ISSUE 2
SPRING, 2022

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THE NUMBERS

Certified Community Health Workers

85

Programs with Certified Community Health Workers

35

Counties with Community Health Workers

37

CONTACT INFORMATION

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KENTUCKY

COMMUNITY HEALTH WORKER STORIES OF SUCCESS

Community Health Workers (CHWs) have been an integral part of the community in Kentucky since 1994 with the inception of Family Health Advisors at Kentucky Homeplace in Appalachia. In the decades following, many organizations have continued to integrate CHWs into their programs to improve access to care, improve health outcomes and connect clients to needed services. As of 2021, there are over 35 programs with Community Health Workers (CHWs). From Federally Qualified Health Centers to hospitals, to universities to Managed Care Organizations to non-profit organizations; Community Health Worker (CHW) programs are as diverse as the communities they serve. CHWs perform deeply impactful work every day. Uniquely situated as trusted members of their community, CHWs are integral to achieving health outcomes and improving community health. This publication was created to highlight the impact of CHWs across the state. We hope that this issue and future issues of this publication will inspire continued support for CHWs across the commonwealth. Please, you enjoy this sampling of CHW "Stories of Success."

A NOTE FROM THE KENTUCKY OFFICE OF COMMUNITY HEALTH WORKERS

Since 2014, the Kentucky Office of Community Health Workers (KOCHW) has been the leading entity to coordinate, expand and elevate the Community Health Worker profession across Kentucky. Since then we have hit many milestones such as the formation of the CHW Advisory Workgroup in 2014, the official launch of CHW Certification in 2019 and receiving the CDC "Community Health Workers for COVID-19 Response and Resilient Communities" grant in 2021 and the anticipated CHW Training Organization Certification. Our office continues to expand with the addition of dedicated staff related to CHW Certification and Recertification, Training and Continuing Education, Data and Visualization and CHW Engagement. The KOCHW is able to increase our abilities to provide support, guidance and technical assistance to new and existing CHWs and CHW programs. As we grow, the KOCHW will continue to ensure that our programs and policies are CHW-centered, evidence-based and built upon the input and best practices of Kentucky CHWs. We are incredibly honored to serve and work with CHWs. Together we will continue to elevate the CHW profession and help make our communities healthier places to live, work, play and pray.

Laura Eirich

Office of Community Health Workers Administrator

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KENTUCKY HOMEPLACE

UNIVERSITY OF KENTUCKY
CENTER OF EXCELLENCE
IN RURAL HEALTH

CHALLENGE

There is a lack of opportunity for workforce development and retention of career-ready healthcare professionals graduating high school in our communities.

PROJECT

Students from local high schools receive dual credits for high school and college courses for attending Community Health Worker classes. Upon completion, students will be eligible for state certification and an apprenticeship with Kentucky Homeplace.

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OVERVIEW

In 2019 UnitedHealthcare awarded a gift to the University of Kentucky Center of Excellence in Rural Health to cover the tuition costs for enrolling 23 Perry County High School students into dual credit courses through Hazard Community & Technical College. The goal was to prepare the students for professional roles in healthcare and increase their knowledge of chronic disease prevention and management in their community. Students from Perry County High School and Hazard High School, were selected by guidance counselors and teachers and completed six Kentucky Homeplace courses accredited by Hazard Community & Technical College with a curriculum developed and taught by UK CERH Staff beginning in January 2020. Each student was assigned to develop plans on improving the health and well-being of those in their communities. Students who complete the CHW courses are offered an 80 hour paid apprenticeship by the UK CERH and Kentucky Homeplace. Upon completion of the apprenticeship, students are then eligible to apply for Community Health Worker Certification awarded by KOCHW. Completing six courses and working as an apprentice for 80 hours allows them to apply a Kentucky Certified Community Health Worker certificate and have valuable "on the job" experience in a healthcare setting soon after graduating high school.

OBJECTIVE

- Provide workforce development for work-ready individuals upon high school graduation, increase awareness of community-specific needs and to develop solutions to build community capacity.
- Offer on-the-job experience through a paid apprenticeship.
- Retain trained community health workers.

COMMUNITY INVOLVEMENT

All CHW students must complete an advocacy project with a focus on innovative community approaches and to identified community-specific needs. Then, develop a program with solutions to impact individuals and or community capacity. Students choose advocacy topics and develop solutions that can be implemented in their communities. Past projects have included suicide prevention programs in their high school and the development of a clothing bank where students can receive clothing free of charge.

INTENDED PARTICIPANTS

Participants are juniors and seniors from high schools in Perry County Kentucky, who have an interest in pursuing a career in health services after graduation. The participants are selected by their teachers and guidance counselors through Kentucky Advanced Technical College High.

PROGRAM PROCESSES

A partnership was formed between UK CERH, Kentucky Homeplace, K-TECH, local high schools, Hazard Community and Technical College and UnitedHealthcare. Students were selected based on career interests and ability to succeed in post-secondary coursework. Students enrolled in CHW 101-106 courses accredited by Hazard Community and Technical College. These courses are taught by Kentucky Homeplace program managers and volunteer faculty of Hazard Community and Technical College and covered topics in the approved CHW training manual. Students developed and presented PowerPoint presentations to the class. They role-played enrolling a client, used motivational interviewing, put together a plan of action, located resources and developed long-term goals. This curriculum, along with the 40 hour practicum, satisfies requirements for the "application based on training" track for their Certified Community Health Worker Certification. Students also complete a community capacity-building project. Once passing grades are awarded to CHW students in all six courses, the student is then invited to complete an 80-hour paid apprenticeship through UK CERH and Kentucky Homeplace. The student will get paid on-the-job training and shadowing experience with Certified Community Health Workers. They are then eligible to apply for state certification free of charge.

OUTCOMES

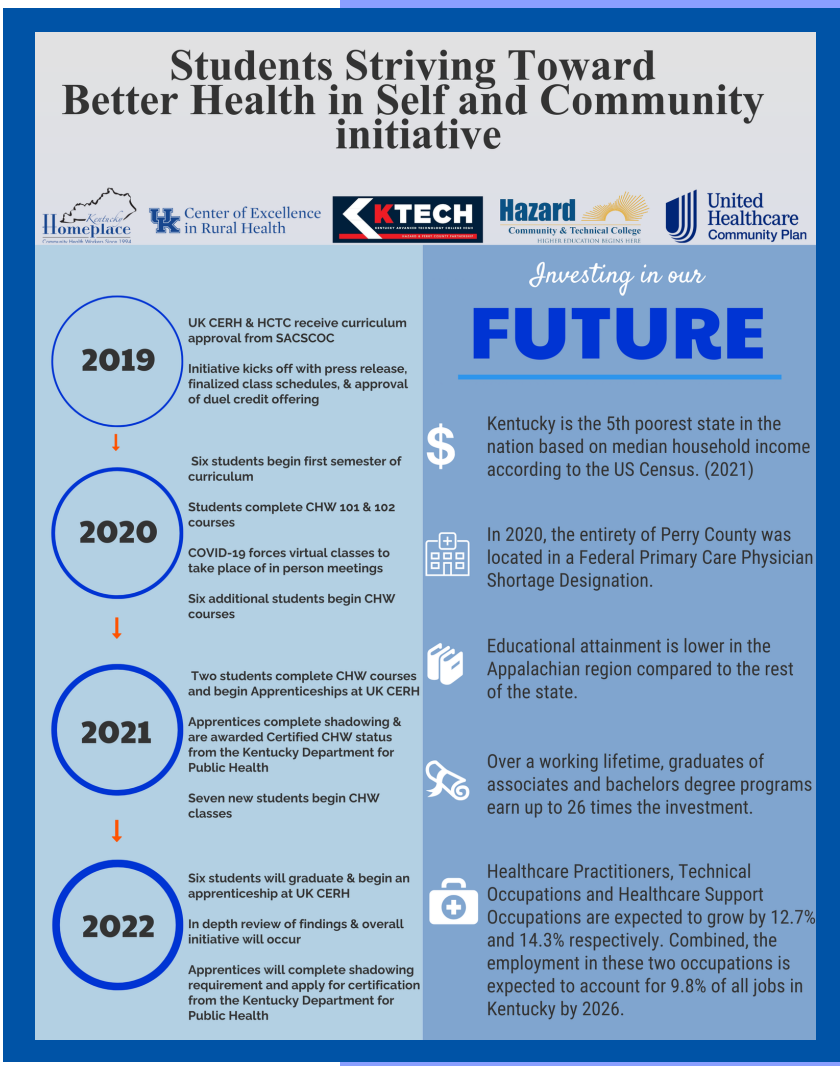
The initiative has successfully graduated 2 students to date with 6 students set to graduate in May 2022. Both successful graduates completed an apprenticeship with UK CERH, shadowed Kentucky Homeplace CHWs and received CHW certifications. Students receive support from multiple organizations to ensure their success.

FUTURE CONSIDERATIONS

Currently, 15 of the 23 students awarded have either graduated from the program or are actively taking classes. We are very fortunate that our unique partnership has brought together so many organizations that are dedicated to healthcare workforce development and retention in Eastern Kentucky. As a team, we continue to seek new funding opportunities to expand and sustain this program. COVID-19 brought on many program challenges that the entire team had to work together to overcome. In September of 2020, HCTC mandated that all classes be moved to a virtual platform due to the pandemic. We were able to work together to deliver the coursework via Zoom to students. Implementation of the Zoom platform identified issues related to internet connectivity and availability in rural Kentucky. Challenges also arise out of the differing calendars between the two high schools involved and Hazard Community and Technical College. Current objectives have been met by graduating students from the program at an increasing rate, participation for students in community advocacy projects and providing paid apprenticeships. Classes have also resumed in person as have CHW job shadowing opportunities.

> We are deeply thankful to UnitedHealthcare for their support, enabling us to invest in our up-and-coming rural health workforce in Kentucky.
> –Dr. Fran Feltner

> This is a tremendous opportunity for students who want to help others and develop a great connection to something they can pursue a career in. Any high school students given this experience, I say go for it... You won't regret it!
> –Program Graduate



BREATHE

Bridging Research Efforts and Advocacy Toward Healthy Environments

College of Nursing

CHALLENGE

Tobacco use disproportionately affects the health of rural communities. Tobacco dependence is common, tobacco use initiation begins at a young age, the tobacco-related disease is a significant burden and exposure to secondhand smoke is excessive.

PROJECT

Two CHWs in two rural counties completed BREATHE's Tobacco Treatment Specialist certification-TTS, to reduce tobacco disparities. We developed Community Action Plans to address tobacco use based on data from community stakeholders and tobacco users.

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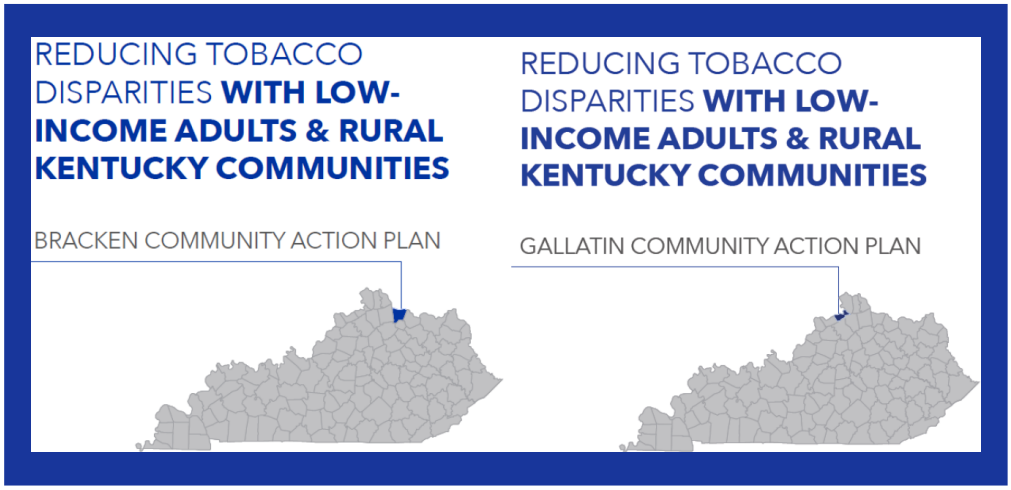
OVERVIEW

BREATHE is a multi-disciplinary research, outreach and practice collaborative of the University of Kentucky College of Nursing. BREATHE'S Mission is to promote lung health and healthy environments for at-risk populations. BREATHE designed a novel approach to engaging CHWs in tobacco treatment with a planning grant from the Interact for Health (IFH) Foundation, called Reducing Tobacco Disparities with Low-income Adults & Rural KY Communities. Given the lack of progress in tobacco control in rural, low-income communities, we had an opportunity to build capacity in reducing tobacco use disparities in rural low-income populations by engaging CHWs in two rural KY counties: Bracken and Gallatin. Both CHWs completed BREATHE's Tobacco Treatment Specialist Certification Program (TTS). The project expanded CHWs' impact in these two counties by providing them with the skills needed to provide education, counseling and support to reduce tobacco use disparities in rural and low-income populations.

OBJECTIVE

The goal was to identify, engage and inspire CHWs to provide leadership in reducing tobacco use disparities in rural low-income populations. Objectives were to enhance our understanding of facilitators and barriers to reducing tobacco disparities and increase the number of trained TTSs in Bracken and Gallatin Counties that could educate the community and counsel and support tobacco users in tobacco treatment.



COMMUNITY INVOLVEMENT

The CHWs attended focus groups to listen to key stakeholders' views on tobacco use and tobacco control strategies and take field notes to assist the project team in analyzing data. The CHWs also engaged with community stakeholders at coalition meetings (e.g., health department, managed care, Kentucky Cancer Program, tourism, Family Resource Youth Service Centers (FRYSC), Regional Prevention Centers, Federally Qualified Health Center, Adult Education, manufacturing, Chamber of Commerce) to provide tobacco disparities education.

INTENDED PARTICIPANTS

Bracken and Gallatin Counties are comprised of low-income, rural residents. Bracken County has a 4.9% unemployment rate, Gallatin-4.0%. Bracken has 21.6% of children living in poverty, Gallatin-17%. Moreover, cancer deaths per 100,000 population in Bracken and Gallatin County are higher than the state and national average. Bracken and Gallatin's counties have a rich agricultural heritage and historically have relied heavily on tobacco production.

PROGRAM PROCESSES

With the help of the Director of the North Central Area Health Education Center (AHEC), we were successful in recruiting an individual living in Northern KY who was willing to be trained to serve as a CHW in Bracken County for this tobacco use disparities project. Similarly, the Gallatin County High School Youth Service Center Director helped us identify an individual from Gallatin County who was a native and familiar with the community and could serve as a CHW. We hired and trained both individuals to work as CHWs in June 2020 and they completed BREATHE's online Tobacco Treatment Specialist training in October 2020, to equip them with evidence-based skills to educate, counsel and support individuals with tobacco dependence across a range of settings.

OUTCOMES

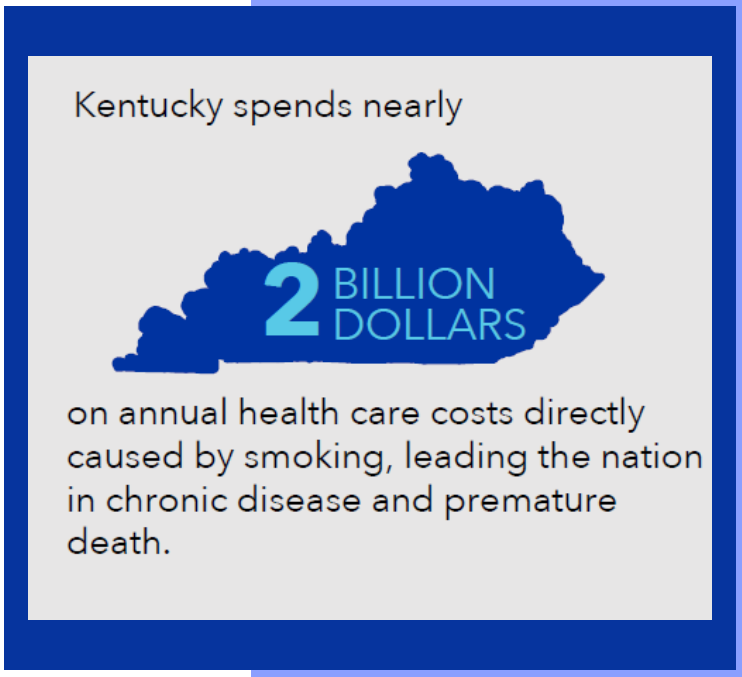
Given the overarching goal to design and implement a novel CHW-TTS partnership model to provide community education and individualized tobacco treatment counseling and support in the under-resourced rural county of focus (Bracken), we reached our goal of engaging and training CHWs in both counties. Before this project there were no CHWs serving Gallatin or Bracken County.

FUTURE CONSIDERATIONS

During the course of planning the grant, our North Central AHEC partner hired the CHW whom we identified and trained as a Tobacco Treatment Specialist in Bracken County. The Bracken CHW is in the process of applying to be a Kentucky Certified CHW through the Kentucky Department for Public Health Office of Community Health Workers. It was through BREATHE's training and partner outreach that prepared the CHW to be able to provide health education and outreach with communities. Additionally, it was through our AHEC partnership, that we were able to build capacity to design and implement a novel CHW-TTS partnership model. Our plan for longevity and sustainability is to test the effectiveness of the CHW-TTS partnership model in Bracken County's new school-based health center. The CHW will identify, educate and engage tobacco users in counseling and support in tobacco treatment. Our future objectives are to design and implement a CHW-TTS school-based health center (SBHC) partner model intervention to reach and deliver tobacco treatment to adult tobacco users in Bracken County, a rural, under-resourced county. Second, we will evaluate the ability of the CHW-TTS/SBHC partner model intervention to reach, educate and engage tobacco users in tobacco treatment. Third, we will examine the impact of the CHW-TTS/SBHC partner model tobacco treatment intervention on tobacco use patterns, quit attempts and rates of quitting. Lastly, we will identify and explore facilitators and barriers to implementing the CHW-TTS/SBHC partner model intervention with key stakeholders (e.g. health department, school nurses, FRYSC, Primary Plus, dental clinic, faith community, health center committee, school administration) to provide recommendations for sustainability.

CHW IMPACT:

Leveraging partnerships, we hired two individuals as CHWs. Before the project, there were no CHWs in either county. As a result of the project, the Gallatin CHW was hired by the Bracken County HD to work on tobacco cessation . The Bracken CHW was hired by North Central AHEC.



"I was very lucky to be part of the BREATHE project, where I finished TTS certification. I learned a lot about tobacco. I am looking forward to helping people with their tobacco cessation journey."
- Pilar Ford, CHW-North Central AHEC

CHI ST. JOSEPH HEALTH

TOTAL HEALTH ROADMAP

CHALLENGE

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

PROJECT

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

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OVERVIEW

Catholic Health Initiatives (CHI) St. Joseph Health's work on the Total Health Roadmap started in December 2017 with a focus on the implementation and evaluation of a scalable approach for screening and referral for social needs in primary care. Three pilot clinics were chosen, two primary care clinics in Berea and London and a pediatric clinic in London. Four full-time community health workers are employed in these clinics and all patients are screened for social needs using a common set of questions. Universal screening is essential for equitable access to the support and referrals provided by community health workers. In January 2020, a fifth full-time community health worker was added in Lexington at an OB/GYN high-risk clinic. In October 2020, a primary care clinic in Kingston was added and in February 2021, a primary care clinic in Corbin was added. These clinics are covered by current community health workers.

OBJECTIVE

Program Goal: Proactive transformation of care delivery and engagement in cross-sector partnerships to address social needs and improve the health and wellbeing of the communities served. The program does this through two objectives. The first objective is sustain and disseminate universal screening and referral for social needs across CHI Saint Joseph Heath in the coming three years. The second objective is, advance two cross-sector community partnerships to close gaps and improve access to resources and programs that address food security and housing needs in the coming three years.

COMMUNITY INVOLVEMENT

A critical role for community health workers is in the maintenance of resource databases for their communities. Before the screening project began, community health workers researched resources in their area and then visited or called agencies to learn more about programs and services. Community health workers also volunteer at partner agencies during selected work hours, strengthening these relationships and providing first-hand knowledge and understanding of the pathways and processes of agencies to whom patients are referred. These relationships have served us well through the COVID-19 pandemic, as organizations that were on lockdown were able to work with our community health workers to supply commodities for patients. Since our work began, over 9,000 referrals have been made to 712 different community organizations. Our community involvement has led to the two community health workers in Madison County receiving the Unsung Hero award from the Richmond Register newspaper.

INTENDED PARTICIPANTS

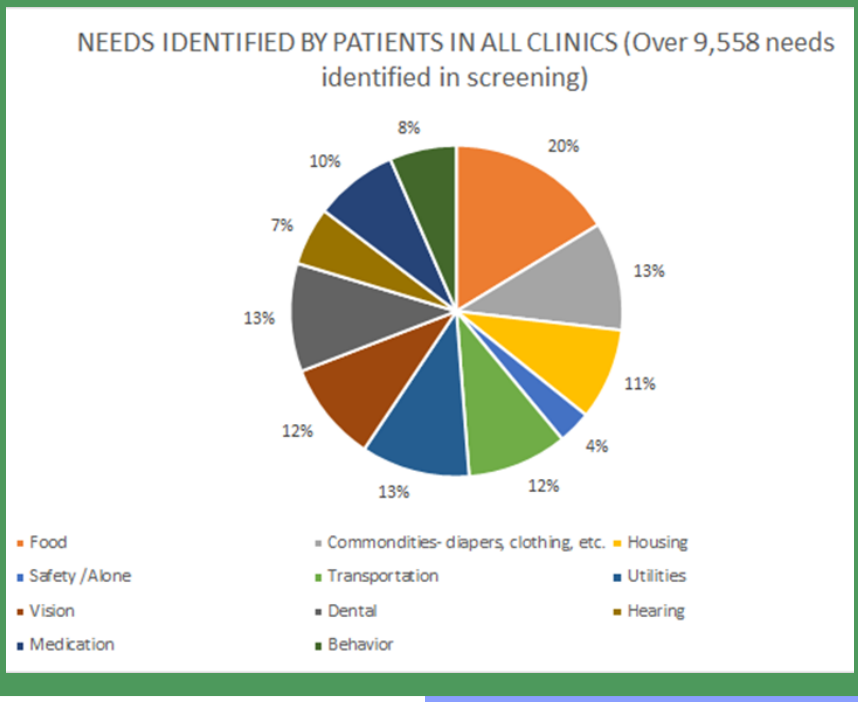
The selection of our original pilot sites included clinics in predominantly rural areas with a large percentage of their patients enrolled in Medicaid. Laurel County's poverty rate is 18%, higher than the state and the proportions of Medicaid patients in our panels are high: 32% in Madison County, 31% in Laurel County and 26% in Fayette County. We began with the assumption that enrollment in Medicaid is often associated with higher health-related social needs. As we have begun to spread and scale, we have included two additional clinics that have a physician's connection to the clinics that were part of our pilot group. Our model is universal screening and referral, meaning anyone who seeks care in these clinics, regardless of health insurance status, has access to a community health worker for support.

PROGRAM PROCESSES

Universal screening is integrated into the clinic workflow, with minor differences in each clinic. In most cases, patients fill out the screening survey on their own, but staff members are available to assist those who are unable to do so. After screening, community health workers reach out to the patients who indicated they wanted assistance. An excel spreadsheet, developed by the community health workers, houses the resource database and is used to provide each patient with a customized set of referrals and to track the progress of patients in navigating those resources. This platform is also used to manage screening and referral data, generate reports to our funders and leaders, understand caseloads, track outcomes of referrals and gain a deeper understanding of the overall scope of needs in our clinic patient panels.

OUTCOMES

We achieved universal screening in all of our clinics. Early analyses of screening data indicate improvements in patient knowledge of available resources and confidence in securing resources. We also observed a shift in provider satisfaction in the pilot clinics when compared to other clinics that have not yet integrated community health workers, demonstrated in part by the expansion to two additional clinics. We have focused our evaluative efforts on implementation; our understanding of the key success factors in our original pilot clinics sped the integration of screening and referral in our two newest clinics. We are now focusing on improving the patient experience by providing more assistance to our patients in the form of becoming Medicaid Enrollment Assisters and offering help with prescription drugs through the Kentucky Prescription Assistance Program.



FUTURE CONSIDERATIONS

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

CHW IMPACT:

- To date, nearly 43,985 patients have been screened for social needs
- One in three patients identified at least one health-related social need
- 77% of patients with identified needs request assistance through the community health workers

"Physician's comment about a community health worker: You always go above and beyond to help our patients and I am so grateful for that! You are such an amazing patient advocate! You are making a huge difference in their lives. I appreciate you!"

WHITE HOUSE CLINICS

CHALLENGE

Patients wishing to improve their health often face barriers that prevent them from achieving health related goals. These barriers have been collectively categorized as Social Determinants of Health.

PROJECT

White House Clinics conduct universal patient screening to allow care teams to identify social determinants of health experienced by patients and focus on the patients' needs, supporting them in finding solutions.

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OVERVIEW

In January 2021, White House Clinics (WHC) launched Universal Screening for Social Determinants of Health (SDOH). SDOH is the conditions in the environment where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks. Typically, SDOH is grouped into 5 categories - Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Environment and Social and Community Context. SDOH plays a significant role in patients' overall health, well-being and quality of life. Often, patients facing social obstacles are unable to overcome those barriers so that they can work towards achieving improved health status. The identification and navigation of social barriers to care are essential in helping patients improve their health status.

WHC screens all patients for SDOH to identify patient barriers related to the unmet health and social needs and aids in the navigation of resources to resolve barriers. Our organization recognizes that patients who experience barriers may not have the ability to focus on their health until the barriers are resolved. Universal screening allows our care teams to focus on the patients' needs and support patients in finding solutions for SDOH.

OBJECTIVE

By 12/31/21, 95% of all encounters conducted in 2021 will include the record of social determinants of health screening.

COMMUNITY INVOLVEMENT

Community Health Workers (CHWs) played a critical role in the Universal Screening for SDOH program. CHWs completed data collection processes and identified patient barriers related to the unmet health and social needs. Our CHWs served as the key contact and resource for patients who identified as having high-risk indicators. CHWs utilize in-house and community resources to navigate these cases and assist the patients with overcoming their identified barriers.

INTENDED PARTICIPANTS

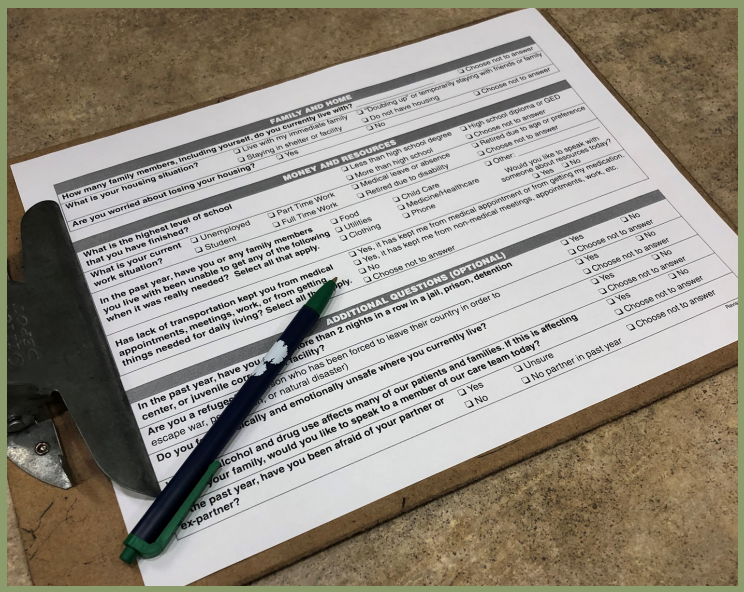
WHC is a federally qualified health center that provides primary care services in Jackson, Madison, Estill, Rockcastle and Garrard Counties. Through a grant opportunity several years ago, WHC began screening Medicaid patients aged 18 and older for SDOH as a part of their routine office visits. This initial program left a large portion of the patient population unscreened, despite knowing that many more patients may fall into risk categories. The intended participants of the 2021 Universal SDOH screening program include all WHC patients.

PROGRAM PROCESSES

SDOH screening is a universal process that is conducted annually for every patient receiving primary care services from our organization. WHC utilizes the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) screening tool. PRAPARE is a national effort to help health centers to collect the data needed to better understand and act on their patients' social determinants of health. WHC uses data collected from the PRAPARE screening tool to identify patient barriers related to the unmet health and social needs. When a patient identifies high-risk indicators, the CHW works with the patient to develop a care plan to address the barrier. At subsequent visits, CHWs review care plans with patients, note progress and adjust care plans as necessary. Universal patient population data on SDOH health allows White House Clinics to define and document the increased complexity of our patients, transform care with integrated services and community partnerships to meet the patient needs, advocate for change in our communities and demonstrate the value they bring to patients, communities and payers.

OUTCOMES

The earliest iteration of SDOH screenings indicated a significant scarcity of food resources in the Jackson County community. Upon further investigation of this pattern, WHC discovered there was only 1 food bank in the entire county with very limited hours. During the summer months, there were no feeding centers available for students during their summer breaks from school. The lack of resources in this county prompted WHC to partner with God's Food Pantry and host a fresh produce event open to the community and become a summer feeding program location for children through the summer. WHC looks forward to analyzing the first year of population-level SDOH data and identifying other areas of need. Once identified, WHC has the capacity to connect with community stakeholders and advocate for population-level solutions to gaps in resources.



FUTURE CONSIDERATIONS

WHC implemented a tremendously impactful SDOH screening program during the height of the COVID-19 pandemic. Our organization is acutely aware of how communities across Kentucky will continue to be impacted by COVID-19 long into the future. While the work completed by CHWs is not currently reimbursed by payors, WHC knows how drastically SDOH can impact the lives and wellbeing of patients and our care teams are committed to continuing this work. Our organization will continue to advocate for reimbursement on behalf of CHWs and share the importance of the services they provide in the care team setting. Additionally, WHC will continue to seek funding opportunities and leverage the capacity of care teams to support universal SDOH screening. Assisting patients in overcoming SDOH is the first and often most difficult step a patient must take in the long journey of improving health.

CHW IMPACT:

During an event on July 23 over 13,000 pounds of fresh foods were distributed to members of the community. Food security was identified as a pressing need and WHC was able to partner with God's Pantry to provide this resource.

WHC hosts car seat installation and check events, as well as CPS lead courses on child passenger safety. Community partners attendance include Estill County Health Department, KY State Police and Richmond Fire Department.

Family Health Centers

CHALLENGE

The effects of the COVID-19 pandemic cannot be overestimated. Within Jefferson County, it was quickly noted that racial and ethnic health and wealth disparities were impacting rates of COVID infections among many of FHC's patients and neighbors.

PROJECT

CHWs responded to COVID by redefining their roles, revising work strategies and focusing their efforts throughout 2021 on COVID-focused education, making COVID testing accessible and helping traditionally underserved communities get vaccinated.

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OVERVIEW

Family Health Centers (FHC) started its CHW program with a grant from Appalachian Kentucky Health Care Access Network (AKHCAN) in 2017. In 2018, with support from the Kentucky Office for Refugees (KOR) the first Refugee-focused CHW began to serve community members from East and Central Africa. Currently, the program has one Full-time CHW for general FHC patients, one part-time CHW specifically for the Hypertension Program, two full-time Refugee Care Coordinators who are cross-trained as CHWs and two Congolese-focused CHWs. FHC has plans to hire a Spanish-speaking CHW in 2022 under a federal COVID-relief grant. The CHWs work out of a primary care setting and are encouraged to help clients set health-related goals and to overcome barriers to wellness.

OBJECTIVE

- To maintain drive-thru/walk-up COVID testing and create vaccine opportunities at FHC locations and pop-up sites where community members feel safe and comfortable;
- To promote testing and vaccination processes that are simple, convenient, free and accessible to all Louisvillians, regardless of immigration status, language preference, insurance status, documentation on hand, or digital literacy skills;
- To encourage vaccination and deepen partnerships to reach our most underserved communities;
- To offer individual and group education sessions about the pandemic, testing and vaccines;
- To educate and support CHW clients in quarantine in culturally appropriate ways.

COMMUNITY INVOLVEMENT

FHC partnered with Bluewater Diagnostics, the Americana World Community Center, the Louisville Metro Department for Public Health & Wellness, Kentucky Nurses Association, LouVax Mobile, the Office of Globalization, La Casita Center and others to make COVID services available at community pop-up locations and in the FHC network. Certified CHW (CCHW) Pauline Mukeshimana shared a story about Community Involvement. She arrived at a client's home to drive 2 clients for their COVID-19 vaccines and found 5 other people were waiting there too. They were convinced and felt ready for the shot. Pauline found transportation help. When they arrived at UL's large mobile vaccination site, a nurse friend called a nurse working onsite and these add-ons were worked in, on the spot. Pauline observed, "Sometimes a village effort is needed."

INTENDED PARTICIPANTS

Target populations are those living in Louisville's West and South ends. Most direct CHW work focuses on newcomers, particularly those who came as refugees from the Democratic Republic of Congo and clients of the Survivors of Torture Services Program.

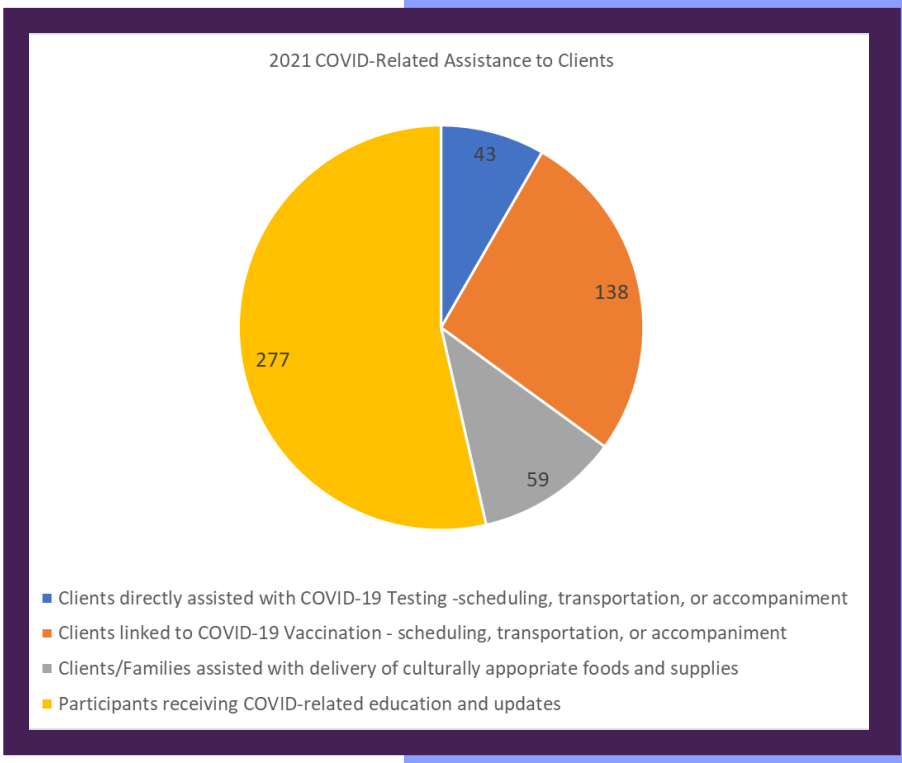
Clients face cultural and linguistic barriers, as well as socio-economic barriers worsened by the pandemic. Working in essential positions, relying on public transportation and having large families in small homes or shared apartments increases the risk of COVID transmission.

PROGRAM PROCESSES

Three of FHC's CHWs assist clients with vaccine and testing – scheduling, transporting and/or accompanying them, acting as a trusted interpreter and offering social support. CHWs worked at the first few large Saturday Vaccination Clinics at the Americana Community Center, providing warm welcome and interpretation skills so that clients would feel safe and comfortable. When COVID-19 testing was initially set up, CHWs and other community leaders helped schedule clients and met them there, too, to normalize it. Pandemic-related education has taken place in person, at churches, on front porches, at the clinic, in cars and via Zoom. Combating misinformation has been a top priority. CHWs also deliver supplies, herbs, teas and culturally familiar foods to families in quarantine, encouraging them to stay home and prevent further spread. At FHC-Americana, COVID vaccines do not require appointments, so CHWs often accompany clients directly there, as soon as they feel ready.

OUTCOMES

FHC's Refugee-focused CHWs have shared vital input in shaping accessible COVID-19 testing and vaccination efforts. FHC and Bluewater continue to offer free drive-thru/walk-up COVID-19 testing on the Americana Campus 4 days a week. No appointment is required and staff has been trained on language access and how to work around data fields that request Social Security Numbers or government IDs, which may be barriers to access. As of 12/15/21, a total of 13,907 COVID tests had been administered across the FHC network; 1,954 took place at Americana. In our Vaccine partnership, LouVax Mobile has been to Americana for Saturday vaccine events 17 times in 2021. As of 12/16/21, a total of 1853 doses have been administered [1062 first doses, 689 second doses, 102 Boosters]. CHWs are integral in assisting community members through the testing and vaccination process, earning trust and providing support.



FUTURE CONSIDERATIONS

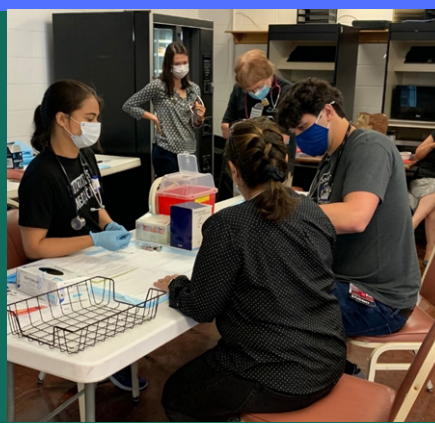
As the need for boosters becomes more evident and more age groups are eligible for vaccination, the work continues. It sometimes takes from 3 attempts to several months-worth of conversations to convince clients to get vaccinated. Some are still hesitant and there remain households with mixed-vaccination statuses. One CHW observed that most Congolese clients were motivated for vaccination once they knew someone in their circle had been vaccinated, so sharing stories remains important. For testing, patients seem to feel comfortable accessing tests at familiar locations. Another CHW states, "The longer the relationship I have with them, the easier it is to get consent...I've noticed that with the new clients if I speak their language, it is also easier to get their consent." We hope to share and build upon these lessons learned.

CHW IMPACT:

One CHW waited after her husband's vaccine before getting hers. She then shared her story with clients. Their trust for her was so strong, in fact, that they did not want just any COVID-19 vaccine, they wanted the same one (Moderna) that she had!

"I think that every person and family that we help to get the vaccine is a success story. I loved when someone would call saying that they have also convinced someone else to take the vaccine, after I talked or helped them." – Gisele Mellen, CCHW

NORTH CENTRAL AHEC
AREA HEALTH EDUCATION CENTER
WWW.NORTHCENTRALKYAHEC.ORG



CHALLENGE

The Northern Kentucky region is facing COVID vaccination hesitancy. Underrepresented populations have had more difficulty in getting vaccinated. There are two issues. First, the misinformation about the vaccine, especially coming from social media. Second, those who got the first of a two dose vaccination did not return for the second dose. Very few Hispanics are coming back to get the second dose or not getting the first dose at all. Hispanic people in the United States are nearly twice as likely as non-Hispanic white people to be infected with Covid-19 and 2.3 times as likely to die from it (CDC Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity).

PROJECT

The NC AHEC CHWs have been working on equitable COVID-19 vaccine distribution and educational classes to combat vaccination hesitancy. The CHWs provide educational information in a variety of formats. It cannot be one-size-fits-all approach when talking about COVID vaccination hesitancy. It is important for the CHWs to share information from trusted sources, especially in the Hispanic community. Our CHWs are creative and have contributed tremendously at each phase of the COVID vaccine rollout. CHWs have played an important role in getting the correct information for the wellness of our community.

CONTACT

North Central Area Health Education Center
500 Technology Way
Florence, KY

(859) 442-1194

OVERVIEW

The North Central AHEC's Community Health Workers (CHWs)/Promotores de Salud program was begun by the NC AHEC in the summer of 2002 to improve the health status of the Hispanic community and reduce overall healthcare costs by stressing the prevention of illnesses and appropriate use of medical facilities. Our CHWs provide health education and outreach services within their communities. Health education, advocacy, emotional support, referrals, information support and community capacity building are common to the work our CHWs do. More recent additions to the CHW role include research-specific activities. The AHEC CHWs have participated in research studies delivering interventions through teaching, demonstration or provision of social support.

The program follows a "lay health worker" model that is utilized in many rural and urban underserved areas in the US. The NC AHEC's CHWs work either for pay or as volunteers in association with the local healthcare system and community-based organizations in both urban and rural environments.

The course manual was originally developed by the Midwest Migrant Health Network for migrant workers and has been modified to address community concerns and health issues in north-central Kentucky. The NC AHEC is a training site for the region. The training is 13 weeks and the group meets every Saturday for 4 hours. The participants complete a 40-hour in-classroom training and 40 hours of experiential work in the community. Participants learn about health education and health promotion and how to address social determinants of health.

OBJECTIVE

The objectives of the CHW program are to:

- Offer culturally appropriate health promotion and health education classes
- Assist in accessing medical services and programs to improve health in the community
- Provide a variety of health screenings at health-related events

The program goal is to train members of the community and for these CHWs to share this knowledge to help reduce health disparities in rural and urban underserved communities.

COMMUNITY INVOLVEMENT

Our CHWs are so versatile that they can assist in a variety of projects. The NC AHEC has two part-time CHWs. CHWs who have completed our training are employed at hospitals, clinics and community-based organizations in different capacities. During the pandemic, CHWs have played an important role in the community. The CHWs have been part from the beginning of the pandemic to plan for vaccination of certain populations of the community. They were involved in the creation of education plans for specific population groups, one of those being the Hispanic community. The CHWs still work on raising awareness of vaccination, encouraging individuals to get vaccinated, addressing myths and assisting with vaccination clinics. The NC AHEC's CHWs provided insight and assistance during the COVID pandemic and reached the Hispanic population. They have been instrumental in sharing information with many organizations and individuals. They are and continue to be invaluable to the work with COVID.

They offer at least two classes a month about COVID education and the prevention of the most common diseases in Hispanics. CHWs also plan and implement tobacco outreach and prevention activities for underserved populations in central and northern KY.

Project deliverables include:

- Distribution of tobacco cessation education and vaping prevention information at Hispanic businesses and other organizations that serve rural and underserved families.
- Promotion of the state line Quit Now Kentucky, the state smoking cessation help line.
- Providing tobacco and vaping cessation education classes.

INTENDED PARTICIPANTS

The program serves underrepresented populations in Northern Kentucky. The area CHWs covered is based on the NC AHEC 16-county region. The CHWs serve low-income Hispanic families from rural counties such as Gallatin, Owen, Grant, Pendleton, Harrison and Bracken. They also serve Hispanic families in urban underserved areas in Boone, Campbell and Kenton counties. The target audience is the youth, adults, families and senior citizens from different cultural and socio-economic backgrounds. They serve vulnerable communities that have little or no access to basic healthcare, health education and disease prevention. Most of our graduates serve Hispanic families and others serve Black communities, English as a Second Language students and other underrepresented communities.

PROGRAM PROCESSES

Currently, the North Central AHEC has two part-time CHWs who provide community health education classes in-person and virtually. We partner with a variety of organizations to provide the services. For example, at Brighton Center, the CHWs offer health education classes about COVID prevention, diabetes, high blood pressure and tobacco prevention among other topics. During the pandemic, a strong partnership has been collaborating with the Northern KY Health Department (NKHD) to disseminate COVID prevention and vaccination information in the Hispanic community. The CHWs also give presentations in the high schools. They facilitate access to services and they try to improve the cultural quality and capacity in the format that these services are offered. The community members who have been trained since 2002 know about the program, so clients and other referrals are mainly by word of mouth. They build individual and community capacity, increasing self-sufficiency and knowledge about a variety of health topics. CHWs have worked on a variety of projects and they educate the community as well. They offer informal tips, social support and advocacy for the vulnerable. The CHWs/Promotores de Salud are getting more involved in clients care with chronic diseases. In addition to conducting health education classes, the CHWs are participating more in research studies. Their intervention helps clients to manage their risk factors better and to improve health in the community.

OUTCOMES

The CHWs met with business owners and church leaders to assess and provide the information needed to increase the number of Hispanics getting vaccinated. At the beginning of the pandemic, the CHWs were able to reach out to:

- 55 Hispanic businesses
- 79 churches in northern KY
- 72% agreed to post information or make regular announcements about COVID-19 in English and Spanish

The NKHD workgroup shared that the work the CHWs have been doing around COVID education and vaccination has contributed to increasing the percentage of NKY Hispanic residents who have at least one shot to 59.2% through December 21st, 2021. In 2021, the CHWs participated in 27 vaccination clinics and 2 health fairs, reaching out to 2,104 members in the community.

FUTURE CONSIDERATIONS

Our program has been successful throughout the years. However, the training program is on hold right now due to funding and the NC AHEC being short-staffed. We hope to expand the program and hire more CHWs to cover more rural underserved communities. In addition, we hope to be able to to offer more health education classes, promote the community health worker career in high schools and improve our data tracking and evaluation systems. Our CHWs/Promotores de Salud will be a strong linkage between the community and social, health services to help improve the health of northern KY families. The sustainability of the CHW program is dependent upon funding, understanding of the social, cultural and institutional context in which it is implemented and being creative and open to local design solutions.

CHW IMPACT:

The North Central AHEC's CHWs are trusted individuals in the Hispanic community. In the first quarter of 2021, the CHWs provided information about COVID vaccines and assisted with vaccination clinics reaching out to 1,277 Hispanic individuals. During the months of April, May and June 2021, the CHWs reached out to 1,907 members of the community. They provided vaccination education, participated in vaccination clinics in collaboration with the Northern KY Health Department and attended different health events that promoted getting vaccinated.

During the months of July, August and September 2021, NC AHEC's CHWs reached out to 1,322 members of the community. The CHWs have continued their participation in the equitable COVID-19 distribution workgroup. The CHWs are key community members who connected with different health organizations in Northern Kentucky as we moved throughout several critical phases of the pandemic. The CHWs had already reached out to 1,450 members of the community during the last quarter of 2021. Our CHWs reside in the community they serve; they have the unique ability to bring information where it is needed the most.

GLENN'S PHARMACIES
www.glennspharmacies.com

CHALLENGE

The communities we serve are rural. A high proportion are aging and many are overweight and have diabetes or pre-diabetes. Many lack the skills to perform higher-paying jobs. There is a lack of resources in our area to assist with higher education and technical training, compounded by a lack of public transportation.

PROJECT

We case plan and have monthly follow-ups to ensure they are getting their healthcare needs met. We are providing PT2 Diabetes classes for 6 participants. We assist with Medicare D, LIS applications and a SDOH assessment to meet other needs.

CONTACT

Glenns Pharmacies
119 East Main Street
Salem, KY 42078
Phone 270-988-3226
Email:
Director@glennspharmacies
.net

OVERVIEW

Our goals are to assist those in need that are suffering from substance use disorder, diabetes, hypertension, mental health issues and other chronic conditions. In assessing the needs of our patients we look to the support system and define who or what that is. In our Prevent T2 Diabetes program, the goal is to prevent diabetes, keep their A1c within range, help the person learn how to keep their A1c within control and to become more active. A care plan is developed and goals are set with the patient. They were followed up each month, on the tasks assigned, for a minimum of 3 months by our pharmacist or Certified Community Health Workers (CCHW). In the care plan we address follow-up with medical provider. We are also working with hypertensive patients with a plan for weekly blood pressure checks at home or in the pharmacy, working with the pharmacist on medications and any issues with weight management.

OBJECTIVE

Our program has been developing since 2015. We saw the need that many of our elderly patients needed assistance with their Medicare D plans, some did not have plans and others were paying a premium that did not pay for all their medications. During open enrollment we began to assess our patient's prescription insurance, offering free comparison reviews for them. It was then that we learned about Low Income Subsidy (LIS) program which will help pay the cost of the premium and reduced copays for the medication. We now assess all of our patients for financial needs and for those who qualify we assist them to file an LIS. What began as a seasonal service went on all year. People are eligible for assistance throughout the year and we are now meeting that need. From this point, we began to forge partnerships with other community partners to assist with specific chronic conditions. One of our most used partners was Pennyrile Health Department. Kelly Dawes, RN, BSN, AAS, MLDE, CDCES, played a vital role in coming to the pharmacy, setting up booths for diabetes awareness and providing classes. She is also a resource to us in developing care plans for those with diabetes. Our CCHW program continues to grow while working with the ones that are underserved and continue to have unmet health or social needs.

COMMUNITY INVOLVEMENT

Community partners are a must. Our resources are limited; however, we reached out to the larger towns to connect many of their resources. There are regional resources we often use: Pennyrile Health Department, Commission for Children with Special Needs, Vocational Rehabilitation, local attorneys, Cabinet for Health and Family Services, local hospitals, insurance case managers and home health to name a few. There are regular community meetings that are attended by our CCHW. We are always looking for resources to improve health equity for our patients.

INTENDED PARTICIPANTS

Most participants in our program have co-morbidities, do not access preventive health care timely and do not receive the medical equipment needed to monitor their health. We work diligently to ensure they have the needed equipment and provide the education to use it at home. Our population is rural with most citizens having a high school diploma or less. Therefore, literacy and comprehension are factors that play a very vital role in their health.

PROGRAM PROCESSES

We have developed a process for better utilization of the CCHW on our staff as a true member of the team. Staff is now identifying patients with needs and making referrals to the CCHW. The CCHW contacts this person completes the assessment and then reviews the information and potential needs of the patient with the pharmacist and pharmacy technicians. We discuss options with the patient and develop a plan. It is everyone's responsibility to follow these patients. The staff keeps each other updated. The CCHW and Pharmacist develop the case plan and the CCHW begins to make calls to the MD office gathering information, recent hospital stays and involvement with community partners and family. Once the patient reaches their goal, we close our case plan. The patients continue to call us and keep us updated on their progress and if they have a new problem, we will discuss that.

OUTCOMES

Outcomes are very important to the patient and our staff. We strive to have successful completion of case plans that can run from one month to two years. During the time we have been working on this model, we have had several success stories. One example of a CHW success story is from a family with multiple Social Determinants of Health (SDOH) issues including aging, multiple-family dwellings, hypertension, smoking and obesity. During the SDOH assessment and case planning, we also learned that a member of the family wanted to become a Certified Nursing Assistant. We worked with the family and her for several months and she was able to complete the CNA program and get a job at a local hospital. She was the first one in her family to further her education, get full-time employment and become independent of the Medicaid system. We have completed over 1500 case plans. With this number, we have had many success stories that are different in needs and time of assistance.

FUTURE CONSIDERATIONS

SUD (substance use disorder) is a nationwide problem. We have been looking at ways to further assist in this area. We are developing a plan to use social determinants of health (SDOH) assessment on current patients that are chronic opioid users, talk with medical providers, drug courts, mental health, vocation rehab and other community resources to develop a model we hope can be used by other Pharmacies and providers. We are reviewing grant opportunities and have contacted our federal legislators. Our model will include consideration of the perspective of the whole person and not just the substance use disorder diagnosis.

CHW IMPACT:

Attendance at our PT2 Diabetes class has been six members weekly during each of the 16 weekly sessions. We have expert guest speakers including a Registered Dietitian, Nurse Practioner, yoga instructor and class members weigh weekly and are completing their A1c with their medical provider.

"We assist with Medicare D and the Low-Income Subsidy. I assist them via the internet or phone. 95% of those I assist qualify. The excitement you hear in their voice when they receive the subsidy is worth everything."

KENTUCKY REGIONAL HEALTH INFORMATION ORGANIZATION

CHALLENGE

As the opioid epidemic grows, there is a greater need for resources related to social determinants of health, recovery centers and more. CHWs can aid in providing a directory of these resources for the patient's well-being.

PROJECT

Expand the knowledge of prevention, education and recovery services while addressing the needs of social determinants of health to substance use patients in rural areas.

CONTACT

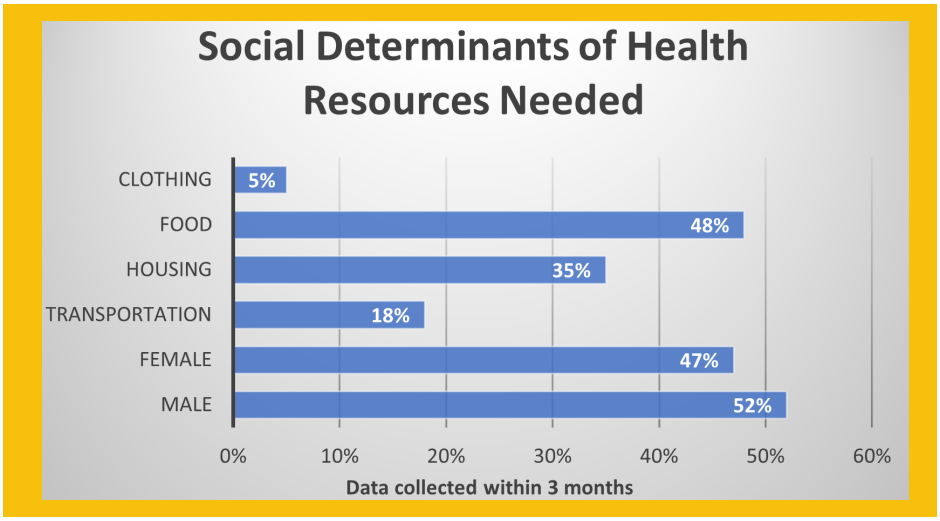
Kentucky Opioid Community Healing Project
344 Christy Creek Road
Morehead, KY 40351
Phone: (855) 385-2089
Email:
Website: www.krhio.org

OVERVIEW

Kentucky Rural Healthcare Information Organization was awarded a Rural Communities Opioid Response Program (RCORP) Implementation II grant in September 2020. This launched the Kentucky Opioid Community Healing Project, K.O.C.H for short (pronounced Coach). This grant allowed us to hire 3 Community Health Workers and we hope to establish sustainability after the grant period ends. The community health worker gathers resources within each county to address the needs of social determinants of health. We printed and disbursed around 200 copies of community resource guides for each county. With resources constantly changing, we will have an app that will provide mobile access to those resources. This will give us the ability to share to a broader audience and ease of updating changes as needed. K.O.C.H. has partnered with The Local Lens Podcast to address the stigma around addiction by hearing from community leaders, people in recovery and more.

OBJECTIVE

The CHW works with substance and opioid use patients. Social determinants of health and substance use background questions are asked to better navigate what resources or programs are needed for the well-being of the patient. Our mission is to remove barriers for patients and reduce the stigma of addiction by providing resources, education and harm reduction.



INTENDED PARTICIPANTS

Within the six counties, we work primarily with substance and opioid use patients and their families. Participants are reached within rural health clinics, food banks, the homeless, coalition and at community events.

COMMUNITY INVOLVEMENT

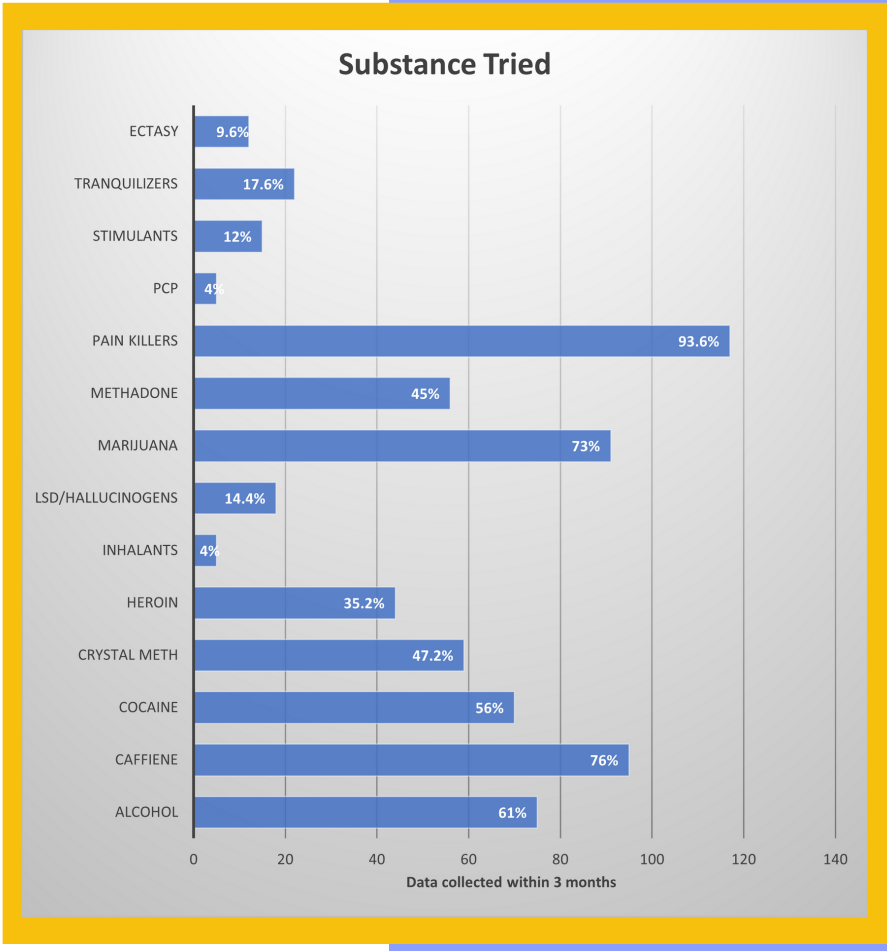
K.O.C.H. participates in numerous community events, Harm Reduction, OD Task Force, Kentucky ASAP, Healthy Communities and Narcan distribution. We provide community and state resources to those in need as well as a recovery aid. With our community involvement, we are able to advocate for Casey's Law and The Good Samaritan Law.

PROGRAM PROCESSES

In a rural clinic setting, after the doctor has assessed the patient, the community health worker is able to collaborate directly with the patient asking questions to provide the resources desired. These answers are recorded in a HIPPA compliant software application not using any personal health information to track the need within the counties we serve. Patients are followed up on either weekly or monthly to determine lifestyle changes and additional resource needs.

OUTCOMES

- CHW provides social determinants of health (SDOH) resources to those in need and regular follow-ups.
- CHW provides regular follow-up and resources to address social determinants of health.
- A Community Resource APP will soon be available to share with a broader audience
- The Local Lens podcast addresses the stigma surrounding addiction as well as harm reduction, prevention and education



FUTURE CONSIDERATIONS

As awareness gains momentum, resources are becoming more accessible and more widely acknowledged. Ending the epidemic will only happen if communities unite. More access to Community Health Workers allows for resources and education on what is available. CHWs within a health care team can connect patients to resources in the community to address daily living needs which allows the medical provider adequate time to address health needs. Sustainability will require collaboration within community businesses and other organizations. COVID will continue to be a challenge while the overdose rate continues to increase. With the APP housing our resources, we can more widely share the resources and education available within our communities.

CHW IMPACT:

"One of the biggest barriers of seeking help is lack of knowledge of resources available."
– Alicia Bowman, CHW

"In 2020, more than 1,964 Kentuckians died from a drug overdose... that's why we have to change the conversation and have access to resources available."
– LeAndre Knox, K.O.C.H. Project Director

Kentucky Public Health
Prevent. Promote. Protect.

Suggested Citation: Kentucky Cabinet for Health and Family Services, Department for Public Health, Division of Prevention and Quality Improvement, Chronic Disease Prevention Branch. (2022). "Kentucky Community Health Worker Stories of Success". Frankfort, KY: Author.