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National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A PROJECT OF
Community Health Center, Inc.
and the weitzman institute

MOSES/WEITZMAN
Health System

Increasing Access to Comprehensive Care: The Crucial Role of the Community Health Worker

Wednesday, October 18th, 2023
2:00-3:00pm Eastern / 11:00am-12:00pm Pacific

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National Training and Technical Assistance Partnership

Clinical Workforce Development

Provides free training and technical assistance to health centers across the nation through national webinars, learning collaboratives, activity sessions, trainings, research, publications, etc.

Team-Based Care

- Fundamentals of Comprehensive Care
- Advancing Team-Based Care

Training the Next Generation

- Postgraduate Residency and Fellowship Training
- Health Professions Training

Emerging Issue

- HIV Prevention

Advancing Health Equity

Preparedness for Emergencies and Environmental Impacts on Health

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Speakers

- **Mary Blankson, DNP, APRN, FNP-C, FAAN,** Chief Nursing Officer (CNO) for Community Health Center, Inc.
- **Marie Yardis, BS, MAT,** Access to Care Director for Community Health Center, Inc.
- **Flor Robertson, MS,** Health Strategies Specialist, MHP Salud

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Objectives

- Understand the concept of increasing access to comprehensive team-based care and its significance in healthcare delivery.
- Explore the crucial roles that Community Health Workers (CHWs) play in patient care and recognize CHWs as integral members of the care team.
- Hear from a peer speaker who will share their firsthand experiences and insights into working with CHWs and utilizing valuable resources.
- Learn strategies to overcome common barriers faced by patients and care teams for better engagement and overall improved healthcare outcomes.
- Review advocacy needs for the continued development and implementation of the CHW role nationally.

What is High-Quality Primary Care?

- High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities. (National Academies of Sciences, Engineering, and Medicine, 2021)
- High-quality primary care is best provided by a team of clinicians and others who are organized, supported, and accountable to meet the needs of the people and the communities they serve. (National Academies of Sciences, Engineering, and Medicine, 2021)

National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

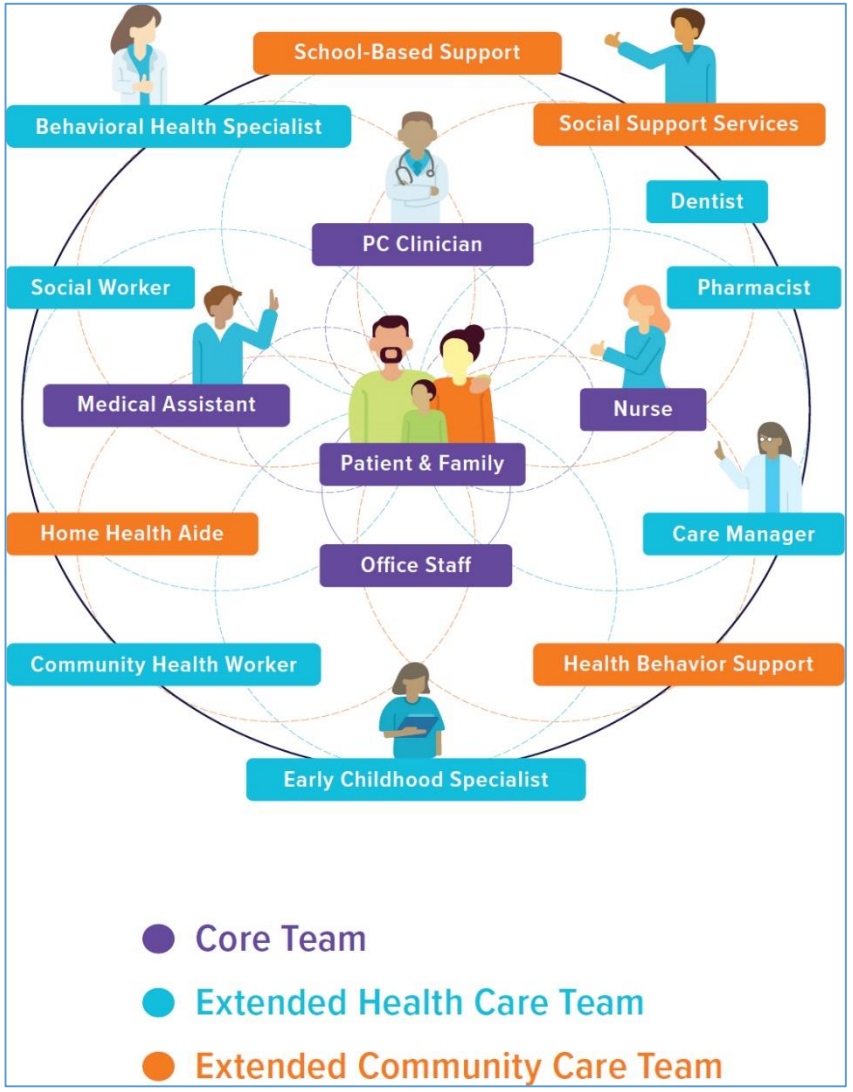
Team-Based Care

- Team-based care is “the provision of health services to individuals, families, [and] their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care. (Mitchell et al., 2012, Okun et al., 2014):
- Advanced models of team-based care provide:
  - Increased access to care and services with a consistent care team
  - Improved quality, safety, and reliability of care
  - Enhanced health and functioning in those who have chronic condition; and
  - More cost-effective care (Hupke, 2014)

Hupke, C. (2014). Team-based care: Optimizing primary care for patients and providers. Institute for Healthcare Improvement.
Okun, S., S. Schoenbaum, D. Andrews, P. Chidambaran, V. Chollette, J. Gruman, S. Leal, B. A. Bown, P. H. Mitchel, C. Parry, W. Prins, R. Ricciardi, M. A. Simon, R. Stock, D. C. Strasser, C. E. Webb, M. K. Wynia, and D. Henderson. 2014. Patients and health care teams forging effective partnerships. NAM Perspectives. Discussion Paper, National Academy of Medicine
Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C. E. Webb, V. Rohrbach, and I. Von Kohorn. 2012. Core principles & values of effective team-based health care. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC

Interprofessional Care Teams

- Facilitators of high-quality primary care include the interprofessional care teams
  - *Interprofessional care teams* - Care provided by teams of clinicians and other professionals fit to the needs of communities, working to the top of their skills, and in coordination leads to better health (National Academies of Sciences, Engineering, and Medicine, 2021)
- Figure on the right demonstrates the composition of interprofessional primary care. (National Academies of Sciences, Engineering, and Medicine, 2021)



National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

CHWs in the Extended Care Team

- *Community Health Workers (CHWs)* – frontline workers who have a thorough understanding of the community being served and focus on engaging as a trusted member of the community. (National Academies of Sciences, Engineering, and Medicine, 2021)
- The role of the CHW in the extended care team has demonstrated effectiveness including:
  - Improving patient health outcomes
  - Eliminating health disparities
  - Demonstrating positive return on investments with improving preventive screening and reducing hospitalizations (Centers for Disease Control and Prevention, Campbell et al., 2015)

Campbell, J. D., M. Brooks, P. Hosokawa, J. Robinson, L. Song, and J. Krieger. 2015. Community health worker home visits for Medicaid-enrolled children with asthma: Effects on asthma outcomes and costs. American Journal of Public Health 105(11):2366–2372.
Centers for Disease Control and Prevention. Technical Assistance Guide: States Implementing Community Health Worker Strategies for the Centers for Disease Control and Prevention's "State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health" Program. Retrieved from https://www.cdc.gov/dhdsp/pubs/docs/Best_Practice_Guide_CHW_508.pdf
National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

CHWs Role in the Community

- CHWs often come from and serve disadvantaged populations, and they earn their expertise by virtue of challenging life experiences, such as:
  - facing discrimination
  - living with financial hardship
  - surviving trauma
  - having a child with complex medical conditions or even simply being a parent.
- The combination of lived expertise and altruism, coupled with appropriate training and work practices, enables CHWs to establish trust, provide nonjudgmental support, and offer practical guidance for a range of social, behavioral, economic, and preventive health needs.
- Their role can include finding social supports; providing health system navigation, health coaching, and advocacy; and connecting individuals to essential resources, such as food, housing, or medications. (National Academies of Sciences, Engineering, and Medicine, 2021)

National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

CHWs Role in the Community

- The COVID-19 pandemic illustrated the role that CHWs play in responding to the needs of the community in which they reside, particularly in addressing the social determinants of health (SDoH) that have been shown to increase the risk of COVID-19 infection. (Peretz et al., 2020)
  - In New York City: health care organizations incorporated CHWs into their interprofessional response to COVID-19. In collaboration with community-based organizations, CHW teams proactively contacted socially isolated patients, connecting them with sources of critically important care and support during the pandemic. (National Academies of Sciences, Engineering, and Medicine, 2021)

Peretz, P. J., N. Islam, and L. A. Matiz. 2020. Community health workers and COVID-19— addressing social determinants of health in times of crisis and beyond. New England Journal of Medicine 383(19):e108.
National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

Who is MHP Salud?

As an HRSA-funded National Training and Technical Assistance Partner (NTTAP), MHP Salud has been able to provide training and technical assistance to FQHCs and other organizations looking to build or enhance Community Health Worker (CHW) programs since 1983.

We are a national nonprofit organization that implements and runs Community Health Worker (CHW) programs. These programs provide peer health education, increase access to health resources, and bring community members closer. MHP Salud also has extensive experience offering health organizations training and technical assistance on CHW programming tailored to their specific needs.

We serve communities by embracing the strengths and experiences of individuals and families, engaging them to achieve health and well-being.

In other words…

A Community Health Worker is a trusted member of the community who empowers their peers through education and connections to health and social resources.

Who Are CHWs?

A Community Health Worker is a health professional who is trusted and knowledgeable of the communities they serve.

Community Health Workers know and understand the culture of the communities served.

Community Health Workers are often the bridge between the community and health and social services.

CHWs meet the community where they are. (where they “are” in terms of setting may be culturally dependent.)

CHW Integration Resources

9 Tips for Integration CHWs into Health Center Teams

- CHWs expertise in the culture of the community puts them in a unique position to contribute to Health Center care teams. This connection to their community can also help a care team better understand the context behind a patient's condition, leading to the development of more effective care plans.

Making the Case for CHWs: Implementation Guide

- A significant obstacle to achieving full integration of CHWs on health care teams is confusion regarding the role of a CHW on part of clinical staff. This guide is meant to address this obstacle to garner stronger support for CHWs in clinical settings.

CHW Clinical Integration Toolkit

- This free toolkit illustrates the 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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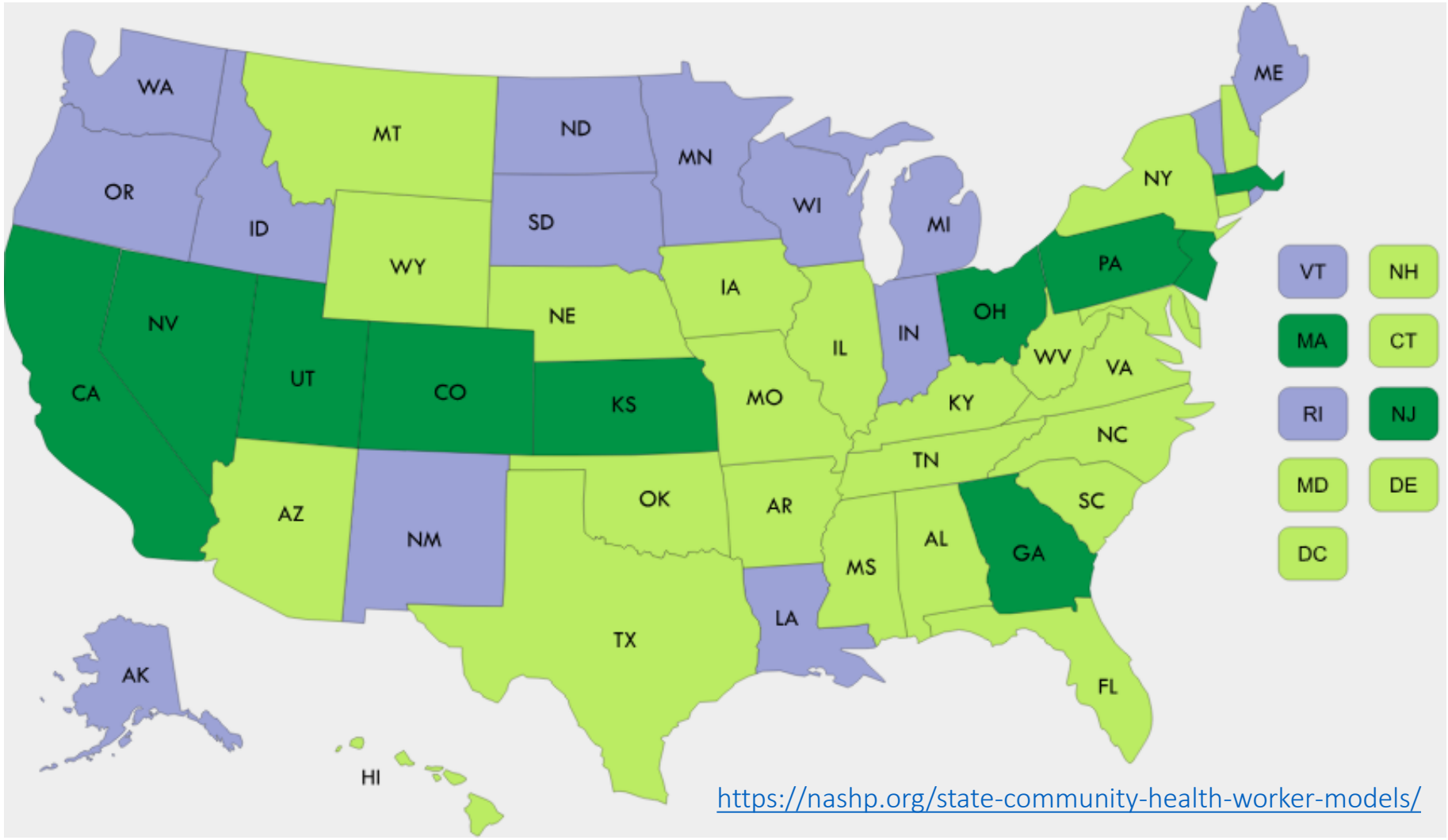
Reimbursement for CHW Services:



https://nashp.org/state-community-health-worker-models/

- Reimburses for CHW services through its Medicaid program (15 states)
- Medicaid does not directly reimburse CHWs for services but MCOs reimburse for services or hire CHWs directly (10 states)
- Does not reimburse for CHW services through its Medicaid program (27 states)

CHWs in Connecticut

Certification and Training

CT started a certificate program in 2020.

State CHW Legislation

Public Act 19-117 became law and states are required to offer CHW certification

Key Partnerships

The CT Area Health Education Centers (AHEC) have worked with CHWs since 2000. The state Department of Public Health oversees the certification of CHWs. The CT Public Health Association includes a CHW association.

Medicaid Reimbursement

Connecticut does not reimburse for CHW services through its Medicaid program

Services Provided

CHWs in the state provide services in the following areas: care coordination, health education, outreach and enrollment

https://nashp.org/state-community-health-worker-models/ 12-10-21

Case Study Example:
Shedding Light on CHW Impact

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About the Patient

- 57 year old male, diagnosed with Type 2 Diabetes, Hyperlipidemia and Hypertension.

Patient Goals

- 1- Obtain stable and affordable housing
- 2- Take better care of himself and feel less pain and tiredness

Provider Goals

- 1- Lower A1c
- 2- Lose Weight
- 3- Obtain CGM, reduce insulin over time

Patient Needs

- Apply for low income housing
- Work fewer hours
- Log blood sugar levels throughout the day
- Begin use of Continuous Glucose Monitor (CGM)
- Lower A1c
- Lose weight

Challenges

- Long-standing lack of Diabetes self management
- Spanish Speaking (Language Line required @ MD visits)
- Provider concerns around ability to use CGM
- Unable to use Zoom for Telehealth visits
- CGM not covered under insurance
- Non compliant with prescribed medications

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Key Strategies Implemented

- Connected patient to a CHW specifically hired and trained to work with the DM population
- 6 month engagement with CHW
- Taught patient to use Zoom for telehealth visits during the pandemic
- Educated patient on medication benefits and set up daily check-ins
- Connected patient to 340B program to reduce cost of medications
- Collaborated with the clinical team and insurance company to obtain coverage for CGM
- Increase frequency of A1c testing

Results

- Daily check-ins with CHW
- Medication adherence
- Nutritionist lead dietary changes
- Significantly lowered cost of medications
- Full insurance coverage for CGM
- Improved self-advocacy skills
- Independently managing his care
- Reduced A1c from **13.2 >7.6**

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Questions?

Wrap-Up

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Comprehensive and Team-Based Care Learning Collaborative

- Free eight-month participatory experience designed to provide knowledge, tools, and coaching support to help health centers and look-alikes implement advanced models of team-based care.
- In this Collaborative, teams will learn how to:
  - Use quality improvement concepts and skills to facilitate their implementation of a model of high-performing team-based care
  - Conduct self-assessments of their current team-based care model to identify areas for process improvement and role optimization
- Outcomes of the learning collaborative:
  - Identified a clinical team to work on a quality improvement project
  - Implemented pre-visit planning and morning huddles
  - Integrated behavioral health with warm welcomes/handoffs
  - Increase UDS measures, such as hyptertension, cancer screenings, etc.
- For more information/questions, please reach out to Meaghan Angers (angersm@mwhs1.com)

Team-Based Care

- **Fundamentals of Comprehensive Care**
- **Advancing Team-Based Care**

Our NTTAP also offers learning collaborative opportunities in Postgraduate NP Residency Programs, Health Professions Student Training, and HIV Prevention!

Explore more resources!

National Learning Library:
Resources for Clinical Workforce Development

https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse

https://www.healthcenterinfo.org/

Contact Information

For information on future webinars, activity sessions, and learning collaboratives: please reach out to nca@chc1.com or visit https://www.chc1.com/nca

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