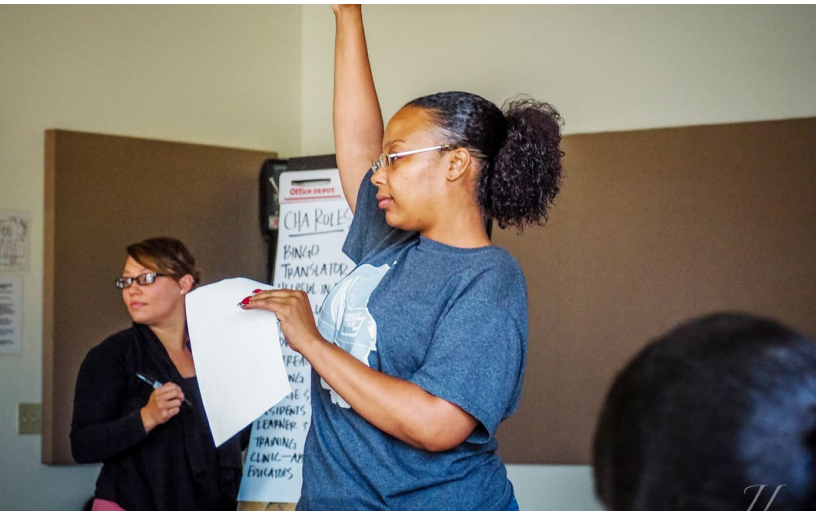
foundation for
healthy generations
CREATING ENDURING HEALTH EQUITY

COMMUNITY HEALTH WORKER PROGRAM PROFILES

Improving Prevention and Management of Chronic Diseases



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BACKGROUND

The American Public Health Association defines a community health worker, or "CHW", as *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.*

In 2015, Washington State Health Care Authority and the Washington State Department of Health convened the CHW Task Force[1], recognizing that CHWs are necessary to achieve the goals of Healthier Washington within the changing environment of health reform. The Task Force made several recommendations to support the integration of CHWs into Washington's health and health care system.

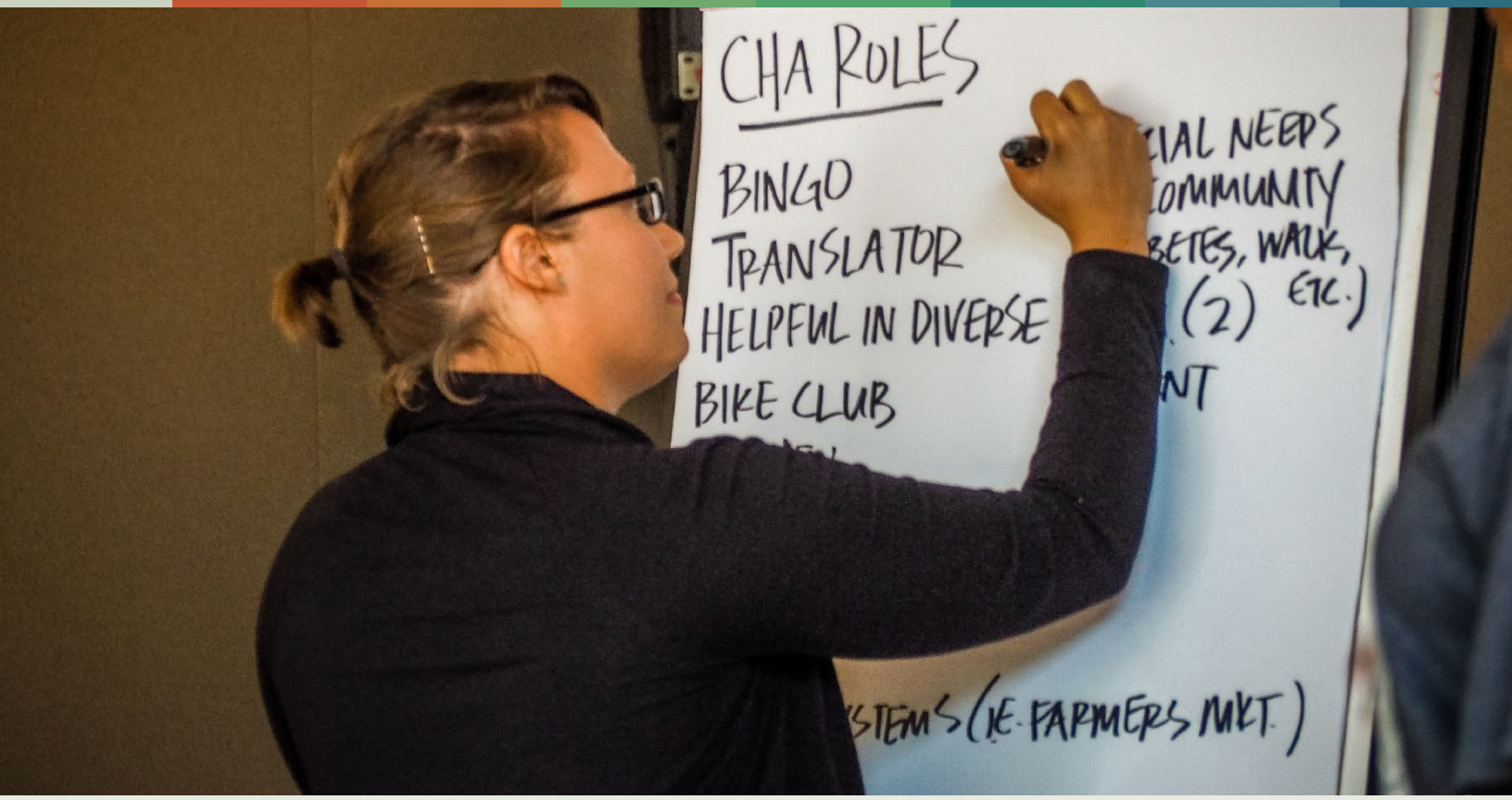
The Task force identified 10 distinct roles that CHWs frequently play, but acknowledged that no CHWs perform all 10 roles. Further, they concluded that due to the diversity of potential roles, the CHW's employer should identify which roles are suitable to achieve their needs, and should provide appropriate training and supervision.

Through new initiatives such as the CHW Integration Pilot, the WA State Department of Health is committed to the development of best practices to integrate and support CHWs for greatest outcomes.

10 Distinct Roles of CHWs[1]

1. Cultural mediation among individuals, communities, and health and social service systems
2. Provide culturally appropriate health education and info
3. Conduct outreach/ recruitment
4. Care coordination, case management, and system navigation
5. Provide coaching and social support to individuals and groups
6. Advocate for individuals and communities
7. Build individual and community capacity
8. Direct service – basic screenings and services
9. Implement individual and community assessments
10. Participate in evaluation and research

[1] Community Health Worker Task Force Recommendations Report for Healthier Washington, December 2015 http://www.healthygen.org/resources/community-health-worker-task-force-final-report



PURPOSE AND DEVELOPMENT OF THE PROGRAM PROFILES

These program profiles highlight nine diverse clinical CHW programs that focus on prevention and mitigation of chronic diseases. The purpose of these profiles is to provide clinic administrators and others tasked with designing CHW programs a few concrete examples of how CHW programs can be structured.

The profiles were developed based on interviews with representatives of nine CHW programs that are affiliated with primary care clinics in the United States. Interviewees were asked to describe their program design, CHW roles and activities, client eligibility and referral procedures, CHW hiring, training, and supervision, as well as how CHWs have been integrated into the clinical care team. The Foundation for Healthy Generations conducted the interviews and developed the program profiles. Interviewees reviewed the profiles to ensure accuracy.

DELTA HEALTH COLLABORATIVE

Community Health Worker (CHW) Program Profile #1

DELTA HEALTH COLLABORATIVE

MISSISSIPPI STATE DEPARTMENT OF HEALTH, GREENWOOD, MS

Program Description	• The rural Delta region of Mississippi has the highest rate of chronic diseases including heart disease, stroke, and diabetes in the nation. • CHWs provide one-on-one support to patients, community outreach services, and lead the Chronic Disease Self-Management Program (CDSMP).
Eligibility & Referral	• Residents of the 18 counties in the MS Delta who are uninsured, have limited access to health care, attend participating health systems, and are at high risk of cardiovascular disease are eligible to enroll in the Clinical Community Health Worker Initiative (CCHWI). • Individuals with uncontrolled risk factors for heart disease and stroke (hypertension, diabetes, and high cholesterol), or no record of a primary care visit within the past 12 months are identified through the electronic health record (EHR) and invited to participate in the CCHWI.
Role of CHW	• CHWs offer quarterly home visits and phone calls to a caseload of 100 patients. This mitigates barriers to care, increases access, and encourages adherence to management plans. They promote the "ABCS" model for heart disease and stroke, which addresses aspirin usage, controlling blood pressure and cholesterol, and smoking cessation.
Hiring Practices	• CHWs are selected via an application and interview process. The program seeks individuals with experience in home health or community health.
Training	• CHWs are certified to teach Chronic Disease Self-Management courses through Mississippi State Department of Health. • Supplemental training includes proper blood pressure monitoring, HIPAA regulations, and EHR use.
Supervision & Integration	• The Program Bureau Director oversees the project. The Community Health Nurse is responsible for program management and CHW supervision. • The team meets monthly to discuss successes and challenges, share resources, review case studies, and recognize the CHWs for their accomplishments. CHWs also meet individually with their supervisor.
Outcomes & Lessons Learned	• In 2011–2014, the program enrolled 700+ patients made over 1,100 service referrals. • Evaluation results showed improvements in key health measures including blood pressure and cholesterol management. • Educating front line staff and providers about the role of CHWs is essential to success.

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GLOBALTOLOCAL

Community Health Worker (CHW) Program Profile #2

CHW & MOBILE HEALTH PROGRAMS

GLOBAL TO LOCAL, SEATAC/TUKWILA, WA

Program Description	• Global to Local (G2L) is a non-profit organization that uses proven effective strategies from developing countries to support underserved communities in the United States. • In partnership with Health Point Community Health Center, Tukwila Community Center and the Matt Griffin-YMCA, G2L runs CHW exercise and Mobile Health programs.
Eligibility & Referral	• Health Point doctors prescribe: 1) CHW Program, an 8-week group exercise course for overweight Latina and Somali women, or 2) Mobile Health, a diabetes case management smartphone application for English-speakers. Participants can also self-refer.
Role of CHW	• Patients with prescriptions are directed to Health Point's Health Desk where a CHW explains the program and arranges for transportation, childcare, and other needs. • CHWs coordinate 8-week series of female-only, culturally-appropriate exercise courses lead by personal trainers with 15-30 participants. Participants attend 2 exercise classes per week, plus weekly telephone-based case management from the CHW. • Mobile Health CHWs maintain caseloads of up to 100 participants. Participants are onboarded and trained to use the diabetes management smartphone app. They send daily blood sugar readings. CHWs provide text-messaging case management support. • All CHWs use motivational interviewing to help participants set weekly goals.
Hiring Practices	• G2L hired Somali and Latina CHWs with diverse backgrounds including midwifery and patient navigation. They aim to hire past program participants when possible. • G2L CHWs have advancement opportunities: Level 1 CHWs track data and administer surveys; Level 2 CHWs manage volunteers, meet with partners, give presentations, stay up to date on research, and train new CHWs; Level 3 CHWs have a program development and evaluation focus and increased management responsibilities.
Training	• CHWs are trained in motivational interviewing and Washington State Department of Health's CHW training, including disease-specific modules and patient navigation.
Supervision & Integration	• Level 1 CHWs are supervised by Level 2 CHWs, who are supervised by G2L's Director of Research and Innovation. The Director reviews all data and case notes. • CHWs and supervisors meet weekly one-on-one. CHWs also participate in monthly team meetings, and attend partner meetings as necessary.
Outcomes & Lessons Learned	• Exercise course participants experienced decreases in weight and hip measurements. Participants regularly choose to re-enroll. Mobile Health reduced A1Cs. Older, low-income, and uninsured participants successfully use the Mobile Health app. • G2L leadership built relationships with clinics, but CHWs now maintain them. Program staff emphasized minimizing burden to healthcare providers and giving CHWs access to Electronic Health Records to leave notes for providers.

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ICHS International Community HEALTH SERVICES

Community Health Worker (CHW) Program Profile #3

COMMUNITY ADVOCATES AND HEALTH EDUCATORS

INTERNATIONAL COMMUNITY HEALTH SERVICES, SEATTLE, WA

Program Description	• International Community Health Services (ICHS) serves Seattle's immigrant and refugee communities including Asian and Pacific Islander, east African, and Latino communities. • ICHS employs CHWs called Community Advocates (CAs) and also employs a team of Health Educators (HEs), whose role has overlap and shares some similarities with CHWs. • CAs provide outreach and education outside the clinic and HEs work inside the clinic providing education to existing patients.
Eligibility & Referral	• CAs connect with participants via outreach in the communities they serve. Participants do not have to be patients at ICHS to access assistance from a CA. CAs refer participants to ICHS clinical services as needed. • To receive HE services, providers refer patients they believe would benefit from further education about a chronic disease or reproductive health issue.
Role of CHW	• CAs work primarily in the community. Their services are flexible, but fall into three main categories: patient navigation, community engagement and empowerment, and direct services. CAs are knowledgeable about a variety of health and social services. • HEs work primarily in the clinic and provide one-on-one patient education on chronic disease management and reproductive health.
Hiring Practices	• CAs and HEs are hired from within the communities they represent. Healthcare experience is required for HEs but not for CAs. • Strong interpersonal skills and experience in community work are essential to success. Basic computer skills is helpful but not required. Applicants must have access to a vehicle.
Training	• Both CAs and HEs complete motivational interviewing training and the WA State Department of Health CHW training. They receive additional on-the-job training and job shadowing to help them meet a set of core competencies customized for their program. • They regularly participate in trainings on team-building and specific health topics.
Supervision & Integration	• CAs are supervised by two coordinators who report to a program manager. • Each CA and HE meets 1-2 times/month with their supervisor one-on-one. They also meet monthly with their team to cover administrative tasks and participate in training. • Additionally, monthly site meetings bring all teams together to hear clinic-wide updates.
Outcomes & Lessons Learned	• Program staff reported that CAs are the bridge between the community, the clinic, and available resources. Hiring CAs through word of mouth from within the communities they will serve is most effective. • Building a cohesive team takes time and patience.

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MARIPOSA COMMUNITY HEALTH CENTER

Community Health Worker (CHW) Program Profile #4

MARIPOSA CARE PLUS & COMMUNITY HEALTH SERVICES

MARIPOSA COMMUNITY HEALTH CENTER, NOGALES, AZ

Program Description	• Mariposa Community Health Center (MCHC) has utilized CHWs called "Promotoras", for over 25 years to support health promotion services in Santa Cruz County, Arizona. • Two Cross-Functional Care Coordinators provide patient services through Care Plus, a care coordination program focused on supporting high needs patients to reduce inappropriate Emergency Department (ED) utilization and overcome barriers. • Additionally, 17 Promotoras coordinate health promotion events, heart health and diabetes management classes, programs, and individual services in the community.
Eligibility & Referral	• Care Plus is available to MCHC patients diagnosed with type 2 diabetes, hypertension or another chronic disease, who have an ED visit or inpatient admission. Patients with type 2 diabetes are eligible for self-management education provided by a Promotora. • Health promotion events and classes are open to anyone living in the community.
Role of CHW	• Each Care Coordinator maintains a caseload of about 20-25 patients/month. • Promotoras work with patients to connect them with local community resources, reduce barriers to care, and promote health management. • Promotoras focusing on chronic disease education provide one-on-one home visits/ telephone support covering nutrition and management for Type 2 Diabetes.
Hiring Practices	• MCHC hires bilingual (Spanish/English) Promotoras who are connected to the community they serve. Over 90% of patients are Spanish-speaking. No previous work history is required for employment, but a high school diploma or GED is required.
Training	• Promotoras are trained on the Arizona Community Health Workers Association's 10 CHW core competencies, and receive program-specific on-the-job and continuing education.
Supervision & Integration	• The Care Coordination Manager oversees Care Plus, including one-on-one monthly supervision meetings, plus weekly informal meetings as needed. Monthly program reports are shared with the Medical Director.
Outcomes & Lessons Learned	• In a recent report, the percentage of participants with diabetes who had achieved A1c<9% improved from 64% to 70%. The percentage of participants with hypertension who had "achieved blood pressure control" (<140/90) increased from 64% to 72%. • Program staff noted the importance of continuously updating protocols and planning extra travel time for rural home visits. Documenting visits in the Electronic Health Record has been critical to successful care coordination between providers and Promotoras.

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neighborcare health

Community Health Worker (CHW) Program Profile #5

COMMUNITY HEALTH WORKER PROGRAM

NEIGHBORCARE HEALTH, SEATTLE, WA

Program Description	• Neighborcare is a Federally Qualified Health Center with over 28 locations throughout Seattle providing services to low-income and uninsured families. • The CHW program is located in their 5 public housing-based clinics. The goal is to increase community access to appropriate healthcare resources and improve individual health outcomes.
Eligibility & Referral	• CHWs provide services to any residents of the housing complex, regardless of whether they are Neighborcare patients. • CHWs visit residents monthly to ensure they are connected to social and support services. In addition, residents can request to meet with the CHW via phone or in the housing office.
Role of CHW	• CHWs lead walking groups, community gardens, health screening events, and other community activities. They also assist residents one-on-one with navigating the health care system, getting connected with primary care, actively engaging in their care plans, and ensuring insurance coverage. • Each CHW serves around 30 residents. The frequency of interaction varies based on individual needs. All interactions are tracked in the Electronic Health Record (EHR).
Hiring Practices	• All CHWs are residents of the housing complex in which they work. The program seeks well-known leaders in the community who are empathetic, and able to connect with residents. There are no educational or prior experience requirements.
Training	• All CHWs complete the Washington State Department of Health CHW training. Ongoing supplemental training includes diabetes, asthma, motivational interviewing, EHR and confidentiality training.
Supervision & Integration	• The Community Programs Manager supervises the CHWs with support from clinicians. • CHWs are part of the clinical care team. CHWs attend monthly one-on-one meetings with their supervisor, as well as regular all-team meetings and multidisciplinary huddles.
Outcomes & Lessons Learned	• Altogether, CHWs provide 1200 interactions with participants each year. The program has demonstrated improvements in health insurance enrollment, rates of depression, and general health status. • The program emphasizes a “pipeline approach” in which CHWs are given career development and advancement opportunities. • Working together, CHWs and their supervisors better defined the scope of services, and determined appropriate referral sources for needs that fell outside this scope.

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ONE COMMUNITY HEALTH

Community Health Worker (CHW) Program Profile #6

SALUD CHRONIC DISEASE MANAGEMENT

ONE COMMUNITY HEALTH, HOOD RIVER & THE DALLES, OR

Program Description	• One Community Health (OCH) has employed CHWs for nearly 30 years. Their Salud program is accredited by the American Association of Diabetes Educators (AADE). • Through Salud, patients are paired with CHWs to support chronic disease management including diabetes, pre-diabetes, childhood obesity, hypertension, and hyperlipidemia. • CHWs also run complementary outreach programs including a 12 week course on nutrition, physical activity and stress reduction; cooking classes; exercise classes; and diabetes and hypertension screening at migrant camps.
Eligibility & Referral	• Patients receiving primary care at One Community Health are eligible for Salud. • Monthly review of diabetic panels in the Electronic Health Record (EHR) prioritizes patients with poorly controlled A1cs (≥ 9%) and those disengaged in care. Providers also refer patients that are newly diagnosed or at high risk for diabetes.
Role of CHW	• Each clinic has 2 CHWs and one Nurse Diabetic Educator. Each CHW maintains a caseload of about 50-100 patients. There is no limit to the number of times patients can meet their CHW. • CHWs meet patients at the clinic or occasionally patients' homes. They provide education and referrals to clinical services and community resources via standing orders. CHWs alert a nurse if they think a patient's medications may need adjustment. • Patients may also meet with a CHW immediately prior to primary care visits. CHWs document patients' self-management behaviors and goals in the EHR for provider review.
Hiring Practices	• One Community Health seeks individuals who are leaders in the community, well known, and trusted.
Training	• All CHWs are trained in self-management behaviors (AADE) and in popular education and motivational interviewing (Multnomah County Capacitation Center). CHWs shadow an experienced CHW and Nurse Diabetes Educator. Training is customized for each CHW.
Supervision & Integration	• Higher experienced Nurse Diabetes Educators provide clinical support and supervision to CHWs. They are supervised by the Enabling Services Manager. • CHWs notify providers of disengaged or poorly controlled patients at monthly provider meetings. CHWs also receive warm hand-offs directly from providers and interact with medical assistants prior to clinic visits for diabetes.
Outcomes & Lessons Learned	• CHWs deliver one-on-one care and time that providers often can't during short office visits. Providers unanimously reported that CHWs make it easier to provide thorough, patient-centered care. Communication via team meetings and EHR is essential. Regular interaction has built trust and helped providers recognize the unique value of CHWs.

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Public Health
Seattle & King County

Community Health Worker (CHW) Program Profile #7

CHW RESEARCH PROJECTS

PUBLIC HEALTH – SEATTLE & KING COUNTY, SEATTLE, WA

Program Description	• For the last 20 years, Public Health – Seattle & King County (PHSKC) has managed research grant-funded partnerships to build an evidence base for using CHWs in chronic disease management for asthma and diabetes. • Participants receive three to five home visits from a CHW over a four month period, as well as additional follow-up for research data collection.
Eligibility & Referral	• CHWs are employed by PHSKC, and work directly with patients from regional safety-net clinics, primary care clinics, and Medicaid Managed Care Organizations (MCOs). • The current research project is a randomized control trial: Clients must meet strict enrollment criteria, sign a consent form, participate in two 2-3 hour interviews and are randomized into the intervention or control group.
Role of CHW	• During home visits, CHWs connect clients to resources, help participants set goals, discuss medications and address barriers to maintaining a healthy lifestyle. Participants also receive free resources to reach those goals, such as vacuums to reduce dust exposure. • CHWs record all interactions in the NextGen Electronic Health Record (EHR) system.
Hiring Practices	• Some CHWs were hired through the Union while others were hired externally. • CHWs represent diverse communities including Latino, African American and Somali, and have ties to different geographic areas.
Training	• Customized training encompasses the core competencies defined by the Healthier Washington CHW task force. This includes co-learning with seasoned CHWs and quality control feedback from supervisors. • Training also covers disease-specific content, motivational interviewing, research principles, professional development, self-care, and mandated reporting.
Supervision & Integration	• CHWs are supervised by the PHSKC Program Manager. Monthly one-on-ones and weekly team meetings allow CHWs to debrief, share, and learn from each other. • CHWs have access to a public health nurse and the program medical director to discuss individual cases. The entire care team shares access to the EHR.
Outcomes & Lessons Learned	• Routine team meetings cover administrative and clinical topics and training, and serve to prevent burn-out, promote self-care, and share best practices. Sitting-in on CHW meetings has helped clinicians understand the benefits of CHW services. • CHWs are employed by PHSKC and not the health system. This made it challenging to secure CHW access to EHRs, and to help providers and patients view CHWs as members of the disease-management team.

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SWEDISH

Community Health Worker (CHW) Program Profile #8

CULTURALLY RESPONSIVE CARE

SWEDISH HEALTH SERVICES, SEATTLE, WA

Program Description	• The program provides health education and connection to services for Chinese, Korean, Vietnamese communities. • CHWs are known as Multicultural Health Navigation Coordinators and maintain a hotline for people who cannot speak English to assist them in obtaining medical care. • Navigation Coordinators organize educational events at community venues (e.g. churches). At events, Swedish healthcare providers present on health topics and answers Q&A. Community members learn about the hotline and can sign up to receive assistance obtaining care for specific needs.
Eligibility & Referral	• Anyone may call the hotline or sign up at a community event to be contacted. The hotline is available in Cantonese, Mandarin, Korean, and Vietnamese. • Navigation Coordinators do not maintain a traditional case load, but there is no limit to how many times clients may call the hotline.
Role of CHW	• Navigation Coordinators organize the educational events and identify presenters. During events, they distribute hotline information and collect sign-ups for assistance. • Navigation Coordinators monitor the hotline and call anyone who signed up for assistance. They take care of scheduling appointments with primary or specialty care at Swedish or elsewhere, and arrange for interpreter services.
Hiring Practices	• Swedish hired three Navigation Coordinators to design and run the program. • Navigation Coordinators have strong connections to their respective communities (Vietnamese, Chinese, and Korean), and diverse professional backgrounds (insurance, healthcare and social services). They identify as the "1.5 Generation" – they were born abroad and attended university in the US, enabling them to be a bridge between the community and healthcare system.
Training	• Navigation Coordinators are certified medical interpreters and insurance navigators, and trained in: HIPAA, safety, cultural responsiveness, electronic health records, and ethics.
Supervision & Integration	• The program was designed, managed, and staffed by the 3 Navigation Coordinators. Swedish plans to hire additional CHWs who will be supervised by the Navigation Coordinators.
Outcomes & Lessons Learned	• There has not been any formal evaluation of the program, but Navigation Coordinators observed that large events don't draw many clients. Small appearances over time work better to build rapport.

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Community Health Worker (CHW) Program Profile #9

VENTANILLA DE SALUD

MEXICAN CONSULATE, TUCSON, AZ

Program Description	• The Ventanilla de Salud (VDS) program is based in the 50 Mexican consulates throughout the US. Through VDS, CHWs known as "Promotoras" provide health information, counseling and referrals. • In Tucson, VDS Promotoras are connected with and refer clients to El Rio Community Health Center. The program addresses a variety of health issues, but diabetes is heavily emphasized.
Eligibility & Referral	• VDS serves Mexican nationals and families of mixed national origin. • People entering the consulate with no insurance or medical home may be connected to VDS. At El Rio, providers refer patients. Monthly new patient orientations cover Promotora services, and self-referral is common.
Role of CHW	• Some Promotoras are based at the consulate while others are based at El Rio. They provide health and nutrition education, pharmacy assistance, and warm hand-offs to clinical and social services including the Diabetes Education and Exercise Program (DEEP). • Promotoras see about 10 participants per day. They do not maintain traditional caseloads, but may meet with clients multiple times if necessary.
Hiring Practices	• Promotoras have various educational backgrounds, including public and community health and social work. Many have bachelor's degrees.
Training	• Training is two weeks long and Promotoras are cross-trained in a variety of areas such as older adult stability, computer and paperwork training, and a new Zika training. • Promotoras also shadow other Promotoras and healthcare providers.
Supervision & Integration	• Promotoras are supervised weekly by a program manager with a social work background and experience as a Promotora. The program is run by a Program Coordinator and a Promotora. • At El Rio, Promotoras participate in daily rounds with providers. They also make referrals to each other through the Electronic Health Record (EHR).
Outcomes & Lessons Learned	• There are many challenges when serving the undocumented population, particularly the limited availability of services. • Program staff noted that having a department supervisor who communicates the role of Promotoras to providers was crucial, as was giving Promotoras access to the EHR.

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