HIGHLIGHTS & ACHIEVEMENTS IN 2021

GREAT RIVERS HUB / AN INITIATIVE OF GREAT RIVERS UNITED WAY
1855 E. MAIN ST., ONALASKA, WI 54650 / (608) 796-1400 / WWW.GRUW.ORG/HUB

DIRECTOR'S WELCOME

Great Rivers HUB Partner,

In this, the second edition of the HUB's annual Impact Report, we hope to provide an enhanced understanding of the HUB's impact in our community. The HUB's work bridges the gap between clinical health and social determinants of health for individuals to improve their well-being. This holistic framework combined with targeted implementation and Community Health Workers (CHWs) brings a culturally competent, person-first approach to addressing health inequity.

Some highlights of the work completed in 2021 include:

- Connecting clients to 561 social service-related needs such as clothing, food, transportation, and other assistance
- Assisting clients in setting up and making 109 medical appointments
- Providing 810 one on one health education sessions
- Support lifestyle changes resulting in improved blood pressure and A1Cs
- Providing responsive and timely COVID-19 education and assisting individuals with making vaccine appointments

Great Rivers HUB has continued to evolve and grow over the last few years. While we have evolved when necessary to respond to the needs of the community, our advocacy efforts have been steadfast. We continue to advocate regionally and at the State level for improved health equity, support for the CHW workforce, and to ensure outcomes are achieved for those at greatest risk of poor health outcomes.

As for our impact, it is our hope that this report provides a summary of our work, as well as demonstrates the value Community Health Workers continue to bring to our community.

Great Rivers HUB anticipates continued growth in 2022, with expansion of the CHW workforce in the region increasing the number of individuals served. We are working with several partners to further enhance our ability to directly address health equity issues in our communities. This expansion is crucial to the HUB reaching its ultimate goal of sustainability. Your continued support is vital as we continue this journey.

Thank you for your continued support,

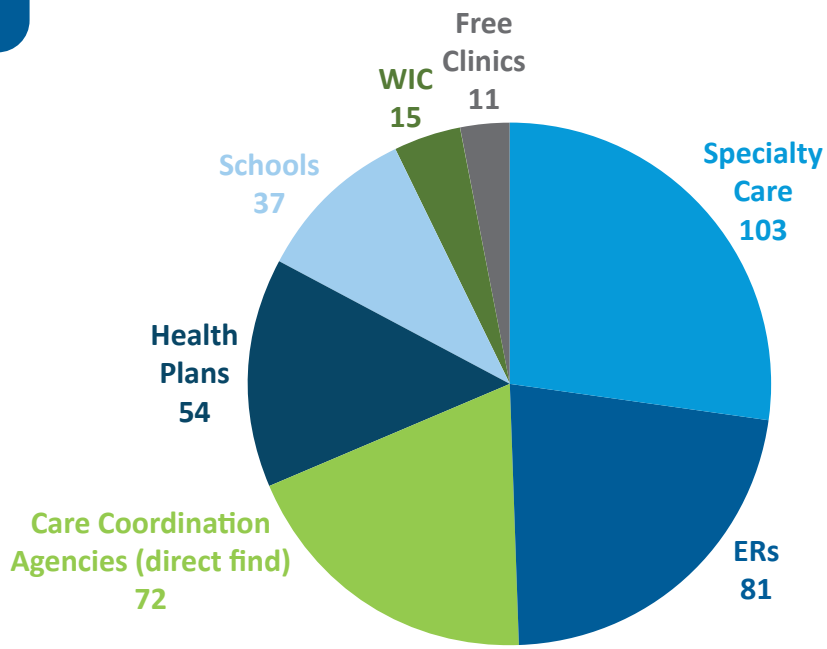
Lindsey Purl
Director, Great Rivers HUB
Great Rivers United Way

TABLE OF CONTENTS

2021 CLIENT OVERVIEW

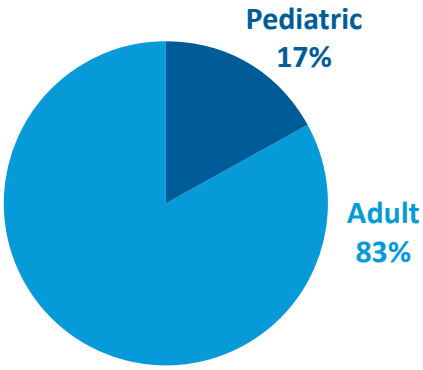
350
Served
in 2021

373
Referrals
(see chart)

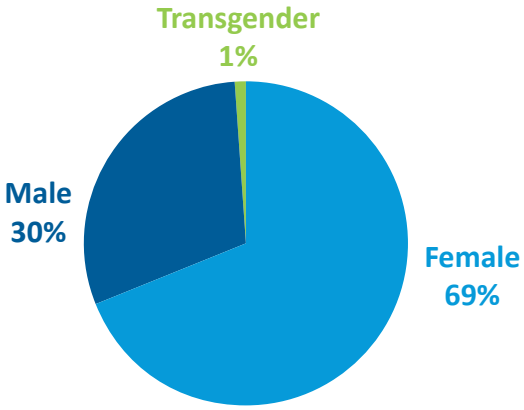


Demographics

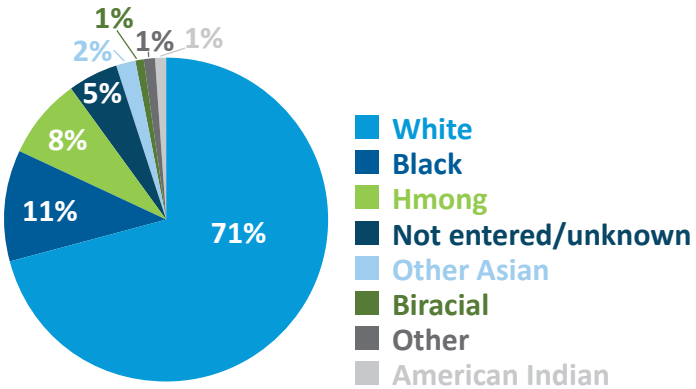
Client Types Served



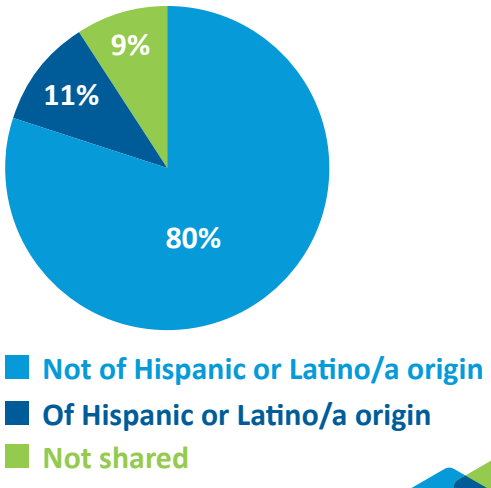
Client Types Served



Adult Reported Race



Adult Ethnicity



MEASURING SUCCESS

For all populations, Great Rivers HUB aims to measure success in a number of ways. One of those is client satisfaction. In partnership with the Medical College of Wisconsin, Great Rivers HUB sent out satisfaction surveys to all clients discharged throughout 2021. This survey included questions related to their satisfaction in working with a Community Health Worker (CHW) as well as whether they felt their health (physical and mental), as well as access to resources (medical and social), had improved as a result of being part of the HUB. The HUB received 22 responses. Responses related to satisfaction with their CHW was an average of 4.35 out of 5 (with 5 being very satisfied). Respondents rated the quality of emotional support provided by their CHW an average answer of 4.25. These positive responses demonstrate the success of CHW relationship development with clients. The HUB hopes to find ways to expand response rate in the future. Below is a table identifying the responses related to whether clients felt their goals were met in each area.

Goal	Fully met goal	Somewhat met goal	Didn't meet goal at all	NA/Didn't work on goal
Improved Physical Health	5	10	0	0
Improved Mental Health	11	4	0	0
Access to Health & Medical Services	13	4	0	0
Access to Social Service Resources	13	4	0	0

In addition to measuring client satisfaction, the HUB focuses on Pathway completion to measure success. Each completed Pathway represents an evidence-based or clinical best practice measure that is known to reduce the risk of poor health outcomes. Below is a table of the Pathways – those identified as a need and being worked on, those not completed, and those completed in 2021. Additionally, for Pathways that were successfully completed, the table shows the median duration of days it took to complete. Together, these numbers paint a picture of need for those enrolled, barriers/gaps in resources, and areas of success. The rest of this report will breakdown Pathway completion for the five programs/populations served by the HUB.

Pathway	Currently Open	Finished Incomplete	Completed	Median Duration to Reach Completion (in days)
Social Service Referral	772	110	561	7
Education	814	5	810	1
Medical Referral	162	29	109	20
Housing	92	17	21	165
Medication Assessment	65	3	50	18
Tobacco Cessation	53	23	3	246
Medical Home	82	11	46	44
Immunization Screening	25	0	27	12
Employment	16	6	10	79
Behavioral Health	19	5	9	69
Pregnancy	40	7	31	98
Health Insurance	18	2	8	25
Postpartum	36	5	25	39
Family Planning	10	1	11	68
Immunization Referral	14	5	8	16
Medication Management	4	1	4	3
Adult Learning	1	1	1	183
TOTAL	**2,223**	**231**	**1,734**	

PUBLIC HEALTH INITIATIVES

COVID-19 Response & Vaccine Outreach

As the COVID-19 pandemic continued through 2021, Great Rivers HUB was able to leverage its community relationships to continue to provide one-on-one education regarding COVID-19 and COVID-19 vaccinations, as well as help setting up and making vaccine appointments. Great Rivers HUB secured multiple grants to support outreach not only through partnering Community Health Workers (CHWs) but also to support other community agencies to outreach to special populations. This includes Independent Living Resources' Housing Navigators and Vang Council of La Crosse. A total of 1,114 education sessions about COVID-19 and COVID-19 vaccines were provided by CHWs and community partners.

Education modules were created by HUB staff using validated and reliable sources. This is key for individuals to be able to make their own health decisions. These modules have been provided to CHWs and our partners in an ongoing basis as the pandemic continued, in order to keep participants up to date.

Education topics included but not limited to:

- COVID-19 vaccine facts
- Booster dose information
- COVID-19 vaccine safety
- Fully vaccinated guidance
- Basic care & prevention
- COVID-19 Vaccine: Addressing Myths

Throughout the rest of this report, "COVID-19 Facts, Safety & Vaccination" indicates that the above topics were covered within specific populations.

TEAM-BASED CARE

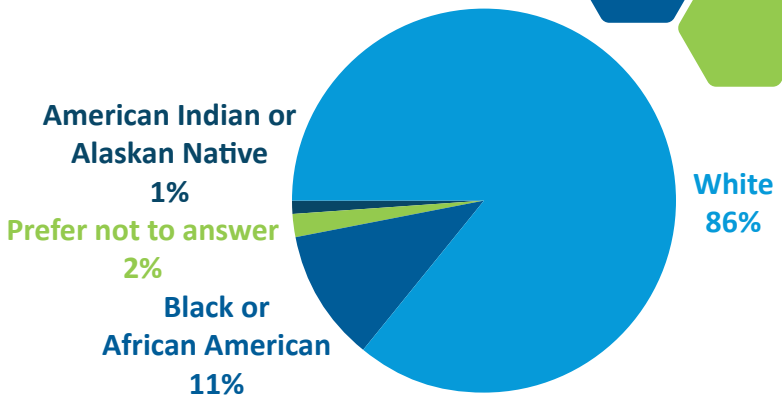
Great Rivers HUB aims to facilitate team-based care coordination among clinical providers and CHWs whenever possible. One successful example of this level of coordination is with local pharmacists. CHWs conduct medication assessments for clients. This assessment is aimed to capture health literacy related to that individual's medication and identify any barriers to access. Great Rivers HUB partners with local pharmacists within Gundersen and Mayo Clinic health systems to electronically reconcile those medication assessments. This partnership has been successful in allowing quick review of medication and providing insight when medications may be taken incorrectly, when solutions to barriers (such as bubble packing) might be available, and to identify when a provider appointment might be necessary for further review. In 2021, there were a total of 59 medication assessment Pathways initiated, with 53 being completed successfully. Of those successfully completed, 89% were reviewed electronically with a partnering pharmacist. This partnership is an example of excellent team-based care that results in improved health for the patient/individual.

"The opportunity for pharmacist collaboration with community health workers to impact social determinants of health is significant. By collaborating together, community pharmacies and community health workers can connect clients to needed resources to help improve medication management, medication adherence and global health outcomes."

– Pharmacy Society of Wisconsin

FREQUENT ER UTILIZATION

103
Served
in 2021



Great Rivers HUB has been serving this population since 2017. Great Rivers HUB's qualifications for the Frequent Emergency Room (ER) Utilization program include: residents of La Crosse County, or those who are experiencing homelessness in La Crosse County, who have visited the ER twice in the past 30 days, or have had four ER visits in the past 12 months. Basic demographic information of those served is identified below. Those served in 2021 under this program ranged in age from 18 to 74; 61 identified as female, 40 as male, and two as transgender.

The general goals of serving this population are to assist in meeting their health needs in order to reduce their ER utilization and increase their engagement with primary care. This includes, but is not limited to, addressing the barriers to finding a medical home, gaining health insurance, and addressing various social determinants of health needs. Social determinant needs include assistance with transportation, food assistance, clothing, and more. In addition to the work above, Community Health Workers provide basic health education such as when it is appropriate to go to the ER verses a primary care provider. The tables below and on the next page demonstrate the needs identified (initiated Pathways), those that weren't able to be completed, and those that successfully resulted in a measured outcome.

Top Pathways 2021

Pathway	Initiated	Finished Incomplete	Completed
Medical Referral	85	20	54
Housing	36	9	8
Medication Assessment	34	2	31
Medical Home	20	4	5
Tobacco Cessation	31	13	0

The top pathways identified above each have a measured outcome known to reduce the risk for poor health outcomes. Outcomes are as follows:

- Medical Referral – made appointment to fulfill medical need such as specialty care, vision, dental, physical therapy, primary care, and mental health appointments
- Housing – secured stable housing for 30+ days
- Medication Assessment – completed a health literacy assessment related to their medications, which was then reviewed by a pharmacist or primary care provider to identify discrepancies
- Medical Home – established a primary care provider and made an appointment
- Tobacco Cessation: successfully quit smoking for 30+ days

FREQUENT ER UTILIZATION

Besides the Pathways identified on the previous page, the following education and social service referral Pathways were the highest utilized Pathways across this program. The tables below demonstrate the top topic and service needs associated with each.

Top education and social service referral tables will be included for each program.

Top Education Topics 2021

Education Topic	Completed
COVID-19 Facts, Safety & Vaccinations	85
ACEs Module 1 or 2	30
Flu Prevention/Flu Vaccine	24
Appropriate Use of the ER	27
Benefits of Quitting Smoking	24
Coping Skills	27
A total of 305 education modules were completed in 2021.	

Top Social Service Referrals 2021

Pathway	Initiated	Finished Incomplete	Completed
Medical Referral	85	20	54
Housing	36	9	8
Medication Assessment	34	2	31
Medical Home	20	4	5
Tobacco Cessation	31	13	0
A total of 267 social service referrals were initiated in 2021. Each completed social service referral indicates the need was met.			

While completion of Pathways is an important demonstration of outcomes and impact, one of the major goals for this program is to reduce emergency room utilization and increase primary care utilization. Great Rivers HUB continues to work with local health systems to best identify progress on this goal.

One local health system's review of data demonstrated that patients enrolled in the HUB for six months or more incurred on average $5,681 less in total charges compared to the six months prior to their referral. For those enrolled more than one year, the average total health care charges was $10,021 less. The total amount saved in health care charges for the group of 137 patients reviewed from January 2019 through June 2020 was $1,155,840.

FREQUENT ER UTILIZATION

SUCCESS STORY

The following is just one example of how a client enrolled in the Frequent ER Utilization program found success with Great Rivers HUB.

John was referred to Great Rivers United Way's Great Rivers HUB program by a health system social worker in October 2021 for help with a variety of health-related needs that had gone unaddressed for several years.

The HUB model is empowering, as it allows clients a choice in which areas, called "Pathways," they want to work on and in which order. John, with help from his assigned CHW, Rachel, has worked to address his dental, vision, and mental health care needs.

One of the most impactful goals John and Rachel have achieved together is getting John a new CPAP mask. His old mask had lost its seal and was causing sores on his face. Rachel was able to access $25 from La Crosse County to purchase a replacement mask, and now John is getting restful nights' sleep that help him feel ready to tackle his other health concerns.

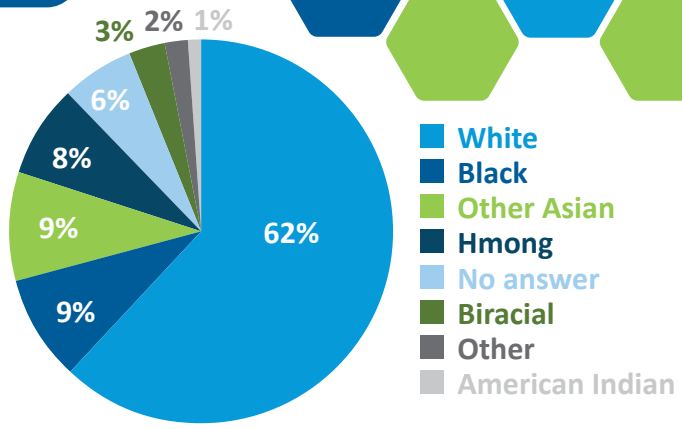
John has had chronic anxiety for as long as he can remember. This has meant that even when he knows where to turn for help with his health, it's difficult for him to advocate for himself. With Rachel's example and support, every healthcare call they've made together has felt easier and easier, and recently, John was able to obtain a new medication he needed on his own.

This Success Story was written with consent following a trauma-informed interview with Great Rivers United Way staff. It has been edited and approved by the client and agency featured. Name(s) have been changed to protect privacy.

HEALTHY BIRTHS & BABIES

28
Births in 2021

98
Served in 2021



Great Rivers HUB has been serving at-risk pregnant women since 2017. Great Rivers HUB's qualifications for this program include: residents of, or individuals who are experiencing homelessness in, La Crosse County who are on Medicaid, and additionally meet one of the following:

- History of or current substance use (to include tobacco and alcohol)
- Person of color/minority ethnic group
- Social determinant of health needs identified

Adults served in 2021 under this program ranged in age from 18 to 41. Children enrolled ranged from new-born to two years old. The goal for those enrolled within this program is to assist them in attending prenatal appointments, provide education on pregnancy and birth, address social determinant needs, and ultimately deliver a healthy baby. After the birth of the baby, Community Health Workers (CHWs) continue to assist in attending postpartum appointments and connect mothers to resources. CHWs help connect these women to transportation, food assistance, clothing, baby needs (such as crib, formula, diapers, etc.), and more.

Top Pathways 2021

Pathway	Initiated	Finished Incomplete	Completed
Social Service Referral	186	27	131
Pregnancy	40	6	28
Postpartum	36	5	24
Housing	23	5	4
Medical Referral	23	3	15
Medical Home	20	1	13

Top Education Topics 2021

Education Topic	Completed
COVID-19 Facts, Safety & Vaccinations	44
Pregnancy/Prenatal	35
Safe Sleep	18
ACEs Module 1 or 2	12
Coping Skills/Emotional Regulation	13
A total of 235 education topics were provided to program participants in 2021.	

Top Social Service Referrals 2021

Social Service Referral Type	Initiated	Finished Incomplete	Completed
Clothing/Baby Items	43	7	33
Car Seat	21	5	14
WIC	18	0	17
Utilities Assistance	17	1	11
Financial Assistance	11	2	7
A total of 131 social service referrals were met in 2021.			

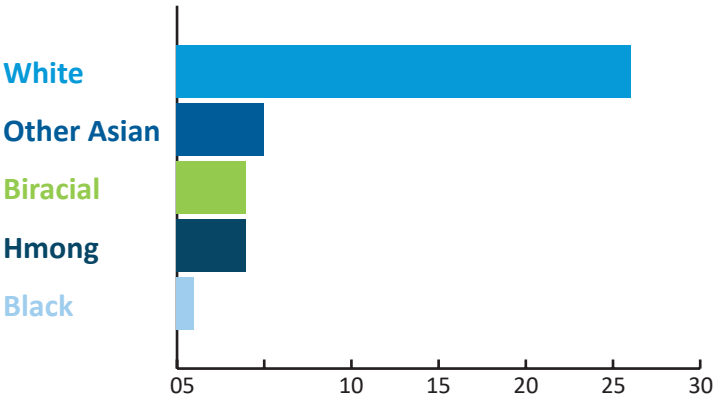
BIRTH OUTCOMES

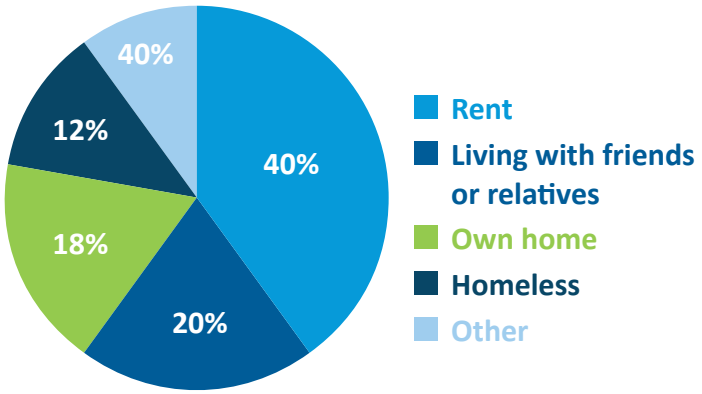
Low birthweight prevention through the HUB model

Low birthweight is one of the top five leading causes of infant deaths in the United States (CDC, 2021). Low birthweight is defined as less than 2,500 grams or 5.5 pounds. According to the March of Dimes (2022), one in 13 babies (7.7%) were low birthweight in Wisconsin in 2020, with black infants being two times as likely as white infants to be born low birthweight. According to the 2021 Compass Now Report, La Crosse County's percent of low birthweight was at 7% (data collection from 2012-18). While low birthweight is a health concern for baby, it is also a major cost to systems of care. According to the United Health Foundation (2022), "The average hospital cost for a low birthweight baby is estimated to be $27,200 and $76,700 for a very low birthweight infant compared with $3,200 for a normal weight newborn. Low birthweight and very low birthweight babies who survive into adulthood often experience serious physical and mental morbidities, significantly increasing the costs of hospitalization throughout their lifespan."

Great Rivers HUB's Healthy Births & Babies program focuses on providing prenatal care coordination in a holistic way to reduce the risk of poor health outcomes, such as low birthweight, by addressing social determinants of health and supporting prenatal care. These populations are higher risk than the general public of which the above data is gathered. This is due to clinical factors contributing to high-risk pregnancies (including substance use and age) and social determinants of health, such as level of education and income.

Forty (40) births have occurred within the program since 2017. Age range for mothers at birth was 18 to 41 years old. Of those mothers, 11 had drug use during the pregnancy, and nine of those 11 also used tobacco during the last three months of pregnancy. Additional information regarding the birthing persons is detailed below.



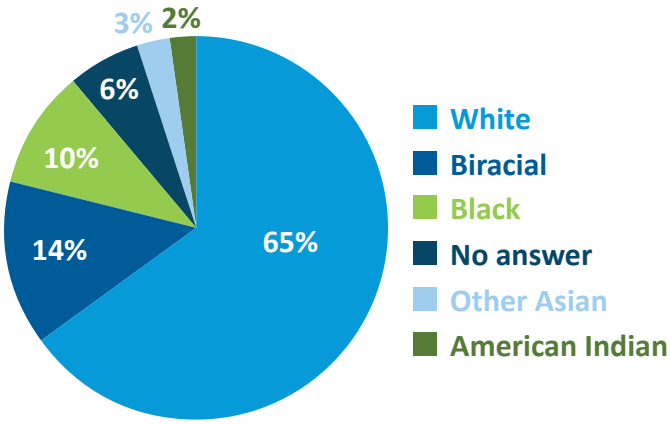


Of the 40 births since 2017 (28 of which occurred in 2021), three births, or 7.5%, were low birthweight. Two of those three low birthweight births were delivered at full term, and both were birthing persons over the age of 35. With all individuals served being high-risk, the HUB considers this rate progress compared to the general public, though work will continue to reduce the percentage of babies born low birthweight. Thirty-two of the 40 infants born were established with a medical home.

The HUB is expanding its work in this program through a partnership with Coulee Health in West Salem. Coulee Health has hired and trained a CHW/Doula position to better serve a diverse range of pregnant individuals with the evidence-based approach of both a doula and CHW. The impact of this position will be explored in next year's Impact Report.

HEALTHY YOUTH & FAMILIES

65
Total Clients Served in 2021



This program serves households with youth. Great Rivers HUB has been implementing this program since Spring 2020, after the HUB's La Crosse County Community Advisory Board identified chronic absenteeism in elementary aged youth as a priority need. The school districts of La Crosse, Onalaska, and Holmen refer into this program. The School District of La Crosse also partners with Great Rivers HUB to serve youth and families in that district who are experiencing homelessness. Community Heath Workers help families get connected to medical providers, address social determinants of health (such as transportation), connect to behavioral health support, and assist parents with navigating issues that may impact youth school attendance. In future Impact Reports, Great Rivers HUB aims to include attendance and academic progress for students enrolled. Those served in 2021 under this program ranged in age from 2 to 54.

Top Pathways 2021

Pathway	Initiated	Finished Incomplete	Completed
Housing	25	1	4
Medical Referral	18	1	4
Medical Home	11	1	2
Tobacco Cessation	18	1	0
Medication Assessment	6	1	1

Top Education Topics 2021

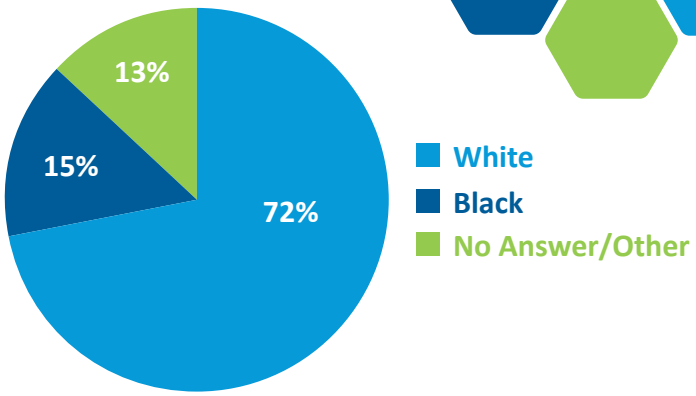
Education Topic	Completed
COVID-19 Facts, Safety & Vaccinations	22
Coping Skills/Emotional Regulation	7
Developmental Milestones	4
ACEs Module 1 or 2	12
A total of 52 education topics were provided to program participants in 2021.	

Top Social Service Referrals 2021

Social Service Referral Type	Initiated	Finished Incomplete	Completed
Clothing Assistance	33	2	23
Community Connection	24	2	21
Food Assistance/Food share	44	2	34
Transportation Assistance	25	4	20
Education Assistance	7	0	7
A total of 199 social service referrals were complete for program participants in 2021.			

HEALTHY HEARTS

60
Served in 2021



Great Rivers HUB has been serving this population since 2019. Qualifications for this HUB program include La Crosse County residents on Medicaid or uninsured who are diagnosed with cardiovascular disease, hypertension, hyperlipidemia, or those eligible for cardiac rehab. This need was identified by Wisconsin's Department of Health Services as part of a statewide effort to address heart health disparities and reduce deaths from heart attacks. This program aims to reduce risks, complications, and barriers to managing and controlling both hypertension and hyperlipidemia. To accomplish this, Community Health Workers (CHWs) support healthy lifestyle change through diet and exercise, and ensure adherence to medication, but often first focus on addressing social determinant of health needs. CHWs also look to engage with providers to help enhance clinical care of patients enrolled in this program. Those served in 2021 ranged in age from 30 to 79.

Top Pathways 2021

Pathway	Initiated	Finished Incomplete	Completed
Medical Referral	40	4	19
Housing	23	0	1
Tobacco Cessation	17	5	0
Medication Assessment	16	1	10
Medical Home	16	1	5

Top Education Topics 2021

Education Topic	Completed
COVID-19 Facts, Safety & Vaccinations	28
Hypertension	22
ACES Modules 1 or 2	18
Diabetes	17
Flu/Flu Vaccine	11
A total of 145 education topics were provided to program participants in 2021.	

Top Social Service Referrals 2021

Social Service Referral Type	Initiated	Finished Incomplete	Completed
Transportation Assistance	20	5	5
Food Assistance	19	3	11
Financial Assistance	9	1	6
Utilities Assistance	8	2	4
ADRC	7	0	4
Community Connection to the Y	3	0	2
A total of 64 social service referrals were completed for program participants in 2021.			

HEALTHY HEARTS

Blood Pressure Improvements

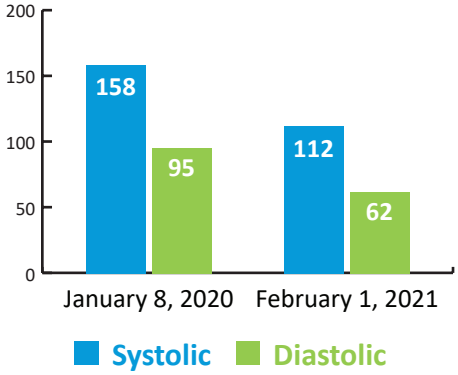
This page demonstrates blood pressure improvements for some enrollees and includes specific pathways completed for those individuals during their enrollment. While these are not the only clients with blood pressure improvements these specifically demonstrate the level of impact possible. Some of these clients engaged in self-monitoring of blood pressure with equipment and coaching providing by the Community Health Worker.

Client A

Enrolled 12/30/19 - 4/29/21

Pathways Completed:

- Medication Assessment
- Hypertension education
- Health Insurance
- Established primary care medical home
- Housing
- Behavioral health care established
- Healthy Change Goals
  - Dash Diet
  - Self-Monitored Blood Pressure
- Dental care
- Vision appointment
- Assistance with clothing & furniture needs

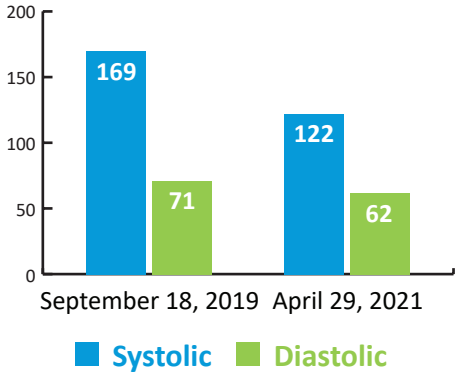


Client B

Enrolled 11/30/19 - 4/30/21

Pathways Completed:

- Heart Health Education
- Established primary care medical home
- Tobacco Cessation
- Healthy Change Goals
  - Self-Monitored Blood Pressure
  - Diet Modifications
  - Exercise

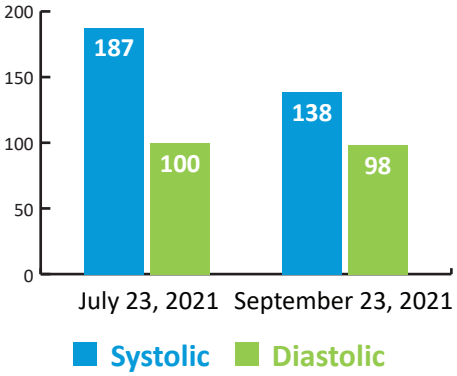


Client C

Enrolled 10/23/20 - present

Pathways Completed:

- Medication Assessment
- Hypertension Education
- Diet & exercise
- Healthy Change Goals
  - Portion control plate
  - Pedometer
  - Dash Diet
  - Self-Monitored Blood Pressure after education & ongoing tracking from CHW

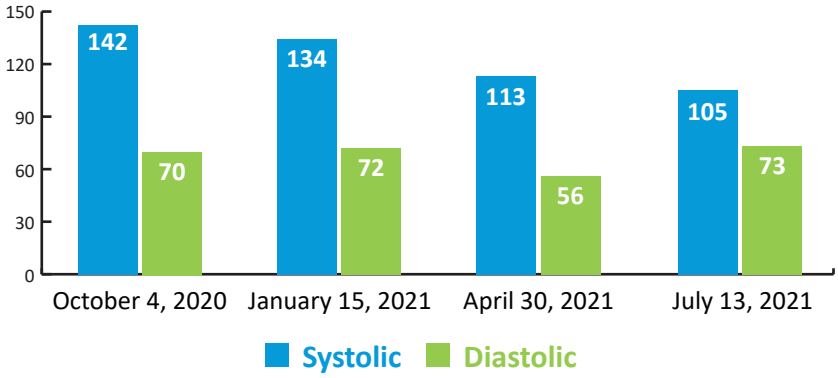


Client D

Enrolled 12/6/19 - 12/28/21

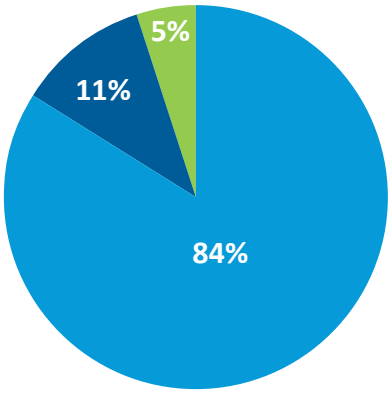
Pathways Completed:

- Housing
- Diet & hypertensive education in addition to other basic health education modules
- Medication Assessment
- Medication Management
- Reduced smoking
- COVID vaccination
- Social Service Referrals for financial assistance & utilities assistance
- Self-Monitored Blood Pressure after education & ongoing tracking from CHW



DIABETES MANAGEMENT

44
Served in 2021



- Of Hispanic, Latino/a, or Spanish origin
- Not of Hispanic, Latino/a, or Spanish origin
- Unknown

Great Rivers HUB has been serving this population since 2019. Qualifications for this HUB program include La Crosse or Trempealeau county residents on Medicaid, or uninsured, who are diagnosed with pre-diabetes or unmanaged type 2 diabetes. This need was identified by Wisconsin's Department of Health Services as part of a statewide effort to address heart health disparities and improve diabetes management. This program aims to reduce risks, complications, and barriers to managing and lowering A1C levels. To accomplish this, Community Health Workers (CHWs) support healthy lifestyle change through diet and exercise, ensure adherence to medications, and address social determinant of health needs. CHWs also look to engage with providers to help enhance clinical care of patients enrolled in this program. The age of participants in this program ranged from 33 to 84. This program contains the most ethnic diversity of all of the HUB's programs, so ethnicity of participants is also reflected above.

Top Pathways 2021

Pathway	Initiated	Finished Incomplete	Completed
Medical Referral	26	1	20
Medical Home	18	0	12
Medication Assessment	12	1	9
Immunization Referral	7	0	7
Housing	8	1	0

Top Education Topics 2021

Education Topic	Completed
Diabetes*	59
COVID-19 Facts, Safety & Vaccinations	21
Flu/Flu Vaccine	10
Quitting Smoking	6
ACEs Module 1 or 2	4
A total of 138 education sessions were provided to program participants in 2021.	

*Diabetes Education Topics include but are not limited to:

- What is Diabetes?
- Foot & Skin Care
- Understanding A1C
- Diet & Exercise

Top Social Service Referrals 2021

Social Service Referral Type	Initiated	Finished Incomplete	Completed
Food Assistance	7	1	4
Transportation Assistance	4	0	3
Legal Assistance	4	0	3
Housing Assistance	3	0	1
Financial Assistance	2	0	2
A total of 37 social service referrals were completed for program participants in 2021.			

DIABETES MANAGEMENT

Diabetes management often requires lifestyle change. Below are topics participants made goals around for healthy lifestyle change. Community Health Workers (CHWs) provided education on the importance of lifestyle change for disease management, coaching on developing achievable goals, and supported participants through the process. Some of these goals are still the process of being worked on, while others have been successfully completed, meaning that the lifestyle change is in the maintenance phase.

Healthy Change Tools		
Program	**Goals Created**	**Goals Successfully Completed**
Heart Health	17	9
Diabetes Management	11	4
ER Utilization	4	1

Together with CHWs, participants had their clinical and social determinant of needs met, were provided basic health education in their language, and worked on lifestyle change. This work resulted in improving insulin compliance, understanding of diabetes diagnosis, and ensuring providers the whole picture of their patient. This works aims to work together to decrease A1C levels. Below is a chart demonstrating A1C decreases in clients enrolled. The chart details A1C measures for 20 clients. Not all enrollees have measures to share. Gaining access to clinical measures such as A1C measures is a goal the HUB is working towards in partnership with local health systems. Some clients listed below only had one A1C measure provided after enrollment and others had two. The last column demonstrates the total decrease in A1C measure from pre-enrollment to during/post-enrollment. Additionally, there were four participants who did not demonstrate a decrease in A1C at the time. Their measures are not included in the chart below.

Healthy Change Tools				
Client	**Referral A1C %**	**1st A1C during HUB Enrollment (3 mo. avg.)**	**2nd A1C during HUB Enrollment (9 mo. avg.)**	**Total Decrease**
Client A	9.1%	8.4%	-	.7%
Client B	9.2%	9%	7.3%	1.9%
Client C	15%	14.7%	14.1%	.9%
Client D	13.7%	13.7%	-	Remained the same
Client E	13.4%	10.5%	11.9%	1.5%
Client F	6.5%	6.5%	-	Remained the same
Client G	6.7%	6.2%	-	.5%
Client H	6.4%	6.3%	-	.1%
Client I	11.5%	8.4%	7.1%	4.4%
Client J	10.4%	9.7%	-	.7%
Client K	10.4%	7.7%	8.3%	2.1%
Client L	10.7%	8.8%	-	1.9%
Client M	7.6%	7%	6.6%	1%
Client N	11.7%	10.2%	7.1%	4.6%
Client O	6.2%	6.1%	-	.1%
Client P	11.5%	8.4%	-	3.1%
Client Q	8.6%	6.5%	-	2.1%
Client R	10.4%	7.7%	-	2.7%
Client S	13.9%	10.5%	-	3.4%
Client T	7.1%	7%	-	.1%

DEMONSTRATED RETURN ON INVESTMENT

The value of a Community Health Worker in terms of impact on health and cost savings has been well documented across the world. Below is research from organizations that have recognized the importance and value of Community Health Workers.

American Public Health Association
"A Community Health Worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."

World Health Organization
"On May 22, 2019, the World Health Assembly recognized that Community Health Workers play an important role in delivering quality primary health care services as part of interdisciplinary teams."

American Diabetes Association
"CHWs can be part of a cost-effective, evidence-based strategy to improve the management of diabetes and cardiovascular risk factors in underserved communities and health care systems."

Center for Medicaid and Medicare;
PDF: Health Care Innovation Awards (HCIA) Meta-Analysis and Evaluators Collaborative, Annual Report, Year 3
"Of six types of innovation components that we evaluated (i.e., used health IT, used Community Health Workers, medical home intervention, focus on behavioral health, used telemedicine, workflow/process redesign intervention), only innovations using Community Health Workers (CHWs) were found to lower total costs (by $138 per beneficiary per quarter)."

Pathways Community HUB Institute (PCHI)
PCHI is the certifying body for all Pathway Community HUB models.
To learn more about the Pathways Community HUB model and review various research studies demonstrating the value of the HUB model and CHWs, please visit: www.pchi-hub.com/resources.

HUB STAFF

LINDSEY PURL, MPH
Director

CHRIS BURKS
Operations Manager

DANIELLE KROZEL, MPH
Clinical Partnerships Manager

LINDSEY SCHWARZ-NICHOLS, CSW
Resource & Health Plan Specialist

GREAT RIVERS HUB

2021 HUB FUNDERS & PARTNERS

MCW MEDICAL SCHOOL | ADVANCING A HEALTHIER WISCONSIN ENDOWMENT

Glendenning Family FOUNDATION

GUNDERSEN HEALTH SYSTEM®

LA CROSSE COMMUNITY FOUNDATION

MAYO CLINIC HEALTH SYSTEM

OTTO BREMER TRUST™

Quartz

WISCONSIN DEPARTMENT of HEALTH SERVICES

aptiv SERVICES FOR PEOPLE WITH DISABILITIES

Coulee Health spine & bodyworks

IFC Family & Children's Center

ILR Independent Living RESOURCES

1851 LC LA CROSSE COUNTY Health Department Nationally Accredited

St. Clare Health Mission

the YMCA

United Way