Penn's innovative community health worker model improves outcomes for high-risk patients

February 10 2014

Trained lay Community Health Worker Mary White (left), from the Penn Center for Community Health Workers, partners with a patient at high risk for poor post-hospital outcomes. A new study in *JAMA Internal Medicine* reports that the Penn Center for Community Health Workers' IMPaCT (Individualized Management for Patient-Centered Targets) intervention improved both patient experiences and health outcomes, while reducing repeat hospital readmissions. Credit: University of Pennsylvania School of Medicine

Experts at the Perelman School of Medicine at the University of Pennsylvania have devised an effective, replicable program using trained lay Community Health Worker (CHWs) to improve a range of outcomes among patients at high risk for poor post-hospital outcomes. In Penn's IMPaCT (Individualized Management for Patient-Centered Targets) model, CHWs hired from within the local community help patients to navigate the health care system and address key health barriers, such as housing instability or food insecurity. A new study in *JAMA Internal Medicine* reports that this intervention improved both patient experiences and health outcomes, while reducing repeat hospital readmissions. The authors suggest the results have positive implications for exporting and adapting the CHW model to other patient populations.

"The new health care laws make health systems accountable for patient outcomes like primary care access, quality, and hospital readmissions. To improve these outcomes, it is vital that health systems implement programs that reach beyond their walls and address the root causes of poor health," said lead study author Shreya Kangovi, MD, MS, assistant professor of Medicine and director of the Penn Center for Community Health Workers. "CHWs have the potential to help tackle these issues. They come from within high-risk communities, can relate to patients, are able to help breach potential breakdowns in communication between patients and their care providers, and address the socioeconomic and behavioral factors that affect health."

Historically, many intervention programs have been difficult to replicate and lacked rigorous scientific evaluation. With these specific issues in mind, the Penn team tested the IMPaCT model in a randomized trial with 446 hospitalized patients who were either uninsured or on Medicaid, and resided in low-income communities in which more than 30 percent live below the Federal Poverty Level. More than one-third of all readmissions to the hospitals participating in the study come from this five-ZIP code region.

Patients randomized to the IMPaCT model received support from CHWs, relatable neighbors and peers hired for traits such as empathy and active listening. The CHWs connect during a patient's hospital stay and continue to partner with patients after they are discharged, helping to overcome barriers or issues such as scheduling doctor appointments, accessing medications, or finding child care or shelter. The control group received routine hospital care, medication reconciliation, written discharge instructions, and prescriptions from the hospital.

Results of the study show that the intervention group had a 52 percent greater chance of seeing a primary care physician within two weeks after being discharged from the hospital. In addition, scores measuring a patient's confidence in managing their own care in the future more than doubled in the IMPaCT group (3.4 in IMPaCT vs 1.6 in the control group, on a 5 point scale). Patients in the IMPaCT group also reported better discharge communication than the control group (91.3 percent vs 78.7 percent) and improvement in self-rated mental health scores on a screening test assessing depressive symptoms (increasing 6.7 vs 4.5 points). While the groups had similar rates of at least one hospital readmission (15 percent vs 13.6 percent), the IMPaCT group was less likely to have multiple readmissions (2 percent vs 6 percent in the control group).

"Most healthcare interventions improve one aspect of care at the expense of others. However, it is more impactful to improve multiple goals simultaneously, even modestly, so we are pleased to see that IMPaCT affects three aims concurrently – improving patient experiences and health outcomes, while controlling costly hospital readmissions," said senior author Judith A. Long, MD, associate professor of Medicine. "So many high-risk communities across the country face the same types of challenges we saw in our population. This model was built specifically to allow for replication across different groups, diseases and settings, so we're excited to see it expand and adapt to other patient populations in

the future."

In response to results from the trial, the University of Pennsylvania Health System has created the Penn Center for Community Health Workers to help integrate the IMPaCT model into routine healthcare delivery. The model, housed within Penn Home Care and Hospice Services, currently serves 1,000 patients per year and is expected to triple by the end of 2014. The Center has also developed resources to help organizations outside of Penn to implement the IMPaCT model, including an open-access toolkit, online workflow systems and technical support.

Provided by University of Pennsylvania School of Medicine

Citation: Penn's innovative community health worker model improves outcomes for high-risk patients (2014, February 10) retrieved 3 May 2024 from https://medicalxpress.com/news/2014-02-penn-health-worker-outcomes-high-risk.html

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