ISSUE 1
SPRING, 2021

THIS ISSUE

Kentucky Homeplace

Laurel County Health Department

CHI St. Joseph Health

Purchase Area Health Department

THE NUMBERS

70
Certified Community Health Workers

23
Programs with Certified Community Health Workers

50
Counties with Certified Community Health Workers

CONTACT INFORMATION

Kentucky Department for Public Health
Community Health Worker Program
275 E. Main Street, HS2WE
Frankfort, KY 40621

Phone:
502-564-7996

Email:
CHW.Certification@ky.gov

KENTUCKY

COMMUNITY HEALTH WORKER STORIES OF SUCCESS

Community Health Workers (CHWs) have been an integral part of the health care team in Kentucky since 1994 with the inception of Family Health Advisors at Kentucky Homeplace in Appalachia. In the decades following, many programs have continued to integrate CHWs into their organizations to improve access to care, improve health outcomes, and connect clients to needed services. As of 2021 there are over 23 programs with Certified Community Health Workers. From Federally Qualified Health Centers to hospitals, Managed Care Organizations to Non-profit organizations; Community Health Worker programs are as diverse as the communities they serve. As the connection between the clinical and the community, 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 document was created to highlight the impact of CHWs across the state. We hope that this issue and future issues of this document will inspire continued support for CHWs across the Commonwealth. We hope that you enjoy this sampling of Community Health Worker "Stories of Success."

A NOTE FROM THE CHW PROGRAM MANAGER

When I came to the Kentucky Department for Public Health in October of 2017, projects like certification and continuing education seemed like abstract concepts. I wasn't quite sure how I was going to formalize or implement anything. Now, 3.5 years later and the CHW Program is thriving. We have 70 Certified Community Health Workers across the Commonwealth, and I anticipate more as the program continues to grow. We now offer KDPH approved continuing education opportunities, and have created partnerships with a multitude of programs to offer even more CEU content. We're about to launch our curriculum approval process, and the Kentucky Association of Communality Health Workers (KYACHW) is preparing for their 6th annual conference, led by an amazing team of CHWs. I am incredibly honored to serve and work with CHWs, and I thank you for the trust and confidence that you have placed in me. Together we will continue to elevate the CHW profession and help make our communities a healthier place to be!

Laura Eirich

Community Health Worker
Program Manager

Kentucky Public Health
Prevent. Promote. Protect.

KENTUCKY HOMEPLACE

UNIVERSITY OF KENTUCKY
CENTER OF EXCELLENCE
IN RURAL HEALTH

PROBLEM

The CDC has identified a diabetes belt located in the southern portion of the United States. Sixty eight of Kentucky's 120 counties are in this diabetes belt, which requires that at least 11% of adults aged 20 years or older have been diagnosed as having type 2 diabetes.

PROJECT

WellCare partnered with Kentucky Homeplace to reach our clients. Clients participated in workshops and learned skills to self-manage their chronic disease at home. WellCare provided gift cards to help offset costs for participants to attend.

CONTACT

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

OBJECTIVE

For the time period 12/30/2016 through 12/20/2018, Kentucky Homeplace community health workers (CHWs) enrolled clients to participate in both chronic disease self-management program (CDSMP) and diabetes self-management program (DSMP) workshops. Health measures including height, weight, blood pressure and waist circumference were obtained by the CHWs. Enrollees who had WellCare as their managed care organization had the following areas assessed both pre- and post- workshop attendance: emergency room visits both emergency and non-emergent, inpatient admissions and inpatient days. Clients were also categorized by the type of chronic disease, such as: hypertension, asthma, diabetes, obesity or behavioral health issues.

OVERVIEW

Kentucky Homeplace was developed and implemented by the University of Kentucky Center for Excellence in Rural Health, based in Eastern Kentucky. Since its inception in 1994, this community health worker initiative has linked tens of thousands of rural Kentuckians with medical, social and environmental services they otherwise might have gone without. Homeplace's community health workers are trained to help medically underserved residents access appropriate health and social services. Emphasis is placed on preventive care, health education 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.

COMMUNITY INVOLVEMENT

CHWs are employed from the communities they serve and are trained as advocates to provide access to medical, social and environmental services and to deliver education on prevention and disease self-management. Homeplace CHWs, as do most CHWs, have the objective of overcoming health inequities across physical, economic, social and cultural dimensions. Kentucky Homeplace CHWs strive to overcome these barriers to improve access to health care for their clients and to assist them in acquiring crucial resources such as eyeglasses, dentures, home heating assistance, food, diabetic supplies, and free medical care. In all of their roles, Homeplace CHWs provide an important bridge between clients with the greatest needs and the primary care physicians and other health providers in the community. They facilitate communication between these clients and primary care physicians, help the clients learn to effectively comply with medical care instructions, and help educate clients to improve their health behaviors, such as improved nutrition, increased physical activity, better weight management, smoking cessation, and improved diabetes self-management.

INTENDED PARTICIPANTS

All clients enrolled into Kentucky Homeplace who met the inclusion criteria to attend a CDSMP or DSMP workshop were offered to participate in this project. Two groups of participants were involved in the project. The first group is all who attended either a CDSMP or DSMP workshop. Measures were also obtained on the second group of WellCare clients who received traditional Kentucky Homeplace services and may or may not have attended the workshops.

PROGRAM PROCESSES

Clients are referred from many different agencies or persons. Kentucky Homeplace receives referrals from partnering agencies such as community action agencies, Department of Community Based Services (DCBS) offices, medical providers, recovery centers, homeless shelters, health departments, senior citizen centers, elected officials, managed care organizations, hospitals and most often by word of mouth. The enrollment process into the KHP database is designed not only to collect pertinent information but also to educate the client on various healthcare issues. Once the information is entered into the database a needs list is generated which addresses things like age appropriate screenings and the social determinants of health. As services are obtained for clients, they are entered into the database and reports can be pulled indicating service type, value, type of visit and CHW time involved. The quarterly reports reflect values such as: number of clients served, amount of medication accessed, and service value so a return on investment can be calculated and reported. The database is continuously evolving as is the healthcare needs of the clients. University of Kentucky IT staff update the database on a regular basis.

OUTCOMES

Among these members, the following data was gathered:
10.3% reduction in emergency room visits
12.9% reduction in non-emergent ER visits
23.3% reduction in inpatient admissions and
27.6% reduction in inpatient days
In members who had diabetes:
16.4% reduction in ER visits
28.9% reduction in ER in inpatient admissions
31.5% reduction in inpatient days

FUTURE CONSIDERATIONS

As a result of the improved health measures of the participants involved, it is evident that the program was successful and the need to continue these efforts is paramount. Discussions are currently underway to continue the partnership between Kentucky Homeplace and WellCare.
One of the biggest program challenges in regard to conducting either CDSMP or DSMP in a rural setting is getting people to attend the six workshops. The gift card helped to defray the barrier of the cost of transportation and increased attendance and completion rates.
CHWs are the ideal persons to recruit eligible participants into workshops, secure meeting spaces and to lead the workshops. The relationships and trust they have built in their communities will enable this program to continue year after year.

Kentucky Public Health
Prevent. Promote. Protect.

“A client who attended a diabetes self-management workshop with Kentucky Homeplace, upon completion of the program, called our community health worker back to say, “I just returned from my doctor’s visit and my A1C went from a 12 to an 8.” He said it changed his life.”

CHW IMPACT:

1,903 WellCare members received 9,066 Kentucky Homeplace services over the duration of the project.

LAUREL COUNTY HEALTH DEPARTMENT

COMMUNITY HEALTH WORKER PROGRAM

Tara Sturgill, Community Health Worker

PROBLEM

In Laurel County, pregnant women with opioid addiction have encountered barriers to receiving prevention, treatment and recovery services like medication assisted therapy. This has contributed to high rates of neonatal abstinence syndrome.

PROJECT

The Laurel County Health Department CHW Program partners with a clinical provider to screen prenatal clients for factors of social determinants of health, to remove barriers to prenatal care and to connect them to needed community-based resources.

CONTACT

Laurel County Health Department
525 Whitley Street
London, KY
40741
Phone: 606-864-5187
Email: marka.hensley@ky.gov

OBJECTIVE

The primary goals and objectives of the Laurel County CHW Program are to provide clinical and community linkages to increase a client's success in navigating health and social systems for a healthy pregnancy and healthy baby.

- The CHW will assess the client's SDOH needs in the first trimester of pregnancy and provide follow-up with appropriate referral actions for identified needs.
- The CHW will assure that clients are able to attend prenatal and referral appointments and provide referrals for transportation as needed.
- The CHW will follow the client until six months postpartum and encourage wrap-around services to promote healthy families and infants.

OVERVIEW

The Laurel County Health Department CHW Program (Laurel County CHW Program) was created as one component of a strategic plan to address the opioid epidemic in Laurel County and the surrounding region. Community needs assessment and strategic planning facilitated by the Laurel County Health Department was conducted in 2018 by the Laurel County Health in Motion Coalition and the Laurel County Rural Community Opioid Response Consortium.

The health coalition and consortium are composed of partners that represent key members of targeted sectors of our community, representing business; education; faith-based communities; law enforcement and judicial officials; local substance abuse and health coalitions; mental and behavioral health; public health; primary health care; treatment and recovery services; and social services. The assessments conducted identified that substance abuse was the number one health problem in Laurel County. Furthermore, it was found that substance abuse was affecting the youngest and most fragile of the population. Laurel County, one of eight counties in the Cumberland Valley Region, has the second highest rate of neonatal abstinence syndrome (NAS) in the state of Kentucky. In response, the Laurel County Health Department and community partners drafted a rural opioid response strategic plan that included the goal to increase collaboration among primary health care, social, and other community-based services to target pregnant women addicted to opioids. Opioid and substance abuse prevention, treatment, and recovery services require the collective impact of community partners working together.

In 2019, the Laurel County Health Department partnered with a consortium member, London Women's Care, the primary prenatal care provider in the region, to launch the Laurel County CHW Program. Laurel County Health Department employs a CHW that travels to London Women's Care. CHW services are provided through referral to prenatal clients that are addicted to opioids and receiving medication assisted treatment (MAT). The program

seeks to reduce the rates of NAS and infant fatality, and to improve pregnancy outcomes by increasing access to needed health (medical and non-medical) services.

COMMUNITY INVOLVEMENT

The Laurel County CHW Program is supported by community involvement to outreach to local resources. Needs identified by screening social determinants of health factors (housing, food security, utilities, transportation, safety, education, substance use history, dental health, social support, and emotional health) can only be successfully met by working with the community and clinical linkages made within the local public health system to improve health.

INTENDED PARTICIPANTS

The target audience for the program is prenatal clients served by London Women's Care that are receiving medication assisted treatment for opioid addiction. London Women's Care was the first primary care center in the region serving pregnant women that developed a MAT Program to provide treatment for opioid addiction.

PROGRAM PROCESSES

The Laurel County Health Department employs a CHW that travels to London Women's Care up to two days per week to conduct social determinants of health (SDOH) screenings. All prenatal clients that are receiving MAT for opioid addiction are referred to the program. Participation is voluntary for the program. The CHW works with clients to connect them to needs identified in the screening. The first visit is conducted face-to-face to introduce the purpose of the program and to establish rapport with the client. Follow-up visits can include not only face-to-face visits but also telephone calls and letters.

OUTCOMES

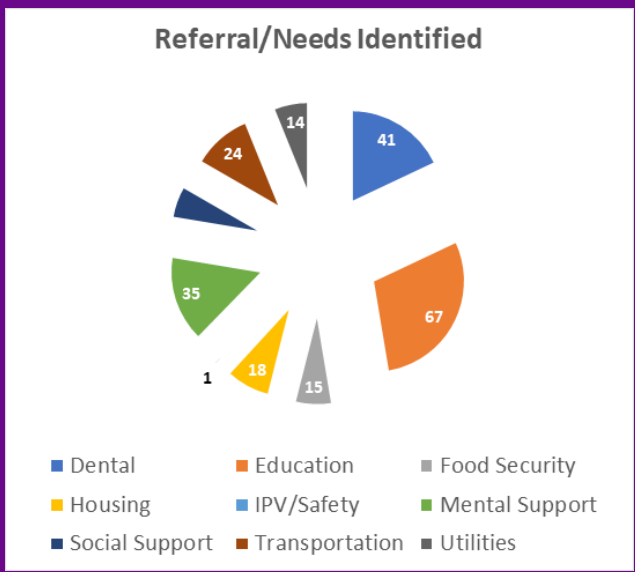
Within the first 10 months of the program, the CHW served 51 pregnant women receiving MAT for opioid addiction. There were 228 referral needs identified by clients and the CHW provided navigation services for each need identified. The top three identified needs were for education, dental health, and mental health services.

FUTURE CONSIDERATIONS

The Laurel County CHW Program can continue to have an impact and improve prenatal and family outcomes for women receiving opioid treatment by responding to identified needs and emerging issues. Community partners, such as the Laurel County Agency for Substance Abuse Policy and the Department for Community Based Services, will work together with individuals that have been referred to social services to share a safe plan of care. Community partners have seen a rising number of near-fatalities with children who have ingested Suboxone prescribed as MAT. The CHW will increase education for safe medication storage to all MAT clients. Partners have also secured resources to provide medication lock boxes that the CHW can provide to clients at London Women's Care.

CHW IMPACT:

Within the first 10 months of the program, the CHW served 51 pregnant women receiving medication assisted therapy for substance use disorder. There were 228 referral needs identified by clients and navigation was provided for each identified need.



The Laurel County Health Department CHW Program has helped to: improve clinical and community linkages, reduce barriers to meeting identified social and non-medical needs, and increase access to needed services that contribute to improved pregnancy outcomes.

CHI ST. JOSEPH HEALTH

TOTAL HEALTH ROADMAP

PROBLEM

Despite advances in modern medicine, socioeconomic disparities continue to impact the health and wellbeing of our communities. Addressing the impact of social determinants is essential to equitable and high-quality healthcare.

PROJECT

CHI Saint Joseph Health has integrated universal screening for social needs into its primary care clinics. Patients are assisted by community health workers who provide referrals and support for addressing needs.

CONTACT

1401 Harrodsburg Road
Building A Suite 410
Lexington, KY 40504
Email:
barbarabaumgardner@sjhlex.org
Phone: 859-313-4447 or
859-321-1504

OBJECTIVE

Program Goal: Proactive transformation of care delivery and engagement in cross-sector partnerships to address social need and improve the health and wellbeing of the communities we serve.
Objective: Sustain and disseminate universal screening and referral for social needs across CHI Saint Joseph Health in the coming three years.
Objective: 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 coming three years.

OVERVIEW

Our work on the Total Health Roadmap started in December 2017 with a focus on the implementation and evaluation of a scalable approach for screening and referral for social needs in primary care. Three pilot clinics were chosen: two primary care clinics in Berea and London, and a pediatric clinic in London. Four full-time community health workers are employed in these clinics, and all patients are screened for social needs using a common set of questions. Universal screening is essential for equitable access to the supports and referrals provided by community health workers. In January 2020, a fifth full time community health worker was added in Lexington at an OB/GYN clinic and a high-risk OB/GYN clinic. In June 2020, CHI Saint Joseph Health received a second, three-year grant from the CHI Mission and Ministry Fund to continue development of this model. Additional expansion has been to a primary care clinic in Kingston.

COMMUNITY INVOLVEMENT

A critical role for community health workers is the maintenance of resource databases for their communities. Before screening began, community health workers researched resources in their area, then visited or called agencies to learn more about programs and services. Community health workers also volunteer at partner agencies during selected work hours, strengthening these relationships and providing first-hand knowledge and understanding of pathways and processes of agencies to whom patients are referred. These relationships have served us well this year through the stresses of the COVID-19 pandemic, as organizations which were on lockdown were able to work with our community health workers to develop alternative distribution pathways for much needed commodities and supplies for patients.

INTENDED PARTICIPANTS

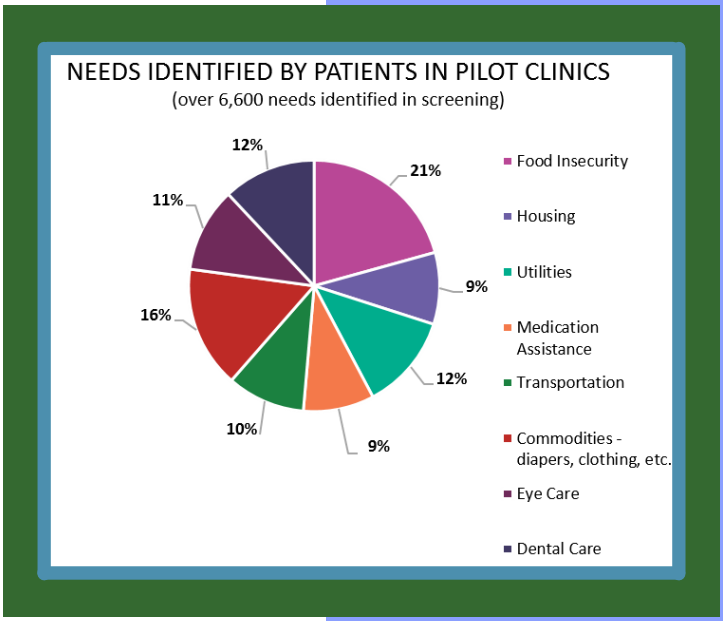
Selection of our original pilot sites included clinics in primarily rural areas with high Medicaid populations. Laurel County's poverty rate is 18% (higher than the state rate), and the proportions of Medicaid patients in our panels are high: 32% in Madison County (Berea), 31% in Laurel County (London) and 26% in Fayette County (home to the newest pilot in Lexington, a high-risk OB/GYN clinic). We began with the assumption that enrollment in Medicaid is often associated with higher health-related social needs. As we spread and scale this work, we will prioritize clinics with high proportions of Medicaid patients, however, our model is universal screening and referral, meaning anyone who seeks care in these clinics, regardless of health insurance status, has access to a community health worker for support.

PROGRAM PROCESSES

Universal screening is integrated into the clinic workflow, with minor differences in each pilot site. Community health workers, along with the clinic staff, have conducted short plan-do-study-act cycles to determine what works best and to assure that universal screening is taking place. In most cases, patients fill out the screening survey on their own, but staff members are available to assist those who are unable to do so. After screening, community health workers reach out to the patients who indicate they want assistance. A web based case management platform that houses the resource database is used to provide each patient with a customized set of referrals and to track progress of patients in navigating those resources. This platform is also used to manage screening and referral data, to generate reports to our funders and leaders, to understand caseloads, to track outcomes of referrals, and to gain a deeper understanding of the overall scope of need in our clinic patient panels.

OUTCOMES

We achieved universal screening in our first three pilot clinics. Early analysis of screening data over time indicates improvements in patient knowledge of available resources and confidence in securing resources. We have also observed a shift in provider satisfaction in the pilot clinics when compared to other clinics that have not yet integrated community health workers. We have focused our evaluative efforts on implementation; our understanding of the key success factors in our original pilot clinics sped the integration of screening and referral in our fourth pilot clinic. We are now prepared to refine our screening tool to address social isolation and to develop additional measures to track the impact of our work.



FUTURE CONSIDERATIONS

Sustainability is our focus in the next three years, and our challenge is to shift conventional thinking and promote the use of multiple lenses to characterize value. We are considering blending resources from value-based payer contracts and direct reimbursement from Medicaid and Medicare, tied to the positive impact on clinical outcomes and cost reduction (i.e., reductions in high cost hospital and emergency care use). We are also examining the value of improvements in patient confidence and satisfaction as well as improvements in provider satisfaction and retention. Another area of development is our organizational commitment to our mission and our investment in community benefit as a nonprofit healthcare system.

CHW IMPACT:

To date, nearly 27,000 patients have been screened, with one in five patients identifying at least one health-related social need, and 71% of patients with identified needs requesting assistance through the community health worker.

> A physician, when asked about screening and referral for social needs: I believe that it has made a big difference in my patients' quality of life and would go as far to say the quantity of life for several.

PURCHASE AREA HEALTH CONNECTIONS

COMMUNITY HEALTH WORKER PROGRAM

PROBLEM

Our community's poor health status with high rates of chronic disease and numerous social determinants of health barriers leads to multiple comorbidities that result in high hospital readmission rates.

PROJECT

The purpose is to improve patient outcomes and quality of life by decreasing avoidable readmissions and improving health outcomes and health literacy for our target population.

CONTACT

Purchase District Health Department
916 Kentucky Avenue
Paducah, KY
42003
Phone (270) 444-9625 ext. 180
Email:
kaylenes.cornell@ky.gov

OBJECTIVE

The program goals are to continue to expand our CHW program for a coordinated system of transitional care for Medicare-eligible, at risk patients discharged from member hospitals to home through 2023 and to continue to expand our network by adding five new sectors to Purchase Area Health Connections by 2023. Our objectives include engaging in strategies to continue to increase understanding of policies and trends in health care and their impact on rural communities and regions.

OVERVIEW

Since 2017, Purchase Area Health Connections (PAHC) members have implemented a transitional care program designed to lower avoidable hospital readmissions in order to improve the overall health of the Purchase Area population. The program first operated within two of the area's largest hospitals and has expanded into two additional hospitals. This has allowed us not only to increase the program's reach, but to improve collaboration, communication, and data sharing amongst all four hospitals.
This is due to many readmissions going to different hospitals as a result of the geography of the area. With Kentucky's leading cause of death being heart disease and being one of the poorest in health in the nation, the impacts of this program will be crucial in promoting the health of the area.

COMMUNITY INVOLVEMENT

The CHWs act as an arm to the health care team and reach out to multiple agencies to address social determinant of health needs through agency referrals, resource allocation, as well as communicating with their medical providers.

INTENDED PARTICIPANTS

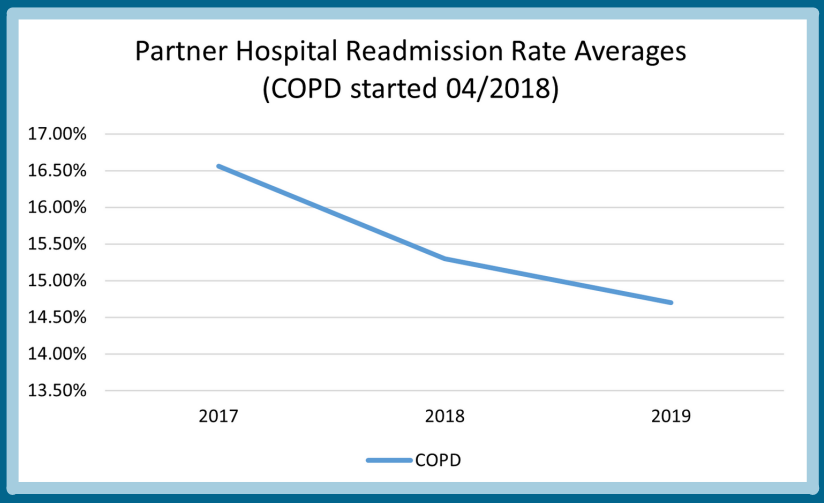
We serve the far western counties of Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Marshall, and McCracken. All of our counties are designated in full or in part as Health Professional Shortage Areas and Medically Underserved Areas. Our target population is rural Kentuckians with high levels of poverty and low levels of educational attainment. Our program typically serves those over 65 years old with multiple comorbidities. We serve clients that live at home with little to no family support.

PROGRAM PROCESSES

The success of the community health worker program relies on our partnerships and collaboration. We have made it a priority to expand our network and include the appropriate people in the decision and processes steps. We have made sure to include all of our counties by collaborating with their health coalitions so that we know the needs and resources on the ground. We accept referrals from patients that were recently in inpatient hospitalization for a specific diagnosis. We use an electronic patient care reporting (EPCR) system to capture our client data which enables us to analyze and share data effectively and efficiently. The collaborative nature of our program has continually strengthened not only our relationships with the hospitals but the relationships between hospitals. These strengthened relationships have allowed us to seek solutions to problems that benefit all, such as utilizing the same readmission risk assessment tool. One of the hospitals even changed the tool they were using so that we could collaborate and share data more effectively. We have been able to collectively plan and seek sustainability for our program and our currently pursuing true sustainability.

OUTCOMES

During the time in which the program has been implemented, COPD readmission rates have decreased an average of 11.23% from baseline. Additionally, in our most populous county, preventable hospital stays have decreased from 69 per 1000 in 2017 to 49 per 1000 in 2020. McCracken County has also advanced from a county rank of 51st in 2017 to 25th in 2020 in health outcomes according to County Health Rankings. Approximately 68% of individuals referred to the program opt in to enrollment. The satisfaction rate of the program is 97.4%. Clients and/or their caretakers are surveyed after graduation.



FUTURE CONSIDERATIONS

Accomplishing the goal of improved community health and reducing readmission rates lies directly with plans for sustainability. Reduced readmission rates will result in cost savings to hospital partners as well as clients' insurance. Avoidable readmissions can cause the hospital to incur Medicare penalties. Overall improved health decreases the client's need to access urgent care services such as the emergency department, EMS services, and unplanned clinic visits which in turn saves managed care organizations (MCOs) and private insurance additional costs. The program's sustainability model will be examined annually while evaluating potential fund sources such as managed care organizations, contributions from hospitals resulting from improved Medicare reimbursement, other grants, and contributions from other private insurers. Some challenges that come with this program have different facets. CHW attrition and adapting to the COVID-19 pandemic are more direct, while one challenge toward multi-organizational sustainability is the fact that it is a new and emerging model that has not previously been implemented.

CHW IMPACT:

The graduation rate from this program in regard to chronic obstructive pulmonary disease (COPD) and pneumonia is 69%.

> **The community health worker program is very helpful, informative and the community health workers are good company for someone who lives alone and doesn't see people often.**
> **– CHW Client**