



**COMMUNITIES  
ORGANIZING TO  
PROMOTE  
EQUITY**

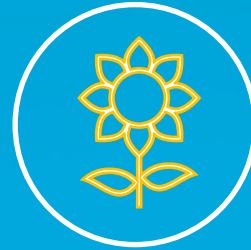
**The role CHWs & community coalitions can play in addressing maternal health:**  
Leveraging community-driven solutions through the Communities Organizing to Promote Equity (COPE) Project

Angela Scott & Christina Pacheco  
Dep. of Family Medicine & Community Health, KUMC  
On behalf of the COPE Team

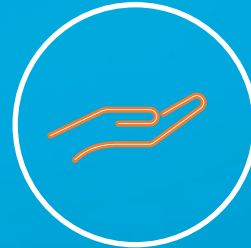


# Overview of presentation

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Overview of COPE



Overview of CHWs



CHW Maternal  
Health Interventions



Community Driven  
Solutions to MCH

# COPE on the Ground Technical Assistance Structure



**West & Central  
CHW PM  
Angela Scott**



**RCL West  
Clarissa Carrillo**



**RCL Central  
Nadine Long**



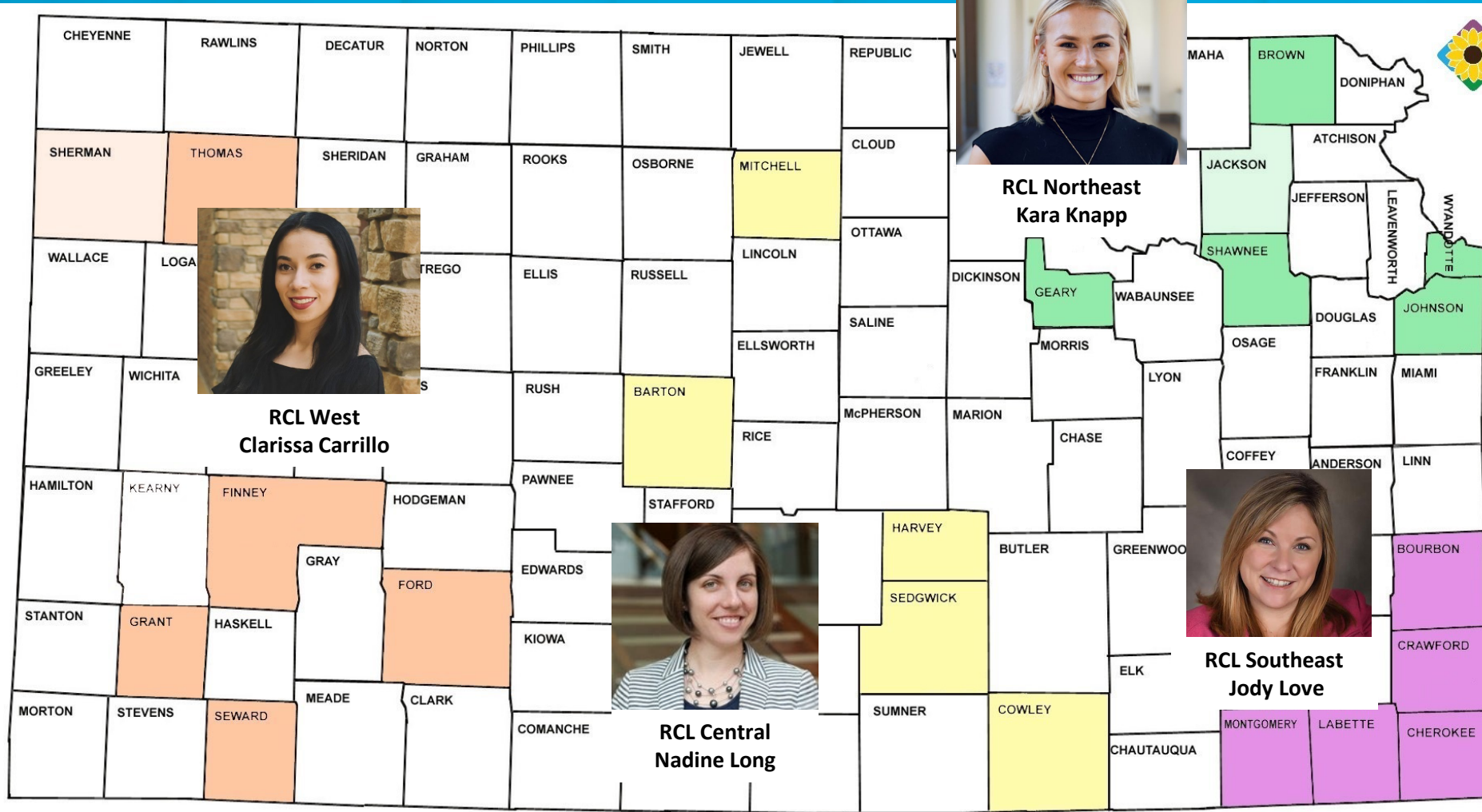
**RCL Northeast  
Kara Knapp**



**RCL Southeast  
Jody Love**



**North & Southeast  
CHW PM  
Ton Miras**



○ WEST

○ CENTRAL

○ NORTHEAST

○ SOUTHEAST



# Community Coalitions

## Who

- Members live in the community and are diverse (e.g., race/ethnicity, gender & sexual diversity, religion, age, ability, education, income)
- Provide links to local networks and organizations
- Understand the context of the community

## What

- Collaborate to identify the specific needs in a community in an ongoing way
- Learn together about assets and barriers in the community
- Build consensus around priorities within the team identity
- Develop action plans and strategies to intervene on issues that keep people from thriving

# Why Community Coalitions?

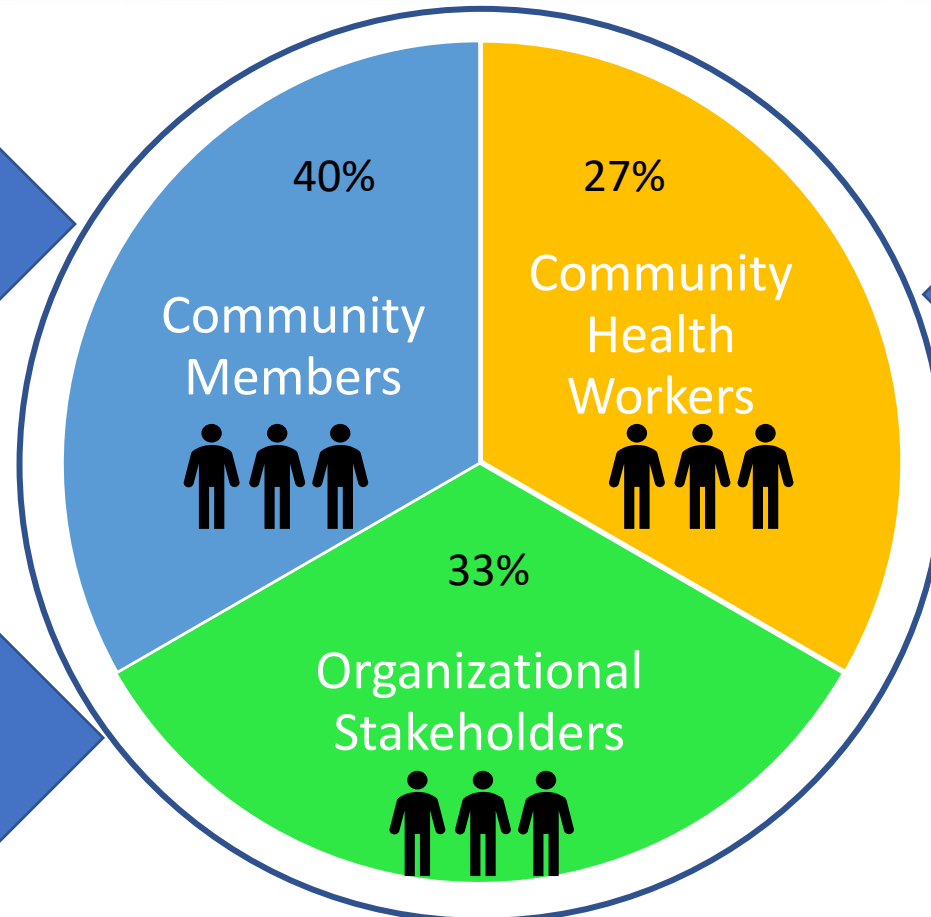


- To optimize community engagement
- Community engagement is based on the democratic idea that everyone who is affected by an issue should have a say in the decision making around it

# Local Health Equity Action Team (LHEAT)

These members provide the lived experience with unmet needs and have innovative ideas on how to improve access.

These members know the services and partners in the region. Also know the existing events/activities.



These members help implement the activities and events planned by LHEAT. Engage the communities identified collaboratively by LHEATs for service connections.

N=216 members, Mar-Sep 2022

# Community Health Worker (CHW) Role



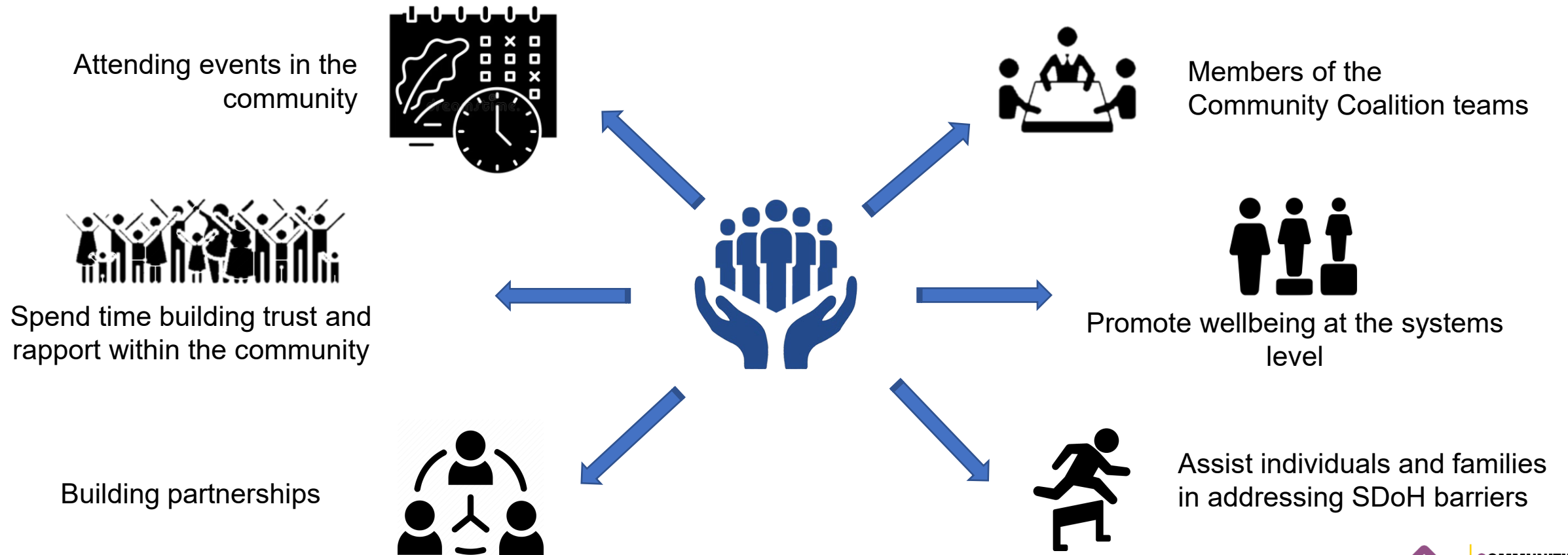
## CHW Definition:

A community health worker is a frontline public health worker who is a **trusted member** of and/or has an unusually close understanding of **the community served**. This trusting relationship enables the worker to serve as a **liaison/link/intermediary between health/social services and the community** to facilitate access to services and improve the quality and cultural competence of service delivery.

A community health worker also **builds individual and community capacity** by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.



# Community Health Worker Role





# How do CHWs work with clients?

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- Clients / patients are referred to CHWs by medical staff, community-based organizations, self-referrals.
- CHW connects with the patient on the phone and introduces the program.
- CHW sets up a time to meet with patient in their houses or in the community.
- CHW assesses clients' needs together create a care plan to address clients' needs & concerns.
- CHW and client work together to complete those goals.
- A client can be enrolled for as long as they have needs. And they always can come back if needed!



# Common tasks a CHW does with a client

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- **Links** clients to medical care.
- **Attends** medical appointments with patients and educates them on navigating the system. Also, **advocates** for them during appointments
- **Helps them apply for benefits** – food stamps, Medicaid, health insurance, WIC, etc.
- **Connects** them to community resources.
- **Teaches clients health literacy** – how to read prescriptions, how to ask the doctor questions, how to refill their medications, etc.
- **Perform home visits.**
- Moves patients towards **self-sufficiency** – teaching the client the skills needed to become self sufficient
- **Cultural mediator**



# Characteristics of CHWs & their Clients



Ton Miras Neira



Angela Scott

## COPE CHWs, n=53

	n	%
<b>Gender</b>		
Female	46	86.8%
Male	7	13.2%
Non-binary	0	0%
<b>Self-Identified Race/Ethnicity*</b>		
White	21	39.6%
Hispanic/ Latino	20	37.7%
Black/ African American	9	17%
American Indian/ Alaska Native	1	1.9%
Asian/ Southeast Asian	1	1.9%
Other	1	1.9%
<b>Languages spoken</b>		
English	30	56.6%
Bilingual English/Spanish	21	39.6%
Bilingual English/ Other	2	3.7 %

## COPE Clients Served: 4,589

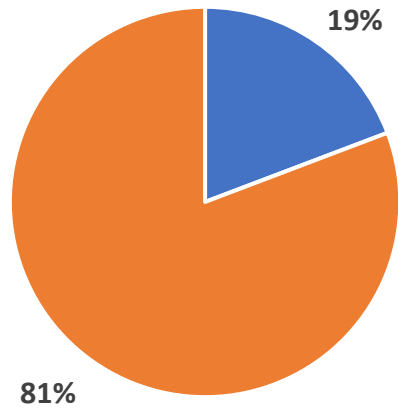
	n	%
<b>Gender</b>		
Male	1,367	29.8%
Female	2,769	60.3%
Not specified/Declined	189	4.1%
<b>Self-Identified Race</b>		
White	2,918	63.6%
Black/ African American	352	7.8%
American Indian/ Alaska Native	70	1.5%
Asian/ Pacific Islander	126	2.7%
Not specified/declined/other	831	18.1%
<b>Ethnicity</b>		
Hispanic/ Latino	1,357	29.6%
Not specified/Declined	723	15.8%



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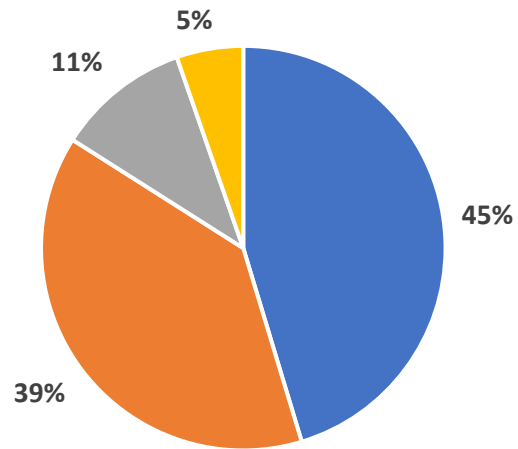
# Placement of COPE CHWs

Urban - Rural CHWs



■ Urban ■ Rural

CHW Placement



■ CBOs ■ Clinics ■ LHD ■ Other



United Way of Central Kansas



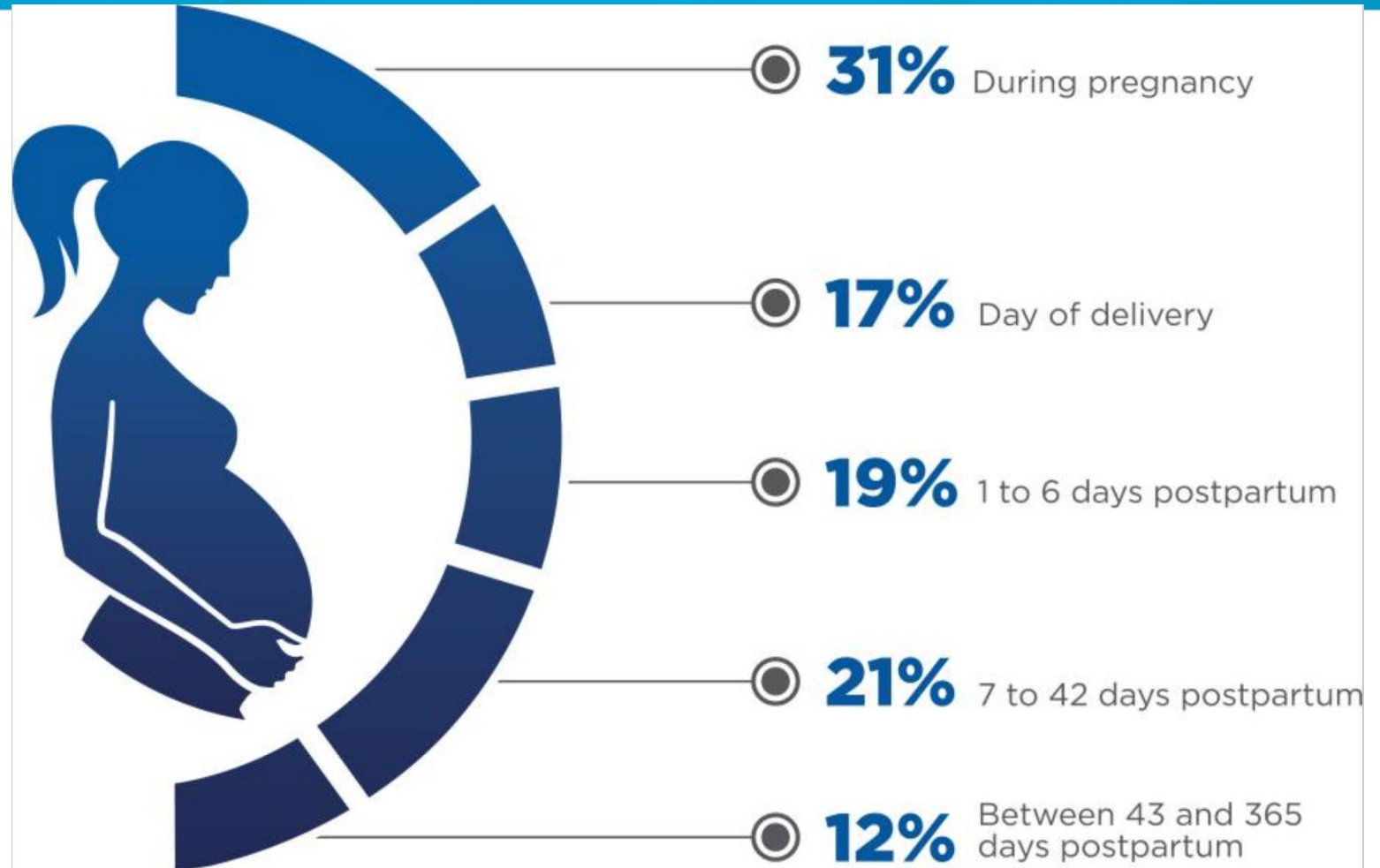
# CHW Maternal Health Interventions

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Fourth Trimester Initiative

# Maternal Mortality in the US – Timing for interventions

- Most KS maternal deaths occur between the time immediately after birth and the end of the 1<sup>st</sup> year.
- Additionally, the first year after birth presents many physical and emotional changes for the mother, baby, and family.
- Data from KDHE Vital Statistics, as well as the Kansas MMRC, demonstrated that **focused evaluation and intentional intervention in the postpartum period should be the primary goal to improve maternal health outcomes.**
- The Fourth Trimester Initiative is an innovative, cutting-edge approach to studying and improving the experience of our mothers and families in KS.



# FTI/COPE CHW HIGH-LEVEL WORKFLOW

## Patient sources

Referral by FTI partner champion(s)  
*(Referral can be sent to CHW through different venues)*

## Outreach

CHW will call client in 24 hours and screen for eligibility  
*(CHW will attempt up to three times to connect with the client)*

## CHW Intake

CHW will meet with client (home visit or phone call) to sign consent and perform a needs assessment.

**COPE trained 25 CHWs on this initiative**

CHW will assist client to produce a care plan and decide next steps.

## Goals/ Referrals

- CHW and client will work together on completing their goals (including follow up visits)
- Once goals are completed, CHW will discharge client from the program.

## Reporting back

- CHW will report back to provider once the care plan is ready, and upon completion.
- Provider can request an update at anytime.

## Documentation

- CHWs document all the encounters with clients in a database

# COPE CHW MCH Client Interactions

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- Established **299** partners that can offer MCH resources
- Served **137** clients:
  - 223 goals related to MCH
  - 181 were successfully completed (81.2%)

- Example client goals:

Connections to baby supplies/resources

Links to childcare services

Connections to pediatric services

Parenting classes

Applying for WIC





# Coalition Maternal Health Interventions

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Local Health Equity Action Teams

# WHAT DO WE DO?

Since LHEATs for each county consist of members from that community, each team creates specific action plans with their unique needs and assets in mind..

Here are some examples...

## WYANDOTTE COUNTY: LAUNDRY LOVE



Goal: address lack of access to clean clothes, water, electricity, ability to wash clothes  
Plan: organize event at local laundromat, connect with Laundry Love to establish a location in WyCo

## COWLEY COUNTY: INTERPRETERS



Goal: provide interpreter services to help non-English speakers access social services and other resources  
Plan: assemble a list people to serve as local interpreters/health care advocates

## JOHNSON COUNTY: BABY SHOWER



Goal: address infant mortality by providing safe sleep environments and safe sleep education  
Plan: organize "SafeKids Johnson County community baby shower" to distribute crib sheets and provide tools and education to families

## CHEROKEE COUNTY: TRANSPORTATION



Goal: provide transportation to patients for medical appointments  
Action: Worked with the Cherokee County Ambulance Association to help fund the purchase of a passenger van

## SEWARD COUNTY: CHILDHOOD VACCINES



Goal: provide COVID-19 as well as routine/school-related immunization for school-age children  
Action: Organized weekend vaccine clinics during Summer 2022

And many more projects surrounding food insecurity, housing insecurity, mental health, financial education, among others!

# Priority Concerns Raised Across LHEATS to Date

# LHEAT Actions

120 Bags Donated to Support Shawnee County Children in Foster Care



Supporting Johnson County Families through Diaper Distribution



Diaper scarcity severely impacts low-income families. In the U.S., [one in three mothers](#) struggles to maintain a steady supply of diapers, further challenging childcare. In early February, the Johnson County LHEAT and CHWs hosted a diaper distribution event to support multiple families with young children.

The Shawnee County LHEAT's "Keep It Real Summit" Champions Youth Mental Wellbeing



📍 Fighting for Birth Equity in Shawnee County 📍



On November 4, [Shawnee County LHEAT](#) hosted a panel to examine infant mortality and the path toward equitable birth outcomes. With a full house in attendance, the panel spotlighted the causes of maternal

3,400 Hygiene Kits To Support Pre-school to college-aged Children in Ford County: The LHEAT and local partners will sustain this effort annually.



Volunteers creating kits

By Phil Handsaker (The Ford County LHEAT Lead)

After the PE uniforms initiative, the Ford County LHEAT is following up with a hygiene kit distribution. It plans to sustain the effort to make the hygiene kit distribution an annual event.

Children ranging from pre-school to college and clients of [Compass Behavioral Health](#), a mental health center, will soon receive kits that contain handmade quilted toothbrush holders.

Protect Beautiful Smiles in Sedgewick County



In partnership with Oral Health Kansas and the Oaklawn Community Wellness Hub, the Sedgewick County LHEAT and Thien Doan (CHW in Sedgewick County with a home base in [GraceMed](#)) sponsored an oral health awareness booth.

Forty 4<sup>th</sup> and 5<sup>th</sup> graders in the Oaklawn Elementary School's after school program participated in an experiment to learn about how to protect their "beautiful smiles." They also learned about how sugary drinks contain excessive amount of sugar. Each student received a dental kit from Delta Dental and a kit from Oral Health Kansas.

# COPE LHEAT MCH Interactions

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- Engaged in/supported **149** MCH related events in 2 years

## Example Community Events:

- Community baby showers/Resource distribution events
- Childcare/Educational Services
- Communication/Promotion/Advocacy
- Healthcare Services

## Example Capacity Building/Sustainable Approaches:

- Community assessment of childcare needs
- New Childcare Facility in the Community through the School District
- Safe Sitter certification classes
- Expansion of Dolly Parton Imagination Library in partnership with United Way
- Breastfeeding pumps rental through local health department
- New playground equipment / Youth football helmet recertification
- Harvey County Resource Guide for Maternal/Infant Health



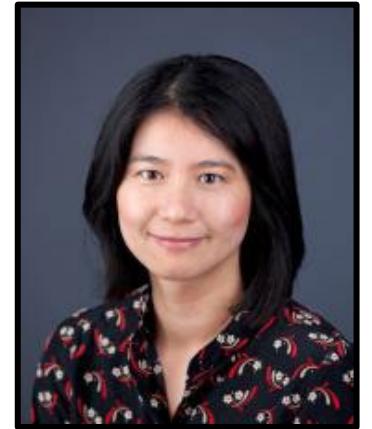
# Monthly Newsletter



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## Subscribe!



Dr. Yvonne Chen

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## Visit!

[www.kumc.edu/COPE](http://www.kumc.edu/COPE) for more information



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**E**EQUITY

**Acknowledgements:**

Thanks to our COPE Team, CHWs, LHEATs, and community partners for their dedication to achieving health equity in Kansas!

Thank you to our funders at KDHE, and CDC for the opportunity to engage in this work and continual brainstorming on how to continue it.