Webinar Q&A: Using Community Health Workers and Volunteers to Reach Complex Needs Populations

Event Date: April 18, 2017

Responses to General Questions

1. ***How do organizations typically pay for community health workers (CHWs) (e.g., Medicaid, health homes, accountable care organizations, grant funding)?***

   There are many ways to pay for CHWs. More information can be found on the National Academy for State Health Policy's index of State Community Health Worker Models, which provides an overview of different financing, education, certification, legislation, and scope of practice regulation. FAMILIES USA's brief "How States Can Fund Community Health Workers to Improve People's Health, Decrease Costs, and Reduce Disparities" discusses the different ways CHWs can be funded through Medicaid.

2. ***Are there models for how CHWs are trained, and which states require certification for CHWs?***

   There are many models for training CHWs. For more information, please see the CHCS brief "Integrating Community Health Workers into Complex Care Teams: Key Considerations," as well as the CHCS blog post "Integrating Community Health Workers into Care Teams: Lessons from the Field." In addition, the National Academy for State Health Policy's index of State Community Health Worker Models provides an overview of different educational materials and certification strategies used by states. The Rural Health Information Hub provides comprehensive information on state certification programs.

Responses from Community Health Partnership of Baltimore and Sisters Together and Reaching, Inc.

1. ***Are there any parts of your training, policies and procedures (e.g., mental health, health literacy, staff safety) that you would be willing to share?***

   Please see STAR's *Training for Community Health Workers*.

2. ***Are there any assessments that you administer that you would be willing to share? What social determinants of health (SDOH) screening are you are using, and is this something you can make available online, or is it homegrown?***

   Please see STAR's *Client Assessment Tool*.

3. ***Have you experienced any barriers in hiring male CHWs? If so, what were they and how have you addressed these barriers?***

   To date we have not experienced any problems in hiring male CHWs. We currently employ four male CHWs, with a potential two under consideration to be hired.

4. ***What policies do you have regarding transportation of clients, and can you share examples of using companies such as Uber, Lyft, etc.?***

   Currently, we do not allow CHWs to transport patients due to insurance liabilities and coverage costs. We do offer transportation assistance through the hospital if services are available. We also assist the patient in setting up transportation.

5. ***How did you convince providers/leadership of the need for CHWs, and gain buy-in for using them?***

   Providers are eager to have CHWs because they appreciate the ability of CHWs to address patients' SDOH, conduct assessments, and make home visits. Leadership has been accepting of CHWs because they are less expensive than case managers, which is viewed as an opportunity to potentially reduce costs without compromising health care delivery.

6. **D*o your CHWs have benefits? What is the average wage?***

   We offer the following benefits to our CHWs: health insurance, vacation, and paid sick leave. The average wage is between $35,000 and $55,000, based on experience.

7. ***What is the caseload for a typical CHW, and how many CHWs does a CHW supervisor typically manage?***

   CHWs have a caseload of 50-60 patients, with the exact mix determined by factors such as geography and case acuity. CHWs receive both clinical supervision from an RN, and operational support from a supervisor with previous experience as a CHW. These individuals typically supervise 10 CHWs.

   For additional insight on CHW caseloads and case mix, please see the CHCS brief "Integrating Community Health Workers into Complex Care Teams: Key Considerations."

8. ***How do CHWs track their interactions with patients, and is there a specific software you use?***

   The CHWs track their interactions on an iPad and also document patient information manually in individual charts. STAR is in process of building its health information system. The neighborhood navigators document their interactions with patients through Research Electronic Data Capture (REDCap) software. While case managers and behavioral health specialists document their interactions in the Johns Hopkins Electronic Health Record system, CHWs do not have access to this system at present, and document in a Salesforce cloud-based system called JCARE.

9. ***Can you describe the difference between a CHW and a neighborhood navigator, and whether or not there is any overlap with these two positions and other health service professionals (e.g., social workers, RN)? If so, how do you handle this?***

   CHWs are frontline public health workers who are trained and employed by STAR. They are typically trusted members of the community who serve as liaisons between the health and social services sectors, identifying community resources and residents. CHWs: (1) conduct home and clinic visits on patients assigned by the hospitals; (2) facilitate personalized interventions to reduce ED visits and readmissions by utilizing patient engagement techniques; and (3) mobilize patients to join bi-monthly lunch and learn community education sessions. The CHWs conduct informal counseling, offer caregiver support groups and advocate on behalf of those they serve.

   Neighborhood navigators are volunteers who are trained and overseen by the Men and Families Center. Navigators: (1) provide general neighborhood education and outreach; (2) conduct informal monitoring of unmet health and social service needs of the neighborhood; (3) conduct home visits to provide social support and promote patient engagement; and (4) mobilize neighborhood residents through participation

and presentation in neighborhood association meetings. The role of a neighborhood navigator is a hybrid of certain aspects of a CHW's role, but their scope of work is different than a CHW.

To ensure that there is no overlap between these two positions, we have been working to create integrated workflows. Currently, CHWs make the first point of contact during which they assess a patient's needs and administer our SDOH screen. The CHW develops the care plan onsite with the patient, and works with the patient's care team, which includes a neighborhood navigator if the patient consents to services and lives in the geographic catchment area they serve.

10. ***Who is eligible for the Community Health Partnership of Baltimore program, and what strategies have you found to be most useful in engaging patients?***

Individuals are eligible for the program if they:

- Have been hospitalized and subsequently discharged from Johns Hopkins Hospital or Johns Hopkins Bayview Medical Center Baltimore City; and/or
- Are Medicaid or Medicare beneficiaries with multiple comorbidities receiving primary care in 19 designated zip codes in Baltimore City.

Please see STAR's *Patient Engagement Training* for strategies on engaging patients.

Contact Information for Presenters

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Responses from Mountain-Pacific Quality Health and ASSIST

1. ***What sort of training do you provide for your volunteers?***

ASSIST: We train our volunteers using a 200-page manual we created that includes a comprehensive directory of local resources. We hold monthly lunches where community experts present information about their area of expertise (Medicaid, Medicare, Veteran's services, hospice, etc.). This allows staff and volunteers to stay up-to-date on all resources. Because each situation is unique, a lot of our training happens on-the-job as volunteers shadow a staff person and visit patients together in the field.

2. ***What strategies do you use to address any health literacy challenges with patients?***

ASSIST: The ReSource nurse and hospital education department have created educational materials. When appropriate (as directed by the medical staff) the volunteer/CHW may help explain the educational material in layman's terms to the patient.

3. How do you protect the safety of volunteers or CHWs that go into patient's homes?

ASSIST: We always have one staff and one volunteer/CHW go to the first visit together. Because our patients are referred to us by a medical person who knows their history, if there are any mental health/domestic violence/behavioral issues or concerns, we always meet in a public place. After the initial visit, if the situation is deemed safe, the volunteer/CHW will go back by themselves when needed. They will also use that opportunity to contact the ReSource nurse, if needed, using iPads. At any meetings with patients, if there are any safety concerns or discomfort, the team has been trained to leave immediately.

4. *What are the protocols (e.g., background checks, buddy system, etc.) for emergencies and liability issues with volunteers and CHWs in the community?*

All volunteers/CHWs undergo background checks through the hospital HR department. Due to our rural nature, we call 9-1-1 if there are health or safety issues. The dispatch center determines whether to send a ground ambulance or an air ambulance helicopter to the location, depending on how remote it is.

5. What is the average caseload for a typical volunteer or CHW, and what factors influence the caseload size?

Caseloads vary by the skill set of the volunteer and their availability. Many of our volunteers dedicate four hours per week to visiting new patients, but then dedicate extra hours at home researching answers and solutions for the people they are serving.

6. How do volunteers or CHWs track their interactions with patients, and is there a specific software you use?

Mountain Pacific: Through our shared care platform, CrossTx, the ReSource nurse is able to lead the communication for the care team and track interactions with patients. CrossTx also allows us to communicate with other organizations outside of the health system (e.g., Medicaid, Meals on Wheels, ASSIST).

ASSIST: We also have a database where staff and volunteers enter their time, mileage and interventions so that we have accurate records of what has been done and the in-kind donations of time and mileage. This database is hosted on a secure web server through the hospital.

7. What assessment tool do you administer to capture the social determinants of health? Would you be willing to share this publically?

Mountain Pacific: One of our sites is looking to use the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool to capture social determinants of health.

8. How many volunteers participate in the ASSIST program?

We have 15-20 volunteers on average. Some dedicate one ½ day per week to visiting patients or working in the office. Others are "on call" and go out when we have someone new they need to see, or someone they need to follow-up with. We have a few volunteers who are "community project" people. They want to help with hands-on projects like helping an elderly person move or picking up furniture from the thrift store. One volunteer is homebound herself, but she is a licensed counselor and just calls some of our seniors to check in with them each week.

9. How do you identify, outreach and engage with patients?

ASSIST: We accept only medically initiated referrals, and they come primarily from the hospital and affiliated clinics when a clinician sees a person who could use extra help. Case managers or social workers send us a referral through a secure intranet with the demographic information and the concerns they have for the patient. We call and try to schedule a visit within 48 hours of the referral, if possible. Patients are generally more willing to let us visit them in their home if they know they've been referred to us by someone they know and trust. When we visit them in their homes we have an intake form that gathers information on their demographics, social support system, self-reported medical condition and financial information. The volunteer and staff person use this well-rounded picture of the patient, along with the information they discern from visiting the home, and develop a plan of action with the patient on connections they may need to community resources.

Mountain Pacific: We use the following criteria: 1) Two or more in-patient visits, and/or multiple ED visits in a six-month period; 2) the patient would benefit from additional primary care coordination; and 3) they are not end-of-life. We look for appropriate patients in the electronic medical record or look retrospectively through claims data. The patient is engaged either in the ED or in the hospital prior to discharge.

10. How does ASSIST help patients with things like housing, transportation, lack of a phone, etc.? If so, what is your process for making referrals and connections to social service agencies?

In the Flathead Valley we are very fortunate that we have a Care Transitions Coalition that is made up of about 50 representatives from different organizations in the community. Through monthly meetings, we have come to understand what each organization does, and have contact people who can help us in a timely manner. We consider ourselves to be connectors. My volunteers are problem solvers, and we do a lot of research and gathering of information on community resources in order to meet common needs: Medicaid, Veteran Benefits, Food and Housing, etc.

Our volunteers are trained to connect care receivers to a list of resources that we provide on our website.

11. Do you require your volunteers to have a means of transportation to see patients? If so, what are the policies?

Yes. Our volunteers all have their own vehicles. Staff has leased vehicles and the volunteers ride with staff for the first visits. Volunteers may go back with their own vehicles on a variety of visits. They have to show proof of car insurance.

Contact Information for Presenters

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