Buffalo County, Nebraska

Health HUB

Community Health Worker Pilot Project

July 2011 - June 2014

COMMUNITY HEALTH ACCESS TEAM (CHAT)
A GOAL WORK GROUP OF BUFFALO COUNTY COMMUNITY PARTNERS®

Buffalo County COMMUNITY PARTNERS®
BUILDING A HEALTHIER COMMUNITY

Buffalo County Community Partners

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Executive Summary

The Buffalo County Diabetes Health HUB pilot project was developed by the Community Health Access Team (CHAT) a coalition powered by Buffalo County Community Partners (Community Partners). In 2000, CHAT's **mission** is for everyone, with a point of entry to service in Buffalo County, to have access to, regularly use, and be satisfied with comprehensive, cost effective, high quality, health services that support optimal quality of life. CHAT's **vision** is that differences between people, such as culture, class, educational attainment, life experiences, employment status and ability to pay will no longer be associated with disparate health outcomes.

History of CHAT

In 2000, key stakeholders joined together to form a coalition to develop a comprehensive community plan to provide 100% access to care with zero health disparities. Stakeholders researched community models around a 'clinic without walls' to unite the community in developing a comprehensive access to care plan. The coalition assessed the community needs through focus groups and data collected in the Adult and Youth Behavioral Risk Factor Surveys. In 2000, 90% of Buffalo County residents reported they were covered under insurance plans. By 2007, the rate of Buffalo County insured adults dropped to 87%. A minority survey in 2007, indicated that 51% of minority Buffalo County residents had health insurance coverage dropping to 48.5% in 2009 and well below the state rate of 54%.

In 2005, Latino focus group meetings brought to light issues around access to dental care, adequate transportation, and language barriers. CHAT prioritized the development of a model dental program to bring students from Central Community College to Gibbon schools to provide screenings and education of dental care. Kindergarten through 3rd grade youth were identified for additional services based on a care plan coordinated by Dr. Karen Sorenson. Models emerged in Kearney Public Schools and sustained efforts for many years connecting parents, schools, student and dental providers eliminating access to care and reducing disparity.

Additionally, CHAT researched models of community health workers and need for certified medical interpreters emerged. In this effort, Community Partners, along with the Spanish speaking providers, participated in "Hablamos Juntos", training for medical interpreters.

A two year planning grant from CHI Health Mission and Ministry in 2010, launched the development of the HUB model to serve a population yet to be named as most at risk. CHAT was guided by the principle to engage a small population of high utilizers of health care with a chronic disease and develop a pathway model to break down barriers to care while tracking outcomes through the use of community health workers. They soon defined the most at risk population with one or more of the following parameters; uninsured, Latino, Diabetic, limited access to medication, limited access to primary care, high utilizer of emergency room, need for diabetic education, access to social services and need for a care plan. This program was a dual effort to increase health outcomes by increasing health access and addressing socioeconomic barriers.

By July 2011, the Health HUB program was implemented through a three year grant awarded by Catholic Health Initiatives Mission and Ministry. Buffalo County Community Partners contracted with UniNet-Kearney (formerly known as Sentinel Health Care) to hire a community health worker(CHW) to enroll 250 diabetic clients. CHAT developed five pathways: Medication Management, Diabetes Education, Safety Net, Payment Source and Social Needs. This program utilized bilingual community health workers to engage program participants and worked with participants to control and manage their Diabetes. In the pathways model, the CHW performs several roles: care coordination, health education, development of enrollment agendas, and building individual and community capacity. The key component of the Health HUB model is designed to identify barriers in a systematical method to track issues as the CHW and the clients work towards overcoming barriers and increasing access to needed services. Action plans hold clients accountable by engaging them to take a primary role in making health care decisions and improving their self-reliance skills.

Outcomes achieved through the implementation of the Health HUB model were revealed by January 2015. Buffalo County Community Partners staff and community health workers utilized Apricot software to enter pathway information throughout the program implementation phase.

- In a post-program survey, clients of the health hub program rated their overall satisfaction as "Excellent," giving the program a rating of 3.7 out of 4.0.
- Medication Access Pathway-193 clients enrolled
    - 182 clients secured medication payment sources
    - 101 clients enrolled in Medication Access Program received 1,513 prescriptions, totaling $726,431.53.
- Diabetes Education Pathway-191 clients enrolled
    - 165 clients served by Diabetes Education classes
    - .4% improvement in overall average A1c score
    - 189 clients referred to local programs for additional education
- Social Service Pathway-175 clients enrolled
    - 88% resolved social services barriers
    - 31% social service applications denied, mostly Health and Human Services programs for which clients did not meet eligibility requirements
- Safety Net Pathway-169 clients enrolled
    - $104,616.67 in increased clinic revenue due to regular client visits
    - 94% secured formal relationship with primary care provider
    - 73% continued to report cost as #1 issue to access
- Payment Source Pathway-160 clients enrolled
    - 74% federal and/or state medical assistance applications denied
    - 84 clients self-reported $300,000 in bad debt with a clinic or hospital

Other beneficial community outcomes occurred as pathways provide a systematic look at Buffalo County's access barriers. The barrier issues were identified by clients and in general form discussed with key stakeholders. Areas further developed due to Health HUB program implementation include;

1) **The need for the state to organize and adopt a community health worker definition, scope of practice and core competencies.** The Buffalo County Health Policy Team submitted a policy statement to support the development of the Nebraska Community Health Worker Steering Committee (NCHWSC). After two years of planning and engaging statewide stakeholders, the NCHWSC presented their plan for community health worker engagement to the Public Health Association of Nebraska's (PHAN) Community Health Worker Association. The Nebraska Community Health Worker Workforce plan was released April 2015 and can be found at www.publichealthne.org. ***Buffalo County team members included; Denise Zwiener and Jessie Perez of Buffalo County Community Partners, Crystal Winfield of UniNet, Julie Weir of Community Action Partnership of Mid Nebraska, Ann Tvrdik of Region 3 Behavioral Health Services, Terry Krohn of Two Rivers Public Health Department and Bob Smoot of CHI Health Good Samaritan.***

2) **An identified need for a Behavioral Health Pathway.** CHAT organized behavioral health stakeholders and primary care providers with input from community health workers to meet and develop a sixth pathway to integrate behavioral care into primary care through community health workers. A new Buffalo County task force emerged, Behavioral Health Integration Partnership (BeHIP) to develop and implement the pathway. Information on the development of this pathway is available at www.bcchp.org. ***Buffalo County team members working in this area include Denise Zwiener and Ariane Aten of Buffalo County Community Partners, Beth Baxter of Region 3 Behavioral Health Services, Susan Henrie of South Central Behavioral Health, Cindy Hayes of University of Nebraska at Kearney Student Health Center, Cindy Kempt of Monsanto, David Hof and Doug Tillman of University of Nebraska at Kearney, Nancy Foster and Stephanie Burge of University of Nebraska Medical Center, Jessie Perez of Nebraska Office of Health Disparities and Health Equity, Jessica Vickers and Susan Winchester of Center for Psychological Services, Ken Shaffer and Crystal Winfield of UniNet, Linda Muhlbach of HelpCare Clinic, Shelly Hansen and Suzanne Goetz of Richard Young Hospital, and Terry Dunlop.*** The Behavioral Health Education Center for Nebraska (BHECN) is working together with BeHIP to develop a model for recruitment and retention of behavioral health CHW in central Nebraska.

3) **Need for primary care for uninsured in Buffalo County.** Barriers to primary care for uninsured Buffalo County residents mobilized health care providers, social service providers, businesses and elected officials to secure funding through the Sherwood Foundation to develop a 'community clinic' to provide primary care for the uninsured. The Community Access Network (CAN), a coalition of Buffalo County Community Partners, formed July 2013 to develop a community clinic. They hired Mark Rukavina of Community Health Advisors, LLC, to consult on the project. By April 2014, plans to create a new non-profit board of directors to lead the development of the HelpCare Clinic were revealed to the community. HelpCare Clinic will provide a 'soft' opening to the Health HUB clients on Thursday, April 30, 2015 with a general public opening to

follow. More information available www.helpcareclinic.org. ***Members of the CAN Team who engaged the community in developing a plan to build a community clinic are Beth Baxter of Region 3 Behavioral Health Services, Carol Wahl-Mike Schnieders-Dennis Edwards of CHI Health, Crystal Winfield-Ken Shaffer of UniNet, Dave Glover of Family Practice, Dustin Lappe of Holy Cross Lutheran Church, Julie Weir-Meredith Collins of Community Action Partnership of Mid Nebraska, Lisa Reese Parish of the Kearney Area United Way, Mike Lawson-Tom McLoed of Platte Valley Medical Clinic, Peggy Dobish of Kearney Clinic, Stephanie Burge of University of Nebraska Medical Center, Terry Krohn of Two Rivers Public Health Department, Tim Peterson-Linda Muhlbach of Kearney E-Free Church and Denise Zwiener of Buffalo County Community Partners and staff.***

4. **Need for Diabetes Referral Network.** Nebraska Health and Human Services supports the development of community health workers and chronic disease management. Through targeted funding and support, Buffalo County Community Partners has developed the Central Nebraska Diabetes Referral Network (DRN) whose mission is to develop referral pathways to facilitate sustainable referral patterns between Network partners and eligible participants into appropriate programs. More information available www.bcchp.org. ***Buffalo County Community Health Partners data coordinator, Ariane Aten, utilized a key informant process to bring the following stakeholders to the table to develop and implement a diabetes referral network; Kati George of HyVee, Cindy Hayes of University of Nebraska at Kearney, Crystal Winfield-Sheila Carnahan-Mariana Sena of UniNet, Denny Placzek and Laura Aden of Kearney Family YMCA, Jessica Rich-Mileah Nickel of CHI Good Samaritan, Jeff McMeen- Krista Cullen of McMeen Physical Therapy, Lisa Steele-Kerry Hansel of Two Rivers Public Health Department, Lynn Goodell, Shelli Vest of Overland Trails, Serena Phillips-Peggy Dobish of Kearney Clinic, Meredith Collins of Community Action Partnership of Mid Nebraska, Jessie Perez of Nebraska Office of Health Disparities and Health Equity, and Denise Zwiener-Ariane Aten of Buffalo County Community Partners.***

Buffalo County Community Partners…

Thank the following volunteers who have worked over 20 years in developing a systemic community plan for better access to care and to eliminate health disparities.

- **Funders**
  - CHI Health Mission and Ministry
  - Sherwood Foundation
  - Nebraska Health and Human Services
  - Behavioral Health Education Center of Nebraska
- **Community Health Access Team Members**
  - Chairman – Denise Waibel Rycek, University of Nebraska Medical Center
  - Mike Schnieders, Carol Wahl, Luann Trutwin, Crystal Hampton, Jessica Rich and Lesley LaFile, CHI Health Good Samaritan
  - Jessie Perez, Nebraska Office of Health Disparities and Health Equity
  - Crystal Winfield, UniNet-Kearney
  - Ann Tvrdik, Region 3 Behavioral Health Services
  - Cindy Kempt, Monsanto
  - Jannette Arram, Walgreens Pharmacy
  - Julie Weir, Community Action Partnership of Mid Nebraska
  - Kelli Urbanek, Kearney Public Schools
  - Lisa Steele, Central Health Services
  - Laurie Jameson, Kearney Housing Agency
  - Stephanie Burge, University of Nebraska Medical Center
  - Terry Krohn, Two Rivers Public Health Department
- **Thank you to the Health HUB Staff**
  - **Carmen Royle, Community Health Worker**
  - **Mariana Hernandez-Sena, Community Health Worker**
  - **Crystal Winfield, Project Site Coordinator**
  - **Jessie Perez, Project Coordinator**
  - **Ariane Aten, Data Coordinator**
  - **Denise Zwiener, Program Director**
  - **Carol Wahl and Lesley LaFile, Grant Coordinators**
- A special thank you to the 250 Health HUB clients and their families for sharing their voices with community leaders and advocate for access to care.

Diabetes Health HUB Pathway Model

An evidence-based model that seeks to identify people at risk, provide treatment, and measure health and human service outcomes.

Developed by the Community Health Access Team (CHAT)
Powered by Buffalo County Community Partners

HEALTH HUB
A GOAL WORK GROUP OF BUFALO COUNTY COMMUNITY PARTNERS

Jessie Perez, Health HUB Coordinator

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Appendices

Diabetes Health Hub Pathway Model

Coordinating Health and Social Services Barriers

The Pathway model is a process designed to follow an infrastructure that increases the accountability of health care, social service providers, the community, and Community Health Workers. A pathway is driven to demonstrate results that are measurable. Applications of the pathways can touch a wide range of biological, psychological, and social conditions with multiple providers in the community. The model provides appropriate, timely access to health care and social services in a coordinated fashion that is driven to produce a high quality of care while reducing healthcare costs and increasing health outcomes for vulnerable populations.

Services for "At-Risk" Populations

Underserved populations receive less-than-adequate health care, are more likely to postpone care, or have a higher incidence of premature death. Members of this population are not limited by ethnicity, refugee status, rural or urban location, homelessness, or age. The social determinants of the underserved and vulnerable populations are crippling and are a direct cause of the health disparity in a complex medical service delivery system that is unable to provide a workforce to meet the demands of growing populations. In addition, medical systems are unable to address both the medical needs of consumers and the social determinants that have a direct impact upon health outcomes. Despite medical advancements, social determinants continue to play a significant role in health outcomes. Community Health Workers are in a position to identify and locate hard-to-reach populations due to geographic locations, disenfranchised persons, and members of ethnic groups with linguist barriers.

Community Health Workers Definition and Scope of Practice

In the last decade, there has been a growing workforce of Community Health Workers (CHWs) that have made considerable efforts to reduce health disparities among underserved populations, increase access to health care, and help reduce medical costs to the public and private sector. CHWs who have integrated into a multidisciplinary care model have improved population health outcomes, increased patients' adherence to healthcare plans, and demonstrated cost savings to health systems and state healthcare budgets. The World Health Organization and The American Public Health Association recognize and recommend the contributions of CHWs as part of the solution to help reduce health disparities of underserved populations and reduce healthcare

costs. Community Health Workers have proven to offset medical costs and, more importantly, break the yoke of social determinants and empower people. They are agents of change. The Health HUB pilot brought an awareness of the need for state policy change. A local team of partners joined together to develop a community health worker policy through UNMC – Nebraska Health Policy Academy. The team presented their findings to Nebraska Office of Health Disparities and Nebraska Health and Human Services Community and Environmental Health, Division of Public Health.

The Buffalo County Health Policy Academy Team adopted the American Public Health Association's definition of a Community Health Worker as:

> ***". . . 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 CHW to service as a liaison/link/intermediary between health/social services and the community to facilitate access to service and improve the quality and cultural competence of service delivery."***
>
> ***"A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy."***

This definition was utilized by the Nebraska Community Health Worker Steering Committee to create a statewide definition and scope of practice, which can be found as Appendix A.

INCREASING ACCOUNTABILITY

The role of the CHW can fall into the realm of six models:

1. ***Outreach and Community Mobilization***
2. ***Community/Cultural Liaison***
3. ***Case Management and Care Coordination***
4. ***Home-based Support***
5. ***Health Promotion and Health Coaching***
6. ***Participatory Research***

In the pathways model for the Health HUB program, the CHW performs several roles: care coordination, health education, development of enrollment agendas, and building individuals and community capacity. The key

component of the Health HUB model is designed to identify barriers in a systematical method to track issues as the CHW and the clients work towards overcoming barriers and increasing access to needed services. Action plans hold clients accountable by engaging them to take a primary role in making health care decisions and improving their self-reliance skills.

Community Care Coordination

Community Care Management is a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes. CHWs provide non-clinical care management to access medical, mental health, and social-economic assistance. At-risk community members need assistance to access services and assistance:

1. ***Initial Assessment of Strengths, Needs, and Priorities***
    a. **Client Selection Process for Community Care Management**: The CHW should identify community members who would benefit from community care management through outreach and referrals. The CHW should then orient individuals/families to the program, services, and policies that create a host perspective of what deliverables will be achieved by community care coordination.
    b. **Client Assessment**: Applying the fundamental principles of patient-centered care, CHWs should make an assessment based on the client's needs and personal goals. Culture, literacy, and linguistic barriers need to be part of the evaluation process.
    c. **Client Problem/Opportunity Identification**: An inventory of the client's strengths, opportunities, and needs should guide the CHW in connecting client with resources.
2. ***Development of Clear Goals and Steps to Achieve those Goals***: The CHW and client should collectively chart a course by identifying short-term and long-term goals that are meaningful and obtainable.
    a. **Planning**: The CHW and client will identify barriers using the Safety Net Pathway, Payment Source Pathway, Diabetes Education Pathway, Medication Access Pathway, and the Social Barriers Pathway to help guide in the planning process. The action plans they build will help create accountability and increase successful goal planning.
    b. **Implementation**: The CHW and client will identify personal and shared responsibilities in the planning phase to promote accountability on behalf of the client. The principles of motivational interviewing skills (also known as OARS) are: **O**pen-ended questions, **A**ffirmations, **R**eflective

listening, and **S**ummarizing. Using these will help the CHW to engage the client in the planning process.

c. **Facilitation, Coordination, and Collaboration**: The CHW's expertise lies in his or her established networks of resources and service providers. It is vital that the CHW helps facilitate, coordinate, and communicate with stakeholders in an attempt to help clients through institutional red tape, but, more importantly, to help facilitate a "No Wrong Door" philosophy, the idea that no matter which entrance a person comes through, they are able to get the resources they need.

d. **Advocating**: The CHW should advocate on behalf of the client when appropriate, ensuring the client's needs and goals are communicated to service providers and decision makers. The CHW should also strive to advocate on a systems and community level, acting as an agent of change to build capacity.

e. **Monitoring**: Agreements for follow-ups should be completed in advance to foster cooperative partnerships. Documentation is vital to the process of helping community members get the services they need and demonstrate outcomes of the intervention services. The CHW should provide ongoing assessment and ensure the client is progressing. Documentation should be brief, based on observations that are not judgmental, and be strength-based using the SOAP standards: **S**ubjective, **O**bjective, **A**ssessment, and **P**lan. Documentation should be completed in a timely manner that ensures the fidelity of information.

f. **Outcomes**: The CHW should document the client's healthcare outcomes through evidence-based data. Document client's Emergency Department visits, costs, and reason for the visit. Maintain proper documentation for all services provided and the challenges and progress made in the implementation of the case management plan.

3. ***Implementation of the Case Management Plan and Discharge or Termination***

   a. **Interdisciplinary and Inter-Organizational Collaboration**: The CHW should promote collaboration among organizations, professional service providers, colleagues, and diverse social and economic organizations.

4. ***Completion of Case Management (Discharge/Termination)***: The CHW should appropriately terminate community care coordination services upon established case closure guidelines. Examples may include but is not limited to: achievement of goals or outcomes, relocation, client refuses further participation in the program, or mutual agreement of termination.

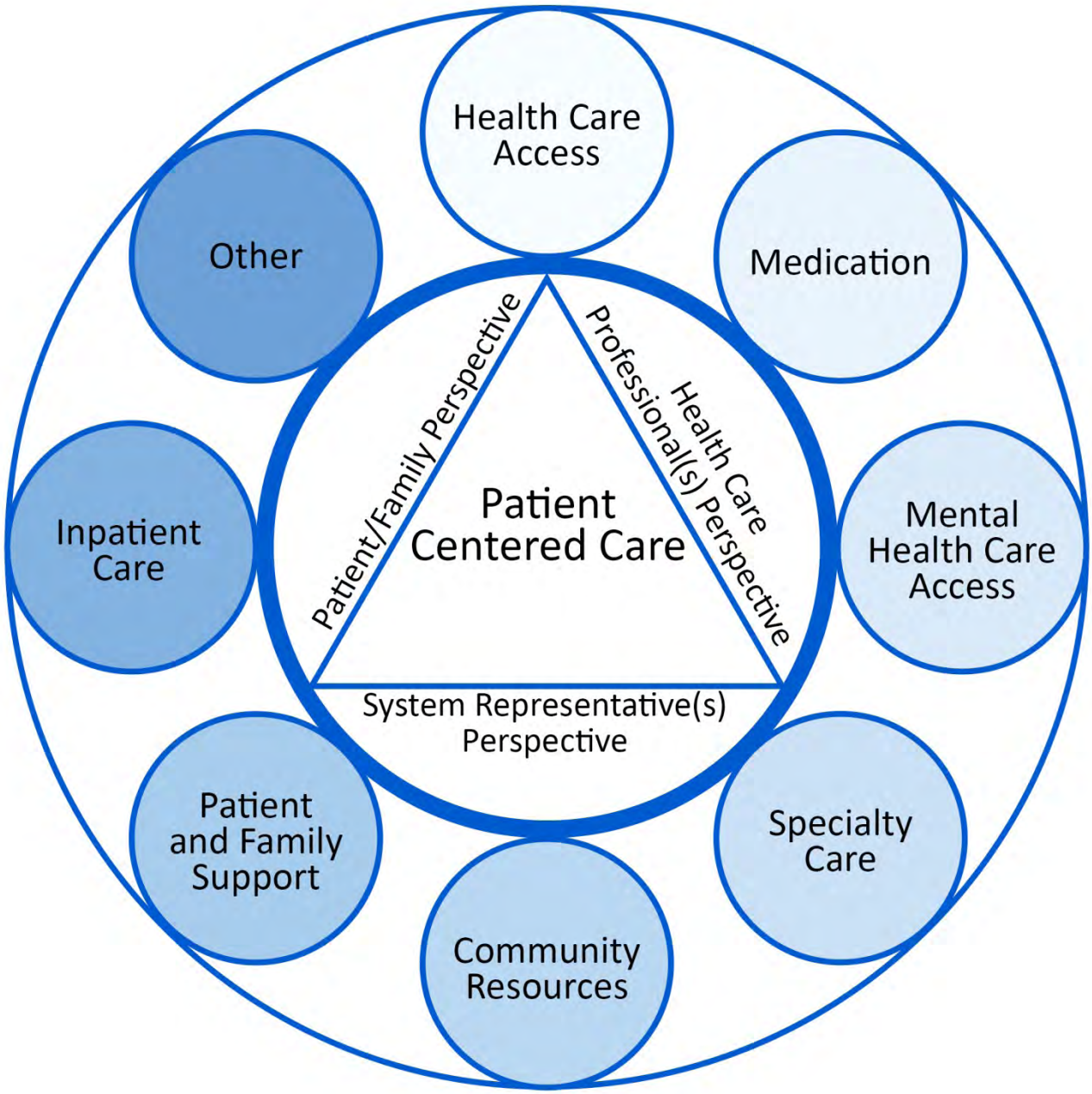
   a. **Assessment of Client's level of Self-Sufficiency**: Throughout the process, the CHW should take into account the client's ability to navigate the healthcare system and service agencies. For

clients who struggle with accessing resources, the CHW should provide a referral to other agencies upon discharge or termination.

b. **Practice Evaluation and Improvement**: When possible, an exit evaluation should be conducted to identify client satisfaction and improvement recommendations.

In determining the CHW's caseload the complexity of the clients rather than a quantified number of clients should be taken into account. A scale should be used to measure the overall complexity of the client and the level of Community Care Coordination that will be provided by the CHW. This scale should have three levels: extensive, moderate, and minimal. The level of medical and human services needs should be characterized by the level of fragmented care and the patient's ability to navigate through the level of resources or health providers with: high, moderate, and low.

COMMUNITY CARE DIAGRAM



Complexity: Extensive, Moderate, Minimal
Fragmentation: High, Moderate, Low
Patient Capacity: High, Moderate, Low
Care Coordination Need: Extensive, Moderate, Minimal

Community Participation

Community Health Access Team

The Community Health Access Team (CHAT) is an advisory board to the Health HUB program and is also powered by Buffalo County Community Partners. It services the community and the Pathways by holding the program accountable and ensuring its transparency. CHAT members are from multi-disciplinary agencies including: human services, health care organizations, education, healthcare providers, government, business and industry, and civic groups/churches/consumers. CHAT reviews reports that focus on increasing critical outcome production, increasing efficiency, decreasing cost, documenting unmet needs of the community, and making recommendations to overcome barriers or changes in the community.

Pathway Definition and Model

Safety Net Pathway

CHWs should encourage clients to identify a Primary Care Provider (PCP) and help foster a partnership between the patient and the PCP. The activities of the CHW, as an integrated member of the health care team, will be to assist in guiding clients in access to health care services, affirming healthcare plans directed by the PCP, teaching clients how to get the most out of their doctor visits, and navigating between emergency department care and primary care visits. The autonomy of the client is considered through the process of establishing a primary care provider to find a medical home.

A Safety Net Pathway is completed when the client has received the following action plans:

- ✓ The client has accepted ongoing care from one primary care provider (PCP).
- ✓ The client has received a summary of a future care plan that has been provided by their health care practitioner.
- ✓ A follow-up appointment is pending.
- ✓ The client has contact information of his/her PCP and understands to call for medical concerns to avoid unnecessary use of emergency department services.
- ✓ The optimum long-term goal for the client is to have an established, trusting partnership with his/her provider to address health concerns.

Payment Source Pathway

Navigating a complex consortium of insurance options, applications processes, and payment and medical debt issues, the CHW should examine and assess the client's options in pressuring payment options that will allow them to have on going care for their health needs. Through private and public insurance options, the CHW will direct clients to apply for health insurance coverage or overcome financial barriers that keep them from making medical appointments with their PCP.

The following actions illustrate a few ways to complete the Payment Source Pathway:

- ✓ An application from the Department of Health and Human Services has been approved to receive health care coverage.
- ✓ An alternative payment source has been established (e.g., church program, donation, one-time emergency CHAT funds, other community resources).
- ✓ A payment plan that is within the client's ability to pay is developed with the clinic.
- ✓ Low-cost clinic source of care (federally qualified clinic, sliding scale clinic, etc.).

Medication Access Pathway

Ensuring the client has access to medication is vital to their health outcomes. Equally important is confirming the client's understanding of how and when to administer medications. Through the medication reconciliation process, a nurse will assess the client's understanding of his or her medication and adherence level and alert the client's PCP of medication concerns. Access to affordable medication is a process the CHW ensures by referring clients to apply for brand name medications through pharmaceutical companies and making generic medications available when possible.

The following actions illustrate a few ways to complete the Medication Access Pathway:

- ✓ The client has been approved to receive prescribed medications from a Medication Access Program.
- ✓ Alternative, low-cost medications are reasonable for clients to pay as prescribed (e.g., generic medication, sample medications, etc.)
- ✓ Alternative/nontraditional prescribed methods have been agreed upon by doctor and patient.

Diabetes Education Pathway

Diabetes is a progressive disease and not all clients' needs and education levels will be the same. An assessment of each client's diabetes knowledge should be established and an action plan to increase the client's knowledge or support system should be agreed upon using evidence-based programs or materials. An individualized knowledge assessment should be performed to determine the course of action that should been taken to increase self-diabetes management.

The following actions illustrate a few ways to complete the Diabetes Education Pathway:

- ✓ The client is working with a certified diabetes educator.
- ✓ The client is attending support group meetings (e.g., Living Well, Diabetes Support Group, Central Health's CHAMP, etc.).
- ✓ The materials or support group is culturally appropriate for the client's self-identified culture and customs.

Social Service Referral Pathway

The conditions in which one is born, raised, lives, works, and ages are social determinants that have a direct link to poor health outcomes for certain populations. Community members dealing with poverty, homelessness, unemployment, and other life crises are poised to face more challenges to access medical care. The properties of shelter, food, and other basic survival needs are primary issues equal to medical care. The overall health report card of a person must address their social and medical needs to improve health outcomes. Community resources and services play an important role in addressing the social barriers of those in need. The CHW is instrumental in connecting those in need with services. An individualized needs assessment should be reviewed to determine the course of action to be taken to address the social determinants of one's health.

The following actions illustrate some of the ways to complete the Social Service Referral Pathway:

- ✓ A referral should be made to any community resources that can address, resolve, or lessen the client's unmet needs (e.g., housing, food, child care, transportation, language barriers, etc.).
- ✓ The application or qualification process has been completed to receive assistance from human service agencies.
- ✓ A resolution has been achieved so the client can learn to access services in the future independently of the Community Health Worker.

Integration of Primary Care and Behavioral Health Services

The merger of health care and behavioral health is a concept that truly embodies the idea of providing holistic care to addresses the health condition of the physiological and the mental health of a person. The model of integrated behavioral health and health care cannot be represented as a cookie cut model as there are many forms in which to develop a care model that address the needs of patients' health care and mental health conditions. The on-site integration care model is one that proves to be most effective as it addresses patients' needs as they are presented in a clinical visit. Other models that are specific to patients' needs and practice are: Improving Collaboration between Separate Providers, Medical Behavioral Health Care, Co-Location, Disease Management, Reverse Co-Location, Unified Primary Care and Behavioral Health, Primary Care Behavioral Health, and Collaborative System of Care. As a model is elected a Four Quadrants of Clinical Integration based upon the patients' needs can help navigate a patient and track accountability as they access medical and behavioral health services.

In a clinical visit a patient may be identified as a candidate in need of behavioral health services dependent upon their health care needs and mental health status. Providers grapple with providing adequate office visit time to develop a care plan. The four quadrant model can help providers refer the level of behavioral health services to best serve the patient. A diabetic patient with mild to moderate depression has low prospects of controlling their blood sugars as the symptoms of depression could impede them from actively engaging in their daily health care management. It may serve well for the person dealing with diabetes and depression to work with a behavioral health specialist to work through the barriers of mild to moderate depression. However, follow-through is one of the greatest challenges as behavioral health services are spread out in different locations and providers host different levels of care. Primary care providers and behavioral health specialist who integrated care have four options in the quadrant model for directing care, they are as follows:

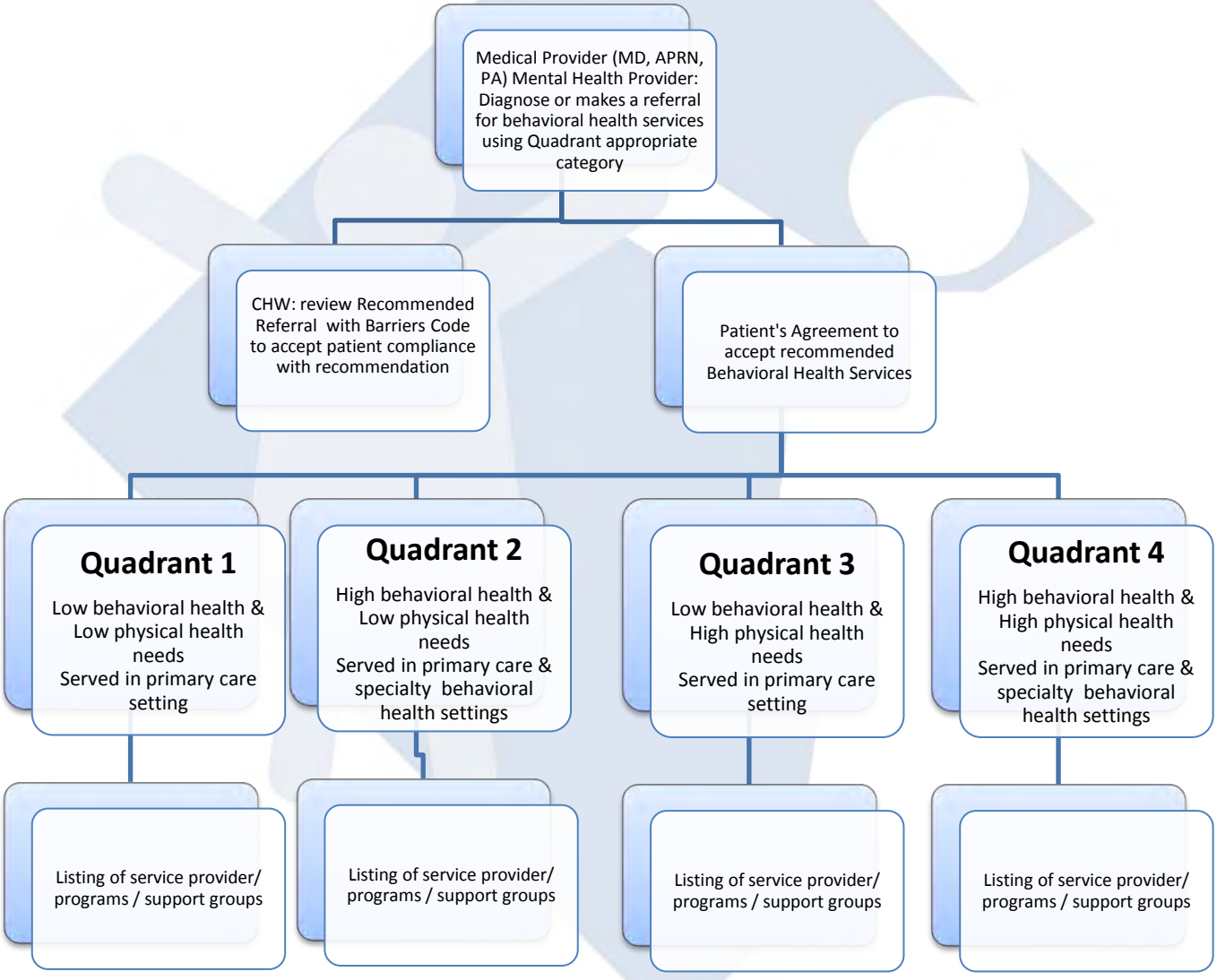
1. Quadrant 1:
    a. Resources/referrals for patients who have low behavioral health and low physical health needs
    b. Served in Primary care setting with a "warm hand-off" to a behavioral health specialist
2. Quadrant 2:
    a. Resources/referrals patients with high behavioral health and low physical health care needs
    b. Served in primary care and specialty mental health settings
3. Quadrant 3:
    a. Resources/referrals patient with low behavioral health and high physical health needs
    b. Served in primary care and specialty mental health setting
4. Quadrant 4:
    a. Resources/referrals patient with high behavioral health and high physical health needs
    b. Served in primary care and specialty mental health setting

LOW←BEHAVOPAL HELATH RISK / COMPLEXITY → HIGH	FOUR QUADRANTS OF CLINCIAL INTEGRATION BASED ON PATIENT NEEDS	
	QUADRANT II • Patients with high behavioral health and low physical health needs • Served in Primary care and specially mental health settings (Example: patients with bipolar disorder and chronic pain) Note: when mental health needs are stable often mental health care can be transitioned back to primary care.	**QUADRANT IV** • Patient with high behavioral health and high physical health needs • Served in primary care and specialty mental health setting (Example: patients with schizophrenia and metabolic syndrome or hepatitis C)
	QUADRANT I • Patients with low behavioral health and low physical health needs • Served in primary care setting (Example: patients with moderate alcohol abuse and fibromyalgia)	**QUADRANT III** • Patients with low behavioral health and high physical health needs • Served in primary care setting (Example: patients with moderate depression and uncontrolled diabetes)
	Low ← Physical Health Risk/ complexity →High	

[1] http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf

Behavioral Health Pathway and Community Health Workers

As Primary health care providers and behavioral health specialist work congruently to produce a care plan, a Community Health Worker (CHW) plays the critical role to help the patients successfully comply and advocate on their behalf. Unlike the other pathway such as the Safety Net Pathway the client is guided by the diagnosis and health care plan set by the providers for a patient to agree upon a care plan in a more structured environment. In this process the health care provider initiates and directs behavioral health services pending community resources for behavioral health providers and their locations.



The CHW will assist the client as they navigate mental health services regardless if the integration services are provided in the same location of clinical care, to ensure accountability as it is typically a high percentage of uncompleted care plans. As the patient progresses though a quadrant pathway it is vital to monitor and measure their needs and successful pathway outcomes. As with selecting measurements there are several

models in which tracking a behavioral health pathway. Several measurable tools can be selected, it is up to clinical practice and patient objectives/ needs that should determine the measuring tools. In this model three tools are considered: Duke Profile, Global Assessment, and the PHQ Screeners

1. **Duke Profile**: takes into account a wide range of health issues using a scale evaluation of the following aspects

    a. Physical Health
    b. Mental Health
    c. Social Health
    d. General Health
    e. Perceived Health
    f. Self-esteem
    g. Anxiety
    h. Depression
    i. Anxiety-Depression
    j. Pain
    k. Disability

    The survey tool is completed by a patient and can be taken over time to provide a pre and post intervention evaluation.

2. **Global Assessment**: can provide a subjective evaluation of a patient's ability to function in his/her daily life. The evaluation is provided by a behavioral health care professional. The Global Assessment is able to capture a holistic snap shot of a person's health and provide a patient's needs for modifying or address issues of behavioral health.

    a) 91-100 Superior functioning in a wide range of activities
    b) 81-90 Absent or minimal symptoms
    c) 71-80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors
    d) 61-70 Some mild symptoms or some difficulty in social, occupational, or school functioning
    e) 51-60 Moderate symptoms or moderate difficulty in social, occupational, or school functioning
    f) 41-50 Serious symptoms or any serious impairment in social, occupational, or school functioning
    g) 31-40 Some impairment in reality or communication major impairment judgment , thinking or mood
    h) 21-30 Behavior is considerable influenced by delusional/hallucinations or serious impairment in communication, judgment
    i) 11-20 Some danger in hurting self or others or occasionally fails to maintain minimal persona hygiene
    j) 1-10 Persistent danger of severely hurting self or others or serious suicidal act with clear expectation of death
    k) 0 Inadequate information

3. **PHQ**: has a wide range of assessment has up to seven screening tools that will screen for depression and does not evaluate other behavioral health issues. The survey tools are completed by the patients and are easy to use.
    a. PHQ
    b. PHQ-9
    c. GAD-7
    d. PHQ-15
    e. PHQ-SADS
    f. Brief PHQ
    g. PHQ-4

As with all pathways the Behavioral Health Pathway is accompanied by an action plan that narrows the patient's goals and objectives to addressing the need for a behavioral Health Pathway and ultimately identifying the barriers to accessing or accepting mental health services. The Action planning is completed by the CHW and the patients as a form of accountability. It is highly recommended that the action plan be followed and updated often to endure that lost-to-follow up is circumvented and adjustments are made a patient needs may change.

Appendix L – Zung Depression Screening tool was used in the Health HUB model to screen clients for depression. Through the use of the Zune tool the Behavioral Health Integration Pathway was developed.

Action Plans

All Pathways have an action plan that is designed to increase client engagement and accountability to change or complete an activity. The action plan follows the change model stages: pre-contemplation, contemplation, preparation, action, and maintenance. The CHW and the client should work together to identify a goal that will help the client change, modify, or accomplish an action. To ensure accountability, an action plan should be concise and easily understandable, asking the questions: who (responsibilities), what (goals), when (timeframe), how (resources and communication).

Return on investment

The contributions of CHWs are two-fold as they reduce healthcare costs and improve health outcomes. This is done by reducing emergency department visits, reducing hospital admissions, and improving primary healthcare access. They also make an impact on health outcomes by addressing human services, which have a significant impact on how and when at-risk populations can access health care. Pre- and post-intervention evaluations are critical to the assessment of return on investment.

Developing Policy for Change

CHWs have been actively engaged as frontline public health workers for over 50 years. Internationally, CHWs have been first responders to the crises of malaria, HIV/AIDS, infant mortality, children's health, and a host of other health topics. It has only been in the last two decades that CHWs in the United States have been recognized for their contributions as accepted, non-traditional healthcare professionals. Nationally, the American Public Health Association has declared definitions and other formal descriptions and the role of CHWs. A handful of states have taken legislative action to sustain the CHW workforce, while others are in the process of formalizing the profession. Despite national and local efforts, the CHW profession struggles to maintain financial stability, recognition, and support to maintain their present capacities and facilitate integration into the healthcare profession. It is imperative that policies are developed to engage government leaders, health departments/associations, civic entities, and community members to promote the advancement of the CHW profession.

Translated Materials

Materials are available in Spanish, upon request.

Acknowledgements

We would like to acknowledge the Community Health Access Team for their many years of work toward developing and building the Community Health Worker workforce. Members of the team include:

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Many others were integral in developing the Health HUB program and advocating for Community Health Workers. We would also like to thank the Community Health Worker Health Policy Academy team, who developed the Community Health Worker definition, scope of practice, and core competencies that assisted the Public Health Association of Nebraska in their adoption of the Community Health Worker workforce.

Nebraska Community Health Workers (CHW) Coalition
CHW Definition, Roles, and Core Competencies

Definition: A Community Health Worker (CHW) is an individual who:

- Serves as a liaison/link between public health, health care, behavioral health services, social services, and the community to assist individuals and communities in adopting healthy behaviors
- Conducts outreach that promotes and improves individual and community health
- Facilitates access to services, decreases health disparities, and improves the quality and cultural competence of service delivery in Nebraska.

A CHW is a trusted member of, or has a good understanding of, the community they serve. They are able to build trusting relationships and are able to link individuals with the systems of care in the communities they serve.

A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. CHW is an umbrella term used to define other professional titles.

Community Health Worker Roles

- Outreach and Community Mobilization
- Community/Cultural Liaison
- Case Management and Care Coordination
- Home-based Support
- Health Promotion and Health Coaching
- Participatory Research

Community Health Worker Functions/Responsibilities/Activities

- Ability to work within the Nebraska CHW Association code of ethics
- Serve as a Cultural Health Liaison or Facilitator
- Empower clients through advocacy and education
- Conduct outreach activities
- Raise awareness of health and wellness needs
- Provide disease prevention education
- Provide social support
- Build community capacity
- Community resources navigation

CHW Knowledge Base

CHWs demonstrate knowledge on a variety of topics based on the needs of the communities, clients, families, and service systems. They provide culturally appropriate health education to individuals they serve. The foundation for CHW practice includes:

- Basic knowledge about social determinants of health
- Basic knowledge of public health principles

- Knowledge of community definition, resources, organization
- Health and social service systems knowledge
- Health education knowledge
- Cultural Competency and Health Literacy
- Interpretation and Translation - understand the role of medical interpreters and boundaries for practice
- Understand the scope of practice of Community Health Worker practice
- Ethics and practice
- Educational and facilitation techniques
- Minimal definition of health, disease and well being
- Basic knowledge of specific health topics when they are related to their scope of activities

Core Competencies of Community Health Worker (skills and qualities)

A. Communication Skills

- ★ Ability to use Active Listening
- ★ Ability to communicate in writing
- ★ Ability to communicate verbally

CHWs will communicate with varied populations, individuals, other community health workers, and professionals in a manner that is appropriate for the audience.

Effective cross cultural communication is a central aspect of CHW activity in all areas. They must be able to use relevant languages, be respectful, and demonstrate knowledge of the cultural group(s) they are engaging. They must be able to convey their knowledge base of basic health and social concerns that are meaningful to the clients and families, especially when behavior patterns are deeply rooted in traditions. Sensitivity must be used when attempting to discuss options and reasons for change.

CHWs are required to write and prepare clear reports on their clients, activities, and assessments of individual and community needs. They will be expected to give presentations regarding the needs and concerns of their clients and communities. Competence in writing and technical skills is expected to increase with experience. CHWs are encouraged to be able to read and write in English, but it may not be essential depending upon their area of focus.

B. Interpersonal skills

- ★ Ability to build relationships
- ★ Ability to work as part of a team
- ★ Ability to understand and work within cultural dynamics

CHWs work with a diverse group of individuals including community members and professionals. They must be able to develop and maintain relationships at all levels. They must be able to work as part of a team, and consider, understand, and respect various perspectives to meet the needs of others.

C. Capacity Building

- ★ Understanding of and ability to apply leadership
- ★ Ability to develop additional skills
- ★ Ability to develop and manage resources
- ★ Ability to use planning skills
- ★ Ability to produce complete, accurate reports
- ★ Understanding of needs assessments

CHWs will increase the capability of their community to be empowered to care for themselves. They will also work collectively with community members and stakeholders to develop plans to increase resources in the community and to expand public awareness of community needs.

D. Teaching Skills

- ★ Ability to teach one-on-one and/or in group settings
- ★ Ability and willingness to learn and be proficient with information being presented
- ★ Ability to lead classes or educational sessions
- ★ Recognize need to continue education
- ★ Ability to adapt teaching style to audience needs

CHWs teach and provide health and social service information and education to individuals they assist. They will effectively support and engage clients and their families in making behavioral changes, following treatment suggestions, and identifying barriers to change that are mutually acceptable and understood by the client, families, and community contact. They will have the ability to make appropriate referrals when needed.

E. Advocacy Skills

- ★ Ability to be assertive and respectful
- ★ Ability to listen and ask questions
- ★ Ability to advocate at different professional levels
- ★ Ability to identify and manage risky situations
- ★ Ability to strengthen social support networks

CHWs must be able to advocate effectively with others so that the individuals they serve are able to receive the services they need. They provide information and support to others and teach them how to advocate for their own needs. They must have knowledge and tools for conflict resolution.

F. Organizational Skills

- ★ Ability to develop plans and set goals
- ★ Ability to manage time and determine priorities
- ★ Ability to manage a budget
- ★ Ability to report and evaluate in community settings

CHWs must have good organizational skills to help support the individuals and families they serve. They must be able to help and teach others to set and achieve goals. They help individuals and families set appointments, follow up with care plans and help address barriers, and complete reporting requirements.

G. Service Coordination

- ★ Ability to identify and access resources
- ★ Ability to make appropriate referrals when needed
- ★ Ability to network, form partnerships, and work with others in planning efforts

CHWs help coordinate the care of their clients. They will be familiar with the agencies and professionals in the community they serve in order to assist clients and families to secure needed care. They understand the need for, and boundaries of, medical interpretation and ability to be a patient advocate. They are able to network, participate in community and agency planning and evaluation efforts directed at improving care, and bring needed services into the community.

H. Outreach Methods and Strategies

- ★ Ability to engage others
- ★ Ability to foster collaborative relationships
- ★ Ability to build trust within the community

CHWs must be committed to outreach efforts that are directed at "meeting the people where they are." Outreach means furnishing health-related information and services to a population that has not been served or is underserved. CHWs use outreach strategies and methods in order to provide these services to populations or groups where they live, work, play, and congregate (such as churches, parks, grocery stores, community centers, etc.). They assist the community in finding, using, creating, and supporting resources among community members and systems of care.

I. Client and Community Assessment

- ★ Ability to understand basic surveys, interviews, and observational methods
- ★ Ability to understand population health data

CHWs must continue to identify community and individual needs, concerns, and assets. They will use standard knowledge of basic health and social indexes to clearly define the needs of the community they are serving. CHWs will engage clients and their families in ongoing assessment of their needs and develop plans and strategies for clients, a targeted population, or community.

Resources

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Nebraska Community Health Worker Scope of Practice

Roles	Tasks	
Outreach and Community Mobilization	• Preparation and distribution of materials • Case-finding and recruitment • Promoting health literacy	• Home visiting • Advocacy • Community strengths/needs assessment
Community/Cultural Liaison	• Community organizing • Community needs/strengths assessment	• Translation and interpretation* • Advocacy
Case Management and Care Coordination	• Family engagement • Individual strengths/needs assessment • Addressing basic needs-food, shelter, etc. • Promoting health literacy • Coaching and problem-solving • Goal-setting and action planning	• Supportive listening • Coordination, referrals, follow-ups • Feedback to medical providers • Treatment adherence • Documentation
Home-based Support	• Family engagement • Home visiting • Environmental assessment • Promoting health literacy • Supportive listening	• Coaching on problem-solving • Action plan implementation • Treatment adherence • Documentation
Health Promotion and Health Coaching	• Translation and interpretation* • Preparation and distribution of materials • Teaching health promotion and prevention • Coaching and problem-solving • Modeling behavior change	• Adult learning methods selection • Harm reduction • Treatment adherence • Leading support groups • Documentation • Promoting health literacy
Participatory Research	• Preparation and distribution of materials • Advocacy • Interviewing	• Computerized data entry and web searches • Documentation

*While informal interpretation and/or translation may take place, there is a certification process for these practitioners. Interpretation and translation are not primary duties of a CHW. Not all CHWs will become interpreters and/or translators.

Adapted from: Matos, S., Findley, S., Hicks, A., Legendre, Y., & Do Canto, L. (2011, October). *Paving a path to advance the CHW workforce in New York State: A new summary report and recommendations*. Retrieved from http://nyshealthfoundation.org/uploads/resources/paving-path-advance-community-health-worker-october-2011.pdf

WELCOME

Client Information: **Enrollment Date:**_____

First Name:_____ Last Name:_____ Initials: _____

Address:_____ Apt/Trailer №:_____ Zip Code:_____ DOB:_____

Gender: Male / Female Social Security №:_____-_____-_____ INS №:_____

Phone №: _____ Alternative Phone _____ E-mail address:_____

How would you like us to communicate with you (check all that apply): ☐ Phone call ☐ Text Message ☐ E-mail ☐ U.S. Mail

Are you foreign born? ☐ No ☐ Yes Citizenship? ☐ No ☐ Yes

Language:

☐ English ☐ Español ☐ Français ☐ Portugês ☐ Sudanese ☐ Somali ☐ Other

Ethnicity:

☐ Caucasian ☐ Asian/Pacific ☐ African American ☐Hispanic ☐ American Native ☐Unknown ☐ other

Emergency Contact:

Name:_____ Relationship:_____ Phone №:_____

Sexuality:

Do you think of yourself as: ☐Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Transgender ☐ Don't Know ☐ Other
☐ Decline to answer

General Information:

Do you have a Primary Care Provider (PCP)? ☐ No ☐ Yes if yes, What is your health Provider's Name? _____

When was your last office visit with your provider?_____

What is your marital status: ☐Married ☐Partnered ☐Single ☐Divorced ☐Widowed ☐ Other_____

For housing do you? ☐Rent ☐ Own ☐ Live with family/friends ☐ Homeless ☐Other _____

What is your job Status? ☐ Full-time ☐Part-time ☐Retired ☐Laid off ☐Disable ☐ Unable to work

Household Yearly Income:

☐ Less $9,999 ☐$10,000-14,999 ☐$15,000-19,999 ☐$20,000-29,999 ☐ $30,000-49,999 ☐$50,000-79,999 ☐ over $80,000

Number of household members _____ Have you recently been released from jail or prison ☐No ☐ Yes

Highest level of education completed: ☐ K-5th ☐ 6th - 11th ☐ Diploma ☐ Some High School ☐ GED ☐ No School ☐ College ☐ Some College

Health Insurance:

Do you have health insurance? ☐ No ☐ Yes How long have you been without Insurance? _____

Medicaid: ☐ Full ☐ Spend down, what is the amount? $_____ Medicare: Part ☐A ☐B ☐C ☐D

Commercial Insurance: Name of Company:_____ Policy No. _____

What is your Premium $_____ What is the Deductible amount: $_____ Do you have prescription coverage? ☐ No ☐ Yes

Have you applied for health insurance in the past ☐No ☐Yes, when _____

Do you have dental insurance? ☐ No ☐ Yes, Name Of Company_____

Do you have vision insurance? ☐ No ☐ Yes, Name Of Company_____

Medical Bills:

Do you have an outstanding bill with a Clinic? ☐No ☐Yes, what is the amount$_____ Name of the Clinic_____

Do you have an outstanding bill with the Hospital? ☐ No ☐ Yes, what is the amount $_____

Do you currently have credit card debt from using a Credit Card to pay for medical bills? ☐ No ☐ Yes,
If yes, what is your best estimate of the Credit Card amount that you own for the medical related charges? $_____

Emergency Room:

Have you been to the Emergency Room for care in the last 6 months? ☐ No ☐ Yes, how many ER visits _____

Were the ER visits related to diabetes complications?

☐ All visits were diabetes related ☐ No, visits were not related to diabetes ☐ Some visits were diabetes related

Have you stayed overnight in a hospital for a short-term illness due to diabetes complications in the last 6 month? ☐ No ☐ Yes

Can you describe the complications for which you stayed overnight in the hospital? _____

Appendix B: Intake Form

Primary Care Provider Needs

□ Safety Net Barrier (check all that apply) **Do you have a Primary Care Provider?** ☐ No ☐ Yes

Find Appropriate Doctor **CHW Time:_____**

□ Help schedule an appointment:

Provider's Name: _____

Date_____ Time _____

□ Client has accepted on going care from one Primary Care Provider

I have selected a Primary Care Provider. I am open to the idea of developing a long-term medical relationship with this provider for my personal health and wellness. However, I also understand my right to change medical providers at any time I choose. In the event that I do decide to change my Primary Care Provider (PCP), I agree to select another PCP from a list of eligible providers.

I accept Dr._____From: _____Clinic as my ongoing PCP.

Client Signature:_____Date:_____

Prepare Client for Office Visit **CHW Time:_____**

□ Take all medication bottles or list to appointment including vitamins & herbs
□ Help prepare a list of questions for their PCP
□ Review "To Be a Better Patient" list
□ Take "My Personal Health Manager Folder"
□ Blood Sugar log or computer generated readout of meter
□ Escort client to doctor's appointment

Follow-up with PCP **CHW Time:_____**

□ Help Educate client to understand the plan of care outlined by the PCP
□ The Client has received a summary for future care plan, provided by their PCP
□ Review the PCP plan with client & check for understanding
□ A copy of PCP's care plan into client's file
□ A follow-up care Appointment is pending: Date:_____ Time:_____
□ Client has contact information for his/her PCP & understands to call the Doctor for Medical concerns to avoid unnecessary/ misuse of the Emergency Room Services*

Primary Care Provider Status **CHW Time:_____**

□ Successful Completed pathway (***Provide a short summary in Apricot)***
□ Unsuccessful Pathway (***Provide a short summary in Apricot)***
If unsuccessful please indicate whether:
□ *Client was lost to follow-up and ultimately discharged* ***(Provide a short summary in Apricot)***
□ *Client was unwilling to keep appointments or otherwise will not execute his/her action plan.*

Track Safety Net Needs **CHW Time:_____**

□ Successful pathway entails completing an action plan that includes follow-up with client within 30 days or less to update needs, changes, progress or set-backs. **(See associated social Barrier Action Plan)**

Client Signature: _____ *D.O.B:* _____

*Community Health Worker*_____*Date:* _____

Barriers Code for Safety Net

Please mark all that apply:

1. Cost too much
2. Needed someone to care for his/her children
3. Would lose pay from work
4. Do not have medical Insurance
5. Bad medical debt with Clinic_____the past due amount is $_____
6. Lack of communication
7. His/Her culture/customs were ignored
8. There were no ethnic group/staff members at the office/Clinic
9. Felt embarrassed when the doctor examined
10. Afraid of what the doctor might find
11. Does not speak English very well
12. Clinic staff does not speak his/her language
13. Did not know where to go
14. Staff at the office/Clinic were disrespectful
15. Had no confidence in the Clinic
16. Prefer to put up with the pain rather than go to the doctor
17. Medical Services are far from where he/she lives
18. Have difficulty walking/walking tires him/her
19. Public transportation is difficult to arrange
20. Care was not available when needed
21. Hours were not convenient
22. Had to wait too long to get an appointment
23. Had to wait too long in the office/Clinic
24. Did not have a ride to the clinic
25. Worried he/she could lose job
26. Other

Barrier Category:
1-5 Financial
6-16 Cultural Competence
17-19 Distance or Geography Barrier
20-25 Clinic Hours Barriers

My Safety Net Action Plan

I have selected a Primary Care Provider and I would like to start a working partnership with my doctor and nurse team, to help me keep my goal. I will:

☐ Seek more Information ☐ Problem solve ☐ Find a resource in the community

1. **My Goal is:** Something I want to do: (e.g., keep my appointments, take my blood sugars)

_____

_____

2. **The Action:** (e.g., communicate with the nurse or doctor, notify changes such as address or phone number)

_____

_____

3. **Problem Solving:** what things might make it hard for me to reach my goal? (e.g., no ride to appointment, my boss won't give me the time off)

_____

_____

4. **The Support:** I need from the Community Health Worker to reach my goal: (e.g., "I would like my Community Health Worker to help me with…")

_____

_____

5. **My Level of Confidence that I will reach my goal is:** I----------I----------I

0 1 2 3 4 5 6 7 8 9 10

6. I am happy to have a follow-up Session to check on the progress I have made in reaching my goal. A follow-up session might include*:* (e.g., have a home visit or phone conversation within 1 or 2 days after my clinic appointment) **Please list agreed to follow-up actions.**

_____

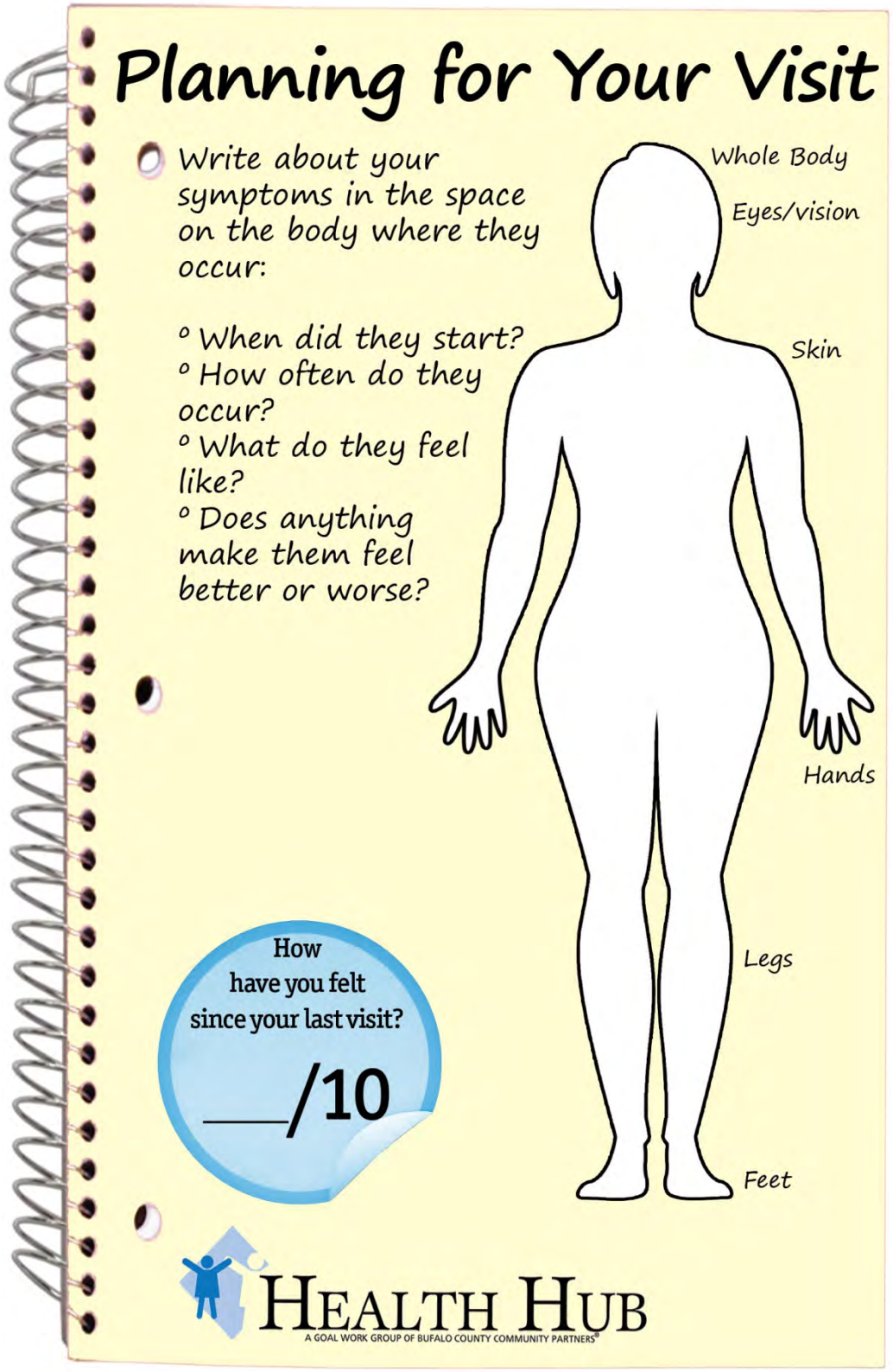
_____

I pledge to follow this action plan and use the offered support to begin an ongoing partnership where I am actively a team member with my doctor and nurse.

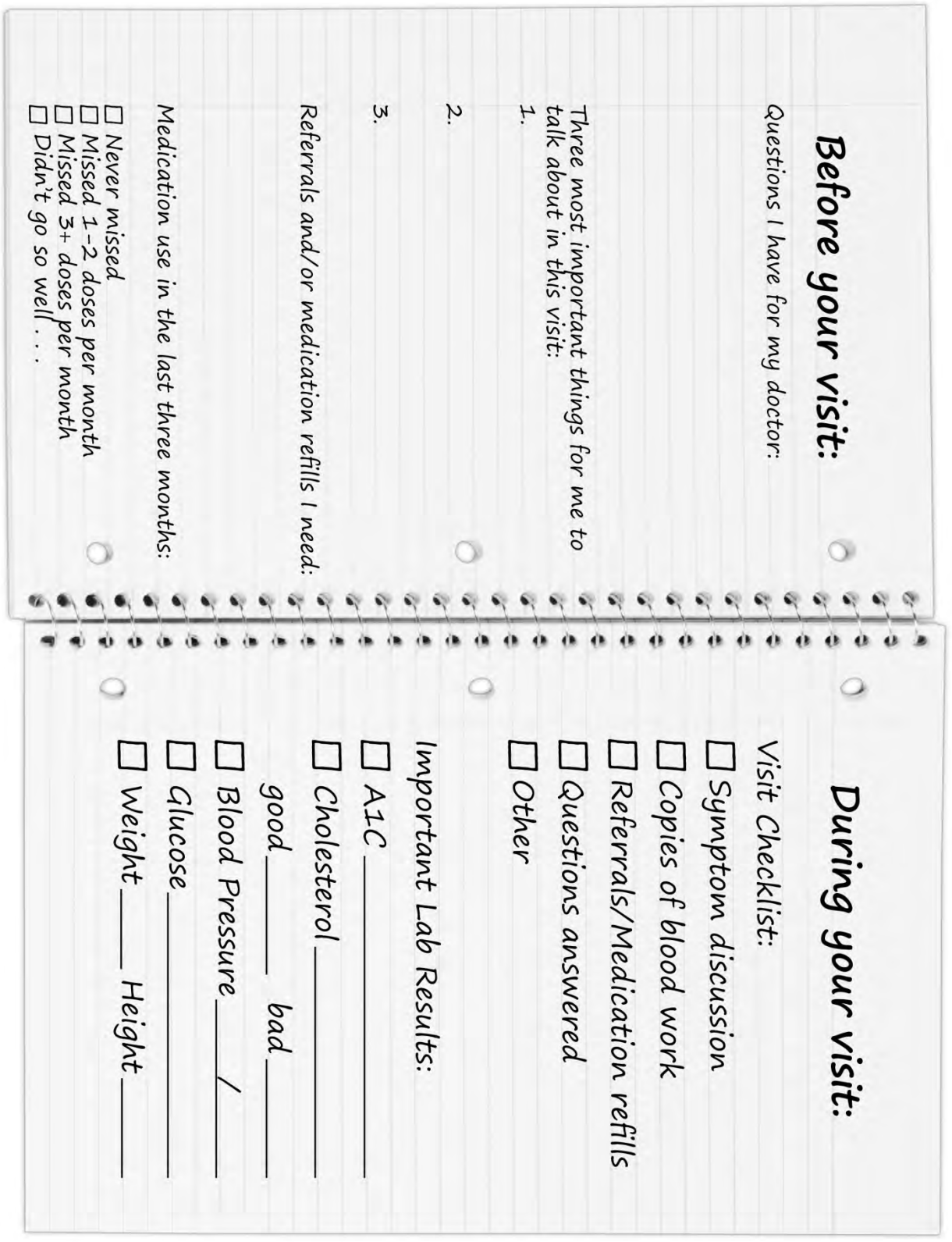
My Signature: _____ Date: _____

Community Health Worker: _____ Date: _____

Cover:


Planning for Your Visit
Write about your symptoms in the space on the body where they occur:
° When did they start?
° How often do they occur?
° What do they feel like?
° Does anything make them feel better or worse?
Whole Body
Eyes/vision
Skin
Hands
Legs
Feet
How have you felt since your last visit?
____/10
HEALTH HUB
A GOAL WORK GROUP OF BUFALO COUNTY COMMUNITY PARTNERS

Inside Pages:



Before your visit:

Questions I have for my doctor:

Three most important things for me to talk about in this visit:

1.

2.

3.

Referrals and/or medication refills I need:

Medication use in the last three months:

☐ Never missed
☐ Missed 1-2 doses per month
☐ Missed 3+ doses per month
☐ Didn't go so well . . .

During your visit:

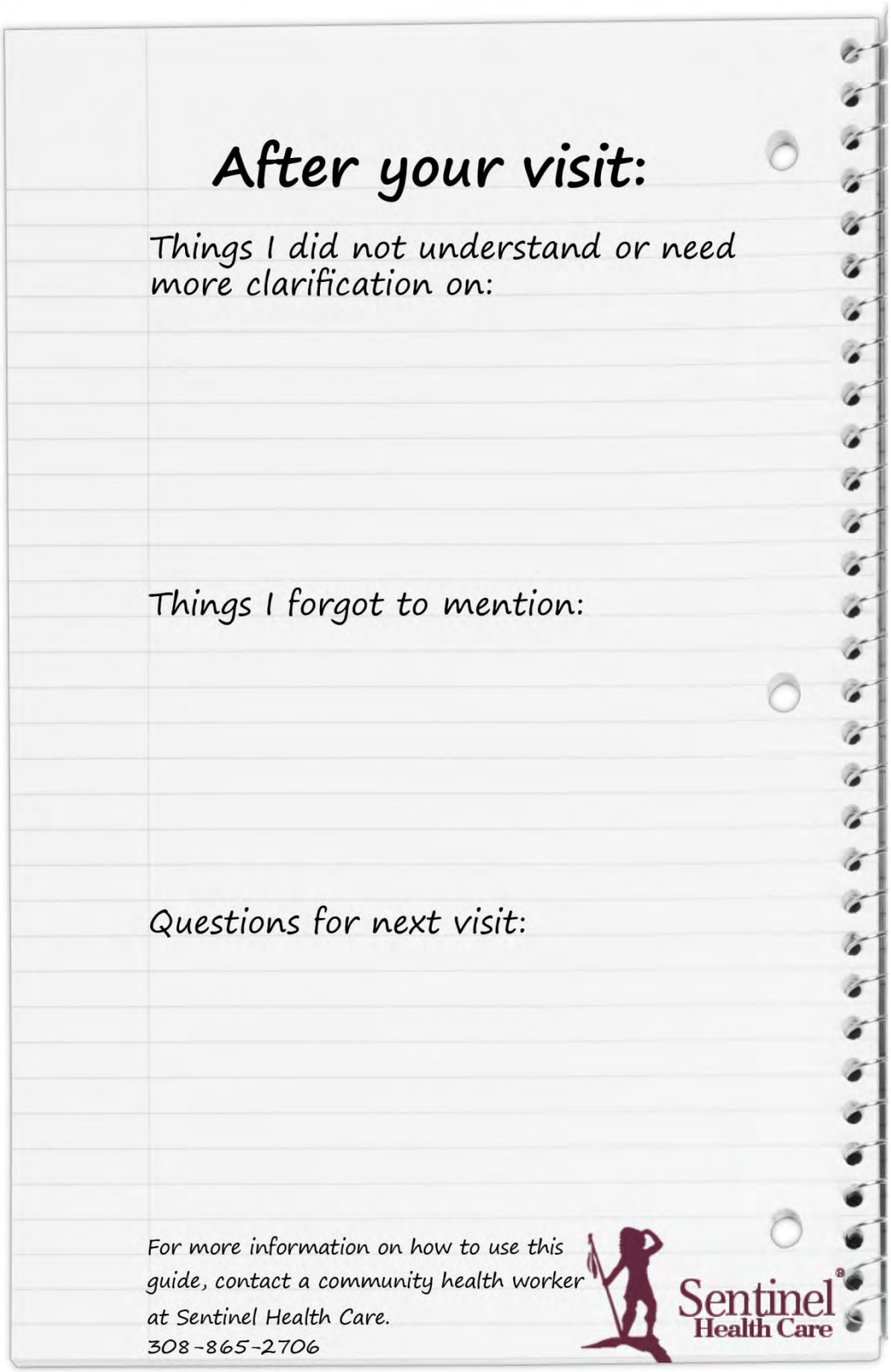
Visit Checklist:

☐ Symptom discussion
☐ Copies of blood work
☐ Referrals/Medication refills
☐ Questions answered
☐ Other

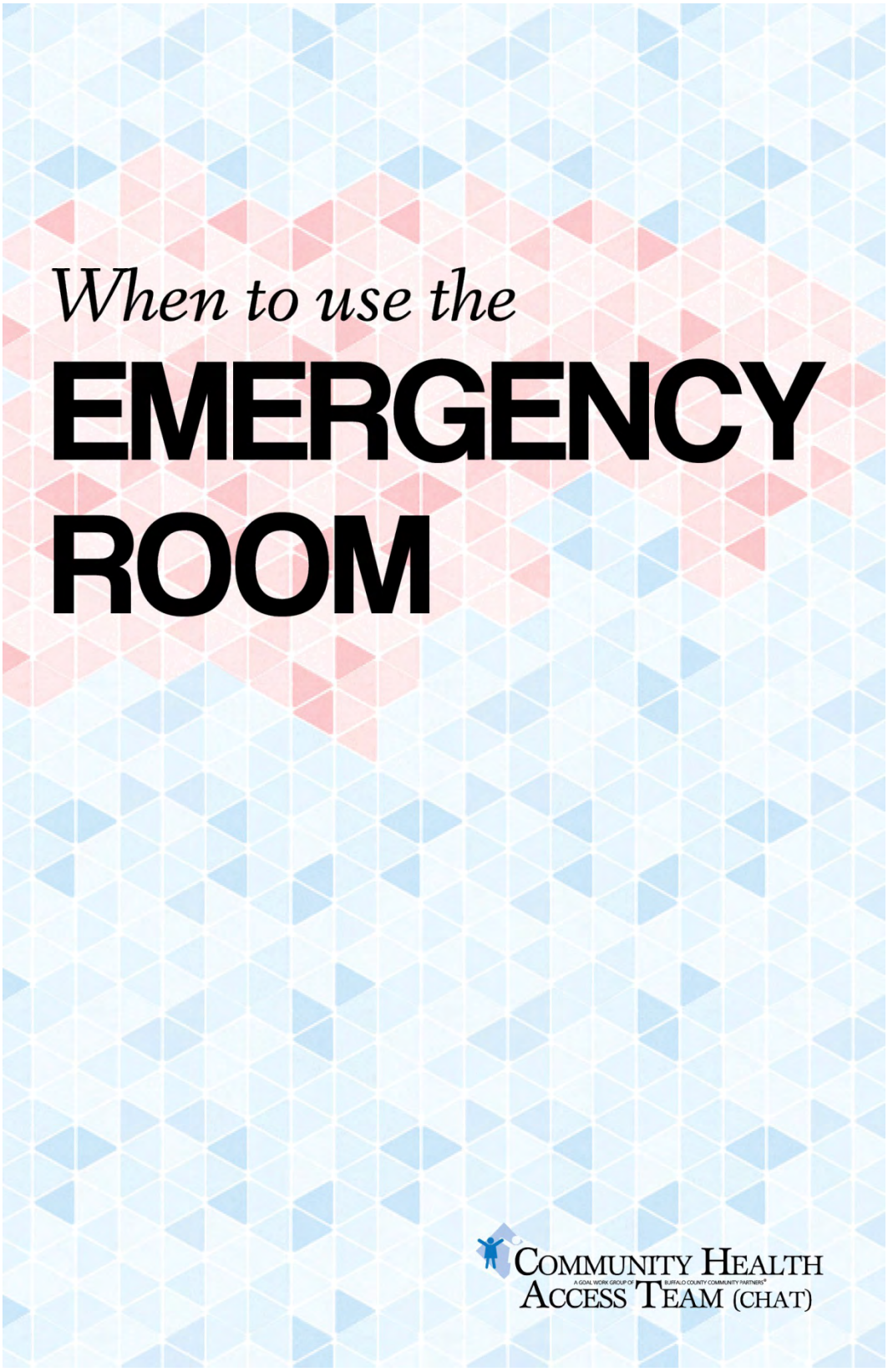
Important Lab Results:

☐ A1C _____
☐ Cholesterol _____
good_____ bad_____
☐ Blood Pressure____/____
☐ Glucose_____
☐ Weight____ Height____

Back Page:


After your visit:
Things I did not understand or need more clarification on:
Things I forgot to mention:
Questions for next visit:
For more information on how to use this guide, contact a community health worker at Sentinel Health Care.
308-865-2706
Sentinel Health Care

Cover:


When to use the
EMERGENCY ROOM
COMMUNITY HEALTH ACCESS TEAM (CHAT)

Inside Pages:

WHEN SHOULD I VISIT THE EMERGENCY ROOM?

If you have a sudden illness or injury, you need to decide how serious it is and how quickly you need to be seen by a medical provider. If your symptoms are life threatening, you should call 911 or go to the emergency room right away.

Signs of an Emergency:

- Severe bleeding that cannot be stopped with pressure
- Weakness in an arm or leg, speech, or sudden drooping
- Coughing or vomiting blood
- Sudden onset of confusion
- Sudden onset of vision problems
- New seizures (lasting 3-5 minutes)
- Any type of chest pain
- Difficulty breathing
- Sudden severe pain
- Fainting
- Poisoning

WHEN SHOULD I CALL OR VISIT MY HEALTH CARE PROVIDER?

Non-Emergency Illnesses that Can Be Treated in a Doctor's Office:

- Earaches
- Minor cuts
- Colds, sore throat, or flu symptoms
- Fever (if you are convulsing)
- Sting or bite from an insect
- Rash, sunburn, or minor burn
- Sexually transmitted disease (STD)

THIS LIST IS INTENDED TO BE USED AS A GUIDELINE AND IS NOT MEANT TO BE ALL-INCLUSIVE. CONSULT WITH YOUR PRIMARY CARE PROVIDER IF YOU HAVE ANY HEALTH QUESTIONS OR CONCERNS.

Back Page:

WHY SHOULDN'T I USE THE EMERGENCY ROOM?

Services you cannot get in the emergency room:

- Ongoing care
- Medication refills for ongoing illness
- Care management

Benefits of having a primary care provider:

- Help you get preventative care
- Guide you to feeling better
- Give you personalized health advice
- Manage ongoing illness (asthma, diabetes, etc.)

Health Care Coverage Needs

□ Payment Source Barrier (check all that apply)

Payment Source/Health Insurance Coverage **CHW Time:_____**

The client has Health Insurance: Yes □ No □

If yes, please indicate the type of insurance that the client has:

□ Private Individual health Insurance
□ Group Insurance Plan through Employer
□ COBRA coverage
□ Pre-existing Condition Insurance plan (from HHS)
□ Medicare
□ Medicare Disability
□ Medicaid (*no spend down*)
□ Medicaid (with a spend down)
□ Kids Connection (SCHIP)
□ Dual eligible: Medicare/ Medicaid
□ Veterans TRICARE
□ Other (*e.g., workmen comp*): _____

If no health Insurance (proceed with an application protocol)

Application Process- Begin application process for: **CHW Time:_____**

□ Private Individual health Insurance
□ Group Insurance Plan through Employer
□ COBRA coverage
□ Pre-existing Condition Insurance plan (from HHS)
□ Medicare
□ Medicare Disability
□ Marketplace
□ Medicaid (*no spend down*)
□ Medicaid (with a spend down)
□ Kids Connection (SCHIP)
□ Dual eligible: Medicare/ Medicaid
□ Veterans TRICARE
□ Other (*e.g., workmen comp*): _____

A Payment Source Pathway Action Plan has been developed: □ Yes □ No If no,

please provide an explanation: _____

Please indicate the date of application submission: _____

Application Follow-up **CHW Time:_____**

Status of Application Selected

□ Approved _____ Date of Activation _____

Policy Information

□ Denied Date of Denial: _____

Alternative Payment Source Options	**CHW Time:_____**
In cases where the client was denied for coverage or could not afford allowable coverage offered, please indicate your arrangements to assist the client with alternative payment options. □ Low cost clinic referral was made □ Donation from charitable organization secured _____ □ An affordable payment plan with a clinic has been arranged and client agrees with it □ Emergency funds as a one-time assistance were secured for the client □ Charity Care from a Clinic (name of physician_____) has been secured for the client □ No Alternative Payment Source Options were secured. Please indicate if: □ Client agrees to seek care and Self pay for that care □ Client will not agree to seek care and cannot Self pay for that care	
Payment Source Pathway Status	**CHW Time:_____**
□ Successfully Completed pathway (***Provide a short summary in Apricot)*** □ Unsuccessful Pathway (***Provide a short summary in Apricot)*** ***If unsuccessful please indicate whether:*** □ *Client was lost to follow-up and ultimately discharged* ***(Provide a short summary in Apricot)*** □ *Client's insurance coverage was denied and also will not agree to seek care and self-pay* □ *Client was unwilling to keep appointments or otherwise will not execute his/her action plan.*	
Track Payment Source Pathway:	**CHW Time:_____**
Successful pathways entail completing an action plan that includes follow-up with client within 30 days or less to update needs, changes, progress or set-backs. **(See associated Payment Source Pathway Action Plan)**	

Client Signature: _____ *D.O.B:* _____

Community Health Worker: _____ *Date:* _____

Barriers Codes for Health Insurance

Please mark all that apply:

1. Employer does not offer insurance coverage
2. Employer offers insurance coverage, but the employee cannot afford his/her premiums
3. Individual health insurance plan costs too much
4. Has health insurance but avoids using it because Deductibles are too high (the amount is $_____)
5. Covered by Medicaid, but avoids using it because the spend down is too high (the amount is $_____)
6. Currently in a waiting period for full coverage (e.g., six month exclusion of certain coverage options)
7. Pre-existing health problems have caused a denial of insurance in the past[1]
8. Client is currently unemployed **(check for COBRA as an option)**
9. Immigration status prohibits state health benefits
10. Does not believe that he/she needs health insurance
11. Can get health insurance but family isn't covered so he/she does not want it
12. Client does not fully understand how to use his/her health insurance
13. Other (please explain):_____

Barriers Categories
1-2 No private coverage options 3-5 Cannot afford private coverage options 6-7 Un-enrolled in public options, including Veteran TRICARE 8 Ineligible for public coverage options 9 Legal status 10-11 Personal choice based on attitudes and beliefs 12 Insurance literacy issues

1 Note: as 2012 clients may be eligible for PCIP, application available through Federal HHS go to www.PCIP.gov)

My Payment Source Action Plan

1. **My Goal** is to apply for the following type of insurance coverage: *(indicate which type of insurance is being applied for)*

_____

_____

2. **The Actions** I agree to take are: (e.g., keep my appointments with my CHW so that an application can be completed and submitted in a timely manner, bring the needed documentation for my application process, etc.)

_____

_____

3. **Problem Solving:** *What things might make it hard for me to gather my needed personal information and make my appointment for enrolling?* (e.g., lack of time, busy schedule, in the middle of moving from where I live)

_____

_____

4. **The Support** I need from my Community Health Worker to reach my insurance application goal is: (e.g., "I would like my Community Health Advocate to help me with…")

_____

_____

5. I am happy to have a **Follow-Up** session as needed to complete all the steps required to apply for insurance. (e.g., have a phone conversation in a week or so or check back in with my Health Worker some other way) **Please list agreed to follow-up actions:**

_____

_____

_____

6. In the event that our joint efforts to secure insurance coverage fail, I am willing to engage with my health worker, as we try to secure an alternative payment source for my health care.

Please list agreed to follow-up actions: (e.g., "I am willing to come to an appointment to consider alternative options.")

_____

_____

I pledge to follow this action plan and use the offered support to complete my insurance application process.

My Signature: _____ Date: _____

Community Health Worker: _____ Date: _____

Buffalo County Community Partners

Medication Needs

□ Medication Barrier (check all that apply)

Medication Reconciliation (RN) **CHW Time:_____**

□ List Medication/Vitamins/Herbs: Name, Dose, Route, Frequency
□ Educate client on the importance of knowing medications they are taking

Apply for Medication Assistance (CHW) **CHW Time:_____**

□ Refer client to the Medication Access Program (**MAP)** to enroll for Rx assistance
□ If PCP is not a member of Sentinel Group, obtain medication application from Rx company
□ (if applicable) Educate client regarding the Medicare Gap "donut hole"

Medication Secured **CHW Time:_____**

□ MAP program approved applicant to receive free medications

Rx Name:_____ Approved period: _____

Rx Name:_____ Approved period: _____

Rx Name:_____ Approved period: _____

Rx Name:_____ Approved period: _____

Rx Name:_____ Approved period: _____

□ Generic medications are reasonable for client to pay for meds
□ Alternative/non-traditional prescribed methods have been agreed upon by doctor and patient

Medication Status **CHW Time:_____**

□ Successful Completed Pathway **(*Provide a short summary in Apricot)***
□ Unsuccessful Pathway **(*Provide a short summary in Apricot)***
If unsuccessful, please indicate whether:
- □ *Client was* lost to follow-up and ultimately discharged **(*Provide a short summary in Apricot)***
- □ Client's *Application for service was denied*
- □ Client was u*nwilling to keep appointments or otherwise will not execute his/her action plan*

Track Medication Needs or re-application needs as needed **CHW Time:_____**

□ Assist client with re-application process (pending Rx company requirements)
□ Address any refill issues or medication changes
□ Re-start the process for any medication changes made through the year
□ Accurate medication count by date

Client Signature: _____ *D.O.B:* _____

*Nurse's Name:*_____ *Date:* _____

Barriers Code For Medication Access

Please mark all that apply:

1. Can't remember to take medications
2. Has difficulty understanding medications regiment
3. Reading Instructions
4. Doesn't believe medications are helping
5. Believes the medications are making him/her feel bad
6. Thinks the medication treatment is complicated
7. Thinks he/she is taking too many medications
8. Is currently using alcohol
9. Feels medication regiment takes a lot of time
10. Has fear of giving himself/herself shots
11. Has trouble opening bottle caps
12. Has trouble swallowing medications
13. Is unable to afford medications
14. Shares medications with other (family/friends)
15. No longer has PCP for medication refills
16. Doesn't have a provider who will refill his/her medications

Barriers Categories
☐ 1-3 Cognitive challenges ☐ 4-10 Adherence challenges ☐ 11-12 Physical challenges ☐ 13-14 Financial challenges ☐ 15-16 Access challenges

My Medication Barrier Action Plan

The Medication issues I am having can be overcome if I:

☐ Seek more Information ☐ Problem solve ☐ Find a resource in the community

1. My Goal is: *Something I want to do:* (e.g., maintain housing, find child care, etc.)

_____

_____

2. The Action(s) I agree to take are: (e.g., keep my appointments, have financial documentation ready)

_____

_____

3. Problem Solving: *What things might make it hard for me to reach my goal?* (e.g., lack of time, busy schedule, avoiding unhealthy foods, etc.)

_____

_____

4. The Support I need from my Community Health Worker to reach my goal is: (e.g., "I would like my Community Health Worker to help me with…")

_____

_____

5. My Level of Confidence that I will reach my goal is: I----------I----------I

0 1 2 3 4 5 6 7 8 9 10

6. I am happy to have a Follow-Up Session to check on the progress I have made in reaching my goal. A follow-up session might include: (i.e., have a phone conversation in a week or so or check back in with my Health worker some other way) **Please list agreed to follow-up actions:**

_____

_____

I pledge to follow this action plan and use the offered support to resolve my medication barriers.

My Signature: _____Date:_____

Nurse: _____Date:_____

Community Health Worker: _____Date:_____

Diabetes Education Needs
☐ Has not seen an Diabetes Educator
☐ Primary Care Provider Prescribe Education
☐ Agency Referral Name
☐ Needs more diabetes education
Identify Diabetes Education Needs **CHW Time:_____**
☐ Certified Diabetes Educations Sessions (Date of Last DM Ed._____)
☐ Registered Dietitian
☐ Has seen as CDE needs only specific health education
☐ Diabetes Group Classes (☐ English ☐Spanish)
Diabetes Education Resources (please check which referral was made) **CHW Time:_____**
☐ CDE Good Samaritan (insurance/charity care)
☐ CDE Sentinel Health Care
DM Educational Program Sessions (please check which referral was made) **CHW Time:_____**
☐ CHAMP PROGRAM (Central Health Center)
☐ Diabetes Support group (Good Samaritan Hospital)
☐ Diabetes Support Group (Spanish) To be Announced
☐ Living Well (Sentinel Health Care)
☐ Nutrition Education
☐ other health related Education _____
Diabetes Education Statues **CHW Time:_____**
□ Successful Completed Pathway **(*Provide a short summary in Apricot)***
□ Unsuccessful Pathway **(*Provide a short summary in Apricot)***
If unsuccessful, please indicate whether:
□ *Client was* lost to follow-up and ultimately discharged **(*Provide a short summary in Apricot)***
□ Client was u*nwilling to keep appointments or otherwise will not execute his/her action plan*
Track Diabetes Education Needs **CHW Time:_____**
Record attendance to selected DM education Resources (***Provide a short summery in Apricot)***
□ client attend complete program, □ client attend one session only
□ client attend partial □ client did not attend any
Record attendance to selected Free Program sessions (***Provide a short summery in Apricot)***
□ client attend all sessions, □ client attend one session only
□ client attend some of the sessions □ client did not attend any sessions

Client Name: _____D.O.B: _____

Nurse Name: _____ Date: _____

Barriers Code for Diabetes Education

Please check all that apply:

1. I Have trouble learning new things
2. I am told I have a learning disability, and so I am concerned that a diabetes education program will not work for me
3. I tried a diabetes education program, but I did not understand all the information
4. I did not know where to go for diabetes education
5. The diabetes education option I tried did not address my cultural needs
6. I tried a diabetes education program, but the staff there were disrespectful
7. Do not speak English very well
8. I already have a good understanding of how to manage my diabetes
9. I am concerned that a diabetes education program will cost too much
10. I am concerned that attending a diabetes education program will conflict with my work schedule and cause me to lose pay from work
11. Trouble with transportation to regularly attend a diabetes education program
12. I will need child care if I am to attend any diabetes education program
13. I have difficulty walking / Walking make me feel tired
14. Other

Barriers Categories
1-3 Perceived or actual learning disability
4 Lack of awareness about available diabetes education program options
5-7 Perceived lack of cultural competency from previous encounters
8 Low or no client perceived need for diabetes education
9 Concerns over cost / paying for a diabetes program
10 Work conflict related barriers
11-13 Logistics barrier (e.g., transport, child care)

My Diabetes Education Action Plan

I pledge to regularly attend and participate in the Diabetes Education & Support Program that I have been referred to.

1. Goal: I want to do learn more about: *(e.g., Nutrition, Carb Counting, long term complications, insulin, how to use my meter etc.)*

_____

_____

2. Support: *(*e.g., *In addition to regularly attending the Diabetes Education program, "I would like family and friends to help me with_____")*

_____

_____

3. Action: *(*e.g., *"I will record my blood sugars daily in a journal")*

_____

_____

4. Problem Solving: What things might make it hard for me to reach my goals? (e.g., "*I can't afford the strips"; "I am afraid to give myself a shot"*)

_____

_____

5. Reinforce: My Diabetes Education Nurse can help me reach my goal by:

_____

_____

6. Level of Confidence: I----------I----------I----------I

0 1 2 3 4 5 6 7 8 9 10

7. I am happy to have a Follow-Up Session to check on the progress I have made in reaching my goal. A follow-up session might include: (e.g., have a phone conversation in a few weeks or check back in with My Diabetes Education Nurse some other way) **Please list agreed to follow-up actions:**

_____

_____

My Signature: _____D.O.B:_____

Nurse Name: _____Date: _____

Social Barrier Needs

□ Social Barrier (check all that apply)

Community Resource Referrals **CHW Time:_____**

□ A Referral was made to the agency identified below so that the client may gain the appropriate service(s) that will address the identified barrier:_____
(name the barrier)

Agency Name:_____

Agency Staff: _____

Program/ Service: _____

Follow-up on Referral Made **CHW Time:_____**

The client arrived at referred agency for scheduled appointment □ Yes □ No

If Yes, list the date of appointment (date)_____
If No, list actions taken to follow-up with client_____

An application was completed by the client to receive assistance from the refereed agency
□ Yes □ No

If No, list actions take to follow-up with client_____

Qualifying Status of Application **CHW Time:_____**

□ Client qualified for the program □ Yes □ No

If No, state reason for denial and any supportive action taken to problem solve regarding this unmet need.

_____

Social Barrier Status **CHW Time:_____**

□ Successful completed pathway (***Provide a short summary in Apricot)***
□ Unsuccessful Pathway (***Provide a short summary in Apricot)***
If unsuccessful please indicate whether:
- □ *Client was lost to follow-up and ultimately discharged* ***(Provide a short summary in Apricot)***
- □ *Client's Application for service was denied*
- □ *Client was unwilling to keep appointment(s) or otherwise will not execute his/her action plan.*

Track Social Needs **CHW Time:_____**

□ Successful pathway entails completing an action plan that includes, follow-up with client within 30 days or less to update needs, changes, progress or set-backs. **(See associated social Barrier Action Plan)**

Client Signature: _____ *D.O.B:* _____

*Community Health Worker*_____ *Date:* _____

Barriers to Social Needs

Please mark all that apply:

1. Child Care – please specify the particular child care- related service needed.
2. Literacy Issues
3. Legal Issues
4. Food
5. Housing*
6. Utilities*
7. Mental Health Issues (Zung scale)
8. Transportation
9. Financial
10. Discrimination
11. Domestic Violence
12. Substance Abuse– please specify the particular Substance Abuse –related service needed.
13. Brain Injury
14. Unemployment– please specify the particular Unemployment-related service needed.
15. English as a second language course (ESL)
16. Other – please specify _____

*The service needs will require that the client first has an appointment with a preliminary agency in order to get a referral to the agency which can meet his or her need.

Tracking a client across these referral steps is expected

My Social Barrier Action Plan

The Social Barrier issues I am having can be overcome if I:

☐ Keep my appointment ☐ Seek more Information ☐ Problem solve

☐ Use the resource in the community to which I was referred

1. My Goal is: *gain access to the service I need:* (write down the name of the service, and why you need it)

_____

_____

2. The Actions I agree to take are: (e.g., keep my appointments, have documentation ready for my appointments, particularly income verification information)

_____

3. Problem Solving: *What things might make it hard for me to reach my goal of getting this needed service?* (e.g., lack of time, busy schedule, avoid unhealthy foods etc.)

_____

_____

4. The Support I need from my Community Health Worker to reach my goal is: (e.g., "I would like my Community Health Worker to help me with…")

_____

_____

5. My Level of Confidence that I will reach my goal is: I----------I----------I

0 1 2 3 4 5 6 7 8 9 10

6. I am happy to have a Follow-Up Session to check on the progress I have made in reaching my service access goal. A follow-up session might include: (e.g., have a phone conversation in a week or so, or checking back in with my Health Worker some other way) **Please list agreed to follow-up actions:**

_____

_____

_____

I pledge to follow this action plan and use the offered support to resolve my social barriers. I also understand that my Community Health Worker will be following up to check on the status of this effort. I have authorized my Community Health Worker to receive an update regarding the referral matter listed above.

My Signature: _____ Date: _____

Community Health Worker: _____ Date: _____

Medical Provider / Mental health Practitioner **CHW Time:_____**

Based upon the evaluation on _____ your provider _____
Date Provider's Name
has recommended the following care plan.

Behavioral Health Education **CHW Time:_____**

☐ Behavioral Health
☐ Substance Abuse

Barriers to Care/ Access to Services:

☐ Barriers to Behavioral Care Code:

CARE PLANNING AGREEMENT **CHW Time:_____**

My Medical Doctor/ Mental Health Care Provider and I have agreed upon a health treatment plan that includes the following: _____.

Does this plan require an appointment with another provider? ☐Yes ☐ No
Name of Provider:_____
Location:_____
Phone Number of Provider: _____
Date of schedule Appointment:_____ Time:_____

I agree to work with my Community Health Worker to work towards the goals that may improve my health and personal goals. We will work together to create an Action Plan that will detail my goals and will be an attainable goal that will meet my needs.

Client Agreement Signature_____ Date:_____

Community Health Worker Signature: _____ Date: _____

Appendix H1: Behavioral Care Pathway-Duke Profile

PRE- Duke Health Profile Date: _____

☐ _____ Physical Health Score
☐ _____ Mental Health Score
☐ _____ Social Health Score
☐ _____ General Health Score
☐ _____ Perceived Health Score
☐ _____ Self-Esteem Score
☐ _____ Anxiety Score
☐ _____ Depression Score
☐ _____ Anxiety-Depression (Duke-AD) Score
☐ _____ Pain Score
☐ _____ Disability Score

☐ **Quadrant 1** – Minimal

Provider Location
Appointment date
□ On Sight
□ Hallway pass off
□ Social Support group
□ Assigned Activities (i.e., journal entry, walking, an apology list)
Notes:

☐ **Quadrant II**- Basic at a Distance Basic On-Site

Provider Location
Appointment date

Notes:

☐ **Quadrant III**- Close partly Integrated

Provider Location
Appointment date

Notes:

☐ **Quadrant IV**- Close Fully Integrated

Provider Location
Appointment date

Notes:

POST- Duke Health Profile Date:_____

☐ _____ Physical Health Score
☐ _____ Mental Health Score
☐ _____ Social Health Score
☐ _____ General Health Score
☐ _____ Perceived Health Score
☐ _____ Self-Esteem Score
☐ _____ Anxiety Score
☐ _____ Depression Score
☐ _____ Anxiety-Depression (Duke-AD) Score
☐ _____ Pain Score
☐ _____ Disability Score

Pathway Progress	**CHW Time:_____**
□ Successful Completed pathway (***Provide a short summary in Apricot)***	
□ Unsuccessful Pathway (***Provide a short summary in Apricot)***	
If unsuccessful please indicate whether:	
□ *Client was lost to follow-up and ultimately discharged/* ***(Provide a short summary in Apricot)***	
□ *Client was unwilling to keep appointments or otherwise will not execute his/her action plan.*	

Barriers to Care (check all that apply)

1. I cannot afford to see a mental health provider
2. I do not have health insurance to see a mental health provider
3. I cannot take off time from work to meet with a provider
4. I do not like the stigma that I feel about mental health providers
5. I do not care/ believe in support groups
6. I do not feel that my needs will be addressed with a mental health provider
7. I have had negative experience in the past
8. I refuse the services: Provide a reason (when possible) _____
9. I believe a social support group will be more helpful
10. I believe my faith / church services will be a more appropriate place for help
11. There are no providers where I live
12. The services I need are not offered in town

Categories to Barriers
☐ 1-3 Financial Barriers
☐ 4-7 Strong beliefs/experiences against Mental Health Providers
☐ 8 Possible Denial
☐ 9-10 Alternative treatments
☐ 11-12 Community Services / Provider(s) deficits

Medical Provider / Mental health Practitioner **CHW Time:_____**

Based upon the evaluation on _____ your provider _____
Date Provider's Name
has recommended the following care plan.

Behavioral Health Education **CHW Time:_____**

☐ Behavioral Health
☐ Substance Abuse

Barriers to Care/ Access to Services:

☐ Barriers to Behavioral Care Code:

CARE PLANNING AGREEMENT **CHW Time:_____**

My Medical Doctor/ Mental Health Care Provider and I have agreed upon a health treatment plan that includes the following: _____.

Does this plan require an appointment with another provider? ☐Yes ☐ No
Name of Provider:_____
Location:_____
Phone Number of Provider: _____
Date of schedule Appointment:_____ Time:_____

I agree to work with my Community Health Worker to work towards the goals that may improve my health and personal goals. We will work together to create an Action Plan that will detail my goals and will be an attainable goal that will meet my needs.

Client Agreement Signature_____ Date:_____

Community Health Worker Signature: _____ Date: _____

Appendix H2: Behavioral Care Pathway-Global Assessment

Pre-Global Assessment of Functioning	Date: _____
☐ 91-100 Superior functioning in a wide range of activities ☐ 81-90 Absent or minimal symptoms ☐ 71-80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors ☐ 61-70 Some mild symptoms or some difficulty in social, occupational, or school functioning ☐ 51-60 Moderate symptoms or moderate difficulty in social, occupational, or school functioning ☐ 41-50 Serious symptoms or any serious impairment in social, occupational, or school functioning ☐ 31-40 Some impairment in reality or communication major impairment judgment , thinking or mood ☐ 21-30 Behavior is considerable influenced by delusional/hallucinations or serious impairment in communication, judgment ☐ 11-20 Some danger in hurting self or others or occasionally fails to maintain minimal persona hygiene ☐ 1-10 Persistent danger of severely hurting self or others or serious suicidal act with clear expectation of death ☐ 0 Inadequate information	
☐ **Quadrant 1** – Minimal	
Provider Appointment date □ On Sight □ Hallway pass off □ Social Support group □ Assigned Activities (i.e., journal entry, walking, an apology list) Notes:	Location
☐ **Quadrant II**- basic at a Distance Basic On-Site	
Provider Appointment date Notes:	Location
☐ **Quadrant III**- Close partly Integrated	
Provider Appointment date Notes:	Location
☐ **Quadrant IV**- Close Fully Integrated	
Provider Appointment date Notes:	Location
Pathway Progress	
□ Successful Completed pathway (***Provide a short summary in Apricot)*** □ Unsuccessful Pathway (***Provide a short summary in Apricot)*** ***If unsuccessful please indicate whether:*** □ *Client was lost to follow-up and ultimately discharged/* ***(Provide a short summary in Apricot)*** □ *Client was unwilling to keep appointments or otherwise will not execute his/her action plan.*	
Post-Global Assessment of Functioning	Date: _____
☐ 91-100 Superior functioning in a wide range of activities ☐ 81-90 Absent or minimal symptoms ☐ 71-80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors ☐ 61-70 Some mild symptoms or some difficulty in social, occupational, or school functioning ☐ 51-60 Moderate symptoms or moderate difficulty in social, occupational, or school functioning ☐ 41-50 Serious symptoms or any serious impairment in social, occupational, or school functioning ☐ 31-40 Some impairment in reality or communication major impairment judgment , thinking or mood ☐ 21-30 Behavior is considerable influenced by delusional/hallucinations or serious impairment in communication, judgment ☐ 11-20 Some danger in hurting self or others or occasionally fails to maintain minimal persona hygiene	

☐ 1-10 Persistent danger of severely hurting self or others or serious suicidal act with clear expectation of death ☐ 0 Inadequate information
Pathway Progress **CHW Time:_____**
□ Successful Completed pathway (***Provide a short summary in Apricot)*** □ Unsuccessful Pathway (***Provide a short summary in Apricot)*** ***If unsuccessful please indicate whether:*** □ *Client was lost to follow-up and ultimately discharged/* ***(Provide a short summary in Apricot)*** □ *Client was unwilling to keep appointments or otherwise will not execute his/her action plan.*

Barriers to Care (check all that apply)

1. I cannot afford to see a mental health provider
2. I do not have health insurance to see a mental health provider
3. I cannot take off time from work to meet with a provider
4. I do not like the stigma that I feel about mental health providers
5. I do not care/ believe in support groups
6. I do not feel that my needs will be addressed with a mental health provider
7. I have had negative experience in the past
8. I refuse the services: Provide a reason (when possible) _____
9. I believe a social support group will be more helpful
10. I believe my faith / church services will be a more appropriate place for help
11. There are no providers where I live
12. The services I need are not offered in town

Categories to Barriers
☐ 1-3 Financial Barriers ☐ 4-7 Strong beliefs/experiences against Mental Health Providers ☐ 8 Possible Denial ☐ 9-10 Alternative treatments ☐ 11-12 Community Services / Provider(s) deficits

Medical Provider / Mental health Practitioner **CHW Time:_____**

Based upon the evaluation on _____ your provider _____
Date Provider's Name
has recommended the following care plan.

Behavioral Health Education **CHW Time:_____**

☐ Behavioral Health
☐ Substance Abuse

Barriers to Care/ Access to Services:

☐ Barriers to Behavioral Care Code:

CARE PLANNING AGREEMENT **CHW Time:_____**

My Medical Doctor/ Mental Health Care Provider and I have agreed upon a health treatment plan that includes the following: _____.

Does this plan require an appointment with another provider? ☐Yes ☐ No
Name of Provider:_____
Location:_____
Phone Number of Provider: _____
Date of schedule Appointment:_____ Time:_____

I agree to work with my Community Health Worker to work towards the goals that may improve my health and personal goals. We will work together to create an Action Plan that will detail my goals and will be an attainable goal that will meet my needs.

Client Agreement Signature_____ Date:_____

Community Health Worker Signature: _____ Date: _____

Appendix H3: Behavioral Care Pathway-PHQ

PRE- TESTING PHQ-9 Date: _____

☐ 0-4 None-minimal Treatment Action: None
☐ 5-9 Mild Treatment Action: Watchful waiting; repeat PHQ-9 at follow-up
☐ 10-14 Moderate Treatment Action: Treatment plan, considering counseling, follow-up and/or pharmacotherapy
☐ 15-19 Moderately Severe Treatment Action: Active treatment with pharmacotherapy and/or psychotherapy
☐ 20-27 Severe Treatment Action: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

☐ **Quadrant 1** – Minimal

Provider Location
Appointment date
□ On Sight
□ Hallway pass off
□ Social Support group
□ Assigned Activities (i.e., journal entry, walking, an apology list)
Notes:

☐ **Quadrant II**- Basic at a Distance Basic On-Site

Provider Location
Appointment date

Notes:

☐ **Quadrant III**- Close partly Integrated

Provider Location
Appointment date

Notes:

☐ **Quadrant IV**- Close Fully Integrated

Provider Location
Appointment date

Notes:

POST- TESTING PHQ-9 Date:_____

☐ 0-4 None-minimal Treatment Action: None
☐ 5-9 Mild Treatment Action: Watchful waiting; repeat PHQ-9 at follow-up
☐ 10-14 Moderate Treatment Action: Treatment plan, considering counseling, follow-up and/or pharmacotherapy
☐ 15-19 Moderately Severe Treatment Action: Active treatment with pharmacotherapy and/or psychotherapy
☐ 20-27 Severe Treatment Action: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

Pathway Progress **CHW Time:_____**

□ Successful Completed pathway (***Provide a short summary in Apricot)***
□ Unsuccessful Pathway (***Provide a short summary in Apricot)***
If unsuccessful please indicate whether:
□ *Client was lost to follow-up and ultimately discharged/* ***(Provide a short summary in Apricot)***
□ *Client was unwilling to keep appointments or otherwise will not execute his/her action plan.*

Barriers to Care (check all that apply)

1. I cannot afford to see a mental health provider
2. I do not have health insurance to see a mental health provider
3. I cannot take off time from work to meet with a provider
4. I do not like the stigma that I feel about mental health providers
5. I do not care/ believe in support groups
6. I do not feel that my needs will be addressed with a mental health provider
7. I have had negative experience in the past
8. I refuse the services: Provide a reason (when possible) _____
9. I believe a social support group will be more helpful
10. I believe my faith / church services will be a more appropriate place for help
11. There are no providers where I live
12. The services I need are not offered in town

Categories to Barriers
☐ 1-3 Financial Barriers
☐ 4-7 Strong beliefs/experiences against Mental Health Providers
☐ 8 Possible Denial
☐ 9-10 Alternative treatments
☐ 11-12 Community Services / Provider(s) deficits

MY BEHAVIORAL CARE ACTION PLAN

The mental health care services I am needing is

1. **My Goal is:**

_____
_____
_____

2. **The Action:** I agree to take (e.g., keep my appointments……..)

_____
_____
_____

3. **Problem Solving:** What issues might make it hard for me to reach my goal for getting help

_____
_____
_____

4. **The Support I need from my Community Health Worker** (e.g., I would like my Community Heath Worker to help me with…

_____
_____
_____

5. **My Level of Confidence that I will reach my goal is:**

6. **I will agree to have a follow-up session to check on the progress I have made in reaching my mental health care:**

_____
_____
_____

I pledge to follow this action plan and use the offered support to resolve my mental health care needs. I also understand that my Community Health Worker will be following up to check on the status of my effort. I have authorized my Community Health Worker to receive an update regarding the referral matter listed above.

My Signature:_____ Date: _____
Community Health Workers: _____ Date: _____

COMMUNITY HEALTH ACCESS TEAM (CHAT)
A GOAL WORK GROUP OF BUFFALO COUNTY COMMUNITY PARTNERS

Criteria for Health HUB Pathway Program:

Clients must be 19 years or older, who have been diagnosed with Pre-Diabetes or Diabetes and meet one or more of the following risk factors:

- Seek Medical Attention with in Buffalo County limits
- Low literacy: highest education level under 12th grade
- No Insurance or Under Insured: see guidelines below
- Insured thru Medicaid or Medicare
- English as a Second Language
- Emergency or Ambulance encounter for diabetes related or complications episode.
- Have an income that meets the poverty guidelines

The criteria is a guideline and should not be limited of other barriers, consult with Health Hub Coordinator for exceptions of the listed criteria.

200% Poverty Guidelines		
Family Size	Monthly Income	Annual Income
1	$1,815	$21,780
2	$2,452	$29,420
3	$3,088	$37,060
4	$3,725	$44,700
5	$4,362	$52,340
6	$4,998	$59,980
7	$5,635	$67,620
8	$6,275	$75,260
Each additional member add		$7,640
2011 Federal Poverty Guidelines		

Client's Bill of Rights

You have the right:

1. To be treated by the staff with respect and dignity
2. To expect that services will be provided to you without discrimination due to race, ethnicity, gender, religious beliefs, age, sexual orientation, disability, political affiliation, or economics status.
3. To voice complaints and to file a grievance regarding your services from Buffalo County Community Health partners and their affiliates without fear of reprisal (see Grievance Procedures).
4. That your confidentiality is protected by Federal Confidentiality Rules (42 CFR Part 2) and no information will be released without your written permission unless:
    a) You report incidents of child abuse, abuse of the elderly, etc.
    b) You report that you are going to intentionally hurt yourself or someone else.
    c) You commit a crime on program property.
    d) You drive to program obviously impaired.
5. To be informed of program rules and regulations that applies to your conduct as a client.
6. You are encouraged to involve your family in your health program
7. To except reasonable continuity and coordination of care following discharge from the program.
8. You have the right to informed consent of any proposed services and to be informed of the health and legal consequences of the refusal.
9. To make informed decisions regarding your treatment planning, provider choices and service options.

You have the responsibility to:

1. Be the leader of your health condition.
2. Follow plans and instructions for treatment that you have agreed upon.
3. Make and attend appointments as well as to provide notice of any cancellation within a reasonable time period.
4. To contribute to the healing environment by treating other clients and staff with respect and dignity.
5. To provide written releases of protected health information as is necessary to participate in the program.
6. Honor and respect the confidentiality of others.

Grievance Procedure

If you believe your rights have been violated or if you have a complaint, please fill your grievance in writing to the Health HUB Coordinator. Be sure to include all the details, including date and times, staff, and/or persons involved, etc.

Buffalo County Community Health Partners
c/o Community Health Access Team Advisory Board
1755 Prairie View Pl.
P.O. Box 1466
Kearney, NE 68848

Office : 308.865.2287
E-mail: chathub@bcchp.org

I. The Advisory Board will investigate and respond to your grievance within 5 business days of receipt of your complaint.

_____
Client's Name

_____ _____
Client's Signature **Date**

_____ _____
Witness Signature and Title **Date**

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION TO BUFFALO COUNTY COMMUNITY HEALTH PARTNERS PURSUANT TO 45 CFR § 164.508

TO: _____

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____

Street Address

_____

City, State, and Zip Code

RE: Client Name:_____

Date of Birth:_____ Social Security Number:_____

I hereby authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with my participation in the Buffalo County Health HUB Pathways Program through the Buffalo County Community Health Partners. I also hereby expressly give Buffalo County Community Heath Partners permission to use any data and information collected, including protected health information, for reporting purposes related to the Program. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient, and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, photographs, video tapes, telephone messages, and records by other medical providers.

All physical, occupational, and rehab requests, consultations, and progress notes.

All laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

All pharmacy/prescription records including NDC numbers and drug information handouts and/or monographs.

All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period beginning six (6) months prior to the signing of this authorization through one (1) year after the signing of this authorization.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the purpose of my participation in the Buffalo County Health HUB Pathways Program. This program serves to help me get medical care and education for my specific health conditions, and serves to assist me in management of my health conditions and to avoid or delay health complications.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR § 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to Buffalo County Community Health Partners, The Buffalo County Health HUB Pathways Program, and to their employees and agents, including but not limited to the Community Health Advocate assigned to me. If you have questions or concerns about this release or the program please contact the Health HUB Coordinator, 1755 Prairie View Pl., P.O. Box 1466, Kearney, Nebraska 68847, (308) 865-2287.

I understand the following: (See 45 CFR § 164.508(c)(2)(i-iii))

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization however my participation in the Buffalo County Health HUB Pathways Program may be denied as a result of not signing this authorization.

Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until the end of the Buffalo County Health HUB Pathways Program at which time this authorization expires. I acknowledge that this authorization and my progress in the Program will be reviewed every twelve (12) months, and I may be required to sign additional authorizations in order to continue with the Program at the time of such reviews.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name and Relationship of Legally Authorized Representative to Patient

_____ _____

Witness Signature Date

Zung Self Rated Depression Scale

Client's Name: Client's D.O.B.:

Date of Assessment:

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days.

Make check mark (✓) in appropriate column.	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping at night				
5. I eat as much as I used to				
6. I still enjoy sex				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to do				

Adapted from Zung, A self-rating depression scale, *Arch Gen Psychiatry*, 1965;12:63-70.

PAM®
Patient Activation Measure®

Level 1 | Level 2 | Level 3 | Level 4

Insignia Health®

Measure. Engage. Activate.

Activation Starts with Measurement

The **Patient Activation Measure® (PAM)®** assesses the underlying knowledge, skills and confidence integral to managing one's own health and healthcare.

PAM segments consumers into one of four activation levels along an empirically derived continuum. Each level provides insight into an array of health-related characteristics, including attitudes, motivators, behaviors and outcomes.

This predictive guidance helps to identify realistic and achievable opportunities to change behaviors and treatment that can move an individual forward on a journey of increasing activation.

PAM in Action

More than 100 leading health organizations use the **Patient Activation Measure** and related Insignia products, including:

American Health Holdings
American Specialty Health
AtlantiCare
Boerhringer Ingelheim
DaVita
Fairview Medical System
Intercare Solutions
Johns Hopkins Healthcare
Kaiser Permanente
Marshfield Clinic
Medica
Moda Health
Monroe Plan for Medical Care
National Health Service (UK)
North Carolina Medicaid
Oregon's Health CO-OP
PeaceHealth
Providence Health Plan
Providence Health & Services
Regence BlueCross BlueShield
Roche
Sanford Health
Sanofi-Aventis
St. Luke's Health System
UnitedHealth Group
Washington State Medicaid
WellPoint

Level 1
Disengaged and overwhelmed

Individuals are passive and lack confidence. Knowledge is low, goal-orientation is weak, and adherence is poor. Their perspective: "My doctor is in charge of my health."

Level 2
Becoming aware, but still struggling

Individuals have some knowledge, but large gaps remain. They believe health is largely out of their control, but can set simple goals. Their perspective: "I could be doing more."

Level 3
Taking action

Individuals have the key facts and are building self-management skills. They strive for best practice behaviors, and are goal-oriented. Their perspective: "I'm part of my health care team."

Level 4
Maintaining behaviors and pushing further

Individuals have adopted new behaviors, but may struggle in times of stress or change. Maintaining a healthy lifestyle is a key focus. Their perspective: "I'm my own advocate."

Increasing Level of Activation

PAM is Backed by Extensive Research

The Patient Activation Measure is a unidimensional, interval level, Guttman-style 10- or 13-question scale developed by Dr. Judith Hibbard, Dr. Bill Mahoney and colleagues at the University of Oregon. PAM was created and tested using Rasch analysis and classical test theory psychometric methods.

To date, more than 150 independent studies worldwide have documented the importance of activation, the ability of this tool to measure activation and its ability to predict a broad range of health-related behaviors and outcomes.

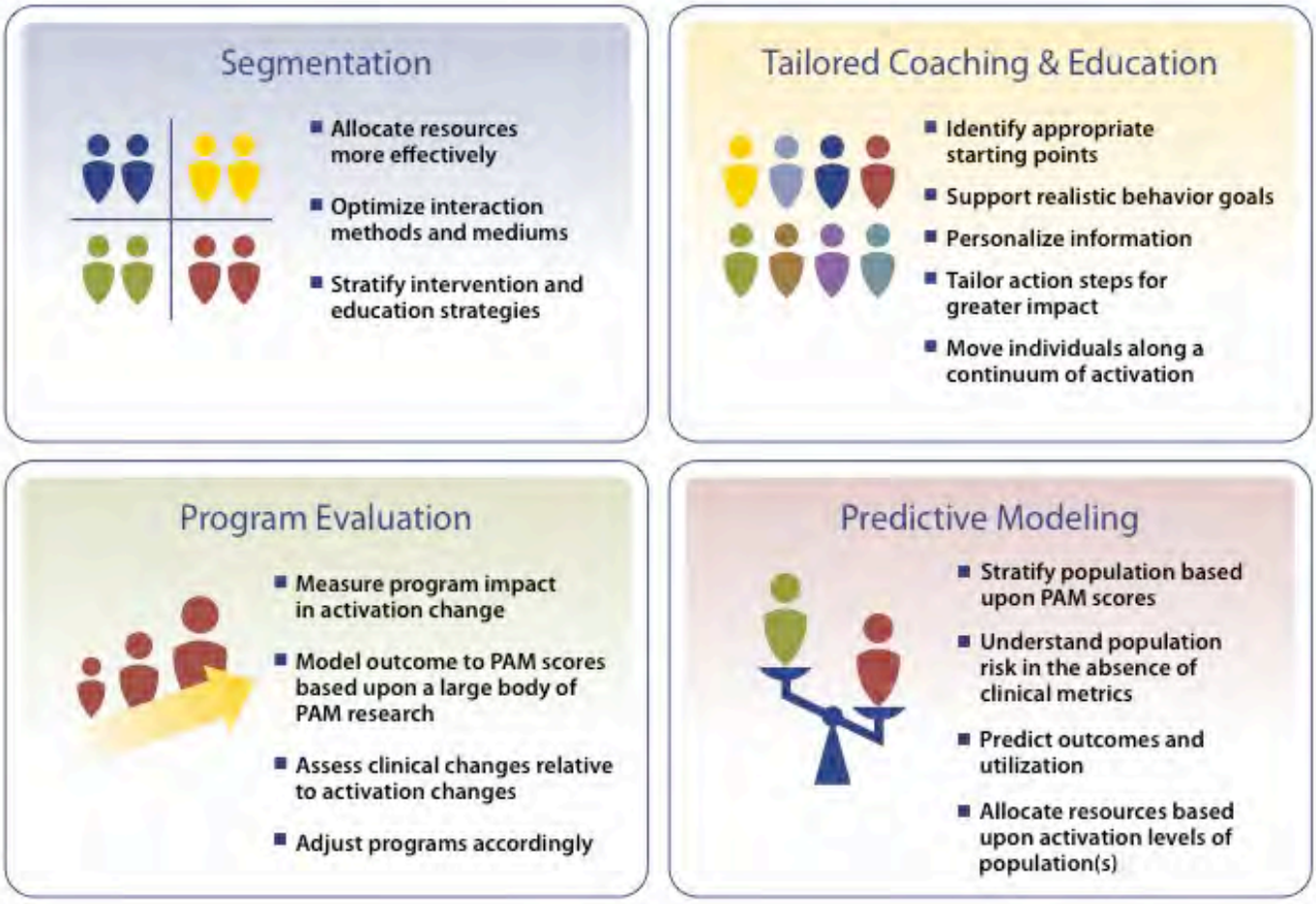
This research consistently demonstrates that individual self-management improves significantly with increasing levels of activation.

PATIENT ACTIVATION MEASURE®

Self-Management Assessment and Applications

The Patient Activation Measure is reliable and valid for use with patients managing chronic conditions and with individuals engaged in disease prevention efforts. It is being used today in population health management programs, disease and case management systems, wellness programs, medical home projects, care transitions, such as hospital discharge protocols, and much more.

More than 200 health-related characteristics have been mapped to a PAM score and level of activation, offering a wealth of insight into an individual's self-management competencies. This empirically derived insight guides Insignia's coaching model (Coaching for Activation®) and consumer facing Web-based program (Flourish®).



About Insignia Health

Insignia Health specializes in helping health plans, hospitals, pharmaceutical firms and other health care organizations assess patient activation and develop strategies for helping individuals become more successful managers of their health and health care. Insignia Health applies its proprietary family of health activation assessments to measure each individual's self-management competencies. The Patient Activation Measure® and a decade of health activation research form the cornerstone of a complementary suite of Insignia solutions, which have proven to help clinicians, coaches and health care organizations improve outcomes and lower costs.

Insignia Health
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www.InsigniaHealth.com
Info@insigniahealth.com

Sentinel Health Care
2605 2nd Avenue
Kearney, NE 68847
Tel. 308.865.2706
Fax. 308.865.9018

Referral Form

Community Health Access Team
Health HUB Program

Client Information:

Client's Name _____ Phone № _____

Address_____ Is an Interpreter required? □Yes □ No

☐ I will contact the Referral ☐ My Community Service Coordinator will call on my behalf

Referral Agency :

Reason For Referral:

Contact Information:

Company Name:
_____

Contact Person:_____

Address:_____

Phone №:_____

Agency Referring:

I authorize _____ to receive an update(s) regarding the referral need listed above.

Community Action Partnership Staff member's name

Signature:_____ Date:_____

Client's Signature

Name: _____ Title:_____

Phone №: _____ Ext №:_____ Email:_____

COMMUNITY HEALTH ACCESS TEAM (CHAT)
A GOAL WORK GROUP OF BUFFALO COUNTY COMMUNITY PARTNERS®

Powered by Buffalo County COMMUNITY PARTNERS®
BUILDING A HEALTHIER COMMUNITY

Health HUB Outcomes

Report

February 15, 2015

Ariane Aten
Data Coordinator/
Program Evaluator
Buffalo County
Community Partners
Admin@bcchp.org
308-865-2289

COMMUNITY HEALTH ACCESS TEAM (CHAT)

A GOAL WORK GROUP OF BUFFALO COUNTY COMMUNITY PARTNERS

Contents

COMMUNITY HEALTH ACCESS TEAM (CHAT)

A GOAL WORK GROUP OF BUFFALO COUNTY COMMUNITY PARTNERS

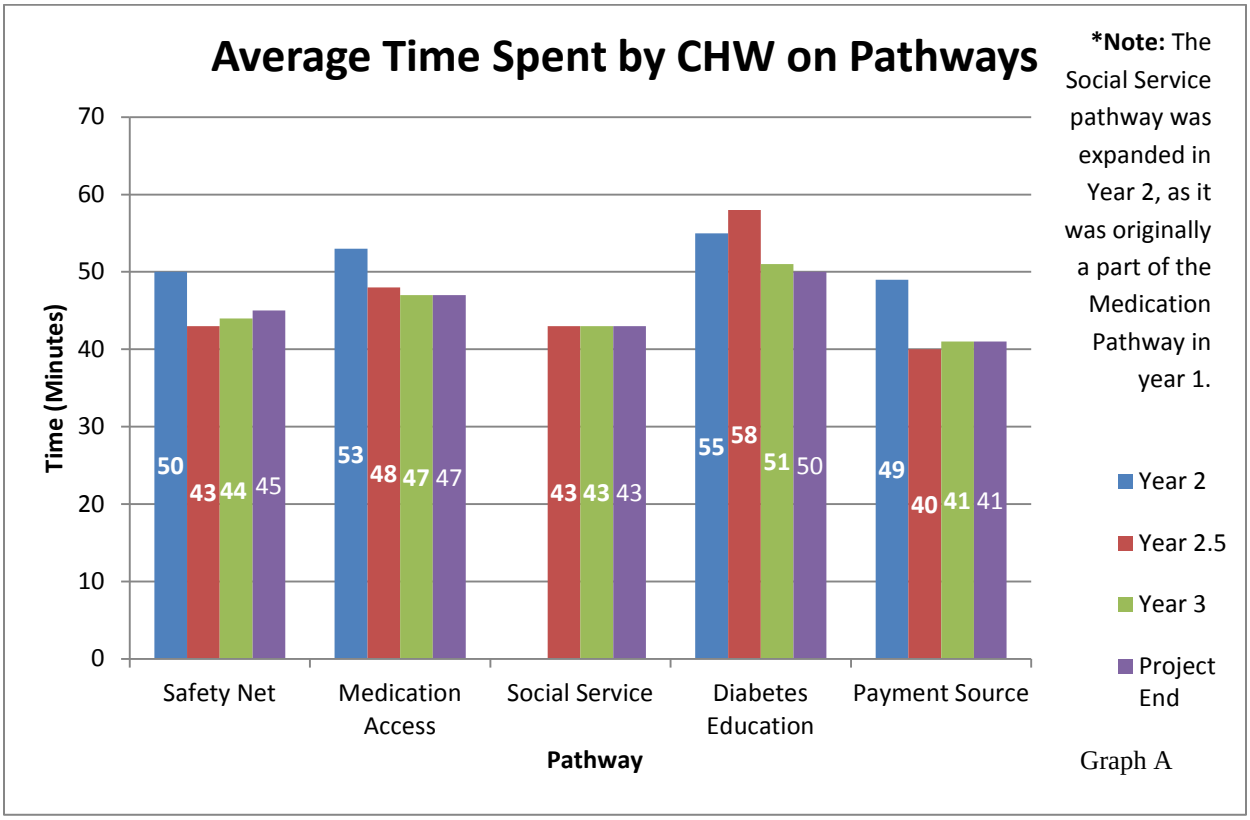
GOAL:

The goal of the Community Health Access Team -- Pathways Health HUB project is to develop a formalized *Pathways* structure and community health worker (CHW) model to overcome various barriers to expand access to healthcare services across Buffalo County. Specifically, this grant project will target qualifying adult Diabetic clients.

General Pathway Progress:

i. The Health HUB currently has one Community Health Workers assisting 250 clients. The recommended case load for a Community Health Worker is 50 clients per Community Health Worker. It has been revealed in this program that due to the lack of primary care coverage for individuals, they need to continue to be monitored through the three-year period.

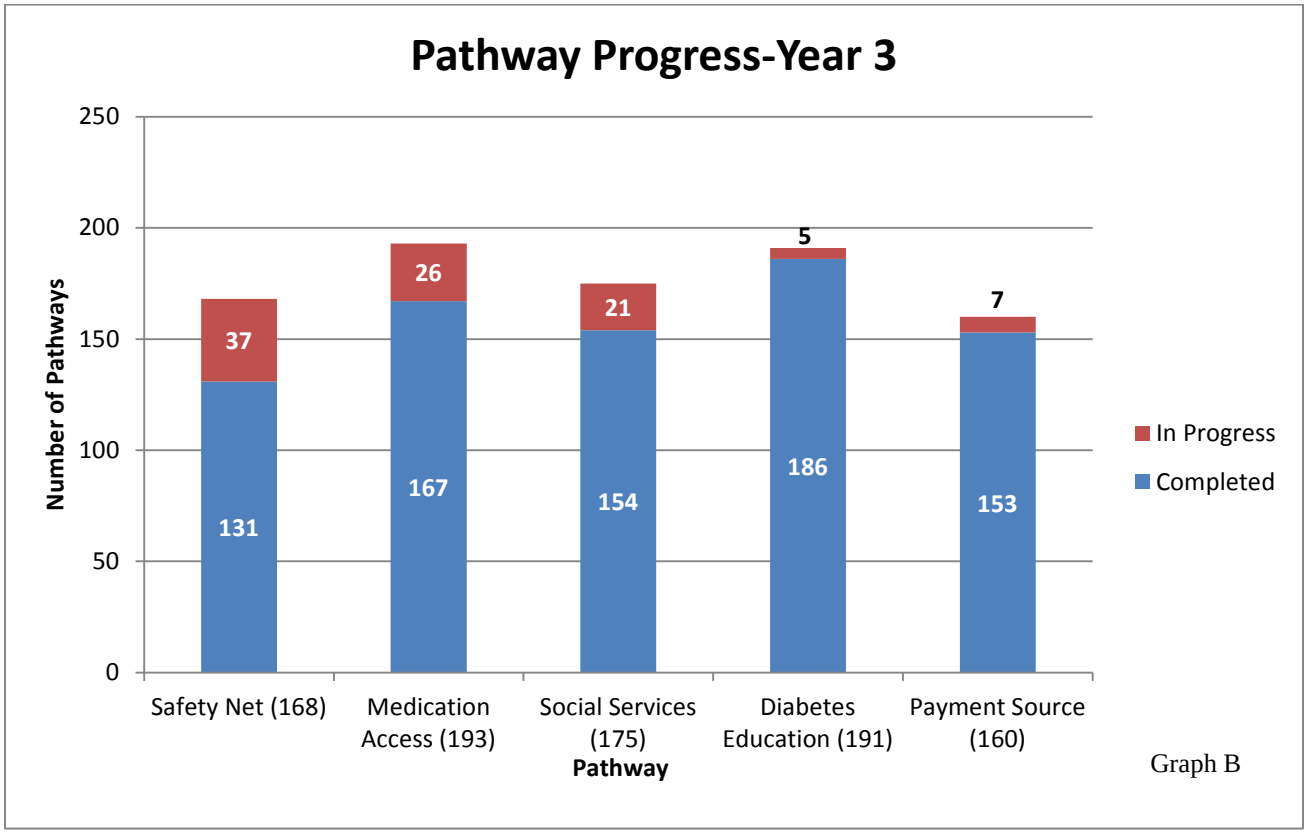
ii. The graph below (***Graph A***) demonstrates the average amount of time the Community Health Workers spend per pathway per client. We have found Community Health Workers are more efficient and due to their caseload, they are spending less time with each client. This documents the need for additional Community Health Workers to meet the increasing client load.



Graph A

iii. Another realization through the program is Diabetes is a chronic disease in which individuals need ongoing support months to years beyond program expectations.

iv. The graph below (***Graph B***) shows the progress of each client as they travel through the pathway. The clients needing to be served in the Safety Net pathway are exceeding the amount to meet primary care needs, which demonstrates our community's need for a patient centered medical home for uninsured individuals.

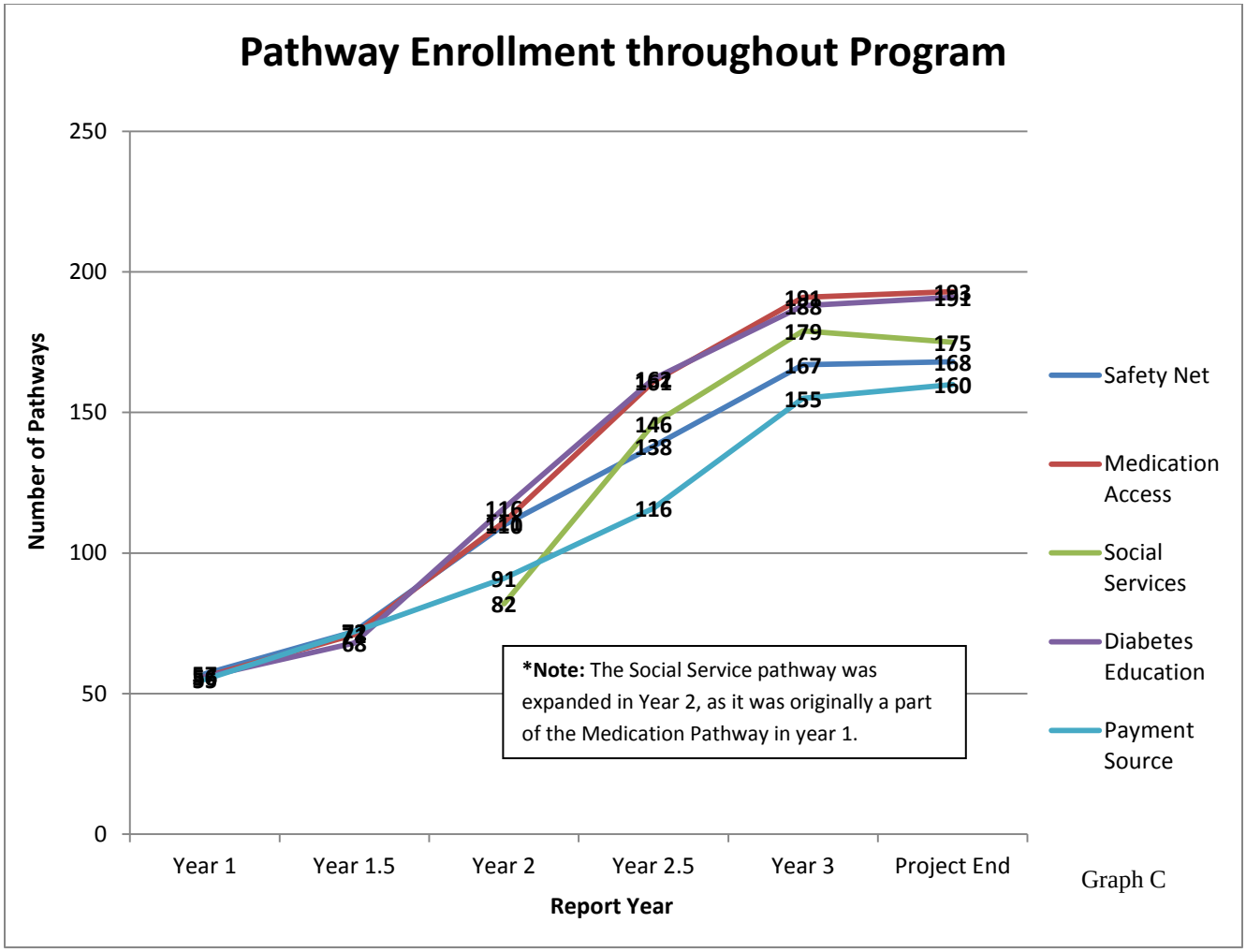


Graph B

v. This information is being used in the development for CHI's local chapter of the Clinically Integrated Network and local physician groups. We used this information to assist Two Rivers Public Health Department in securing grant funds for a Community Health Worker to be housed in Family Practice Associates clinic in Kearney.

vi. 33 clients have been dismissed from the program due to: lost to follow-up, client relocation, client declining program help, or client's death.

vii. The graph below (***Graph C***) shows the number of clients enrolled in each pathway over the life of the program. Both the Medication Access and Diabetes Education pathways remain the most utilized pathways. Following close behind include (in order) the Social Needs, Safety Net, and Payment Source pathways.



Graph C

COMMUNITY HEALTH ACCESS TEAM (CHAT)

A GOAL WORK GROUP OF BUFFALO COUNTY COMMUNITY PARTNERS

Safety Net Pathway

Objective 1: Implementation of the **Safety Net Pathway** (*Name revised from Medical Home Pathway and Medical Referral Pathway integrated*) to help the community understand the importance of a relationship with a Primary Care Physician (PCP), improve access to a PCP and to understand appropriate use of the emergency room(ER). We can then infer that with an ongoing relationship with their PCP, their health status will improve as documented by improved A1C or other clinical measures (*Definition of Pathway expanded*);

Year one- Development of the Safety Net Pathway completed. Renamed at request of physicians who refer to the program. Medical Referral Pathway incorporated into a separate pathway.
Year two- Successfully utilizing the Safety Net Pathway to provide services to clients.
Year three- There are 250 clients in the Health HUB program. Of the 250 clients, 168 clients are enrolled in the Safety Net Pathway. Of the 168 clients needing a primary care provider (PCP), 94% (158) of those clients secured a formal relationship with a PCP. The remaining 6% (10) still have not established a relationship with a PCP. However, 73% (122) of the 168 clients still report cost as the number one barrier for continued care. Therefore, outcomes from the Safety Net Pathway have demonstrated a need for a community clinic.

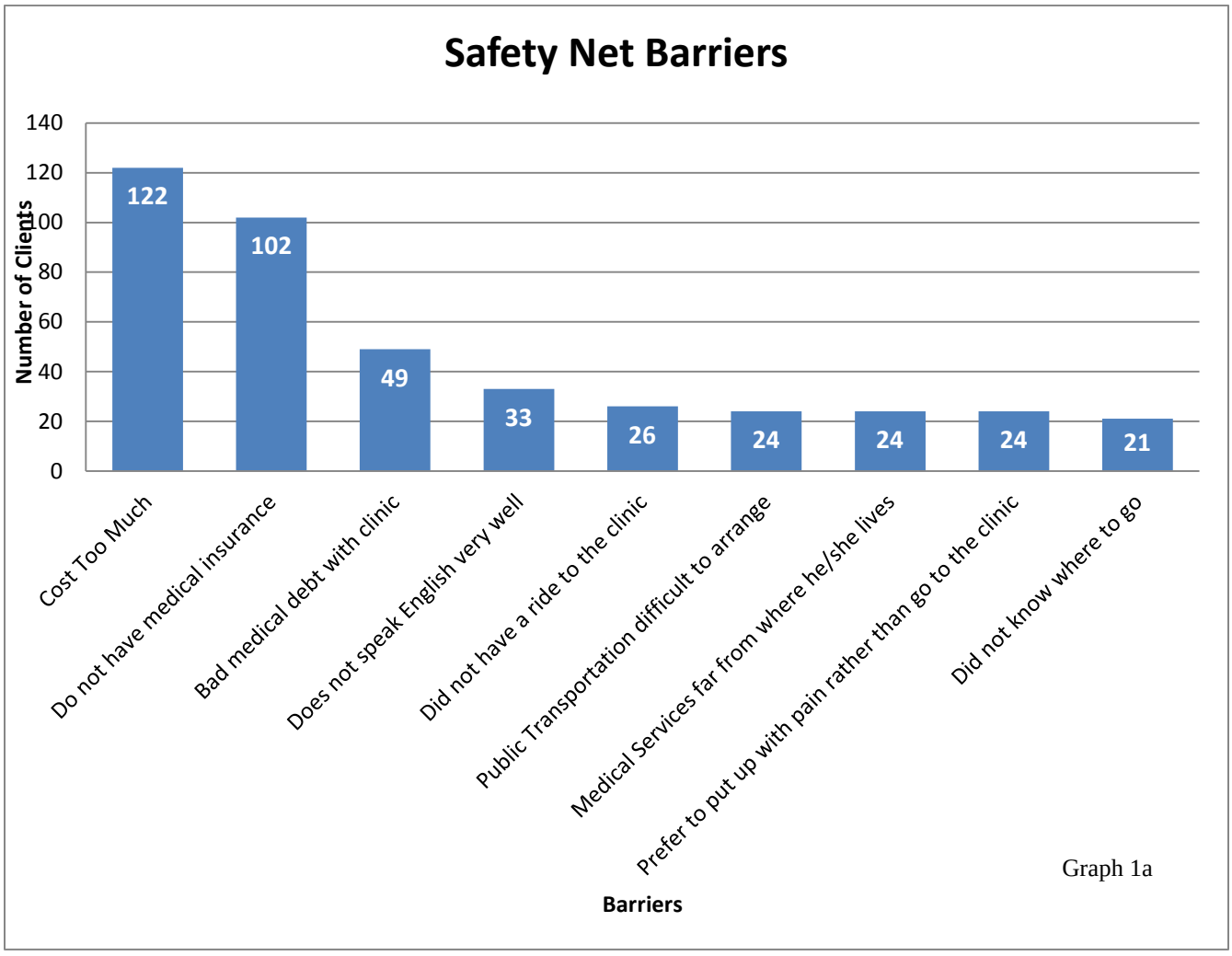
Outputs:

A) Completion of Safety Net Pathway
B) 250 program participants over 3 year project period.
C) 168 clients enrolled in the Safety Net Pathway
D) 45 minutes is the average time spent by the Community Health Workers to complete the Safety Net Pathway

Outcomes:

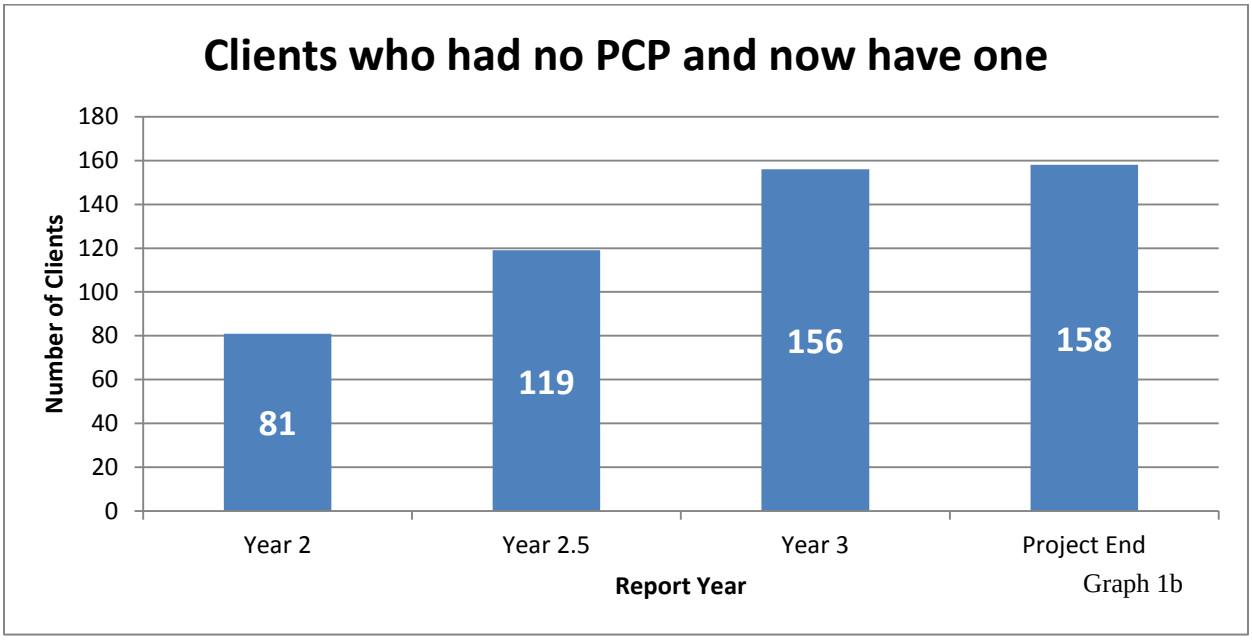
The use of the Safety Net Pathway has resulted in the following outcomes for clients:

i. The graph below (***Graph 1a***) shows the barriers that prevent clients from going to see a Primary Care Provider. Cost, no medical insurance and bad debt are major barriers of clients seeking primary care. 65 clients self-reported having $200,466.82 in debt from a clinic. This amount coupled with the financial barriers that clients reported there is a demonstrated need for a community clinic, since cost is a limiting factor in accessing traditional primary care.



Graph 1a

ii. The graph below (***Graph 1b***) shows the number of clients from year 2 to year 2.5 to year 3 to project end who had no formal relationship with a Primary Care Provider and with assistance from the Community Health Workers, they have developed an ongoing relationship with a Primary Care Provider. While 94% (158 of 168) of clients needing a Primary Care Provider have secured a formal relationship, 73% (122) of the 168 clients still report cost as the number one barrier for continued care.



Graph 1b

iii. Community Health Workers have also done education on the importance of a relationship with a primary care provider, as well as appropriate use of the Emergency Room. The educational tools used during these discussions were developed by Buffalo County Community Partners with guidance of Dr. Ken Shaffer, Medical Director of CHI's local chapter of the Clinically Integrated Network, UniNet.

COMMUNITY HEALTH ACCESS TEAM (CHAT)

A GOAL WORK GROUP OF BUFFALO COUNTY COMMUNITY PARTNERS

Medication Access Pathway

Objective 2: Implementation of **Medication Access Pathway** *(Redesigned into the Medication Management Pathway)* to is to determine medication adherence, education on the importance of taking medications and obtaining access to medications. We can then infer if community members are able to obtain their medications and understand how to take their medications, their health status will improve. *(Definition of Pathway expanded);*

Year one- Development of the Medication Access Pathway completed.
Year two- Successfully utilizing the Medication Access Pathway to provide services to clients.
Year three- The outcomes of the Medication Access Pathway have demonstrated the need for Medication Access Programs to be available at a community clinic. With over1,500 prescriptions between 101 clients, the Medication Access Program is helping clients overcome barriers to afford the many medications for their chronic illness.

Outputs:

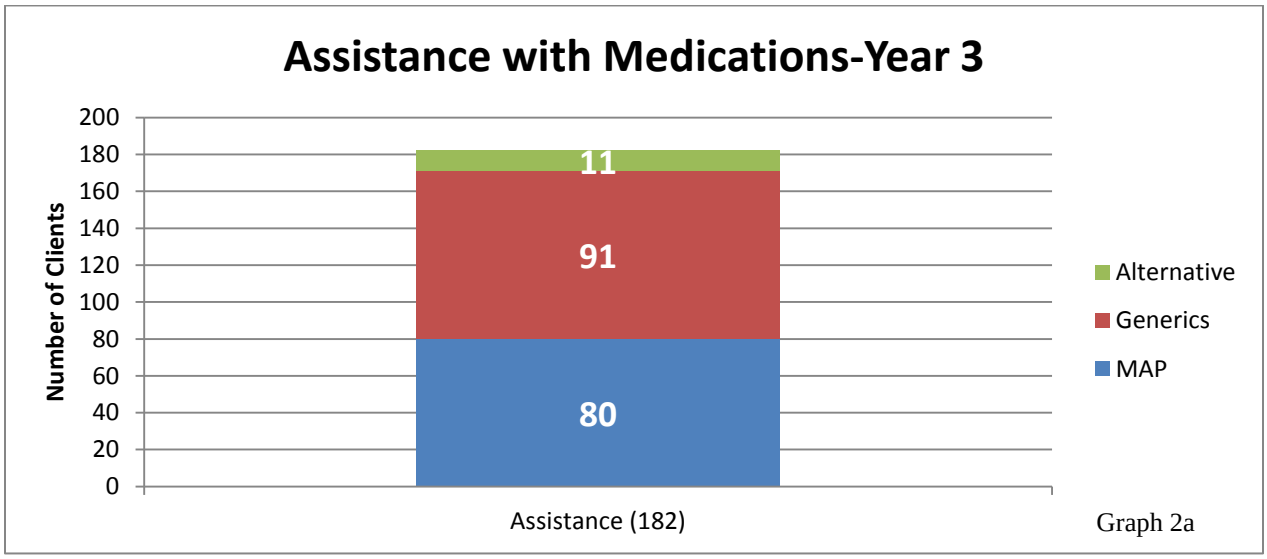
A) Completion of Medication Access Pathway
B) 250 program participants over 3 year project period.
C) 193 clients enrolled in the Medication Access Pathway
D) 47 minutes is the average time spent by the Community Health Workers to complete the Medication Access Pathway

Outcomes:

The use of the Medication Access Pathway has resulted in the following outcomes for clients:

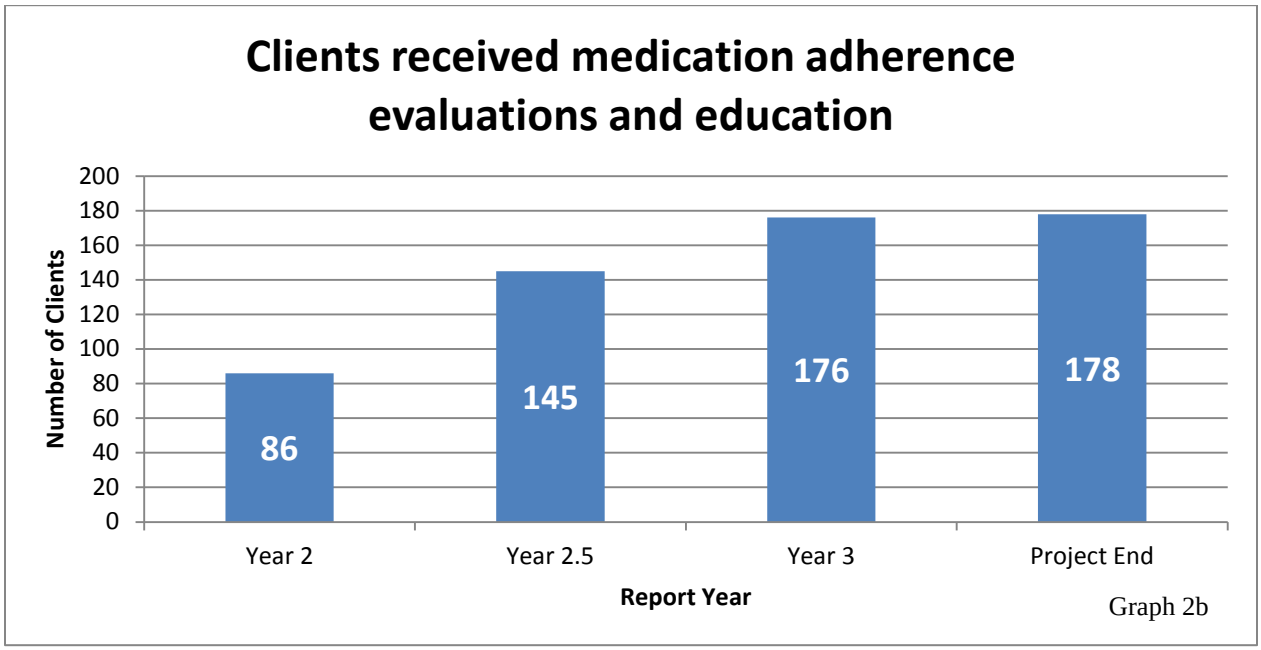
i. 101 clients in the Medication Access Program received 1,513 prescriptions for a total drug cost of $726,431.53.

ii. The graph below (***Graph 2a***) shows the work of the Community Health Workers to secure medication payment sources for 182 clients. Alternative sources is a non-specific category for those who use their cultural remedies based upon their values, such as blending medications or herbal/home remedies (Patient's primary care provider is aware of patient's decision to use alternate cultural remedies).



Graph 2a

iii. The graph below (***Graph 2b***) shows the Community Health Workers evaluation and education with clients on their medication adherence. The graph documents significant achievement with medication adherence.



Graph 2b

COMMUNITY HEALTH ACCESS TEAM (CHAT)

A GOAL WORK GROUP OF BUFFALO COUNTY COMMUNITY PARTNERS

Social Service Referral Pathway

Objective 3: Implementation of **Social Service Referral Pathway** to help the community member remove any financial/social barriers to accessing health care or managing their health conditions. Again, socio-economic issues have the largest impact on health outcomes so improving these issues should improve overall health;

Year one- Development of the Social Service Referral Pathway completed.

Year two- Successfully utilizing the Social Service Referral Pathway to provide services to clients.

Year three- The outcomes of the Social Service Referral Pathway have demonstrated the importance of educating and linking Community Health Workers to social services within the community. While pathway was not established in year one, the following years prove the success of Community Health Workers to help clients overcome social needs so they may focus on their health. 175 clients are linked to social services with the top agencies being Department of Health and Human Services and Community Action Partnership of Mid-Nebraska who are assisting with the top barriers of food, financials and utilities.

Outputs:

A) Completion of Social Service Referral Pathway
B) 250 program participants over 3 year project period.
C) 175 clients enrolled in the Social Service Referral Pathway
D) 43 minutes is the average time spent by the Community Health Workers to complete the Social Service Referral Pathway

Outcomes:

The use of the Social Service Referral Pathway has resulted in the following outcomes for clients:

i. A list of referred agencies and how many referred clients (*Note: clients were referred, but may not have qualified for services, graph 3b):

1. Department of Health and Human Services: 74 clients
2. Community Action Partnership of Mid-Nebraska: 19 clients
3. Kearney Eye Institute: 12 clients per year
4. Housing Authority: 8 clients
5. Vocational Rehab: 6 clients
6. Social Security Administration: 2 clients
7. RYDE: 4 clients
8. Jubilee Center: 5 clients
9. Agency on Aging: 2 clients

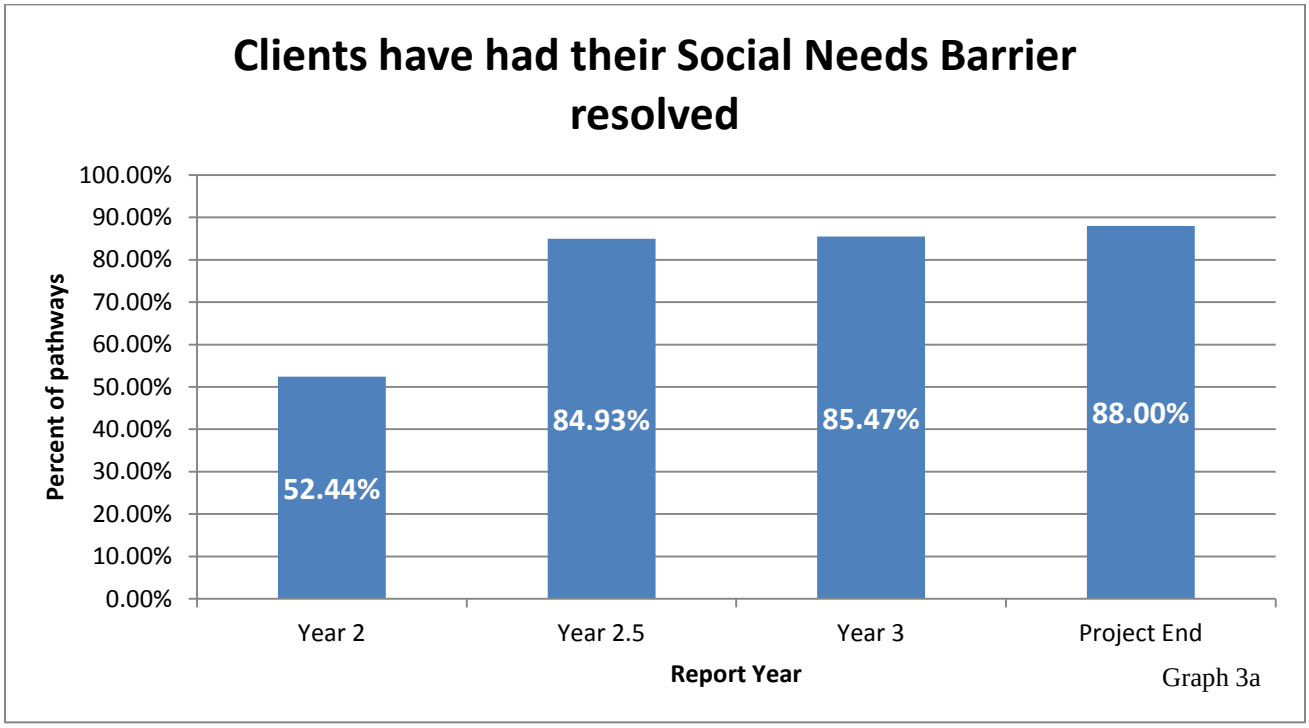
10. SAFE Center: 3 clients
11. Salvation Army: 2 clients
12. Valley Pharmacy: 1 client
13. Kearney Eye Institute: 2 eye exams from Lion's Club Donation
14. Legal Aide: 1 client
15. Nebraska Family Parents Teen Hotline: 1 client
16. South Central Behavioral Services: 1 client
17. Central Community College: 1 client
18. Region 3 Behavioral Health Services: 1 client
19. Collection Agency: 1 client
20. Walgreens: flu shots and A1C's
21. UNK counseling department: counseling by students

ii. A list of social needs barriers that clients report having:

1. Food: 69 clients
2. Financial: 50 clients
3. Utilities: 46 clients
4. Housing: 32 clients
5. Transportation: 19 clients
6. Unemployment: 17 clients
7. Mental Health Issues: 12 clients
8. Literacy Issues: 8 clients
9. Legal Issues: 8 clients
10. English as a secondary language: 7 clients
11. Child Care: 7 clients
12. Brain Injury: 2 client
13. Discrimination: 2 client
14. Eye Exams: 2 clients
15. Dentist: 2 client
16. Domestic Violence: 1 client
17. Substance Abuse: 1 client
18. Chore Provider: 2 clients
19. Fan: 1 client
20. Counseling for Couples: 1 client
21. Translation Services: 1 client
22. Phone: 1 client
23. Counseling: 2 client

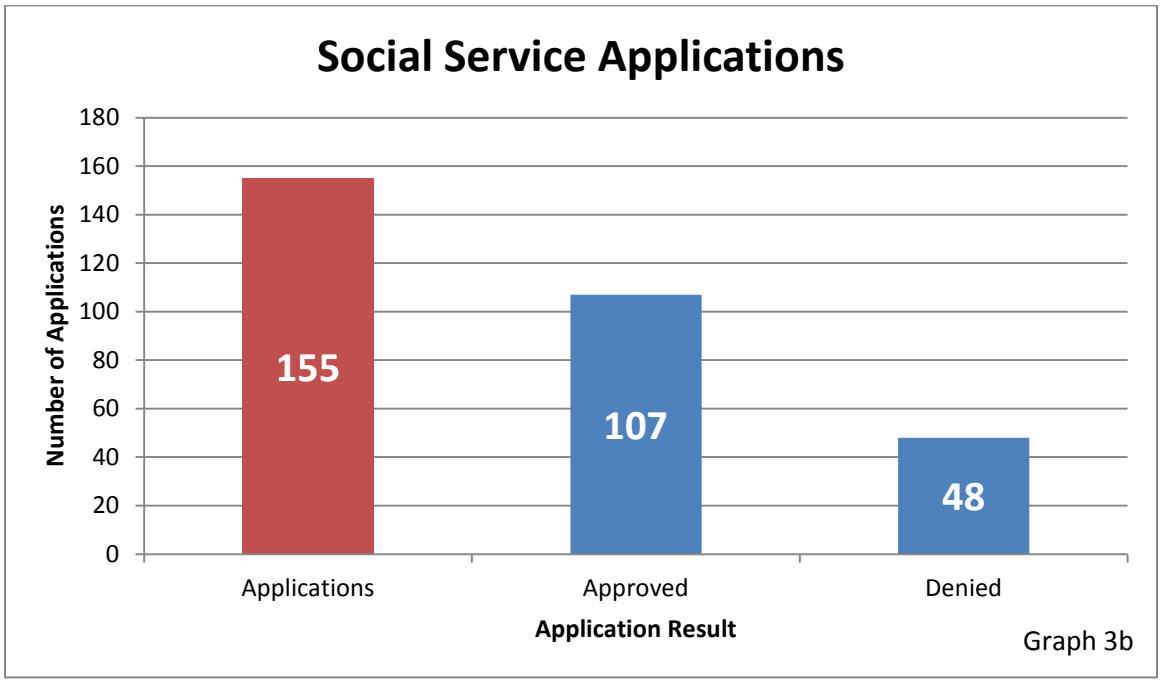
iii. 175 clients of the total 250 enrolled in the Health HUB program reported having social needs barriers that needed to be addressed

iv. The graph below (***Graph 3a***) shows the progress from year 2 to year 2.5 to year 3 to project end of the Community Health Workers in resolving social needs that the clients have encountered. Of the clients in the Social Needs pathway, 88.00% have resolved their social needs barrier by receiving assistance such as, completing Power of Attorney or tax forms, arranging counseling appointments, getting free scrub uniforms for work, getting school supplies for children, paying for the electric bill and a majority of other essential needs that the clients encounter.



Graph 3a

v. The graph below (***Graph 3b***) illustrates the number of social service applications that the Community Health Workers assisted clients with. The results show that 107 applications were approved and clients qualified for services, while 48 applications were denied. Among the applications that were denied, 38 were for Health and Human Services programs, such as Supplemental Nutrition Assistance Program and Energy Assistance. The clients were denied due to eligibility requirements, which shows the need for more local programs and services.



***What we learned:** Need to have a way for the Community Health Worker to be prompted to complete pathway document for each barrier as clients may have more than one active barrier. This would allow to better capture and follow up on each social service barrier a client is facing. It can be assumed that the client is being helped with all barriers, but documentation may not capture it all.

COMMUNITY HEALTH ACCESS TEAM (CHAT)

A GOAL WORK GROUP OF BUFFALO COUNTY COMMUNITY PARTNERS

Diabetes Education Pathway

Objective 4: Implementation of **Diabetes Education Pathway** is to assess the community members understanding of their disease, determine any gaps in knowledge, provide education and improve the patients' ability to self-manage their condition;

Year one- Development of the Diabetes Education Pathway completed.
Year two- Successfully providing diabetes education to clients.
Year three- The outcomes of the Diabetes Education Pathway have demonstrated the need for Community Health Workers to receive training in specific chronic disease prevention training. While professional programs are needed by the client, education is key to linking the Community Health Worker with the client and achieving successful disease management.

Outputs:

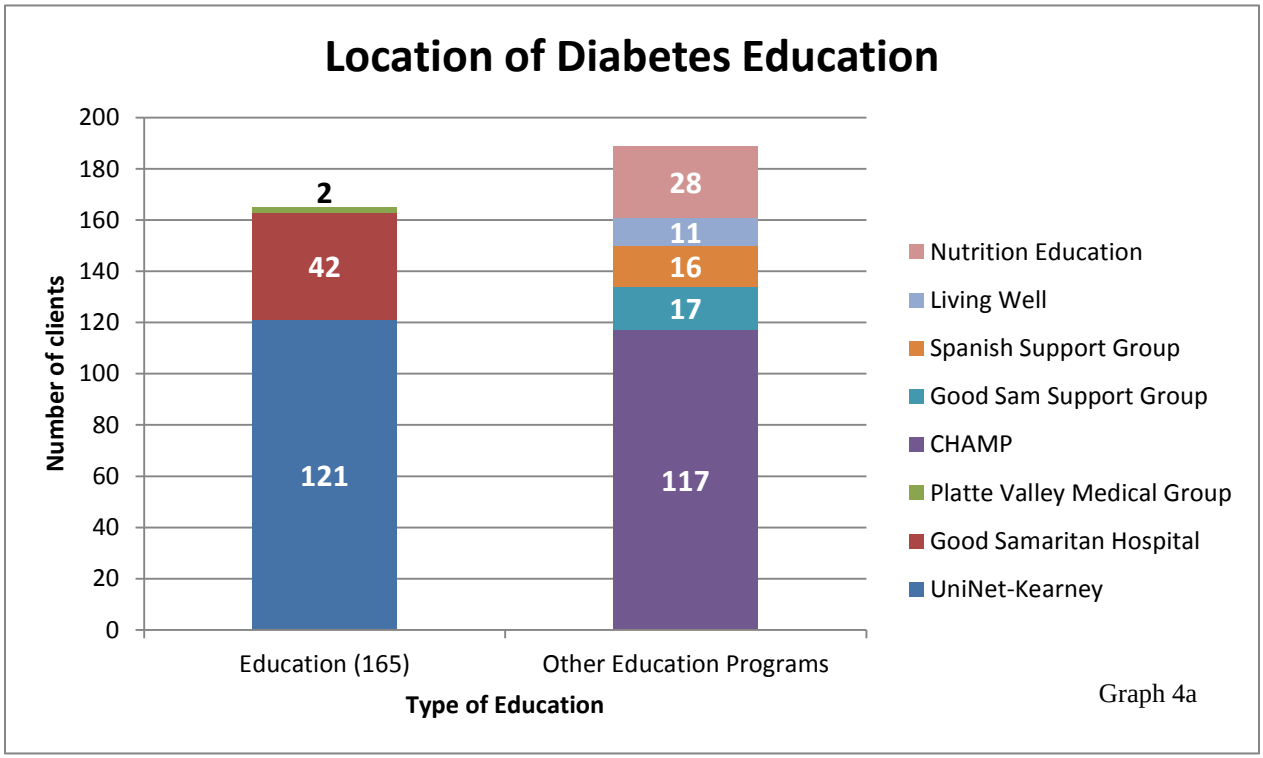
A) Completion of Diabetes Education Pathway
B) 250 program participants over 3 year project period.
C) 191 clients enrolled in the Diabetes Education Pathway
D) 50 minutes is the average time spent by the Community Health Workers to complete the Diabetes Education Pathway

Outcomes:

The use of the Diabetes Education Pathway has resulted in the following outcomes for clients:

i. 89 clients have taken Diabetes Knowledge pre-test, 72 have taken post-test and maintained or improved scores

ii. The graph below (***Graph 4a***) shows where the clients' diabetes education classes have taken place. The column on the right shows referrals to other types of education programs. It also demonstrates that 117 clients have been referred to Central Health Center's CHAMP (Choosing Health and Maximizing Prevention) program which is a free 8-week program that promotes and educates individuals on the importance of adopting a healthy lifestyle through good nutrition and increased physical activity. The program teaches the importance and value of nutrition and physical activity and their link to preventing diabetes, obesity and cardiovascular disease. Other education programs the clients have been referred to are also shown on the graph.



Graph 4a

COMMUNITY HEALTH ACCESS TEAM (CHAT)

A GOAL WORK GROUP OF BUFFALO COUNTY COMMUNITY PARTNERS

Payment Source Pathway

Objective 5: Implementation of **Payment Source Pathway** to assist clients to create a stable form of payment for health care services. And then we can infer that with a stable form of payment, the patient will be able to improve their health by accessing health services, medications, etc. This pathway was expanded from the Medical Home Pathway.

Year one- Development of the Payment Source Pathway completed.
Year two- Successfully establishing stable payment options for clients.
Year three- The outcomes of the Payment Source Pathway have demonstrated the need for a community clinic, as many clients are unable to receive insurance and afford medical debt.

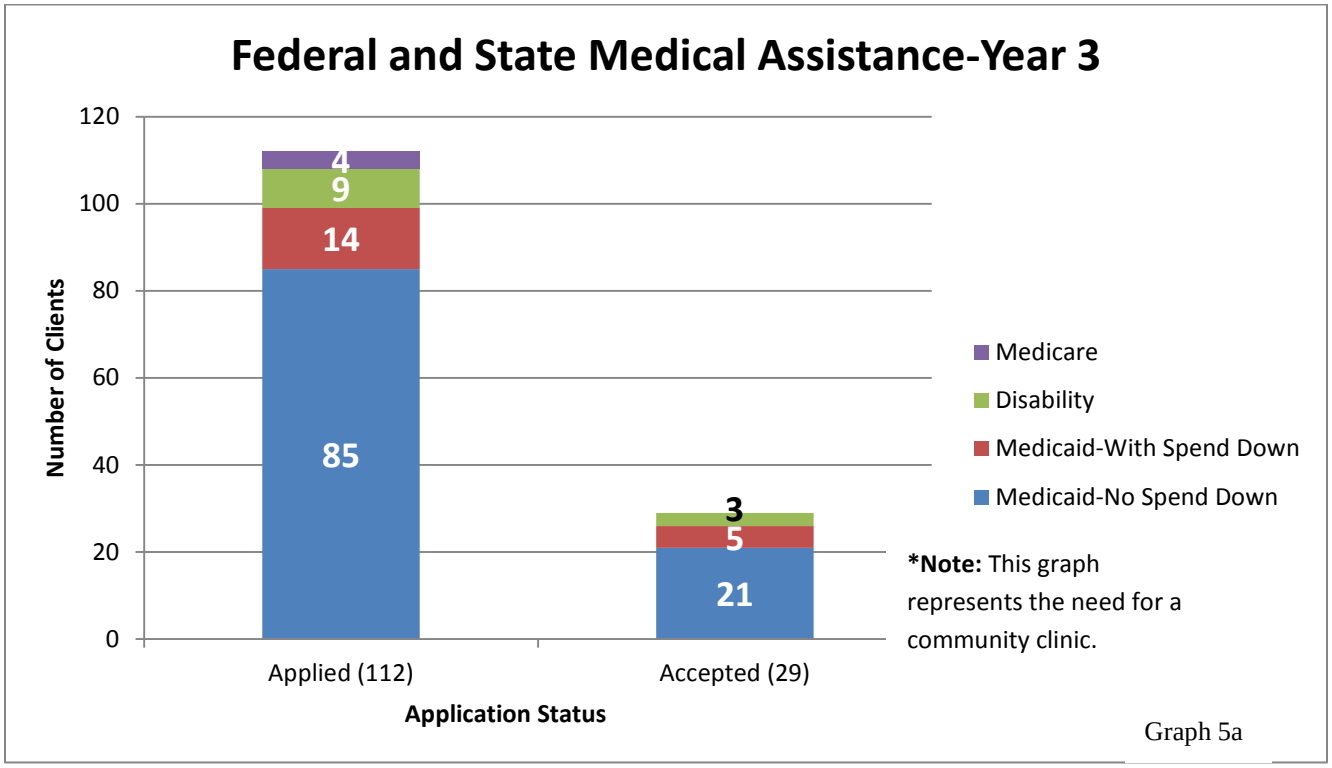
Outputs:

A) Completion of Payment Source Pathway.
B) 250 program participants over 3 year project period.
C) 160 clients enrolled in the Payment Source Pathway
D) 41 minutes is the average time spent by the Community Health Workers to complete the Payment Source Pathway

Outcomes:

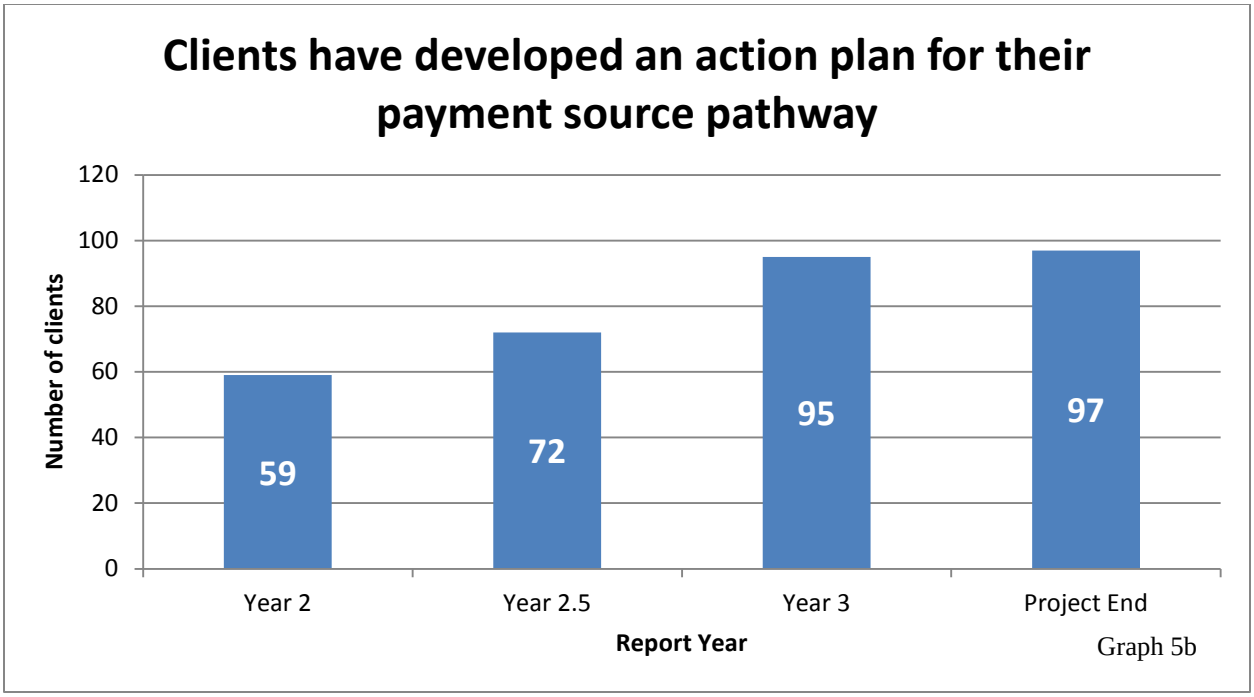
The use of the Payment Source Pathway has resulted in the following outcomes for clients:

i. The graph below (***Graph 5a***) shows how many clients have filed for state and federal medical assistance with the help of the Community Health Workers compared to how many clients have actually been approved. Of the 112 applications, only 26% (29 clients) were approved for state or federal medical assistance. This demonstrates that there is a population that is unable to access medical insurance. The State of Nebraska legislature has again chosen not to fund Medicaid Expansion for the Affordable Care Act, which could have provided insurance for this population. This exposes the continued need for a community clinic in this area.



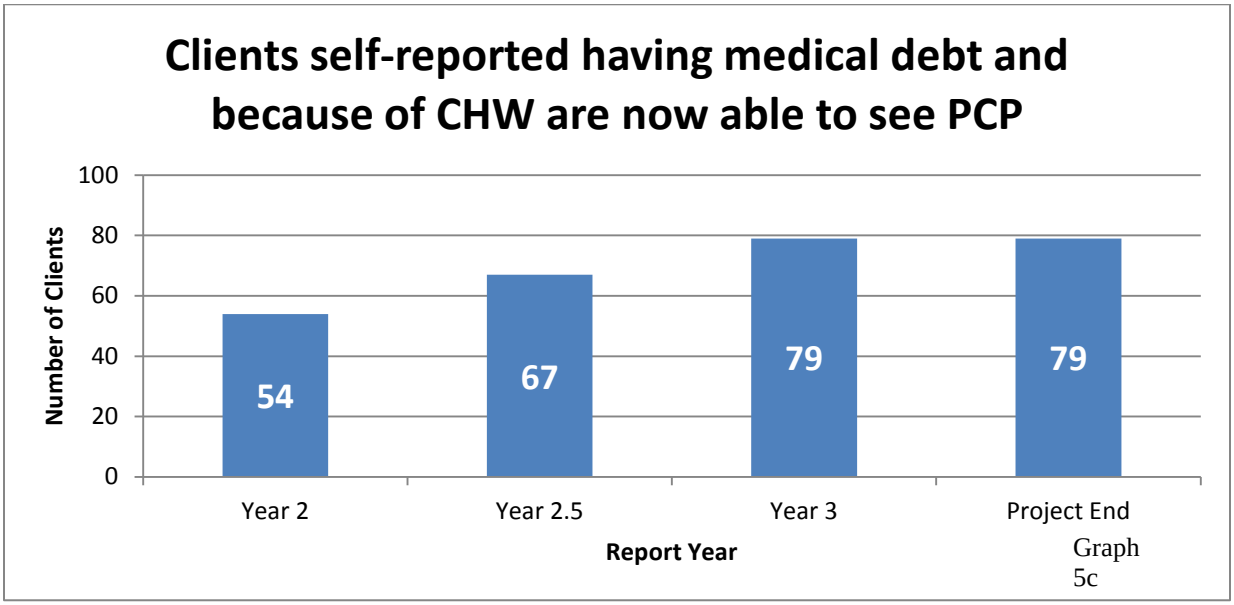
Graph 5a

ii. The graph below (***Graph 5b***) shows how many clients have worked with a Community Health Worker to develop an action plan for their payment source pathway in order to manage their barriers.



Graph 5b

iii. The graph below (***Graph 5c***) shows how many clients had medical debt with a clinic and with assistance from the Community Health Worker have set up an agreement with the clinic and can now go see their Primary Care Provider.



Graph 5c

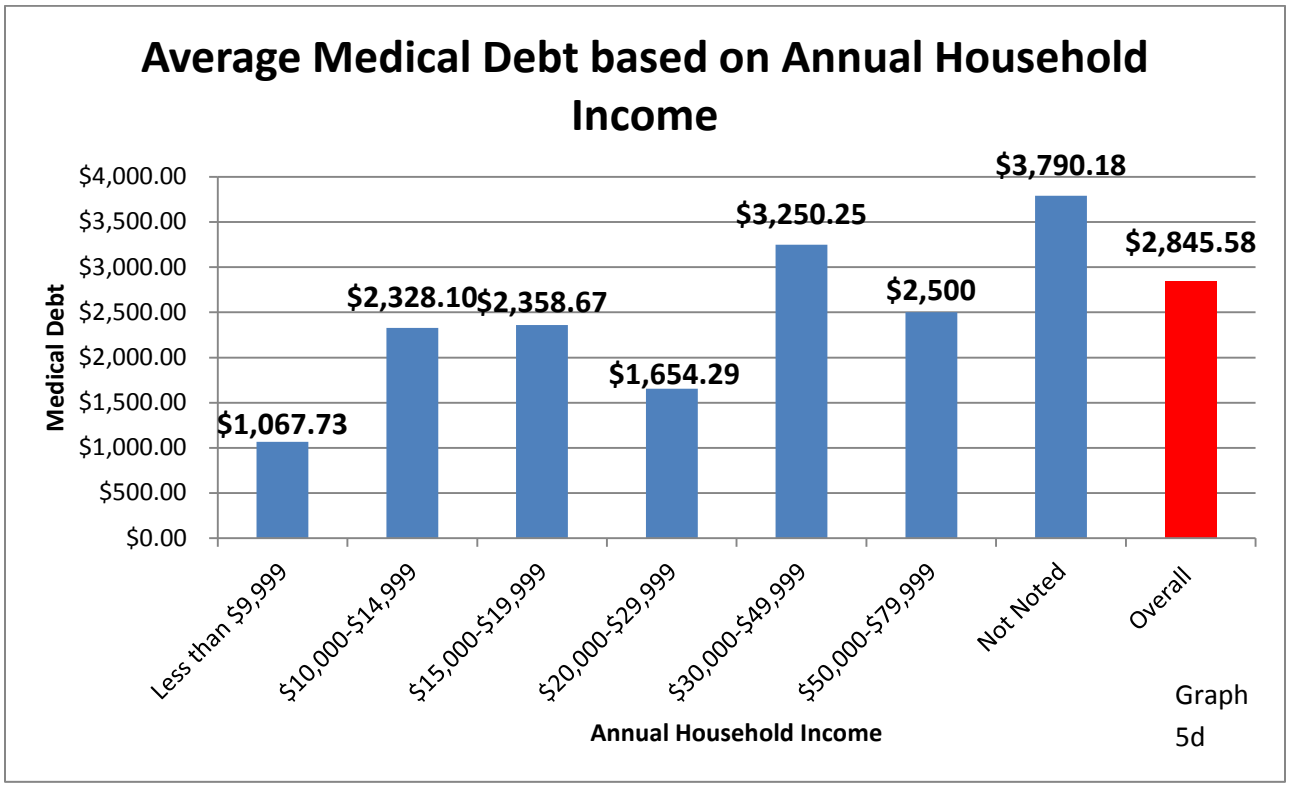
iv. 39% (42 out of 107 clients) of uninsured Health HUB Clients, despite the assistance of a Community Health Worker, are still without a primary payment source. This demonstrates that there is a population that continues to have financial barriers to primary care.

v. 51% (27 out of 53 clients) of insured Health HUB clients received supplemental health insurance.

vi. 59% (67 out of 115 clients) of Health HUB clients, who applied for some form of health insurance, and with assistance of a Community Health Worker, were approved for health insurance or supplemental insurance.

vii. 84 clients self-reported having $300,074.82 in debt either from a clinic or hospital.

viii. At intake, clients reported their Household Annual Income and Medical Debt incurred from clinics or hospitals. The graph below (***Graph 5d***) shows the average medical debt per person within each income bracket. *****Note*:** In the $10,000-$14,999 income bracket and the $20,000-$29,999 income bracket, there were two outliers excluded from the data. These outliers were also removed from the Overall category. An outlier was defined as any medical debt that exceeded 2 standard deviations from the mean.



Graph 5d

ix. The information below is the bulleted form of the information presented in the graph with the addition of number of people within each income bracket, as well as, total debt per income bracket.

a) Making less than $9,999 (15 people)
   - **Average Debt- $1,067.73** (Total: $16,016)

b) Making $10,000-$14,999 (19 people)
   - Average Debt-$4,310.83 (Total: $81,905.82)
     - ***Note:* One person had $40,000 in medical debt, which skews the figure, so without this person in account (18 people):
       i. **Average Debt-$2,328.10** (Total: $41,905.82)

c) Making $15,000-$19,999 (15 people)
   - **Average Debt-$2,358.67** (Total: $35,380)

d) Making $20,000-$29,999 (8 people)
   - Average Debt-$13,697.50 (Total: $109,580)**
     - ***Note:* One person had $98,000 in medical debt, which skews the figure, so without this person in account (7 people):
       i. **Average Debt: $1,654.29** (Total: $11,580)

e) Making $30,000-$49,999 (4 people)
   - **Average Debt: $3,250.25** (Total: $13,001)

f) Making $50,000-$79,999 (1 person)
   - **Average Debt: $2,500**
     - ***Note:* There is only one person represented in this bracket.

g) Income Not Noted (11 people)
   - **Average Debt: $3,790.18** (Total:$41,692)

h) Overall (73 people)
   - Average Debt: $4,110.61 (Total:$300,074.82)
     - ***Note:* With top and bottom outliers removed (71 people):
       i. **Average debt: $2,845.58** (Total: $202,035.82)

Health Outcomes and Cross-Tabulation Analyses:

a. As stated from page 5, 94% (158 of 168) of clients attained a Primary Care Provider, yet 73% (122) of the 168 report cost as the number one barrier for continued care. A cross tabulation was done to see of the 158 clients who developed a relationship with a PCP what their insurance status through the payment source pathway was. The results of the cross tabulation were: Of the 158 clients who developed a formal relationship with a PCP, 41% (65 clients) also secured some form of insurance through the payment source pathway with the assistance of a Community Health Worker. 48% (80 clients) of the 168 clients accepting ongoing care from a PCP, still are without any form of insurance and are considered self-pay.

ER Outcomes:

a) There was a 35% reduction in the overall number (running total) of Emergency Room visits by 150 clients before entering the program (405 visits) to after being in the program (262 visits).

b) 38% of the 250 clients enrolled in the program continue to use the ER for their primary care and other needs (94 clients). *(*See ER Usage paragraph)*

c) A snapshot of CHI Health Good Samaritan Emergency Room usage was taken for all clients individualized by capturing the visits during the time they have been enrolled in the program vs. visits during that same amount of time before entering the program. Using this method, all pre-Emergency Room visit total charges came to $4,232,493.14 and all post- Emergency Room visit total charges came to $3,093,390.24, resulting in a savings of $1,139,102.90.

d) There were only 150 of the 250 clients who utilized the Emergency Room. This results in an Emergency Room usage cost savings of $7,594.02 per person.

e) Running total of billable Emergency Room charges to Good Samaritan Hospital for all clients from January 2010 to each client's enrollment date documents benchmark total charges of $5,907,351.17. It is anticipated that a comparison report done in December 2018 will show significant reduction in Emergency Room costs due to clients being enrolled and participating in the Health HUB program.

f) Community Health Worker consultant, Carl Rush, notes that Community Health Worker programs should retain a 3:1cost ratio of pre ER costs to grant costs. While more research is being done to understand all costs apart of the cost ratio and will be documented at program end, preliminary work indicates a 4:1 cost ratio, better than national recommendation establishing the program need in Buffalo County to reduce ER usage.

g) One-year period *(**See One-year period paragraph)* Emergency Room Cost Reduction (trending pattern below by report dates):

1. As of January 2014, 71 clients resulted in a 46% reduction in the total Emergency Room cost ($498,293 to $268,922)
2. As of August 2014, 126 clients resulted in a 44% reduction in the total Emergency Room cost ($2,154,827.26 to $938,680.58)
3. As of January 2015, 167 clients resulted in a 52% reduction in the total Emergency Room cost ($2,466,684.33 to $1,190,419.51).
    a. Program research seems to indicate that over a two-year timeframe a significant potential Emergency Room cost reduction of between 46%-59% is reported. Our findings at the end of the program demonstrate the effective use of Community Health Workers to reduce Emergency Room costs.

h) 67% of clients enrolled in the program for one complete year* have NOT been to the ER since enrolling in the program (112 clients of the 167 enrolled for one complete year).

i) Total Charges reduced from $2,466,684.33 to $1,190,419.51= $1,276,264.82 for clients enrolled for one complete year

j) One client reduced ER visits from 13 to 1 after being in the program for one complete year* ($70,973 in total charges for the 13 visits to $1,688 for the one visit).

k) Two clients reduced ER visits from 10 to 0 after being in the program for one complete year* ($203,737.63 and $56,103 in total charges for the 10 visits).

l) One client reduced ER visits from 7 to 1 after being in the program for one complete year* ($157,137.96 in total charges for the 7 visits to $2,101 for the one visit).

m) One client reduced ER visits from 5 to 0 after being in the program for one complete year* ($59,504.30 in total charges for the 5 visits).

n) Many clients reduced ER visits from 3-4 to 0-1 after being in the program for one complete year* resulting in a reduction of thousands of dollars.

**ER Usage Summary for Returning Clients: The clients that are returning to the Emergency Room are persons who have not been able to resolve the payment source pathway to secure a form of health insurance or alternative payment resource to see a primary care provider. There were also a small percentage of clients who experienced a health episode that required emergency medical attention. Ifa client has bad medical debt with a clinic or does not have health care coverage they have no other alternative but to seek medical care in the emergency room. The Community Health Workers have been able to help modify health seeking behavior of clients who have once relied upon the emergency room after they have secured health insurance through public benefits or employer sponsored coverage. Community efforts are progressively being made and bench markers have been defined by the Community Access Network Team to resolve the unmet need of affordable health care. The prediction is to have affordable access to health care with a community clinic that will resolve the unmet need and redirect vulnerable clients away from the emergency rooms for non-emergency medical incidents*

***One Year Period: The one year period was chosen as a tool for best measurement to evaluate Emergency Room usage along with the "same amount of time" period.*

Diabetes Health Outcomes:

Clients who have increased their level of compliance have improved their A1c. These clients reduced the number of diabetes-related complications of heart attack, chronic angina stroke, peripheral vascular disease, other forms of atherosclerosis, vision loss, neuropathy, kidney failure, and limb amputation; all have significant medical cost saving potential. Research has shown that for every 1.0% decrease in Hgb A1c results in 21% reduction in diabetes associated mortality, a 14% reduction in myocardial infarction, and a 37% reduction in microvascular complications. One program utilized this information and determined that for their participants, the potential lifetime health care cost savings resulting from improved management of diabetes is estimated to be $686,933.[1]

a. 11 clients decreased their A1c scores by 1.0%
b. 6 clients decreased their A1c scores by 2.0%
c. 4 clients decreased their A1c score by 3.0%
d. 4 clients decreased their A1c score by 4.0%
e. 1 client decreases their A1c score by 7.0%
f. 1 clients decreased their A1c score by 8.0%
g. 18 clients decreased their A1c score by less than 1.0%
h. 42 clients decreased their A1c scores by less than 0.0%

Overall clients with at least two A1c scores, on average, improved their A1c scores by 0.05%

Of the 250 clients enrolled in the Health HUB program, 33 clients have been dismissed from the program due to: lost to follow-up, client relocation, client declining program help, or client's death

Of those 217, 162 clients have at least one A1c record.

Of those 162, 87 clients have at least two A1c records.

52% (45 out of 87 clients) of Health HUB clients with at least two A1c scores either maintained or improved their A1c scores.

Note: There are 250 clients in the Health HUB program. Of the 250 clients, 168 clients are enrolled in the Safety Net Pathway. Of the 168 clients needing a primary care provider (PCP), 94% (158) of those clients secured a formal relationship with a PCP. The remaining 6% (10) still have not established a relationship with a PCP. However, 73% (122) of the 168 clients still report cost as the number one barrier for continued care. Therefore, outcomes from the Safety Net Pathway have demonstrated a need for a community clinic. The focus of the original grant was to provide a safety net for clients, the closing of the Clinic of Good Health in Gibbon in year one of the grant caused difficulty in providing routine access to care. Improved A1C are linked to regular primary care visits, it can be theorized that A1C would reach a greater improvement rate once the HelpCare Clinic is established and providing routine diabetes care.

[1] H Jeffreys. *Hemoglobin A1C Value for Evaluating a Community Diabetes Education Series*. The Internet Journal of Advanced Nursing Practice. 2007 Volume 9 Number 2.

Successful Outcome:

Due to the Community Health Workers efforts, UniNet-Kearney has chosen to sustain the position to continue assisting Health HUB clients in the future. The proven success of Community Health Workers has been noticed by many organizations within our community who have hired or want to hire a CHW since the start of this program, including: Family Practice Associates, HelpCare Clinic, Two Rivers Public Health Department, Behavioral Health Education of Central Nebraska, Central Nebraska Diabetes Referral Network, Creighton University, and Central Nebraska Prenatal Advisory Council.

Clinic Outcome:

A $104,616.67 increased revenue for primary care clinics because 169 Health HUB clients were coming in to see their provider on a regular basis (quarterly) as prescribed by their condition. This is a shift from inappropriate care (using the Emergency Room) to appropriate care (going to a primary care clinic), which results in reduced cost to the healthcare system.

Client Satisfaction Survey:

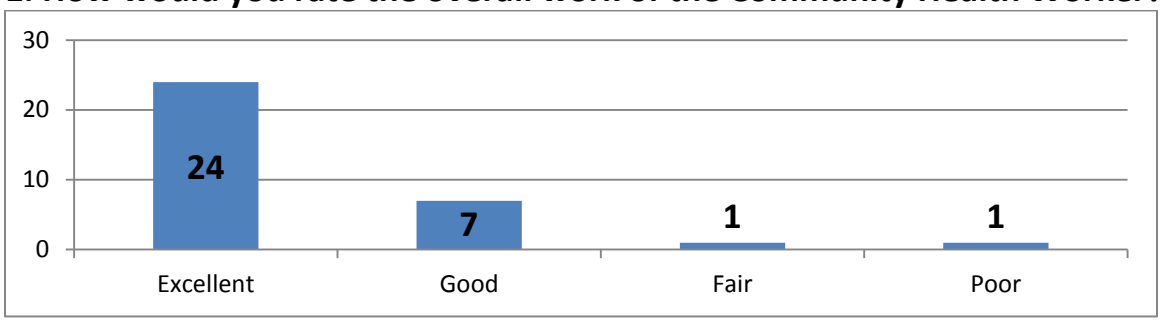
To assess how clients felt about the Health HUB program, we called 146 of the 250 clients to ask them a few short questions. There were 33 survey participants. Attached on the following pages is the survey tool that was used. In summary of the survey report, a majority of clients felt the program was very successful and were happy with their participation. There are a couple of clients who did not feel the program was successful, yet when asked if they would be willing to work with a community health worker in the future almost every single client said yes. This question alone shows the need to continue building the Community Health Worker workforce within our community.

COMMUNITY HEALTH ACCESS TEAM (CHAT)

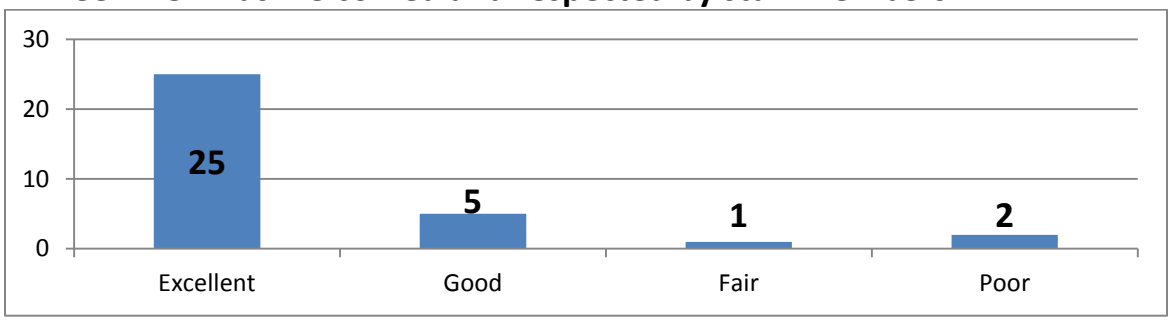
A GOAL WORK GROUP OF BUFFALO COUNTY COMMUNITY PARTNERS

Client Satisfaction Survey: Community Health Worker

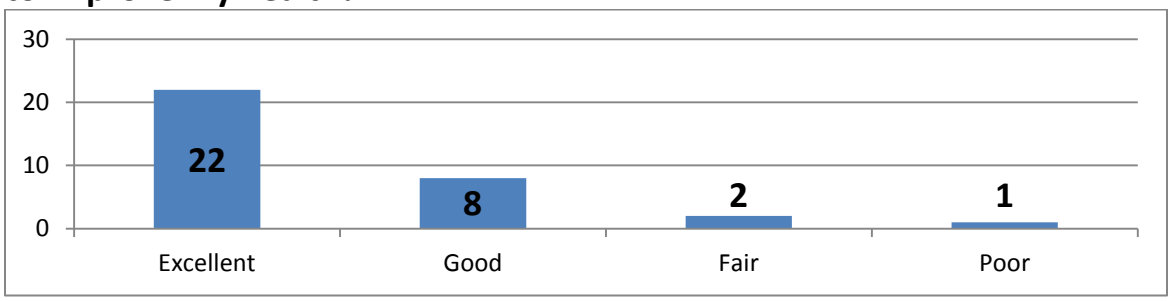
1. How would you rate the overall work of the Community Health Worker?



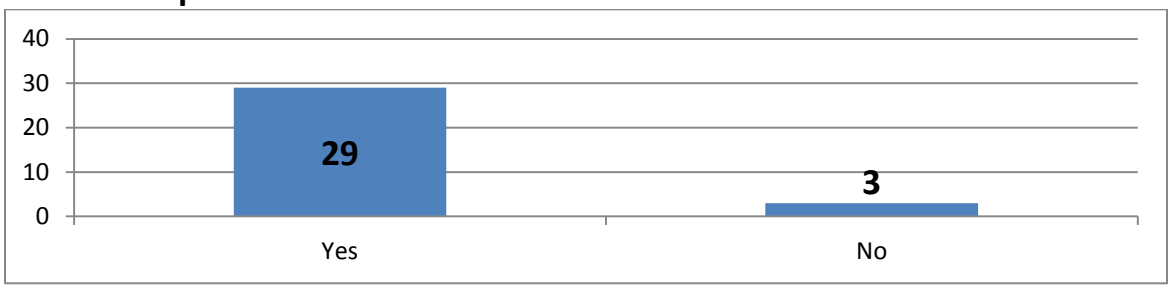
2. I feel like I was welcomed and respected by staff members.



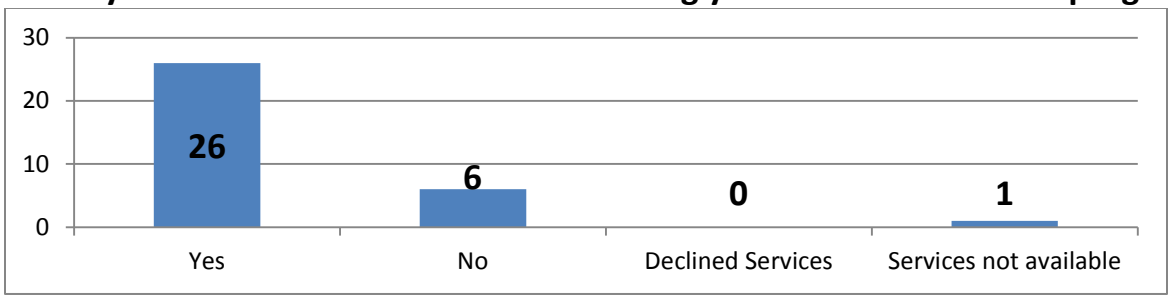
3. I feel that the help I received from the community health worker helped me to improve my health?



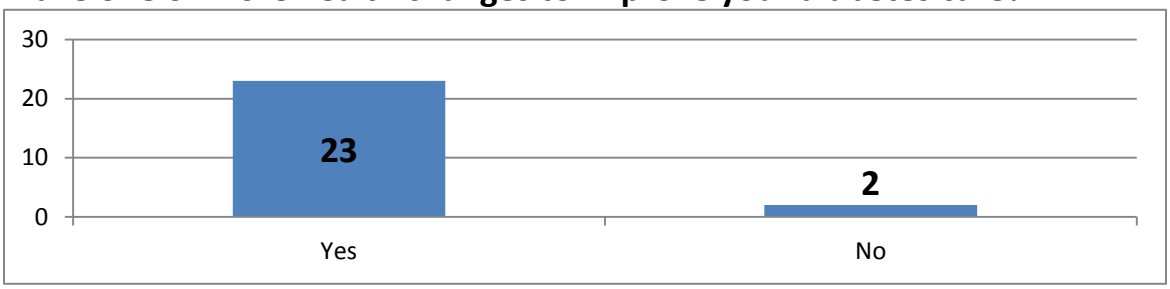
4. Was your Community Health Worker easy to access or call upon when you needed help?



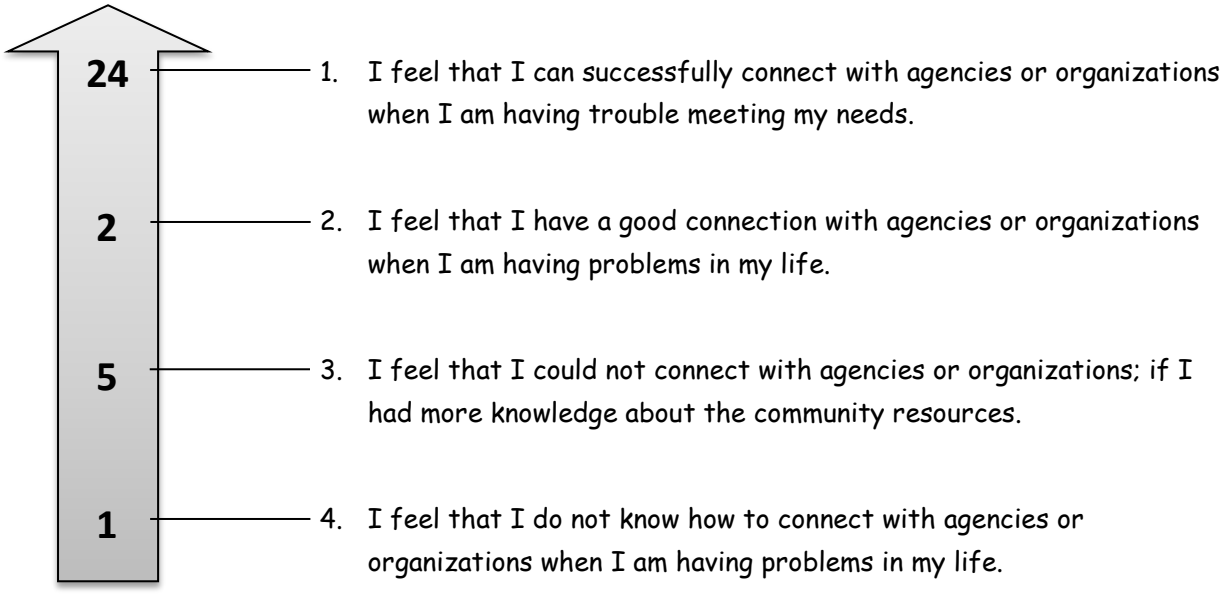
5. Did you receive Diabetes Education during your enrollment of the program?



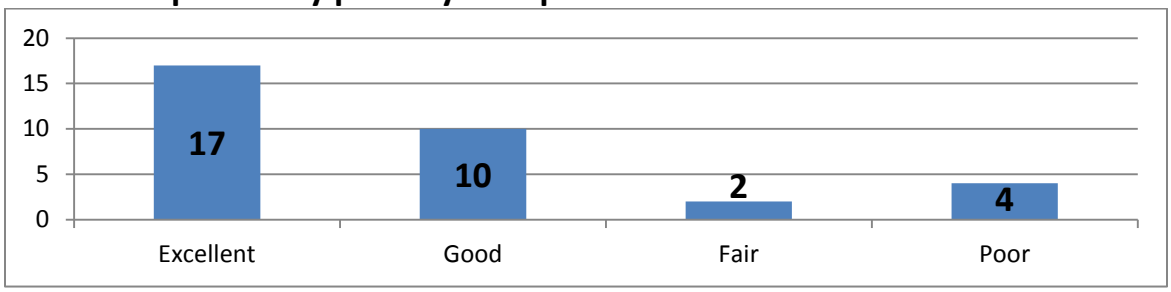
If yes, did you feel that you increased your knowledge of Diabetes enough to make one or more health changes to improve your diabetes care?



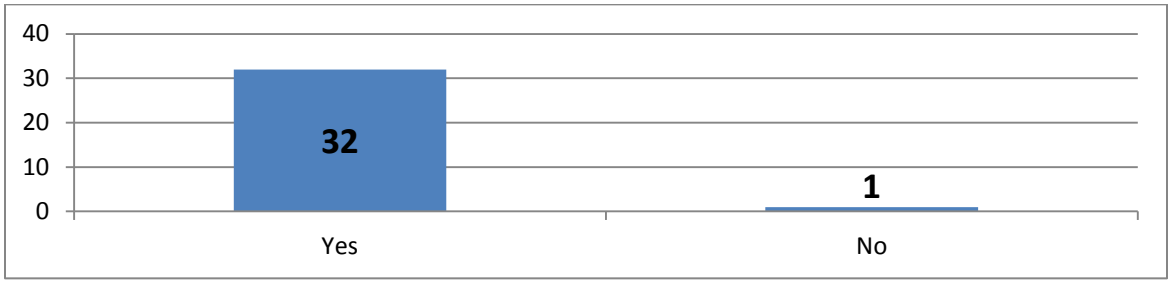
6. How do you feel about independently connecting with community resources to meet your social needs? Circle the number that reflects how you feel.



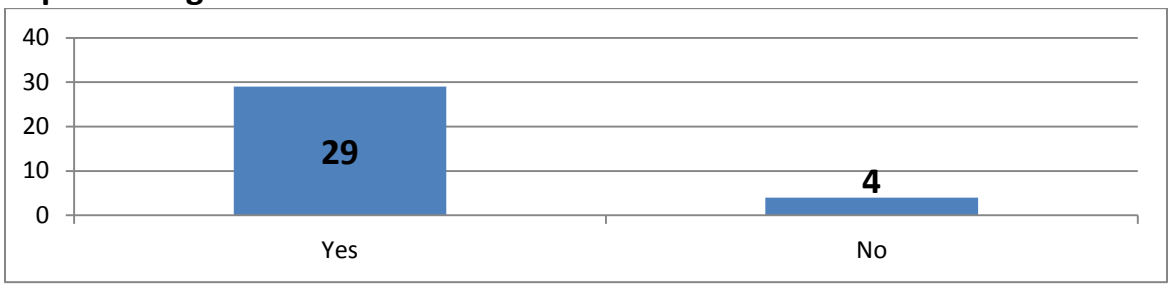
7. I feel that my community Health Worker helped me build a working relationship with my primary care provider.



8. In the future, would you be willing to work with a Community Health Worker?



9. The Community Health Worker helped me overcome the barriers that I was experiencing at the time.



HEALTH HUB

A GOAL WORK GROUP OF BUFALO COUNTY COMMUNITY PARTNERS®

Pathways Model

+

Institute for Healthcare Improvement Triple Aim

Powered by

Buffalo County COMMUNITY PARTNERS®

BUILDING A HEALTHIER COMMUNITY

PROJECT GOAL

. . . to develop a formalized pathways structure and community health worker (CHW) model to overcome various individual barriers in order to expand access to healthcare and social services across Buffalo County. Specifically, this CHI Health Mission and ministry grant project targeted 250 qualifying adult Diabetic clients from 2011 to 2014.

In a post-program survey, clients of the Health HUB program rated their overall satisfaction as "Excellent," giving the program a rating of 3.7 out of 4.0.

Medication Access Pathway - *193 clients enrolled*

. . . to determine medication adherence, education on the importance of taking medications, and obtaining access to medications. If community members are able to obtain their medications and understand how to take their medications, their health status will improve.

 # 182 *secured medication payment sources*

$ $726,431 *saved by providing 1,513 prescriptions to 101 clients enrolled in Medication Access Program*

Diabetes Education Pathway - *191 clients enrolled*

. . . to assess community members' understanding of their disease, determine any gaps in knowledge, provide education, and improve patients' ability to self-manage their condition.

 # 165 *clients served by Diabetes Education classes*

↑ .4% *overall improvement in average A1c scores*

 # 189 *referred to local programs for additional education*

Social Service Referral Pathway - *175 clients enrolled*

. . . to help the community member remove any financial/social barriers to accessing health care or managing their health conditions. Socio-economic issues have the largest impact on health outcomes so improving these issues should improve overall health.

% **88%** *resolved social services barriers*

% **31%** *social service applications denied, mostly HHS programs for which clients did not meet eligibility requirements*

Safety Net Pathway - *169 clients enrolled*

. . . to help the community understand the importance of a relationship with a Primary Care Physician (PCP), improve access to a PCP, and to understand appropriate use of the emergency room (ER). With an ongoing relationship with their PCP, health status will improve as documented by improved A1C or other clinical measures.

$ **$1.139 million** *in cost-savings to CHI Health Good Samaritan Emergency Room*

$ **$104,616** *in increased clinic revenue due to regular client visits*

% **94%** *secured formal relationship with primary care provider*

% **73%** *continued to report cost as #1 issue to access*

Payment Source Pathway - *160 clients enrolled*

. . . to assist clients to create a stable form of payment for health care services. With a stable form of payment, the patient will be able to improve their health by accessing health services, medications, etc.

% **74%** *federal and/or state medical assistance applications denied*

84 *clients self-reported $300,000 in bad debt with a clinic or hospital*

A COMMUNITY HEALTH WORKER:

. . . serves as a liaison/link between public health, health care, behavioral health services, social services, and the community to assist individuals and communities in adopting healthy behaviors

. . . conducts outreach that promotes and improves individual and community health

. . . facilitates access to services, decreases health disparities, and improves the quality and cultural competence of service delivery in Nebraska.

. . . is a trusted member of, or has a good understanding of, the community they serve. They are able to build trusting relationships and are able to link individuals with the systems of care in the communities they serve.

. . . builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.

. . . is an umbrella term used to define other professional titles.

COMMUNITY HEALTH WORKER ROLES:

- Outreach and Community Mobilization
- Community/Cultural Liaison
- Case Management and Care Coordination
- Home-based Support
- Health Promotion and Health Coaching
- Participatory Research

COMMUNITY HEALTH WORKER FUNCTIONS, RESPONSIBILITIES, AND ACTIVITIES:

- Ability to work within the Nebraska CHW Association code of ethics
- Serve as a Cultural Health Liaison or Facilitator
- Empower clients through advocacy and education
- Conduct outreach activities
- Raise awareness of health and wellness needs
- Provide disease prevention education
- Provide social support
- Build community capacity
- Community resources navigation

Developed in part by the Buffalo County Policy Academy Team and approved by the Nebraska CHW Steering Committee.
*For more information about Community Health Workers, visit **bcchp.org/chw**.*