

Enhancing the Delivery of Care: The *Promotor(a) de Salud*/Community Health Worker Role on Clinical Care Teams

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Health Outreach Partners

WWW.OUTREACH-PARTNERS.ORG



WHO WE ARE: We support health outreach programs by providing training, consultation, and timely resources.

MISSION: Our mission is to build strong, effective, and sustainable health outreach models by partnering with local community-based organizations across the country in order to improve the quality of life of low-income, vulnerable and underserved populations.

WHOM WE SERVE

Health Centers

Primary Care Associations

Safety-net health providers

MHP Salud

WWW.MHPSALUD.ORG



WHO WE ARE: National organization focused on implementing Community Health Worker programs and helping other organizations start-up or strengthen Community Health Worker Programs. HRSA National Cooperative Agreement

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.

WHOM WE SERVE

Under-served Latino Communities
Health Centers
Health Systems
Non-profits



Ice Breaker and Introduction

Pair Activity

1. Name, Organization, Role
2. How are you involved in the provision of care coordination OR what would you like to learn about regarding care coordination?
3. What is one thing you have in common with each other?



Objectives

1. Participants will learn the definition of care coordination and understand specific outreach functions that support care coordination.
2. Participants will identify at least three benefits to including a CHW as a member of the clinical care team.
3. Participants will understand how to use at least one tool to advocate for CHWs on clinical care teams.

Introduction to Care Coordination



What is Care Coordination

According to the Agency for Healthcare and Quality Research, care coordination involves **“deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care. This means that the patient’s needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.”**

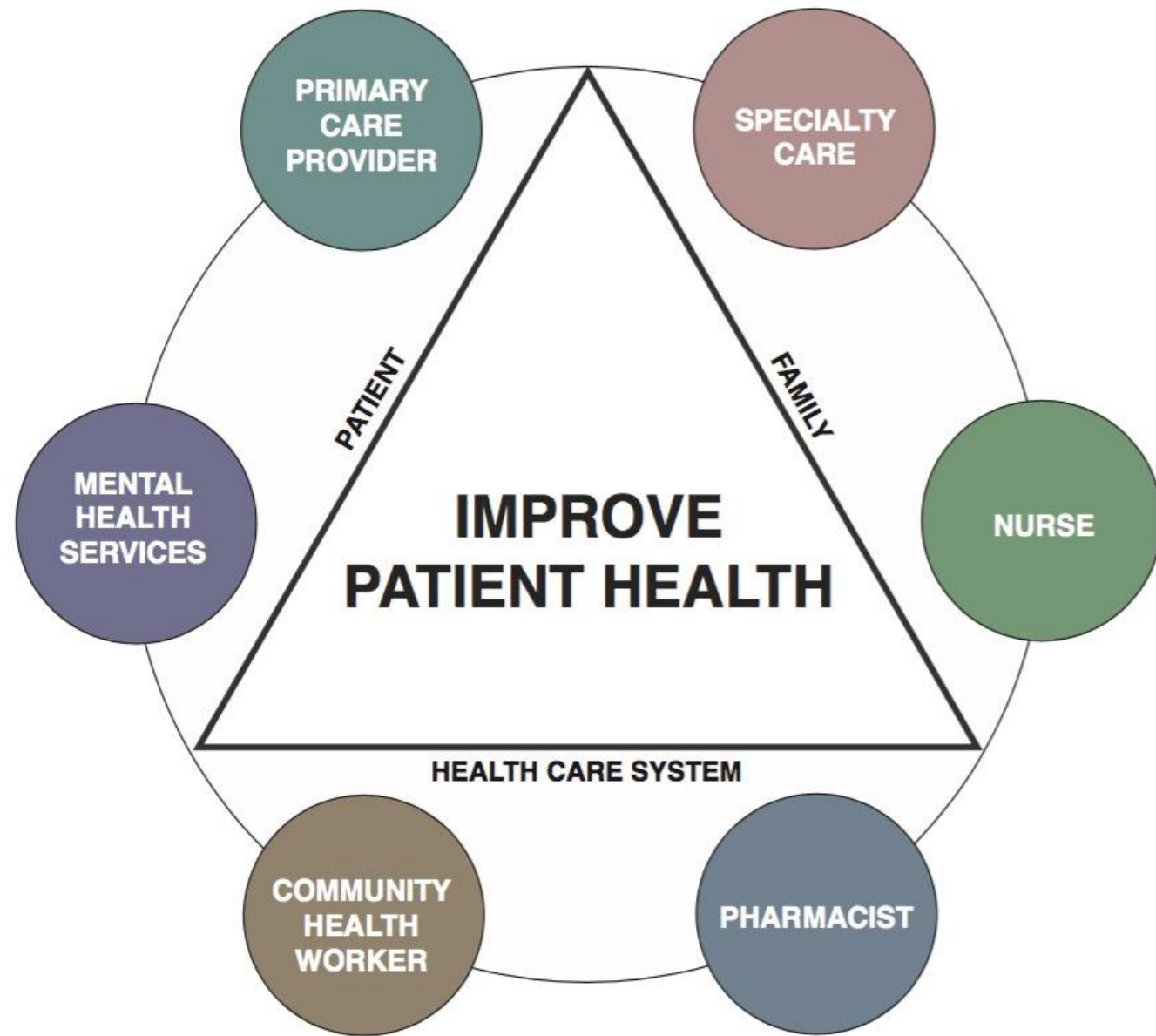


Why Care Coordination

Expected rise of Americans with one or more chronic condition by 37% between 2000 and 2030 (46 million people)

Complex needs of populations served by health centers, including unique barriers such as cultural and linguistic needs, low socioeconomic status, unreliable transportation, lack of insurance, unfamiliarity with the healthcare system, and limited health literacy skills.

Call for service delivery model reform through Triple Aim framework



Care Coordination Quick Overview



Who Provides Care Coordination?	Who is a Part of the Care Team?	What are examples of Care Coordination?
Clinical or non-clinical healthcare workers, such as a public health nurse or outreach worker. Care coordination can be provided by a small team or by an individual care coordinator.	The care coordinator(s) works closely with the care team, which can be composed of doctors, physician assistants, behavioral/mental health providers, pharmacists, etc. A care coordination director or manager, PCMH administrator, or other leadership/administrator role often oversees care coordination and is involved in long-term planning for care coordination efforts.	<ul style="list-style-type: none">• Patient navigation• Health education• Creation of a plan of care• Individualized health coaching• Engaging and motivating patients• Identifying and supporting patient self-management goals• Benefits coordination



Case Management vs. Care Coordination

CASE MANAGEMENT

Services typically provided in a “package” by a health plan or managed care plan.

Tend to focus solely on a patient's medical needs.

CARE COORDINATION

Not limited to only high-risk patients, but could be used to address the preventative needs of all patients.

Employs a much broader social service model than is typically used in case management.

Takes into account patients’ full psychosocial context—such as housing needs, income, and social supports—as it pertains to health.

Who Are Community Health Workers



Who Are Community Health Workers (CHWs)?



“A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.”

- American Public Health Association



Other Titles

- Outreach Worker
- Peer Educator/Peer Health Educator
- Community Health Representative
- Health Coach
- Health Aide
- Patient Navigator
- *Promotora de Salud*





What do CHWs do?

- Cultural mediation among individuals, communities, and health and social systems
- Provide culturally appropriate health education and information
- Care coordination, case management, and system navigation
- Provide coaching and social support
- Advocate for individuals and communities
- Build individual and community capacity
- Provide direct services
- Implement individual and community assessments
- Conduct outreach
- Participate in evaluation and research

The Role of CHWs in Care Coordination



Why a CHW on a Care Team?



“We can’t make our patients better in 10-15 minutes because there are a lot of factors that shape their health. CHW’s are much better [at addressing social issues] than me. They get more information that helps me understand my patient and allows me to focus on their medical issues.”

- Dr. Rose Johnson, Center for Family Health, Michigan





A CHW's Role on a Care Team

- On a care team, CHWs are the **experts** in the patient's environment and culture
- CHWs should be treated as **peers** to other team members
- CHWs do **not** have a clinical role on a team



What IS and IS NOT a CHW'S Role on a Care Team

ON A CARE TEAM, A CHW DOES

- Conduct outreach
- Measure and monitor blood pressure
- Assist with medication or treatment adherence
- Facilitate goal setting with patients
- Problem-solve obstacles to comply with a given treatment
- Navigate healthcare and other social service systems
- Provide health education
- Provide patients and their family with social support
- Assess how a self-management plan is progressing
- Assist patients in obtaining home health services

ON A CARE TEAM, A CHW DOES NOT

- Give patients medical advice
- Do administrative work for the care team
- Complete or participate in clinical procedures (unless specifically trained to do so)
- Analyze clinical data
- Make clinical decisions regarding a patient's care or care plan
- Provide formal counseling or therapy
- Administer medications, wound care, or other interventions (unless specifically trained to do so)



2015 Clinical CHW Study Results

The most frequently reported CHW roles on care teams are:

- Helping people gain access to medical services (86%)
- Advocating for individual needs (86%)
- Teaching people how to use health care and social services (78%)
- Helping people manage chronic conditions (77%)

CHW's Role



Primary Roles	CHW	Case/Care Manager	Nurse
Cultural mediation among individuals, community, and health and social service systems	X		
Provide culturally appropriate health education and information	X		
Care coordination, case management, and system navigation	X	X	
Provide informal counseling and social support	X		
Provide coaching and social support	X		
Advocate for individuals and communities	X	X	X
Provide direct services and administer health screening tests (as appropriate)	X		X
Build individual and community capacity	X		
Assist with medication or treatment adherence	X	X	X
Facilitate goal setting with patients	X	X	
Problem-solve obstacles to comply with a given treatment	X	X	
Provide outreach	X		
Asses how a self-management plan is progressing	X	X	X
Assist patient in obtaining home health services	X	X	



CHW Education and Training

- Majority of knowledge base does not come from formal training
- Rely heavily on 'soft-skills'
- Qualified candidates demonstrate
 - A strong desire to and are passionate about serving the community
 - Strong interpersonal communication skills
 - An ability to gain respect and build rapport with community members
 - A strong sense of empathy
 - Creativity and resourcefulness
 - Natural leadership ability or potential
 - Responsive to the needs of others
 - Cultural competence



CHW Education and Training

- Some states **require** a CHW certification
- Typical organizational training/orientation of 40 hours
- Specialty training on health topics
- All practicing CHWs in a clinical setting will be proficient in these core skill areas:
 - Communication
 - Interpersonal and relationship-building
 - Service coordination and navigation
 - Capacity building
 - Education and facilitation
 - Individual and community assessments
 - Outreach
 - Professional skills and conduct
 - Evaluation and research
 - Knowledge base (core principles of public health)



How do you believe a CHW could
benefit your care coordination
practice?



Recommendations

1. Prep the Team
2. Hire full-time staff
3. Recruit the right candidate
4. Provide an intensive orientation
5. Ensure Regular supervision meetings take place
6. Include CHWs in frequent team meetings
7. Allow CHWs to document their work on EHRs
8. Support professional development
9. Share results with leadership and other stakeholders

Case Studies



Benton County Health Services

- CHWs are an integral part of BCHS' delivery of quality care.
- 22 CHWs serving as health navigators who are heavily involved with care coordination.
- Roles: outreach and enrollment, clinic support, connecting students and families to social services, policy and advocacy.
- Care teams work/sit in the same work space and are composed of physicians, registered nurses, medical assistants, pharmacists, behaviorists, and CHWs.
- CHWs discuss with the care team barriers that prevent patients from taking medication or accessing care.
- Care team provides treatment by working closely with CHWs.



Bronx Lebanon Hospital

Questions for Discussion:

1. What conditions facilitated the integration of a CHW on the care team in this case?
2. What were some of the barriers staff encountered during the CHW integration process and how were they handled?
3. Are there aspects of this case study that are similar to the community or location where you work?

Resources & Closing



Care Coordination Tools & Resources

- HOP's ['The Role of Outreach in Care Coordination Reference Manual'](#)
- MHP Salud's ['Tip Sheet on Successfully Integrating CHWs Into Clinical Care Teams'](#)
- MHP Salud's ['Making the Case for Community Health Workers on Clinical Care Teams: A Toolkit'](#)



Questions?



Contact Us

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Thank You!

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