Navigating Primary Health Care: Community Health Navigator Program

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2023 PCN Strategic Forum

UNIVERSITY OF CALGARY | Primary Care Networks | UNIVERSITY OF ALBERTA SCHOOL OF PUBLIC HEALTH

Teaming Up, Moving Forward

Disclosure of Financial Support

- **<u>Potential for conflict(s) of interest</u>:**
  - Kerry McBrien is an employee of the University of Calgary, a physician contractor with AHS, and has received research funding from Canadian Institutes of Health Research (CIHR) and Alberta Innovates
  - Kimberly Manalili receives post-doctoral research support from CIHR, AHS and the University of Calgary
  - Natalie Ludlow is an employee of the University of Calgary
  - Anisha Badoni is an employee of Edmonton O-day'min PCN

  - This program was funded by the Canadian Institutes of Health Research (CIHR) and Alberta Innovates.

Mitigating Potential Bias

- The scientific planning committee has contributed to the consideration of learning needs, the determination of learning objectives, the development of program content, and the choice of speakers or presenters.
- No sponsorship funds have been received.
- The scientific planning committee has reviewed the content of the presentations and ensured that content presented is evidence-based and free of undue influence.

Agenda

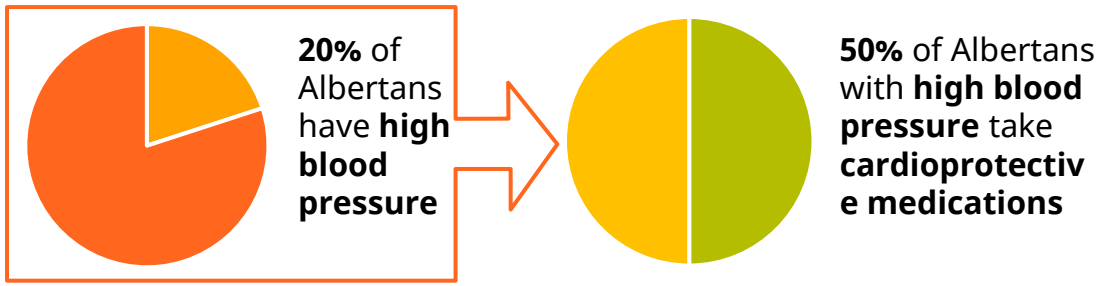
Agenda Item	Presenter(s)	Time
Welcome		5 min
Overview of the CHN Program and ENCOMPASS Research	Kerry McBrien	10 min
CHN Program Implementation at the Edmonton O-day'min PCN	Anisha Badoni	5 min
Post Study CHN program implementation and sustainability	Natalie Ludlow	5 min
Facilitated Discussion		30 min
Wrap-up	Kerry McBrien	5 min

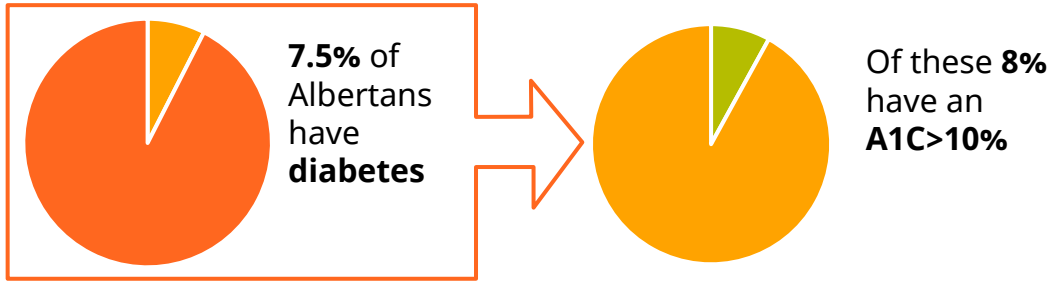
CHN Program

Chronic diseases are prevalent and gaps in care exist

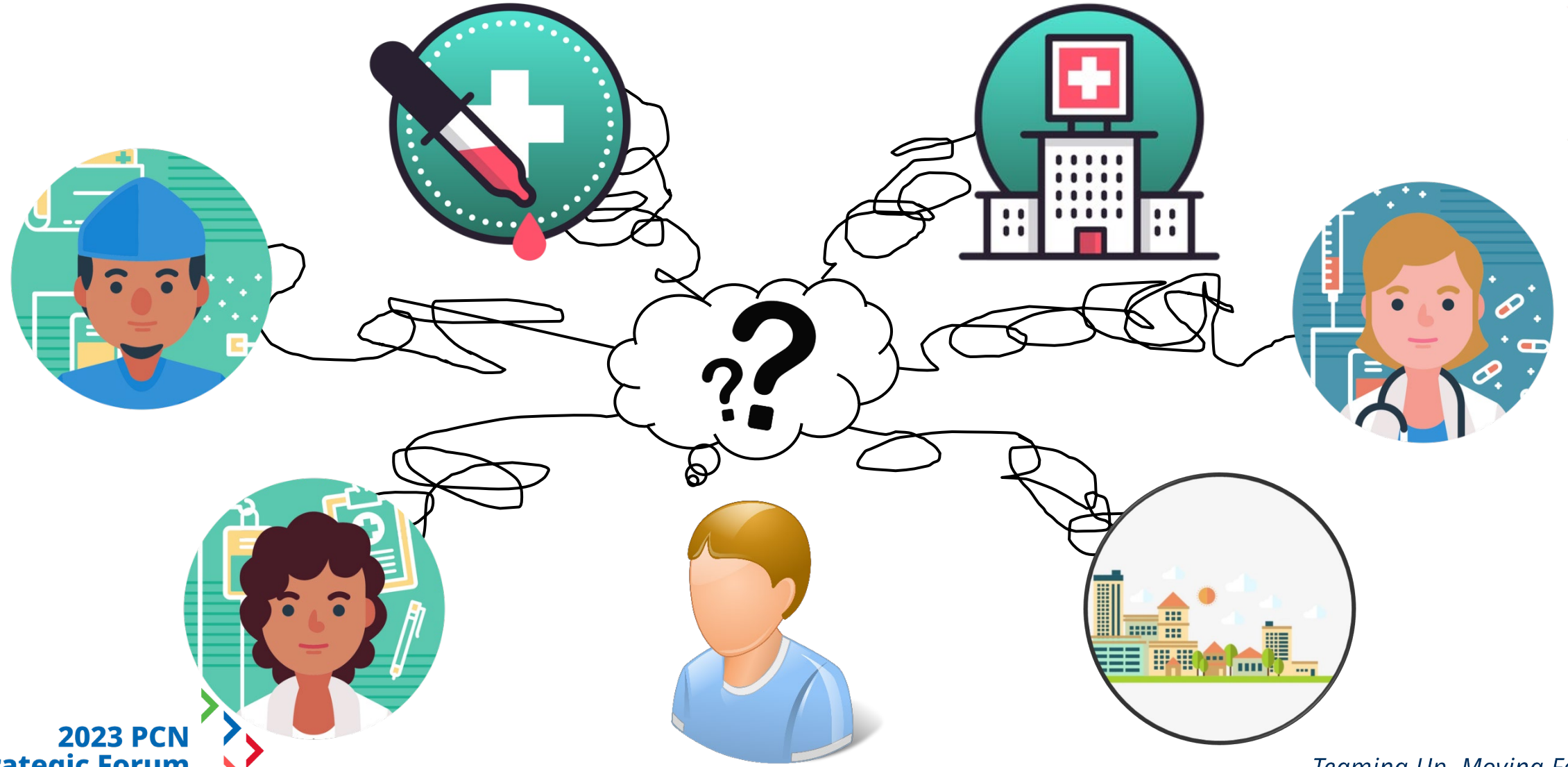
30% of adults have a **chronic disease**

70% if ≥60 years old

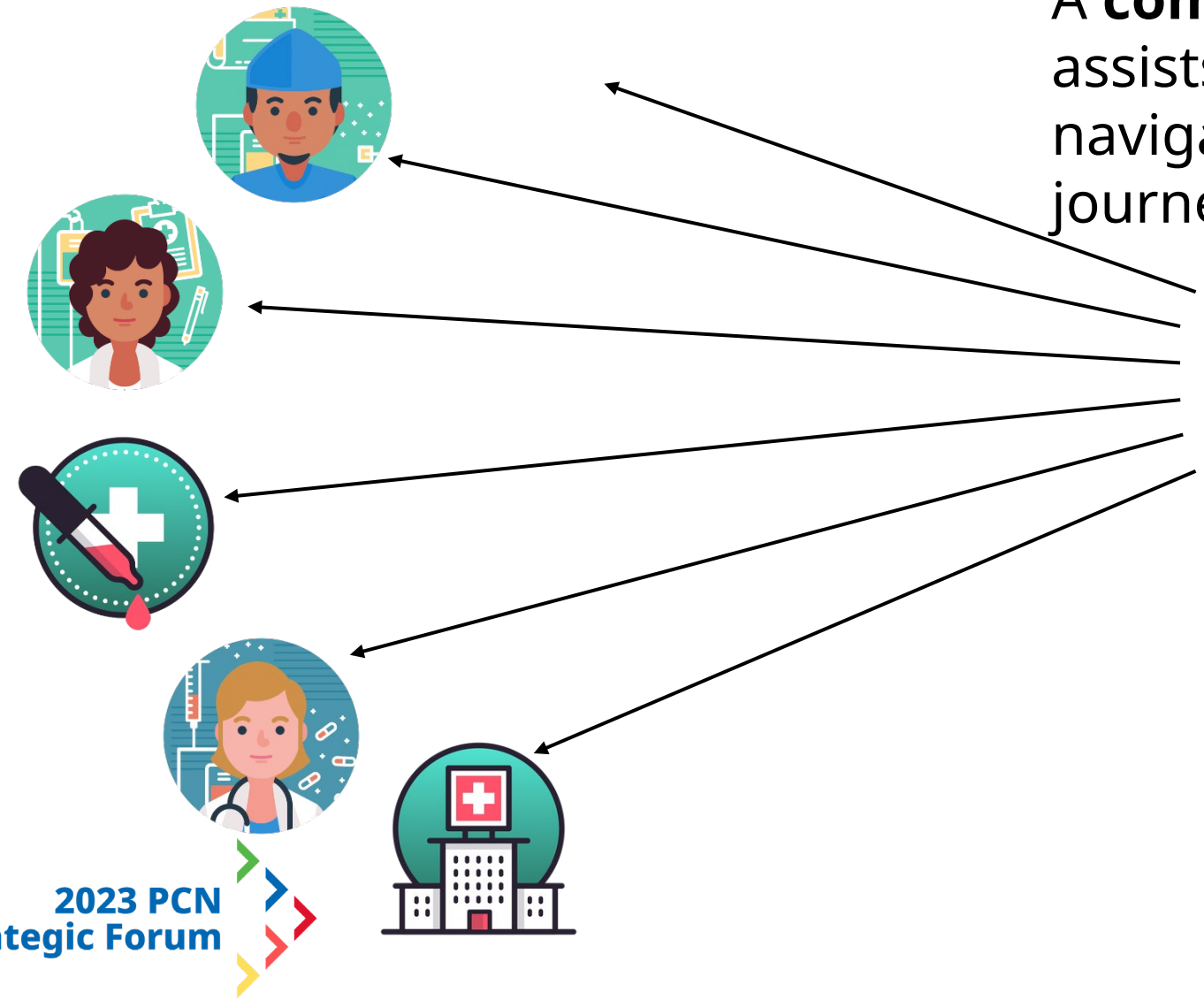




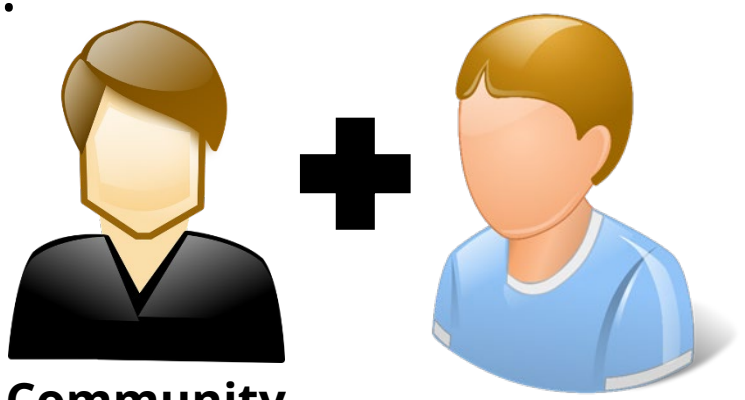
The health-care system is difficult to navigate



A community health navigator can help



A **community health navigator (CHN)** assists patients with chronic conditions navigate through their healthcare journey.



Community Health Navigator

Patient

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What is a Community Health Navigator (CHN)?

- While not a health care professional, a CHN is a patient-centred care provider with strong roots in the community.
- They are an expert in health, social and cultural resources available in their community. They can provide helpful advice on everything from finding bus routes to and from clinics and appointments, to navigating language barriers.
- A trusted member of the primary care team, a CHN can accompany patients through their health care journey.

The Role of the CHN

Community health navigators can support patients in three areas that contribute to better management of chronic health conditions:

1. **System Navigation**
2. **Patient Self-Management**
3. **Social Connection**

Evidence for Patient Navigation

Support community-based, equitable care

Support patients with complex health and social needs

Support integration of social care to address upstream factors

Improvement in cardiovascular risk, diabetes control, BMI and tobacco use

Improve care coordination and access to care

Reduce emergency department use

PCN Implementation Models

	Centralized	Clinic-Based
Program Integration	• CHNs integrated within a central team/program/clinic.	• CHNs integrated within Medical Home teams at participating clinics.
CHN Program Organization	• All clinics and primary care providers can refer patients to the CHN program. • Works well where PCN has a central clinic/program to process patient referrals across the PCN.	• Clinics choose to participate based on their practice needs (e.g., population, panel size, clinic structure). • Works well where clinics have robust co-located teams.

ENCOMPASS Program of Research

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ENCOMPASS – ENhancing COMmunity health through Patient navigation, Advocacy, and Social Support

- A program of research to evaluate the impact of a primary care Community Health Navigator (CHN) program on health outcomes for patients with multiple chronic health conditions.
- A partnership between the University of Calgary, the University of Alberta, and four Primary Care Networks in Alberta.
- Supported by CIHR and Alberta Innovates through a SPOR Innovative Clinical Trials grant and a PRIHS grant.

Outcomes and data sources

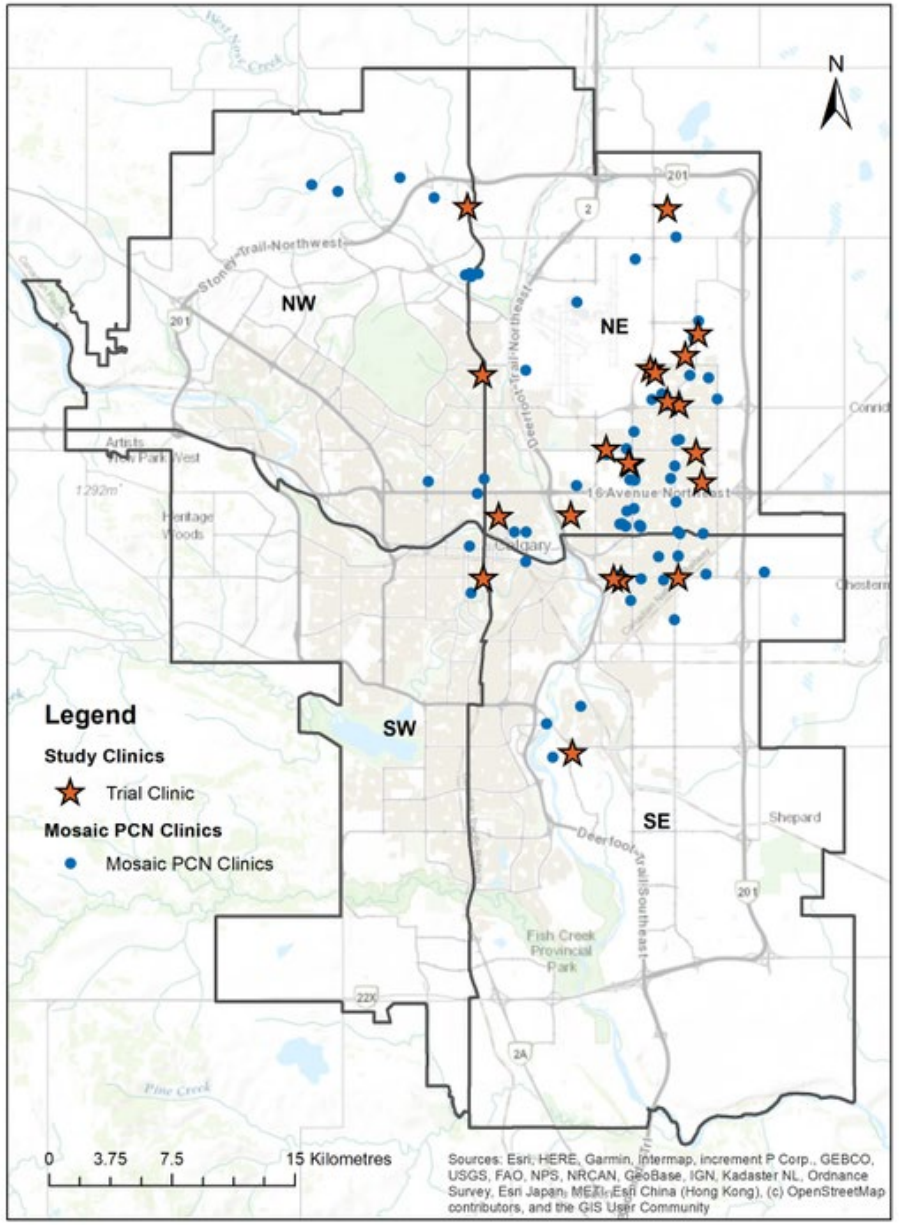
Acute care use	ED visits Hospital admissions	Administrative health data
Patient-reported measures	Experience/activation Social support Anxiety/Depression	Structured surveys
Intermediate health outcomes	Glycemic control Illness exacerbation Medication use	Lab data PIN data Administrative data
Experience and Implementation	Patient/CHN/Provider Reach, Adoption, Implementation	Interviews Process data

Mosaic PCN Cluster RCT

23 clinics in 19 clusters

- 12 Intervention (10 clusters)
  - 78 patients
- 13 Control (9 clusters)
  - 98 patients

Last patient graduated January 2023



PCN Expansion Studies

Calgary West Central RCT

194 referrals

183 enrolments (intervention = 90; control = 93)

Last patient graduated May 2022

Edmonton O-day'min RCT

144 referrals

96 enrolments (intervention = 49; waitlist control = 46)

Last patient graduated August 2022

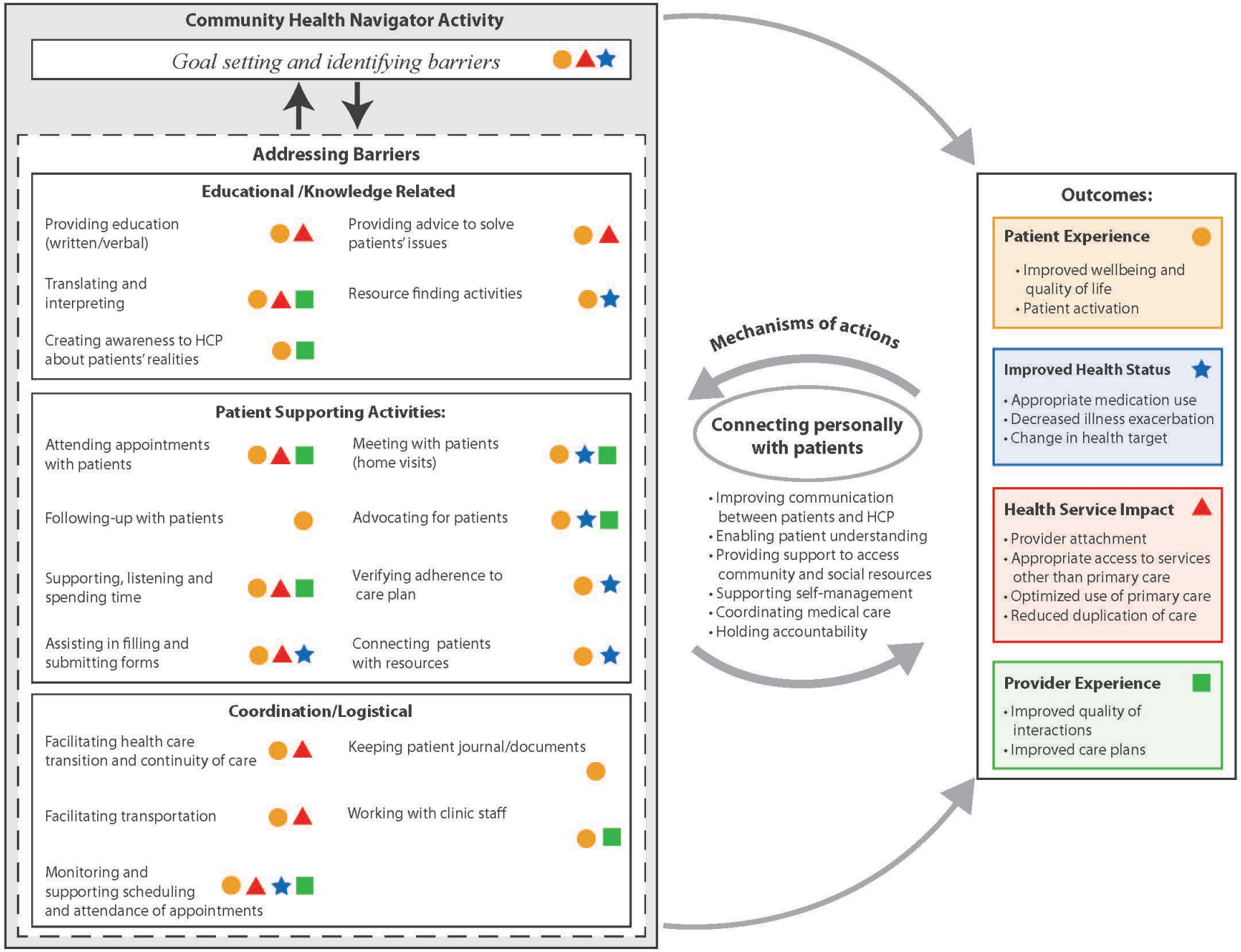
WestView RCT

114 referrals

61 enrolments (intervention = 30; waitlist control = 31)

Last patient graduated January 2023

Preliminary findings


Community Health Navigator Activity
Goal setting and identifying barriers
Addressing Barriers
Educational /Knowledge Related
Providing education (written/verbal)
Providing advice to solve patients' issues
Translating and interpreting
Resource finding activities
Creating awareness to HCP about patients' realities
Patient Supporting Activities:
Attending appointments with patients
Meeting with patients (home visits)
Following-up with patients
Advocating for patients
Supporting, listening and spending time
Verifying adherence to care plan
Assisting in filling and submitting forms
Connecting patients with resources
Coordination/Logistical
Facilitating health care transition and continuity of care
Keeping patient journal/documents
Facilitating transportation
Working with clinic staff
Monitoring and supporting scheduling and attendance of appointments
Mechanisms of actions
Connecting personally with patients
• Improving communication between patients and HCP
• Enabling patient understanding
• Providing support to access community and social resources
• Supporting self-management
• Coordinating medical care
• Holding accountability
Outcomes:
Patient Experience
• Improved wellbeing and quality of life
• Patient activation
Improved Health Status
• Appropriate medication use
• Decreased illness exacerbation
• Change in health target
Health Service Impact
• Provider attachment
• Appropriate access to services other than primary care
• Optimized use of primary care
• Reduced duplication of care
Provider Experience
• Improved quality of interactions
• Improved care plans

Preliminary findings: Barriers and facilitators to adoption, reach, implementation, and maintenance of the CHN program

Participant group	Facilitators	Barriers
PCN leadership	• Values • Awareness of patient needs & SDOH • Partnership with research team • Program is well designed, feasibility tested	• COVID • Family practices are private business • Cost (post-study) • Competing priorities • Level of understanding of the CHN program

"I would say when it first rolled out, […] I saw them [CHNs] less as I want to say a teacher and more as just that support. So, I don't think I realized the value of actually the final outcome being, "OK we've taught this person how to manage this goal or achieve this goal." I think I saw it more like, "OK, we need someone to get from point A to point B and they have too much anxiety and this CHN can definitely do that." And so, while that is still an intervention that they do, I think I saw that as the end goal as opposed to a larger, broader end goal of finally a patient being able to navigate the system hopefully on their own" (Leader, 104)

Preliminary findings

Participant group	Facilitators	Barriers
Physicians	• Team (especially nurses) co-located within the family practice • Early successes/experiences with program • Evidence of program effectiveness • Communication (patient reports from CHNs)	• Low understanding of patients' needs/barriers (SDOH) • Poor understanding of the CHN program • Time is limited • Values • Lack of compensation (ie. time meeting with CHNs)
Team	• Good understanding of patients' needs and barriers (SDOH) • Generally, a good understanding of CHN program scope • Early patients' successes	• Increased workload • Level of understanding of the CHN program (at least initially) • Concerns about CHN-Patient boundaries

"Again, like I said, my expectations were a little bit different from the beginning of the program to now that I've seen what the CHNs can do. So, now that I'm a bit more aware and I'm learning a bit more, I could do a lot more in terms of educating patients on what the program actually involves" (HCP, 104)

"When I first heard about it [the program], I had lots of hope for the program that it could really help my patients to overcome some of the barriers that they are currently facing. […] I think that this is what our most vulnerable patients need, honestly. There's only so much that we can do as physicians […] I think that the CHN program has so much opportunity there to do it in a very cost-effective way. These are providers who don't need to be trained in health care to do this work, which I think makes it really interesting" (HCP 107)

Preliminary findings

Participant group	Facilitators	Barriers
CHNs	• Early successes with patients • Strong training • Community based, great knowledge of resources • Rewarding role • Integration with clinic/clinic teams • EMR access* • CHN leadership/supervisor	• Challenging engagement with some patients (“ghosting”, unrealistic expectations of the CHN role scope, boundaries) • Limited access to resources because (or not) of COVID • Lack of integration with clinic/clinic team (ie. EMR access for charting, communication etc)
Patients	• Previously established trust with their physicians and clinic staff • Physician referred/discussed program with patient • Awareness of their needs & in need of support • Isolation / loneliness • Extent of motivation/activation	• Unrealistic expectations • Unaware of their needs/unable to identify needs • Work schedule - patients who work 9-5 regular hours limited to participate • Timeline to access resources • Transportation

"I feel really good about it. I have that support person that challenges me when I need to be challenged, and you know, I have somebody to talk to about my health issues and ask questions and, you know, we both look to seek solutions and answers when we have our discussion"
(Patient 4004)

(Interviewer): "*And how do you feel about managing that, your insulin and your diabetes?"*

(Patient 1026): "*Oh, I find it OK now. Before it was pretty hard when I didn't quite understand what was going on, and now that I understand I'm a lot better"*

Next steps for research

Timelines for analysis

Patient surveys & Administrative data

- To begin fall 2023

Program Theory revisions

Updating program theory based on qualitative results of trial and expansion studies

Implementation evaluation

Assess indicators such as barriers, facilitators for implementation, patient experiences, and outcomes.

Qualitative and quantitative data

CHN Program Implementation at the Edmonton O-day'min PCN

Presenter: Anisha Badoni

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Post Study program implementation

Post-study Program Implementation

CHN program was maintained at Mosaic PCN in Calgary, Edmonton O-day'min PCN in Edmonton, and WestView PCN in Spruce Grove.

PCN-specific program guides were co-developed by a working group of researchers, PCN CHN program leads, and patient-partners

- Referral criteria were broadened
- Flexible timeline for support
- Integration with EMRs

Over 350 referrals post study across the 3 PCNs

Spread and scale planning

- Generic program guide based on PCN guides is under development
- Provincial Advisory Committee formed to advise on scale/spread planning and strategy – first meeting held in May 2023
  - Representation from: AHS, Alberta Health, patient-partners, PCNs, research team, implementation science
- Primary Health Care Integration Network is offering assistance in our spread and scale initiatives
- Expression of Interest submitted for the HIIS 3 competition
- Planning to engage with provincial PCN/AHS committees

A few testimonials

"Patients are responding well to the additional support, having someone to talk to about their medical situation, and getting help advocating for themselves with their doctor. So far one of my patients is achieving health goals such as exercising regularly and feeling less overwhelmed with their home duties and hoarding. With another patient I have supported them in managing their blood sugars at night and getting a referral to the diabetic nurse." ***CHN***

My CHN jumps in head first with exceptional effort. I have never felt comfortable talking about my problems but my CHN provides a safe and welcoming space to share what I am feeling and get things off my mind. I was shocked by the amount of support she offered me – taking the time to not only support and advocate for me at an appointment, but she even rode transit with me. No one has ever been there for me like that before. When I need her, she's there. All the time and effort has been exceptional. ***Patient***

Being able to work with the CHNs has been amazing. Such sweet team work! Working with them to support patient goals, with innovative check ins every other week, sharing in the team approach, and overall patient centred care is seen at its finest.
Pharmacist

Facilitated Discussion

Discussion topics

Suitability of the CHN program within your PCN/context (how might the program be integrated within existing workflows, processes, available resources, etc.)

Considerations for provincial scale up, spread, and sustainability (barriers, facilitators, readiness of PCNs and clinics)?

Thank you for attending

If you have any questions, you can contact us at encompass@ucalgary.ca

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