



## Community Health Workers and COVID-19 Kansas City Metro CHW Collaborative — Area Perspective: 2022

### Key Lessons Learned

Community Health Workers (CHW) were instrumental in supporting local health organizations and other community-based organizations working with clients and patients impacted by COVID-19, both from health impacts and economic impacts. Throughout the pandemic, CHWs were recognized as trusted individuals by patients who needed care and support. Among the lessons learned, agencies employing CHWs gained experience with emergency conditions due to the pandemic, which exposed a need regionally to broaden partnerships and communication among provider partners and with governmental agencies. These strengthened relationships enabled all parties to share information to ensure CHWs and agencies understand the disease and resource availability and improve data sharing among regional organizations while reducing redundancy of multiple social health referral platforms.

### **This trusting relationship between a CHW and a client enabled agencies to help clients:**

- Understand the seriousness of the pandemic and distinguish fact from myth.
- Recognize the risks associated with the disease and take preventive measures, including hand washing, social distancing and wearing masks.
- Overcome reluctance to seek testing and vaccination.
- Know how and when to seek health services from a Federally Qualified Health Center (FQHC), urgent care or hospital emergency room.
- Know how and when to seek virtual (telehealth) appointments and in-person services.
- Overcome hesitancy and be willing to share important information when contact tracing for communicable diseases is essential to prevent the spread.
- Apply for public benefits.
- Find emergency and other resources to address urgent needs.

### **Community Health Workers require additional training and support during disaster and other emergency events to address:**

- Their individual and family needs for health care and other services.
- Access to and ability to use technology to communicate with their agency, clients and providers of resources.
- The increased stress and trauma affecting patients.
- The potential for signs of trauma and burn-out for themselves and their co-workers.
- Setting appropriate boundaries in helping clients address their needs so the CHWs are not personally involved.
- How to help clients during and following disaster events, including increased awareness and understanding by CHWs of emergency services response.

- Early in disasters, determine what education (e.g., COVID education) is needed to support clients and answer questions, and update information as needed (e.g., COVID information, testing, vaccination evolved over course of the pandemic).
- Support public health departments and health providers to develop culturally appropriate materials to ensure understanding among target population(s) of health information and mitigation strategies.

**The role of CHWs might be modified during a disaster or other emergency events, allowing CHWs to support:**

- Providing assistance at public health events, such as testing and vaccination clinics, particularly in helping clients remain calm by translating information or explaining health-related information that clients may not otherwise understand.
- Helping greater numbers of clients to identify and secure resources to address urgent needs.
- Providing information to local government agencies and community-based organizations based on their experiences on the greatest unmet needs among clients that require greater community support.
- Helping to prepare communications to target communities.

**More public health departments, area agencies on aging, health care organizations, and community-based organizations should consider employing Community Health Workers as important members of their health care teams and provide episodic or ongoing support to clients. The strategic use of these professionals will:**

- Help engage residents who are reluctant to provide health or other information to ensure their appropriate and timely care and services.
- Provide culturally competent support, including language services, to engage clients around meeting their needs.
- Offer additional support at public events such as testing and vaccination clinics.
- Help look for resources to assist clients with urgent needs.
- Help agencies identify resources most needed and where availability of resources is most challenging.
- Be more effective if prior memorandums of agreement with hospitals and among providers could be put in place to support access to patient records to support efficient and timely patient care.
- Be more effective if public health departments communicated early with agencies employing CHWs to ensure they had the most up-to-date information possible to support working with patients.

**As a region, clinical, community, public health and governmental partners could outline collaborative agreements to ensure preparedness for future public health emergencies. Collaborative agreement may outline:**

- Roles and responsibilities of partners.
- Parameters regarding communication and collaboration (e.g., meeting frequency).
- Processes for tracking and reporting community resource availability and eligibility.
- Communication on regulatory flexibilities regarding key resources such as housing assistance.
- Preferred platforms for making and accepting community resource referrals.

## Introduction

Community Health Workers are an important part of the community's health care system. CHWs serve as a link between a client and health or social service agencies, working to improve health outcomes by improving access to services and quality of care. CHWs are trusted members of the community and have a close understanding of the community they serve. This trusting relationship enables the worker to facilitate access to services and improve the quality and cultural competence of service delivery.

The COVID-19 pandemic caused dramatic health and economic consequences for many residents in the Kansas City region, and health organizations increasingly relied on CHWs to help clients secure emergency and other resources, understand the risks from the coronavirus disease and the importance of mitigation measures, testing and vaccines. The Kansas City region experienced an increase in the number of agencies employing CHWs between the first quarter of 2020 and the first quarter of 2022, and an expansion of the roles that CHWs delivered in serving patients and the community.

Like much of the health care system during the early days of the pandemic, CHWs faced challenges due to the increased demands of their clients, limitations on in-person visits, limited emergency resources, and the health and economic issues that the CHWs personally faced. The demands by clients and the stresses faced by the health care system have continued to create stress and burn-out among CHWs.

This report summarizes findings from conversations with representatives from 10 agencies in the Kansas City metro area who employ CHWs to increase understanding of the role of CHWs in responding to a public health crisis, and what was learned that could contribute to strengthening the region's health care system if another emergency situation arises.

## Agencies Surveyed

The Mid-America Regional Council (MARC) reached out to agencies identified in our January 2022 inventory of those employing CHWs. Interviews were conducted with:

- Community Health Council of Wyandotte County (August 2022)
- Johnson County, Kansas, Department of Health and Environment
- Juntos, University of Kansas Medical Center (September 2022)
- COPE Project, University of Kansas Medical Center (September 2022)
- Kansas City CARE Center (September 2022)
- Kansas City Quality Improvement Consortium (August 2022)
- Nurture KC
- Samuel Rodgers Health Center (August 2022)
- Swope Health
- Uzazi Village (September 2022)
- Vibrant Health

A copy of possible discussion questions is attached as Appendix A.

## **What was the CHW Scope of Work prior to the pandemic? What was the impact of COVID-19 on your CHW Scope of Work?**

### **Community Health Council of Wyandotte County (CHC of WyCo)**

The CHC of WyCo employs 27 CHWs; the client caseload is 50-55 with a maximum at 60. In the first six months of the pandemic (March 2020 – August 2020), there was an increase of at least 300% in clients needing support. At that time, the organization had five CHWs. The increased client load was due in part from those needing quarantine or isolation having been referred from contact tracing. Many of these clients required emergency assistance resources, particularly due to the need to isolate or quarantine.

Prior to the pandemic, CHWs mostly served low-income clients as personal navigators and assisted individuals in the community to navigate the health care system, find and access additional resources, and apply for benefits. CHWs support several programs including Every Baby to 1, Management Diabetes Program, Food Rx research, general CHW services, and clients during the perinatal period (pregnancy–age 4). All programs are offered barrier-free (no income, residency or citizenship requirements).

In response to the pandemic, CHWs served a broader range of people with incomes between 300-400% of the federal poverty level, ranging from those who lost jobs and needed help accessing public insurance to individuals who needed help locating COVID testing and vaccines to individuals who were afraid to leave their house due to a chronic condition and fear of COVID.

The CHW scope of work expanded and pivoted in response to COVID. CHWs helped with:

- Food delivery for COVID-positive individuals.
- Delivered COVID tests.
- Helped individuals navigate testing sites.
- Set up and supported testing sites.
- Provided support to individuals at vaccine clinics.
- Supported individuals impacted by COVID and long-haulers to address economic impacts of COVID-19 — housing, utility assistance, insurance applications.
- Assisted clients via Zoom, Teams, WhatsApp (double-encrypted messaging service) about how to use food being delivered.
- Provided COVID education.

### **Johnson County Dept. of Health and Environment**

JCDHE's Community Health Worker program began in April 2021 with a grant from the Kansas Department of Health and Environment. This was made possible by the Centers for Disease Control and Prevention's funding to address health disparities, with special attention to ensuring underserved communities access COVID-19-related assistance, education, testing and vaccination. Since then, the CHW program has been supported using a variety of funding sources, including the COPE grant through the University of Kansas Medical Center. JCDHE employs four full-time CHWs; three are bilingual in English and Spanish, one is bilingual in English and West African French. The average CHW caseload is currently 15-20 clients. During the height of the pandemic, each CHW had an average of 32 cases.

In response to COVID, CHWs:

- Supported testing once resources were available with a focus on those needing services (e.g., unserved parts of the county, lower income, essential workers, persons of color).
- Provided support to help individuals isolate or quarantine.
- Helped with the operation of pop-up clinics and increased access to the vaccine by going to community groups, schools and churches.
- Provided health education to residents.
- Provided assistance in applying for public and health-related benefits and securing transportation and food.

### **Juntos, University of Kansas Medical Center**

Juntos employs one promotora who conducts health-related outreach and health education in community settings (e.g., Diabetes Prevention Program); participates in data collection and provides feedback to inform the development and implementation of health-related research programs; engages in intervention protocols and in identifying barriers to change; and connects participants with the appropriate resources to improve their health.

For a period of time after the onset of the COVID-19 pandemic, the CHW ceased health education and shifted to community COVID response efforts, such as distributing COVID tests and health education with the community around COVID-19 testing, vaccinations and the biology of the disease. CHWs helped train clients on how to use telemedicine technology for COVID response work. Juntos supported COVID response for the Wyandotte County public health department through COVID health education; and helped individuals identify where to get testing, how to clean their home, how to isolate and where to get vaccines. Over the long-term, COVID-19 hastened the transition from delivering evidence-based health education from in-person to text-based (Diabetes Prevention Program) approaches.

### **KU COPE**

In partnership with the Kansas Department of Health and Environment, the University of Kansas Medical Center (KUMC) built Local Health Equity Action Teams (LHEATs), comprised of community leaders and a new cadre of CHWs to mobilize communities to work together to promote health equity, particularly as it related to COVID-19, in Kansas. Activities included supporting the development of LHEATs in each targeted county to engage diverse stakeholders in shared learning and action to reach communities with less access to COVID-19 services and support. Central to this effort was the role of CHWs to build trust, support social needs, and advance outreach efforts driven by the LHEATs. Caseloads averaged 15 clients (although varied by county). The COPE program began after the emergence of the COVID-19 pandemic to help support clients impacted by COVID, CHWs:

- Addressed social needs like food/housing/transportation/connection to clinical providers.
- Distributed COVID tests to residents throughout a multi-county area.
- Had conversations with community members around COVID testing/vaccine/biology of disease.
- Helped train clients on how to use telemedicine technology.
- Led and/or attended community vaccination events in collaboration with Health Departments, FQHCS and CBOs to ensure that individuals and families had access to the COVID vaccines and to the most updated information about the pandemic.

### **KC CARE Health Center**

KC CARE employs 14 CHWs. In early 2020, due to the pandemic, caseloads and the clinic paused home visits. Prior to the pandemic, CHWs provided support to address social determinants of health (SDOH) and conducted home visits. As a result of the pandemic, CHW scope shifted for a period of time. CHWs:

- Helped clients get comfortable with telemedicine.
- Taught clients how to use technology.
- Supported testing and vaccine distribution.
- Supported mobile testing sites.
- Delivered COVID packs and medications to COVID clients.

CHWs served a broader range of demographics at testing sites (e.g., some higher income/non-minorities) and higher income individuals that had lost jobs.

### **Nurture KC**

Nurture KC is a community collaborative dedicated to reducing infant and maternal mortality and improving family health. The collaborative works together to:

- Change policy for broad impact.
- Transform systems to improve health outcomes at a local level.
- Provide one-on-one support to connect families to resources.

Healthy Start, a key program of Nurture KC, serves pregnant women and their children, up to 18 months old, through a CHW model connecting them to the resources vital to a healthy pregnancy and baby. Nurture KC employs eight CHWs.

During the COVID-19 pandemic, the CHWs employed by Nurture KC shifted largely to a virtual model and modified in-person efforts that minimized contact including in-person visits at a distance and a drive-thru parking lot to distribute produce and diapers. CHWs reported spending more time talking with clients virtually to identify and support needs.

### **Samuel Rodgers Health Center**

Samuel Rodgers employs 12 CHWs and, at the time of this interview, had four open positions. CHWs, except those who work in the maternity program do not have caseloads or work with clients over an extended period of time. CHWs contact patients for pre-visit engagement and screen for SDOH. The CHW program started in February 2020. Samuel Rodgers reported no significant change in terms of the numbers of clients served between pre/post pandemic levels. During COVID, CHWs:

- Helped patients with applications for emergency rental assistance. (The clinic saw an increased need for housing and helped patients with housing applications.)
- Conducted health education about the disease.
- Supported testing drives.

### **Swope Health**

Swope employs five CHWs across all locations. CHWs are part of the care team and work with providers to identify patients that have SDOH needs. CHWs have slightly different focus depending on population served and the department in which the CHW is embedded (e.g., pediatrics vs general medicine), but all CHWs

perform standardized SDOH screening, documenting in the electronic medical record, connecting clients to resources, tracking resources referred, and ensuring closed loop food insecurity referrals using UniteUs. During COVID, CHWs also asked questions regarding vaccine status and provided COVID health education to clients. Early in the pandemic, CHWs kept lists of individuals who were socially isolated or food insecure.

### **Uzazi Village**

The Village Doula program was a home visiting program, with clients coming to the Uzazi office for the first appointment. All doulas were CHWs. There were 16 staff, ten doulas with caseloads of three births/month, including three prenatal and three postpartum visits. Generally, the length of engagement was during pregnancy and three months postpartum. Sister Doulas provided pregnancy navigation, home visiting, health assessments, mental health assessments, resource referrals, individualized education, healthy behavior modeling, nonmedical labor support, breastfeeding assistance and parenting support.

COVID-19 impacted both the type of support needed and overall demand for support. Uzazi created a virtual visit policy, started using Zoom for client appointments, and moved toward grants to purchase supplies such as diapers due to decline in donations. In addition, Uzazi moved to curbside resource distribution, such as diapers.

### **Vibrant Health**

Vibrant employs two clinic-based CHWs who provide episodic resource coordination. During the pandemic, CHWs assisted with drive-through COVID testing; client needs assessments for intakes; home deliveries for medical supplies including access to self-monitor blood pressure cups and glucometers. CHWs also supported a drive-thru food pantry.

## **What challenges did your organization and CHWs face in shifting its focus during the COVID-19 pandemic?**

### **Community Health Council of Wyandotte County**

There was a challenge shifting to technology-based communication. Generally, the community CHC works with doesn't have access to technology and is limited in available minutes with smart phones. As a result, the CHWs heavily relied on WhatsApp and Facetime. When hotspots became available, CHWs access to clients improved. CHWs also provided technical assistance to clients on how to use Zoom or Teams. In addition, the organization had to adjust to remote work and to work through logistics like how to get food to people, masks, etc. In addition, with such an increase in demand, the CHC had to hire more CHWs to respond quickly.

### **Johnson County Department of Health and Environment**

The Johnson County Department of Health and Environment supported testing, once resources were available, with a focus on those needing services (unserved parts of the county, lower income, essential workers, persons of color). Many were referred from disease investigation to help them isolate or quarantine. Once the vaccine became available, CHWs helped with operation of pop-up clinics and increased access to the vaccine by going to community groups, schools, churches. The CHWs helped clients to apply for public and health-related benefits and securing transportation and food.



### **Juntos, University of Kansas Medical Center**

Juntos had to cease traditional diabetes health education for a period of time. However, COVID did hasten its transition to text-based health education and virtual delivery of its traditional services.

### **KU COPE**

Since all the CHWs were newly hired, one of the challenges was to provide them with the right education about COVID, help them understand the importance of social distancing, masking, getting vaccinated, and conveying this information to the community members.

### **KC CARE Health Center**

During the pandemic, KC CARE transitioned to virtual telemedicine and by May 2020, returned to normal visit numbers with 50% of patients through telemedicine. As an infectious disease site, KC CARE has strong epidemiology staff and had capacity to understand epidemiological reports on COVID and to identify valuable information. As such, KC CARE set up a COVID command center and met regularly with staff to educate them on COVID. Improved coordination between the state and federal governments in terms of information sharing would have been helpful as the information from these entities wasn't always supportive of CHW efforts to educate community on COVID mitigation strategies (e.g., masks stigmatized; personal protective equipment not always available and price gouging occurred).

There was a time period when the clinic conducted 400 COVID tests a day – more than the number of clinic visits a day across all four sites. The clinics operated more at crisis levels as opposed to providing proactive care management. Only critical personnel were in the clinic to meet CDC spacing guidelines. As a result, referrals to CHWs from clinical staff declined.

Over the long term, marketing through testing and vaccinations helped to grow clinic presence regionally. In addition, the shift to telehealth helped to increase clinic visits back to normal levels. (Telemedicine is now 12-15% of total visits.) CHWs are beginning home visits again and seeing a return to traditional CHW work.

### **Nurture KC**

Nurture KC reports that the challenges during COVID-19 included a new CHW forming relationships with clients virtually; support for clients to use virtual platforms; addressed vaccine hesitancy among pregnant women; and provided public health guidance in a timely manner. Nurture KC launched a new service right before the pandemic. Under the new service, a Registered Nurse would support Healthy Start moms. Launching this service was challenging because the moms did not want to go to the clinical setting and the service really needs to be in-person to complete the assessment (e.g., blood pressure checks).

### **Samuel Rodgers Health Center**

As an organization, Samuel Rodgers saw an increase in the number of patients accessing the food pantry; created a COVID clinic for testing; took over what was going to be urgent care; shifted to a rolling schedule of two weeks on and two weeks off; closed satellite locations between March 2020-July 2020. As a result, all clients needed to come to the downtown location for care, which was a barrier for some. The clinic observed a decrease in the number of individuals accessing services as some individuals were fearful of impacting their immigration status.



## **Swope Health**

Swope reports that finding staff continues to be a challenge. In addition, Swope continues to search for the appropriate balance between telehealth and in-person. During COVID, CHWs did use phone and telehealth to reach clients. Clients often heard vaccine disinformation, and Swope held training sessions to ensure staff understood that the vaccine was not experimental, and had secured federal approvals without shortcuts. Swope held community events to constantly voice the science and emphasize that there were no shortcuts in clinical trials. Swope also reported challenges with the CDC changing the information presented to the public. Swope tried to stay with single sources for COVID guidance.

## **Uzazi Village**

In the first six months of the pandemic, there was a change in the type of support and in overall need. The organization moved to a virtual visit policy but did not see a decrease in client demand. Donations were down for supplies, so Uzazi secured grants to purchase supplies. Clients needed supplies, including diapers and an increased need for cleaning items. Delivery for diaper service became curbside. Uzazi received referrals through the IRIS system and from health programs for families and refugees.

Hospital birthing policies changed frequently in terms of who was allowed/how many individuals were allowed in the birthing room and this information was difficult to track. As a result, doulas did a lot of training for family/support members through virtual technology.

Uzazi shifted to remote work but had to develop policies to access the site for supplies. Uzazi tested all staff and doulas for COVID once a month. Uzazi created a COVID clinic for anyone to be able to come and get tested.

## **Vibrant Health**

Vibrant reported telehealth calls increased during the pandemic versus in-person clinic visits, as well as referrals from off-site clinics. During the pandemic, Vibrant saw a decrease in patient visits, which caused challenges with continuing to manage care for chronic disease patients (e.g., lab work, kids keeping up immunizations, providing needed clinical visits). Vibrant reported, at the time of the interview, that it was still working to get back on track, including helping staff feel safe and supported.

## **What other organizations did you and your CHWs work with to respond to the pandemic?**

### **Community Health Council of Wyandotte County**

The agency worked closely with the local public health department on health education and creating education materials that could be understood easily by the community including on testing and vaccinations. It also worked closely with the local FQHC, hospitals, schools, employers, faith-based leaders and local news stations, such as Telemundo, to talk about work being done and provide information on COVID and available resources.

### **Johnson County Department of Health and Environment**

Johnson County Department of Health and Environment worked with community organizations, faith-based groups, particularly Catholic organizations to support the Latino population. Johnson County engaged a

physician with KC Refugee to build trust. It also offered a 20-minute COVID information program on a Spanish language radio every other week.

### **Juntos, University of Kansas Medical Center**

Juntos worked closely with the Unified Government, especially in the beginning, to translate materials into Spanish.

### **KU COPE**

COPE worked with clinical providers throughout Kansas to serve clients. COPE Local Health Equity Action Teams and CHW teams developed over 2,000 partners in the community to address any COVID related Social Determinants of Health needs. Those partners include clinical providers, local health departments, hospitals, community based organizations, etc.

### **KC CARE Health Center**

KC CARE Health Center reported it worked well with the Kansas City Missouri Health Department and University Hospital. It also worked with the Mid-America Regional Council's Area Agency on Aging's Spira Care project to provide COVID support to people impacted by COVID.

### **Nurture KC**

Nurture KC reports during the pandemic they began a new partnership with University Health to provide drive-through produce boxes. This effort lasted for two and a half months. Nurture KC also reported continuing to refer clients to KC CARE Health Center for clinical services, but also began a new partnership with them for Homeroom Health.

### **Samuel Rodgers Health Center**

Samuel Rodgers conducted events with health departments to provide testing and vaccinations.

### **Uzazi Village**

Uzazi Village reported working mostly with hospitals prior, during and after the pandemic due to the nature of the doula scope of work.

### **Vibrant**

During the pandemic, the United Government Health Equity Taskforce, with which Vibrant was involved, helped build relationships with other community leaders (e.g., churches) and supported expansion of telehealth services as well as broad distribution of testing and vaccines in different neighborhoods. The task force worked together to break down barriers, meet people in the community and distribute free medical biometric resources.

**What resources were most needed by clients? Were resources available? Did the availability of federal funds support response?**

### **Community Health Council of Wyandotte County**

Community Health Council of Wyandotte County reported the resources most needed were food, utilities and rent support (there was no moratorium on utility payments). The CHC reported they encountered problems

with agencies that use MAACLink (e.g., people couldn't get food from multiple food banks because they were already in the system as having gotten food. This was a problem for people who picked up food for multiple families because they had cars.) For undocumented people and refugees, the main barrier they encountered was fear of deportation (e.g., if a client tried to access resources or go to testing sites and showed a non-US ID). The CHC reported they did not initially receive federal relief funds but did receive rapid response funds in 2021.

### **Johnson County Department of Health and Environment**

Johnson County Department of Health and Environment reported work changed to greater outreach and advocacy at public locations; experienced an increase in more clients than the CHWs could support, and clients had more complex needs. Cases are taking longer to find needed resources.

### **KU Juntos**

Juntos reported that resources most needed during the pandemic were PPE, food, COVID tests and transportation. Juntos reported experiencing challenges accessing resources for clients because not everyone was aware of what the COVID funds would cover and had conflicting information about who could qualify for certain resources. Client resource information was not available in large print.

### **KU COPE**

COPE reported the following resources most needed: food and household supplies, COVID tests/vaccines, assistance with medical system navigation, and transportation. COPE reported it was challenging for CHWs to understand the eligibility requirements around accessing resources and felt that many federally or state-funded resources were underutilized due to lack of knowledge and awareness of both availability and rules.

### **KC Care Health Center**

KC CARE reported the resources most needed by clients were affordable housing and transportation.

### **Nurture KC**

Nurture KC reported the resources most needed by clients during the pandemic included housing assistance, utility assistance, food assistance and addressing unique requests for needed basic resources such as furniture. Nurture KC received immediate response funding from the Kansas City Regional COVID-19 Response and Recovery Fund.

In terms of housing assistance, it was time intensive to find placements, but they were successful in finding placements for all who needed them.

### **Samuel Rodgers**

Samuel Rodgers reported clients most needed housing and food support. The Samuel Rodgers' Happy Bottoms program (diapers) more than doubled in response to demand. CHWs faced challenges helping clients process applications for housing assistance (e.g., a four-six week wait to for processing applications and clients often would not hear back).

### **Swope Health Center**

Swope reported the greatest need to be housing including gentrification in zip codes served, inflation, housing availability and affordability, and clients losing government housing. The other challenges reported as a need

included food insecurity, employment and immigration status as a barrier to care on the Kansas side, which makes cases more complicated for immigrants. Swope serves 45,000 patients a year.

### **Uzazi Village**

Uzazi reported that rent and utility assistance (referred to MAAC/Jackson Co rent assistance) and mental health support were the resources most needed due to COVID impact. Uzazi reported that to support mental health needs, doulas would identify mental health support in the community that offered support with sliding scale or free. Uzazi also offered in-house mental health support for doula clients. Uzazi kept a resource book and consulted 211 to understand eligibility requirements for resources. Donations for car seats ceased during COVID. Uzazi used COVID money to purchase car seats and pack-n-plays.

### **Vibrant Health**

Vibrant reported the greatest needs it saw during the pandemic were food insecurity; new Medicaid applicants; supplies for childcare (e.g., car seats, diapers); and a need to respond to an increase in bed bugs. As an FQHC, Vibrant received funds from the American Response and Recovery Act.

## **What were the lessons learned from your agency and CHW response to the pandemic?**

### **Community Health Council of Wyandotte County**

The CHC reported a better understanding of how to provide client support and work together as an organization remotely. In terms of lessons learned for preparedness for future public health emergencies, CHC reported that access to state or county level data across state lines is critical to provide support in the future (e.g., to identify the number of people in need of services in the region). Emergency response departments may have agreements or protocols in place to work together; however, community organizations were not often aware of or had access to such protocols. The CHC reported a need for hospitals to work together more proactively and with community organizations like CHC during future emergencies. Having contingency or other agreements in place between critical partners in the event of an emergency would ensure a more smooth and rapid response. Agreements should outline:

- How organizations will work together.
- Which departments are responsible for what activities/services.
- What resources could be available and at what capacities.

Emergency preparedness plans need to be prepared to address:

- Transportation – significant gaps with transportation to help clients get to health care or other services and there has been no sustainable funding for this service.
- Affordable housing, utility assistance, and policies on mortgage and rent moratoriums.
- Ensure all “systems” can talk and integrate to send community resource referrals.

### **Johnson County Department of Health and Environment**

The use of CHWs was instrumental in building patient trust, speaking in terms and language understood by their clients. CHWs were resourceful in building relationships with community organizations and identifying resources. CHWs were important health care team members in supporting testing and vaccination events hosted by the public health department and community partners.

## **KU COPE**

Health and resources information is not always available in native languages and in an accessible place. Connectivity and networking were limited between critical organizations, such as CBOs and clinical providers. There is a need for improved coordination among critical organizations that serve clients. Social health referral platforms are helpful, but also community organizations accepting referrals from those platforms have a hard time managing levels of resources requested. Those supporting the CHW program identified the need to identify a lead organization for each resource type with backup plans to maintain capacity. Finally, one social health referral platform that is universally used by community organizations would make the availability of resources clear to CHWs.

## **KC Care Health Center**

The pandemic highlighted the need for modifications to the health center's facility and use of technology. In addition, there was a need for modifications for human resources to retain staff, reducing the number of systems used in-house to reduce dual documentation by CHWs, which is too labor intensive.

## **Nurture KC**

Nurture KC reports that as an organization they weathered well and were able to meet the target numbers of clients, improve organizational communication strategies for virtual work, and are "tougher" as an organization. They report that quicker and more digestible public health guidance including short, animated videos would have been helpful. They also report that the silo of services in Kansas City was challenging including the lack of collaboration across organizations. Access to tangible services was helpful such as gift cards to grocery stores, but asking for too much personal information was a barrier.

## **Samuel Rodgers Health Center**

Samuel Rodgers Health Center reported that more timely information from local public health would have helped in early weeks/months in responding to patient needs. Samuel Rodgers reported that they realized a need to establish telehealth support and an urgent care clinic to respond to the increased demands for health services. During the pandemic, Samuel Rodgers moved to a different Electronic Medical Record to enable remote entries, but training and support made use of a new system during a disaster event even more challenging.

Samuel Rodgers reported a challenge with sharing information among resource agencies as there are too many social health referral platforms in the region and not one way to disseminate information. Furthermore, hospital systems are not well-connected to health centers (e.g., people weren't sure when to go to emergency room versus clinic for COVID), and more collaboration between these two groups would improve the delivery of care.

## **Swope Health**

Swope recommends preparing for the next crisis as a region collaboratively in order to best serve the most vulnerable. Preparations should include strategies to maintain staff and provide affordable housing. Swope notes that continuing telehealth is needed but may depend on legislation. Preparing for future pandemics will require regulatory flexibility and clarity from the federal government. Swope notes that payment reform is needed for CHWs, including Medicaid reimbursement to ensure CHWs are sustained in their organizations.

### **Uzazi Village**

Uzazi reported a need for the hospital systems to clearly communicate COVID policies. Because the policies changed almost daily, keeping updated with hospital policy changes and COVID policies was an added burden on clients and doulas. Due to COVID impacts, clients missed appointments more often due to needing to take care of family impacted by COVID, and it was challenging to properly prepare clients for births due to missed appointments. Uzazi had to be creative to continue to serve clients (e.g., adopt curbside delivery of supplies / technology for doulas). Uzazi incorporated the use of IRIS and Unite US to help refer people for needed resources and with cross-referrals. It was challenging to learn multiple systems while keeping track of emerging health policies and guidance. In order to better prepare for future public health emergencies, the community could be prepared to address supply shortages such as formula, car seats, pack n plays and personal hygiene. Hospitals should consider doulas as part of support team not as a visitor so that proper support can be provided during births.

### **Vibrant Health**

During the pandemic, Vibrant forged partnerships and it continues working with community partners and the Unified Government of Wyandotte County. Vibrant recommends training CHWs in disaster response so that CHWs can be a source of support for community members in challenging times.

*This report was prepared by the Mid-America Regional Council with assistance from Erika Saleski, ES Advisors, and funded through grants from the Kansas Department of Health and Environment and the Health Forward Foundation.*

## **Appendix A**

### **KDHE – COVID-19 Response by Agencies Deploying CHWs**

Design and complete an evaluation of COVID-19 response efforts undertaken by the KC Regional CHW Collaborative and other regional partners to support clients impacted due to health, economic or other factors. Prepare guidance to inform future projects involving CHWs, including preparedness and disaster response.

#### ***Nature of the Need for Support due to COVID-19 and its Impact on CHW services and clients***

1. How many CHWs are employed by your agency? What is the average patient caseload per month/year?
2. The type of clients that required support – did the client base change due to the pandemic?
3. What was the nature of changes?
4. Were the demographic characteristics of those impacted by COVID-19 different than clients served pre-pandemic?
5. Did your agency employing CHWs have access to information about the prevalence of the disease and available resources (testing early, vaccines, treatment options)? Did your local public health department provide needed information about COVID-19? Was the flow of information adequate?

#### ***Nature of the Response***

1. How did CHWs support clients who were impacted by COVID-19?
2. Did the type of support or level of support change from pre-pandemic services? If yes, in what ways?
3. Did CHWs proactively contact socially isolated patients? Was more effort made to offer health education or to dispel misinformation?
4. Did the agencies employing CHWs work directly with public health departments to support clients who tested positive or had health impacts from the disease? If so, were there challenges working with public health departments?
5. Did the CHWs work with other health care providers? If so, which types of health care providers did CHWs work with most often?
6. Did the agencies employing CHWs work with new or different partner organizations to provide support and services?
7. Did the mode of CHW service delivery change? For example, did CHWs rely on phone, text, tele-health visits rather than in-person meetings? What response gaps did these changes expose?
8. How did the pandemic affect your agency's ability to respond to all client needs? Staffing shortages? Changes in operations? Greater hesitancy by clients in receiving services? Other?

#### ***Resources Needed During Response***

1. What type of support was most often needed? Were the resources available or were their significant resource gaps?
2. Was there a difficult time obtaining information on available resources? Did 211 play a helpful role? Were there other means to identify resources for clients? Which partnerships, if any, helped in securing resources for clients?
3. What were the major barriers to clients receiving services? e.g., citizenship/immigration status, language, lack of address, lack of papers, lack of resource availability?



4. Did your agency have access to flexible federal or other dollars to help those clients needing resources?
5. Thinking about demand for CHW and other supportive services now, has the demand for services or the types of services changed since the beginning of the pandemic? Is your case load greater, about the same as during the height of the pandemic, back to pre-pandemic levels? Why do you think the demand for support is different if it is?

***Lessons Learned/Preparation for Another Emergency/Disaster Event***

1. What were the greatest challenges serving clients impacted by COVID-19?
2. What steps might your agency take to be better prepared for an emergency event that could increase the number of clients, change the needs to be addressed, cause impact on agency staffing and operations, etc.?
3. What, if any, improvements in information systems or information sharing with public health agencies would help your agency and CHWs respond to public health or other emergency or disaster events in the future?
4. Would any specific information system improvements help your CHW document client needs and services provided? What type of information system improvements would be necessary to facilitate communication with other critical resource agencies in another emergency/disaster event?
5. What types or organizations are critical to work together to prepare for future events?
6. What relationships should your agency consider strengthening to enable more efficient response? Would agreements with those agencies be useful?
7. What other infrastructure should be put in place community-wide to ensure the KC region is prepared for future emergency/disaster events?
8. What training would help your staff, including CHWs, need to be better prepared for disaster/emergency events?

Following an analysis of the survey and interview results and any needed focus group or further discussion with agency personnel and public health departments, guidance will be prepared using national best practice guides to support agencies toward preparation for a future event.