Field Notes

St. Johnsbury, Vermont, Community Health Team

Problem:

High rates of hypertension, diabetes, and asthma in a fragmented health care system prompted the state of Vermont to create an initiative that addressed chronic disease control and helped to remove barriers by attending to patients' social needs.

Project:

The Community Health Team (CHT) is an integrated group of multidisciplinary practitioners, including community health workers (CHWs), that addresses the spectrum of medical and nonmedical needs of patients with chronic disease conditions.

For more information please contact

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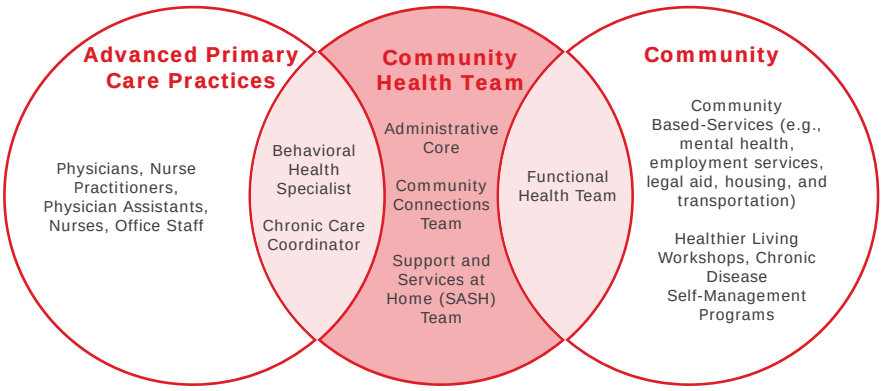
Overview

In 2008, the St. Johnsbury, Vermont, Community Health Team (CHT) was developed with support from the Vermont Blueprint for Health (Blueprint), a state health reform agency. The Blueprint aims to provide seamless coordination of care across a broad range of health and human services that address social determinants of health. Through the CHT model, the Blueprint targets individual, community, and health care system outcomes to improve client well-being, patient health outcomes, and rates of emergency room and inpatient hospital use.

In St. Johnsbury, the CHT model has five components (see Figure 1):

- *Administrative Core*: A program manager provides managerial and programmatic support, as well as oversight. A care integration coordinator is responsible for overseeing CHT components and actively building and sustaining partnerships with community organizations.
- *Advanced Primary Care Practices*: These patient-centered medical homes, recognized by the National Committee for Quality Assurance, are staffed with health care providers, chronic care coordinators, and behavioral health specialists. Working in collaboration with the health care providers, office staff, and other CHT members, chronic care coordinators are responsible for coordinating the care of patients with, or at risk for, chronic conditions. Behavioral health specialists provide short-term, solution-focused therapy.
- *Community Connections Team*: Community Health Workers (CHWs), a cornerstone of the St. Johnsbury CHT model, and the care integration coordinator make up the Community Connections Team. Two CHWs are primarily responsible for linking clients to community-based and local state agencies that provide financial and other tangible resources to meet clients' needs, such as vouchers for heating and transportation assistance. A third CHW, known as the chronic care CHW, provides similar services, but acts primarily as a health coach to improve clients' chronic disease self-management skills. The CHWs are supervised by the care integration coordinator.
- *Functional Health Team*: The Functional Health Team includes approximately 30 community partners that provide a variety of services such as legal aid, housing, and transportation.
- *Support and Services at Home (SASH)*: In SASH, members of the CHT connect Medicare patients to health and long-term care systems. SASH implements specific interventions that include fall prevention, medication management, control of chronic conditions, and healthy behaviors.

Figure 1. An illustration of the relationship between the St. Johnsbury CHT model core components in the community clinical context.



Field Notes (cont.)

Goals and Objectives

The primary goals and objectives of the CHT are to:

- Optimize patients' experience (including quality, access, and reliability) and engagement.
- Improve the long-term health of the population.
- Reduce (or at least control) health care costs.

As a part of the CHT, the CHWs specifically aim to help meet client social needs so that patients can improve their life conditions, health, and ultimately their well-being.

Intended Participants

The target audience for the program is all members of the community in the hospital service area. Many of the clients referred from the advanced primary care practices to other CHT members have hypertension, diabetes, and asthma—the three chronic diseases targeted by the Blueprint. Clients are referred to the Community Connections Team by staff in the advanced primary care practices through word-of-mouth and from local, state, and community-based agencies.

Progress toward Implementation

The inclusion of CHWs as part of the CHT was unique to the St. Johnsbury site and served as a pilot program in 2008. However, statewide efforts have been initiated to include CHWs on all CHTs. In 2012, the CHT model was further enhanced with the addition of the SASH component.

Community Involvement

The CHT's connection to the community is accomplished through the work of the CHWs. The CHWs help establish and maintain relationships that facilitate community-clinical links. These relationships are forged through the network of community-based organizations that make up the Functional Health Team.

Reach and Impact

Key findings from a comprehensive evaluation of the St. Johnsbury CHT model revealed that:

- As of spring 2012, at least 22,106 unique patients were cared for by the five advanced primary care practices.
- Compared to the overall sample, higher proportions of patients exposed to one CHT component were also exposed to other health team components. This suggests CHT staff successfully work together to coordinate care for their clients.
- Health care providers said that the model provides opportunities to use the short patient encounter timeframe to provide more comprehensive care and allows them to link patients to other CHT members to address a full range of patient needs.
- CHW clients improved in key aspects of well-being targeted by the Community Connections Team, including health insurance, prescription drugs, housing, and health education. CHW clients also reported that they were more aware of and attentive to their overall health after receiving services, suggesting that CHWs can improve the overall health of clients.

Resources:

An executive summary of the St. Johnsbury CHT evaluation report can be found at http://www.cdc.gov/dhdsp/docs/es_stjohnsbury_community.pdf.

The CHT provides "wrap-around" services by surrounding patients with all of the different resources and services that they need.

"What's changed since I've started using Community Connections is that when I come in with an issue, I always end up leaving [thinking]—this issue can be dealt with."
—CHW client