

COMMUNITY HEALTH WORKER PROGRAM



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WHAT IS A COMMUNITY HEALTH WORKER (CHW)?



- Frontline public health worker
- Trusted community member
- Typically share similar life experiences as their patients
- Dedicated to building relationships and connecting with others
- Link patients to healthcare services, social services, and community resources
- Patient advocate and accountability partner



TIMELINE





PROGRAM AT A GLANCE

Overall Goal

Improve patient outcomes by reducing readmission rates

Target Populations

Frequent emergency department utilizers and in-patients at high risk of readmission

Referral Process

Come from providing physician but can be initiated by case managers and nurses

Consultation

Prior to hospital discharge when possible

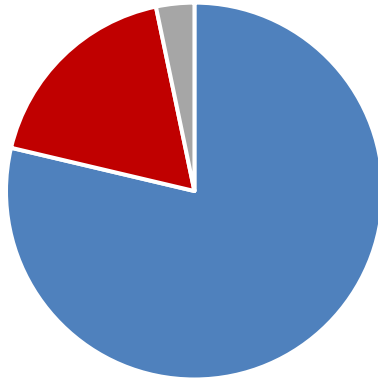
Visit Types

Home, phone, or hospital



DATA

Referral Source



■ In-patient ■ Emergency Department ■ Clinic

Readmissions

Out of the 48 in-patients whose 30-day goal has passed 4 had readmissions in under 30 days

One ED patient had two readmission instances in under 72 hours while part of the program



Age Range



6 months

94 years



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Objectives

1. Explain how community health workers (CHWs) support the proper use of health care services
2. Describe the process for integrating a CHW into a healthcare system
3. Identify innovative ways to use CHWs to relieve workforce demands



Problems that Lead to Misuse of Healthcare Services

- Lack of overall knowledge/understanding
- Fear of being denied care
- Undiagnosed/mismanaged mental health conditions
- Loneliness



Problem: Lack of Overall Knowledge/Understanding

Solution: Education

- Levels of care
- Appropriate situations for each level of care
- Benefits of treating chronic conditions with primary care
- Finding a health home and establishing care



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Problem: Fear of Being Denied Care

Solution: Tangible Assistance and Education

- Applying for health insurance
- Applying for sliding fees/financial assistance
- Liaison between patient and billing department
- Finding a health home and establishing care



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Problem: Undiagnosed/Mismanaged Mental Health Conditions

Solution: Reducing Stigma/Referrals/Increase Compliance

- Reduce stigma by education/relationship building
- Refer to behavioral health services
- Support groups
- Facilitate continuity of care by acting as liaison between patient at PCP
- Accountability
- Medication Compliance
- Healthy Coping Skills



Problem: Loneliness

Solution: Build a Strong Social Support Network

- Companionship referrals
- Support groups
- Community involvement
- Encourage opportunities for creating connections



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Integrating a CHW into a Healthcare System

- Establishes program goals and framework
- Identify key benchmarks to monitor program successes and growth
- Outline CHW job description and duties
- Define the role the CHW will have with different service lines
- Facilitating opportunities for creating connections
- Network with other programs and ask questions
- Allow mistakes and opportunities to re-evaluate processes
- Be active in learning community resources
- Stay engaged statewide



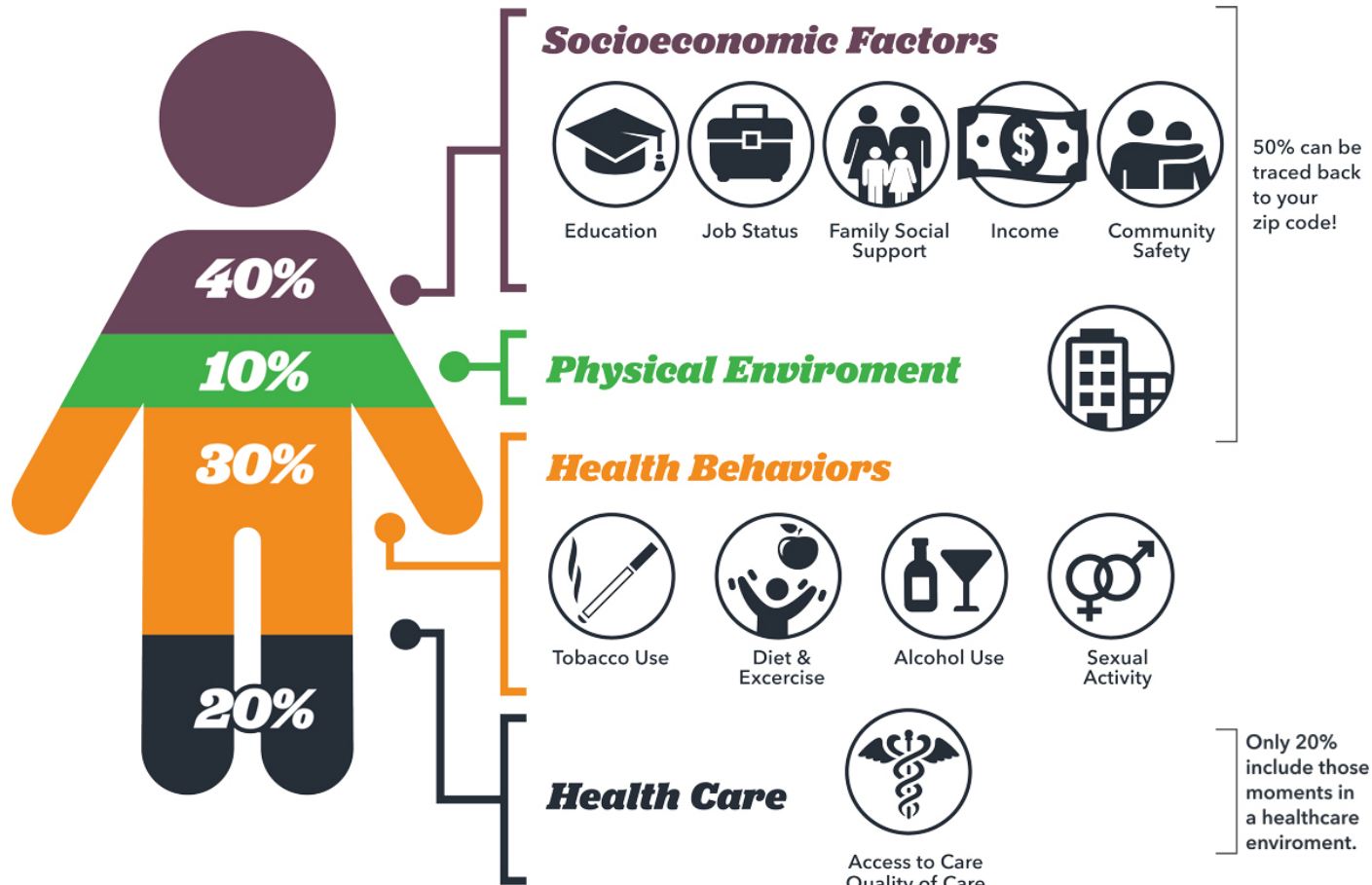
Relieving Workforce Demands

- Increase proper usage of healthcare services
- Lower readmission rates
- Reduce emergency department visits
- Address social determinate of health allowing healthcare providers to focus on their job duties



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SOCIAL DETERMINATES OF HEALTH



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

<https://noahelps.org/sdoh/>



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MOST COMMON NEEDS

- Basic household items
- Furniture (beds)
- Transportation
- Social support/accountability
- Communicate skills (specific to communicating with healthcare professionals)
- Lifestyle coaching
- Health insurance/financial assistance applications
- Food resources



CASE STUDY

Middle aged individual

- Lives alone
- Recent death of spouse
- Multiple chronic health conditions
- Non-compliant with medications
- History of no-show to follow up visits
- Does not want people in home
- Struggles with hoarding
- Long history of refusing services offered



CHW INTERVENTION

- Extended consult prior to discharge
- Built rapport
- Encouraged and recognized the huge step patient took by admitting to and putting hoarding struggle into words
- Broke down barriers by connecting on a deep personal level by sharing my own experiences
- Acknowledge and discussed the shame, guilt, and fear the patient was feeling
- Reinforced benefit of skilled home health services



RESULTS

With collaboration from PT, OT, HH, family involvement, and myself, the patient is now:

- Regularly taking medications
- Checking blood sugar
- Seeing mental health counselor
- Attending doctor appointments
- Getting help with cleaning their home
- Wearing clean clothes
- Enjoying repaired plumbing in home
- Able to take regular showers/baths
- Set up with ERS (emergency response system)
- Having Meals on Wheels delivered daily
- Has started driving again



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THANK YOU!

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