GREAT RIVERS HUB

2022 IMPACT REPORT

HIGHLIGHTS & ACHIEVEMENTS IN 2022

GREAT RIVERS HUB / AN INITIATIVE OF GREAT RIVERS UNITED WAY
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DIRECTOR'S WELCOME

Great Rivers HUB Partner,

In this, the third edition of the Great Rivers HUB's (HUB) annual Impact Report, we hope to provide an enhanced understanding the impact of the Pathways Community HUB model within our community. The HUB's work bridges the gap between clinical health and social determinants of health for individuals to improve their health and well-being. This holistic framework leverages Community Health Workers (CHWs) who bring a culturally competent, person-first approach to addressing health inequity.

This past year has been one of significant growth. Great Rivers HUB continued its work in both La Crosse and Trempealeau counties while also working towards expansion in Jackson and Monroe counties, which is planned for 2023. Great Rivers HUB also added an additional evidence-based program, Care Transitions Intervention (CTI), which includes the addition CTI Coach Sashae Silas to our team. More on this program can be found on pages 19-20.

In 2022, Great Rivers HUB has also focus on the expansion and support of the CHW workforce both locally and across the state. Great Rivers HUB secured funding to support local expansion of CHWs, had its own staff certified to provide CHW Core Competency training, and is part of a statewide HRSA grant award to certify CHW training, increase the number of trained CHWs, and build an apprenticeship program in Wisconsin. Great Rivers HUB also participated as a pilot site with the national common indicators group. This work was to utilize common indicators designed to evaluate the impact of CHW work. In addition to these larger initiatives, Great Rivers HUB continued to see success within our various programs, which are outlined in the pages that follow.

We continue to be an advocate both regionally and at the state level for improved health equity, support for the CHW workforce, and to ensure measurable outcomes are achieved for those at greatest risk for poor health.

As for our impact, it is our hope that this report demonstrates the value that both CHWs and the Pathways Community HUB model brings to our community.

Thank you for your continued support,

Lindsey Purl
Director, Great Rivers HUB
Great Rivers United Way

TABLE OF CONTENTS

CHW WORKFORCE EXPANSION

"Our CHW is truly a Godsend, we appreciate all the help she has given us." – HUB Client

None of the work outlined in this report would be possible without the Community Health Workers (CHW) connected to Great Rivers HUB. According to the American Public Health Association, CHWs are front-line public health workers that have a unique understanding of the community they serve. It is this unique understanding that allows for trust to quickly build between a CHW and the individuals they serve.

All CHWs connected to the HUB have received C3 Core Competency training, Pathways Community HUB model training, and training for documenting in the HUB's database, Care Coordination Systems (CCS). Each of these CHWs are hired by partnering agencies. Their experience and background range widely, each leveraging their own experiences to provide trauma-informed and holistic care to the individuals they serve. Great Rivers HUB is an advocate for ensuring any CHW position, whether or not the position is partnered with the HUB or includes a validated C3 Core Competency training. This is why we: 1) have invested in the HUB becoming a validated training site, and 2) are partners on the HRSA grant supporting CHW training standards in Wisconsin.

At the end of 2022, Great Rivers HUB had 12 FTE CHWs that were either trained or in the process of completing training.

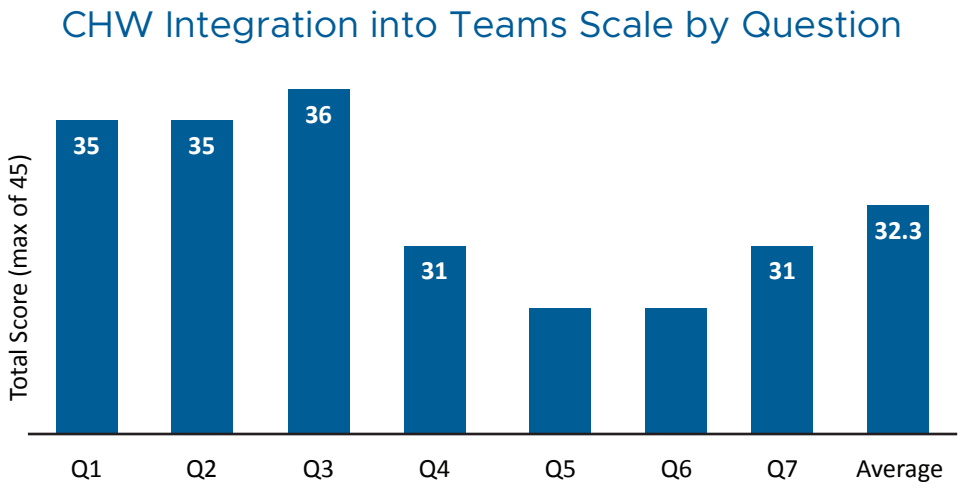
COMMON INDICATORS DATA COLLECTION & CARE TEAM INTEGRATION

The Common Indicators (CI) Project is focused on identifying key indicators for collecting data to demonstrate Community Health Worker (CHW) impact and workforce support. Great Rivers HUB served as a pilot site for Wisconsin to implement several common indicators from 2021 through 2022.

In 2022, Great Rivers HUB piloted five of 12 total indicators with its network of CHWs. This work has been supported by CI Project staff and staff from Wisconsin's Department of Health Services. These indicators are being embedded in many of the HUB's data collection processes. One of these indicators is specifically focused on CHW integration into care teams. As the CHW workforce expands locally, this will continue to become an area the HUB hopes to continue to build opportunities for to enhance patient care. The results from 2022, which demonstrate progress towards this goal, are included in this report.

The data below is representative of one of the specific indicators that measures the CHW's integration into clinical teams. This data collection was conducted with Great Rivers HUB CHWs and the analysis was provided by the CI Project team. See citation on the following page for details.

CHW Integration into Teams (Indicator #5)
For Indicator #5, all 9 CHWs completed a 7-question assessment on the extent to which they felt integrated into their teams as CHWs. Each question had 5 options that can be placed on an ordinal scale with 1 representing the least integration and 5 representing full integration. No CHW surveyed selected the lowest score option for any of the 7 questions. When looking at individual questions in the assessment, the maximum possible total score for each question was 45 (9 respondents multiplied by a max score of 5). Totals for each question can be viewed in the bar chart below with scores ranging from 29 (64% of max score) to 36 (80% of max score) for individual questions. The average question score was 32.3 (72% of max score).



COMMON INDICATORS DATA COLLECTION & CARE TEAM INTEGRATION

If we calculate an average 1-5 score for each question, we can see that each question's average score falls between 3 and 4, which would indicate a moderate to good level of CHW integration into teams. The distance between each step in the ordinal scale of team integration from 1 to 5 cannot be assumed to be equal, so making assumptions based on averages could be somewhat misleading. These data will be most powerful once they can be collected multiple times and compared over time to track increases or decreases in scores for individual questions and complete assessments, which can inform the team integration work of CHW Employers. Additionally, once these data are collected across multiple organizations, we will be able to identify common scores on the assessment that organizations can use to benchmark themselves against peers. Current responses can be reviewed in GRH team meetings, which could prompt discussion from CHWs and others on the teams about what if anything can be improved.

In addition to the 7 questions on team integration based upon their role as a CHW, the 9 CHWs surveyed also responded to 4 questions about how they felt their race/ethnicity impacted their team integration. Each question had 5 options that can be placed on an ordinal scale with 1 representing race/ethnicity having a significant negative impact on team integration and 5 representing no impact. No CHW surveyed selected the lowest two options for any question. The maximum possible total score for individual questions with 9 respondents was 45. Total scores ranged for individual questions from 40 (89% of max score) to 43 (96% of max score) for individual questions. The average question score was 41.8 (93% of max score).

The maximum possible total score for individual respondents on the scale is 20. Across the 9 respondents, the scores ranged from 16 (80% of max score) to 20 (100% of max score) with an average of 18.6 (93% of max score), which indicates the surveyed CHWs felt that their race/ethnicity had little to no impact on their team integration. Cultural congruence between supervisors and CHWs may have contributed to this finding.

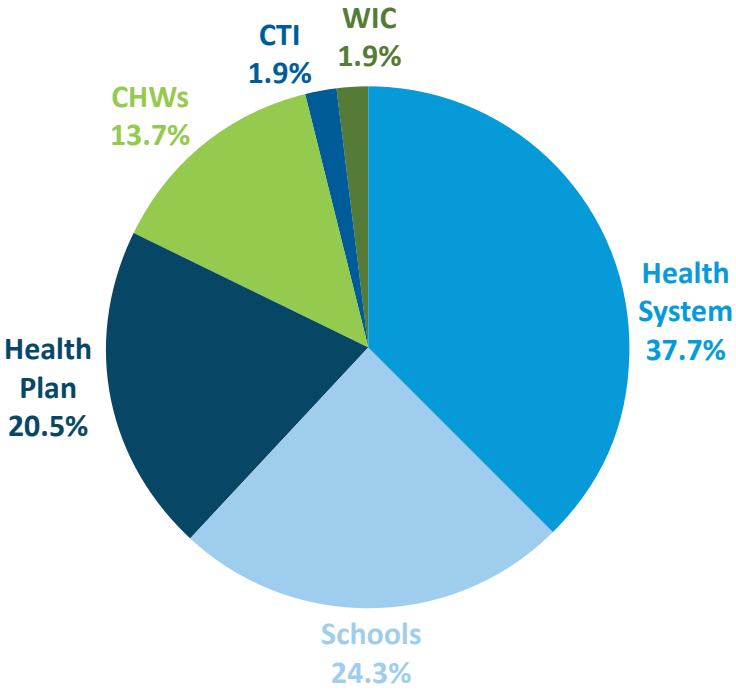
Finally, the 9 CHWs were asked 4 individual questions related to team integration that are not part of a larger scale. The first question asked CHWs about the extent to which their team understood their work. Responses for this question can be placed on an ordinal scale from 1 to 5 with 1 representing no understanding and 5 representing full understanding of the CHWs work. All 9 responses fell between 2 and 4 on the scale with a median score of 3 (some understanding). CHWs were also asked about their comfort, asking other tea members about participant needs. Responses could be placed on a similar 1 to 5 scale with 1 representing no comfort and 5 representing full comfort. Responses ranged from 2 to 5 on the scale with a median score of 4 (a lot of comfort). Finally, CHWs were asked if they had access to their employer's main participant record data system and if they had an adequate, dedicated workspace. Eight of 9 of CHWs surveyed reported having data system access and all 9 CHWs reported access to an adequate, dedicated workspace.

Citation: *Developing Common Indicators to Advance The Community Health Worker Workforce: 2021-2022 Year End Report. Primary Author: Tommy English. Secondary Authors include: Victoria Adewumi, Pennie Jewell, Keara Rodela, Kenneth Maes, Susan Mayfield-Johnson & Noelle Wiggins.*

2022 CLIENT OVERVIEW

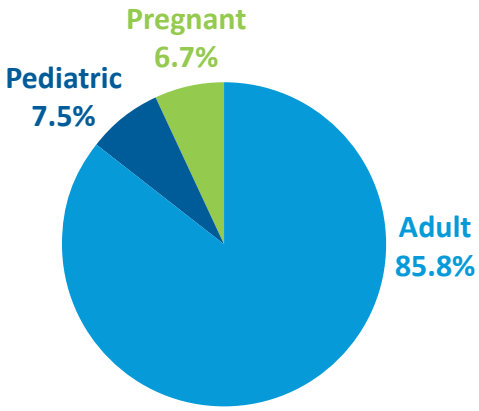
225
Served
in 2022

263
Referrals
(see chart)

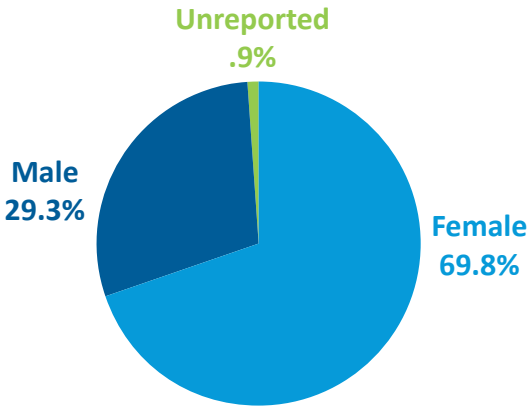


Demographics

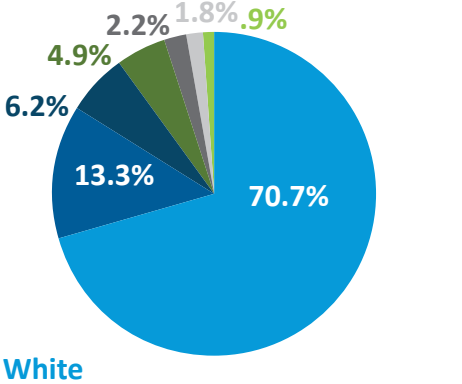
Client Types Served



Client Gender

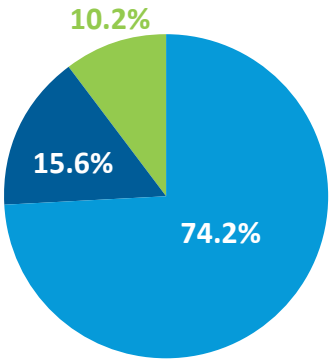


Adult Reported Race



- White
- Black
- Unreported
- Biracial
- Other
- American Indian or Alaskan Native
- Hmong

Adult Ethnicity



- Not of Hispanic Latino/a or Spanish Origin
- Of Hispanic Latino/a or Spanish Origin
- Unreported

MEASURING SUCCESS

The Pathways Community HUB model utilizes standardized and evidence-based outcomes, called Pathways, to measure success in various areas for each client served. Each completed Pathway represents a measure that is known to reduce the risk of poor health outcomes.

Below is a table of Pathways identified for clients in 2022. This table includes Pathways that were still being worked on as of December 31, 2022 (open), those unable to reach measured success point (incomplete), and those that reached successful risk reduction (completed). Additionally, the program areas in this report each outline the top Pathways worked on by program to help illustrate barriers/gaps, and areas of success, for each population focus.

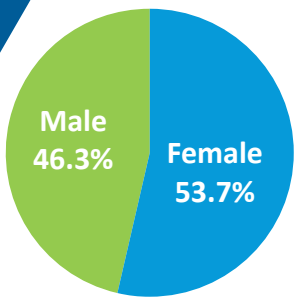
Pathway	Open as of 12/31/22	Incomplete	Completed
Adult Learning	2	0	1
Behavioral Health	7	3	18
Education	6	0	325
Employment	5	2	7
Family Planning	2	0	1
Health Insurance	12	0	2
Housing	26	3	21
Immunization Referral	0	0	6
Medical Home	46	1	17
Medical Referral	21	4	55
Medication Assessment	9	2	11
Medication Management	0	0	1
Postpartum	4	1	10
Pregnancy	10	1	14
Social Service Referral	147	23	793
Tobacco Cessation	41	1	2
TOTAL	**338**	**41**	**1,284**

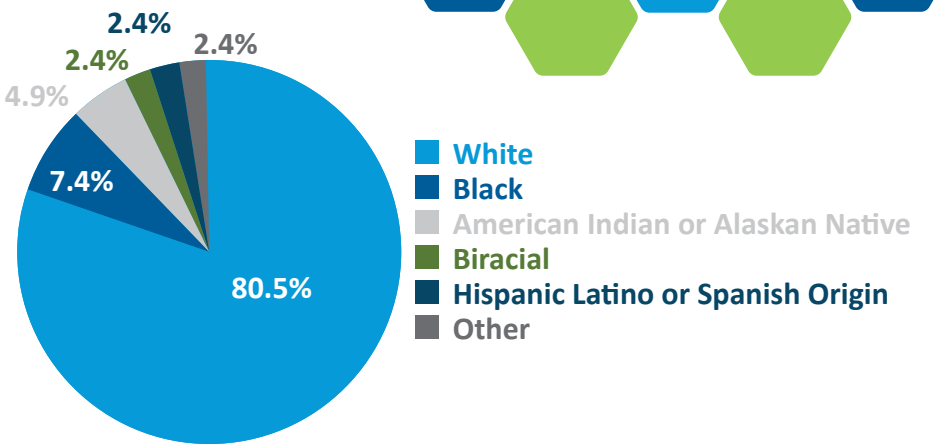
Great Rivers HUB partnering CHWs also track several other metrics to demonstrate impact, such as the PHQ-9. This is a validated depression screening tool. Each month, when CHWs meet to do a needs assessment, part of that assessment includes a PHQ-2 (two question screening). If an individual answers “yes” to one or both questions, that automatically populates a PHQ-9 for the CHW to complete with the individual.

A total of 189 PHQ-9 screenings were administered to 104 individuals in 2022. Of those, 41 individuals (or 39% of the total) had a PHQ-9 triggered more than one time. Fifty-six percent of those screened more than once improved their PHQ-9 score over their time with a CHW.

FREQUENT ER UTILIZATION

41
Served
in 2022





Great Rivers HUB's initial launch was focused solely on serving individuals frequenting the emergency room (ER) in La Crosse County.

This program's qualifications are for individuals who have visited the ER a minimum of twice in the last 30 days or four times in the last 12 months, and a maximum of 12 visits in the last 12 months. The general goals for individuals enrolled in this program are to: assist in meeting health needs, increase primary care utilization, and address social determinants of health needs. In addition to this work, CHWs provide basic health education, such as when it is appropriate to go to the ER versus primary care.

Frequent ER Utilization Pathways			
Pathway	**Open as of 12/21/22**	**Incomplete**	**Completed**
Adult Learning	1	-	-
Behavioral Health	-	2	2
Education	-	-	91
Employment	1	-	3
Family Planning	1	-	-
Health Insurance	1	-	1
Housing	7	-	3
Medical Home	4	-	2
Medical Referral	9	2	8
Medication Assessment	1	-	2
Social Service Referral	34	6	127
Tobacco Cessation	6	1	-
TOTAL	**65**	**11**	**239**

FREQUENT ER UTILIZATION

Top Education Pathways	
Education Module	**Modules Completed**
Appropriate Use of the Emergency Room	12
ACEs & Resilience	12
Coping Skills/Emotional Regulation	12
Depression	11
Quitting Smoking	6

Top Social Service & Medical Referral Needs Identified	
Social Service Need	**Medical Referral Need**
Transportation	Dental
Food Assistance/Foodshare	Other
Housing Assistance/WERA	Specialty Medical Care
Clothing	Mental Health
Financial Assistance	COVID Testing & Vaccination

CLIENT SUCCESS STORY

An individual was referred to the HUB at the beginning of December 2022. The individual had an accident that caused them to be seen at the ER multiple times. They were uninsured and had recently lost employment.

At their first meeting, the CHW was able to connect the client with a representative from Western Region for Economic Assistance over the phone and start the applications for BadgerCare and Foodshare. The client also received an application for the jeans day fund to assist with an expensive medication.

The CHW assisted the client in filling out and submitting the applications for BaderCare and Foodshare. The client was approved for both programs effective January 3. The CHW was able to confirm for client that Badger-Care benefits were back dated to November 2022, which meant the costs associated with their accident would be covered.

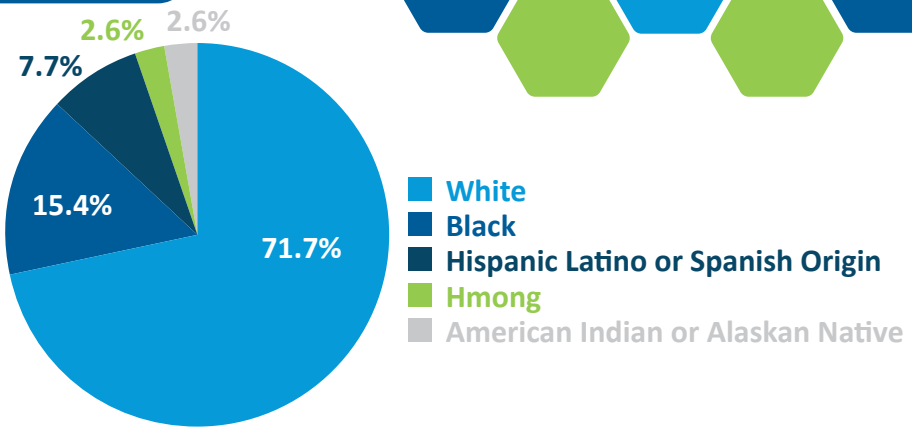
With those barriers navigated, the client was able to focus on regaining employment. The client does not have access to internet at their home, so the CHW and client went to the La Crosse Public Library, where the CHW assisted the client in getting a library card so that they could access the Workforce Connections website.
As a result, the client started building a resume and applying for jobs.

In just over a month of working with a CHW, the client received insurance benefits, Foodshare, funds for a bus pass, monthly food delivery from WAFER Food Pantry, education on proper use of the ER, and started their job hunt.

HEALTHY BIRTHS & BABIES

17
Births in 2022

39
Served in 2022



Great Rivers HUB has been serving at-risk pregnant women since 2017. Great Rivers HUB's 2022 qualifications for this program included residents of or individuals experiencing homelessness in La Crosse or Trempealeau counties who are on Medicaid or are uninsured and additionally meet one of the following:

- History of or current substance use
- Person of color/ethnic group
- Social determinant of health needs identified

The goal for those enrolled in this program is to ensure connection to prenatal care, provide basic health education on pregnancy, birth and postpartum, address social determinant of health needs, and ultimately deliver a healthy baby. After the birth of the baby, CHWs continue to assist in supporting postpartum and well-baby visits and connecting to other resources to ensure the family continues to be healthy.

Healthy Births & Babies Pathways			
Pathway	**Open as of 12/21/22**	**Incomplete**	**Completed**
Adult Learning	1	-	1
Behavioral Health	1	-	1
Education	2	-	113
Employment	1	-	1
Family Planning	1	-	1
Health Insurance	4	-	-
Housing	7	-	4
Medical Home	8	1	1
Medical Referral	2	-	10
Medication Assessment	3	-	-
Postpartum	7	-	9
Pregnancy	11	1	12
Social Service Referral	40	2	151
Tobacco Cessation	7	-	-
TOTAL	**94**	**3**	**299**

HEALTHY BIRTHS & BABIES

Top Education Pathways	
Education Module	**Modules Completed**
Pregnancy	43
ACEs & Resilience	12
Baby Development	10
Depression	8
Coping Skills/Emotional Regulation	6
Quitting Smoking	4

Top Social Service & Medical Referral Needs Identified	
Social Service Need	**Medical Referral Need**
Clothing/Baby Items	Other
Transportation	Primary Care
Food Assistance/Foodshare	Well Child Visit
Utilities Assistance	Dental
Financial Assistance	

CLIENT SUCCESS STORY

A client referred to the HUB had recently moved to the area from out of state with two young children with high needs. The client was pregnant and living in a hotel with her partner and children. Some of the biggest barriers she faced were transportation to prenatal appointments and not having care for her children while she attended them.

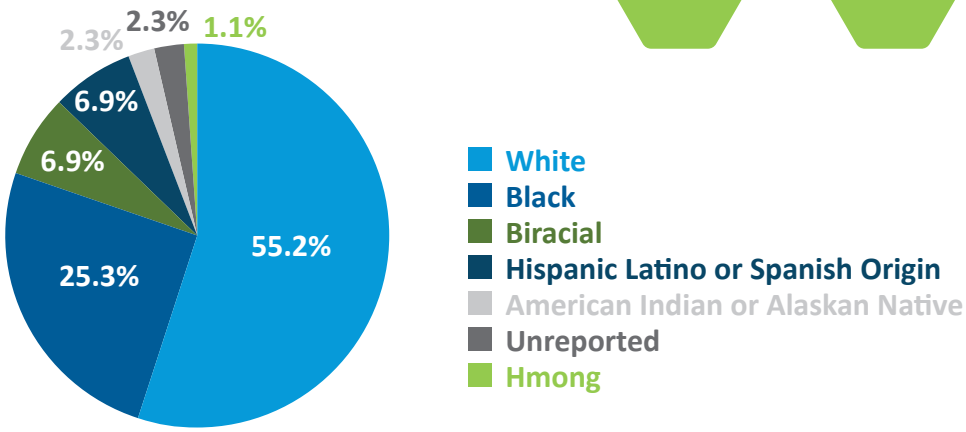
The CHW was able to transport the client to her prenatal appointments as they worked together on transportation resources available in the community. Through this process, the CHW built a trusting relationship with the client and started to attend the prenatal appointments with the client to support them in advocating for themselves, and to help with the two young children who had to attend the appointments with Mom.

This client's biggest success was the birth of a healthy baby at a normal birthweight.

"Our CHW/Doula was very considerate, patient, thoughtful, and informative. We can't imagine how things would've been without her techniques, support, and knowledge. She had our best intentions at hand, and [I] felt so assured that she would uphold our birthing plan."
– HUB Client

HEALTHY YOUTH & FAMILIES

87
Total Clients Served in 2022



The Healthy Youth & Families program was started after stakeholders in La Crosse County identified the need to work with elementary-aged youth, especially around chronic absenteeism, in 2019. The program was implemented in Spring of 2020, and has since expanded to various school districts in La Crosse County. Additional counties will be added in 2023.

In 2022, the school districts of La Crosse, Onalaska, and Holmen were referred into this program. The School District of La Crosse also partners with Great Rivers HUB to serve youth and families in the district who are experiencing homelessness. CHWs help families and individuals in this program get connected to medical providers, address social determinants of health, connect to behavioral health support, and assist parents with navigating issues that may impact school attendance.

Healthy Youth & Families Pathways			
Pathway	**Open as of 12/21/22**	**Incomplete**	**Completed**
Behavioral Health	3	-	6
Education	-	-	46
Employment	3	1	2
Health Insurance	8	-	1
Housing	10	2	11
Medical Home	20	-	7
Medical Referral	5	-	13
Medication Assessment	2	1	3
Postpartum	1	-	-
Pregnancy	-	-	2
Social Service Referral	59	7	402
Tobacco Cessation	7	-	-
TOTAL	**118**	**11**	**493**

HEALTHY YOUTH & FAMILIES

Top Education Pathways	
Education Module	**Modules Completed**
Coping Skills/Emotional Regulation	10
ACEs & Resilience	6
Quitting Smoking	6
Financial Literacy	4
Attendance	3

Top Social Service & Medical Referral Needs Identified	
Social Service Need	**Medical Referral Need**
Food Assistance/Foodshare	Primary Care
Clothing/Baby Items	Mental Health
Financial Assistance	COVID Testing & Vaccine
Transportation	Dental
Housing Assistance/WERA	Vision

A mother and daughter who had moved to La Crosse from Saint Paul, MN, were living in an area hotel when referred to Great Rivers HUB. When the CHW connected with the client, the family needed financial assistance for the hotel they were living in.

The CHW assisted the client in filling out a WERA application though Couleecap to help keep the family in the hotel. Then, the CHW and the client started working towards the client's other goals, which included finding affordable housing, establishing a medical home in La Crosse, and attaining reliable transportation for her daughter to attend school.

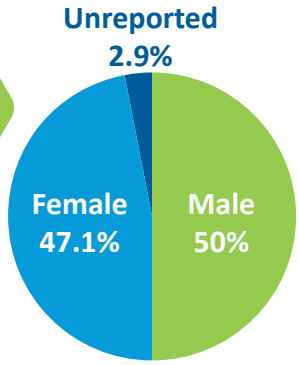
The client identified that one of her barriers was the stress of filling out applications. Over the course of the next two months, the CHW worked alongside the client in filling out applications for Section 8 housing. This turned out to be a stressful time for the client, but the CHW was there to help the client navigate the unexpected barriers that came up while waiting for Section 8 approval.

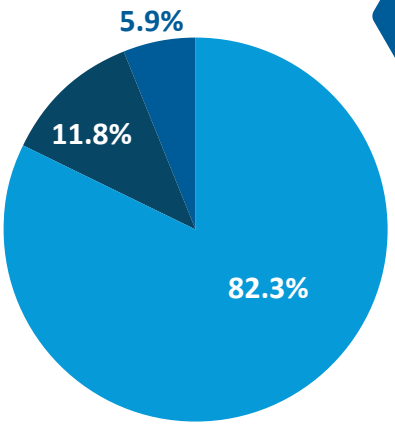
Once approved, the CHW worked with the client to identify the things she would need to move. Since the family had been staying in a hotel, they were in need of furnishings for their new apartment. The CHW was able to connect the family with local resources, such as The Exchange, where they were able to get furniture. The expense of moving left the family with few resources to celebrate the upcoming Christmas holiday. Through community donations, the CHW was able to surprise the family with a Christmas tree and lights so they could enjoy the holiday in their new home.

"Through January 4, 2023, we have identified 140 students as experiencing homelessness. Last school year, we identified 162 in total. In regard to the impact that our Community Health Workers have had on our work... the data tells a powerful story of the need that our students and families who are experiencing homelessness face, but more than the numbers, we know that the partnership with Great Rivers HUB and the YMCA Community Health Workers has been invaluable. The Community Health Workers work in partnership with students, families, and staff, and are truly helping navigate systems and making a difference for students and families. They have been an incredible asset to our team and have certainly helped us serve our students experiencing homelessness in more efficient and better ways."
– Alicia Place, Community Services Coordinator, School District of La Crosse

HEALTHY HEARTS

34
Served in 2022





- White
- Hispanic Latino or Spanish Origin
- Black

Great Rivers HUB has been serving this population since 2019. Qualifications for this HUB program include those 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 (DHS) 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 2022 ranged in age from 31 to 79.

Healthy Hearts Pathways

Pathway	Open as of 12/21/22	Incomplete	Completed
Adult Learning	-	-	-
Behavioral Health	-	1	-
Education	-	-	55
Employment	-	-	1
Family Planning	-	-	-
Health Insurance	-	-	-
Housing	-	-	1
Medical Home	6	-	1
Medical Referral	1	1	9
Medication Assessment	3	1	2
Postpartum	-	-	-
Pregnancy	-	-	-
Social Service Referral	8	3	75
Tobacco Cessation	2	-	1
TOTAL	**20**	**6**	**145**

Top Education Pathways

Education Module	Modules Completed
Hypertension	13
Coping Skills/Emotional Regulation	9
Depression	6
ACEs & Resilience	4
Quitting Smoking	3

Top Social Service & Medical Referral Needs Identified

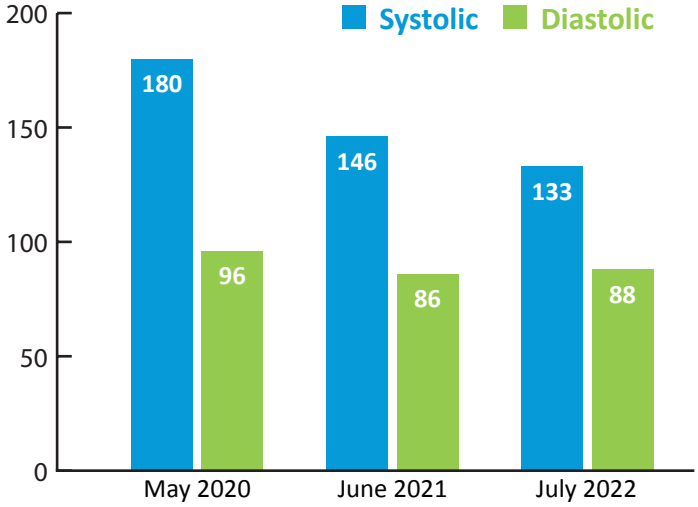
Social Service Need	Medical Referral Need
Transportation	Dental
Financial Assistance	Primary Care
Utilities Assistance	Mental Health
Food Assistance/Foodshare	Free Clinic Visit
Lifestyle-Community Connection	COVID Testing & Vaccination

HEALTHY HEARTS

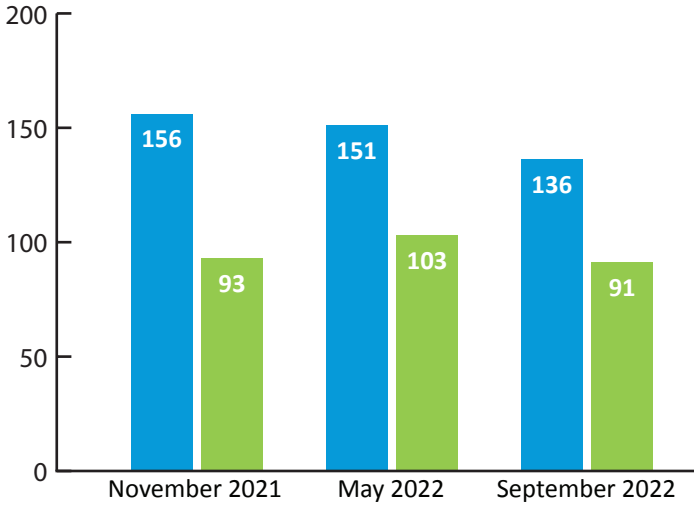
Program Metrics

This page demonstrates blood pressure improvements for some enrollees in the Healthy Heart program. The data also 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.

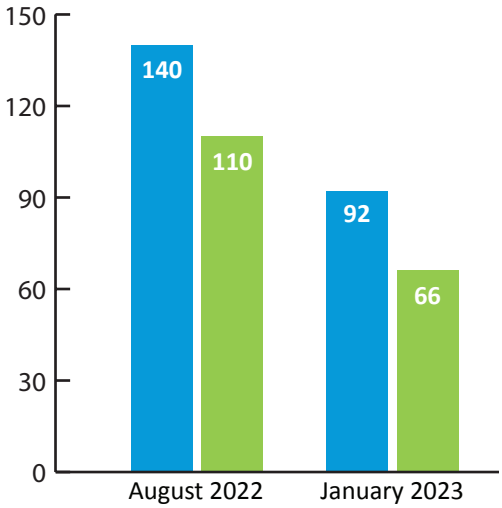
Client A Enrolled 5/29/20 - Present
Pathways & Tools Completed:
- Care protocol Education
- Medical Home
- Medication Assessments
- Utilized Self-Monitor Blood Pressure (SMBP)
- Housing
- Medical Referral
- Healthy Change Tool



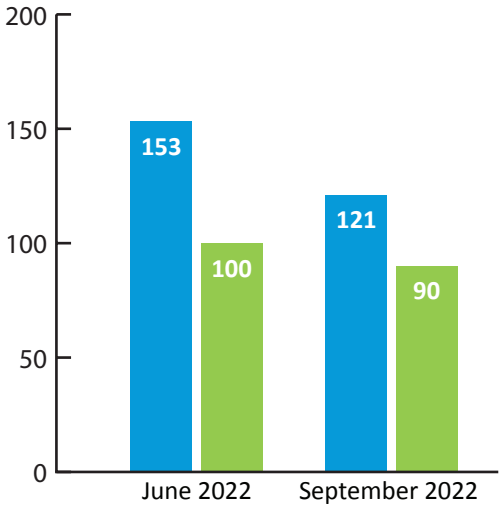
Client B Enrolled 11/1/21 - 6/6/22
Pathways & Tools Completed:
- Protocol Based Education
- Social Service Referrals:
  - Transportation
  - Smoking Cessation Pathway



Client C Enrolled 8/29/22 - Present
Pathways & Tools Completed:
- Protocol Based Education
- Social Service Referrals:
  - Transportation
  - Utilities
  - ADRC
  - Food Assistance

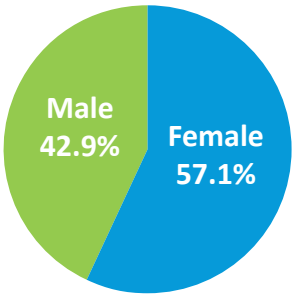


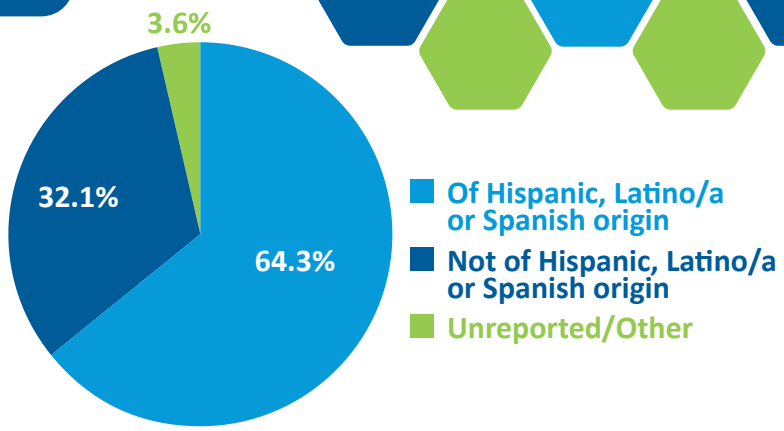
Client D Enrolled 6/14/22 - Present
Pathways & Tools Completed:
- Protocol Based Education
- Social Service Referrals:
  - Job Assistance
  - Volunteer Opportunities



DIABETES MANAGEMENT

28
Served in 2022





Great Rivers HUB has been serving this population since 2019. Qualifications for this program include those 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 health disparities and improve diabetes management. The 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 determinants of health needs. CHWs also look to engage providers to enhance clinical care of patients enrolled in this program. The age of participants in this program ranged from 34 to 80. This program contains the most ethnic diversity of all the HUB's programs, so ethnicity of participants is also reflected above.

Diabetes Management			
Pathway	**Open as of 12/21/22**	**Incomplete**	**Completed**
Adult Learning	-	-	-
Behavioral Health	-	-	-
Education	2	-	27
Employment	-	1	1
Family Planning	-	-	-
Health Insurance	-	-	-
Housing	-	-	1
Immunization Referral	-	-	6
Medical Home	2	-	4
Medical Referral	1	1	5
Medication Assessment	3	1	2
Postpartum	-	-	-
Pregnancy	-	-	-
Social Service Referral	2	-	41
Tobacco Cessation	1	-	-
TOTAL	**11**	**3**	**87**

Top Education Pathways	
Education Module	**Modules Completed**
Diabetes Management Education	20
Diet/Exercise	4
Quitting Smoking	3
COVID 19	2

Top Social Service & Medical Referral Needs Identified	
Social Service Need	**Medical Referral Need**
COVID 19 Home Test Kits	Free Clinic Visit
Medication Assistance	Vision
Transportation	
Clothing Assistance	
Food Assistance/Foodshare	

DIABETES MANAGEMENT

A1C Improvement Charts

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

Healthy Change Tools			
Program	**Goals Created**	**Goals Successfully Completed**	**Lifestyle Change**
Diabetes Management	18	15	Exercise, Diet, Stress, Smoking Reduction
Heart Health	3	1	Coping Skills, Diet, Exercise

Together with CHWs, participants had their clinical and social determinant of health needs met, were provided basic health education in their first language, and worked on lifestyle change. This work resulted in improving insulin compliance, understanding diabetes diagnosis, and ensuring providers had the whole picture of their patient. This work aims to support reduction in A1C measures. Below are charts for various clients demonstrating the A1C reduction throughout their enrollment in the HUB.

Client A	
Date	**A1C %**
11/19/21	15%
3/2/22	9.4%
4/6/22	-
7/19/22	-
8/3/22	-

Client B	
Date	**A1C %**
1/29/21	11.5%
3/2/21	8.4%
9/1/21	9.5%
11/3/21	7.1%
2/2/22	7%
9/7/22	7.1%

Client C	
Date	**A1C %**
6/1/21	10.8%
1/5/22	10.1%
7/6/22	8.8%
9/7/22	8.1%
12/8/22	7.7%

Client D	
Date	**A1C %**
12/1/21	12.3%
2/2/22	12.1%
5/4/22	8.2%
8/2/22	8.9%

An individual was referred to the HUB for Diabetes Management. At the time of referral, the client's main goal was to start making changes to their health. One of their biggest concerns was still being able to eat culturally-significant foods. Their CHW, who is from the same cultural background, was able to understand the importance of this concern. Using education provided by the HUB and their own lived experience, the CHW provided the client with education and assisted them in making a healthy change to their diet that allowed the client to make healthier choices, while keeping foods important to their culture at the center. This interaction helped the CHW build trust with the client and allowed the CHW to introduce additional health education. The CHW has since provided tobacco cessation education to the client. Since working with the CHW the client has quit smoking and their A1C has decreased from 11.0 to 7.0.

CARE TRANSITION INTERVENTION

History

Care Transitions Intervention®, previously the Coleman model, has been researched through random control trails and proven to reduce readmission rates in various populations. This model was based on Dr. Coleman's experience as a primary care provider and therefore started with end user as the focus – complex patients going in and out of the hospital.

The Care Transitions Intervention®

The Care Transitions Intervention® (CTI) is an evidence-based, short-term model that complements a systems' care team by activating patient engagement in their health management. During a 30-day program, clients with complex care needs (and/or family caregivers) will work with a Transitions Coach®, to build self-management skills that will ensure their needs are met during the transition from hospital to home. This intervention is comprised of a five (5) encounters: a hospital visit (when possible), a home visit, and three (3) follow-up phone calls after the home visit has occurred. Uniquely critical to the program is the role of the Transitions Coach®. Transitions Coaches® immediately tap into what motivates and matters to the patient and puts them in the driver's seat to navigate through personal skill development. Through the guidance of a Transitions Coach®, patients will identify a 30-day goal, practice skills, and gain confidence in four key areas of health, known as the Four Pillars®:

- Medication self-management: Client/family caregiver is knowledgeable about medications and has a medication management system.
- Use of a patient-centered record: Client/family caregiver understands and utilizes the Personal Health Record (PHR) to facilitate communication and ensure continuity of care across providers and settings.
- Primary Care and Specialist Follow Up: Client/family caregiver schedules and completes follow-up visit with the primary care physician and/or specialist physician and is prepared to be an active participant in these interactions.
- Knowledge of Red Flags: Client/family caregiver is knowledgeable about indicators that suggest their condition is worsening and has an action plan about how to respond.

The Transitions Coach® empowers the client and/or family caregiver to develop self-care skills that help them assume a more active role in their health. Transitions Coaches® model and facilitate new behaviors, guide a patient on Skill Transfer® opportunities, and practice communication strategies. Further, they build patients' confidence to successfully respond to common problems that arise during care transitions.
https://caretransitions.health/about

An additional component of CTI is to have the patient set a goal that he/she would like to work towards meeting within the 30-days. There is no pressure on the patient for completing the goal in 30 days, but working toward meeting that goal is ideal.

CARE TRANSITION INTERVENTION

For example, the CTI Coach worked with a client that set their goal as being able to work out more. The client started working toward this goal by taking walks everyday while it was warm out. Once winter hit, the client wanted to utilize a gym to continue working out. The CTI Coach connected with a partner from the YMCA and was able to connect the client with a 3-month YMCA membership to get them started. The client was very happy about the news and stated,

"I'm very happy I got connected with you, I have been trying for months to get a YMCA membership and things did not work out as I planned. Thank you for all the hard work that you do, and I really appreciate you going above and beyond to get me this membership".

Below are the number of referrals received for the program in 2022, those referrals that chose to participate, and those who had successfully completed or were still enrolled in the program by December 31, 2022.

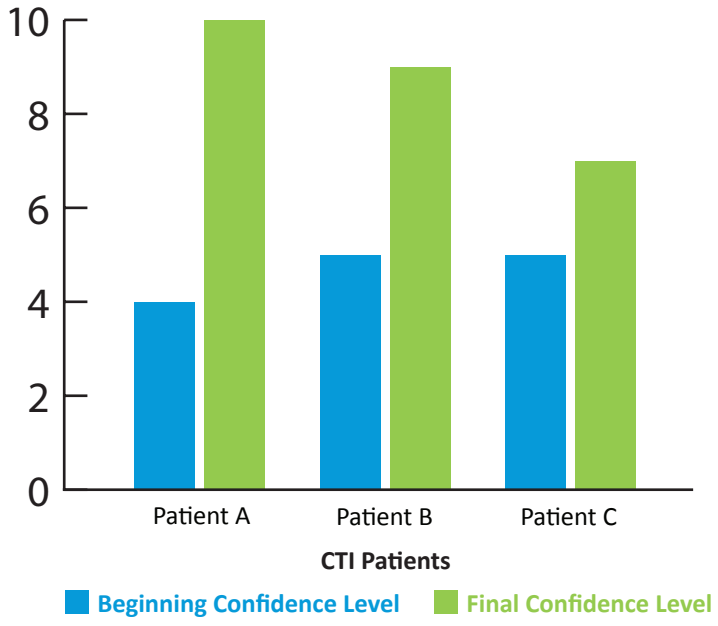
8 CTI Referrals

5 Patients Participated

3 Successfully Completed

2 Currently Enrolled

During each intervention, the CTI coach conducts a Patient Activation Assessment (PAA) to measure confidence levels to manage their own care. The graph below depicts patients' confidence levels at the start of CTI and then upon completion the 30-day intervention. The blue bar represents the beginning confidence level on a scale from 0 to 10, and the orange bar represents the final confidence level upon completion of the 30-day intervention.



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GREAT RIVERS HUB

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St. Clare Health Mission

the YMCA

United Way