The Role of Community Health Workers in Collaboration with Public Health Nurses

October 13, 2016

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Who We Are

- An independent non-profit resource that **builds partnerships** across sectors and **cultivates innovative solutions** to improve health and well-being **for all people and communities** throughout VA, DC and MD.

- Facilitate Cross Sector Partnerships
- Training, Technical Assistance, and Capacity Support
- Support Effective Public Policy
- Design, Implement, and Evaluate Innovative Public Health Strategies
IPHI’s Role Creating Sustainable CHW Models

- CHW workforce and integrated care team training
- Creating partnerships with CBOs, medical providers, and Medicaid MCOs to test CHWs as a business strategy
- Facilitate state-level CHW policy development

Developing
Adapting
Implementing
Evaluating

- CHW program models across the region to create best practices for the region.

- 400+ CHWs trained
- 30+ CHW employees
- 40+ CHW jobs created
- Thousands enrolled in CHW services across our region

Institute for Public Health Innovation
“A Community Health Worker applies his or her unique understanding of the experience, language and culture of the populations he or she serves to promote healthy living and to help people take greater control over their health and their lives. CHWs are trained to work in a variety of community settings, partnering in the delivery of health and human services to carry out one or more of the following roles:- Providing culturally appropriate health education and information- Linking people to the services they need- Providing direct services, including informal counseling & social support- Advocating for individual and community needs, including identification of gaps and existing strengths and actively building individual and community capacity.”

(Interim Report: The Status, Impact, and Utilization of Community Health Workers, James Madison University, 2005)
What is Distinctive About Community Health Workers?

- Do not provide clinical care
- Generally do not hold a professional license
- Expertise is based on *shared life experience* (and often culture and community) with people served
- Rely on relationships and trust more than on clinical expertise
- Relate to community members as peers rather than purely as clients or patients
- Can achieve certain results that other professionals cannot

Acknowledgement: Carl Rush, Community Resources LLC
VA CHW Scope of Practice

Role 1: Community Mobilization and Outreach
Role 2: Health Promotion and Coaching
Role 3: Service System Access and Navigation
Role 4: Care Coordination/Management
Role 5: Community-Based Support
Role 6: Participatory Research
VA CHW Core Competencies

#1: Communication Skills

#2: Cultural Humility and Responsiveness

#3: Knowledge Based Skills

#4: Service Coordination and System Navigation Skills

#5: Health Promotion and Disease Prevention

#6: Advocacy and Outreach Skills

# 7: Professionalism
Why Community Health Workers? Why Now?

✓ Increased recognition of the evidence base related to **improved health outcomes**

✓ Emerging evidence base demonstrating significant **Return on Investment (ROI)** – average of about 3:1

✓ Recognition of CHWs as an official **job classification** by the Department of Labor in 2010

✓ Medicaid rule change opens door for **Medicaid financing** of CHWs

✓ Federal government and many states, incl. VA, involved in work to promote **CHW workforce development** and utilization

✓ Trends toward **Patient-Centered Medical Homes, Accountable Care Organizations**, and **value-based financing**
The Resource Centers:
Community Health Partnership in Richmond Public Housing Communities
The Resource Centers - Who We Are:

A team of staff: Nurse Practitioners, Nurses, Resource Center Specialists, Community Advocates, and Housing Advocates
The Resource Centers — What We Do:

✓ Satellite health clinics located in renovated low-income housing communities that aim to:

- REMOVE BARRIERS to health care services including:
  - Lack of knowledge, transportation and trust
- PROVIDE SERVICES that focus on health promotion & prevention
- CONNECT individuals to local medical homes
- INVEST in indigenous leaders who provide support to the community
Resource Center Space
The Community & Housing Advocate Model

Strategy: Each Resource Center has a Community Advocate and Housing Advocate who focus on:

- Community outreach
- Health and housing education
- Navigating individuals to medical, housing, education, and employment resources
- Improving community quality of life by addressing social determinants of health
Who are our Advocates?

Trained community leaders who understand the barriers of their own neighborhood and educate, motivate, and inspire other community members to make positive lifestyle choices.
“I do what the community needs me to do. I make sure that residents have healthcare and insurance so that they can have access to their own physician. I call and make appointments for residents who are unable to do so for themselves. If they need jobs, I will find one on the bus line that would interest them. Whatever they need I try to make sure I get information for them.”
# Community Partnerships

## Financial Support
- City of Richmond
- The Community Foundation & Jenkins Foundation
- Bon Secours
- VCUHS
- RCHD

## In-kind Support
- RRHA

## Referring Medical Homes
- Daily Planet
- Crossover
- Bon Secours
- VCU Health Systems
- Center for High Blood Pressure
- CAHN

## Community Partners
- Family Life Line
- YMCA
- HOME
- CARITAS
- Full Circle Grief Center
- RBHA
- Shalom Farms
- Challenge Discovery
- Senior Connections
- 7th District Wellness Initiative
- Richmond Promise Neighborhoods

## On-Site Service Providers
- Fan Free
- Minority Health Consortium
Impact: Cost Savings

Average Cost per Patient Visit

<table>
<thead>
<tr>
<th>Type of Visit</th>
<th>Average Cost per Patient Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room</td>
<td>$1265</td>
</tr>
<tr>
<td>Primary Care</td>
<td>$199</td>
</tr>
<tr>
<td>Health Center</td>
<td>$108</td>
</tr>
</tbody>
</table>

“Access Granted: The Primary Care Payoff.” http://tinyurl.com/cpe2yfs
CA and PHN relationship

1. Coordination and navigation to medical homes and resources that address social determinants of health
2. Improved professional development and overall self-sufficiency of CAs
3. Relational and physical connection for city resources into public housing developments
CAs, PHNs and Diabetes Prevention

- PHNs and CAs partner to engage in diabetes prevention in communities
  - Nurses provide screening as well as more in-depth clinical support on treatment needs for patients, while CHWs support patients with their self management.
  - CAs are trained to do blood pressure screening and glucose testing
  - CAs also provide chronic disease self management training to residents through health education and cooking classes
  - CAs provide linkage to education and support services to prevent diabetes.
  - CAs to be trained to conduct CDC Pre-diabetes screening in the community
SDOH in RC Referrals in FY 2016

- Primary Care and Health Care Coverage: 31%
- Job Opportunities: 18%
- Health Promotion: 15%
- Education: 17%
- Housing + Utility: 13%
- Food Access: 2%
- Mental Health/Substance Abuse: 3%
- Wholistic Services (reentry + seniors): 1%
Linkage to Care

- Medical home referrals and utilization
  - Identify participating medical homes
  - MOUs
  - Designated Agency Personnel
  - Staff Training
  - Referral Tracking
- 2015 Service Profile
<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Visits</strong></td>
<td></td>
</tr>
<tr>
<td>Total number of patient visits</td>
<td>3129</td>
</tr>
<tr>
<td>Total unduplicated number of medical patients</td>
<td>2237</td>
</tr>
<tr>
<td><strong>Sexually Transmitted Infection (STI) Control</strong></td>
<td></td>
</tr>
<tr>
<td>Total number of patients screened for sexually transmitted infections (STI)</td>
<td>1034</td>
</tr>
<tr>
<td>Percentage of patients screened for sexually transmitted infections (STI)</td>
<td>46%</td>
</tr>
<tr>
<td>Total number of STI screenings</td>
<td>3200</td>
</tr>
<tr>
<td>Number of patients with positive STI</td>
<td>444</td>
</tr>
<tr>
<td>Percentage of patients with positive STI receiving treatment at Resource Centers</td>
<td>78%</td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td></td>
</tr>
<tr>
<td>Number of patients of childbearing age who received education regarding birth control options</td>
<td>857</td>
</tr>
<tr>
<td>Percentage of patients of childbearing age who received education regarding birth control options</td>
<td>85%</td>
</tr>
<tr>
<td>Number of patients who received a long-term method of birth control</td>
<td>130</td>
</tr>
<tr>
<td>Percentage of patients using long-term method of birth control who do not become pregnant within next year</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Cancer Prevention</strong></td>
<td></td>
</tr>
<tr>
<td>Number of patients who received a breast exam</td>
<td>199</td>
</tr>
<tr>
<td>Number of patients who received a pap smear</td>
<td>197</td>
</tr>
<tr>
<td><strong>Chronic Disease</strong></td>
<td></td>
</tr>
<tr>
<td>Number of patients receiving blood sugar screening</td>
<td>66</td>
</tr>
<tr>
<td>Number of patients receiving blood pressure screening</td>
<td>1387</td>
</tr>
<tr>
<td><strong>Referrals for Health and Social Services</strong></td>
<td></td>
</tr>
<tr>
<td>Number of referrals from RCHD staff for any social or community service</td>
<td>1577</td>
</tr>
<tr>
<td>Total number of community organizations</td>
<td>175</td>
</tr>
<tr>
<td><strong>Referral and Navigation to a Medical Home</strong></td>
<td></td>
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<tr>
<td>Number of patients referred to a medical home</td>
<td>205</td>
</tr>
<tr>
<td>Number of patients referred to a medical home and presenting for initial appointment</td>
<td>95</td>
</tr>
<tr>
<td>Percent of patients referred to a medical home and presenting for initial appointment</td>
<td>46%</td>
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<tr>
<td><strong>Healthcare Coverage Referrals</strong></td>
<td></td>
</tr>
<tr>
<td>Number of patients referred for assistance with enrollment in Medicaid or FAMIS</td>
<td>79</td>
</tr>
<tr>
<td><strong>Community Outreach and Education</strong></td>
<td></td>
</tr>
<tr>
<td>Number of classes led or facilitated by Community Advocates</td>
<td>419</td>
</tr>
<tr>
<td>Average number of classes led or facilitated by 6 CAs per month</td>
<td>35</td>
</tr>
<tr>
<td>Number of outreach events led or facilitated by Community Advocates</td>
<td>456</td>
</tr>
<tr>
<td>Average number of outreach events led or facilitated by 6 CAs each month</td>
<td>38</td>
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Tools Used

- CHW Care Connect website
- https://CHWCareConnect.org
**Pre-Diabetes Risk Screening**

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<th>No</th>
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<tr>
<td>9</td>
<td>0</td>
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**IF YOUR SCORE IS 3 TO 8 POINTS**

This means your risk is probably low for having prediabetes now. Keep your risk low. If you’re overweight, lose weight. Be active most days, and don’t use tobacco. Eat low-fat meals with fruits, vegetables, and whole-grain foods. If you have high cholesterol or high blood pressure, talk to your health care provider about your risk for type 2 diabetes.

**IF YOUR SCORE IS 9 OR MORE POINTS**

This means your risk is high for having prediabetes now. Make an appointment with your health care provider soon.
THANK YOU!

Any questions?