



Navigator Tool: Linking Patient Preferences and Needs to Programs

Bree Holtz, PhD

bree.holtz@va.gov

Ann Arbor VA Healthcare System

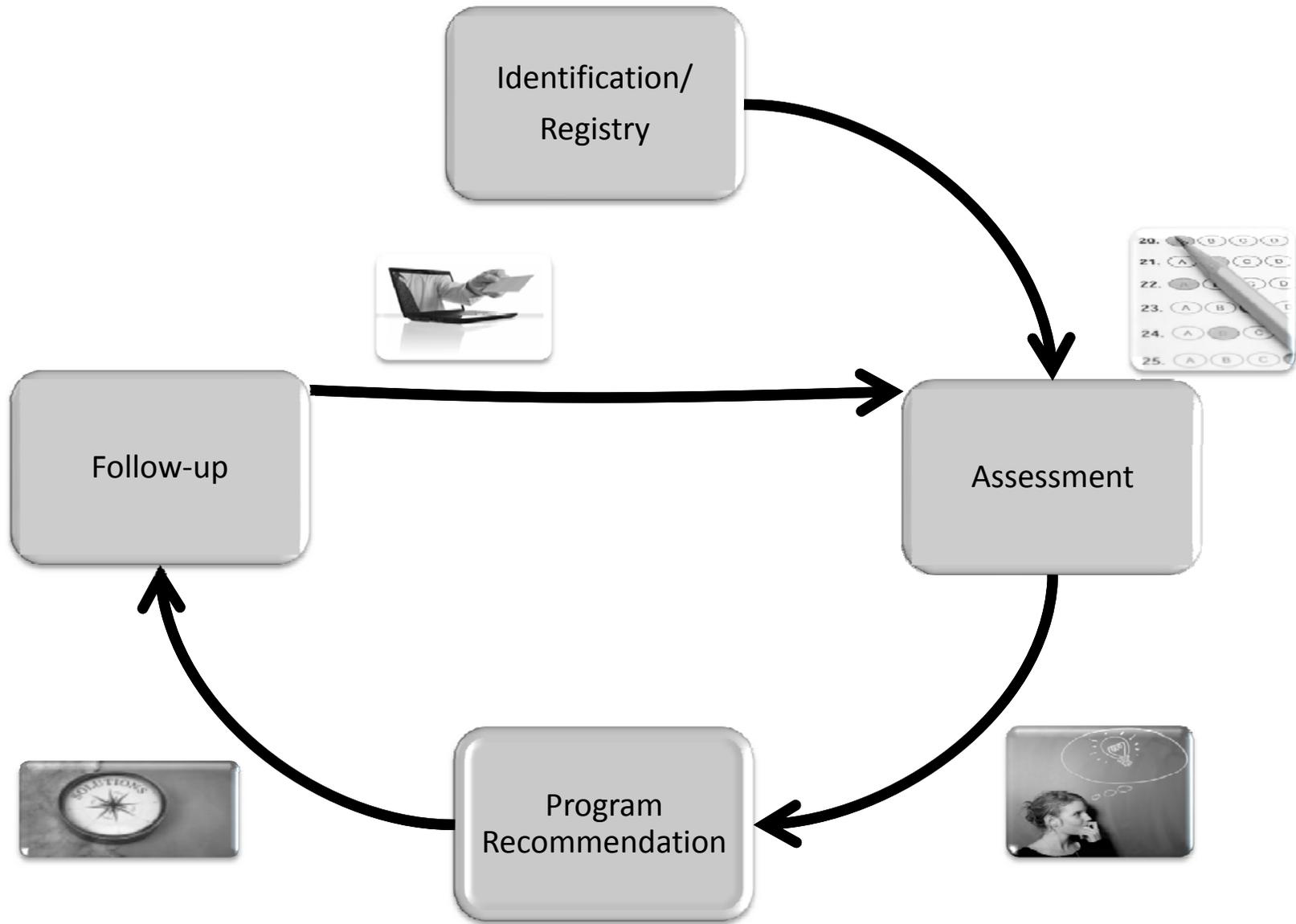
Past Literature

- Previous Navigation:
 - Cancer Care & Pediatrics
 - Who has been the Navigator
 - Outcomes
- PACT: Navigation
 - Shifted paradigm
 - Improve patients' access to services
 - Engage in shared decision making

Navigator in PACT - Objectives

- Patient-centered care
- Non-traditional care options
- Care coordination
- Match patients to programs based on their needs and preferences

The Navigator Tool



The Navigator Tool



Not a “case management” tool



Domains

- (Chart review)
- General Patient Information
- Cognitive Questions*
- Depression
- Living Situation
- Social Support
- Literacy*
- Tobacco Use
- Alcohol Use
- Medication Adherence
- Self-Care Management Adherence
- Frailty
- Pain
- Self-Efficacy
- Fall Risk*
- Transportation
- Technology Use
- Health Priorities/Preferences*



Initial Assessment – Depression

SSN: Patient Notes [Schedule Activity or Call Back](#)
Date of Birth

[Patient Information](#) [Chart Review](#) [Initial Assessment](#) [Referrals](#) [Follow Up](#)

Assessment Date:

[Intro](#) [Cognitive](#) [Depression](#) [Living Status](#) [Health Lit.](#) [Self Care](#) [ADLs](#) [Falls/Pain](#) [Self-Efficacy](#) [Programs](#) [Computer](#) [Recommen](#) ◀ ▶



Initial Assessment - Depression

SSN: 666123456 | 77_Adams | Mike | Patient Notes | Schedule Activity or Call Back
 Date of Birth 6/12/1950 | Save and Close

Patient Information | Chart Review | Initial Assessment | Referrals | Follow Up

Assessment Date: 5/1/2011 10:04:48 AM | Initial Assessment Complete: Save and Close

Intro | Cognitive | Depression | Living Status | Health Lit. | Self Care | ADLs | Falls/Pain | Self Efficacy | Programs | Computer | Recomm |

Over the past two weeks how often have you been bothered by having little interest or pleasure in doing things?	Several days
Over the past two weeks how often have you been bothered by feeling down, depressed, or hopeless?	Several days
Over the past two weeks how often have you been bothered by trouble falling or staying asleep, or sleeping too much?	
Over the past two weeks how often have you been bothered by feeling tired or having little energy?	
Over the past two weeks how often have you been bothered by poor appetite or overeating?	
Over the past two weeks how often have you been bothered by feeling bad about yourself--or that you are a failure or have let yourself or your family down?	
Over the past two weeks how often have you been bothered by trouble concentrating on things such as reading the newspaper or watching television?	
Over the past two weeks how often have you been bothered by moving or speaking so slowly that other people could have noticed. Or the opposite--being so fidgety or restless that you have been moving around a lot more than usual.	
Over the past two weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself in some way?	

Depression Screen [X]

PHQ9 Score is 3--Alert PCP or MH Provider with Depression screen results. Please remember to complete your clinical reminder

OK



Initial Assessment - Depression

SSN: Patient Notes

Date of Birth

Patient Information | Chart Review | Initial Assessment | Referrals | Follow Up

Assessment Date:

Intro | Cognitive | Depression | Living Status | Health Lit. | Self Care | ADLs | Falls/Pain | Self-Efficacy | Programs | Computer | Recommen

Over the past two weeks how often have you been bothered by having little interest or pleasure in doing things?

Over the past two weeks how often have you been bothered by feeling down, depressed, or hopeless?

Over the past two weeks how often have you been bothered by trouble concentrating on things such as reading the newspaper or watching television?

Over the past two weeks how often have you been bothered by moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual.

Over the past two weeks, how often have you been bothered by thoughts that you would be better off dead, or of hurting yourself in some way?

How likely do you think it is that you will harm yourself or end your life sometime over the next few days?

Very or somewhat likely

Not likely at all

Code Orange

Start Code Orange-DO NOT continue the assessment. Call the National VA Crisis Hotline at 585-393-7938, if you can't reach anyone at this number page the suicide prevention coordinator at 734-651-4027 and case manager at 734-651-5294 with a 911 after your extension. If you do not receive a call back within 3 to 5 minutes page the Emergency Department mental health staff at VA Pager 366.



Initial Assess – Living Situation

SSN: Patient Notes Schedule Activity or Call Back

Date of Birth

Patient Information | Chart Review | **Initial Assessment** | Referrals | Follow Up

Assessment Date:

Intro | Cognitive | Depression | **Living Status** | Health Lit. | Self Care | ADLs | Falls/Pain | Self-Efficacy | Programs | Computer | Recommen

Who do you currently live with?

Where do you currently live?

Is this a temporary situation?

**During the last 3 months, have you received help from family or friends with health related tasks? For example, filling prescriptions, managing medicines, arranging medical appointments.....
.....filling out medical forms or making decisions about health care?**

Is there anyone who comes with you to your VA medical appointments?

Can you think of any family or friends who would be interested in learning more about how they can support you in managing your health conditions? This can be someone who lives with you, lives nearby, or lives far away. If can be someone who already gets involved with your health care, or someone who hasn't been involved yet.

Assessment Notes:



Initial Assessment – Health Priorities

SSN: 666123456 ZZ_Adams Mike Patient Notes Schedule Activity or Call Back
Date of Birth 6/12/1950 Save and Close

Patient Information Chart Review Initial Assessment Referrals Follow Up

Assessment Date: 5/1/2011 10:04:48 AM Initial Assessment Complete: Save and Close

Intro Cognitive Depression Living Status Health LiL Self Care ADLs Falls/Pain Self-Efficacy Programs Computer Recomme

I'm looking at your chart and see that you have:
Diabetes CHF Pain Is this something you would like to work on? Yes No

Of all the things going on with your health, what concerns you the most?
Select from this list to classify patient's response Managing diabetes

The VA has over 25 different programs or classes to help you maintain or improve your health. I just have a few more questions and then we can talk about some of the programs that might work for you.

Some of the programs require you to come in to the VA to take part in these sessions. Would you be interested in coming into the Ann Arbor VA for any programs? Yes No

Are you currently enrolled in another clinical program, for example, telehealth, MOVE or CarePartner? Yes No

Do you like it? Yes No

What don't you like about it?

Assessment Notes: Go to next page

Initial Assessment – Technology Use

Patient Information | Chart Review | **Initial Assessment** | Referrals | Follow Up

Assessment Date:
Initial Assessment Complete:

Intro | Cognitive | Depression | Living Status | Health Lit. | Self Care | ADLs | Falls/Pain | Self-Efficacy | Audit-C | Programs | **Computer**

Yes No

If no internet access, suggest community resources for internet access

Yes No

Assessment Notes:



Initial Assessment – Program Recommendation

SSN: 666123458 77_Sanderson lake Patient Notes Schedule Activity or Call Back
 Date of Birth 7/9/1943 Save and Close

Patient Information | Chart Review | Initial Assessment | Referrals | Follow Up

Assessment Date: 9/15/2011 Note Initial Assessment Complete: Save Undo my selection and close form

Depression | Living Status | Health Lit. | Self Care | ADLs | Falls/Pain | Self-Efficacy | Audit-C | Programs | Computer | Recommendations

Great, now that I have all of your information, let's talk about some programs that might be a good match.

Calculate Referral Recommendations | Open Wiki For Referral Information

CLASSES	CLINICS	FACILITATED SELF MANAGEMENT
Tobacco Cessation* ± Does not apply	RN Case Management Face to Face ± Not Appropriate	My Healthe Vet ± Not Appropriate
Diabetes Classes ± Not Appropriate	RN Case Management Phone ± Highly Recommended	Care Partners CHF ± Recommended
MOVE ± Not Appropriate	PC Clinical Pharmacy Highly Recommended	Care Partners Diabetes ± Recommended
Cardiac Risk Reduct. Does not apply	Substance Abuse Clinic Not Appropriate	Tele-MOVE ±
DEPARTMENTS		CCHT - Telehealth ± Recommended
Geriatric ± Recommended		
PCP Referral Recommended		
Social Work ± Recommended		
Homeless* ± Does not apply		
HBPC ± Recommended		
OEF/OIF ± Does not apply		
PCMH Not Appropriate		



Resource Guide

https://vaww.visn11.portal.va.gov/sites/Ann-Arbor/hsrd/AAVAPRG/Pages/Home.aspx

va.gov https://vaww.visn11.portal.va.gov/sites/Ann-Arbor/hsrd/AAVAPRG/Pages/CCHT - Telehealth.aspx

Google Scholar Gmail UDM Lax AAVA Resource VVAHb CCMR VANIS MLibrary

Site Actions - Browse Page

Ann Arbor VA Patient Resource Guide -> CCHI - Telehealth

Ann Arbor VA Patient Resource Guide Discussion Board All Sites

Status: Published and visible to all readers

Home Last modified at 3/5/2012 11:29 AM by Masourang, Elizabeth [Edit this page]

All programs list *Back to All programs list*

Program categories

Chronic Disease Management

Clinics

Social Work Programs

End of Life Terminal Illness

Geriatrics

Lifestyle - Education Classes

Mental Health Programs

Other Support Services

Primary Care

Vet Centers

Women Veterans Health Care

Resource Guide Information

Ann Arbor VA Patient Resource Guide Documents

Patient Education Materials - Ann Arbor Link (opens in new window)

Program	CCHT (Care Coordination/Home Telehealth)
Description	A telephone based program that connects with the VA and allows for you or a caregiver to provide valuable information such as your weight, blood pressure, pain etc. which is sent to a nurse and forwarded to your primary care provider allowing for closer monitoring of vital information to maintain your health.
Services offered	Chronic Disease management via monitor in the patient's home. Available modules include DM, COPD, CHF, IITN, Palliative care & Pain
Contact Person	Veterans: Contact your VA health care provider, Providers: Sherry Miller
Phone	(734) 769-7100 Ann Arbor Staff : ext. 55005, ext. 53683, ext. 55864, or ext 55871 Toledo Staff : ext. 57630 or ext. 57548
Email	
Brochures	Yes
Service Agreement/Referral Criteria	N/A
Criteria for Eligibility	Active landline/ability for self-entry of data into equipment or have assistance of entry. Need to use at least 3 times a week, often times daily usage.
Wait List	No
Location Availability	
Documents	Telehealth.pdf

Page
Cater
No ca

1 / 2 84.8% Find

What is the Home Telehealth Program?

The Home Telehealth program helps to manage depression, diabetes, congestive heart failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), hypertension, chronic pain, cancer, and weight management. After a short training session at the VA, you can complete sessions from home using a home phone, cell phone, or internet connection. Information you enter, such as: your blood pressure readings, weight, or even your blood sugar readings are reviewed by our staff and if needed, changes in your treatment can be made before your next visit.



How do I find out if the Home Telehealth Program is right for me?

If you are interested, check the items below that apply to you and show this form to your healthcare provider.

- Do you have a working phone and electricity?
- Are you willing to enter information 5 times week?
- Do you have diabetes, heart failure, COPD, hypertension, depression, chronic pain or receive palliative care?
- Do you live alone?
- Are 75 or older (you can be younger and still participate)?
- Have had two or more hospitalization in the past year?
- Have had ten or more clinic visits in the past year?
- Have had two or more ER visits in the past year?
- Do you need help with preparing meals, housework, shopping, bathing, or dressing?
- Do you need a cane, walker, or scooter to move around?
- Do you have trouble remembering to take medications?

VA Ann Arbor Healthcare System
Home Telehealth Program
2215 Fuller Road -Ann Arbor, MI 48105
(734) 769-7100
Ann Arbor Staff : ext. 55005, ext. 53683, ext. 55864,
or ext 55871
Toledo Staff : ext. 57630 or ext. 57548

HOME TELEHEALTH PROGRAM



Telehealth

Our mission at the VA is to provide the right care, in the right place, at the right time.



Ann Arbor + Flint + Jackson + Toledo



Initial Assessment – Program Recommendation

SSN: 666123458 77_Sanderson lake Patient Notes Schedule Activity or Call Back
Date of Birth 7/9/1943 Save and Close

Patient Information Chart Review **Initial Assessment** Referrals Follow Up

Assessment Date: 9/15/2011 **Note** Initial Assessment Complete: Save Undo my selection and close form

Depression Living Status Health Lit. **Programs** ADLs Falls/Pain Self-Efficacy Audit-C Computer Recommendations

Great, now that I have all of your information, let's talk about some programs that might be a good match.

Calculate Referral Recommendations Open Wiki For Referral Information

CLASSES	CLINICS	FACILITATED SELF MANAGEMENT
Tobacco Cessation* ± Does not apply	RN Case Management Face to Face ± Not Appropriate	My Healthe Vet ± Not Appropriate
Diabetes Classes ± Not Appropriate	RN Case Management Phone ± Highly Recommended	Care Partners CHF ± Recommended
MOVE ± Not Appropriate	PC Clinical Pharmacy Highly Recommended	Care Partners Diabetes ± Recommended
Cardiac Risk Reduct. Does not apply	Substance Abuse Clinic Not Appropriate	Tele-MOVE ±
DEPARTMENTS		CCHT - Telehealth ± Recommended
Geriatric ± Recommended		
PCP Referral Recommended		
Social Work ± Recommended		
Homeless* ± Does not apply		
HBPC ± Recommended		
OEF/OIF ± Does not apply		
PCMH Not Appropriate		



Note

Notes generated based on patient assessment findings

You can select, right click, then copy and transfer to CPRS to edit

Navigator initial assessment was completed on 9/15/2011. Approximate time for assessment was __ minutes.

HEALTH GOAL:
Patient set a goal to: Limit alcohol.

COGNITIVE STATUS:
On a revised MMSE conducted over the phone the patient displayed moderate cognitive impairment.

PHQ-9 SCORE:
Patient scored 0 on the PHQ-9.

LIVING SITUATION:
Patient has reported living in own home.
Patient lives with spouse or significant other.

CAREGIVER SUPPORT:
Patient reports getting help from for health related tasks.
Patient is accompanied by for VA appointments.
Patient reports there are friends or family members who would be interested in helping patient regarding health, specifically: .

HEALTH LITERACY:

Close

Note to user: Page Up or Page Down if parts of progress note are hidden.

Patient Characteristics

- Average patient is a 67 year old male
- Cognitively healthy (93%)
- Is not depressed (only asked the PHQ-2)
- Live with spouse or SO (56%)
- Has someone come to appointment with him (50%)
- Drives (73%)



Patient Characteristics

- Would rather not come to the VA for programs (74%)
- Comfortable using the phone (83%)
- Has a computer that he uses regularly (51%)
 - Has access to the internet (63%)



Program Referrals

Technology-Based Programs:

167 Patient Referrals

My HealtheVet (24%)

Tele-RN Case Management (16%)

CCHT (13%)

TeleMove (11%)

CarePartners (10%)

Enhanced Care:

168 Patient Referrals

RN Case Management (12%)

MOVE (11%)

CVD Risk Reduction (8%)

Diabetes Classes (4%)

PCMH (4%)

**Initial Navigator
Assessment**

N=358

Traditional Care:

93 Patient Referrals

Social Work (18%)

Primary Care Provider (11%)

Pharmacist (3%)

Geriatrics (1%)

Refused a Program:

69 Patients

Patient choice

Education and follow-up is provided

The Navigator System: A Patient Story of Prevention



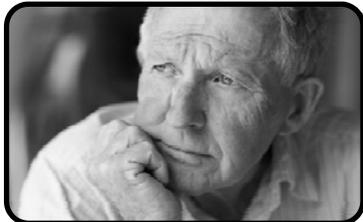
62 yr old male Veteran was referred to social work due to financial issues; his home was in foreclosure. He had no plans as to what to do.

“Thank you for all your help. I got names of agencies that are helping me keep my house; I didn’t think anyone cared.”

Patient Feedback



“It’s nice that the VA cares enough to ask these questions”



“I am not concerned about my diabetes; I’m more concerned about my wife’s cancer”



“It’s nice that a nurse would take the time out and call me”



“I didn’t know you had different things I can do”

Implementation Challenges

- Stand-alone system
- Teamlet formation
- Space



Nurse Feedback



The Navigator may open up more clinic time for patients



This will help prevent re-admissions, urgent care visits, and walk-ups



Older Veterans use technology more than I thought



The Navigator will help patients to not fall through the cracks



Navigator Development Team

Wendy Morrish, Diane Hooker, Jenny Davis, Liz
Masserang, Molly Harrod, Jess Ott, Sarah Krein &
Bree Holtz

Questions: bree.holtz@va.gov



Using Peer Mentors to Improve Diabetic Outcomes

Using Peer Mentors to Improve Diabetic Outcomes

Judith A. Long, MD

Funding:

CHERP Pilot Grant Long (PI)

NIA Roybal Center 1P30AG034546 Volpp (PI)

NIDDK R01 DK087874-01 Long (PI)



Diabetes Care and Outcomes

- What are we good at?
 - Improving processes
 - Checking blood tests (Hba1c, LDL)
 - Ordering appropriate care – retinal exams
 - Performing office based care – diabetic foot exams
- What are we bad at?
 - Improving intermediate and long term clinical outcomes
 - e.g. improving HbA1c, avoiding micro-vascular complications
 - Especially for low income and minority populations



Life

Family/friends

Socio-economic factors

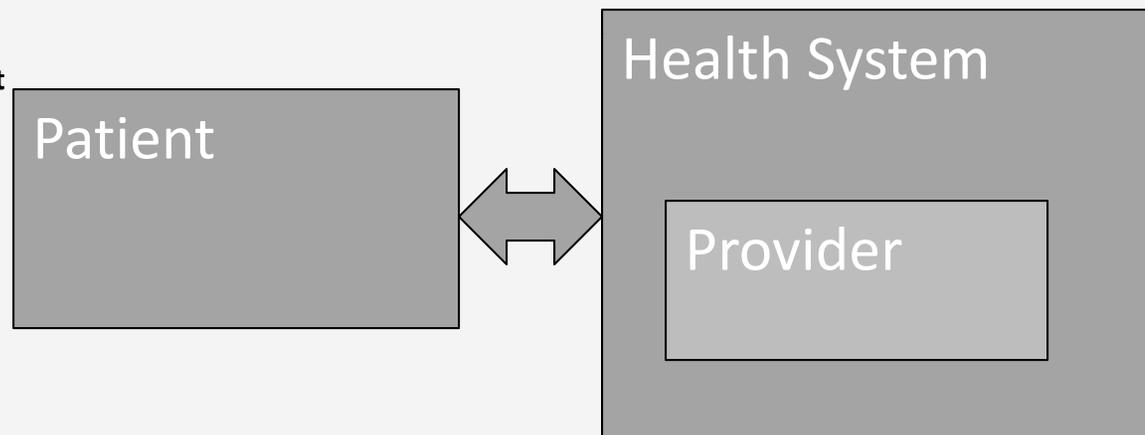
Cultural factors

Neighborhood environment

Community support

Access to care

Policy ...



Hours awake per year \approx 6,000: Hours with providers per year \approx 3 (max)

Need interventions that follow a patient out of the health care system

Peer Intervention Models



- Group-based self-management
 - Involves professional support
 - Usually conducted within the confines of the health care system
- Peer community health workers/Peer health navigators
 - Peers are semi-professionals and usually salaried
- Peer coaches or mentors
 - Most flexible and informal
 - Can occur anywhere

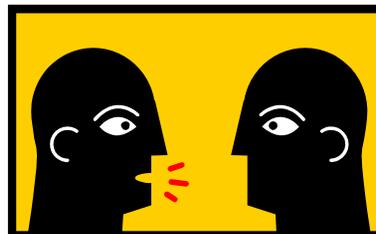
Heisler. *Fam Pract* 2010;27 (suppl 1): i23-i32
Webel et al. *AJPH* 2010;100:247-253

Peer Mentors

- Usually have same culture, language, and disease process
- Often from the same community
- Innately culturally sensitive

- Modes of delivery

- Face-to-face
- Telephone based
- Web and e-mail based



Heisler. *Fam Pract* 2010;27 (suppl 1): i23-i32
Webel et al. *AJPH* 2010;100:247-253

Peer Mentoring and Financial Incentives to Improve Glucose Control in African American Veterans. A Randomized, Controlled Trial

Judith A. Long, MD

Erica Jahnle

Diane M. Richardson, PhD

George Loewenstein, PhD

Kevin Volpp, MD, PhD

Ann Intern Med March 2012



Design

- 6 month long, randomized controlled trial
- Participants
 - African American, veterans, 50-70 years old
 - Enrollees: persistent poor DM control
 - Last two HbA1c $> 8\%$ with last measure being within 3 months of enrollment
 - Mentors: currently in good DM control
 - HbA1c of $> 8\%$ in the past 3 years and an HbA1c $\leq 7.5\%$ within 3 months of enrollment

Procedures: All Enrollees

- HbA1c drawn at enrollment and 6-month
- Notified of baseline and final HbA1c and provided with ADA and VA recommendations for HbA1c targets
- Monthly calls assessing for hypoglycemic symptoms and serious adverse events
- \$25 to enroll and \$25 to complete final HbA1c

Intervention Procedures

Mentor Arm

- Matched to mentor by gender and age (+/- 10 years)
- Mentors:
 - 1 hour one-on-one training with RA
 - Provided with mentee's phone number
 - Called monthly to reinforce training
 - \$20 per month if talked at least 4 times in month

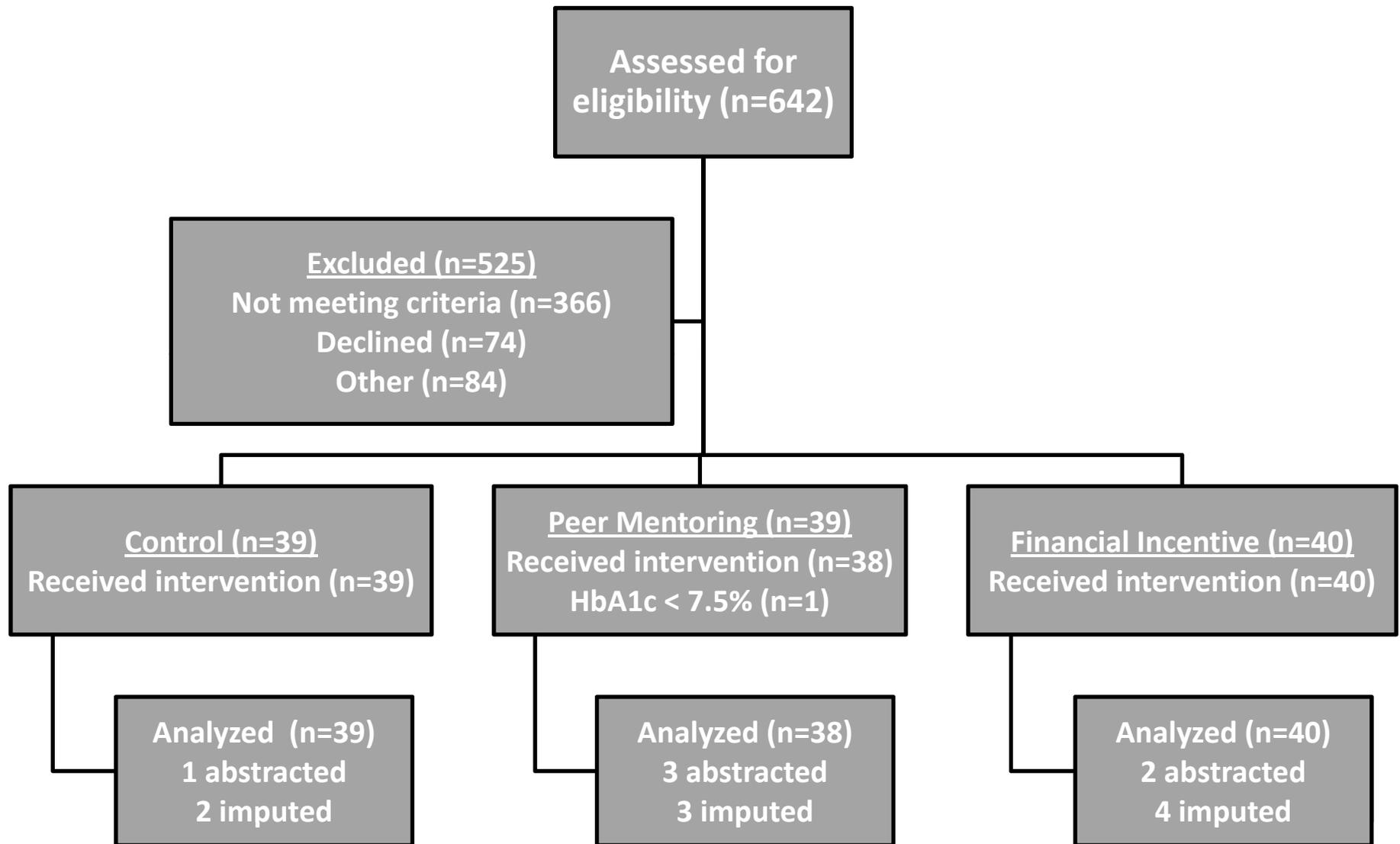
Incentive Arm

- Lump sum for achieving goal at 6 months : \$100 for 1 point improvement, \$200 for 2 point improvement or HbA1c of 6.5%

Analysis

- Intention-to-treat
- Main outcome: change in HbA1c
- Missing follow-up:
 - If an HbA1c was found in the medical record around time for follow-up (+/- 4 weeks), used record HbA1c
 - If no HbA1c in the medical record used multiple imputation

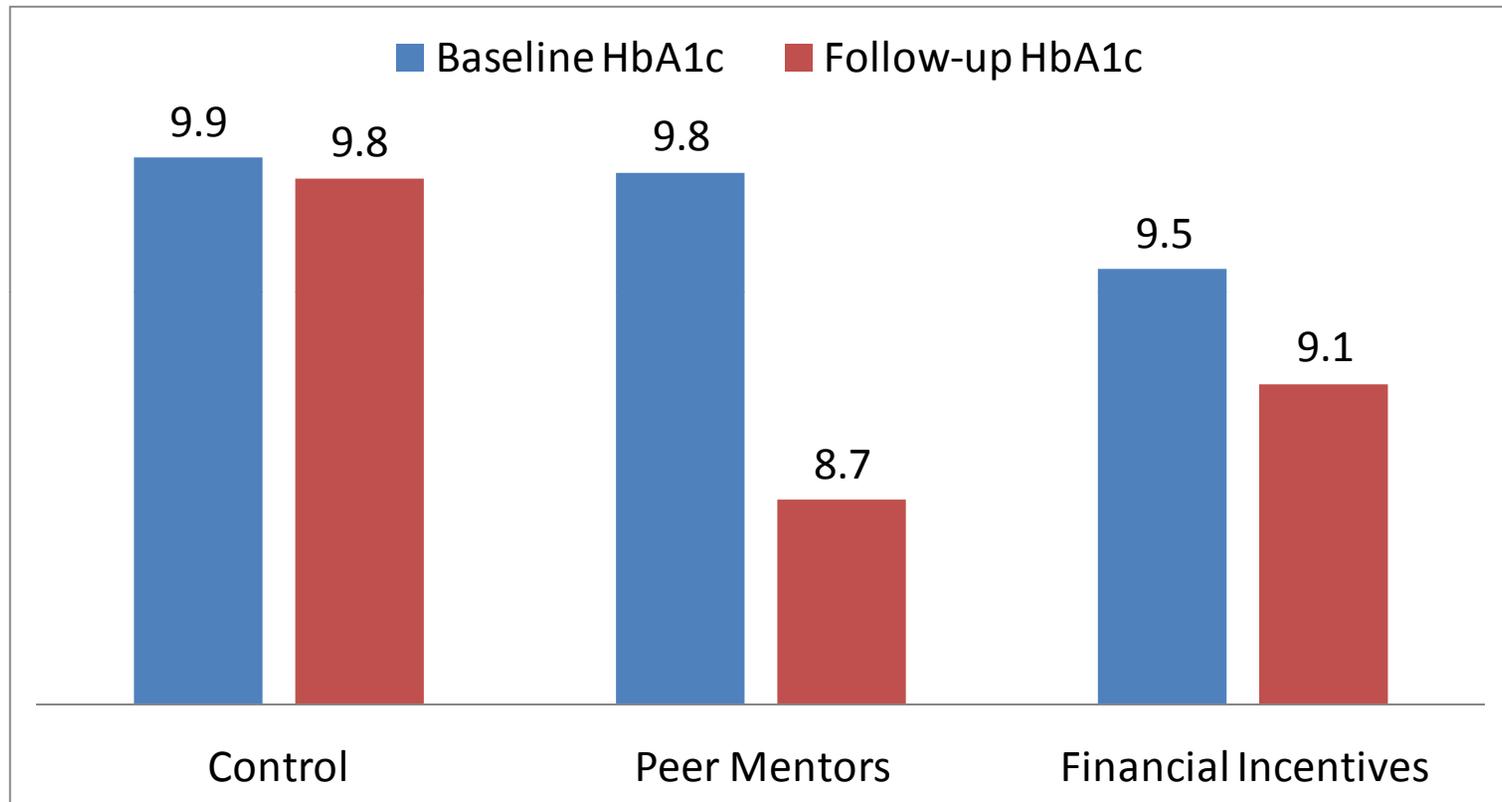
Study Flow Diagram



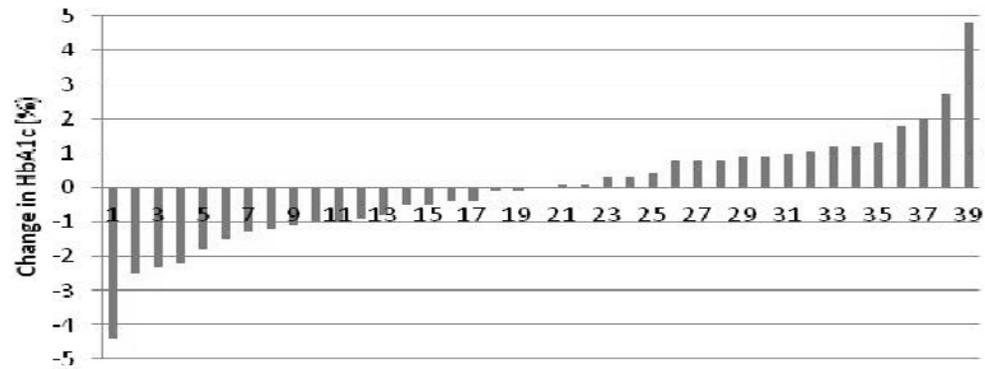
Participant Characteristics

	Arm 1 Control (39)	Arm 2 Mentoring (38)	Arm 3 Incentives (40)
Mean Age, (SD)	59.8 (4.4)	58.8 (5.1)	59.1 (4.9)
Education <12, %	64.1	68.4	50.0
Married, %	46	58	38
On Insulin, %	71.8	71.1	62.5
Diabetes >10 years, %	66.7	55.3	52.3
Any DM Co-morbidity, %	92.3	81.6	97.5
Smoker Current, %	33.3	47.4	27.5
All healthcare at VA, %	74.4	73.7	72.5
Good Adherence, %	66.7	78.9	80.0
Mean Baseline HbA1c, (SD)	9.9 (1.6)	9.8 (1.8)	9.5 (1.2)
Mean Days Between Tests, (SD)	185 (11)	195 (15)	185 (13)

Pre and Post HbA1c



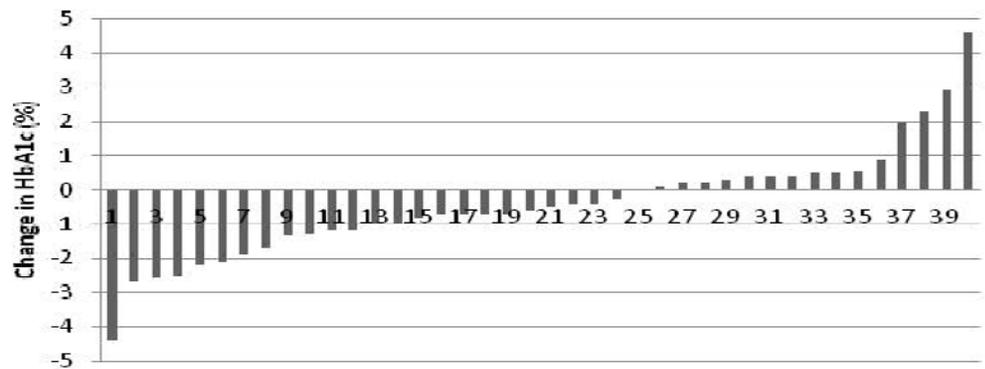
Control



Peer Mentoring



Financial Incentives



Mean Change in HbA1c Level

Mean Change	Usual Care	Peer Mentoring	P Value	Financial Incentive	P Value
From Baseline (95% CI)	-0.01 (-0.52 to 0.51)	-1.08 (-1.62 to -0.41)		-0.46 (-1.02 to 0.10)	
Relative to Control (95% CI)*		-1.07 (-1.84 to -0.31)	0.006	-0.45 (-1.23 to 0.32)	0.25

*Covariates: baseline HbA1c, marital status, insulin use, diabetic comorbid conditions, duration of diabetes, self-reported adherence

Adverse Events

	Usual Care	Peer Mentoring	Financial Incentive
Deaths	0	0	0
Serious Hypoglycemic Events	1	0	1
Minor Hypoglycemic Events/Month			
0, n (%)	142 (71)	107 (61)	121 (64)
1-3, n (%)	28 (19)	52 (30)	51 (27)
>3, n (%)	21 (10)	15 (9)	16 (9)

- All events unexpected
- No enrollees removed from study due to adverse events

Qualitative Feedback re Peer Mentors

Mentees

- Important that the mentor had diabetes (26/28)
- Appreciated the support (14/28), education (9/28)
- Trouble getting in touch (4/28), lack of compatibility (3/28)
- Wished for a face-to-face introduction (8/28)

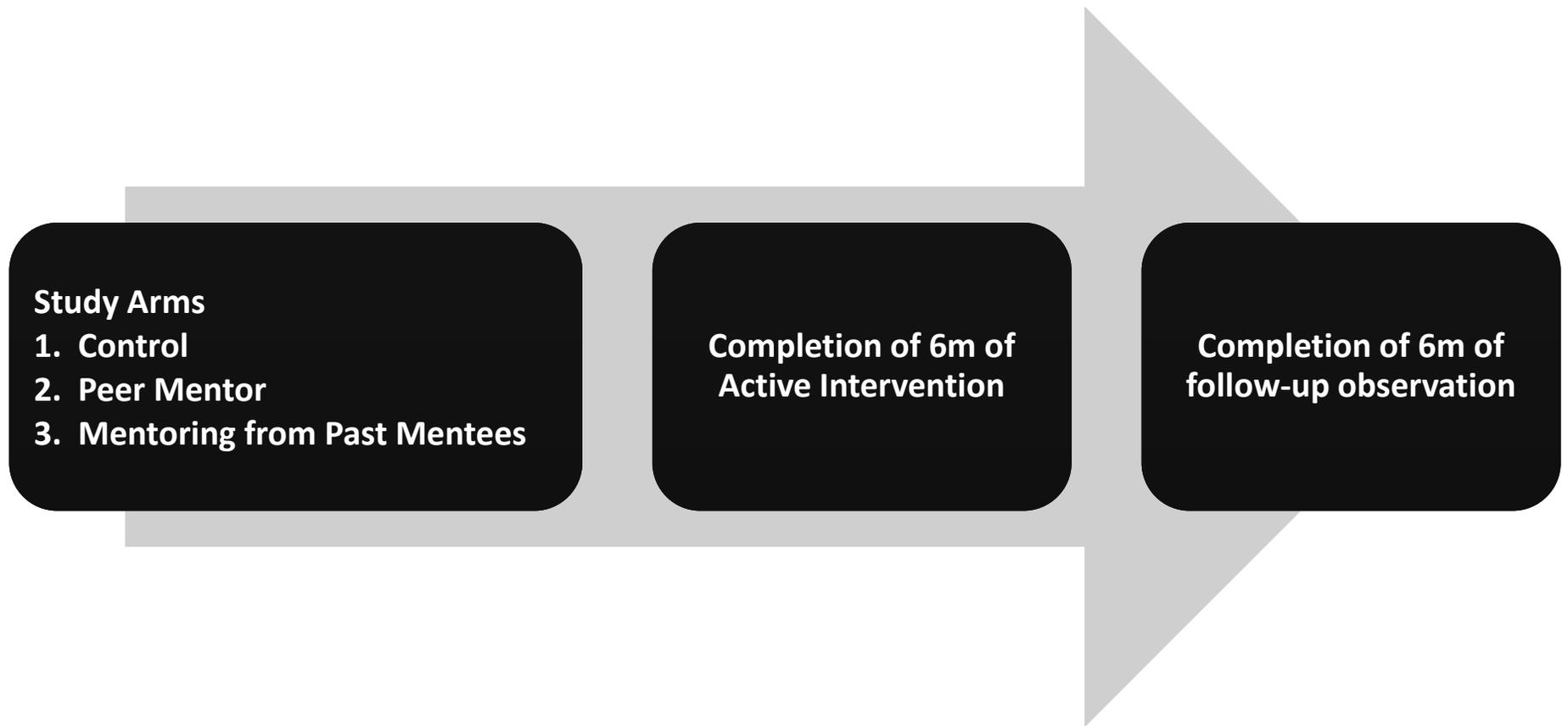
Mentors

- Appreciated helping others (12/24)
- Thought it important previously been out of control (15/24)
- Trouble scheduling (5/24), disinterested mentees (5/24)
- Wished for a face-to-face introduction (15/24)

Limitations

- One race study
- One institution study
- Financial incentives given in lump sum – did not really provide immediate reward for delayed benefit
- Can not determine if the effects will persist

PACT Peer Mentor Study



Conclusions

- Peer mentors had a strong effect in improving glucose control in a population with persistently poor control
- The peer mentor training was extremely short and straight forward – making the intervention very appealing
- Peer mentoring may be a powerful tool to reducing disparities in glucose control and improving clinical outcomes in minority populations
- One size is unlikely to fit all – using navigators may be one way to best fit patients and program together

Thank You

❖ jalong@mail.med.upenn.edu

❖ Questions 