholz, H. (2013). Quality collaborative and campaigns to reduce readmissions and campaigns to reduce readmissions: What strategies are hospitals using. *Journal of Hospital Medicine, 8*(11), 601-608. doi.1002/jhm.2076

Brewster, A. L., Curry, L. A., Cherlin, E. J., Talbert-Slagle, K., Horwitz, L. I., & Bradley, E. H.

     (2015). Integrating new practices: a qualitative study of how hospital innovations become

     routine. *Implementation Science : IS*, *10*, 168. http://doi.org/10.1186/s13012-015-0357-3

Burns, M. E., Galbraith, A. A., Ross-Degnan, D., & Balaban, R. B. (2014). Feasibility and

     evaluation of a pilot community health worker intervention to reduce hospital

     readmissions. *International Journal For Quality In Health Care*, *26*(4), 358-365.

     doi:10.1093/intqhc/mzu046

Centers for Medicare & Medicaid Services (CMS) (2012b). Community-based care transitions

     programs. Retrieved from [www.innovations.cms.gov/initiatives/partnership-for-](www.innovations.cms.gov/initiatives/partnership-for-patients/CCTP/index.html)

     [patients/CCTP/index.html](www.innovations.cms.gov/initiatives/partnership-for-patients/CCTP/index.html)

CHW Network NYC (n.d). Community Health Worker Network Training.

     http://www.chwnetwork.org/

Cik Yin, L., Beanland, C., Goeman, D., Johnson, A., Thorn, J., Koch, S., & ... Lee, C. Y. (2015).

     Evaluation of a support worker role, within a nurse delegation and supervision model, for

     the provision of medicines support for older people living at home: the Workforce

     Innovation for Safe and Effective (WISE) Medicines Care study. *BMC Health Services*

     Research, *15*(1), 1-11. doi: 10.1186/s12913-015-1120-9.

Clough, J., Lee, S., & Chae, D. H. (2013). Barriers to health care among Asian immigrants in the

     United States: a traditional review. *Journal of Health Care for the Poor and*

     Underserved, *24*(1), 384-403.

DePue, J. D., Dunsiger, S., Seiden, A. D., Blume, J., Rosen, R. K., Goldstein, M.

G.,…McGarvey, S. T. (2013). Nurse-community, the health worker team, improves

diabetes care in American Samoa: Results of a randomized clinical trial. *Diabetes Care,*

36(7), 1947-1953. http://doi.org/10.2337/dc12-1969.

Doherty, T., & Coetzee, M. (2005). Community health workers and professional nurses: defining

the roles and understanding the relationships. *Public Health Nursing*, *22*(4), 360-365.

Dyer, N., Sorra, J. S., Smith, S. A., Cleary, P., & Hays, R. (2012). Psychometric properties of

the consumer assessment of healthcare providers and systems (CAHPS®) clinician and

group adult visit survey. *Medical Care*, *50*(Suppl), S28–S34.

http://doi.org/10.1097/MLR.0b013e31826cbc0d.

Findley, S. E., Matos, S., Hicks, A. L., Campbell, A., Moore, A. & Diaz, D. (2012). Building a

consensus on community health workers' scope of practice: Lessons from New York.

American Journal of Public Health, *102* (10), 1981-1987. doi:

10.2105/AJPH.2011.300566

Hines, A. L., Barrett, M. L., Jiang, J. & Steiner, C. A. (2014). Conditions with the largest number

of adult hospital readmissions by payer, 2011: Healthcare cost and utilization project.

Agency for Healthcare Research and Quality, Statistical Brief #172. Retrieved from

www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf.

Institute of Medicine (2003). Institute of Medicine [IOM]. (2003). Unequal treatment:

Confronting racial and ethnic disparities in healthcare. Washington, DC: National

Academies Press.

Institute for Healthcare Improvement [IHI]. (2009). Triple Aim Concept Design. Retrieved from

http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

Juon, H., Strong, C., Kim, F., Park, E., & Lee, S. (2016). Lay health worker intervention

improved Hepatitis B vaccination in Asian Americans: Randomized controlled

trial. *PLoS ONE, 11*(9), 1-14. doi:10. 1371/journal.pone.01622683

Lee, J. W., Brancati, F. L. & Yeh, H. C. (2011). Trends in the prevalence of type 2 diabetes in

Asians versus whites: results from the United States National Health Interview Survey,

1997-2008. *Diabetes Care, 34*(2), 353-357. doi.org/10.2337/dc10-0746.

OneCity (2016). DSRIP initiatives coming in 2016: Reducing avoidable emergency room use.

OneCity Health News. Retrieved from www.onecityhealth.org/dsrip-initiatives-coming-

2016-avoidabble-emergency-room-use

Saha, S., Beach, M. C., & Cooper, L. A. (2008). Patient Centeredness, Cultural Competence,

and Healthcare Quality. *Journal of the National Medical Association*, *100*(11), 1275–

1285

Shah, B. R., Thomas, K. L., Elliot-Bynum, S., Thomas, K., Allen LaPointe, N., Calhoun, S.A.,

Thomas, L., Mathews, R., Califf, R., M. & Peterson, E.D. (2013). Check it, change it, a

community-based intervention to improve blood pressure control. Retrieved from

http://circuitoutcomes.aha.journal.org

Sorkin, D.H. & Ngo-Metzger, Q. (2014). The unique health status and health care

experiences of older Asian Americans: Research findings and treatment

recommendations. Clinical Gerontologist, 37(1), 18-32. doi:10.

1080/07317115.2013.84751

Strachan, D. L., Källander, K., ten Asbroek, A. H. A., Kirkwood, B., Meek, S. R.,

Benton, L., Hill, Z. (2012). Interventions to improve motivation and retention of

community health workers delivering integrated community case management (iCCM):

stakeholder perceptions and priorities. *The American Journal of Tropical Medicine and Hygiene*, *87*(5), 111–119. http://doi.org/10.4269/ajtmh.2012.12-0030

Vetter, M.J., Bristow, L. & Ahrens, J. (2004). A model for home care clinician and home health aide collaboration: diabetes care by nurse case managers and community health workers. *Home Healthcare Nurse, 22*(9), 645-648.

Table1: SWOT

Internal Forces (project)	External Forces (organization or environment)
Strengths	*Opportunities*
☐ CHW connection with the community ☐ Understands the language, culture & community needs ☐ High-quality leadership who understands the need for change ☐ Cost effective way to reduce healthcare costs ☐ CHW can be trained and mentored by RNs to provide high level of support to them	☐ Health care system restructure and financial incentives for reducing readmission ☐ Need for patient-centered care ☐ CHW can act as cross referral to improve population health outcome ☐ High patient satisfaction
Weaknesses	*Threats*
☐ Lack of standardization of CHW training ☐ Cost of initial training ☐ Requires consistent funding ☐ Statistical data	☐ Patients unwillingness to trust CHW ☐ Recruitment and selection of qualified staff as CHW ☐ Poor relationship between nurse & CHW ☐ CHW saw as threat by RN ☐ Lack of interest by RNs ☐ Inadequate training of CHW ☐ Lack of government funding ☐ Lack of motivation of CHW

Table 2: Budget

EXPENSES		REVENUE	
Direct		Billing—RN visits @ $130/visit /pp x 2	$9,880
Salary and benefits- prorated x 8 weeks—RN Base salary $70k/yr. x 2; CHW base @ $42k/yr. x 2	$79,950.77	Grants	0
Supplies	0	Institutional budget support	$79,950.77
Services			
Statistician	$1000		
Refreshments for meetings	$300		
Indirect			
Overhead	0		
Total Expenses	$80,950.77	Total Revenue	$89,830.77
Net Balance			$8,880.00

Table 3

Demographics

Variable	Frequency	Percent
Gender		
Male	18	48.6
Female	19	51.4
Total	37	100.0
Ethnicity		
Asian	37	100.0
Language		
Mandarin	16	44.4
Cantonese	14	38.9
Fujianese	2	5.6
Taiwanese	2	5.6
Japanese	2	5.6
Total	36	100.0
Primary Diagnosis		
Asthma	2	5.4
Cerebrovascular Accident	1	2.7
Chronic Fatigue Syndrome	1	2.7
Chronic Kidney Disease	2	5.4
COPD	2	5.4
Coronary Artery Disease	3	8.1
Diabetic Neuropathy	1	2.7
Gait Impairment	2	5.4
Gout	1	2.7
Hypertension	6	16.2
Major Depressive Disorder	1	2.7
Osteoarthritis	6	16.2
Polyarthritis	3	8.1
Uncontrolled Diabetes	6	16.2
Total	37	100.0

Figure 1: Comparison of 2016 and 2017 30-Day Readmission and Non-Urgent ED Visit Rate
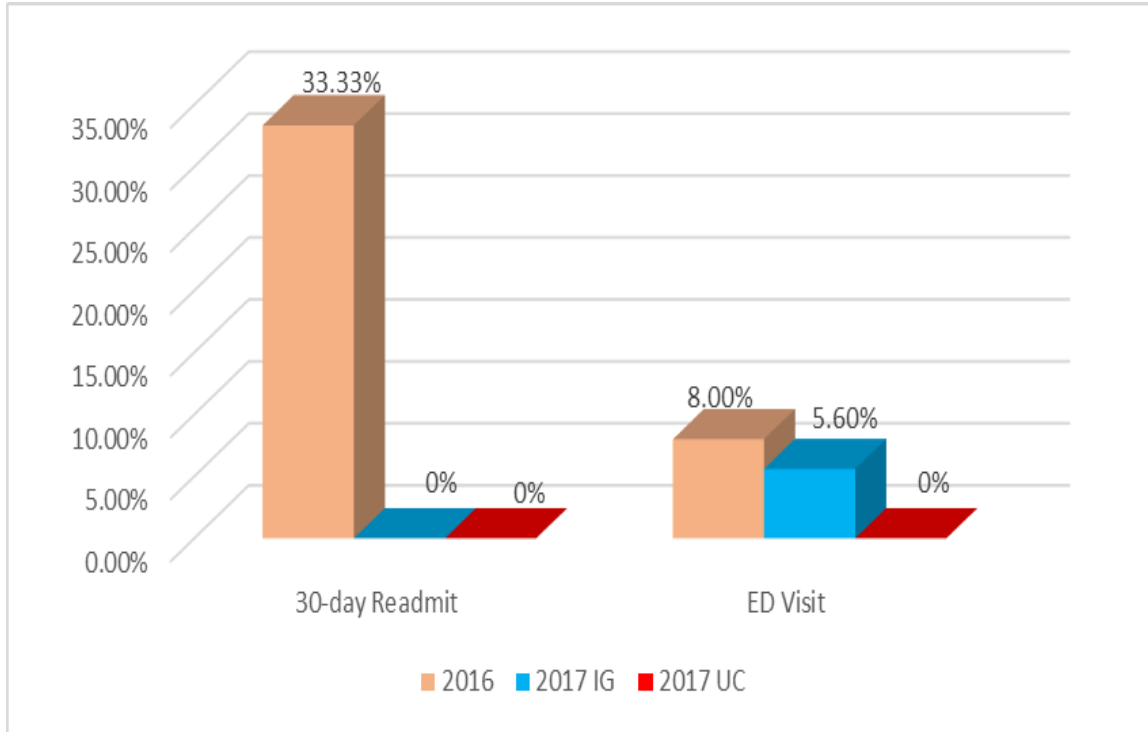
Note: IG = Intervention Group, UC = Usual Care, Year = 2016, 2017

Figure 2: Top Three Chronic Disease—Usual Care vs. Intervention Group
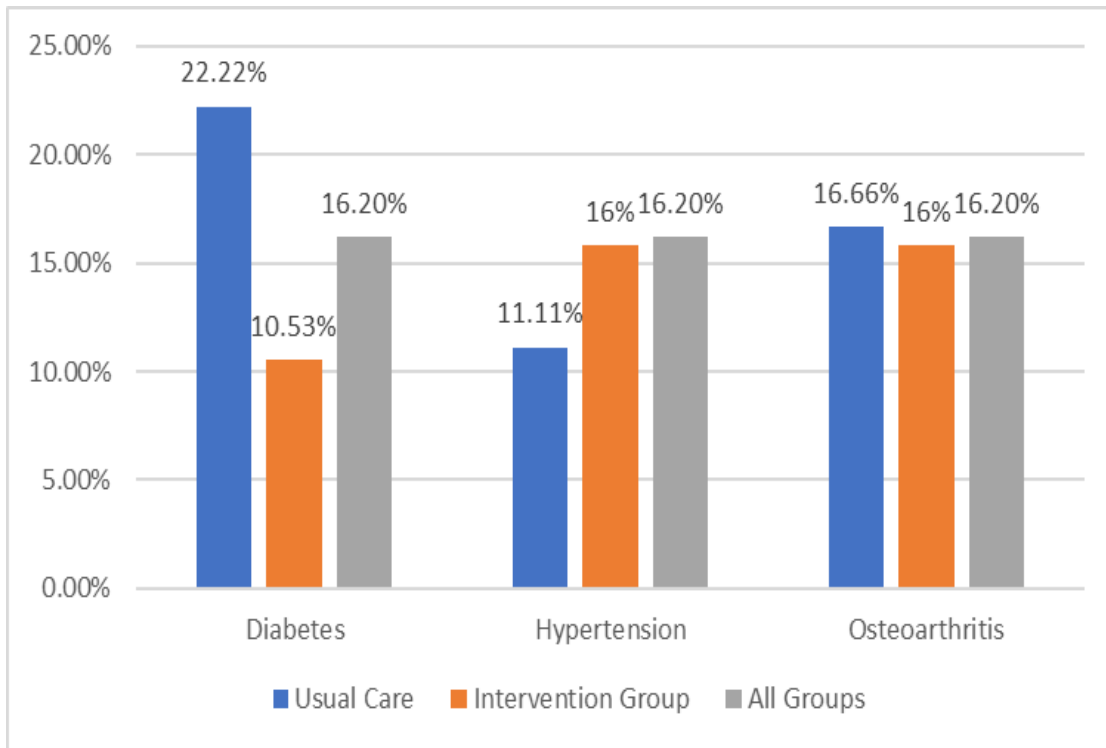
Appendix A

Summary of Primary Research Evidence

Citation	Question or Hypothesis	Theoretical Foundation	Research Design (include tools) and Sample Size	Key Findings	Recommendations/ Implications	Level of Evidence
Burns, M., Galbraith, A. A., Ross-Degnan, D. & Balaban, R. B. (2014). Feasibility and evaluation of a pilot community health worker intervention to reduce hospital readmissions. *International Journal of Quality in Health Care*, 1-8. doi: http://dx.doi.org/10.1093/intqhc/mzu046	CHW, when introduced before hospital discharge and followed up immediately post-discharge, is cost effective in improving transitional care in vulnerable populations was clearly written	Culture-specific care was clearly defined	Randomized quality improvement intervention; n= 423; Telephone calls Online survey tool, Daily activity log, Debriefing interview facilitated evaluation throughout the data collection period	Readmission rates were lower in patients with CHW intervention (15.4%) versus those with usual care (17.9%); with females having a lower readmission rate (16.9 vs. 21.4%) in comparison to their male counterpart (13.7% vs. 14.3%); the initial contact by CHW during hospitalization had a positive impact on CHW + pt. Relationship and responsiveness to telephone contacts facilitated generalization	The effectiveness of CHW also relied on their ability to utilize problem-solving skills, act as social support and liaisons; access to database management tool with client contact and to log contact outcome is essential to enhance and improve continuity of care. Mentoring, training, closer supervision and access to community resources are necessary to increase CHW effectiveness	Level 1
Kangovi, S., Mitra, N., Grande, D., White, M.L., McCollum, S., Sellman, J., Shannon, R.P. & Long, J. A. (2014). Patient-centered community health worker intervention to improve post-hospital outcomes: A randomized clinical trial. *The Journal of American Medical Association, 174*(4), 535-543. doi: 10.1001/jamainternmed.2013.14327	Pts. That receive CHW intervention post hospital discharge has increased access to care, improve medication adherence, increase self-management, and lower 30-day readmission was evident.	Patient-centered care was clearly defined	2-Armed, single-blind randomized clinical trial; n=446; Electronic medical record, Questionnaires--Literacy Screener, 12-item short form health survey, Morisky Medication Adherence Scale, Patient Satisfaction Questionnaire	The use of CHW influence care outcome in patients with social and behavioral factors that act as barriers to care. Additionally, the use of patient-centered care improved access to care (60% vs. 47.9%) clearly reflected the hypothesis; it facilitated generalization	Redesign of healthcare practice to include new workforce such as CHW that targets specific patient groups/population can lead to improving financial and clinical outcomes for healthcare organization	Level 1
Allen, J.K., Dennison-Himmelfarb, C.R., Szanton, L., Hill, M. N.,	Evaluate if NP/CHW Model of care is effective in chronic	Community-based participatory research	Randomized clinical trial; n= 525 where NP/CHW (n=261),	CHW intervention group experienced an improvement in	Individualized care with Nurse led the team with CHWs is effective in	Level 2

Levine, D....& Anderson, K. (2011). Community outreach and cardiovascular health (COACH) trial: A randomized clinical trial of nurse practitioner/community health worker cardiovascular disease risk reduction in urban community health centers. *Circulation Cardiovascular Quality Outcomes, 4*, 595-602. doi:10.1161/CIRCOUTCOMES.111.961573	disease management in vulnerable populations; the clinical was evident		Usual care (n=264); Patient Assessment of Chronic Illness Care survey tool, Habits & Food Frequency Questionnaire, Stanford 7-Day Physical Activity Recall, 5-Item EuroQol questionnaire, Healthcare utilization data	biometric measurements such as HbA1c, triglycerides, BP, Total cholesterol, LDL-C over a 12-month period	reducing health risk status in pts with chronic care needs. However, CHW funding is needed to ensure sustainability	
Miyong, K., Kim, T., Kim, B. & Han, H.R. (2014). The effectiveness of community-based multifaceted intervention (STOP-DM) designed for Korean-Americans with type 2 DM. (2014). Retrieved fronmNursinglibrary.org	RN/CHW Teams can be effectively used to improve self-management in pts. with chronic disease	Community-based participatory research	Open-label randomized clinical trial; n=250;	Data that was collected over a 12-month period showed that HbA1C in the intervention group with CHW was 1.0% while that of the uncontrolled group was 0.3% to 0.6 %reduction;	The results indicated that there is statistical significance of improvement in self-care	Level 2
Mobula, L.M., Okoye, M.T., Ebony Bouware, L., Carson, K. A., Marstellar, J. A. & Cooper, L. A. (2014). Cultural competence and perceptions of community health workers' effectiveness for reducing health care disparities. *Journal of Primary* Care *and Community Health*, 1-6. doi: 10.1177/2150113191454 0917.	Is there a relationship between provider and staff self-report cultural competency and their perception about the effectiveness of the use of CHW in reducing healthcare disparity?	Cultural competence	In a cross-sectional study among healthcare providers and staff the ACT Study, Project ReD CHiP clinical trial intervention, 5-Point Linkert –type Scale and Cultural Competence Assessment Instrument. were used to collect self-report data; Descriptive Statistics and 2-way T-tests analysis and Fischer exact test were used for comparison among the groups; n = 119	Although CHW are lay workers, 58% of the health providers that participated in the study considered them CHW use as an effective intervention to reduce health care disparities in comparison to 38% of frontline staff	Implications for further study regarding the use of CHW in various settings, reimbursement strategies for CHW services and training of CHW to ensure buy-in from frontline staff	Level IV

Lopes, S. C., Cabral, A. J., de Sousa, B. (2014). Community health workers: to train or restrain? A longitudinal survey to assess the impact of training community health workers in the Bolama Region, Guinea-Bissau. *Human Resources for Health, 12*(8). doi: 10.1186/1478-4491-12-8	Is there a need for continuous support and supervision of CHW post their initial base training?	Community health worker, training, impact, diagnosis accuracy, diarrheal diseases; however, there was no theoretical framework	N=22; CHW performance was observed and quantitative data collected was analyzed using two non-parametric tests: Friedman's variance analysis and Cochran's Q test to compare the accuracy of the data. Additionally, a logistic regression model was used to assess the relationship between the variables. SPSS software was used with a 5% significance level	The overall level of performance was found to decrease after completion of the first 90 days of employment. Performance ad competency of CHW may be affected by the workers' failure to apply knowledge received from training into the workplace; it can also be affected by them being left unsupervised and mentored	The selection, supervision, and support of CHW that are recruited for training is equally important as them receiving continuous training	Level 3
Woods, E., Bhaumik, U., Sommer, S., Ziniel, S. I., Kessler, A. J., Chan, E., Wilkinson, R. B., Sesma, M. N., Burack, A. B., Klements, E. M., Queenin, L. M., Dickerson, D. U., Nethersole, S. (2012). Community Asthma Initiative: Evaluation of a quality improvement program for comprehensive asthma care. *Pediatrics, 129*(3) 465-472. doi:10.1542/peds.2010-3472	Is the use of comprehensive home visits by CHW and office-based nurse case management cost effective and does it improve asthma outcomes? PICOT was clearly written	Cultural sensitive family-centered approach	N=283, Statistical analysis using Strata 10.1 was used to analyze dichotomous variables while a multivariate analysis was used on trichotomous variables. All variables were analyzed showing changes from baseline to 6mth and 12 mth markers; Paired T-tests and logistic regression analyses were also performed; a longitudinal research was done to compare data over a period	Schools days, work days, ED visits and hospitalizations decreased at both six mth and 12 mth levels. Reduction is as follows: ED visits at 6 mth 66%, 12 mth 68%; hospitalization at 6 mth 80%, 12 mth 85%, Missed school days at 6 mths 45%, 12 mths 41%, Missed work at 6 mths 53%, 16 mths 50%, The results clearly reflect the clinical issue	RN/CHW visits facilitates the provision of culture-specific care, reduces non-urgent ED visits and readmission	Level 2

Legend:

Appendix B

Summary of Systematic Reviews (SR)

Citation	Question	Search Strategy	Inclusion/ Exclusion Criteria	Data Extraction and Analysis	Key Findings	Recommendation/ Implications	Level of Evidence
Shah, M., Heisler, M. & Davis, M. (2014). Community health workers and the patient protection and affordable care act: An opportunity for research, advocacy, and policy agenda. *Journal of Health Care Poor Underserved, 25(1),* 17-24. doi: 10.1353/hpu.2014.0019	Can CHW as members of the interdisciplinary health team fulfill the goals of the Affordable Care Act, 2010?	Community health Worker, health reform, PubMed, CINAHL	None identified	CHW offered the opportunity for various quality improvement models of care and was found to be effective a savings of $2000pp for in a project among Medicaid diabetics; It also was successful in obtaining >30% reduction risk in newborn mortality in an RCT; Also, reduce Medicare reimbursement in 2012 by 1%;	Evidenced-based model that can be tailored to meet the specific need of the population being served; the article was clear and concise and showed how risk could be reduced	The CHW serves a bridge in the healthcare system, and it acts as a cost-effective, evidence-based strategy to reduce healthcare cost and to fulfill the ACA laws; it serves to strengthen communities. Credentialing of training programs remain at large	Level 1
Lee, J. W., Brancati, F. L., Yeh, H. C. (2011). Trends in the prevalence of type 2 diabetes in Asians versus whites: results from the United States National Health Interview Survey, 1997-2008. *Diabetes Care, 34*(2), 353-357. doi.org/10.2337/dc10-0746.	Are Asians at a higher risk for type 2 diabetes in comparison to non-Hispanic whites?	PubMed, CINAHL, Cochrane, publication after 2010	Inclusion: Adults 18yrs and older, Asians, non-Hispanic whites Exclusion: Individuals are missing age at the time of initial diagnosis, pts. diagnosed with diabetes before age 25, Individuals missing height & weight data	Data collected from self-reports over a 12-year period was extracted, and different sampling designs were used with stratification by gender; 2-tailed t-tests and x tests were performed using Strata/SE analysis and non-parametric trends examined across various years; α level 0.05	Genetic predisposition and acculturation predisposes Asians to higher risk of diabetes than non-Hispanic whites; Asian American were 30-50% more likely to develop diabetes;	Diabetes prevalence in Asian populations is public health issue that requires serious attention	Level 3
Kim, K., Choi, J. S., Choi, E., Nieman, C. L., Joo, J, Lin, F., Gitlin, L. N. & Han, H.R. (2016). Effects of community-based health worker interventions to improve chronic disease	Is the use of CHW a cost-effective intervention that promotes optimal patient outcome in chronic disease management among vulnerable	PubMed. CINAHL, Cochrane, EMBASE	None identified	Data was extracted by trained research assistants from assistants using a standardized data collection tool that was developed by the authors	Findings showed that the use of CHW in community-based programs is a cost-effective strategy for chronic disease prevention and care improvement	CHW is effective for managing certain illness and has great implications for improving health outcomes in underserved and vulnerable populations.	Level 3

Citation	Question	Search Strategy	Inclusion/ Exclusion Criteria	Data Extraction and Analysis	Key Findings	Recommendation/ Implications	Level of Evidence
management and care among vulnerable populations: A systematic review. *American Journal of Public Health, 106*(4), e3-e28.doi:10.2105/AJPH.2015.302987	populations?						

Legend:

Appendix C

Project Schedule

Activity	NR702 Wk1	Wk2	Wk3	Wk4	Wk5	Wk6	Wk7	Wk8	NR705 Wk1	Wk2	Wk3	Wk4	Wk5	Wk6	Wk7	Wk8	NR707 Wk1	Wk2	Wk3	Wk4	Wk5	Wk6	Wk7	Wk8	NR709 Wk1	Wk2	Wk3	Wk4	Wk5	Wk6	Wk7
Meet with faculty & preceptor	X								X								X								X						
Prepare project proposal	X	X	X	X	X																										
Project Proposal						X																									
IRB Proposal										X																					
Stakeholder Meeting			X											X												X					
Train RNs on CHW roles															X																
Select CHW																X															
Train CHW																	X	X													
Orientation of RN & CHW																				X											
Selection of Subjects																					X										
Implement RN/CHW visits																						X	X	X	X	X	X	X	X		

Activity	NR702								NR705								NR707								NR709						
	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7
Collect Data																						X	X	X	X	X	X	X	X		
Review Data																						X		X		X		X			
Data aggregation & Analysis																														X	
Final Paper																														X	
Final Presentation – Chamberlain & Home Care																															X

Tool 2: Readmission Review Tool (Appendix D)

Purpose: Obtain qualitative insights into why readmissions occur.

Description: Adapted from the well-known STAAR approach, this one-page interview guide prompts clinical or quality staff to elicit the patient, caregiver, and provider perspective about the causes of readmissions.

Staff: Quality improvement, nursing, case management staff.

Time required: 15 minutes per interview; 10-20 interviews suggested to start; many teams review ALL readmissions when the patient is readmitted

Tool 2: Readmission Review

Ask your patients, their caregivers, and providers "why?"

While it is important to have a good understanding of your organization's quantitative readmission data, these data do not help you understand the kinds of barriers patients, families, and providers face during the posthospital transitional care period or the circumstances leading patients to return to the hospital soon after discharge. Adapting from a popular approach from the Institute for Healthcare Improvement's State Action on Avoidable Rehospitalizations (STAAR) Initiative (www.ihi.org/staar), we recommend your readmission team conduct 5-10 "readmission interviews."

These reviews are designed to elicit the "story behind the story": going well beyond chief complaint, discharge diagnosis, or other clinical parameters to understand the communication, coordination, or other logistical barriers experienced in the days after discharge that resulted in a readmission.

Some teams may be concerned that patient interviews will be time-consuming. You can address time constraints by using a simple framing script at the beginning of the interview (see next page). Readmission teams uniformly report that these reviews yield valuable information that would otherwise be difficult to obtain from charts or data.

While we provide a script, the most important principle of conducting these interviews is to give patients, family members, and providers an opportunity to provide detail about why they/their loved one/their patient had to return to the hospital. The prompts are only meant to help elicit the stories from the individuals you interview. The readmissions interview has three main parts:

☐ Brief chart review of the first admission and the readmission.

☐ Patient/family caregiver interview.

☐ Provider interview.

Drawing on an innovation to the readmission interview developed by Feigenbaum and colleagues at Kaiser Permanente, we recommend capturing all the reasons patients, caregivers, and/or providers cite that factored into the readmission event. As Feigenbaum and team discovered, an average of 9 factors spanning the domains of hospital-care, predischarge preparation, the discharge process, and posthospital time period contributed to each potentially preventable readmission they reviewed.

Implementation tip: these interviews should take no more than 40 minutes each. It is often easiest to find one or two patients currently in your care who were recently readmitted and interview them. Remember to call the relevant cross-continuum partners (physician, home health nurse, discharging physician, community based case worker, mental health provider, etc.) to get their perspective.

Section 1: Brief chart review (10-15 minutes)

Elicit the following basic information:

☐ Date of first admission

☐ Date of first discharge

☐ Active medical issues during first hospitalization

☐ Discharge disposition

☐ Comments on first transitional care plan (i.e., whether teaching/written instructions given/ referrals made/ appointments scheduled)

☐ Date of readmission

☐ Number of days between discharge and readmission

☐ Site of care readmitted from (home, skilled nursing facility, etc.)

☐ Readmission chief complaint, as recorded in the chart

☐ Active medical issues during the second hospitalization

☐ Discharge disposition (if they are no longer in the hospital)

☐ Comments on documented transitional care plan (was anything done differently?)

Section 2: Patient/family caregiver interview (10-15 minutes)

(Suggested script: "We are working to improve the discharge process and noticed that you have been in the hospital twice recently. I'd like to ask you for about 10 minutes of your time to give us some feedback about what happened between the time you were discharged and the time you returned to the hospital. This will help us understand what we might be able to do better for you and what we might be able to do better for our patients in general. Would that be o.k. with you?")

☐ What brought you to the hospital the first time? [insert reference to date of first hospitalization]

☐ Did you think the doctors, nurses and other staff helped you get ready to leave the hospital?

☐ Did you understand what the plan was for your care when you left the hospital?

☐ Did you receive information about whom to call if you had questions or problems?

☐ Tell me about anything that was unclear or confusing for you when you left the hospital.

☐ I see you went to (discharge disposition). How did it go once you got there?

☐ Did any new symptoms or issues come up after you were discharged?

☐ Did you see a doctor, nurse, or other provider after you were discharged? Who?

☐ Why do you think you needed to come back to the hospital?

☐ Was there anything that could have been done differently [so you didn't develop that symptom or issue]?

☐ Do you have any other suggestions for us? Thank you.

Section 3: Provider interview (3-5 minutes)

(Suggested script: We are working to improve care transitions and reduce avoidable readmissions. One of your patients was recently readmitted to our hospital and we'd like to ask for your thoughts on how we can improve our transitional care processes. It will take no more than 5 minutes of your time.)

☐ Did you know [insert patient name] was admitted on (first hospital date)?

☐ Did you know the patient was discharged to (setting) on (date)?

☐ Did our hospital contact you at all about the admission or discharge plan? If so, describe the interaction or information you received.

☐ Did the patient contact you after discharge with questions or issues, or for follow up?

☐ Did you have contact with the patient after discharge? If so, were there points of confusion about the plan,

symptoms, or other issues we should be aware of?

☐ Why do you think the patient ended up being readmitted?

☐ Do you think there was anything that could have been done for this patient, or others like him/her (socially or

clinically) to prevent readmissions?

- Data Collection –Patient Satisfaction Survey

RN/CHW Patient Satisfaction Survey

1. How would you rate the quality of the service?

○ Very high quality

○ High quality

○ Neither high nor low quality

○ Low quality

○ Very low quality

2. Do you have any other comments, questions, or concerns?

```
[                                                    ▲ ]
[                                                      ]
[                                                    ▼ ]
[ ◄                                                  ► ]
```

3. Overall, are you satisfied with the employees at our company, neither satisfied nor

dissatisfied with them, or dissatisfied with them?

○ Extremely satisfied

○ Moderately satisfied

○ Slightly satisfied

○ Neither satisfied nor dissatisfied

○ Slightly dissatisfied

○ Moderately dissatisfied

○ Extremely dissatisfied

4. What do you like most about our new service?

```
┌──────────────────────────────────────────────┐▲
│                                                │
│                                                │▼
│                                                │
│◄                                              ►│
└──────────────────────────────────────────────┘
```

5. How well did our customer service representative answer your question or solve your problem?

○ Extremely well

○ Very well

○ Moderately well

○ Slightly well

○ Not at all well

6. During your most recent visit, did your healthcare provider give you easy to understand information about these health questions or concerns?

○ Yes, definitely

○ Yes, somewhat

○ No

7. What is your ethnicity? (Please select all that apply.)

☐ American Indian or Alaskan Native

☐ Asian or Pacific Islander

☐ Black or African American

☐ Hispanic or Latino

☐ White / Caucasian

☐ Prefer not to answer

☐ Other (please specify)

[   ]

8. In general, how would you rate your overall health?

○ Excellent

○ Very good

○ Good

○ Fair

○ Poor

9. In general, how would you rate your overall health?

○ Excellent

○ Very good

○ Good

○ Fair

○ Poor

10. During your most recent visit, did your healthcare provider explain things in a way that was easy to understand?

○   Yes, definitely

○   Yes, somewhat

○   No

Appendix E

- Community Health Network of New York CHW Training Curriculum Overview

Training introduction and orientation

Introduction to participants and staff

Orientation/Ground Rules/ Expectations

CHW History & CHW Roles/boundaries, Skills, Tasks

History of CHWs

Role, Advocacy, and Outreach

CHW Identity-Activity

- Definition-Qualities, roles, skills
- Workforce profile
- Core Values-code of Ethics
- Social Justice Perspective

Legal and Ethical Responsibilities

Integrating CHWs

CHW supervision

Communication

Verbal, non-verbal and para-verbal messages

Active listening

Cross cultural communication

Barrier to communication

Outcomes for poor communication

Email communication

Compassionate communication

Making observation

Feelings/needs

Making suggestions-not demands

Positive Action statement

Cultural Competency

What is culture?

Other definitions of culture

Stereotyping

Cultural self-awareness

What is cultural competency?

Why do we need cultural competency?

Why do we need cultural competency in our role as CHWs?

Cultural competency tools

Cognitive Behavioral Theory

Human behavior

Stage theory/life span theory

Adult learning theory and Practice

Popular Education

Adult learning

Positive Psychology-Informal Counseling 1

Strength-Based assessments

Empowerment Approach

Power inequalities

- Power and Privilege
- Ethical use of power
- Sanctity of Life
- Oppression/dehumanization
- Labeling & judging

Behavior change Theories and Practice

Stages of Change

Process of Change

Tailored Interventions

Goal setting

Teaching and Capacity Building

Establishing healthy lifestyles and clients developing agreements to take responsibility for

achieving health goals

Method for planning, developing and implementing plans with clients to promote wellness

Coordination, Documentation, and Reporting

Appropriate, accurate and clear documentation with consideration of legal and agency

requirements

                    Role of the CHW-Health Promotion Competencies

Asthma

This training focuses on CHWs working with clients in controlling and improving their Asthma condition. Emphasized is on understanding Asthma among different populations, types of asthma by severity of symptoms, factors that affect or trigger Asthma. Strategies to help asthma clients to better control asthma and avoid ER visits & Hospitalization. CHW will assist in asthma education, resource identification and medication management.

Heart Disease & Stroke

The training focuses on CHWs working with clients and community members in preventing heart disease and stroke as well as working with those who already have heart disease or have experienced a heart attack or stroke. Emphasized is an understanding of the physiology of the heart, risk factors and warning signs for heart disease and stroke, emotional and socio-economic impact of heart disease and stroke and common treatments. Also included are strategies for CHWs to work with clients on prevention, achieving healthy lifestyles and accessing needed resources.

Diabetes

The training focuses on the role of CHW in working with clients with diabetes. Emphasis is on understanding diabetes, its risk factors, signs and diagnoses and its long term complications. Strategies for assisting diabetic clients with balancing their lives to achieve the highest level of wellness are primary focus. The role of the CHW in diabetes prevention, control, resource identification and education is also included

Hypertension

The training provides CHWs with an introduction to hypertension. Emphasis is on CHW role in assisting clients with understanding the causes and symptoms of hypertension. Control of hypertension has become the key national priority in the US. The increasing prevalence of the

condition is blamed on lifestyle and dietary factors. Regular BP check, healthy lifestyle and adherence to medication is very important.

Nutrition, Activity & Wellness

The training focuses on the knowledge and skills a CHW needs to assist clients in realizing healthy eating patterns, controlling their weight, integrating exercise into their lives, taking their medications, talking with their health providers, controlling substances such as tobacco, managing stress, achieving life balance and attaining personal and family wellness. Emphasis is on learning strategies that can be used to aid in client awareness, their education and incorporation of health into their daily lives. This training also provides information and activities in which the CHW can assimilate these concepts into their own lives.