Kentucky Public Health
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KENTUCKY COMMUNITY HEALTH WORKER STORIES OF SUCCESS

ISSUE 3 | SUMMER 2023

Community Health Workers (CHWs) have been an integral part of the community in Kentucky since 1994 with the inception of Family Health Advisors at Kentucky Homeplace in Appalachia. In the decades following, many organizations have continued to integrate CHWs into their programs to improve access to care, improve health outcomes and connect clients to needed services. As of 2023, there are over 50 organizations who employ Community Health Workers (CHWs). From Federally Qualified Health Centers, hospitals and universities to Managed Care Organizations to non-profit organizations, Community Health Worker (CHW) programs are as diverse as the communities they serve. CHWs perform deeply impactful work every day. Uniquely situated as trusted members of their community, CHWs are integral to achieving health outcomes and improving community health. This publication was created to highlight the impact of CHWs across the state. We hope that this issue and future issues of this publication will inspire continued support for CHWs across the commonwealth. Please enjoy this sampling of CHW "Stories of Success."

IN THIS ISSUE

THE NUMBERS

227
Certified Community Health Workers

60+
Programs with Certified Community Health Workers

A NOTE FROM THE OFFICE OF COMMUNITY HEALTH WORKERS

Since 2014, the Kentucky Office of Community Health Workers (KOCHW) has been the leading entity to support, strengthen and promote financial sustainability of the Community Health Worker profession across Kentucky. Since then we have achieved many key milestones such as the formation of the CHW Advisory Workgroup in 2014, the official launch of CHW Certification in 2019, receiving the CDC "Community Health Workers for COVID-19 Response and Resilient Communities" grant in 2021, and the start of CHW training organization approval in 2023.

In 2022, Kentucky passed key legislation with House Bill 525, which promoted financial sustainability of the profession through Kentucky Medicaid. Medicaid billing for CHWs in Kentucky officially began on July 1, 2023. The KOCHW is at full capacity, with staff dedicated to CHW Certification, Training, Data and Impact, Engagement, and Integration. The KOCHW provides support, guidance and technical assistance to new and existing CHWs and CHW programs. As we grow, the KOCHW will continue to ensure that our programs and policies are CHW-centered, evidence-based and built upon the input and best practices of Kentucky CHWs. We are incredibly honored to serve and work with CHWs. Together we will continue to elevate the CHW profession and help make our communities healthier places to live, work, play and pray.

Laura Eirich

LAURA EIRICH
OFFICE OF COMMUNITY HEALTH WORKERS ADMINISTRATOR

PENNYROYAL HEALTHCARE SERVICES

Community Medical Clinic

CHALLENGE

Our clinic saw a need for systematically screening patients for social determinants of health needs, particularly older adults

PROJECT

We implemented an SDOH screening for all patients, and using CHWs to outreach to older adults.

CONTACT

Pennyroyal Healthcare Services, INC.
dba Community Medical Clinic
1102 S. Virginia St.
Hopkinsville, KY 42240
eharrison@communitymedicalclinic.org
www.communitymedicalclinic.org

OVERVIEW

Our goal at Community Medical Clinic (CMC) is to not only provide quality medical care, but to treat the whole person. Research has proven there is a correlation between health outcomes and the environment, which is called the Social Determinants of Health (SDoH). Medical care is estimated to account for only 10-20% of healthy outcomes for a population. The other 80-90% of healthy outcomes are attributed to SDoH. Our challenge was determining the best way to collect SDoH data from our patients and community and then targeting the population that was deemed most vulnerable in an effort to have a positive impact. Community Medical Clinic is a full service family practice offering high quality comprehensive care through every phase of life to residents in Princeton, Hopkinsville, Oak Grove and surrounding areas in Southwestern Kentucky. We strive to make a difference in our communities by helping eliminate health care disparities. Our CHW program will help bridge the gaps and empower individuals to have a healthier quality of life.

OBJECTIVE

Our objective was to be able to identify patient SDoH needs, bring awareness of barriers to meeting these needs, and put resources in place to refer to or meet these needs.

COMMUNITY INVOLVEMENT

We work with community partners to ensure the success of our program. In working with seniors, we partner with senior centers and other agencies such as the housing authority, and assisted living facilities.

INTENDED PARTICIPANTS

We are a FQHC, so we see a variety of individuals regardless of their financial status. All patients at CMC participated in SDOH screening,, but the focus was on our older population, as they have the most needs that are not being addressed.

PROGRAM PROCESSES

To enhance our screening, we developed a social needs checklist that is handed out to patients at every appointment. This checklist also includes a COVID screen and a depression screen (PHQ-9). We also developed CHW flyers and cards to distribute in the community. We partnered with local Senior Centers to have monthly activities with our CHWs. Educational activities at Senior Centers regarding health issues, fall risks, relationship issues, and sometimes just fun activities that they enjoy. We also have resources that are available such as BP checks, healthy eating resources, kynectors, HIV tests, etc. at some of our Senior Center visits. We have the seniors fill out the Protocol for Responding to & Assessing

Patients' Assets, Risks & Experience (PRAPARE) lite form at events and connect them to resources available at the event or give them info on how to contact resources. Our CHW flyers are prominently displayed at each Senior Center and staff are aware of our services and can reach out if there is a need.

OUTCOMES

In screening for SDOH, transportation, housing, utility assistance, food and insurance seem to be the top areas of need. Success in meeting these needs depends on making relationships and gaining the trust of individuals. CHWs are the voice of the people who have a need. We have been able to connect many individuals to needed resources and the Senior Center participants look forward to the monthly CHW visits/activity. Senior Center staff have notified our CHWs of the success of their visits. Staff is amazed at how our CHWs have gotten individuals to participate in activities. Several individuals have successfully received resources they were not aware of how to access before this program started.

FUTURE CONSIDERATIONS

We intend to continue our screenings, and expand monthly activities into the Senior Homes in the community. A lesson learned from the project was the importance of developing relationships in order for individuals to be open to disclosing needs that needed to be addressed. Also, having too many resources at an event can be overwhelming, and having just CHWs at an event seems to work better in getting individuals to open up regarding a need. We will continue to expand our resources to help meet the social needs of seniors and all individuals in our community. We have recently purchased a van that will be used for assistance with transportation needs. We will also have a mobile clinic in the coming years which will make healthcare more readily available to individuals that might not otherwise access healthcare.

> *"The CHW has gone above and beyond in an effort to help my mother. It gives me peace of mind knowing the CHW is there."*
>
> - Daughter of patient

SHAWNEE CHRISTIAN HEALTHCARE CENTER

SHAWNEE CHRISTIAN HEALTHCARE CENTER
SERVING GOD, SERVING PEOPLE

CHALLENGE

HIV diagnoses are on the rise in Louisville, with hotspots frequently located in the city's West End. SCHC is in the heart of the Shawnee Neighborhood in West Louisville

PROJECT

Testing, outreach, and education about HIV and PrEP (medication used to prevent HIV) are key components to lowering rates of HIV. With that, SCHC received a grant aimed to employ an HIV Services CHW.

CONTACT

Shawnee Christian Health Center
Lejla Cosic, Community Health Coordinator
234 Amy Avenue
Louisville, KY 40212
https://www.shawneechristianhealthcare.org/

OVERVIEW

Shawnee Christian Health Center (SCHC) is a clinic in the heart of the Shawnee Neighborhood in West Louisville providing medical, mental health, dental, and pharmacy services. In order to address the increasing rates of HIV in Louisville, and specifically the parts of the West End, SCHC works to increase access to prevention, testing, and treatment for HIV, and to raise awareness of HIV in our community. An important tool for HIV prevention is the pre-exposure prophylaxis medication (PrEP), which is taken daily to dramatically lower the risk of contracting HIV. To support these efforts, SCHC received a grant to employ an HIV Services CHW.

OBJECTIVE

Our project aims to utilize a CHW for targeted outreach, education, and testing. Our goals are to:

- Increase awareness of HIV
- Encourage and increase testing
- Reduce stigma
- Provide linkage to HIV care
- Increase awareness of and prescribe PrEP
- Continue targeted outreach

COMMUNITY INVOLVEMENT

Our CHW has partnered with several organizations providing HIV and wraparound services, including the 550 Clinic, which serves people living with HIV and AIDS, Volunteers of America, which provides HIV testing and related services, and syringe exchange sites. Additionally, she works closely with several recovery and transitional houses.

INTENDED PARTICIPANTS

Our program aims to reach all those who may be at risk of HIV in the community, as well as the groups with elevated risk factors, such as injection drug use.

PROGRAM PROCESSES

Meeting people where they are is at the core of engaging more individuals to test for HIV and discuss PrEP. Our CHW is always on the move and boots on the ground. She conducts outreach to encourage individuals to get tested at SCHC to know their status, educate on HIV, testing, and PrEP, and also encourage individuals who may be eligible for PrEP to begin this discussion with our provider. Outreach takes place in more traditional settings, such as tabling events. However, in order to reach the most at risk populations, our outreach extends beyond that to other community sites.

As mentioned, PrEP is a medication that can be taken to prevent HIV. With this grant and our CHW, SCHC is able to provide PrEP through our in-house pharmacy — thus, aiding in eliminating the barrier of having to go to another location for medication. Taking PrEP is more work than most medication. Though it is just a once-a-day pill, it does require routine testing and lab work that can be a burden to patients. For this, our CHW works closely with the patient for navigation of PrEP, compliance, and other concerns. while also working with them for any other social determinants of health barriers the patient may be experiencing.

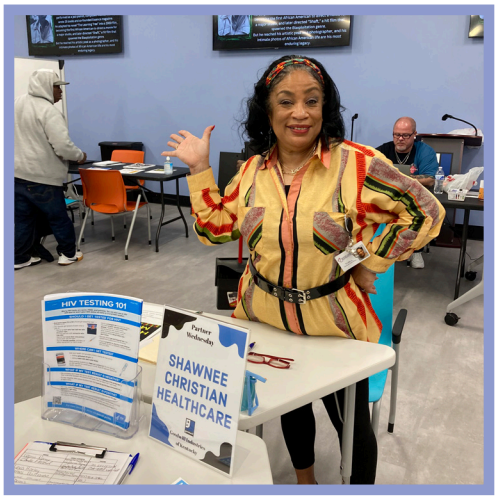
OUTCOMES

Though the number of patients on PrEP is small right now, we expect them to grow as our CHW continues outreach to make sure the community is aware that this even exists.

FUTURE CONSIDERATIONS

Many individuals are not even aware of PrEP or feel they may not be a candidate for it, when in actuality, they are. For this we are working on training for providers, medical assistants, CHWs, and other staff to ensure we are doing better at collecting sensitive information, such as drug use and sexual histories.

“Showing up to make a difference!”



KENTUCKY HOMEPLACE

UNIVERSITY OF KENTUCKY CENTER OF EXCELLENCE IN RURAL HEALTH

Kentucky Homeplace
Community Health Workers Since 1994

CHALLENGE

With high levels of poverty and poor health outcomes, individuals living in Appalachia are expected to live on average 2.4 years less than those living in non-Appalachian states. They also face access issues related to COVID-19 education and vaccination, preventative education and health screenings.

PROJECT

The goal of Appalachian Community Health Days is to intensify efforts at the local level to increase COVID-19 vaccination rates in a 32-county region of Appalachia Kentucky and neighboring counties in West Virginia

CONTACT

University of Kentucky Center of Excellence in Rural Health
750 Morton Blvd.
Hazard, KY 41701
Phone: (606) 439-3557
Email: michaela.amburgey@uky.edu
www.kyruralhealth.org

OVERVIEW

In the early 1990s, many rural Kentuckians were going without health care services, and in particular, preventive care. The Commonwealth's General Assembly took the unique step in 1994 of earmarking taxpayer money to develop one of the first community health worker models, Kentucky Homeplace. The program's beneficiaries are the medically underserved or "the neediest of the needy." Most clients are at 100% - 133% of the federal poverty level.

Homeplace CHWs are employed from the communities they serve and trained as advocates to provide access to medical, social, and environmental services and deliver education on prevention and disease self-management. The mission of Kentucky Homeplace is to provide access to medical, social, and environmental services for the citizens of the Commonwealth with a vision of a healthier Kentucky.

Still, many rural Appalachians are underserved and underinsured. Transportation and lack of insurance coverage are just some of the barriers that many communities face. Communities are often in remote locations and our topographical features make it even more of a challenge for the residents to access healthcare services. COVID-19 intensified these challenges, and clinic closures at the beginning of the pandemic meant that routine preventive screenings fell sharply. The goal of Appalachian Community Health Days (ACHDs) is to intensify efforts at the local level to increase COVID-19 vaccination rates in a 32-county region of Appalachian Kentucky and neighboring counties in West Virginia.

OBJECTIVE

The objectives of the ACHDs were to:

- Vaccinate Appalachian communities
- Provide community outreach
- Increase access and remove barriers to vaccines and prevention information and;
- Provide education and positive messaging to increase vaccine confidence.

COMMUNITY INVOLVEMENT

Within the 30-county service area, many partners came together to educate individuals and families on the importance of vaccines and provide preventative education and access to self-management tools and the vaccine. Each event was different based on community need. Where the event was located was based on who were trusted sources in the community, and were already addressing some of the barriers and providing resources. These agencies were able to help us tailor the events to the community needs.

INTENDED PARTICIPANTS

The ACHD events were intended for the residents of the service area, particularly those with the highest barriers to accessing preventive services.

PROGRAM PROCESSES

Kentucky Homeplace CHWS worked with community partners to coordinate Appalachian Community Health Days. At each event, people received health screenings such as blood pressure checks, diabetes and pre-diabetes screenings, A1C testing, stroke prevention screenings and oxygen level checks. In addition to health screenings and providing access to health care providers, attendees were also given the opportunity to receive COVID-19 and flu vaccinations. The goal of the CHWs will be to work with community partners to increase access to vaccination sites. Education on the importance of COVID-19 vaccinations and conducting outreach activities is key to increasing the vaccination rates in our underserved hard to reach population.

We wanted to help individuals learn about COVID-19 and the vaccine, have an opportunity to ask questions, and then decide if vaccinations were right for them. The goal is to move the people served from vaccine hesitancy to vaccine confidence.

OUTCOMES

Numerous measurable outcomes resulted from the ACHD project.

- 90 events held in the service area
- 2,294 health screenings at the events
- 1,242 vaccines administered
- 3,246 educational sessions
- 26,153 views of the online event calendar
- 631,688 views of the ACHD stories on Facebook
- 3,303,692 digital media impressions (total # of times social media browsers have been shown your content)

FUTURE CONSIDERATIONS

We plan to continue the program by carrying out the remaining ACHD events, and celebrating with our 32 counties on the success they have made toward COVID-19 vaccinations. We will continue to work with our community partners (old and new) to continue these events in the remote rural communities.

As a result of these events, new connections and partnerships were built in the 30 counties in which the events were held. These invaluable connections will enable Kentucky Homeplace and these partners to continue to work together to address the health needs of their communities going forward. Kentucky Homeplace plans to continue annual community health events, pulling together vested agencies with the overall goal of better community health.

The project did encounter challenges, especially because ACHD events hinged largely upon the availability of COVID-19 vaccines. One of the biggest challenges was securing contracts with organizations that could provide enough vaccine on our timeline and could commit resources to travel to remote locations. However, the ACHD team continually adjusted events based on feedback from individuals and community partners to make sure the project was a success. Our model has been recognized by CDC in COVID-19 Vaccination Field Guide Addendum: Rural Considerations for Vaccine Confidence and Uptake Strategies as an effective strategy in rural communities.

> *“My 85-year-old mom got her first COVID-19 vaccination today! Because this was close to home and because she was allowed to stay in the vehicle for the injection, she agreed to go get it. Knowing Darla Shepherd [a Kentucky Homeplace Certified CHW serving Harlan county] organized the event also helped. She spoke over and over of the kindness shown to her. Thank you to Darla and everybody who helped with this for our little community! ”*

JUNIPER HEALTH

CHALLENGE

The launch of our CHW program coincided with the catastrophic flooding in Eastern Kentucky. Many of our service areas were vastly affected by this disaster.

PROJECT

With their unique role, CHWs were available to help with recovery in many ways.

CONTACT

Juniper Health Clinic
1484 Lakeside Drive
Jackson, KY 41339
juniperhealth.org

OVERVIEW

The main challenge our organization faces is lack of available resources in our service areas. Several of Juniper Health's service areas were affected by the historic flooding in July 2022. Our service area in Breathitt County was hit hard by the flood, which destroyed a food pantry and several churches that provided resources to the community. Overall, the natural disaster created a larger need for resources than this area can provide.

OBJECTIVE

Our project's goal was to screen patients for social determinants of health barriers. By incorporating the Protocol for Responding to & Assessing Patients' Assets, Risks & Experience (PRAPARE) screening tool, we were successful with identifying immediate needs and long-term needs.

COMMUNITY INVOLVEMENT

Most of our current community faces these challenges daily. This includes patients, but the lack of resources also affects Certified Community Health Workers (CCHWs) when managing a case.

INTENDED PARTICIPANTS

The intended participants in the program were clinic patients aged 18 or older who identified a barrier on the PRAPARE screening. However, after flooding, the CCHWs went out of the clinic to visit communities affected by the flooding in our service area and assessed immediate barriers to health as well.

PROGRAM PROCESSES

Our program is working and partnering with available local community resources to better serve our patient's needs. We conduct outreach through hosting community events and educational events for the area.

Hosting community and educational events allows us to reach out to more patients and provide them with the resources we do have available.These events also allow us to collect data on what is needed in our area. After collecting this data, we can then reach out to our resources and community to connect them.

This program was completely new to our health center, so it was challenging thinking where to begin. We had to attend a lot of training sessions to learn how we needed to assist people. But our program was soon put on the spot when the flooding in our area occurred. Our CHW program was nowhere near where we wanted it to be but our CCHWs had to jump right in and start assisting flood survivors. They never hesitated to assist and connect with community partners and have not stopped helping others since. As a new program, we

worked to build up our community resource list by reaching out to all partners we knew and gathering information on what they offered. We then compiled a list of available resources to be able to handout to flood survivors and patients.

OUTCOMES

Our program has made an impact on our service areas. After the historic flooding disaster happening in July 2022, our health center and our CCHWs helped flood survivors apply for the disaster recovery grant. This received a lot of response from our service areas and was a great help to everyone who was a recipient. Our program and CCHWs were a great help in connecting flood survivors and other clients to many temporary resources.

FUTURE CONSIDERATIONS

The next step for our project is to increase community outreach. Our program's long term plan is to help increase knowledge of available resources to patients and the community. By reaching this long-term goal we will help eliminate common Social Determinants of Health (SDOH) barriers. We also want to continue building our relationships with community resource partners to better serve our patients and community.

Throughout this project, we learned about resources most people were not aware we had in this area. Our service areas still suffer a huge deficit compared to larger cities, but we will continue to serve our people with what we do have available.

"It's been a pleasure watching this field grow. The pandemic was difficult in numerous ways but it really highlighted the kind of work that a Community Health Worker could do and how important they are to patients."

-Juniper Health Clinic Social Worker

"Working so far as a CCHW has been a rewarding experience and we are here to help anyway we can!"

-Juniper Health Clinic Social Worker

CLOVER FORK CLINIC

CHALLENGE

It can be difficult for rural clinics to meet the needs of their patient populations, particularly older adults and the unhoused.

PROJECT

Clover Fork Clinic identified the need for a CHW, began working towards deploying a CHW in their community, and building trust with these groups.

CONTACT

Clover Fork Clinic
P.O. Box 39
Evarts, KY 40828
cloverforkclinic.org

OVERVIEW

Clover Fork Clinic is a clinic in Eastern Kentucky, a federally qualified health center look-alike (serving the same role as an FQHC but not receiving federal funding). In their service area, clinic leadership was aware of the many social determinants of health impacting their patients and saw many clients with limited incomes, lack of transportation, and insecure housing. These made it difficult to access health care and medications. The size of the clinic's service area also made it difficult to address these patient needs.

OBJECTIVE

Previously, the clinic had set an objective of learning about the social determinants of health needs of their patient population, partnering with The Kentucky Regional Extension Center at the University of Kentucky and Medicare. From the statistics gathered by Clover Fork staff, the need for assistance for clients outside the clinic became clear, and the clinic set its objective to hire a community health worker. In June 2022, they were able to hire their first CHW through CDC 2109 funds, and the clinic's objective became to deploy the CHW to help the most vulnerable in their patient population.

COMMUNITY INVOLVEMENT

The clinic developed relationships with many local service organizations and partners to establish their CHW program. However, the program recognized that it could be difficult for community members to communicate their needs. As staff noted, "we also faced the challenge of getting clients to verbalize a need and open up to us," but that, "they are learning to trust our CHW".

INTENDED PARTICIPANTS

All clinic patients are screened for social needs, and the CHW program was intended to be available to clinic patients and community members. However, clinic staff identified the elderly and unhoused populations in the area to be most vulnerable, and particularly in need of one-on-one assistance.

PROGRAM PROCESSES

The new CHW worked with many community partners to establish the program in the community. One such organization was the local homeless shelter, Christ's Hands. The shelter also hosts monthly clothing and food distribution. The CHW has assessed that many people served by the organization were uninsured, and the team planned to do enrollment outreach at the next distribution date, and to provide flu shots at the event. This addressed both insurance barriers and transportation. The CHW described the event as "a good opportunity to get out into our community and meet the people where they are." The CHW, CHW

Supervisor, and nurse manager also distributed informational materials about COVID-19, CHW services, and other local resources. The event allowed them to reach out to new clients and build trust and awareness in the community. The event allowed them to reach out to new clients and build trust and awareness in the community.

OUTCOMES

At their first outreach to Christ's Hands, they were able to administer five flu shots, but were also able to reach out to 70-100 people with information and established a relationship to continue in the future.

FUTURE CONSIDERATIONS

The program's initial outreach activities have continued and grown, and the team has learned successful strategies along the way. This includes going to where people gather, and taking seasonal variations into account. They also learned about the need to be persistent with partners and finding the right person in the organization to work with when holding new outreach events.

CHI SAINT JOSEPH HEALTH

OVERVIEW

CHI Saint Joseph Health recognizes that timely access to quality health care is critical to quality of life, yet the health care delivery system drives only 20% of health outcomes. Social determinants of health play a much larger role in overall health. Since 2017, CHI Saint Joseph Health has been working to better meet patient needs related to the social determinants of health.

CHI partnered with Total Health Roadmap (THRM), Common Spirit Health and the Robert Wood Johnson Foundation to begin out CHW program, piloting a screening and referral system for social needs in primary care. Starting with three pilot clinics in 2017, located in rural areas of the state, the CHW program has grown to eight CHWs working across primary care clinics, behavioral health clinics, and a high-risk OB/GYN practice. Our model is based on universal screening and referral: anyone who seeks care in these clinics, can access a community health worker for support, regardless of health insurance status.

OBJECTIVE

The goal of the program is proactive transformation of care delivery and engagement in cross-sector partnerships to address social needs and improve the health and wellbeing of the communities we serve. Our objectives are to 1.) sustain and disseminate universal screening and referral for social needs across CHI Saint Joseph Heath in the coming 3 years, and 2.) advance two cross-sector community partnerships to close gaps and improve access to resources and programs that address food security and housing needs in the next three years.

INTENDED PARTICIPANTS

For the sake of all patients, the Total Health Roadmap specialty integrates screenings for basic human needs into our primary care settings along with specialty clinics. These needs represent a range of physical, social and psychological conditions such as availability of food and safe housing, transportation, quality childcare, access to behavioral health service, and social support. All patients are offered the questionnaire at their clinic visit, if a CHW is located in the clinic. We never determine who is “in need.” Anyone regardless of their income, family situation, location, or other demographics can ask and receive assistance from a CHW.

PROGRAM PROCESSES

Since our program’s inception we have tracked the number of patients screened, those who identify a need, the number of needs, assistance requests, and if the resources given met their needs. Staff give a questionnaire to all patients in the clinics with CHWs, no matter their income level, family, environmental concerns, demographic or location. As a result, the CHW program saw not only

CHALLENGE

It can be difficult to help medical staff understand the role CHWs play as part of the care team. CHWs’ ability to collaborate with staff and partner with a patient can prevent staff some frustration and make a difference in getting someone the help they need.

PROJECT

CHI Saint Joseph Health has integrated universal screening for social needs into four primary care clinics, two specialty clinics and one pediatric clinic. Patients are assisted by community health workers who work alongside providers, nurses and other staff to find resources that meet their social needs.

CONTACT

CHI Saint Joseph Health
Total Health Roadmap (THRM)
1401 Harrodsburg Rd, Building A,
Suite 410
Lexington KY 40504
https://www.chisaintjosephhealth.org/

the Medicaid population but other patients who had commercial insurance, Medicare or self-pay that were in need of assistance with food, utilities, transportation, etc. Over the course of the program, we have changed the questionnaire to benefit the needs that the CHWs were addressing, such as vision, dental, child care, and adult day care services.

One question on our screener addressed safety concerns, reading, "are you worried about your physical or emotional safety where you currently live?" We felt the wording of the question needed to be changed to have a better way of addressing the need and changed to "Do you often feel alone?"

OUTCOMES

The Total Health Roadmap (THRM) is making an impact in our communities and with our patients by building trust and a relationship with the CHW. Noteworthy CHW outcomes include:

- Partnering with Mountain Outreach and University of Cumberlands to build a home for a family in need,
- Partnering with Kentucky Prescription Assistance Program to identify sources of free and low-cost medications offered by pharmaceutical companies,
- Partnering with the clinics to reach out to patients who miss appointments to understand and address barriers, such as transportation.

In our recent tracking of overdue diabetic eye exams, one clinic with a CHW significantly stands out after seeing a drop in incomplete diabetic eye exams from 78% incomplete in April 2021 to only 16% in December 2022.

2022 IDENTIFIED PATIENT NEEDS

Behavioral Health | 10%
Medication Assistance | 9.5%
Hearing Care | 3.5%
Dental Care | 9.8%
Vision Care | 6.4%
Utilities | 8.6%
Food | 17.2%
Commodities | 5.1%
Literacy | 7.5%
Loneliness | 8.8%
Transportation | 7.5%

FUTURE CONSIDERATIONS

Our next steps are seeking funding to expand the Total Health Roadmap to three other locations including an OB/GYN clinic, Express Care Clinic and emergency department, for a total of eleven CHWs in ten CHI Saint Joseph Health sites for fiscal year 2023. We continue to be guided by our mission to build healthier communities and deliver exceptional patient care for everyone, especially those who are most vulnerable. We are also examining the value of improvements in patient confidence and satisfaction, as well as provider satisfaction and retention. Our new EMR system collects SDoH data along with electronically referring patients to community-based organizations. Our next objective is to track this data for needs being met as a result of these referrals.

Through the time with COVID-19, we have found that our strong connections to community organizations has helped the CHWs find resources, even when things were essentially closed. CHWs need to continually explore resources and build connections in the community, volunteer with partner organizations to see how they operate, and explore new partnerships to see what these organizations have to offer patients.

BLUEGRASS COMMUNITY HEALTH CENTER

BLUEGRASS COMMUNITY HEALTH CENTER

Better Health, Better Life

CHALLENGE

Food security is common in our community, but is often a hidden problem

PROJECT

Our health center engaged staff and CHWs to screen patients for food insecurity, and to begin distributing food from community partners.

CONTACT

Bluegrass Community Health Center
1306 Versailles Road
Suite 120
Lexington, KY 40504
Phone: (859) 259-2635
https://bchcky.com/

OVERVIEW

Food insecurity, or the lack of access to food for a healthy life, is associated with adverse health and social outcomes. Risk factors associated with food insecurity include unemployment, income shock, and poverty. According to a University of Kentucky study, 32.1% of households with income below the federal poverty line face food insecurity. Food insecurity is more common in both larger cities and rural areas than suburban areas, and disproportionately affects Black and Hispanic households. Fayette County has not been spared from the growing food insecurity in the community, with 15.3% of residents being food insecure. Interventions can reduce food insecurity, such as regular screening for nutrition needs, and participating in food assistance programs.

The CHW program at Bluegrass Community Health Center began in spring 2022 to identify the needs of our patients and grow community engagement for the eight communities we serve. We have an outreach team and care coordinators but multiple aspects overlapped, and became overwhelming for these staff. It became clear that a CHW could help bridge gaps within our growing organization. We initially had difficulty finding CHWs to support the two groups we wanted to target: refugee and Hispanic communities. After many interviews and support from other CHWs programs, we found two strong CHWs, Gloria Hehl and Francine Namegabe. With CHWs in place, we identified food insecurity as a focus area.

OBJECTIVE

The objective of our program was to find reliable food sources to provide to patients. Staff would assess food insecurities during triage and other patients encounters by asking the patient if they had run out of food recently, or if they worried about running out of food and not having the money to purchase more. Staff would also count food boxes distributed weekly, and evaluate the need for additional services.

COMMUNITY INVOLVEMENT

We reached out to community partners including Campus Kitchen and God's Pantry food banks, who became important collaborators on this project.

PROGRAM PROCESSES

After setting our goal to increase screening for food insecurity and connect our patients in need with resources to improve food stability, we faced challenges such as difficulty finding locations to donate and proper storage at our facilities.God's Pantry initially offered to sell us boxes at discounted prices, and after 4 months of this service, they offered these for free and refunded us from the previously ordered boxes, allowing us to increase the amount of boxes we can distribute. We also spoke with Campus Kitchen, affiliated with

the University of Kentucky. While they have access to food donations, it is not a consistent source and a majority of the food is fresh and does not allow for long term storage.

We started off with 10 boxes a month from God's Pantry and received intermittent donations from other sources. When this project was first started, we had boxes left over each month. After announcing and promoting more in the clinic, it soon became popular to distribute these among patients, and we quickly started running out. At that point we decided to reach out to more options in the community for donations. Now we are getting donations from Jif and soon will start receiving them from a local church. We also noticed that some of the food from God's Pantry was not culturally appropriate for international patients. We utilized volunteers to help us collect appropriate foods such as beans, rice, and lentils.

FAYETTE COUNTY

15% Food Insecurity Rate

48,330
Food Insecure Population

OUTCOMES

Since this project started in late August, BCHC has provided food boxes to 74 patients. The feedback we received from recipients was positive. They appreciated having the food and were able to provide 2-3 days' worth of food to the household. This is a small amount, but impactful for each patient.

FUTURE CONSIDERATIONS

Our future plan for this project is to continue to search for food supply options. We are offering the food boxes during our group sessions and plan to offer them during outreach events. We want to follow-up with those who screened positive for food insecurity after 30 and 60 days to ensure that they are still receiving the food that they need. We educate those who received the boxes that they can come back and get more, but want to reach out to them to ensure they continue to participate in the program. Our goal is to increase the amount and selection of food by engaging more volunteers, and by starting a community garden. We have learned that we must screen everyone for food insecurity and that we can't assume the patient will ask for help. We also learned that there are sources of food in the community, it just takes time and dedication to find them.

Sources: Feeding America; Overall (all ages) Hunger & Poverty in Kentucky | Map the Meal Gap (feedingamerica.org)
USDA; USDA ERS - Charts of Note

BLOUNT RURAL HEALTH CENTER

BLOUNT
RURAL HEALTH CENTER

CHALLENGE

Food insecurity is an ongoing challenge in rural Kentucky.

PROJECT

An outreach approach using existing social networks increased food donations to help meet the needs of clients in need of nutrition assistance.

CONTACT

Anita Jo Powell, RN, CRHCP
Executive Director
Blount Rural Health Center
810 S Main St
P.O. Box 277
Elkton, KY 42220
(270) 265-5600
anitapowell@blountrhc.org

OVERVIEW

From its beginnings, Blount Rural Health Center (RHC) in Elkton, Kentucky - a small town location in Todd County, in the rural western part of the state - has shown resilience and creativity to meet the needs of the local community. The county in which it operates has 12,500 residents and lacks many of the resources available to larger population centers. This program was established in 1999 as a free clinic to serve the populations of uninsured people and migrant workers in the area. Much of their support came from charitable gambling - staff and volunteers ran twice weekly bingo nights to raise the funds to provide for community medical needs. Over the years, the clinic took advantage of new opportunities and funding sources to expand services, such as pursuing designation as a rural health center, and becoming one of the first RHCs in the state to offer dental services. Another new opportunity was funding for community health workers (CHWs) through the 2109 Centers for Disease Control and Prevention (CDC) Grant.

OBJECTIVE

As a new CHW program, Blount Rural Health Center set their objectives to better understand their community's needs outside the clinic and to find ways to address them.

PROGRAM PROCESSES

While the CHW program was new to Blount, the approach to working to address the holistic needs in the community was familiar. The program identified challenges that are a common theme among CHW programs around the state and has developed creative and locally specific approaches to addressing them.

As the CHWs at Blount RHC allowed the organization to reach out further into their rural communities, one of the key challenges they identified was the lack of transportation in the region, aside from non-emergency medical transport available to some eligible Medicaid enrollees. In response, the clinic made the decision to invest in a van and to pay for insurance that allows them to use it to transport clients to appointments at the health center or to accompany clients to referral appointment. This also made it easier for CHWs to travel to home visits and community events. Blount's community health worker program also found creative avenues for promoting program services, reaching people around the county through billboards, radio ads, and sandwich boards at community events, posing the simple prompt "Ask me how I can help!" They have also created awareness through an active social media presence. As knowledge of the CHW program grows, they receive more questions and requests for assistance.

Food insecurity is a common problem, and one that some clients may be hesitant to share without first developing trust. The CHWs work with local food banks to ensure that their clients have access to healthy food and distribute information

about their services at the food pantries to help reach new clients. However, sometimes specific nutrition needs can't be easily filled. One such patient had a medical treatment that required her to maintain a specific weight threshold. Her doctors would stop her treatment if she didn't maintain her weight. However, this required supplemental nutrition that was not affordable. Without disclosing sensitive information, the CHW team took to local social media groups and other channels to share the need for supplemental nutrition and received an overwhelming response from community members and local groups, ensuring a secure supply of specialty food for the client, and reserving stock for the clinic to help meet future needs.

Through their ongoing partnership, they recognized that the food bank run by a local church was unable to meet the needs of local families during the holidays, especially when many families were struggling economically. To supplement donations provided by the church's congregation, they used their social media network to post about the need for food donations, dramatically increasing the food available for distribution at this critical time.

OUTCOMES

Early lessons for Blount's CHW program center around the need to find the right CHW's who are resourceful problem solvers and willing to engage with the community. The CHWs continue to find creative ways to tap into existing resources, and to highlight inequities in order to improve the health and well-being of those they serve.

> *"You know, a lot of times when a patient goes to the doctor's office, they don't open up and tell them all the things that are keeping them from staying healthy. You know, some people are too prideful to say, 'I don't have the money to buy my medications', or 'I don't have the money to get to my appointments every so many months."*
>
> -Anita Powell, Executive Director

A+ FAMILY HEALTHCARE

CHALLENGE

Underserved rural communities have many challenges related to health.

PROJECT

Building a CHW program to meet the needs of the community.

CONTACT

A+ Family Healthcare
210 South Main Street
Suite 101
Brownsville, KY 42210
Phone: 270-975-4050
https://www.aplushealth.org

OVERVIEW

A Plus Family HealthCare opened its doors on November, 17, 2017 with the goal to serve an underserved rural community with very limited resources. Operating an entire facility with only two support staff and one nurse practitioner was a task. However, driven with the goal to be community strong prevailed and in September 2019 A Plus Family HealthCare became the only non-profit Federally Qualified Health Center in Edmonson County. Within three years, our staff had grown to 50 strong and the organization grew to include seven sites. These sites included the first ever school-based facilities in Edmonson County history, working to provide much needed health care to every child in our schools who often don't have resources for care. Programs within our health center grew rapidly, and in 2022 A Plus Family HealthCare partnered with the Kentucky Primary Care Association and the Kentucky Office of Community Health Workers to employ Certified Community Health Workers (CCHWS), another first for Edmonson and Larue Counties.

OBJECTIVE

The objective of the overall program in the last eight months was to build a strong CHW program that is responsive to emerging needs in our community.

COMMUNITY INVOLVEMENT

A major concern of community involvement was observing the documented needs of our patient population, and the health status and needs in our county. We also built relationships with non-profits and institutions (such as the local health department and school system) in our region to build our program and bridge gaps in health and health care access.

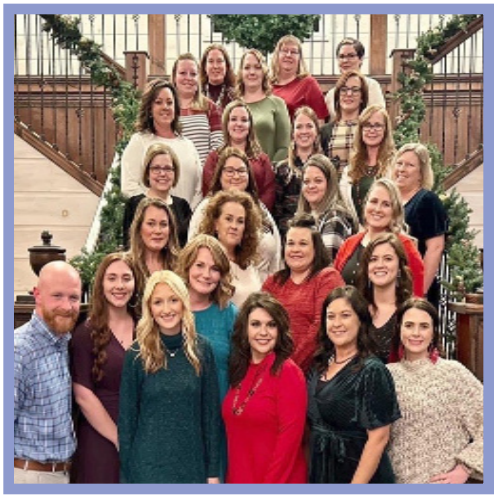
INTENDED PARTICIPANTS

Our intended participants were the population of our regions, including our patients, and others in need. Populations of special concern include the uninsured, elderly adults, and those with disabilities.

PROGRAM PROCESSES

With a large portion of uninsured and underinsured patients in our service area, there was a tremendous push to include eligibility assistance inside of our facilities to break down financial barriers to care. The ability to assess and screen socio-economic barriers as well as the ability of community health workers to lend support to our clinical staff by alleviating barriers of healthcare for our patients was a tremendous leap for our program. A Plus Family HealthCare truly believes that preventative care plays a major role in reduction of emergency room visits and chronic condition improvement, which in the past has been sorely lacking inside of our service areas. With the addition of our CCHWs, our

facilities have been able to partner with outside resources to advance assistance for our patients and entire community. Building much needed relationships with Feeding America and St. Johns Food Pantry we are able to serve 400 families in our service area that face food insecurities as well as provide on-site prepackaged food.



OUTCOMES

Our CCHWs change the way patients see healthcare. The importance of involving patients in their healthcare outcomes make patients feel comfortable and genuinely cared for. From helping hearing-impaired patients gain access to free hearing-impaired home and cell phones to helping a refugee who was extremely ill afford health care and free health supplies and emergency Medicaid services, to encouraging victims of domestic abuse to seek shelter, and to connection patients who can't afford much needed prescriptions, our CCHWs have many success stories. Making a difference in the health and overall well-being of each patient is a shared goal and vision of our CHW program.

FUTURE CONSIDERATIONS

The future of our program focuses on expanding the programs we have already initiated as well as create quality improvement plans using the Plan Do Study Act (PDSA) model to lower the non-compliance rate of diabetic patients in our area by healthy eating habits, informal education, and medication/supply assistance. Our goal is to change the way patients see health care and to focus on involving patients in their health outcomes. The amount of growth this program has achieved in 8 months is staggering. We can't wait to see what the future holds for our CHW program.

FAIRVIEW COMMUNITY HEALTH CENTER

OVERVIEW

Fairview is a Federally Qualified Health Center and serves as the safety net provider in the Bowling Green/Warren County area. Bowling Green has experienced a lot of growth over the last few years, from both a population and economic standpoint. In the 2022 federal fiscal year, the International Center resettled 826 refugees, and a majority of those new arrivals received medical care.

Here at Fairview Community Health Center, our population's needs are unique and require individualized attention. With our very diverse and vulnerable patient population, we needed to implement the same universal screening process throughout all areas of our clinic to ensure that everyone had the same opportunity to have their needs addressed.

OBJECTIVE

Our prenatal patients have been universally screened since 2019 by a Social Worker already on staff, with a focus on those high-risk for social or medical reasons. The form used both then and now is the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE). Three Community Health Workers were added Summer 2022, which has dramatically increased the number of screenings completed and patients being linked to assistance.

COMMUNITY INVOLVEMENT

With the official development of our CHW program, they have become involved in multiple community events and committees, which has helped promote their outreach, and education efforts. This includes working with Managed Care Organization (MCO) Representatives, Family Resource Youth Service Centers (FRYSC), and staff at other Community Health Centers across the region.

INTENDED PARTICIPANTS

The target has been focused on our new patients entering into care, however, a patient can be referred to a CHW at any time, by anyone. Even if a patient is referred to a CHW by a provider for a specific reason, a full screening will always take place to ensure no other needs are missed.

PROGRAM PROCESSES

The success of the implementation of our CHW program depended upon other employees, providers, our administrative team, patients, and community partners. Our community partners have played an integral role for not only our CHWs but also for our patients. We have had a strong relationship with the International Center and Barren River District Health Department.

CHALLENGE

Bowling Green has experienced rapid growth, including in its international community, but it is also recovering from tornadoes that affected the area in December 2021

PROJECT

The expansion of CHWs has helped reach newly arrived immigrant communities to promote health and meet social needs

CONTACT

225 Natchez Trace Ave., Bowling Green, KY 42103
Phone: (270) 783-3573
Fax: (270) 783-4081
fairviewcommunityhealth.org

A case worker with the Center periodically hosts us to teach us a cultural orientation class on the purpose of a PCP, when to visit the ER, and car seat safety to their new arrivals. An MNT Nutritionist II at the Health Department facilitates WIC enrollment for our new prenatal patients at the same time as their new OB visit, which is allowing quicker access to their benefits. This is extremely helpful for those that are experiencing food insecurity, have a language barrier, or don't have consistent contact information and are not able to be reached otherwise.

> *"It's been a pleasure watching this field grow. The pandemic was difficult in numerous ways but it really highlighted the kind of work that a Community Health Worker could do and how important they are to patients."*
>
> -Clinic Social Worker

Bowling Green was already in the midst of an affordable housing crisis before the tornadoes hit in December 2021. That strain was increased as over 500 families lost their homes. However, in the aftermath we were all witness to the kind of work that can happen when a community rallies together to support each other. There were endless amounts of donations, schools being used as shelter, and companies were stepping forward ready to help their employees in any way that they needed.

OUTCOMES

1,466 patients total have been screened via PRAPARE, and over half (780) of those patients identified their country of origin as being outside of the United States. Thanks to in-house, telephonic, and visual interpretation services, our clinic has thrived at handling the increased volume of refugee and immigrant patients. One priority of our CHW program is to bring additional community partners/their services to the clinic that our patients, including those where English is not their first language, would benefit from.

FUTURE CONSIDERATIONS

Two of our CHW's have been trained as Certified Application Counselors, giving patients the ability to apply for state benefits such as Medicaid coverage in-house. This has been a huge advantage as it allows for families to quickly add their newborn child onto their case while they're already here for an appointment.

Our Family Practice and Pediatric CHW's are also bilingual, which has really helped disseminate medical information from trusted members of the community. As shared by one of our CHW's, "After a few days of resettlement in Bowling Green, KY, our home got hit by a tornado. Later on, we were displaced at a hotel for more than 15 days. It was a tragedy but also a funny moment for us as we had left Kabul for war or conflict and got hit by the tornado. Often in our life we feel down and slumping, but we can never give up". As our CHW program continues to expand, so will the number of patients screened, thereby ensuring every patient has access to the services they need.

> *"Having someone that can directly answer a patient's question about transportation, insurance, or food assistance is a huge help. It allows me to focus on the patient's medical issues at hand and for us to collaborate directly when necessary."*
>
> -Provider

FAMILY HEALTH CENTERS, INC.

CHALLENGE

Louisville's large Latinx population has many needs and challenges when using the health care system.

PROJECT

Family Health Centers, Inc., contracted with La Casita Center, a grassroots community organization, to hire a bilingual Spanish-English CHW to assist both agencies to better serve the Latinx community.

CONTACT

Family Health Centers - Americana
4805 Southside Dr.
Louisville, KY 40214
eaedghill@fhclouisville.org
fhclouisville.org
lacasitacenter.org

OVERVIEW

Family Health Centers, Inc., is a federally qualified health center (FQHCs) with 10 locations serving Jefferson County, including many patients from diverse international backgrounds. To recognize the needs of patients with limited English proficiency (LEP), high uninsured rate, and lack of familiarity with the US healthcare system, FHC started its CHW program in 2017, mainly serving community members from East and Central Africa. Generally, the CHWs work out of a primary care setting and help clients set health-related goals and to overcome barriers to wellness. However, while FHC had refugee-focused CHWs on staff, there was no Spanish speaking CHW who could outreach to Louisville's sizable Latinx community.

While a large percentage of FHC's patient encounters are with Spanish speakers, and while FHC has always offered high-quality, affordable health care to all, regardless of insurance, income, or immigration status, building trust with some of our community's most vulnerable residents can be difficult. La Casita Center (LCC) in Louisville is an organization long embedded in the Latinx community, and familiar with their unique needs and strengths within this group.

LCC increased health empowerment work during the pandemic, alongside their other services, but had no CHW position and no direct access to FHC's medical, pharmacy, and dental services. Our two agencies collaborated regularly, particularly around COVID-19 testing and vaccination efforts, but we lacked clear and efficient communication and referral systems that would benefit our shared clients.

OBJECTIVE

The overall objective of our project was to pilot having a CHW entrenched in both FHC, an FQHC with a health care focus, and in LCC, a grassroots community organization, to optimize interagency communication pathways and to empower families in Louisville's Latinx community. This pilot project is centered around the goal of improving healthcare and social service access so that it is more inclusive and equitable for our shared accompaniments.

COMMUNITY INVOLVEMENT

The project was based on FHC's long history serving the Latinx community and on the deep and respected place in the community held by LCC. Together, there is shared knowledge of gaps in services, both in healthcare and other domains of the social determinants of health.

INTENDED PARTICIPANTS

Given the large and rapidly growing Latinx population with the need for services, the project narrowed its focus to clients facing the greatest challenges. This includes individuals without health care coverage, those who are medically

fragile, and those navigating complex health challenges. During this initial project period, a new category of clients of focus emerged: uninsured pregnant women.

PROGRAM PROCESSES

The project's objective was to contract with LCC to hire a bilingual Spanish-English CHW who could link the agencies more closely together and facilitate information sharing, interagency referrals, and trust-building among community members for both organizations. To link these two different kinds of organizations, the first steps were to enter an agreement, including a contract, and memorandum of understanding and Business Associate Agreement (BAA) to outline responsibilities, data sharing and HIPAA compliance, supervision, and financial considerations. FHC and LCC staff members would jointly supervise the CHW.

LCC did the initial work of outreach to identify the right candidate, so that the CHW be part of their grassroots efforts and would be seen foremost as a trusted member of the community. Ismara Lopez was hired and began her work in June 2022, completing CHW training and receiving mentorship from the FHC CHWs, as well as well as LCC staff. In her work, she is able to link clients back and forth between the two organizations seamlessly.

An important program development came from a large number of CHW referrals for uninsured pregnant women. Many uninsured women in the Latinx community have been foregoing early prenatal care, hearing that they can get Medicaid at the end of pregnancy, but not understanding that affordable care still exists at places like FHC and that early entry into care has positive health impacts.

The goal now is to help them establish prenatal care at FHC and still help them carefully time applications for Presumptive Eligibility Medicaid so that it will cover late-term specialty visits, ultrasounds, etc. These women need navigational assistance with transitions to OB care outside of FHC, and then need to be linked back to FHC for follow-up care and getting the newborn established with a healthcare provider too. The CHW can help them prepare for the baby, seek out baby supplies, and can offer education so that they feel prepared to parent here in the U.S.

OUTCOMES

In the initial pilot of the program, we feel like we have made good progress in terms of recruiting a CHW who is a perfect fit for this unique role. She has completed her training and certification and is continually open to new training opportunities, such as a recent car seat safety training so that she can share the information with her community and assist FHC's Health Educators when they install car seats for Latinx families. She has assisted many clients and has earned respect as a key team member both at FHC and LCC.In her first six months, Ismara has supported 409 people over 1,006 service encounters, and made 100 referrals. The top five referral categories were for medical care, legal services, food pantries, DCBS, and prenatal and childcare.

FUTURE CONSIDERATIONS

We continue to take steps to integrate the CHW into the care team at FHC, which has meant working to provide her with access to the Electronic Health Record System, rather than having to rely on the other CHWs who have access through their direct employment by FHC. She will also be conducting more outreach focused on prenatal patients in the next phase of the project and doing individual and small group education sessions around healthy pregnancy and parenting. We are setting new objectives around helping pregnant women from the Latinx community enter into prenatal care within their first trimester. FHC has a Population Health Department working toward that goal, and we plan for Ismara to meet with and assist them more regularly. On the LCC side, she will reinforce health education with their Health Empowerment Coordinator via their robust social media outreach and through in-person events.

PRIMARY PLUS

PrimaryPlus
www.primaryplus.net

CHALLENGE

Meeting the needs of rural patients in low-income counties requires attention to the social determinants of health, which are often outside the scope of clinics already stretched to provide clinical care.

PROJECT

To better screen for social determinant of health needs and integrate new CHWs into the clinic workflow, Primary Plus built the PREPARE lite screener into their EMR system.

CONTACT

Brooke Perkins, CCHW
CHW Director, Primary Plus
PO Box 550
Vanceburg, KY 41170
PerkinsB@primaryplus.net
www.primaryplus.net

OVERVIEW

Meeting the needs of rural patients in low-income counties requires attention to the social determinants of poor health outcomes, which are often outside the scope of clinics already stretched to provide clinical care. The PrimaryPlus network operates a clinic in eight counties in the Eastern part of the Ohio River Valley. The network has expanded over the years to include services such as maternal and child health, behavioral health, dental clinics, and on-site pharmacies to meet the needs of their communities. In some counties in which they operate, they are the only health care provider.

With a history of working innovatively to respond to community needs, it was easy for PrimaryPlus to see the benefits of having CHWs when the funding became available as part of the 2109 CCR grant. Adding trained and certified CHWs operating within the clinic network offered a specialized approach to the previous adhoc teams of providers, case managers, referral clerks, and others that emerged whenever a client had underlying needs that impacted their health care. PrimaryPlus hired five community health workers, with each working between two of the network's clinic sites, and in surrounding community settings.

OBJECTIVE

As with other new CHW programs, PrimaryPlus had to grapple with ways to integrate CHWs into their workflow, without unduly burdening existing clinic staff. They also needed to find ways for staff to take advantage of the unique services of CHWs within and outside the clinic walls, without overtaxing the new employees as they learned their role. The CHW program team prioritized three objectives 1) ensuring the connection of CHWs to new clients and 2) integrating CHWs into the busy clinic workflow with minimal new demands on providers and other staff, and 3) integrating the PRAPARE lite questionnaire into the clinic intake process, to assess social needs of patients that could impact their health

COMMUNITY INVOLVEMENT

As the CHWs became more comfortable in their roles, they started reaching out to the community by way of community events. The CHWs are involved with their County Schools, County Interagency Collations, and Health Collations just to mention a few. Just recently, two of the PrimaryPlus CHWs became Certified Youth Mental Health First Aid Instructors and will be offering the courses. Our communities have been very receptive to the PrimaryPlus CHWs.

INTENDED PARTICIPANTS

At the very beginning of the program, the primary focus was on new patients to the clinics, but now we have expanded to include Medicare Annual Visits, Annual Exams for both primary care and women's health, and all initial obstetrical visits.

PROGRAM PROCESSES

In starting their CHW program, the PrimaryPlus team saw that some of the PRAPARE questions were already asked in their existing Electronic Medical Record (EMR) and added the remaining questions to intake forms filled out by clients when they met with CHWs for the first time after being referred by clinical providers. However, as the program grew, the team identified a need to streamline the process. They worked with the clinic administration and EMR developers to create an interface that embedded PRAPARE into new patient paperwork. New patients for any of the clinics in any department receive a link to fill out forms electronically at home, or in the office with a clinic tablet before their appointment.Clinic staff are on hand to assist with any technical barriers the patient may have. With all PRAPARE lite questions now included in the intake paperwork, the EMR system automatically converts the completed questionnaire into a document in the patient's file, visible to providers and other staff. CHWs review new patient files each week, and now have a clear screening tool in each chart to identify patients that would benefit from CHW services. They can then contact the patient directly to assess their needs and willingness to participate in the program. CHWs can then circle back with the providers and develop a care plan together. While providers can still refer patients to CHWs, this allows for a more proactive approach.

OUTCOMES

Since the beginning of the program, the CHWs have developed stronger relationships with not only the clinical staff but also the community. CHWs have been able to build strong connections with Community Leaders and with those connections, are able to meet the needs ofour patients faster. The Providers in the office are seeing this and are increasingly referring patients to the CHW program. The CHWs are also getting community referrals from patients talking to other patients. The CHW director works with other clinicians within PrimaryPlus (i.e, Case Mangement and Remote Patient Monitoring) to really start building a team mentality around referring patients more.

FUTURE CONSIDERATIONS

This data collection process is still in its pilot phase, and the team will continue making adjustments to ensure they have a system that works for CHWs, clinics, and patients alike. They hope that the CHW case load will grow as providers see the benefit of their services, and become more aware of what they have to contribute to patient care. The team also continues to present the program's benefits and clarify their roles to providers, such as by speaking at provider meetings. The program will continue adapting their technology to bridge the gaps between clinic and community and meet the complex, holistic needs of patients.

> *"So they were coming into the office and saying "Hey, this patient needs this. You help them." So that's the way it was - word of mouth. With this built into our EMR, we'll be able to really make sure that those patients' needs are met."*
>
> -CHW

MEET THE KOCHW TEAM

BARBARA CRUSE
INTEGRATION COORDINATOR

LAURA EIRICH
CHW ADMINISTRATOR

MALEA HOEPF YOUNG
ENGAGEMENT COORDINATOR

JOA MCDANIEL
TRAINING COORDINATOR

KACEY RHODES
DATA COORDINATOR

TRACEY SPARKS
CERTIFICATION COORDINATOR

CONTACT US

Kentucky Office of Community Health Workers

Kentucky Department for Public Health,
Office of Community Health Workers
275 E. Main Street, HS2WE
Frankfort, KY 40621
502-564-7996
CHW.Certification@ky.gov
https://chfs.ky.gov/agencies/dph/dpqi/cdpb/Pages/chwp.aspx