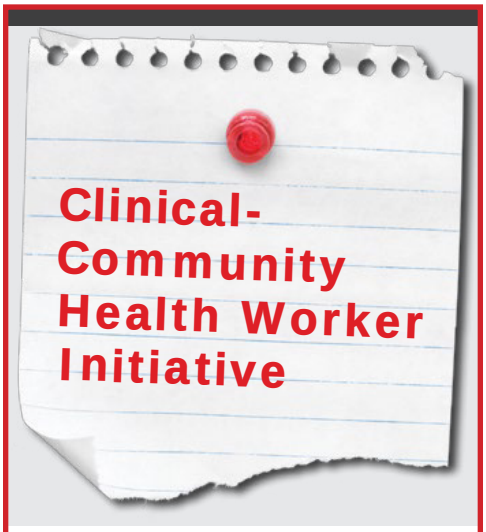
Field Notes



Problem:

The Mississippi Delta is a rural 18-county area in the northwest region of the state whose residents experience persistent poverty and a higher proportion of chronic diseases and related risk factors than those in other regions of Mississippi. Many patients with high blood pressure and diabetes risk factors need more support and access to community resources than is commonly provided by routine doctor visits.

Project:

Community health workers (CHWs) are community members who work with patients to deliver culturally appropriate lifestyle support to increase patients' awareness and understanding of the importance of chronic disease risk factors and the benefits of physical activity, diet, and self-monitoring in managing chronic diseases.

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Overview

The MDHC, an initiative of the Mississippi State Department of Health, provides leadership and guidance in the Mississippi Delta to improve the cardiovascular health of the population through the promotion of the ABCS—appropriate **A**spirin use, **A**1c (hemoglobin control), **B**lood pressure control, **C**holesterol management, and **S**moking cessation. The MDHC works to achieve these goals by putting into action heart disease and stroke prevention strategies that include environmental and systems changes, community-clinical linkages, and collaboration with a diverse group of partners.

Program Structure

The Clinical-Community Health Worker Initiative (CCHWI) began in 2011 as an effort to link patients to CHWs for enhanced support in managing their chronic conditions. CHWs see patients who are referred because of chronic disease risk factors such as elevated blood pressure or glucose levels. Referrals come from healthcare providers in federally qualified health centers (FQHCs) and rural clinics. Five clinical sites have formalized their commitment to implement CCHWI by signing a Memorandum of Agreement outlining accountability, processes, communication, and tracking systems. CHWs also receive referrals of clients with elevated blood pressure from health screenings conducted in barbershops, churches, and other MDHC partner locations.

CCHWI oversight is provided by a MDHC program manager and two registered nurses who are available for frequent and ad hoc consultation with the CHWs. Currently eight CHWs visit patients throughout 17 of the 18 Delta counties.

Program Processes

Patients are primarily referred through the FQHCs and other MDHC interventions, which are the Delta Pharmacy Project, the Barbershop Hypertension Reduction Initiative, and the Delta Alliance for Congregational Health (DACH). Once referrals are made, the CHWs follow up with patients within 48 hours through face-to-face contact, phone calls, or mailings to establish and maintain linkages to healthcare, promote adherence to treatment protocols, and work toward improvement in the ABCS.

Specifically, CHWs:

Conduct home visits that last about one hour, where they:

- Offer informal counseling on medication adherence, tobacco cessation, healthy nutrition, and physical activity.
- Encourage patients to use a primary care provider if screenings indicate the need.
- Reduce barriers to healthcare access by arranging transportation, assisting patients with scheduling appointments, and helping patients prepare for medical visits.

- Contact clinical systems when patients have elevated blood pressures.
- Use an online web-based portal to collect quantitative and qualitative information during the home visits as part of MDHC's ongoing evaluation.

Field Notes (cont.)

Link patients to the following programs:

- Group sessions on self-management (facilitated by the CHWs) that integrate cultural competence into program design and focus on self-management skills, such as modifying lifestyles, setting goals, creating action plans, and developing problem-solving techniques.
- The state health department Tobacco Quitline.

Goals and Objectives

CCHWI seeks to increase identification and referral of patients with high cardiovascular disease risk factors who are not enrolled in a medical home. Additionally, CCHWI aims to increase the number of participants who may have a medical home but have not responded to the usual interventions and may require enhanced lifestyle support through the services offered by CHWs. Ultimately the goal of the initiative is to reduce high blood pressure and diabetes risk factors among all participants.

Intended Participants

CCHWI seeks to make contact with African Americans, aged 18 years or older, who live in the 18-county Delta region and who may be uninsured or have limited access to healthcare. Specifically, the CHWs work with adults diagnosed with hypertension, diabetes, or elevated cholesterol levels.

Progress Toward Implementation

The CHWs have sought out opportunities to expand their skillset and the range of services that they are able to provide. Specifically, the CHWs have obtained certification in Chronic Disease Self-Management and in Diabetes Self-Management. Additionally, there are plans to fully integrate the CHWs as team members of the participating healthcare sites. MDHC is seeking to establish a system for statewide credentialing and certification of CHWs.

Community Involvement

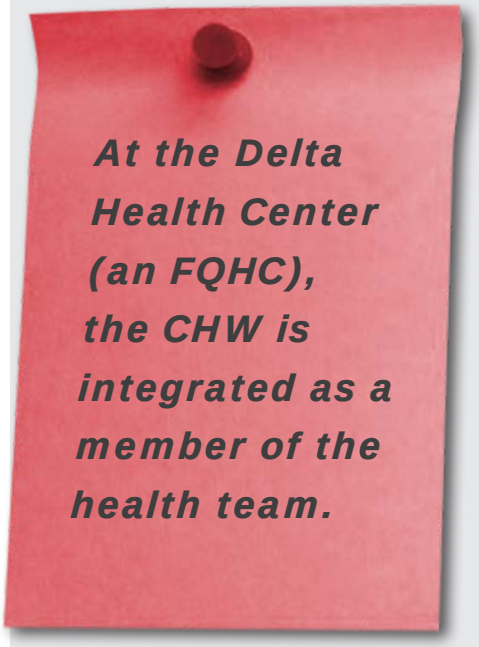
Community involvement has been integral to CCHWI. CCHWI has also been integrated in other MDHC community initiatives, such as DACH, the Barbershop Initiative, and the Pharmacy Project, in which the CHWs are available to connect and follow up with participants during screening events. Additionally, the CHWs conduct Chronic Disease Self-Management classes that are available to participants as well as community members.

Reach and Impact

From 2011–2014, CHWs have enrolled more than 700 patients and have made more than 1,100 referrals. Between August 2012 and September 2014, improvements in key health measures were observed in the 410 active participants (individuals with at least one baseline visit and one home encounter). Improvements include:

- Patients' average blood pressure decreased from 150/93 to 140/83.
- The percentage of patients with hypertension who have adequately controlled blood pressure increased by 2.9%.
- The percentage of patients with high cholesterol who are effectively managed increased by 8.7%.
- The percentage of patients at increased risk of cardiovascular events who are taking aspirin increased by 15.8%.

This document does not constitute an endorsement of any organization or program by the CDC or federal government, and none should be inferred.



At the Delta Health Center (an FQHC), the CHW is integrated as a member of the health team.

A Warren County participant of CCHWI was doing so well in the program that his wife joined. Both participants appreciated the CHW's caring attitude and the time spent with the CHW.