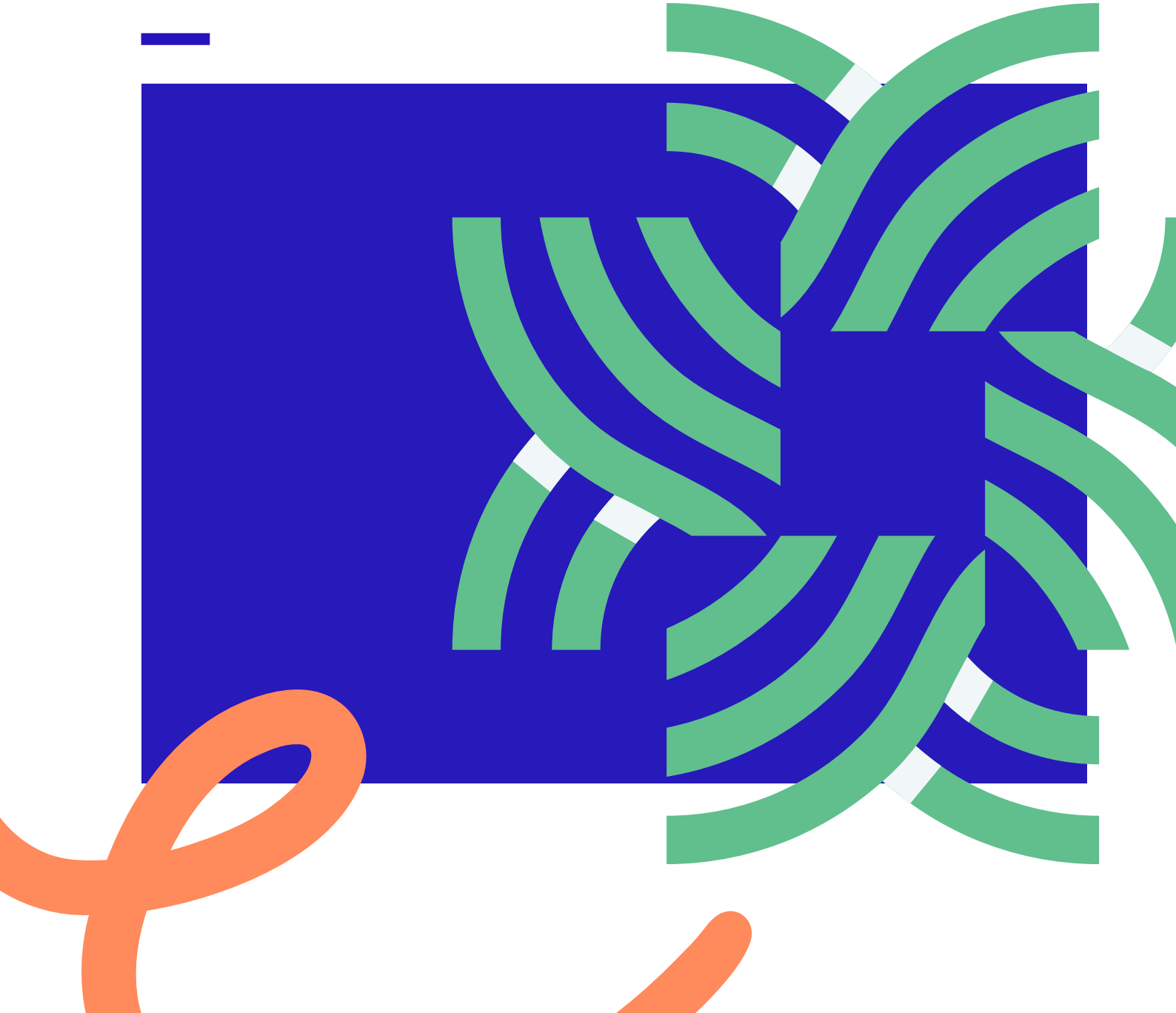
MEDTRONIC LABS | Virtua Health

Healthy Neighbor Design & Implementation Toolkit



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Introduction

Medtronic LABS and Virtua Health shared a vision to measurably improve health outcomes for chronic disease patients by developing a replicable, community-based model. Through this collaboration we created Healthy Neighbor, a community health worker-led model that provides integrated health and social care support for patients living with hypertension and type 2 diabetes. The program launched in August 2023 and has demonstrated clinically meaningful impact on patient outcomes. This toolkit will take you through a step-by-step guide for implementing the Healthy Neighbor model within your organization. The model is defined by the following core elements:

- Community health workers (CHWs) provide culturally relevant support that improves patient outcomes
- Technology enables CHWs to extend care into community settings
- Data analytics provides unique insights into program operations and impact

Role of CHWs In Chronic Disease Management

According to the American Public Health Association, a community health worker is "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."[i]

CHWs play a critical role in the management of chronic diseases by bridging healthcare systems and communities, particularly in underserved populations. Studies have shown that CHWs provide culturally relevant education, enhance patient adherence to treatment, and offer social support, leading to improved health outcomes for chronic conditions, improved perceptions of quality of care, and reduced hospitalizations and healthcare costs.[ii,iii,iv,v]

Medtronic LABS has seen the positive impact of CHWs in extending care into communities through global work in sub-Saharan Africa and South Asia. By leveraging digital technologies to link communities and health systems, we have seen significant improvements in chronic disease outcomes. In a study published in the Journal of Clinical Hypertension, the Medtronic LABS model demonstrated an increase from 46% to 77% of the enrolled patients with controlled blood pressure and an average reduction in systolic blood pressure of 18 mmHg for patients who enrolled with uncontrolled hypertension.[vi]

CHWs are increasingly recognized as essential frontline health professionals in the U.S., bridging gaps in healthcare access. Their role has expanded beyond health education to include care coordination, chronic disease management, and social determinants of health interventions. With growing evidence of their effectiveness in improving health outcomes and reducing healthcare costs, states are integrating CHWs into Medicaid programs and value-based care models.[vii],[viii]

Case Study

Case Study: Healthy Neighbor - Camden, New Jersey

Healthy Neighbor is a joint initiative of Virtua Health and Medtronic LABS designed to address the burden of hypertension and type 2 diabetes in Camden, New Jersey. Together, we developed a technology-enabled, community health worker program that provides integrated clinical and social care in the community. Through this work we aim to address the significant health disparities in cardiovascular disease in the region and measurably improve outcomes for chronic disease patients across the city. It is technology that empowers us, but our commitment to the community that drives us.

Within 2 years of operations, Healthy Neighbor enrolled over 250 individuals into the program. Participating patients face a wide range of health and social care needs. Over half of patients are living with 2 or more chronic conditions and have visited the emergency department in the last year. Patients report an average of 3 social determinants of health needs including financial strain, food insecurity, housing and utilities, and transportation barriers.

Through a combination of clinical and social support delivered by trusted community health workers, Healthy Neighbor has been able to demonstrate a significant impact on patient outcomes. In an analysis of outcomes to date, 74% of patients with uncontrolled hypertension achieved meaningful improvement with an average reduction in systolic blood pressure of 15 mmHg; 69% of patients with uncontrolled diabetes achieved meaningful improvement with an average reduction of 1.2% in HbA1c.[ix]

This represents a significant reduction in risk of associated complications, leading to better overall health and wellness. However, the numbers do not tell the full story. Patient feedback focuses on the support and care provided by trusted community health workers who go above and beyond to help patients reach their goals – whether that's access to nutritious food, health education, or essential home repairs.

“Healthy Neighbor is a blessing. It helps connect you with everyone in every area that you’re struggling with.”

Healthy Neighbor Patient

The Healthy Neighbor Model

Healthy Neighbor extends care outside clinical walls by empowering CHWs with the tools to deliver integrated chronic disease management support and social care in one-to-one, community-based visits.

Who implements the program?

The program is embedded within a health system and closely linked to primary care offices serving the target geography.

Care Team

- Community health workers
- Clinical supervisor
- Program manager
- Social worker
- Medical director

Who is the program designed for?

Patient cohort: Adults with a hypertension and/or type 2 diabetes diagnosis. Healthy Neighbor shows the biggest impact for patients with a baseline blood pressure >140/90 or A1C > 8%.

Healthy Neighbor was designed for adults (age 18+) with hypertension and/or type 2 diabetes living in a medically underserved area. On average, the individuals enrolled in Healthy Neighbor identified 3 social resource needs and are living with multiple comorbidities. A targeted geography should be selected to enable CHWs to serve their community and meet individuals in their homes or at convenient community locations. A first step for implementing Healthy Neighbor is to identify areas where residents experience the impact of significant health inequities leading to higher prevalence rates of chronic disease, high mortality from cardiovascular disease, and lower life expectancy.

- Health systems implementing Healthy Neighbor should determine specific enrollment requirements based on clinician feedback and existing programs that may be a better fit.
- Health conditions that impact blood pressure management should be flagged by the referring provider (for example, patients on dialysis). In these situations, the Healthy Neighbor clinical supervisor and provider should determine if Healthy Neighbor is the right fit; if so, unique targets may need to be set.
- Patients that are currently pregnant should be provided with pregnancy-specific resources within the health system. If pregnant patients participate in Healthy Neighbor, the medical director should ensure that tailored clinical pathways are developed before launch that capture best practices in managing hypertension during pregnancy and identifying hypertension disorders of pregnancy.
- The operational approach outlined in this toolkit works best for patients who can engage directly with a CHW. The model could be adapted to support caregivers with revised referral pathways and additional content to address the unique challenges faced by caregivers.

Healthy Neighbor Service Blueprint

	REFERRAL	ENROLLMENT	FIRST ASSESSMENT	COMMUNITY-BASED FOLLOW-UP	LINKAGE TO CARE	REPEAT
Patient	Patient visits a primary care office or Emergency Department	Receives a call or in-person meeting from a CHW	Patient selects location for first in-person meeting: home, clinic, community site.	Receives home-visits from CHW each month & bi-weekly phone call	Connected to follow-up care as needed	
CHW	CHW may be available for a warm handoff and to provide program information	Calls patient to provide information on Healthy Neighbor and complete enrollment module	Performs baseline BP check, glucose check, and administers SDOH assessment	Performs BP and glucose monitoring, health education, and navigation	Supports patient in navigating communication with primary care and specialists	
Clinician	Provider refers patient into the Healthy Neighbor program	Clinician is notified if patient enrolls		Receives updates as needed regarding patient health	Receives longitudinal patient data and social information to inform care planning	
Tech	Referrals documented in the EHR system	Enrollment module captures patient contact information, SDOH assessment, PHQ-4, and program goals	If not completed at enrollment, first assessment includes SDOH, PHQ-4, and patient survey	Assessment module captures patient health and social information. Automatic alerts are triggered for out-of-range values.	Longitudinal patient record and risk stratification for patient review	

How are patients referred?

Referral mechanism: Primary care providers and emergency departments.

Hypertension and type 2 diabetes are primarily managed by primary care providers which enables Healthy Neighbor to reach a higher volume of patients.

- Primary care providers meet with patients or review a list of eligible patients.
- If a patient has an upcoming appointment, the provider will introduce the Healthy Neighbor program and inform the individual they are being referred.
- Primary care providers send referrals to the Healthy Neighbor department via the electronic health record system.

Referrals can be extended to specialty care offices serving a high volume of patients in the target geography, with a particular focus on cardiology, endocrinology, and wound care practices. Due to the frequent use of the emergency department for primary care services, referrals can also be accepted from the emergency department. In that case, the first objective is to help a patient get established with a routine primary care provider to support chronic disease management.

How are patients enrolled?

Enrollment: Phone-based or in-person enrollment

- The Healthy Neighbor supervisor reviews referrals to ensure the patient meets enrollment requirements.
- The supervisor assigns patients to a community health worker for outreach.
- CHWs will make 3 outreach phone calls and send a message to patients to share information on Healthy Neighbor and ask if they want to enroll.
- If the patient chooses to enroll, they will schedule the first in-person visit, ideally within 2 weeks.

In-person enrollment may be an option at your practice. This often happens when patients have an upcoming visit with their provider. In that case, CHWs should plan to meet the patient at the clinic after their appointment for a warm hand-off from the primary care provider.

What does the program entail?

- Program duration: 6-12 months based on individual needs
- Setting: Home visits (or other convenient community location)
- Key components: Blood pressure and glucose monitoring, health education, social resource navigation

	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	Visit 6
Education	Introduction to Hypertension & Diabetes	Medication & treatment plan adherence	Healthy eating	Physical activity	Stress management	Reducing risks
Clinical	Check blood pressure & glucose Symptom inquiry Provide BP monitor	Check blood pressure & glucose Symptom inquiry Provide pill box	Check blood pressure & glucose Symptom inquiry PHQ-4	Check blood pressure & glucose Symptom inquiry	Check blood pressure & glucose Symptom inquiry	Check blood pressure & glucose Symptom inquiry PHQ-4
Social Resource Connection	SDOH assessment		SDOH assessment			SDOH assessment
Goal Setting	Help uncover a patient's long-term goal	Define a monthly goal	Update monthly goal	Update monthly goal	Update monthly goal	Update monthly goal
Bi - Weekly Phone Call	Check in on previous session follow-ups: referrals and/or applications for services, healthcare navigation, and general wellness check-in.					

Home Visits

Community health workers meet patients in their homes once a month for an in-person visit. Home visits present many advantages by addressing transportation barriers, creating a comfortable setting for conversation, and enabling CHWs to understand more about a patient's home environment. However, it is important to provide additional meeting locations for patients who may face challenges with privacy, safety, or discomfort with new people entering their home. Healthy Neighbor offers the option to meet at a convenient community location or the primary care clinic.

Bi-weekly Phone Calls

Between in-person visits, CHWs connect with patients over the phone to check-in, answer any follow-up questions, and share updates on social resource navigation. For patients facing immediate social resource needs, this communication may happen more frequently as the CHW guides their client through urgent connection to community-based organizations or coaches them on benefits applications.

Additional component: Community Screenings

Community screenings are an effective way to increase awareness of high blood pressure and prediabetes. It also provides an entry point to engaging with healthcare for community members who are disconnected from primary care services. For patients screened in the community, the initial goals are connection to a primary care provider and insurance enrollment.

Required Inputs:

· Clinical logic for automatic referrals to follow-up care

· Scripting for CHWs to address low blood pressure, elevated blood pressure, hypertensive urgency/crisis

Materials to Provide Patients

·Informational packet including handouts on high blood pressure, prediabetes, and diabetes, as well as low blood pressure as applicable

·Screening card to write patient name, date, blood pressure readings, and pre-diabetes risk score

·List of primary care providers in the area with contact information

·Additional community resources

Technology

Core to the model is the deployment of a digital health platform that enables CHW activities and program monitoring & evaluation. Healthy Neighbor was launched using SPICE, an open-source digital health platform developed by Medtronic LABS. Similar workflows can be developed within existing digital health systems.

Core principles of digital technology for this work include:

- Simple workflows to guide CHW screening, program enrollment, and patient assessments
- Immediate, automatic alerts for out-of-range BP and glucose values that outline clear CHW follow-up steps
- Risk-based stratification to guide clinical review of patients
- Linkage back into the health system to support team-based care
- Realtime dashboards for monitoring program implementation and identifying opportunities to better serve participants

“People are the core. We know there’s a lot of success in having a people-centered approach enabled by tech.”

Dan Master,
Director of Community Health and Impact, Virtua Health

MONITORING & EVALUATION

Operational Data

Operational data flows into a real-time dashboard to track key implementation metrics:

- Screening: number of patients screened, date, referral status, and screening location
- Enrollment: number of patients enrolled, date, key demographics, and CHW assigned
- Follow-up assessments: number of follow-up assessments completed per patient, location (home, community, clinic), and BP/glucose alerts
- CHW caseload of active patients: patients currently engaging in program by CHW
- Time between referral, enrollment and follow-up

Enrolled Patient Insights

Data from enrollment flows into a dashboard that helps us understand who we are serving and how to meet community needs:

- Health information like diagnosis, BMI, and cardiovascular disease risk status
- Demographic information like race & ethnicity, age, gender, zip code, preferred language, and education
- Provider information including clinic name, primary care provider, and patient reported hospitalizations/emergency department visits
- Social determinants of health domain areas reported by patients

Impact Evaluation Framework

Every 6 months, in-depth analysis is done to understand participant outcomes and factors that may be influencing success in the program. It is best practice to align the goals of your community health worker program with existing organizational priorities. For example, if your program will largely focus on a patient population within your employed medical group, aligning with HEDIS metrics or other priorities developed in partnership with your patients' health plans will demonstrate impact to a higher degree than if your impact metrics are isolated to your program.

> We have been instrumental in closing care gaps for our patients.

Fanny Ochoa,
Community Health Worker

Operational Data

Operational data flows into a real-time dashboard to track key implementation metrics:

	Targets	Tool	Metrics
Clinical Outcomes	• Improve blood pressure control rates • Clinically meaningful improvements in blood pressure	• SPICE digital health platform for longitudinal BP tracking	• Average blood pressure at enrollment • Monthly average blood pressure over 6-12 months • Change in blood pressure from enrollment to current date
	• Improve medication adherence	• Patient survey (every 3 months)	• Hill-Bone medication adherence score
Social Resource Connection	• 100% of enrolled patients screened for SDOH needs • Needs addressed through CHW engagement	• SPICE SDOH screening form (every 3 months) • Patient feedback survey (every 3 months)	• SDOH assessments completed • SDOH need domains identified every 3 months • Patient feedback
Patient Experience	• Improved confidence to self-manage condition • High engagement with CHWs	• SPICE assessments (monthly)	• Patient reported ranking of confidence to self-manage condition • # of community follow-ups completed per patient
	• Increased trust in the health system • Quality of Life • NPS score > 60%	• Patient survey	• Increased trust in the health system • Quality of Life • NPS score > 60%
Cost Effectiveness	• Reduction in emergency department utilization • Reduction in inpatient stays	• Electronic Health Record	• Annual ED visits 6-12 months before/during/after programming • Hospital admissions and duration 6-12 months before/during/after programming

Expected impact

With 3 CHWs and a clinical supervisor, program teams can expect:

250 patients

Enrolled per year

70% of active patients

realize clinical improvement

>10mmHg average drop in in blood pressure

for patients with uncontrolled hypertension

>1% reduction in HbA1c

for patients with uncontrolled diabetes

IMPLEMENTATION

Program Design Process

Leadership support is essential to program success. The first step is to form a multidisciplinary steering committee to guide design and implementation. This core group will be responsible for assembling dedicated work groups and making final program decisions.

Dedicated work groups will bring expertise to inform decision-making on key program components. Direction from leadership is essential in setting the expectation that all workgroup members will be expected to leverage their expertise and/or network to streamline the implementation process. This process will be no different than the process that results in the planning for an implementation of a new service line for your organization.

- **Population health analytics:** Use chronic disease prevalence data and health outcomes disparities to identify the right geography for the program.
    - o Select health system sites
    - o Leverage feedback from the community health needs assessment, patient ambassadors, and community advisory boards to understand community priorities
    - o Review M&E framework and develop tailored research plan
- **Clinical pathways:** Convene a group of clinicians to review defined clinical pathways, enabling CHWs to take blood pressure and/or glucose readings.
    - o Set clinical skills training requirements and identify training lead
    - o Review and sign off on alert thresholds, CHW follow-up action, and CHW communication to patient scripting
    - o Provide medical oversight to the program and support care team with complex patients
- **Digital health platform:** Select the right tools to enable Healthy Neighbor workflows and manage deployment.
    - o Map referral pathways into the program
    - o Select digital tool for CHWs
    - o Complete IT review process for any new platforms
- **Workforce recruitment & training:** Define the right team structure for the organization and recruit a Healthy Neighbor care team.
    - o Identify workforce needs
    - o Engage community partners to recruit CHWs
    - o Review CHW training programs (state and local) and program-specific training plans
- **Financial sustainability:** Pursue sustainable funding models.
    - o Understand existing CHW reimbursement pathways and implement reimbursement infrastructure if relevant
    - o Create a plan to help enroll patients without health insurance in appropriate plans and train CHWs on navigating existing benefits
    - o Engage philanthropy leadership to pursue grant funding for program development
- **Community engagement:** Identify strategic partners in the community.
    - o Map existing community partners and identify any new partners
    - o Establish plans to work with strategic partners and what the partnership will entail (patient referrals, screening locations, or social resource support)
    - o Connect with leaders in the service area to share information on the program and engage community members to gather feedback on program content and structure

- **Legal & Compliance:** Understand local regulations and compliance requirements

  o Review CHW scope of practice and reporting requirements in your state. In many locations, CHWs must report into a licensed clinician to take BP and glucose readings. Ensure adherence to local regulations for CHW scope of practice.

  o Develop consent forms for screenings and enrollment into the program

  o Ensure the team has proper insurance coverage for community- and clinic-based work

  o Review follow-up pathways and CHW scripting for community screenings to ensure compliance with regulations on engaging patients who have not established care with your organization

Care Team Recruitment & Professional Development

For a high touch model like Healthy Neighbor, it is important to have fully dedicated team members who follow-up with a cohort of patients over time. Best practices in hiring this workforce:

o Hire full time roles with competitive salaries and benefits
o Provide training as part of the onboarding process
o Look for a group of candidates with diverse backgrounds in healthcare, home health, social work, and community-based organizations

Healthy Neighbor CHWs are individuals passionate about the wellbeing of their community, who show up to build strong relationships with patients, and are comfortable working across healthcare settings and community-based organizations.

o Have a close understanding of the community they will work in and have demonstrated a history of engagement, community service, or leadership

o Enjoy working directly with patients and comfortable working with a diverse group of individuals

o Demonstrated interest in health education and coaching through personal, volunteer, or professional experience

In addition to recruitment, it is important for your human resources representative to think about what growth pathways could be developed for your team. Growth pathways are a key ingredient for team retention. For example, if your organization has the capability to create custom curriculum for different roles, developing that pipeline will likely lead to increased retention of key staff within your program.

Training & Onboarding

Healthy Neighbor is a unique model that combines health education, chronic disease monitoring, and social resource navigation. Training reflects these different core competencies.

In addition to program specific skills, it is important for the program's leadership to intentionally integrate the community health worker team into the larger organization. Strategies could involve introductions to your organization's formal culture, shadowing relevant community impact or primary care teams, or facilitated team trainings teaching character profiles like DISC or Clifton Strengths.

Community health workers are connectors and need opportunities to engage with their team and the broader organization to flourish in their roles.

CHW Core Competencies

CHW certification: depending on the state, a CHW certification may be required. If this is the case, this may need to be complete before onboarding. If not, we recommend building in time for CHWs to become certified while in this role.

> "The role is unique, it's because of the way we look at healthcare. We're looking into the why, the barriers."
>
> **Alexis Nieves, Community Health Worker**

My favorite thing about this work is connecting with my patients. Caring for them. Seeing their health improve, A1Cs and blood pressure scores dropping, and the impact that has on their lives.

La Shawn Dutton-Spruill,
Community Health Worker

Program Knowledge & Skills

Healthy Neighbor has a 3-week training plan that covers core program skills. However, a supportive supervision model is critical to ongoing team engagement and development.

- Clinical skills training must be led by a clinical supervisor or designated training team within a health system. This includes taking blood pressure using an automatic cuff, performing finger sticks for glucose checks, and point of care A1C. CHWs must complete the clinical skills training and perform a demonstration for the clinical supervisor for sign-off. Skills should be refreshed annually. If your organization has its own education team, developing a partnership can support CHW training.

  For example, at Virtua Health, the Mobile Intensive Care Unit (MICU) has a dedicated training team that is mostly designed for onboarding new Paramedics and Emergency Medical Technicians. However, during the design process for Healthy Neighbor, it was uncovered that the modules offered by the MICU training team would provide a very suitable education pathway for CHWs due to the training's focus on community care delivery.

- Chronic disease education can be led by the clinical supervisor with possible guest lectures by diabetes educators, nutritionists, and primary care clinicians. Education should be delivered through a mix of lecture, written tests, and interactive practice sessions where CHWs complete the full assessment, education, and documentation workflow.

- Social resource navigation training is important to review best practices for identifying social resource needs, contacting preferred community partners, and utilizing any social resource navigation platforms in place or publicly available, like FindHelp.

- Digital health system utilization onboarding should include a walk through of each module for patient interactions as well as best practices for documentation.

- Build in time for mock sessions where CHWs pair up and practice leading patient assessments and education sessions. This can be done after training on each educational module. One mock session should be done with the supervisor before direct patient engagement.

- In future cohorts, create time for newly onboarded CHWs to shadow 2-3 patient encounters as well as the documentation process.

Supportive supervision is a best practice for CHW programs. Supportive supervision focuses on mentorship, problem-solving, and capacity-building and involves regular, collaborative interaction between supervisors and CHWs. For Healthy Neighbor, implementation of supportive supervision looks like:

- Supportive monitoring by helping CHWs as they prepare for initial patient interactions and observing field visits to provide an opportunity for coaching

- Going into the community once per month with each CHW to help brainstorm solutions for patients, observe skills, and identify development opportunities

- Holding weekly team huddles to discuss complex patients and share resources and learnings across the team

- Leading annual refresher trainings on clinical skills and chronic disease management education to ensure quality care as well as incorporating new trainings for continuous learning

Ongoing Trainings

Ongoing trainings are important for team engagement and development of advanced skills. These sessions may include:

- Motivational interviewing
- CPR certification
- Mental Health First Aid
- Narcan training
- Diabetes education
- Nutrition

Standard Operating Procedures

Training should cover all program SOPs as well as systemwide onboarding requirements. SOPs should include:

- Clinical triage workflows
- Communication & documentation
- HIPAA
- Safety
- Mandatory reporting

Launch

Develop a launch plan for the first year of program operations. This can include targets for monthly patient screening and enrollment, phased approach to onboarding referring clinics and/or community-based organizations, key milestones to hire additional community health workers, and timeline for formal evaluation. Collect regular feedback from CHWs, partnering providers, and patients to continue to identify areas that may need to adapt to best meet community needs. Continue to engage key stakeholders through quarterly meetings with steering committee members and program advisors that tracks program progress, identifies opportunities to iterate on the model, and celebrates success.

> “It’s becoming a true partnership between the providers and us. We have become those connectors and liaisons to the patients.”

Fanny Ochoa,
Community Health Worker

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