I-PaCS

Integrated Primary Care and Community Support

A Population Health Model for Clinics and Communities to Improve Health Outcomes & Reduce Healthcare Costs through the Integration of Community Health Workers

I-PaCS Integrated Primary Care and Community Support

ACKNOWLEDGEMENTS

The I-PaCS Model is the result of collaboration between the New Mexico Human Services Department Medical Assistance Division, University of New Mexico Health Sciences Center Office for Community Health and the Southwest Center for Health Innovation, along with partnerships with clinical sites at First Choice Community Healthcare, Hidalgo Medical Services and University of New Mexico Hospital Primary Care Clinics.

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INTRODUCTION

Social determinants play a larger role in health outcomes than our healthcare delivery system. Patients with adverse socio-economic conditions have worse health outcomes and consume more health service than do patients who do not face such challenges. Primary care providers are frustrated by their inability to affect the health of these patients and lack resources to address adverse social determinants of health (SDH) within the primary care clinic and community. Our research has shown that CHWs, of all health team members, are best equipped to address adverse social determinants.

The **Integrated Primary Care and Community Support (I-PaCS)** model integrates Community Health Workers (CHWs) into care teams in the primary care setting to screen for and address the adverse social determinants of health affecting patients.

The main assumption of the I-PaCS model is that, by addressing SDH within the primary care clinic— through the integration of CHWs into the care team— patients living in adverse socio-economic conditions will increase their utilization of, and satisfaction with, primary care as well as demonstrate improved health outcomes; clinic providers will have increased satisfaction; payers will enjoy cost savings; and health equity will be increased. In short, I-PaCS reallocates some resources traditionally allocated to health care delivery toward SDH for greater health benefit, and improves outcomes for the triple-aim measures.

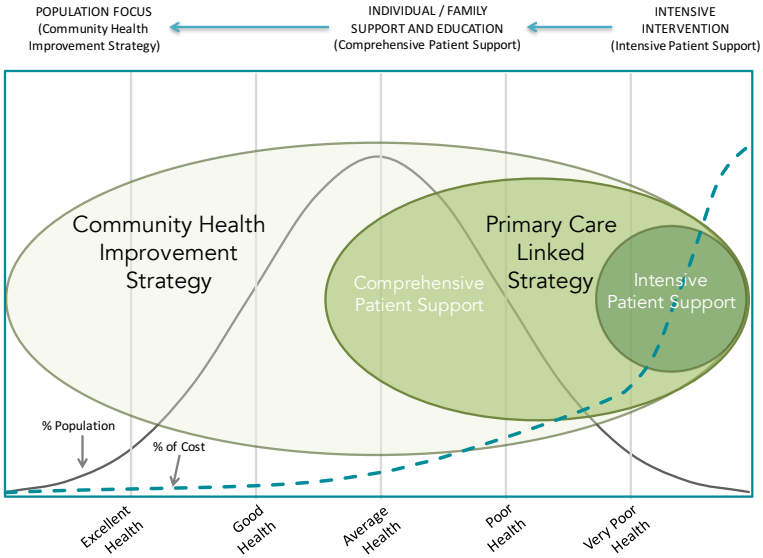
I-PaCS presents integrated community and clinic-based strategies for improving population health. Within the clinic-based strategy is a two-tiered model of intervention including Comprehensive Patient Support and Intensive Patient Support. At each level of intervention, CHWs embedded in primary care teams support patients' access to appropriate resources for both their health and social needs. The intensity of the CHW intervention is dependent on the complexity of patient health and social needs. In addition to clinical intervention, I-PaCS includes infrastructure for community-based population health improvement.

The University of New Mexico Health Sciences Center (UNMHSC) Office for Community Health (OCH) and the Southwest Center for Health Innovation (SWCHI) together with their primary clinical partners, UNM Department of Family and Community Medicine, First Choice Community Healthcare and Hidalgo Medical Services, have worked diligently to design and pilot I-PaCS in the form that is included in this report. Within this report are included an in-depth description of the model; standards and guidelines to ensure that Medicaid and Medicaid Managed Care Organizations, alongside clinics, are able to implement a consistent and documentable CHW product that warrants a distinction in service payment under contract; and an implementation toolkit— designed with CHW input and founded in evidenced base practice— that can guide MCOs and providers in the development of the I-PaCS program. The toolkit contains example materials and practical, step-by-step narrative that details our best recommendations for implementation.

We hope this report proves useful as a tool for implementing this innovative population health model.

EXECUTIVE SUMMARY

Integrated Primary Care and Community Support (I-PaCS) is a comprehensive Medicaid patient support delivery system that addresses an individual's medical and social needs to improve health outcomes and utilizes information gathered from all patients to address the social conditions that impact health, health costs and well-being. Through I-PaCS, Medicaid patients are actively involved in their own care beyond clinical compliance. With the active engagement of Community Health Workers, fully integrated in and outside of the primary care setting, Medicaid eligible individuals will inform community health improvements, with a focus on patient support *and* community health, leading to economic and social services improvements that will address the overall health of the Medicaid population.



I-PaCS aims to address population health and healthcare cost through a spectrum of interventions that target health and social needs of patients all along the population bell curve, not only the highest utilizers of the health system. I-PaCS shifts the flow of resources from short-term savings to long-term, upstream investments in the health of entire communities. Projections suggest that implementation of this model will ultimately yield much greater returns both in terms of cost and wellbeing.

At the core of the model, Community Health Workers (CHWs) provide a wide range services, from Comprehensive Patient Support to Intensive Patient Support, as well as community health improvement strategies. I-PaCS was developed through a process of piloting evidence-based practices that have evolved in integrated primary care settings to a standard of services that can be independently compensated by third party insurers including Medicaid Managed Care Organizations (MCOs).

The I-PaCS model maintains primary care payments as an incentive to build primary care capacity in support of clinical prevention and diagnostic and treatment services while providing a separate payment system for CHW patient support services not incidental to the primary care visit. In this way CHW patient support services are leveraged to provide more comprehensive or intensive support that extends beyond the four walls of the exam room and even beyond the walls of the clinic. The I-PaCS evaluation projections reveal greater cost savings than traditional primary care visit payment enhancements.

THE I-PaCS MODEL

I-PaCS
Integrated Primary Care and Community Support

INTEGRATED PRIMARY CARE AND COMMUNITY SUPPORT: AN OVERVIEW

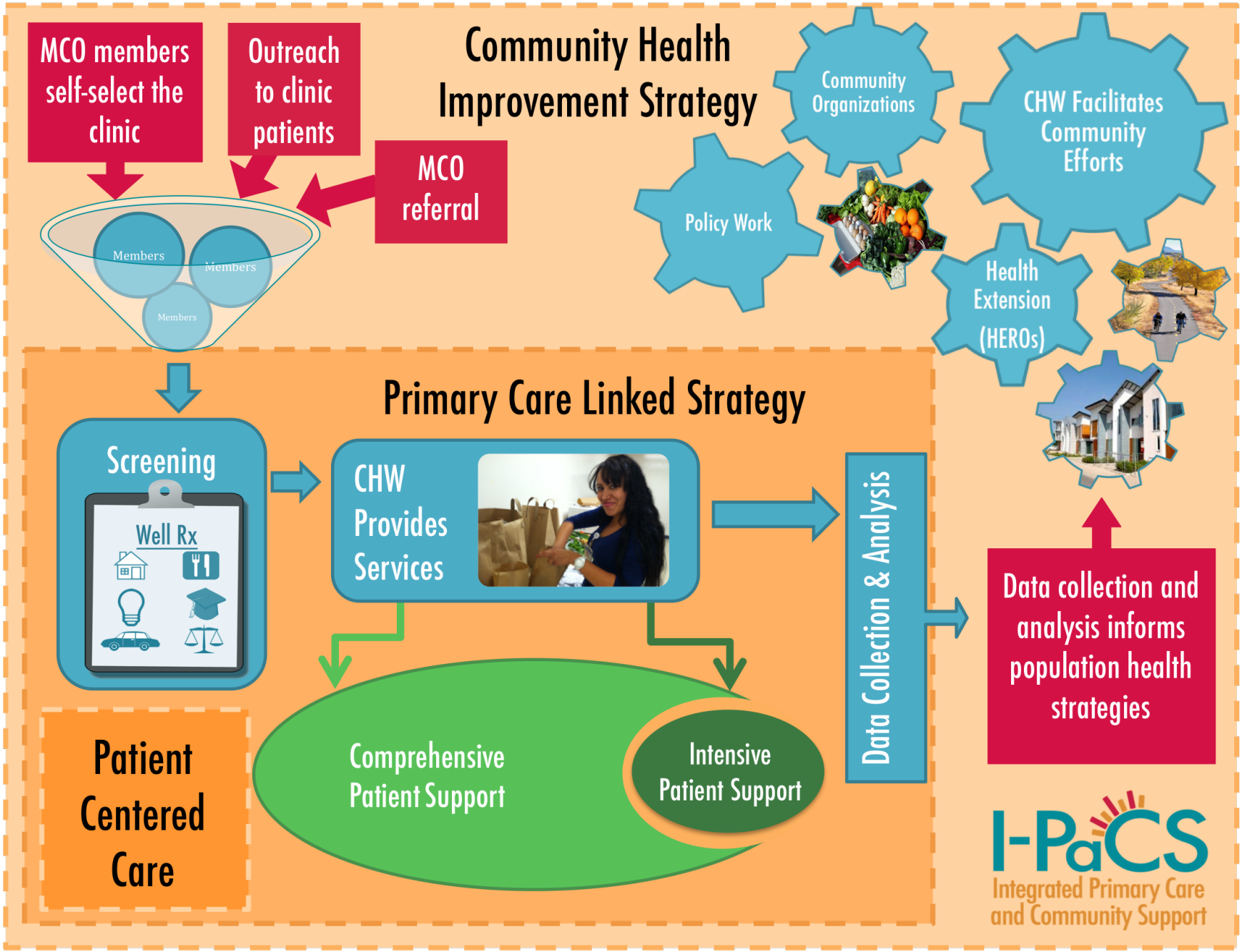
Integrated Primary Care and Community Support (I-PaCS) is a comprehensive Medicaid patient support delivery system that addresses an individual's medical and social needs to improve health outcomes and utilizes information gathered from all patients to address the social conditions that impact health, health costs and well-being. At the core of the model, Community Health Workers (CHWs) provide a wide range services, from Comprehensive Patient Support to Intensive Patient Support, as well as community health improvement strategies. I-PaCS was developed through a process of piloting evidence-based practices that have evolved in integrated primary care settings to a standard of services that can be independently compensated by third party insurers including Medicaid Managed Care organizations.

This narrative describes a framework for the integration of CHWs into primary care teams to screen for adverse social determinants of health (SDH), and provide appropriate resources to those in need. We describe the integrated strategies used to implement the model in clinics and communities to improve population health; the payment system used to finance the model and lower healthcare costs; a framework for qualitative and quantitative evaluation of the model; and recommendations for dissemination and expansion of the model based on experience and lessons learned in the pilot year.

The I-PaCS model is composed of two fully-integrated and complementary strategies: a **Primary Care Linked Strategy (PCLS)** and a **Community Health Improvement Strategy (CHIS)**.

Primary Care Linked Strategy (PCLS)	Community Health Improvement Strategy (CHIS)
PCLS refers to the clinic-based components of the model including patient intervention which then informs population health and community-based efforts. PCLS includes patient intake and record review, Well Rx screening, two tiers of CHW interventions (Comprehensive or Intensive Patient Support), and referral to services that provide assistance to address social needs. This toolkit examines the process of integrating CHWs into Primary Care Clinics to screen members for adverse SDH. We describe the two levels of interventions that CHWs provide to members at clinics and also in communities.	In addition to the PCLS, this guide examines the process to develop strategies to improve population health. Summary data collected in the PCLS that identifies the health and social service needs of Medicaid beneficiaries is shared with partner organizations such as health councils and coalitions to inform collective efforts to improve health in the community. A community-based CHW can serve as a liaison or facilitator between the local agencies, community service providers, the clinic, and Medicaid beneficiaries to develop a strategic action plan that addresses those social determinants impacting the health of members served by the clinic and the community.

The graphic on the following page illustrates the complimentary strategies.


MCO members self-select the clinic
Outreach to clinic patients
MCO referral
Members
Members
Members
Community Health Improvement Strategy
Community Organizations
CHW Facilitates Community Efforts
Policy Work
Health Extension (HEROs)
Primary Care Linked Strategy
Screening
Well Rx
CHW Provides Services
Data Collection & Analysis
Data collection and analysis informs population health strategies
Patient Centered Care
Comprehensive Patient Support
Intensive Patient Support
I-PaCS
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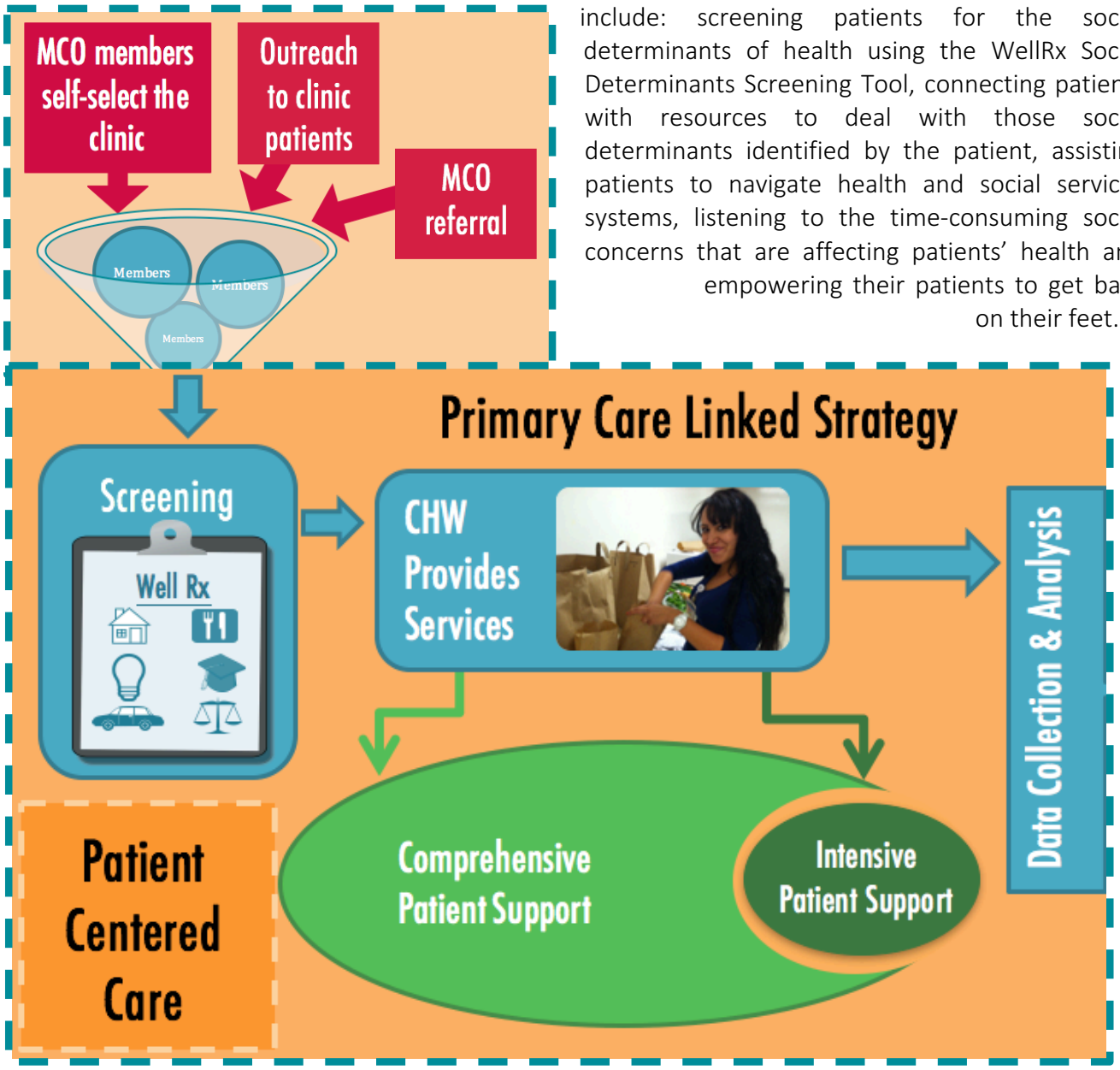
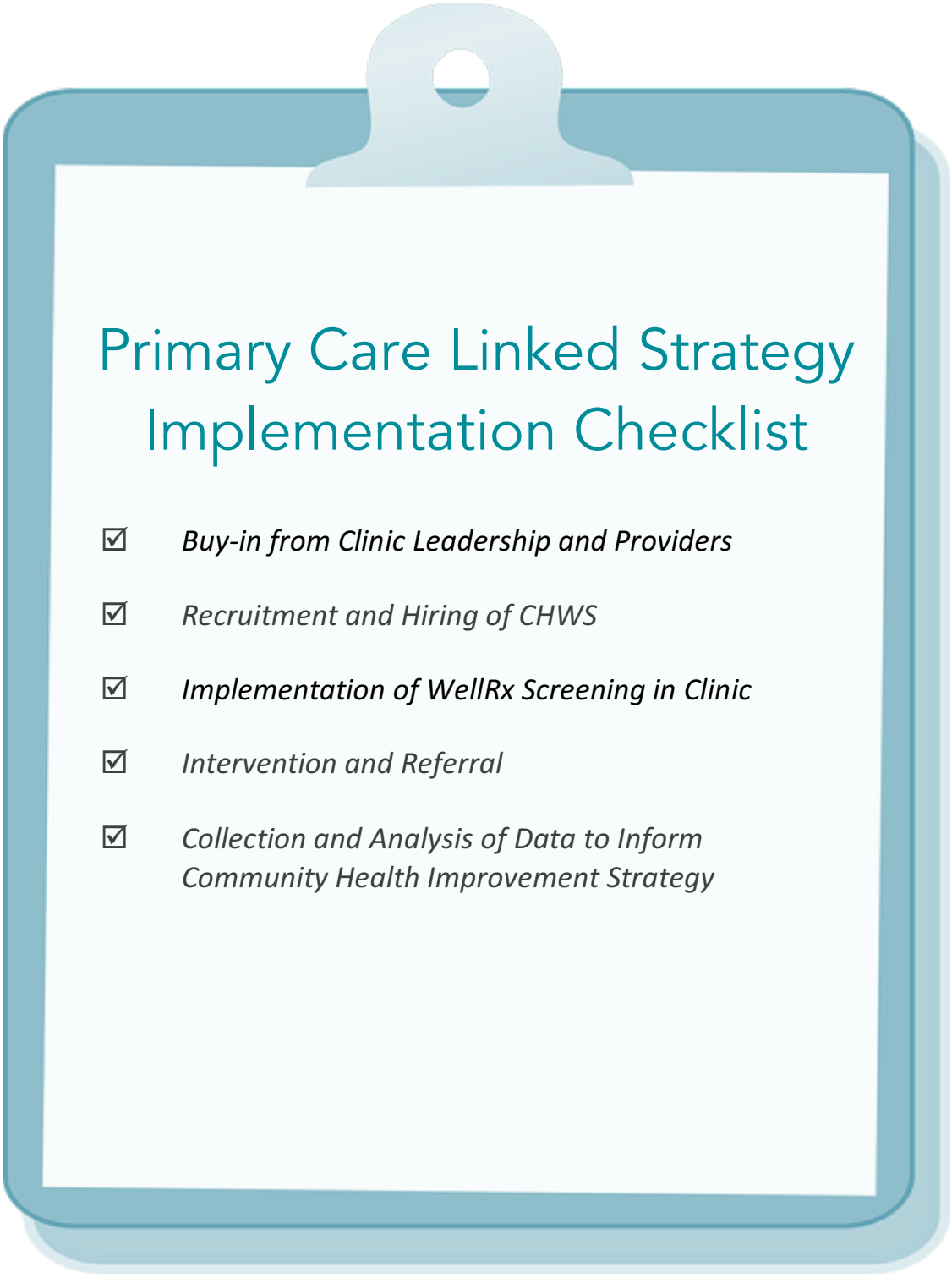
PRIMARY CARE LINKED STRATEGY (PCLS)

Medicaid patients, who are among the poorest people in New Mexico and the majority of whom are representative of disproportionately underserved racial and ethnic populations, are the most likely to be negatively affected by adverse conditions in their community and in the health care system. In order to achieve the Triple Aim, other state agencies, insurers, providers, and their partners must pay specific attention to both individual health as well as social conditions underlying ill health in the community.

CHWs work with the clinic staff to identify Centennial Care members who receive clinical services, and provide additional services to those members, including helping members identify community and social support services and access those services; encouraging them to develop an ongoing relationship with their PCP at the clinic; and documenting each encounter with a member and possible systemic barriers faced by the member. Specific interventions include: screening patients for the social determinants of health using the WellRx Social Determinants Screening Tool, connecting patients with resources to deal with those social determinants identified by the patient, assisting patients to navigate health and social services systems, listening to the time-consuming social concerns that are affecting patients' health and empowering their patients to get back on their feet.





Primary Care Linked Strategy Implementation Checklist

- ☑ *Buy-in from Clinic Leadership and Providers*
- ☑ *Recruitment and Hiring of CHWS*
- ☑ *Implementation of WellRx Screening in Clinic*
- ☑ *Intervention and Referral*
- ☑ *Collection and Analysis of Data to Inform Community Health Improvement Strategy*

Integration of CHWs into the Primary Care Setting to Screen for Social Determinants of Health

In the I-PaCS Primary Care Linked Strategy (PCLS), members coming to a participating primary healthcare clinic are screened for SDH. According to the screening, and depending on their specific health needs, members may receive two levels of services from CHWs: Comprehensive Patient Support (ComPS) and Intensive Patient Support (IPS). To determine the appropriate level of intervention, the CHW and healthcare provider analyze the specific health and social needs of the Medicaid beneficiary, which throughout this document may be referred to as Medicaid member or Medicaid patient.

Comprehensive Patient Support	Intensive Patient Support
• Understand social and clinical issues impacting patient's lives. • Pre-visit preparation is conducted. [CHW checks the electronic medical record (EMR) of member to see if he/she has been ordered lab tests, referrals to specialists, etc.] • Provide member with written List of resources to address social needs identified through the screening. • Assist member to fill out paperwork to get re-certified for Medicaid and to obtain Income Support, SNAP or other government programs as well as housing and/or other needs. • Provide general information about resources available at the clinic and in the surrounding community such as mobile markets, nutrition classes, walking trails, etc. • Assist member in making appointments to social service agencies and follow up with the member to make sure that they indeed went to the appropriate agency. • Serve as parts of the primary care system that address health concerns including health education, one-on-one support services, facilitates access to group learning opportunities, etc.	IPS includes all services from ComPS, and in addition, may also include any of the following services: • Develop care plans with patients and providers for MCO review; review progress and follow-up at least monthly. • Review prescriptions and directives from all healthcare providers with member. • Explain value-added benefits provided by MCO to member. • Assist member to find co-pay assistance or discounted medicines from a generic list. • Conduct SF-12 (or other similar assessment of functionality) • Facilitate member access to primary care provider (PCP). • Educate member on their chronic disease(s) and/or other health issues. • Work with member to develop a plan for chronic disease self-management.

**Refer to the "Standards and Guidelines" section for more detailed information on ComPS and IPS.*

Screening

Systematically screening for and addressing patient's social needs during every visit in busy primary care settings can be valuable for improving patient health. Researchers at UNM HSC Office for Community Health developed and piloted an 11-question instrument to screen and address social determinants of health by convening providers and community health workers to identify domains of greatest need among their patients and communities: food insecurity, housing, utilities, income, employment, transportation, education, substance abuse, child care, safety, and abuse. These domains were then incorporated into a questionnaire that was reviewed by a literacy specialist to ensure the wording conformed with potential low literacy, and then pre-tested for three months in clinic settings. The resulting tool is known as the "Well Rx" social determinants screening tool, and is the recommended screening tool for I-PaCS. The Well Rx screening process can produce "concrete data about the magnitude of social needs in primary care patients' lives, resulting in better-informed clinic providers and staff, who are now able to develop more effective intervention and management plans."[1]

Patient Name: _____MR# _____ DOB_____
UNM Clinic___ First Choice Clinic ____ HMS Clinic _____

Assessment to be used by CHWs

1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food? _____ Yes _____ No
2. Are you homeless or worried that you might be in the future? _____ Yes _____ No
3. Do you have trouble paying for your gas or electricity bills? _____ Yes _____ No
4. Do you have trouble finding or paying for a ride? _____ Yes _____ No
5. Do you need daycare, or better daycare, for your kids? _____ Yes _____ No
6. Are you without regular income? _____ Yes _____ No
7. Do you need help finding a better job? _____ Yes _____ No
8. Do you need help getting more education? _____ Yes _____ No
9. Are you concerned about someone in your home using drugs or alcohol? _____ Yes _____ No
10. Do you feel unsafe in your daily life? _____ Yes _____ No

    Domestic violence? _____ Yes _____ No
    Other safety issues? _____ Yes _____ No
    If yes, which issue? _____

11. Do you need help with immigration or legal issues? _____ Yes _____ No

Is someone from another agency helping you with any of these issues? _____ Yes _____ No
If yes, which agency? _____

Are you enrolled in Medicaid? _____ Yes _____ No
If yes, who is your insurance company or Managed Care Organization? _____

Todays' Date_____ Name of CHW_____

Version date: 8-25-15
Citation: The WellRx Toolkit was developed by Janet Page-Reeves, Ph.D. and Molly Bleecker, MA at the Office for Community Health at the University of New Mexico in Albuquerque.

Page-Reeves, et al. Addressing social determinants of health in a clinic setting: the WellRx pilot in Albuquerque, New Mexico. J Am Board Fam Med. 2016 May-Jun;29(3):414-8.

Clinics are encouraged to implement universal screening protocols for SDH, and integrate the questionnaires into the general clinic workflow. Ideally, SDH screening will be offered to 100% of patients who enter the clinic, although this is not a specific contracting requirement—universal screening will make it easier to integrate SDH screening into the clinic workflow (rather than carving out a population) and may provide valuable information to the clinic about their entire patient panel.

Who Can Perform the WellRx Screening?

Screening for SDH can be done by many in the clinic- for example, front desk clerks giving patients screening forms to fill out in the waiting room; Medical Assistants asking patients the questions in the exam room; or CHWs screening patients directly.

The first steps in implementation of SDH screening in clinics are training staff and providers how to use the Well Rx tool, and setting up protocols for screening and communication between staff and providers. Clinics may choose to use the WellRx, or may develop their own screening tool.

During the pilots of the I-PaCS model, an attempt was made to screen all patients at each visit, either by self-administered questionnaires distributed by the front desk staff, by MAs during recording of vital signs, or by CHWs. Patients who screened positive for unmet social needs were asked if they would like assistance, and CHWs would meet to connect them with appropriate services and resources. In the pilots, implementation of the WellRx revealed ways to transform primary care, highlighted the important role of CHWs, and in addition, expanded the role of MAs in clinic practice. MAs who were given the responsibility of identifying patients' social needs not only demonstrated that implementation of the screening questions was feasible, they provided patients with valuable information about resources or connected them with a CHW for further assistance. The expanded role for MAs directly improved patient care and enhanced the work and integration of the primary care team.

Addressing Patient Needs

The CHW plays a vital role in communicating with the patient in a culturally humble way, addressing patient needs with a care team, and connecting patients to appropriate resources. As a result of the trusting relationship that patients develop with the CHW, patients are more likely to accept the education, advocacy, and support provided by the CHW with the goal of facilitating access to healthcare and social services. One of the most important roles of the CHW is empowering patients to develop self-management skills resulting in an improved quality of life.

Care teams within primary care settings should be well informed of the scope and competencies of CHWS as defined by the state, and trust CHWs to use their unique communication skills, motivational interviewing, and community networks to support patients. The relationship building skills of CHWs and patient centered approach are the keys to this model.

When patients screen positive for adverse social determinants of health, CHWs work with their care team to decide the best course of intervention for both the patient's health and social needs. After determining whether a patient requires ComPS or IPS, the care team will provide guidance and coaching to the CHW to identify the specific tasks and interventions required, while the CHW is the frontline in support the patient to complete their targeted goals. A unique quality of CHW work is the hands-on, face-to-face, approach in both medical and community settings—and in some cases, the patients home. The CHW is able to assess immediate needs and assist patients to access the services that they require.

Providing Comprehensive Patient Support (ComPS)

CHWs provide a spectrum of services to patients that screen positive on the WellRx. For all Medicaid members, CHWs preform a pre-visit record review: the CHW checks the EMR of each member to see if he/she is current on recommended medical screening, have and pending lab tests or referrals to specialists, etc. This includes but is not limited to:

- Colorectal Screenings (Colonoscopy or FOBITA)
- Pap Smears
- Mammograms
- Wellness exams
- Eye Exam
- Dental Exam
- Immunizations
- Any other labs that pertain to the specific patient's medical condition

Another role of the CHW in this model is to match Medicaid member's identified social needs with community service providers and/or assist members to identify other social supports. Interventions will vary greatly depending on the number of positives that the patient screened for on the WellRx, and the intensity of those needs. In some cases the intervention may be very simple and straightforward: a patient screens positive for trouble paying an electricity bill, and the CHW provides information on a resource that they can access to help them get their electricity turned back on. In this case, the CHW will follow up with the patient to make sure that they were able to successfully access the resource and meet their goal. No further intervention may be needed. Other interventions within ComPS may be more time intensive and require multiple encounters with a patient. Examples of this may be helping clients to apply for government assistance or housing, which are more time-and-effort-intensive endeavors.

In addition, a widely-used tool in clinical settings is the "SF-12" survey, a twelve question short form survey that can provide a glimpse into a patient's self-reported physical and mental health, as well as overall health-related quality of life. The survey is included on the following page for reference.

SF-12® Health Survey Scoring Demonstration

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
b Climbing several flights of stairs	☐	☐	☐

3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
a Accomplished less than you would like	☐	☐
b Were limited in the kind of work or other activities	☐	☐

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	Yes	No
a Accomplished less than you would like	☐	☐
b Did work or other activities less carefully than usual	☐	☐

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
b Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
c Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

Thank you for completing these questions!

Identifying Members Who Require Intensive Patient Support

In order to qualify for IPS, patients must have: a) two ER Visits in last 12 months and a positive screen for one or more questions on the WellRx, OR; b) screened positive for five or more positives on the WellRx.

These criteria are based on guidelines set forth by CMS' Accountable Health Communities (AHC) model as well as comparison of patient screening results on the WellRx with the statistical bell curve for patient health needs. Approximately 6% of completed surveys included 5 or more "yes" responses on the WellRx, which is relatively consistent with the percent of the population that we would expect to have intense social needs, accounting for members who refuse service.

In addition to these criteria, MCOs may also choose to refer high risk/high cost patients they would like to receive this advanced level of service. Criteria for referral, in this case, are at the discretion of the MCO.

Addressing the Needs of Members Who Require IPS

When patients meet criteria for IPS, they will receive the same services from the clinic as ComPS patients, but in addition will receive Intensive Patient Support services. CHWs will work closely with MCOs and the care team to design a comprehensive care plan that meets the intense social and medical needs of the patient. In IPS, CHW interventions may include, but are not limited to:

- Monthly follow-up with Medicaid member to assess status of social services referral(s), prescription adherence and/ or referrals to specialists or for labs.
- Collaboration with patient/family/treatment team to develop individual care plan including goals that are updated at each relevant visit.
- Referral to educational resources to assist in chronic disease self-management
- Work with Medicaid member to develop an ongoing relationship with their Primary Care Provider, facilitating access to initial or follow up patient visits, and serving as a patient advocate.
- Education on alternatives to the emergency department and information on resources such as nurse advice line, urgent care sites, and outpatient management of medical conditions.

Fully addressing the needs of IPS members will most certainly be more time intensive and complex. Clinics should take this into consideration and adjust the CHW caseload accordingly.

If referred by the MCO the CHW will also check to see why these patients are considered eligible for care coordination services. Does the patient have a chronic disease or special condition? If yes, what type? The CHW will remind members of their appointment(s), ask them if they have gotten their Lab test or seen a specialist if the doctor has ordered an internal or external clinical referral of any kind during the previous visit. The CHW will follow up with the patient after the scheduled visit, lab, etc. to make sure that the patient was able to make the appointment, and if not, to help them troubleshoot barriers.

Plan of Care

CHWs are a vital member of the care team, playing a highly visible role in connecting the member with the most appropriate resources and services. As a result of the trusting relationship members develop with CHWs, they accept the education, advocacy and support provided and are empowered to develop self-management skills resulting in an improved quality of life. Through the hands-on, face-to-face approach described in the I-PaCS model, CHWs are able to provide guidance and coaching, identifying specific ways to begin to address the adverse social determinants the member may be facing. In working with members around addressing adverse social determinants, the CHW will develop a plan of care that will complement the plan of care that the member's healthcare provider and/or case manager may also develop. Common elements of care plans include:

- Connect members to community resources
- Provide culturally sensitive communication and education, fostering trust with the member
- Educate member on Medicaid benefits available to them (vision, dental, behavioral health, transportation, etc)
- Teach concepts of prevention and chronic disease management
- Guide practice of self-management skills for chronic conditions
- Bridge communication between member and healthcare providers

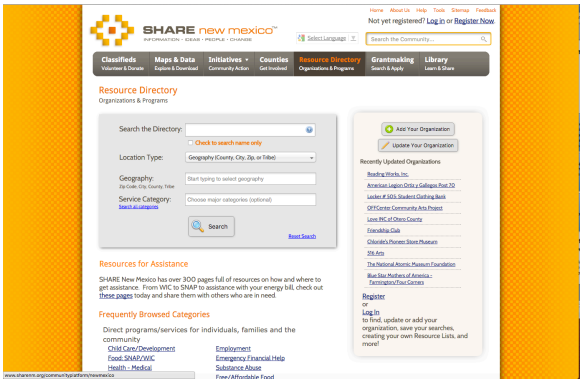
If appropriate, the CHW may also set some self-management tasks with the member. Some examples may include statements such as "Member agrees to meet with CHW once a month"; "member agrees to attend primary care appointment to monitor chronic disease"; or "member agrees to attend cooking class offered at clinic". The specific self-management goals would vary depending on the needs and circumstances of the member.

Referral to Resources

Although there is no perfect, single protocol or timeline for guiding and supporting patients through the steps necessary to meet their social needs and health goals, clinics must create internal processes for documentation of patient encounters and referral to resources. In this section we describe the process to formalize a database of available resources in the community, and examples of how referrals may be documented.

Developing a Community Resources/Services Database

The I-PaCS team has developed a partnership with SHARE New Mexico to provide web access to resource and service provider information on the SHARE website. SHARE is a free, statewide, community web space for sharing information and providing collaborative action to improve the quality of life of New Mexicans. SHARE has developed a robust and comprehensive directory of non-profits and service providers at regional and local levels. CHWs and other clinic staff may use the database to locate services in order to refer patients, and in addition,



may be given access to add and edit the information on the database to reflect new or changing organizations. SHARE will provide training to CHWs who need resource directories in expansion counties, including assistance to help identify, save, export and share searches for services.

We recognize however, that Internet access may be unreliable in certain areas of the state. In addition to the use of the SHARE website, we recommend that clinics work to develop hard copies of a general resource guide, to be updated periodically by CHWs or other clinic staff. Resource lists may be available through local organizations like health councils, public health offices, community coalitions or philanthropic agencies. Hard-copy guides should include listings of both the most closely located resources as well as the most frequently used resources.

Another way to gather information for resources guides is a process called "community resource mapping", which directs attention to the resources that individuals, organizations, and local institutions have to offer. The process acknowledges that together, they have the capacity to create real change in their communities, but that no agency can do it alone. With tight budgets, resource shortages, and fragmented services, it is a wise decision for communities to encourage inter-agency coordination. Resource mapping can identify both assets and gaps in services in a community. When combined with existing community information, resource maps can provide a comprehensive picture of a community's vision, goals, projects, and infrastructure. In short, community resource mapping can help communities to accomplish a number of goals, including:

- Identifying new resources;
- Ensure that all residents have access to the resources they need;
- Avoid duplication of services and resources;
- Cultivate new partnerships and relationships; and
- Encourage collaboration.

Tracking Referrals

Referrals to different resources should be tracked and followed-up. The CHW may refer within clinic depending on clinic staff and services. Some clinic and health centers, especially those that already qualify for PCMH, will have many services available on-site such as dental, behavioral health, social work, etc. One option for tracking these internal referrals is to use the EMR to send messages between clinical staff, detailing services recommended by CHWs. If an electronic system is unavailable, another form of communicating and documenting referrals would need to be agreed upon and developed.

Referrals to outside entities need to be reflected in the clinic note in the spreadsheet, including any follow-up that the CHW has agreed to do with the patient regarding the referral, for continuity of services as well as for evaluation purposes. The networks of community based resources accessed by the patients are closely tied to the Community Health Improvement Strategy, described in the following sections.

COMMUNITY HEALTH IMPROVEMENT STRATEGY

In the Community Health Improvement Strategy (CHIS), efforts are informed by data collected in the clinic by CHWs. A community-based CHW facilitates efforts in the community to share data with community leaders and coordinate efforts by community coalitions and organizations to address those SDH that identified through PCLS.

CHIS will vary by site and community needs: the role of the CHW as a bridge and liaison to community efforts should be very flexible and organic to the context in which they work. In our pilots, we found that additional clinic staff- often the clinic champion- also participated in CHIS.

Depending on the size of the clinic and patient panel, a single CHW may play a role in implementing both PCLS and CHIS, or multiple CHWs will have district roles and responsibilities in implementing each strategy.

Community Health Improvement Strategy Implementation Checklist

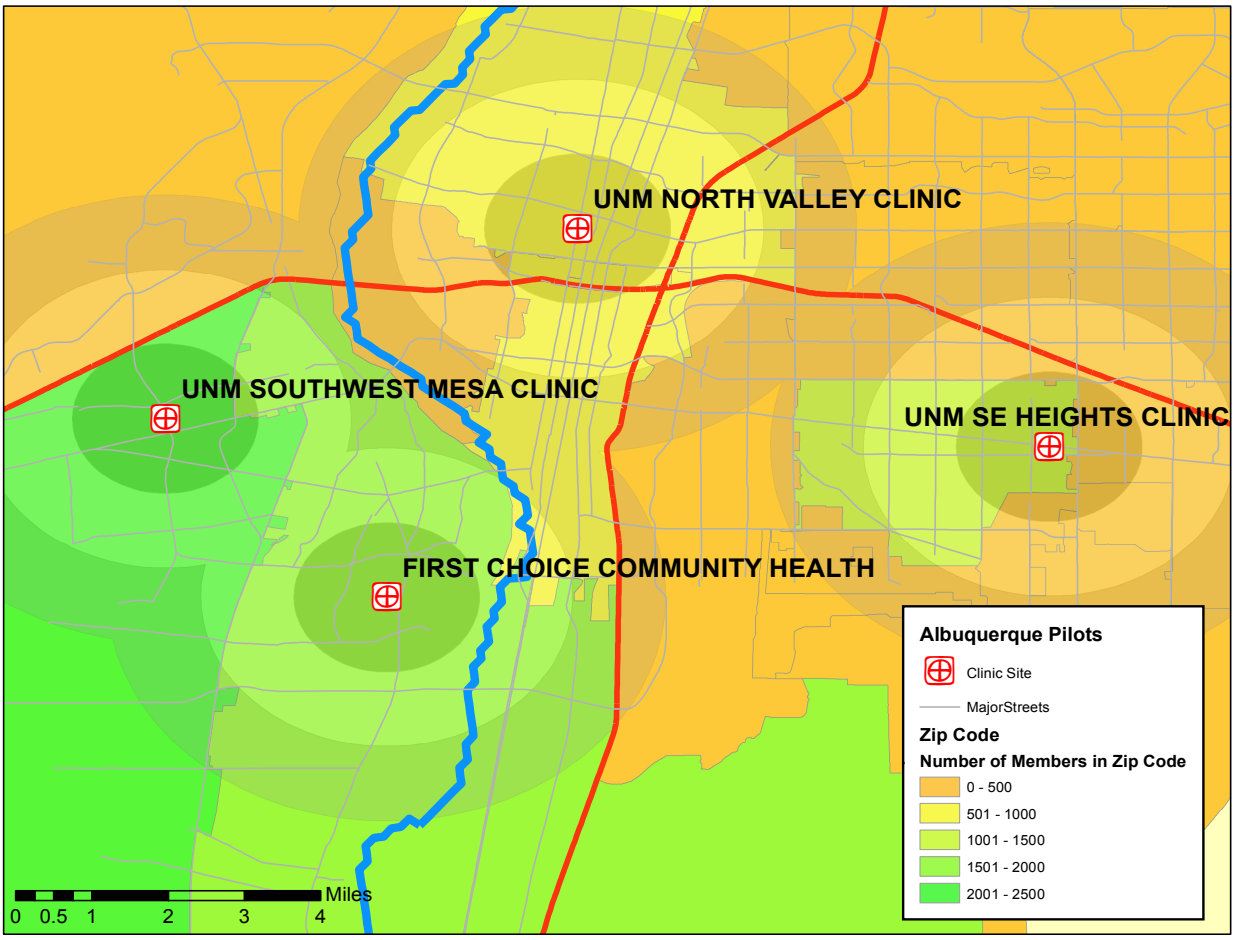
- ☑ *Define population and geographic target area*
- ☑ *Rank priority social needs using screening data collected in clinics*
- ☑ *Learn about existing resources and efforts in priority areas*
- ☑ *Develop strategies with community partners*
- ☑ *Conduct community-based activities and outreach*
- ☑ *Activities/outreach tracking and data collection (ongoing, mostly qualitative)*
- ☑ *Assess efforts with partners and staff (Ongoing)*

Defining Geographic Target Area for CHIS

There are several ways to identify a geographic target area for the implementation of this model, and strategies will vary greatly depending on whether the clinic site is located in a rural, urban or frontier area. The recommendation of this guide is to begin by identifying areas in the community where most Medicaid beneficiaries live. In urban settings this may mean simply identifying pockets of Medicaid beneficiaries in the geographic area surrounding the clinic, as pictured in the map on the following page.

Clinics may also access census data to identify zip codes or census tracts with the highest need. This is particularly pertinent to rural settings in which a clinic or health center may serve an entire county or region with a need to focus resources and efforts in the areas with the greatest need and number of Medicaid users.

Another excellent resource is the NM Community Data Collaborative, which, "develops and shares neighborhood data with local organizations that promote community assessment, child health and participatory decision making." The NMCDC contains aggregated data, for public use, organized by sub-county areas such as census tract, zip code, school districts and other administrative boundaries.



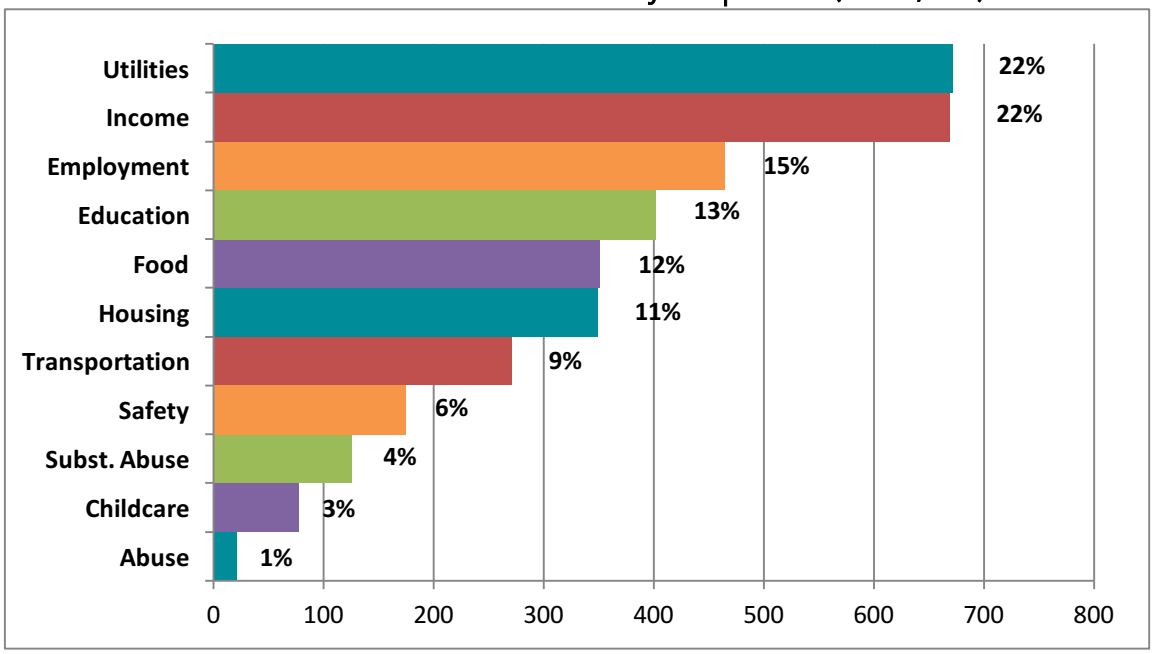
Ranking Social Needs Identified through Data Collected at Clinics

The first step towards identifying social needs is to create quarterly or monthly reports by compiling the data collected using the Well Rx survey at clinics. The following table and graph are examples of how this was done at the pilot clinics:

WellRx Survey Responses - All Pilot Sites

	Total	Percent of patients surveyed
Number of completed surveys	3048	--
Surveys with at least one "yes" response	1413	46%
Patients with 2-5 "yes" responses	792	26%
Patients with 6-11 "yes" responses	98	3%

All Sites Combined Well Rx Survey Responses (n = 3,048)



As we can see, for these clinics' patients, the most pressing needs were utilities and income. The recommended strategy would be to tackle the top issues as priority areas within the CHIS.

Engaging with Existing Efforts

Health centers and care teams need to become familiar with health promotion efforts that are already in place in their communities. One way for sites to learn about efforts that could potentially target the priority areas identified with the WellRx screening is to perform a gap analysis to identify existing resources and define which resources need to be developed. Health councils, community coalitions, and DOH health promotion teams are good source for this information, since they are mandated to preform county health needs assessments on a regular basis.

However, the best way for clinics to identify efforts in the community is to hire a CHW from the community that the clinic serves. The CHW is likely to already have extensive networks with community leaders/organizers and social services that exist in the area. The CHW will have knowledge the needs and assets of the community beyond what the raw data can provide.

Reaching Out to Community Leaders

Once data has been collected and analyzed, the CHW can begin to reach out to community leaders and social service organizations to share the findings and priority issues of the patient panel. CHWs work collaboratively with the clinic, community leaders, and organizations to develop a comprehensive and integrated plan to strengthen existing programs and develop capacity where there are gaps.

Integration of CHWs into Community Health Improvement Efforts

Implementation of CHIS should and will vary from site-to-site. Although this guide provides some tools and instructions for engaging with community health and social service promotion efforts, strategies should be organic, unique to the context of the clinic and its panel, and most importantly, grounded in the needs and strengths of the community served.

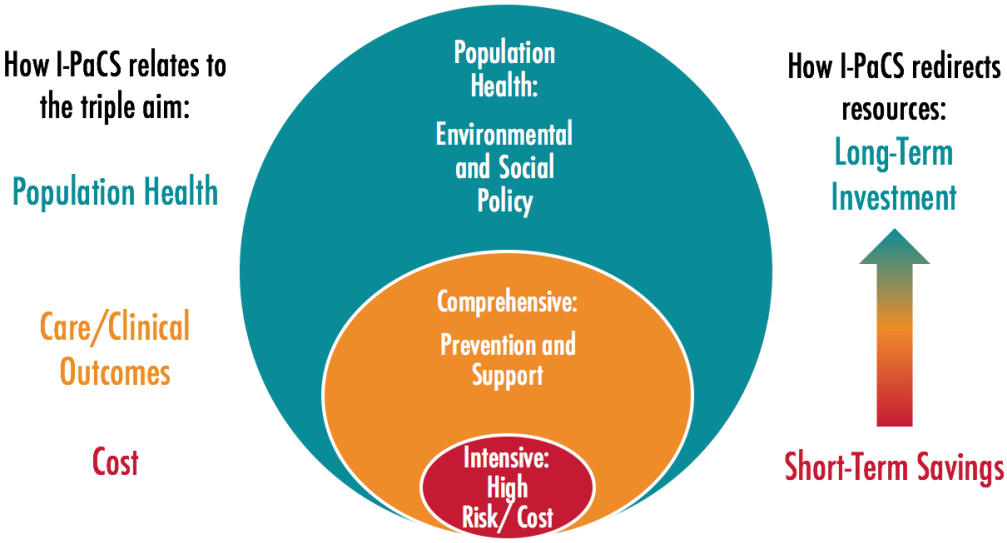
In addition to the resources that exist in communities, towns or counties, clinics may access a number of statewide networks and resources including Health Extension Rural Offices (HEROs). Health Extension is a method of helping communities, and the primary care practices that serve them, to overcome barriers to transformation by sharing common resources including local expertise coupled with the technical resources of universities, health departments and social services agencies. HEROs have the potential to provide skills based training opportunities to CHWs as they are hired and integrated into by primary care teams. While CHWs are skilled at mobilizing community members and local organizations, HEROs can play a vital role in harnessing the community consensus to address policy issues and system transformations affecting the social determinants of health. More information on how CHWs can work closely with HEROs, including contact information by region, can be found at www.healthextensiontoolkit.org.

I-PACS MODEL FINANCING AND SUSTAINABILITY

Upstream Support for Medicaid Members

I-PaCS supports the latest thinking in health system innovations. The model utilizes many of the best, currently evolving practices in health systems transformation while acknowledging that the historic linkage between payment systems and the "medical model" falls short in meeting the health outcome and cost saving goals of recent public policy.

With its focus on the social and health context of individuals, the I-PaCS model advocates that certain aspects of the medical system should be incentivized, like clinical preventive services, a strong primary care system, comprehensive community-driven emergency, and primary care-integrated hospital services. Many of these services, while expensive, are cornerstones of community health systems, especially in rural, frontier and otherwise underserved areas. Therefore, I-PaCS supports the local health system by seeking to avoid the unnecessary use of expensive or over-utilized services through better patient decision-making. The Community Health Improvement Strategy (CHIS) will help create healthier living opportunities through environmental improvements at the community level. In the I-PaCS model, data is collected that helps inform and address health, economic and social policy improvements at all local, state and national levels. I-PaCS plans to address the three-part aim of health system improvements:



The I-PaCS financing model is unique. It adds specific resources for contracted purposes consistent with each of the goals of the services described in more detail below. It preserves the primary medical, dental and behavioral health care financing relationship between providers and MCOs and other potential payers. It recognizes the unique contribution of CHWs in achieving the goals of new payment system priorities—the triple aim of improving the experience of care, improving the health of populations, and reducing healthcare costs. It serves to create better balance between medical intervention financing, patient support and population health priorities by creating a specific financing stream that is

independent of clinical provider services and not subordinate to it. It therefore raises the status of CHW effort as a specific revenue stream within a health system. This is meaningful in terms of requiring specific investments in health outcomes and population health related through non-clinical or social determinant focused services. It allows for the development of intentionally designed strategies that augment the medical revenue driven health care system.

Significance of the Payment System

The design of most CHW programs has been driven by grants or the needs and requirements of specific providers, leading to CHWs providing only specific patient support services or categorical interventions. Studies have shown the value of CHW investments at all levels of service delivery from complex patient management support to population health engagement. Up until now however, there has not been a coherent model of CHW service delivery that traditional payers of health care such as Medicaid, Medicare or private insurance can embrace as a payable product. After all, payments in the health industry are based on very specific provider certification and licensure processes and accreditation schemes.

I-PaCS recognizes and specifically addresses the health intervention "levels" of Centennial Care in that every enrollee in Centennial Care is screened using a Health Risk Assessment (HRA). The I-PaCS model is designed to acknowledge risk in illness or health and provides specific strategies to reduce costs and improve outcomes through improved health service and social processes. The data gathered from HRAs, clinical visits and social assessments also guide population health strategies.

I-PaCS understands the need to establish a certifiable program expectation to warrant public and private insurance payments. This is a large part of the American health system model: we make assumptions about quality and safety based on public and private contracts to deliver services in a defined environment with detailed expectations. Even in private delivery models, an invoice or bill for services is a contract that ensures that a licensed and credentialed provider provided the services.

There are minimum standards inherent in the systems that warrant financial remuneration. I-PaCS seeks to establish service guidelines for CHWs in licensed and certified health systems, that ensures public and private insurance payments incentivize a range of high quality patient support and community health services.

I-PaCS provides a model for meaningful financial support for services and systems improvements necessary to address the shortcomings of the traditional medical model, foster clinical intervention, and improve the overall health system, impacting the Medicaid eligible patients both inside and outside of the bricks and mortar of health facilities. The model engages patients to make better, more informed choices regarding utilization of health and social services and healthy behaviors. The data gleaned from these processes is used to improve health systems, as well as economic and social service policy, which better supports the environment necessary for improved population health and a balanced Medicaid budget.

Tomes have been written about various aspects of health improvement processes. Many like PCMH models, meaningful use of electronic health records, revenue sharing and other touted strategies look to clinical or medical delivery systems improvements to impact cost and value in the health care marketplace. Much of this innovation is driven by Medicare and Medicaid through requirements for contracting MCOs or ACOs in a variety of efforts to constrain the costs of care through "value" incentives

for more efficiently delivered services, improve health outcomes by meeting milestones in patient care and disease monitoring through accreditation or standardization of patient care processes. These models more frequently look at the patient through the eyes of the licensed health professional. After all, for the last several generations licensed health professionals have been at the center of the health system because they are until recently in the US, the only source of revenue for the health care system. The system is therefore literally built around technical provider skills and the tools they need to do their jobs and generate sufficient resources to continue to build their system. This story of resultant spiraling health care costs and its causes is well documented.

Even with public health intervention strategies, the focus is often on individuals (smoking cessation) or disease processes (diabetes support groups) rather than the upstream investments necessary to impact health more broadly by reducing social stress and improving opportunities for better health. Small investments over large populations have been proven to bring greater gains in population health.

Innovative Capitated Payment System for CHWs

Until recently, the U.S. health system has relied solely on Fee-for-Service (FFS) payments to ensure patient care, especially in underserved population settings. The relatively new emphasis on value and population-based payments, as well as shared savings have the potential to meet the triple aim of health care (i.e. improving the experience of care, improving the health of populations, and reducing the per capita costs of health care).

Much of the current work around payments for patient support services is linked to the FFS model. Billing codes have been created in Medicare and the ICD-10 now has Z-codes to document social impact on health. The coding and payment processes are inexorably linked to clinical events, requiring a face-to-face licensed provider encounter to either initiate the CHW intervention or link the encounter to every CHW intervention. This places a burden on already provider-centric systems of care and does not take advantage of the non-clinical aspects of the health process such as social services facilitation or patient processes that do not require a licensed health professional.

When CHWs are linked to the FFS model—a volume-focused concept that encourages frequency but not quality interventions—it negates the effectiveness of the CHW role. The FFS model documents that an activity has occurred but doesn't respond to critical questions such as outcomes or improvements, which are the fundamental principles of CHW program development. Some recent contracting with third party payers require reporting on HEDIS or other outcomes measures, and patient satisfaction surveys to supplement improvement priorities, but they are separate requirements from the FFS payment concept.

Under the I-PaCS model, a PMPM contract is developed that specifically identifies the services provided and the deliverables required to warrant the PMPM payment. Intensive Patient Support services are reviewed monthly as described below. Upstream patient and community support services also have specific outcomes goals. On a monthly basis, the contracted provider certifies that the work has been done and the MCO reviews progress. This does several things in terms of health system improvement. First, the payments are not based on the frequency of licensed provider contact as in FFS thinking, but based on performance and meeting the terms of the contract. This reduces the volume incentive and

allows the contracting organization and CHWs to focus on quality as prescribed. It changes the traditional rapid diagnoses and treatment approach to short-term episodic problems and replaces it with a non-clinical support system well beyond the four walls of a clinic.

This payment model serves to raise the status of CHWs in the work place by providing a directly auditable revenue stream that can be evaluated by organizations in the same manner as any revenue-generating department. This shift from "soft-money" or cost shifting within an organization recognizes I-PaCS as social or non-clinical service line that exists based on its value to the organization as well as the patient. In terms of overall health equity and disparities, this is an important development in the changing health care system.

As a business model, I-PaCS is an insurance product formed under contract between providers and MCOs either separately or as a section of a service contract. As a social, primary care linked strategy for improving care, cost and health it is uniquely articulated health care innovation that is comprehensive and replicable across any setting.

MCOs Care Coordination Mandate

Centennial Care is the New Mexico Human Service Department's "Section 1115" Waiver. Within both the Centennial Care 2012 application and the 2014 NM-HSD Medical Assistance Division Managed Care Policy Manual there are many references to care coordination, which is cited as a primary principle of the program. I-PaCS builds these principles into a comprehensive services delivery system to achieve the goals of Centennial Care in improving health and reducing costs. The I-PaCS model serves to wrap Medicaid patients in medical and social services while identifying key issues impacting New Mexico's most vulnerable populations in terms of health. The following table shows how I-PaCS responds to key components of the state Medicaid program priorities and how local clinic-based care and population health strategies can supplement or improve care coordination requirements.

In summary, I-PaCS is the most comprehensive and integrated model and the only one dedicated specifically to Medicaid patient support. It actively assists MCOs and providers in identifying high needs patients, social determinants underlying ill health and creates strategies for improving the environment in which Medicaid patients receive care as well as where they live.

Care Coordination Activity/Goal	System Improvement through I-PaCS
ELEMENTS OF 1115 WAIVER: SECTION 3	
Stratify recipients by risk	Each member registered at the clinic and that has received services within the past two year, regardless of their level of risk, is screened when they seek healthcare services at a clinic or other point of service for social determinants of health using the Well RX, and for use of an emergency room during the past 12 months. Screening results determine if the member requires CHW services, and IPS services in addition to the ComPS services. MCO is contacted for approval to proceed with IPS services.
Capitation payment will be adjusted by risk	I-PaCS has a two-tiered payment system based on risk. Members needing only ComPS services are billed a small PMPM and those who are approved for IPS services are billed at a higher PMPM.
Increase the health literacy of its recipients	CHWs provide health literacy education within the clinic setting and through community referrals.
Increased integration through the expansion of patient centered medical homes and health homes with intensive care management provided at the point of service	For clinics with PCMH recognition I-PaCS enhances services by addressing SDH and strengthens the clinic to community connection. For clinics without PCMH recognition, I-PaCS provides a structured approach towards building core components required for PCMH recognition. I-PaCS is projected to have a greater return-on-investment than PCMHs.
Emphasize the use of technology to bring health care to underserved populations and maximize the use of alternative care settings over emergency rooms	I-PaCS encourages the use of EHRs for pre-visit screening of Medicaid members to determine if the patient is compliant with provider prescribed labs, appointments, immunizations, referrals and other recommended health care. Via the EHR system providers are alerted to patient non-compliance and the CHW can assist the patient with overcoming barriers and improving access to care.
Prepare for the newly eligible population under the PPACA	Local clinics offer an open door to Medicaid members and potential Medicaid members. Local outreach efforts are typically more culturally appropriate than are centralized efforts in getting people into the clinic and verifying if a patient has Medicaid coverage. Those without insurance are identified by clinic staff and are referred to CHWs assist with enrollment.
A new emphasis on payment reform in selected pilots to reward providers based on patient outcomes, as opposed to the volume of care provided	The I-PaCS model is designed to track the health care costs and health outcomes for each member receiving intervention by the CHW. Specifically, ER and primary care utilization is tracked along with the number of social needs addressed, for members receiving CHW intervention (ComPS and IPS). Results are compared to members who do not receive CHW intervention.
ELEMENTS OF 1115 WAIVER: SECTION 4	
Assess each recipient's physical, behavioral, functional and psychosocial needs.	Results of CHWs pre-visit EHR screenings, as well as the WellRx and SF-12 screenings, are shared among clinic team members, providing a comprehensive assessment of the patient's needs.
Identify the medical, behavioral and long term care services and other social support services & assistance (e.g., housing, transportation or income assistance) necessary to meet identified needs	Comprehensive screening help identify both clinical needs and social support needs. I-PaCS is unique in that it identifies social determinants and facilitates connecting the member with appropriate community and clinical supports. Referral tracking and follow-up with the member will ensure that these needs have been addressed.
Ensure timely access and provision, coordination and monitoring of services.	CHWs develop trusting relationships with members and assist them with navigating complex healthcare systems. Pre-visit checks will monitor access to and coordination of care. Missed appointments or the lack of compliance are addressed by CHWs in a respectful and caring manner to resolve barriers to care.
Facilitate access to other social support services and assistance needed in order to promote each recipient's health, safety and welfare.	This principle is one of the cornerstones of the I-PaCS model. CHWs will link members with appropriate resources and follow-up to be sure that the members' needs have been met.

EVALUATION FRAMEWORK

The main assumption of the I-PaCS model is that, by addressing SDH within the primary care clinic setting, patients living in adverse socio-economic conditions will increase their utilization of, and satisfaction with, primary care and demonstrate improved health outcomes; clinic providers will have increased satisfaction; payers will enjoy cost savings; and health equity will be increased. While patients with many medical needs receive intense care coordination under a different model, patients with less intense or no health issues can also benefit from CHW services such as health education, health management planning, and care coordination assistance in the primary care setting.

Process Evaluation

Since sites have some leeway in how the model is integrated into their facilities, clinics adopting the I-PaCS model will be asked to document the way that the project is designed and implemented at their sites (e.g., who is responsible for doing what, what tools are being used, how is data being captured, etc.). Clinics will document whether implementation is following protocols that have been established for the project and identify what aspects of the project are working well and what aspects have proven to be challenging. They will also document perceptions of clinic stakeholders regarding the value of the project to providers in their provision of patient care and to patient health outcomes and to provide impressions about the ways that the model may have affected the relationship between the clinic and the community.

Reach Evaluation

The model has the potential to impact health on the individual, patient panel, clinic, community, and state levels. The reach component of the process evaluation pertains to measuring these impacts, which requires documentation of: the numbers of patients impacted, the number of SDH needs identified, the number of resources to which patients were linked (e.g., social services, utilities assistance, etc.), the number and quality of relationships built between participating clinics and other organizations or systems (e.g., community groups, state agencies), and the number of policies, procedures, or interventions developed as a result of the model's adoption (e.g., a policy to open closed panels to Medicaid patients without a medical home, traffic lights installed on dangerous streets).

Outcome Evaluation

The outcomes evaluation is divided into short-, medium- and long-term outcomes. In the short-term, a data reporting system needs to be established to document the patient intervention from the CHW, the clinics will need to provide a list of paneled patients who are members of the participating MCOs to the MCOs, the participating MCOs need to assign Health Risk Assessment (HRA) levels to the panels, and the MCO or New Mexico Human Services Department needs to provide cost and utilization data, from billing records, based on the clinic-provided lists. The medium-term outcomes are specific to the change in medical care utilization by clinic patients and the social needs that were identified and addressed. Three utilization measures of interest include the number of emergency department visits, the count of hospital readmissions and the number of primary visits per patient. The long-term outcomes focus on the concepts of effectiveness, efficiency and equity of care. The long-term measures include cost-of-care reductions, improved outcomes of care, measures of patient and provider experience, and evidence of health equity improvement.

I-PaCS Evaluation Logic Model

Ecology & Context	Structure	Process		Outcomes		
		Process Evaluation	*Reach Evaluation*	*Short-term*	*Medium-term*	*Long-term*
Rationale	*Evaluation Resources*			*Data Reporting System*		*Ultimate impacts*
Patients with adverse socio-economic conditions have worse health outcomes and consume more health service resources	UNMHSC-OCH and SWCHI staff members' experience developing and implementing a pilot program	How was the model implemented? What were challenges and successes?	How many members participated?	CHWs document their work with patients in an internal database that is shared with the OCH Evaluation Team	Number of ER visits and rehospitalizations reduced	Reduced cost
Primary care providers are frustrated by their inability to affect the health of these patients because of the confounding effects of SDH.	UNMHSC-OCH faculty and staff members' experience evaluating similar programs	Do providers believe the model improves care and/or ease of care?	How many SDH were identified?	Clinics provide lists of empaneled patients to MCOs, which provides HRA level assignments to them	Percent increase in primary care utilization	Improved outcomes
No focus on and lack of resources available within the primary care clinic site to address SDH	Buy-in from clinic systems, Medicaid, and MCOs	How were CHWs integrated into clinic operations and how did that process go?	To which external resources were members linked?	HSD and/or MCOs provide cost and utilization data on enrolled patients to OCH Evaluation Team	Number of social needs addressed via CHW referral	Improved patient satisfaction
Members could benefits from CHW services in the primary care clinic setting		How has the model changed the relationship between clinic and community?	With which external organizations or systems were relationships formed?			Improved provider satisfaction
Members could benefit from community health improvement			What policies or procedural changes have resulted from the			Improved health equity

Assumptions

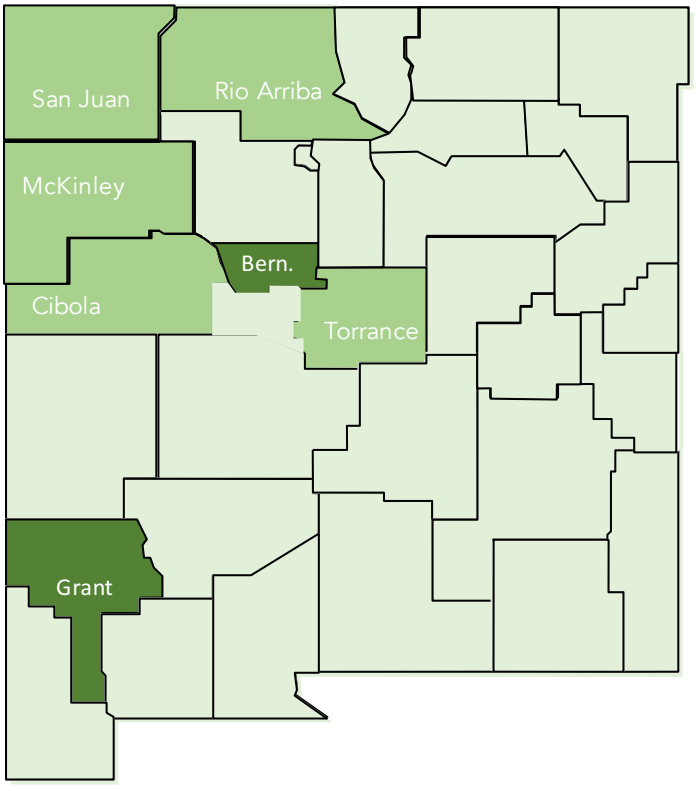
By addressing social determinants of health within the clinic setting, patients with adverse socio-economic conditions will increase their utilization of, and satisfaction with, primary care and demonstrate improved health outcomes; clinic providers will have increased satisfaction; payers will enjoy cost savings; and health equity will improve.

DISSEMINATION AND EXPANSION OF I-PACS MODEL

The development of the I-PaCS model has taken place over many years, with two years of piloting the model and payment system—first in one Federally-Qualified Health Center in Bernalillo County and then in three additional primary care sites in Albuquerque and one in Silver City. These pilots further informed the model, and allowed for testing of concepts. In coming years, we recommend the dissemination and expansion of I-PaCS to more sites and into more counties, and performed a preliminary analysis of potential future sites.

Service Areas with Low Health Status Indicators

In order to determine the counties most in need of the I-PaCS intervention, attempts were made during the first year to obtain Medicaid per capita expenses by county in New Mexico. Since MCO contracts are based on a Per Member Per Month payment to MCOs based on attribution to the MCO rather than an average cost per person, these data were not readily available in a form that would allow prioritization of counties based on cost. It was determined therefore, to use health and social status as a predictor of high priority Medicaid areas. Based on a broad analysis using County Health Ranking factors that included not only on overall health factors, but also Social and Economic Factors, Physical Environment, and Health Behaviors, we found the following counties to be the highest priority areas: McKinley, San Juan, Cibola, Rio Arriba, and Torrance counties.



Social and Economic

- % High school graduates
- % With some college
- % Unemployment
- % Children in poverty
- Income inequality
- % Children in single-parent household
- Social associations
- Violent crime
- Injury deaths

Physical Environment

- Air pollution/particulate matter
- Drinking water violations
- % Severe housing problems
- % Driving alone to work
- Long-commute driving alone

Health Behaviors

- % Adult smoking
- % Adult obesity
- Food environment index
- % Physical inactivity
- % Access to exercise opportunities
- % Excessive drinking
- % Alcohol-impaired driving deaths
- Sexually transmitted infections
- Teen births

RECOMMENDATIONS FOR I-PACS ROLLOUT

Provider Contracting Readiness Assessments

The development of I-PaCS will be dependent on its adoption over time by state Medicaid MCOs, and their priorities for roll out of the model. Direction for priority areas can be provided internally at MCOs based on their assessment of cost, such as emergency room over-utilization or performance and health outcomes related measures like HEDIS. These specific criteria may best determine the greatest cost savings and health outcome improvements. The state could also use overall prioritization data such as presented above in the services are priorities section to determine that greatest possible impact. Another possibility is the general distribution of information about the program to all Medicaid providers to ascertain interest in program development. All of these approaches (MCO identified priorities, state identified priorities and self-Identification) are reasonable approaches to program development.

Once an area or provider is identified as a priority for development, I-PaCS development staff at UNM would conduct a readiness assessment for program implementation. A provider or providers regardless of method of identification, would be contacted for interest. Information about the program would be sent electronically with links to program information and criteria. A message or phone based conversation would initiate the effort. Assuming provider interest, an on-site visit would be conducted where a formal assessment of readiness would be conducted by I-PaCS development staff using the standards and guidelines included in this report as well as other assessment such as determining Patient Centered Medical Home (PCMH) status or the status and scope of services of existing patient support programs within the provider organization.

Following the visit, a report will be prepared for each interested provider determining readiness status and gaps in service delivery necessary to meet I-PaCS program / MCO contracting criteria. The report will contain recommendations for development technical assistance that can be performed by I-PaCS staff. After the technical assistance is perform and gaps in readiness are remediated, the provider will be “certified” for MCO contracting by the I-PaCS program.

Technical Assistance

UNMHSC Office for Community Health (OCH) and its partners propose incorporate a statewide technical assistance program in support of I-PaCS dissemination. The combined experience of OCH and SWCHI in CHW model development allows for a wide range of expertise on CHW training, patient support system integration in primary care settings, behavioral health and primary care CHW support, etc. UNM and CHI staff have a statewide presence through the HEROs program and community based outreach locations. Each I-PaCS involved staff will receive train-the-trainer level preparation for the following areas of technical assistance:

Medicaid / MCO Contracting

1. Site Readiness Assessment
2. Standards and Guidelines Evaluation and Certification

3. MCO contracting for I-PaCS Services

Provider / Site Contracting

4. Community Health Worker Program Development – Organizational Planning
5. Community Health Workers Basic and Skilled Training – Comprehensive Patient Support
6. Community Health Worker Advanced Training – Integrated Care Coordination Services
7. Program Detailing and Clinical and Non-Clinical Service Integration
8. I-PaCS Program Budgeting - PMPM vs Fee-for-Service Financing
9. Primary Care and I-PaCS Data Integration and Reporting
10. Community Engagement and Population Health
11. Program Evaluation

I-PaCS is proposing to utilize year two of the HSD contract to develop staff capacity in these areas based on the development of the model. Future, technical assistance support will consistent of on-going Medicaid sub-contracting including MCO contracts. These contracts would include site assessment and program context work with providers. OCH and CHI will also devise a contracting mechanism for technical assistance directly with providers developing I-PaCS contracts with MCOs.

STANDARDS & GUIDELINES

I-PaCS
Integrated Primary Care and Community Support

I-PaCS is a community health worker model and health service delivery product that reflects the industry contracting standards for reimbursable services. It standardizes a broad range of Medicaid patient support services that are amenable to PMPM payments based on the quality of services provided. The I-PaCS standards are a structured way to transform healthcare delivery to address the needs of all Medicaid members, ranging from those who are very healthy to those who are very unhealthy. They provide guidelines for CHWs to provide patient support strategies at both the clinic and community levels. The standards recognize the inadequacy of the current system and its impact on the health of individuals and communities. The I-PaCS model and these standards support principals of patient empowerment, patient-centered care, quality care and prevention. The standards are based on nationally recognized and evidence-based frameworks, including Community Centered Health Homes, community health worker models, Patient Centered Medical Homes (PCMH), care coordination and the CMS Accountable Health Communities model. I-PaCS also incorporates the main concepts of the 2016 New Mexico Department of Health and Human Services Departments, Health System Innovation design (SIM) project. Please see the appendices for more information on these frameworks.

The standards are designed to promote health by empowering both individuals and communities to address conditions that influence health using CHWs. For health care facilities that currently have PCMH recognition, these standards will assist them in taking a lead role in becoming a Community Centered Health Home. For health care facilities that do not yet have PCMH recognition, the standards can serve as a high quality road map that leads to PCMH recognition in collaboration with the NM Health System Innovation design. Finally, the standards and associated requirements provide a tool for model fidelity, practice accountability and quality assessment. Each contracted entity (CE) must demonstrate the ability to provide services as specified or have a time-framed plan for internal systems development to do so.

The following section details a checklist of standards that provide a clear infrastructure for contracting requirements and deliverables for 13 elements related to both the primary care linked strategy and the community health improvement strategy of the I-PaCS model:

Comprehensive Patient Support	A	Assess and stratify member's individual needs
	B	Community Service & Health Care Navigation
	C	Follow-up
	D	Documentation and Data Collection
	E	Culturally and Linguistically Appropriate Services
	F	CHW Care Coordination Training, Supervision, and Practice Team
Intensive Patient Support	G	Verification of Eligibility
	H	Referral Follow-up
	I	Plan and Manage Care
	J	CHW Training, Supervision and Practice Team
Community Health Improvement	K	Community Assessment
	L	Outreach
	M	Training and Practice Team

I-PaCS Standards and Contracting Requirements

Primary Care Linked Strategy (PCLS)

Comprehensive Patient Support (ComPS)

Support for any Medicaid beneficiary who comes to a primary care site and who screens positive for 1 or more social needs included in the WellRx questions or Z-codes in ICD-10 and / or may require health system navigation or prevention-related services to stop the progression of a recently identified health issue. For Comprehensive Patient Support, CHWs provide general information about and facilitate access to available resources, provide health education or other information, and assist in scheduling appointments with social services agencies.

Model/Framework

	STANDARD	REQUIRED ACTION / DELIVERABLE	I-PaCS	CMS-ACH	PI-CCHH	PCMH	SIM
ELEMENT A Assess and stratify member's individual needs	**A1. Document** the number of Medicaid members that access the clinic annually for preventive services and/ or care.	☐ Provide written documentation of policy regarding consistent recordkeeping and documentation. ☐ Monthly report.		*			
	A2. Verify Medicaid eligibility, contact and demographic information.	☐ Keep and submit log of contact or record review. ☐ Document proof of Medicaid eligibility in patient record.					
	A3. Well Rx Screening: Minimum of 80% of CE patients who access the clinic are offered a screening for social determinants of health at each visit [using the Well Rx and/or CMS Z-Codes in patient health records].	☐ Administer WellRx and record results in patient record. ☐ Provide written documentation of policy regarding administration of WellRx. ☐ Enter corresponding Z-codes in EHR system. ☐ Annual report with analysis of WellRx results, report of Z-codes entered into EHR.	*	*	*	*	*
	A4. SF-12: 100% of Medicaid members who screen positive for adverse SDH and want services, complete or are offered an SF-12 to determine member's self-assessment of functionality. SF-12 completed at intake and yearly at annual exam.	☐ Provide written documentation of policy to offer SF-12 to all MCO members. ☐ Administer SF-12 to those who are interested. ☐ Document results in patient record. ☐ Annual report with number and % of MCO members completing SF-12 and analysis of SF-12 results. The research core, if needed, will provide technical assistance.	*				

	STANDARD	REQUIRED ACTION / DELIVERABLE	I-PaCS	CMS-ACH	PI-CCHH	PCMH	SIM
	A5. Identify high-risk or complex patients (see IPS definition) and communicate with MCO regarding these members, following established criteria and process.	☐ Provide written documentation of high-risk or complex patients. ☐ Monthly invoice report with documentation.				*	*
	A6. Pre-visit preparation is conducted. [e.g. CHW checks the EMR of each Medicaid member to see if he/she has been ordered lab tests, referrals to specialists, etc. Checks the MCO referral to see why these patients are considered eligible for care coordination services.]	☐ Provide written documentation of PnP for pre-visit review. ☐ Documentation system for obstacles and member needs. ☐ Report summarizing obstacles and member needs.	*			*	*
	A7. Review clinical diagnoses and primary care referrals from prior visits. Determine status of follow-up and any member obstacles and needs.	☐ PnP showing review process. ☐ Documentation of obstacles or member needs. ☐ Report summarizing obstacles and member needs.					
ELEMENT B Community Service & Health Care Navigation	**B1. Systems:** The CE establishes referral and follow-up systems for social or related services. The CHW matches Medicaid member's identified social needs with community service providers and/or assists member to identify other social supports.	☐ Community services resource inventory. ☐ Documentation of CE referrals to CHW. ☐ Keep CHW log of intervention with patient including patient referral to community service providers and other social supports. ☐ Create patient care plan as appropriate (IPS members only).	*	*			
	B2. **Referral review** and summary with Medicaid member and distributes copy to member.	☐ Provide written documentation of policy to ensure that information is provided to patients in a consistent manner.		*			
	B3. Community resource list: Maintains a current community resource list on topics of importance to the Medicaid member population as determined by WellRx or Z-codes.	☐ Sample list of community resources		*		*	*

	STANDARD	REQUIRED ACTION / DELIVERABLE	I-PaCS	CMS-ACH	PI-CCHH	PCMH	SIM
ELEMENT C Follow-up	**C1. Documentation**: CE documents the follow-up contact with Medicaid member within 2 weeks of member accepting community referral.	☐ Create community services resource inventory. ☐ Keep log of contact with member.	*	*			
	C2. Results: Documentation of Medicaid member connection with community service provider or connection unattained and determined as unresolvable.	☐ Keep log of contact with members who accept intervention. ☐ Document outcomes of referral in Log of Contact ☐ Create Care Plan (IPS members only).		*			
	C3. Contact: When Medicaid member has an appointment with healthcare provider at the clinic, CHW or other clinic staff calls the day before and assesses if patient would like to meet again.	☐ Keep Log of Contact or record review. ☐ Provide written documentation of PnP regarding referral and follow-up system.					
ELEMENT D Documentation and Data Collection	**D1. Policy and procedure:** CE has policy and procedure (PnP) for documenting Medicaid member's information (name, DOB, race, ethnicity, telephone, address, dates of previous clinical visits, PCP, etc.) if separate from the primary care provider information system. If one system, verifies Medicaid member's information.	☐ Provide written documentation of PnP for documentation of patient data. ☐ Register patients. ☐ Keep log of contact or record review.					
	D2. Forms and operations: PnPs support documentation of CHW intervention using standard forms and operating procedures. Information must include Medicaid member name, ID, DOB, subscriber ID, CHW name, length of interaction time, nature of interaction, results of interaction, follow-up and resolution.	☐ Provide written documentation of PnP to document CHW interventions. ☐ Keep log of contact or record review.					
	D3. Encounters: PnPs support documentation of each encounter with a Medicaid member and possible systemic barriers faced by members	☐ Provide written documentation of PnP to identify and document member barriers. ☐ Keep log of contact or record review.					
	D4. Patient satisfaction: The practice conducts a patient satisfaction survey to evaluate Medicaid member/family experience on at least three categories according to CE approved PnPs.	☐ Provide written documentation of PnP to administer patient satisfaction survey. ☐ Administer patient satisfaction survey and provide summary of survey results.				*	

	STANDARD	REQUIRED ACTION / DELIVERABLE	I-PaCS	CMS-ACH	PI-CCHH	PCMH	SIM
ELEMENT E Culturally and Linguistically Appropriate Services	**E1. Race/ethnicity**: Assess the racial and ethnic diversity of the Medicaid members.	☐ Provide written documentation of PnP to document racial and ethnic self-identification of MCO members ☐ Summary of racial and ethnic report.				*	*
	E2. Language: Assess the language needs of the Medicaid members.	☐ Provide written documentation of PnP to assess the language needs of MCO members. ☐ Summary of language needs report.				*	*
	E3. Services: Provide clinically relevant materials and prevention services that meet the language needs of Medicaid.	☐ Provide written documentation of PnP to provide linguistically appropriate materials to MCO members. ☐ Examples of services provided.				*	*
	E4. Materials: Provide printed materials in the languages of MCO members.	☐ Screen shot or supporting documentation.				*	*
ELEMENT F CHW Care Coordination Training, Supervision, and Practice Team	**F1. Role/scope**: CE demonstrates job descriptions and processes that define CHW (and/or other CE staff) that ensure role and scope for comprehensive patient support.	☐ Provide written documentation of job description. ☐ Provide written description of patient flow matrices or operational policies for patient support services.				*	*
	F2. Training: At a minimum, CE will document that CHWs or other CE staff have functional comprehensive patient support knowledge in: prevalent health conditions, mental health disorders, substance use disorders, interviewing techniques, care planning, cultural competency, self-advocacy, self-direction, parent/family engagement, and community-specific resources, data collection and documentation.	☐ Provide written documentation of policy related to CHW training requirement. ☐ Create a training schedule. ☐ Create HR system for documentation of training. ☐ Provide documentation of training curriculum.		*			
	F3. Supervision: CE provider staff and staff with ties to clinic operations, provide supervision.	☐ Provide written documentation of job description. ☐ Provide documentation of org chart outlining supervisory roles.					
	F4. Check-ins: For CHWs providing comprehensive patient support, one-on-one supervision is provided at least bi-weekly (2x per month).	☐ Provide supervision. ☐ Supervisor keeps notes from check-ins and supervisory meetings.					
	F5. Communication: Having regular CHW team meetings or a structured communication process between CHWs and providers, and among CHWs, regarding identified clinical and social issues.	☐ Provide documentation of PnP regarding regular CHW team meetings and communication. ☐ Keep minutes from meetings (at least quarterly) ☐ Create and keep agendas from meetings.				*	

INTENSIVE PATIENT SUPPORT (IPS)

CEs providing Intensive Patient Support must meet all standards for Comprehensive Patient Support Elements A-F, PLUS Elements G-I.

Individuals who qualify for Intensive Patient Support services must have a) two or more ER visits in last 12 months and identify at least 1 positive on the WellRx, or other social determinant screening tool; b) more than 4 positives on the WellRx or other social determinant screening tool; or c) be referred to the I-PaCS provider by the MCO. CHW intervention may include more intensive follow-up and referral monitoring, home visits, individualized and approved care plans, chronic disease management, case review by MCOs, applying for a broad range of social service assistance, etc.

	STANDARD	REQUIRED ACTION / DELIVERABLE	I-PaCS	CMS-ACH	PI-CCHH	PCMH	SIM
ELEMENT G Verification of Eligibility	**G1. Well Rx**: Complete initial clinical and SDH assessment (WellRx or Z-codes) within 30 days of referral from MCO.	☐ Complete assessment. ☐ Place assessment results in patient file. ☐ Provide documentation of completed assessments.					
	G2. PCP: Medicaid member's primary care provider's office of record, if known, is contacted to inform provider of involvement with member.	☐ Keep log of contact or record review					
ELEMENT H Referral Follow-up	**H1. Monthly follow-up:** CHW will follow-up at least monthly with Medicaid member to assess status of social services referral(s), prescription adherence and/ or referrals to specialists or for labs.	☐ Conduct monthly follow-ups. ☐ Keep log of contact or record review. ☐ Document results of follow-up contacts.					
	H2. Missed appointments: CHW will follow up with Medicaid members who have not kept important appointments.	☐ Keep log of contact or record review.				*	*
ELEMENT I Plan and Manage Care	**I1. Develop Care Plan**: CHW collaborates with patient/family/treatment team to develop individual care plan including goals that are updated at each relevant visit.	☐ Document visit to develop plan of care in log of contact. ☐ Plan of care is documented in patient record.	*	*		*	*
	I2. Share with member: Medicaid member is given a written care plan according to established CE protocols.	☐ Monthly report or record review.				*	*

	I3. Referral: Refers at-risk Medicaid members to educational resources to assist in chronic disease self-management and/or other health issues. Provides a list of community resources.	☐ Maintain referral-tracking log. ☐ Enter activity into patient record.	*			*	*
	I4. PCP Relationship: Work with Medicaid member to develop an ongoing relationship with their Primary Care Provider by serving on a care team or facilitating access to initial or follow up patient visits and serving as a patient advocate within the CE.	☐ Maintain in log. ☐ Enter activity into patient record.	*				
	I5. Services: If CE offers group visits or educational services, the CHW or other CE representative coordinates group visits for members with similar chronic diseases. If not, the CE facilitate access to peer support or other group modalities for care coordination and support.	☐ Create and keep meeting agenda. ☐ Take and keep meeting minutes. ☐ Create and keep meeting sign-in sheet. ☐ Other peer support activities are documented in log of contact.	*				
	I6. Navigation: Medicaid member is educated in navigating health care system (Nurse Advice Line, use of ER, urgent care, etc.) more appropriately.	☐ Maintain log of contact or record review. ☐ Maintain CHW intervention log.	*				
	I7. Utilization: Medicaid member is educated on best way to utilize their PCP, SPC, Urgent Care facilities and other condition management programs.	☐ Maintain log of contact or record review.					
	I8. Monitoring: Plan of Care is developed in collaboration with Medicaid member, MCO and CHW including goals that are updated at each relevant visit.	☐ Complete and have patient sign Plan of Care. ☐ Place copy of care plan in patient record				*	*
	I9. Review goals: Meet with MCO to review and determine if Medicaid member has successfully met established goals in Plan of Care at the end of 180 days.	☐ Maintain log of contact or record review.	*				
	I10. Report to MCO on Plan of Care including but not limited to the Medicaid member's progress and barriers and solutions to member's care.	☐ Maintain log of contact or record review.					
	I11. Duration of services: Continue to see Medicaid members until such time as the member is no longer eligible to receive services; refuses services; us unable to be contacted; has successfully met Plan of Care goals; or is unwilling or unable to comply with Plan of Care.	☐ Maintain log of contact or record review.					

	STANDARD	REQUIRED ACTION / DELIVERABLE	I-PaCS	CMS-ACH	PI-CCHH	PCMH	SIM
ELEMENT J CHW Training, Supervision and Practice Team	**J1. Role/scope**: Define CHW role and scope for the Intensive Patient Support services for both clinical and nonclinical team members.	☐ Provide written documentation of job description. ☐ Provide written documentation of PnP for reporting.				*	*
	J2. Training: At a minimum, Level 3 CHWs shall have functional knowledge in all the comprehensive patient support areas.	☐ Provide written documentation of policy related to CHW training requirement. ☐ Provide documentation of training curriculum. ☐ Create a training schedule. ☐ Create HR system for documentation of training		*		*	*
	J3. Supervision is provided by CE staff with ties to primary care operations and providers.	☐ Provide written documentation of job description. ☐ Provide documentation of org chart.					
	J4. Check-ins: For CHWs providing Intensive Patient Support, one-on-one supervision is provided at least bi-weekly (2x per month).	☐ Provide supervision. ☐ Supervisor keeps notes from check-ins and supervisory meetings.					
	J5. Communication: Having regular CHW team meetings or a structured communication process between CHWs and providers regarding identified social issues.	☐ Provide documentation of PnP regarding regular CHW team meetings and communication. Keep minutes from meetings (at least quarterly) ☐ Create and keep agendas from meetings.				*	

Community Health Improvement Strategy (CHIS)

	STANDARD	REQUIRED ACTION / DELIVERABLE	I-PaCS	CMS-ACH	PI-CCHH	PCMH	SIM
ELEMENT K Community Assessment	**K1. Social needs**: Contracting Entity (CE) works with Health Council, or other community health planning entity, to conduct an assessment of Medicaid patient health and social needs that includes inquiry, analysis and action. Inquiry: Collect data from Medicaid patients and how needs relate to a community-wide perspective Analysis: Analyze trends within the data and establish priorities for health interventions, bearing in mind that any intervention must be appropriate to Medicaid members within the context of the particular community. Action: A written action/work plan and updates on the interventions. Communications with the community take place to ensure outcomes are satisfactory to all.	☐ Summary of Medicaid members' socials needs are shared with community ☐ Community assessment is conducted incorporating Medicaid members' social needs. ☐ Provide written documentation of time-framed and prioritized action/work plan and strategies. ☐ Provide monthly updates included with MCO invoices for I-PaCS payments.				*	
	K2. Health needs: CE works with Health Council or related entity to conduct a community assessment of health equity/disparities. Assessment to include key factors impacting the health of Medicaid patients **OR** CE works with Health Council or related entity to conduct a comparative analysis of health status indicators to determine health disparities between Medicaid eligible individuals to determine health disparities.	☐ Identify population health data sources. ☐ Identify key equity issues for the community.	*				*
	K3. Grassroots efforts: CE demonstrates CHW or other CE representative's participation in grassroots efforts to address social issues that affect the health of Medicaid community members. If participation is not by CHW, CE must demonstrate how information is shared with CHWs and providers.	☐ Create and keep meeting agendas. ☐ Take and keep meeting minutes. ☐ Keep sign in sheets. ☐ Create community action plans. ☐ Keep plan updates. ☐ Keep meeting logs. ☐ Document communication between CE representative (if applicable), CHWs and providers.					*

	STANDARD	REQUIRED ACTION / DELIVERABLE	I-PaCS	CMS-ACH	PI-CCHH	PCMH	SIM
ELEMENT L Outreach	**L1. Preventative services**: CE demonstrates efforts to inform all clinic-registered Medicaid members about the benefits of clinical preventive services […including but not limited to primary medical, dental and behavioral health care, nurse advice line, and preventive services such as pre-natal care, vaccines and screenings.]	☐ Create PnP for disseminating information. ☐ Copies of materials disseminated and/ or of electronic communication.	*	*			
	L2. **Community resources**: CE demonstrates efforts to inform all clinic-registered Medicaid members about community resources available to support preventive care including but not limited to health education classes around healthy and active living, nutrition, walking groups, cooking classes and other health prevention related issues; and information events such as health fairs and eligibility and enrollment fairs.	☐ Create PnP for disseminating information. ☐ Copies of materials disseminated and/ or of electronic communication.	*				*
	L3. Resource list: CHWs and/or other CE staff contributed to community resource list, which may include SHARE NM.	☐ Create list or database of community services and coalitions. ☐ Create PnP for ensuring that the list is maintained and updated.		*			*
ELEMENT M Culturally and Linguistically Appropriate Services	**M1. Role/scope:** Defined CHW role and scope for population health strategies.	☐ Provide written documentation of job description.					
	M2. Population Health CHW Training: At a minimum, CHWs shall have functional knowledge in: leading and/or participate in community health-related coalitions, community needs assessment, interviewing skills, and effective oral communication.	☐ Provide written documentation of policy regarding training. ☐ Provide written documentation of training schedule and curriculum.					
	M3. Communication: CE has regular CHW team meetings or a structured communication process between CHWs and providers regarding identified population health and social issues.	☐ Provide documentation of PnP regarding regular CHW team meetings and communication. ☐ Keep minutes from meetings (at least quarterly). ☐ Create and keep agendas from meetings.				*	

TOOLKIT

I-PaCS
Integrated Primary Care and Community Support

ENGAGING WITH CLINICAL SITES

Addressing Social Determinants of Health

The I-PaCS model is designed to address the SDH that greatly affect a patient's health. In Primary Health Care teams, we know that the social needs of our patients are important. We see patients every day who tell us that they can't take their medications because they can't afford them, make it to important medical appointments because they lack adequate transportation, they do not follow diet and exercise advice because they can hardly afford cheap and filling fast food for them and their families much less the organic vegetables we recommend that they eat. This reality is highlighted in the 2011 RWJF Foundation report "Health Care's Blind Side." This survey of 1,000 mostly primary care physicians in the United States showed that the great majority of these physicians felt that addressing the social needs of their patients was as important as addressing their medical conditions. These physicians, however, did not feel confident in responding to or addressing these social needs, and because they did not address SDH, the physicians felt that their patients' health was worse.

A health system that ignores the social needs of patients does not just adversely impact patient health; it makes the work of primary care more difficult. There are countless patients who never tell us about the social needs they face and when they are then unable to follow our treatment plan, it can be frustrating for both the patients and the care team. In our experience asking about these needs from the beginning of a clinical encounter and having a skilled member of the care team to assist the patient to address these needs transforms our ability to care for patients and unburdens the team.

For some members of your care team, screening patients for social needs and working with CHWs will be something that they are enthusiastic to take part in. Others may see this process as one more thing to add to an already overflowing workload. The following are suggested approaches that have been used to help get buy-in from different members of the care team and facilitate the successful integration of this new clinic process.

Preliminary Steps with Clinic Staff and Providers

Stage 1: Preliminary negotiations

- Present model to leadership at clinic sites.
- Identify "clinic champion" (provider).
- Review existing data collected by I-PaCS in Bernalillo and Grant counties.
- Define scope and sites:
  How many Medicaid beneficiaries by MCO?
  How many CHWs are needed?

Stage 2: Gather information from clinics

- Listen to clinic staff and providers:
  - Needs and Expectations
  - Review roles for CHWs
  - Study roles of existing positions within the clinic that may be similar to the CHW
  - Adapt job description of CHWs to meet the needs of the clinic.
- Get buy-in from Medical directors of each clinic to engage medical personnel.

Stage 3: Adapt training for CHWs and Providers

- Adapt I-PaCS curriculum for CHWs to meet the specific clinic context and needs.
- Adapt I-PaCS training for healthcare providers within the clinic.

Stage 4: Review roles and workflow at the clinic

- Define possible caseload for each CHW providing Comprehensive Patient Support and/or Intensive Patient Support.
- Facilitate a large meeting between providers, clinic staff and new CHWs to clarify roles and modify clinic workflow.
- Decide:
  - Who will do the screening and when.
  - How to share results of screening with provider.
  - Process for connecting patient to CHW, if patient wants help.

Buy-in from Providers and Clinic Leadership

Regardless of the operational structure of your clinic, buy in from the administrative and clinical leadership is imperative. However, it may not necessarily be the best or only starting point for getting buy-in from the team. Starting with providers and leadership in parallel is often a better strategy because providers will be intimately involved in piloting the needed process changes and they often have the ability to inspire other members of the care team to adopt changes. If providers are not on board not on board also have the power to quickly put a stop to this kind of initiative. Another advantage of starting with providers and leadership concurrently is that those who are reluctant to start screening their patients for social needs and work with CHW are very quickly able to see the advantages of working with these new team members. In our experience, providers who were reluctant to adopt the model at first had a change of heart after

observing the benefits reaped by early adopters.

Clinic Champion

In our experience, getting provider buy-in was facilitated by identifying and supporting a provider to be the "Clinic Champion." The "Clinic Champion" should be someone who believes in the proposed changes from the get-go and is frustrated by our inability to address social needs, or at a minimum is involved in quality improvement initiatives in the clinic and would be willing to take this on. It is important for "Clinic Champions" to be in the clinic most days of the week so that as challenges arise, the champion can address them promptly, and so they can be involved personally in piloting the process changes.

Clinic Champions

The clinic "champion" can help providers and clinical staff to understand how they- and their patients- will benefit from the integration of CHWs and SDH screening. This will help prevent teams from feeling like clinic leadership has simply imposed the model.

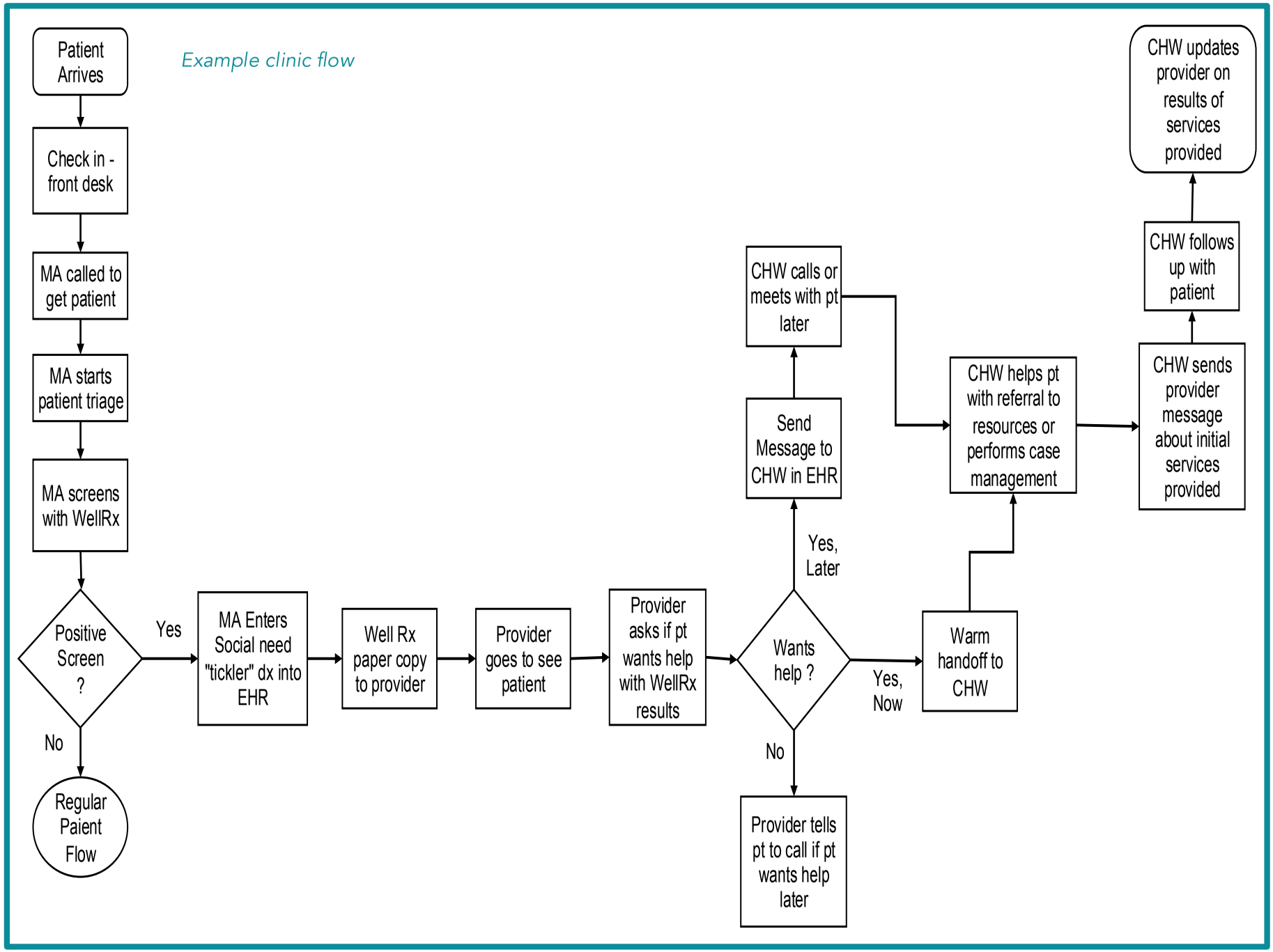
Unburdening Providers and Staff

Framing the process of screening for social needs and referral to community health workers as something that unburdens the care team instead of something that adds more to their plate was not just something that we found useful in convincing providers or staff to take part, but something that we found to be true as well. Many providers expressed that this change allowed them to focus more time and energy on the medical needs of their patients for which they have training rather than searching aimlessly for resources which they have little or new training in. Developing a short training for providers on the role of the community health worker-and how to work successfully in a team- can help to ease the transition.

Involving the Entire Care Team in Clinic Flow Redesign

While providers were important starting points for piloting these changes, some of the most valuable ideas and feedback have come from other members of the care team, like our medical assistants and either care managers or other team members involved in helping with chronic disease management. Similar to any quality improvement process, during the initial phase of piloting, the care team frequently discussed, during morning huddle, how the new clinic flow was working and what changes should be made. Changes were then incorporated into the clinic flow and tested quickly to assess whether or not they were changes that should continue.

Example clinic flow



Reassuring Leadership that Clinic Efficiency Will Not Be Adversely Affected

One of the most significant pressures on primary care clinics is the need within what remains a largely fee for service system to see as many patients as possible. Anything that slows patient flow will decrease enthusiasm from the clinical and administrative leadership of clinics as well as providers. To ensure that I-PaCS is efficient, we observed our MAs and actually timed them with stop watches to see how long it took them to screen patients for social needs. We specifically asked MAs to tell patients that their providers would be discussing the results of the answers of the screening with them and that they should not discuss answers with patients. We found that on average it took about 35 seconds for MAs to ask and get answers for our 11-question social needs screening tool.

Another pressure that clinic leadership faces is evaluating and ensuring that they receive designation as patient centered medical homes (PCMH). This designation often comes with additional funding for clinics. We found that clinic leadership teams were often happy to learn that integrating CHWs into their teams could potentially help them to become eligible for a higher level of PCMH designation. However, I-PaCS goes beyond PCMH requirements for recognition. The I-PaCS model provides more comprehensive clinical and social support services (see the Standards and Contracting for parallel standards).

Identifying Similar Positions to CHW and Clarifying Roles

CHWs

Connects patients with resources to deal with Social Determinants such as:

- *Transportation*
- *HUD Subsidized Housing*
- *Food, including clinic's pantry.*
- *Legal assistance*
- *Employment*
- *Assist with applications to government benefits.*
- *Utility assistance.*

Provides health education on wellness programs or disease management.

RN Case Manager

Provides referrals to:

- *Home Health Care*
- *Oxygen*
- *Home hospice*
- *Durable Medical equipment.*
- *Advance Directives*
- *Care giver issues*
- *Patient care Conferences*
- *Long term planning.*

Provides health education on home healthcare.

Social Worker

Co-pay deferment/ Financial issues

Substance Abuse

Psychosocial needs

Crisis Counseling

Domestic violence

Provides health education on behavioral health issues.

Patient Support Worker or MAs

Screens for social determinants and other issues.

Refers patients to CHWs if they screen positive for social determinants.

Reminds patients of appointments and to do the labs.

The above positions are just examples of the ones I-PaCS team has encountered at clinics. Before placing a CHW at a clinic, its management/providers need to clarify roles of similar positions within the clinic.

DEPLOYING AN EFFECTIVE CHW WORKFORCE

CHWs serve as a community based member advocate and resource and are a vital part of the healthcare team. They provide outreach to locate and/or provide support for members. They educate members and are advocates for vulnerable members, engaging and assisting them in managing their healthcare needs. CHWs provide non clinical paraprofessional duties and are thoroughly familiar with the members' community and the resources available. Exercising independent judgment and discretion, they assist members with all aspects of their health and wellness by collaborating with the primary care clinical team, community based healthcare, social services and other providers.

Stage 1: CHW Hiring	Stage 2: CHW Training	Stage 3: Providers/Staff Training	Stage 4: Ongoing Supervision
▪ Post appropriate job description ▪ Initiate formal/informal recruitment ▪ Customize hiring questionnaire and conduct interviews with selected candidates ▪ Hire CHWs	▪ Conduct initial training for new cohort of CHWs ▪ Provide hands on shadowing opportunities to new CHWs ▪ Provide monthly supplemental training for CHWs	▪ Train providers at clinic ▪ Train staff at clinic ▪ Facilitate monthly meetings with providers and staff from clinic to address issues that arise during implementation	▪ Bi-weekly, one-on-one supervision for CHWs ▪ Strengthen the relationship between CHWs in the clinic and other CHWs working in the community by facilitating networking meetings and shadowing opportunities

Defining the Scope for Clinic and Community-Based CHW Work

The recent Report of the Community Health Worker Core Consensus Project (commonly referred to as the "C3 report", a follow-up to the National Community Health Advisor Study) has concluded that there are 10 core roles for CHWs:

1	Cultural Mediation among Individuals, Communities, and Health and Social Service Systems
2	Providing Culturally Appropriate Health Education and Information
3	Care Coordination, Case Management, and System Navigation
4	Providing Coaching and Social Support
5	Advocating for Individuals and Communities
6	Building Individual and Community Capacity
7	Providing Direct Service
8	Implementing Individual and Community Assessments
9	Conducting Outreach
10	Participating in Evaluation and Research

Each of these roles is reflected in the work CHWs perform within the I-PaCS model. The specific scope of work for CHWs imbedded in primary care teams will vary depending on site, as well as the number of CHWs that the clinic is able to hire.

The main duties of a CHW include providing informal counseling and support, connecting community members with resources, delivering culturally appropriate health education, advocating for individual and community needs, making sure people get the services they need, and building individual and community capacity. To effectively perform these duties, the CHW should have certain personality traits including humility, empathy, patience, resourcefulness and a strong desire to help others. The job interview needs to include questions that assist in finding the person with these traits.

Recruitment

Defining Qualifications

Given that one of the most important roles that a CHW plays when integrated in healthcare teams is to provide cultural mediation between communities and the health system, it is very important to recruit a CHW that understands the cultural and socio-economic background of the people served at the clinic. Whenever possible hire someone that is a member of the community being served. The level of education and professional experience is less important for this job than the knowledge of community and cultural issues affecting the patients that are served at the clinic. If the majority of the patients at the clinic were low-income Spanish-speaking Latino immigrants who reside in the neighborhood where the clinic is located, the ideal candidate for the CHW position would be a Latino immigrant who lives in the neighborhood and speaks Spanish. What happens if this specific type of candidate does not apply for the job? Look for someone among the pool of candidates that shares as many characteristics with the community being served as possible. If may be necessary in some cases to re-post the position in order to find the right person. Take the time until you find the right person. Remember, the CHW needs to be a trusted member of the community being served.

You could (and should) train CHWs on computer skills, documenting their work, knowledge of resources /services available in the community, communication and advocacy skills, etc. but you can't modify their intrinsic characteristics and cultural and socio-economic background.

Recruitment can happen through formal channels- such as an institutional hiring site- and informal channels- such as word of mouth and community/organization list serves. Job postings for CHWs should be distributed to both channels to reach as wide of an applicant pool as possible.

Job Posting

It is important to provide a job description that accurately reflects the complex role of the CHW in order to attract a strong pool of candidates. Included below is a sample job description for CHWs at I-PaCS pilot sites. We expect that sites will modify this description as necessary to reflect the needs of the clinic and community.

Example Job Description

CHW Integrated into Primary Care Clinics

UNM-HSC Office of Community Health

Under indirect supervision, CHWs work closely with medical providers, primary care teams, and social services agencies to provide short-term care coordination, connection to resources and support to adults, children or adolescents and their families who are patients of health care facilities. CHWs work in both clinical and community-based settings, including client's homes to improve the health and overall wellbeing of community members.

Duties and Responsibilities:

1. Communicates to patients of a given clinic the purpose of having a CHW supporting them and the impact it may have on their health and wellbeing.
2. Helps patients identify socio-economic issues that affect their overall health and develop health/social management plans and goals.
3. Assists patients in understanding the services, plans and instructions of the Managed Care Organization to whom they are enrolled for their Medicaid.
4. Communicates with Managed Care Organizations about interventions provided to their members seeking services at the clinic where the CHW works.
5. Facilitates communication and coordinates services between providers and the patients.
6. Connects patients to community resources, including but not limited to locating, housing, food, clothing, education, life skills classes and employment.
7. Helps patients learn where to find community resources, scheduling appointments with social services agencies and completing applications for benefits /programs for which they may be eligible.
8. Assists patients in accessing primary care and behavioral health related services, including but not limited to: obtaining a medical home, providing instruction on appropriate use of the medical home, overcoming barriers to obtaining needed medical care and /or social services.
9. Provides support and advocacy during initial medical visit or when necessary to assure patient's needs are understood.
10. Coordinates and monitor services, including comprehensive tracking of patients' compliance in relation to care plan objectives.
11. Coach patients in effective management of their chronic health conditions and self-care.
12. Motivates patients to be active and engaged participants in their health and overall wellbeing.
13. Documents all encounters and contacts made on behalf of patients in an effective manner. Documents also service plans and outcomes achieved by patients.
14. Completes and submits monthly reports; maintains comprehensive patient files, which include notes, release of information, assessments and other documents acquired on behalf of the client.
15. Effectively works with people from diverse cultural and socio-economic backgrounds.
16. Works collaboratively and effectively within a team (medical/social services) and establishes positive, supportive relationships with staff and providers.
17. Continuously expands knowledge and understanding of community resources and services.
18. Travels regularly to community locations, various agencies, and other outreach destinations.
19. Performs miscellaneous job-related duties as assigned.

Minimum Job Requirements:

High school diploma or GED; at least 3 years of experience that is directly related to the duties and responsibilities specified; or on the Job training and 2 years of experience.

Knowledge, Skills and Abilities Required:

- Strong interpersonal and communication skills and the ability to work effectively with a wide range of constituencies in a diverse community.
- Knowledge of community agencies and resources.
- Ability to plan, implement and evaluate individual client care plans.
- Knowledge of socio-economic barriers that may be encountered by client.
- Skill in use of personal computers and related software applications, including e-mail.
- Strong organizational skills and ability to establish priorities.
- Bilingual/bicultural (Spanish-English).

Conditions of Employment:

- Must pass a pre-employment criminal background check and obtain medical clearance.
- Possession of a valid New Mexico driver's license is a requirement for this job.

Working Conditions and Physical Effort:

- No or very limited exposure to physical risk.
- No or very limited physical effort required.

Hiring CHWs

Interview Process

Below is a sample set of interview questions used at pilot sites in Albuquerque. Many of the questions used are specific to the clinics and populations served. These questions may be modified as needed to address specific priorities of clinics or health centers in other regions of the state.

Example Interview Questions for CHWs

Interviewer _____
Interviewee name _____ Date: _____

1) Can you tell us about your experience(s) as a Community Health Worker/Promotora? What experience have you had working in a primary care setting? You may include volunteer experience in your explanation.

2) Tell us your experience working with clients in community settings and in the home. Explain your level of experience interviewing, supporting, and educating clients/community members about health and social issues.

3) What attracts you to this type of work and what do you feel are your strengths and weaknesses in this area? What do you perceive as challenges in this position?

4) Please describe your knowledge of social service organizations, programs and resources in your community. What kinds of resources have you accessed in your own community? What are some of the agencies that you are familiar with in your community?.

5) How would you feel working in a small team that includes doctors, nurses, medical assistants, and/or social workers? Have you worked in a role that required shared decision making with the group? What kinds of concerns would you have? Please describe your experience.

6) Tell me about a recent client that you assisted. What was the main issue? What did you do for this client? What happened as a result of your assistance?

7) I am going to read a case scenario and ask you to develop a plan to help the client described:

Maria is a single mom with three kids. She is from Mexico and does not have authorization to work in this country. Her youngest son, who is a US citizen, has asthma and last week had another asthma attack. She took him to the ER like she always does. At the ER she was told that her son's Medicaid is not active and that she needs to buy the prescription. She comes to the clinic today for assistance in filling her son's prescription. While she was waiting she felt dizzy. When the staff asked what was wrong, she said that she has diabetes and hasn't taken insulin since last week because the guy at the flea market was not there. She said that she buys it from him because she does not have health insurance or Medicaid. After the doctor saw this patient and her son she called you and asked you to help Maria. To start you asked Maria for additional questions about her non-medical problems and she Maria told you:

- My car broke down. I did not have any money to pay for the repairs and that is why I lost my job taking care of an elderly person and I do not have any savings.
- I owe two months of rent, so my landlord can kick me out any time.
- I do not qualify for benefits. I went to the food pantry but I did not have an ID with me. When I went back it was closed so I have to wait until next week.
- The father of my kids is not living with us, but he wants to visit the kids and I do not feel ok with that because he has been abusive with the children and me in the past. It is not safe.

    (a) What can you do to help Maria? How would you prioritize her needs? What resources would you utilize?

    (b) How would you communicate your assessment/plan of action with this client to the healthcare team? What does collaboration with the clinical team look like in order to help this client?

8) Describe a time when you had to overcome significant obstacles in order to achieve a goal.

9) Tell me about a time when you had to complete several tasks following a schedule or deadline. How did you prioritize the tasks to meet the deadlines?

10) Describe a time in which you had a conflict with a coworker and how you dealt with it.

11) Describe your experience using computer software for tracking and reporting.

12) What is your primary reason for leaving your current employer or for having left your previous employer?

13) This is a full-time position that occasionally requires working after hours or on weekends. Is this possible for you to do? What is your availability to start if chosen?

14) Do you have any questions for us?

TRAINING

Developing or Adapting Training for CHWs

Included in this guide are materials used in CHW pilot training and onboarding. The slides that we have included outline a suggested curriculum for this training, but the materials can and should be modified to meet the needs of individual site. This guide acknowledges that implementation will vary from place to place depending on location and region (is the site urban or rural, and where is it located geographically in the state in relationship to resources and other sites), and the unique needs of different communities. It is imperative to consider the culture and language of the community being served when designing training for CHWs.

All CHW trainings should include a brief summary of major resources and networks in the community. This will require the site to do a brief survey of social resources in the community and consider which ones the CHWs will be most likely to connect with. CHWs will likely enter the job with extensive knowledge of their community, but it is helpful to reiterate, and will assure that the person training or supervising the CHW is also aware of the existing resources in the community. For more information about how to find resources in the community, please refer to the resources section under Primary Care Linked Strategies.

Training Team

The team that provides new CHWs with training would ideally include the CHW's supervisor, and additional team members that the CHW will work with such as a provider and MA, a social worker in the clinic or community, the unit director, and any other CHWs who work in the clinic. If there are no other CHWs currently working in the clinic, the onboarding team may choose to reach out to a seasoned CHW in the community that could provide a shadowing opportunity. We also highly recommend engaging a regional HERO in the training and orientation and guidance of the CHW in community-based aspects of their role when possible.

Reiterating statements from the PCLS section on preliminary steps with clinic staff and providers, it is crucially important that a clinic champion in present for as much of the CHW's training and integration as possible. This may be the provider champion, or another member of the clinical staff that will support and advocate for the role of the CHW from the onset of their work and as they join the clinic team.

Ongoing On-the-Job Training

Upon completion of the 3-day intensive onsite training, CHWs are paired with other experienced CHWs to shadow them in the clinic and community. The point of the shadowing period is not to teach the CHWs how to be CHWs, but for them to:

- Observe communications skills of clinic staff and CHWs experienced in this role
- Learn how to use the clinic's electronic record and data tracking systems.
- Learn to administer the WellRx and/or explore screening results with patients

- Incorporate best practices, tools and resources used by other CHWs for clinic specific issues
- Learn clinic specific protocol from clinic staff

Focused on the job training and shadowing should last 2-3 weeks, but role development and learning opportunities should be made available on an ongoing basis.

As I-PaCS programs are first developing, we understand that in some cases there will not be other CHW's in the clinic- or perhaps even the immediate community- to shadow. For the CHW's clinic-based role, the CHW may shadow employees with similar or complimentary roles- such as an MA, patient advocate, social worker, etc.

Shadowing in the community-based role should last at least one week, and up to two if possible. For the shadowing in the community-based role, the ideal would be to shadow a more experienced I-PaCS CHW. When an I-PaCS CHW is not within a reasonable distance of the clinic, the next step would be to seek out an experienced CHW in the community, if one is available and willing to be shadowed. It will help incentivize community -based mentors if they are fairly compensated for their time. Clinics are encouraged to reach out to their region's HERO and social service and community organizations.

Supervision

There are two types of supervision that the CHW should be receiving: Administrative and Clinical.
It is at the discretion of the clinic to decide which clinical or administrative staff member(s) will be the most appropriate to supervise I-PaCS CHWs.

Administrative Supervisory Duties	Clinical Supervisory Duties
• General HR: Leave/Hours, Annual/Performance Review • Bi-Weekly Check-ins • Promoting awareness of CHW role and value • Providing opportunities for CHW to be involved in planning and design of model implementation strategies	• Familiarity with CHW competencies and scope • Assuring that CHW is trained and proficient in clinical systems • Regular communication with CHW about SDH screening and patient health needs • Facilitation of huddles with care team • Provide professional support and learning opportunities

Practice Supervisors should set aside time for bi weekly check-ins, at the very least. Check-ins are an important part of fostering rapport and mutual accountability between CHWs and supervisors. Check-ins are also an important part of job satisfaction and turnover prevention. They are an opportunity to troubleshoot, do case review, talk about system barriers and processing options.

At each check-in, Supervisors should ask questions similar to the examples listed:
- How are you doing? Were you able to resolve any issues addressed in the last check-in? What additional support do you need?
- How many cases are you working on? (Is that manageable for you?)
- What are the most difficult cases you are working on?
- Are you experiencing any barriers in making connections or referrals?

- How are YOU doing? (Self-care check) Are you doing things to keep you healthy and focused?
- Are you facing any challenges with burnout or professional boundaries?

CHW Caseload

Determining the appropriate caseload for a CHW can be tricky. We surveyed CHWs from the pilots and other community organizations- and found that on average, CHWs were working with 40 clients, while most of them felt like a more reasonable caseload would be 25-30. As you work to determine an appropriate workload for CHWs at your site, consider the number of patients who will need Comprehensive Patient Support versus those who will need Intensive Patient Support.

Retention and Support Strategies for CHWs

Hiring Community Health Workers is only a first step. Employers need to develop and implement effective human resource retention and support strategies to keep CHWs for an extended period of time. These strategies need to be adaptable based on the composition of the community- the health and social issues affecting that specific community- in order to meaningfully tailor their role to meet the community's needs and priorities. If effective retention and support strategies are implemented, retention of CHWs that are productive and committed to the organization's vision and mission will be more likely.

The recent national "C3 Project" recommends that CHWs:

- Share lived experience with the communities they serve
- Be recognized as members of a unique profession with a unique scope of work
- Be meaningfully involved in efforts to create policy for their field
- Be recognized and rewarded for their experiential knowledge
- Be trained and supported in a full range of roles to work across all levels of the socio-ecological model from the individual level to the family, community and policy levels
- Participate in initial and on-going training that is informed by and based on popular education and adult learning and that includes relevant and practical content
- Receive sufficient and appropriate supervision that supports their professional growth
- Be compensated at a level commensurate with their skills and as they gain experience, be involved as trainers for new CHWs

Innovative and creative strategies that go beyond pay and benefits can be employed to attract and retain CHWs, these include but are not limited to: recognition, flexible work arrangements, work-life balance, employee engagement, health and safety, communication, workplace diversity, formal wellness programs, inclusion and employee development. Retention and support strategies and practices help save costs and improve health outcomes within a health facility.

Below is a list of retention and support strategies that could be implemented within your organization:

Acknowledgement and Respect

- Promote their role in system and policy change
- Inform staff who they are and their roles within an interdisciplinary team
- Refer to their role and impact in the healthcare system based on what the evidence shows
- Educate other health professionals on how to meaningfully integrate them into the interdisciplinary team
- Treat them with respect and courtesy, as any other member of the clinical team

Employment Stability and Compensation

- Long-term employment vs. temporary or one-year contracts
- Full-time employment vs. part-time or temporary contracts
- Descent, honorable and competitive salary
- Provide ongoing training, coaching and mentoring along the way
- Health, vision and dental benefits
- Paid time off (annual/sick/maternal/paternal leave)
- Retirement plan

How to Determine a Living Wage at Your Site

Several tools are available online to help you determine what a living wage is in the area where you live. One example is the living wage calculator at http://livingwage.mit.edu. We recommend using the index for "1 Adult and 1 Child" to set the minimum amount that you will pay the CHWs that you hire.

Camaraderie and fun

- Provide incentives, recognition events and celebrations to acknowledge their contributions
- Connect them to other groups that work with other CHW/Rs
- Consider having fun event, not work-related at least once a year (pic nic, camping trip, etc.)

Flexibility and time off

- Be flexible with their work schedule in order for them to be responsive to the needs of the community
- A work schedule that balances family needs and responsibilities
- Time off for academic, professional or personal development opportunities

Increased responsibility and challenge

- Create an environment within the team where their opinions, ideas, recommendations and comments are heard and validated
- Give them the opportunity to design, plan and provide input in programming from the beginning
- Include them in program design, grant writing and other program development and implementation activities

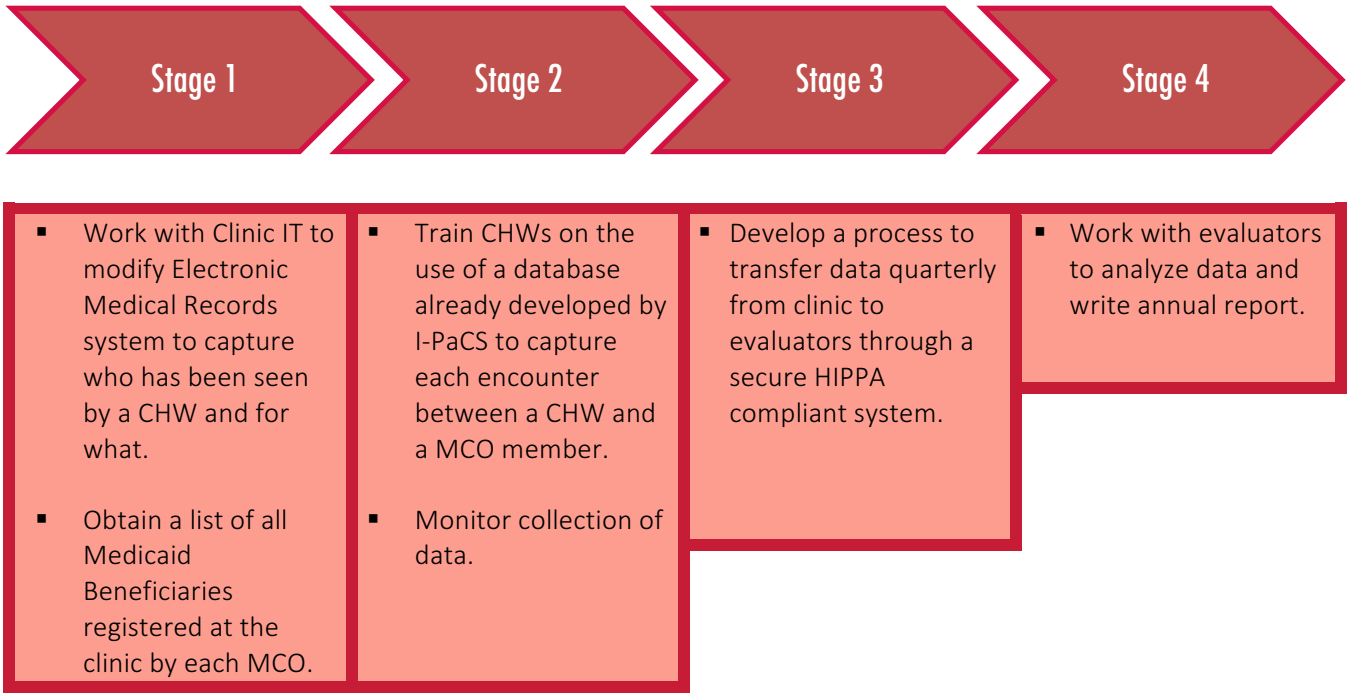
Personal Development

- Provide a forum where they can have a safe place and space to voice their frustrations, concerns and fears; which does not include face-to-face meetings with supervisor
- Develop a networking system where they can grow and connect with other people and groups within an organization, at the community, state and federal level.
- Provide ongoing professional development opportunities.
- Give them the opportunity to attend state and national conferences.
- Create career ladders and opportunities for them to further their education or move into other positions, including leadership positions
- Provide self-care strategies, workshops and seminars

Tips for Preventing CHW Job Turnover

1. *Offer a salary that, at a minimum, meets standards for a living wage.*
2. *Offer health and other benefits.*
3. *Offer stability with respect to employment:*
    - *Long term vs. One-year contracts*
    - *If possible, offer full-time employment vs. part-time or contract work*
4. *Promote awareness and education of who they are and what they do:*
5. *Create an environment within the team where their opinions, ideas, recommendations and comments are heard and validated*
6. *Give them the opportunity to design, plan and provide input in programming from the beginning.*
7. *Provide ongoing professional development opportunities.*
8. *Provide ongoing training, coaching and mentoring*
9. *Provide incentives, recognition events and celebrations to acknowledge their contributions to (1) improving health outcomes and (2) decreasing health inequities.*
10. *Provide self-care strategies, workshops and seminars.*
11. *Always keep in mind that CHW/Rs also includes males.*

CREATING A SYSTEM TO COLLECT DATA



Modifying Electronic Health Record Systems to Capture Screening Results and Work Done by CHWs

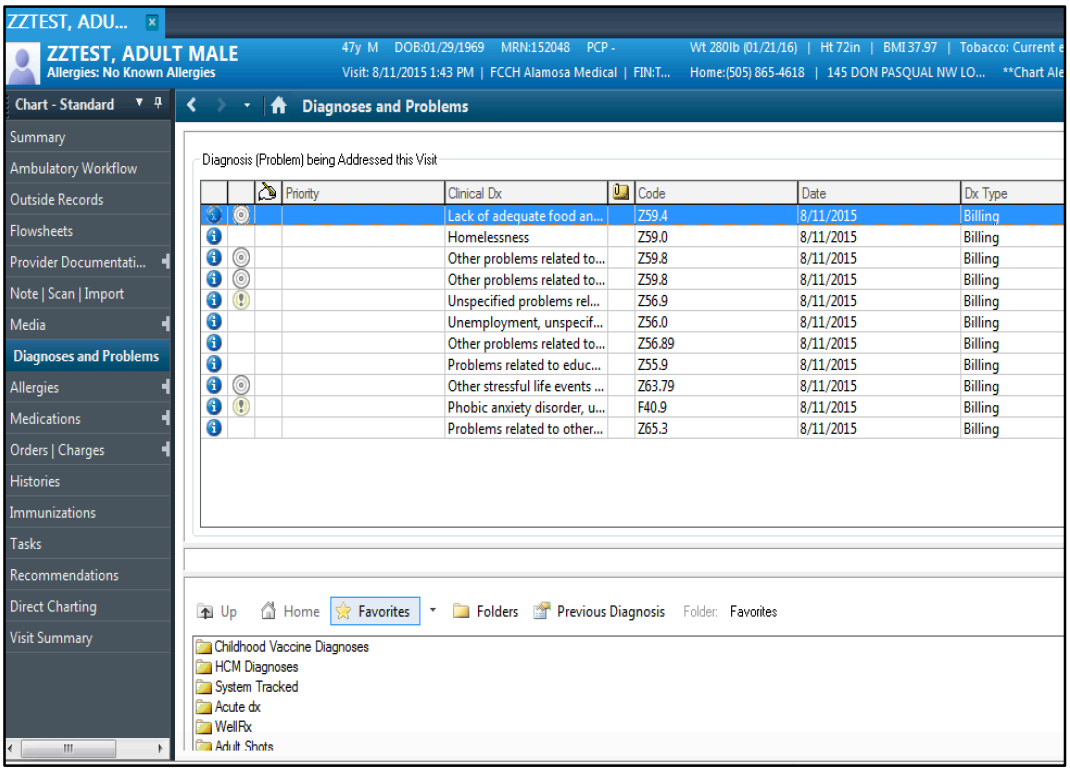
Primary care practice workflow is driven to a large degree by electronic health records. As such, it is very important for each practice to plan from the beginning how to integrate I-PaCS processes into their particular electronic health record such as: tracking results of social needs screening, referrals to community health workers, community health worker documentation within the electronic health record and provider billing for the social need screening and referral. Making sure that you address these factors from the beginning of this process may seem like a lot of work, but we have found that these steps help to more easily integrate these new valued team members into your primary care teams and avoid the risk for creating more work for providers who otherwise may not know what to do with this new information they are learning about their patients.

Ideally, formalizing a referral process that lets you record and later retrieve data about referrals to community health workers from within the electronic health record would be best. At a bare minimum, sending electronic messages from within the electronic health record to your community health workers as you refer patients to them, helps to set up an easy way to get feedback from the community health workers notifying you of the help they were able to provide for patients.

Many practices use “tickler diagnoses” or temporary diagnoses entered by medical assistants or nursing staff to remind providers when important screenings have been done or are due at that visit (e.g. depression screening, smoking cessation counseling, colon cancer screening). For the purpose of this pilot, we leveraged this existing workflow process and empowered our medical assistants to

initially add an ICD-9 “tickler diagnosis” of “Inadequate Community Resources” for all patients who screened positive for any social needs. If the providers took action on these issues (referred or did a warm handoff to our community health workers) we then would add this diagnosis to our assessment, plan and bill for it. One very helpful element of ICD-10 has been the addition of new diagnoses that correspond to almost any social need that you may want to screen for. We are currently testing use of a favorite diagnosis folder for our medical assistants called “WellRx” that has all of the ICD-10 codes for the 11 areas of social need that we screen for. See the graphic below.

At this point is remains unclear what, if any, significant reimbursement implications there are for billing for these separate social need diagnoses, but at a bare minimum it is a simple and effective way of documenting the social needs that exist for the patient at that particular visit in a way that is retrievable by most electronic health records.



Medical assistants now ask the 11 social needs questions and when a patient answers yes to any question, the medical assistant adds the specific corresponding ICD-10 “tickler diagnosis” to the chart. When the provider opens the chart, they see the corresponding diagnoses.

Because so many of our patients screen positive for social needs and frequently multiple areas of social need, we have also created “quick texts” that very quickly enable us to insert a pre-written plan for each of those diagnoses instead of arduously hand typing a plan for each one. The particular quick text that we use is the following: “Patient screened positive today for multiple areas of social need on the WellRx screening tool. Patient was referred today to community health workers.”

Z-Codes Crosswalk

Commonly Used Z-Codes in Pilot	
Z-Code	Description
F40.9	Fear for personal safety
Z55.9	Lack of education (Problems related to education and literacy, unspecified)
Z56.0	Unemployed
Z56.89	Other problems related to employment
Z59.0	Homelessness
Z59.1	Inadequate housing
Z59.4	Lack of Food
Z59.8	Inability to acquire transportation (Other problems related to housing and economic circumstances)
Z59.9	Housing Problems
Z60	**Problems related to social environment**
Z60.0	Problems of adjustment to life-cycle transitions
Z60.2	Problems related to living alone
Z60.3	Acculturation difficulty
Z60.4	Social exclusion and rejection
Z60.5	Target of (perceived) adverse discrimination and persecution
Z60.8	Other problems related to social environment
Z60.9	Problem related to social environment, unspecified
Z63.72	Substance abuse – family

WellRx Questions	Z-Code Crosswalk
1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?	Z59.4
2. Are you homeless or worried that you might be in the future?	Z59.0, Z59.1
3. Do you have trouble paying for your gas or electricity bills?	Z59.9
4. Do you have trouble finding or paying for a ride?	Z59.8
5. Do you need daycare, or better daycare, for your kids?	Z56.89
6. Are you without regular income?	Z59.8
7. Do you need help finding a better job?	Z56.0
8. Do you need help getting more education?	Z55.9
9. Are you concerned about someone in your home using drugs or alcohol?	Z63.72
10. Do you feel unsafe in your daily life?	F40.9
11. Do you need help with immigration or legal issues?	Z60.8

We have found that we communicate electronically with our community health workers through the electronic health record as frequently as we do with our nursing or medical assistant staff and orienting and training them to use your electronic health record is an important up-front investment in time that will help to formalize their place as valued members of your team. Our community health workers briefly document their encounters with patients for both one time visits and for ongoing, more in-depth case management encounters within the electronic health record and then forward those notes on to the providers that referred the patients as a way to keep the primary care providers up to date with changes to their social needs.

Defining Clients Eligible for PMPM

The compensation mechanism is a per member per month (PMPM) payment from the MCO to clinics. Clinics need to generate a list of patients who are member beneficiaries of the MCOs who are registered with the clinic and have received services within the past two years. MCOs link the patient list to Health Risk Assessment (HRA) level and provide back to the clinic. The PMPM total amount is derived from the combined list.

Defining what Data to Collect

The data collected specific to the I-PaCS protocols need to include the specific social determinants that were identified for referral to a CHW, evidence of the referral, the quality of life assessment (SF-12) of the patient at the time of CHW intervention, and the specific areas of intervention provided by the CHW. Follow up SDH and SF-12 assessments are necessary for the recorded resolution of social needs and quality of life change.

Process evaluation data can be collected via surveys and inventories that are completed online or in hardcopy. The questions included in the instruments will vary depending upon the intended audience (e.g., clinic front desk and support staff, nurses, MAs, medical providers, and clinic managers or leadership; stakeholders outside the clinic). Surveys should be anonymous and leave a space for the person to add ideas or comments in addition to their responses to specific questions. Information and input can also be gathered through stakeholder interviews, focus groups or facilitated group discussions. The research core at the Office for Community Health will provide technical assistance to practice to develop these instruments.

Using the I-PaCS Database to Capture MCO Member Data

Data tracking spreadsheets are one method for tracking and collecting data about MCO members who are screened at the clinic—some sample data fields to collect are included below. In the pilots, the clinic-based CHWs created spreadsheets using the following field. Spreadsheets are used to track patient information, screening results, intervention and follow-up.

Note: *We are currently in the process of developing a centralized database for clinics to share and analyze data. This data entry method will contain the same fields as the spreadsheet, but will be a more efficient and accurate replacement. We anticipate that development of the I-PaCS database will be complete and ready for rollout by August 2016.*

Sample Data Tracking Spreadsheet Fields

Demographic Information	Clinic Location
	CHW Name
	Patient Last Name
	Patient First Name
	DOB
	MRN
	Gender
	Race
	Ethnicity
	Insurance/Payer (self-report)
	Subscriber ID (if available)
	Care Coordinator
	Referred by MCO? (Y/N)
	Referred by Clinic? (Y/N)
SF-12	SF-12 Completed? (Y/N)
Well Rx	Q1 Food
	Q2 Housing
	Q3 Utilities
	Q4 Transportation
	Q5 Daycare
	Q6 Income
	Q7 Job
	Q8 Education
	Q9 Substance Abuse
	Q10 Safety
	Q11 Legal/Immigration
Type of Encounter & Time Spent	CHW Intake (30 min)
	Clinic Visit (30 min–1 hour)
	Home Visit (1-2 hours)
	Community Visit (1-3 hours)
	Telephone Attempt (5 min)
	Telephone Follow-Up (15 min)
	Documentation (30 min)
	Research (1 hour)

Intervention Code	1 Activities of Daily Living
	2 Caregiver Assistance/Education
	3 Childcare Resources
	4 Chronic Disease Self-Management
	5 Community Resources
	6 Durable Medical Equipment
	7 ER Utilization and Education
	8 Government Agency Assistance
	9 HRA or Other as Needed
	10 HEDIS Alerts Prevent Screening
	11 High Cost Dollar Member Needs
	12 Home Environment Evaluation
	13 Home Healthcare Assessment
	14 Housing Assistance
	15 Located Member
	16 Long-Term Services Support
	17 Medication Fulfillment/Adherence
	18 Mental Health Concerns
	19 Mental Health Resources
	20 MCO Benefits Education
	21 Nurse Advice Line Education
	22 Nutritional Needs Assessment
	23 Previous Encounter Follow-Up
	24 Provider Resources, Appt. Scheduled
	25 Release of Information Assistance
	26 Schedule a Face-to-Face Visit
	27 Substance Abuse Resources
	28 Telehealth Assistance
	29 Transportation Resources
	30 Transition Assistance
	31 Other/See Comments
Encounter Information	Date of Service
	Encounter Notes
Follow-up Information	Appt. Set for Follow-Up?
	Follow-Up Appointment Date

For qualitative and demographic information, the CHW enters the individual's personal information. For fields that would typically be answered "yes or no", a 1 for yes or 0 for no is entered so that data may later be aggregated in order to rank the social needs of all members. Data for a single member

may be added on multiple occasions for encounters or follow-ups by simply adding a new row to the spreadsheet.

Writing Encounter Notes

Writing good encounter notes is important both for communicating with team members in the EHR, as well as for qualitative data collection. Oftentimes, the same encounter note can be copied and pasted between the spreadsheet and EHR.

In the pilots, CHWs had success using the DAR format (data, assessment, plan) to document encounters. These are examples of well-written encounter notes for phone contacts using the DAR format:

"D: Patient screened positive today for multiple areas of social need with MA on the WellRx screening tool. A: Pt was referred today to community health workers. R: CHW will follow-up with patient."

"D: CHW followed up with patient and addressed issues around transportation and daycare. A: CHW provided application for daycare and application for safe ride. Client will complete applications and have them at next visit. R: CHW and client will meet in 3 days to go together to turn in applications. "

"D: MCO referred. A: CHW called and spoke with Spanish speaking member. Member stated she would call CHW back to schedule Well Rx. Member has not called. R: CHW will call member again in attempts to schedule Well Rx."

See "Documentation, the DAP format , and Writing Incident Reports: A Self-Study Curriculum" from New Vitae , Inc.

Having a method for tracking patient encounters and CHW interventions is a mandatory element of the implementation of this model. A reliable system for collecting data is absolutely essential to accurately inform Population Health Strategies, and will be useful in generating quarterly reports (required by most MCO contracts as well as I-PaCS standards). However this spreadsheet is simply a suggestion for one possible way to collect data. Some clinics may have access to alternative systems for tracking patient information and encounters, and may choose to modify their existing system to include the required fields for reporting, rather than adding an additional step for CHWs and providers.

Analyzing Data

Data transferred to the central repository will include individual-level characteristics from the WellRx, the SF-12, and the CHW invention tracking system. This data will be linked to billing data on the utilization of outpatient, inpatient, emergency department and pharmacy services. The linked data form the basis of analyzing the effect of the I-PaCS program at the clinic and system level from the perspective of improved patient outcomes, improved patient experience and reductions in overall costs of care. While each clinic will have the opportunity to assess the impact of the I-PaCS program on clinic operations, the expectation is for the programmatic assessment to be conducted through a central evaluation unit.

APPENDICES

I-PaCS
Integrated Primary Care and Community Support

GLOSSARY

Community Health Worker (CHW)

The American Public Health Association defines a Community Health Worker (CHW) as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This relationship status enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and competence of service delivery. A CHW also builds individual and community capacity by increasing patient and community health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy." CHWs are known by many different names, including Promotoras, Community Health Representatives, Community Support Workers, Health Navigators, etc.

> **Promotor/a:** A Promotor/a is a lay health worker, usually in Hispanic/Latino communities, who receives specialized training to provide basic health education in the community. Often Promotores are residents of and/or identified leaders in their community. Promotores serve as liaisons between their community, health professionals, and human and social service organizations.
>
> **Community Health Representative (CHR):** Community Health Representatives are specially trained, medically guided, tribal and Native community members, who provide a variety of health services within American Indian and Alaska Native communities.

Comprehensive Patient Support (ComPS)

Support for any Medicaid beneficiary who comes to a primary care site and who screens positive for one or more social needs included in the WellRx screening tool questions or Z-codes in ICD-10 and / or may require health system navigation or prevention-related services to stop the progression of a recently identified health issue. For ComPS, CHWs provide general information about and facilitate access to available resources, provide health education or other information, and assist in scheduling appointments with social services agencies. CHWs also follow up with patients to make sure they received the services that they needed.

Intensive Patient Support (IPS)

Individuals qualify for Intensive Patient Support services if they have a) two or more ER visits in the last 12 months and identify at least one social need on the WellRx or other social determinant screening tool; b) more than four identified social needs on the WellRx or other social determinant screening tool; or c) been referred to the I-PaCS provider by the MCO. CHW intervention may include more intensive follow-up and referral monitoring, home visits, individualized and approved care plans, chronic disease management, case review by MCOs, applying for a broad range of social service assistance, etc. Intensive Patient Support is paid for at a higher capitated rate than Comprehensive Patient Support.

Community Health Improvement Strategy (CHIS)

Data collected on the social needs of the patient population through the Primary Care Linked Strategy identifies the health and social service needs of Medicaid beneficiaries and is shared with partner organizations from the community where the clinic is located, such as health councils and coalitions. A community-based CHW works closely with their regional Health Extension Officer (HERO), who serves as a liaison or facilitator between the governmental agencies, community service providers, the clinic, and Medicaid beneficiaries to develop a strategic action plan that addresses those social determinants impacting the health of the community.

Health Extension Rural Officers (HEROs)

Health Extension agents are, in essence, community health practitioners, with deep roots in their local communities. They are active in community organizations, and work to link higher education, health systems, philanthropy, and community partners to address priority health issues.

There are six core functions carried out by health extension agents: technical assistance, training and education, facilitation and coaching, addressing priority health needs, linking to shared resources, and advocacy and informing policy. HEROs are key community allies for I-PaCS CHWs.

Primary Care Linked Strategy (PCLS)

Participating primary care clinics screen patients for social needs and connect those who screen positive to clinic-based CHWs. This strategy includes patient intake, WellRx Screening, CHW interventions (Comprehensive or Intensive), and referral to services that provide assistance for social needs.

Social Determinants of Health (SDH)

The World Health Organization defines the social determinants of health as “the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.”

WellRx Screening Tool

An 11-item questionnaire, available in English and Spanish, used to screen patients for common social needs. The 11 questions on the WellRx correspond to the Z-codes listed in the ICD-10. See Appendix IV.

Z-Codes

A recent addition to the health service ICD-10 coding for the identification of patient social service needs or deficits. Can also be used to screen patients for social needs and create a uniform data set for identifying trends in social deficits.

BODY OF EVIDENCE SUPPORTING CHW WORK

The following resources served as references in the development of the I-PaCS model, and contain a strong evidence base supporting CHW work. There are a wealth of research papers, white papers, and reports available; this list encompasses just a few.

- "Understanding Scope and Competencies: A Contemporary Look at the United States Community Health Worker Field—Progress Report of the Community Health Worker (CHW) Core Consensus (C3) Project: Building National Consensus on CHW Core Roles, Skills and Qualities" (2016, Rosenthal et al)
- "Addressing Chronic Disease through Community Health Workers: A Policy and Systems-level Approach" (2015, Centers for Disease Control and Prevention)
- "Paving a Path to Advance the Community Health Worker Workforce in New York State: A New Summary Report and Recommendations" (2011, Matos et al)
- "Foundations for Community Health Workers" (2009, Berthold et al)
- "Community Health Worker National Workforce Study" (2007, Health Resources and Services Administration)
- "Advancing Community Health Worker Practice and Utlization: The Focus on Financing" (2006, Dower et al)

In addition, the I-PaCS development team has published the following academic articles based on over a decade of implementing CHW innovations:

- Johnson, et al. Community health workers and Medicaid managed care in New Mexico. J Community Health. 2012 Jun;37(3):563-71
- Page-Reeves, et al. Addressing social determinants of health in a clinic setting: the WellRx pilot in Albuquerque, New Mexico. J Am Board Fam Med. 2016 May-Jun;29(3):414-8.

CONCEPTUAL FRAMEWORKS

The I-PaCS model's "Standards and Guidelines" are based on several conceptual frameworks. Included below are visual representations of these frameworks, for reference.

Patient-Centered Medical Home (PCMH)

https://pcmh.ahrq.gov

Prevention Institute's Community Centered Health Home (CCHH)

preventioninstitute.org

TABLE 1. THRIVE community health factors

PLACE

1. What's Sold & How It's Promoted is characterized by the availability and promotion of safe, healthy, affordable, culturally appropriate products and services (e.g. food, books and school supplies, sports equipment, arts and crafts supplies, and other recreational items) and the limited promotion and availability, or lack, of potentially harmful products and services (e.g. tobacco, firearms, alcohol, and other drugs).

2. Look, Feel & Safety is characterized by a well-maintained, appealing, clean, and culturally relevant visual and auditory environment; and actual and perceived safety.

3. Parks & Open Space is characterized by safe, clean, accessible parks; parks that appeal to interests and activities of all age groups; green space; outdoor space that is accessible to the community; natural/open space that is preserved through the planning process.

4. Getting Around is characterized by availability of safe, reliable, accessible, and affordable methods for moving people around. This includes public transit, walking, and biking.

5. Housing is characterized by the availability of safe and affordable housing to enable citizens from a wide range of economic levels and age groups to live within its boundaries.

6. Air, Water & Soil is characterized by safe and non-toxic water, soil, indoor and outdoor air, and building materials. Community design should help conserve resources, minimize waste, and promote a healthy environment.

7. Arts & Culture is characterized by a variety of opportunities within the community for cultural and creative expression and participation through the arts.

EQUITABLE OPPORTUNITY

8. Racial Justice is policies and organizational practices in the community that foster equitable opportunities and services for all. It is evident in positive relations between people of different races and ethnic backgrounds.

9. Jobs & Local Ownership is characterized by local ownership of assets, including homes and businesses, access to investment opportunities, job availability, and the ability to make a living wage.

10. Education is characterized by high quality and available education and literacy development for all ages.

PEOPLE

11. Social Networks & Trust is characterized by strong social ties among all people in the community – regardless of their role. These relationships are ideally built upon mutual obligations, opportunities to exchange information, and the ability to enforce standards and administer sanctions.

12. Participation and Willingness to Act for the Common Good is characterized by local leadership, involvement in community or social organizations, participation in the political process, and a willingness to intervene on behalf of the common good of the community.

13. Norms/*Costumbres* are characterized by community standards of behavior that suggest and define what the community sees as acceptable and unacceptable behavior.

TABLE 2. An evolving approach to health

THE COMMUNITY ENVIRONMENT

COMMUNITY-CENTERED HEALTH HOMES

- Collect data on social, economic, and community conditions
- Aggregate health and safety data
- Systematically review health and safety trends
- Identify priorities and strategies with community partners

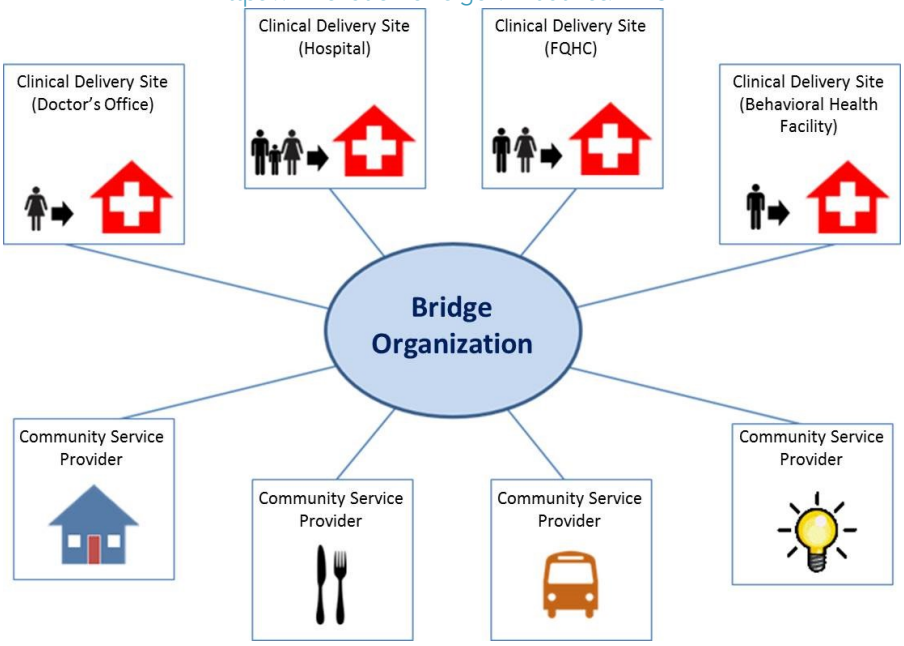
HIGH-QUALITY MEDICAL SERVICES
(Patient-Centered Primary Care, Medical Home, Health Home)

- Coordinated, comprehensive care among clinical team (e.g., MDs, NPs, PAs, RDs, pharmacists)
- Ongoing relationship between patient and a personal physician
- Clinical practices are informed by evidence-based medicine
- Referrals to community and social support services
- Integrated clinical prevention and health promotion efforts
- Patients, families, and authorized representatives are empowered and supported
- Culturally- and linguistically-appropriate care
- Health information technology (HIT) supports the integration of care across the health care system
- Increased access to care (e.g., expanded hours, transportation support, and electronic communication)

- Coordinate activity with community partners
- Act as community health advocates
- Mobilize patient population
- Strengthen partnerships with local health care organizations
- Establish model organizational practices

Center for Medicaid and Medicare Services (CMS) Accountable Health Communities (AHC)

https://innovation.cms.gov/initiatives/AHCM



New Mexico's Health System Innovation (SIM) Model

nmhealth.org

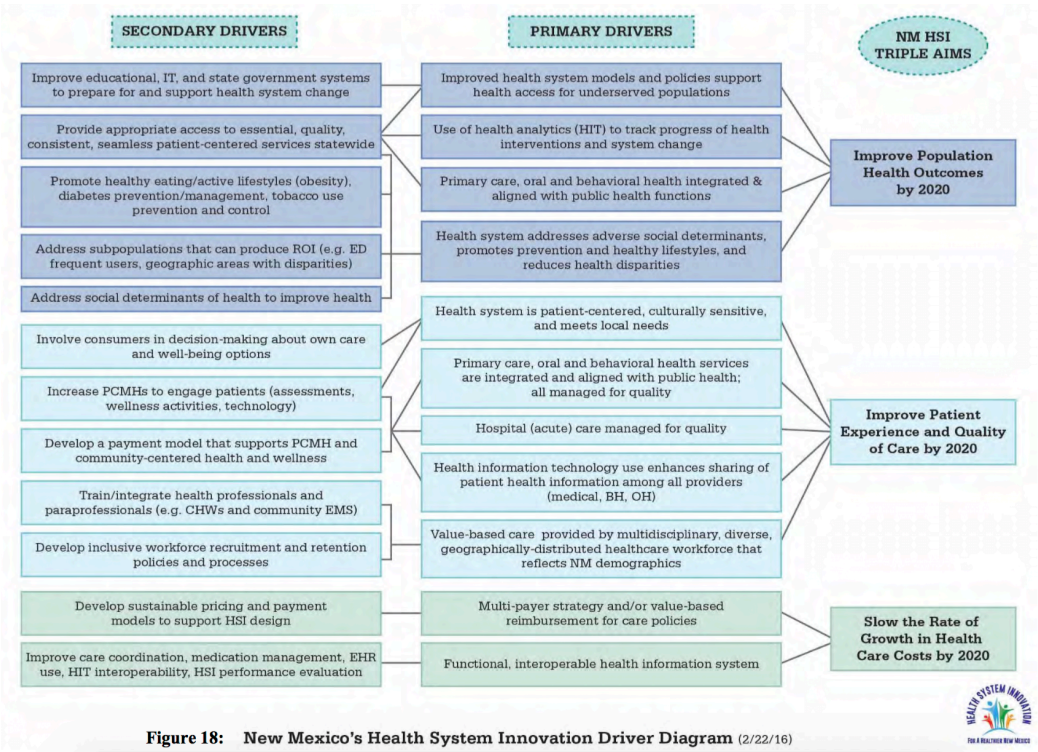
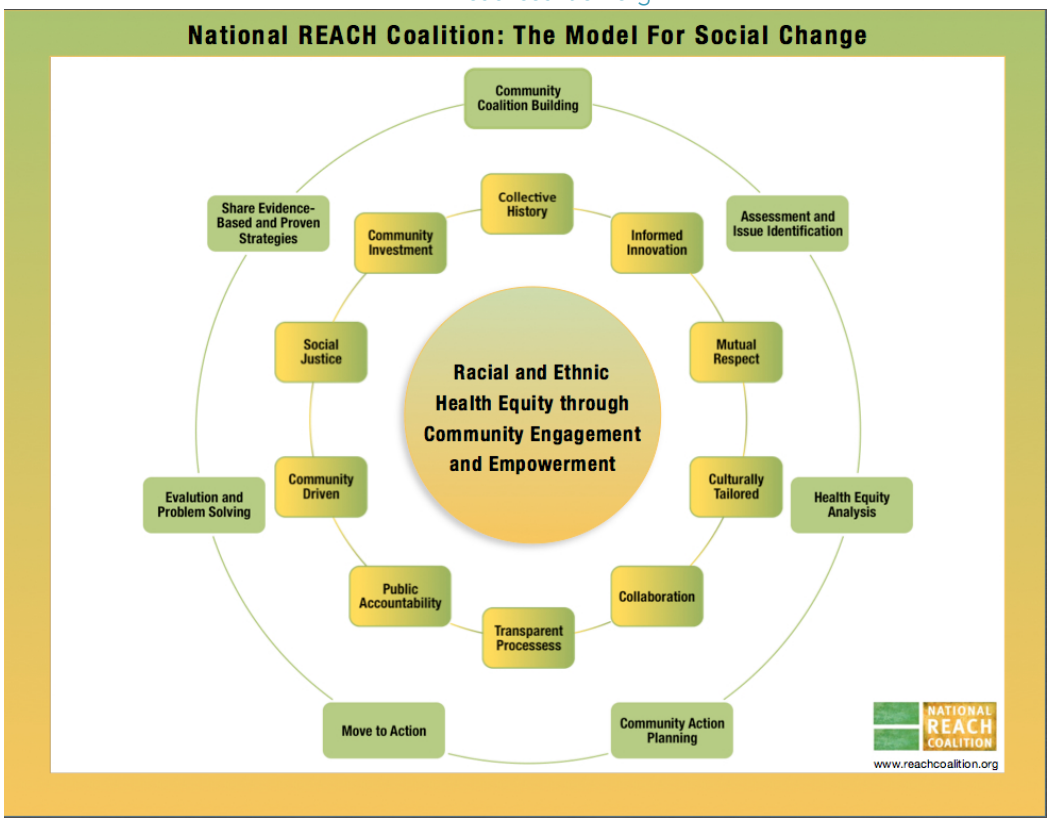


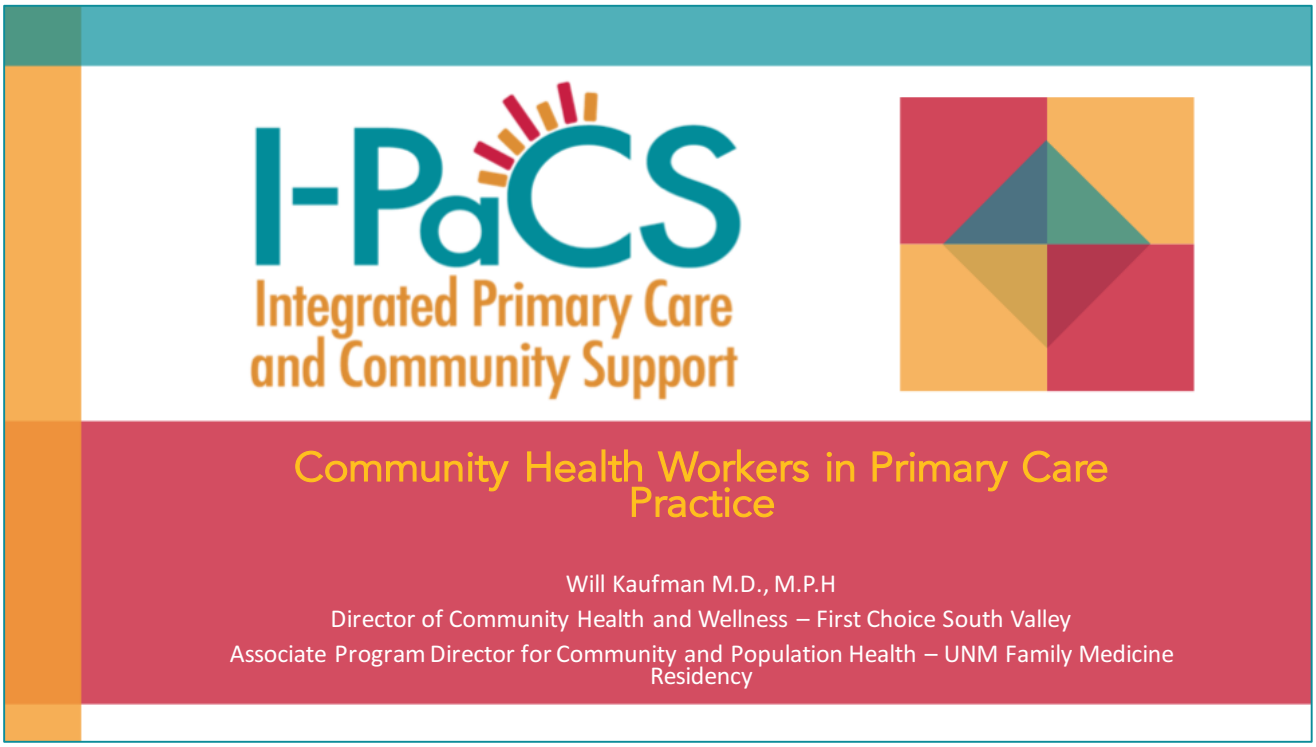
Figure 18: New Mexico's Health System Innovation Driver Diagram (2/22/16)

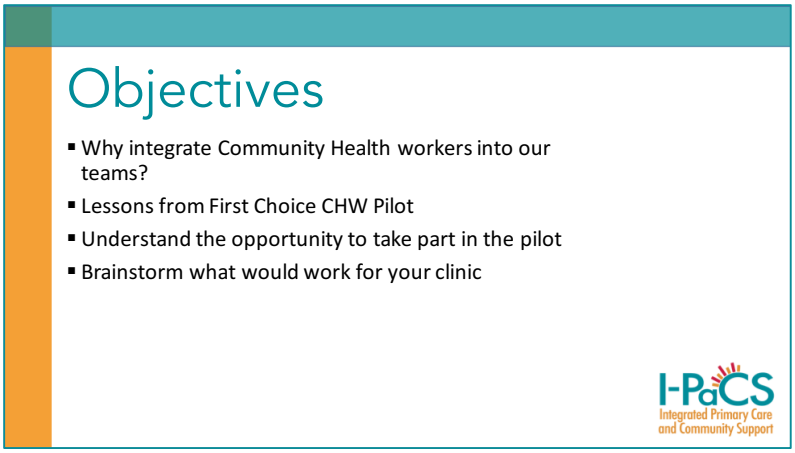
National REACH Coalition

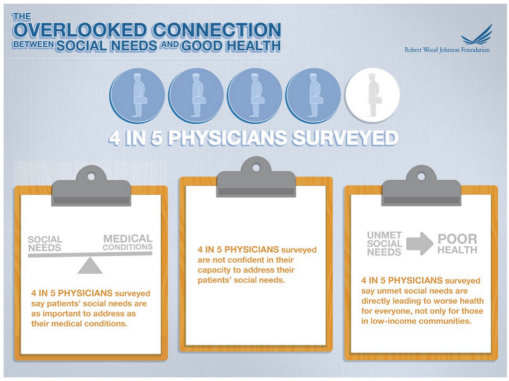
www.reachcoalition.org



TRAINING MATERIALS FOR CLINIC STAFF AND PROVIDERS







I-PaCS Integrated Primary Care and Community Support

Healthcare teams know that the social needs of their patients are as important as their medical conditions. We hear about these needs often at inopportune times, like as when are running behind and half out the door.

Addressing Social Needs

I-PaCS Integrated Primary Care and Community Support

Often, our most medically complex patients face extreme social needs.

Patient Example

RM – 21 yo M previously healthy, ATV accident resulting in C7 burst fracture, C6 fracture, near complete transection of spinal cord at C7.

- Undocumented
- Uninsured
- Wheelchair
- Medical supplies- diapers, wipes
- Medication
- Neurology f/u
- Physical Therapy
- Transportation
- School

I-PaCS Integrated Primary Care and Community Support

Questions on Help You May Need

1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?
   _____ Yes _____ No
2. Are you homeless or worried that you might be in the future?
   _____ Yes _____ No
3. Do you have trouble paying for your utilities (gas, phone)?
   _____ Yes _____ No
4. Do you have trouble finding or paying for a ride?
   _____ Yes _____ No
5. Do you need daycare, or better daycare, for your kids?
   _____ Yes _____ No
6. Are you unemployed or without regular income?
   _____ Yes _____ No
7. Do you need help finding a better job?
   _____ Yes _____ No
8. Do you need help getting more education?
   _____ Yes _____ No
9. Are you concerned about someone in your home using drugs or alcohol?
   _____ Yes _____ No
10. Do you feel unsafe in your daily life?
    _____ Yes _____ No
11. Is anyone in your home threatening or abusing you?
    _____ Yes _____ No

I-PaCS Integrated Primary Care and Community Support

What if health care providers knew about these needs at the beginning of a visit, just like vital signs?

What if health care teams had experts in addressing social needs?

Concerns

- Too many questions!
- This will take too long
- I'll be waiting for my patients for forever
- Too many questions!
- All my patients will answer yes and they I won't know what to do
- Our CHWs will be overwhelmed
- Still too many questions!
- If I get too busy I won't be able to address all of these issues

I-PaCS Integrated Primary Care and Community Support

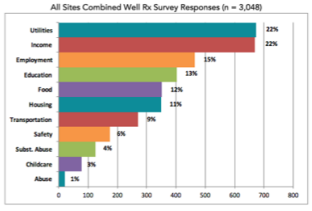
We wanted to learn about the social needs of our patients and take action on social needs but we were worried? Could this be done in our busy community health center setting?

We learned that our patients do indeed experience significant social needs.

WellRx Survey Responses - All Pilot Sites

	Total	Percent of patients surveyed	Completed surveys with positive screen
Number of completed surveys	3048		
Surveys with at least one "yes" response	1413	46%	
Patients with 2-5 "yes" responses	792	26%	56%
Patients with 6-11 "yes" responses	98	3%	7%
Most Noted Domains	Utilities	22.0%	47.6%
	Income	21.9%	47.3%

All Sites Combined Well Rx Survey Responses (n = 3,048)



I-PaCS Integrated Primary Care and Community Support

CHW Workflow in the Clinic

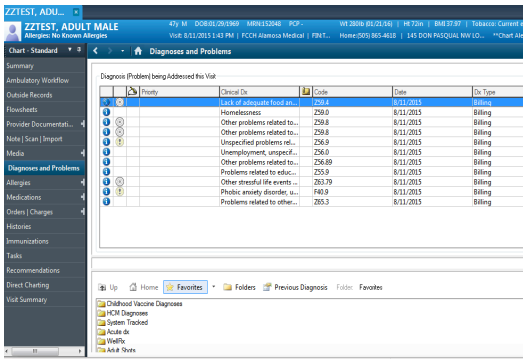
- MA asks all 11 WellRx questions
  - Takes no time
- If yes to any questions, MA enters diagnosis:
  - "Inadequate Community Resources" – V60.2
- MA places filled out WellRx into "visit folder"

I-PaCS Integrated Primary Care and Community Support

We integrated CHWs as valued and respected members of our teams.

We integrated social need screening and CHWs into our clinic work flow.

We learned that ICD 10 allowed us to document these needs in the EHR.



I-PaCS Integrated Primary Care and Community Support

CHW Workflow in the Clinic

- Doctor asks patient if they would like help with any of the issues they answered yes to.
  - Scripted
- If they want help and would like to talk to CHW
  - Warm handoff or if CHW not available, Communicate to both CHWs to call when they get a chance.
- Handouts available if they don't want to meet with a CHW.
- CHWs send provider message after they contact patient and with any progress.

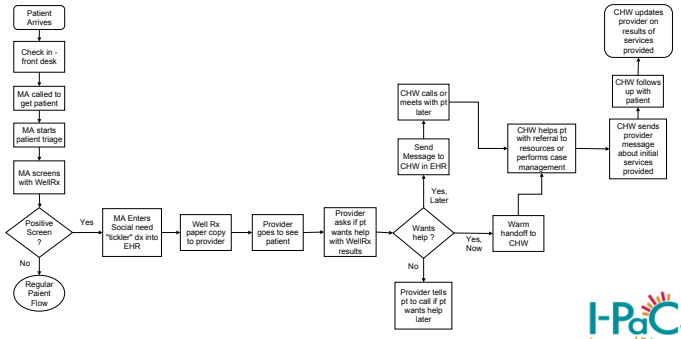
I-PaCS Integrated Primary Care and Community Support

CHW Workflow in the Clinic

Providers, MAs, Front Desk staff, and nursing can all do a warm handoff or communicate to connect patients or community members with CHWs.

I-PaCS Integrated Primary Care and Community Support

Here's how we integrated social need screening and CHWs into our clinic work flow.



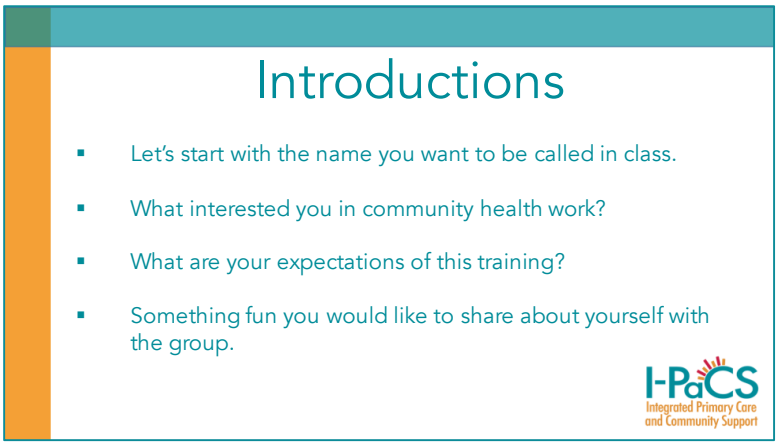
I-PaCS Integrated Primary Care and Community Support

In the end, screening for social needs and responding to those needs with community health workers took a lot of work off of the full plates of our busy health teams and gave us greater confidence that our patients health would improve based on our actions.

END

Thank you for your participation!

TRAINING MATERIALS FOR CHWS



TRAINING OVERVIEW

Day 1

- Introductions
- Defining Your Role
- Competencies
- Code of Ethics
- HIPAA
- Documentation
- Case Management
- Service Coordination

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TRAINING OVERVIEW

Day 2

- Health Promotion
- Home Visitation Guidelines
- Cultural Humility

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TRAINING OVERVIEW

Day 3

- Motivational Interviewing

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Welcome CHW participants to the training and describe the topics that you will be covering. Refer participants to the training schedule.

DAY 1

Defining your Role

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Before sharing the definition of CHW developed by the World Health Organization, ask participants how they define themselves and their role as a CHW. Do they call themselves something other than CHW?

Who is a CHW?

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**. This trusting relationship enables the CHW to serve as a **liaison/link/intermediary** between health/social services and the community to facilitate **access to serv**ices and **improve the quality** and **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.**

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Many Names…

Shasthyo Sebika
Village Health Workers
Agente Comunitario de Salud
Saksham Sahaya
Community Health Agents
Agente comunitário de saúde
Visitador/a
Group Leaders
Maternal Health Worker
Community Nutrition Worker
Anganwadi Workers
Community-based Workers
Community Health Volunteer
Village Malaria Worker
Maternal Child Health Workers
Voluntary Malaria Workers
Promotores/as de Salud
Community liaison
Community organizer
Community outreach worker

Nutrition Volunteers
Raedat
Accompagnateurs
Community Health Volunteer
Behvarz
Village Health Guide
Nutrition Worker
Colaborador Voluntario
Community Drug Distributor
Village Health Helper
Posyandu
Village Drug-Kit Manager
Community Reproductive Health Worker
Mental Health Workers
Postnatal Support Worker
Community Volunteer
Community Health Advocates
Community Health Representative

Community Health Aide
Village Health Promoters
Rural Health Worker
Brigadistas
Community-based Skilled Birth Attendant
Dai
Bidan Kampong
Dayas
Community Volunteers
Facilitator
Change Agents
Doot
Peer Educators
Lay Counselor
Volunteer Counselor
Volunteer Peer Counselor
Peer Support Worker
Health Ambassador
Patient navigator
Public health aide

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Scope of Practice

Role I: Outreach and Community Mobilization

Role II: Community and Cultural Liaison

Role III: Case Management and Care Coordination

Role IV: Home-Based Support

Role V: Health Promotion and Health Coaching

Role VI: System Navigation

Role VII: Participatory Research

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Provide participants with the C3 project's Scope of Practice for CHWs and discuss the elements of each role.

Differences from Other Professionals

- Social workers: The practice of social work requires knowledge of human development and behavior, of social, economic and cultural institutions, and of the interaction of all these factors. Social workers help people overcome some of life's most difficult challenges: poverty, discrimination, abuse, addiction, physical illness, divorce, loss, unemployment, educational problems, disability, and mental illness. They help prevent crises and counsel individuals, families, and communities to cope more effectively with the stresses of everyday life.

I-PaCS Integrated Primary Care and Community Support

Differences from Other Professionals

- Nurse case managers are registered **nurses** (RNs) who develop, implement, and evaluate individualized patient care plans. They can advocate patient welfare, and serve as a liaison between patients, their families, and healthcare providers.

Another role that is similar to the role of the CHW is that of of Health Educators. There is often overlap, and CHW may also be a health educator.

Roles In the Clinic Setting

- Understand social and clinical issues impacting patient's lives.
- Pre-visit preparation is conducted. [e.g. CHW checks the EMR of each Medicaid member to see if he/she has been ordered lab tests, referrals to specialists, etc.
- Provide MB with written List of resources to address social needs identified through the screening.
- Assist MB to fill out paperwork to get re-certified for Medicaid and to obtain Income Support, SNAP, or other government programs as well as housing.

- Provide general information about resources available at the clinic and in the surrounding community such as mobile markets, nutrition classes, walking trails, etc.
- Assist MB in making appointments to social service agencies and follow up with MB to make sure that they indeed went to the appropriate agency.
- Are parts of the primary care system that addresses health concerns including health education, one-on-one support services, facilitates access to group learning opportunities, etc.

EFFECTS ON HEALTH OUTCOMES

Access to care
Health promotion/disease prevention
Immunization (adults & children)
Malaria
ACI (children)
Breastfeeding
Reducing mortality (elderly & children)
Tuberculosis
Cognitive/motor development

Positive behavior change
Knowledge change
Breast cancer screening
Injury prevention
Birth weight
Language development
Tobacco and drug exposure
Failure to thrive
Maltreatment

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EFFECTS ON COMMUNITY HEALTH

Community transformation only through community participation

With people, not for them

Role of CHWs:
- enhance existing networks
- engage in problem-solving
- natural researchers
- build community capacity
- empower communities

I-PaCS Integrated Primary Care and Community Support

EFFECTS ON HEALTH SYSTEMS

- Cost-effectiveness
- Lack of economic analyses in existing studies
- CHW interventions not easily analyzed
- Other contributions than just cost-savings

I-PaCS Integrated Primary Care and Community Support

"EFFECTS" slides describe the impact that CHWs have at each level in the health environment and system.

Evidence shows that CHWs can improve health outcomes for individuals in the areas listed.

CHWs transform community health through participation and community advocacy. They form a bridge from the community to health and social services, and may empower communities by helping to build capacity.

Roles and Competencies

I-PaCS Integrated Primary Care and Community Support

CORE CHW ROLES

- Cultural mediation between communities and health and social systems
- Informal counseling and support
- Provide direct services and referrals
- Provide culturally appropriate health education
- Advocate for individual and community needs
- Assure people get the services they need
- Build individual and community capacity

Source: Berthold, Tim, Jennifer Miller, and Alma Avila-Esparza. Foundations for Community Health Workers. San Francisco, CA: Jossey-Bass, 2009.

I-PaCS Integrated Primary Care and Community Support

For each bullet under CHW roles, ask participants to describe how they think that role is carried out, or what that role means to them.

Read the quotes from CHW peers for each role and discuss.

Cultural Mediation

"As a CHW, I work regularly with doctors to assist them to communicate with our Cambodian patients. Because the Cambodian community is so small, sometimes patients have to wait many hours to speak to someone at a clinic who can understand them. By me working at the clinic, the patient doesn't get lost in the system—they can easily come to me for what they need. Besides not understanding English, some of our patients don't read or write well and have a hard time understanding their medications. One of the patients I worked with suffered from hypertension, diabetes, and heart disease. She thought that needed to finish one type of medicine first before she can start on another, even though sometimes she needed to take fifteen different medications a month. Because of this her diabetes was out of control and the doctor asked me to aid in the arrangement of her daily medication schedule. When I explained to her that she could take the medications simultaneously she was shocked because she had been doing what she thought was right for ten years."

Source: Berthold, Tim, Jennifer Miller, and Alma Avila-Esparza. Foundations for Community Health Workers. San Francisco, CA: Jossey-Bass, 2009.

I-PaCS Integrated Primary Care and Community Support

Informal Counseling And Social Support

"Smoking within the Asian community, especially with men, is very integrated into the culture. Many men know about some of the health hazards of smoking for themselves but don't really know a bout second hand smoke or the other health impacts of smoking on their families. Because it is so hard for them to quit, the doctors refer them to me to get smoking cessation counseling. Of course not everyone is ready to quit or even wants to quit, but for those who are, I assist them in creating a plan to reduce or stop smoking; give them some education on the harmful effects of cigarettes, and just provide support and encouragement. In every session, I talk with them about their smoking experience and explore their ambivalence to quitting. Sometimes just talking will get those who were not ready to quit at least thinking about the possibility of it, and this can lead to another appointment and another opportunity to make a plan to quit."

Source: Berthold, Tim, Jennifer Miller, and Alma Avila-Esparza. Foundations for Community Health Workers. San Francisco, CA: Jossey-Bass, 2009..

I-PaCS Integrated Primary Care and Community Support

Providing Direct Services And Referrals

"When I can't provide the services for a patient, I refer them to services at another program or agency. It is important as a CHW to know what resources are available in the community. Part of my job is to make sure the patient gets the right care—I'll walk them to their appointment or to another agency if the patient needs me to."

Source: Berthold, Tim, Jennifer Miller, and Alma Avila-Esparza. Foundations for Community Health Workers. San Francisco, CA: Jossey-Bass, 2009.

I-PaCS Integrated Primary Care and Community Support

Providing Culturally Appropriate Health Education

"I am a CHW at a clinic in Oakland. I see and give presentations to patients who are young adults, ages 14-20. I find that during my presentations, I have to ditch lecture-based teaching and make it as entertaining as possible. But the entertainment is also speaking to the youth and relating to their everyday experiences—not from a textbook but from the radio, internet, music, and the everyday words they use. Being culturally appropriate isn't just knowing their language but relating to them as youth, not talking down to them, and respecting their space so they feel comfortable and willing to ask questions. I find the more the you laugh, the more they pick up on ideas and information that deal with safer sex practices and access to clinical services."

Source: Berthold, Tim, Jennifer Miller, and Alma Avila-Esparza. Foundations for Community Health Workers. San Francisco, CA: Jossey-Bass, 2009.

I-PaCS Integrated Primary Care and Community Support

Advocate For Individual And Community Needs

"Earlier this year, Bernalillo County Commissioners voted on a very important issue: a tax that would allow for coordinated mental health services in the county. The response of the community was overwhelming; constituents reached out to these public [elected] officials and shared their support for this tax. Many CHWs, community advocates, and concerned citizens testified and shared their stories to illustrate how passing this tax would help the people of Bernalillo County."

I-PaCS Integrated Primary Care and Community Support

Assure People Get The Services They Need

"We are usually the first ones to receive questions—and complaints—from patients. It's fun but challenging work, because the routine is never the same. Once patients come in, I find out what services they need and assist them to get these services. I try to empower the patients to seek the services themselves, but if they need it, I'll assist in guiding them through the clinical side of checking in, seeing a doctor, and offering additional resources. I see what else they might need and try to find an organization in the community that can assist them, like food or legal issues."

Source: Berthold, Tim, Jennifer Miller, and Alma Avila-Esparza. Foundations for Community Health Workers. San Francisco, CA: Jossey-Bass, 2009.

I-PaCS Integrated Primary Care and Community Support

Building Individual And Community Capacity

"One of the most important ways that I know that I am doing a good job is when my clients no longer need me, or need me as much. Everything I do is based on supporting the client not to be dependent on me any more. I want to support them to take charge of their own health, to negotiate healthy relationships, to navigate the health care system, to communicate with health care providers and to get the treatment they want and deserve. And sometimes I get to work with communities and support them to speak out for policy changes. Instead of me testifying before the Board of Supervisors (City Council) on behalf of the communities I work with, I want to support them to testify and speak out for themselves. They are the experts about what they need and want, and their voices are the voices that need to b e heard."

I-PaCS Integrated Primary Care and Community Support

11 CORE COMPETENCIES

- ❑The CHW Profession
- ❑Effective Communication skills
- ❑Interpersonal skills
- ❑Health Coaching Skills
- ❑Service coordination skills
- ❑Capacity-building skills
- ❑Advocacy skills
- ❑Technical Teaching skills
- ❑Community Health Outreach skills
- ❑Community knowledge and assessment
- ❑Clinical Support Skills (optional)

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The competencies listed are the the core competencies required for certification of CHWs in the state of New Mexico.

Below are important qualities for CHWs to possess, qualities that the participants bring to the table. Depending on your audience, you may ask participants to describe examples of each of these qualities and how they themselves represent the qualities of a CHW.

Refer to the C3 Project's CHW Qualities.

CHW QUALITIES

- Interpersonal warmth
- Trustworthiness
- Objectivity
- Sensitivity
- Competence
- Commitment to social justice
- Good psychological health
- Self awareness and understanding

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CHW Code of Ethics

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What are ETHICS?

A system of moral principles that guide you in making decisions.

➢When dealing with clients, certain boundaries need to be maintained

Source: Community Connector Training, Molina HealthCare

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Ethical Challenges

- CHWs want to help the people we serve and our communities
- We don't want to cause harm
- Sometimes CHWs face professional situations in which it isn't clear how to achieve these goals and what course of action to take

Source: Community Connector Training, Molina HealthCare

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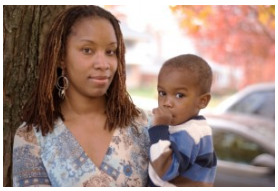
Ethics: Case Scenario

You've been working with Julia, a 28-year old single mother for the last 2 months. Her main focus was finding employment. She was offered a position at the local convenience store, but she doesn't have transportation and she is working weekend evenings. She asked you to give her a ride since you live nearby. You know how much she needs this job and the income.

What would you do?



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After talking about ethics, the facilitator may read the case scenario.

Solicit answers from the group about how they would address the situation.

When participants are not on the right track, ask their peers to give feedback.

Ethics And Values

- How you handle an ethical dilemma will be influenced by your values
- Values vary from individual to individual and are influenced by culture, community, family upbringing, personal experience and society

Source: Community Connector Training, Molina HealthCare

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Ethical decisions will be influenced by individual and community values, and will also be shaped by policies at different sites and places of work. Work with undocumented clients is a good example of where the law and ethics may be in conflict and create an ethical dilemma.

Ask: If someone is in the country illegally, should you provide the same compassionate, patient centered care that you would provide to any other patient?

Ethics and The Law

- Ethics and the law are related, yet different
- Ethics is about doing what is morally right
- Laws are established by governments to prevent and punish behavior that is destructive to a society's well-being

Source: Community Connector Training, Molina HealthCare

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Professional Boundaries

- Limitations or ethical guidelines that a professional establishes within working relationships.
- Allow CHWs to better protect the welfare of clients, themselves, employers and the community.

Source: Community Connector Training, Molina HealthCare

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When CHWs are working with clients, protecting the client, and protecting themselves from liability and burnout, are of utmost importance.

Boundaries are key: they need to be established immediately and continuously reinforced.

Discuss situations when people have struggled with professional boundaries in the past, and if needed, share some possible scenarios.

Relationship Conflicts

- Dual relationships
- Romantic/sexual relationships

Source: Community Connector Training, Maine HealthCare

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Especially in small towns, CHW's clients may also be their friends, neighbors, or even family members.

If there is a conflict of relationship, its best to refer.

When that is not possible, it is even more important to have very clear boundaries and assure the client that their information will be kept confidential.

Framework for Decision Making

- Describe the problem
- Review ethical guidelines/codes
- Review laws/regulations
- Seek consultation from colleagues, a supervisor or mentor
- Consider possible action
- Outline consequences of decisions
- Decide on action

Source: Community Connector Training, Maine HealthCare

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When CHWs are faced with an ethical dilemma, this is the process for making decisions about how to address the issue.

Refer back to the case scenario with "Julia". Ask questions to stimulate discussion, such as, "What if you got into a car accident while transporting Julia? What would that look like?"

Ask participants to come up with other problems that could arise.

Purpose

- Adopted by the American Association of Community Health Workers
- Provides a framework for CHWs, supervisors, and employers to discuss ethical issues facing the profession.
- Strive for excellence, provide quality service and accurate information

Source: Community Connector Training, Maine HealthCare

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Article 1: RESPONSIBILITIES IN THE DELIVERY OF CARE

1.1 honesty
1.2 confidentiality
1.3 scope of ability and training
1.4 quality of care
1.5 referral to appropriate services
1.6 legal obligations

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The following slides detail the article of the code of ethics from the American Association of CHWs.

Discuss how the code of ethics aligns with CHW qualities and roles.

Article 2: PROMOTION OF EQUITABLE RELATIONSHIPS

2.1 cultural humility
2.2 maintaining the trust of the community
2.3 respect for human rights
2.4 anti-discrimination
2.5 client relationships

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Article 3: INTERACTIONS WITH OTHER SERVICE PROVIDERS

3.1 cooperation
3.2 conduct
3.3 self-presentation

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Article 4: PROFESSIONAL RIGHTS AND RESPONSIBILITIES

4.1 continuing education
4.2 advocacy for change in law and policy
4.3 enhancing community capacity
4.4 wellness and safety
4.5 loyalty to the profession
4.6 advocacy for the profession
4.7 recognition of others

CHW Pledge

I, (your name), pledge to:

- Respect the dignity of all people and behave in a manner that communicates respect
- Respect each individual's right to make their own life choices and to embark on a recovery journey with every person I serve, letting them direct their own healing process
- Fight stigma wherever I find it, to educate the community and to promote community integration for the people I serve
- Not allow my words or actions to reflect prejudice or discrimination regarding a person's race, culture, gender, or sexual orientation.
- Strive to both seek and provide culturally sensitive services for each person and to continually increase my own cultural awareness
- Help people find and acknowledge their strengths and to use these strengths in their journey and recovery
- Help people achieve maximum self-responsibility and to find and use services that promote increased knowledge, skills, and competencies

Source: Community Connector Training, Malka Hacohen

Refer to CHW Pledge Handout. Read aloud as a group.

I, (your name), pledge to:

- Acknowledge the power of self-help and peer support, and encourage participation in these activities
- Be honest with myself, my colleagues, the people I serve, and others involved in their care
- Keep confidential all information entrusted to me by those I serve except when to do so puts the person or others at grave risk, and to explain the limits of confidentiality to those I serve at the beginning of our work together
- Strive to maintain health relationships with the people I serve, avoiding confusing or multiple relationships and keeping the relationship focused on the individual's needs, not my own.
- Consult with my supervisors, obtain training, or refer any individual with a need I do not feel capable of addressing
- Remain curious, learn, grow, develop, and use opportunities for continuing education in my field
- Advocate for the people I serve, for their rights, for equal treatment and for resources to meet their needs
- Learn the laws and regulations governing my practice and abide by them
- Work supportively with my colleagues and keep their confidence

Source: Community Connector Training, Malka Hacohen

HIPAA and CONFIDENTIALITY

HIPAA

Federal Health Insurance Portability and Accountability Act of 1996.

The primary goal of the law is to make it easier for people to keep health insurance, protect the confidentiality and security of healthcare information and help the healthcare industry control administrative costs.

http://www.hhs.gov/ocr/privacy/

Violations & Enforcement

U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR).

OCR is responsible for administering, investigating and enforcing HIPAA privacy standards.

The Centers for Medicare & Medicaid (CMS) enforce the code set and security standards.

http://www.hipaa.com/the-reality-of-hipaa-violations-and-enforcement/

The following slides describe HIPAA oversight and reporting, and penalties for non-compliance.

HIPAA Fines

- The fine for a first time infringement by someone who did not know they violated HIPAA could be as low as $100 or as high as $50,000.
- The fine for a violation due to willful neglect, but corrected within the required time period, is a minimum of $10,000 per violation with a maximum of $50,000.
- The fine when the willful neglect violation is not corrected increases from $10,000 to $50,000.

http://www.hipaa.com/the-reality-of-hipaa-violations-and-enforcement/

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HIPAA Compliance

- **Physical safeguards** include limited facility access and control, with authorized access in place. All covered entities, or companies that must be HIPAA compliant, must have policies about use and access to workstations and electronic media. This includes transferring, removing, disposing and re-using electronic media and **electronic protected health information (ePHI)**.
- **Technical safeguards** require access control to allow only the authorized to access electronic protected health data. Access control includes using unique user IDs, an emergency access procedure, automatic log off and encryption and decryption.
- Audit reports, or tracking logs, must be implemented to keep records of activity on hardware and software. This is especially useful to pinpoint the source or cause of any security violations.
- **Technical policies** should also cover integrity controls, or measures put in place to confirm that ePHI hasn't been altered or destroyed. IT disaster recovery and offsite backup are key to ensure that any electronic media errors or failures can be quickly remedied and patient health information can be recovered accurately and intact.
- **Network, or transmission, security** is the last technical safeguard required of HIPAA compliant hosts to protect against unauthorized public access of ePHI. This concerns all methods of transmitting data, whether it be email, Internet, or even over a private network, such as a private cloud.

http://www.onlinetech.com/resources/references/what-is-hipaa-compliance

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Confidentiality

- Why is it important?
- What are your obligations to maintain confidentiality?
- What if a family member asks how the patient is doing?
- What other kinds of disclosures are inappropriate?

https://depts.washington.edu/bioethx/topics/confiden.html

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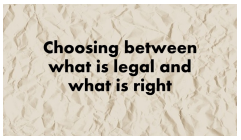
Confidentiality Exceptions

- Harm to self or others
  - suicidal/homicidal intention
- Suspected abuse or neglect
  - child/elder
- Legal requirements to report certain conditions or circumstances
  - Public health vs. individual



https://depts.washington.edu/bioethx/topics/confiden.html

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In NM these are the guidelines for mandated reporting; these override normal patient confidentiality.

Note: Public Health vs. Individual may have to do with the spread of infectious disease. A CHW is not likely to be involved in this kind of reporting.

Confidentiality: Case 1

You've been working with Juan for a couple of months. He has a variety of health issues to include hypertension and diabetes and you've connected him to the local health clinic and he is getting himself checked regularly. He just told you that he was tested for STDs and his results show that he has HIV but he doesn't want to tell his girlfriend because she'll kick him out and he will be homeless.

What do you do?

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Discuss the case scenario and the different components that contribute to the complexity of the case.

The CHW CANNOT break confidentiality to call the girlfriend and tell her.

Ask: What other measures can the CHW take?

Confidentiality: Case 2

Ms. Sanchez is a 83 year old patient that came to the clinic after a recent trip to the ED. You notice she has bruises on her arms and legs and she seems very shy and withdrawn.
She tells you that she lives with her daughter and her son-in-law.

How do you handle this situation?

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In this scenario there is suspected elder abuse. Discuss what the options are, and the regulations for reporting.

Documentation

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Types of DOCUMENTATION

Progress Notes:

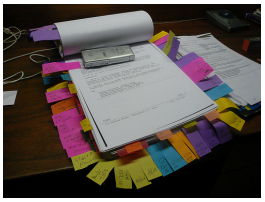
- **Brief notation as a follow to an original assessment.**
- **Review the problem, evaluate the effectiveness of the plan, and indicate change**
- **Pre-established intervals (daily, twice a week, monthly, etc)**

S-
O-
A-
P-

Subjective
Objective
Assessment
Plan

D-
A-
P-

Data
Assessment
Plan



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Describe the two methods of documentation and provide several examples of both.

Documentation TIPS

- In black pen—no pencils or erasing.
- If mistakes occur, mark through the ~~error with one line,~~ add the word "error", initial beside the error, and add the correction.
- Abbreviations must be approved by the facility.
- Do not make suggestions on medical diagnosis.
- All documentation must be dated and signed with your title.
- There should be no large gaps/blank space between entries.
- Do not express your personal opinions or make criticisms of the patient or other caregivers. Remember that others are reading your notes!
- Be concise, thorough and accurate.

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Practice: DOCUMENTATION

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Good and bad documentation: Case scenario

Marissa is a 16 year-old first-time mom. Her daughter, Destiny, is 2 months old. Marissa lives with her cousin, Sonia, in a one bedroom apartment. Marissa and the baby sleep on the couch at night. She currently has enough food, clothes, and diapers to take care of Destiny but isn't sure what she'll do in a couple months. Marissa dropped out of school when she got pregnant. She was in the 9th grade at the time. The father of the Destiny is not involved and does not provide child support.

You work as a CHW for a home visitation program for first time moms through a community health center. Marissa joined the program because she's interested in getting help signing up for different programs, including WIC and SNAP. She also wants to go back to school but isn't sure how to do it. Marissa has been in your program for 3 weeks now. You visit her at least once per week.

Today when you arrive on your home visit, Marissa and Sonia are fighting. Sonia says she needs some personal space with her boyfriend and that Marissa can't always be around. Marissa doesn't say much except tells Sonia she's ungrateful because she helped her through tough times too. Sonia tells Marissa she needs to find another place to live in the next week and then storms out of the apartment, slamming the door behind her. This wakes Destiny who you hold and help to calm down while Marissa sits in silence. Marissa looks relieved that you're holding Destiny. You notice Marissa's personal items – blankets, clothes, baby items – are all nicely folded or organized in a corner of the living room. The rest of the house looks clean.

Marissa tells you how mad at herself she feels for getting pregnant. She says she's not sure what to do and feels depressed. You listen to her. You ask her if she would be interested in meeting with the counselor at your clinic. She says, "Maybe." Marissa says that what she needs the most is to go back to school, but that she doesn't want to do it until Destiny is a year old.

Based on the case scenario, give a poor example of documentation: omit date, include judgmental comments, do not include sufficient plans for follow-up.

Divide participants into small groups. Ask participants to practice documentation and provide better examples of both types of encounter notes.

Case Management

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What is Case Management

- http://www.ncbi.nlm.nih.gov/books/NBK116484/

In simple terms…. It is a way of helping people identify the areas where they need help and connecting them to the personal and community resource that will help them.

Frankel 2012

Use the link. Discuss the different definitions of case management. What are the themes?

Case management is a model of practice that is versatile and can be incorporated into different settings.

Key Concept in Case Management

- People are responsible for the outcome. The Case manager is responsible for the process.
- People are ultimately responsible for making change happen. Case managers cannot force change on them. Instead, the Case Management process attempts to influence change.

Case Management Principles

- Offers a single point of contact with all health and social services
- Client-driven and driven by client needs
- Involves advocacy
- Community-based
- Pragmatic
- Anticipatory
- Flexible
- Culturally-sensitive

From SAMHSA TIP 27, Comprehensive Case Management for Substance Abuse. Page 13.

Case management process

- Defining the problem
- Determining the severity of the problem
- Developing hypotheses concerning why problems are occurring
- Establishing goals
- Developing/implementing service intervention plan
- Evaluating success of service intervention
- Termination
- Follow up

From Case Management: An Introduction to Concepts and Skills

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Defining the problem

- Conducting an assessment (biopsychosocial)
- What is the "presenting problem"
- What other issues need to be addressed?
- Multiple layers of issues; some may be evident, others are not. Trust is key.

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Defining the problem

- Conducting an assessment (biopsychosocial)
- What is the "presenting problem"
- What other issues need to be addressed?
- Multiple layers of issues; some may be evident, others are not. Trust is key.

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Why are the problems occurring?

- When theory becomes practice: understanding your client's situation
- May need to dig some more but don't compromise rapport

Establishing goals/developing a plan

- What are the expected behavior changes?
- What services should be utilized?
- What self-initiated skills are expected?
- Use SMART goals:
  - Specific
  - Measurable
  - Attainable
  - Result-focused
  - Time-specific

Evaluation

- Goals dictate evaluation
- Did I do a good job?
- Were all the goals met? If not, what happened?
- What can I do to improve my practice?

Termination

- Process
- Preferred it occurs when its planned
- Opportunity to explore what clients' learned
- Review and summarize progress notes: meet with client to review success
- Physical and emotional separation
  - Develop a sense of self-efficacy

1. Clients have reached their goals
2. Clients have satisfactorily demonstrated they can self manage
3. Clients are successfully working with referral sources

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Follow up

- Part of best practice, but least utilized.
- A phone call? A letter?
- Simple but not everyone does it. Why?

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Group Exercise

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Provide a case scenario for CHWS to practice using the case management process.

Scenarios can be developed or pulled from sources such as "The Fundamentals of Case Management Practice: Skills for the Human Services" by Nancy Summers

Service Coordination

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How do you get referrals?

What screening/assessment tools do you use?

Once a client is referred to you what do you do?

How do you communicate this information back to the team?

Source: CHW/R Competency Training: Service Coordination Skills Pilot Version

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Discuss the clinic flow at your site. Talk through each step of the process and discuss the roles of each team member.

Well-Rx

Assessment to be used by CHWs

1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?	____ Yes ____ No
2. Are you homeless or worried that you might be in the future?	____ Yes ____ No
3. Do you have trouble paying for your gas or electricity bills?	____ Yes ____ No
4. Do you have trouble finding or paying for a ride?	____ Yes ____ No
5. Do you need daycare, or better daycare, for your kids?	____ Yes ____ No
6. Are you without regular income?	____ Yes ____ No
7. Do you need help finding a better job?	____ Yes ____ No
8. Do you need help getting more education?	____ Yes ____ No
9. Are you concerned about someone in your home using drugs or alcohol?	____ Yes ____ No
10. Do you feel unsafe in your daily life?	____ Yes ____ No
Domestic violence?	____ Yes ____ No
Other safety issues?	____ Yes ____ No
If yes, which issue?	_____
11. Do you need help with immigration or legal issues?	____ Yes ____ No

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Describe the WellRx, its purpose, and who will be responsible for screening and communicating results to the care team.

Refer back to Social Determinants slides if necessary.

Building Relationships And Networking

1. Start with people you already know
2. Identify who you don't know and think about ways to work together
3. Network (see the handout Smart Networking)
4. Communicate and follow-up
5. Expand your contacts

Source: CHW/R Competency Training: Service Coordination Skills Pilot Version

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Walk through the steps listed and provide examples.
Keep both the client and organization or contact engaged, and ask to follow up regularly. CHWs can call contacts with patients if needed.

Expanding contacts: if one individual or group is unavailable to provide services, who can?

Improving Access And Identifying Barriers

What barriers keep clients from having the best health possible?

What other barriers do your clients and community face?

Why do these barriers exist for your clients and community?

How have you helped clients to remove barriers?

Source: CHW/R Competency Training: Service Coordination Skills Pilot Version

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Preparing for barriers: What is needed to fill out an application or access a service? What are the social determinants of health in the community where the client lives?

Talk about the process for referral at your site: Who is responsible for referrals to CHW, and who can a CHW refer a client to?

Are there places where you shouldn't refer: sometimes a client doesn't want to go to a clinic or agency because of a bad experience. This doesn't mean that you can't refer them, but CHW can work with client to mitigate past issues. CHW might accompany client to visit in this case, or work with the org to provide a better. Important to follow-up and make sure agencies are following through.

Refer Clients And Follow Up

- What is a referral?
- What does referral mean?
- What is a referral agency?
- Make a referral for your client

  Before you make referrals and set up appointments for clients, what do you need to think about or do?

Are there places you shouldn't refer clients? Why or why not?

Source: CHW/R Competency Training: Service Coordination Skills Pilot Version

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"The thing I always hated when I was a client was when someone would hand me a slip of paper with the name of some organization I never asked them for and tell me that I should call up such-and-such agency and they could help me with such-and-such problem. Then they would just change the topic or leave and act as if they had done me some kind of favor. First of all, don't tell me to go somewhere without even asking me if I'm interested—that drives me crazy! Second, even if I was interested, do you think some paper with an address or phone number or even a business card is gonna help me down the road if I don't really understand what the place is or what they do or who to talk to or anything? That's not a referral, that's an insult!"- TG

Source: Berthold, Tim, Jennifer Miller, and Alma Avila-Esparza. Foundations for Community Health Workers. San Francisco, CA: Jossey-Bass, 2009. 281.

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This community health worker expresses the frustration of how not to do a referral. A referral should be a collaboration with the client and a warm hand off to the next provider.

Service Connection: Case 1

Luisa Sandoval was referred to you by the physician for transportation issues. This was the third appointment she had made but was a no-show for the previous ones. After completing the Well-Rx, you discover that she needs assistance with other issues in addition to transportation. She is a mother of 3, two of the kids have physical and mental health disabilities and are not receiving benefits/services. She doesn't have a steady income and doesn't always have enough money to buy enough food for her family. Right now she is living in a small studio, paying month-to-month and she struggles to make the rent. She left her husband last month and he is constantly threatening to deport her so she lives in constant fear. She went to the Dr. because one of her kids is sick.

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In small groups (2s or 3s) discuss your steps around service coordination for Luisa.

- Prioritize Luisa's needs
- Using the resource manual, what referrals would you make?
- How would you present this information to Luisa?
- How do you follow up?

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A manual of community resources is given to each group to utilize during this exercise. Each group has the opportunity to present their plan based on the questions on this slide.

Service Connection: Case 2

Ms. Cook is a 28-year-old African American woman currently on probation for shoplifting, passing bad checks, vandalism, and parole/probation violations. She is currently awaiting trial for battery. Ms. Cook has been incarcerated twice during her adulthood (once for 10 months and, most recently, for 10 days). Ms. Cook is currently living with her grandmother, who had raised her. She is the mother of four children (ages 11, 7, 4, 2 years). The older two sons are living in foster care. The younger two daughters have complex health problems and developmental delays; they live with another relative. She is no longer in contact with any of the children's fathers. She also discloses that she has been drinking alcohol and smoking crack. She called 911 when she couldn't breathe and felt she was having a heart attack.

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Let's try another case. Meet Ms. Cook. Again, in dyads or triads, discuss the issues presented by Ms. Cook.

- Prioritize Ms. Cook's needs
- Using the resource manual, what referrals would you make?
- How would you present this information to Ms. Cook?
- How do you follow up?

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Just like the previous group exercise, each group will have the opportunity to present their suggestions for helping Ms. Cook.

- When you're ready to make referrals, how do you:
  - Make them **client-centered**?
  - Help everything **run smoothly**?

When setting up appointments:

- How will you handle someone who is **rude or in a hurry**?
- How will you **introduce yourself** and describe what you need?
- What should you **write down**?

Source: CHW/R Competency Training: Service Coordination Skills Pilot Version

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What does making a referral client-centered mean? These questions generate discussion among the group and as a group decide on adequate answers.

- **Scenario 1: Maxine**

Maxine is a 34 year-old single mother of five children, ages 2, 5, 7, 12, and 14. She was in a physically abusive relationship with her ex-husband who moved out last year. The kids were not physically abused but witnessed the violence. Maxine is new to town, having moved here from Arizona to get away from her ex-husband. She has a 5th grade education and is currently unemployed. Maxine's brother is paying Maxine's rent for 3 months but, after that, she needs to take over. Maxine has asked to be in your program. She says she's ready to make changes.

- **Scenario 2: Robert**

Robert is a 22 year old homeless male. He was diagnosed with schizophrenia one year ago. He sometimes goes to see a counselor at a local church. He doesn't remember ever taking medication for his illness. He says he has family in town but doesn't want to see them. Robert has asked to be in your program. He says he's ready to make changes.

- **Scenario 3: Gilberto**

Gilberto was in jail for 3 years for robbery. He was released a year ago but has had a hard time finding a job. He is interested in finishing his GED but says he has a hard time focusing. He's currently living with his mother but she wants him out by next month. Gilberto says he feels like stealing is easy because he knows what to do, but, at the same time, doesn't want to go down that road again.

Gilberto has asked to be in your program. He says he's ready to make changes.

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These are optional cases that can be used for additional practice on service coordination.

- **Scenario 4: Rosie**

Rosie is a 55 year-old woman who has full custody of her two grandchildren, ages 8 and 10. She gets food stamps and disability but it's not enough to take care of the household. She's behind on her rent and is thinking about getting back together with her boyfriend who is a drug user. She doesn't love him but feels he can at least help pay for things. Rosie has asked to be in your program. She says she's ready to make changes.

- **Scenario 5: Mary Beth**

Mary Beth, a 28 year-old woman, has uncontrolled diabetes and high blood pressure. She is overweight and under a lot stress to support her mother who has cancer and her 3 kids. She sometimes skips taking her insulin because she can't afford her medications. She just joined a diabetes support group and is starting to walk each day. Mary Beth has asked to be in your program. She says she's ready to make changes.

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Follow Up

After referring a client, the next step is to follow-up. Follow-up is not only checking to see if a client went to an appointment, but also finding out what the experience was like. The point of follow-up is to make sure clients actually get the services they need in a way they find beneficial.

- What kind of follow-up is needed for a client who kept her/his appointment?
- What kind of follow-up is needed for a client who didn't keep her/his appointment?

Source: CHW/R Competency Trainings: Service Coordination Skills Pilot Version

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Follow up is an important piece of referral. Discuss the differences between the two questions addressed in this slide.

- What has changed for you since we created the last plan together?
- On a scale of 0-10, with 10 being the highest, how important is reaching this goal to you now?
- What other help or support do you need to finish your steps by the dates you picked?
- What do you think is getting in the way of you taking these steps to reach your goals?
- In what ways do you think not taking the steps we talked about might affect your goal?
- How can we change the goals and steps to make them work for you?

Questions like these can help clients think through their situation, feel motivated and confident again, and focus on what to do next.

Adapted from Fundamental Skills for Case Managers: A Self-Study Guide, Center for Health Training, 2003.

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If a client does not follow through with their referrals, here are some Motivational Interview-style, non-confrontational ways to address noncompliance.

DAY 2

Health Promotion

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Public Health

- Promotes the health and well-being of all people
- Population-based:
  - Geographic and political boundaries
  - Demographic characteristics
  - Health-related data on groups with similar patterns of risk factors
- Examines health inequalities
- Emphasizes on social determinants of health

Source: Berthold, Tim, Jennifer Miller, and Alma Avila-Esparza. Foundations for Community Health Workers. San Francisco, CA: Jossey-Bass, 2009. p. 47.

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Ask: Why is public health important in community health work?

Review of some public health terms that are common in community health work.

Health Promotion Terms

- *Social determinants of Health:*
  - Economic, social, and political policies and dynamics that influence whether or not people have access to resources and opportunities essential to good health.
- *Health Equity:*
  - all people have the opportunity to attain their full health potential
- *Health disparities:*
  - unfair and avoidable differences in health status seen within and between populations

Source: Community Connector Training, Molina HealthCare

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Social Determinants Of Health

- Safe housing and public transportation
- Proper and sufficient nutrition
- Civil rights and protection from discrimination
- Employment, safe working conditions, and a living wage
- Affordable health care
- Personal safety
- Clean water, soil, and air
- Recreational facilities and green space
- Cultural resources
- Personal safety
- Quality education

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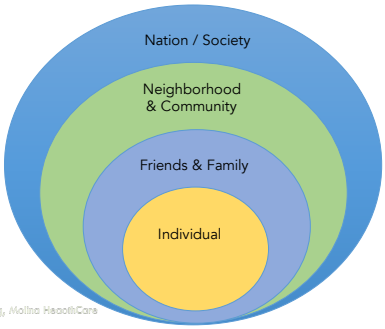
Review of social determinants of health. Do our clients experience these challenges? Do our communities? What does it look like?

Ecological Model



Source: Community Connector Training, Molina HealthCare

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The ecological model illustrates how various systems can influence resources and barriers and help CHWs identify ways they can intervene.

Prevention

Any activity that protects individuals or communities from health threats and their consequences.

3 stages of prevention:

✓Primary – preventing the disease from occurring in the first place
✓Secondary- early diagnosis & treatment of disease
✓Tertiary – minimize complications of the disease

Source: Community Connector Training, Molina HealthCare

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Example: CANCER PREVENTION

TYPE OF PREVENTION	INDIVIDUAL LEVEL	POPULATION LEVEL
Primary *(preventing disease)*	Education on healthy lifestyles	Marketing campaign to raise awareness; Anti-smoking campaign
Secondary *(early diagnosis)*	Referral for mammogram from PCP	Mobile clinic to increase access to cancer screenings
Tertiary *(minimize complications)*	Follow-up exam to check for reoccurrence	Access to self-management classes & support groups

Source: Community Connector Training, Molina HealthCare

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Let's take cancer as an example to illustrate how prevention works.

Group refers to table for examples on primary, secondary, and tertiary levels of prevention. Group can discuss other examples.

SPECTRUM OF PREVENTION

Source: Community Connector Training, Molina HealthCare

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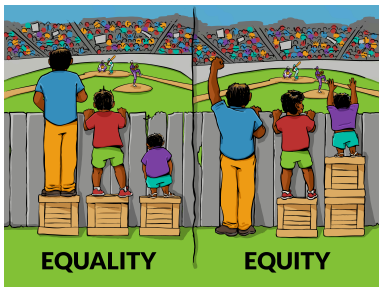
Prevention can also be viewed as a spectrum of various levels of intervention: from individual interventions to influencing policy and legislation.

Health Equity



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Ask participants to reflect on the differences between health equity and health equality, especially when social determinants are a factor.

Health INEQUALITY

"Significant differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill."

- Richard Hofrichter (2007)

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In community health work, you are going to see significant gaps in population health. As a CHW, your role will be to identify, intervene, advocate for health equity.

Causes of Health Inequalities

- Income and wealth
- Racism and discrimination
- Segregation
- Environmental racism
- Sexism, homophobia, transphobia
- Working conditions, status, control
- Living conditions

Exposure to stress

Source: Berthold, Tim, Jennifer Miller, and Alma Avila-Esparza. Foundations for Community Health Workers. San Francisco, CA: Jossey-Bass, 2009.

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POLICIES DESIGNED TO PROMOTE HEALTH EQUALITY

- ✓Promote understanding of the social determinants of health
- ✓Improve income and reduce wealth inequalities
- ✓Improve the physical and built environment
- ✓Promote racial justice
- ✓Promote better working conditions
- ✓Improve conditions for children
- ✓Improve social inclusion
- ✓Improve education
- ✓Improve food security and quality
- ✓Improve public and sustainable transportation
- ✓Use health impact assessments
- ✓Provide universal health care

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Here are a few examples of how we can help provide health equity.

Cultural Humility

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In CHW work, you will encounter diversity; individuals that don't share the same culture, beliefs or values. That is why it is important for CHWs to be culturally aware and humble when working with people.

Defining Culture

- Includes beliefs, behaviors, attitudes, and practices that are learned, shared, and passed on by members of a particular group.
- Dynamic, always changing
- Multifaceted

Source: Berthold, Tim, Jennifer Miller, and Alma Avila-Esparza. Foundations for Community Health Workers. San Francisco, CA: Jossey-Bass, 2009.

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What is culture? Ask the group to share some examples of how they define culture.

Reflections

- Have you ever had someone ask you, “where are you from? Or what are you?”
- Have you ever had someone mistakenly assumes one of your cultural identities?
- How did this make you feel?
- How did you react?
- How do you define your cultural identities?
- Does this change depending upon the circumstances?

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This is slide is important in helping the group frame what the experience may be for a person being asked these questions.

Building Self-awareness

1. What types of clients/communities do you think might have the greatest difficulties in accessing health or social services? Why?
2. What types of clients and communities do you lack experience with and knowledge about?
3. What types of clients or communities may you be less comfortable working with? Why?
4. How can you keep your personal attitudes and feelings from influencing the way you work with diverse clients?
5. What can you do to acknowledge your own stereotypes and prejudices? Why is this an important step to becoming an effective CHW?
6. Is it okay to be uncomfortable at times with clients of a particular cultural identity, or does this make you an unskilled CHW?
7. Is it okay to talk with your colleagues when you find that your are challenged in working with a client?
8. How can you learn to accept critical feedback about your work with diverse clients?

Source: Berthold, Tim, Jennifer Miller, and Alma Avila-Esparza. Foundations for Community Health Workers. San Francisco, CA: Jossey-Bass, 2009.

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In small groups, ask participants to answer these questions and report back to the whole group.

Principles of Cultural Awareness

- Define culture broadly
- Value clients’ cultural beliefs
- Recognize the importance and complexity of language interpretation
- Facilitate learning between providers and communities
- Involve the community in defining and addressing service needs
- Collaborate with other agencies
- Professionalize staff hiring and training
- Institutionalize cultural competency training and standards

Source: Berthold, Tim, Jennifer Miller, and Alma Avila-Esparza. Foundations for Community Health Workers. San Francisco, CA: Jossey-Bass, 2009.

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Defining Cultural Humility

Incorporates a lifelong commitment to self evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations.

--Melanie Tervalon and Jane Murray-Garcia (1998)

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Cultural Humility

- Engage in self reflection and self critique, including reflection about our own assumptions and biases
- Understand that our own culture is no better than any other—all cultures deserve our respect
- Admit when we don't know about the culture and social context of our clients
- Seek out resources that may broaden our understanding of the various cultures of the communities and clients we serve
- Recognize that only the cli8ent is the expert about her own culture, values, and beliefs
- Place our assumptions aside when working with others, and ask clients and communities to share their own experiences, knowledge, resources, needs, and priorities with us so that we may best support their health and well-being.

Source: Berthold, Tim, Jennifer Miller, and Alma Avila-Esparza. Foundations for Community Health Workers. San Francisco, CA: Jossey-Bass, 2009.

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Transference of POWER

Think back to your last doctor appointment:

- Who asked most of the questions?
- Were the questions the ones you wanted to answer in order to get to the problem at hand?
- Were you able to fully express yourself, or did you find the appointment limiting?

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Ask participants to reflect on their last doctor's visit in small groups of 2-3.

The Explanatory Model

- What do you call the problem?
- What are the signs and symptoms of the illness that you're experiencing?
- What are your concerns or fears?
- Why do you think this illness or problem has occurred?
- How does the illness affect you or your family?
- How do you think the sickness should be treated?
- How do you want us to assist you?
- Who do you turn for assistance?
- Who should be involved in decision making?

Source: Berthold, Tim, Jennifer Miller, and Alma Avila-Esparza. Foundations for Community Health Workers. San Francisco, CA: Jossey-Bass, 2009.

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Describe the explanatory model.

Understanding Cultural Health Beliefs

- What are the health beliefs in your family or culture?
- Where did your family go to receive health care?
- What were the home remedies for illnesses?
- How were they used?
- What do you still practice today?
- Were there health topics or issues that were considered "taboo" or were forbidden to discuss?

Source: Berthold, Tim, Jennifer Miller, and Alma Avila-Esparza. Foundations for Community Health Workers. San Francisco, CA: Jossey-Bass, 2009.

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Ask participants to reflect on cultural beliefs about health in their own families.

LEARN Model

L – listen with sympathy and understanding to the client's perception of the problem

E – explain your perceptions of the problem

A – acknowledge and discuss the differences and similarities between the perceptions of the client and the CHW

R – recommend resources

N – negotiate agreement

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CHWs can utilize the LEARN model for effective, culturally humble communication with clients or patients.

Cultural Humility TIPS

- People from rural areas may have been living a more traditional lifestyle than people who have been living in urban areas.
- Economic status and education vary greatly among people within a cultural group or people who come from the same country.
- People from the same country may have migrated to the US fro very different reasons, including seeking economic opportunity, escaping religious or ethnic persecution, fleeing civil strife, or joining relatives.
- Generational differences may exist among people of different ages within the same cultural group and may include different belief systems.

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Reflection

- What three strengths do I bring to this work on cultural humility? In what ways could I build on these strengths?
- What three gaps (or challenges) do I want to work on?
- Did any data, discussions, definitions, principles, or questions in this section provoke a strong emotional reaction in me? What are those feelings? What can I do to respond to my feelings in a way that honors my own experiences and perspectives and at the same time assists me to understand and honor the experiences or perspectives that are provoking those feelings?
- Over the next six months to a year, what activities could I undertake to strengthen my capacity to work across differences of race, class, culture, and language?

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Ask participants to reflect on these questions in small groups.

Home Visitation Guidelines

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WHY DO HOME VISITS?

- Unable to come to the office
- Follow up
- Contact clients who have not stayed in touch
- To see clients who have a decline in health
- Because family/friends contact you with concerns
- Support new parents/guardians
- Assess home environment and possible health risks
- Provide support on med management

Challenges Of Home Visiting

- May not want you to visit
- May be embarrassed about living conditions
- May be concerned about their privacy
- May worry about judging them
- May have had bad experiences
- You may witness or learn about drug use, neglect, abuse
- You may face risks to your personal safety

Preparing For A Home Visit

- Place yourself in the client's shoes
- Respecting a client's right to privacy—discreet home visits
- Get off to a good start—shadow another CHW
- Review and prepare client files
- Organize and pack resources
- Plan how to get to the client's home
- Identify key objectives

Common Courtesies And Guidelines

- Respect the client's time
- Announce yourself
- Introduce yourself
- If the client is not at home….
- Dress for the occasion
- Demonstrate respect and establish a positive connection
- Practice cultural humility
- Speak clearly, slowly, and not too loudly
- Maintain healthy boundaries
- Stay on topic
- Overcoming distractions

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Safety Guidelines

- Be prepared
- Pay attention, and be discreet
- What to do if conflict or danger arises

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CHWs should always have a plan in place for what to do if a dangerous situation arises on a home visit. Always make sure that someone in the clinic knows where you are going and how long you plan to be gone.

How To Conduct A Home Visit

- Conduct an assessment
- Conduct an environmental assessment
- Provide case management, health education, service connection
- Explain the next steps
- Good-bye and thank you

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After The Visit

- Complete paperwork, documentation
- Write down future appointments
- Investigate possible referral options
- Follow up with client
- Discuss/debrief with supervisor

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Common Challenges

- Visits to people without homes
- When clients are angry
- Working with clients who are incarcerated

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Self-Care

A few words about burnout….

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Self-care is important as a CHW. Stress is the cause of most chronic illness.

In your work you will encounter individuals that have a lot of emotional stress and difficult situations. It is important to seek professional advice if you are feeling overwhelmed. Talk to your supervisor or set up an appointment with a therapist.

DAY 3

Motivational Interviewing

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Ask participants to share what they already know about Motivational Interviewing and about their experiences learning or using the practice.

The Spirit of MI

Collaborative: Partnership between the patient and provider/CHW

Evocative: Builds on what patients already have within them, including personal goals, values, and aspirations.

Honors Patient Autonomy: Acceptance that people can and do make choices about the course of their lives, even if it is not the healthcare providers recommendation or desired outcome.

Rollnick, S., Miller, W. R., Butler, C. C., & Aloia, M. S. (2009). Motivational interviewing in health care: helping patients change behavior.

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MI is NOT a technique for tricking people. It is a style of eliciting patients' own motivation and reasons for making behavior changes for better health. The spirit of MI is that it is evocative, collaborative, and honors patient's ability and right to make their own decisions.

Guiding Principles

- Express Empathy
- Develop Discrepancy
- Roll with Resistance
- Support Self-Efficacy

Rollnick, S., Miller, W. R., Butler, C. C., & Aloia, M. S. (2009). Motivational interviewing in health care: helping patients change behavior.

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Discuss the guiding principles and describe what each one means.

Why Do People Change?

- Self-efficacy
- Intrinsic motivation

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People rarely make changes simply because they are told that they need to. To make real change, patients must be internally motivated and feel empowered to follow through with their goals.

Stages Of Change

Stage	Description
Pre-Contemplation	Not intending to make a change soon. Not necessarily opposed to change, just not ready to start.
Contemplation	Thinking about making a change soon (in the next six months). Ambivalent about "costs" vs "benefits" of the efforts required
Preparation	Intending to make a change in the near future. Convinced potential benefits outweigh the risks.
Action	Major behavior changes have been made.
Maintenance	Maintained behavior change for at least six months. New behavior has become routine

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OPEN Questions
AFFIRM
REFLECT
SUMMARIZE

The basic approach to interactions in motivational interviewing is captured by OARS.

Open or Closed?
A Time and Place for Both

- Were you able to go and pick up your food box?
- Are you having a hard time making it to your appointments?
- Do you feel safe at home?

The questions on this slide are all examples of closed questions. An open-ended question allows the client to create the impetus for forward movement. Although close-ended questions have their place - all of the questions on the WellRx are closed questions for example - the open-ended question creates a forward momentum that we wish to use in helping the client explore change.

Open Questions…

- *"How do you want to spend our time together?"*
- *"What was that like for you?"*
- *"How can I support you?"*
- *"Tell me a little bit more about that…"*

These are examples of open questions that can be used to elicit more information about a patient's values, motivations, and what they feel is important to share with you.

Exercise: Closed to Open

Turn the following closed questions into open-ended questions:

Do you want to take a cooking class?

Are you taking the medicines that the doctors prescribed you?

Are you staying sober or using drugs again?

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In pairs, ask participants to turn the closed questions into open questions. Ask pairs to share their ideas, then show the examples on the following slide.

Do you want to take a cooking class? -> *What kinds of peer support classes do you you think you might be interested in?*

Are you taking the medicines that the doctors prescribed you?-> *How's it going with the medicines that Dr. Martinez prescribed at your last visit?*

Are you staying sober or using drugs again? -> *Tell me about how it's going with your sobriety.*

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Affirmations

- "The fact that you came in today means a lot, especially with everything that you've got going on!"
- "You showed a lot of strength by doing that."
- "I can tell you really care about…"

Validation: https://www.youtube.com/watch?v=Cbk980jV7Ao

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Affirmations are very important in helping clients build self-efficacy, even if it's for very small accomplishments, like making it to the appointment. Affirmations should be sincere and truthful. If you pay attention, there is always something to affirm.

If time allows, show the short video.

Reflections

- Statements, not questions!
- You are holding up a mirror:

Patient: *Picking up food from the food bank in my neighborhood is embarrassing for me. I'm worried that someone might see me and will know that I can't provide for my family.*

CHW: *Its embarrassing for you to pick up food boxes in your neighborhood because you are worried that someone you know might see you and think that your are not providing for your family.*

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Reflections help close the loop of communication and show your client that you are really listening to them.

Summarize

- Collect the clients expressed motivation for change in a summary!

Partner Exercise: For one minute, one partner talks about something in their life that they would like to change, and why. The other partners listens. At the end of one minute, the listener summarizes what the speaker said. Switch roles.

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Have participants practice summaries in pairs.

Change Talk

- Change vs. Sustain Talk
- Recognizing and Reinforcing Change Talk
- Eliciting and Strengthening Change Talk
- Rolling with Resistance

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Developing a Change Plan

Brief Action Planning:

- Make a specific, client centered plan:
  - How, What, When, Where
  - Barriers and plans to overcome them
- How confident is the client that they can follow through?
- Ask the client to restate their plan.
- Follow-up

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END

Thank you for your participation!

Example 3-Day Training Schedule for Community Health Workers

Day 1	
9:00 – 12:00	**Introductions** **Defining your role: What are the duties of a Community Health Worker?** Overview of duties, responsibilities and role within the clinic Scope of Practice o Core Role of the CHW o CHW competencies **Code of Ethics** Review of Articles 1-4. o Purpose of the code o Responsibilities in the delivery of care o Interaction with other service providers o Professional rights and responsibilities Community Health Worker Pledge (handout) Ethics scenarios o Ethical challenges and values o Ethics and the law o Professional boundaries o Relationship conflicts o Value conflicts **HIPAA and Confidentiality** **Documentation** What to document? How to document? Different types of documentation o DAP o SOAP
12:00 – 1:00	**Lunch Break**
1:00 – 4:00	**Case Management Skills** o Assessment o Basic interviewing skills o Attending to personal issues o Active listening o Focusing and furthering

- Summarizing
- Empathy, praise, and support
- Setting boundaries

Service Coordination

Knowing your community
Accessing community resources
Improving access to resources
- Identifying gaps in services

Enrolling clients in different programs
Self-efficacy: Teaching clients how to follow-up

Day 2	
9:00 – 12:00	**Health Promotion** Brief Overview of Social Determinants of Health) Prevention - Primary, secondary, and tertiary prevention - Spectrum of prevention **Health Equity** Definition Causes of health inequities Suggested: Unnatural Causes Documentary and Discussion Real-life stories: How to battle social determinants of health as a CHW
12:00 – 1:00	Lunch Break
1:00 – 4:00	**Cultural Humility** Defining and understanding culture Building cultural self-awareness Defining cultural humility Understanding cultural health beliefs - The LEARN model Value Conflicts - CLAS standards

Day 3	
9:00 – 12:00	**Motivational Interviewing** The Spirit of MI o Collaboration o Evocation o Autonomy Principles of MI o Express empathy o Develop discrepancy o Roll with resistance o Support self-efficacy Stages of Change o Pre contemplation o Contemplation o Preparation o Action o Maintenance
12:00 – 1:00	Lunch Break
1:00 – 4:00	o Review Spirit of MI OARS Change Talk o Change vs. sustain talk o Recognizing and reinforcing change talk o Eliciting and strengthening change talk Developing a change plan

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