



Using Community Health Workers to Improve Linkage and Retention in HIV Care

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Welcome



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Webinar Goals

- Describe and define community health workers as part of the U.S. health care workforce.
- Give examples of how community health workers are utilized in the HIV service system.
- Describe the emerging role of community health workers in HIV care continuum.

HRSA CHW Project: FY 2016-2019

- Funded through the Secretary's Minority AIDS Initiative Fund (SMAIF)
- Administered by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB), in the Division of Community HIV/AIDS Programs (DCHAP)

HRSA CHW Project: Goals

1. Increase the utilization of CHWs to strengthen the health care workforce, improve access to healthcare and health outcomes for racial and ethnic minority people living with HIV (PLWH).
2. Assist Ryan White HIV/AIDS Program-funded (RWHAP) medical provider sites with the support needed to integrate CHWs into an HIV multidisciplinary team model.
3. Develop tools, materials and resources to increase the use of CHWs in health care teams.
4. Evaluate the effectiveness of CHWs on linkage and retention in care for PLWH and assess the CHWs models implemented by RWHAP providers.

Who are we?

- Boston University: Technical Assistance and Evaluation Center
- Multnomah County Health Department (MCHD)
 - Community Capacitation Center
 - HIV Service Center
- University of Texas Health/Texas Public Health Training Center
- Centers for Social Innovation/T3
- Impact Marketing and Communications



Advisory Group

- Amelia Broadnax, CA
- Deborah Borne, CA
- Ana Cossio, SC
- Catherine Haywood, LA
- Precious Jackson, CA
- Alex Lozano, CA
- Arteya McGuire, MS
- Allan Rodriguez, FL
- Paula Saldana, TX
- Nancy Scott, MA

Who are all of you?



How many of you work in an organization (clinic, community based organization, hospital, etc.) that has community health workers?

- Yes
- No
- Don't Know



If you already have CHWs in your organization, in what areas, conditions, roles, and/or functions do they work?

- HIV
- Substance Use
- Chronic Diseases (e.g., Diabetes, Hypertension)
- Maternal/Child health & Nutrition
- Other



What populations do community health workers serve in your organization?

- Racial and Ethnic Minority Populations
- Women
- Young Adults and Youth
- People with substance use or mental health disorders
- Other



What are the position titles under which community health worker duties are carried out by your organization?

- Peer navigator or Peer advocate (PLWH)
- Health advocate/educator
- Patient/Health navigator
- Outreach worker
- Other

Community Health Workers in the Health Care Workforce

Geoff Wilkinson, MSW

Clinical Associate Professor

Boston University School of Social Work

APHA Definition of CHWs

“... frontline public health workers who are **trusted members of and/or have an unusually close understanding of the community they serve**. This trusting relationship enables CHWs 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.

CHWs also build 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.”

CHWs May Work Under Many Job Titles



Community Health Educator

Outreach Educator

Outreach Worker

Enrollment Worker

Health Advocate

Peer Advocate

Peer Leader

Street Worker

Youth Outreach Worker

Family Advocate

Family Planning Counselor

Family Support Worker

Doula

Patient Navigator

Promotor de Salud

Community Health

Representative

CHW Work in Multiple Settings

- Ryan White HIV/AIDS program clinics
- Community health centers
- Hospitals
- Substance use treatment providers
- State and municipal health departments
- Community based organizations
- Public housing authorities
- Public safety



CHWs Address Diverse Health Issues

- **Infectious disease**
- **Chronic disease**
- **IPV, Assault, Youth violence**
- **Maternal & Child health**
- **Nutrition services**
- **Tobacco control**
- **Lead Poisoning prevention**
- **Early detection/intervention**

Distinctive Capabilities of CHWs

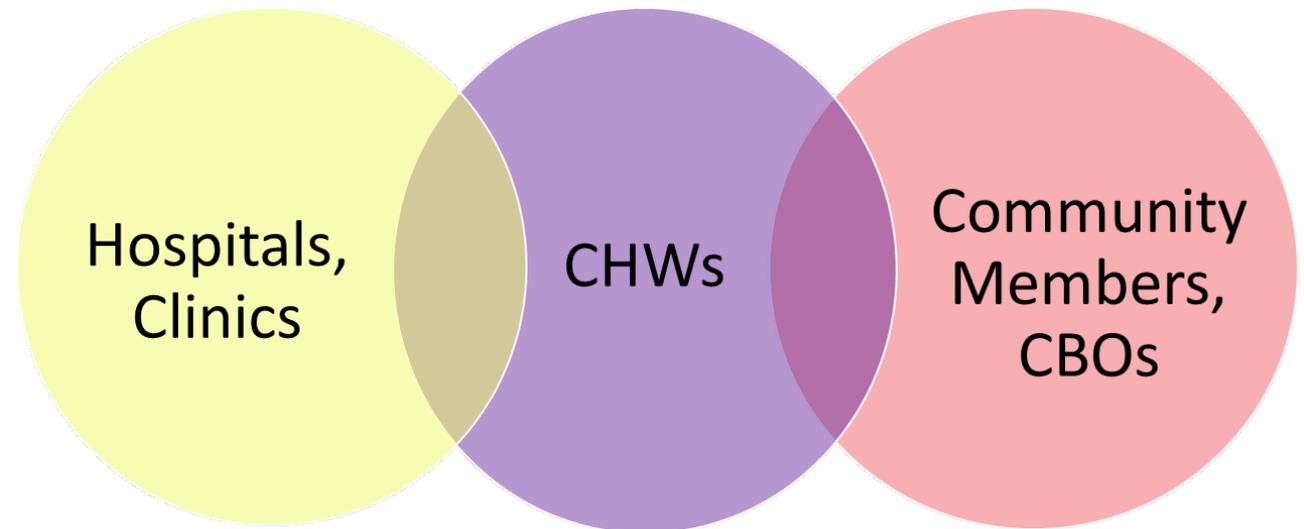
- Establish close relationships with patients based on shared life experience and unique community knowledge.
- Build trust: overcoming power distinctions and mistrust of institutions.
- Foster candid and continuous communication.

CHW Roles: *CHW Core Consensus (C3) Project*

1. Cultural Mediation Among Individuals, Communities, and Health and Social Service Systems
2. Providing Culturally Appropriate Health Education and Information
3. Care Coordination, Case Management, and System Navigation
4. Providing Coaching and Social Support
5. Advocating for Individuals and Communities
6. Building Individual and Community Capacity
7. Providing Direct Service
8. Implementing Individual and Community Assessments
9. Conducting Outreach
10. Participating in Evaluation and Research

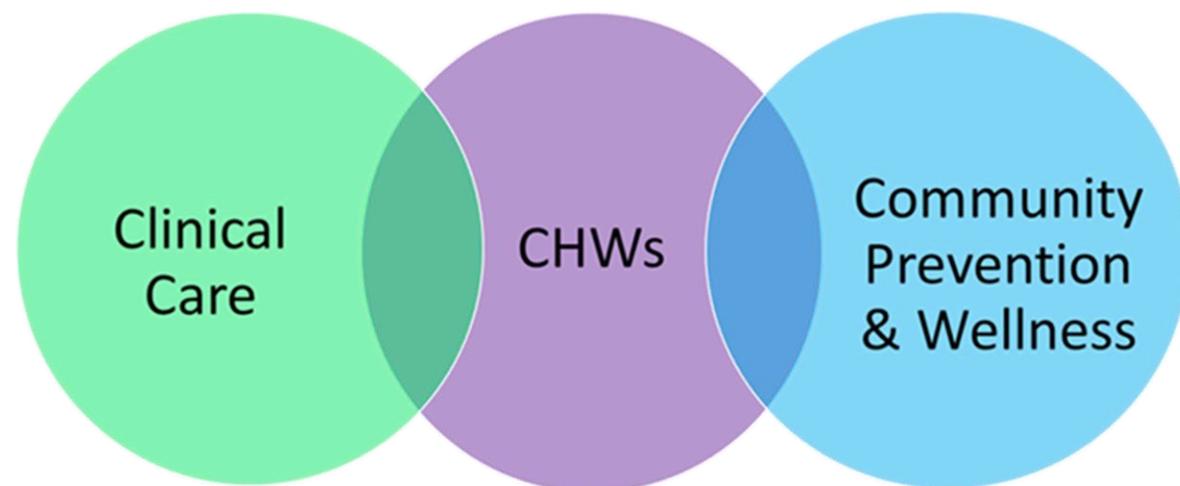
CHWs Bridge Health Providers and Communities

- Spend more time with individuals/family in home, community or clinical settings.
- CHWs possess the “Three C’s” of community:
 - Connectedness
 - Credibility
 - Commitment



CHWs bridge health care and public health

- Address Social Determinants of Health (SDOH)
 - Assist patients/families in dealing with upstream, non-medical issues (e.g., “health related service needs”)
 - For example, issues that are barriers to retention in care and medication adherence
 - Help clinicians understand “whole picture” of patients’ lives (SDOH expert on team)
 - Strengthen community partnerships to
 - Address macro issues
 - Bring additional resources into the HIV care continuum

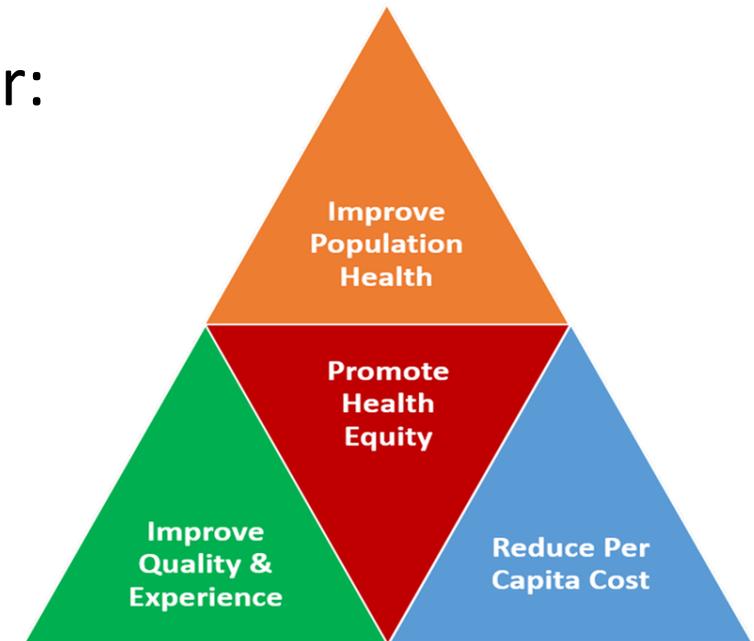


CHWs Promote Health Equity

Core values based in equality, justice, empathy

Improve health outcomes & reduce disparities for:

- Racially and ethnically diverse patients/clients
- Patients with high cost, complex conditions including HIV/AIDS
- Linguistic minorities
- Low-income communities
- Rural communities



CHWs Increase Access to:

- Health care coverage
- Primary care, including HIV primary and specialty care
- Preventive education, screenings, and treatment, including immunizations
- Mental health/behavioral health services
- Community/Social services
- The HIV care continuum



CHWs Improve Quality of Health Care Services

- Improve chronic disease management and prevention, e.g., diabetes, asthma, high blood pressure, nutrition
- Help improve outcomes of primary care teams
 - Care coordination– To maintain communication among several providers
 - Rx adherence– To answer patient questions and provide education
 - Retention in care– To quickly address missed appointments; minimize gaps
 - Care plan utilization– Can help patients navigate system & access needed treatment
 - Patient self-management– To help patients follow their own self-care goals
- Improve patient health literacy
- Strengthen culturally competent provider practices (organizational effectiveness)

CHWs Help Contain Costs

- Asthma
- Birth outcomes
- Cancer screenings/early detection
- Cardio-vascular disease
- Diabetes
- ER utilization
- Fewer Hospital readmission
- Better Immunization rates
- Medication/Treatment adherence
- Super-utilizers



Return on Investment (ROI) can be dramatic – net 3:1 or more

Source: Rush, C.H. (2012). Return on Investment from Employment of Community Health Workers. *J Ambulatory Care Manage*, 35(2): 133-137.

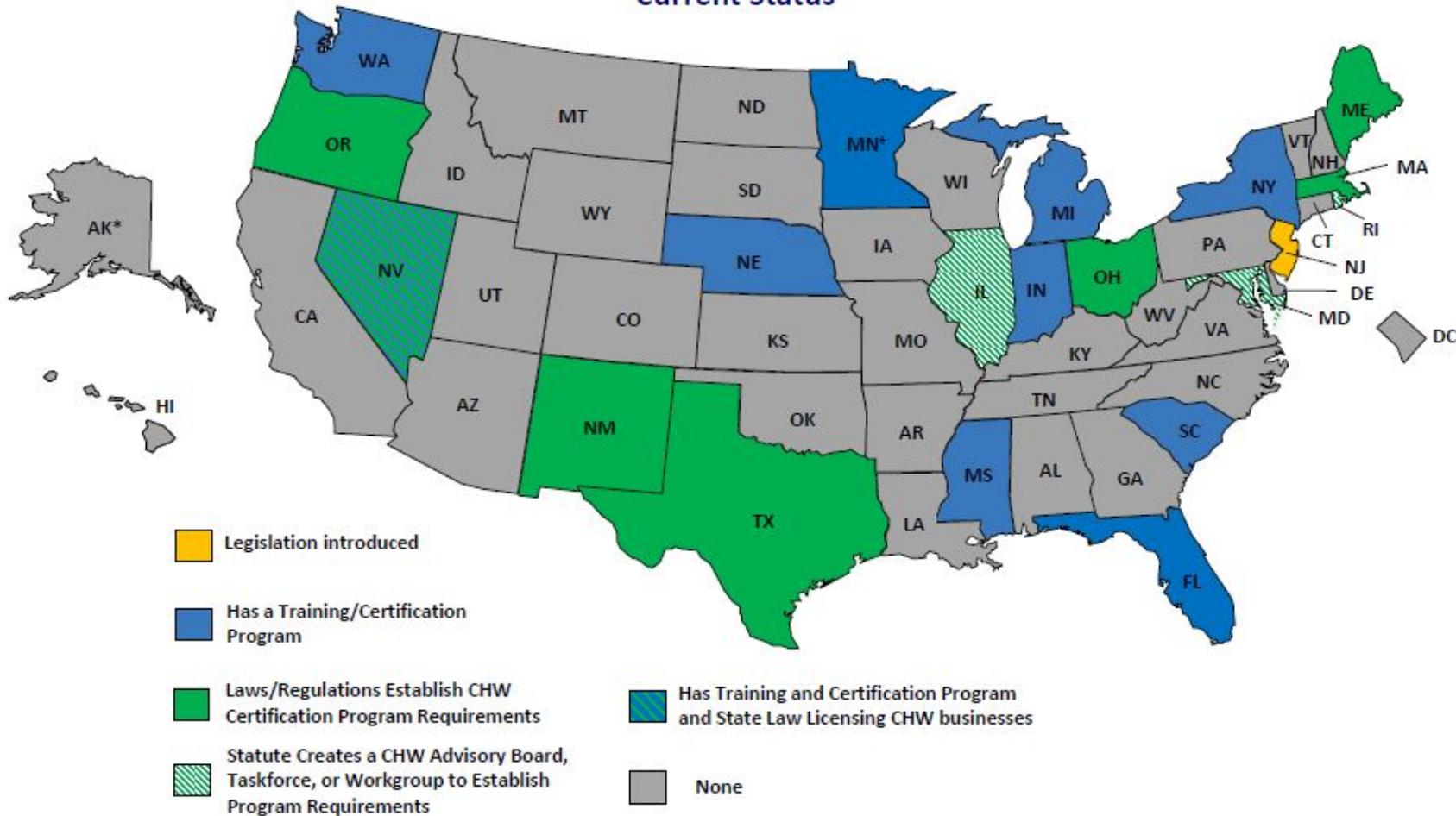
CHWs: An Emerging Profession

- National workforce definition
 - HRSA workforce study (2007)
 - Uniform Claim Committee provider code (2007)
 - Dept. of Labor Standard Occupational Classification (21-1094, eff. 2010)
- Cited in list of “primary care professionals” (§ 5101)
- CMS preventive services ruling (2013)
- AMA House of Delegates 2015 report describes CHWs as a “profession”



Community Health Workers (CHWs) Training/Certification Standards

Current Status



*AK does not have a state-run CHW training program, but statutorily provides community health aide grants for third-parties to train community health aides.

+MN also allows Medicaid payments for certified CHW services

Last updated: 1/17/2017

Community Health Workers in the HIV care team

Jodi Davich

HIV Health Service Center, Multnomah County Health
Department, Portland Oregon

Multnomah County Health Department's History with CHWs

- MCHD is located in Portland, Oregon
- CHWs widely used in a variety of settings for over 25 years
- Serving a diverse group of communities



CHWs at MCHD

- The roles of CHWs were initially very informal
- Job titles varied for field staff doing what now falls under the umbrella of CHWs
- In the late 1990's, MCHD began to develop a comprehensive CHW program
- **In 2000, the Health Department established the Community Capacitation Center (CCC) as a hub for CHW activity**



MCHD Community Capacitation Center

- Culturally specific health promotion
- Teaching popular education
- Conducting community-based participatory research (CBPR)
- Providing training to CHWs and others that meet continuing education requirements



Multnomah County HIV Clinic: A Little Context...

- HIV Clinic opened in 1990 as a Ryan White Part C grant recipient.
 - The clinic also received RWHAP Parts A, B and D funding
- Certified as a Patient Centered Medical Home (PCMH) in 2012
- Provides patient centered, team based primary and HIV specialty medical care with a focus on trauma informed care
- Serves over 1450 PLWH each year
- Integrates behavioral health into its service delivery model



Why MCHD's Ryan White Clinic Needed CHWs

LaMar's Profile

- Untreated AIDS, syphilis, bipolar disorder, schizophrenia
- **Erratic engagement in care** limited to crisis situations
- Chronic Homelessness
- Estranged from family
- History of poly-substance misuse
- Long history of Methamphetamine +-misuse
- Untreated mental illness
- No income, uninsured
- **Low CD4 Count**
- **High Viral Load**
- Outstanding arrest warrants



How the Initial CHW Program was Structured & Funded



- Started as a 5 year Special Project of National Significance (SPNS) project
- Integrated into a well established medical home model
- Built on CHW, PCMH and Critical Time Intervention models
- **Designed to address stages of the HIV Care Continuum**

Criteria for getting CHW services

CHW PROGRAM	ELIGIBILITY	DURATION
INTENSIVE LONG TERM ASSISTANCE	<ul style="list-style-type: none"> • Homeless or at risk of homelessness • History of mental health and/or drug & alcohol abuse • Unsuppressed HIV viral load • Poor engagement in care, out of care, or newly diagnosed • Needs assistance to connect with medical care/ critical services 	Determined on an individual basis—usually 9 – 12 months
ONE TIME SHORT TERM ASSISTANCE	<ul style="list-style-type: none"> • Needs assistance attending a specialty appointment • Needs other specific short term service (clear beginning/end) 	1-2 meetings with navigator

CHWs & Clients Navigate the Path to Viral Suppression

HIV CARE CONTINUUM:

The series of steps a person with HIV takes from initial diagnosis through their successful treatment with HIV medication



CHW Role: Engaging & Retaining Persons in Care



Patients who do not engage in care within 3 months, take an average of 22 months to get into care (CDC Medical Monitoring Project study)

- Establish rapport with clients
- Facilitate relationship building between the patient and their medical team
- Advocate for clients
- Work with the client to address barriers to care
- Access needed services



CHW Role: Engaging & Retaining Persons in Care



- Attend medical team huddles and semi-monthly case consult meetings with the provider team staff.
- Accompany clients to appointments to facilitate access to medical care, substance abuse treatment, mental health services, housing and other needed services.
- Work collaboratively with medical case managers, housing case managers, and other service providers to develop individual client goal plans and provide intensive support to clients in carrying out their goal plan.

CHW's Role in Medication Adherence & Viral Suppression

- Can meet patients where they are at—literally.
- Help patients to
 - Learn about HIV and ART therapy
 - Fill and refill prescriptions
 - Store medications
 - Develop a simple routine for taking meds
 - Get and interpret lab results

Since integrating CHWs into the County HIV medical team, viral suppression for all clients increased from 79% to 87%!



CHWs Use Stages of Change & Motivational Interviewing Strategies to Promote Viral Suppression

- Educate on risks vs benefits and positive outcomes related to change.
- Identify barriers and misconceptions.
- Address concerns Identify support systems.
- Develop realistic goals and timeline for change.
- Provide encouragement and support.



Who are Patient Navigators?



Other Things to Think About

- Start small.
- Hiring your CHWs.
- Supervisory and management staff need to be readily available.
- The navigation process is not linear.
- You will see your CHWs' patients more frequently.

Some Other Things to Think About

- Integrate Trauma Informed Care principles.
- Collect and address feedback about CHW services from staff and clients.
- Consider sustainability.
- Don't reinvent the wheel.



CHW Role in the HIV Care Continuum

CHW role (C3)	HIV Care Continuum
Conduct Outreach	Support Linkage & Engagement in Care: <ul style="list-style-type: none"> • Identify, test & link newly diagnosed individual to HIV care • Find PLWH who are out of care & build relationship
Care Coordination, Case Management, System Navigation	Support Linkage & Engagement in Care: <ul style="list-style-type: none"> • Make referrals to health specialists or mental health services • Appointment reminders • Accompany to medical appts
Providing Coaching & Social support	Support Adherence to Treatment & Achieve Viral Suppression: <ul style="list-style-type: none"> • Educate about HIV treatment • Obtain medications • Address side effects • Understand labs
Implementation of Community & Individual Needs Assessment	Support Retention in Care: <ul style="list-style-type: none"> • Collaborate with HIV medical case manager to develop a care plan to address patient goals

Summary

- ✓ CHWs are unique members of the health care workforce bridging the community & health care system

CHWs can:

- ✓ Increase access to care
 - ✓ Improve the quality of services
 - ✓ Reduce health disparities
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- ✓ In the HIV care team, support patient linkage, retention, adherence & viral suppression

Questions?

Instructions for submitting questions will be added here

For more information:

Boston University School of Public Health/Center for Advancing Health Policy & Practice

- <http://cahpp.org/project/chw>

Association of State and Territorial Health Officials

- <http://www.astho.org/Search.aspx?s=Community%20Health%20Workers>

Mass. DPH Office of CHWs

- <http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/prevention-and-wellness/comm-health-wkrs>

Multnomah County Health Department

- HIV Health Service Center: <https://multco.us/health/hiv-health-services-center>
- Community Capacitation Center: <https://multco.us/health/public-health-practice/community-capacitation-center>

CHW Central

- <http://www.chwcentral.org/>

Survey

Link to evaluation will be added here:



THANK YOU!

CONTACT US FOR ADDITIONAL INFORMATION OR QUESTIONS



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