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

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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

National Network of Public Health Institutes

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IPHI's Role Creating Sustainable CHW Models

- CHW workforce and integrated care team training

Developing
Adapting
Implementing
Evaluating

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

- Creating partnerships with CBOs, medical providers, and Medicaid MCOs to test CHWs as a business strategy

- Facilitate state-level CHW policy development

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

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Virginia CHW Definition

"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)

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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

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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

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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

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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**

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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

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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

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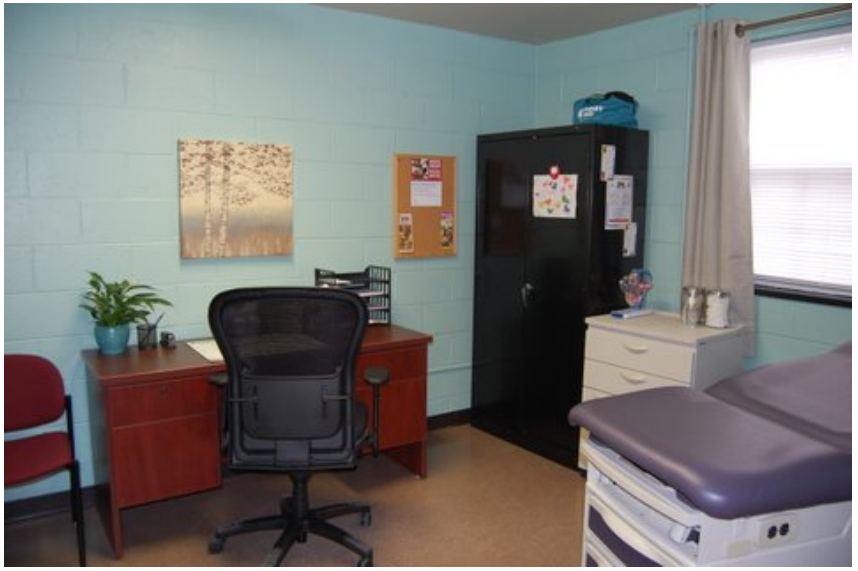
Resource Center Space



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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*

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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

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Shikita Taylor, Community Advocate

"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."

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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

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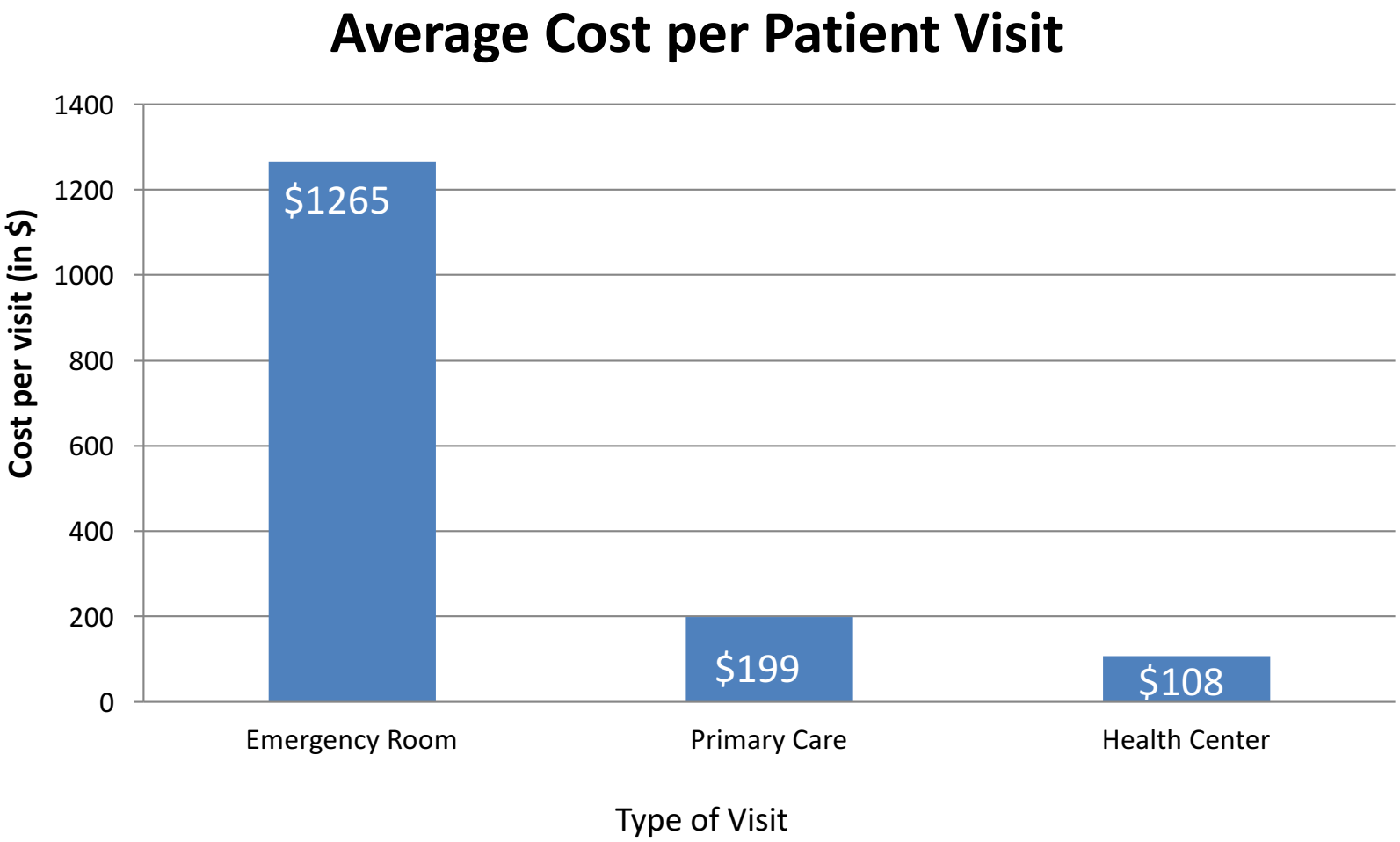
Impact: Cost Savings



"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

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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

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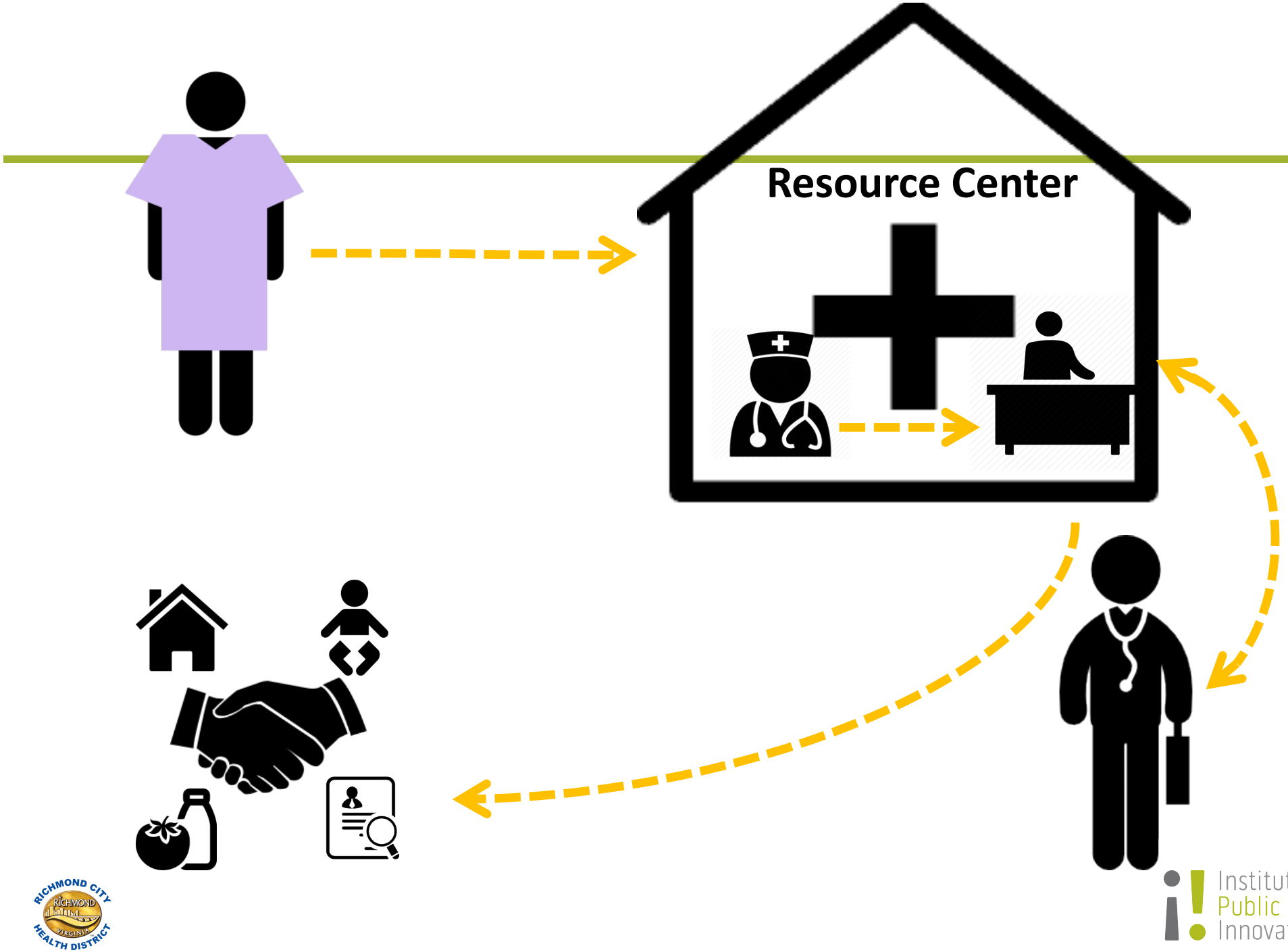

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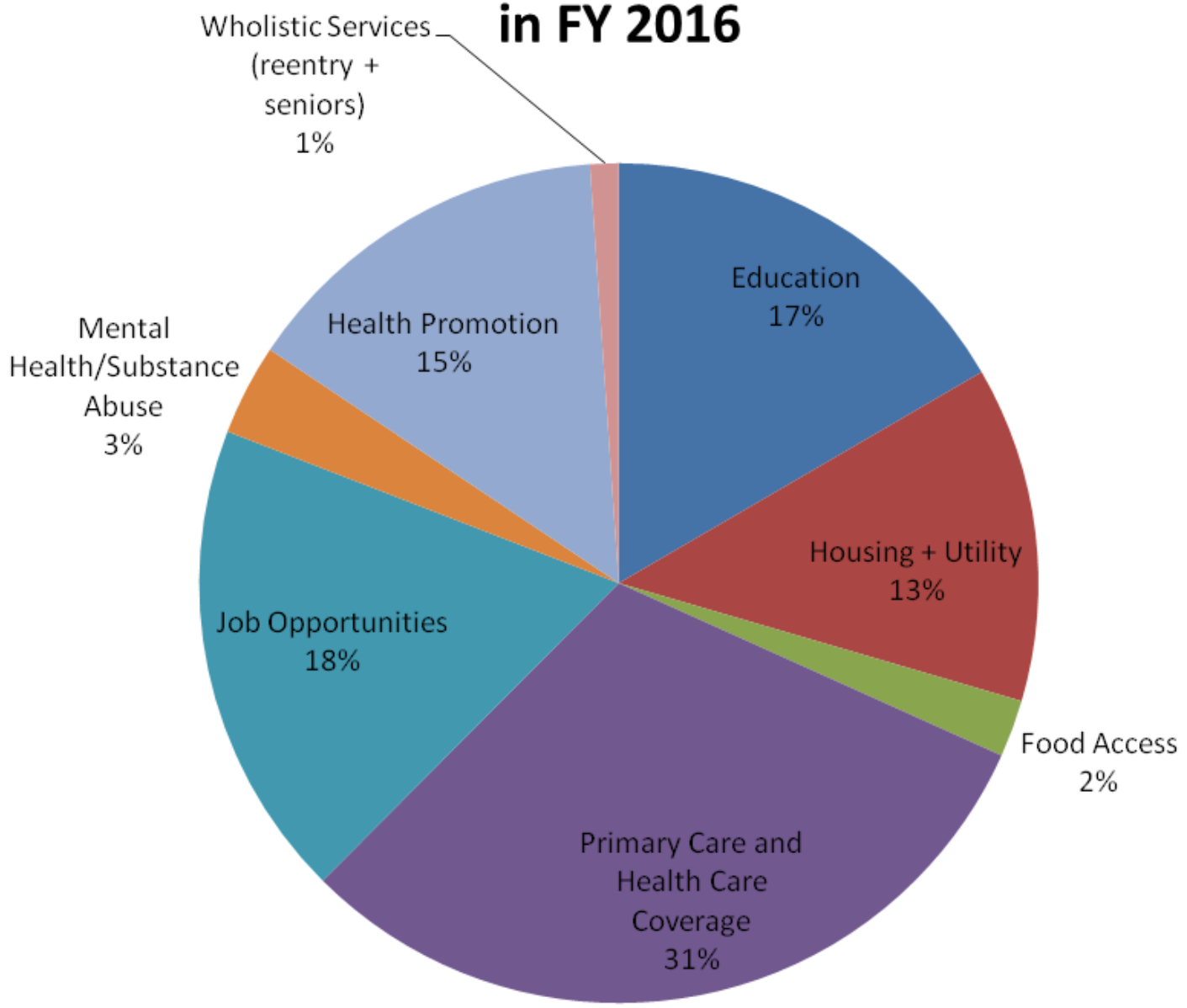
SDOH in RC Referrals in FY 2016



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Linkage to Care

- ✓ Medical home referrals and utilization
  - ✓ Identify participating medical homes
  - ✓ MOUs
  - ✓ Designated Agency Personnel
  - ✓ Staff Training
  - ✓ Referral Tracking
- ✓ 2015 Service Profile

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

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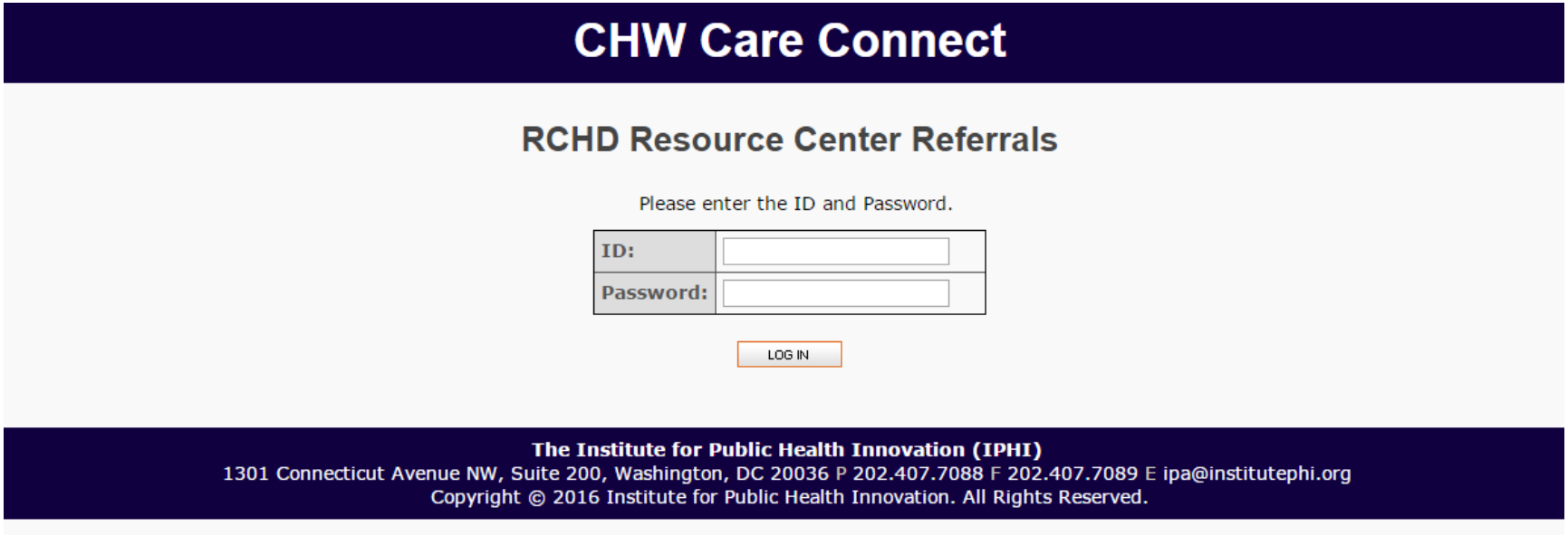
Tools Used

- ✓ CHW Care Connect website
  - ✓ https://CHWCareConnect.org



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Pre-Diabetes Risk Screening

Yes	No	
1	0	Are you a woman who has had a baby weighing more than 9 pounds at birth?
1	0	Do you have a sister or brother with diabetes?
1	0	Do you have a parent with diabetes?
5	0	Is your body mass index (BMI) above 25.0? (see chart above)
5	0	Are you younger than 65 years of age and get little to no exercise in a typical day?
5	0	Are you between 45 and 64 years of age?
9	0	Are you 65 years of age or older?
		Total

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.

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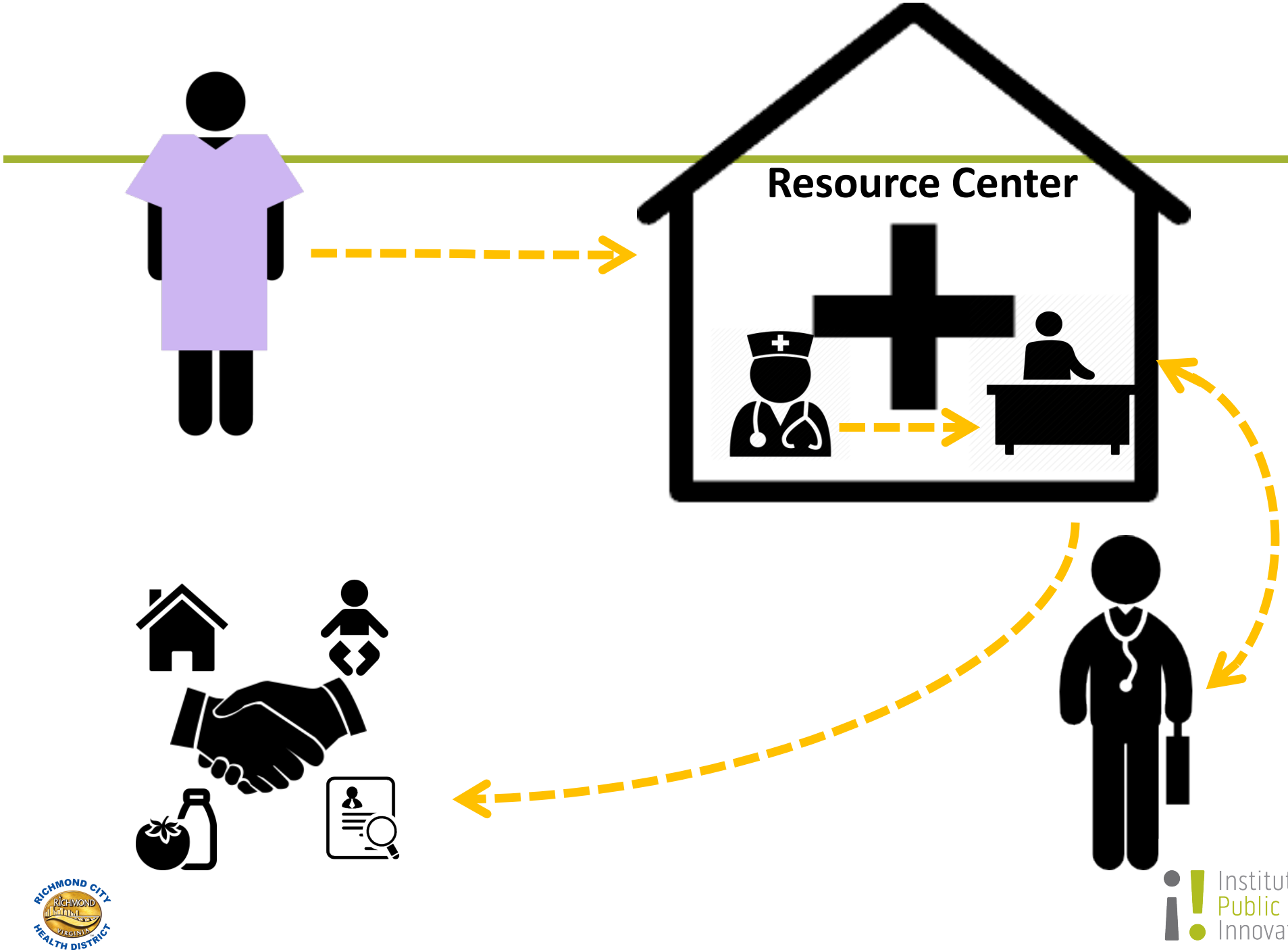

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THANK YOU!

Any questions?