

Standard 2: Health Equity Improvement Part 2

This Standard identifies key components of an effective Health Equity Improvement strategy. In order to achieve the Standard, your network must achieve the goals and demonstrate improvement on the process measures, as detailed below.

Goals:

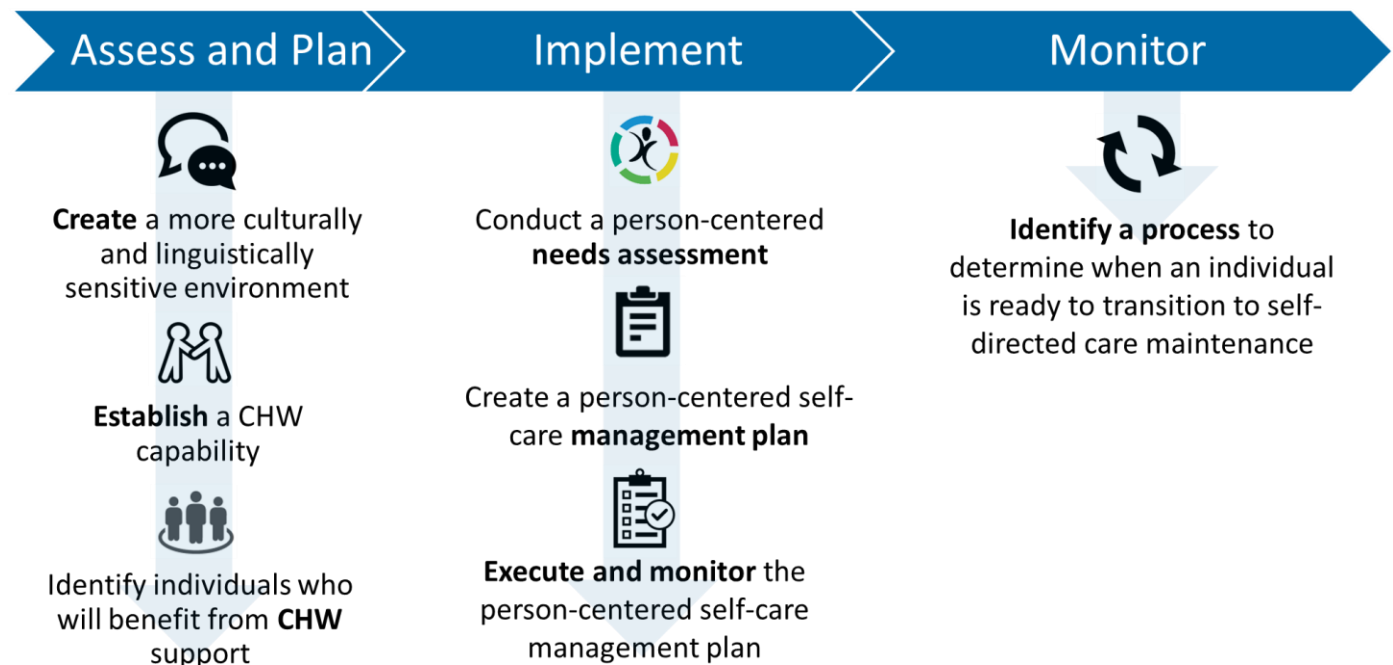
Your network has a **clear, documented policy and procedure** for identifying individuals who would benefit from a Community Health Worker capability, implementing that capability, and identifying when individuals are ready to transition to self-directed care.

5 of your practices have fully implemented the CHW capability

Process Measures:

Process measures will be unique to the subpopulation and disparity identified for your intervention

Key Elements of Health Equity Improvement





Create a more culturally and linguistically sensitive environment

1. Provide culturally and linguistically appropriate services informed by the root-cause analysis including:
 - i. Culturally informed and health literacy sensitive methods of patient engagement, treatment, support, and education
 - ii. Interpretation/bilingual services as necessary
 - iii. Printed educational materials



Establish a CHW capability

1. Incorporate Community Health Workers into target practices. Options include:
 - i. Employ the CHWs within the practice
 - ii. Employ the CHWs at one or more hubs in support of multiple practices
 - iii. Contract with community organizations for CHW services
2. Determine how CHWs will be made available to individuals identified for the intervention
3. Establish appropriate supervision and case load for CHWs
4. Establish training for all care team members involved in the CHW intervention annually to:
 - i. Identify values, principles, and goals of the CHW intervention
 - ii. Redesign the primary care workflow
 - iii. Orient the primary care team to the roles and responsibilities of the CHW
5. Ensure CHWs receive core competency and disease-specific training based on the intervention



Identify individuals who will benefit from CHW support

1. Establish criteria to determine who receives CHW support by assessing whether an individual:
 - i. Is part of the focus sub-population for the intervention
 - ii. Has a lack of health status improvement for the targeted clinical outcome
 - iii. Has cultural, health literacy and/or language barriers
 - iv. Has social determinant or other risk factors associated with poor outcomes
2. Electronically alert the medical home team when individuals meet the criteria for a CHW intervention



Conduct a person-centered needs assessment

1. Conduct a person-centered needs assessment with individuals identified for the intervention that includes:
 - i. Family/social/cultural characteristics
 - ii. Behaviors affecting health
 - iii. Assessment of health literacy
 - iv. Social determinant risks
 - v. Personal preferences and values
2. Establish a policy- **when, where, how, and by whom** the assessment is completed



Create a person-centered self-care management plan

1. The CHW, the individual, and their natural supports collaborate to develop a self-care management plan. The care plan should:
 - i. Incorporate the individual's values, preferences and lifestyle goals
 - ii. Establish health behavior goals reflective of the individual's stage of change
 - iii. Establish social health goals reflective of identified needs/barriers

- iv. Identify actions steps for each goal and establish a due date
2. Establish a policy- **when, where, how, and by whom** the plan is developed



Execute and monitor the self-care management plan

1. Hold regular care team meetings and establish key touchpoints with individuals to monitor progress on self-care management plans
2. Establish a Policy:
 - a. **Who** attends meetings and **Who** is involved in key touchpoints
 - b. **When** and **Where** meetings and key touchpoints are held
 - c. **How** individual's progress and risks are tracked and reported in a standardized way
 - d. **How** health information is exchanged across settings to accommodate CHW support
 - e. **How** individuals are connected to needed community services (i.e. social support services)



Determine when an individual is ready to transition to self-directed maintenance

1. Develop criteria to evaluate when the individual has acquired the necessary education and self-care management skills to transition to self-directed maintenance that includes:
 - a. Collaborating with the individual to assess their readiness to independently self-manage their care
 - b. Assessing improvement on the relevant clinical outcomes
 - c. Assessing achievement of individual identified care goals