CHW Stories of Success

September 10th, 2020

Kentucky Public Health

Prevent. Promote. Protect.

Stories of Success

- A compilation of impactful Community Health Worker (CHW) projects from the past 18-24 months
- Purpose
  - To highlight CHW program impacts across Kentucky
  - To inspire continued support for CHWs
- Digital and print

Use

- Presentation to legislatures, community members, and other stakeholders
- Can assist with grant applications and other funding sources

Deciding on a Success Story

- How to choose a story
  - Feedback received from clients/community/stakeholders
  - Significant or interesting project outcomes
  - Learning experience projects
- One story entry per program

WellCare and Kentucky Homeplace partner to remove barriers to healthcare

October 3, 2019 449 Views

LOUISVILLE, Ky. and TAMPA, Fla. — A pilot program in eastern Kentucky designed to remove barriers to healthcare services has shown promising results, including a reduction in emergency room (ER) visits and hospital admissions among a group of nearly 2,000 rural Kentuckians.

WellCare of Kentucky, a WellCare Health Plans, Inc. company, partnered with Kentucky Homeplace, a program of the University of Kentucky's Center of Excellence in Rural Health, to help Kentuckians with chronic diseases like asthma and diabetes access health coaching to manage their conditions. The partners announced initial findings from the program at UK's Center of Excellence in Hazard on Oct. 3.

Through the partnership, 22 community health workers from Kentucky Homeplace provided a variety of six-week health coaching workshops throughout eastern Kentucky. All program participants were diagnosed with chronic diseases such as asthma, diabetes, high blood pressure or obesity. Participants met weekly with trained community health workers to help take steps toward improvement in nutrition, medication use, exercise, communication, decision-making and more. Classes covered topics from diabetes management to mental health, first aid, CPR and beyond.

"Community health workers saw a real change in members once they had the tools to improve their health and the confidence to know how to use them," said Kentucky Homeplace Director Mace Baker. "No matter what challenges they were facing, this holistic approach to meeting a variety of needs equipped participants with the tools they needed to better manage their health.

A key component of the 30-county program was to provide participants with gas cards to ensure transportation issues did not prevent them from attending health-coaching classes. A year after the program, Kentucky Homeplace reported participants had a 10% reduction in ER visits, a nearly 13% reduction in non-emergency ER visits and a 23% decrease in inpatient admissions. Additionally, hospital inpatient days dropped by more than 27%. WellCare estimates the cost of healthcare for program participants fell by 13.5% – or nearly $2,300 per year.

EXAMPLE

WellCare further analyzed the results of the program by comparing the participants' healthcare service utilization one year pre- and post-interaction and found sizeable reductions in healthcare utilization. Among members with diabetes, ER visits dropped by 16% and hospital admissions were reduced by nearly 29%. Costs fell by 16.9%, or $3,424 per member, per year. Members with both asthma and diabetes showed 22% fewer non-emergency visits to the ER. Reductions were even greater among groups with a variety of chronic conditions like asthma and COPD.

"These findings illustrate two crucial components of better healthcare. One, when people have direct education and support from a trusted healthcare provider, they can better manage their chronic conditions," said Dr. Fran Feltner, health director at the UK Center of Excellence in Rural Health. "Second, sometimes all it takes to make sure a patient makes it to an appointment is a tank of gas. When we can remove barriers like transportation, suddenly healthcare is more accessible."

"We know when people have trouble putting food on their tables or paying their water bill it's difficult to focus on managing their health," said Ben Orris, COO for WellCare of Kentucky. "When we can close those gaps in care – helping people get reliable transportation, healthy food and a safe place to live we can see real progress in health outcomes and lowered healthcare costs."

Each Kentucky Homeplace community health worker is trained as an advocate to provide access to medical, social and environmental services and to deliver education on prevention and disease self-management. Top services received during this partnership with WellCare included free or reduced-cost healthcare, health literacy, food pantry assistance and utility assistance. Over the two-year program, 1,903 WellCare members with chronic diseases also received referrals through WellCare's Community Connections program to more than 9,000 social services ranging from health literacy classes to food pantries to utility assistance programs.

https://www.lanereport.com/117664/2019/10/wellcare-and-kentucky-homeplace-partner-to-remove-barriers-to-healthcare/

Structure

- Brief problem and project descriptions
- Two highlights – quotes or data points
- Photo and Logo
- Contact information
- Program descriptive sections
  - Introduction and Overview
  - Goals and Objectives
  - Intended Participants
  - Community Involvement
  - Program Processes
  - Outcomes or Impact
  - Future Considerations

Kentucky Community Health Workers *Stories of Success*

Your Program name and

LOGO

Overview

Describe the project or grant to which you are discussing.

Problem:

Similar to a "problem statement." describe the issue facing your community.

Program Structure

Please describe your program/project structure. You may include information such as: the type of patients the CHWs see, how you receive referrals, who oversees the program and supervises CHWs, etc.

Project:

An overview of your program in general.

Program Processes

Detail your program process and the role of CHWs.

INSERT YOUR ORGANIZATION'S PHOTO HERE

Contact Information:

Your program name here

Your address here

Phone: (555) 555-5555

Email: program@email.com

Website: www.programwebsite.com

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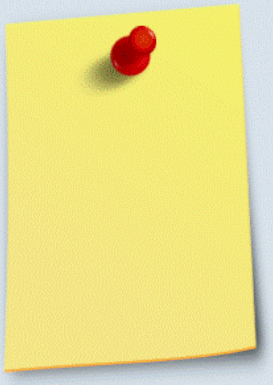
Goals and Objectives

Please include your program's goals and objectives here. Remember that all objectives should be SMART (specific, measurable, attainable, realistic, and time-bound).

Intended Participants

Include information about the intended participants. Does your program focus on one type of patient? For example, your program could focus on adults aged 18 or older who live in a specific zip code and have been to the hospital for a specific chronic condition.



Community Involvement

...Include how the larger community has been or will be involved with your program or project.

Reach and Impact

Similar to a "results" section. Describe your success in reaching goals and objectives described earlier. For example, if one of your objectives was to increase self-efficacy, describe the percentage increase in self-efficacy scores. You may also include financial statistics such as return on investment. Also describe the overall impact of the project.

What's Next

Address the plan for longevity of the program. How will it continue after the grant ends? If this program doesn't pertain to a specific grant, how will you continue to achieve objectives or will you set new ones?

This may also be an appropriate time to discuss how you will address challenges as well.

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Problem:

You may use this space to insert meaningful quotes from CHWs, program staff or program participants.

You may also use this space to insert photos from your project (provided all individuals in the photos have signed your organization's photo release).

You can also use this space to highlight specific statistics related to your goals and objectives.

St. Johnsbury, Vermont, Community Health Team

Problem:

High rates of hypertension, diabetes, and asthma in a fragmented health care system prompted the state of Vermont to create an initiative that addressed chronic disease control and helped to remove barriers by attending to patients' social needs.

Project:

The Community Health Team (CHT) is an integrated group of multidisciplinary practitioners, including community health workers (CHWs), that addresses the spectrum of medical and nonmedical needs of patients with chronic disease conditions.

For more information please contact

Centers for Disease Control and Prevention
1600 Clifton Road NE
Atlanta, GA 30333
Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348
Email: cdcinfo@cdc.gov

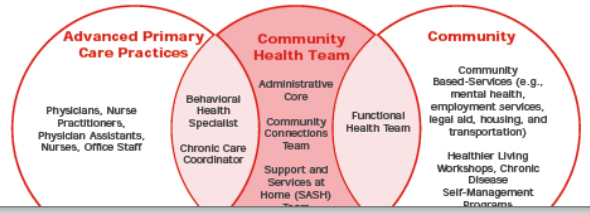
Overview

In 2008, the St. Johnsbury, Vermont, Community Health Team (CHT) was developed with support from the Vermont Blueprint for Health (Blueprint), a state health reform agency. The Blueprint aims to provide seamless coordination of care across a broad range of health and human services that address social determinants of health. Through the CHT model, the Blueprint targets individual, community, and health care system outcomes to improve client well-being, patient health outcomes, and rates of emergency room and inpatient hospital use.

In St. Johnsbury, the CHT model has five components (see Figure 1):

- *Administrative Core*: A program manager provides managerial and programmatic support, as well as oversight. A care integration coordinator is responsible for overseeing CHT components and actively building and sustaining partnerships with community organizations.
- *Advanced Primary Care Practices*: These patient-centered medical homes, recognized by the National Committee for Quality Assurance, are staffed with health care providers, chronic care coordinators, and behavioral health specialists. Working in collaboration with the health care providers, office staff, and other CHT members, chronic care coordinators are responsible for coordinating the care of patients with, or at risk for, chronic conditions. Behavioral health specialists provide short-term, solution-focused therapy.
- *Community Connections Team*: Community Health Workers (CHWs), a cornerstone of the St. Johnsbury CHT model, and the care integration coordinator make up the Community Connections Team. Two CHWs are primarily responsible for linking clients to community-based and local state agencies that provide financial and other tangible resources to meet clients' needs, such as vouchers for heating and transportation assistance. A third CHW, known as the chronic care CHW, provides similar services, but acts primarily as a health coach to improve clients' chronic disease self-management skills. The CHWs are supervised by the care integration coordinator.
- *Functional Health Team*: The Functional Health Team includes approximately 30 community partners that provide a variety of services such as legal aid, housing, and transportation.
- *Support and Services at Home (SASH)*: In SASH, members of the CHT connect Medicare patients to health and long-term care systems. SASH implements specific interventions that include fall prevention, medication management, control of chronic conditions, and healthy behaviors.

Figure 1. An illustration of the relationship between the St. Johnsbury CHT model core components in the community clinical context.



E X A M P L E

Goals and Objectives

The primary goals and objectives of the CHT are to:

- Optimize patients' experience (including quality, access, and reliability) and engagement.
- Improve the long-term health of the population.
- Reduce (or at least control) health care costs.

As a part of the CHT, the CHWs specifically aim to help meet client social needs so that patients can improve their life conditions, health, and ultimately their well-being.

Intended Participants

The target audience for the program is all members of the community in the hospital service area. Many of the clients referred from the advanced primary care practices to other CHT members have hypertension, diabetes, and asthma—the three chronic diseases targeted by the Blueprint. Clients are referred to the Community Connections Team by staff in the advanced primary care practices through word-of-mouth and from local, state, and community-based agencies.

Progress toward Implementation

The inclusion of CHWs as part of the CHT was unique to the St. Johnsbury site and served as a pilot program in 2008. However, statewide efforts have been initiated to include CHWs on all CHTs. In 2012, the CHT model was further enhanced with the addition of the SASH component.

Community Involvement

The CHT's connection to the community is accomplished through the work of the CHWs. The CHWs help establish and maintain relationships that facilitate community-clinical links. These relationships are forged through the network of community-based organizations that make up the Functional Health Team.

Reach and Impact

Key findings from a comprehensive evaluation of the St. Johnsbury CHT model revealed that:

- As of spring 2012, at least 22,106 unique patients were cared for by the five advanced primary care practices.
- Compared to the overall sample, higher proportions of patients exposed to one CHT component were also exposed to other health team components. This suggests CHT staff successfully work together to coordinate care for their clients.
- Health care providers said that the model provides opportunities to use the short patient encounter timeframe to provide more comprehensive care and allows them to link patients to other CHT members to address a full range of patient needs.
- CHW clients improved in key aspects of well-being targeted by the Community Connections Team, including health insurance, prescription drugs, housing, and health education. CHW clients also reported that they were more aware of and attentive to their overall health after receiving services, suggesting that CHWs can improve the overall health of clients.

Resources:

The CHT provides "wrap-around" services by surrounding patients with all of the different resources and services that they need.

"What's changed since I've started using Community Connections is that when I come in with an issue, I always end up leaving [thinking]—this issue can be dealt with."
—CHW client

https://www.cdc.gov/dhdsp/docs/vt_field_note.pdf

Submitting Success Stories

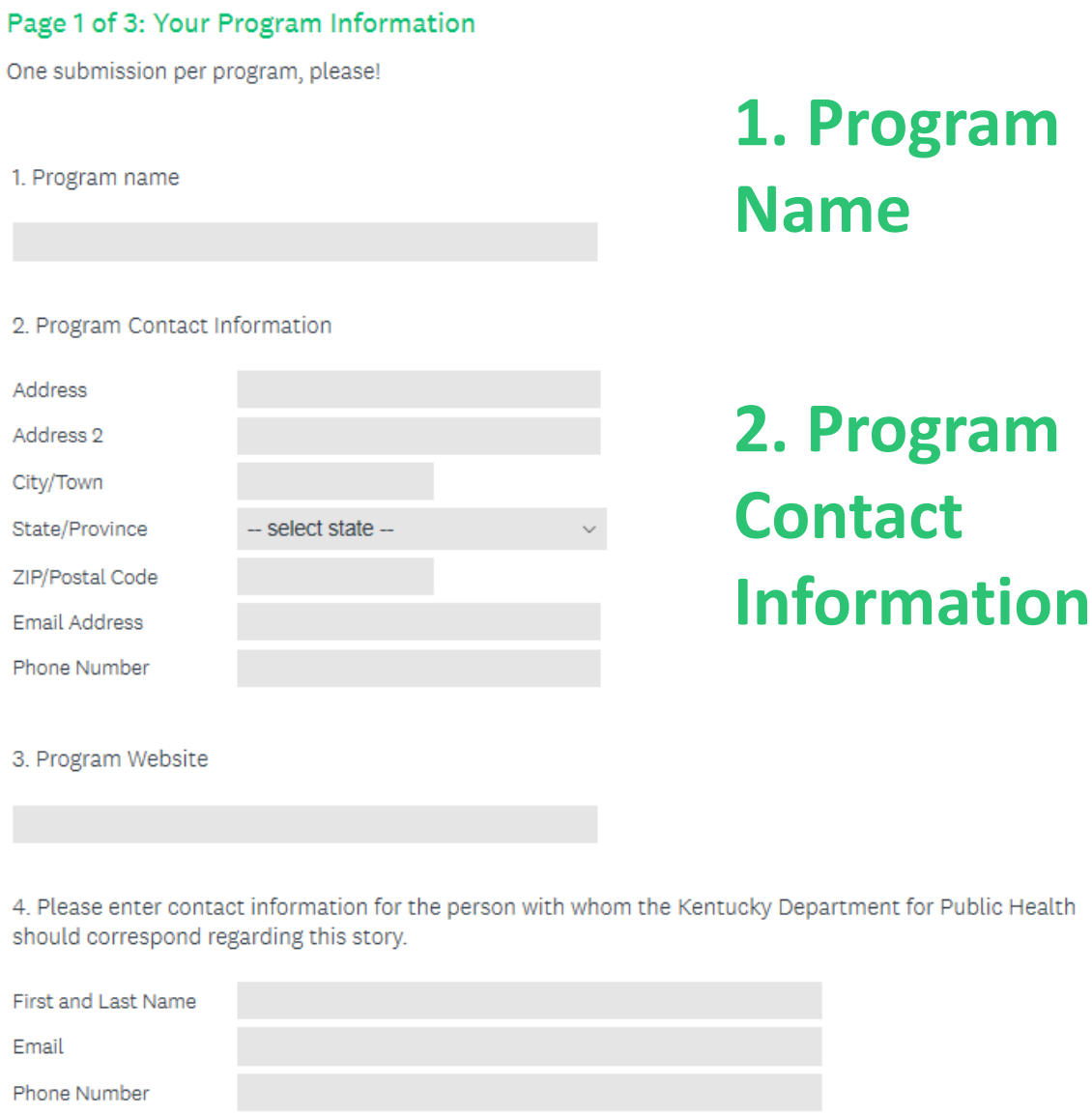
- SurveyMonkey

https://www.surveymonkey.com/r/PMT3RNX

Page 1 of 3: Your Program Information

3. Program Website

4. Contact Person for Your Story



Page 1 of 3: Your Program Information

One submission per program, please!

1. Program name

2. Program Contact Information

Address

Address 2

City/Town

State/Province -- select state --

ZIP/Postal Code

Email Address

Phone Number

3. Program Website

4. Please enter contact information for the person with whom the Kentucky Department for Public Health should correspond regarding this story.

First and Last Name

Email

Phone Number

1. Program Name

2. Program Contact Information

Page 2 of 3: Program Highlights

5. Problem Statement

6. Project Statement

7. Highlight #1

8. Highlight #2

Page 2 of 3: Program Highlights

Please complete the following text boxes and **note the character limit for each response** (utilize Word, Pages, or other software to count characters prior to entering your responses).

5. Problem Statement. Briefly describe the issue facing your community (100-250 characters with spaces).

6. Project Statement. Briefly describe your project that addresses the aforementioned problem (100-250 characters with spaces).

7. Highlight (1 of 2). Enter a quote, result, or data point you would like to highlight (50-250 characters with spaces).

8. Highlight (2 of 2). Enter a quote, result, or data point you would like to highlight (50-250 characters with spaces).

Page 2 of 3: Program Highlights (Logo & Visuals)

9. Program Logo

* 9. Program Logo. Please upload your program logo.

By uploading this file, I give KDPH permission to use it.

Choose File No file chosen

10. Visual #1

* 10. Visual #1. Please upload a photo, figure, chart or other visual to represent your story.

By uploading this file, I give KDPH permission to use it.

Choose File No file chosen

11. Visual #2

* 11. Visual #2. Please upload another photo, figure, chart or other visual to represent your story.

By uploading this file, I give KDPH permission to use it.

Choose File No file chosen

Page 3 of 3: Your Story

12. Program Overview

13. Goals and Objectives

14. Intended Participants

15. Community Involvement

Page 3 of 3: Your Story

Please complete the following comment fields and note that **the total number of characters from all responses on this page ADDED TOGETHER should be between 700-800 with spaces** (utilize Word, Pages, or other software to count your responses prior to entering them here).

12. Program Overview. Introduce your program by describing its history, purpose and background.

13. Program Goals and Objectives. Objectives should be SMART: Specific, Measurable, Action-oriented, Realistic, and Time-bound.

14. Intended Participants. Describe the relevant characteristics of the population your program intends to serve (e.g. poverty level, family structure, environmental concerns, ethnic backgrounds, location, etc).

15. Community Involvement. Describe the services your CHWs provide and how your CHWs interact with the local community.

Page 3 of 3: Your Story

16. Program Processes

* 16. Program Processes. Explain the methods your program uses to attain its goals. This may include: partnerships, policy work, health communication, program management, choosing CHW clients, receiving referrals, data/surveillance, evaluation etc.

17. Outcomes

* 17. Outcomes. Did your program make an impact or reach its goals? Why/how? E.g., describe a percentage increase or decrease in client self-efficacy scores and explain contributing factors.

18. Future Considerations

* 18. Future Considerations. Describe plans for program longevity/sustainability. Address any program challenges/setbacks. Explain how you will achieve current objectives or set new ones.

19. Character Count

* 19. By clicking SUBMIT, I agree that I copied and pasted all of my **responses** from this page (Q12+Q13+Q14+Q15+Q16+Q17+Q18) into the text box below and the total number of characters equals between 4800 and 5500.

Timeline

Submissions Open:

September 15

Close: **OCTOBER 15**

Compile and edit: Fall 2020

Complete: **Early 2021**

Questions?

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Rahel Basse, MPH

Environmental Health and Equity Coordinator

Rahel.Basse@ky.gov

Submissions Open:
SEPTEMBER 15

Close:
OCTOBER 15