

# Community Health Workers

Providing the resources needed to build healthier communities

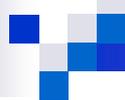


# The Impact of Community Health Workers (CHW)



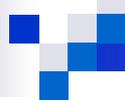
“The unique role of CHWs as culturally competent mediators (health brokers) between providers of health services and the members of diverse communities, as well as CHWs’ effectiveness in promoting the use of primary and follow-up care for preventing and managing disease, have been extensively documented and recognized for a variety of health care concerns, including asthma, hypertension, diabetes, cancer, immunizations, maternal and child health, nutrition, tuberculosis, and HIV and AIDS.”\*

\* Addressing Chronic Disease through Community Health Workers, A Policy and Systems-Level Approach, A Policy Brief from the Center for Disease Control and Prevention, Second Edition, National Center for Chronic Disease Prevention and Health Promotion, April 2015.



# Presentation Objectives

- Describe the role of the CHW
- Describe the training and supervision of a CHW
- Describe integration with ICM team
- Review a case scenario showing coordination with ICM nurse
- Discuss additional CHW community involvement



# Community Health Worker Goals

The CHW uses a person-centered, non-clinical model approach to help members:

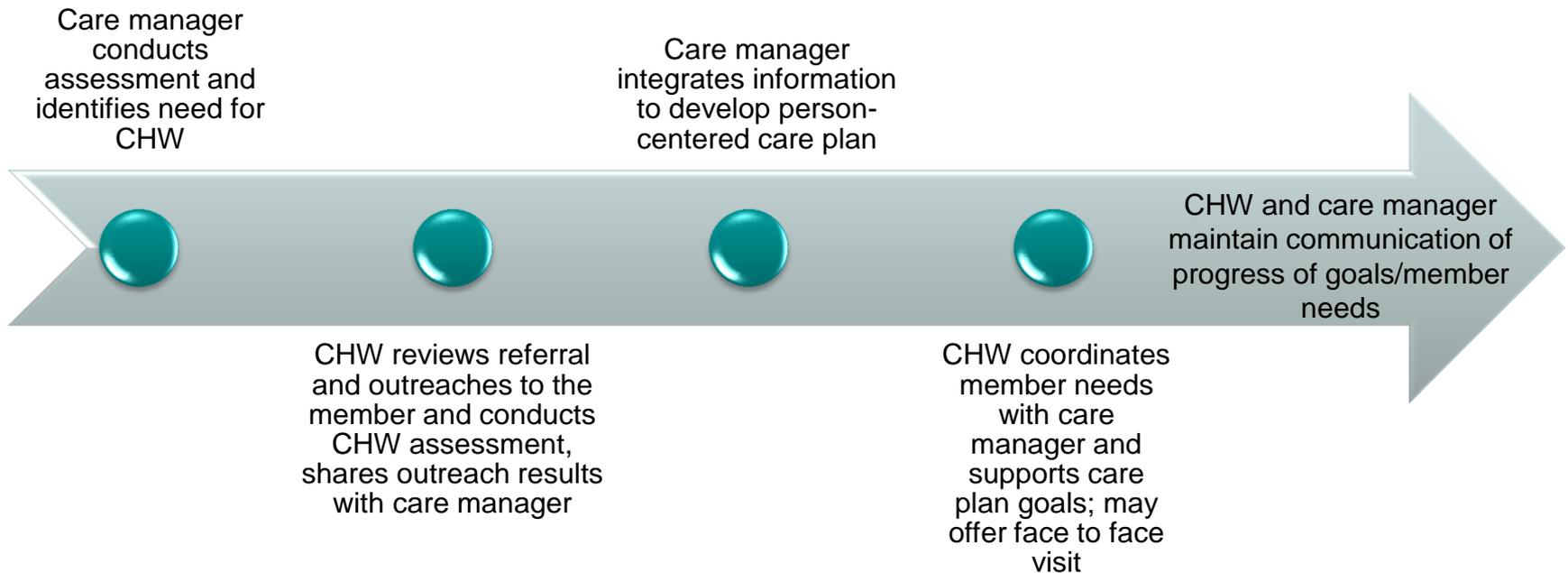
- Work with a multidisciplinary ICM team
- Empower families to improve their healthcare and stabilize their living situations
- Meet their basic human needs by helping to identify and access resources within the community
- Access appropriate resources for those identified at risk for domestic violence
- Review and use their HUSKY Health benefits

# Community Health Workers at CHNCT

***Community Health Workers do NOT provide clinical care,  
but instead compliment Care Management services***

- CHW staff integrated into ICM teams
- Regionally based across the state
- Five staff are bi-lingual (English/Spanish)
- Multiple areas of expertise including social work, domestic violence advocacy, health education
- CHW staff and ICM trainers participated in a nationally recognized CHW CORE Competency Training provided by Southwestern Connecticut Area Health Education Center (no CHW credentialing program in Connecticut)
- 90 day orientation and on-going training as needed with community agencies such as the Connecticut Fair Housing Center
- Staff supervised by Manager of Community Support Services (ICM nurses supervise CHW work conducted for each member)

# Integration and Coordination with Care Manager



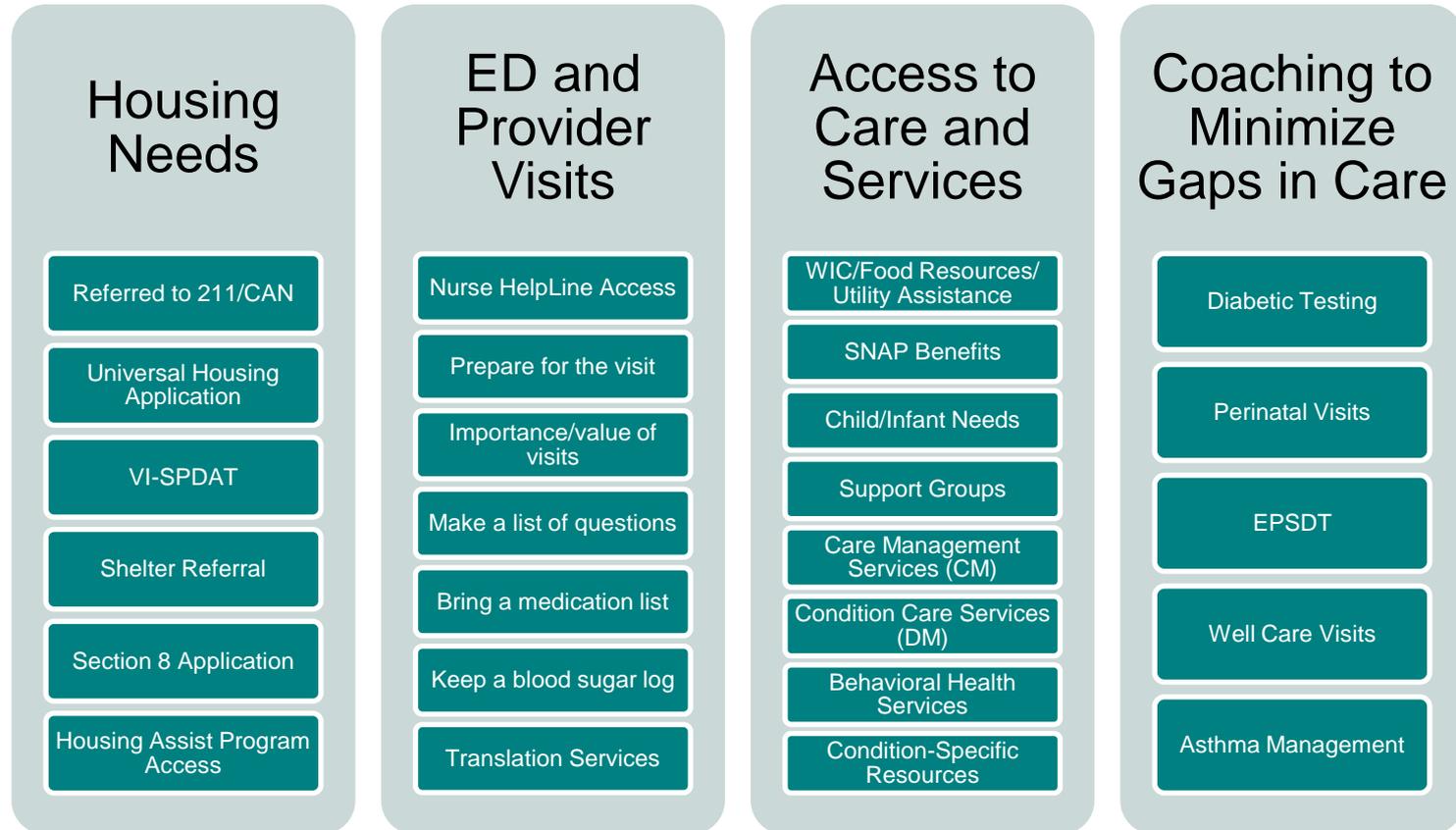
# CHW Roles

- Help members navigate the health care system
  - Support person-centered care plan by reinforcing goals, updating care manager of progress or barriers
  - Provide coaching to members and families on following care plans and recommended treatments at direction of care manager
  - Empowering member to self-manage chronic disease management such as asthma and diabetes
  - Help members develop relationships with their health care providers
  - Assist with scheduling routine appointments
- Maintain awareness of community culture and values
  - Knowledgeable about resources available in their communities
  - Utilize appropriate linguistic and cultural translation services
- Conduct face-to-face visits in the community or at a member's home
  - Provide social support by listening to concerns or questions and empowering the member to solve their problems
  - Conduct joint visits with ICM nurse as indicated
  - Assess home environment, identify and offer assistance to additional HUSKY members

# CHW Roles (cont.)

- Refer to community agencies to help address social determinants of care
  - Food Insecurity – food pantries, farmers markets, soup kitchens
  - Energy Assistance – Operation Fuel, New Opportunities, area fuel banks
  - Transportation – LogistiCare, bus route information
  - Social Supports – medical support groups, parenting education groups
- Ongoing coaching and support
  - Motivate members to engage in healthy behaviors by following proper diet, reducing asthma triggers at home, etc.
  - Provide support and encouragement for maintaining their behavior
  - Support individualized goal setting

# 2016 CHW Member Resources Provided



CHW staff provided members with 4,756 resources during the first two quarters of 2016, which include but are not limited to, the list above.

# CHW Case Scenario

Mr. X is a male in his 60's well-known to ICM from multiple hospital visits

- Medical history:
  - Chronic alcohol abuse
  - New diagnosis of liver cancer
  - Acute kidney failure
  - History of non-participation of treatment plan
  - Increased confusion and forgetfulness with disease progression
- Social Issues:
  - Divorced, strained family relationships
  - At risk of being evicted by family member who owned member's home
- Integrated ICM Interventions:
  - Close coordination with nurse to engage member in care management after multiple outreach attempts; member very resistant to services
  - Conducted joint face-to-face visits to offer support and encouragement to member; developed team concept with member
  - Seven face-to-face visits over five months
  - Met with member and his family supports at DSS office to discuss services available to member, including re-instituting his SNAP benefit
  - Over 40 calls to member between care manager and CHW including appointment reminder calls, as member became more forgetful
  - Assisted member with obtaining a Safelink phone

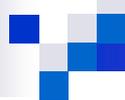
# CHW Case Scenario (cont.)

## Outcomes:

- Care manager and CHW worked closely together to gain member's trust and to identify his goals and wishes
- Engaged member's family (with his permission) to provide support, negotiate family dynamics
- Care manager able to obtain home care agency for medication management and teaching
- CHW advocated for member at Social Security office and he obtained benefits
- Provided member support and coaching as he moved into "end of life care"
- Care manager and CHW visited member at bedside before he passed

# Additional CHW Community Involvement

- Staff attend Community Care Collaborative (CCT) meetings at Yale-New Haven Hospital, Hartford Hospital, New London Hospitality Center
- Participate in regional Coordinated Access Network (CAN) meetings to work with housing providers such as Opening Doors Fairfield County
- Conduct provider presentations with ICM nurses to educate providers on the ICM program and CHW services
- Participate in back to school health fairs
- Staff attended Greater Hartford homeless document fair to assist homeless people who asked for assistance obtaining medical records, looking for doctors, etc.



# Resources

- Addressing Chronic Disease through Community Health Workers - A Policy Brief from the Centers for Disease Control and Prevention, Second Edition, April 2015  
[http://www.cdc.gov/dhdsp/docs/chw\\_brief.pdf](http://www.cdc.gov/dhdsp/docs/chw_brief.pdf)

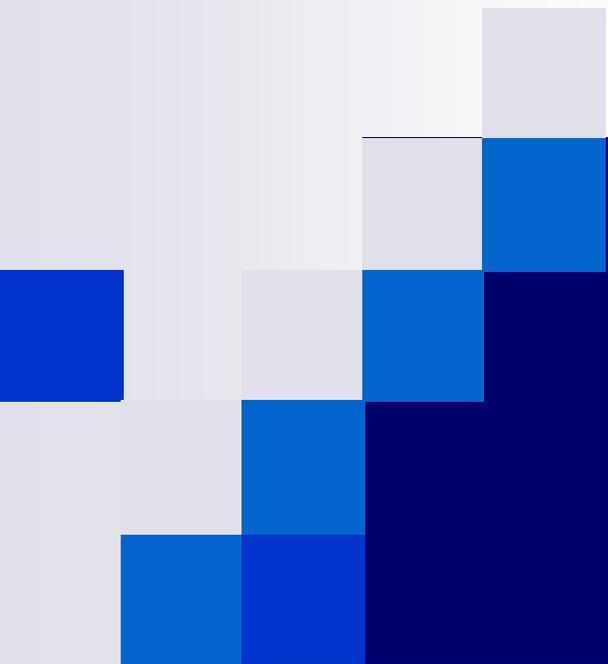
# Thank you letter from family:

RECEIVED  
FEB 3 2016  
Feb. 1, 2016

Dear [REDACTED],

I long to tell the world about a wonderful woman, Anna Luna, who works for the Community Health Network of Connecticut.

I am the aunt of [REDACTED] who died on [REDACTED]. He was single, unemployed, penniless, and nearly homeless. His situation was dire but Anna became a bright light in [REDACTED] life and my life. I would never have been able to navigate through the help [REDACTED] needed without Anna. Anna's knowledge was always very professional. She answered and returned phone calls and knew services I had no idea of. Through her coordination my nephew received excellent care and lived out his last months with dignity. It is with deepest gratitude I write in hope you can truly understand how valuable this angel was to [REDACTED] and I. Most Sincerely,  
[REDACTED]



# Questions?