Community Health Workers in Health care for the Homeless

A guide for administrators

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NATIONAL HEALTH CARE *for the* HOMELESS COUNCIL

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> **I diagnosed "abdominal pain" when the real problem was hunger; I confused social issues with medical problems in other patients, too. I mislabeled the hopelessness of long-term unemployment as depression and the poverty that causes patients to miss pills or appointments as noncompliance. In one older patient, I mistook the inability to read for dementia. My medical training had not prepared me for this ambush of social circumstance. Real-life obstacles had an enormous impact on my patients' lives, but because I had neither the skills nor the resources for treating them, I ignored the social context of disease altogether.**
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> **—Laura Gottlieb, MD, San Francisco Chronicle 8/23/10**[1]

INTRODUCTION

The purpose of this guide is to introduce the community health worker (CHW) model to HCH administrators for integration in the HCH model of care. There are multiple existing CHW programs, but this guide is intended to help HCH projects prioritize those parts of the model that are most applicable to practice and funding. This is a first step in our support of integrating cost saving and effective community health worker programs into all of the work HCH projects do.

BACKGROUND OF COMMUNITY HEALTHWORKERS

Community health workers are employed around the world to address the shortage of doctors and nurses in vulnerable communities and reduce health disparities. Perez and Martinez[2] note that the earliest records of CHWs date back to a shortage of doctors in early 17th century Russia, when lay people, called "feldshers," received training to provide basic medical care to military personnel[3].

In 1940's China, Chairman Mao Tse Tung instituted the program of "Barefoot Doctors" to address the disproportionate concentration of doctors in cities and other wealthy areas of China. They were given training in basic medicine and sanitation and were assigned to the communities in which they lived. By 1977, there were 1.7 million barefoot doctors, but the program was abolished in 1981 due to wider distribution of physicians[4]. Similar models have been utilized in developing nations in South America, Asia, and Africa[5]. In 1978, the World Health Organization (WHO) recognized the potential for national CHW programs in promoting primary care[6].

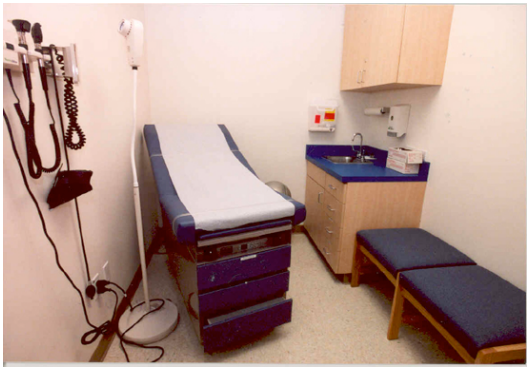
As in China and other developing nations, there is a large and growing number of very poor who lack access to adequate health care the in the United States. Among the various efforts to give the most vulnerable Americans access to health care in the past 40 years has been the creation of various community health worker programs – a new concept for a developed nation. These programs specifically target health disparities among a population who lack access to adequate health care, or fear/distrust the health care options offered. The two common characteristics of all CHWs are that they share a relationship with their community (e.g., shared language, similar age, geography, race/ethnicity, disease, or condition) and the absence of professional medical training[7].

HOW CAN A CHW CONTRIBUTE TO THE WORK OF AN HCH?

CHWs can focus on the resources, motivations, challenges, and strengths of each consumer and the community as a whole. Community health workers are not focused on diagnosis or treatment – they are tasked to help the client and the larger community access medical resources. CHWs improve health

outcomes through education*, navigation services, enabling services†, accompaniment, outreach work, and community education and advocacy. One of many advantages of employing CHWs is the relatively short time needed for on-the-job training, usually only a few days before they are ready to start helping clients[8].

COST EFFECTIVENESS AND IMPROVED HEALTH



There are several promising studies showing that community health work is an effective tool for reducing health disparities, improving health and reducing the cost of health care[10-10]. Recent research on the effectiveness of community health workers document a reduction in the use of emergency services and a reduction of hospitalizations while client health improved, both empirically and self-reported.

Fedder[10] found that community health workers were especially effective helping people with chronic conditions who are not using a regular source of health care. He found that after one year of weekly contact with a CHW offering navigation, monitoring, and health education, study patients enrolled in Medicaid in Baltimore reduced their cost of care by 27% compared to the year prior to working with a CHW. Emergency room visits declined 38% and admissions from ER visits went down 30% during the same period. This was accomplished while patients reported an improvement in their quality of life. Researchers at Denver Health[9] utilized a community health worker and documented a return on investment of $2.28 for every dollar invested, an average annual net savings of more than $95,000 per community health worker.

Another study looking at a population of asthma sufferers in Hawaii documented a 75% decrease in overall health care spending and an 83% drop in emergency room visits after community health worker interaction while participants reported improved quality of life[10]. A CHW Program[11] at Brackenridge Hospital, one of the busiest in Austin, Texas and Christus Spohn Hospital in Corpus Christi also report great success using community health workers to divert consumers from costly emergency and uncompensated urgent care in a culturally appropriate way while improving patient-reported quality of life. Christus Spohn Hospital reported an average savings of $25,000 per month as a result of their CHW program.

For HCH projects, the cost savings of CHWs are expected to be even greater as more eligible patients become enrolled in Medicaid and Medicare, fewer clients overuse clinic services, and more consumers learn how to manage their health even within limited means. In addition to expected improvements in physical health outcomes, there are also psychological benefits for consumers as they learn health maintenance skills that minimize their need for medical intervention.

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* "education of patients and the general population served by the health center regarding the availability and proper use of health services" – - section 330(b)(1)(A)(v) of the PHS Act

† ***Enabling Services*** are "services that enable individuals to use the services of the health center (including outreach and transportation services and, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals)" - section 330(b)(1)(A)(iv) of the PHS Act.

NATIONAL EVALUATIONS

Center for Medicaid and Medicare Services Office of Clinical Standards and Quality recently conducted a 28-month study of their Every Diabetic Counts (EDC) program. They found that minorities were underrepresented in the reimbursement requests for tests ordered for diabetic patients such as HBA1C, lipids, and eye exams in over half the states. CHWs were utilized as part of a non-technical team that delivered diabetes self-management education classes to primarily Medicare beneficiaries to increase health literacy. The results of the EDC program included a 28% increase in HBA1C tests, 25% increase in the tests for lipids, and an 8% increase in eye exams in the six states where the initiative was demonstrated[12].

Health Resources and Services Administration (HRSA) recently released several studies evaluating community health worker programs and workforce development. In 1998, HRSA published a paper entitled "Impact of community health workers on access, use of services, and patient knowledge and behavior[13]." The major finding of this paper is that CHW programs are as diverse as the communities they serve and their challenges are as well. This study led to more attention across the country to the potential benefits of community health workers addressing health care access, quality, cost, and disparities with a community-centered approach.

In 2002, HRSA furthered the work by publishing "A literature review and discussion of research studies and evaluations of the roles and responsibilities of community health workers (CHWs)[14]". This study looked at the work of defining roles and the elements of a successful evaluation as documented in 19 reviewed studies. In 2007, HRSA published its "Community Health Worker National Workforce Study[15]", the most comprehensive study of the community health worker profession. This study concluded that there is a lack of peer-reviewed literature evaluating the effectiveness of community health work, but there is evidence that CHW involvement in the delivery of health care, health education, and prevention benefit underserved and vulnerable communities. Two of these three papers are available to read at: aspe.hhs.gov/pic/reports/hrsa/6355.pdf; http://bhpr.hrsa.gov/healthworkforce/chw/communityhealthworkers.pdf.

DIFFERENT APPROACHES TO COMMUNITY HEALTH WORK

Several states have implemented various programs and, in 2010, the Department of Labor issued a labor code to community health workers[16] as an umbrella term, although they are known by various titles such as "lay health advisors", "lay health advocates", "lay health workers", "peer health promoters" and "community health advisors". In other areas, they are also referred to as "village health workers", "patient advocates", "community health agents", "natural helpers" and "community health aides". In addition, there are specific titles assigned to specific tasks and functions, such as "shamans" who provide spiritual/herbal healing.

Another title, promotores/promotoras de salud is frequently used in border towns and in Migrant Health programs serving native Spanish speakers who lack access to care because of language barriers, immigration status, poverty, fear, or distrust of the American health care system. These promotores/as are important because they can translate and speak to the cultural experiences of health care in the community – one example is the preference for the use of herbal products over Western medicine. They can also serve to ensure that appropriate translation services are provided.

Peer support advisors and peer health advocates are titles frequently given to community health workers who support those who are in recovery from substance abuse and/or mental health. They are themselves survivors of these issues and can offer hope, advice, and support. They are well integrated into several mental health/addiction teams around the country and much can be learned from this specific field of community health work.

There are several models of care in the literature that explain how community health workers affect the health status of vulnerable people. Most focus on specific health issues such as diabetes, asthma, pregnancy, or cancer screening. One such program and its results are described below:

> *In Baltimore City, Maryland, a community health worker program[7] reached out to African-American diabetes patients whom Medicaid covered and who frequented the emergency room. The trained CHWs then contacted patients at least once a week. Their contacts involved linking patients to services, helping patients make and keep appointments, promoting self-care behaviors (including monitoring), establishing or maintaining Medicaid eligibility, and providing social support. The researchers found that the patients who received assistance from a CHW saw a significant decrease in ER visits (38%), hospitalizations (30%), and Medicaid expenditures (27%) a year after introducing CHWs compared with the year before while the patients experienced an improving quality of life.*

WHAT CHW WORK DOES NOT INCLUDE

Community health workers are valuable members of health teams, but are not professionally medically trained. As such, they should not dispense medical advice, violate HIPAA or confidentiality outside HCH clinical staff, or provide formal counseling.

HEALTH REFORM AND THE COMMUNITY HEALTH WORKER[17]

The Patient Protection and Affordable Care Act authorizes the Centers for Disease Control and Prevention (CDC) to issue grants to organizations using CHWs to extend care to the medically underserved in the following ways:

1) Educate, guide, and provide community outreach
2) Provide guidance regarding effective strategies to promote positive health behaviors and discourage risky behaviors
3) Conduct outreach regarding enrollment in Children's Health Insurance Program, Medicare, and Medicaid
4) Refer and enroll underserved populations into appropriate health care agencies
5) Provide home visitation services regarding maternal health and prenatal care

The Centers for Disease Control and Prevention are specifically interested in reviewing the effectiveness of the activities listed in the Department of Labor classification[16] of CHWs, such as:

1) Serving as a liaison between communities and health care agencies
2) Providing guidance and social assistance to community residents
3) Enhancing community residents' ability to effectively communicate with health care providers
4) Providing culturally and linguistically appropriate health or nutrition education
5) Advocating for individual and community health
6) Providing referral and follow-up services or otherwise coordinating care

7) Proactively identifying and enrolling eligible individuals in Federal, State, local private, or nonprofit health and human services programs.

"I was scared to get the lump [my doctor] found checked out. What if it was cancer? I thought I didn't want to know.. Then my CHW told me that she would go with me to my appointment and that we would get through this together – that really helped me get the courage to get a biopsy. Thankfully the lump was benign."

HOW CHWs CAN ADDRESS THE UNMET NEEDS OF PEOPLE EXPERIENCING HOMELESSNESS

Because of their status in the community, CHWs are uniquely positioned to identify and address some of the unmet health needs of those who are experiencing homelessness. Currently, those experiencing homelessness generally lack publicly funded health insurance unless they are disabled and receive SSDI or SSI or unless they have dependent children who qualify for Medicaid. While the Affordable Care Act expands Medicaid eligibility to all whose income is 133% of poverty, it does not go into effect nationwide until 2014. Intensive enrollment efforts will be necessary once eligibility is expanded, and preparing a corps of CHWs to do that work is a pressing current concern. As 2014 approaches, there is still a great need to enroll homeless individuals who qualify for current public health insurance plans. An estimated one in five Americans, without regard to class or insurance status, lack adequate access to needed primary care[18]. This is a need that also merits community-level action led by a community health worker.

Affordable housing is the most pervasive unmet health need of those who are homeless. The stock of low-income housing has steadily declined since the 1980s. There is a lack of tolerance for those experiencing homelessness as demonstrated in popular culture's acceptance of violence against homeless persons and in policies negatively impacting the quality of life for those on the streets.

Baggett, et. al[19] found that almost 75% of those who are homeless have at least one unmet health need and almost half reported more than one. The most prevalent documented needs they found (in order) were: eyeglasses and dental care, prescription drugs, medical and surgical care, and mental health care. The reason most were not able to access these needed services was the lack of ability to pay and the lack of insurance. One unique challenge Baggett and his colleagues found is that the more a homeless person works, the more likely they are to be without health insurance. The lack of available employment with benefits is another unmet need that could be addressed by an awareness campaign managed by community health workers.

HCH-SPECIFIC ACTIVITIES OF COMMUNITY HEALTH WORKERS

Most community health work within an HCH setting should fall into one of three categories: outreach and enrollment, logistical support (navigation), and community advocate/educator. While not all activities of community health workers fall neatly into these roles, the roles themselves are intended to help define the scope of work for CHW positions within an HCH.

Outreach and enrollment

- Assist with enrollment into housing, nutrition, and health insurance programs and entitlements (see section on Affordable Care Act).
- Provide culturally competent enrollment, health education, and outreach services.
- Motivational interviewing and rapport building with potential clients using empowering language and taking the lead from the client.
- Offer friendly and helpful advice based on problems and concerns identified by the client.
- Offer day-to-day survival tips and kits such as first aid, socks, water, hand sanitizer, etc.

"…I thought my doctor was just supposed to give me my medicines and that was that… I didn't feel I should take her time asking a lot of questions…I now realize how much I didn't know at all…"

Logistical support (Navigation)

- Encourage homeless persons to access primary and preventive care at a health center rather than the emergency room or critical care facility
- Provide culturally-appropriate case management services
- Help clients fill out and file paperwork for Medicaid, Medicare, Veterans Services, HUD, local housing authority, HCH clinic, prescription coverage, and any other services
- Follow-up and track individuals experiencing homelessness and/or recently housed
- Schedule and remind clients of appointments and provide transportation if necessary[20]
- Reinforce behavior and mobilize social support
- Assist with signing up for medical respite
- Ensures interpretation services are appropriate and that they meet the needs of the consumer
- Facilitate client empowerment to fully engage with all members of their health care team
- Accompanies consumers on medical visits as a source of support
- Support maintenance of improvements in health status
- Help consumers access needed supports for transitions such as attaining housing

"We educated the local police about the importance of understanding what it's like for those who experiencing homelessness. After hearing several personal stories and a role reversal activity, I think the police will be more open to helping those who are homeless get to needed services rather than arresting them. It was a good day."

Community Advocate/Educator[21]

- Address the social determinants of homelessness, lack of proper nutrition, human rights, safety, etc.
- Collecting information about a local problem and work with the community to develop a solution
- Knowledge and sharing of homeless rights and local status laws such as sit/lie, panhandling, public feeding, and other such ordinances
- Develop and utilize connections with community service representatives to help clients get what they need
- Update provider teams at the health center about what issues consumers are facing, both specifically and generally, within the community and individually by the consumers themselves
- Encourage and teach consumers to advocate for their own needs
- Advocate for changes needed in the community to better the lives of all citizens, especially those without homes. Issues to be addressed locally can include: human rights violations, increased arrests of homeless, increased violence against those who experience homelessness, ordinances aimed at criminalizing homelessness, the closing of a needed shelter, the lack of nutrition or needed medical

services, lack of educational opportunities, dispelling myths about homelessness, reducing the stigma associated with being homeless, etc.

RECRUITMENT AND RETENTION OF COMMUNITY HEALTH WORKERS

HRSA[15] found that networking was the recruitment strategy used by almost three fourths of employers who are hiring CHWs. 69% of employers coupled networking with traditional advertising. The study also reported that some clinic-based programs recruit from among their patients[22]

It is entirely appropriate to seek former HCH consumers or formerly homeless persons when recruiting CHWs. While they don't have to have experienced homelessness to serve the community in a meaningful way, those who are recruited will need experiential skills to help people without homes navigate the issues of housing, primary health care, poverty, mental illness, and substance abuse[5].

Program administrators should implement policies that maximize the effectiveness of CHWs and minimize risk to CHWs. CHWs work in unsafe areas and with at-risk populations[15]. Self-care efforts will help with retention, especially among CHWs who may be new to the concept of self-care.

HCH projects should consider asking local Consumer Advisory Boards, to the extent possible, to help identify community needs, characteristics, and challenges, as well as helping HCH determine whom CHW efforts should target. Those whose physical or behavioral health status continues to deteriorate? Developing the answers to these questions will help determine the skill set needed by potential CHW candidates. While the HCH is responsible for hiring, the CAB can help the project with their needs assessment related to community health work.

Natural helpers may emerge from these activities and can help develop the appropriate role for community health work. These leaders and others can also help Identify those who are doing the work in the community already and provide them with additional training, financial, and informational resources to enhance the work they are already doing[23].

Funding Considerations

Programs may be able to use VISTA, AmeriCorps or other volunteer organizations to pay for these positions initially. While in the position, AmericaCorps volunteers can engage consumers in identifying community needs and develop leaders in the community so they can continue the community health work upon the volunteers' departure (typically after 12,16, or 24 months). Also consider cross-training CHWs as EMTs, CNTs, CMAs or HITs or visa versa. Many are interested in medical professions and should at the very least be promoted from within the organization from these positions and/or assisted in their continuing education to the extent funds allow.

CHW positions are allowable expenditures under Health Center grants from HRSA. As new Health Center funding opportunities become available, HCH grantees and other Health Centers should consider the benefits of CHWs and allocate resources to these activities. As mentioned above, the Affordable Care act authorizes a CDC grant program in this area. Medicaid reimbursement for CHWs is dependent on State level decisions.

WHAT THE STATES ARE DOING

Several states have active community health worker, community health advisor, promotores/promotoras, lay health advisor, and lay health worker programs. Below is a description of a few of the CHW programs around the United States:

- **Alaska**[24] – Community Health Aide Program (CHAP) established in 1964. The program focuses on Native Alaskans and is unique because the CHWs provide health and dental care services to remote locations (after extensive training, certification, supervision, and experience).
- **Indiana** – Statewide program offers prenatal care coordination teams made up of a registered nurse, a social worker, and a CHW. State-trained instructors at local sites deliver state-developed curricula. CHWs who qualify are credentialed after passing an exam. The state receives Medicaid reimbursement for CHWs who work with licensed medical professionals – an option for all states.
- **Massachusetts**Error! Bookmark not defined. – Strong CHW program designed to help enroll the underserved in services they now qualify for with the enactment of 2006 Massachusetts health reform law. CHW services have been in use in Massachusetts at least since the 1960s and the state has what many regard to be the strongest state community health worker association. The Massachusetts Blue Cross Blue Shield Foundation funds the program. Three licensed sites provide training for CHWs and certification is available for CHWs at the state level.
- **Minnesota** – Like Indiana, Minnesota uses the Medicaid option to pay for CHW position and similarly, only licensed CHWs with medical supervision can bill Medicaid. The Minnesota State Colleges and Universities' Health Education-Industry Partnership, funded by Blue Cross and Blue Shield of Minnesota Foundation and Robert Wood Johnson Foundation, is developing a standardized training program for community health workers.
- **Ohio** – The Ohio Board of Nursing administers their CHW certification program created a "Certificate to Practice" and the model of care is very medical in nature. Some nursing tasks are delegated to CHWs with supervision from a Registered Nurse after an extensive curriculum heavy in medical content. http://www.nursing.ohio.gov/CommunityHealthWorkers.htm
- **Texas** – First state in the country to certify community health workers for the public health system. State law requires all paid CHWs/promotores to be certified and that all health and human service agencies have CHWs/promotores involved in helping recipients of medical assistance.
- **Virginia** – State sponsored extensive study of CHWs included recommendations for "shaping a more effective and increasingly responsive health and human services workforce." Virginia intends to move from on-the-job training to a more standardized statewide training program that both legitimizes the work and enhances reimbursement opportunities.

CHALLENGES/LESSONS LEARNED

There are several challenges to the community health worker profession. Chief among them are the lack of standard definitions, benefits, training, or secure funding[14,25]. Much of this stems from a common CHW struggle with becoming a part of the medical community while remaining connected to those who are not. Similarly, the CHW has competing time constraints of being in the clinic and being out in the community. Experienced CHWs recommend that a balance between the two be developed to the extent possible[20] – it is often necessary to visit a shelter or emergency room to stay in touch with clients.

One challenge that should be addressed is that of dual relationships. CHWs are selected precisely because they have established relationships with people in their community. These client relationships are not like those with medical professionals, but there are some minimal boundaries that might be beneficial such as not working with family members and avoiding conflicts of interest. The CHW's role as advocate for

consumers' interests can also create conflicts, sometimes with the very agency that employs the CHW. The agency's clear recognition of and support for the advocacy role is one key to making these complex relationships work, as are tact and skill on the part of the CHW.

Time is another challenge for community health workers. One way utilized for maximizing time, providing quality information, and reaching multiple patients at once is in a structured group. Both one-on-one and group activities seem to support self-management and improve doctor-patient relationships[26]. Some group activities allow patients to have a safe space to feel like they are not alone in their struggles – minimizing hopelessness in some people. Groups can also serve to provide empowerment tools to patients so they can take a more active role in their health care.

The academic community needs to be alerted to the need for research on community health workers. Much of the great work that community health workers are doing around the country remains unpublished in professional journals – perhaps due to the common conflict CHWs have of being a part of the medical community and their community of origin at the same time[27].

CASE STUDY

An HCH project in New England starts a community health worker (CHW) program to address those consumers who are frequently using clinic services, defined as more than once per month. The CHW is a former consumer of the clinic and is promoted from a previous position prior to becoming the HCH's full-time community health worker.

High-use consumers are assigned to the CHW and an initial appointment is made. During this appointment, the CHW prepares for several scenarios so she can listen and respond to the needs of the consumer. More often than not, their primary health concern is housing and she comes prepared with applications for various housing programs the consumer may be eligible for.

After this initial "listening" meeting, there are several follow-up and assisting sessions scheduled. About half of the time, the CHW can be found accompanying a consumer to an appointment or procedure either at the clinic or the nearby hospital. The CHW will call consumers who have a phone, or go find them if they do not, to remind them of their appointment times and make sure they have what they need to get to the appointment on time. Sometimes the biggest barrier is anxiety, which the CHW addresses by encouraging and accompanying the consumers to appointments.

In between appointments, the CHW and consumer talk about how, from the consumer's perspective, they can work together to improve the conditions that necessitate frequent visits to the HCH clinic. This CHW does everything from helping a diabetic patient make better choices with their EBT food benefit at the grocery store to helping them identify and apply for community services to address their greatest needs.

One of the current struggles that the CHW reports is the current inability to visit consumers once they have housing – there is only one CHW and no one to accompany her with the exception of 4 hours a month. This isn't nearly enough to ensure that those who are negotiating the often-difficult transition from the streets to housing have the support they need from someone they trust. There are other times when collaboration with another CHW would be beneficial for the consumers. Many of the issues consumers present require problem-solving creativity and two heads are better than one!

Supplements to the CHW document

NHCHC Resources

Code of Ethics

Core Competencies

Personal Characteristics of a Successful Community Health Worker

CHW Knowledge Basics

ENDNOTES

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