CHW Symposium 5-24-16- CHW Service System Design

Notes from Joanne Calista's presentation on Design of CHW Service Systems in the morning plenary, with notes from afternoon facilitated discussion and report-back inserted

Foundation of CHW Service System Design:

- Over-arching principle: CHW self-determination – CHWs guide their practice
- Definitions – guide scope of work
    - Question: Adopt national standards/definitions or customize to specifics of CT?
    - CHW definition: APHA developed one, CT Association of CHWs tweaked it
    - CT DEFINITION:
      A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of, and ability to communicate with the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary among the community, health and social services to facilitate access to resources and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

      Definition and Scope Workgroup, CHW Task Force, February 2013.
      Modification of the APHA CHW Definition.

    - Key to definition:
        - part of the community, close ties to community, to facilitate trust,
        - not hired because of degree or license, but because of shared experience- this can be challenging to hiring organizations and sponsors
        - **Definition needs to be broad, NOT EXCLUSIVE to clinical setting**

- **Roles played by CHWS:**
    - Multitude of titles – more than 66 in Massachusetts
    - Workforce may not know that they are CHWs
    - **Scope of Practice:**
        - Mediation, health education, care coordination, coaching, social support, advocating, research (see slide),
        - Adopt a CHW focused, comprehensive scope of work that addresses the fundamental SDOH
    - **Scope of Practice from afternoon session:**
        - CHWs develop relationships of trust with community members, facilitating their ability to achieve what is listed below.
        - CHWs are problem solvers
        - CHWs build partnerships
        - CHWs provide continuity of care
        - CHWs bridge the gaps between people and community resources and between community members and their clinical providers
        - CHWs are team players and serve as part of the health care team

        - CHWs address social determinants of health that impact health and adherence to health care guidance.
        - CHWs facilitate improved chronic disease management
        - CHWs advocate on behalf of clients and instill advocacy skills
        - In one community-based model that was presented, CHW core skills include mental health competencies (PTSD population), chronic disease management, and medication management
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    - **Skills:**
        - Skills and roles can be confusing
        - Ex. "Systems Navigation" skills to support this are assessment, communication, advocacy
        - Communication, relationship-building, service coordination, capacity building, advocacy, education and facilitation, individual and community assessment, etc.
- **Service Design:**
    - Stay away from "Dualistic" Planning and Over Simplification---it is "both, and" on a spectrum, not an either/or.
    - Collaborating b/t community and clinical sectors is complex, but rich - helping others realize the value of both
    - Should CHWs be generalists or specialists?
        - Patients may be overwhelmed by having 10 specialized CHWs
        - However, there is a time and place for specialized CHWs
        - Can also be a career ladder, path, for CHWs
    - What should the "dose" be? What should be the intensity?
        - No one answer
    - Should CHWs be organizationally based? Contracted? Medical interpreters do work on a contracted bases—model can be more widely used
    - Support CHW network
    - Customized CHW Supervision—preparing organizations for successful integrating of CHWs
        - Kennedy CHC Toolkit
    - Evaluation---what is working? What is not? What do we need to tweak?
    - Workforce development necessary
    - Models, build on strengths that already exist in the community
- **Statewide Associations:**
    - Can help others to understand the role of CHWs
    - Provide organized voice for CHWs in the state (from Terry Mason's presentation)
    - Can address issues regarding development of CHW infrastructure:
        - In MA worked on issue of code of ethics
        - Most professions have one.
        - CHW have complicated considerations, and this complexity makes it even more critical for this workforce
        - Example from this Code of Ethics—confidentiality, professionalism, interpretation, etc.

- Employers still need to have employee guidelines

Notes from afternoon facilitated discussion

- **How can CHWs make even more of an impact?**
  - CHWs are particularly useful in low-income, communities of color, but can be used in any population given the complexities of health and health care.
  - CHWs are natural researchers and thus understand challenges and barriers in our community, which they can communicate to the rest of the healthcare team. The whole team should move toward identifying gaps, and CHWs can help by educating providers.

- **What do CHWs need to have even more of an impact?**
  - CHWs often become overloaded due to a lack of cohesiveness and lack of definition. CHWs need to be valued as part of a team, be actively engaged in communication processes, and their roles need to be clearly defined.
  - Provisions for ongoing development, training, customized supervision, feedback, support needs to be built in and protocols for communication
  - CHWs must be elevated to leaders to advocate for health reform and share their knowledge of what is really happening on the ground
  - CHWs must have sustainable funding through reimbursement by public and private payers

- **What is needed to make real policy changes for CHWs?**
  - An assessment that identifies the cost savings resulting from the use of CHWs. (It was suggested that this evidence has already been documented.)
  - Provider and consumer education on CHWs- what they do and how to access them

- **Challenges and suggestions:**
  - It's difficult to gather evidence on the return on investment for CHWs because funding streams for CHW programs end so quickly. It was suggested that evidence from Connecticut and elsewhere could be helpful here.
  - CHWs tend to be very individualized in the US, which makes them difficult to define
  - It may be helpful to categorize patients by disease to gather evidence. For example, a diabetes patient that avoids amputation because of CHW intervention demonstrates cost savings. We can show where the money is saved in this way.
  - In developing a model, it is important to maintain both the community and clinical components of CHW work, as insurance companies may push to only pay for the clinical piece.

- **Where do we start?**
  - In order for Medicaid to pay CHWs, there has to be a definition- what they do, what they don't do, what is a CHW, what isn't.
  - Then we can move toward real action to develop sustainable funding streams.

From report-back session – summarizing facilitated discussion

Design Summary—Grace

- “Community, community, community, SDOH, SDOH, SDOH”
- Emphases on SDOH, addressing SDOH in community, CHWs basing services in community
- System protocol for linkage to health care settings and communication structures, so that the community/clinic system is well working
- CHW can be the center of the team, can be a leader, needs to be acknowledged
- Integrally involved in design of service system
- CHWs trained as leaders
- Needs a sustainable salary
- Provider teams are woefully unaware of CHWs
- Strong sentiment of need for education
- Need data—already a lot of data, some data from CT, need more in CT to make case for sustained funding
- CHW health care transitions and gaps
- Medicaid leads private insurance
- CHWs are needed