Dual Track Care for Wheeler County residents

Community Health Worker:

Taking a broad view of healthcare, recognizing the CHW is a critical link between our rural communities and various resources, and health and social services systems.

Many factors contribute to a person's health status, but having access to care and using preventive services are critical to narrowing the health disparities gap.

Mobile Integrated Health–Community Paramedicine:

Utilizing the CHW's level of emergency medical state licensure to assist Providers with focused and targeted follow up care in the home.

Mobile, as its taken to the patient's home. *Integrated*, as it extends the reach of primary care. *Community*, ...because that's ideally what we are.

- *CHW: Community Health Worker*
- *MIH: Mobile Integrated Health*
- *CP: Community Paramedicine*

Teamwork for success!

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Health Starts Here

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An Integrated Program ~ sustaining a continuum of care for Wheeler County

CHW, MIH-CP:

The CHW, MIH-CP Program at Asher CHC is staffed by Joan Field, an Oregon state-registered Community Health Worker (CHW) and is an active Oregon EMT-Intermediate.

The program is designed to bridge healthcare gaps and to help coordinate care, so our Wheeler County residents can receive high quality and targeted healthcare based on their specific conditions or challenges.

How is this achieved?

With a dual-track program combining *Community Health Work* and *Mobile Integrated Health-Community Paramedicine*.
Access to the program is through Provider Referral, or by direct contact from the patient or their family. There are case-load limits and required patient agreements.

Gathering all the pieces... for Success!

What can we do?

Community Health Work

- ◊ Patient Advocate: Individual, communal
- ◊ Healthcare System and Resource Navigation
- ◊ Care Plan Goals: Support and resources
- ◊ Medication management: Education and support
- ◊ Chronic Conditions: Education, monitoring
- ◊ Nutrition and Lifestyle: Education and support
- ◊ Substance Abuse: Education and support
- ◊ Social Assessment: Evaluate and refer to resources
- ◊ Care Team: facilitate team communication
- ◊ Proactive Intervention: Early communication of changing conditions
- ◊ Transportation Coordination when appropriate

Bringing various resources together

Mobile Integrated Health-Community Paramedicine

- ◊ Patient Education: Available for every patient visit, and as the Provider requests
- ◊ Chronic Conditions: Monitor, report findings, instigate supportive activities
- ◊ Monitor Vital Signs: Monitor and assess, report findings
- ◊ EKG Administration: Conduct in-home, report findings
- ◊ Blood Glucose: Monitor in-home, report
- ◊ Lab Draw: Obtain specimen, process routing
- ◊ IV Catheter: Assess, monitor, remove/reinsert
- ◊ Pt Medication Compliance: Education, support

Cont:

- ◊ Post Discharge Follow Up: Provider request
- ◊ History & Assessment: Provider request
- ◊ Home Safety Assessment: Provider request
- ◊ *...and if its not listed, ask us.*

Vision: To improve the health and wellbeing of all Wheeler County residents.

Mission: Our mission is to bridge the divide between Residents and Resources, and to assist and support Care Providers and Patients in their mutual quest for improved health.

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