

FY10 United Way Year-End Report for the Wellness Passport

Program: Wellness Passport

Agency: Blue Ridge Medical Center

Date: 12/31/2009

1. For the current funding period, please highlight your program's goals, activities, and results, noting any changes to your original plan/proposal. Include any relevant budget and/or financial information. Limit your response to no more than one page.

Since June, the Wellness Passport program has continued to be busy. Flyers promoting the Wellness Passport were distributed and hung throughout the community. The new Wellness Passport Coordinator, Vanessa Moss, did a fine job in helping increase the enrollment of the Wellness Passport Program. A Spanish-speaking Summer Intern was brought on staff and has been very instrumental in promoting the Program. Many inquiries are being made and applications mailed due to the decline in local jobs and the increase in lay-offs. Calendar year 2009 (December 31) ended with 210 individuals enrolled in the Wellness Passport program.

Ms. Moss continues to go to workforce development sites in the area and has made presentations to residents who have recently lost their jobs, are doing part-time work where they were once employed full-time, and to workers who are taking temporary assignments while looking for full-time work with benefits. The Wellness Passport program was well-received and has been viewed as a lifesaver to many individuals who were formerly insured.

In addition, RHOP has made presentations to area nonprofit agencies and to departments of social services to introduce/reintroduce the Wellness Passport. Many of the people served by these agencies are eligible for Wellness Passport benefits. The program has been presented to businesses that do not provide benefits to their employees. Brochures are distributed at many area businesses for employees and patrons to see and learn about the program.

Blue Ridge Medical Center has made space available in its lobby for the Wellness Passport coordinator to explain the program to patients of the center. These events have increased awareness of the program with patients and some of the center's insured patients have referred people they know who qualify for the Passport.

We have seen an increase in the number of enrollees who are scheduling their physical exams which are included as a benefit of enrollment. Our nurse practitioners are addressing more acute care issues during these exams much like other healthcare facilities where patients are requesting more time with providers to address multiple issues during a single visit.

The SF12 survey has been given to all enrollees, with 60 being returned. Results have been entered and data is being scored. A follow-up report will be filed as soon as this is complete.

2. Please share a success story from your program. We are especially interested in stories that show a long-term impact on a person or family, and stories that show collaborations or referrals with other community programs in meeting a client's multiple needs.

During one of our regular health depots, where we conduct screenings and consult with people about their health, and encourage enrollment into the Wellness Passport Program, we screened a middle-aged male who was shown to be in danger of having an imminent stroke. We were able to refer him directly to an emergency room where he was seen by a doctor, and subsequently follow-up for proper care. And of course, he was enrolled in the Wellness Passport Program.

3. Complete the following Outcome Measurement update (based on your application for funding) for the fiscal year to date.

Projected Number of Intended FY10 Primary Beneficiaries 220 **Actual Number of Primary Beneficiaries** 210

| Projected FY10 Outcomes | FY10 Indicators Tracked | FY10 Outcome Results (provide specific numbers and percentages) |
|---|---|--|
| Target Group will utilize primary care and chronic care services appropriately and comply with treatment recommendations. | At least 50% of patients followed by RHOP NP re: chronic illnesses will have complied with at least one treatment recommendation such as taking medication as prescribed or changing diet. | # WP Enrollees served: 210 110 (52%) WP patients seen by NP |
| RHOP patients and clients will show improvement in health status. | At least 50% of RHOP patients served at least 3 times will show improvement in at least 1 relevant health status indicator | 65 patients served 3 times 16 (25%) patients showing improvement in at least 1 relevant health status indicator |
| Target Group will understand the importance of preventive health care and how to access appropriate resources for primary and chronic care. | At least 50% of RHOP's diabetic or hypertensive patients and clients served at least 3 times will demonstrate improvements in healthy lifestyles, treatment plan compliance, or health status | 59 of RHOP diabetic or hypertensive pts/clients served 3 times. 20 (33%) of those served 3 times demonstrated improvement |
| | At least 30% of Passport enrollees seen at least 3 times will progress along the continuum of Prochaska's Stages of Behavior Change, the SF-12, or other health outcomes measuring tool. | The SF-12 is now being used. Case management and goal setting is currently in place with participants. 60 WP have been surveyed using SF-12. Future tracking will give more complete data. |

4. Impact Report. We are looking for issues and statistics specific to our local area: you are also welcome to include some general issues that set the framework for the local statistics. Under the Actual results heading, we are looking for impact, especially long-term results, not just numbers served. For the Financial Impact section, have each example highlight a different thing (in other words, don't just multiply the first answer three more times).

a. Community Needs or Issues Your Program Addresses—please include at least 3 local issues/statistics and cite your source

12.1% of Nelson County's 15,127 residents live in households with incomes below the federal poverty level. Thirty-one percent of County residents are living at or below 200% of the federal poverty level and 31% of BRMC users reported incomes at or below 200% of poverty.

| <i>Healthy Communities Indicator</i> | <i>Nelson</i> | <i>Planning District</i> | <i>Virginia</i> |
|--|---------------|--------------------------|-----------------|
| Heart Disease Rate | 245.0 | 175.8 | 186.7 |
| Malignant Neoplasms | 271.5 | 175.8 | 182.7 |
| Chronic Lower Respiratory Disease Rate | 59.6 | 42.1 | 38.3 |
| Diabetes Disease Rate | 26.5 | 19.2 | 21.6 |
| Distance to nearest Emergency Dept. | 22.1 miles | | 6.5 miles |

As estimated 15% of the population does not have any form of health insurance. The number of uninsured patients increased from 32.9% in 2007 to 47.8% in 2008.

b. Your Program's Solutions that United Way Community Impact Funds Support

The Wellness Passport is a health benefits program that, for \$25 per year, provides:

- 1) A comprehensive physical exam with a protocol of age and gender specific screenings and tests, health history, and health goal setting session.
- 2) Primary care with one of 3 family practices for \$20 per office visits (including lab/X-ray at BRMC).
- 3) Access to specialty care is case managed to find the most affordable solutions. Assistance is provided with sliding scale applications, and referrals are made to partnering providers who give deep discounts or pro-bono care.
- 4) Follow-up contacts to provide coaching on health goals and to help enrollees stay connected to health and human services as needed.

c. Actual Results – based on your stated outcomes; please use percentages and numbers served to help show outcomes

In 2010 Wellness Passport enrollment increased by 8% over 2009 and by 35% over 2008. Having a full-time coordinator meant we were able to market the program and have the staff to handle increases in paperwork and case management. An RHOP program manager on the premises meant a focused approach to all activities, including the Wellness Passport.

60 Wellness Passport participants received the SF12 survey. Data for the first half of the 2010 grant year will be presented when scoring is complete.

Financial Impact of Donations -- (i.e. \$3/week provides...; \$5/week provides...; \$10/week provides)

- i. **\$10 per week** provides two screening clinics at the local Food Bank
- ii. **\$5 per week** provides 2 Wellness Passport exams.
- iii. **\$3 per week** provides 3 group education sessions for Wellness Passport enrollees with Diabetes.

FY10 United Way Latino Outreach Mid-Year Report

Program: Latino Outreach

Agency: Blue Ridge Medical Center

Date: 12/31/2009

1. For the current funding period, please highlight your program's goals, activities, and results, noting any changes to your original plan/proposal. Include any relevant budget and/or financial information. Limit your response to no more than one page.

During July through September, the Community Health Promoters (CHPs), formerly referred to as Lay Health Promoters, and RHOP staff made 14 visits to 7 of the Nelson County migrant camps. Over 75 people received screenings for blood pressure and blood sugar. During the initial visits, CHPs helped determine who needed to be medically seen by the RHOP nurse practitioner. They then worked in conjunction with the Latino Outreach Coordinator, RHOP staff, and the nurse practitioner to make follow up visits to the camps. Many of the workers are unwilling or unable to take time off from work to go to the doctor, and those who are willing often are unable to find transportation. During the follow up visits, the CHPs also performed further screenings and assisted in interpretation for the nurse practitioner. As a result the nurse practitioner was able to see 26 individuals with various medical issues. Those individuals were then followed up with the appropriate case management by the Latino Outreach Coordinator.

Blue Ridge Medical Center served 488 Latino patients in 2009. Of those, approximately 85% need some case management and/or interpretation services. All of the case management and the majority of the interpretation services are provided by the RHOP Latino Outreach Coordinator. Some examples of case management are arranging referral appointments with specialty practices, assistance with health and human service paperwork and reporting lab results to patients in Spanish. Interpretation begins at check-in and continues through the entire office visit, including translating prescription instructions to Spanish. The services provided by the Latino Outreach Coordinator positively impact the quality of care of Latino patients in Nelson County.

Hispanic Community Day was held on September 13, 2009. Multiple vendors were present including:

Nelson County Health Department, UVA Cancer Center, UVA Diabetes Education and Management program, Shelter for Help in Emergency, Legal Aid Justice Center, VA Employment Commission, MACAA, Nelson Volunteer Coalition, and the Piedmont Baptist Association. The CHP's and the RHOP staff were also present and were performing screenings for blood sugar, blood pressure, vision, hearing, and cholesterol. The Piedmont Baptist association provided a linen closet for the participants as well as lunch. Games and activities for children took place throughout the event. Approximately 200 people attended the Hispanic Community Day. We changed the venue this year to Tye River Elementary School. The overall consensus was that this venue was preferable.

Currently, RHOP staff is enrolling CHPs for the upcoming spring training. Training will take place in Nelson County this coming spring over a 3 month period. It will also be offered to interested Latino or Spanish speaking individuals in the surrounding counties who wish to volunteer within their communities. RHOP hopes to recruit and train up to new CHPs through an expanded program. A formal graduation ceremony will follow at the end of the program.

| | | |
|--|---|--|
| | | in 2007: 138 # camp & worksite encounters in 2008: 83 # camp & worksite encounters in 2009: 109 |
| | Number of attendees at Community Day increases | 2005: c. 150 2006: c. 200 2007: c. 225 (12.5% increase) 2008: c. 200 (11% decrease 2009: c. 200 |

4. **Impact Report.** We are looking for issues and statistics specific to our local area: you are also welcome to include some general issues that set the framework for the local statistics. Under the Actual results heading, we are looking for impact, especially long-term results, not just numbers served. For the Financial Impact section, have each example highlight a different thing (in other words, don't just multiply the first answer three more times).

a. **Community Needs or Issues Your Program Addresses**—please include at least 3 local issues/statistics and cite your source

Census estimates (2008) show 2.9% of Nelson County's population (about 444 individuals) is "Hispanic or Latino". Each year the number of Spanish speaking patients at Blue Ridge Medical Center (BRMC) increases. Trend data for 2002 - 2007 show a 34.67% increase in the number of Latino patients. During the harvest season, the Latino population in Nelson typically doubles. At BRMC, 69% of Latino patients are uninsured. About 80% qualify for the sliding scale, indicating a decided income disparity when compared to other ethnic groups in the County. National statistics for Hispanics that are also true in Nelson County show that they are more likely to rely on community or public clinics for regular care, less likely to visit a doctor if uninsured, less likely to get routine screenings such as mammograms, be less satisfied with care primarily due to language barriers, and have less access to dental care than other local ethnicities.

Many parents of children born here do not trust local agencies enough to enroll their children in FAMIS and FAMIS Plus.

b. **Your Program's Solutions that United Way Community Impact Funds Support**

United Way funds support the activities of the Latino Outreach Coordinator and the RHOP nurse practitioner as they train and work with CHPs (Lay Health Promoters); and connect Latinos in need with the services that will help them through transportation, interpretation, case management, coordination of services with other agencies, health care services, and events such as the Hispanic Community Day.

c. **Actual Results** – based on your stated outcomes; please use percentages and numbers served to help show outcomes

The number of participants attending the Hispanic Community Day in 2009 was about the same as in 2008 (approx. 200). The issues from 2008 (extreme heat with no A.C. as well as a conflict with the use of the soccer field) may have contributed to the level number, but the positive feedback from the 2009 Event is sure to result in increased attendance next

year. . However, we expect this number to exceed 2008 as we increase advertising and planning efforts.

There was an increase in the number of encounters by the CHPs and staff at summer camps due primarily to an increased effort by RHOP to organize these visits. We can confidently say that 100% of the Latinos served by the Latino Outreach Program have a more positive experience as a result of the program than if they had no contact at all.

Financial Impact of Donations -- (i.e. \$3/week provides...; \$5/week provides...; \$10/week provides)

- i. **\$3/week (\$156/year)** pays for one lay health promoter to receive two three hour training sessions.
- ii. **\$5/week (\$260/year)** pays for 561 miles of transportation for Latino patients.
- iii. **\$10/week (\$520/year)** pays for interpretation at 43 medical visits.