

## CHOW Role in Hope Center

### Goals:

*The CHW Provides:*

- Client advocacy within and among multiple systems
- Assistance with complex problem solving related to living in poverty with multiple health issues
- Motivational Interviewing to resolve ambivalence about health-related behavior change
- Opportunities for patient to identify as something other than a “patient”
- Opportunities for patient to experience success and feel confident
- Role modeling advocacy and relational skills

### Objectives:

*Assist with system navigation/self-advocacy to ensure that:*

- Pt can negotiate an agenda with the provider
- Pt can schedule transportation to/from medical events
- Pt can schedule his/her own medical appointments
- Pt calls our team when: they have trouble navigating the system or they are thinking of going to the hospital

*Follow up on social service referrals to ensure that:*

- Pt has secure housing
- Pt has State ID, Social Security card, birth certificate
- Pt has facilitated adequate food through food bank, grocery teaching, or otherwise
- A plan is in place for pt when temporary food “runs out”

### Tactics:

- Meet with RN immediately after patient intake to discuss care plan & what parts the CHW will be responsible for
- Meet with patients weekly for first month they are enrolled, then can de-escalate to every other week after discussion with RN
- Document – briefly! – each encounter in Nextgen
- If facing barrier or have question about patient, alert RN or LCSW
- Close loop on all communications initiated by other team members by email or in person



## Care Management Health Coach Tasks

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### Daily

- Check voicemail
- Check LCR task list for admissions or discharges from SFGH
  - Update Access database accordingly
- Appointment reminders for the next day's appointments

### Weekly

- Copy any new patient appointments from the LCR into the weekly planner
- Check each patient's visit history for ED visits
- Prepare and print documents for weekly team meeting (see directions below)
- Update the team calendar with any home visits or scheduled clinic visits
- Print and hang the weekly Clinic Provider schedule for reference

### Monthly

- Add patient birthdays to the calendar from the "Birthdays this Month" report in the data tab of the Access database

### Quarterly

- Make a back-up copy of the Access Database
- Update utilization data

### Yearly

- Create annual report
- Schedule and plan team retreat

### Continuous Projects

- Outreach to new patients
- Maintain database and waitlist
- Research and create patient education materials

## Documents for Weekly Team Meetings

### Dashboard

The Weekly Dashboard gives the team an overview of what is happening throughout the week. To start a new dashboard open the most recent dashboard and save it as a new week. Follow the steps below for each section to update the information:

- A. *Activity Table*: Delete date in the 4 wks ago column and shift the remaining data to the left. To add in new data, open Access. In the "Data" tab, click the "Dashboard Activity Data" button to open the report. Add together the phone calls and use the other categories to fill out the consults and clinic visits boxes. Leave the hospitalization and home visit boxes blank for now.
- B. *New Hospitalizations*: Use the LCR Tracking List to see how many enrolled patients have been admitted over the previous week. Check this with the "Patients in the Hospital" report in Access. Count up the number of enrolled patients who have been admitted over the last week. Place this number in the Activity table as well.
- C. *Home Visits*: Look at the calendar and "Dashboard Activity Data" to see how many home visits there were. Place the correct number here and in the Activity Table.
- D. *What's coming up?*: Keep this section updated with upcoming events, team members on vacation, etc.
- E. *New Patients*: List the names and date of assessments of any patients enrolled in the previous two weeks.
- F. *Who's in the hospital?*: List the names and dates of admissions for hospitalized patients. If a patient was discharged within the last week, write "DISCHARGED" in front of their name and add the date of discharge. If the patient is not at SFGH, note which hospital.
- G. *Level breakdown*: In the Access database, go to the data tab and click "Number of Patients by Level" to get these numbers. When entered into excel, the Totals on the right will automatically update.
- H. *Care Plan Review*: Choose two care plans of patients (either from rotating list or a team member request) and summarize the mail goals on this section of the dashboard. Print a copy of the complete care plan from LCR.
- I. **Don't forget** - change the date of the week in the header!!

### Active Patient List

For the team meetings, the active patient list organizes patients by acuity and allows the team to focus their attention on the highest acuity patients. On the Data tab in the database, click the "by Status" button under Active Patient Lists.

### Care Plans

Print copies of each care plan under review from the LCR.

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## Case Presentation Form for the Huddle

Presenter

Client: Age, Gender

Health Markers

Social Determinants of Health and Co-morbidity (substance abuse/dependence issues, Mental Health concerns, cognitive abilities, family system, environmental factors)

Risk/safety issues

Natural Supports

Clients' strengths

What drives utilization? Why do they go to hospitals?

What other agencies/systems are involved?

What is the identified concern?

What Interventions have been attempted?

What are the barriers to successful resolution?

Other pertinent information

What questions do you have for the group?

Ideas for the goals and successful interventions. Next steps?

Follow up with the group in 2 weeks.