

Community Health Worker Clinical Integration Toolkit

Incorporating CHWs into Care Teams and Clinical Processes: **Strategies**

MHP Salud

mhpsalud.org

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About MHP Salud

MHP Salud is a national nonprofit organization with 35 years of experience developing, implementing, and evaluating community-based, culturally tailored Community Health Worker (CHW)/Promotor(a) de Salud programs and promoting the CHW model through training and consultation services.

Our Mission

MHP Salud implements Community Health Worker programs to empower underserved Latino communities and promotes the CHW model nationally as a culturally appropriate strategy to improve health.

Our Vision

Our populations and their communities will enjoy health without barriers.

Acknowledgements

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Angela Herman-Nestor, MPA, CPHQ, PCMH-CCE,
Quality and Performance Improvement Manager
Missouri Primary Care Association

Beverly Sirvent, B.S.Ag.E, Director of the Agricultural Program
Sirene Garcia, Director of Special Programs
Finger Lakes Community Health

Kelly Volkmann, MPH, Health Navigation Program Manager
Benton County Health Services

Luis Lagos, Community Outreach Program Manager
Family Medicine Residency of Idaho

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Introduction

With a long history of successfully and effectively addressing health disparities, Community Health Workers (CHWs) can fill the gaps in services that many health care organizations experience in reaching underserved populations. For instance, six published studies on CHW interventions on the prevention and management of diabetes have shown significant positive outcomes, including changes in HbA1c levels and improved self-reports of dietary changes. In addition, six studies of CHW interventions focused on cervical cancer prevention reported positive outcomes, including a significant increase in the number of patients receiving a Pap smear and a larger change in the number of patients ever having a Pap smear.1 These outcomes support the effectiveness of the CHW model in prevention and disease management within Care Teams.

The purpose of this toolkit is to illustrate different strategies for incorporating CHWs within Care Teams. Additionally, it will provide real-life case studies from various health entities throughout the nation to support the success of the implementation of these strategies.

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Making the Case for Community Health Workers Toolkit-Overview

Making the Case for Community Health Workers is a toolkit that provides a solid foundation of who CHWs work with, what they do, and how valuable CHWs are to organizations and the communities they serve. CHWs serve a function on a Care Team that is not available through other team members or sources.

Their work not only improves the individual practice of a clinician, but also improves the way a team works together and the way a healthcare organization serves the community; this leads to an overall improvement in the community's health. It is advised that Clinical Teams review this information as it explores the impact CHWs have on health outcomes, service delivery, cost of care, and cost-effectiveness.

Access this toolkit here: https://mhpsalud.org/portfolio/making-the-case-for-community-health-workers-on-clinical-care-teams-a-toolkit/

Roles of CHWs in Clinical Settings

The incorporation of CHWs in clinical settings have the potential to develop proactive care teams who can work together to improve patient outcomes.[1]

Some examples of CHW roles in clinical settings are:

- Creating connections between vulnerable populations and healthcare systems.[2]
- Supporting cultural competence among healthcare professionals serving vulnerable populations.[3]
- Advocating for underserved individuals and communities to receive appropriate services.[2]
- Providing culturally appropriate health education on topics related to chronic disease prevention and healthy living.[3]
- Supporting individualized goal-setting, implementation of self-management plans, and long-term self-management support[3]
- Providing informal counseling, health screenings, and referrals.[2]
- Helping patients navigate health care and social systems (e.g. providing assistance with enrollment, appointments, referrals, transportation to and from appointments, and interpreter services at appointments).[3]
- Educating health system providers and stakeholders about community health needs.[2]
- Collecting data and relaying information to policymakers to inform policy change and development.[2]
- Building capacity to address health issues.[2]

Overall, CHWs serve as integral members of the Health Care System by supporting the Care Team's patient-centered goals and interventions.3 Every profession within an organization has a defined scope of work, and it is important for all professions, including CHWs, to understand the parameters and expectations of their position. Having a clear understanding of each team member's contribution ensures patients are served to the best of the organization's ability.

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Principles for Integrating CHWs

- Promote respect for CHWs among team members to strengthen clinical outcomes.
- Educate all members of the clinic on who CHWs are, what they do, and how they are an integral part of the team.
- Incorporate CHW core competencies into program design, including advocacy and community-based work on social determinants of health.
- Involve CHWs in integration planning and implementation at all system levels.
- Provide opportunities for CHWs to share their unique understanding, perspectives, and value of the community with the organization and team.
- Include CHWs in regular meetings with the full team (and more frequently with supervisor).
- Provide CHWs access to electronic health records and integrate CHW notes into the patient record for improved continuity of care.

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Association of State and Territorial Health Officials (2018).Community Health Worker Integration: Issues and Options for State Health Departments- ASTHO (PDF), Available at: www.astho.org/community-health-workers/ (Accessed August 9, 2018)

Additional Benefits CHWs Bring to Clinical Settings and Care Teams

Act as a link to collaborate with community-based organizations, including:

- Social service providers
- Legal, housing, education, and employment sources of information
- Food pantries
- Community development organizations

Additionally, they can offer educational sessions that can help improve the patient's health status, such as:

- Healthy eating and food demonstration workshops
- Health, wellness, and physical activity workshops
- Financial literacy workshops

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Association of State and Territorial Health Officials (2018).Community Health Worker Integration: Issues and Options for State Health Departments- ASTHO (PDF), Available at: www.astho.org/community-health-workers/ (Accessed August 9, 2018)

Case Studies for Integrating CHWs into Care Teams Overview

To illustrate successful innovative strategies for integrating CHWs into Care Teams, selected health organizations throughout the nation will be showcased in real-life case studies. With over 45 years of combined experience, these organizations have demonstrated the ability to effectively use CHWs:

- Missouri Primary Care Association - Missouri, US
- Finger Lakes Community Health- New York, US
- Benton County Health Services- Oregon, US
- Family Medicine Health Center - Idaho, US

Thank you Note:

MHP Salud would like to express our great appreciation to all of the contributors of this toolkit. Thank you for your willingness to give your time so generously and provide in-depth insight into the success of your CHW programs. Undoubtedly, your contributions will be a great asset to other health organizations wishing to start or strengthen their CHW clinical integration.

CHWs and Electronic Health Record Data Entry

Electronic Health Records (EHRs) are electronic platforms that contain individualized health records for patients. Typically, these records include a patient's medical history, diagnosis, treatment plans, immunization dates, allergies, radiology images, pharmacy records, and laboratory and test results.[1] EHR systems can share patient information electronically across state and national health care organizations and agencies, pharmacies, laboratories, and third-party billing organizations.[2,3] The effective transmit of EHRs expands communication among these entities and minimizes medical errors; and ultimately, enhances the quality, safety, and efficiency of patient care.[4]

According to the Office of the National Coordinator for Health Information Technology, these advantages include:

- Providing accurate, current, and complete information about patients at the point of care
- Providing quick access to patients' records
- Ensuring security and privacy when sharing electronic information with patients and other medical and health professionals
- Improving patient and provider communication
- Improving health care convenience
- Helping health care providers improve productivity and efficiency
- Reducing costs through decreased paperwork, improved safety, reduced duplication of testing, and improved health.[5]

Electronic Health Record data platforms are an important tool for all Frontline Health Workers (FHWs), including CHWs, nurses, midwives, pharmacists, physician assistants, and doctors. FHWs are commonly the first and only point of contact for individuals seeking healthcare services.

They are responsible for providing interventions to meet the community healthcare needs and act as a bridge between healthcare resources and the community.[6] Their role in the community's health demands reliable and effective data collection methods such as EHRs. Paper surveys have been used for many years to collect health data, but they may present problems such as frequent errors, storage costs, and double data entry issues.[3] In an effort to improve data collection and entry processes, health care providers and other organizations developed electronic data collection methods. These methods are much faster, relieving the need to collect data on paper and then transfer the results into a computer database. Additionally, these methods have reduced the risk of transcription error and increased data accuracy.[7]

Because CHWs play an essential role in improving a community's health, the data collection tools and methods they use should be reliable and efficient. Many CHW-led organizations are opting for EHR platforms to improve participant outcomes and achieve organizational goals. According to the Office of the National Coordinator for Health Information Technology, FHWs, including CHWs, using these platforms can:

- Better healthcare by improving all aspects of patient care, including safety, effectiveness, patient-centeredness, communication, education, timeliness, efficiency, and equity.
- Improve health by encouraging healthier lifestyles in the entire population, including increasing physical activity, improving nutrition, reducing behavioral risks, and expanding the use of preventative care.
- Increase efficiencies and lower health care costs by promoting preventive medicine and improved coordination of health care services, as well as by reducing waste and redundant tests.
- Strengthen clinical decision making by integrating patient information from multiple sources.[5]

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Case Study: Success in Using Electronic Health Record Data Entry Platforms with your Community Health Workers in Missouri Primary Care Association

Introduction

Missouri Primary Care Association (MPCA) is a non-profit organization with the mission to be Missouri's leader in shaping policies and programs that improve access to high-quality, community-based, and affordable primary health services for all Missourians. To this end, the Missouri Community Health Worker Program was started with the purpose to:

- Improve patient engagement in care with a focus on preventative, chronic disease management, and self-management services.
- Serve as an integral part of the care team serving as a liaison between care team and patient when the patient is outside of the four walls of the health center.
- Assess and Address Patient Social Determinants of Health Needs utilizing the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) tool.
- Connect patients to needed community-based services.
- Reduce potentially avoidable emergency room visits, admissions, and readmissions for preventative acute and chronic conditions such as diabetes.

The program received funding in spring 2016 and began implementation in fall of the same year. The program included 19 Missouri Federally Qualified Health Centers (FQHCs) in the start but by July 2018, that number grew to include 26 out of 29 FQHC grantees in Missouri. The project was able to maintain approximately 50 CHWs throughout the program.

Challenge: Missouri PCA strives to improve access to high-quality, community-based, and affordable primary health services for all Missourians through partnerships with local health clinics. However, they noticed the need for a more comprehensive tool that better captured the work of CHWs and examined Social Determinants of Health (SDOH) within the communities they served. They also encountered some resistance from providers and other care team members because they were unaware of the value and potential CHWs can provide by engaging patients in their own care.

Strategy: The health centers working with the MPCA invested in Electronic Medical Record (EMR) template additions, CHW structured documentation within EMR, and hiring of CHWs. MPCA also invested in mapping and data validation from health center EMR/practice management systems to Azara Data, Validation, and Visualization System (DRVS) and invested in SDOH mapping that connected to DRVS. These systems assisted in the successful implementation of CHW programs (Appendix A). The next step was to develop a training work plan that focused on the following nine areas:

1. Complete CHW training program (for CHWs in need of formal CHW training)
2. Utilize the PRAPARE tool to assess the social determinants of health (Required)
3. Connect patients with community-based services. (Required)
4. Improve patient engagement in preventive, chronic disease management, self-management services (Required)
5. Include three measures, one from each category: cancer screening, preventative, and chronic disease control/ management derived from UDS Electronic Clinical Quality Measures (eCQM) (Required)
6. Implement strategies to reduce avoidable emergency room visits and hospital admissions (Required)

In addition, the training could be enhanced by selecting one of the three options below:

7. Increase screening, brief intervention, and referral to treatment (SBIRT) for identification of Substance Use Disorder

8. Improve patient engagement for pregnant women by increasing adherence to prenatal services

9. Provide CHW Continuing Education

Once implemented it was important to evaluate the CHW's performance. This was completed using quarterly review of qualitative, PRAPARE tool and CHW encounter/interventions reports that captured patient stories, successes and barriers to implementation, training/technical assistance needs. Included as well were the most common Social Determinant of Health (SDOH) needs derived through the PRAPARE SDOH assessments. It was also important to review successful referrals to outside organizations and patient follow through, i.e. kept appointment, visited food pantry, etc.

Conclusion: It can be stated that the overall performance of CWHs has improved after implementation of the program. This is evident as quarterly reports have shown a larger number of patients being served, higher number of PRAPARE SDOH assessments being completed, and successful referrals being made. Overall knowledge and acceptance of the value CHWs bring to care teams also improved. Many providers expressed how invaluable CHWs were to their daily practice and cannot imagine working without them.

Best Practices: Setting the programmatic purpose, goals, CHW functions and expected outcomes of your CHW program should be one of the first steps you take as an organization. Having these guidelines established will help create strategic partnerships with Medicaid, State Health Departments, Managed Care Organizations (MCOs), Regional CHW Organizations, Hospital associations and CHW Peer Learning Networks. These connections help to display health center efforts, achievements in population health and determine success in a value-based payment environment. All of these factors have been instrumental in ensuring CHWs become an integral member of the care team, subsequently engaging patients in care and increasing planned chronic and preventive visits by assessing and addressing patients individual SDOH needs. Establishing a CHW Peer Learning Network was also helpful in making networking, training and technical assistance available for CHWs.

Lessons Learned: It's imperative that any organization looking to integrate CHWs and their supervisors into EMR/EHR invest in training and technical assistance. It is critical for them and other members of the care team to have a firm understanding regarding team-based care and effective patient engagement techniques.

Angela Herman-Nestor, MPA, CPHQ, PCMH-CCE, Quality and Performance Improvement Manager. Missouri Primary Care Association. Questionnaire Responses. Thursday, October 25, 2018.

CHWs Participating in Care Team Daily Huddles

A huddle is a short, stand-up meeting lasting 10 minutes or fewer. These meetings are typically used at the start of each workday in a clinical setting. The main purpose of these gatherings is to discuss patient processes to be performed during the day. Additionally, it serves to actively manage the quality, safety, and effectiveness of the services provided.[1] Routine huddle meetings contribute to an interdependent team culture, improved relationships, and the delivery of safe and reliable patient care.[2] Huddle meetings should involve all team members that can offer valuable input to clinic flow and patient needs, such as providers, medical assistants, nurses, social workers, case managers, etc. Every day, more clinics are opting to include CHWs in these meetings as they offer expertise in the dynamics and culture of the patients. Additionally, they provide invaluable insight into their health behaviors that can help clinicians to determine the best possible treatment decisions.[3]

Overall, these gatherings serve to unite all health workers on the Care Team. Each member's skills and knowledge are valued and considered so that the team can provide better support to patients on understanding their health conditions, establishing health goals, and taking actions to improve their health and wellbeing.

Additional resources on how to run a huddle meeting:

- **Team Huddle Agenda, A Daily "Stand Up" Meeting** http://www.emergenceconsulting.com/wp-content/uploads/2015/08/Team-Huddle-Agenda.pdf
- **The Team Huddle: A Meeting Tip that will Simplify your Company's Life** https://appfluence.com/productivity/team-huddle-tips-ideas/
- **6 Tips to Successfully Conduct the Daily Huddle** https://status.net/templates/daily-huddle/

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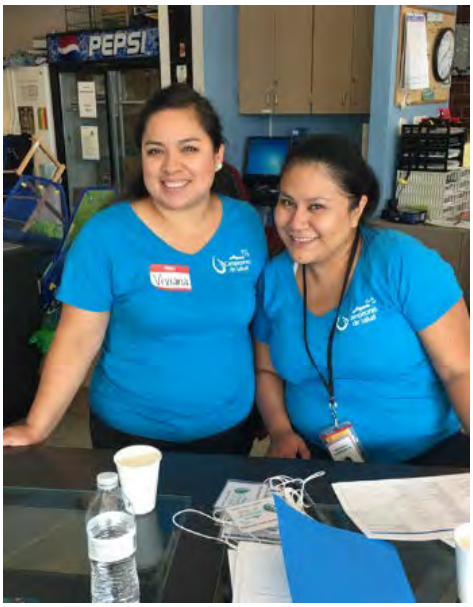
Case Study: Success in Integrating Community Health Workers in huddle meetings in Benton County Health Services

Introduction

Community Health Centers of Benton and Linn Counties (CHC) is a Federally Qualified Health Center (FQHC) located in Willamette Valley, Oregon. Organizationally integrated with the Benton County Health Department, the CHC serves low income, rural, migrant and homeless populations in Benton and Linn Counties. This collaboration, named Benton County Health Services, serves rural, migrant, and homeless populations in Oregon. They understand how physical health, mental health, and oral health all affect each other and are committed to helping each person achieve their personal health goals and lead a happier, healthier life. CHCs Health Navigation Program began in 2008 with one grant-funded, part-time CHW. This program aids the community in making the best health care decisions for their lifestyle, current situation, and conditions. Community Health Workers, in the role of health navigators, work in several settings including 10 primary care teams and 3 schools. The success of the program is evident in the growth they have experienced by increasing the number of CHWs from one to 28.

Challenge: Benton County Health Services strives to provide well-rounded services to every patient by incorporating CHWs in the clinical care team as Health Navigators. However, some Medical professionals were hesitant to include non-medical professionals without formal medical training in the patient care team.

Strategy: Introducing CHWs to the care team included formal training for CHWs, and providers received a presentation that covered CHW roles, responsibilities, scope, limitations, and strengths. Providers were also engaged in discussions to determine how CHWs would be used within the Care Team which set a strong foundation in developing a more cohesive team dynamic. An essential component to developing this team dynamic is providing extensive



Community Health Workers, Viviana Gonzalez and Analuz Torres Giron, are ready for the crowds to arrive for the Garfield Swim Day and Health Fair.

training to CHWs. This training lasts about 6 months and includes shadowing a CHW, having side by side training, and then transitioning to individual work (see Appendix B). Participation in team huddles begins on day one to allow CHWs to see the dynamic of the interactions and learn from providers.

As important as it is for CHWs to understand the clinical setting, it was just as important for the providers to understand how CHWs contribute to patient health outcomes. This understanding helped alleviate some of the initial hesitancy in integrating CHWs within the Care Team. However, it took almost two years of trust building and improved outcomes for CHWs to be considered an essential and valued member of the team.

Conclusion: Providers and care teams' have been able to see the value CHWs bring to the care team. They have a unique ability to connect with their community and build relationships in ways that can't be done within a 20-minute visit. Additionally, CHWs feel they have an open line of communication with providers where they can discuss anything from patient health literacy, patient compliance with provider instructions and patient needs or current life situations due to the trust they built. As a result, CHWs are respected members of the team and the value they bring to patient care has been expressly recognized.

Best Practices: Though CHWs are being integrated into the clinical team, they still spend a large portion of their time in the community they are serving. Due to this, it is important to have a set time for formal team huddles. This simple but important point will enable the CHW to be present more often and facilitate a seamless integration into the care team.

Clinical Community Health Worker, Jesus Guzman, getting ready to talk with clients about healthy eating and active living at a health fair.

Lessons Learned: It is crucial for the clinical staff and CHWs to take the time to understand how to work with each other. Sometimes it can be difficult for other professionals to receive input from CHWs because they do not understand the value of the knowledge the CHW contributes. It is equally detrimental, when a CHW does not know how to interact with other members of the clinical team - e.g. protocols to follow, language, cultural appropriateness, etc. Unfortunately, the integration of CHWs into primary care will not be successful when the CHW does not fully understand their roles and the clinical staff does not understand how to effectively use them. Having a knowledgeable supervisor, a provider champion, and clearly defined roles and expectations are critical to successfully integrating CHWs into a primary care home.

Kelly Volkmann, Health Navigation Program Manager. Benton County Health Services. Personal Interview and Questionnaire Responses. Wednesday, November 7, 2018.

CHWs Utilized in Telehealth

Telehealth, also known as e-health (electronic health) or m-health (mobile health), is the use of electronic information and communication technologies to enable virtual access to health care. This type of innovation commonly uses computers and mobile devices to perform video conferencing, instant messaging, streaming media, store-and-forward imaging, among other features.[1]

Telehealth is a platform used to overcome barriers such as geographic, financial, and/or workforce specific issues; it provides patients with remote access to the health care team, including physicians, nurses, pharmacists, and CHWs.[1]

Overall, the main goals of telehealth are:

- Making health care accessible to individuals living in isolated communities
- Increasing access to services for individuals with limited mobility, time, or transportation issues
- Providing easier access to health care specialists
- Improving communication and coordination of care between the health care team and patients
- Motivating patients to achieve self-efficacy regarding their health
- Providing support for patient's self-management of health care[2]

The integration of CHWs into telehealth technology can assist health care entities to reach their goals by positively impacting patients' health.[3] Additionally, it has been demonstrated that CHWs can incorporate telehealth with culturally sensitive programs and increase access to high-quality care.[4]

CHWs can contribute in the following ways:

- Educate patients on how to use mobile devices or computers and access patient portals. [2]
- Provide health education and resources (videos, fact sheets, interactive activities, etc.) [2]
- Send email, text, or phone reminders when patients need to be seen by the care team [2]
- Collect field-based health data [5]
- Increase communication between the patient and provider [5]

In conclusion, integrating CHWs into clinical processes using telehealth approaches improves the quality of care provided, the efficiency of services, and the capacity for program monitoring. [5]

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Case Study: Success in Using Telehealth with Community Health Workers to Bridge Patients to Health Services in Finger Lakes Community Health

Introduction

Finger Lakes Community Health (FLCH) is a Federally Qualified Health Center that provides services to patients of all incomes, ethnicities, and walks of life in the Finger Lakes region. This Health Center strives to bring a new standard of health care through education, technology, and preventive care. FLCH is an early adopter of telehealth technology, which provides a bridge for patients who cannot travel to visit a provider and connects patients with appropriate services through remote education, training, specialist consultations, and diagnosis via real-time video conferencing technology.

Furthermore, FLCH has an outstanding CHWs program and possesses almost three decades of CHW experience. At present, this program consists of 23 CHWs assisting patients in accessing care, chronic condition self-management education, short-term intervention in acute or emergency cases, and prenatal and post-partum services.

Challenge: FLCH discovered that many individuals were not visiting FLCH centers due to fear based on their immigration status, limited transportation, and cultural and language differences.

Strategy: After identifying barriers preventing individuals from visiting health centers, FLCH explored innovative ways to reach patients at their location and provide appropriate health services. FLCH established Telehealth technology as one strategy to connect patients to needed health care services. CHWs play an essential role in providing support to access health care services; therefore, they have been incorporated as key components of this strategy. Two FLCH CHWs are involved in telehealth and their main duty is performing outreach activities to reach individuals in the community who are in need of their services. Each CHW is equipped with a laptop computer installed with Synchronous, a live video conferencing system supported by the Cisco platform. This service is readily available for CHWs and patients to connect to Medical Providers in real-time. During the first video visit

established with the provider, the patient is assessed to determine if the health services needed can be performed from a distance or whether a physical visit to the clinic is required. If telehealth is feasible, consequent video-appointments and appropriate follow-ups are scheduled for these patients.

To successfully implement this strategy, CHWs receive in-depth training on the use of the otoscope, stethoscope, blood pressure cuff, and oral camera. CHW training encompasses general computer processes and internet connection troubleshooting as well as simulated calls to assess their ability to successfully utilize the telehealth technology.

This telehealth initiative has been active for six months and is planned to continue for 12 to 24 more months as a pilot program. This time frame will allow FLCH to address any issues that may arise and make necessary changes for the betterment of the program.

Conclusion: The integration of telehealth in FLCH has positively impacted its patients, clinical team, and the overall health care system. Patients have been able to overcome barriers and receive care from the FLCH clinical team at their location, reducing the time, effort, and cost of travel to a health center. The clinical team has expanded their services to remote areas of the community, increased direct patient interactions, and strengthened their network to other health specialists in the nation. The health care system has been positively impacted by the improved health care access and health outcomes, increased resource utilization, and enhanced clinical team's cost and time efficiency.

Best Practices: A successful integration of CHWs into a new strategy such as telehealth, requires health center leadership and care team members to be onboard and informed. In FLCH, the Chief Executive Officer, Chief Medical Officer, medical providers, and other members of the clinical team received appropriate information in regards to the CHWs' specific role, duties, and expectations in this strategy. In response, they supported the integration and encouraged the program to launch.

It is incredibly important to ensure that all CHWs participating in telehealth are properly trained. This will produce trust among other members of the clinical team and will ease their integration into this service. FLCH provides intense training with multiple assessments and simulated calls to assess CHWs telehealth mastery competence. At present, CHWs have successfully worked alongside the entire clinical team.

Lessons Learned: FLCH serves rural communities, where adequate internet connectivity is difficult to obtain restricting CHWs effective use of telehealth technology. Therefore, to ensure success, it is important to identify and address connectivity issues prior to implementing telehealth in these communities.

Beverly Sirvent, Director of Agricultural Program and Sirene Garcia, Director of Special Programs, Finger Lakes Community Health. Questionnaire information. Thursday, November, 15, 2018.

Impact of Using CHW- Collected Data in Clinical Decision Making

The collection of reliable and timely health data is essential for addressing health issues. Meaningful health information is used to formulate interventions that improve the health of patients. Reliable and timely health data becomes a necessity when emergent diseases or other health threats arise, and actions need to be made to prevent or treat these health issues. CHWs can offer support to clinical decision-making by providing data obtained while performing health care services to patients such as health education, referrals to health services, support groups, follow-ups, etc[1] Additionally, CHWs can analyze SDOH and use collected data to connect patients to community resources, assist with care coordination, and improve provider-patient communication.[2]

Overall, the inclusion of CHWs into care teams allows clinical health professionals to use the health information collected by CHWs to improve patient's access to and quality of care.[3]

References:

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Case Study: Success in Using Community Health Worker Collected Data for Clinical Decision Making in Family Medicine Health Center

FAMILY MEDICINE HEALTH CENTER

Introduction

Family Medicine Health Center (FMHC) is a FQHC located in Ada and Canyon counties in Idaho. This center prepares broadly-trained family medicine physicians and encourages them to work in Idaho's underserved and rural areas and serves low-income, uninsured, disabled, and other vulnerable populations in a Patient-Centered Medical Home. FMHC has a Community Health Worker program composed of six Community Health Workers (CHWs) and a Community Outreach Program Manager. This program started four years ago in 2014, with one grant-funded CHW from the surrounding community whose goal was to identify and increase the Migrant-Agricultural population's access to services. By 2015, the CHW program started to increase its presence among the Latino community. Consequently, the health center incorporated an outreach program with a new group of certified CHWs serving as Enrollment Counselors or Navigators. Their impact and value were shown with a gradual increase of Agricultural Workers served: from 16 in 2014 to 618 in 2018, as reported in the UDS (Uniform Data System).

Challenge: FMHC is determined to better the health and quality of life of all patients. Nonetheless, they have recognized that patients may face barriers to good health associated more with social, cultural, or economic factors. Therefore, it is important to implement interventions that focus on these factors to help patients achieve overall health and wellness and an improved quality of life.

Strategy: CHWs in FMHC are trained and equipped to assess patients' SDOH, such as their economic stability, physical and social environments, education level, employment status, housing, health care access, and other important factors that may act as barriers to good health and a balanced quality of life. Gathering this type of data is essential to design health programs that can effectively overcome the patients' barriers to good health. This data is collected after a medical provider consults the patient and identifies the need for a personal assessment.

Thereafter, the provider completes a Social Rx referral form which is transferred to the CHW team. The Social Rx form is a fast-tracking tool that includes 24 questions designed to assess a patient's SDOH. These questions range from transportation, housing, employment, nutrition, physical activity, sexual activity, social isolation, smoking, interpretation needs, and others. Each question is linked to an observation term, which allows the CHWs to connect patients to the appropriate department and clinical team members to receive the help and support needed.

Results: Based on the data collected by CHWs through the Social Rx tool, the clinical team is able to identify the specific social needs of every patient screened. At present, this tool has been used with a small percentage of the patient population. Nonetheless, this collected data has given the clinical team the ability to take a glance at the overall needs of the community they are serving. This data was reported in the Resources Patient Needs graphic (please see Appendix C). The graphic portrays a visualization of all the different barriers or needs patients face in their journey to good health.

Based on these results, the CHWs and clinical team discovered that the findings did not correspond to the needs expressed by patients. For example, only 3% of the screened patients identified as smokers. However, clinical studies and anecdotal information from CHWs identified smoking-related health issues as a major barrier to good health among patients. These findings raised concern and a priority to understand the low-reporting of smoking from patients. As the Care Team looked deeper, they found that the smoking question included in the Social Rx assessment may not have addressed all the types of tobacco use such as cigarettes, e-cigarettes (vapes), chewing tobacco, cigars, orbs, strips, sticks, hookah, etc. In response, FMHC partnered with the Central District Health Department of Boise, Idaho. This department's emphasis is on decreasing risk factors for chronic disease, improving quality of life, and increasing the years of healthy living among residents. Through this partnership, they started a smoking cessation program which included nicotine replacement therapy (NRT), tobacco education, and counseling. NRT is considered the first step of this program. During their initial NRT visit, medical doctors or pharmacists provide patients with a free two-week supply of tobacco cessation products such as patches, gums, and lozenges. If needed, patients have the opportunity to obtain up to two and a half months of additional tobacco cessation products. Next, patients are referred to the CHW team where they complete innovative screening forms such as 3 A's and R Protocol (see Appendix D) and participant information forms. These forms allow the CHW team to assess the participant's tobacco use and offer the appropriate continuous support.

This support includes tobacco cessation resources such as free evidence-based classes, telephone- and- web-based counseling, and a mobile application that contributes to the patient's quit journey.

Conclusion: The Tobacco Cessation program was designed using CHW-collected data and has proven successful in lowering smoking rates. Within the first six months of implementation (July 2018 to December 2018), these rates decreased by .5% from 21.9% to 21.4%. During the same time frame, percent of patients formally counseled on smoking cessation increased 16.9% from 29.8% to 46.7%. The successof this program demonstrates the value of CHW-collected data. What started as a CHW program goal soon became an organizational goal and a clinical measure.

Family Medicine Health Center CHW Department
Top left: Luis Lagos, Diane McKinnis, Marcial Angulo
Bottom Left: Jeanie Levinski, Martha Madero, Cinthya Hererra-Buitrago

Furthermore, this program has given more revenue to the CHW program at FMHC as the health center is monetarily compensated for each patient screened. Undoubtedly, CHW-collected data is valuable for clinical decision-making as it has the power to identify needs to construct initiatives that produce a positive change among patients.

Best Practices: It is important to always share CHWs' successes to all members of the health center including leadership and upper management of different departments. This communication will ensure better acceptance, trust, and support of the CHWs' work. In the end, the whole clinical team is working towards the same goal: improving patient's health and quality of life.

Lessons Learned: To prevent confusion in regard to CHWs' roles and duties among other members of the clinical team and/or patients, it is important to define the CHWs' scope of work. Additionally, developing an evaluation to assess CHW performance can be helpful to improve the quality of the programs implemented.

Luis Lagos, Community Outreach Program Manager. Family Medicine Residency of Idaho. Personal Interview. Wednesday, October 23, 2018.

Conclusion

These case studies have illustrated how successfully integrating CHWs into clinical functions that include EHR data input, telehealth, team huddles, and clinical decision- making can lead to improved patient outcomes. It also highlights the importance of having an established process for integration that is inclusive of other team members.

It is important to note that this is a long-term investment that can enhance the organization's overall goals. It is a process that will take time, effort, and resources to establish successfully. Nonetheless, the positive impact it will make both internally and externally will be immeasurable. For more information on integrating CHWs into clinical settings, please see the included resource list or contact MHP Salud at info@mhpsalud.org.

Appendices

APPENDIX A

TO IMPLEMENT COMMUNITY HEALTH WORKER INITIATIVE CONTRACT BETWEEN MISSOURI COALITION FOR PRIMARY HEALTH CARE AND [ ]

July 1, 2018- May 31, 2019 Work Plan Strategy

Required Strategy 1. Strategy 1 is required if CHC has CHWs that have not completed formal CHW training program.			
Strategy #1 To complete CHW training program (If all CHWs have completed training this strategy is not required)	**Expected Completion Dates for Action Steps**	**Responsible Parties**	**Expected Outcomes**
Action Steps **1.** **2.** **3.** **4.**	 **1.** **2.** **3.** **4.**	 **1.** **2.** **3.** **4.**	 **1.** **2.** **3.** **4.**
Required Strategies 2-6. Complete action steps, completion dates, responsible parties, and expected outcomes for strategies 2-6.			
Strategy #2-Required: To assess the social determinants of health of Medicaid patients: utilize the PRAPARE tool to assess social determinants of health data and integrate in EHR to allow mapping to DRVS for organizational aggregation and statewide aggregation of SDOH.	**Expected Completion Dates for Action Steps**	**Responsible Parties**	**Expected Outcomes**
Action Steps **1.** **2.** **3.** **4.**	 **1.** **2.** **3.** **4.**	 **1.** **2.** **3.** **4.**	 **1.** **2.** **3.** **4.**

Strategy #3 Required: To connect patients with community based services: Track CHW intervention/encounters with patients and referrals to community partners and integrate into EHR to allow mapping to DRVS for organizational and statewide aggregation of SDOH interventions.	**Expected Completion Dates for Action Steps**	**Responsible Parties**	**Expected Outcomes**
Action Steps **1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**
Strategy #4 Required: To improve patients engagement in preventative, chronic disease management, self-management services	**Expected Completion Dates for Action Steps**	**Responsible Parties**	**Expected Outcomes**
Action Steps **1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**

Strategy #5 Required: To implement strategies to improve clinical quality measure performance (UDS, PCHH, MU, HEDIS, etc.) Choose three quality measures-one from each category. **Choose at least one measure per category for a total of three measures.** **Cancer Screening:** • Colorectal Cancer Screening • Cervical Cancer Screening **Preventative:** • Child weight screening and counseling for physical activity and nutrition • Adult BMI screening and follow-up for patients with BMI outside normal parameters • Depression screening and follow-up • 2 year old childhood immunizations **Chronic Disease Management:** • Diabetes control A1C >9.0 or untested • Hypertension control • Asthma controller medication	**Expected Completion Dates for Action Steps**	**Responsible Parties**	**Expected Outcomes**
Selected Quality Measures: 1. **Cancer Screening:** 2. **Chronic Disease Management:** 3. **Preventative:** **Action Steps** **1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**

Strategy #6 Required: To implement strategies to reduce avoidable emergency room visits and hospital admissions	**Expected Completion Dates for Action Steps**	**Responsible Parties**	**Expected Outcomes**
Action Steps **1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**
Optional Strategies 7-9. Select at least one optional strategy and complete action steps, completion dates, responsible parties, and expected outcomes for selected optional strategy.			
Strategy #7 Optional: To increase standardized screening assessment Screening, Brief Intervention, and Referral to Treatment (SBIRT) for identification of Substance Use Disorder and implement process for referral treatment.	**Expected Completion Dates for Action Steps**	**Responsible Parties**	**Expected Outcomes**
Action Steps: **1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**
Strategy #8 Optional: To improve patient engagement for pregnant women by increasing adherence to prenatal services	**Expected Completion Dates for Action Steps**	**Responsible Parties**	**Expected Outcomes**
Action Steps **1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**
Strategy #9 Optional: To complete CHW training and continuing education.	**Expected Completion Dates for Action Steps**	**Responsible Parties**	**Expected Outcomes**
Action Steps **1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**

Appendix B

Competency List: Health Navigation:

Employee Name:_____ Supervisor: _____ Manager: **Kelly Volkmann**

Note: First assestment needs to be completed by employee at 3-months. At end of 6-month probationary period, employee is expected to meet at least 60% of listed competencies. At end of 1 year, employee expected to meet at least 90% of listed competencies.

Method of Instruction Key:
P = Protocol/Procedure Review
E = Education Session/Class/Training
S = Self Learning Package
C = Practice
D = Demonstration/Shadowing

Method of Evaluation Key:
O = Observation
RD = Return Demonstration
V = Verbal Review
N/A = Not applicable

	Self-Assessment by Employee				Validation of Competency		
	Never Done Date	Needs Review Date	Competent Date	Instruction Method (Use Instruction Key at Left)	Date	Initials	Evaluation Method (Use Evaluation Key at Left)
A. Basic Computer / Technology Skills (ALL HNs)							
1. Demonstrate understanding and use of Outlook calendar and email:							
* Send meeting invitations							
* Reserve meeting rooms							
* Forward documents using "save and send" feature							
* Create contact and "group contact" list							
* Calendar request - limited details							
* Protected trust - how to add the plug-in and use it							
* Add signatures							
* Add auto replies (ex - out of office replies)							
2. Demonstrate understanding and use of Word:							
* Create a new word document							
* How to use bullet lists, headers, footers, page numbers							
* How to check for spelling, grammar, and reading statistics							
* Edit drafts using track changes							
3. Demonstrate understanding and use of Excel:							
* Create basic spreadsheet							
* Create basic charts and graphs							
* Create and use basic formulas							
* Use basic filters							
4. Demonstrate understanding and use of Power Point:							
* Create new slide show							
* Health literacy principles as applied to power point (font size, use of color, use of animation, text formatting)							
5. Demonstrate understanding and use of Publisher:							
* Create a basic document (flyers, post cards, other marketing materials)							
6. Other computer programs skills							
* One Note							
* Photoshop							
* Other:							
7 Demonstrate understanding and use of cell phone:							
* Voice mail							
* Exchange email							
* Exchange calendar							
* Use Protected Trust							
* Go To Meeting							
*							

Competency List: Health Navigation:

Employee Name:_____ Supervisor: _____ Manager: **Kelly Volkmann**

Note: First assestment needs to be completed by employee at 3-months. At end of 6-month probationary period, employee is expected to meet at least 60% of listed competencies. At end of 1 year, employee expected to meet at least 90% of listed competencies.

Method of Instruction Key: P = Protocol/Procedure Review E = Education Session/Class/Training S = Self Learning Package C = Practice D = Demonstration/Shadowing	**Method of Evaluation Key:** O = Observation RD = Return Demonstration V = Verbal Review N/A = Not applicable	**Self-Assessment by Employee**				**Validation of Competency**		
		Never Done **Date**	**Needs Review** **Date**	**Competent** **Date**	**Instruction Method (Use Instruction Key at Left)**	**Date**	**Initials**	**Evaluation Method (Use Evaluation Key at Left)**
8. Demonstrate basic understanding and use of OCHIN/EHR:								
* Look up client using name/MRN/Ph. No./DOB/SSN								
* How to do a mini-reg								
* How to look for demographics								
* How to chart an interim note/encounter								
* How to chart a telephone note								
* How to use PCPCH coding (Patient Center Primary Care Home)								
* How to chart self-management appointment								
* How to document "care steps"								
* How to schedule, edit, re-schedule and cancel appointments								
* How to use OCHIN in-box for sending or receiving messages								
* How to read clinician notes, chief complaints, care plan								
* How to find who is on client care team and/or attach yourself								
* How to "oops"/"error" an encounter								
* How to do a basic chart review for labs, care plan, problem statements								
* How to create addendums								
* How to run a referral report and edit it								
* How to use dot phrases or smart text								
* How to look for Release of Information (ROIs) and other documents								
* How to send messages to (individuals, pools, classes)								
* How to access Remote OCHIN/Portal (need permission for remote OCHIN)								
9. Demonstrate <u>excellent</u> knowledge/understanding								
* HIPAA, ethics, appropriate boundaries, dual relationships								
* Documentation protocol								
* Role/scope of HN within defined "teamlet" (ex - within primary care/school/outreach)								
* Mandatory reporting								
* Confidentiality								
* Release of Information								
* Charting (language, expectations, writing shortcuts, legal do's and don'ts)								
* Medicaid Fraud and Abuse								
* Client boundaries and safety								
10. Demonstrate <u>basic</u> knowledge/understanding								
* Medical/health interpretation terminology and protocol								
* Public health and prevention principles								
* Health literacy								
* Patient-Centered Primary Care Homes, CCOs, and health care reform								

Competency List: Health Navigation:

Employee Name:_____ Supervisor: _____ Manager: **Kelly Volkmann**

Note: First assestment needs to be completed by employee at 3-months. At end of 6-month probationary period, employee is expected to meet at least 60% of listed competencies. At end of 1 year, employee expected to meet at least 90% of listed competencies.

Method of Instruction Key: P = Protocol/Procedure Review E = Education Session/Class/Training S = Self Learning Package C = Practice D = Demonstration/Shadowing	**Method of Evaluation Key:** O = Observation RD = Return Demonstration V = Verbal Review N/A = Not applicable	**Self-Assessment by Employee**				**Validation of Competency**		
		Never Done **Date**	**Needs Review** **Date**	**Competent** **Date**	**Instruction Method (Use Instruction Key at Left)**	**Date**	**Initials**	**Evaluation Method (Use Evaluation Key at Left)**
B. Knowledge of Resource and Service Navigation								
1. Demonstrate knowledge/understanding of Oregon Medicaid (OHP, CWM, CWX, Open Card, OMC, CCOs)								
* OHP/CWM eligibility and enrollment process								
* OMC/CWX eligibility and enrollment process								
* Open Card eligibility and enrollment process								
* Medicaid/Medicare MMIS verification								
* Application process:								
* ONE System								
* PDF								
* Paper applications								
* Tracking and documentation								
* Excel Tracking sheet								
* OCHIN documentation								
* Consent forms								
* Reports								
* WTI								
2. Demonstrate knowledge/understanding of how to access/refer to CHC:								
* Primary care and Family Planning providers								
* Public Health Programs (WIC, MCM, CACOON, Healthy Start, Babies First, Imms)								
* Children and Adult MH and AOD services								
* Developmental Diversity								
* Chronic disease self management programs								
* Other Health Navigators								
3. Applications Assistance								
* Financial Assistance, Lions Club, Workers Comp., Housing, SNAP, etc.								
* Complete application								
* Documents verification (check list)								
* Complete general release of information letter / ROIs								
* Complete authorization form / statements								
* Application follow up								
* Billing or any other issues follow up								

4. Demonstrate knowledge/understanding of community/social resources and supports: **others:**

___ DHS Programs	___ Ride Line Services	___ Love Inc.	___ Legal Aid	___ _____
___ Food Share	___ CASA	___ Dental Resources	___ Linn-Benton Comm College	___ _____
___ Parks and Rec	___ Boys & Girls club	___ Well Mama	___ Linn B Linn Benton Furniture Share	___ _____
___ Vina Moses	___ Energy Assistance	___ MCC	___ Willamette, and Linn Benton Housing	___

Competency List: Health Navigation:

Employee Name:_____ Supervisor: _____ Manager: **Kelly Volkmann**

Note: First assestment needs to be completed by employee at 3-months. At end of 6-month probationary period, employee is expected to meet at least 60% of listed competencies. At end of 1 year, employee expected to meet at least 90% of listed competencies.

Method of Instruction Key: P = Protocol/Procedure Review E = Education Session/Class/Training S = Self Learning Package C = Practice D = Demonstration/Shadowing	**Method of Evaluation Key:** O = Observation RD = Return Demonstration V = Verbal Review N/A = Not applicable	**Self-Assessment by Employee**				**Validation of Competency**		
		Never Done **Date**	**Needs Review** **Date**	**Competent** **Date**	**Instruction Method (Use Instruction Key at Left)**	**Date**	**Initials**	**Evaluation Method (Use Evaluation Key at Left)**
C. Tracking and documentation								
1. Demonstrate knowledge and ability to complete tracking								
OCHIN entries in less than 48h, preferable same day								
* **OHP/Outreach Tracking**								
* **OHP Tracking**								
* **OMC Tracking**								
* **Events Tracking**								
* **School/Commumunity Tracking**								
* **School Tracking**								
* **Clinical Tracking**								
* **OCHIN Referrals**								
* **Clinical Tracking**								
* **IHN - SHS Tracking**								
D. Events Planning								
1. Demonstrate initial ability to develop and coordinate lessons, projects, and events:								
* Intial outline and overview of the project								
* Timeline of activities								
* Initial basic budget (supplies needed, food, rooms, etc)								
* Materials list (supplies needed, food, rooms, etc)								
* Scheduling and coordination of class logistics								
* Develop marketing materials and outreach								
* Develop agendas and project/event materials								
* Documentation and filing								
* How to evaluate / debrief outcomes								
* QI Project forms - PDSA (Plan, Do, Study, Act)								
* Use of outreach and event tracking tool								
E. Team Member								
1. Demonstrate initial understanding/ability to be part of a multi-disciplinary team:								
* Communication and coordination with multiple supervisors								
* Work with diverse teams to coordinate client services/supports								
* Sharing calendars								
* Transparent work								
* Flexibility								
* Accesibility								
* Good communication skills								
F. Use of motor pool cars								
1. Reserve motor pool car								
* Health Department								
* Public Works								
* OSU motor pool								
2. Put gas in a County motor pool car								
3. Transporting client protocol								

Competency List: Health Navigation:

Employee Name:_____ Supervisor: _____ Manager: **Kelly Volkmann**

Note: First assestment needs to be completed by employee at 3-months. At end of 6-month probationary period, employee is expected to meet at least 60% of listed competencies. At end of 1 year, employee expected to meet at least 90% of listed competencies.

Method of Instruction Key: P = Protocol/Procedure Review E = Education Session/Class/Training S = Self Learning Package C = Practice D = Demonstration/Shadowing	**Method of Evaluation Key:** O = Observation RD = Return Demonstration V = Verbal Review N/A = Not applicable	**Self-Assessment by Employee**				**Validation of Competency**		
		Never Done **Date**	**Needs Review** **Date**	**Competent** **Date**	**Instruction Method (Use Instruction Key at Left)**	**Date**	**Initials**	**Evaluation Method (Use Evaluation Key at Left)**
G. Understanding of County GOAL Evaluation system								
1. Demonstrate understanding of GOAL acronym								
* Name each GOAL element								
* Describe criteria for evaluation levels								
H. Knowledge of Clinical Navigation								
1. Demonstrate knowledge/understanding of Care Coordination								
* Care team roles and functions and how a clinical HN fits into the care team								
* Running reports, working with Panel Manager								
* Chronic conditions								
* Community outreach								
* Standing orders: Scheduling office visits and labs								
* Making referrals, working with Referral Specialist								
* Recall activities (follow-up activities)								
* Preliminary triage (HN vs RN)								
* Client assistance (resources, paperwork, follow up, and support)								
* Basic Knowledge using Care Everywhere								
* Referral pathways								
* Self-mgmt for chronic conditions								
* Tobacco cessation								
* Tomando Control/Living Well, and other classes								
* Resources (Health Insurance, Vision, Hearing, food access, medications, etc.)								
* Other:								
* Other:								
* Other:								
2. Demonstrate basic understanding of disease processes:								
* Diabetes, including pre-diabetes, hyper-/hypo-glycemia, metabolic syndrome								
* Obesity								
* Hypertension								
* Oral health								
* Lipids								
3. Demonstrate knowledge/understanding of Self-Management Education								
* HN Curriculum for Self-Management								
* Outreach-referrals								
* Scheduling								
* Pre-Visit planning								
* Introduction								
* Patient assessment								
* Self-management education								
* Goal setting								
* Follow up								
* Charting								

Health Navigation Training Tracker

Dates / Range

HN Name: Started date:

HN position: 1
2
3

Topic	Subject	Date Completed
Agency Trainings	Health Department Orientation	
	HIPAA	
	Medicaid Fraud, Waste, and Abuse	
	Mandatory Reporting	
	Ethics and Boundaries	
	Civil Rights	
	Safety Training	
	Bloodborne	
	IT Security	
	CPR	
Big Picture	Intro to Public Health	
	Introduction to PCPCH	
	Prevention and Public Health	
	Social Determinants of Health	
	Breaking Barriers (Poverty)	
	Institutional Racism	
	Medical Interpretation	
	Health Literacy 101	
	Incident Report	
	Consumer Compliant form	
	Boundaries	
	Interactions with the care team (In person, in OCHIN)	
	Charting	
	Excel Class	
	CHW Leadership Development training	
	Scavanger Hunt of Resources	
	Safety During Home Visits	
OHP / OMC / Enrolment	OHP Enrolment	
	ONE System	
	Federal Market Place	
	OMC Training	
	WTI Training	
	WIC / COMPASS	
School / Community	SafeSchool Mandatory online Training (*Blood Born Pathogens, Sexual*	
	Overview: Title Survey/McKinney-Vento (children experiencing	
	Overview: SIS (Student Information System)	
	Overview: School Screenings	
	Overview: Kinder Intake Days	
	Overview: School Registration process	
	Overview: After school programs (Boys & Girls Club)	
	Overview: Weekend Food program	
	Overview: Free/Reduced Lunch program	
	Overview: Basecamp	
	Overview: School groups/organizations (ex. PTA)	
	Overview: Community Partners/Collaborations	
	Overview: Comcast Essentials Program	
Clinic-Oriented	Experiential: Shadow Primary Care and Family Planning	
	Overview: Clinical Resources and Health Care System	

	Overview: Asthma and COPD	
	Overview: Heart Disease and Stroke	
	Overview: Cancer	
	Overview: Arthritis	
	Overview: Autism	
	Overview: Hypertension	
	Overview: Hyperlipidemia	
	Tobacco Cessation	
	START / ASQs	
	Medical interpretation protocol and basic terminology	
Self-Management	Fundamentals of Diabetes (Class at SHS)	
	Healthy Eating and Exercise	
	Chronic Disease Self-Management	
	Finger Stick Blood Glucose Training	
	How to prepare and use a glucometer Using Safety Standards	
	Tomando Control de su Salud Facilitador Training	
	Tomando Control de su Diabetes Facilitador Training	
	Living Well with Chronic Conditions Facilitator Training	
	Walk with Ease	
Outreach-Oriented	Overview: Finding and Accessing Community Resources	
	Safety During Outreaches	
	Communication Skills	
	Building Leadership and Advocacy Skills	
	Community Organizing and Collaboration	
Education-Oriented	Popular Education	
	Motivational Interviewing	
	Mental Health First Aid	
	CHW leadership development training	
Additional Trainings	ASIST (Suicide Prevention)	
	Social Media for underserved populations	
	Participant-centered education (WIC)	
	Child Sexual Abuse Prevention	
	Cultural Competencies for Gender Minorities (LGBTQ)	
	Infant adoption	
Other trainings specific to individual HN		
Conferences attended		

Health Navigation Awards and Certifications

Dates / Range

HN Name: Started date:

HN position: 1
2
3

Topic	Tittle	Date	Expiration Date
HN Certifications	CPR & First Aid		
	Mental Health First Aid		
	Tomando Control de su Salud		
	Tomando Contro de su Diabetes		
	Living Well With Chronic Conditions		
	CHW / THW		
	Car Seat Technician		
Awards received as individual or team			
HN Profesional Memberships			
Interviews to HN			

Leadership, Community Mobilization and Engagement
Health Navigation Presentations, and Trainings given by HN

Dates / Range

HN Name: Started date:

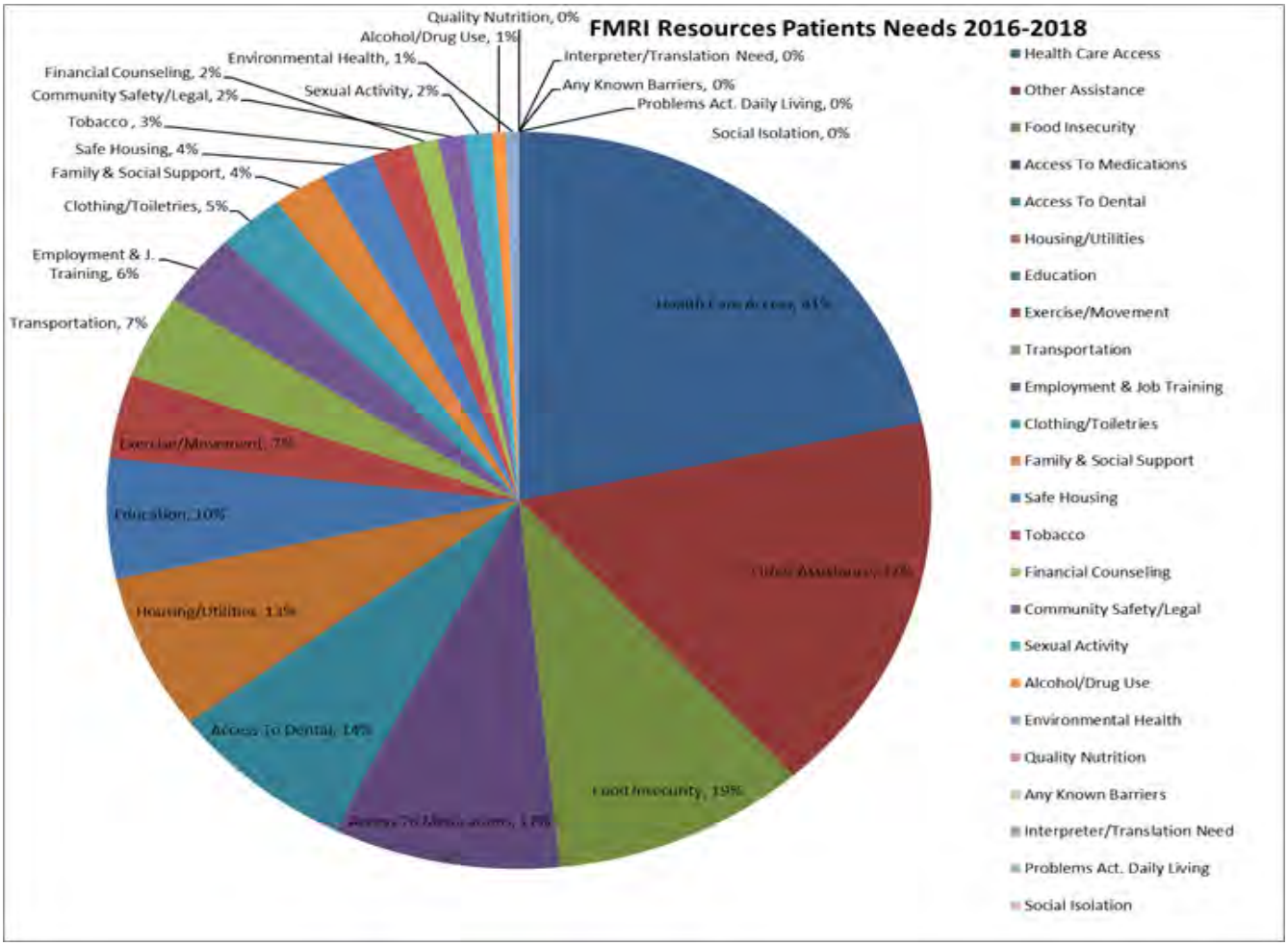
HN position: 1
2
3

Presentation, trainings, and Focus Groups for Benton County Teams		
Presentation, trainings, and Focus Groups for the Community / Community Partners		
Taking a leadership in special projects or events		

Appendix C

	FMRI Resources Patients Need 2016-2018	%
1	Health Care Access	41%
2	Other Assistance	32%
3	Food Insecurity	19%
4	Access To Medications	17%
5	Access To Dental	14%
6	Housing/Utilities	13%
7	Education	10%
8	Exercise/Movement	7%
9	Transportation	7%
10	Employment & Job Training	6%
11	Clothing/Toiletries	5%
12	Family & Social Support	4%
13	Safe Housing	4%
14	Tobacco	3%
15	Financial Counseling	2%
16	Community Safety/Legal	2%

17	Sexual Activity	2%
18	Alcohol/Drug Use	1%
19	Environmental Health	1%
20	Quality Nutrition	0%
21	Any Known Barriers	0%
22	Interpreter/Translation Need	0%
23	Problems Act. Daily Living	0%
24	Social Isolation	0%



Appendix D

3A's and R Protocol

Step 1: ASK about the patient's tobacco use

"Do you currently smoke or use any other forms of tobacco or nicotine (cigarettes, vaping, chewing, hookah or smokeless tobacco)?" Or, "Have you used tobacco in the past 30 days?"

Step 2: ASSESS willingness to quit

"Are you interested in quitting?"
Or, "Would you like to receive information about free help to stop tobacco?"

Step 3: ADVISE the patient to quit using tobacco

"Quitting tobacco is the single biggest improvement you can make in your health and the health of your family."
Talk about different quitting techniques (resource card), stress management tools (4 D's: deep breathing, drink water, distract and delay) etc. Go over patient's barriers to quitting and use the Overcoming Barriers handout to cover alternatives to those barriers.

Step 4: REFER the patient to additional resources

"You don't have to quit on your own. We have free resources and options you can select from to make your quit attempt successful!" Provide the resource card to the patient.

Step 5: Fill out the Tobacco Cessation Participant Information (PI) form.

Complete the PI form. Fill out the counseling notes section for additional comments.

Note: This document was provided by Family Medicine Health Center.

Lesson Plan

This lesson plan is designed to provide information that will assist Health Center staff in integrating CHWs on their care team. This is accomplished by identifying CHW skills and roles, assessing training needs, and exploring data collection

Objectives	
1	Participants will identify CHW skills and roles and use them to define position parameters within a Care Team.
2	Participants will identify key ways to improve their CHW program through targeted training opportunities.
3	Participants will explore CHW data collection methods that can improve the services provided by the health center.

Materials

Time: 2 Hours

1. PowerPoint slides and projection equipment

2. Printed case study: Success in Using Community Health Worker Collected Data for Clinical Decision Making in Family Medicine Health Center - One per participant (see pg. 29)

3. Handouts from lesson plan – One per participant

Intoduction

Time: 5

Slide 1 - Introduce yourself and your position. Ask each person in the room to introduce themselves (if less than 20 participants).

Slide 2 - Explain the objectives for the presentation. If applicable, explain why this training is important at this particular time. For example, if the health care organization recently received funds to start a CHW program or is looking to strengthen their existing CHW program.

Slide 3 – This toolkit is the continuation of the Making the Case for Community Health Workers on Clinical Care Team Toolkit. If you are considering integrating

CHWs into Care Teams and understanding the benefits and contributions they provide, we suggest you review that toolkit before moving forward as this one takes a deeper dive into successfully implementing CHWs into the team.

Community Health Worker Roles and Sub-roles

Time: 25 Minutes

Slide 4 – Review Appendix 1, CHW Roles and Sub-roles
CHWs have many skills that lead to a variety of roles; it is important to define the parameters of the CHWs role within the clinic. This will improve the CHW and clinical team collaboration in clinical processes.

Facilitator's Note:

Distribute CHWs Roles and Sub roles handout to participants. Individually they will fill in the handout with the information pertaining to their organization's current roles filled, clinical needs, and wants. Once completed, briefly discuss as a larger

Discussion

- Are there any roles/sub-roles that are currently performed by the same individual/title? or more than one person?
- How does that affect your daily workflow?
- Looking at this chart, and your clinical needs, in what ways would your health center benefit from integrating a CHW?

Facilitator's Note:

The conversation should flow naturally to how each individual in the clinical team works together.

Slide 5 – Brief Overview of Skills Assessment Review.
Skills assessments are used to analyze individual skills, including those that are transferable from one position to another or those that need to be developed. This assessment can determine whether an individual is qualified for a certain role or position and identify whether further training is needed.

Facilitator's Note:

Distribute Appendix 2, Skills Assessment Sample

Discussion

- Has your health center ever used one of these assessments?
- What benefits do you think it provides?

Slide 6 - Summary Points

- Every individual within your organization has a defined role and sub-roles. It is imperative that all Care Team members understand each other's roles to effectively collaborate in clinical processes.
- Skill assessments can be used to further explore the skills of all team members and identify areas of expertise and/or need for training that will assist the organization in better serving the community.
- Defining CHWs scope of work and opportunities for professional growth will foster trust in their abilities and acceptance of their role within the Care Team.

Building Trust within the Care Team

Time: 45 Minutes

Facilitator's Note:

This section will begin with discussion questions and will continue with Training examples (slide 8), and Benefits of Properly Trained CHWs (slide 9).

Slide 7 - Using training to strengthen the CHW role within your health center.

Discussion

- What types of trainings do you believe CHWs need?
- How can well trained CHWs impact your health center?

Slide 8 - Training Examples

1. Clinical Service Delivery
Examples: Dynamics of health center, CHW position parameters, schedules, and Clinical Team members' responsibilities and duties.

2. Program specific
Examples: Curriculum, educational workshops on disease prevention and health promotion, and outreach techniques.

3. Medical terminology
Example: Language used to precisely describe clinical components, processes, conditions affecting it, and procedures performed upon it.

4. Technology use
Examples: Use of technology to input patient's information and use of Telehealth.

5. Accessing health care and social service systems
Example: Navigation within appropriate system platforms

6. Translating, interpreting, and facilitating client-provider communications
Example: CHWs interpreting provider's indications to a patient in their language.

7. Educating social services staff and providers on community/population needs
Examples: Social Determinants of Health (SODH) and field observations

Slide 9 - Benefits of Properly Trained CHWs

- Build trust with other Health Professionals
- Successful integration into health center's daily dynamics
- Gained respect from health center's leadership (supervisors, managers)
- Minimized data anomalies

Slide 10 – Using CHWs to Enhance Data Collection

CHW-collected data is important as it provides meaningful patient information that supports health interventions within the Clinical Team.

CHW-collected data may include:

1. Patients' SDOH information such as their economic stability, physical and social environments, education level, employment status, housing, health care access, among other important factors that may be barriers to good health and a balanced quality of life.
2. Case Management Reports that demonstrate patient's knowledge or behavior change during a period of time
3. Pre-and-post education evaluations that demonstrate patient's knowledge or behavior change.
4. Records of increased patient's doctor visits (time-framed)
5. Record of increased patient's medication adherence (time-framed)

Slide 11 - Example of how CHW- collected data impact programmatic decision making

Facilitator's Note:

Please distribute case study: Success in Using Community Health Worker Collected Data for Clinical Decision Making in Family Medicine Health Center -One per participant (see pg. 29)

Discussion

- After reviewing FMRI case study, how did CHW-collected data impact FMRI's programmatic decision making?
- What CHW collected data do you think is the most important for your Health Center?
- At present, what is the most impactful CHW collected data you have gathered or evaluated within your health center?

- How CHW collected data can influence new interventions/program in your health center?

Slide 12 – Summary Points

- Training is essential for the success of CHWs within care teams as it helps to enhance or develop their skills; consequently, improving their confidence and building trust within the Care Team.
- CHW- collected data is essential for addressing health issues as it provides insight into patients' SDOH and other information that may not be readily available to other members of the Care Team.
- Establishing trust in the role of CHWs in data collection will improve acceptance, trust, and utilization of data within the Care Team.

Team Huddles & Communication (Group Activity)

Time: 45 Minutes

Facilitator's Note:

At this point, the participants should have a clear understanding of the CHW roles and responsibilities, approaches to strengthen their professional skills, and their impact in clinical decision-making. We will now see how these concepts can be implemented in their health center.

Slide 13 – Activity 1: Role Play
Time: 25 Minutes

Comprehensive care begins before the patient enters the health center and continues once they have left. It is important to have a clear understanding of how CHWs, Care Team members, and patients interact in the three domains which includes pre-visit, visit, and post visit.

Facilitator's Note:

Each health center will complete a role play of their current workflow within the Care Team. If more than one health center is present, each health center will be assigned one domain (pre-visit, visit, or post visit). If all participants are from the same health center, then all three domains will be played by the same group.

In both cases, the facilitator will take on the role of the patient.

Slide 14 – Activity 2: Let's Talk
Time: 20 Minutes

Facilitator's Note:

We understand that clinics run on a tight schedule however in order to ensure that the clients are receiving appropriate care, it is important to establish clear communication. Many health centers have incorporated team huddles to discuss their daily duties in patients' care plan.

Please distribute **Appendix 3, Team Huddles: Making a Plan Fill worksheet** to participants and allow 5-10 minutes for participants to complete individually. Next, distribute **Appendix 4, Team Huddles: Making a Plan** and discuss and compare responses as a large group.

Slide 15 – Presentation Summary

- Every individual within your organization has defined roles and sub-roles. It is imperative that all Care Team members understand each other's roles to effectively collaborate in clinical processes.
- Skills assessment can be used to further explore the skills of all team members and identify areas of expertise and/or need for training that will assist the organization in better serving the community.
- Defining CHWs scope of work and opportunities for professional growth will foster trust in their abilities and acceptance of their role within the Care Team.
- Training is essential for the success of CHWs within care teams as it helps to enhance or develop their skills; consequently, improving their confidence and building trust within the Care Team.
- CHW- collected data is essential for addressing health issues as it provides insight into patients' SDOH and other information that may not be readily available to other members of the Care Team.
- Establishing trust in the role of CHWs in data collection will improve acceptance, trust, and utilization of data within the Care Team.

Lesson Plan Appendices

Appendix 1

Community Health Worker Profession Roles and Sub-roles

Directions: Place a checkmark or an X in each box based on your clinical needs. You can identify your needs based on the Role i.e. Cultural Mediation or by the individual Sub Role i.e How to use health and social service systems. Once completed, you will fill in the title of the Individual that performs that role.

Role	Sub-Roles	Currently Have	Title	Need to Have	Want to Have
Cultural Mediation	a. How to use health and social service systems b. Community perspectives and cultural norms c. Health literacy and cross-cultural communication				
Culturally Appropriate Health Education	Health promotion, disease prevention, and health condition management that is culturally and linguistically appropriate				
Care Coordination, Case Management, and System Navigation	a. Providing assistance and coordination over time b. Making referrals and providing follow-up c. Helping to address barriers to service d. Care system navigation				
Coaching and Social Support	a. Motivating people to access care and services b. Supporting behavior change c. Facilitating community-based support groups				
Advocating	a. Identifying community needs and resources b. Advocating for clients and communities c. Empowering communities to pursue their own desired policy change				
Building Capacity to Address Issues	a. Building individual and community capacity b. Training with CHW peers and among networks				
Individual and Community Assessments	Participate in holistic individual- and community-level assessments				
Outreach	a. Recruitment of individuals b. Informing individuals c. Representing your organization at community events				
Evaluation	a. Data collection b. Assisting in interpreting results c. Sharing results and findings				

Modified from C3project,

Skills Assessment

Use this form to develop a baseline assessment of your skills, including those that are transferable from one position to another, or those that you want to develop. Rate your current level of proficiency, if desired, from "1" (low, beginning level) to "5" (high, expert level). You can also use this form to solicit peer feedback on your skill level.

Obviously, some of the skills listed below will have no bearing on your career, present or future. Feel free to pass on any such items.

Skill	**Level of Proficiency** *Low* 1 2 3 4 5 *High*	**Transferable** Yes	No	**Key Skill I Want to Develop**
Communication Skills				
Writing				
Presentation				
Facilitation				
Listening				
Interviewing				
Influencing				
Giving and Receiving Feedback				
Conflict Resolution				
Negotiating				
E-mail Communication				
Editing or Copyediting				
Proofreading				
Technology and Computer Skills				
Keyboarding				
Word Processing				
Calendars				
Spreadsheet				
HTML				
E-mail				
Presentation Software				
Graphics Software				
Employee Portal/ Employee Self-Service				

Financial Skills				
Accounts Receivable				
Accounts Payable				
Payroll Processing				
Budgeting				
Financial Analysis				
Cost Accounting				
Forecasting				
Tracking and Management				
Cash-Flow Analysis				
Other:				
Supervisory Skills				
Hiring				
Coaching				
Delegating				
Setting Goals and Objectives				
Assessing Performance				
Leading				
Motivating				
Training and Support Development				
Analyzing Work Flow and Processes				
Recruiting and Retention				
Other:				
Management Skills				
Managing Change				
Managing Customers, Internal and/or External				
Project Management				
Managing Upward				
Solving Business Problems				
Business Analysis, Critical Thinking				
Internal Consulting and Networking				
Creative Thinking, Brainstorming				
Teamwork Skills				
Group Problem Solving				
Keeping Teams on Target				
Working with a Virtual Team				
Assuming Team Membership Roles				
Collaborating				
Other:				

Self-Management Skills				
Self-Awareness				
Emotional Intelligence				
Time Management				
Balancing Work and Life				
Career Development				
Stress Management				
Limit Setting and Goal Setting				
Seeing Multiple Perspectives				
Other:				
Administration Skills				
Calendar Management				
Meeting Coordination				
Event Planning				
Transcription				
Travel Coordination				
Handling Correspondence				
Interfacing with contacts, visitors, callers				
Photocopying				
Conducting research (library and web-based)				
Course Materials Preparation				
Other:				

Other Locally-Specific, Industry, and/or Job-Specific Skills (List)	

Appendix 3

What is the difference between a Team "Meeting" and a "Huddle"?

	TEAM MEETINGS	"HUDDLES"
Meeting Frequency		
Amount of Meeting Time		
Attendees		
Focus of meeting		
Excerpts from Cambridge Health Alliance Team-Based Care Toolkit ©		

Appendix 4

Excerpts from Cambridge Health Alliance Team-Based Care Toolkit ©

What is the difference between a Team "Meeting" and a "Huddle"?

	TEAM MEETINGS	"HUDDLES"
Meeting Frequency	o Goal: weekly o Minimum: biweekly	Goal: before each session (AM & PM)) Minimum: once a day Ideal: In addition, post-session quick huddle for f/u tasks
Amount of Meeting Time	30-60 minutes depending on weekly/ biweekly *This meeting time should occur during a time when team members CAN ATTEND and coverage for their work is available. Team meetings are part of administrative time for providers.*	Average 10 minutes or less! * Who's coming in today: what do they need? * Who was in the hospital/ED and what is the plan for f/u?
Attendees	All assigned members of the Planned Care Team **Required participants:** Provider, Nurse, Medical Assistant, Medical Receptionist, Planned Care Coordinator, and Complex Care Managers (for high risk case discussions) **Support team participants:** Clinical Pharmacist, Nutrition, Mental/Behavioral Health, Social Work, Patient Navigators, Community Resource Specialists	• A provider and the MA who are working • together to see the patient that day. • The receptionist joins the team if at all possible to assist with scheduling of appointments. • The team RN connects with this team either during the huddle or sometime during the day to review the hospital/ED f/us.
Focus of meeting	Planning for care of a *panel/population* of patients. This includes patients who touch the health care system regularly (during appointments and phone contacts) and those who do not touch the health care system regularly. Includes planning for their: o Health Maintenance issues o Chronic Care issues o Social and Resource issues o High risk patients	Planning for care of the patients scheduled *to receive care* during the session/day by the provider. Includes planning for flow of the session *(i.e. provider informs RN that this patient on the schedule will be a quick follow up and an add on can be double booked in this slot)* Includes planning for patient's: o Health Maintenance issues o Chronic Care issues o Urgent Care issues *(i.e.provider informs MA that this patient will need an EKG, this one a throat culture, etc.)*

Huddle Strategies and Checklist

A good huddle can be done in as little as 10 minutes. It does require everyone to show up on time, which means, if your first appointment is at 8:30 am everyone on the patient care team must show up at 8:15 am to begin the huddle. Most teams build their huddle time into their work schedules.

What is needed for a successful huddle?

1. All team members present (typical teams include the provider, MA, and Nurse) added benefit to have other members: team receptionist, pharmacist, nutrition, covering PA/NP, behavioral health
2. Everyone is on time!
3. A place for the team to meet with a couple of computers available for the team to use
4. Intense and purposeful focus. No interruptions! Do not be distracted by phone calls, emails, or other staff.
5. Proximity! A team shouldn't spread out in a room sitting in chairs to huddle. Imagine how sports teams huddle. They get up close, heads together, and speak to each other with focus and energy. Try to mimic this kind of huddle.

Team Huddle Guidelines:

1. Occur twice a day- before each session
2. Be kept to less than 10 minutes
3. Become a daily clinic practice routine

The Goal of Huddles is for everyone to feel calm: It is so much calmer planning for these bumps before they happen rather than dealing with them in the midst of seeing patients, isn't it?

What do you talk about? You discuss the patients that are coming in that day for their appointment and people you may need to worry about:

1. Patients with chronic disease: administering PHQ-9's for depression, Asthma questionnaire/Peak Flow, or removal of shoes and socks for Diabetics
2. Patients who are often late, problematic or have high service needs
3. Canceled appointments
4. Patients who need follow-up from the hospital or ED
5. Team communicates about future/standing immunization, lab, and radiology orders and Provider places those future/standing orders not covered under CHA Standing Order Policies
6. Confirm which patients may need an interpreter for their visit
7. Population Health: those who will need FOBT cards, mammography, pap smear, PSA

What determines "an effective" huddle:

1. Everyone contributes
2. Team anticipates as much as it can
3. Strategies are developed to handle potential problems or scenarios

More strategies for effective huddle and high performing team:

1. Do a quick check in with everyone
    A. How is everyone feeling today?
    B. Is anyone leaving early?
    C. Is anyone out today?
    D. How can we support each other through the session?
2. Know the status of each team member because everyone is critical to the success of the team.

Team Huddle Assessment Tool:

Purpose: Huddling seems variable by teams within and across the system. We are looking for best practices around huddling. This tool is for use by members of the team in team self-evluation.

Huddle defined: Discussing the days care

	Every session	Most sessions	Some sessions	rarely
Do you huddle with a provider?				
Do you huddle with a nurse?				
Do you huddle with a medical assistant?				
Do you huddle with a receptionist?				
Do you discuss admitted patients, ER admits, or recently discharged patients with your care team?				
Do you huddle with other clinic staff?				

	always	sometimes	rarely
Do you discuss admitted patients with your care team			
Do you discuss patients recently discharged with your care team			
Do you discuss patients recently discharged from the ED with your care team			

Huddling with the MA is good because:
Could be better if:

Huddling with the RN is good because:
Could be better if:

Huddling with the front desk is good because:
Could be better if:

If a member of your team had information about patients admitted to non CHA hospitals or being discharged from non CHA ED's do you have a system to address the needs of the patient in transition?

Team Huddles: Making a game plan for today

	MA	Provider	RN	Receptionist
Prepare for the huddle.	o Review schedule of patients for the session, and reasons for visits o Review health maintenance needs o Review DM/asthma/ depression chronic care needs o Review open orders o Assist in preparation of intake packets	o Review specialist and hospitalist communications about patients coming in/in the hospital. o Review test results o Note if patients with complex/chronic disease need a care plan updated o Note any orders/referrals that are outstanding (incomplete) o Enter any orders you would like done in advance of rooming as future orders.	o Prepare list of team patients discharged from the hospital. o Prepare list of team patients in ED since last huddle. o Discuss risk and follow up with provider and team in preparation to call later. o Identify high risk patients on today's schedule for warm handoff to RN or to complex care manager. o Review immunization needs	o Note number of available appointments and requests for appointments. o Note who needs to be offered MyCHArt and text messaging. o Complete preparation of intake packets o Note any orders/referrals that are outstanding (incomplete) o Note which extended team members are present and availability
Review patients coming in today.	o Ask for clarification of priorities (How much can we get done today?) o Clarify open orders to complete o Proactively discuss likely issues with flow, lateness, or high service needs	o Suggest extended team members who might assist patients for possible warm handoffs o Proactively discuss likely issues with flow, lateness, or high service needs	o Suggest extended team members who might assist patients for possible warm handoffs	o Plan to assist with scheduling overdue referrals or tests. o Proactively discuss likely issues with flow, lateness, or high service needs
Review patients discharged from the hospital or ED		o Discuss when to see patients who have been in the ED or inpatient unit for follow-up.	o Discuss when to see patients who have been in the ED or inpatient unit for follow-up.	o Schedule these patients based on patient and team preferences.
Review major patient requests for letters, forms etc				o Review requests for referrals, forms, letters etc with the team.
Document individual patient plans for today in Snapshot Specialty field	**Documentation in EPIC:** Allows other staff to assist today if needed, for example during breaks or busy times Allows notes to remain in place for the future if patient misses or reschedules the appointment Serves as a reminder for today for each team member			

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