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Integrating Community Health Workers Into Primary Care to Support Behavioral Health Service Delivery

A Pilot Study

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Abstract: Community health workers (CHWs) collaborating with health care teams improve health outcomes. The feasibility of employing CHWs to support behavioral health in primary care is unknown. We offered experienced CHWs a 48-hour behavioral health training and placed them at health centers. Supervisors received technical assistance to support integration. We interviewed team members to explore CHW interactions with patients and team members. There was evidence of CHW integration. Major CHW roles included care coordination, outreach, and screening. It may be feasible to integrate behavioral health–focused CHWs into primary care settings. Both CHWs and supervisors need ongoing training and support. **Key words:** *behavioral health, community health workers, mental health, primary care*

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APPROXIMATELY 1 in 5 adults in the United States experiences a mental illness in a given year and an estimated 20 million have a substance use disorder (Substance Abuse and Mental Health Services Administration, 2013). Americans receive more mental health services from general practitioners than from mental health specialists (Wang et al., 2006), leading the primary care system to function as the "de facto" mental health system (Regier et al., 1993). Patients rarely identify behavioral disorders as the reason for seeking primary care, although more than 20% of visits may be related to depression alone (Zung et al., 1993).

There is a clear need to ensure appropriate screening and access to treatment of behavioral health issues within primary care settings, as reflected by US national public health priorities (*Healthy People 2020*, US Department of Health and Human Services, 2015). The National Center for Quality

Assurance recently released updated guidelines related to behavioral health for practices seeking Patient-Centered Medical Home accreditation (National Center for Quality Assurance, 2014). Similarly, the Institute for Healthcare Improvement has offered recommendations for behavioral health integration (Laderman & Mate, 2014).

Employment of community health workers (CHWs)—frontline public health workers who fill a variety of nonclinical roles—may be a promising model for identifying behavioral health conditions within primary care settings and increasing access to treatment. Because members of this workforce generally share the life experiences of the communities they serve, they are a trusted resource for providing culturally responsive health coaching, social support, and connection to community resources (American Public Health Association, 2009), and they may be uniquely suited to help patients overcome stigma associated with behavioral disorders. CHWs frequently function as primary care team members (Findley et al., 2014; Thompson et al., 2007;), and they have improved outcomes for chronic illnesses such as diabetes (Shah et al., 2013) and hypertension (Brownstein et al., 2007), which are often comorbid with behavioral disorders (Anderson et al., 2001; Carroll et al., 2010). They have reduced depressive symptoms among participants in chronic disease prevention programs (Cutshaw et al., 2012). Specific roles in behavioral health have included addressing contextual sources of depression (Waitzkin et al., 2011), supporting Latina immigrants to reduce depression (Tran et al., 2014), and conducting outreach to expand collaborative care in a postdisaster setting (Wennerstrom et al., 2011).

There is strong evidence that team-based behavioral health care delivered in primary care settings improves outcomes for mood disorders (Unutzer et al., 2002). However, little is known about the feasibility of employing CHWs to complement behavioral health service delivery in primary care settings. We outline the development of a curriculum to train CHWs to engage patients in receiving behavioral health services, examine the experiences of CHWs and their supervisors in creating a behavioral health role for CHWs at 4 Federally Qualified Health Centers (FQHCs) in Texas, and offer suggestions for future interventions.

METHODS

An experienced CHW trainer (A.W.) created a 48-hour behavioral health curriculum for experienced CHWs. The course focused on reinforcing nationally recognized core competencies (Health Resources and Services Administration, 2007; Wiggins & Borbón, 1998), developing new knowledge and skills for collaborating with a behavioral health team, and introducing a modified version of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model (Madras et al., 2009). Brief interventions included basic motivational interviewing skills and activity planning, which is an evidence-based treatment of depression (Cuijpers et al., 2007). The curriculum outlined a range of roles that CHWs could fill, depending on needs and capacity of their employing agency. Roles included conducting outreach, serving as a liaison between patients and the health care team, referring patients with positive behavioral health disorder screenings to clinical providers, and speaking with patients after provider visits to coordinate behavioral health services and combat stigma. The course emphasized operating within the scope of practice to maximize CHWs' unique strengths and avoid overlap with activities reserved for clinically trained providers.

Trainee and trainer manuals incorporated materials adapted from 2 previously implemented CHW education programs (Wennerstrom et al., 2011, 2014) and educational materials published by the Substance Abuse and Mental Health Services Administration. The curriculum was based on adult learning theory principles, which include active learner participation (Cranton, 2006). To ensure that CHWs were engaged in learning, each 4-hour module included a variety of teaching techniques such as discussion, role-playing, kinesthetic activities, pair work, and direct instruction. An in-depth review of the curriculum was

completed by a national advisory board that included a CHW with 20 years of experience working in mental health and substance abuse (A.L.K.), as well as experts in CHW training, behavioral health, and the SBIRT model.

A State-of-Texas-certified community health worker instructor who is a Master Community Health Education Specialist (L.H.) used the curriculum to train 4 experienced CHWs. All CHWs had previously completed or were in the process of completing the State of Texas 160-hour CHW core competency certification course. CHWs completed a posttraining satisfaction survey that contained 20 items related to instructor performance (eg, instructor explained material clearly) using 5-point Likert scale (1 = hardly ever, 5 = almost always).

Each CHW was selected by 1 of 4 FQHCs in Texas that agreed to serve as a pilot implementation site. Half of each CHW's salary was funded by the project, and agencies contributed the remainder. Two FQHCs served primarily Latino/Hispanic populations. CHWs at those sites were bilingual in Spanish and English and equally comfortable using both languages; CHWs at the other 2 sites spoke only English. One clinic's patients were predominantly white, whereas the other served a patient population that was roughly half white and Latino/Hispanic. An 8-hour training was offered to FQHC supervisors to orient them to the CHW model including unique strengths and the possible roles outlined in the CHW curriculum. FQHCs were provided with several strategies to encourage CHW integration such as creating CHW job descriptions, holding regular care team meetings to discuss and refine workflow processes, and providing CHWs with ongoing mentorship, feedback, and support. Sites retained freedom to determine their own workflow practices and CHW activities based on their unique patient, staffing, and community circumstances. Research team members provided technical assistance through site visits, phone calls, and e-mails. Approximately 3 months postimplementation, a researcher unaffiliated with training or project implementation (S.M.) conducted in-person interviews in English with all CHWs and supervisors to assess impressions of the training, as well initial experiences with integrating the CHWs into practice. Six months postimplementation, the researcher conducted another series of interviews to further explore each site's behavioral health care delivery model. Interviews were audio-recorded and transcribed verbatim. Two researchers (A.W. and S.M.) independently reviewed transcripts and met to create a codebook for analysis. All interviews were coded using Atlas.ti software (Version 6.2.27, GmbH, Berlin, Germany). Researchers met again to review codes and identify illustrative quotes.

RESULTS

The CHW training curriculum is outlined in Table 1. Although the course was initially designed to be taught in person, the distance between the FQHCs made travel to a central location challenging. The trainer made slight adaptations to structure but not content of the curriculum to deliver 8 modules online. The 4 segments (modules 7-10) that focused most heavily on promoting behavior change and implementing the SBIRT model were offered in person to ensure that CHWs could practice new skills. CHWs reported high levels of initial satisfaction with the training program. Mean scores for all 20 elements of instructor effectiveness ranged from 4.5 to 5.0.

CHWs indicated that role-playing patient interactions and practicing using screening tools were vital elements of the course. They valued learning behavioral health communication skills. Participants agreed that there were disadvantages to the online portion of the training. They cited difficulty with technology and a desire for more in-person interaction. Suggestions for course improvements included conducting all sessions in person and offering more culturally tailored resources for patients of diverse backgrounds. Some CHWs desired a comprehensive health and social services resource list to facilitate referrals to services not available at FQHCs. All CHWs expressed an interest in ongoing education. A summary of these finding is included in Table 2.

In terms of activities, participants reported that screening patients for behavioral health issues, conducting outreach, and

Table 1. Curriculum Overview for a Pilot Behavioral Health–Focused CHW Training Program

4-h Lesson	Topics	Method
1. Introduction to CHW Roles in Behavioral Health	Professional boundaries CHW roles, responsibilities, and limits in behavioral health Introduction to SBIRT	Online
2. Primary Care and Behavioral Health Systems	Overview of primary care system and providers Overview of behavioral health system and providers Communicating with health care team members about roles, responsibilities, and patients Confidentiality and HIPAA	Online
3. Overview of Behavioral Health	Behavioral health in the United States Determinants of behavioral health Behaviors of people who are mentally and physically well Individual and community trauma Behavioral health asset mapping	Online
4. Common Behavioral Health Issues—Part 1	Signs/symptoms and common treatments/supports for: Depression Anxiety Bipolar Psychotic disorders Relaxation techniques Scheduling pleasant activities	Online
5. Common Behavioral Health and Related Issues—Part 2	Addiction Suicide Domestic violence Developmental disabilities Harm reduction strategies	Online
6. Communication and Safety	Using positive language and addressing stigma Supporting individuals and families in making treatment decisions Cultural humility Safety strategies and handling emergencies	Online
7. Supporting Behavior Change	Stages of change Motivational interviewing Setting SMART goals	In person
8. The "S" in SBIRT: Screening	What is a screening tool? Screening vs diagnosis Principles of administering a screening tool Selecting the appropriate screening tool Practice using screening tools	In person

(*continues*)

Table 1. Curriculum Overview for a Pilot Behavioral Health–Focused CHW Training Program (*Continued*)

4-h Lesson	Topics	Method
9. The "BI" in SBIRT: Brief Interventions	Ask: Screen and provide results Advise: Educate Assess: Willingness to change Assist: Action planning Arrange: Follow up Practice with brief interventions	In person
10. The "RT" in SBIRT: Referral to Treatment	Making internal and external referrals Documentation Follow-up Addressing social issues	In person
11. Identifying Resources to Assist Clinicians, Patients, and Families	Creating a resource list for referrals Creating a toolbox of educational resources Communicating with family members Providing community education	Online
12. Support for the CHW	Basic time management Requesting support from supervisors Peer support networks Self-care	Online

Abbreviations: CHW, community health worker; SBIRT, Screening, Brief Intervention, and Referral to Treatment.

coordinating care were common. Screening was thought to be helpful for identifying various behavioral health and related social issues, as well as facilitating rapid access to services. Three of 4 CHWs mentioned engaging in some community outreach to encourage use of all FQHC services. Care coordination was a common activity at all sites and included answering telephones, making and tracking referrals, supporting medication management, scheduling office visits, and following up with patients who missed appointments. Interviewees stated that CHWs addressed patients' social challenges including accessing transportation and assistance programs.

Interview participants offered evidence of CHW integration, as indicated by intra-agency referrals. In some cases, CHWs identified and referred to an onsite provider those patients in need of clinical services. CHWs briefed clinicians on patients' unique circumstances. Health care providers called on CHWs to speak with patients who had fears or misconceptions about behavioral health services. FQHC team members said they used multiple methods of team communication including electronic health records, computer-based instant messaging systems, e-mail, text messages, and phone calls. Some CHWs participated in regular team meetings.

Supervisors valued CHWs' ability to serve as liaisons between patients and other members of the health care team and facilitate entry into care. However, some participants expressed that the lack of a clear definition of the CHW role hindered complete care integration or led to CHWs feeling undervalued. CHWs felt frustrated that behavioral health and social resources were sometimes unavailable or unaffordable. Table 3 contains a summary of these results.

DISCUSSION

This study details a pilot program that trained and integrated CHWs into 4 FQHCs in Texas to support behavioral health services delivery to diverse populations. CHW

Table 2. Community Health Worker Impressions of a Pilot Behavioral Health–Focused Community Health Worker Training Program in Texas, 2014

Theme	Illustrative Quotes
Most useful aspects of training	
Role-playing	"Actually doing the role plays and having that little bit of experience . . . gives you that ground to go off of when the situation presents itself."
	"When I've had a patient that's in distress or they start crying, the role playing really helped me being able to put myself in the patient's situation or position, just to be more sensitive and understanding."
Communication skills	"Being that they're already behavioral health patients, you have to be very careful how you communicate with them and talk to them."
Disadvantages of online portion of training	
Difficulty with technology	" . . . sometimes the computer didn't work or the video screen wasn't working. There were times when I couldn't log in when the class had already started."
Lack of interaction	"Interaction was limited. Even though we were able to see each other, that's still not the same."
Suggestions to improve training	
Conduct classes in person	"I actually enjoyed having class in person better . . . to be there and actually interact in person with everyone."
Cultural sensitivity information	"I thought maybe a little bit more of cultural sensitivity may be needed."
Provide resource list	"Maybe after we left the training as behavioral health community health workers, we could have had a list of local agencies to refer patients to."
Desire for continuing education	"I want to do more trainings. The more you know the better."

satisfaction with the training program and feeling of preparedness to address behavioral health suggests that the content of the curriculum was appropriate and could possibly be used in other settings. Although online education was not preferred, in this case, it appears to have been an effective complement to in-person sessions that focused heavily on practicing communication and screening skills.

Engagement in supporting clients with social needs was expected and a vital component of the CHW role. We were pleased that CHWs conducted screening for common behavioral health issues and made interagency referrals. However, overall uptake of the SBIRT model was limited in that CHWs did not mention delivering brief interventions such as activity planning or motivational interviewing, despite having been trained to conduct such activities. Follow-up training in these areas may be necessary and would likely be welcomed, given CHWs' desire for continuing education.

We were somewhat surprised that reports of making referrals to outside agencies were limited, although this may be explained

Table 3. Initial Findings From a Pilot Program Integrating Behavioral Health–Focused CHWs Into 4 Federally Qualified Health Centers in Texas, 2014

Theme	Illustrative Quotes
CHW activities	
Screening	"If they're in the lobby, I will come get them and take them to my office to screen them and see what needs we can help them with." (CHW)
	"(CHW) is on call most of the time if we get any behavioral health patients with issues that need to be addressed after hours. The psychiatrist wants our CHW always to handle those situations . . . (CHW) can do most screenings and triages because the wait list can be a little lengthy for our psychiatrist." (Supervisor)
Outreach	"I am our outreach person that goes out in the community . . . teaching them what we offer at our organization." (CHW)
	"(CHW) does a lot of what we call community outreach . . . to help enroll, enroll patients in one of our grant programs . . . (CHW) is also in charge of, kind of getting out there like our community liaison, so like we partner a lot with churches, the school districts, through our county to try to coordinate services." (Supervisor)
Care coordination	"I answer the phone, I schedule multiple appointments . . . if they (patients) haven't come in in 2 months and they were supposed to come in, (I) follow up with that patient to see the reason why." (CHW)
	"Most frequent thing we have him doing right now is calling patients, following up with the behavioral patients . . . . He's actually keeping a chart that shows which patients are cancelling and which patients are actually coming in." (Supervisor)
Address social determinants of health	"We do enrollment for the Affordable Care Act, application assistance for Medicaid/CHIP/Food Stamps and TANF." (CHW)
	"(CHW) provided transportation for our clients that did not have transportation to the clinic . . . he's served as an interpreter for people that need interpretation. He's served as a reference for people who need help on services, either services that we provide or services in other areas." (Supervisor)
Evidence of care team integration	
Referrals between CHWs and the care team	"Before the patient is passed on to the LPC, I write a briefing, back information, so the LPC will know a little about the patient." (CHW)

(*continues*)

Table 3. Initial Findings From a Pilot Program Integrating Behavioral Health–Focused CHWs Into 4 Federally Qualified Health Centers in Texas, 2014 (*Continued*)

Theme	Illustrative Quotes
	"If patients have a behavioral health issue (counselor) calls me in to make that connection and do away with the stigma." (CHW)
	" . . . when (CHWs) are filling out a PHQ4 or the 9 form, if they notice a need right then, then that's an automatic referral to the counselor." (Supervisor)
Multiple forms of communication	" . . . through our EMR system, we message each other and we have something called Spark interoffice messaging system. Of course if it's urgent I'll go directly to (health care providers) and speak to them in person." (CHW)
	"We're really pushing for them to be an intricate part of all the medical team. They participate in huddles every day . . . . All the electronic referrals that come through the providers go directly to the CHW . . . . There's a lot more sharing of information recorded in the chart so that the right people have the information they need." (Supervisor)
Supervisor impressions of the CHW role	
Benefits of having CHWs on the team	"This program's been great in letting us think outside the box and having someone else besides the behavioral person dealing with patients, having the CHW is that middle man." (Supervisor)
	"(CHW)'s really been shrinking that wait time down . . . between the time the patient makes an appointment and the time they can be seen cause that's just a killer especially in behavioral . . . you have a number of things that can happen before . . . that the patient is not going to be available to see the physician." (Supervisor)
Challenges to care team integration	
Unclear roles	" . . . at times I feel they (team members) don't understand my role here." (CHW)
	"Not having the role fully defined, where she fits in, and what her duties are." (Supervisor)
Challenges of working as a CHW	
Accessibility/affordability of resources	"Our resources are very, very limited . . . have little to none out here to really help these patients to the full extent. (CHW)
	"We're surrounded by all types of resources. Most of them, you have to pay for services. The population that we serve is very impoverished. That leads to non-compliance. It's not that they're lazy. If a dad is working two jobs, to come to the clinic he would have to miss work." (CHW)

Abbreviations: CHW, community health worker; LPC, licensed professional counselor.

by CHWs' difficulty in accessing affordable resources. CHWs new to the field may benefit from additional assistance from social workers or other team members to learn about off-site behavioral health providers and related organizations. Agencies should also encourage employees to participate in professional networks to ensure access to information about community services and opportunities for professional development.

We were encouraged that supervisors perceived the new staff members to add value to each agency and that there was evidence of team integration. Reported challenges with CHW roles being unclearly defined were unsurprising, given that all care team members did not participate in the CHW model training and that each agency had flexibility to develop its own workflow and set of specific duties. Confusion about appropriate activities may explain CHWs' involvement in some administrative duties under the guise of care coordination (eg, answering phones). Future implementation sites will undoubtedly require training for all staff members. Agencies may benefit from additional technical assistance to create workflow and communication models that not only suit each agency's staff and client needs but also ensure that CHWs' distinct ability to connect with individuals in need and serve as cultural mediators is not squandered on administrative work.

There are several limitations to this study. Our sample included only 4 CHWs and 4 supervisors. All participants worked in Texas and served primarily Latino/Hispanic or white populations. It is possible that these results are not generalizable to other areas of the country or other populations. Patient perspectives and health outcomes are not considered. Nonetheless, this study provides initial insight into how CHWs focused on identifying and assisting patients with behavioral health issues can serve as members of primary care teams. This pilot demonstrated the feasibility of integrating behavioral health–focused CHWs into the patient care flow in these primary care FQHCs. Lessons learned may be applicable to other FQHCs seeking to offer additional support and care coordination for patients in need of behavioral health services.

CONCLUSION

Our project team, advised by a team of national experts including a CHW, developed a well-received pilot curriculum that prepared CHWs in this study to serve as a complement to behavioral health in primary care. Initial results of care team integration suggest that CHWs may be valuable team members, particularly for their roles in conducting screening and care coordination. However, further work is needed to refine and test a care team integration model that uses CHWs to their full potential. We are expanding this initiative to other states and will develop detailed recommendations for effective care delivery based on findings. Additional investigations should assess whether CHW members of primary care teams affect behavioral health outcomes.

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