Community Health Worker (CHW) Workforce Development

Methodologies for CHW use in addressing the SDOH in vulnerable populations

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National Center for Health in Public Housing (NCHPH)

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- The mission of the National Center for Health in Public Housing (NCHPH) is to strengthen the capacity of federally funded Public Housing Primary Care (PHPC) health centers and other health center grantees by providing training and a range of technical assistance.

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Panelists

- Dr. Kevin Lombardi, MD, MPH, Manager of Health Policy, Promotion and Advocacy, National Center for Health in Public housing (NCHPH)

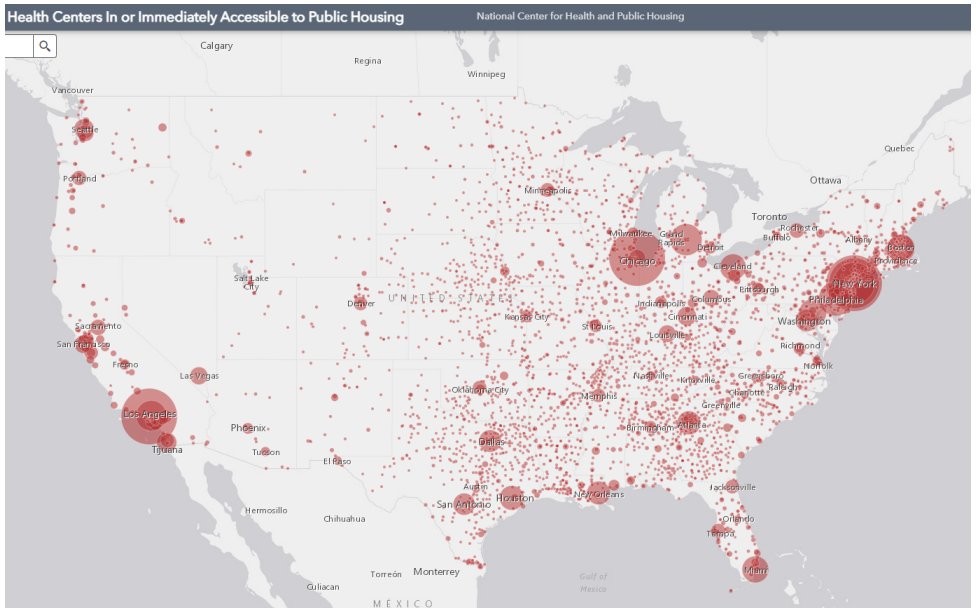
- Jason Amirhadji, Neighborhood & Community Investment Specialist, U. S. Department of Housing and Urban Development (HUD)

- Rod Auton, Administrator, Albion Health Care Alliance

Health Centers Close to Public Housing

- 1,373 Federally Qualified Health Centers (FQHC) = **30 million patients**
- 458 FQHCs In or Immediately Accessible to Public Housing = **5.7 million patients**
- 108 Public Housing Primary Care (PHPC) = **911,683 patients**

Source: 2021 Health Center Data



Source: Health Centers in or Immediately Accessible to Public Housing Map

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Public Housing Demographics

1.5 Million Residents

2 Persons Per Household

38% Disabled

52% White

91% Low Income

43% African-American

26% Latinx

19% Elderly

36% Children

32% Female Headed Households with Children

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Session content objectives

1. Discuss the recommended frameworks for using CHWs in health/housing partnerships and their real-world applications.
2. Review opportunities available to health centers to fund and support CHW integration into health center workflow.
3. Present an overview of key cases and promising practices that give insight into effective and efficient use of CHWs in supporting health/housing and other SDOH concerns.

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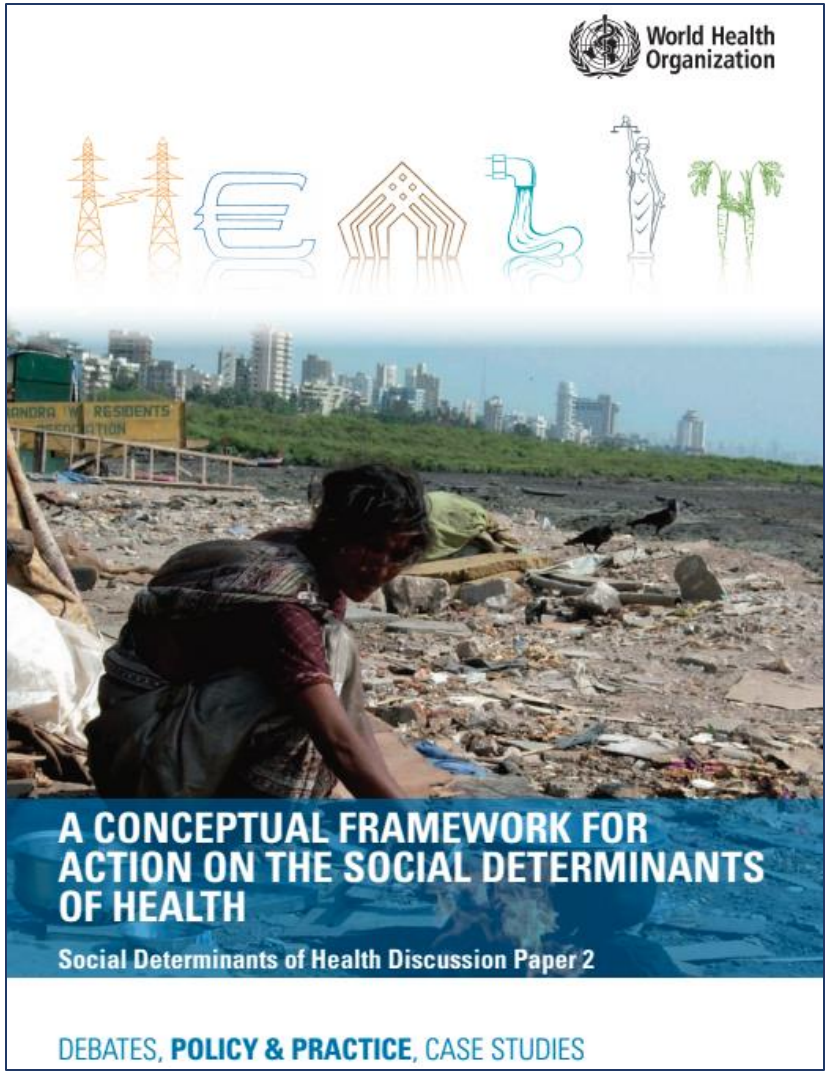
WHO Conceptual Framework



Human Rights → Policy Choices → More equitable outcomes

Link to Resource: [WHO Conceptual Framework]

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The SDOH: Conceptual Overview

Link to resource: [Healthy People 2030]

The use of SDOH Screening tools: Application

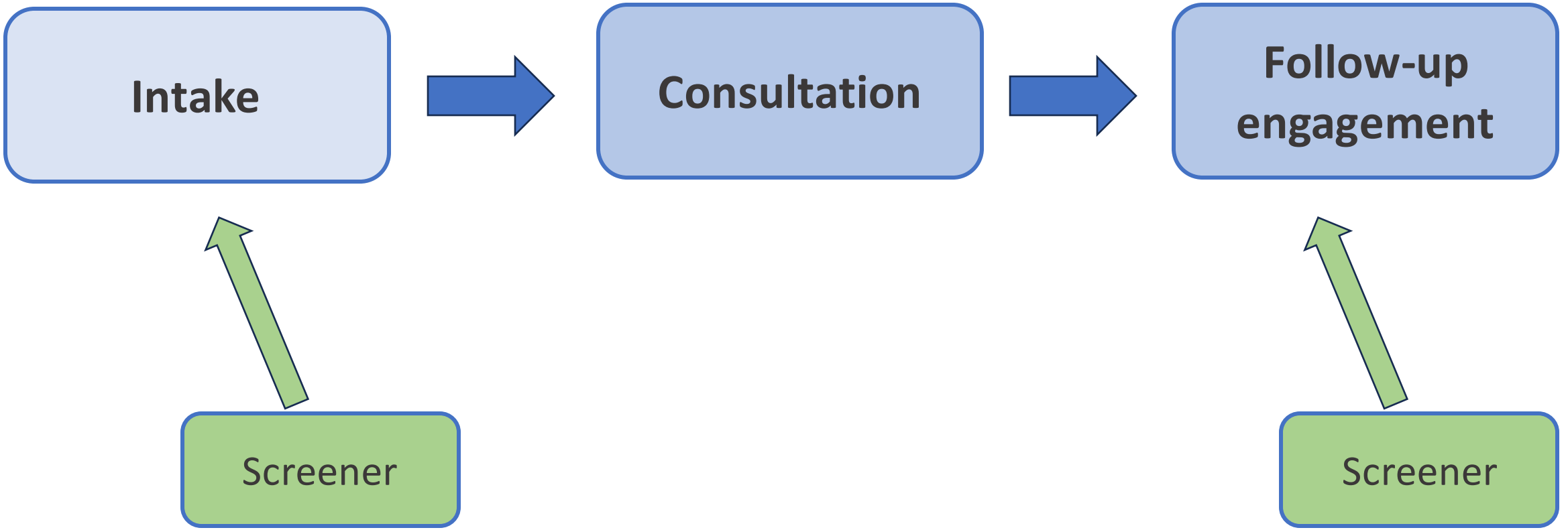
When planning implementation of a new screener:

1. Examine organization structure and workflow.
2. Identify key patient care interactions.
3. Consider data collection.
4. Consider workflow integration.
5. Consider screener design.

When planning revision of an existing screener:

1. Examine organization structure and workflow.
2. Examine locations where SDOH data is collected.
3. Examine impact of SDOH screener on workflow and patient care

The use of SDOH Screening tools: Application



Model 1: Integration of CHW and Social-Services into inpatient workflow.

CHW performs standardized SDOH assessment

- Assessment performed using standardized tool.
- Tool results added to patient's file or entered directly into EHR.
- Patient educated regarding resources and access.

Physician makes referrals, integrates results into care

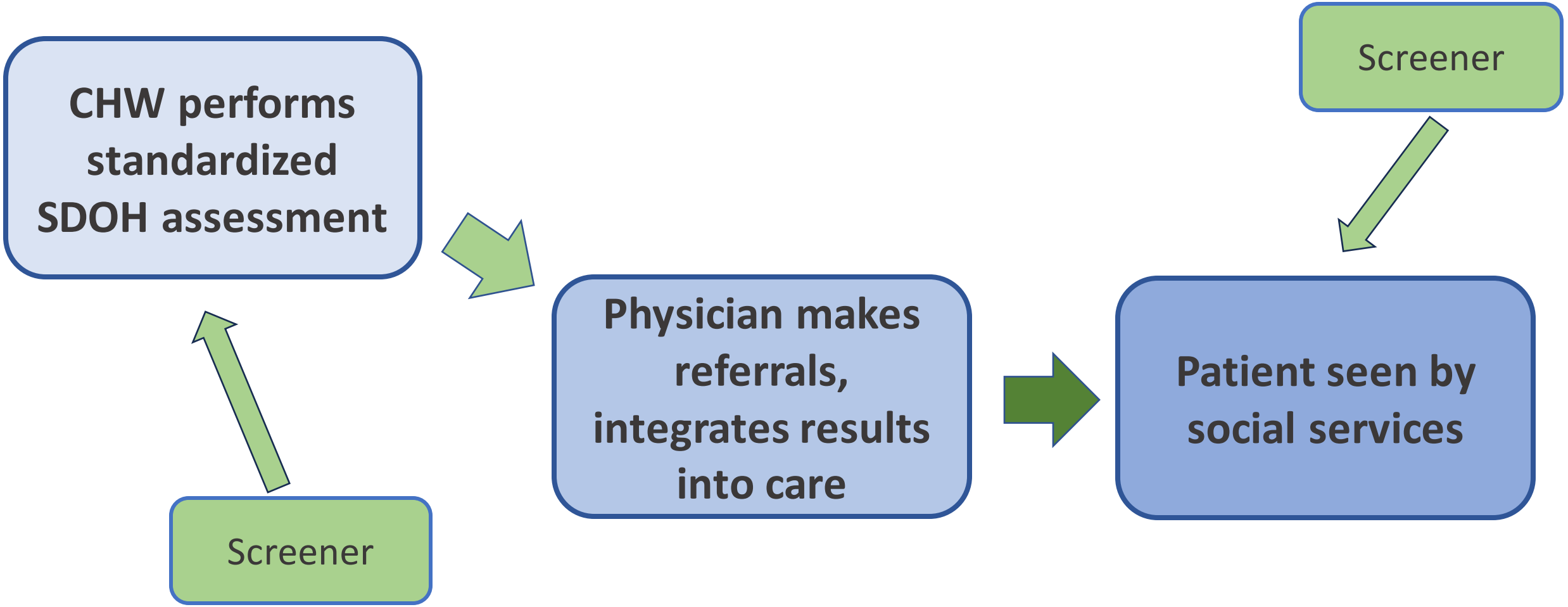
- Using form data, physician integrates data into patient care.
- Physician approves referral to social services.

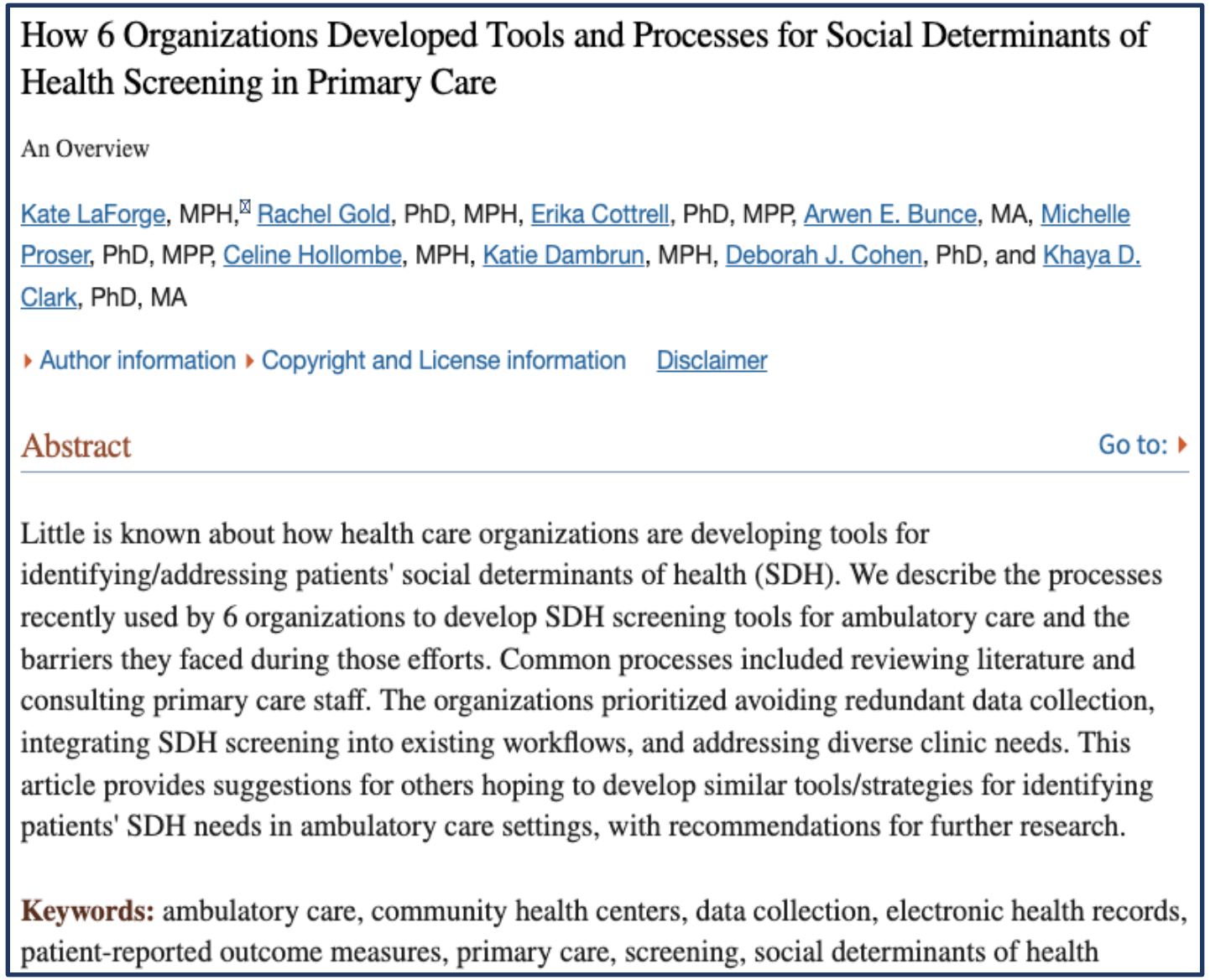
Patient seen by social services

- Patient consulted regarding available resources they qualify for.
- Patient assisted in resource application process.

Link: To Publication

The use of SDOH Screening tools: Application





How 6 Organizations Developed Tools and Processes for Social Determinants of Health Screening in Primary Care

An Overview

Kate LaForge, MPH, Rachel Gold, PhD, MPH, Erika Cottrell, PhD, MPP, Arwen E. Bunce, MA, Michelle Proser, PhD, MPP, Celine Hollombe, MPH, Katie Dambrun, MPH, Deborah J. Cohen, PhD, and Khaya D. Clark, PhD, MA

Abstract

Go to:

Little is known about how health care organizations are developing tools for identifying/addressing patients' social determinants of health (SDH). We describe the processes recently used by 6 organizations to develop SDH screening tools for ambulatory care and the barriers they faced during those efforts. Common processes included reviewing literature and consulting primary care staff. The organizations prioritized avoiding redundant data collection, integrating SDH screening into existing workflows, and addressing diverse clinic needs. This article provides suggestions for others hoping to develop similar tools/strategies for identifying patients' SDH needs in ambulatory care settings, with recommendations for further research.

Keywords: ambulatory care, community health centers, data collection, electronic health records, patient-reported outcome measures, primary care, screening, social determinants of health

Link: To Publication

Takeaways:

1. Institutions have wide breadth to improve on existing tools.
2. Customizability of tools to local SDOH concerns is key to program strength.
3. Organizational culture is a key component of promoting SDOH policies.

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BRIEF | OCTOBER 2017

CHCS Center for Health Care Strategies, Inc.

Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations

By Caitlin Thomas-Henkel and Meryl Schulman, Center for Health Care Strategies

IN BRIEF

With the recognition that social determinants of health (SDOH) can account for up to 40 percent of individual health outcomes,[1] particularly among low-income populations, their providers are increasingly focused on strategies to address patients' unmet social needs (e.g., food insecurity, housing, transportation, etc.). This brief examines how organizations participating in *Transforming Complex Care* (*TCC*), a multi-site national initiative funded by the Robert Wood Johnson Foundation, are assessing and addressing SDOH for populations with complex needs. It reviews key considerations for organizations seeking to use SDOH data to improve patient care, including: (1) selecting and implementing SDOH assessment tools; (2) collecting patient-level information related to SDOH; (3) creating workflows to track and address patient needs; and (4) identifying social service resources and tracking referrals.

Compared to other industrialized nations, the United States spends much less on social services, and much more on health care.[2] This is true despite evidence that social determinants of health (SDOH) — including income, educational attainment, employment status, and access to food and housing — affect an array of health outcomes,[3] particularly among low-income populations.[4] Individuals with unmet social needs are more likely to be frequent emergency department (ED) users, have repeat 'no-shows' to medical appointments, and have poorer glycemic and cholesterol control than those able to meet their needs.[5]

[Link: To Publication]

Takeaways:

Screening tools should be adapted to meet the following:

- Capacity to address specific SDOH needs.
- Availability of local resources and referral networks.
- Ease of use within clinical setting (workflow).
- Ability of tool to capture needs the organization can realistically address.

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PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?
Street:_____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work

[Link to resource]

Additional considerations for community use of PRAPARE:

1. Housing details related to health and safety.
2. Access to transportation.
3. Location data.
4. Community-specific trauma-informed care.
5. Eviction and debt collection risk.

When altering a screener, be sure to consult your data steward.

Appendix

WellRx Questionnaire

DOB_____ Male___ Female _____

WellRx Questions

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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, electricity, 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

Link: To Resource

_____ 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

Link: To Resource

NEJM Catalyst | Innovations in Care Delivery

CASE STUDY

A Nebraska Community Proactively Addresses Social Drivers of Health

Jessica Sattler, RN, MS, WHNP, Matthew Goudreau, John Loughnane, MD, Linda Dunbar, PhD, RN

Vol. 4 No. 6 | June 2023

DOI: 10.1056/CAT.22.0383

Activate Care, a for-profit company and leader in social risk management solutions, partnered with a direct health care company and a Nebraska managed care organization to fund a pilot program focused on affecting social determinants of health in a Medicaid population in the Omaha area. They began with a community assessment that identified the resources available, barriers to obtaining care, root causes of disparities, and assets within the community. Leveraging the Activate Care application to streamline care and resource navigation processes, they launched the evidence-informed intervention,

Link: To Resource

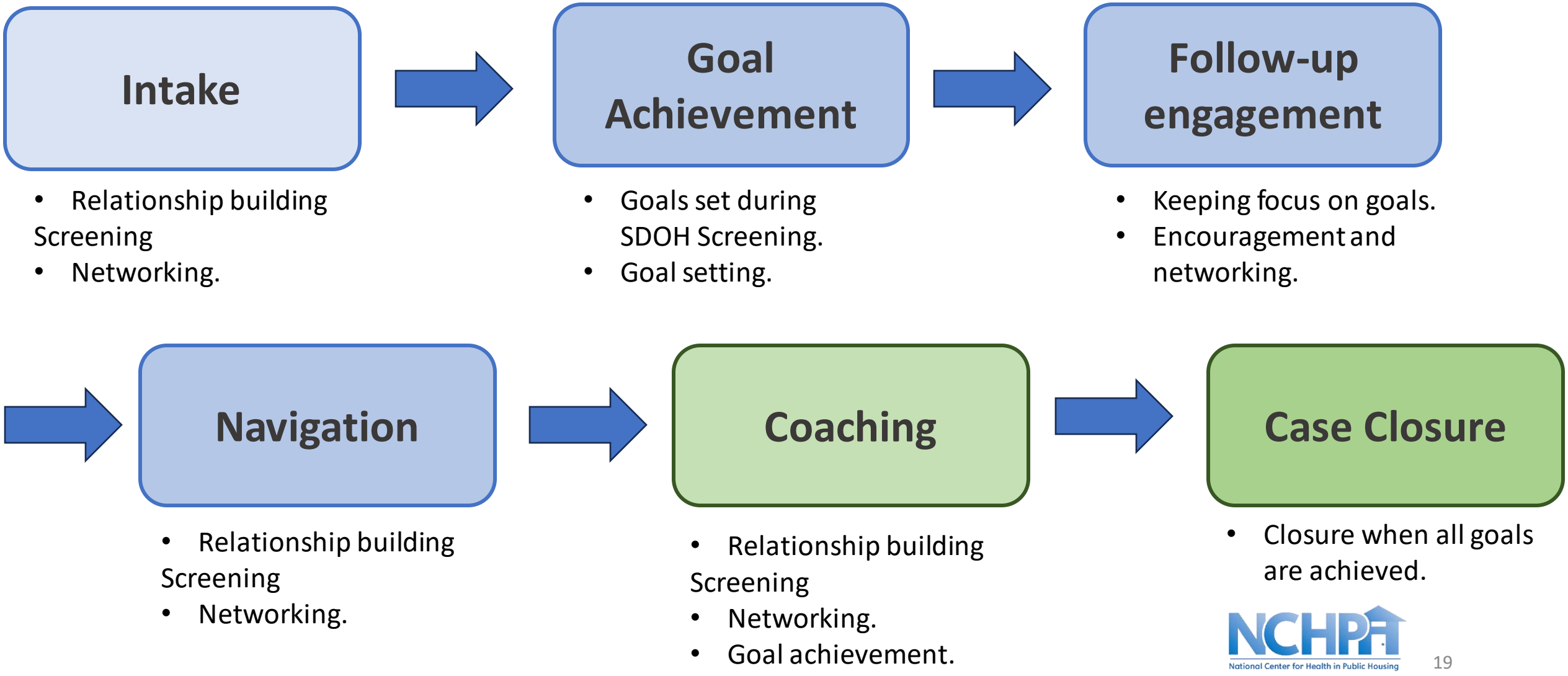
Case Study: SDOH Program Intervention

In this study, a Nebraska-based consortium implemented a SDOH community assessment and a community-based SDOH intervention.

Key elements covered:

1. Pre-intervention Assessment.
2. A model for outreach and screening.
3. The role of CHW's in SDOH program implementation.
4. Key takeaways of program implementation.

Case Study: The Role of CHWs



Categories Consistent with OMB 2+5 Standards

- Ethnicity
  1. Hispanic or Latino.
  2. Not Hispanic or Latino.
- Race
  1. American Indian or Alaska Native.
  2. Asian.
  3. Black or African American.
  4. Native Hawaiian or Pacific Islander.
  5. White

Capacity to Address Social Needs Affects Primary Care Clinician Burnout

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ABSTRACT

PURPOSE Primary care clinicians disproportionately report symptoms of burnout, threatening workforce sustainability and quality of care. Recent surveys report that these symptoms are greater when clinicians perceive fewer clinic resources to address patients' social needs. We undertook this study to better understand the relationship between burnout and clinic capacity to address social needs.

METHODS We completed semistructured, in-person interviews and brief surveys with 29 primary care clinicians serving low-income populations. Interview and survey topics included burnout and clinic capacity to address social needs. We analyzed interviews using a modified grounded theory approach to qualitative research and used survey responses to contextualize our qualitative findings.

RESULTS Four key themes emerged from the interview analyses: (1) burnout can affect how clinicians evaluate their clinic's resources to address social needs, with clinicians reporting high emotional exhaustion perceiving low efficacy even in when such resources are available; (2) unmet social needs affect practice by influencing clinic flow, treatment planning, and clinician emotional wellness; (3) social services embedded in primary care clinics buffer against burnout by increasing efficiency, restoring clinicians' medical roles, and improving morale; and (4) clinicians view clinic-level interventions to address patients' social needs as a necessary but insufficient strategy to address burnout.

CONCLUSIONS Primary care clinicians described multiple pathways whereby increased clinic capacity to address patients' social needs mitigates burnout symptoms. These findings may inform burnout prevention strategies that strengthen the capacity to address patients' social needs in primary care clinical settings.

Link: To Publication

Takeaways:

- SDOH burnout impacts clinicians' ability to meet patient needs.
- SDOH burnout has a severe impact on clinician emotional health and wellbeing.
- Social services in PCP clinics are protective against SDOH burnout.
- Clinicians see in-clinic social services as effective, but insufficient to meet patient needs.

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RESEARCH ARTICLES | DECEMBER 01 2021

Community Health Worker Intervention to Address Social Determinants of Health for Children Hospitalized With Asthma FREE

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POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

Hosp Pediatr (2021) 11 (12): 1370–1376.
https://doi.org/10.1542/hpeds.2021-005903

BACKGROUND

Social determinants of health (SDOH) contribute to racial disparities in asthma outcomes. Community health worker (CHW) programs represent a promising way to screen for SDOH and connect patients to resources, but the impact of CHW programs in the inpatient pediatric setting has been examined in few studies. In this study, we aimed to evaluate a CHW program for children hospitalized with asthma in a predominantly Hispanic community by examining rates of SDOH and social resource navigation.

Key insights:

- CHWs practicing in a person-centered healthcare network are effective in meeting unmet SDOH needs.
- CHWs are effective in increasing access to services in Spanish speaking populations in the US.
- CHWs are instrumental in resource navigation in Spanish speaking populations in the US.

Link: To Publication

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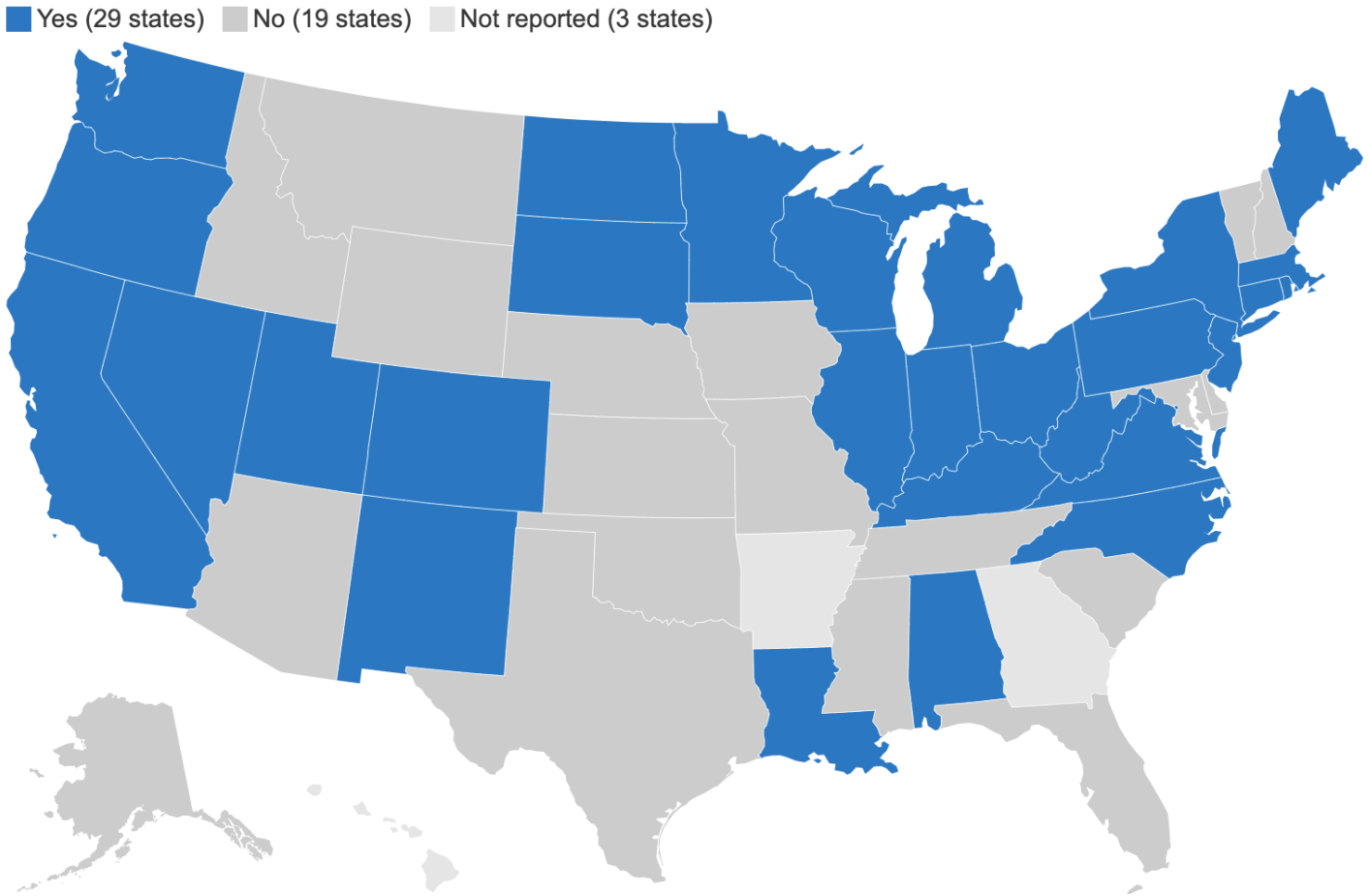
Figure 1

States that Allow Medicaid Payment for Services Provided by Community Health Workers (CHWs) as of July 1, 2022



NOTE: Arkansas, Georgia and Hawaii did not provide responses to this question.
SOURCE: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2022. • PNG

KFF

Link to Resource: [KF Report]

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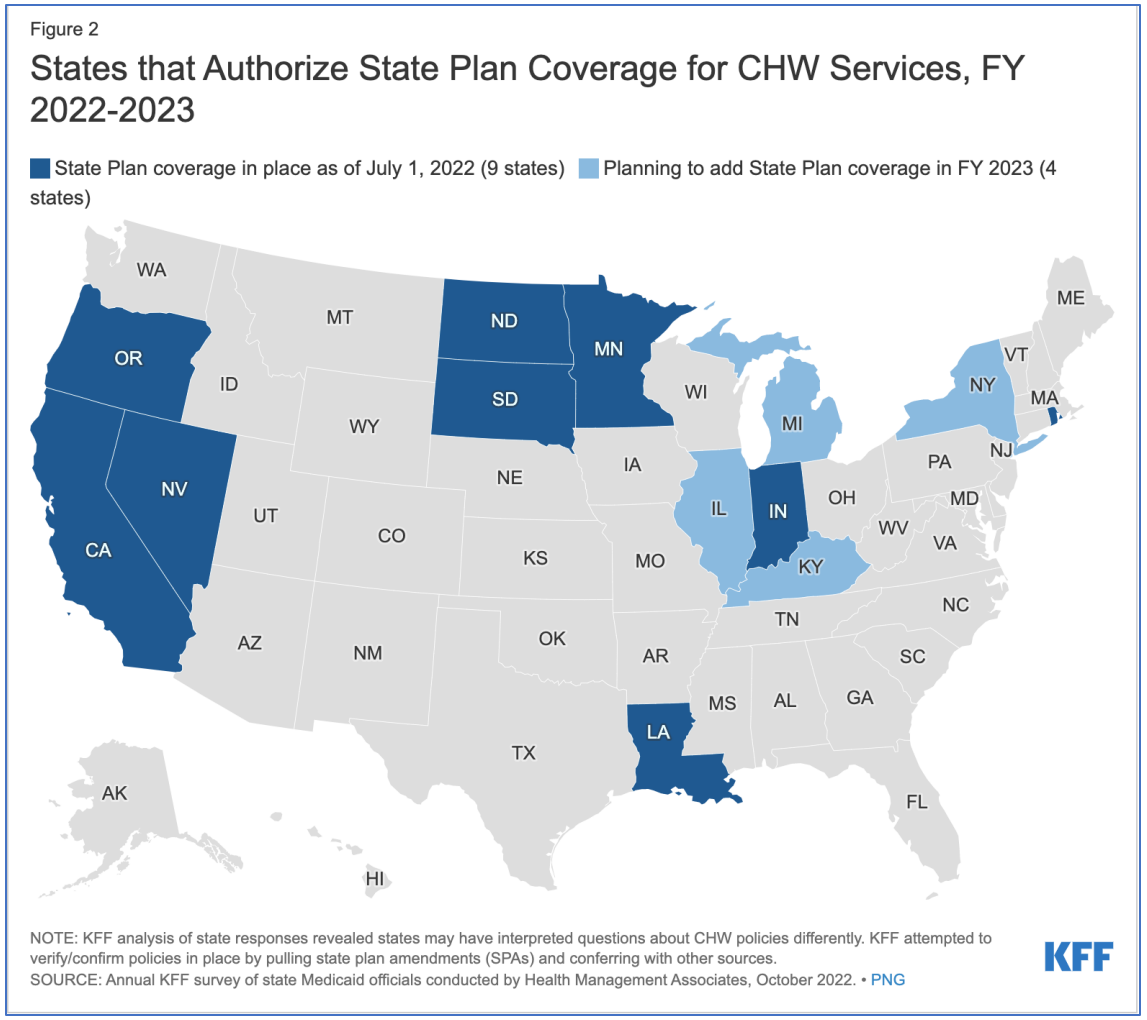
Funding CHW Staff:



Key takeaways:

- Nine states have authorized CHW funding through their state insurance plans for specific services.
- Four states (CA, LA, NV, RI) initiated this coverage in 2022.
- Four additional states (IL, KY, MI, NY) will begin implementing coverage in 2023.

Link to Resource: [KF Report]

National Center for Health in Public Housing

FY23 Omnibus Budget Bill (passed)

Sec. 1616. (1) By September 30 of the current fiscal year, **the department shall seek federal authority to formally enroll and recognize community health workers as providers and to utilize Medicaid matching funds for community health worker services, including the potential of leveraging of a Medicaid state plan amendment, waiver authorities, or other means to secure financing for community health worker services.** The appropriate federal approval must allow for community health worker services on a **statewide** basis and must not be a limited geography waiver. The authority should allow the application of community health worker services statewide and maximize their utility by providing financing that includes fee-for-service reimbursement, value-based payment, or a combination of both fee-for-service reimbursement and value-based payment for all services commensurate to their scope of training and abilities as provided by evidence-based research and programs.

(2) By September 30 of the current fiscal year, the department shall report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office on the progress of meeting the requirements in subsection (1).

Link: To Resource

Q&A Session

Complete our Post Evaluation Survey

https://www.surveymonkey.com/r/8Z7X58X

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Thank you!