Grady Healthy Living:
Health Coaching Program in Green Pod

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Dr. Maura George
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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

- **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%)

Zoe Kopp, Andy Saxon, Rewa Choudhary, Mehul Tejani MD, Tracey Henry MD, Maura George MD, Jada Bussey Jones MD
Emory University School of Medicine
CASHI Award

- $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?

☐ Yes  ☐ No  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?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
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
- 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

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

**Patient Insurance Status (n=995)**

- **Uninsured**: 11.6%
- **Medicaid**: 35.0%
- **Grady card**: 34.5%
- **Private**: 12.2%
- **Medicare**: 30.9%

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

- **SNAP**: 60.0%
- **Social Security**: 50.0%
- **Energy Assistance**: 40.0%
- **SGT**: 30.0%
- **TANF**: 20.0%
- **Unemployment**: 10.0%
Survey Results: Providers

**Current Resident SDOH Screening Practices**

<table>
<thead>
<tr>
<th>% of surveyed residents</th>
<th>% of patient visits in which SDOH screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>5%</td>
</tr>
<tr>
<td>1-25%</td>
<td>40%</td>
</tr>
<tr>
<td>26-50%</td>
<td>30%</td>
</tr>
<tr>
<td>51-75%</td>
<td>20%</td>
</tr>
<tr>
<td>76-100%</td>
<td>10%</td>
</tr>
</tbody>
</table>

**Barriers to Screening for SDOH**

<table>
<thead>
<tr>
<th>Barriers</th>
<th>% of surveyed residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don't have time</td>
<td>90%</td>
</tr>
<tr>
<td>I lack resources/tools to address barriers</td>
<td>70%</td>
</tr>
<tr>
<td>I'm not sure how to screen effectively</td>
<td>40%</td>
</tr>
<tr>
<td>It's not my job or role</td>
<td>10%</td>
</tr>
</tbody>
</table>
## Comparing Results: Patients vs. Providers

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

“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

- **POVERTY**
  - In 37/62 GHS communities, >20% residents are living ≤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 ⅕ 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)