FY2017 CHNA Progress Report
Clearwater Valley and St. Mary's Hospitals and Clinics
5/10/17

Priority #1
Access to Care

Target Population
Residents of Clearwater, Lewis, and Idaho Counties

Goals
Increase the number of residents who have at least one annual health contact that could result in a measurable impact on their health
Improve the rate of residents who obtain, retain, and use health insurance

Accomplishments to Date
Strategies, details, metrics
Strategy #1: Implement a corps of community health workers to conduct screenings and outreach.

Expected Short Term Outcomes
16% of area residents will experience at least one health contact per year; 48% will be reached by April 30, 2018. At least 20% of adult outreach event participants – one in five – will report not having had a medical office visit in the past 12 months. 350 residents will undergo a FIT test annually
85% of screening participants requesting assistance will become established in a primary care medical home within 2 months of request.
Expected Long Term Outcomes
48% of area residents will experience at least one health contact by April 30, 2018. 660 new cases of high blood pressure, 400 cases of diabetes, 4,995 cases of pre-diabetes, and 4,050 cases of obesity will be identified by April 30, 2018.

A corps of community health workers varying from 3.0 to 4.25 FTE (full-time equivalent) staff conducted 94 outreach events over a tri-county region from May, 2016 to April, 2017. Events were coordinated with Public Health, Tribal Health, and multiple social service agencies. They were conducted in settings which included food banks, workplaces, senior centers, and even livestock auctions.

1402 individuals, about 5% of the total population, attended these outreach events. Community health workers provided 1,251 blood pressure checks, and 1,091 blood sugar tests for diabetes. The FIT test target was exceeded; 405 tests were done for community members. 71 participants requested assistance in establishing care in a patient-centered medical home. 92% of those requests were filled within 2 months.

Strategy #2: Provide navigation services to existing resources by implementing a benefits counselor program.

Expected Short Term Outcomes
90% of adult outreach participants will be screened for insurance status.
Enroll or retain insurance for 500 individuals annually.
Expected Long Term Outcomes
By 2018, identify 2,100 uninsured individuals and enroll or educate 1,500 individuals on using public or private health insurance.

All community outreach participants and clinic patients have been screened for insurance status. The benefits counselor position has been filled for the entire year, and she is far exceeding her targets. She has assisted 920 people with enrolling, retaining, or using their insurance coverage. 167 previously uninsured individuals attained health insurance coverage from August, 2016 to March, 2017. An additional 329 people verified renewal of insurance coverage.

In addition to the target numbers, the human impact of the program is high. A couple with an adopted child recently moved to the area from another state. Neither Idaho nor the healthcare system had contracts with that state's Medicaid system. The benefits counselor negotiated with all parties for almost a month to ensure contracts were in place. The child now has Medicaid coverage until the age of 19.

Challenges to Date

Recruitment and retention of community health workers have been larger barriers than anticipated. One issue has been the difficulties of scheduling multiple public screening events while working in a part-time capacity. Workers who resigned for reasons other than health cited the difficulty of coordinating schedules with their other part-time jobs. An additional challenge, discussed below in "changes to consider" is finding people in our frontier area who are not already established with a primary care provider.

The biggest barriers to increased enrollment continue to be lack of Medicaid expansion in Idaho, political resistance to the State Marketplace (aka "Obamacare"), and the high premium cost for many products. These barriers are beyond the scope of this initiative. However, leaders in the hospital systems have shared those concerns at the state and national level. Locally, we continue with outreach and enrollment efforts. The benefits counselor has established good personal rapport with most of the consumers she has met. That message spreads by word of mouth in our communities. Despite the political turmoil of the last open enrollment season, targets for enrollment and education far exceeded projections.

Changes to consider in upcoming fiscal year

The original intent of the community health worker program was to work outside the walls of our clinics to improve the health of our communities. We focused on preventive screens, getting people established with health care providers, and identifying wellness gaps in our community. However, we seem to have saturated the market with events for preventive screenings. We don't seem to be finding many patients who are not already established with providers. One change we're considering is asking for the date of the

last provider visit. We suspect that many people have gaps of multiple years between visits.

We also plan to refine the role of community health workers to allow more integration with clinic care teams from multiple health care systems. Early adapters include Clearwater Valley and St. Mary's Hospitals and Clinics and Snake River Community Clinic. Proposed secondary adapters are Public Health and Syringa Hospital. Community health workers will help with existing patients as "extenders" of case managers and connectors to community resources. Sample tasks:

- Home visits to assess environmental and social determinant issues for wellness
- Reminders and logistical assistance for follow-up visits
- Outreach calls to inactive patients
- Check-in calls before the weekend for highest risk patients, to reduce preventable ED visits
- Enrollment assistance for social service benefits (This would involve referring patients with a warm handoff to our benefits counselor for insurance enrollment assistance. The community health workers would not enroll individuals in ACA products or otherwise duplicate the work of the benefits counselor.)

The refinement may produce fewer public events and health screenings than proposed in the original implementation plan. However, we anticipate better clinical outcomes, increased access to case management services, and a better understanding of gaps in community wellness resources.

NA for benefits counseling

Priority #2
Obesity and other contributors to chronic disease

Target Population
Residents of Clearwater, Lewis, and Idaho Counties

Goals
Build community wellness resources

Expected Short Term Outcomes
Identify gaps in nutrition, fitness, or health education resources in up to 10 communities
100% of outreach participants will receive prevention and self-care guidance corresponding with their personal risk level of risk and literacy level.
Expected Long Term Outcomes
At least 10 small-scale/high-visibility projects established by May, 2018 100% of outreach participants will receive referrals to community-based wellness resources. Track types and quantity of community referrals in clinic setting.

Accomplishments to Date

Strategies, details, metrics
All participants – more than 1,000 -- who were screened at outreach events received prevention and self-care guidance which corresponded with their personal level of risk. The guidance included links to community-based wellness resources. 985 attendees, or 70% of total event attendees, agreed to be screened for obesity.

Community health workers helped create sustainable wellness resources in multiple communities. In White Bird, population 92 and almost a time zone apart from the rest of the project area, the community health worker coordinated the creation of a community center. The center is heated with electricity paid for by a community partner, so she no longer has to arrive several hours before a meeting or class to start a wood stove. In Nezperce, the community health worker and a project coordinator have been actively involved in the planning for a new community meeting room. Thanks to their efforts, the new fire hall has a community wellness room included in its design.

7 cohorts of the evidence-based Chronic Disease Self-Management Program have been offered. Community Action Partnership has provided training materials for these classes. 4 diabetes support groups are meeting.

There were 4 cohorts of the CDC-approved National Diabetes Prevention Program offered in 2 different locations. A total of 52 participants were involved in those cohorts with average attendance of 17 out of 24 sessions. That gives an average total of meetings attended at 884 from May 1, 2016 through April 30, 2017.

During that same time, there were also 3 separate community awareness events to educate the residents/public on the difference between pre-diabetes and diabetes and how to make lifestyle changes to reduce the risk of developing type 2 diabetes for those with pre-diabetes or undiagnosed at this time. Those already diagnosed with type 2 diabetes were encouraged to adopt certain lifestyle changes to reduce the risk of complications associated with their chronic disease condition. There were a total of 111 people who attended these three separate events.

Finally, 2 events were held in conjunction with elementary schools involving 54 families of elementary school children. Education was on healthy meal planning and shopping on a budgets as well as family fun activities for increased engagement of the whole family in physical activity.

Challenges to Date
While we are hopeful about building momentum with small-scale projects, we know that having a measurable impact on rates of obesity and chronic illness will take more time. Measuring success in the interim is a challenge for maintaining that momentum.

Changes to consider in upcoming fiscal year
Additional partners, measures, strategies as applicable
Community health workers will be trained in offering the version of the Chronic Disease Self-Management Program which specializes in pain relief. This new community

resource will help fill gaps for contributors to chronic disease and for mental health issues.

Priority #3
Mental Health

Target Population
Residents of Clearwater, Lewis, and Idaho Counties

Goals
Improve awareness, screening, and access to care

Expected Short Term Outcomes
500 telepsych visits annually
50% of outreach participants will be screened for mental health status
Expected Long Term Outcomes
1,500 telepsych visits by April, 2018

Accomplishments to Date
Strategies, details, metrics
65% of outreach participants, a total of 921 individuals, were screened for mental health status. These participants all received self-care guidance based on their risk levels, as well as links to community resources.

Between May, 2016 and April, 2017, 564 telepsych visits were conducted at Clearwater Valley and St. Mary's Hospitals and Clinics. This exceeded the target of 500 visits.

Challenges to Date
Once individuals are screened, there are few treatment resources available overall, and even fewer for people with low incomes. The entire state of Idaho continues to be a mental-health professional shortage area. However, community consortium members continue to explore collaborative options to the issue.

Changes to consider in upcoming fiscal year
Additional partners, measures, strategies as applicable
Community health workers attended a regional suicide prevention awareness conference and may include some learnings in next year's action plans. As they begin making personal visits with clients and offering community classes on living with chronic pain, we expect they will be well-positioned to make more connections to community resources for those with mental health issues.