COMMUNITY HEALTH WORKERS: BRINGING CARE AND COORDINATION INTO THE COMMUNITY

Kentucky Rural Health Association Annual Conference
September 17-18, 2015
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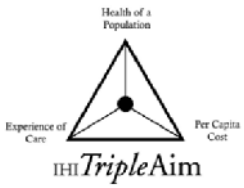
THE BRIDGE/EL PUENTE PROGRAM

- Began in 2006 with HRSA Rural Health Outreach Funding;
- Initially, most of our clients were undocumented Hispanic workers;
- Initially, program goals were improved cultural competency in the community and increased access to primary medical and dental care and mental health services;
- As we continued, program goals evolved toward identification and management of chronic disease, improved health outcomes and sustainability;
- Maintained our focus on the Latino population but increased our population to included non Latino uninsured and underinsured, as well.

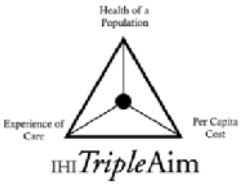
IMPROVING THE PATIENT EXPERIENCE OF CARE

- Improved access to care;
- Improved self-efficacy;
- Improved medication adherence;
- Increase in perceived health status;
- CHWs are members of the communities they serve – they are trusted by the individual clients they serve. Model is built on fostering relationships through empathy.



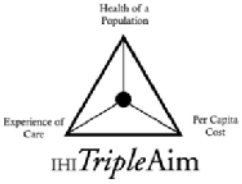
IMPROVING THE HEALTH OF POPULATIONS

- CHWs provide innovative outreach and care coordination to hard to reach populations;
- CHWs serve as members of the healthcare team and provide vital information to form a holistic picture of the patient;
- CHWs advocate on behalf of the community as well as the patient;
- CHWs promote the importance of chronic disease management and preventive services through education and referrals.



REDUCING THE PER CAPITA COST OF HEALTH CARE

- Reduced emergency department visits;
- Reduced admissions and readmissions to the hospital;
- Emphasis on medical home, preventive screenings, chronic disease management.
- Patients receive the appropriate level of care – "right care, right time, right place";
- CHWs are typically unlicensed lay individuals.



FIRST TWO ROUNDS OF FUNDING

- 700 people enrolled;
- 98% Hispanic;
- 650 Medical encounters;
- 550 Dental encounters;
- 150 Mental health encounters;
- 33 Trained promotoras.

DEMOGRAPHICS

- 203 clients since 2013;
- 56% Female;
- 48% 19-39 years of age
- 51% White/Caucasian;
- 38% Hispanic;
- 88% live below the federal poverty level;
- 35% speak primarily Spanish at home;
- 54% are unemployed or not looking for work;
- 55% do not have a high school diploma or GED.

BASELINE DATA

- 51% do not have enough money to pay their bills each month;
- 41% utilize SNAP or food stamps;
- 11% do not have reliable transportation to and from appointments;
- 32% have difficulty accessing or providing housing, food, clothing, or utilities;
- 33% have high blood pressure;
- 24% have mental health issues;
- 17% have diabetes, type II;
- 34% use tobacco products on a regular basis;
- 33% do not engage in any physical activity or exercise;
- 82% do not have medical coverage or insurance;
- 28% do not have a primary care provider.

KEY FINDINGS

- 8% gained medical coverage;
- 13% gained a primary care provider;
- 7% obtained reliable transportation;
- 18% overcame difficulties accessing or providing housing, food, clothing, or utilities;
- Increase in medical appointment compliance;
- Increase in medication adherence;
- Statistically significant decrease in ER visits;
- Statistically significant increase in self-efficacy;
- Statistically significant increase in perceived health status;
- 33% met their care plan goals.

FOR MORE INFORMATION

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