Community Health Workers and Chronic Disease Prevention and Management

- **Project goal:** Amplify community health worker (CHW) capacity to link patients with hypertension, high cholesterol, and/or diabetes with community resources to help manage their chronic
- disease(s). **Project sites:** One Health serving Hardin (2020 to 2021, Year 3); Clark Fork Valley Hospital serving Plains, Hot Springs, Thompson Falls (2021 to 2022, Year 4); Carbon County Public Health serving Belfry, Boyd, Red Lodge (2022 to 2023, Year 5).
- Seven CHWs received career-specific training and assisted **107 total patients**.

Results

Workflow Changes

- Creating or improving referral process from providers to CHWs.
- Need to learn about and develop relationships with community supportive programs.
- Need to communicate frequently and consistently with patients.
- Meet patients where they are (virtual, phone), not where the CHWs are.

Major Successes

- Providers began to see the value of working with and referring to CHWs for added patient support (but needed occasional reminders).
- Improved patient knowledge, confidence, and self-care practices.
- Rebuilding relationships with public health

Major Challenges

- Learning how to approach and market the project to providers.
- Provider and staff turnover.
- Patients who refused to participate or dropped out of support programs.
- Assisting patients in outlying communities with fewer resources.
- Patients not participating in group classes because they didn't want other community members to know they have medical conditions.
- Patients not available for follow-up vitals.

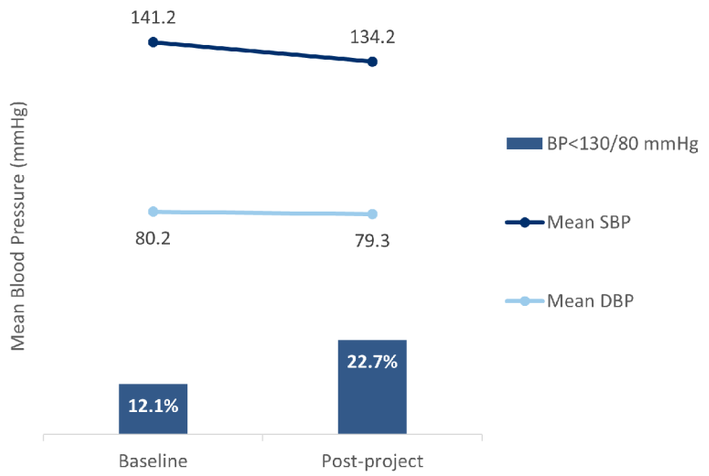
Major Facilitators

- Clinic information technology support to streamline referral process.
- Person-to-person recruitment.
- Self-monitoring blood pressure cuff loaner program.
- Virtual class offerings and telephone outreach.
- Going to where patients feel comfortable.

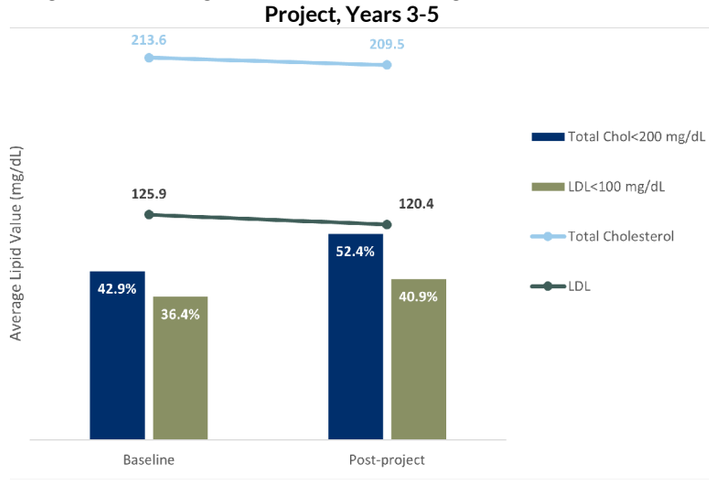
Community Programs Referred To

- Living Your Best Life with Diabetes
- Strong Bodies
- Health Coaches for Hypertension Control
- Hypertension workshops
- Montana Journey to Wellness Health Coaching
- National Diabetes Prevention Program (DPP)
- Diabetes Self-Management Education and Support (DSMES)
- Stepping On
- Primary Care Provider
- Registered Dietitian

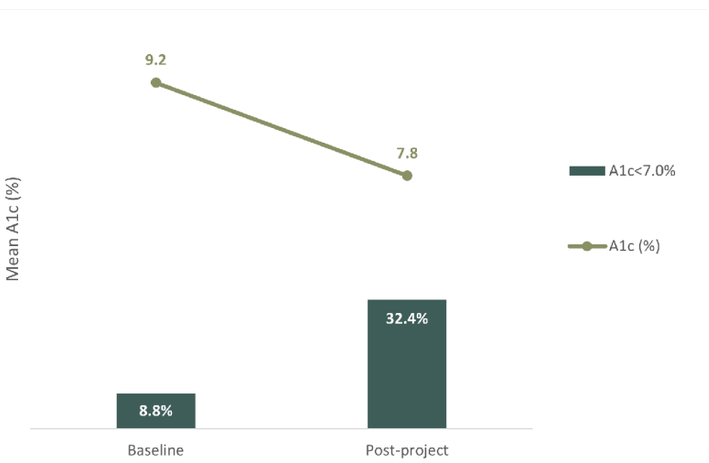
Average Systolic and Diastolic Blood Pressure (BP) Measures and Percentage at Target (BP<130/80 mmHg), Baseline and Post-Project, Years 3-5



Average Lipid Measures (LDL and Total Cholesterol) and Percentage at Target (LDL<100 mg/dL or Total Chol<200 mg/dL), Baseline and Post-Project, Years 3-5



Average HBA1c Measure and Percentage at Target (A1c<7.0%), Baseline and Post-Project, Years 3-5



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