

## Community Health Worker Definition

As **defined** by the **Community Health Worker** Section of the American Public **Health** Association: “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 the **community** served.

## Themes to Consider in our work today:

- CHW workforce development
- CHW scope of work
- CHW supervision
- Integration of CHW's
- Financial Support for CHW programs
- Evaluation and Outcomes of CHW programs

## Guided questions for consideration:

- How would you explain the benefit of Community Health Workers?
- How are you using the Community Health Worker Workforce in your organization/ CCO/ community?
- Who are those getting trained as Community Health Workers in your community?
- What are barriers to integrating Community Health Workers into systems (healthcare, schools, dental, etc.)?
- How is Community Health Work being paid for?
- How are Community Health Workers effective?
- What promising practices employing Community Health Workers are you aware of?
- What does CHWS supervision look like?
- What do evaluation outcomes look like?



# Agenda

- ORCHWA's Mission
- A (very) Brief Overview of the CHW Movement in Oregon
- CHW and Role Definition
- CHW Models Across Oregon
- Looking Forward

# ORCHWA

- **Our Mission:**

A unified voice to empower and advocate for community health workers and our communities.

- **Our Vision:**

Community health workers are recognized as members of a profession, working together for community health, social justice and equity.



# A word about Traditional Health Workers in Oregon

- Traditional Health Workers is the umbrella name for 5 distinct worker types:
  - Doulas
  - Peer Support Specialists
  - Peer Wellness Specialists
  - Personal Health Navigators
  - Community Health Workers

# Setting the stage for Oregon's CHW workforce

- Oregon's strong history of CHWs programs
  - Federally Qualified Health Centers
    - La Clinica del Cariño, Hood River
    - Virginia Garcia Health Memorial Clinic, Hillsboro
  - Parish based promotores
    - Providence Health and Services
  - Community-Based Organizations
    - El Program Hispano Católico
    - NAYA



# Components of the formalization of the CHW workforce in Oregon

- Patient Protection and Affordable Care Act of 2010, provided a unique opportunity and call for the health care system to utilize CHWs
- Oregon Community Health Worker Association (ORCHWA) established in 2011
- In 2013 the creation of the HB 3407 to create the Traditional Health Worker Commission –*Nothing About Us with Out Us*
- On going training programs based on Popular Education
- Creation of certification program based on core competencies & approval process for training programs
- On going financial investments from health systems for infrastructure building and on-going education and alignment

# HB 3407 – Traditional Health Worker Commission

- Effective January 1, 2014
- Formalized the THW Steering Committee into a formal Commission in statute
- Designates seats for a majority (10/19) of THWs to ensure that THWs are able to create and inform policy regarding their own profession
- Functions under the Oregon Health Authority Office of Equity and Inclusion with at least one dedicated staff
  - Tool kit available online:  
<https://www.oregon.gov/oha/OEI/Pages/THW-Resources.aspx>

# What do we know about CHWs?

- A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.

- American Public Health Association, 2016

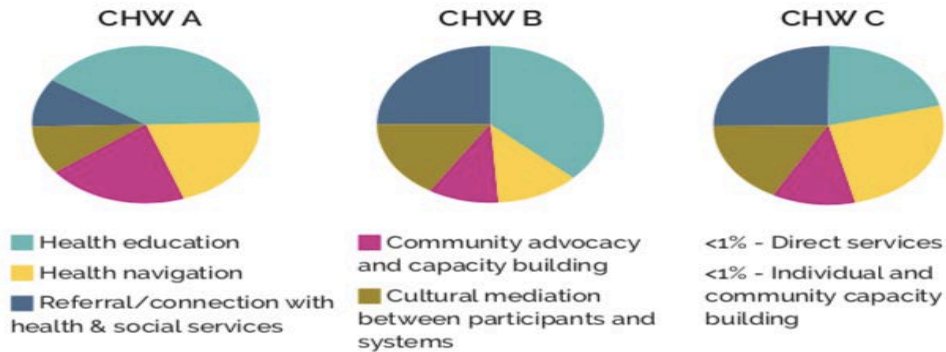
# Roles of CHWs

<b>Cultural Mediation among Individuals, Communities, and Health and Social Service Systems</b>	<b>Providing Culturally Appropriate Health Education and Information</b>	<b>Care Coordination, Case Management, and System Navigation</b>	<b>Providing Coaching and Social Support</b>	<b>Advocating for Individuals and Communities</b>
Building Individual and Community Capacity	Providing Direct Service	Implementing Individual and Community Assessments	Conducting Outreach	Participating in Evaluation and Research

Community Health Worker Core Consensus (C3) Project

# Examples of CHW scope of work

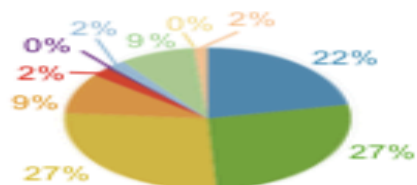
➔ **CHWs played a full range of roles and CHWs' services are specific to their respective communities and responsive to community needs.** Three CHWs' services were analyzed to compare their roles. The table reflects percentages of frequency of each CHWs playing the top 5 of the 7 CHW roles.



## CHW SERVICES SPECIFIC TO THEIR RESPECTIVE COMMUNITY NEEDS

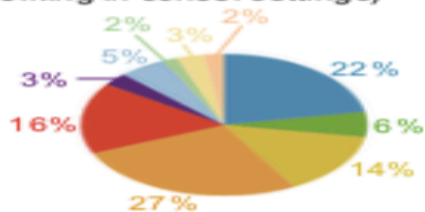
### CHW A

(working mainly with seniors)



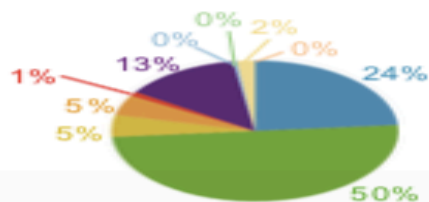
### CHW B

(working in school settings)

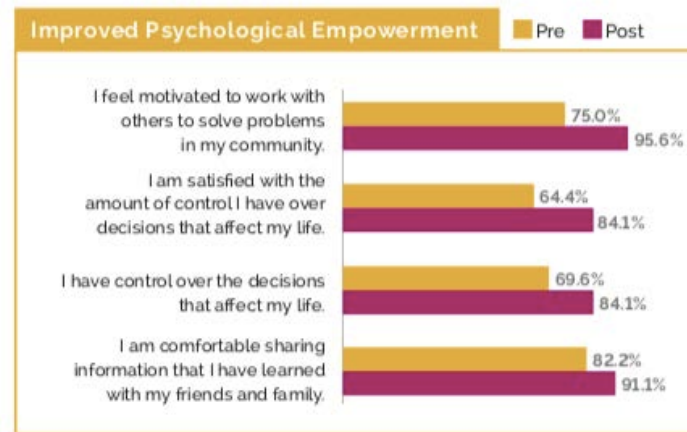
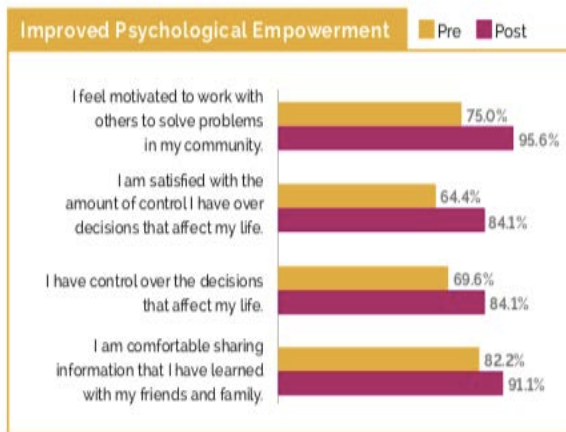


### CHW C

(providing Living Well & Diabetes Prevention classes)



# Outcomes and appropriate measures



# Some CHW models

- Clinic-based
  - Part of care teams. Provides health navigation, connects patients to social services, outreach and enrollment
  - Paid by some Medicaid codes, alternative payment mechanisms, operations funds & grants.
- Community-based
  - Employed by community based- organizations. Provide outreach and enrollment, health and social services navigation, individual case management, and group support.
  - Paid by grants, some state and government contracts
- School-based
  - Part of the school team. Employed by school or partnering community-based organization. Community engagement, connecting families to services. Paid by grants.
- Cross sector/Co-location
  - Community-based CHW contracted by health care systems, public health, CCOs, etc. ORCHWA is leading collaborative programs in chronic disease, child and maternal health and early learning, where ORCHWA serves as a single point for contracting.



# What are we working on

- Need for THW sustainable payment mechanisms
  - Policy changes: State investment, THW metric?
- Increasing and on going CHW supervisor trainings to best support and promote workforce
- Evaluation and outcomes that measure the long term impact of CHWs
- Ongoing standardization of workflows and processes for community-based CHW program's integration into health care delivery
- Ongoing education of the importance investing in community based CHW programs to address SDoH and prevention.
- Scaling up pilot programs and aligning when appropriate CHW initiatives, including , evaluation and data collection practices, sup

# ORCHWA HSO Partnership

## Health Share Investment Overview

**Health Share Board of Directors approved an investment to ORCHWA in the amount of \$3.3 million, over the course of two years.**

These funds were approved to create and sustain an infrastructure that supports connection to culturally specific and community-based CHWs.

This investment enables ORCHWA to identify and customize a health information tracking system to capture the efforts and outcomes of CHWs; identify sustainable payment mechanisms for CHWs; create a path for health systems to reliably contract for community-based CHW services; provide technical assistance to systems and organization employing CHWs to support utilization of community-based CHWs; and, to enhance professionalization and workforce development efforts for CHWs.

## Four Components of this Investment



**1. Community Health Worker Integration**



**2. Workforce Development**



**3. Technical Assistance**



**4. ORCHWA Internal Capacity-Building**



THANK YOU!





# Making CHWs part of your community health strategy

Supporting Community Health Worker Training & Certification

*Bridging the Future of  
Healthcare*

# Training at the local community college

## Southwestern Oregon Community College (SWOCC)

- History
- Trainings to Date
  - Spring 2017
  - Spring 2018

# Local Community Agency Participation

- Physical Health
- Oral Health
- Specialty Clinics (Orthopedic)
- Federally Qualified Health Center
- Public Health
- Mental Health
- Behavioral Health
- Community Advisory Council (CAC) Members
- Peer Advisory Council
- Social Service Agencies (People experiencing homelessness)
- Employment Agencies
- Coordinated Care Organization
- Department of Health Human Services (DHS)
- Community Action
  - Essential Services (Food, Lights, Heating, Housing)
  - CASA (Court Appointed Special Advocates)
  - Head Start

# What Worked

- Filled both classes
  - Spring 2017: n= 19
    - Oregon State University (OSU)
    - SWOCC
  - Spring 2018: n=13
    - SWOCC
- Advanced Health Scholarships
  - 100% Spring 2017
    - \$1,200
  - 77% to 100% 2018
    - \$500 - \$650
      - CAC: n=3



# Impact on CHWs:



# Lessons Learned

- Spring 2018:
  - Two weeks notice to sign up for class
  - Clear understanding of “What is a CHW?” (Lennae Wright: student/teacher)
    - 50% not clear
    - Pre-session: come and learn the role
  - Clear understanding of how to apply knowledge
- Continuing Education Units (CEU)
  - 20 hours of OHA approved CEU every three years
  - Submit an application to OHA (90 days)

# Next Steps

- Frequency of trainings
- Annual budgeting for scholarships
- Develop a curriculum for Peer Support Specialists

Thank you!



# Bridges to Health Pathways Program

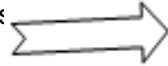
Original grant funding provided by:

PacificSource Community Health Excellence Grant, PacificSource Foundation, Columbia Gorge CCO-(Columbia Gorge Health Council and PacificSource Community Solutions), Meyer Memorial Trust, Oregon Community Foundation, Providence Clinical Transformation Council, Providence Hood River Memorial Hospital

Suzanne Cross MPH, CHW – Columbia Gorge Health Council Senior Program Manager  
suzanne@gorgehealthcouncil.org



Sam is a Community Health Worker who works for Head Start and is doing a home visit on a child suspected of having developmental delays



While Sam is there he learns that the child lives in a 2 bedroom apartment with his mother and grandmother. Also living in the home is the child's aunt and her 3 children. She is a survivor of domestic violence.



Sam has concerns for the Aunt's health and for the older children. But his job description and the funding for his position only support his work with the youngest child in the household.





### Clients

Agree to participate  
Agree to data sharing with Hub



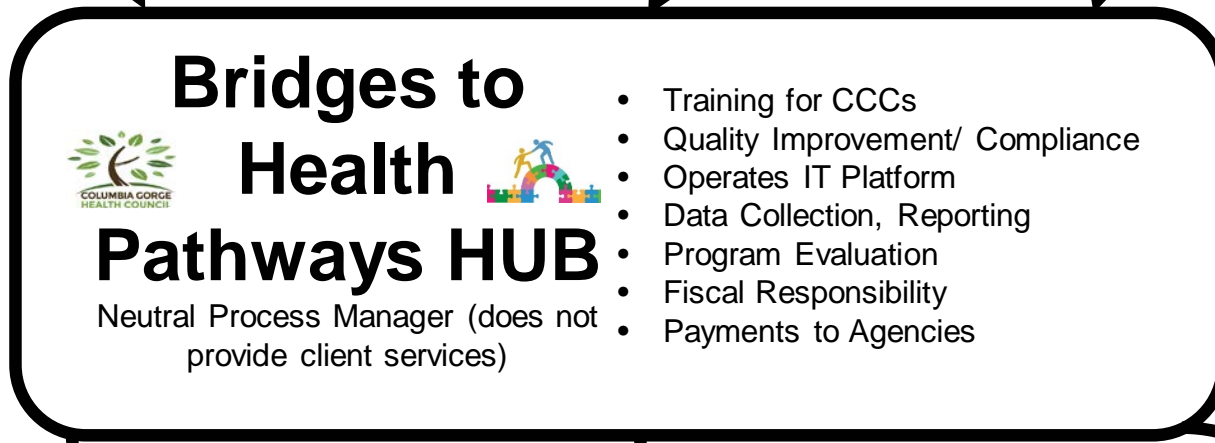
### Community Care Coordinators (CCC/ CHW's)

Employed by own Agency  
Trained as CHW's or equivalent  
Find eligible clients  
Track work



### Funders

Contribute money  
Articulate goals



### Empower Community Members Most in Need to Improve Overall Health and Wellbeing

- Address the needs of the household
- Engage clients where they are

### Increase Collaboration of Services in and out of Healthcare

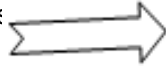
- Standardized Outcomes Based Process
- Data Driven Community Decision Making
- Address System Service Gaps

### Improve Access to services/ resources by addressing disparities

- Build on Community Strengths
- Limit Duplication of Services
- Identification of Roadblocks



Sam is a Community Health Worker who works for Head Start and is doing a home visit on a child suspected of having developmental delays.



While Sam is there he learns that the child lives in a 2 bedroom apartment with his mother and grandmother. Also living in the home is the child's aunt and her 3 children. She is a survivor of domestic violence.



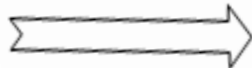
Sam checks CLARA and learns that no one in the household has yet been entered into the system.



Sam has concerns for the Aunt's health and for the children. He asks the Aunt if she would be interested in participating in Pathways. She is.



Sam does a Bridges to Health Pathways assessment with the Aunt and learns that she has stopped going to her counseling appointments due to lack of transportation. He also finds out that she no longer has her health insurance because of lost paperwork.



Sam and the Aunt agree to work on the Pathways that opened based on her needs:

- Social Service Referral (transportation)
- Health Insurance
- Housing
- Behavioral Health



- Sam assists the Aunt in completing and turning in her health insurance paperwork and follows up to make sure she is enrolled.
- He teaches her how to use the transportation support available to her and insures that she has gotten back to her counseling appointments and confirms that 3 appointments were attended.
- They begin the process of completing the Housing Voucher application and submit it to the Housing Authority.
- Sam will continue to follow up with the Aunt and the Housing Authority in hopes of the family finding a home.





## Bridges to Health Pathways Program



### Core Pathways (Needs)

- Behavioral Health
- Developmental Screening
- Developmental Referral
- Education
- Family Planning
- Food
- Immunization
- Pregnancy
- Postpartum
- Employment
- Health Insurance
- Housing
- Medical Home
- Medical Referral
- Medication
- Tobacco Cessation
- Social Service Referral (transportation, debt management, utility assistance, legal, documentation, etc.)



## Evaluating our goals:



## Community members most in need to improve their overall

- **Process**
  - Expand # of CCC's
  - CCC's maintain caseloads
  - Collect and share data re: clients needs
- **Outcome (client based)**
  - Improve health
  - Improve self-efficacy
  - Improve quality of life
  - Improve social support
  - Improve connection to resources/ services
  - Decrease stress
- **Outcome (CCC based)**
  - CCCs feel supported
  - CCC's feel job satisfaction

## Services and resources by addressing

- **Process**
  - Data is shared with agencies about Pathways  
CLOSED INCOMPLETE
  - Identify gaps in systems/ services with data
  - Measure cost prevention
- **Outcome**
  - Decrease % of Pathways  
CLOSED INCOMPLETE
  - Costs of high care services decrease
  - Costs of prevented services increase

## collaboration of services in and out of

- **Process**
  - Sign contracts with key agencies (healthcare and social service)
  - CLARA integration with Reliance
  - CLARA integration with EMR's
- **Outcome**
  - Agency employees feel improved collaboration
  - Workforce (healthcare, CCC's and social service) feel improved satisfaction in patient care
  - "No wrong door" is common place



## CHALLENGES

## OUR SOLUTIONS

**HIPAA regulation and interpretation-** cross sector collaboration involves HIPAA covered entities and non-covered entities

Data sharing agreements, providing HIPAA training and certification for those outside healthcare

**True COMMUNITY care coordination takes time –** building relationships, trust

Reminder: we are DOING WORK DIFFERENTLY, INNOVATION is exciting and scary, share data on outcomes to encourage collaboration

**Software Challenges-**  
Double data entry, discomfort with technology, time consuming

Incorporate time for data entry into the work and pay for it

**Healthcare is typically provided in an office-** Care Coordinators are in the “office” <math>\frac{1}{2}</math> the time, out in the community

Provide lots of opportunity for good communication- team meetings, status reports, trainings

**Proving program success takes time-**  
Value qualitative data, start with process outcomes, measure success amongst all partners, plan for a three year runway

Leap of faith by PacificSource Community Solutions using health plan spending to commit to well being



# Bridges to Health Pathways:



## SUCSESSES

Clients are met where they are most physically comfortable and empowered to prioritize needs most important to them

Community Health Work aids in recognizing and eliminating disparities in care

Shared data systems allow for data driven decision making approach to recognizing and addressing systemic inequities and barriers to care

Cross sector partnerships break down silos, build relationships, avoid duplication of services- better client experience

Provides healthcare with a lens outside the walls of the system

Health plan funding is possible



## Client Outcomes after 4 months in the program

- ❖ Feel better connected to services: 84%
- ❖ Feel in good health: 52%
- ❖ Feel in fair health: 48%
- ❖ Health has gotten better: 32%
- ❖ Health has stayed the same: 42%
- ❖ Health has gotten worse: 26%
- ❖ Quality of life has improved: 74%
- ❖ Feel more confident in managing health and health needs: 50%



## Client Comments on program:



"I feel more stable, some attention can be directed at me"

"I feel supported and have some financial relief"

"Not worried about insurance right now and also have help with financial assistance"

"My care coordinator has helped me understand about my disease"

"Feel supported, someone is keeping an eye out for me"

"Have insurance and medical care"

"Advocacy, having other support"

"Advocacy, help with resources"

"I was able to get help with my diabetes- an elliptical, measuring cups, and little books. Logs, that she made for me. I wouldn't be able to do this or pay for these on my own"

"I appreciate the help and support with all the paperwork and phone calls- it's daunting for me to try to deal with these things"

"Advocacy help with gas, kept employed and help looking for housing"

"Help with Resources, Services, keeps me more active"

"I know who to call to point me in the right direction"



## Stories:

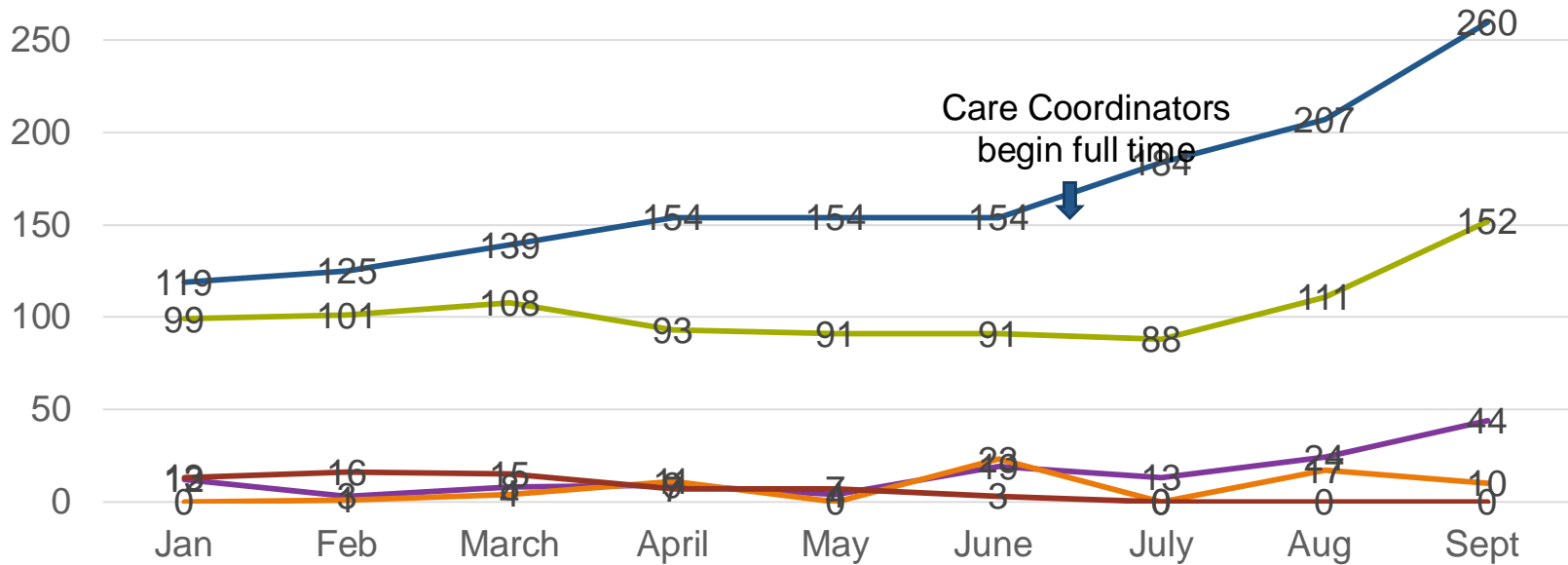


- Client with low literacy struggling to understand her diabetes diagnosis and all that comes with it A1C, diet, glucose checks, etc. The Community Care Coordinator (CCC) working with the client was able to devote the time need to help the client have a better understanding of her disease. The CCC provided 1:1 home visits to go over all provider and nutritionists orders and dietary recommendations using pictures and hands-on examples. This included taking instructions from provider and dietician and converting them to an all picture, laminated document for the client to be able to follow instructions and track outcomes using a dry erase marker. As a result, client has maintained control of her diabetes and was able to travel outside the US safely for the first in a long time.
- Single mother of ill young baby seen in the Emergency Department (ED) multiple times for illness. ED recognized the living conditions were not adequate for the infant and likely contributing to illness as they were living without heat, electricity and running water. Social worker was unsuccessful in tracking down family and called in CCC. CCC had built relationships with the community and was able to gain access to location of mother through a trusted member. Because the CCC had become a trusted person she was able to work with mother. In the short term mother obtained WIC, a heat and electrical source, warm clothing and blankets, dependable transportation and a relationship with a primary care provider for a well child check and for herself. Long term, she was able to get into her own apartment, apply for a job and get herself regular health and dental care. Baby is thriving.



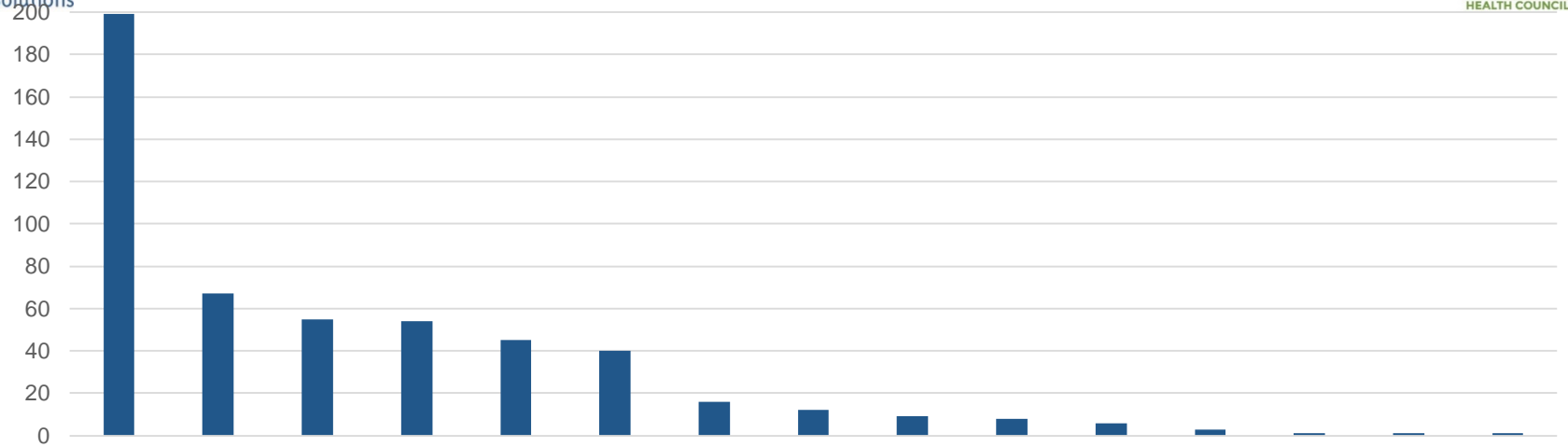


## Bridges to Health Program Enrollments through September 2018



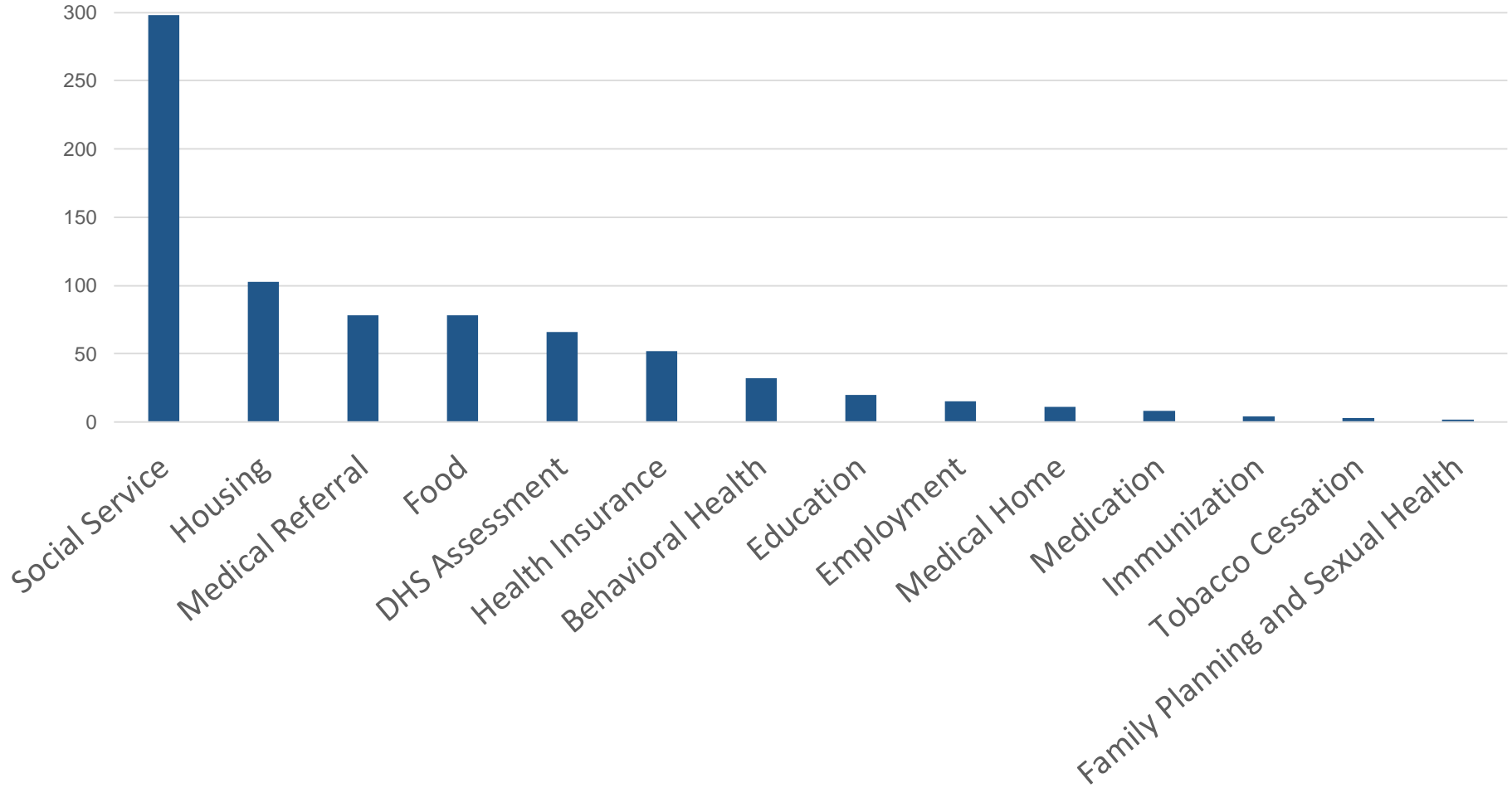
— Total Enrollments YTD (including disenrollments)  
— Current Enrollments

# Identified Needs

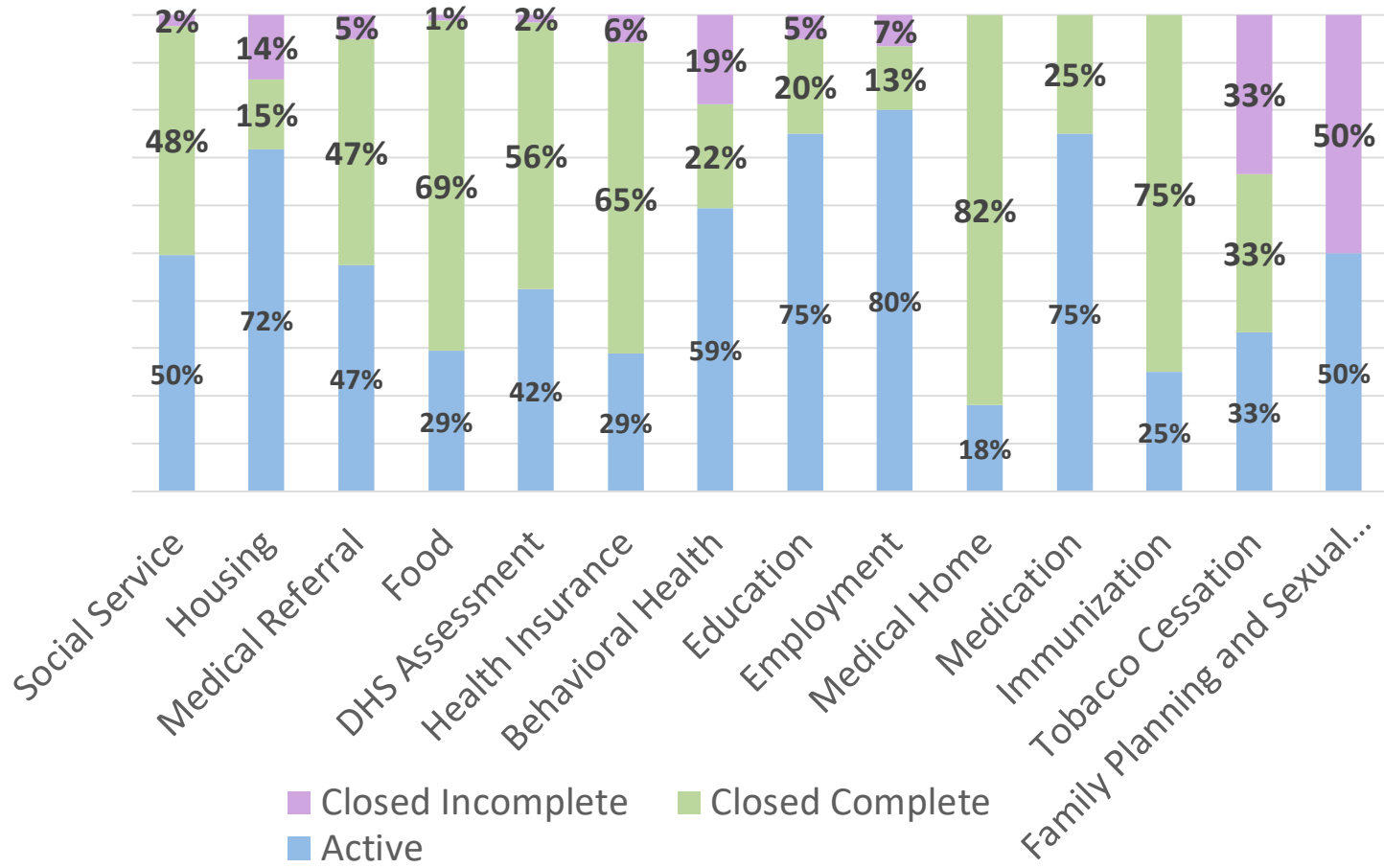


Social Service Referral  
Stable Housing  
DHS Assessment  
Medical Referral  
Food  
Health Insurance  
Behavioral Health  
Education  
Employment  
Medication Management  
Medical Home  
Tobacco Cessation  
Family Planning-Sexual Health  
Immunization  
Family Planning- Pre Contraception

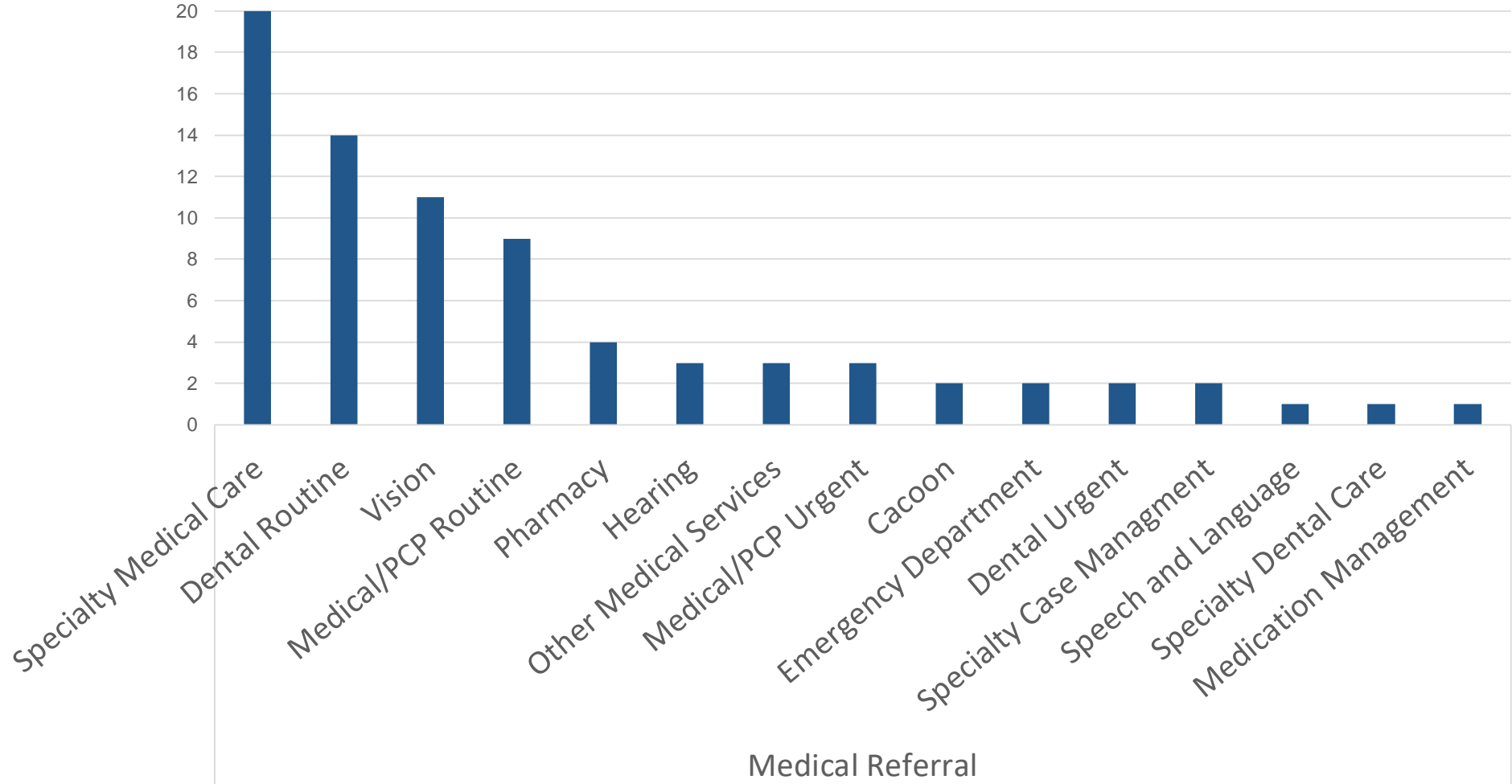
# Pathways



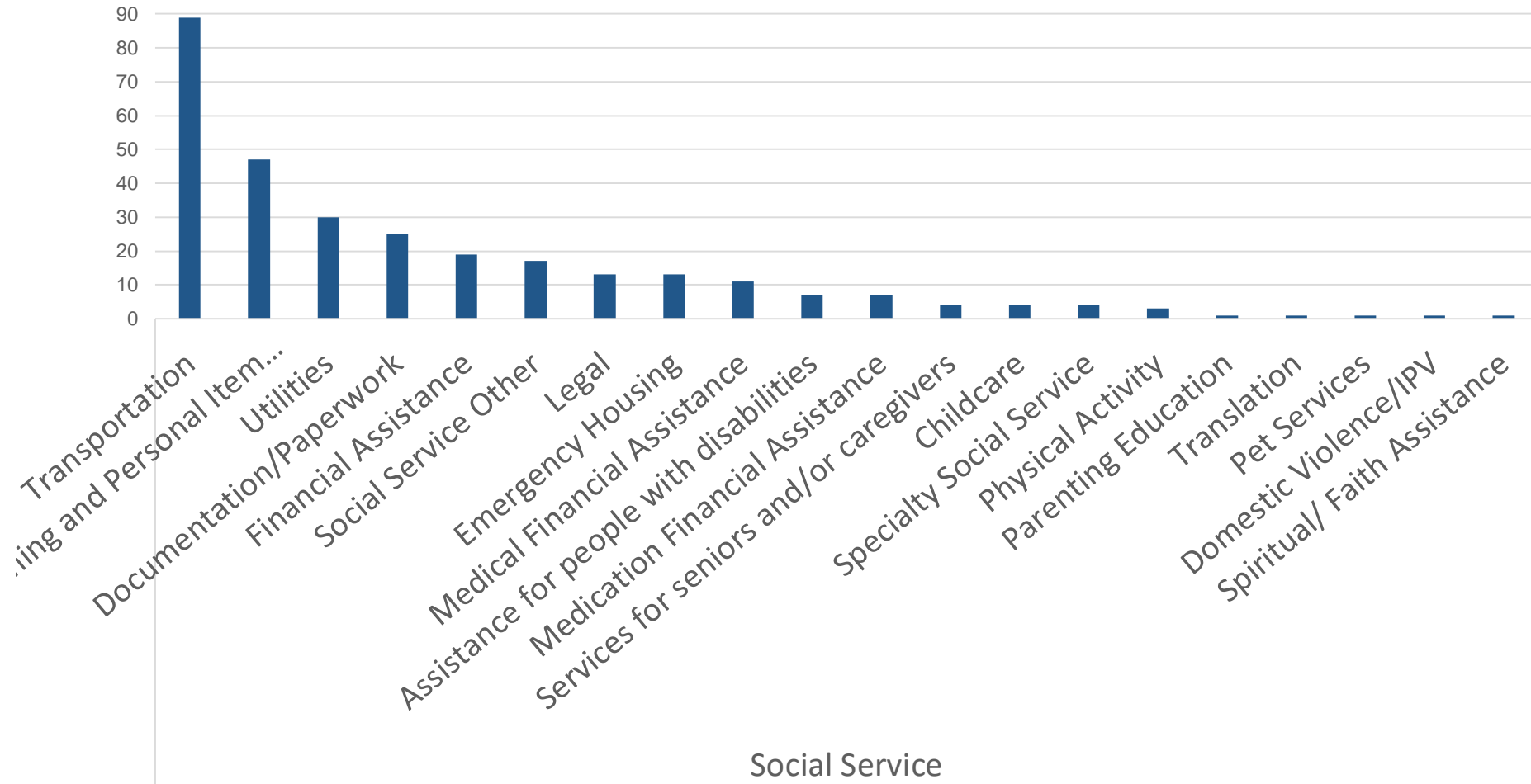
## Pathways Status



# Medical Referral Needs Broken Out



# Social Service Needs Broken Out



# How CCO's can pay for Community Care Coordination

Type of SDOH Services	Applicable Federal Regulations and Guidelines	Financial Implications
<p><b>Community Care Coordination Services</b> An MCO's contractual responsibility to identify and coordinate community based, nonmedical services that are related to meeting a patient's health needs, with medical services.</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Coordinate the transition between settings of care</li> <li>• Coordinate services enrollee receives from community and social support providers</li> </ul>	<p>"Coordination and Continuity of Care" provision: <a href="#">42 C.F.R. § 438.20(b)(2)(iv)</a></p> <p>Medical loss implications: <a href="#">42 C.F.R. § 438.4(e)(1), (e)(2)(i)(A)</a> (referring to direct claims paid to providers for services covered under the contract) <a href="#">42 C.F.R. § 438.4(e)(1), (e)(3)(i)</a>, (referring to activities that improve health care quality) <a href="#">45 C.F.R. § 158.15(b)(2)(i)(A)(1)</a> (listing care coordination as an activity that improves health care quality)</p> <p>Calculation of capitation rate: <a href="#">42 C.F.R. § 438.4(b)(3)</a></p>	<p>May be considered in the numerator of the medical loss ratio for the MCO as a standard contract requirement for all MCOs and an activity that improves health care quality</p> <p>Must be considered for MCO capitation rate setting purposes</p>
<p><b>Value-added Services</b> Additional services that are outside of the Medicaid benefit package but that seek to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care.</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Assessing the home for asthma triggers</li> <li>• Medication compliance initiatives</li> <li>• Identifying and addressing ethnic, cultural, or racial disparities</li> <li>• Mosquito repellent to prevent Zika transmission</li> </ul>	<p>"Value-added Services" provision: <a href="#">42 C.F.R. § 438.4(e)(1)(i)</a></p> <p>Medical loss implications: <a href="#">42 C.F.R. § 438.4(e)(1), (e)(2)(i)(A)</a> (referring to incurred claims and services under <a href="#">42 C.F.R. § 438.4(e)</a>) <a href="#">42 C.F.R. § 438.4(e)(1), (e)(3)(i)</a> <a href="#">45 C.F.R. § 158.15(b)</a> (referring to activities that improve health care quality)</p> <p>Calculation of capitation rate: <a href="#">42 C.F.R. § 438.4(e)(1)(i)</a></p> <p>Referred to as Value-added Services <a href="#">Federal Register (May 6, 2016), Vol. 81, No. 88, page 27526.</a></p>	<p>May be considered in the numerator of the medical loss ratio for the MCO as "incurred claims" or "activities that improve health care quality."</p> <p>May not be considered for MCO capitation rate setting purposes.</p>

<sup>i</sup> D. Bachrach, J. Guyer, and A. Levin. "Medicaid Coverage of Social Interventions: A Road Map for States." Manatt Health, July 2016. Available at: [http://www.milbank.org/uploads/documents/medicaid\\_coverage\\_of\\_social\\_interventions\\_a\\_road\\_map\\_for\\_states.pdf](http://www.milbank.org/uploads/documents/medicaid_coverage_of_social_interventions_a_road_map_for_states.pdf). Although value-added services may not be included in developing capitation rates, these services can be included as incurred claims in the numerator for the medical loss ratio calculation. Federal Register (May 6, 2016), Vol. 81, No. 88, page 27526.

## Find

- People at risk or in need
- In the community and through agencies

← Coordinated Care Organization Members

## Treat

- Behavioral Health Referral
- Dental Referral
- Developmental Screening
- Developmental Referral
- Education
- Employment
- Family Planning
- Food
- Health Insurance
- Housing
- Immunization
- Pregnancy
- Postpartum
- Medical Home
- Smoking Cessation
- Social Service Referral

← Can navigate TO cessation but not provide it

## Measure

- Individual Outcomes
- Community Resource Gaps

← Priority to address with Shared Savings from CCO



- Coordinated Care Organizations: <http://www.oregon.gov/oha/HPA/Pages/CCOs-Oregon.aspx>
- Oregon Solutions: <http://orsolutions.org/>
- Pathways HUB Manual, Agency for Healthcare Research and Quality: <https://innovations.ahrq.gov/qualitytools/connecting-those-risk-care-quick-start-guide-developing-community-care-coordination>
- Collective Impact: [https://ssir.org/articles/entry/collective\\_impact](https://ssir.org/articles/entry/collective_impact)
- Collective Impact Health Specialist: [https://www.ruralhealthinfo.org/community-health/project-examples/957?utm\\_source=racupdate&utm\\_medium=email&utm\\_campaign=update060717](https://www.ruralhealthinfo.org/community-health/project-examples/957?utm_source=racupdate&utm_medium=email&utm_campaign=update060717)