Team Members “Behind the Scenes”
Community Health Workers as Members of Innovative Care Teams in the PCMH

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Objectives

To understand the following:

- Who are Community Health Workers (CHWs)?
- One health center’s approach to integrating CHWs into the care team: Successes and barriers
- Importance of CHWs as integral members of innovative care teams in the PCMH and what is needed to make their role sustainable
## PCMH Transformation Framework

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What do CHWs Do?

- Cultural mediation/ liaison
- Social support and informal counseling
- Health education
- Advocacy
- Link people to necessary services
- Individual and community capacity building
- Basic screening services

What Are CHWs Called?

Community Health Workers is the umbrella term, CHW’s go by many names:

- Outreach Worker *
- Health Educator
- Promotor(a) de Salud
- Peer Advocate
- Family Support Worker/ Family Partner *
- Patient Navigator *
- Care Coordinator *
Our Story...
| Primary Care Providers | • 5.6 FTE physicians  
• 5.9 FTE NP’s |
|------------------------|--------------------------------------------------|
| Number of Patients Served | • 12,000 patients served in 2011  
• 61,000 visits in 2011 (medical, dental, behavioral health, and vision) |
| Characteristics of the Population Served | • 62% at or below Federal Poverty Level  
• 49% uninsured  
• 52% require provision of services in a language other than English (Spanish, Portuguese, Haitian Creole, Thai, Vietnamese, etc.) |
| Primary Care Improvement Initiatives | • HRSA’s Diabetes Health Disparities Collaborative: 2006-2009  
• Commonwealth Fund-Qualis Safety-Net Medical Home Initiative: 2009-2013  
• Massachusetts Patient-Centered Medical Home Initiative 2010-2013 |
Barriers to Primary Care

- Poverty
- Limited English and primary language literacy
- Lack of health insurance
- Unemployment
- Immigration and refugee status
- Homelessness
- Inability to access transportation
- Social Isolation
- Depression/ Dysthymia
- Hopelessness
- Chronic Stress
- History of trauma/ PTSD
Barriers to Engaging in your Own Care

- Logistics: Time, money, energy
- Feelings: Shame/Fear/Guilt/Anger
- Motivation
- Understanding of disease/illness

Tools You Use to Overcome these Barriers

- Family
- Friends
- Social media/Blogs
- Informational opportunities like classes/seminars
- Community Supports: Work, School, Church
Four Different Names for CHWs at JMSCHC

• CHWs/ “Outreach”
• Family Partners
• Patient Navigators
• Care Coordinators

Two JMSCHC CHWs – a patient navigator for the Prevention and Wellness dept. and a CHW/ “Outreach Worker” – in training at a Patient Navigator Certificate Course at the Outreach Worker Training Institute (OWTI), A program of Central Massachusetts AHEC, Inc. (Photo Courtesy of: OWTI)
CHWs/ Formerly “Outreach Workers”

Link people to necessary health center & community services

• Health Insurance/ Food stamps/ Affordable housing
• ESL classes/ Citizenship classes/ Legal services/ Transportation
• Domestic Violence/ Behavioral Health

Language Interpretation/ Cultural mediation/ liaison

• Trained Medical Interpreters in Spanish, Portuguese, Thai, Vietnamese and Haitian Creole – provide interpreting during appointments and by phone

Basic screening services

• Periodic health screenings
• Trainings in chronic disease health education is ongoing

Health education/ Social support and informal counseling – in most cases, together with clinical staff

• Prenatal Centering
• New Mom & Baby Groups/ Spanish Support Group (for post-partum moms)
• Behavioral health groups for Haitian patients & local community after earthquake
• Special events CHW staff help plan, such as our Men’s Health Fair Fall 2012
Barriers to Integrating CHWs into Care Teams

- Grant-based funding since not yet recognized in payment/reimbursement structure
- Not managing a case load
  - Focus on broader provision of services
  - Secondary focus on individual families
  - Case load defined by cultural population health center has & CHW serves, not the size of that population
- Internal communication with care teams
  - Some methods for improving communication
    - EMR tasking, closing the loop on CHW referrals in the EMR
    - Shared trainings: Motivational Interviewing, population management
    - Multidisciplinary meetings: working together with Complex Care Managers to manage high-risk patients
Family Partner in “MyChild” Program*

- Cultural mediation/ liaison
  - Family Partner is a parent of a special-needs child
  - Differing from professional stance: the CHW may have been through some of the same experiences as the patient/family

- Social support and informal counseling
  - “Coffee Talk”
  - Helps to ameliorate the shame/ guilt/ fear and improve self-efficacy

- Linking to services
  - Acting as a bridge between family and social/ community supports
  - Taking mom to social security office, child’s medical or dental visit, even RMV
  - Helps coordinate care with other agencies like the child’s school

- Individual capacity building
  - The best family partners are those who are further along in the change process
  - Able to help catalyze the change process by meeting folks where they are at

*Grant funded as part of larger demonstration project to determine effectiveness of providing Medical Home for children with Severe Emotional Disturbance (SED) – otherwise would not be able to afford staff
Barriers to Family Partner Role

- **Sustainability**
  - Currently funded by grants.
  - Can this be reimbursed?

- **Logistical Availability**
  - The Family Partner is a parent of a child with special needs
  - This is a full time job in and of itself
  - May interfere with Family Partner’s availability and consistency.

- **Emotional Availability**
  - The experience of trying to help another family may be overwhelming for the family partner
  - The most successful family partners are those who are already fairly far along in the process of acceptance and coping with having a child with special needs

- **Not fully integrated with clinical care teams**
Prevention and Wellness Navigators

- **Health education/ Linking to services**
  - Working from reports to identify patients in need of preventive care services
  - Catching these patients as they come into the health center or calling them by phone
  - Educate patients about the importance of preventive services in their language
  - Schedule needed appointments
  - City of Boston/Dana Farber mammogram van

- **Cultural mediation/ liaison**
  - Patient Navigator training through DPH on basic health education about screenings, reducing barriers to care and cultural competency

- **Care Coordination**
  - Managing panels of patients in need of preventive cancer screenings (breast, cervical, and colorectal) and closing the loop on these referrals
  - Very high-level of care coordination, including timely follow-up and coordination with outside facilities, e.g. to acquire previous mammogram films for comparison
Barriers to Prevention and Wellness (PnW) Navigator Role

- Grant-based funding: Funding was cut significantly in March 2012 & is subject to variability in State & Federal budgets
- Lack of full integration with care teams
  - Terrific care coordination and accountability for patients managed by PnW, but not for other medical patients like those with chronic disease
  - PnW Navigators managed as different department than medical staff, difficult to feel/act as a team, but we’re working on integration
Assume: High Risk equals poor health outcomes which equals higher utilization of healthcare resources.

**Team-based Care (Medical Assts, CHWs, Care Coordinators)**
- Planned care at every visit
- *Check-out function*

**PnW Navigators/ Medical Navigators**
- Tracking cancer screenings
- *Expand to include outreach to diabetics overdue for services*

**Nursing**
- Nurse education visits
- Triage: Office visits

**Complex Care Management Team**
- *Tasks mimic those of PnW and Nursing but for most at-risk pts.*
- Collaborate with CHWs, behavioral health, medical specialists, home care services, etc. as needed

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**Risk level**
- **Primary Prevention**
- **Secondary Prevention**
- **Tipping point to declining health/high utilization**
- **High health risk/high utilization of resources**

Note: PnW = Prevention and Wellness dept.
CHW = Community Health Worker

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New Role: Care Coordinator

Located on the 1st floor with the medical team

- Health education/ Linking to services
  - Part of the clinical care team
  - Cross-trained as medical assistants
  - Perform the check-out function to ensure patients are aware of and have scheduled needed preventive care and chronic condition appointments

- Cultural mediation/ liaison
  - Patient Navigator training through DPH about basic health education, screenings, reducing barriers to care, and cultural competency

- Able to initiate with grant funding
New Role: Medical Navigator

Located on the 2nd floor with the PnW Team

- **Health education/ Linking to services**
  - Works with the PnW case management team and Nursing to contact patients in need of screening or follow up
  - Areas of focus include cancer screening and also chronic disease management
  - Works from reports (or via referral) to identify patients overdue for services
  - Contacts patients by phone or letter and works to assess and address any barriers to care

- **Cultural mediation/ liaison**
  - Patient Navigator training through DPH about basic health education, screenings, reducing barriers to care, and cultural competency

- **Able to initiate with grant funding**
Why Do We Need CHWs?

CHWs help us meet the Triple Aim of optimizing health system performance:

1. **Improve health outcomes**
   - e.g. Project Dulce: ↓A1c, B/P, and Cholesterol

2. **Reduce costs**
   - Improve access to primary health care
   - Increase utilization of primary health care

3. **Improve patient experience**
   - Better access to care
   - Cultural liaison
   - Educate & engage patients without judgment

And also...

- Reduce health disparities.
Workforce Issues and Barriers to Recruitment and Retention of CHWs

• High turnover if employee doesn’t have good understanding of & commitment to position & population served – we have not experienced too much turnover
• Lower wages since not clinical staff
• Lack of opportunity for career advancement in practices since not clinicians
• Poor job security due to reliance on grant funding
• Unpredictable funding

Findings from the Massachusetts Community Health Worker Survey [Internet]; Available at http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/comm-health-workers-narrative.pdf
Proposals for the Future of CHWs

The Massachusetts DPH proposes the following action steps and areas for further study:

• Core competencies and guidelines for CHWs
• Collaborate with training organizations to improve consistency in training and expectations
• Propose a career ladder for CHWs and their supervisors
• Fair and equitable pay scales for CHWs
• Further research to document and raise awareness about the unique contribution of CHWs to the health system
• Educate health providers and policy makers about this contribution
• Identify stable funding sources that promote long-term program planning and sustain CHW services – e.g., include in any capitated payment structure
Image source:
Payment Reform Options to Support Change and Transformation To A Medical Home

Coming together is a Beginning.

Keeping together is Progress.

Working together is Success.
Questions?
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References


Institute of Medicine, Crossing the Quality Chasm: A New Health System for the Twenty-first Century (Washington: National Academy Press, 2001).

National Conference of State Legislatures, Goodwin, K, and Tobler, L. Community Health Workers: Expanding the Scope of the Health Care Delivery System. [Internet]; April 2008; Available at http://www.ncsl.org/print/health/chwbrief.pdf


Outreach Worker Training Institute (OWTI) of Central MA AHEC, Inc. 35 Harvard Street, Worcester MA 01609
www.cmahec.org


U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Professions: Community Health Worker National Workforce Study [Internet]; March 2007; Available at http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf

Wagner E. Care Coordination in the PCMH. [Internet]; January 19, 2011; Available at http://www.safetynetmedicalhome.org/change-concepts/care-coordination