

Grady Healthy Living: Health Coaching Program in Green Pod

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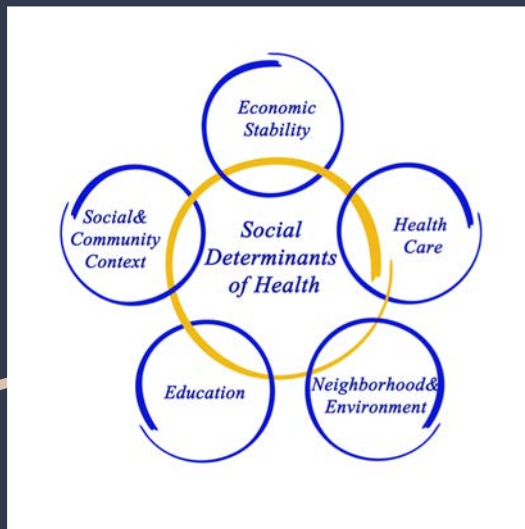
9/7/2019

Agenda



- Introduction to Grady Healthy Living (GHL)
- Grady Health Coaching Program Overview
 - Goals of Program
 - How we work: health coaches and mentors
 - Our findings to date
 - Patients
 - students
- CASHI Award
- Challenges, Goals and Next Steps

Social Determinants of Health (SDoH) Overview



- “The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life” - WHO
- Issues that impact patient health
 - Food insecurity
 - Housing insecurity
 - Job Insecurity
 - Access to Healthcare
 - Transportation
 - Cost
 - Literacy
 - Mental health
 - Childcare
 - Exposure to Violence
 - Toxic Stress & Adverse Childhood Experiences

Goals of Health Coaching Program



Health
Coaching

- **Improve chronic disease management among primary care patients at Grady, especially including:**
 - Obesity
 - HLD
 - DM
 - HTN
 - Exercise
 - Medication Adherence
 - Smoking Cessation
- **Student education: medical/health professional students**
 - Introduce health coach volunteers to social determinants of health
 - Improve ability to assess patient management of chronic disease
 - Practice motivational interviewing and health coaching
 - opportunities for MedEd education / mentorship practice for older mentors
- **Provide Grady with SDoH data** on primary care patients (2018-2019)

Green Pod Health Coaching Program: Leadership Team



Executive Leadership:

- Dr. Maura George
- Dr. Stacie Schmidt
- Dr. Jada Bussey Jones

Student Leadership:

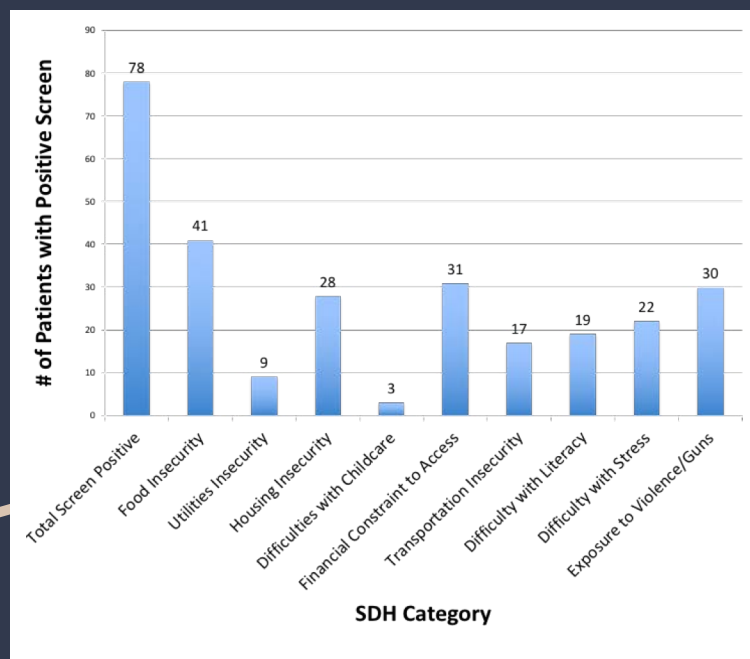
- Sahil Angelo (M4)
- Meselle Jeff-Eke (M4)
- Claire Edelson (M3)
- Robert Louis (M2)
- Kat Metz (M4)
- Nicole Treadway (PGY1- Emory)
- *Zoe Kopp, founder* (PGY2 - UCSF)

MPH student data team (2018-2019):

- Emily Goggins
- Miah Davis
- Erin McKeever
- MacKenzie Collins
- Stephen Kim

Pilot (Spring 2018)

SDH of Patients at Grady



- Green Pod Pilot Study, Spring 2018 (n=123 patients)
- Highest educational level achieved by 63.4% was some or all of high school/GED
- 66.6% were unemployed or unable to work
- 36.6% insured by Medicare, 35% insured by Medicaid
- 42.3% received government assistance in the form of SNAP
- 40.7% receiving social security
- 63% screened positive for at least 1 SDoH category
 - food insecurity (33.0%)
 - financial constraints to accessing healthcare (25.0%),
 - exposure to violence (24.0%),
 - housing insecurity (23.0%),
 - difficulty coping with stress (18.0%),
 - poor health literacy (15.0%)
 - transportation insecurity (14.0%)

CASHI Award



The
Commonwealth
Fund



The Collaborative to Advance Social Health Integration (CASHI)

- \$10,000 Grant
- Collection of > 20 primary care organizations across the country
- Goal: Identify “effective diffusion strategies for improving primary care patients’ social support”
 - Ex 1) *There is an increase in the percentage of patients who report they have the essential resources to be healthy*
 - Ex 2) *75% or more patients report they are confident that they can control and manage most of their health problems.*
- Technical support and expert consultation
 - Live learning sessions to connect with 17 other organizations across USA
 - Business case/financial sustainability, building partnerships in the community, effective communication across healthcare team, improvement science/program evaluation

Focus Groups to Develop Screening Tool (Summer 2018)



- Consulted with Dr. Miranda Moore
- Tool adapted from Health Leads USA clinically validated SDoH screening tool
- 3 focus groups

Grady Healthy Living: SDoH Assessment and Health Coaching Program

Lay Summary:

The Grady Healthy Living Health Coaching Program aims to help primary care patients at Grady Memorial Hospital manage their chronic diseases and the societal factors that shape them, via Social Determinants of Health assessment (SDoH), resource connection and traditional health coaching. The program will also enable physicians to address SDoH and collect data for Grady's primary care quality improvement initiatives involving financial investment, community partnerships and increased social services. Assessments will aim to capture social determinants of health including food insecurity, housing insecurity, need for utilities assistance, job insecurity, barriers to accessible health care (transportation, health literacy, cost of care, mental health), child care difficulties, and exposure to violence. We hope the focus group will enable us to select appropriate questions that our patients consider relevant and respectfully worded.

Social Determinants of Health Screening Tool

On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

On average, how many minutes do you exercise when you do it? _____ minutes

☐ Yes ☐ No Within the past 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

☐ Yes ☐ No In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?

☐ Yes ☐ No Are you worried that in the next 2 months, you may not have stable housing?

☐ Yes ☐ No Do problems getting child care make it difficult for you to work or study?
☐ I do not have children.

☐ Yes ☐ No In the last 12 months, have you needed to see a doctor, but could not because of cost?

☐ Yes ☐ No In the last 12 months, have you needed to see a psychiatrist, psychologist, therapist or counselor but could not go because of money?

☐ Yes ☐ No In the last 12 months, have you ever had to go without health care because you did not have a way to get there?

☐ Yes ☐ No Do you ever need help reading hospital materials?

☐ Yes ☐ No Do you often feel that you lack companionship?

☐ Yes ☐ No Are you afraid you might get hurt in your apartment building or house?

☐ Yes ☐ No Do you or someone in your household own a gun?

☐ Yes ☐ No Have you or someone you know been a victim of gun violence?

What is your biggest stressor today?

Turn page ov

How We Work

Health Coaches

- Assigned to one patient
- Coaches responsible for calling patients during OPEX “off week”
 - Patient’s health SMART Goal
 - Motivational interviewing: assessing progress and barriers to improvement
 - Community resources to address SDOH
 - Document in SOAP note format
 - Attend patient’s physician visits with their permission, when possible.
- Attend lectures, mentor meetings and review SDoH Virtual Resources

Mentors

- Small Group Teaching - (3-4 coaches per group)
 - Chronic Culprits: Disease and Determinants of Health
 - Coach like a Boss
 - EPIC (!) note-taking
 - Motivational interviewing
 - Promoting physical activity
 - Behavioral health psychology
 - Food insecurity
- Supervision and provider contact when necessary



How to Recommend Resources?

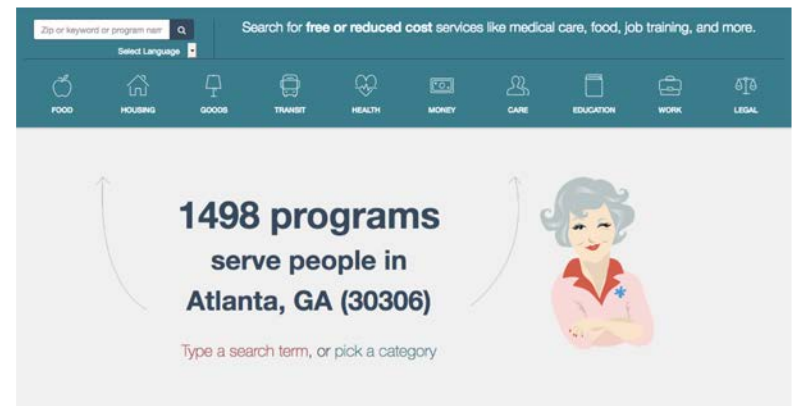
- Grady Community Resource Guide

2018 Grady Healthy Living Resource Guide

Atlanta Area Resources (by Neighborhood)

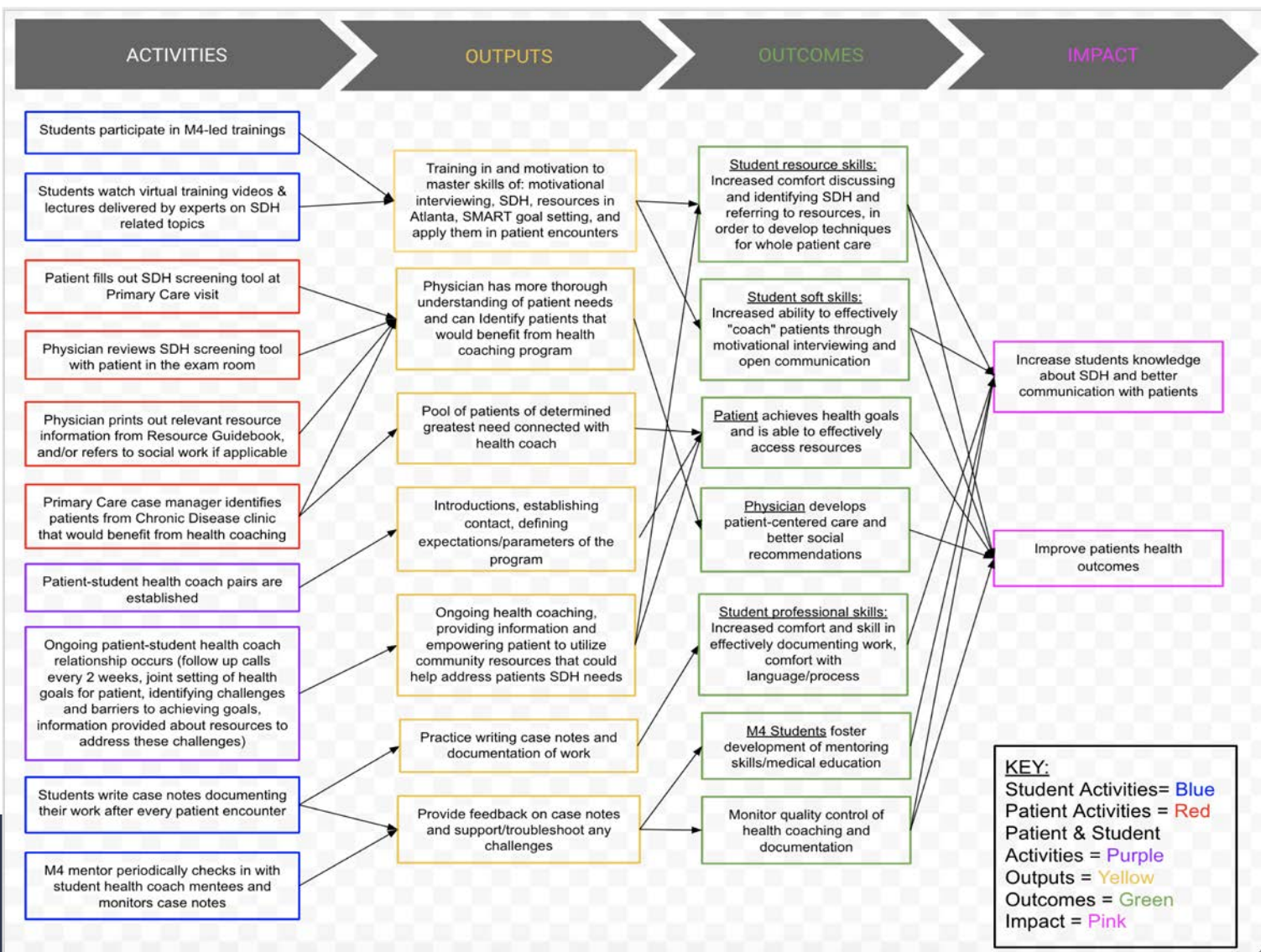


- www.AuntBertha.com



Goals for Data Analysis

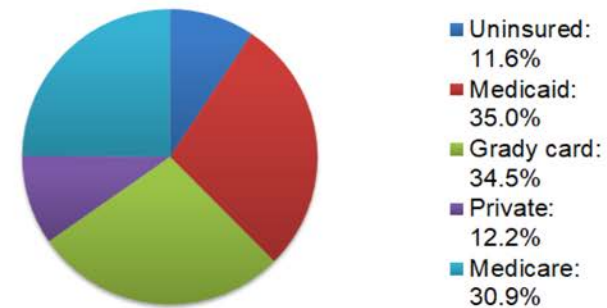
- **Students**
 - Health Coaches: pre/post surveys
 - Mentors: exit interviews/reflections
- **Patients**
 - Chart review health outcomes
 - Pt health beliefs: pre/post
 - # Resource Connections: post
 - All tools created by MPH data team



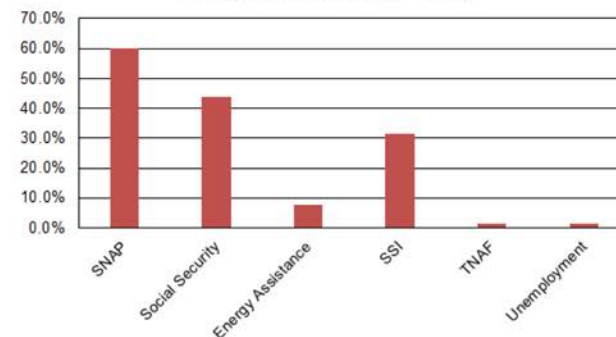
Survey Results from 2019: Patients

Social Determinant of Health	% of Patients who experienced in previous 12mo (n=1,061)
1. Food Insecurity	25.3%
2. Couldn't access MD due to cost	25.1%
3. Unemployment	24.8%
4. Social Isolation	19.6%
5. Lack of Transportation	18.1%
6. Inaccessible mental health resources due to cost	17.9%
7. Housing Instability	16.9%
7. Lack of Utilities at home	16.9%
9. Community Gun Violence	16.7%
10. Limited Literacy	16.6%

Patient Insurance Status (n=995)

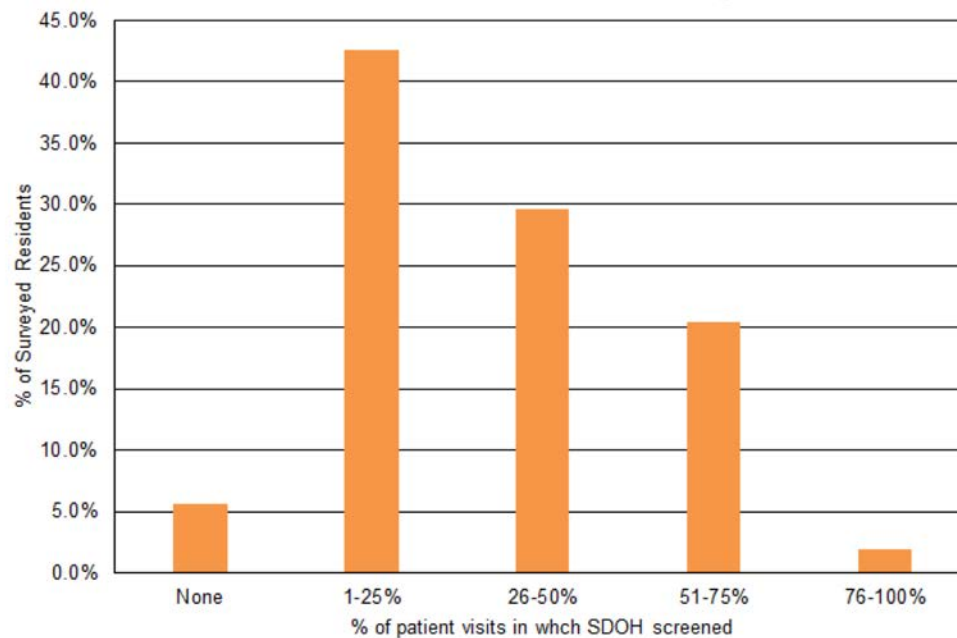


% Patients Enrolled in Govt Assisted Programming (n=709)

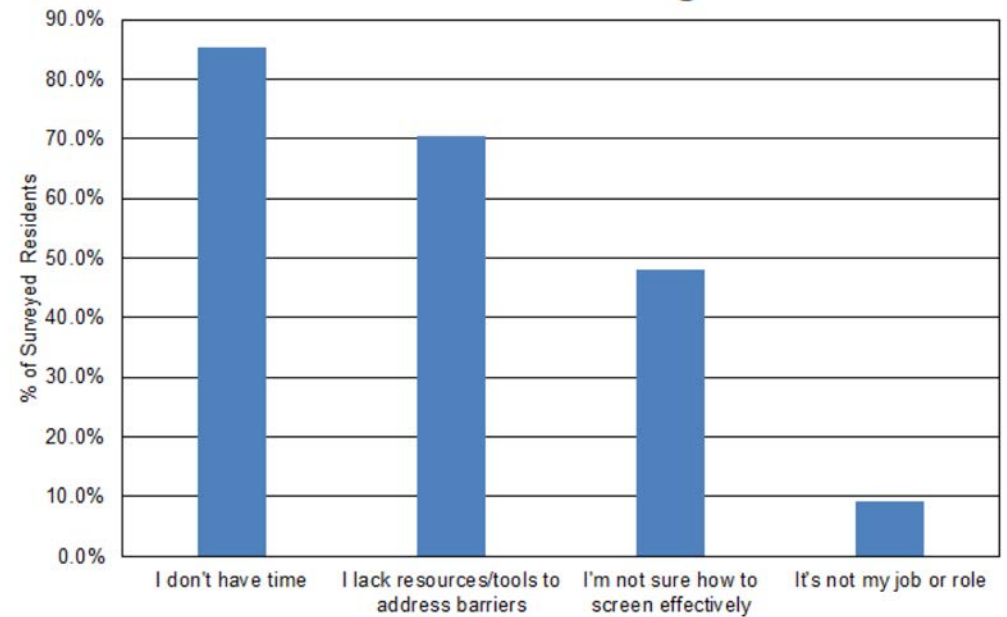


Survey Results: Providers

Current Resident SDOH Screening Practices



Barriers to Screening for SDOH



Comparing Results: Patients vs. Providers

Social Determinant of Health	Residents (%) Perceptions of Most Pertinent SDOH	Patient's Perceptions of Most Pertinent SDOH (# = patient ranking)
1. Lack of transportation	64.8%	18.1% (#5)
2. Unaffordable healthcare / Lack of insurance	55.6%	25.1% (#2)
3. Housing Instability	55.6%	16.9% (#7)
4. Unemployment	44.4%	24.8% (#3)
5. Food Insecurity	35.2%	25.3% (#1)
6. Limited Literacy	29.6%	16.6% (#10)
7. Inability to access mental health services	20.4%	17.9% (#6)

Results 2019: Health Coaching

- 28 Student health coaches
- Overall increase in self-reported:
 - Ability to define SDH
 - Knowledge on resources to address pt SDH
 - Confidence in health coaching ability
- Success of interdisciplinary small groups and our curricular materials

"I called Pt back about the resources for food/nutrition class/food vouchers and wheelchair repair. I told Pt about the GHL nutrition class that is on Fridays from 2-3pm in the purple pod. I gave her the names/locations of some Farmer's markets around her neighborhood that accept EBT (food stamps)-- East Atlanta, Grant Park, and Decatur. I told her that the 3 farmer's markets I listed to her are on different days, so she can go different ones depending on when she is free. I asked about how she is doing with hre SMART goal, and said its going fairly well. She's still focusing on decreasing her fried food each week and cooking at least 4 dinners at home each week."

"Will be back in touch after diabetes clinic appointment on 3/20/19. Then we will touch base about current A1C and his goals going forward. Shared with him the Hope Atlanta and Metro Atlanta Taskforce information for housing resources".

Reflections and Challenges from last year

- Delayed timeline...reworking as a pilot program impact on
 - # of health coaches
 - student volunteer recruitment
 - length of health coaching relationship
- → impact on data/analysis
 - Distribution and completion of surveys
 - Small sample sizes
 - Actual impact of the programs from patient perspective
- Logistics of screening in the clinic setting
- Patient Recruitment
 - Mindfulness about which patients were referred to us
 - Pt drop out and health coach reassignment
- M4 mentors ability to copy/paste health coach notes into pt chart in EPIC

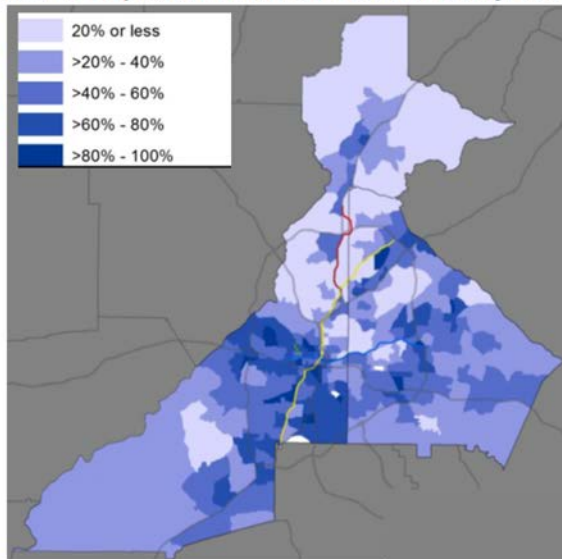
Next Steps: goals and gearing up for fall 2019

- Goal: expand to 50 patients
- Lengthen relationship timeline
 - Improve # of Resource Referrals
- Process for handling pt drop out
- More robust data collection & analysis
 - New system for tracking longitudinal pt progress over consistent, concise survey questions
- Solidify partnerships with other schools: recruitment from
 - Nursing, PA, MPH, MD programs
- Sustainability of program leadership

Appendix

SDoH: Need in our Neighborhoods

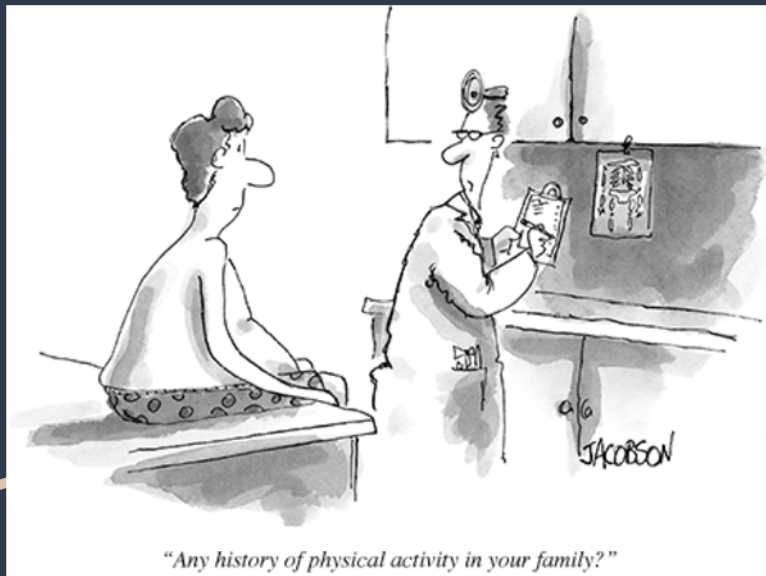
Figure 1: Percent of Population Below 200% Federal Poverty Level, 2010-2014



US Census Bureau, Atlanta Regional Commission

- **POVERTY**
 - In 37/62 GHS communities, >20% residents are living \leq FPL (\$24,300 for a family of four)
- **EDUCATION**
 - In 10 communities with highest community need, residents without a HS diploma or GED range from 16% to 29% (mean=23.5%)
- **EMPLOYMENT**
 - 14 Zip codes where $\frac{1}{5}$ residents are unemployed
- **INSURANCE (<65yo)**
 - Georgia: 22.2% uninsured, 19.6% Medicaid
 - Dekalb County: 23.5% uninsured, 19.7% medicaid
 - Fulton County: 19.6% uninsured, 18.3% medicaid

Health and Behavior in our Neighborhoods



- OBESITY
 - 30.5% adults across GA
 - 26.3% adults in Dekalb county
 - 28.8% of adults in Fulton County
- NUTRITION
 - 71 % of Dekalb adults report consuming < 5 servings of fruits/vegetables per day
 - 74% Fulton adults report consuming < 5 servings of fruits/vegetables per day
- ACTIVITY
 - 19% Fulton County Adults are inactive
 - 21% Dekalb County Adults are inactive
- SMOKING
 - Compared to 12% overall, smoking more common when annual income <\$15,000 (35%) or when annual income between \$15,000 and \$24,000 (29%)

What is Grady Healthy Living (GHL)?



- Umbrella student-run volunteer organization
- Mission :
 - provide health education including nutrition, fitness, and chronic illness management, to Grady patients
 - empower Emory medical students to motivate, coach and facilitate healthy lifestyle change
- Promotes patient wellness through student-led initiatives:
 - traditional teaching (GHL Friday Classes)
 - Individualized SDoH screening and health coaching (**GHL Green Pod Health Coaching**)
 - physical activity (Walk with a Doc, Walk with a Student Doc)