

Transcript

Care Coordination in Rural Communities

Kristine Sande

Good afternoon everyone. Thank you for joining us today. I'm Kristine Sande, program director at the Rural Assistance Center. I'd like to welcome you to today's webinar—Improving Care Coordination in Rural Communities. Care coordination is a hot topic right now, as evidenced by the overwhelming interest we saw for this webinar. We've got a great slate of speakers today, and I'm excited to hear what they have to share with us today.

We'll start out with hearing from Alexa Brown, who will tell us about the evidence base for care coordination, as well as the types of program models that can be used in rural communities. Alexa is a senior research analyst with the NORC Walsh Center for Rural Health Analysis. In that role, she conducts qualitative research and analysis for projects focused on public health systems and services research, health policy, and rural health, among other topics. Since 2009, Ms. Brown has supported NORC's evaluation of the rural outreach tracking and evaluation program, funded by the federal Office of Rural Health Policy. She developed the care coordination toolkit that is housed on the Rural Assistance Center website, as well as the community health workers toolkit. Brown has a Bachelor of Science degree in Health Policy and Administration from the Pennsylvania State University and is currently completing a Master of Public Health Degree in Health Promotion from George Washington University.

Our next two speakers will share with us their first hand experiences in implementing care coordination programs that serve rural areas. Melissa Miles is a project manager with Bi-State Primary Care Association. Melissa designs and implements grant-funded projects to increase access to healthcare for rural and underserved populations. In 2012, she received an Office of Rural Health Policy-Rural Healthcare Services Outreach grant to work with the University of Vermont Migrant Education Program and the Open Door Clinic—a member of the Vermont coalition of clinics for the uninsured to implement a care coordination program in eight counties in Vermont. She has over 14 years of experience with access to care for migrant farm workers and previously worked for a state-wide migrant health program in North Carolina. Miles holds a Masters in Public Health from the University of North Carolina at Chapel Hill.

Our final speaker will be Heidi Blossom, who is the Care Transitions Coordinator for MHA—an association of Montana health care providers. She joined MHA in November, 2011. Ms. Blossom is also the Transition to Practice Council Co-lead for the Montana Center to Advance Health through Nursing. Ms. Blossom has been a nurse for over 20 years. She is currently an adjunct professor at Carroll College, and has developed curriculum for nursing students, as well as education majors. For six years, Ms. Blossom was the manager of a case management company that provided services to major medical, as well as worker's compensation claims. Ms. Blossom has worked as a staff nurse in three Montana hospitals. She is a graduate of Carroll College, and has her Master's degree from Gonzaga University in Nursing Education. Ms. Blossom was published in the Journal of Professional Nursing in July and August of 2013 issue. So now, we're ready to hear from our first presenter, Alexa Brown. Alexa?

Alexa Brown

Thank you, Kristine. I'd like to welcome you all again to today's webinar, and I'm excited to tell you about the rural care coordination toolkit that we developed. As a brief overview, I'll start today by giving you some background information. I will discuss the program under which the toolkit project was funded, and I'll give you a brief overview of the 330A Outreach Authority grant program, as well as the reason for focus on care coordination in our toolkit. I'll also describe our process for developing the toolkit, and share some findings and lessons learned. After that, we'll hear from our other speakers about their experiences with care coordination in the field.

This toolkit project is part of our project called the Rural Health Outreach Tracking and Evaluation program, and this is a four-year project that was funded by the Health Resources and Services Administration's federal Office of Rural Health Policy, or ORHP. And the NORC Walsh Center for Rural Health analysis, which is co-directed by Michael Meit and Alana Knudson, is working in partnership with the University of Minnesota Rural Health Research Center to implement the project. We are also working with the National Organization of state Offices of Rural Health, and the National Rural Health Association to disseminate findings from the evaluation.

The Rural Health Outreach and Tracking Evaluation project is designed to monitor and evaluate the effectiveness of federal grant programs under the outreach authority of Section 330A of the Public Health Service Act, and this program was created in 1991, and since its inception, almost half a billion dollars have been invested in rural communities. Through this funding, nearly 900 consortia projects have participated in the grant program, and these projects have sought to expand access to rural health care, to coordinate limited resources and also to improve the quality of rural health care services. The Outreach Authority operates a total of eight grant programs, and I listed them all on this slide. I won't read them all to you, but just to name a few, there's the Rural Health Care Services Outreach grant, the Network Development Planning grant and the Rural Health Network Development grant.

As part of our project, we have developed a number of evidence-based toolkits on rural health topics, and today's focus is on our new Care Coordination toolkit. The reason HRSA and ORHP are interested in care coordination is because it holds promise to improve quality of care, to reduce costs and to improve health outcomes. They're also really aware of the increase in care coordination programs being implemented in response to new models of care delivery and reimbursement.

Finally, there's a need to identify and disseminate evidence-based and promising practices and resources to rural communities. These will help to support their implementation of care coordination programs. Evidence-based practices are important because they guide implementation of strategies that have been shown to be effective, and it's really important to invest in programs that have demonstrated an impact on the communities that they serve. However, we know that the research and evidence we have on rural-specific strategies for care coordination is pretty limited. For these reasons, we've compiled an evidence-based and promising practices toolkit, and the resources that are in the care coordination toolkit will help support rural communities and program planning and implementation.

The NORC project team that developed the rural care coordination toolkit consisted of myself as well my colleagues, Alicia Bain, Alana Knudson, Naomi Hernandez and Molly Jones. As I have already mentioned, our goal was to identify evidence-based and promising models that may benefit ORHP grantees, future applicants and rural communities. We documented the scope of their use in the field, and with that, we built the care coordination toolkit. To build the toolkit, we started out by reviewing ORHP grantees' applications, as well as information available in the literature, and in doing so, we identified several models that are used by communities to improve rural care coordination.

Our next step was to conduct semi-structured telephone interviews with six ORHP grantees and two non-grantees who were implementing care coordination programs. We then developed a toolkit using the information that we gathered from the literature and the interviews. The toolkit offers a collection of promising practices, resources and guidance about how to conceptualize, plan and implement and evaluate care coordination programs. The toolkit is available online through the Community Health Gateway at RACOnline.org, and here is a snapshot of the toolkit, so that when you go to this Web site, this is what you'll see.

The next slide just presents our organization of the toolkit. We have a total of seven modules in the care coordination toolkit. The first module, Module One, is an introduction to care coordination, and it provides an overview of the topic and addresses rural-specific issues. Module Two presents care coordination program models, and there are a total of six of them. I will review those models next after this slide. Module Three provides implementation consideration for each of the program modules that are described in Module Two.

The next module, Module Four, is sustainability strategies for grantees. The next section, Module Five, is on evaluation, and it provides frameworks, data sources, objectives and measures that grantees can use. Module Six provides dissemination methods for sharing program results, and then the final module, Module Seven, is a program clearinghouse. And in this clearinghouse, we have examples of care coordination programs that have been implemented already in rural communities.

Our project findings highlight six different models for care coordination that are frequently implement in rural communities. I'm going to review each of these models with you, quickly, and I just think it's important to note that many of the grantees and non-grantees that we spoke with are actually using elements of more than one of these models to implement effective care coordination programs.

The first model in our toolkit is the Care Coordinator model, and it is a model where Care Coordinators deliver services to patients and help patients overcome barriers to care and treatment. Care Coordinators can be clinical or non-clinical health care workers, and the different types of care coordinators that we identified are Health Educators, Patient Navigators, Care Managers and Community Health Workers.

The next model in our toolkit is the Health Information Technology model, and this is one that supports care coordination by using electronic health records and other health information technology to facilitate the coordination of care between patients, care coordinators and health

care providers. The third model that we present in our toolkit is the partnerships model, and in this model, health care organizations form partnerships to achieve their care coordination goals. They usually form partnerships with hospitals, clinics and community partners, and many rural programs that we spoke with also established consortia to help manage their programs.

The next model that we identified in the toolkit is the patient-centered medical home, or the PCMH model. This model is defined by the agency for health care research and quality, as well as the Patient Center Primary Care Collaborative. It is a model for providing patient care that is comprehensive, patient-centered, coordinated, accessible and high-quality. PCMH characteristics include a strong relationship with patient and primary care physician, coordination between the primary care physician and the medical care team, as well as coordination of care across settings, and PCMH has also required the use of electronic health records.

The next model for care coordination that's in our toolkit is the Health Homes model. Health Homes are established by the Affordable Care Act, and they serve as comprehensive person-centered systems of care. Specifically, Health Homes coordinate care and services for Medicare and Medicaid dual-eligible enrollees who have two or more chronic conditions, one chronic condition and at risk for a second or one serious and persistent mental health condition.

The last model for care coordination that we present in our toolkit is the Accountable Care Organization, or the ACO model, and ACO is a system of care that integrates people, information and resources for patient care activities. It also creates financial incentives to engage in care coordination. Rural providers can participate in an ACO by forming a legal entity with other Medicare providers, and we learned that the ACO model is best-supported by other models for care coordination, such as Health Information Technology, and some ACOs also use care coordinators to help monitor high-risk patients, and to achieve the goals of care coordination.

Those are the models that we present in our toolkit, and ultimately, the goal of all of these models is for care coordination to improve patient outcomes. To wrap up, I'd like to just share some lessons learned that we gathered during the development of the toolkit. Through our conversations with grantees and non-grantees, we learned that care coordination programs' partnerships are really critical to their success. Grantees and non-grantees that we spoke with said that care coordination programs should adopt a whole-person mindset to help focus on diverse patient needs; these needs really range from transportation, home safety, nutrition and health literacy.

To address these needs, it's also important for successful programs to involve staff from diverse disciplines. Finally, we learned that because care coordination is a relatively new concept, it's important to engage health professionals by educating them and informing them about the goals of care coordination. In doing so, you can really increase buy-in and familiarize them with the elements of coordinated care.

One of the challenges that we heard is related to funding and workforce. We heard that many rural programs experience barriers recruiting, retaining and training the appropriate and qualified staff to support care coordination. The people we spoke with also discussed evaluation

approaches, and while many of the communities we talked with are documenting their successes through evaluation, it's often difficult for them to measure impact, so we've included some examples in our evaluation module in the toolkit of how to do this, to hopefully help grantees and others to implement successful programs.

That wraps up what I have for you today, and this slide just provides my contact information, as well as the contact information of Alana Knudson and Michael Meit, who are the co-directors of the Walsh Center.

Kristine Sande

Great, thanks so much, Alexa. I'd just like to remind everyone that at the end of our presentation, you'll be able to submit questions for our presenters in that Q and A box at the bottom of your screen. And next, we'll have Melissa Miles, who will be sharing her experiences with care coordination in rural Vermont. Melissa?

Melissa Miles

Thank you for the opportunity to present today on our Bridges to Health/Puentes a la Salud grant. We were funded in May of 2012 to provide care, coordination and direct services for migrant dairy workers, and our target area is eight counties of Vermont, seven of which are in Northern Vermont, which is really along the Canadian border, where the majority of the dairy workers are located. And through past experience and research, care coordination is an excellent platform to increase access to care for migrants and improve the quality of care, to reach under-served and complex to treat populations.

What I'm going to talk about today are the care coordinators, medical providers and volunteers who have made this project work, so critical. I'm going to weave them throughout the presentation; for example, this is a picture of a volunteer nurse who provide information to a migrant dairy worker at one of our consortium clinics, open-door clinics. We'll be talking about the population and the model and outputs and the outcomes, and our lessons learned.

We have a number of people who are involved in our model. For myself, I work at a primary care association, which is a two-state association, and our membership is broad and includes FQHCs, rural health clinics, hospitals, Planned Parenthood, and the Coalition of Clinics for The Uninsured in Vermont. We really work on increasing access for under-served populations, and in partnership with the University of Vermont, the migrant education program and the open-door clinic, we worked collaboratively to write the grant to establish the Bridges to Health program.

I would say that we utilize a lay health, or community health worker model, which is a model that builds upon existing staff and knowledge in local communities, particularly if they have a bilingual, bi-cultural experience with the population. For example, the migrant education program is funded by the Department of Education at the federal level to do migrant education outreach throughout the state. When they were out on the farms, they were finding health concerns, and the education recruiters did not know how to respond to the farm workers' requests. The staff is bilingual and bi-cultural, and they have a great comfort rapport working with the farm workers already.

The Director and I started to talk about how we could collaborate and leverage that incredible resource of bilingual capacity in Vermont, because, frankly, there are not as many bilingual professionals in Vermont. The open-door clinic is another partner, and they're in the densest migrant region of the state. They're a free clinic there, and they've developed a great collaboration with their local stakeholders to serve farm workers.

Our consortium meets regularly to discuss the needs and strategies and sustainability, and it's nice that VMEP brings a very state-wide perspective, because they are on farms throughout the state, and the open door clinic brings a local perspective and they bring a clinical component. The other partners and collaborators are throughout the state, and I'll talk about them throughout the presentation as I go. We are fortunate that we have a nice relationship with our state office over our health and primary care, who has provided a pot of funding each year to us that we've been able to use to do additional projects that come up throughout the year. We've done some intensive cultural competency trainings where we've been able to hire facilitators, and have we had a nice project this summer where we did some intern supervision. We had about five interns working in one community, so that really helped to augment that portion that we had discovered as a need.

These are the goals of our project, the large goals, and so it was to train that staff and really increase the knowledge and to improve the access to care for migrant dairy workers. We are trying to take a systems-level approach, so we have different points of intervention to increase knowledge and comfort among farm workers and farmers, and the clinics in the local communities. Migrant farm workers are actually a fairly recent population to Vermont, and people were having a little trouble knowing how to respond when a farm worker would walk in for care.

At one point, VMEP was driving patients an hour, an hour and a half for care from the Canadian border down to the open-door clinic because that was where they felt safe taking the workers for care, or the worker would end up going to the emergency room because the health problems had increased to that proportional level. But what we found in the last year is we've been able to decrease this drive as the patients are now accessing care less than 30 minutes from their farms.

We also provide a significant amount of training and supervision for the community health workers staff, to know that they're comfortable to provide that care coordination, and they meet monthly to talk about challenges and opportunities. Then we also talk with all of the workers' employers about where they should be taking the patients for care and what the hours of the clinics are, and then with the health clinics, we're doing cultural competency trainings, and we're providing presentations and we're translating forms if they need it, and really just trying to be there for them to provide that systems-level approach, which will hopefully endure sustainability long-term.

I wanted to highlight our population that we're working with. The majority are from Mexico and speak an indigenous language, and almost all are uninsured. They work 70 hours a week here, so they are working probably three shifts a day, where they're milking cows, and they've not been here very long. They actually tend to stay for only about a year and a half and then they go back to their home country, and they tend to be young, about 26. Relatively healthy population, but

there is no visa program for the dairy industry as there is for regular agriculture, so many workers tend to be here without the legal documentation to work, which poses a really significant access issue for a farm worker to feel comfortable to leave their farms.

Sometimes a farm worker has been on a farm for over a year, and the first time they leave it to go to the doctor, or the care coordinator who does the outreach to the farm may be the first person they encounter in Vermont that speaks their language. You can imagine there might be some pent-up demands and needs that are expressed. This is typical work setting for a dairy worker, as I mentioned. They work really long, intensive weeks, but luckily he looks pretty happy doing his job.

Why focus on the migrant farm workers? Nationally, I've worked in migrant health in three states, and the barriers have really been the same in every state. Do the migration farm workers have a limited knowledge of where to go for care, if it's safe and what it will cost? They might not know the difference between an FQHC or a rural health center or a hospital. They're also concerned about when they walk in the door, will they be able to communicate effectively with the front desk staff, and will they be able to afford the prescriptions? I'd also say that farm work is dangerous work, so most of our workers are young and healthy, but there have been some pretty significant injuries with workers being stepped on by cows, or being pinned in the pens by them, because they work very closely with the cows milking on a daily basis.

This is a picture of an intern, actually, providing some oral health care in the worker's homes, so that's one partnership we've had with a hygiene school here. Our care model is to build upon the existing people in the communities who are the assets in their local communities, and to grow their knowledge and skills and confidence to help them assist patients with making appointments. We also complete health insurance forms, and we always carry the local health forms' centers intake forms with us, we help them complete all of those, so when the patient needs to go in for care, they've got all that completed. We arrange transportation, and we have kind of a matrix so that we are not the ones providing that, we'll provide it at last resort.

Then, same with language, we really try to utilize the existing systems that should be in place. The language lines are the local interpreters, and once again at last resort we will, but in order to preserve our own resources to be able to continue to do the outreach and the assessments for building on that local capacity of what should be in place.

We also provide direct nursing and medical services. Here's a picture of a woman, that same outreach volunteer nurse who opened our clinic providing tetanus shot from the farm. At the open door clinic, we have a bilingual outreach nurse who's been a real asset with our consortium. She goes out and does assessments and confers with the medical director about whether the patient should go in for care. She also does extensive care coordination; for example, this fall she drove a patient to Boston for open heart surgery because he had a congenital heart defect that was discovered when he was being seen in their clinic.

The Migrant Education Program partners with the UVM Medical School to provide monthly health visits on the farms, and this is with medical residents, and so it provides the residents an opportunity to do a rural health community rotation, and to see firsthand why it might be hard for

farm workers to get off the farm for care, and just to expose them to some cultural competency. Vermont tends to be a pretty non-diverse state, so it's a nice opportunity to see what else is out there. We're exploring additional ideas, like maybe telemedicine in the future, because we're having trouble providing culturally-appropriate mental health services.

These are some of the tools that we use, of which some are included in the rural care coordination toolkit that Alexa spoke about. We've tried to develop them based on the local needs; for example, with the health access guides, we did interviews with farm workers to see what they'd want in a guide, and then we replicated that in four counties by using the questions.

We would interview, then, the health centers, and then fill in the guides, so that they're bilingual, and we'd had them out to the farm worker and the farmer on the farm, so that they have a tangible local resource of where to go for care. Same with the bilingual contact cards, that was based on farm workers presenting at a place, but not knowing what the address was where they were living locally, or maybe a local phone number where they could be contacted. It gives them some capacity and strength within themselves to be able to provide the care, and then we, as mentioned, have extensive training and protocols for the care coordination modules for them to be able to do their jobs well.

I wanted to highlight, we have something called an "accessibility tool," and it's a self-assessment that practices use to score themselves. The care coordinators expressed firsthand that they would not want to do this job if the clinics were not also working on their own ability to provide the linguistically and culturally-appropriate services, so we adopted a tool that I had used back in North Carolina, and we have used it with health clinics for them to do a self-assessment. It provides a really good starting point for conversation.

An example of how it was implemented was, we were working with an FQHC that had five different clinics, and we had them all in a room, and each of their office managers completed the tool independently, and then we came together for discussion and found very common threads with all the five clinics, but they were having trouble with language access, didn't know how to use a language line if someone walked in for care, and then they also found that the EHR didn't have maybe the best cultural competency trainings. So we were able to form our technical system's response to this, and help them complete forms and test the language lines. It provides a tangible way to do some technical assistance.

This was from our PIMS report from the first year. The outreach number is broad, reaching farmers and farm workers on the farms that we were targeting throughout Vermont, and then over 300 of those resulted in unduplicated care coordination encounters, and the other ones that are medical visits, they really were all for uninsured patients, so we really know that the workers who are getting seen needed that access to care. We've really done some significant work with the health centers, as I've kind of peppered throughout the presentation. We've met with health centers just to do awareness-raising and gone into some very in-depth technical assistance with them to ensure their success.

To tie that together, this summer we had four medical students from UVM working in a community where they interviewed farm workers on their perception of access in that

community, because farm workers weren't going in for care there. The accessibility tool was used with the local FQHC, and as a result, they found their language systems needed to be beefed up, so they purchased some dual handset phones to make interpretation easier. It resulted in some really nice outcomes, a lot of patients now are going there for care on a regular basis.

This is also just a slide that talks about our impact. One of the ways to measure our success was, we wanted to know of the care coordinators that refer patients for care, how many of those complete their health visits, and 95% so far have been able to access care. That was an exciting promise for us. The health centers are making policy changes in their practices to improve access, or doing more trainings, or having their forms translated, so the health centers are really also making the strides. These are survey results up in the northern part of Vermont, all along that Canadian border where they are still feeling like they have access barriers to care, and they still wouldn't feel comfortable calling to make doctors' appointments.

For example, with this data, we are working more one on one with patients to have them ... We sit next to them and they pick up the phone and call the clinic. There was a mom with a new baby, and she would obviously need to be making a lot of appointments for her child, and we wanted to give her that capacity. She is now making appointments on her own after knowing that when she called, the language line would be patched through, and she would have success. Hopefully, these survey results will increase. We're going to do the survey again next year.

This is our lessons learned slide. Staff and dedicated staff are such an asset to making any program successful, and I think especially when you're working with an underserved population because they just have this dedication of wanting it to succeed. We have found a lot of pent-up demand, and outreach and care coordination takes a lot more time than, probably, we're able to budget for, so we're needing to prioritize a little bit, or rely on volunteers in the communities or the local health centers. We've also really wanted to set people up for success, whether they're at the clinics or they're at the health centers, so that training and technical support, and letting people know that we're available, has been, I think, very critical in establishing those local relationships.

Also, farm workers move around, so there's always going to be turnover and there's always going to be need, up to 50% don't stay on one farm for any one year, so they might move to a different part of the state, and then they won't know where to go for care at that local level. But at least they know that the migrant education program that they could call them and get set up in their local community.

Finally, this is just a picture of some of the different community partners that we work with. There's an interesting program out of the university extension program where they're growing local herbs for farm workers out in local plants, and then they bring them out to the farms and the farm workers are able to plant them where they live. The picture to the right is a student working with workers, and down at the bottom is a medical director and what a clinic might look like when she goes out to the farm to set it up, using a massage table. Finally, on the right is one of our leaders. She's a care coordinator, but she's also the supervisor for the care coordinators. We're lucky that she came from a dairy farm, so she knows how to speak the dairy language with the workers, and she's done a lot of training for workers on safe milking and conditions. She

also actually was invited to go to AHCA last year with the Family Nurse Practitioner Program as faculty. I really feel like we're developing hopefully long-term leaders in these communities, who will be able to provide care for the underserved migrant dairy workers in Vermont. Thank you!

Kristine Sande

Thank you, Melissa. Now, I'll pass it to our final speaker, Heidi Blossom. Heidi?

Heidi Blossom

Hello! Thank you for inviting me to participate. My name is Heidi Blossom, I'm an RN, and you guys heard my bio, so I don't need to go into that. I have been working with the Hospital Association for going on three years with this grant. It has really been a great opportunity for the people of Montana.

We got the grant through HRSA in 2012, and the purpose of the grant was to improve the status of Medicare and Medicaid beneficiaries living in frontier areas. A lot of people don't really understand what a frontier area is, and what that means is there is less than six people per square mile. That's kind of hard to wrap your brain around if you're from a larger community, but basically I have facilities that participate that have less than 1400 people in their whole county, and I have one that has 10,000 people in their county.

The reason why their county is so populated is because that's where our coal mining is located at, and there are 11 facilities that are participating in our grant. This is a map of the state. I'm here in Helena. Plentywood is one of our facilities that participate, and for me to visit, it's over 500 miles one way. There is a lot of land to cover and very few resources in these areas. Most of their facilities in counties do not have home health, they have no visiting services, so our program has really been a value to them.

What do community health workers do? Well, they go out and they visit with clients who need some assistance, basically, in their health care. We schedule appointments, we help them figure out what medications they are needing. We help them with education, help them understand what type of diagnosis they have, and how they can best live healthily with it. In a lot of these facilities, education is kind of not as good as we'd like it to be, because there is no diabetic educator. There are no cardiac educators. So, a lot of these folks, when they get diagnosed, they get kind of a piece-meal education; they go home and then they're really not sure what they're supposed to do.

Another thing that community health workers are great at is, they are an extra set of eyes in the homes for these providers. Providers, we all know, usually spend about five minutes with their patients, and they miss a lot just because of that small amount of time. A great story was one of the providers didn't understand why a client was non-compliant, because when they were in the office, they acted like they got it. Well, the community health worker was able to get into their home and find out that this woman actually had some beginning dementia, and she just didn't really understand what the doctor was saying, but while she was in the office, she was able to fool the doctor into believing that she knew what was going on. So it really does help the doctors and providers in our state understand what's going on with their clients in their homes.

I am the Care Transition Coordinator, and what that means is that the community health workers call me and we discuss the files. We discuss how these people should get better health care. There's been a lot of times when the community health workers will go to tertiary facilities with their clients, and they see a specialist and the specialist talks to them, and they have no idea what the specialist just said. They call me up and I help the client and the community health worker understand the recommendations from the cardiologist or the diabetic educator, if they're not understanding it.

The Community Outreach is another part of our community health workers. We have taken the Red Hat Ladies, I don't know if you have those in your communities, but they're a group of ladies who get together and have tea, and one of the community health workers asked them if they would like to visit shut-ins in their communities. The Red Hat Ladies are now doing that in one of the communities. Another thing that some of the community health workers have done in a lot of these small areas, these seniors live in low income housing apartments.

And one of the community health workers was noticing that one of her clients with Type 2 diabetes was having a lot of low blood sugars, and she found out she wasn't eating very well. There was a number of her clients in that building, and she found out that that was kind of the case for these widows and widowers—that they didn't really want to cook for themselves, that they were living on instant oatmeal for dinner. So she went door to door and asked them if they would be interested in having a pot luck. Now that retirement apartment complex once a week has a pot luck, and all the studies have shown that people eat better when they're eating with others.

One of the other things that some of the community health workers have done is transportation coordination. A lot of these communities, it's over 100 miles to get to a tertiary facility. One of the community health workers noticed that there was really no way for a number of her folks to get to these tertiary facilities, so she went to every civic organization. She talked to all the communities of faith, and now they run a bus system to get these folks in and out of the tertiary facility. Another program that two of my community health workers are doing, and there's two more waiting in the wings to take the class, is the Stepping On program. This is a program offered by the Montana Department of Health and Human Services, and it is a fall prevention program. It's a seven week program, and they talk about such things as exercise, balance exercises, diet, medication management, and how to assess fall risks in your home. This is done through the community health workers, a lot of them are actually doing it in the hospitals that they are working out of, so it's a win-win for the hospital, the community, and the community health worker.

Another thing that a person has done is city planning. Her community does not have sidewalks, and she is really trying to push for sidewalks, and for sidewalks that are accessible to the handicapped and to the elderly, because she noticed there had been a lot of falls while people were trying to walk in her community.

So, who gives the referrals for the community health workers? We get referrals from providers, we get them from senior centers, the community health workers usually go in and have lunch weekly or monthly with the senior centers, and they provide some education or talk about

different programs that are going on. We get referrals from low-income housing. We've had a number of referrals from the Sheriff's Department, communities of faith, and through word of mouth by families and friends.

Some of the wonderful stories that we have done, Montana is a large state with a small population, and like I said, most of these communities are very small, with less than six people per square mile, so our numbers are not huge. But some of the things that we have done have just been absolutely incredible. We have prevented elder abuse, we have prevented a disaster, one of the community health workers went into a woman's home and smelled gas, opened up all the windows and doors and had found out that there was a gas leak in her stove, and the woman could not smell it. We were able to get the gas shut off and get her into a different living situation until the gas line could be fixed.

We have lowered emergency room visits, as a matter of fact, in one community, the Sheriff actually called the community health worker and thanked her for being part of this woman's life, because weekly she was calling the Sheriff's Department. And since she has been part of the program, she has only gone to the emergency room once, where she was averaging a couple of ER visits a month. We have been able to do that.

We have also been able to ... There was one lady who was living by herself, and she had heart failure as well as a pulmonary problem, and she was fearful that every time she would have a respiratory episode that she would die by herself on the carpet, and so every time she couldn't breathe, she would just dial 911. The community health worker, they made an agreement that next time she had one of these breathing problems, the community health worker would go over and she walked her through taking her inhalers, doing her pursed lip breathing, relaxation techniques, and after about 20 minutes, the lady looked at her and said, "Hey, I don't have to go to the emergency room!" So that has really been very helpful.

We have assisted clients in receiving the care that they need; meaning that we have been able to hook them up with other providers. A lot of the folks in these small communities, they are very fearful to go see another provider in a tertiary facility, because they're fearful that their provider in their home town will find out and then be mad at them. We have been able to alleviate some of those fears, and get people into some of the programs that they need. A lot of times people also don't realize what's available out there, and the community health workers are able to access resources to get them hooked up with the types of care that they need.

Then, we've been able to help people understand their diseases and treatment. It's amazing how many people, unfortunately, leave the hospital and really don't understand their discharge planning. And part of the community health worker's job is to be there in hospital at time of discharge, so that they can hear what is being said, and then they make an appointment, go into the people's home five, six days later, and make sure that they really truly understand what's being said.

We had one client who was diagnosed with nearly Type 2 Diabetes, and her takeaway was she needed to eat better. So in the morning, she decided she would drink smoothies, so she was having this smoothie with two bananas and pineapple and juice and yogurt, and she thought she

was really doing herself good and couldn't figure out why her sugars were so high. When they did the carb talk, she just thought carbs were nothing but bread and grain products, and she didn't understand that fruits were carbs as well.

A lot of folks, we've helped them with getting diabetic foot care. That's something that also gets kind of put off by the wayside; people don't hear the importance of checking your feet with diabetes. We've been able to prevent some ulcers and get people in some good diabetic shoes.

Some of the barriers that we have are our clients themselves. Montana is a rural frontier state, with a lot of ranchers and farmers, and there's two mentalities that go with that. The first mentality is that I don't need help, thank you very much, and the other mentality is that I am not sick unless I can't get out of bed. And so, we've had a number of folks decline our services because, well, I'm not really sick, I can get up and function, so I don't need your help. Another incidence that we have noticed is that people are unwilling to participate because this is a grant. They feel that we are asking them to take Welfare, and there have been some very unhappy people about that. On the whole, we don't tell people this is a grant, and most people are happy to join up if we don't tell them that.

Part of the facilities' problems is they're really concerned about the success of this program and how it will affect the bottom line. With the small numbers that they have, every person coming through the door keeps the lights on, so there are some concerns about that. There is a lot of ... In these facilities, there is no space for the community health workers to work. They have no extra computers for them to utilize, so the community health workers are using their home computers. When a lot of the communities' facilities signed up, there was very limited communication between the CEO and the providers, so a lot of the providers didn't quite understand the program, and didn't understand what the CEO was thinking about, and so there was a lack of buy-in on the providers' parts.

Another issue I've noticed is that you need to have a champion, and if the champion leaves the facility for whatever reason, the program kind of languished. Part of the providers' concerns, where they believed that patients should be handled by nurses, and I did have one facility provider called the Board of Nursing to make sure that I wasn't overstepping the bounds of practice. There's also concerns about government intervention, some of them feel that they don't have any control. Also, there's concern about the bottom line as well. The lessons learned is that every facility needs a champion. They need somebody to really believe in this program to rally everyone behind it.

Community health workers should be from the community that they serve. There have been some instances where in these small towns, they've hired people from outside the community, and they were outsiders and they felt like outsiders, and didn't stay in the position very long. Another issue is the turnover. This grant provided enough funding for the community health workers to work approximately 10-12 hours a week for approximately \$12 to \$15 an hour, and there's a lot of folks who only want to do that because they're retired, and there were a number of young women and men who signed up as community health workers and just needed more money to survive. One of my community health workers, I'm really proud of her, she thought that this was a really wonderful job, and she resigned so she could go on to nursing school.

Another thing is that resourceful people make the best community health workers, and the community health workers that go out and visit their communities of faith and talk to all the civic organizations and explain what they do and look for opportunities to make their community a better place, are where the communities that are thriving with this program are.

Thank you very much for allowing me to tell you about my program!

Kristine Sande

Thanks, Heidi. That was really interesting! It looks like we're coming close to the end of our webinar time, but if people have a question or two, we would probably have time for that. You can enter your questions in that Q and A box on your screen. Just so folks know, too, we will be providing the contact information for all of our speakers to you by e-mail following the presentation, so if there's questions we don't have time for, you'll have an opportunity to direct those questions to them privately. Currently there are no questions, but we'll just give it a little bit of time here, and see if anyone has a question. Will we provide information on accessing the recorded webinar is a question, and yes, we will provide that information as soon as the recorded webinar is available? We'll send out the information to everyone who was registered today.

Another question is whether the slides will be available later. Those are currently available on the RAC Web site, so RACOnline.org/webinars is where you can access them. Here we do have a question, does anyone have experience with specific populations, such as persons with disabilities? Heidi or Melissa, do you want to weigh in on that?

Heidi Blossom

Well, we do see a lot of ... Most of my client base is geriatrics. We just see the chronic diseases, dementia, that kind of thing. Disabilities, we do see a lot of mental illness. But disabilities in the way I'm thinking of disabilities, no, I don't see much of that. How about you, Melissa?

Melissa Miles

No, I don't. I am working on a separate project with an ACO where we're going to be developing some care coordination models with the agencies who do work specifically with those populations, but I don't have enough knowledge under my belt just to have any parting words.

Kristine Sande

All right. Here is a question, what training was done for staff in the Step Up Falls program?

Heidi Blossom

The Stepping On program is a four-day or three-day training, I'm not really sure, I've never taken it. It's put on by the Department of Health and Human Services here in Montana, and it is a ... My understanding from the community health workers who have taken the training a very intensive and a very good training. I really can't answer that question as I, myself, have never taken that training. But you could contact the Department of Health and Human Services in Montana for more information on that program.

Kristine Sande

All right, thank you. Another question is, I'm from a large hospital, and I'm curious if any of your speakers could speak to how larger institutions might partner with rural facilities in outlying areas.

Heidi Blossom

One of the concerns that the providers have here in Montana is lack of communication between the providers and the tertiary facilities. The clients or patients go to these large facilities, they have things done. Their meds get changed, they come home, and their general provider does not have that information as to what has been changed; what medications they've been added, what actually was performed in these tertiary facilities. And I know that better and timelier communication is one of the things providers here in Montana would like to have.

Kristine Sande

Okay. Let's see, there's a question of whether ORHP funds available are from the federal government or from the state Offices of Rural Health. Now, I believe we had an outreach grant that was, Melissa, that was through the federal government?

Melissa Miles

Yes.

Kristine Sande

And then the funding you had, Heidi, that was also through the federal government, correct?

Heidi Blossom

Correct.

Kristine Sande

All right.

Melissa Miles

And our State Office of Rural Health does have a little bit of funding that they provided to us each year as well.

Kristine Sande

Oh, great! Here's another question. What is a typical caseload for a community health worker in your programs, and what effect can this have on how well the program operates?

Heidi Blossom

Well, because most of the community health workers are working ten to 10 to 12 hours. They average between five and ten clients, although I do have some community health workers that are working more hours and are visiting about 12 to 16 clients. So how does that have impact? A lot of times, with the elderly here in these very rural communities, they have no family left in these small areas, their children have left to get better jobs, their grandchildren are not around. A lot of times, just actually even having that emotional support, somebody coming over to their

house to listen to them, have coffee with them, has been extremely helpful, plus providing all the other services such as education and transportation.

Melissa Miles

And for our program, I'm not exactly sure what the caseload is. I know that for one FTE down in North Carolina, they would manage probably about 300 clients. But it really does, I think, matter as to the purpose of the program, whether you're focusing on access and outreach, getting patients in for care, or whether you're working on the comorbid conditions, which, I think, that case management tends to be more intensive, and therefore your client load would be significantly less.

Kristine Sande

Thank you. All right, we'll do one last question before we're done today. We are over our time already, and again, the rest of you, please do contact the speakers with your specific questions for them. This last question is, how do you address the mental health need you see in folks receiving services from community health workers? Are local supports available?

Heidi Blossom

No, that's kind of the problem. The local supports are not available. We are trying to get the mental health first aid training for all the community health workers, but in Montana, that's been rather hard to find a trainer to train us. A lot of times what the community health workers will do is, they'll call me, I do have a girlfriend who is a mental health Nurse Practitioner, and I do call her and ask her questions, try to get people set up into the system. A lot of my communities, there is a counselor that does come once a week to see clients. A lot of the folks have to go 50 plus miles for medication management. So all the support we can provide them is very beneficial.

Kristine Sande

All right, well, thank you.

Melissa Miles

And I was just going to add that I think that the emotional support that community health workers can provide is truly incredible, because so many of these patients tend to be isolated. Just having that person to talk to and support them, I think, makes a big difference in mental health.

Kristine Sande

Absolutely.

Melissa Miles

We've had trouble with finding bilingual people in our communities who can provide appropriate services, so it's definitely a challenge.

Kristine Sande

All right. Well, thank you very much! That brings us to the close of our webinar today. On behalf of the Rural Assistance Center, I'd like to thank our speakers for the great information and

insights that you've shared with us today. I'd also like to thank our participants for joining us. Please note that a survey will be e-mailed to you following the webinar, and we really encourage you to complete that survey. That provides us good feedback so that we can improve our future webinars.

Once again, the slides used in today's webinar are available at www.raonline.org/webinars, and a recording and transcript will be available in the near future, and we'll notify you of that as well. So, thank you so much for joining us today, and have a great day! Thanks!