

USE OF COMMUNITY HEALTH WORKERS (CHW) IN PREVENTING READMISSIONS

Bridges to Wellness Program

HealthVisions Midwest

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BRIDGES TO WELLNESS

- ✘ St. Catherine Hospital & HealthVisions Midwest
- ✘ 30 days program
- ✘ Preventing avoidable readmissions
i.e. CHF, Diabetes, Pneumonia, Infection...
- ✘ CHWs assist in a team approach with chronic disease self management

TRAINING AND ATTRIBUTES OF BTW COMMUNITY HEALTH WORKER

- ✘ From the community; knowledgeable of resources
- ✘ Received general CHW training
Carl Rush, Texas
- ✘ Chronic disease such as diabetes, congestive heart failure, hypertension, kidney disease
- ✘ Cultural competent and speak same language

TEAM APPROACH

Hospital staff

Patient

Care
Coordinator

CHW

PROCESS

- ✘ Referral
- ✘ Meet patient
- ✘ Discharge instructions
- ✘ Telephone pre screen
- ✘ Initial Home Visit
- ✘ Weekly CHW visit
- ✘ Weekly call

COLLABORATION

- ✘ Weekly hospital rounding
- ✘ Hospital personnel provides clinical feedback and other potential useful tips and resources
- ✘ Work together with BTW team to provide services and fill gaps
- ✘ Work with other community organizations, pharmacies, programs

CHW TASKS

- ✘ Reinforces teaching about warning signs, treatment and diet
- ✘ Provides resource and referrals
- ✘ Assists bridging issues
- ✘ Provides feedback

CHW ROLE

- ✘ Participates team reviews
- ✘ Participates in initial visit
- ✘ Reinforces teaching
- ✘ Assists patient (non clinical)
- ✘ Post visit team review

AFTER THE 1ST HOME VISIT

- ✘ Post team review
- ✘ Review information gathered
- ✘ Concur on the findings
- ✘ Establish a plan of action.

POST CHW WEEKLY VISITS

- ✘ Update team
- ✘ Update chart
- ✘ Update list of services provided
- ✘ Update database

PATIENT

- ✘ Teaching reinforcement is tailored to disease, orders from physicians, meds and needs
- ✘ Attention is focused on health literacy & patient engagement

RESOURCES

- ✘ Health Diary
- ✘ Emergency numbers to CC and CHW
- ✘ Educational materials
- ✘ Any other needed

END OF 30 DAYS

- ✘ Last weekly visit and call
- ✘ Provide Patient with certificate of completion

WHAT IF...

- ✘ If Patients return to the hospital after 30 days, they are considered new referrals.
- ✘ If Patients are readmitted within the 30 days new referrals are generated after discharge.

PRELIMINARY DATA

- ✘ Referred to BTW

Recurrent admits w chronic disease (visit ER or Hospital at least once per month)

- ✘ 51% of Patients referred stayed out post 30 days with Bridges to Wellness support

THANK YOU

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