Presa Community Center

New Directions in Community Work

PRESA
COMMUNITY CENTER

- Who we are
- What we do
- Community Empowerment through job skills
- Community Health Worker Certification
- Project PUENTE (Bridges)

What is a Community Health Worker?

CHWs are uniquely qualified as connectors because they live in the communities in which they work, understand what is meaningful to those communities, communicate in the language of the people, and recognize and incorporate cultural norms (e.g., cultural identity, spiritual climate, traditional health practices) to help community members navigate health care services. CHW's serve as "bridges" (Puentes) between community members and health care services.

CHW (Promotora) History

- Started in Latin American countries-gained momentum in US in 60's with Migrant Worker Communities
- 2001-Senate Bill 1051 directed DSHS to develop and implement a CHW training and certification program
- 2011-legislation directed DSHS to conduct a study with recommendations to maximize employment and access to CHW's for individuals with public and private insurance
- Jan, 2014-CMS has identified a CHW as a billable position with Medicaid/Medicare if part of Doctor's prevention/treatment plan for patient

CHW certification mandates these 8 core areas of training

- Communication Skills
- Interpersonal Skills
- Service Coordination Skills
- Capacity-Building Skills
- Advocacy Skills
- Teaching Skills
- Organizational Skills
- Knowledge on Specific Health Issues

8 classes since December 2012

- Presa approved as a training site in June, 2012
- 119 graduates
- 95% currently working as CHW's-starting pay $15 per hour

Project PUENTE
-using a culturally sensitive approach with a fragile community

Integrated patient care and disease management model, started in 2014 with a goal to redirect acute high-risk patients with chronic diseases to the most appropriate care settings, using population health

Top three diagnoses of participants:

- Chronic Heart Failure (CHF)
- COPD
- Pneumonia

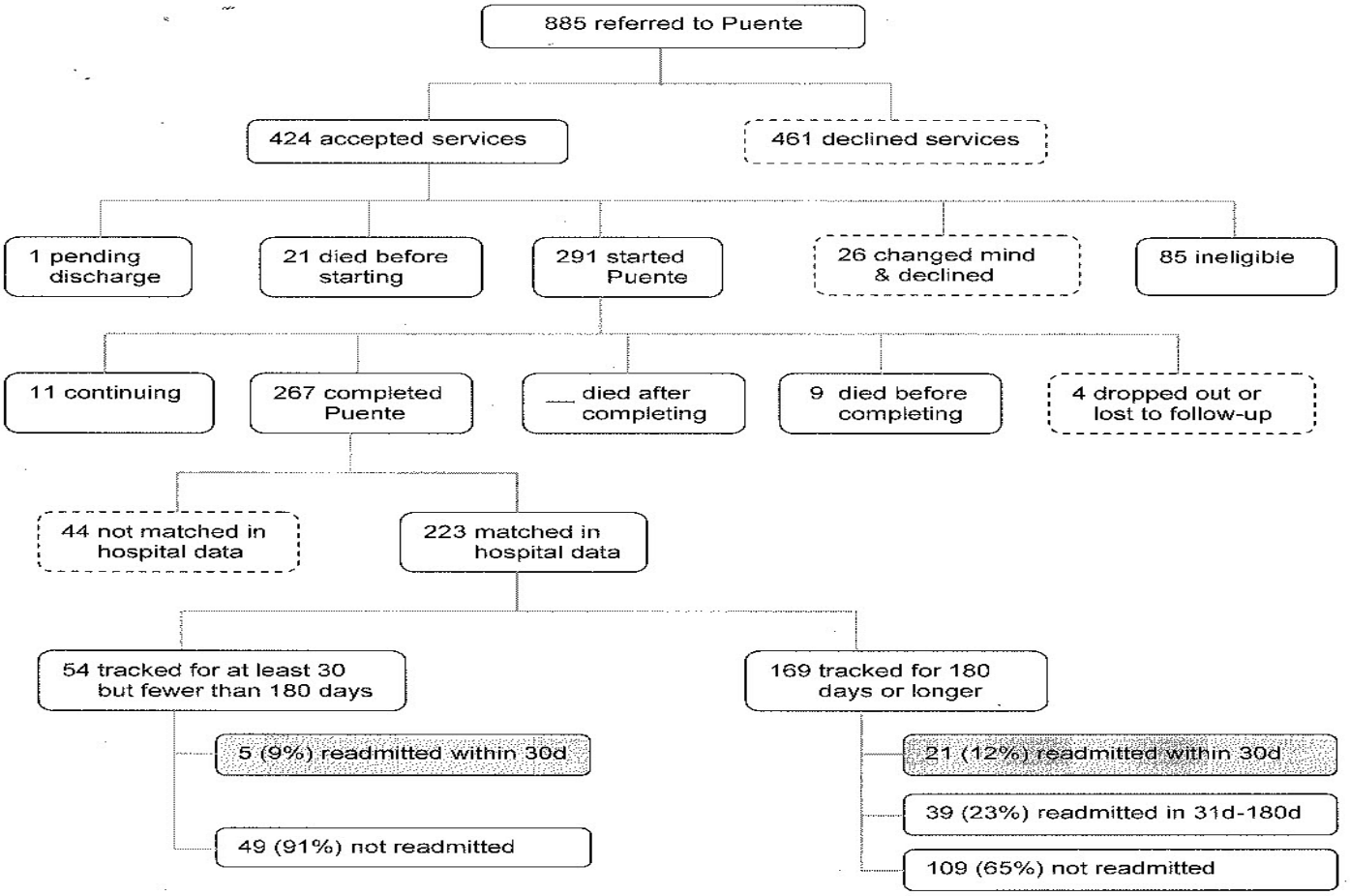
Project PUENTE

- First year, 2 hospitals and CHF patients
- End of year one, added 2 hospitals and COPD and Pneumonia diagnoses
- 885 initial referral
- 424 agreed to services/461 declined services
- 267 completed
- 26 readmitted within 30 days

Rate of Readmission

- Nationally-24%
- Baptist Hospital System-15%
- Project PUENTE-11.6%
- Adjusted PUENTE rate-7%

Project Puente Patient Status



	Tracked 30-179 days	Tracked 180+ days	Total tracked 30+ days
Number of completers	54	169	223
Readmitted within 30 days	5 (9%)	21 (12%)	26 (12%)
Readmitted in days 31-180		39 (23%)	
Subset readmitted in days 31-37		5 of 39 (13%)	

Characteristic	All patients (n=223)	CHF (n=75	Readmits-all cause(n=26)	Readmits-CHF(n=9)
Median age	69.0	68.96	39.10	70.3
No. of patients w/30 day readmit	26(11.66%)	9(12%)	26(100%)	9(100%)
No. of patients in program 180 days with 180 day readmit	60(26.91%)	26(34.67%)	21(80.8%)	8(88.9%)
RACE				
White	31 (13.90%)	11 (14.67%)	5 (19.23%)	1 (11.11%)
African Amer	39 (17.49%)	14 (18.67%)	9 (34.62%)	3 (33.33%)
Hispanic	152 (68.16%)	49 (65.33%)	12(46.15%)	5(55.56%)

Cost of Services

Range of cost per patient for 30 day readmission-$4,904-$7,121

Cost for Project Puente intervention per patient-$920

Successful Interventions

- In-hospital CHW visit; individualized education plan based on client needs
- Post discharge home visit 24-48 hours and weekly telephone follow-up call in-between visits
- Prompt scheduling and follow-up with PCP/specialty care visits within 3 to 5 days of discharge
- Medication access, self-management, and adherence
- Encouraging active participation and involvement of patient's family/ caregiver
- Greater health knowledge retention using the teach-back method
- Patient health record for care continuity

Supplemental Resources

TANGIBLES

RESOURCE	RECEIVED
Exercise/ Health Equipment	27
Food	40
Food Demo	22
Home Repair Funds	1
Medical Equipment	18
Nutritional Information / Recipes	55
Prescription Funds	22
Rent Assistance	2
Self-Care	57
Transportation	51
Utility Funds	5
Other	5

INTANGIBLES

REFERRAL/APPLICATION	RECEIVED
Adult Protective Services	6
Long-term food assistance	26
Home health provider	28
Home repair	8
Housing	9
Senior program	27
Smoke detector	5
Utility assistance	3
Other	15

Trends Identified

- Age greater than 69 years
- Two or more comorbidities
- Functional impairment e.g., physical, emotional, and cognitive
- Past or current diagnosis of behavioral health issues, often untreated
- Lack of understanding of discharge materials provided to the patient and/or family upon release
- Inadequate support system e.g., housing, financial, and social

Lessons Learned

- Expand time/meetings with patients who need more assistance
- CHW becoming Benefit Enrollment Specialist to enroll those uninsured to allow for access to resources and care
- CHWs added educational videos for use with patients/families
- Interdisciplinary team – Transitional Care Coach, Social Worker, Community Health Worker, Caregiver, and providers are a key to success

Lessons Learned continued

- Follow up calls 90 days after completion
- Moved from traditional education to experiential education- cooking demos
- Including caregiver/family member/home health provider in educational component for greater support and impact
- Attending appointments with clients to demonstrate and coach advocacy for oneself
- Clinic visits more effective when CHW teaches patients how to prepare/what to expect and meets patients at clinic

WHAT NEXT?