Utilizing Community Health Workers in the Clinic Setting
Community Health Workers program

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Definition:
Community Health Worker (CHW)

- **Frontline** public health worker.
- Trusted community member who *deeply understands the community* being served.
- **Liaison between** health and social services in the community.
- Facilitates *access and connections* to services.

Definition:
Community Health Worker (CHW)

- Builds **individual & community capacity** to improve health outcomes via:
  - Advocacy and Education
  - Social support & Hand holding
  - Patient encouragement and self-sufficiency
  - Linkage to care & community resources
Roles for CHWs

- Assessor & Care Plan Developer
- Cultural Mediator
- Trusted Advocate
- Informal Counselor
- Resource Connector
- Capacity Builder
Community Health Worker trainings.

- Community Health Worker Course
- Diabetes and other Chronic disease training
- Mental Health First Aid
- Healthy Homes
- Medicaid, Food stamps and other programs
- Motivational Interviewing
- Mandated reporter training
- Biannual Skills Fair
Bridging the gap between communities & health/social service systems: Core CHW Roles

Communities

Build individual & community capacity
Advocate for individual & community needs

Community Health Worker

Provide direct services
Promote wellness by providing culturally appropriate health information to clients & providers

Health & Social Service Systems

Assist in navigating the health & human services system

CHWs at KC CARE

- 1990s: Prevention and outreach staff
- 2003: HIV Peers started
  - Patient support and adherence program
- 2011: CHW for other chronic conditions
  - Care coordination (patient navigation)
- 2019- current:
  - 12 Care Coordination CHWs
  - 5 HIV Peers
  - 4 Prevention and outreach staff
CHW Care Coordination Role

- Initially patients are screened with PRAPARE or referred by care team
- Individualized assessment and care plan developed
- CHWs function as a medical tour guide for patients: walking side-by-side they teach patients to navigate the health care and social service systems
  - Navigate access to primary care and specialty care
  - CHW Attendance at appointments
  - Home/Community visits
CHW Care Coordination

• Care plan
  • Based on assessed needs of each patient
    • Utilize Arizona Self Sufficiency Matrix (ASSM)
    • Multiple domains scored on Likert scale
    • Creates total score and domain specific scores
  • Drives goals and length of relationship
  • Strategies for each domain identified by the ASSM

• Outcomes measures
  • Data gathered at enrollment and discharge
## CHW Care Coordination Tasks

<table>
<thead>
<tr>
<th>Category</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td></td>
</tr>
<tr>
<td>Link to Primary Care Physician/Medical Home</td>
<td>40.97%</td>
</tr>
<tr>
<td>Link to specialty medical care</td>
<td>18.50%</td>
</tr>
<tr>
<td>Link to pre-exposure prophylaxis (PREP)</td>
<td>14.98%</td>
</tr>
<tr>
<td>Other</td>
<td>10.57%</td>
</tr>
<tr>
<td>Link to medical equipment/medical supplies</td>
<td>7.05%</td>
</tr>
<tr>
<td>Link to affordable health services</td>
<td>2.64%</td>
</tr>
<tr>
<td>Link to a Primary Care Physician/Medical Home</td>
<td>1.76%</td>
</tr>
<tr>
<td>Vision</td>
<td>1.32%</td>
</tr>
<tr>
<td>Link to diagnosis-specific education/resources</td>
<td>1.32%</td>
</tr>
<tr>
<td>Assist patient with telehealth services</td>
<td>0.44%</td>
</tr>
<tr>
<td>Link to women’s health services</td>
<td>0.44%</td>
</tr>
</tbody>
</table>
# Medication Costs

<table>
<thead>
<tr>
<th>Category</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assist client in accessing generic medications ($4 list)</td>
<td>34.18%</td>
</tr>
<tr>
<td>Link client to agency that helps with medication costs</td>
<td>26.58%</td>
</tr>
<tr>
<td>Link to Prescription Assistance Program</td>
<td>17.72%</td>
</tr>
<tr>
<td>Link client to discount cards/coupons</td>
<td>17.72%</td>
</tr>
<tr>
<td>Other</td>
<td>3.80%</td>
</tr>
</tbody>
</table>
## Transportation tasks

<table>
<thead>
<tr>
<th>Category</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link to Share-A-Fare (Ride KC)</td>
<td>48.47%</td>
</tr>
<tr>
<td>Assist client in using Medicaid transportation</td>
<td>20.25%</td>
</tr>
<tr>
<td>Other</td>
<td>18.40%</td>
</tr>
<tr>
<td>Provide short term transportation (Lyft – Bus Passes – Gas Cards)</td>
<td>7.36%</td>
</tr>
<tr>
<td>Link client to reduced-fare bus pass(disability/senior/child)</td>
<td>2.45%</td>
</tr>
<tr>
<td>Link client to clinic/hospital-provided transportation</td>
<td>1.84%</td>
</tr>
<tr>
<td>Assist client in using bus system</td>
<td>0.61%</td>
</tr>
<tr>
<td>Explore client’s support system for transportation</td>
<td>0.61%</td>
</tr>
</tbody>
</table>
Time per area of need

- COVID: 14%
- Medical: 11%
- Housing: 10%
- Food and Basic Household needs: 15%
- Transportation: 8%
- Health Insurance: 8%
- Income: 6%
- Medication Cost: 4%
- Dental: 4%
- Mental Health: 3%
- System Utilization: 3%
- Other: 4%
- ED Utilization: 10%
- Medical Costs: 4%
- Housing: 10%
- Education: 10%
Sufficiency scores for direct health needs

<table>
<thead>
<tr>
<th></th>
<th>Enrollment</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>4.5</td>
<td>5.0</td>
</tr>
<tr>
<td>Dental</td>
<td>3.5</td>
<td>4.0</td>
</tr>
<tr>
<td>Mental Health</td>
<td>4.0</td>
<td>4.5</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>5.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Medical Adherence</td>
<td>4.0</td>
<td>4.5</td>
</tr>
</tbody>
</table>

KC CARE HEALTH CENTER
Differences in health status and related concepts

- Poor/Fair Health Status
- Unsatisfied with health
- Low Motivation to be Healthy
- Low Self-Efficacy
- High stress
- Always get needed social support

Legend:
- Enrollment
- Discharge
Differences in utilization and unhealthy days

- Visited ED recently
- Inpatient stay recently
- At least 1 mentally unhealthy day in the past month
- At least 1 physically unhealthy day in the past month

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<tr>
<th>Condition</th>
<th>Enrollment</th>
<th>Discharge</th>
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</thead>
<tbody>
<tr>
<td>Visited ED recently</td>
<td>40%</td>
<td>10%</td>
</tr>
<tr>
<td>Inpatient stay recently</td>
<td>20%</td>
<td>5%</td>
</tr>
<tr>
<td>At least 1 mentally unhealthy day in the past month</td>
<td>70%</td>
<td>60%</td>
</tr>
<tr>
<td>At least 1 physically unhealthy day in the past month</td>
<td>80%</td>
<td>75%</td>
</tr>
</tbody>
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Legend:
- Blue: Enrollment
- Orange: Discharge
Questions?

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