



Community Health Workers and Chronic Disease Prevention & 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).
- Projects at One Health serving Miles City (2020/21, Year 3); Clark Fork Valley Hospital serving Plains, Hot Springs, Thompson Falls (2021/22, Year 4).
- **Seventy-three** patients assisted. **Five** CHWs received career-specific training.

Results



Workflow Changes

- Creating or improving referral process from providers to CHWs.
- Need to learn about and develop relationships with community supportive programs.
- 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 and self-care.

Major Challenges

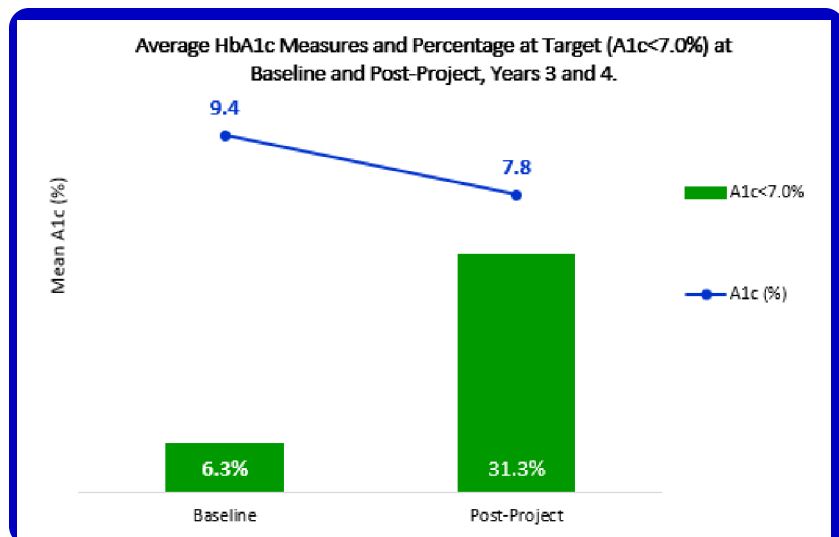
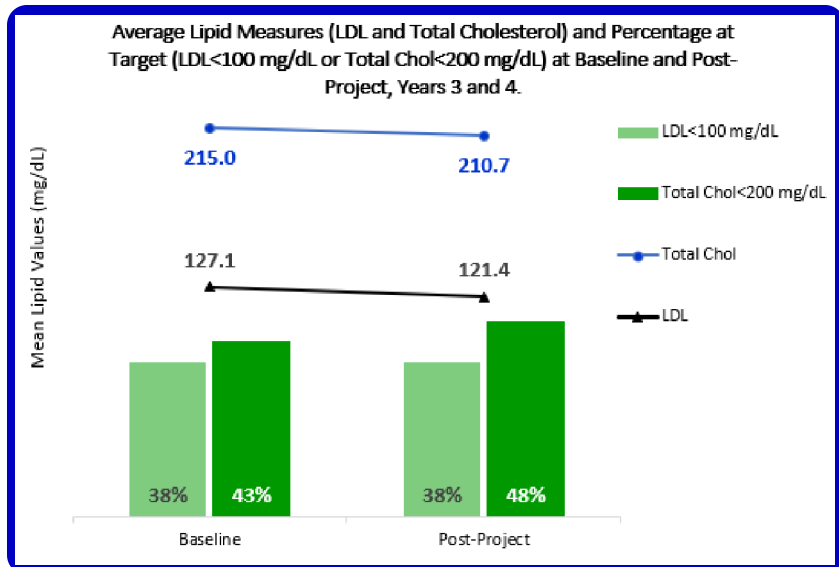
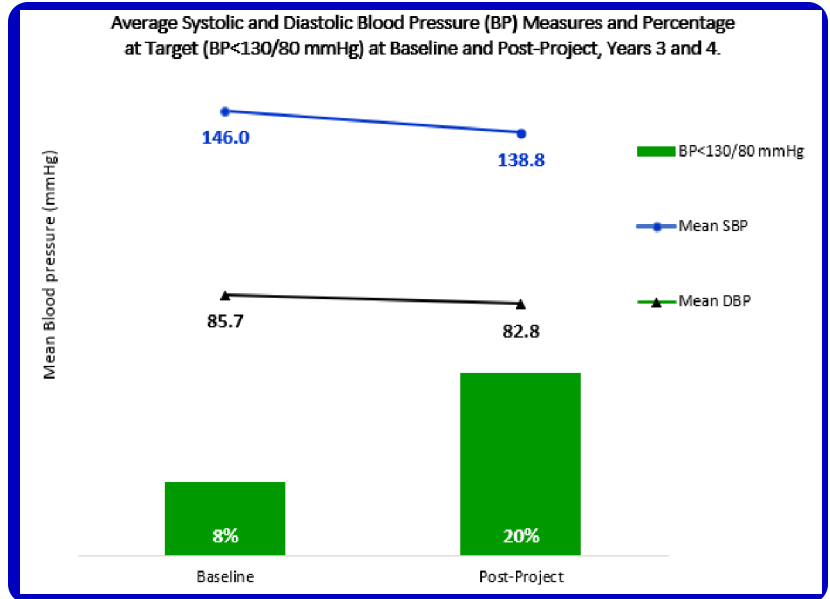
- Learning how to approach and market the project to providers.
- Provider turnover.
- Patients who refused to participate or dropped out of support programs.
- Assisting patients in outlying communities with fewer resources.
- Patients not participating in group classes because they didn't want other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

Major Facilitators

- Clinic information technology (IT) support to streamline referral process.
- Person-to-person recruitment.
- Self-monitoring blood pressure cuff loaner program.
- Virtual class offerings and telephone outreach.

Community Programs Referred To

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



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