KC CARE Community Health Workers

No one turned away. Whether or not they can pay.
Community Health Workers (CHW)

- A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. (APHA)
CHW Care Coordinators

- Started in 2010 with two CHWs working in “afterhours” of KC area safety net clinics
- 2017: Regional “hub” of 26 CHWs partner with
  - Four Hospital systems
    - St. Luke’s Health System, KU Medical Center, Research Medical Center, North KC Hospital
  - Nine Safety Net Clinics
  - CBOs – domestic violence shelters, etc.
  - Faith based organizations
Care Delivery Team Members

- CHWs embedded in care teams at hospitals and clinics
  - Each CHW is onsite in either Emergency Department or Primary Care clinic several days per week
    - Spend balance of time in community, home visits, etc
  - Document in Electronic Health Record of Hospital or Clinic
  - Referrals from nurses, social work and providers
“Workflow”

- **Care plan**
  - Based on assessed needs of each patient
  - Drives goals and length of relationship
  - Not a disease centered model

- **Designed as a time limited intervention**
  - Teaching patients to self manage
  - Graduation timeline is driven by care plan and determined by both patient and CHW
Care Coordination Role

- Individualized assessment and care plan developed
- CHWs function as a medical tour guide for patients: walking side-by-side they teach patients to navigate the health care and social service systems
  - Navigate access to primary care and specialty care
  - CHW Attendance at appointments
  - Home/Community visits
- Motivational interviewing techniques
Care Coordination Tasks

☐ Assist with navigating health care services
  ▪ Coordinating appointments: primary, specialty care
  ▪ Accessing medications

☐ Benefits enrollment
  ▪ Medicaid, Medicare, Marketplace, Disability, etc

☐ Social services referrals and navigation
  ▪ Basic supports: Food, housing, etc.
Patient Engagement

- Patient Education
  - Wellness and disease specific education
  - Patient Notebook

- Self management capacity building
  - Ask me three
  - Pre-appointment planning
  - Post-appointment review

- Operationalizing the care team plan
  - Ex: Home visits or trips to the grocery store
HOW is this different? What Value?

- CHWs are:
  - Cultural and Linguistic liaisons
    - This is a peer model intervention. CHWs have a shared lived experience with their clients and connect in ways that the “professionals” in health care team do not
    - Teach patient to work with care team
  - Care Team extenders
    - CHWs extend the work of care team and RN and SW case managers into the community, home, and beyond
    - Provide feedback to care team with information otherwise unknown
CHW client Outcomes

- 85% of patients report an improvement in their overall health during time working with a CHW (avg = 4 mos)
- 88% of people are linked to a medical home
- 93% of clients are helped with medication access
- 86% overall reduction in patient use of ED
- 87% of clients with improved self-sufficiency (Pre and post scores on ASSM)
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