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community health foundation

Supporting Community Health Workers to Enhance Effectiveness in Advanced Primary Care Settings

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Learning Objectives

- To summarize the contributions of CHWs and how they help transform the primary care team
- To discover the potential for CHWs in integrated behavioral health primary care settings
- To explain the need for leadership in developing and advocating for the enhanced primary care team model.

Aims of the RCHN CHF Population Health Initiative

- To support community health centers in fulfilling their mission as a provider of comprehensive primary care and agent of positive change for at-risk populations & communities
- To support health center-level progress toward improving population health management capacity and outcomes
  - Strengthen capacity to identify, engage and manage health in a defined population
  - Deepen features of patient- and community- centered health home
  - Influence social determinants of health
  - Encourage local and regional collaborations and broader opportunities for sharing best practices

Outcome Objectives

- Strengthened capacity for population health management that addresses social determinants of health
- Implementation of population health management interventions to achieve documented outcomes
- Strengthened or new partnerships with organizations addressing health and the social determinants of health
- Development of enhanced potential for sustainability and expansion of interventions to additional populations
- Development and implementation of learning community to share information, processes.

Total Population Health Definition

- Addressing the health and wellbeing of all people within a given geographic area
- Development of non-traditional partnerships among different sectors of the community to achieve outcomes
- Alignment of “panel” population health efforts with broader “total” population health efforts

Population health management is essential …..

- as a component for practice transformation to advanced primary care
- for delivering and documenting value-based primary care
- to promote sustainability in evolving health reform initiatives at national and state levels

Supported Projects Round 1

- **Health outcomes in defined geographic areas:**
  - African American Infant Mortality (Erie County Community Health Center, Ohio)
  - Smoking reduction in New York City's Chinatown (Charles B. Wang CHC, New York, N.Y.)
- **Patients identified with defined health center or system of care**
  - High-risk, chronically ill homeless individuals (Santa Rosa Community Health Centers, Ca)
  - Patients with uncontrolled diabetes (Access Family Care, Joplin, Missouri)
  - Colorectal and other cancers (Adelante Healthcare, Phoenix, Arizona) and cervical cancer screening (CO Community Health Network, Colorado)
  - Pediatric emergency room utilization & enhanced care coordination for children (Hudson Headwaters, Queensbury, New York)

Supported Projects Round 2

- **Patients identified within health center or system of care**
  - FVRx Intervention for patients with un-controlled diabetes (Mariposa Community Health Center, Nogales AZ and Idaho Primary Care Association, ID)
  - Home intervention model for Pediatric Asthma patients (St. John's Well Child and Family Center, Los Angeles CA)
  - Integrated health home for patients with significant mental health or substance abuse disorder (Access Community Health Center, Chicago IL)
  - High Acuity Transgender patients with high ED utilization (Fenway Community Health Center, Boston MA)
- **Planning Grants**
  - Improving Care for Incarcerated Youth (Georgia PCA)
  - Assessing role of CHWs in Integrated Primary Care Settings (NWRPCA)

Interventions Developed

- Added staff for care coordination and case management & developed new care-team models
- Added quality improvement staff
- Developed intervention for larger population to address social determinants of health
- Expanded existing external collaborations or initiated new relationships and partnerships
- Worked with Medicaid Agencies to develop support for new payments structures to support designed interventions
- Developed ongoing learning community sessions among grantees

Projects with CHWs as an Intervention

- SJWCFC: Home visits, care management and asthma education by CHW
- Mariposa: Home visits, care management and nutritional education by CHW
- Erie County: Care management and pre- and post-natal education by CHW
- NWRPCA: Assessment of CHWs in Integrated Health and Behavioral Health Settings

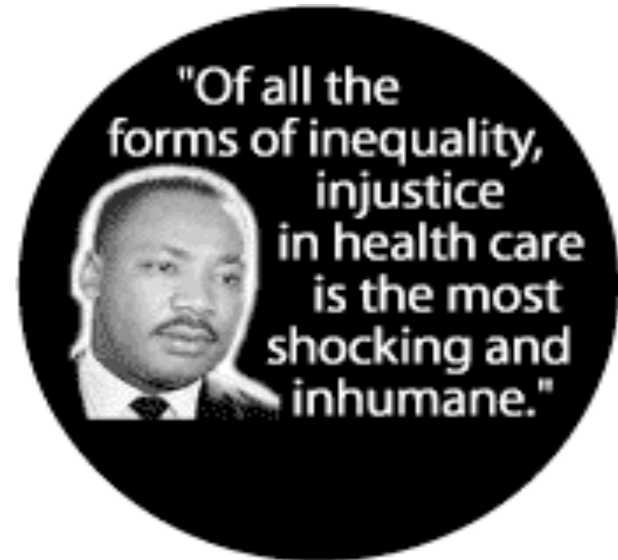
Who are Community Health Workers (CHWs)?

EMERGENCE OF CHWS IN U.S.

1962: Migrant Health Act

1964: Economic Opportunity Act

1968: Indian Health Service Establishes Community Health Representative Program



"We are re-discovering the value and role of community health workers, and I've got to add it's about time."
-- Dr. H. Jack Geiger

DEFINING THE FIELD

Bureau of Labor Statistics Standard Occupational Classification: DOL 21-1094 Community Health Workers--Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health.

May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs. Excludes "Health Educators" (21-1091). Illustrative examples: *Peer Health Promoter, Lay Health Advocate*

DEFINING THE FIELD

American Public Health Association:

A Community Health Worker (CHW) 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 CHW 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 CHW 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.

Key Characteristics

- **Trusted member of the community being served**
- **Shared life experiences**
  - Language
  - Culture
  - Race/Ethnicity
  - Sexual Orientation
  - Socio-economic circumstances
  - Chronic disease condition
- **Strong desire to help community**

CHWS HAVE MANY TITLES

Outreach Worker

Health Advocate

Community Health Representative

Promotor(a) de Salud

Eligibility Worker

Patient Navigator

Lay Health Educator

Village Health Worker

Care Coordinator

Peer Support Specialist

CHW Skills: CHW Core Consensus (C3) Project

1. Communication Skills
2. Interpersonal and Relationship-Building Skills
3. Service Coordination and Navigation Skills
4. Capacity Building Skills
5. Advocacy Skills
6. Education and Facilitation Skills
7. Individual and Community Assessment Skills
8. Outreach Skills
9. Professionals Skills and Conduct
10. Evaluation and Research Skills
11. Knowledge Base

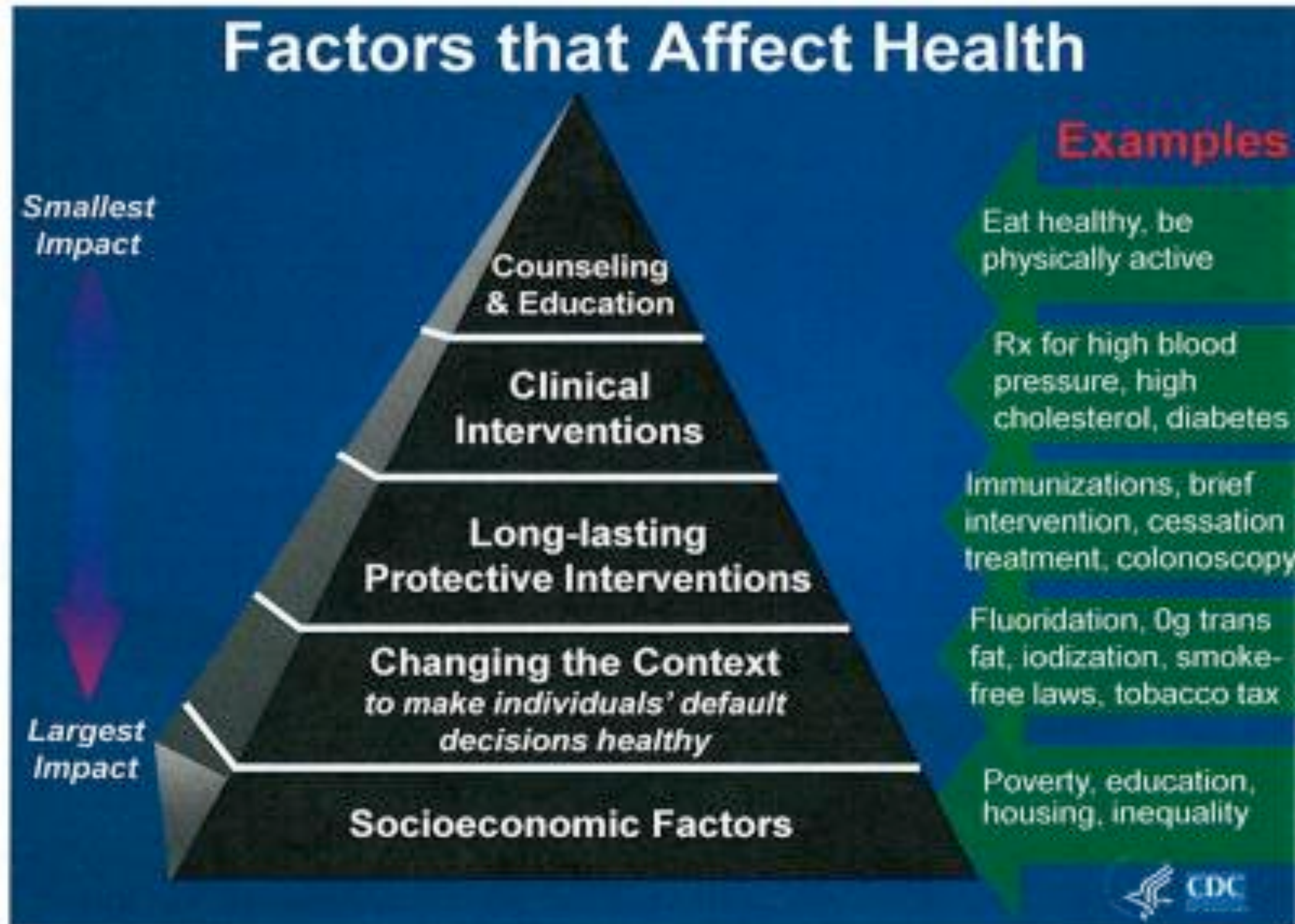
Source: The Community Health Worker Core Consensus (C3) Project: 2016 Recommendations on CHW Roles, Skills, and Qualities

CHW Roles: CHW Core Consensus (C3) Project

1. Cultural Mediation Among Individuals, Communities, and Health and Social Service Systems
2. Providing Culturally Appropriate Health Education and Information
3. Care Coordination, Case Management, and System Navigation
4. Providing Coaching and Social Support
5. Advocating for Individuals and Communities
6. Building Individual and Community Capacity
7. Providing Direct Service
8. Implementing Individual and Community Assessments
9. Conducting Outreach
10. Participating in Evaluation and Research

Source: The Community Health Worker Core Consensus (C3) Project: 2016 Recommendations on CHW Roles, Skills, and Qualities

A Framework for Public Health Action: The Health Impact Pyramid



CHWS ARE UNIQUELY QUALIFIED TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

“One of the first objectives for family physicians is to understand the living conditions patients face when they leave our office or when they leave the hospital. What is the social and environmental context they are going back to? How does it affect treatment plans?"

Steven Woolf, MD, MPH, AAFP News, 8/3/11

ACA PROVIDES OPPORTUNITY

1. Expanded insurance coverage and access to healthcare
2. Improving quality of care (CMS Innovation Center)
3. Prevention and health promotion measures (PCMH, ACOs)
4. Promoting community and population-based activities (National Prevention Strategy, Prevention and Public Health Fund)

Source: Stoto, M.A. *Population Health in the Affordable Care Act Era*. Academy Health; 2013.

Supporting Community Health Workers to Enhance Effectiveness of Behavioral Health-Primary Care Integration

Planning Grant

Project Deliverables

- Advisory Committee
- Literature Review
- Survey
- Focus Groups
- Concept Paper

Mental Health v. Emotional Wellness

Mental Health

Clinical
Diagnosis and treatment

Emotional Wellness

Holistic
Relational/ addressing SDOH

Select the behavioral health activities CHWs engage in at your organization

	Activity	Frequency	Percent
Top 5 responses	Social Determinants of Health Related Activities	124	59.3
	Wellness and Healthy Living	123	58.9
	Outreach Work	120	57.4
	One-on-One	119	56.9
	Classes/Training	115	55.0
Bottom 5 responses	Substance Use Disorder	67	32.1
	Support Groups	66	31.6
	Immigration Education	58	27.8
	Chronic Pain Management	46	22.0
	Migrant Camp Visits	33	15.8

In your opinion, how integrated is behavioral health in your organization?

	CHW N=106		Management N=62		Provider N=33	
Level of Integration	Frequency	Percent	Frequency	Percent	Frequency	Percent
Very Integrated	48	**45.3**	24	38.7	14	42.4
Somewhat Integrated	44	41.5	27	**43.6**	15	**45.5**
Minimally Integrated	8	7.6	8	12.9	2	6.1
Not Integrated	6	5.7	3	4.8	2	6.1

In your opinion, are there ways that CHWs can be better utilized to enhance behavioral health services in your organization?

	CHW N=108		Management N=60		Provider N=31	
Response	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	71	**65.7**	48	**80.0**	16	**51.6**
Unsure	30	27.8	10	16.7	13	41.9
No	7	6.5	2	3.3	2	6.5

Exploring CHW roles

- *“As CHWs we always work with social determinants of health, sometimes in limited ways but wherever possible we are offering time, support, openness to families for connection to mental health supportive services/treatment as well as substance use/abuse treatment and supportive services.”*

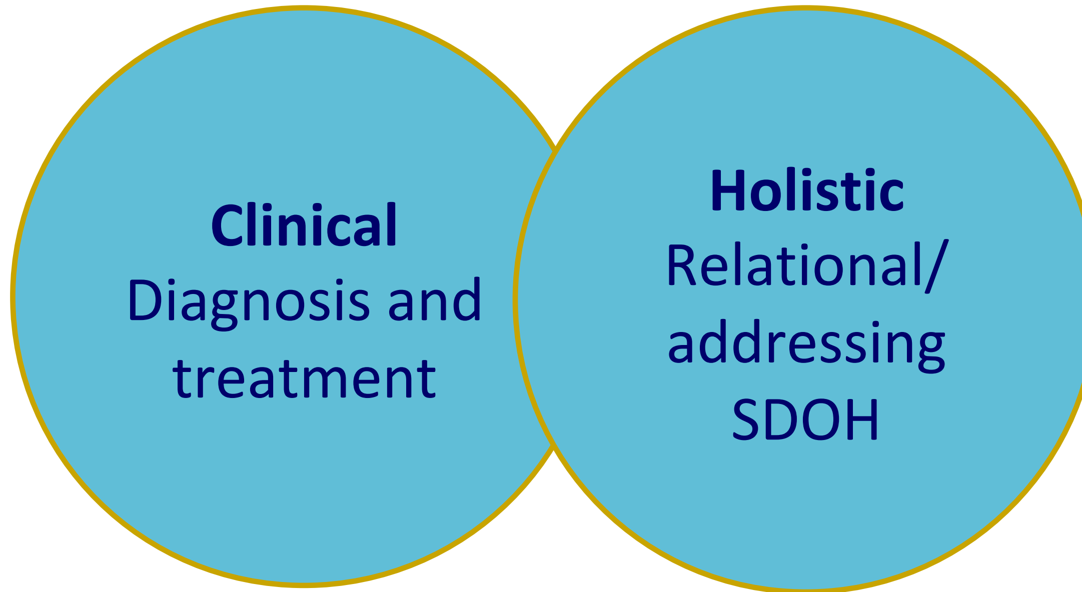
- *“Providers still have the impression that behavioral health is for mental health or addiction issues only.”*

- *“Not enough people understand how CHWs can make a difference.”*

Recommendations

- Better identify and clarify the range of roles of CHWs, including the impact they have in the access and utilization of health services in primary care and behavioral health settings.
- Provide training and professional development opportunities for CHWs, particularly in areas of mental health (e.g. mental health first aid, motivational interviewing).
- Offer some of the same CHW training modules to supervisors and ensure constant and consistent communication to all members of the primary care team regarding the roles and contributions of CHWs.
- Designate clear office space in the health center for CHWs. Make them visible.
- Advocate for funding models that include CHWs as essential members of the primary care team.

Final Thought



"We promote bonding. We combat isolation. We do the collective work. That's what we do as CHWs. We do the collective work instead of the individual work. We bring people together and that's mental health work."

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