

Finding Answers

Disparities Research for Change

Integrating Community Health Workers into Health Care Teams to Improve Equity and Quality of Care



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Learn more about *Finding Answers'* tools and resources to reduce disparities, including the Roadmap to Reduce Disparities, online at: www.solvingdisparities.org.

Integrating Community Health Workers into Health Care Teams to Improve Equity and Quality of Care

This Finding Answers Strategy Overview provides pragmatic implementation information for health care organizations considering the integration of community health workers into their outpatient healthcare teams. We explain how community health workers can improve care and outcomes for racial and ethnic minority patients and outline best practices discovered through the experiences of Finding Answers grantees that have implemented and evaluated several community health worker model programs¹.

The *Choosing, Adapting, and Tailoring a Community Health Worker Model Program: Summary of Lessons Learned and Best Practices* appendix provides a bullet-point style, high-level summary of key recommendations for successfully integrating community health workers into health care teams to improve equity and quality of care.

Introduction

There is a growing evidence base and broad recognition of the key role Community Health Workers (CHWs) can play in improving the quality of health care in general, the prevention and control of chronic diseases specifically, and in reducing health and healthcare disparities faced by racial and ethnic minority patients.

In addition, health care practices, policy makers and payers are recognizing that CHWs can help to make healthcare more patient-focused and directly tied to community resources. Section 5313 of the Patient Protection and Affordable Care Act of 2010 authorizes the CDC and the Secretary of Health and Human Services to collaborate in awarding grants that promote positive health behaviors and outcomes in medically underserved communities through the use of CHWs. The Centers for Medicare and Medicaid Services issued a final rule (CMS-2334-F), effective January 2014, which provides mechanisms for the provision of preventive services by non-licensed providers. In addition, as of 2013, 15 states and the District of Columbia had CHW laws addressing infrastructure, definitions of the profession, workforce development, and financing. Seven of these states had laws encouraging the integration of CHWs into team based care models for selected services and organization types and three provided Medicaid reimbursement for CHWs^{2,3,4,5}.

While it is expected that laws and policies designed to encourage the use of CHWs will continue to multiply, little is known about the precise mechanisms by which CHWs can improve care, and health care organizations often struggle with fully integrating CHWs into existing teams⁶.

Community Health Workers can play an important role in improving the quality of health care and in reducing health and healthcare disparities faced by racial and ethnic minority patients.

- 1 This strategy overview does not cover the roles community health workers can play outside of team-based care for patients, such as community outreach, community education or community capacity building.
- 2 Centers for Disease Control and Prevention. Policy Evidence Assessment Report: Community Health Worker Policy Components. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2014.
- 3 Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion (U.S.), Division for Heart Disease and Stroke Prevention. Addressing Chronic Disease Through Community Health Workers: A Policy Brief on Community Health Workers. 2nd Edition; 2015.
- 4 Institute of Medicine. A population-based approach to prevent and control hypertension. Washington, DC: National Academies Press. 2010.
- 5 Viswanathan M, Kraschewski J, Nishikawa B, Morgan LC, Thieda P, Honeycutt A, Lohr KN, Jonas D. Outcomes of Community Health Worker Interventions. Evidence Report/Technology Assessment No. 181 (Prepared by the RTI International–University of North Carolina Evidence-based Practice Center under Contract No. 290 2007 10056 I.) AHRQ Publication No. 09-E014. Rockville, MD: Agency for Healthcare Research and Quality. 2009.
- 6 O'Brien, M., Squires, A., Bixby, R., & Larson, S. Role development of community health workers: An examination of selection and training processes in the intervention literature. *American Journal of Preventive Medicine*, 37(6 Suppl. 1), S262-S269. 2009.

Finding Answers has reviewed the growing body of literature on interventions to reduce racial and ethnic disparities in health care and found that CHWs are a promising strategy for improving the healthcare and health of racial and ethnic minority populations⁷. Finding Answers has also examined the efficacy of six CHW programs in reducing health disparities by testing their success in 21 ambulatory outpatient settings, including federally qualified health centers, academic medical centers, safety-net clinics, hospital based clinics and an emergency department. See Appendix 1 for program model descriptions. We collected and compared detailed program implementation data across settings to distill a core set of practical recommendations and best practices for successfully incorporating CHWs into ambulatory healthcare teams.

What is a Community Health Worker?

CHWs are a rapidly emerging professional group that holds a variety of roles in patient care⁸. As paid employees or volunteers, they go by a number of titles including: patient advocate, peer, coach, care manager, promotor and navigator. While some states are taking steps to define CHW professional roles and establish certification programs, great variability still exists across the country and within states regarding basic qualifications, recommended skill sets and training requirements. Even so, evidence suggests that CHWs may be helpful in addressing healthcare disparities, especially in ambulatory care settings.

The roles that CHWs held in the Finding Answers programs varied, yet each provided direct service to patients as an integral member of a larger healthcare team. All Finding Answers CHW model programs met the following Massachusetts Department of Health definition:

A Community Health Worker (CHW) is a public health outreach professional who applies his or her unique understanding of the experience, language and/or culture of the populations he or she serves in order to carry out at least one of the following roles:

- Bridging/culturally mediating between individuals, communities and health and human services, including actively building individual and community capacity;
- Providing culturally appropriate health education and information;
- Assuring that people get the services they need;
- Providing direct services, including informal counseling and social support; and
- Advocating for individual and community needs.

A CHW is distinguished from other health professionals because he or she is hired primarily for his or her understanding of the populations he or she serves, and conducts outreach at least 50% of the time in one or more of the categories above⁹.

In 2005, the Robert Wood Johnson Foundation launched *Finding Answers: Disparities Research for Change* to seek and evaluate projects aimed at reducing racial and ethnic health care disparities. Finding Answers partnered with 33 health care organizations to evaluate a variety of intervention strategies in different health care settings to find out what works—and what does not—to improve care.

7 Chin, MH, Clarke, AR, Nocon, RS, Casey, AA, Goddu, AP, Keesecker, NM & Cook, SC. A Roadmap and Best Practices for Organizations to Reduce Racial and Ethnic Disparities in Health Care. *Journal of General Internal Medicine*, 27(8), 992-1000. 2012.

8 Health Resources and Services Administration (HRSA), Bureau of Health Professions, Community Health Worker National Workforce Study, U.S. Department of Health and Human Services, 2007, p. vi, available at <http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf>.

9 The Massachusetts Department of Public Health; adapted from Rosenthal, E.L., The Final Report of the National Community Health Advisor Study. The University of Arizona. 1998.

Impact on Care and Outcomes: Improving Patient-Centered and Culturally Relevant Care

Time spent with patients

CHWs can typically spend more time with patients than a traditional medical provider and can use this time to provide additional highly-tailored patient education and counseling and to ensure patient understanding. This additional time also provides ongoing opportunities to recognize and attempt to address social and cultural barriers that might exist between the patient and the healthcare team.

Peer Status

In addition, CHWs often have a common identity and shared perspective with patients that can facilitate connections based on trust and elicit information beyond that which is shared during traditional patient encounters. This peer status between a CHW and patient is often based upon having a common health challenge, but it can also be based upon other aspects of shared identity considered critical by the targeted patient population, such as gender, race, ethnicity, medical diagnosis, sexual orientation, immigrant status or preferred language. Peer status can also be based on more than one aspect of shared identity (e.g., Latinas diagnosed with breast cancer).

Traditional providers primarily enhance the healthcare relationship by bringing their superior medical expertise to the patient encounter, while CHWs primarily enhance the healthcare relationship by enhancing patient-centered care via their peer status. Peer status facilitates gathering additional information from patients that can be used to further tailor care and to address social or cultural barriers that impact the patient's health and disease self-management. For example, CHWs may learn details about the patient's home, neighborhood and work environments, beliefs and values about health, illness, and healthcare, familial and social relationships and challenges (e.g., substance use or abuse, financial struggles). CHWs may learn this information in less overall time, and in more detail, than a traditional healthcare provider because patients are typically more comfortable sharing personal and potentially stigmatizing information about themselves with someone they know and trust. This additional detail can enhance overall communication, allow tailoring of patient education, strengthen the relationship between the patient and the healthcare team and go far in creating truly patient-centered medical care.

CHWs also share a different kind of peer status with members of the health care team that allows them to engage team members in improving overall cultural competency. CHWs may formally and informally educate their team members about the unique and culturally specific perspectives, needs and desires of their patients. Informal education can occur gradually over time, via typical day-to-day interactions with team members as they share information about patients and address challenges in their care. Their unique role on the healthcare team and their distinctive working relationship with patients is one of the main ways that CHWs can help to enhance the provision of culturally appropriate care.

“They [CHWs] have been very effective, because it is that simpatico sort of relationship that they can develop with the patients. And they speak the same language... I don't mean literally because they speak Spanish or Portuguese, but they speak it in a way that's culturally and ethnically grounded, that the professional, medical team often can't.”

Joan Pernice
Massachusetts League of
Community Health Centers

Integrating Community Health Workers into the Care Team and Maximizing Their Impact

The CDC summarized the evidence base for the use of various components of CHW activities as they relate to the prevention, control, and improvement of chronic disease outcomes in its 2014 policy evidence assessment report. They found that the inclusion of CHWs in team-based care models was one of eight CHW policy components that fell into their strongest and best evidence base category¹⁰. However, inadequate integration of CHWs into the healthcare team can dilute or negate the strengths and effectiveness of such a program. Adding a CHW to the health care team is more than just adding another staff person. It involves changing the way care is delivered. As a result, some important steps are necessary to increase the likelihood of a successful CHW program.

Research with Patients

Making assumptions about what peer-based attributes CHWs in your program should have and how they can be helpful to patients may lead to creating a sub-optimal CHW program and hiring CHWs who are a poor fit with patient needs. Make sure you understand your patient population and their needs by asking them directly how a CHW could be helpful and what potential CHW attributes are most important to them. For example, patient focus groups might reveal that working with a CHW experienced in successfully balancing the needs of work, caring for extended families and their own diabetes management will be more valuable than a CHW from a similar culture or ethnic background living with diabetes, but who is inexperienced in balancing work life and caring for a family.

Recruit and Hire the Right Person

Write an accurate job description. While it is generally considered discriminatory to hire staff based on particular demographics, such as race or ethnicity, health status, or socioeconomic status, recruiting CHWs from a specific target population may be acceptable criteria when judging candidates on their ability to relate to and maintain culturally competent interactions with patients. These required abilities should be clearly indicated in the job description and posting. Program designers should work closely with human resource personnel to address these issues while creating the job description and selecting candidates.

Common skills and attributes in CHWs are: cultural congruence, ability to keep up a conversation, enthusiasm, trustworthiness, pleasant demeanor, ability to learn from mistakes, and ability to deal with challenging or hesitant personalities. Strong communication skills are also important and can increase the potential for successful CHW-patient discourse. These skills include speaking confidently and clearly in a professional, modulated tone, and talking and pausing at an appropriate rate. These attributes can implicitly convey the importance of the relationship and remove communication barriers that can sometimes inhibit a discussion. An attitude that exudes courtesy, respect, and sincerity can also make the difference between gaining cooperation and losing patient interest. Both interpersonal characteristics and communication skills are critical in developing a patient's first impression.

Adding a CHW to the health care team is more than just adding another staff person. It involves changing the way care is delivered.

Make sure that you understand your patient population and their needs by asking them directly how a CHW could be helpful and what potential CHW attributes are most important to them.

¹⁰ Centers for Disease Control and Prevention. Policy Evidence Assessment Report: Community Health Worker Policy Components. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2014.

Develop a Recruitment Plan

Since CHWs are a relatively new field, some of the best candidates might not know these types of opportunities exist. Current patients, community groups and staff may help you identify potential candidates. If current staff members are being considered for a CHW position, it is important to select those who are genuinely and innately supportive of the program mission, who are enthusiastic about participating in the program, and who do not view the program as extra work. Otherwise, there is a risk that the new CHW responsibilities will not be prioritized as intended, particularly in the case of competing demands if the CHW will retain other job responsibilities part-time.

It may not be possible to find CHW candidates who have all of the qualifications and characteristics noted above. It will then be important to find candidates who have the best mix and prioritize the search based on the needs of the patient population. It should also be noted that racial/ethnic congruence is not synonymous with cultural competence and that a CHW candidate's cultural competence should not be assumed, but rather adequately assessed and trained.

Provide Adequate Training and Support

Certification and education requirements for CHWs are currently lacking and raise concerns about inadequate training and preparation for the role. However, placing minimum education or certification requirements on these types of positions may block those most associated and allied with populations and communities suffering health disparities from being able to serve as CHWs. Regardless of education or certification requirements, comprehensive initial and ongoing training, supervision and support are critical to the success of a CHW program and should never be devalued or minimized. Essential topics include:

- Communication and interviewing skills
- Disease-specific knowledge, including etiology, assessment and diagnosis, treatment options and protocols, associated lab tests and values, medication adherence and co-morbidities
- Basic counseling techniques
- Behavior change theory and behavior change facilitation techniques
- Establishing and maintaining interpersonal boundaries (e.g., working with aggressive patients)
- Maintaining professional boundaries (e.g., providing health information while always deferring to the Primary Care Provider as the primary partner and resource for making healthcare decisions with the patient).
- Preventing and addressing burn out, including accepting rejection and patients who fail to improve
- Assessing needs and making effective referrals (e.g., basic assessment for cognitive disabilities and mental health challenges that require referral)
- Federal, state, municipal and organization regulations (e.g., confidentiality, HIPAA, mandated child abuse and neglect reporting)
- Community resources
- Documentation protocols

Role-playing can be an effective and essential training tool for CHWs. By working through challenging scenarios ahead of time, CHWs can become more confident in their delivery

“The people who are most successful are the peer coaches [CHWs] who identify the most with caring about other people and how they can help other people. The incentive for them is not how much compensation they can get out of doing this work, but the gratification of helping others. That is what we look for.”

Shelly Joseph
University of Pennsylvania

when working with actual patients. Additionally, role-playing can improve staff cohesion by creating a supportive environment for team-based learning.

Training opportunities should continue after the CHWs have started seeing patients and ongoing training topics should be based upon CHW self-reported needs and supervisor observations. All Finding Answers CHW interventions recommended additional and ongoing training opportunities for their CHWs. In particular, they recommended additional training on how to work best with patients struggling with co-morbid mental health challenges such as depression. The CDC has prepared a compilation of CHW training and capacity building resources (e.g., curricula, supervision tools) in their CHW policy assessment report¹¹.

Finally, CHWs may become a source of significant support to their patients. As a result, they may end up being exposed to and assisting with challenging aspects of a patient's care, such as mental health challenges, substance abuse, and domestic violence. Addressing these types of issues can be emotionally draining and stressful for CHWs; they need regular, ongoing training and supervisory support to help them establish and maintain effective professional and emotional boundaries. Because of this, and the consistent emphasis on facilitating behavior change in their work with patients, individuals with advanced behavioral health or social services education and experience are ideally equipped to supervise CHWs.

Training Team Members and Gaining Buy-In

It is imperative to introduce members of the health care team to this new position, the professional role CHWs play and the benefit they can provide to the team and patient care. If proper introductions do not happen, CHWs can be viewed as “nice-to-have” extra or optional resources. Worse, other providers may view CHWs as potentially interfering in their patients' care or as an unnecessary complication to clinic operations and flow.

Active buy-in and support from clinic leadership plays a key role in successfully integrating CHWs into the existing clinic flow and patient care so that their work is respected and they are seen as important contributors to patient care. Part of this integration includes giving CHWs access to patient health information, including medical and lab records, and the training to properly understand it. Allowing access to this type of information will allow CHWs to better help patients manage their health condition.

Just like other team members, CHWs' time and priority duties need to be protected, particularly within busy and under-resourced community health centers. Settings with limited resources will often be tempted to utilize CHWs for other tasks, which may limit the time they spend with patients, as well as the number of patients they reach.

Conclusion

CHWs are a promising strategy that health care organizations can use to help improve care for racial and ethnic minority patients. However, it can be challenging to implement a CHW program without the right pieces in place. Inadequate implementation and integration into the care team risks never fully benefiting from the improved patient-centered and culturally competent care that CHWs can provide to patients. Essential components include identifying the right people, comprehensive training and support protocols and fully integrating the CHW role into existing clinic operations.

"Patients were able to share things [with their CHW] such as I'm having problems with sexual dysfunction because of my diabetes that they feel uncomfortable sharing with their doctor. Then the coach encourages them to talk to their doctor about that. There is a lot of satisfaction. The patients are more satisfied that they have the peer coach that is kind of walking along with them. The doctors are more satisfied because they find that it makes their visits more efficient."

Quyen Ngo-Metzger
University of California-Irvine

¹¹ Centers for Disease Control and Prevention. Policy Evidence Assessment Report: Community Health Worker Policy Components. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2014.

Appendix 1: Finding Answers Community Health Worker Program Model Descriptions with Key Implementation Considerations

Introduction

The key implementation considerations that accompany the program model descriptions on the following pages are overarching findings, experiences and suggestions related to program design and implementation. They are the key factors that the people who designed and implemented these programs noted they would address if they had the opportunity to implement similar programs again.

For additional information about each of the following programs, please see:

<http://www.solvingdisparities.org>

Choctaw Nation Health Services Authority

To improve **diabetes** outcomes for their **rural** primary care clinic patients, The Choctaw Nation Health Services Authority augmented their Community Health Educator (CHE) program staffed by active **Choctaw Nation community members**. Each CHE would make a series of eight, hour-long **home visits** over the course of nine months. To prepare for the visits, CHEs receive 12 hours of interactive, workshop-based training on semi-structured interviewing techniques. The CHE program focused on bridging the gap between patients' and providers' personal and cultural understanding of diabetes—beliefs about diabetes development and progression, treatment, and preferred lifestyle changes. By bridging the gap that can exist between patients' and providers' cultural understanding and beliefs about diabetes, the program hopes to improve patient-provider communication, mutual understanding, and patient adherence to treatment and health outcomes.

KEY IMPLEMENTATION CONSIDERATION

CHWs programs benefit from close supervision and support that facilitates early identification of challenges and the maintenance of program fidelity.

- **Provide thorough and ongoing training and support around documentation protocols.** The project's original protocol required the CHEs to write down the patient's responses to questions during the home visits. However, the CHEs often had difficulty completing this task and many of the interview forms were returned blank, which left project leaders with little information about how the patient visits were going and what explanatory models of diabetes patients preferred.
- **Provide on-site supervision and support.** Project leaders were located 5 hours (by car) away from the project site and were not able to interface with the CHEs on a regular basis. As a result, sometimes the CHEs prioritized some aspects of their jobs more than others and the patient interaction protocols were not instituted as intended.

“One community health representative [CHW] was a traditional Choctaw woman ...assigned to go in and talk with a gentleman who is older, traditional Choctaw, a Choctaw speaker. He was just not taking care of his diabetes... He was approaching kidney failure, his vision was going, he was on the verge of an amputation. And she spoke with him about his disease and diabetes in the Choctaw language. It totally turned him around. He was walking, he lost weight. He started off with a small thought that he could do something, and then it became this big thought, and so he was just doing wonderfully.”

L. Carson Henderson-
Choctaw Nation
Health Services Authority

University of California – Irvine

To improve **diabetes** outcomes among their **Mexican- and Vietnamese-American** patients, **university-affiliated primary care clinics** incorporated diabetes coaches into their health care team. **Diabetes coaches, who themselves have type 2 diabetes**, were recruited directly from the local community and trained to work one-on-one with patients who are identified using an existing electronic diabetes registry. **The coaches shared language and socio-demographic characteristics with the patients** and had the ability to serve as “cultural brokers” for what may otherwise be a hard-to-reach population within the clinics. The coach-patient interaction occurred 20 minutes before regularly scheduled medical appointments, in a private area of the doctor’s office. During that encounter, the diabetes coach addressed self-efficacy, social and cultural barriers to care, lifestyle changes and medication adherence. Using the patient’s personal medical information, obtained directly from the patient and the medical record, the coach tailored the meeting to the patient’s individual needs. After a patient’s visit with the doctor, coaches held a debriefing session to help them understand their treatment plan. Coaches also followed up with phone calls two weeks after the first doctor’s visit, and one week prior to subsequent visits, which usually occurred every three months.

KEY IMPLEMENTATION CONSIDERATION

CHW programs often need plentiful initial and ongoing training and supervision opportunities that focus on how to work with challenging patients.

- **Expand initial training of the coaches to include dealing with challenging patients**, such as those who had depression and lack of motivation to improve their diabetes control.
- **Provide more training on how to handle inappropriate behaviors by some patients** who did not respect professional boundaries between themselves and the coaches.
- **Schedule ongoing supervision meetings on regular basis and provide “drop-in” supervision** for coaches to receive the support necessary for their jobs.

“We’re finding again that the cultural experience and the background of our patients really does play a very significant role in their ability to interact with the physician and also, ultimately, to manage their own diabetes.”

“We have three Latina coaches, three Vietnamese coaches and three non-Hispanic white coaches. They’re all women who have type 2 diabetes themselves, and they have a lot of personal experience trying to manage their own illness, and so they bring that expertise to our patients.”

Dara Sorkin-
University of
California-Irvine

Massachusetts League of Community Health Centers

To improve **diabetes** control among their **African-American and Latino** patients, seven **urban and rural primary clinics** of the Massachusetts League of Community Health Centers, formally trained **existing staff who are culturally and linguistically congruous with the population** and re-incorporated them into their health care teams as CHWs. Project leaders in partnership with the Central Massachusetts Area Health Education Center adapted a nationally-recognized community health worker training program to include information on how to assist patients in their efforts to manage diabetes and improve glycemic control. Each community health worker received 45 hours of classroom and field-based training and was assigned to care for patients with diabetes at his or her community health center. In addition to the initial training, periodic in-service conference calls were held and three additional training workshops were offered. Patients met with the community health worker for 30 minutes before each scheduled appointment or spoke with them in advance by phone. The primary objective of each meeting was to help the patient develop and work toward a self-management goal. During each meeting an encounter form was completed to help guide the discussion and document topics addressed.

KEY IMPLEMENTATION CONSIDERATIONS

CHW programs often need plentiful initial and ongoing training and supervision opportunities that focus on how to work with challenging patients. Steps should be taken to discourage resource constrained health centers from diverting CHWs away from their primary duties to assist with other tasks. Supervisors also need specialized training in behavioral health and should focus on minimizing the documentation burden of CHWs.

- **Plan for ongoing training.** Originally, the project did not anticipate providing continuous ongoing training and had to scramble to find the resources necessary to adequately meet the needs of their CHWs.
- **Hire CHWs as full time employees.** Individuals whose duties were divided between work as a CHW and another position (e.g., medical assistant or medical interpreter) were often distracted and pulled away from the CHW aspects of their position.
- **Provide training for CHW supervisors** that includes the topics of boundary setting, potential for enmeshment between the CHW and patient, and burnout prevention for CHWs. Concurrent training along with the CHWs is also beneficial.
- **Provide ongoing training for the use of a patient encounter form** to guide patient interactions and document treatment.
- Provide a laptop or tablet to each CHW to access updated patient records and **make data entry and timing of sessions easier.**
- Fully integrate CHWs into care team by allocating adequate time to **educate team members about the importance of the CHW role. Actively involve the entire team in planning how to incorporate CHWs into the care team and patient encounter.**

University of Pennsylvania

African American patients with **hypertension** received disease management support from a health educator and peer coach while receiving care at a **university-affiliated primary care clinic**. This practice-based peer coach and health educator intervention addressed patient cardiovascular disease risk with five monthly contacts; three calls by a peer coach alternating with two clinic visits with a health educator. **Peer coaches were nominated by practicing physicians because of their well-controlled hypertension and cardiovascular disease and because they were meeting their goals for cardiovascular disease risk reduction. They were retired or not working, aged 50 or older and ideally had a history of volunteering in other settings.** The peer coach served as a role model who provided convenient phone support about the patient's self-reported barriers while the health educator offered face-to-face information tailored to the patient's blood pressure, lipids and other cardiovascular disease risk factors. The peer coach and health educator focused on medication adherence, exercise and diet by addressing attitudes, social norms and perceived behavioral control. The health educator and peer coach concurrently monitored patient progress as part of a team-based care model. Patients also received American Heart Association brochures and community resources about hypertension and diet developed for African American patients with low literacy. **Peer coaches volunteered their services and received a stipend up to \$1600 for working with 18-20 patients** over a period of approximately 6-months.

KEY IMPLEMENTATION CONSIDERATIONS

Anticipate the reality that new CHWs may not fully understand the nature of the position until after they have been hired. Consider the benefits of incorporating home- or clinic-based face-to-face visits into CHW programs.

- **Offer peer coaches a trial run** because several peer coaches dropped out after receiving training. Some did not appreciate how difficult and demanding it would be to reach people by telephone and talk about issues related to cardiovascular risk. Other approaches to reduce staff turnover include recruiting individuals with similar work experience (such as American Heart Association volunteers).
- **Consider going out into the community** because making a special trip to the doctor's office for an education session is asking a lot of patients and they sometimes see it as disruptive. And, those who have the hardest time making appointments are often the ones in most need of further chronic disease management education.

“It really gives patients a face-to-face connection. It gives them someone to talk to about their health. All the providers are really busy and they have about 15 minutes ...to see these patients with multiple problems. They have high cholesterol, they have high blood pressure. They have diabetes. They might smoke. They might be overweight. We can really give the patient a lot of information, but also give them a human connection. The patients really need that and enjoy that, because it can be really scary ...and no one has a lot of time to really sit down and talk to you about how you might feel about it and what you can do daily to improve your health.”

Kavita Pandit
University of Pennsylvania

University of Southern California

Latino community health workers who are **bilingual** and able to interact in a **culturally competent** manner with Latino patients in the surrounding communities screen patients for **depression** and other mental health challenges while they seek care in a Los Angeles **emergency department**. Those who screened positive for depression review depression-education materials with a community health worker and were scheduled to meet with a bilingual, bicultural social worker who provided services on-site. Using depression care guidelines, the social worker offered patients a choice of treatment consisting of eight weeks of problem-solving therapy, antidepressant medication, or both and made appropriate referrals. Patients also received information about mental health resources in their community and a letter for their primary care physician to inform them that they have screened positive for depression.

KEY IMPLEMENTATION CONSIDERATIONS

Supervisors also need specialized training in behavioral health and should focus on minimizing the documentation burden of CHWs. Work with the patient population to determine their needs and desires for a CHW program and the services it will provide (e.g., focus groups, surveys); particularly how to make it accessible and responsive to patient needs.

- **Establish therapeutic connections early** by having the patient and social worker meet briefly shortly after the screening is administered.
- **Make the intervention site accessible and welcoming** by securing transportation ahead of time (both to and from the site). Efforts should be made to include family members if the patient desires.
- **Maintain current and accurate patient contact information**, including two or three alternate contacts.
- **Follow-up with patients regularly** by reaching out to them outside of regular office hours and providing incentives for them to continue participating.
- **Provide adequate training for leaders and project managers.** Project leaders should be experienced and ensure adequate supervision for all staff including the community health workers. In addition, the project should include intensive, weekly supervision of social workers in psychotherapy and caseload management.

Lancaster General Health

Lancaster General Health based in Lancaster County, Pennsylvania trained and incorporated care managers into **established systems of perinatal depression care** with the goal of improving depression care for low-income, minority women. **Pregnant women with a high risk of depression** who received a diagnosis of a major depressive episode were provided with the services of a trained care manager. The goal of the project was to initiate evidence-based treatment of depression within one month of diagnosis of a major depressive episode. The care managers were selected for their **ability to provide culturally competent and linguistically appropriate support for patients**. They connected patients with the health care system and served as coaches, collaborators and negotiators on behalf of patients by **reinforcing care messages, supporting disease self-management, linking patients to community resources, and supporting health care navigation**. Two **Federally Qualified Health Centers (FQHCs)** and two **hospital-based outpatient practices** that provide care to Medicaid patients participated.

KEY IMPLEMENTATION CONSIDERATIONS

If the CHW program leverages existing human resources to expand clinical capacity, it is especially critical to gain buy-in from all of the staff involved. Teambuilding events, member recognition, training sessions, and regular feedback can strengthen the commitment to the program despite competing priorities.

- **Provide thorough and ongoing training and support around documentation protocols.** The project's original protocol required the CHEs to write down the patient's responses to questions during the home visits. However, the CHEs often had difficulty completing this task and many of the interview forms were returned blank, which left project leaders with little information about how the patient visits were going and what explanatory models of diabetes patients preferred.
- When possible, **align the CHW program with ongoing priorities** to assist with staff buy-in, streamline implementation, and improve the likelihood of sustainability.
- **Build leadership at multiple levels** to integrate the program with existing responsibilities of current staff members while avoiding conflicting priorities.
- **Engage staff members in team building processes away from the work environment** to foster solidarity and stimulate commitment to the CHW program.
- **Identify and celebrate team member efforts** to support the CHW program.
- **Host regular informational events** to increase team awareness of the CHW program and its progress. Such events are also an opportunity to receive ongoing feedback.
- **Provide initial and ongoing team training** to support the CHW program.

"Some of them [patients] would like to set goals. We'll say you know 'why don't we try doing 15 minutes of exercise on Monday and Wednesday, and let me know how that works.' Then we call...and say 'How did that work for you? Was it too much?' And maybe do something interactive...trying to involve the family and that helps a lot too. The more involved we are with them, the more they can say *"Ok, I have someone who's going to assist and not just leave me there."*

Makeba Wilson
Lancaster General Health

Appendix 2: Choosing, Adapting, and Tailoring a Community Health Worker Model Program: Summary of Lessons Learned and Best Practices

Introduction

While researching CHW programs and funding models that might work for your organization, it is important to actively engage patients, leadership, providers and other front-line staff in advance planning activities to determine what type of CHW model program will work best and how to adapt and tailor a CHW model program (or components of different programs) to your organization's unique circumstances. The following information includes recommendations for choosing, adapting and tailoring a CHW model program and a summary of key points outlined in the main body of this strategy overview.

QUESTIONS TO FACILITATE PROGRAM DESIGN

- What are the patients' beliefs about how a CHW can be helpful? What potential CHW attributes are most important from the perspective of the patient? How can your organization gather this information (e.g., patient surveys or focus groups)?
- How much education do staff and providers need about CHWs and how they can enhance patient care?
- What existing and upcoming quality improvement programs or goals can be enhanced or achieved by utilizing CHWs? For example, CHWs could become an integral part of meeting the accreditation requirements of various patient centered medical home models and care management programs.
- How will patients be introduced to the CHW program?
- When will CHWs see patients during the office visit (before and/or after the primary care provider)?
- Should CHWs have contact with patients between office visits (on the phone, in patients' homes)?
- Will the timing and length of patient appointments change to accommodate time spent with the CHW?
- Where will CHWs meet with patients (a private setting is best)?
- Will CHWs follow the same patients over time or will patients see whichever CHW happens to be available at the time of their appointment?
- What procedures will be followed if patients miss their meeting with a CHW?
- How will CHW contacts with patients be documented?
- Will patient encounter forms and billing protocols need to be altered?

“I initially was... providing protocol driven care for post-partum depression. We set up within a much-esteemed clinical location for mental health delivery...and we invited women who were at risk for depression to come for their evaluation and treatment. It turned out that none of them came. We adapted. We did a number of qualitative group and individual interviews to find out what worked, what didn't work. And so that's what led to this particular model.”

Ian Bennett
Lancaster General Health

- How will relevant patient-care information be shared with CHWs (e.g., labs, treatment decisions and protocols, patient self-management goals and successes or challenges meeting them)? How will CHWs share relevant patient-care information with other staff?
- How will the CHW program be evaluated? What data will be collected and analyzed to determine the program's success? Can quality data already being gathered be used to evaluate the success of the CHW program?
- How will patients provide feedback about their experiences with the CHW program?

RECRUIT AND HIRE THE RIGHT CHWs

- Work with human resources personnel to create an accurate and appropriate job description and posting
- The job description and posting should require the ability relate to, and maintain culturally competent interactions with, the priority patient population.
- Common skills and attributes in CHWs include:
 - Cultural congruence
 - Enthusiasm for the health and well-being of the priority patient population
 - Trustworthiness
 - Pleasant demeanor
 - The ability to learn from mistakes
 - The ability to deal with challenging or hesitant personalities
 - Strong communication skills, including the ability to keep up a conversation
 - Courteous, respectful, and sincere attitude
- Develop a recruitment plan that includes non-traditional recruitment venues such as local community-based organizations, social groups and churches that serve the priority population, neighborhood newsletters and newspapers, and social media used by the priority population.
- Remember that racial/ethnic congruence is not synonymous with cultural competence. A CHW candidate's cultural competence should not be assumed, but rather adequately assessed prior to offering a CHW position.
- If current staff are considering applying for a CHW position to avoid layoffs or work reductions, select individuals who are genuinely and innately supportive of the program mission, who are enthusiastic about participating in the program, and who do not view the program as extra work. This is particularly important if they will maintain part of duties of their current position while adding the new duties required of a CHW.

PROVIDE ADEQUATE TRAINING AND SUPPORT

- People with advanced behavioral health or social services education and experience are ideally equipped to supervise CHWs.

- CHW time and priority duties need to be protected to maximize program impact.
- Comprehensive initial and ongoing training, supervision and support are critical to the success of a CHW program and should never be devalued or minimized. Essential topics include:
 - Communication and interviewing skills
 - Disease specific knowledge, including etiology, assessment and diagnosis, treatment options and protocols, associated lab tests and values, medication adherence and co-morbidities
 - Basic counseling techniques
 - Behavior change theory and behavior change facilitation techniques
 - Establishing and maintaining interpersonal boundaries (e.g., working with aggressive patients)
 - Maintaining professional boundaries (e.g., providing health information while always deferring to the primary care provider as the primary partner and resource for making healthcare decisions with the patient).
 - Preventing and addressing burn out, including accepting rejection and patients who fail to improve
 - Assessing needs and making effective referrals (e.g., basic assessment for cognitive disabilities and mental health challenges that require referral)
 - Federal, state, municipal and organization regulations (e.g., confidentiality, HIPAA, mandated child abuse and neglect reporting)
 - Community resources
 - Documentation protocols
- Role-playing is an especially effective training tool for CHWs.
- Training opportunities should continue after the CHWs have started seeing patients and ongoing training topics should be based upon CHW self-reported needs and supervisor observations.

MAXIMIZING PROGRAM IMPACT

- Obtain leadership buy-in and support early and actively maintain it throughout the life of the program.
- Properly introduce the CHW position to providers and staff. Begin during the program design phase by educating providers and staff about the role CHWs can play and the benefits they can provide while simultaneously addressing questions and concerns and incorporating feedback into program design whenever possible.
- Give CHWs access to their patients' medical records, including labs (and the training to understand the information) to fully equip them to assist their patients with self-management goals and objectives.