Essential Workforce: Integrating Community Health Workers into Primary Care Homes

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Today's Discussion

- The continuum of services that Community Health Workers (CHWs) can provide in a primary care home
- Benefits and challenges of integrating CHWs into the primary care team
- Strategies for recruitment, training, supervision, and retention of CHWs as members of the primary care team

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Benton County Health Services

- Benton County Health Department
- Community Health Centers of Benton and Linn Counties
- Federally Qualified Health Centers, Migrant Health Centers
  - Four clinic sites
  - Two of them School-Based Health Centers
- All four are "Tier 3 Patient-Centered Primary Care Homes"

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Let me tell you a story…

- **Carmen**
  - 67 year old Latina, monolingual Spanish speaker
  - Diagnosed with diabetes in Mexico, Winter 2012
  - Relocated from Mexico to Oregon to live with adult children
  - Established care at CHC March 2012
- Uncontrolled Diabetes
  - HbA1c at 9.7
  - Glucose readings from 58-500
- At risk for depression
  - Expressed feeling like a burden to her adult children

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Carmen…

- Took Diabetes Education Class at local hospital
  - English only, used telephone interpretation
  - Hard to hear, hard to understand
- Provider concerned about communication challenges
  - Multiple family members involved in care
  - Carmen lived with one daughter, but a different daughter came with her to appointments
- Provider was seeing Carmen every 2 weeks for a 40-minute appointment…
- But diabetes was still uncontrolled

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“Health Navigator” Program

- Began in 2008 with one grant-funded, part-time Community Health Worker / “Navigator”

Today…

- 16 Community Health Workers (CHWs) who work as “health navigators” (HNs)
  - 13 bilingual-bicultural Spanish
  - 3 monolingual English
- Provide a variety of services across the continuum:

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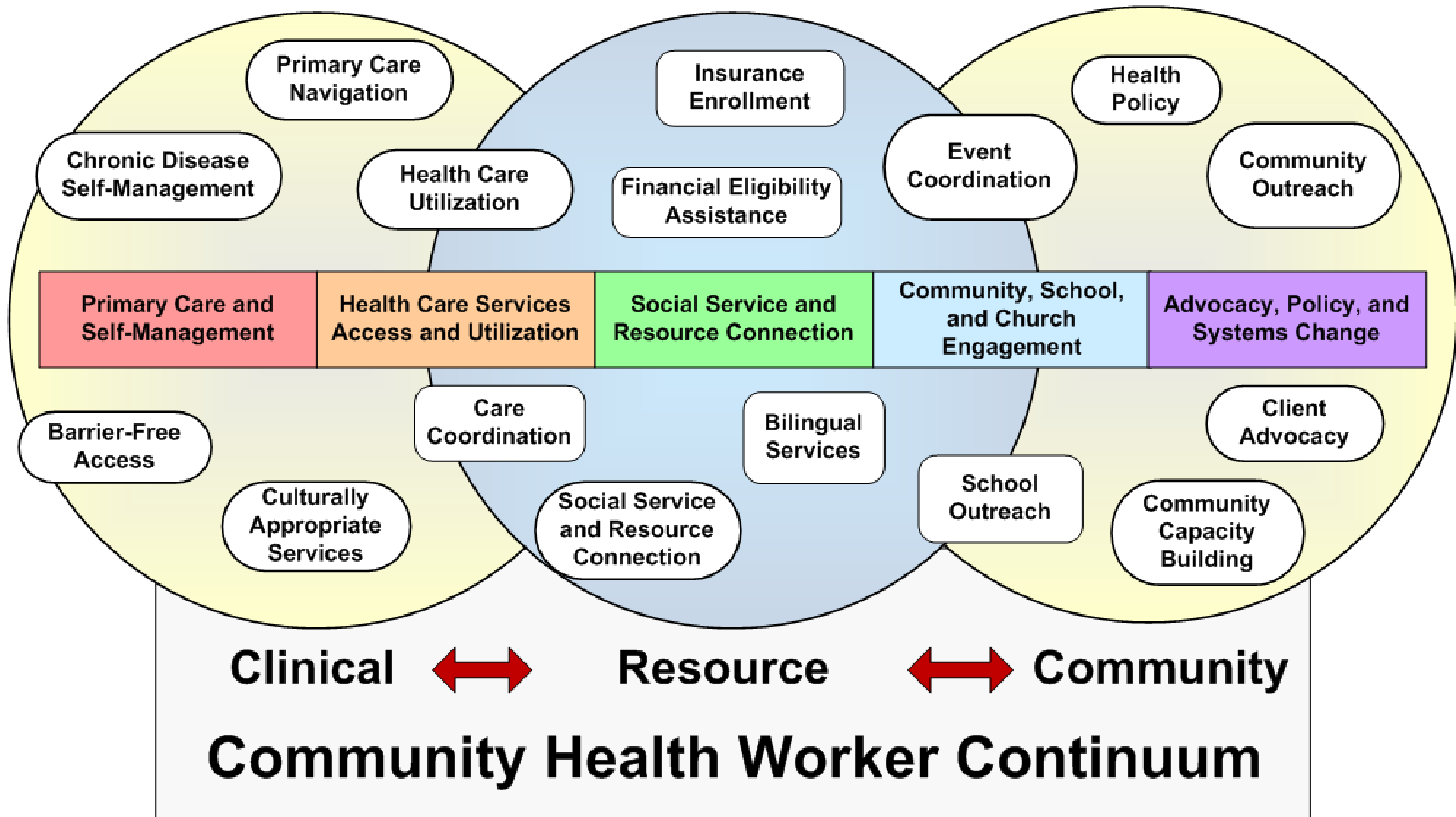
Primary Care
Navigation
Chronic Disease
Self-Management
Health Care
Utilization
Insurance
Enrollment
Financial Eligibility
Assistance
Event
Coordination
Health
Policy
Community
Outreach
Primary Care and
Self-Management
Health Care Services
Access and Utilization
Social Service and
Resource Connection
Community, School,
and Church
Engagement
Advocacy, Policy, and
Systems Change
Barrier-Free
Access
Care
Coordination
Bilingual
Services
Client
Advocacy
Culturally
Appropriate
Services
Social Service
and Resource
Connection
School
Outreach
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Capacity
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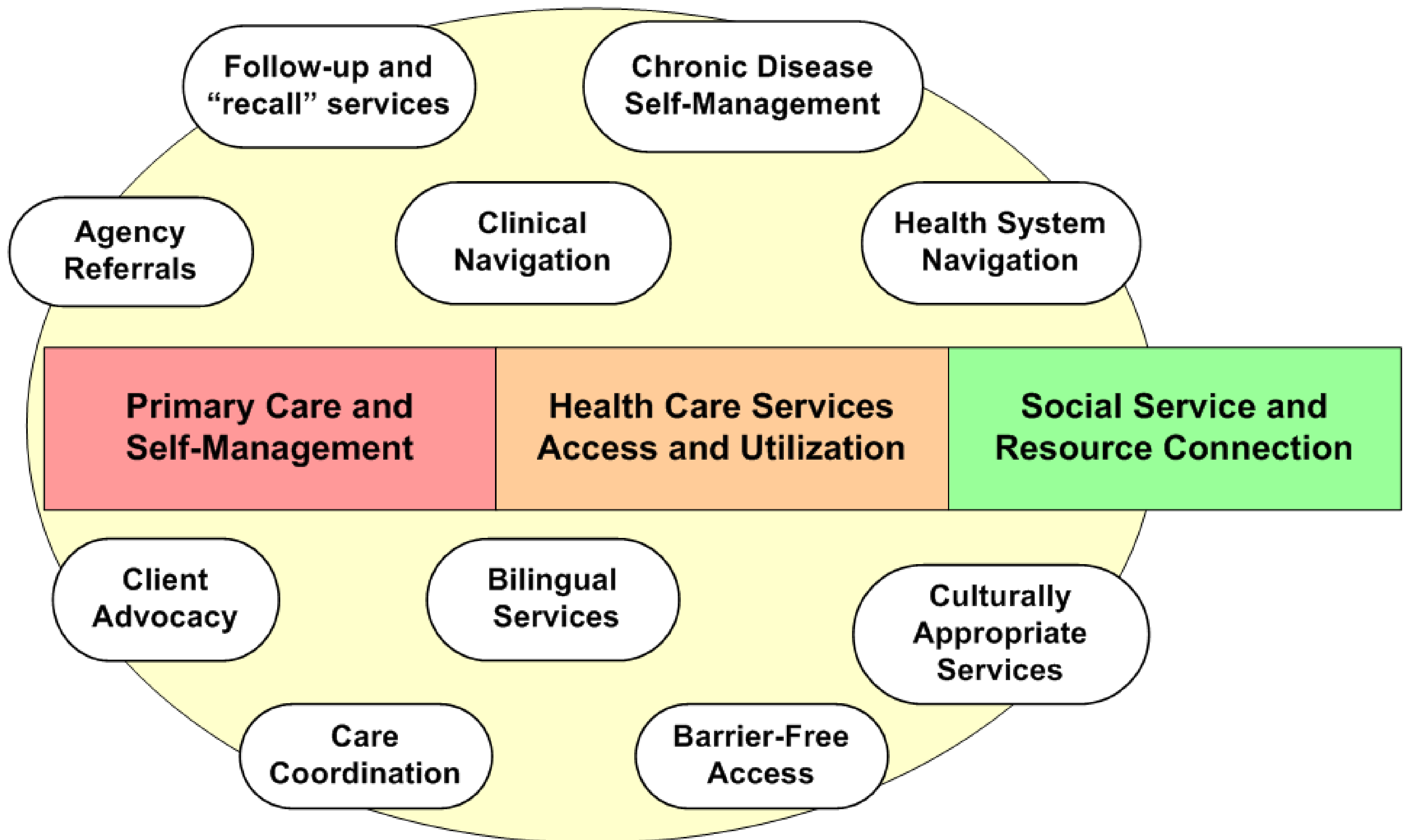
Community
Community Health Worker Continuum



"Clinical"

Community Health Worker Continuum

Community Health Worker: Clinical Roles

- Integral member of the care team
- Help clients navigate the healthcare system
- Utilization of services
  - Clinical system navigation
  - Care coordination
  - Patient advocacy
- Can provide
  - Chronic disease prevention
  - Self-management education and support
  - Nutrition and exercise coaching

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Clinical CHWs and Pt. Centered Medical Homes

Integrated Behavioral Health
- Education
- Chronic disease self-management
- Diet and exercise
- Tobacco cessation
- Stress management
- Mental Health services

Team-Based Care
- Ongoing coordination with Primary Care Team
- Charting
- Identify best teaching methods
- Contributes to needs assessment
- Has input into action plan
- Clinical procedures

Panel Management
- Chart review
- Review of blood sugars
- Schedule lab and provider appointments
- Telephone contacts
  - Triage
  - Answer questions
- Medication adherence and refills

Barrier-Free Access
- Assist with Internal and external referrals
- Assist with social services
- Assist with transitions between providers and phases of care
- Filling out medical forms
- Transportation assistance
- Interpretation services

Customer-Driven Care
- Social-Cultural competency
- "Cultural Broker"
- Increased health literacy
- Increased "patient activation" and empowerment
- Personal relationship building
- Models advocacy for self and family

Integration into Care Team

- Direct connection and pairing with RN Care Coordinator
- Best use of skills for each worker
- Each practicing at the "top of skill set"
- Each has a role to play in the care coordination/case management of clients
- Best scenario includes a "loop-back" between CHW, RN, and primary care providers to ensure all parties informed

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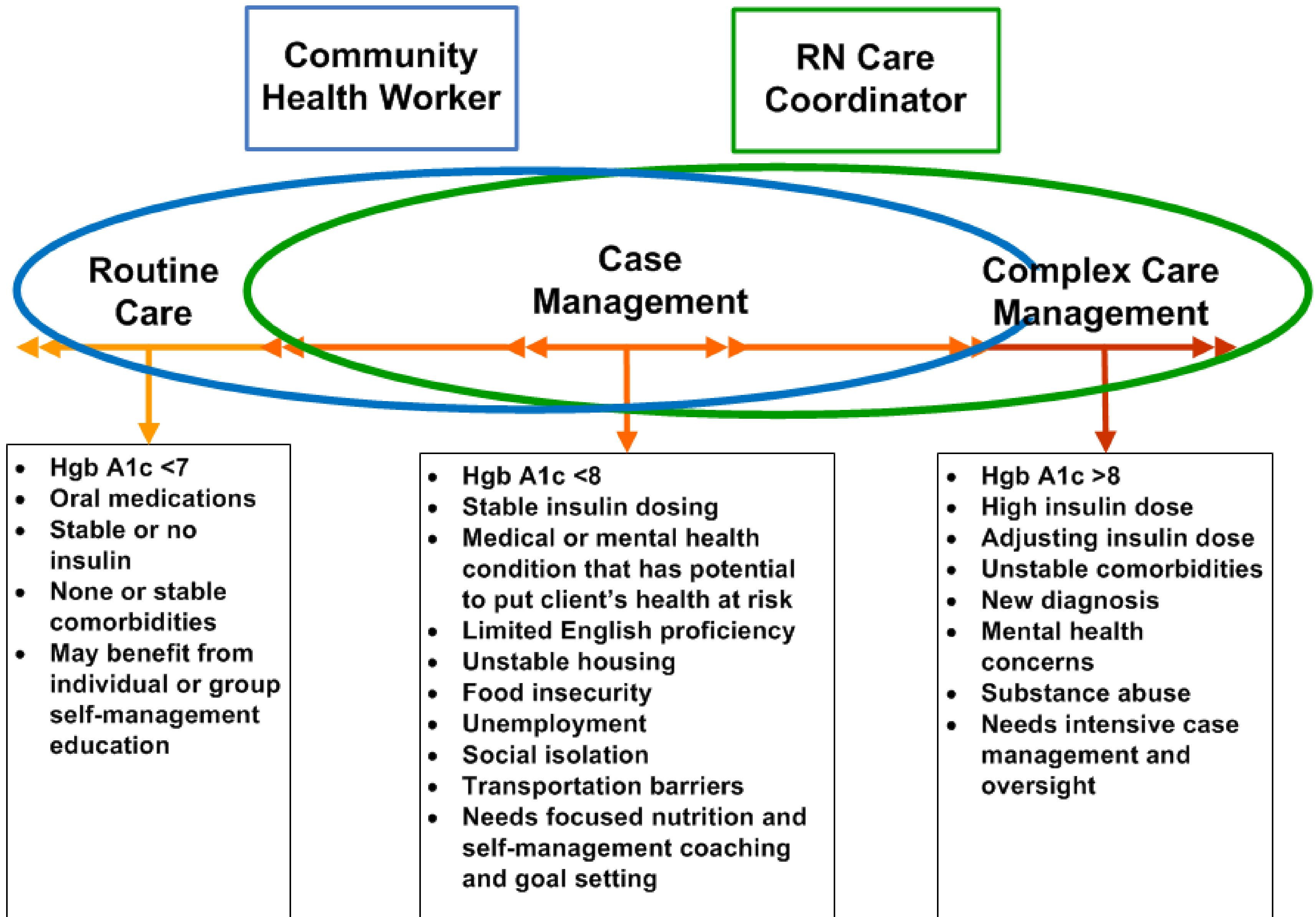
Level of Care Matrix



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Define the "case load"

- Must decide what role the CHW will play
  - Social service and resource connection?
  - Self-management education?
  - Some of both?
- CHW can't be all things to all care teams/providers/patients
  - Need to limit the possibilities to keep the job manageable
- What patients will the CHW work with?

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Different possible scenarios

- **1 CHW to 1 Provider**
  - CHW/RN work with all patients on provider panel
- **1 CHW to 1 Care Team:**
  - CHW/RN work with all of the patients referred to him/her by all of the providers on a care team
- **1 CHW to 1 Chronic Disease type**
  - CHW/RN work with all patients in a practice with the identified chronic disease

➡ Still need to define the scope of the CHW role

➡ Important to use a care matrix of some kind to provide structure and keep workload manageable

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Referrals to CHWs

- A good idea to have referrals coming through a "gatekeeper" such as the RN
  - Very easy to overwhelm CHW if receiving many referrals from different providers
- How will referrals be sent?
  - Can be as simple as an inbasket in EHR
- Need to track referral so all parties know progress
  - CHW must keep RN and Provider "in the loop" and let them know when referral has been closed
  - **This is important step in building trust in CHW**

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Documentation in EHR

- All CHWs document in our EHR ("OCHIN")
- Chart using an interim note
  - Non-billable encounter
- Also use telephone encounters
- Each encounter is routed back to the RN and provider to "close the loop" so that care team is fully informed
  - This has really increased the trust between providers and CHWs
- All "touches" are documented and reportable in OCHIN

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CHWs do NOT give advice…

- Our CHWs are carefully trained in their role
- They provide resources, linkages, connections, self-management education
- They assist patient to make their own goals
- If patient asks CHW "What do you think I should do?" or "What is wrong with me?" the CHW knows to say:

"It sounds like you have a question
that needs to be answered by your nurse/provider.
Let me see if I can find/call her…"

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CHW on the Care Team: Benefits

- Increased connection to patients
  - Improved communication between patient and provider
  - "Someone who looks…talks…IS… like me"
- Increased patient engagement and "activation"
  - Higher likelihood of adherence to self-management goals and protocol
- CHW able to address barriers to care
  - Patient may be more open to sharing what those barriers are
  - Transportation, language, culture, finances

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CHW on the Care Team: Challenges

- Difficult to gain provider trust in "unlicensed personnel"
  - "We just don't know what those navigators do…"
  - Have to be diligent and have a consistent presence
  - CHW needs a strong champion on the Care Team

- Learning to handle a large workload once trust is established and the referrals start coming in
  - Every Care Team will want their own CHW!

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Recruitment Challenges

- HR Practices
  - Online postings and applications
  - Confusing paperwork
- Minimum qualifications
  - CHW may have trouble meeting education or job experience requirements
- Position description development
- Potential barriers related to
  - Language
    - Clinical position will need to be bilingual and biliterate
  - Limited familiarity with systems

Recruitment Strategies

- Consider:
  - Alternate application formats
  - Using "…or equivalent life experience" and volunteer work as alternative to years of employment, education, or degree
- Write broad position descriptions
  - But think carefully about what roles you want the CHW to perform and what skills or training will be needed
- Traditional interview structure may be intimidating
  - Consider having key community member or liaison on interview panel

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CHW Training Needs

- Currently no national training standard or curriculum
- Agency must be willing (and have the expertise) to train new CHWs in their role
- Not like hiring a new RN or an MA – clinical CHWs probably won’t come to you with a certain set of knowledge and skills
- We spend at least 3 months intensively training new CHW staff
  - And another 3-6 months adding in trainings as needed and available

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CHW Training Topics

- HIPAA, Ethics
- Disease-specific education
- Self-management and coaching
- Motivational interviewing and stages of change
- Case management, care coordination, and system navigation
- Popular education
- Health literacy
- Health promotion
- Outreach and mobilization
- And much, much more….

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Supervision Needs

- Supervision needs will be determined by type of program
- Clinical CHW program will need licensed supervisor
  - RN or other provider
- Outreach or enrollment program will need health promotion or health navigation supervisor
  - Ideally, supervisor has experience with targeted community outreach and understands the role of outreach
  - May also need direct connection with licensed provider or health educator

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Unique Supervision Needs

- CHW may not be familiar with bureaucratic systems
  - May need extra coaching and longer training or probation period
- Cultural differences and power differentials
  - CHWs may not be comfortable telling supervisor that they don't understand or that they have a problem
  - Supervisor may not want to listen to suggestions from CHWs or may have unrealistic expectations
- **Organization needs to train/coach both CHWs and agency staff**

Retention Challenges

- Clinical setting and personnel unfamiliar with CHWs
  - Mistrust of "non-licensed personnel"
  - A clinic champion is essential for success
- CHWs may not feel valued for the unique skills they bring
  - May be relegated to interpretation or transportation
- Unending community need
  - Leads to burnout
- CHW programs tend to be grant-funded and limited duration
  - Grant ends, so does the CHW position
  - **This will ruin a clinical program and make it harder to restart**

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Retention Strategies

- Embed CHW positions into stable clinic funding
- Commit to training both CHWs and clinical staff
- Create clinic culture where CHWs are equal members of primary care team
- Professional Development
  - Provide CHWs with opportunities for leadership, advancement, and promotion within clinic
- Be willing and prepared to advocate for CHW staff

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Remember Carmen?

- Began working with bilingual, bicultural **Community Health Worker** to provide care coordination, extended diabetes self-management education and support
- CHW attended office visits
  - Used teach-back methods to ensure that Carmen understood and agreed to plan of care
- Patient engagement and education
  - Engaged daughter who lives with Carmen regarding treatment plan
  - Referred Carmen to *Tomando Control de su Salud* - Chronic Disease Self-Management workshops
    - Attended with daughter who lived with her
    - Carmen's positive feedback resulted in son and daughter-in-law attending another *TC* workshop

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Carmen…

- Culturally appropriate adaptations
  - Created health literacy appropriate monitoring instructions and glucose recording spreadsheet
  - Addressed dietary needs and requirements in culturally appropriate ways
- Phone follow up calls for additional outreach and engagement
  - Reduced need for extended office visit
    - Provider available to see other patients
- Coordinated care with other services
  - Dental van, women's health

Carmen - Results

- Within 3 months, Carmen reported improved health status and greater confidence
- Adult children know more about her disease and are more understanding and supportive of her needs
- Glucose readings more stable
  - Ranging between 110 and 180
  - HbA1c at 7.6 (dropped from 9.7 in 3 months)
- Decreased risk for depression
- Expressed to CHW that she “is enjoying her life now”

Conclusion:

CHWs

can and should be an

integral member

of your Primary Care Team!

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Questions?

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Thank You!