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

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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
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.


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 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
<table>
<thead>
<tr>
<th>Personnel</th>
<th>FTEs</th>
<th>Clinical Visits</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Managers</td>
<td>8,496</td>
<td>4,632,073</td>
<td></td>
</tr>
<tr>
<td>Patient/Community Education Specialists</td>
<td>2,585</td>
<td>1,697,246</td>
<td></td>
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<tr>
<td>Outreach Workers</td>
<td>2,688</td>
<td></td>
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<tr>
<td>Transportation Staff</td>
<td>751</td>
<td></td>
<td></td>
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<tr>
<td>Eligibility Assistance Workers</td>
<td>4,455</td>
<td></td>
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</tr>
<tr>
<td>Interpretation Staff</td>
<td>1,129</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Workers</td>
<td>1,130</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Enabling Services</td>
<td>497</td>
<td></td>
<td></td>
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<tr>
<td>Total Enabling Services</td>
<td>21,732</td>
<td>6,329,319</td>
<td>2,549,897</td>
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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.
Your online guide of what works to promote healthy communities

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

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.
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.
FROM ONE CHW TO ANOTHER:
A Community Health Worker's Guide

MIAII HEALTHY HEART INITIATIVE

(CES4Health.info: Product ID# K6GJYM8G; 2014)
**Tales from the Miami Healthy Heart Initiative: The Experiences of Two Community Health Workers**

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Ernesto Reyes-Arcecho, MS
Andrea Castillo, MS
Olivier Carassoula, MD, MPH
Sonja 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 acknowledged. The Miami Healthy Heart Initiative is a randomized controlled 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.

C**

Community health workers (CHWs) are community members without formal health training who serve as a link between patients and the formal health care system. Among their scope of activities are health education, patient navigation and advocacy services. Although CHWs have been used for decades in the United States and much longer in other countries,1 evidence on the impact of CHW intervention on clinical outcomes from rigorously designed randomized studies is limited.2 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 MHHI intervention is currently underway. In this manuscript...
Overview of CHW intervention

Initial Phase: Months 1 & 2

**Intervention:** Assessment  
**Objective:** Help participant develop a list of issues that affect their 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 their 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:** Mobile Based Technology  
**Type:** Messaging to their FG960 cell phone/personal cell phone  
**Number:** One BP monitoring and SRRFs (Stroke Risk Factor) messaging per day  
**When:** Throughout action phase (months 3-12)  
**Objective:** (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:** 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:** 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 healthy (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 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.

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

*p < 0.05

### Table 2. Differences in Primary Outcomes at 12 Months Between the CHW and EUC Groups*

<table>
<thead>
<tr>
<th>Analysis</th>
<th>Primary Outcome, Mean Difference (95% CI)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>HbA1c Level, %</td>
</tr>
<tr>
<td>Unadjusted</td>
<td>-0.59 (-1.1 to -0.11)</td>
</tr>
<tr>
<td>Adjusted for baseline value</td>
<td>-0.52 (-0.94 to -0.09)</td>
</tr>
<tr>
<td>Adjusted for baseline values and covariates*</td>
<td>-0.51 (-0.94 to -0.08)</td>
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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

**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.

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**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.

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**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.
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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