***Enhanced Care Planning and Clinical-Community Linkages to Comprehensively Address the Basic Needs of Patients with Multiple Chronic Conditions***

Agency for Healthcare Research and Quality (AHRQ) VCU IRB Approval HM20011992

Study Period: March 2019 to February 2024

Participants: Primary care clinicians and patients with uncontrolled multiple chronic conditions

***Research Question***

Many patients with uncontrolled chronic conditions struggle with unhealthy behaviors, mental health needs, and unmet social risks. Health systems and communities are recognizing these needs and working towards connecting patients to services, but how primary care clinicians and patients can participate is unclear. We propose to test an innovative model that will support primary care clinicians in helping patients to create care plans and collaborate with local community programs using support from a community health worker. We will test whether this process works better than traditional medical care to help patients control chronic conditions.

***Study Design***

We are looking to recruit 60 clinicians in the Greater Richmond region. For each clinician, we will survey 50 patients with chronic conditions about their health behaviors and mental health, as well as how your practice does with managing chronic conditions. 10 patients with uncontrolled conditions will be randomly selected for study participation. Then half of the clinicians will be randomized to continue usual care and half to enhanced care planning for their 10 patients.

***Enhanced Care Planning Intervention***

The enhanced care planning intervention includes four key components.

1. Your patient completes an **online care planning tool** that assess for risks, walks your patient through telling their story, helps your patient set a personal goal, and directs your patient to create an evidence-based strategy to address his/her goal.
2. You identify a staff member to serve as a **patient navigator**. The navigator helps the patient refine his/her goals and checks in on the patient weekly.
3. We provide a **community resource registry** with all the programs and resources by zip code to help your patient address his/her goals.
4. You can direct your patient to a **central community health worker** who knows our community’s resources and can build a clinical-community connection for your patient.

***What’s in it for me?***

* Support to better manage unhealthy behaviors, mental health, and social risks
* A better understanding about your patients’ goals and how they want to achieve them
* A baseline and one-year assessment on how your practice does with managing chronic disease
* Use of an enhanced care planning tool
* Staff training for a member of your team to function as a patient navigator
* Support from a community health worker
* $500 per year for 3 years for data collection and your patient navigator

***What are you asking my practice to do?***

* Help support 10 patients through the enhanced care planning process
* Provide basic provider/practice demographics at the start of the study
* Complete a brief questionnaire about the climate of your practice at the beginning of the study
* Identify a member of your staff to be a patient navigator
* Allow your patient navigator time to check in on your patients
* Help identify 50 adult patients with chronic conditions
* Allow the VCU research team to survey your patients
* Permit the VCU research team access to your record to measure outcomes
* Participate in a 30-minute exit interview

(All of our research is done in partnership with our practices – we can modify any of the above steps based on you, your practice, and your health system’s needs. For example, if you cannot allow access to your records, your patient navigator can do the chart review or if you do not have someone who can be a patient navigator, we can provide one for you).

We hope you are interested in working with us!

*Learn more by contacting*

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**VCU Family Medicine & Population Health**

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