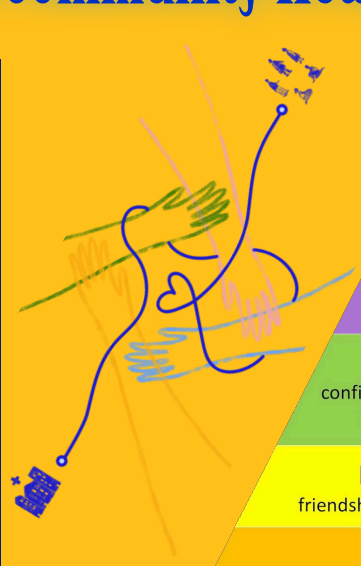
USD 257 Iola
School-Based Community Health Worker

What is a School-Based Community Health Worker?

A trusted member of your school that can help improve the overall health and wellbeing of a student or family by helping find resources, services, and solutions that will allow students to meet their personal goals.



What CHWs can offer:

- Assist students and families as they work towards self sufficiency and goals.
- Assist with removing barriers to be able to have regular attendance at school.
- Assistance with finding resources such as: food insecuriy, housing, transportation, appointments, budgeting, signing up for insurance, in home support, parenting skills, behavior modificaion, improving social skills, employment and many others.

Your Community Health Worker:

Bayleigh Weide
620-704-4477
Bayleigh.weide@usd257.org
bweide@chcsek.org

Geoff Bennett

Community Healthcare Worker

Four County

SERVING: CANEY, SEDAN, NEODESHA SCHOOLS

The community healthcare worker position works with families in need of assistance. The assistance can come in many forms (see partial list below). Referrals can be made in person, via email to gbennett@fourcounty.com or by phone at 620 926-1436. Once a referral is made the family will be contacted for a short assessment to determine their needs.

Resource List

Food and clothing

Household Items

Financial Assistance

Medical services and Prescriptions – Presumptive eligibility (Medicaid)

Counseling, Mental Health, Substance Abuse

Transportation

Shelter

Employment

Legal Assistance

Student Mentoring

COFFEYVILLE PUBLIC SCHOOLS

Community Health Workers

Hailey Collins will be serving **Early Learning Center** and **Community Elementary School** students and families.
620-515-5671 - Work Cell

Esther Cuevas will be serving **Roosevelt Middle School** and **Field Kindley High School** students and families.
620-515-5673 - Work Cell

NEED HELP?

CHW'S CAN HELP WITH THE FOLLOWING:

- BASIC NEEDS (FOOD, UTILITIES, CLOTHING, SHELTER, ETC.)
- MEDICAL NEEDS (GLASSES, MAKING APPOINTMENTS, TRANSPORTATION TO APPOINTMENTS, ETC.)
- ASSISTANCE WITH SCHOOL ATTENDANCE
- ANYTHING A STUDENT AND FAMILY NEEDS

Scan to make a referral!

SCAN ME

Or go to:
https://www.cvilleschools.com/Page/950

In Partnership With:

Telehealth ROCKS Communities

ESCUELAS PÚBLICAS DE COFFEYVILLE

TRABAJADORES DE SALUD COMUNITARIOS

Hailey Collins estará sirviendo a los estudiantes y familias del **Centro de Aprendizaje Temprano** y de la **Escuela Primaria Comunitaria**.

620-515-5671

Esther Cuevas estará sirviendo a los estudiantes y familias de la **Escuela Intermedia Roosevelt** y de la **Escuela Secundaria Field Kindley**.

620-515-5673

FUNCIONES Y RESPONSABILIDADES QUE LOS TSC PUEDEN DESEMPEÑAR EN LA COMUNIDAD:

- Ayudar a coordinar la atención para los estudiantes y sus padres: médico, dental, salud mental, etc.
- Lleve a los niños y a sus padres a cualquier cita necesaria.
- Haga visitas a casa/chequeos de pozos para hacer un seguimiento de la asistencia o otras necesidades en el hogar.
- Proporcionar o encontrar CUALQUIER recurso para que los estudiantes y sus familias que no están satisfaciendo sus necesidades básicas puedan tener éxito en la escuela, es decir, alimentos, ropa, refugio. *Esto INCLUYE a los padres, si las necesidades de los padres no se satisfacen, esto afectará la capacidad de los estudiantes para tener éxito aquí en la escuela.*
- Actuar como enlaces entre todos los recursos comunitarios y las agencias de atención médica de la escuela.

¡Escanee para hacer una referencia!

SCAN ME

O vaya a.:
https://www.cvilleschools.com/Page/950

En Asociación Con:

Telehealth ROCKS Communities

Community Health Center of Southeast Kansas

School-Based Community Health Worker

What we can offer:

- Assist families as they work towards self sufficiency.
- Assist with removing barriers that negatively impact regular attendance at school.
- Assist with finding resources for any need, including but not limited to food, housing, transportation, healthcare, childcare, budgeting, insurance, in-home support, and employment.

Your Community Health Workers:

Jeremiah Jones

620-687-2102

jjones@usd250.org

Jenna Cuthbertson

620-704-4847

jcuthbertson@usd250.org

Community Health Center of Southeast Kansas

PATIENT ENGAGEMENT RESOURCE GUIDE

The overall goal of the Patient Engagement department is to engage high-risk, underserved populations and work to decrease the impact of exacerbations on health status and accelerate recovery through community outreach, benefits enrollment, care coordination, care management, patient education, and community partnerships. Often staff go above and beyond to provide support in nontraditional settings such as patient homes, neighborhoods, and communities. Patient Engagement staff are flexible, knowledgeable about disease processes, community resources and CHC/SEK care systems, and able to address barriers to improved health outcomes. They strive to understand, motivate, and help our patients achieve their goals in health and wellness by building rapport, eliminating barriers, collaborating with patients to set goals, and working within a multidisciplinary care team.

Community Health Workers (CHW)

CHWs focus on addressing social determinants of health and navigating patients through complex healthcare and needs within CHC/SEK's regional offices. CHWs address the social determinants of health (SDOH) and serve in both clinic and community-based environments, see below.

Clinic-Based CHWs

Each county has a CHW stationed at a central clinic location, available to patients for walk-in needs and by appointment. Staff can refer to CHW in clinic, by phone, or via eCW action or Telephone Encounter. Please review the "Master Services List" to find your nearest CHW

Refer to Clinic-Based CHWs for:

1. Uninsured coverage status
2. Completing any application including SNAP (food stamps), Medicaid, LIEAP (utility assistance), WIC, etc.
3. Questions about health insurance coverage or saving money on a monthly premium with Marketplace, Medicaid, and Medicare
4. Food insecurity and access to food pantries
5. Coordinating transportation for medical appointments
6. Community referrals

Community-Based CHWs

Community-Based CHWs provide direct patient support in non-clinical environments including schools, correctional facilities, shelters, community centers, libraries, and patient homes. Community-based CHWs not only provide direct patient support in their environments but also provide a link for partner agencies, promoting a multi-disciplinary approach to patient care.

School-Based CHWs: Primary focus is student support and the family and/or social support system. The CHW will address SDOH needs and assist with resources for the entire family. School-Based CHW's serve as an extension for administration, teachers, counselors, social workers, and school nurses.

Correctional Health CHWs: Correctional Health CHW's functions in local correction facilities to ensure resources are offered to patients in our jails. The Correctional Health CHW will address SDOH needs and assist with resources outside of the correctional facility to promote reintegration and achieve goals in securing housing, employment, and community involvement. They will assist with the patient's family needs as well to provide wrap-around care for all involved.

Community Health Action Team (CHAT): CHAT functions as a lead Community Health Worker spending most of their time out in the community visiting patients who are homebound and socially isolated. These staff are trained to provide basic clinical services like administering vaccines, COVID tests, lab draws, well checks, etc. to support patient care for high-risk community members. In the home environment, CHAT workers are able to identify education and resource service opportunities that might better support patient health and treatment plans.

Clinical staff should refer to CHAT when patient is homebound and in need of support and/or when a home assessment could be helpful to patient care. CHAT is available in limited counties at this time. Please review the "Master Services List" to find your nearest CHAT Lead.

Refer to CHATs for:

1. Following up with a patient post-discharge
2. To follow up with a patient in their home
3. To assess social determinants of health at home
4. To set up patient monitoring devices like BP Cuffs

Benefits Enrollment Team

Benefits Enrollment Specialists support patients through benefit education, eligibility determination, and enrollment in various local, state, and federal programs.

This team works closely with the CHWs and overlap in responsibilities. Often, CHWs respond to more immediate/urgent needs and Benefits staff follow up to further promote comprehensive services.

Benefits staff are primarily located in Pittsburg but are assigned regions to support. Please review the "Master Services List" to find your nearest BES.

Refer to BES for:

1. Patients with complex Medicare coverage questions
2. Enrolling in any type of health coverage
3. Patients needing a same-day Financial Assistance application for medication coverage

Family Resource Specialists (FRS)

FRS provide services for anyone throughout pregnancy and all families with children in need of care management through the statewide programs for Maternal Child Health and Teen Pregnancy. FRS work closely with providers to promote integrated support for growing families. Staff work to provide prenatal and parental education throughout care and facilitate referrals to internal and external resources (WIC, ATS, pelvic floor therapy, etc.).

Crawford, Cherokee, Bourbon, and Labette counties currently have FRS support. Please review the "Master Services List" to find your nearest FRS.

Refer to FRS for:

1. Connect families with essentials such as car seats, formula, diapers, pack-and-plays, etc. Families needing case management services
2. Connections to community resources like Birth to Three, or other home-based services
3. To work with families with children with special needs

OneCare Kansas (OCK)

OneCare Kansas is a comprehensive care management program led by a team of nurses and patient engagement specialists. OCK services include social support, community resource navigation, patient-centered action plans, transitional care support, health education, and care coordination. Services are documented in patient charts primarily through CCOORD visit types. Patients currently enrolled in the program are identified by global alert.

Refer to OCK when:

1. A patient has Kansas Medicaid or would qualify for Kansas Medicaid
2. Is diagnosed with bipolar, schizophrenia, depression, or asthma
3. Patient is struggling with managing their medical care or needs support
4. Patient struggles to cope with symptoms in their daily life

Send an eCW action to Patient Engagement Manager, Colette Lee, to have team review eligibility and provide support.

Chronic Care Management (CCM)

CCM is a program available to patients established with a CHC/SEK provider and traditional Medicare or Medicare Advantage plans. CCM services are traditionally provided by clinical staff via telephone and include chronic disease education, care plans, care coordination, medication/treatment plan questions, and community resource referrals. As of July 2020, CCM services are primarily provided by a remote team of nurses, MAs, and social workers through a third-party organization, TimeDoc. TimeDoc Care Managers list their contact information in a global alert, identifying patient enrollment, and document patient visits through Telephone Encounters in patient charts.

Refer to CCM when:

5. A patient has Medicare or Medicare Advantage plan and is established with CHC/SEK
6. Has at least two chronic conditions
7. Patient would benefit from monthly check-ins to promote self-management for chronic conditions

Send an eCW action to Patient Engagement Manager, Colette Lee, to have team review eligibility and provide support.

Remote Patient Monitoring Devices (RPM)

RPM devices support patients connecting to their health data in the home through blood pressure cuffs, weight scales, and tablets. Some of the devices have the capability to send the readings to eCW or other software for clinical staff to access. The RPM Nurse is dedicated to identifying patients that could benefit from device access, providing chronic disease education, and when available, remotely monitor data and communicate with clinical teams as appropriate. Each clinic does keep a small supply of devices to distribute. Please refer to RPM Ordering workflow to coordinate and request more devices. Request copy of workflow from Karen Bennett, RPM Nurse.

Long-Term Care and Home Visits

The Home and Long-Term Care Team (LTC) provides two distinctly different areas of service and should be addressed as separate resources for patient engagement. The Home and Long-Term Care Team is comprised of provider Brenda Brennan, APRN and nurse coordinator Bea Crockett, RN, along with support staff. Support staff includes an Activities Coordinator that collaborates to provide outreach activities and support alongside facilities, families, and community partners.

This team provides medical and outreach services to patients who live in either skilled nursing or assisted living facilities in Crawford County. LTC services can be accessed by a referral from a skilled nursing facility or assisted living. Patients and their families can also request a referral. Patients are seen in their facility residence by Brenda Brennan, APRN and receive the following services:

1. Timely medical treatment with direct access to patients' provider available to facility nursing staff
2. Preventative care
3. Wellness visits
4. Chronic disease management
5. Palliative care
6. Referrals to specialists, including frequent utilization of CHC wrap-around services when applicable
7. Connection to outreach and transitional services upon discharge from a facility

8. Supplemental activity participation and psycho-social support provided by the LTC Activities Coordinator

Home visits are also available to homebound patients in any Kansas service location who are unable to access services in a clinical setting. These patients are visited by provider Brenda Brennan, APRN in their private residence and receive services that generally address the entirety of the patient's circumstances. Using an eCW referral, PCPs can refer directly to Brenda Brennan, APRN for home visit services. Patients and caregivers can also request a referral when the patient is no longer able to be seen in a clinical setting.

1. Prompt medical treatment and direct access to provider's nurse coordinator for assistance
2. Preventative care
3. Wellness visits
4. Chronic disease monitoring/management
5. Palliative care
6. Referrals to internal and external specialty and comprehensive care
7. Immunizations
8. DME or other medical supplies at no cost
9. Visitation for emotional and psycho-social support provided by Activities Coordinator

Transitional Care Management (TCM)

When a Medicare patient is discharged from an inpatient stay, a Population Health Nurse will make an outreach via phone call within two days of discharge date. This will be documented in a telephone encounter. During this encounter, the nurse will ask about health status, medication changes, needs to support transition home, and schedule a hospital follow up with provider in 7-14 days depending on severity. To learn which Population Health Nurse is assigned to your clinic reach out to the Director of Population Health, Jenna Mikrut.

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School-Based Community Health Workers

Background of Community Health Workers in Schools

School-based community health workers help advance schools' vision for all children to have access to quality education by helping families resolve barriers to reaching their goals and building linkages between the school and community. These barriers are influenced by many factors that include access to health care, food, clothing, shelter, and other needs. To help students and families meet these needs and to foster student success and wellbeing, some school districts are making use of Community Health Workers in their schools to help ensure that all students have the same opportunity for success in school and in life. School-Based Community Health Workers (SB-CHW) have been located in Missouri schools since 2016 and in Kansas schools since 2022.

What is a School-Based Community Health Worker?

A community health worker (CHW) is trusted member of the community who facilitates access for the people they serve to needed resources. School-Based Community Health Workers (SB-CHW) are trusted members of the school and the community they serve, coordinating across school staff and connecting students and families to resources and services needed for each student's health and academic success. They can be employed by school districts or local partner organizations from the community. SB-CHWs support school staff in helping each student meet their goals, allowing teachers, school behavioral staff, and school administration to focus on a student's academic success. They are available to work with any student or family in need of help. While SB-CHWs work with individual students and families, they also help address the needs of the school and community through facilitating community partnership and education to help create communities that meet residents' needs.

CHW Certification

CHWs can become certified by passing a CHW training course, focused on helping CHWs gain the practical skills needed to be successful in their roles. While certification is not required for someone working as a CHW to be certified, the course provides access to ongoing skills training, resources, and professional development that is helpful for success in the role. For CHWs working in schools, additional training and skills development focused on children and families and the school environment may be beneficial to supplement the current training. Generally, CHWs who receive certification do so after they begin working in a school district.

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School-Based Community Health Workers

How Do Schools Support a Family's Choice to Utilize SB-CHWs?

School-Based Community Health Workers fill many roles in order help students and families meet their needs and create overall community change:

- Coordinate care, manage cases, and navigate systems
- Build individual and community capacity
- Provide coaching and social support
- Provide culturally appropriate health education
- Initiate cultural mediation among individuals, communities, and health and social service systems
- Advocate for individuals and communities
- Conduct outreach
- Participate in evaluation efforts

What are the benefits of SB-CHWs to schools and communities?

Having a SB-CHW is profoundly beneficial for schools and their communities. While each school district utilizes SB-CHWs in different ways, here are some benefits school districts have gained from using SB-CHWs:

- Improved academic/attendance outcomes
- Increased family engagement
- Strengthened collaboration and partnerships between the school and community organizations
- Improved social and health outcomes for students and families

"CHWs are the Swiss Army knife of school staff."

"For our staff to know they don't have to shoulder all of the burden of worrying about their students' unmet needs helps them not feel alone, helping to reduce burnout and increase staff morale. **A CHW in our school frees up the administration, counselor, and teacher to help all kids focus on the work in front of them** and not the roadblocks that get in the way. The question isn't how CHWs fit into the broader school team. The question districts should be asking themselves is what need do we have, and how could a frontline staff member like CHW help resolve it?"

–School District Director of Special Education

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School-Based Community Health Workers

Examples of SB-CHW Activities

Work within school teams

- Help the school monitor attendance and work with the administration team, teachers, and parents to develop strategies for addressing barriers to attendance.
- Collaborate with the school nurse/school clinic to manage screening events and disseminate health information.
- Coordinate with vocational/technical instructors and students to encourage participation in mentorship activities and disseminate career information.
- Coordinate back-to-school information and events that provide parents and students with information about available resources.
- Assist with after school program guidance and resources and aid Parents as Teachers and preschool instructors with activities and events that help increase school readiness.

Work with students and families

- Assist with scheduling and transportation to health care, dental care, and behavioral care appointments for students and their families.
- Collaborate with students and their families to develop greater agency in connecting with available resources to meet unmet needs so they may successfully participate in school and school activities.
- Help students and families in emergency situations, crises, or natural disasters.

Work within the community

- Identify community resources or funds that assist students and families in need.
- Partner with community groups to organize and stock clothing closets and food pantries for those in need, both in the school and community.
- Serve as leaders, board members, or regular attendees of community groups and charitable organizations, sharing opportunities to help children and families.

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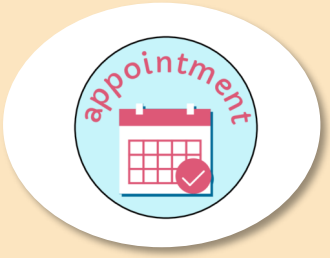
School-Based Community Health Workers

Examples of SB-CHW Successes

"A mother reached out asking about school supplies for her four children. They had just moved to town and were still trying to get on their feet. After talking with the mother, I realized they needed more than just school supplies–three of the children were sleeping on foam pads. The mother was hesitant to ask for help because she didn't want to feel like a burden. I assured her that this is exactly what a CHW is here to help with–making sure you and your children have everything you need to focus on school and work. We were able to work with a partner organization and get all four children beds and bedding of their very own.

–SB-CHW on connecting families to resources



"The school counselor was working with a student and their family to address some mental health concerns and referred the family to a community behavioral health organization for additional resources and services. However, the family informed the counselor that they were currently uninsured. The school counselor reached out to the SB-CHW to assist the family. We went ahead and completed the presumptive eligibility while their Medicaid application was being processed. The family was approved and the mother was very thankful. She was out of her medication, all of the children needed to go to the eye doctor and dentist, and now they can move forward with the behavioral health referral."

–SB-CHW on integration with community health providers

"Since building connections with the teachers and school staff, I have had five male students referred to me that have been struggling with attendance and behavioral issues in the classroom. I have started meeting with these students regularly to give them a space to connect and decompress. Our conversations focus on their interests, including sports and cars. As I have been able to establish trust with each student, we have been able to talk through some of their struggles in the classroom. Their teachers and other school staff have noticed an improvement in grades, attendance, and behavior for at least three of these students so far.

–SB-CHW on addressing academics and attendance