Integration of Community Health Workers/Promotores-Navigators as Members of the Health Care Team:

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May 10th, 2021

www.ChulaVistaCC.org

As we move forward in 2021, a moment to recognize the lives lost to current **COVID-19 pandemic** and the countless number of people affected in so many ways… hope is in!

CHWs/Promotores & Navigators have played a public health role in COVID-19 vaccination outreach, education and support.

Now they can continue to assist in **chronic disease management** and **telehealth readiness/support.**

Overview

Context

CHWs/Ps & Navigators in Service Delivery, Research and Clinical Interventions is US

Progress on health disparities research/interventions incorporating CHWs/Ps & Navigators to address social determinants of health

APHA Definition:

"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 services and improve the quality and **cultural 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."

https://www.apha.org/APHA-Communities/Member-Sections/Community-Health-Workers

HHS Action Plan to Reduce Racial and Ethnic Health Disparities

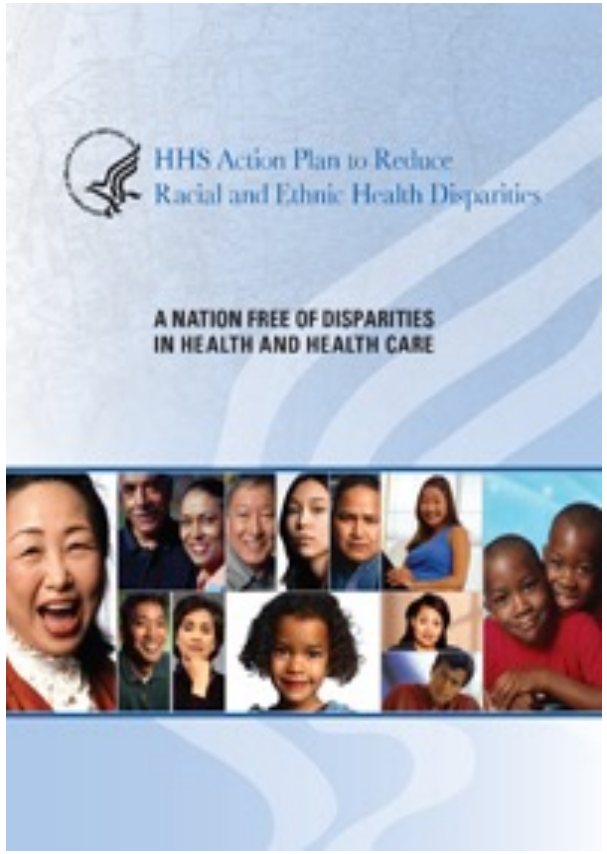
The overriding intent of the goals, strategies and actions in this plan is to generate national momentum toward **health equity** by aligning resources of HHS in focused efforts.

Coordinated by OMH and available at:
http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

Strategy II.B: Promote the use of community health workers and Promotores.

Actions II.B.1 Increase the use of Promotores to promote participation in health education, behavioral health education, prevention, and health insurance programs.

Lead/Participating Agencies: OASH/OMH, CMS, HHS/OGHA, HRSA, CDC, ACF, AOA, NIH, and SAMHSA

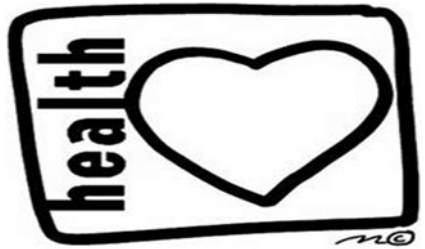


Towards Integration: Department of Labor

Recognition as health professionals with a unique **standard occupational classification code (SOC) 21-1094** for CHWs/P

2010 with Affordable Care Act (ACA): CHWs promote health behaviors and outcomes, by increasing **access to preventive services and management of chronic diseases**

State Innovation Models (SIMs) were developed to improve health outcomes and quality of care, and include CHWs in workplans



CHWs/P in Service Delivery, Research and Clinical Interventions in US

- CHWs **integral link** that connects disenfranchised and medically underserved populations to the health and social service systems intended to serve them.
- *"Natural researchers"* who as a result of **direct interaction with the populations** they serve can recount the realities and propose remedies for it.
- Contribute to **best practices** while informing public policy with the information they can share.
- CHWs also advocates for **social justice as the voice of Patients and their carers.**

Health Care Teams:

Health promotion and healthcare are a **team effort**!
Each member of the team with a special role:

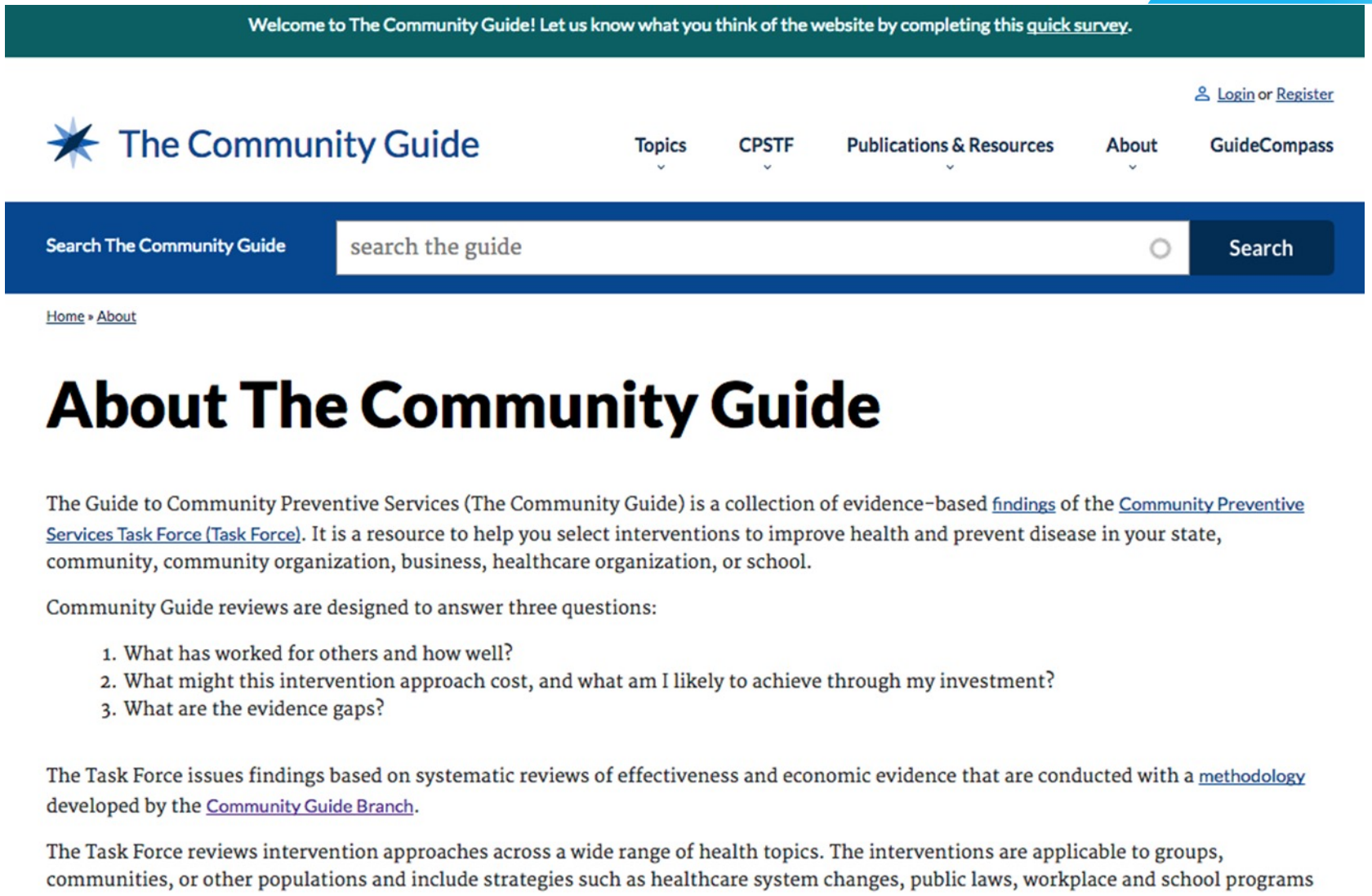
- Doctors
- Physician Assistants
- Nurses
- Pharmacists
- Dentists
- Technologists and technicians
- Therapists and rehabilitation specialists
- Emotional, social and spiritual support providers
- Administrative and support staff
- **Connectors: Community health workers, *promotores* and patient navigators**

Bureau of Primary Health Care (BPHC)

2017 National Staffing & Utilization Data Reported by 1,373 Health Center Grantees			
Personnel	**FTEs**	**Clinical Visits**	**Patients**
Case Managers	8,496	4,632,073	
Patient/Community Education Specialists	2,585	1,697,246	
Outreach Workers	2,688		
Transportation Staff	751		
Eligibility Assistance Workers	4,455		
Interpretation Staff	1,129		
Community Health Workers	1,130		
Other Enabling Services	497		
Total Enabling Services	**21,732**	**6,329,319**	**2,549,897**

https://bphc.hrsa.gov/uds/datacenter.aspx?q=t5&year=2017&state=

Interventions and Research: Challenges and Effective Practices



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About The Community Guide

The Guide to Community Preventive Services (The Community Guide) is a collection of evidence-based findings of the Community Preventive Services Task Force (Task Force). It is a resource to help you select interventions to improve health and prevent disease in your state, community, community organization, business, healthcare organization, or school.

Community Guide reviews are designed to answer three questions:

1. What has worked for others and how well?
2. What might this intervention approach cost, and what am I likely to achieve through my investment?
3. What are the evidence gaps?

The Task Force issues findings based on systematic reviews of effectiveness and economic evidence that are conducted with a methodology developed by the Community Guide Branch.

The Task Force reviews intervention approaches across a wide range of health topics. The interventions are applicable to groups, communities, or other populations and include strategies such as healthcare system changes, public laws, workplace and school programs

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Community Health Workers Help Patients with Diabetes

The Community Preventive Services Task Force recommends interventions that engage community health workers to help patients manage their diabetes. Evidence also shows interventions are cost-effective.
Read more >>

CPSTF Meeting October 18-19

Lifestyle Interventions Benefit Adults with Type 2 Diabetes

Explore Popular Features of The Community Guide

Patient Segmentation and Implications for Care Delivery

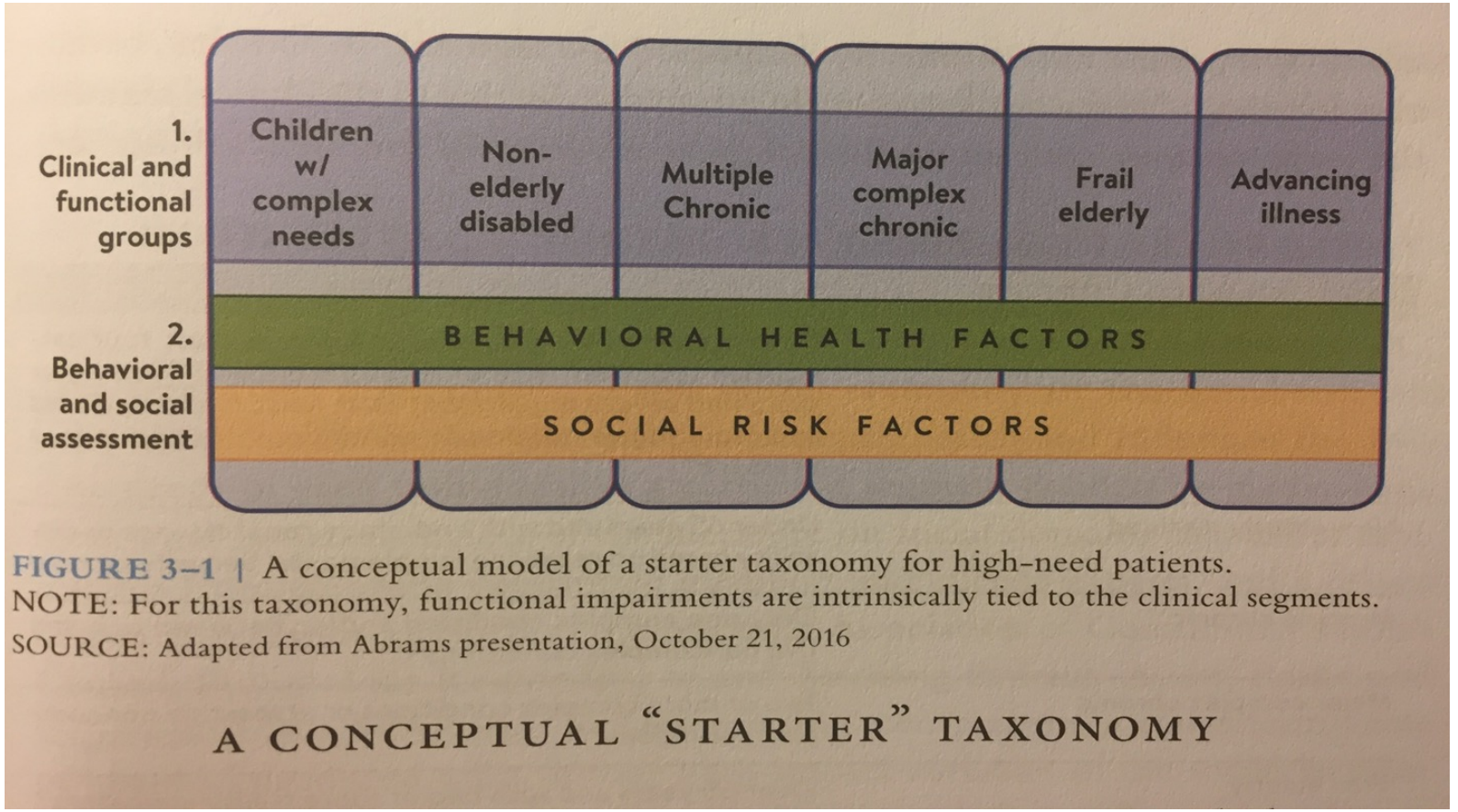


FIGURE 3–1 | A conceptual model of a starter taxonomy for high-need patients.
NOTE: For this taxonomy, functional impairments are intrinsically tied to the clinical segments.
SOURCE: Adapted from Abrams presentation, October 21, 2016

A CONCEPTUAL "STARTER" TAXONOMY

Of particular relevance to the Medi-Cal Healthier California for All initiative, formerly known as California Advancing and Innovating Medi-Cal (CalAIM), a multi-year delivery system and payment reform initiative designed to improve the quality of life and health outcomes of the state's Medicaid population.

CENTER FOR HEALTHCARE RESEARCH & TRANSFORMATION

November 2017

Revisioning the Care Delivery Team: The Role of CHWs within State Innovation Models

Lapedis, J.; Kieffer, E.; and Udow-Phillips, M. Revisioning the Care Delivery Team: The Role of CHWs within State Innovation Models. Nov. 2017. Center for Healthcare Research & Transformation. Ann Arbor, MI.

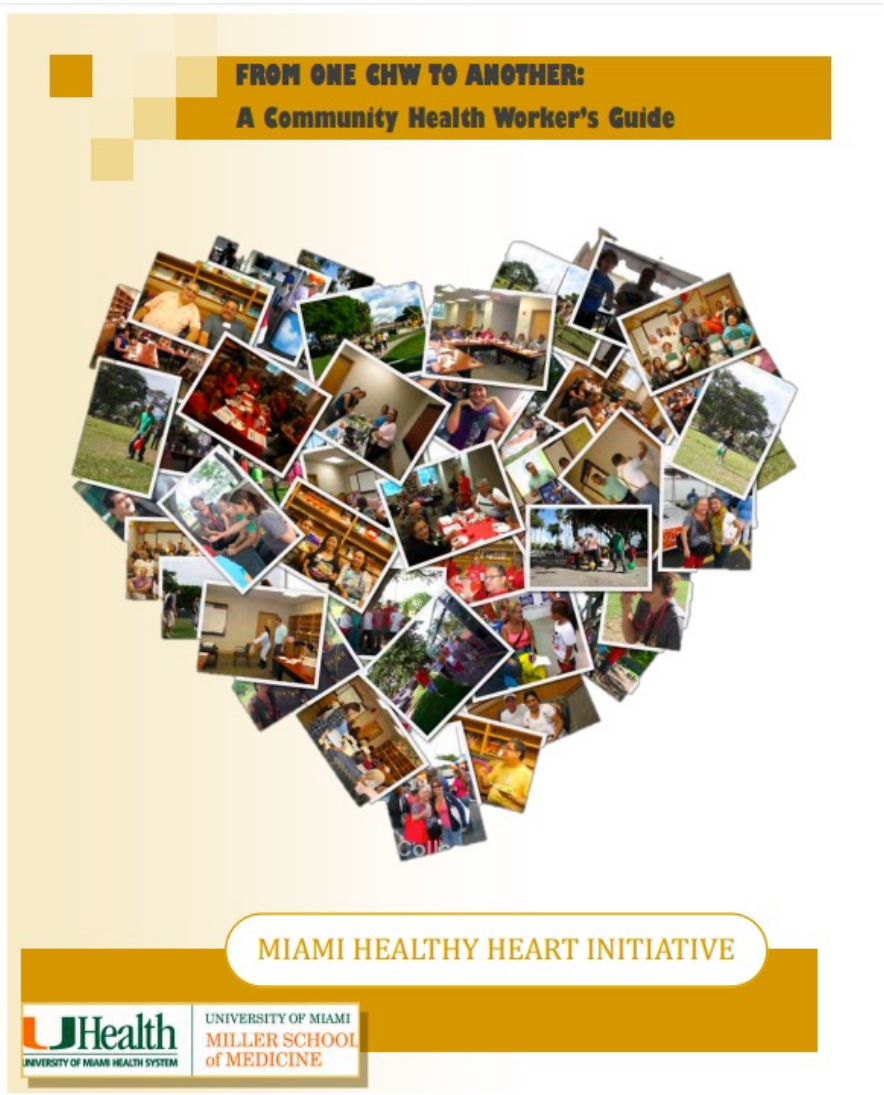
State Innovation Models (SIM) grants aimed to improve health care while reducing costs.

- Colorado, Connecticut, Idaho, Maine, Massachusetts, Michigan, Minnesota, Rode Island, Vermont and Washington

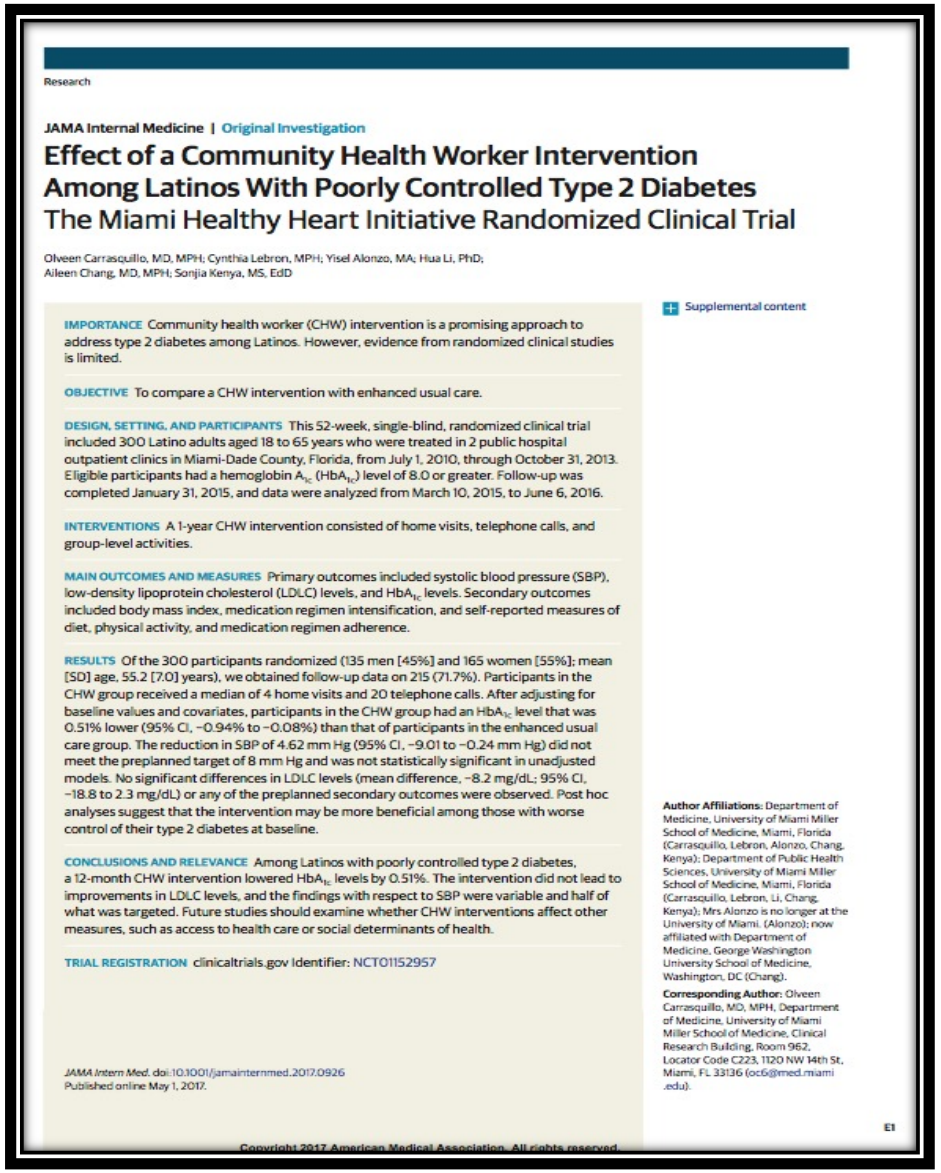
CHWs was one of the approaches with solid **outcomes**.

Lessons Learned: Call for workforce development and **more integration of CHWs into health care/systems.**

Resource: CHWs in Clinical Interventions



(CES4Health.info: Product **ID# K6GJYM8G**; 2014



Research

JAMA Internal Medicine | Original Investigation

Effect of a Community Health Worker Intervention Among Latinos With Poorly Controlled Type 2 Diabetes
The Miami Healthy Heart Initiative Randomized Clinical Trial

Olveen Carrasquillo, MD, MPH; Cynthia Lebron, MPH; Yisel Alonzo, MA; Hua Li, PhD; Aileen Chang, MD, MPH; Sonjia Kenya, MS, EdD

IMPORTANCE Community health worker (CHW) intervention is a promising approach to address type 2 diabetes among Latinos. However, evidence from randomized clinical studies is limited.

OBJECTIVE To compare a CHW intervention with enhanced usual care.

DESIGN, SETTING, AND PARTICIPANTS This 52-week, single-blind, randomized clinical trial included 300 Latino adults aged 18 to 65 years who were treated in 2 public hospital outpatient clinics in Miami-Dade County, Florida, from July 1, 2010, through October 31, 2013. Eligible participants had a hemoglobin A_{1c} (HbA_{1c}) level of 8.0 or greater. Follow-up was completed January 31, 2015, and data were analyzed from March 10, 2015, to June 6, 2016.

INTERVENTIONS A 1-year CHW intervention consisted of home visits, telephone calls, and group-level activities.

MAIN OUTCOMES AND MEASURES Primary outcomes included systolic blood pressure (SBP), low-density lipoprotein cholesterol (LDLC) levels, and HbA_{1c} levels. Secondary outcomes included body mass index, medication regimen intensification, and self-reported measures of diet, physical activity, and medication regimen adherence.

RESULTS Of the 300 participants randomized (135 men [45%] and 165 women [55%]; mean [SD] age, 55.2 [7.0] years), we obtained follow-up data on 215 (71.7%). Participants in the CHW group received a median of 4 home visits and 20 telephone calls. After adjusting for baseline values and covariates, participants in the CHW group had an HbA_{1c} level that was 0.51% lower (95% CI, −0.94% to −0.08%) than that of participants in the enhanced usual care group. The reduction in SBP of 4.62 mm Hg (95% CI, −9.01 to −0.24 mm Hg) did not meet the preplanned target of 8 mm Hg and was not statistically significant in unadjusted models. No significant differences in LDLC levels (mean difference, −8.2 mg/dL; 95% CI, −18.8 to 2.3 mg/dL) or any of the preplanned secondary outcomes were observed. Post hoc analyses suggest that the intervention may be more beneficial among those with worse control of their type 2 diabetes at baseline.

CONCLUSIONS AND RELEVANCE Among Latinos with poorly controlled type 2 diabetes, a 12-month CHW intervention lowered HbA_{1c} levels by 0.51%. The intervention did not lead to improvements in LDLC levels, and the findings with respect to SBP were variable and half of what was targeted. Future studies should examine whether CHW interventions affect other measures, such as access to health care or social determinants of health.

TRIAL REGISTRATION clinicaltrials.gov Identifier: NCT01152957

Supplemental content

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Tales from the Miami Healthy Heart Initiative: The Experiences of Two Community Health Workers

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Andrea Castillo, MS
Olveen Carrasquillo, MD, MPH
Sonjia Kenya, EdD, MS, MA

Abstract: Community health workers (CHWs) have been bridging the gap between underserved populations and health care systems for centuries; however, their experiences are rarely recounted. The Miami Healthy Heart Initiative is a randomized control trial designed to examine the effectiveness of CHWs on reducing the risk for cardiovascular disease among Hispanics with poorly controlled diabetes in South Florida. This manuscript, told from the perspective of CHWs, is a summary of cases that were successful and some that did not achieve optimal outcomes. These case summaries include anecdotal data and clinical variables that demonstrate each patient's progress during the intervention.

Key words: Community health workers, diabetes disparities, diabetes among Hispanics, community-based diabetes interventions.

Community health workers (CHWs) are community members without formal health training who serve as a link between patients and the formal health care system.[1] Among their scope of activities are health education, patient navigation and advocacy services. Though CHWs have been used for decades in the United States and much longer in other countries,[2–3] evidence on the impact of CHWs intervention on clinical outcomes from rigorously designed randomized studies is limited.[4] The Miami Healthy Heart Initiative (MHHI) is a clinical trial examining the impact of a one-year community health worker-led intervention on diabetes outcomes among 300 Latinos with poorly controlled diabetes.

A formal analysis of the MMHI intervention is currently underway. In this manuscript

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Open Access Full Text Article

STUDY PROTOCOL

Rationale and design of the Miami Healthy Heart Initiative: a randomized controlled study of a community health worker intervention among Latino patients with poorly controlled diabetes

This article was published in the following Dove Press journal:
International Journal of General Medicine
27 February 2014
Number of times this article has been viewed

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Background: Type 2 diabetes mellitus disproportionately affects the Latino community. Latinos with diabetes are also less likely to have adequate control of cardiovascular risk factors such as cholesterol and blood pressure. Community health workers (CHWs) are increasingly being used to address various health disparity conditions, including diabetes. However, evidence of their effectiveness from randomized controlled trials is limited.

Methods: The Miami Health Heart Initiative is a randomized controlled trial of 300 Latino patients with diabetes. Patients with hemoglobin A_{1c} (HbA_{1c}) ≥8.0% were recruited from Miami-Dade's public hospital system. At baseline, all patients underwent phlebotomy, physical examination, and a structured 90-minute research interview. They were then randomized to either usual care or a CHW intervention called Cariño. For participants in the Cariño arm of the study, CHW services included assistance with nonmedical social services, health education, and patient navigation in which the CHWs serve as a bridge between patients and the health care system. These services were delivered through home visits, phone calls, and group visits. At 12 months, all subjects had a follow-up examination. The primary outcomes at 1 year are changes in systolic blood pressure, low-density lipoprotein, and HbA_{1c}. Secondary outcomes include medication adherence, medication intensification, diabetes self-efficacy, physical activity, and self-reported fruit and vegetable intake.

Discussion: The Miami Healthy Heart Initiative is one of the first rigorously conducted randomized controlled trials to provide evidence on the impact of CHWs on diabetes intermediate outcomes among Latinos. If the data support our primary hypotheses, the study would lend added support to ongoing efforts to incorporate CHWs as part of our national efforts to reduce and ultimately eliminate health disparities.

Keywords: Hispanic, type II diabetes, health care support, community health workers, randomized trial, health care disparities

Background

Type II diabetes affects one in ten adults over the age of 45 years.[1] With increasing prevalence of obesity, rates of diabetes among the US population are expected to continue to increase. Control of blood pressure and dyslipidemia in patients with diabetes markedly reduces their risk of cardiovascular complications.[2,3] In addition, glycemic control reduces the risk of microvascular complications such as retinopathy and nephropathy.[4,5] Achieving optimum management of these conditions often requires coordination of health care service delivery among various providers, lifestyle modifications, and adherence to several concurrent medications, making diabetes

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Journal of Community Hospital Internal Medicine Perspectives

co action PUBLISHING

RESEARCH ARTICLE

A profile of Latinos with poorly controlled diabetes in South Florida

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Introduction: Latinos are the largest minority group in the United States and diabetes or pre-diabetes affects more than 70% of Latinos aged 45 years and older. Miami-Dade County is home to one of the highest populations of diverse Latinos. In this descriptive manuscript, we present baseline characteristics of participants enrolled in the Miami Healthy Heart Initiative (MHHI). This was a study conducted to determine the effects of a community health worker (CHW) intervention among Latinos with poorly controlled diabetes in South Florida.
Methods: We recruited 300 diverse Latino adults with suboptimal diabetes outcomes (HbA1c ≥ 8) into MHHI. This randomized control trial examined the impact of a 1-year CHW-led intervention on glycemic control, blood pressure, and cholesterol levels. At baseline, physiologic measures, including HbA1c, LDL, blood pressure, and BMI, were assessed. Data on socio-demographic characteristics and additional determinants of health such as depression status, provider communication, diet, exercise, cigarette smoking, readiness to change diabetes management behaviors (stages of change), and confidence in ability to improve diabetes self-care (self-efficacy) were collected.
Results: Participants came from 20 different countries, with Cuban Americans representing 38% of the sample. Most had lived in the US for more than 10 years, had completed at least 12 years of school, and had high levels of health literacy, yet 48% had very low acculturation. Nearly 80% had poor self-efficacy, 80% met the criteria for depression, and 83% were not adherent to their medications. More than half the population was not at their target for blood pressure, 50% were above the recommended LDL goal, and most were obese.
Conclusion: In a diverse population of Latinos with poorly controlled diabetes in Miami, we found high rates of depression, obesity, medication non-adherence, poor self-efficacy, and provider communication. These may contribute to poor diabetes control, high blood pressure, and elevated cholesterol.

Keywords: *diabetes among Latinos*; *South Florida*; *diabetes disparities*; *Hispanics with diabetes*

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Latinos are the largest minority group in the United States (US) (1). By 2060, it is projected that nearly one in three persons in the US will be Latino (1). The incidence and prevalence of diabetes in this population is more than double that of non-Hispanic whites (2). Recent data from the Hispanic Community Health Study found that more than 70% of Hispanics aged 45 years and older have diabetes or pre-diabetes (3). With 64% of residents in Miami-Dade County being Latino (4), the county has one of the highest concentrations of Latinos in the US. In addition, with a rapid influx of Central and South Americans, South Florida is also rapidly becoming one of the most diverse Latino populations in the country (5, 6).

In this descriptive study, we provide an overview of a heterogeneous group of Latinos coming from a multitude of Latin American countries with poorly controlled diabetes, being cared for at the largest public hospital system in South Florida. We describe baseline characteristics of 300 Latino adults who were enrolled in a randomized study and provide data on physiologic measures, as well as socio-demographic, behavioral, and diabetes-specific constructs.

Citation: Journal of Community Hospital Internal Medicine Perspectives 2015, **5**: 26586 - http://dx.doi.org/10.3402/jchimp.v5.26586

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Overview of CHW intervention

Initial Phase: Months 1 & 2

Intervention: **Assessment**
Objective: Help participant develop a list of issues that affect his/her overall health and well-being

Type: Home visit
When: Within 1st month of randomization

CHW will address participants: (1) social context, (2) current knowledge (3) current medications, (4) Barriers to facilitators of medication adherence, (5) pertinent lifestyle and health behaviors, and (6) barriers to communicating and doing business with the healthcare system (7) Knowledge of mobile phone and use text messaging

Intervention: **Goal Setting & Dealing with Barriers**
Objective: Assist participant in developing an individualized plan to advance his/her overall health and well-being

Type: Home visits
When: Within months 1 & 2 but after "assessment" visit

CHW efforts include: (1)stimulate principles of self-management by teaching problem-solving skills (setting priorities, making goals, developing a plan, reviewing results, and revising the plan), (2) facilitate navigation of the healthcare system, (3) provide referrals to or assistance in accessing both social and medical community-based resources, and (4) give counseling & coaching aimed at the improving lifestyle behaviors (5) pharmacist consultation

Action Phase: Months 3-9

Intervention: **Phone Calls**
Type: Phone call (CHW may also utilize home visits)
Number: Minimum of 1 call per week
When: Throughout action phase (months 3-9)
Objective: Follow up with participant to (1) Help facilitate participant's health goals (2) continue healthcare system navigation assistance (i.e. providing appointment reminders, bridging communication with PCP regarding prescription refills, or rescheduling missed appointments)

Intervention: **Community Events**
Type: Group sessions
Number: Monthly calendar will be provided with free community events.
When: Throughout each month
Objective: (1) Activities will have a cultural component, be entertaining and educational. (2) Aimed at improving mental health, health management skills as well as physical activity.

CHW will utilize formalized scripts as a general guide which are designed to address anticipated issues.

Intervention: **Mobile Based Technology**
Type: Messaging to their FG360 cell phone/personal cell phone
Number: One BP monitoring and SRFs (Stroke Risk Factor) messaging per day
When: Throughout action phase (months 3-12)
Objectives: (1) Blood Pressure monitoring (2) health education, coaching on medication adherence and lifestyle risk factors (3) individualized messaging based on prior assessment and goals setting by CHW

Intervention: **Visits**
Type: Home visits/ Clinic visits/ Social service visits
Number: Minimum 1 visit per month
When: Throughout action phase (months 3-9)
Objective: (1) Help facilitate participant's health goals by checking on progress of intended plan of action and addressing new problems (i.e. may follow- up on adherence to medications), and (2) continue the education of healthcare system navigation assistance (i.e. providing appointment reminders, bridging communication with PCP regarding prescription refills, or rescheduling missed appointments) (3) Educating and providing resources available (i.e. information on obtaining disability, cash assistance, insurance, housing.) (4) Educate on living heathy (i.e. eating habits, fitness activities, maintaining blood pressure, cholesterol, and diabetes under control).

Maintenance Phase: Months 10-12

Intervention: **Phone Calls**
Type: Phone call (CHW may also utilize home visits)
Number: Minimum of 1 call per month
When: Throughout maintenance phase (months 10- 12)
Objective: Monitor participant's ability to (1) Navigate healthcare system. (2) Find available resources. (3) Schedule doctor's appointments and refill prescriptions. (4) Maintain a healthy life style (i.e. eating habits, fitness activities, maintaining blood pressure, cholesterol, and diabetes under control.)

Table 2. Differences in Primary Outcomes at 12 Months Between the CHW and EUC Groups[a]

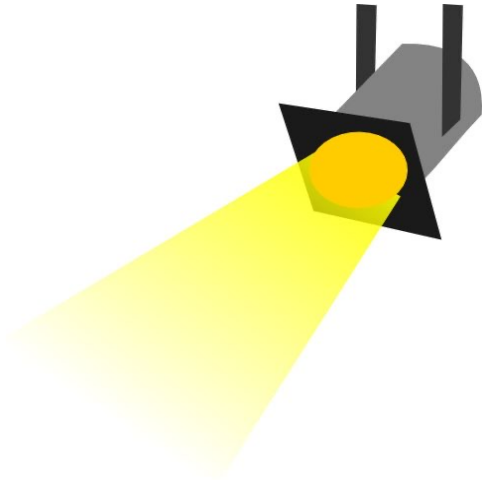
Analysis	Primary Outcome, Mean Difference (95% CI)		
	HbA_{1c} Level, %	SBP, mm Hg	LDLC Level, mg/dL
Unadjusted	−0.59 (−1.1 to −0.11)[b]	−2.03 (−6.93 to 2.87)	−3.54 (−15.28 to 8.19)
Adjusted for baseline value	−0.52 (−0.94 to −0.09)[b]	−3.91 (−8.28 to 0.46)	−8.13 (−18.57 to 2.30)
Adjusted for baseline values and covariates[c]	−0.51 (−0.94 to −0.08)[b]	−4.62 (−9.01 to −0.24)[b]	−8.21 (−18.74 to 2.32)

Table 1. Self-reported access to care and utilization in the last 12 months. Data from the Miami Healthy Heart Initiative where enrollment began in 2010 and follow-up was completed in 2015.

	Usual Care (n=104)	**Intervention (n=111)**
Inability to access needed care*	43%	30%
Unable to obtain necessary prescriptions*	41%	28%
Able to communicate with provider in language of choice	100%	98%
Somewhat difficult to contact doctor**	78%	72%
Self-Reported Utilization		
Number of Outpatient Visits *(IQR)*	7.0 (9.0)	8.0 (8.0)
Proportion with Inpatient Stay	32%	24%

*p <0.05

CARIÑO Highlights



- **65%** of participants were reached by the first phone call.
- **85%** of the visits were conducted in the home.
- 60% of visits took 1-2 hours.
- **60%** of our participants received blood pressure monitor. Others already had one.
- **50%** of our participants received some form of mental health support.
- The average blood pressure reading upon Exit was 125/80.
- An average of 4 health education sessions were conducted per participant per month.
- An average of 8 social services were provided per participant per year.
- The top 3 social service provided were:
  - Arranging medical appointments, followed by finding a PCP and providing medications support.

Neighborhood Navigator Model - San Diego

- Community Care Organizations
- Chula Vista Community Collaborative (Network of five Family Resource Centers)
- Cover geographic areas of the County (3 CCOs)
- Hire CHWs/P as Care Coordinators/Neighborhood Navigators
- Supervise and train staff
- Provide support and resources to staff
- Work closely with Network manager
- Ensure deliverables are met

Member A

Female, Hispanic (Spanish speaking only) Mid 70's, Diabetes

- Goal: Lower A1C levels from 7.4 to 7 in the next 3 months
- Intervention: Member will record food intake weekly and report it with Care Coordinator in efforts to keep diet balanced and healthy
- Outcome: Member will apply lifestyle changes to better her health and keep her diabetes under control

more outcome:

As individuals they have their own goals and as a couple, they are committed to helping each other by taking walks and managing what they eat.

Member A and Member B are a **cou**ple

Benefits

The daughter is very involved with assisting both members with this program. It brings the family together and helps them work as a team Created a family interaction opportunity to set health goals. We are educating members on how to manage their health.

Member B

Male, Hispanic (Spanish speaking only) Early 70's, Heart Problems due to mobility

- Goal: Add exercise 2-3 times a week to increase heart rate and mobility during the next three months
- Intervention: Care coordinator will provide a list of in homework outs and provide weekly exercise log in sheet for member to track progress
- Outcome: Member will decrease his chances of heart failure by applying lifestyle changes that help with mobility and weekly exercise.

The power of integrating social determinants of health and patient values into patient care, such as health literacy and socioeconomic status to understand what might prevent them from **showing up for follow-up visits, understanding how to manage their disease, or adhering to care plans.**

Nearly 100% of Insights Council members believe in the importance of using social determinants of health in patient care and they consider the top two benefits to be **improving patient experience** or **satisfaction.**

eBook, The Power of the Patient Voice, Pg 6

Equality sounds fair.

Equity IS fair.

CHWs/P & Navigators make health equity happen addressing Social Determinants of Health

THANK YOU!

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