Community Health Workers: Partners in the Care of Children

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CHW 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."

Source: Community Health Worker Section of the American Public Health Association

CHW Roles

- Outreach and community mobilizing
- Community/Cultural Liaison
- Case Management/Care Coordination
- Health Promotion and Health Coaching
- System Navigation
- Participatory Research

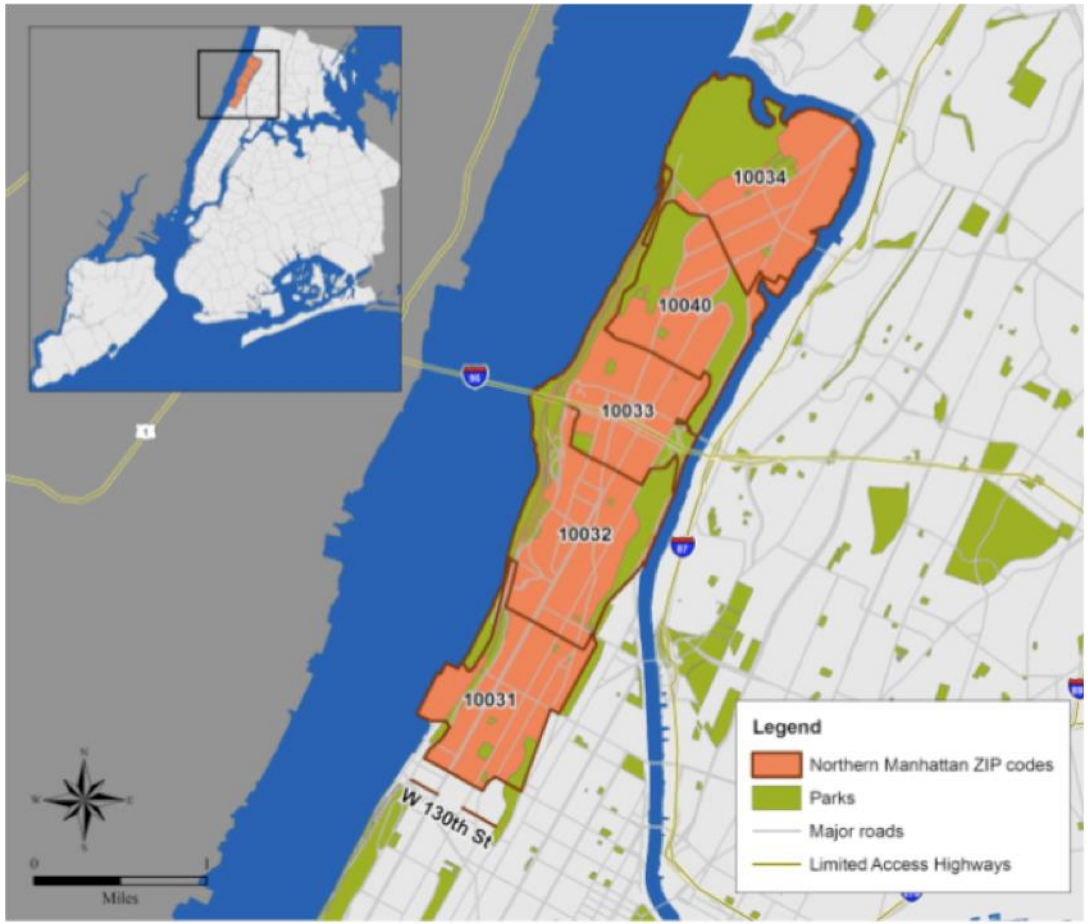
Source: CHW Network of NYC

CHW Scope of Practice

- Consult with PCP or subspecialists involved in treatment plan
- Outreach/engagement with emerging needs and on-going continuity of care
- Advocate and refer to services
- Support for medical appointments
- Coordinate with ED/hosp when events occur
- Assist with medication reconciliation
- Support post-discharge
- Assist with advance directives/rights
- Ensure translation services are utilized
- Connect to support groups/social services

Zahn.D et al. Making the Connection: The Role of CHW in Health Homes

Our Community
Northern Manhattan



Community Data- Census 2015

- 66% Hispanic
- 54% foreign-born
- 52% Spanish-only
- 56% Low acculturation score
- 43% have a household income <$20,000

Background

- Asthma affects nearly 9% of American children
- Disproportionate burden in low-income and minority communities
  - N. Manhattan: 18-25% prevalence
- Gaps in health care system contribute to growing disparities
  - Lapses in insurance, underinsurance, long-waits for appointments, low health literacy, complex system

CHW MODEL: WIN for Asthma

- Hospital-Community Partnership
- Community Health Workers
  - Bilingual
  - Community-based
  - Peer support & education reinforcement
  - Members of health care teams

Peretz P, Matiz LA, et al. Community Health Workers as Drivers of a Successful Community-Based Disease Management Initiative. American Journal of Public Health: August 2012, Vol. 102, No. 8, pp. 1443-1446

PROGRAM STAGES: PEDIATRIC ASTHMA

Stage 1 Months 1 - 3	**Stage 2** Months 4 - 6	**Stages 3** Months 7 - 12
Comprehensive Education	Monthly Check-In	Bi-Monthly Check-In
Home Visit/Home Environmental Assessment	Home Visit	Home Visit
Goal Setting & Service Referrals	Goals Check-in	Service Referrals
Provider-Led Workshops	Service Referrals	12 Month Follow-up
Intake Survey	6 Month Follow-up	Graduation

*Frequency of check-ins and intensity of services determined by participant needs

CORE TRAINING CURRICULUM

NYP Credentialing	Shadowing Senior Workers
CHW Core Competencies	Asthma 101
Home Visiting	Health Literacy
Case Management	Influenza 101
Goal Setting	Behavioral Health 101
Motivational Interviewing	Health Literacy
Cultural Competency	Home Remedies
Integrated Pest Management	HIPAA
Time Management/Case Management	Mental Health/Wellness

WIN for Asthma Outcomes

- Since 2006:
  - 1420 patients enrolled in year-long program
  - ED visits decreased by more than 55%
  - Hospitalizations decreased by 65%
  - Nearly 100% of graduates stated that they feel in control of child's asthma

PCMH-BASED SUPPORT AND EDUCATION

- **Community Health Workers:**
  - Work as members of the team and participate in multidisciplinary meetings and rounding
  - Apply non-clinical, peer-based approach to reinforce key health messages
  - Help patients/parents understand diagnoses and uncover disease management obstacles

Impact: 2300 patients have received practice-based support & education since February 2011.

Matiz LA. et al. The Impact of Integrating Community Health Workers into the Patient Centered Medical Home. *J Prim Care Community Health*. 2014 Oct;5(4):271-4.

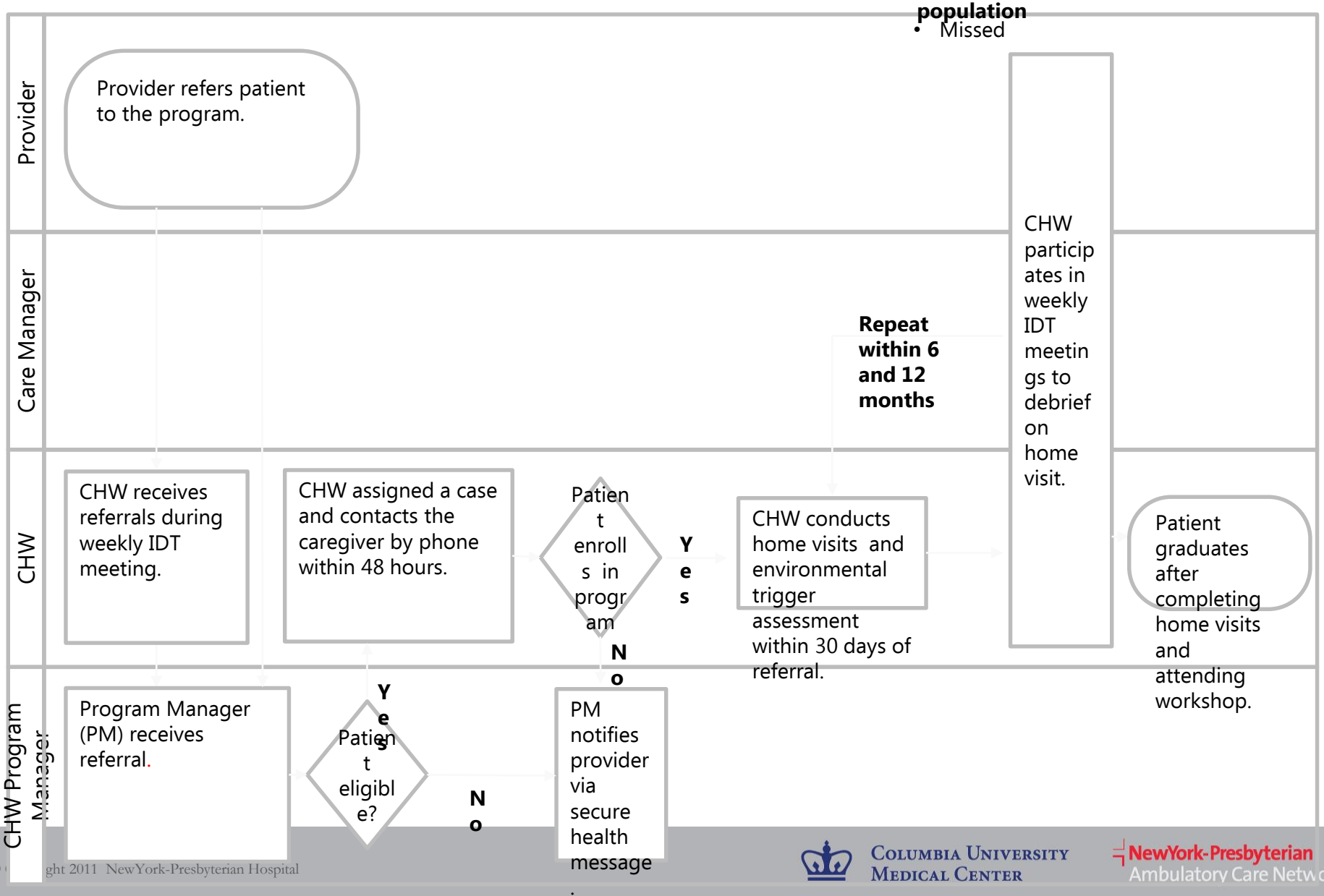
WIN for Asthma CHW Program

Patient Eligibility Criteria:*

In past 6months:

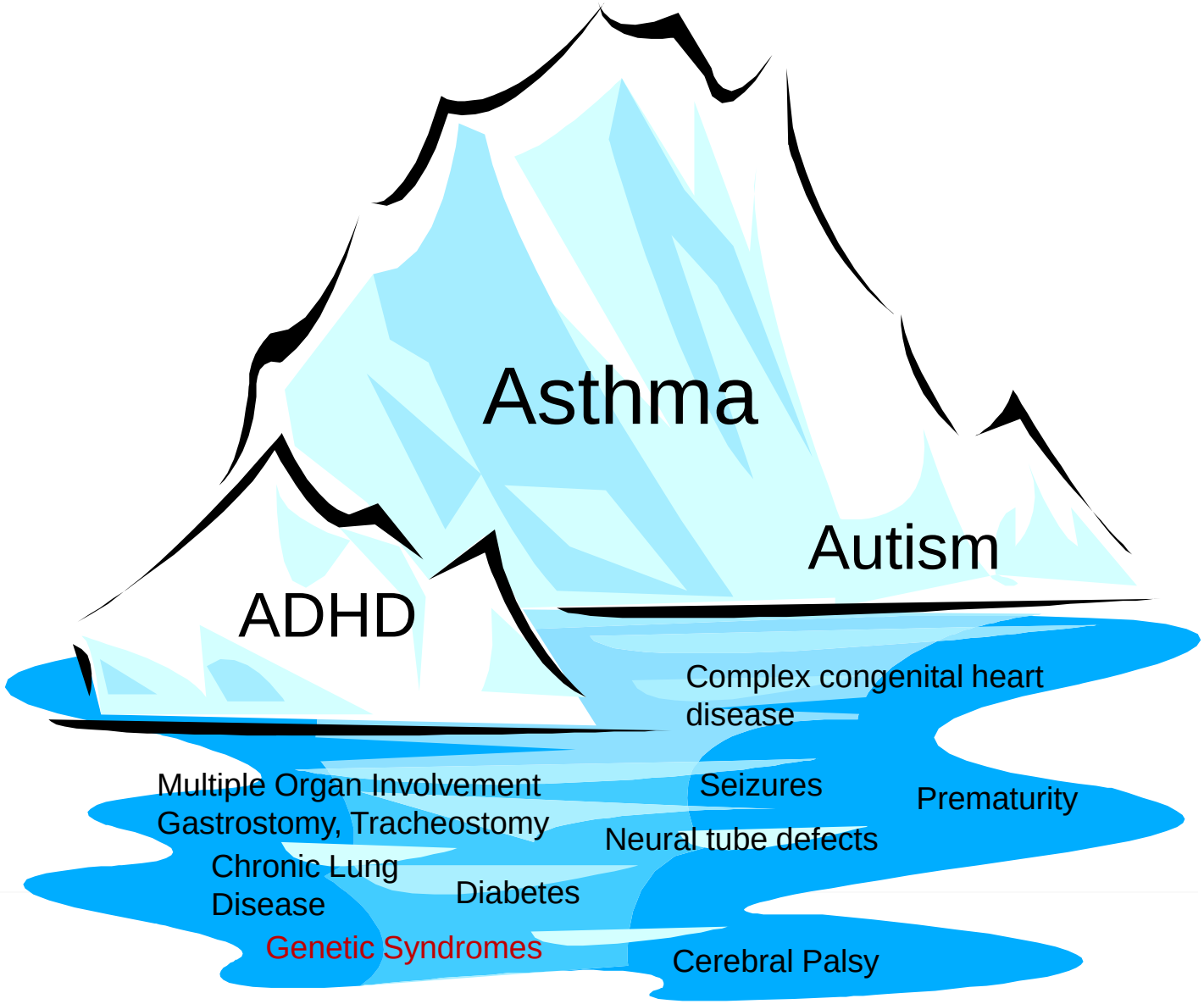
- Had an ED visit,
- Had an inpatient
- Missed school/work,
- And/or referral at the discretion of

***Criteria will depend on the patient population**



Children with Special Health Care Needs (CSHCN)

"those who have or are at increased risk for a chronic physical, developmental or emotional condition and who also require health and related services of a type or amount beyond that required by children generally"



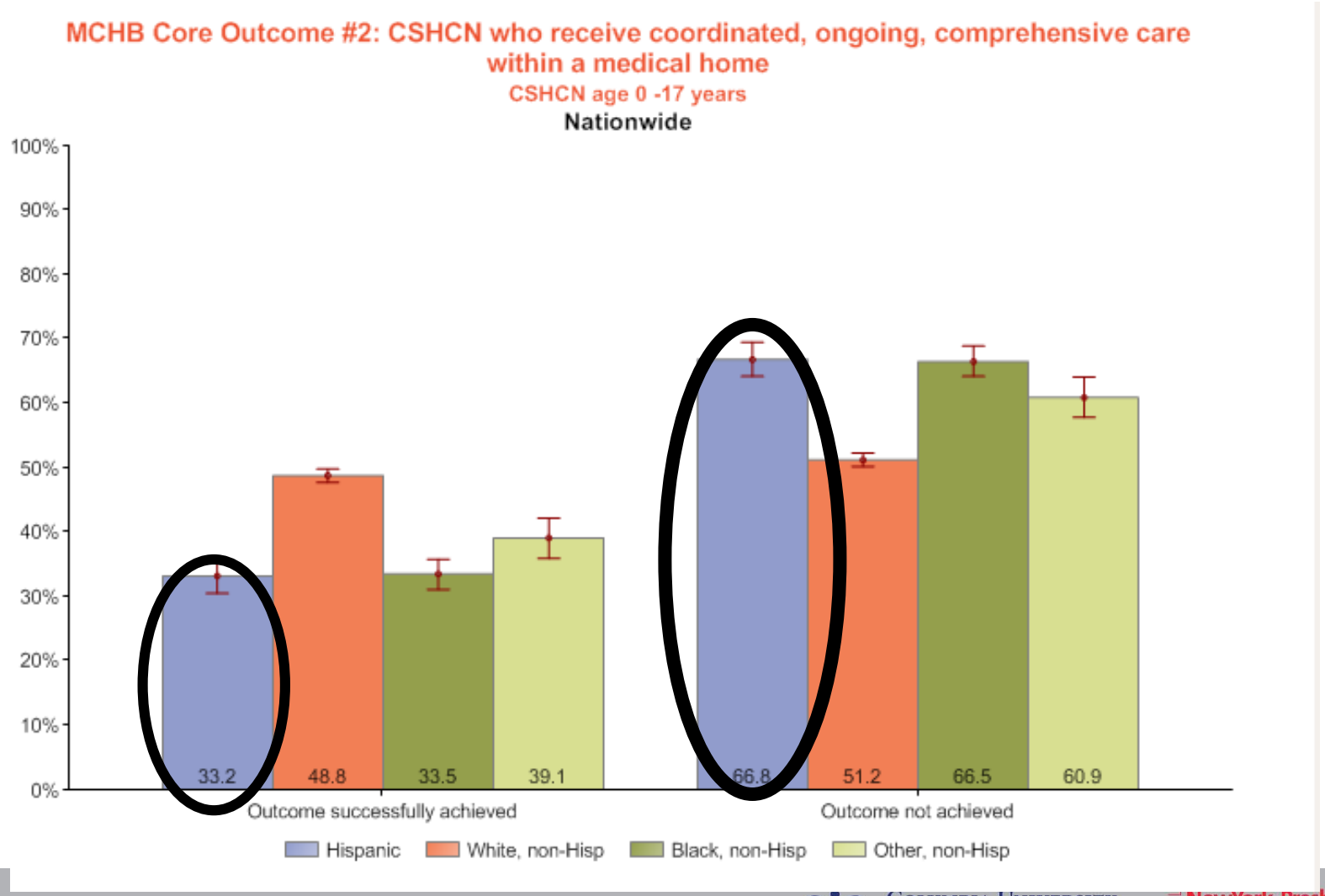
WHY?

- CSHCN comprise 15-18% of all children in US (12.5 million)
- CSHCN account for 80% of pediatric health care expenses
- CSHCN have grown by 30% in the past 20 years due to improved medical care and testing
- Account for >2.5 times the number of school absences, 2x as many unmet health needs, >5 times as many hospital days/ 1000 children

Latino Children in the US

- Fastest growing minority population in the US (16%-2011)
- Multiple health disparities, health access and socioeconomic challenges
- Patient and family-centered care can help to address health disparities and improve population health

National Survey of CSHCN, 2009/2010



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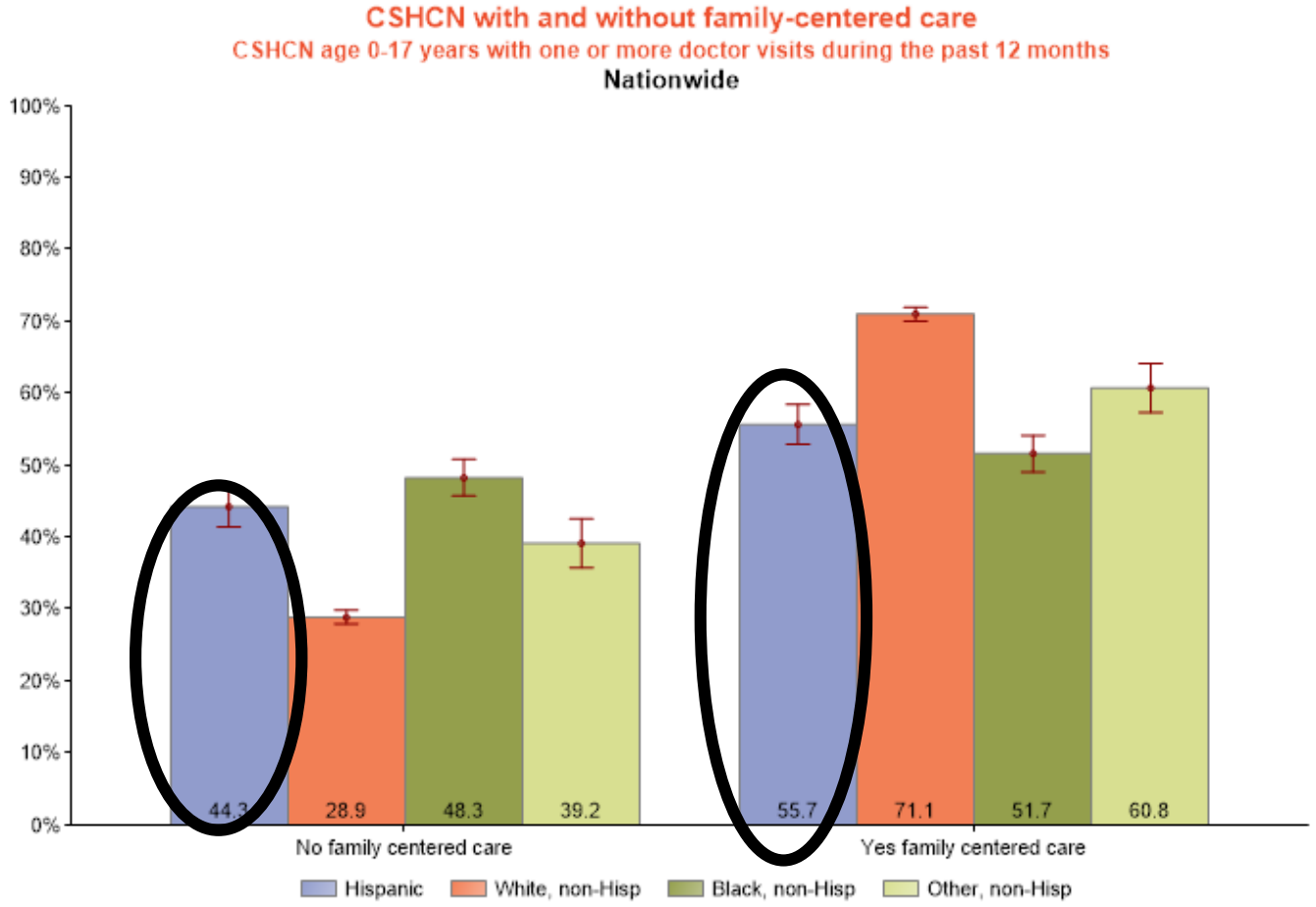

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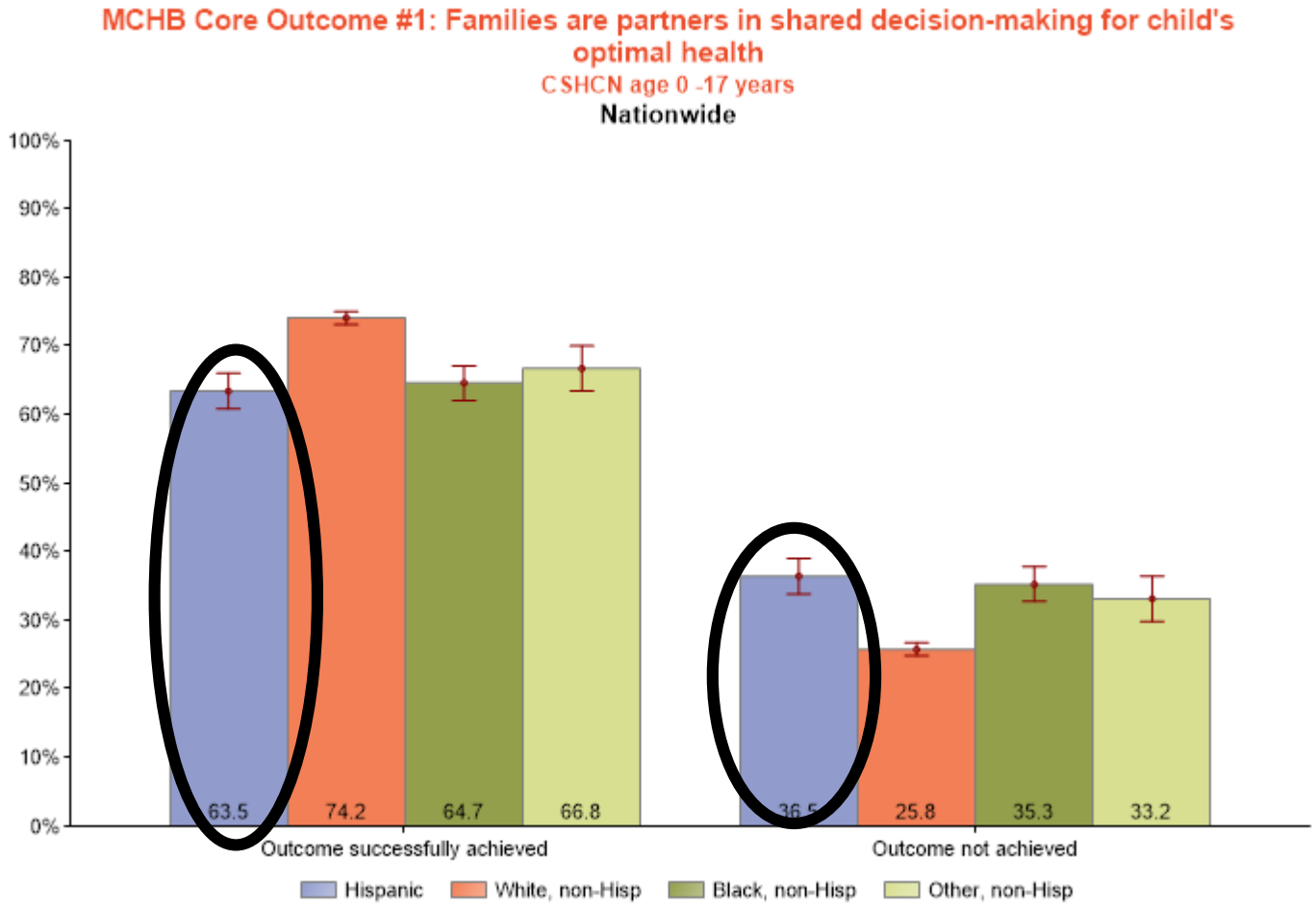


Case

- Patient Y born with prenatally diagnosed TEF, VSD
  - s/p TEF repair and at age 3 mos suffered esophageal rupture
  - subsequent critical course and major complications
  - 9 months admission at Childen's Hospital discharged with:
    - esophageal stricture
    - G tube and J tube
    - chronic lung disease
    - global developmental delay
    - hypertension

Special Kids Achieving Their Everything (SKATE) CHW Program

- 2015- Hospital-Community partnership model
  - –CBOs to better serve families of CSHCN
- Provide peer-level culturally-sensitive education and support
- Bilingual CHWs
- Trained on CSHCN support topics
  - –Disease based, services (SSI, EI, special education)
- Address social needs which compete with self-management and coordination of care
  - –Housing, literacy, food insecurity, immigration

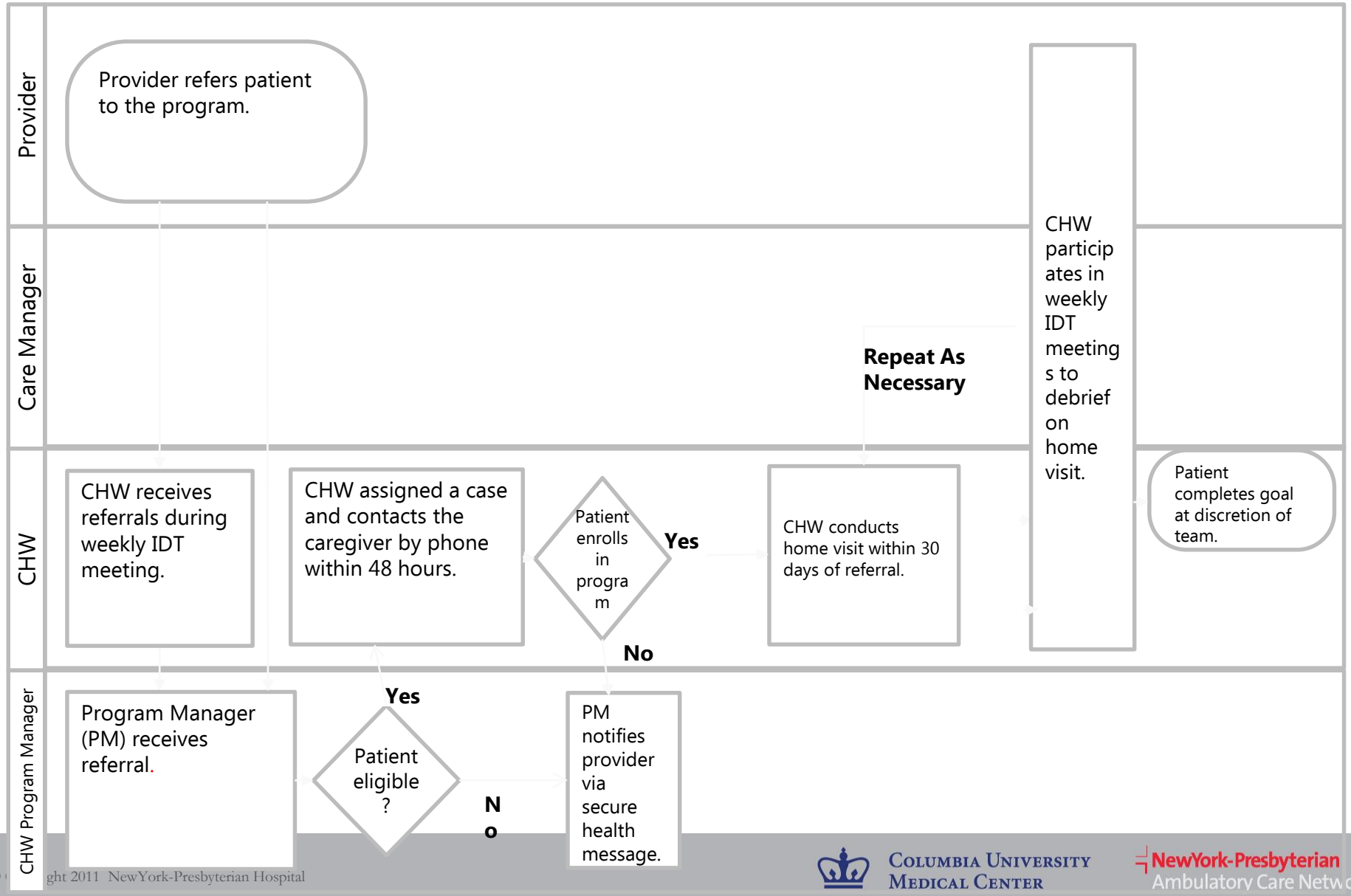
Intervention

- Home visits
- Appointment accompaniment (medical, social services, school)
- Key messages:
  - knowing your child's condition(s)
  - knowing how to access health care for your child
  - keeping your child's condition(s) under control
- Support on self-directed goals around their child's care
  - Medications
  - transitioning from pediatric to adult medicine,
  - organization skills to coordinate care
  - social service referrals
    - housing, immigration, and employment

Special Kids Achieving Their Everything (SKATE) CHW Program

Patient Eligibility Criteria:

- 3A or 3B patient
- Established primary care patient in ACN practices
- Clinical goal for patient in program referral



Metrics

Program

- Social determinants
  - Housing, access to care, food insecurity
- Goal attainment
  - Provider and family
- Social service referrals
- Number of monthly contacts
- ED and hospitalization

Patient/Family

- Diagnosis understanding
- Knowledge on accessing care
- Medication management
- Confidence in self-management
- Level of distress
- School connectivity

LESSONS LEARNED

- CHWs from the local community are uniquely positioned to build trusting partnerships with patients and colleagues
- CHWs can move fluidly between community and health care settings
- CHWs can be the "voice" of the community in clinical settings and bridge gaps in care
- CHW models can be transferable to other areas and populations

CONTACT INFORMATION

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