

FY11 United Way Year-End Report for the Wellness Passport

Program: Wellness Passport

Agency: Blue Ridge Medical Center

Date: 08/05/11

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 our December 2010 mid-year report, the Wellness Passport program has continued to be busy. Flyers promoting the Wellness Passport continue to be distributed and hung throughout the community. The new Wellness Passport Coordinator, Susan Morris, did a fine job in helping increase the enrollment of the Wellness Passport Program. Many inquiries are being made and applications mailed due to the decline in local jobs and the increase in lay-offs. As of July 31, 2011, approximately 340 individuals are enrolled in the Wellness Passport program.

Susan Swink, our Corporate Wellness Coordinator, has worked diligently to present the program to small businesses. This extra effort gives us more exposure to businesses that may otherwise not know about the benefits of the Wellness passport Program. 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 community groups, including Social Services, Health Department, The Inter-Agency Council, and others, 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.

Later last year we "enhanced" the program to include "the Wellness Passport at Work," which is a way to "market" or promote the program to business owners and managers to offer this program to qualified employees and family members. We have about four businesses comprising about 20 employees who are either being enrolled or are committed to enroll. The new Coordinator is currently following up on these leads.

Blue Ridge Medical Center continues to make 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. The new Wellness passport Coordinator is also working more closely with the Sliding Scale Program Coordinator at BRMC and the new Latino Outreach Coordinator to increase enrollment.

We have seen an increase in the number of enrollees who are scheduling their physical exams which are included as a benefit of enrollment. In calendar year 2010, we conducted 166 Wellness Passport exams, and have conducted about 90 for the first half of 2011, which is a significant increase for the second year in a row. 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.

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.

There are well over 305 members of Wellness Passport at this time. We reach a diverse group of people in Nelson County and the surrounding communities. With the economy in decline, we are talking to more and more people about the program. Many are losing their jobs and consequently they are losing their coverage. Currently, and in the near future we foresee a large increase in the number of people applying and qualifying for the Wellness Passport Program. Many have expressed the feeling of some semblance of security they feel when they pursue preventative health care. On many occasions they have had no insurance for greater than a year and have recently found out about this program. The relief expressed by those that are able to sign up for this accessible health care has been overwhelming.

Susan Morris, our Wellness Passport Coordinator, recently spoke with a gentleman that has been on the program for more than 2 years now. His hours at his job were reduced to less than part time. He has looked diligently for work and has not been able to find anything that is full time. He lost his insurance and has been receiving assistance with food, through a food pantry program. When she spoke with him, her heart broke. One can obviously tell this man is proud and humble. He has struggled with the feeling that he has lost control and is unable to support himself. He said to Susan, "This program has allowed me to participate and be active in my ongoing health care." He expressed his appreciation for what we are doing.

Susan also had the opportunity to speak to a woman who recently got married. The couple lived together for many years and decided that they wanted to "do things right". They too have been hit with the down turn of the economy. Neither one has been able to find full time jobs, and barely get by with what limited income they have. They are independent and have not only been taking care of themselves, but have been involved in the care of her mother, as well. She mentioned that she also helps another family member at times. She told Susan, that it was time she started to take care of herself, too. She signed up for the Wellness Program so she could take an active role in getting healthier. This program has allowed her to improve her health, with the purpose of being able to continue to help others.

Susan says, "Since I have become the Wellness Passport Coordinator, I have started with a focus on improving the process by which a patient can sign up, become active, schedule their initial Wellness Passport Physical, and start the process of coaching their way to better health."

These stories exemplify the mission of all of our outreach programs: to identify persons at high-risk for disease and complications and support them in accessing help for recovery and/or treatment.

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 275 **Actual Number of Primary Beneficiaries** 305*

Projected FY11 Outcomes	FY11 Indicators Tracked	FY11 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	# WP Enrollees served: 305 235 (77%) WP patients seen by NP 120 complied with at least one treatment recommendation

	such as taking medication as prescribed or changing diet.	
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	166 patients served 3 times 100 (60%) 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	62 RHOP diabetic or hypertensive pts/clients served 3 times. 52 (84%) of those served 3 times demonstrated improvement

*While “305” is the technical number of current enrollees in our electronic medical records, we have another approximate few dozen records of active enrollees that are being assimilated into the system. We estimate actual enrollment to be around 340. Most of the records being assimilated are Hispanic clients.

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 2011 Wellness Passport enrollment increased by 25% over 2010 enrollment. 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.

Around 65% of enrollees receive quarterly health coaching. The health coaching enables them to set goals for problem areas, or continue healthy habits, and the health coach helps keep them on track with their health goals.

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.

FY11 United Way Latino Outreach Year-End Report

Program: Latino Outreach

Agency: Blue Ridge Medical Center

Date: 08/11/11

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.

In preparation for the return of migrant and seasonal farm workers on the summer, training of Community Health Promoters (Promotoras) took place in spring and summer of 2011. The curriculum was planned and speakers lined up, including providers from Blue Ridge Medical Center, and many community professionals.

During the 8-week program participants learned:

- how to take vital signs, when medical treatment is necessary and how to advise clients with abnormal results,
- the relationship between dental hygiene and nutritional status, good oral hygiene, an understanding of plaque, periodontal disease and decay, and local resources,
- the long term effects of sun damage on skin and eyes, to explain and identify skin problems ie. allergic reactions, general signs of bacterial infection and fungal infections of the skin and nails,
- the role nutrition plays in health, how to use the food pyramid, how to make healthy choices, prepare healthy foods, understand portion sizes and the benefits of eating whole, natural foods,
- the anatomy of the female body, how various birth control methods work and the benefits of well-woman-care, including gynecological exams,
- signs of reproductive health problems, the prevention of sexually transmitted diseases, the difference between HIV and AIDS, and community resources for testing and treating STDs,
- about pregnancy: preconception and prenatal care, changes in the body during pregnancy, pregnancy needs and clinic needs for prenatal care and resources for pregnant women,
- cultural influences, risks of injury and accidents, schedule of childhood immunizations, good exercise and nutrition patterns for children and community resources,
- about sexual assault, domestic abuse and date rape, the signs and symptoms of violence and abuse and community resources,
- substance abuse: how to identify signs of alcohol abuse, difference between empathy and enabling and resources for rehabilitation,
- about prostate, cervical, breast skin and colon cancer, early warning signs, importance of self exams and screenings and cancer resources.
- Participants completed the American Heart Association CPR "Heart Saver" course and were certified.

Participants graduated the course and expanded the work they were already doing in the community. We formalized the schedule for camp visits, ordered supplies. The first camp visits were in July and continue into November.

Hispanic Community Day is scheduled for September 18, 2011. Planning is underway, and this year's event will include some new features that should increase the level of interest and

CHPs become established leaders in their community, serving as a bridge between Latino residents and health and human resources. New residents turn to CHPs for assistance.	Increase the number of contacts per CHP over FY10	# of LHPs identified for training in 2007: 5 # of CHPs trained in spring of 2008: 9 # of CHPs trained in spring of 2009: 12 # of CHPs trained in spring of 2010: 9 # of CHP's trained in spring of 2011: 8
	Number of camp and worksite encounters increases.	# camp & worksite encounters in 2006: 115 # camp & worksite encounters in 2007: 138 # camp & worksite encounters in 2008: 167 # camp & worksite encounters in 2009: 158 # camp & worksite encounters in 2010: 162
	Number of attendees at Community Day increases	2006: c. 200 2007: c. 225 (12.5% increase) 2008: c. 200 2009: c. 200 2010: c. 150*

*The number attending Hispanic Community Day decreased because of one major issue: “last minute” change of venue. Having received approval to use Tye River Elementary School 6 months in advance, they canceled on us with only 10 to the event, due to construction crisis regarding the roof. We had to change the venue with less than a week to communicate the new location.

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 (2009) show 3.1% of Nelson County's population (about 480 individuals) is “Hispanic or Latino”. Each year the number of Spanish speaking patients at Blue Ridge Medical Center (BRMC) increases. Trend data for 2008 - 2010 show a 43% increase in the number of Latino patients with 668 having been served at Blue Ridge Medical Center in calendar year 2010. 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 nursing staff 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
2010 encounters were about 479 over 2009 (36% increase). The steady higher number of encounters continues to be related to a steady number of Latinos coming to BRMC from other areas (Charlottesville, Madison Heights and Lynchburg). CHPs also impacted the number of visits by being able to recommend office visits where symptoms and problems would otherwise have been ignored. (2006 = 1062, 2007 = 729, 2008 = 1342, 2009= 1327, 2010= 1806.

About the same number of CHPs were trained during FY2011 (8) as FY2010 (9). More people in the community can be served when there are people trusted by the population who have the training and authority to make recommendations for care. With the addition of a full-time Latino Outreach Coordinator, as well as a part-time Latino Outreach Promoter, we are confident that we can improve the recruiting process. We continue to “tweak” the curriculum to have the best CHP training possible.

There was a very slight increase (2.5%) of encounters with Latinos in their homes (camps) and workplaces from 2010 (2010= 158, 2011= 162). These onsite visits help to minimize the barrier of transportation and the problem Latinos in camps experience of not being able to get time away from work to schedule doctor's appointments.

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 472 miles of transportation for Latino patients.
- iii. **\$10/week (\$520/year)** pays for interpretation at 43 medical visits.