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Title

Evaluating the Feasibility of Enhanced Care Planning and Clinical-Community Linkages for Primary Care Teams to Better Address

Priority 1 (Research Category)

Community based participatory research

Presenters

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Abstract

Context: Patients with MCC have a range of needs that extend beyond traditional medical care including behavioral, mental health, and social needs. While primary care does its best to address these needs, few practices can undertake a systematic approach without broader health system and coordinated community support. We are conducting a randomized controlled trial to compare a package of four tools (an online health risk assessment called My Own Health Report (MOHR), patient navigator, community health worker, and linkage to community programs) versus usual care to better address these root causes of poor health. Objective: To assess the feasibility of patient navigation as part of an enhanced care planning approach. Study Design and Analysis: Clinician level randomized control trial and descriptive analyses. Dataset: MOHR study and navigator field notes. Population Studied: Practices from the Virginia Ambulatory Care Outcomes Research Network (ACORN) in the Greater Richmond metro and the Northern Virginia areas participated. 12 practices, 45 clinicians, 87 intervention patients, and 109 control patients have participated in the trial. Intervention/Instrument: Study and navigator field notes in MOHR. Outcome Measures: We determined navigator recruitment for practices and clinicians, the number of navigator phone contacts for patients assigned to the care planning condition, and the length of these contacts. Results: Only 1 of 12 practices had staff that could serve as a patient navigator, even for extra pay. For the other 11 practices, a research team member needed to provide navigation services. On average, 95 patients needed 25 weeks of support to work on their care plans for health behaviors, mental health, and social needs. The average time for each patient session is about 7 minutes. As navigation sessions do not occur every week, this is an average total contact time of 124 minutes or about 2.1 minutes per week. Conclusions: Helping patients create care plans and connecting them with a patient navigator for the short-term may have long-term benefits for patients and care teams. Yet, this model of team-based care is not currently feasible for many practices. Primary care will benefit from increased health system and community support to make this model more viable to better support the complex needs of patients with MCCs.

