Community Health Worker Integration: 
*Issues and Options for State Health Departments*

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Objectives

1. Provide context and a framework for talking about CHW integration.
2. Offer practical guidance for SHD officials working with internal and external colleagues.
3. Offer practical guidance for providers and payers.
4. Provide examples of integrated CHW programs.
Context: Why integrate CHWs?

- Political consensus: health “system” in transformation.
- Persistent equity, cost, quality, and outcome challenges.
- Volatile health *policy* environment.
- States and healthcare organizations are driving innovation.
- Growing perception of CHW *value* propels increasing interest and investment.
- Reaching limits of benefit from CHWs as peripheral, grant-funded, temporary resources.
Investment in CHWs: Approaching the “tipping point”

- Increased attention & investment
- "Anecdotal" evidence of CHW value
- Evidence of ROI and positive health outcomes
- Increased research
- Pilots & grant funding
Conceptual Framework

1. Understanding the workforce.
2. Growing emphasis on population health.
3. Forms of CHW engagement.
4. Domains of integration.
Understanding the workforce

- “CHW” as an umbrella term.
- Dozens of job titles.
- Common workforce definition (APHA).
- Common definition of roles and skills (C3).
- CHWs are people, not a “model.”
Growing emphasis on population health

- Healthcare system is facing increased pressure and incentives to address population health.
- CHWs are in unique position to “bridge” healthcare and public health.
Forms of CHW Integration in Healthcare

1. Supporting clinical operations that don’t use teams.
2. As adjuncts to teams, but not team members.
3. Integrated as members of inter-professional care teams.
Integration within 4 domains

- Healthcare organizations
- Treatment and prevention programs
- Care teams
- Financing of services
CHWs help link fragmented healthcare and public health domains

- Chronic disease treatment and prevention.
- Clinic and community-based care.
- Behavioral health and primary care.
- Oral health and medicine.
- Care coordination.
- Social determinants of health.
CHWs help form expanded external relationships

In addition to CHW direct roles and responsibilities, effective integrated programs often include:

- **Collaborations with community-based organizations:**
  - Social service providers, YMCAs/YWCAs.
  - Legal, housing, education, and employment.
  - Food pantries, farm stands.
  - Community development corporations.
  - Issue advocacy and organizing groups.

- **Supplementary programs and services:**
  - Nutrition education and cooking classes.
  - Health, wellness and physical activities (walking clubs, dance, aquatics, support groups, etc.).
Discussion

What are examples from your states of how you’re dealing with these issues?
Principles for Integration

- Achieving the “Triple Aim” and health equity objectives demands CHW integration.
- Promoting respect for CHWs strengthens outcomes.
- Integration requires all members of an organization to understand who CHWs are and what they do.
- Incorporate all CHW core competencies into program design, including advocacy and community-based work on social determinants of health.
Principles (continued)

- Involve CHWs in integration planning and implementation at all four system levels.
- CHWs bring unique understanding, perspectives, and value to organizations and teams.
- In team settings, CHWs should meet regularly with the full team (and more frequently with supervisor).
- CHWs should have access to (and record in) electronic health records.
Focus: CHW integration into organizations and teams

- Different organizations involve different integration challenges (e.g., hospitals, FQHCs).
- Use a systems change approach—CHW integration requires more than “fitting them in.”
- Scope of practice challenges involve other professions as well as CHWs.
- Organizational policies and procedures matter.
- Integration requires sustainable funding.
Elements of the CHW Integration Process

▪ Advance systems planning.
▪ Effective recruitment and selection.
▪ Quality training and supervision.
▪ Leadership promotion of inter-professional relationship-building and collaboration.
▪ Planned approach to support, retention, and career advancement.
▪ Research to support sustainable funding.
Implementation Steps

▪ Organizational assessment – readiness for change.
▪ Care model re-design: impact on relationships, patient flow.
▪ Planning for team integration.
▪ Working with existing team members—all disciplines, all responsibilities.
▪ Advance infrastructure and logistical support.
▪ Preparation of entering CHW team members.
What does real integration require?

CHWs speak out at 2017 Unity conference, Dallas, TX.

- Respect for CHW life experiences, roles, and capacities:
  - “Our voices are valued equally within the team.”

- CHW leadership:
  - “We engage, empower, and educate.”
  - “CHWs have to be part of determining what happens.”
  - Influence on internal systems, community-based partnerships, care delivery, health policy.
Support from leadership and colleagues.
Mobilization of internal resources and champions.
Empowering job titles and clear job descriptions.
Acknowledgement of CHW impact and expertise.
Training, continuing education.
Respectful, informed supervision.
Discussion

What questions are you hearing or what challenges do you face in promoting CHW integration?
Key consideration:

Do not underestimate the potential clash between CHWs and the culture of healthcare.
Hierarchy and power

“Once they saw what I could accomplish with patients and how I could make their work easier, they respected me more.” (CHW)

Hierarchy and power is based on clinical knowledge

CHWs may have less formal education

CHWs often need clinical backup

“I hate documenting my work because I can’t use the kind of words the doctor does and I don’t want him to think I’m stupid.” (CHW)
Narrowly defined roles

“How am I supposed to go in and talk to her about asthma triggers when she’s worried about how she can’t afford to give her children enough to eat?” (CHW)

Systems are more accustomed to narrowly defined roles

CHWs are neither clinical nor administrative personnel
CHWs often work independently in the field
Services built on specific interventions

“They give me a certain number of encounters per client, but I need to spend a lot more time with some clients than others.” (CHW)

“Officially, I am supposed to only work with the one client, but I can’t always do that without figuring out how to help their other family members, too.” (CHW)
Organizational culture

“They sent me home to change my blouse because it wasn’t professional enough. I just about quit.” (CHW)

“Systems have their own culture... and may be culturally diverse”

“CHWs have multiple cultures to “bridge” – the system’s, community members’ and their own”

“I’ve lived in this community a lot longer than I’ve worked for (agency).” (CHW)
Required to record and report concrete results

“I learned so much about that client’s life that the doctor should know. I wrote it all down in the record but they made me go back and change it to two sentences.” (CHW)

Systems require reporting of concrete results and outcomes

CHWs may have less experience documenting and reporting

Results of CHW work may be less tangible
Although the system includes five hospitals, we serve the community as a truly integrated health services organization.

Serves families and communities in western NY and Finger Lakes region.

Offers a wide range of services and has 28 FQHC sites.

11 - DSRIP project funded health transformation initiatives.

Integrating CHWs into services for high risk/high cost patients including: Medicaid low/non-utilizers, and self-pay population.
Integration challenges within a hospital setting

- Hospital
- Different professions
- Partner Organizations
- Targeted disease/population programs
- Various CHW job titles
Example: Spectrum Health (Michigan)

- Core Health Program: population health initiative run by charitable arm of health system.
- Uses nurse-CHW teams.
- Successful in chronic disease management.
Example: Bronx-Lebanon Hospital Center (NYC)

- Began employing CHWs in 2007 under grant funding.
- Pilot showed net 2:1 ROI from reduced hospitalizations and ED visits, increased primary care revenue.
- Now 35 CHWs supported from “operational funds.”
- Clinical staff receive specific training on working with CHWs.
- CHWs present cases at team meetings.
Questions/Discussion
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