NORTH CAROLINA AHEC PRACTICE SUPPORT

Example CHW Program Operations Guide

The purpose of this guide is to describe standard work, performance and supervision expectations for Community Health Workers working as part of [Name of Healthcare Facility] team.

Patient Population: People with chronic diseases like diabetes, high blood pressure, tobacco use, and/or unhealthy weight.

Setting: Services are provided virtually (telephone or telehealth) and in-person in the community, the person's home and/or in the clinic.

CHW Caseloads:

- ***CHWs focusing on clinic-based setting***: Up to 25-30 clients at one time with a goal of serving 50-60 clients per year. Balancing caseload acuity levels is crucial to CHW success and capacity. At any one time, caseloads should include no more than 5 - 6 clients (20%) with a high acuity level. Time period for CHW services in this case is, on average, 6 months.
- ***CHWs focusing on transitions of care***: Up to 25-35 clients at one time with a goal of serving 75-100 clients per year. At any one time, caseloads should include no more than 12 – 18 clients (50%) with a high acuity level. Time period for CHW services in this case is, on average, 3 months.

See below criteria for acuity levels:

Acuity Level	Utilization Criteria (last 6 months)	Clinical Criteria	Subjective Criteria
High	3 or > ED visits 1 or > readmissions for any reason 1 or > hospital admission for chronic condition	1 unstable behavioral health condition 2 or > stable behavioral health condition	Experiences complications from chronic conditions and/or complex25-SDOH gaps (unhoused OR > 3 additional gaps)

		3 or > active chronic conditions 2 or > clinical indictor of uncontrolled chronic condition (e.g., BP > 140/90, A1C > 9)	
Moderate	1 ED visit related to chronic condition 1 hospital admission for any reason.	1 stable behavioral health condition < 3 active chronic conditions History of cancer 1 or > clinical indictor of uncontrolled chronic condition (e.g., BP > 140/90, A1C > 9)	Uncontrolled chronic conditions without complications and/or stable chronic conditions 2-3 SDOH gaps and housed
Low	No ED visits or hospital admissions	No behavioral health or chronic health conditions	102 SDOH gaps and housed

Adapted from: Dom Dera J. AAFP Risk Stratification Algorithm. American Academy of Family Physicians. 2019. Available at: https://www.aafp.org/fpm/2019/0500/fpm20190500p21-rt1.pdf Accessed: November 30, 2021.

CHW Service Duration: Each client will be assessed for acuity level, progress on goals, and eligibility for continued CHW services every 3 months. This provides an opportunity to adjust the care plan and consider additional resources or strategies to support improvement of health and wellness of the individual. As needed, the care team can decide to continue CHW services beyond the pre-determined average time for CHW services outlined below.

- Clinic-based CHW Services – 6 months
- Transition of Care CHW Services – 3 months

It is appropriate for clients supported in transitions of care to transfer over to clinic-based setting services, which would mean total time of services would be, on average 9 months.

Standard CHW Services: CHWs working on the [Name of Healthcare Facility] team focus on ensuring clients:

- Access primary and preventive care services effectively
- Prevent and/or reduce use of urgent care and emergency department services for non-urgent reasons
- Prevent and/or reduce hospitalizations
- Experience high quality, culturally appropriate care
- Reach beyond the clinic walls to identify and address systemic and social drivers of health that are the root causes of uncontrolled chronic disease
- Perform and document assessments used in identifying care needs by the [Name of Healthcare Facility] team

Three phases of services include 1) Establishing Goals and Action Plans, 2) Providing Active Capacity Building Support, and 3) Transitioning into Independence.

- ***Establishing Goals and Action Plans*** - Working with clients, providers and other care team members to establish concrete and achievable long-term goals. Recommended to keep number of goals a client is working on at anyone time to 1-2. CHW's will also help client develop specific short-term goals that will help clients build confidence, knowledge, skills and capacity to achieve their long-term goals. For each short-term goal, CHWs will be responsible for supporting the client in developing and implementing a clear action plan, including assessing for level of readiness and anticipated barriers and challenges that the CHW can help the client address.

  Example:

  - Long-Term Goal - "I'd like to lose 20 lbs"

    NOTE: if client says that they would like to lose 100 lbs in 6 months, the CHW help client identify a realistic goal that can lead to

increased confidence and capacity in the client to continue the work towards a longer-term goal of losing 100 lbs

- Short-Term Goal - "I'd like to cut out sugar drinks in my diet"
- Action Plan – 1st week: replace 1-2 sodas a day with water; 2nd week: increase the # of sodas a day replaced with water: continue to increase the # until all sodas and sugar beverages are replaced with water and/or or an equivalent.

- Next Short-Term Goal - "I'd like to increase my physical activity"
- Action Plan – 1st week: wear a pedometer and track # of steps per day; 2nd week: add 500 steps/day; 3rd week: add 1,000 steps/day; and so forth.

- ***Providing Active Capacity Building Support*** - Involves coaching, supporting, and navigating to social and medical resources in order to help clients achieve their goals. Capacity building is provided through building trust and caring relationship; providing emotional support; sharing culturally appropriate health information; demonstrating new skills (e.g., self BP measurement and recording results on a log, cooking); building confidence through accompanying clients on clinical visits and in activities to establish new behaviors (e.g., grocery store shopping, exercise, completing paperwork for enrolling in services); facilitating connection to resources (e.g., ensuring client has access to prescribed medications, dropping paperwork off at social services, using NCCARE360); and using behavior change tools to support increasing confidence and readiness to change.

- ***Transitioning into Independence*** - Intentionally plan with patient to transition to independence and sustain the progress they have made for the long-term. This could include transitioning clients into an internal or external support group, access support from family and friends, and effectively using healthcare resources. This transition plan may include backing off on the frequency of client

contact and ensuring client knows how to access CHW support in future as needed.

Measures of Success:

- CHWs provide care to 50 patients per year or 75 if providing transitions of care services only.
- Follow up on new referrals within 2 business days of receipt.
- Present for hospital discharge plan review and transition to home or facility.
- Follow up with individuals discharged from facility within 24 hours (high acuity) and 48 hours (moderate acuity).
- People discharged from hospital receive their discharge medications.
- Support minimum goal for weekly contacts with active caseload.
- Decreased no show appointments.
- Increased and appropriate use of primary care (e.g., people with chronic conditions seen every 3 months, people seen within 14 days of discharge from facility)
- Reduction in ED.
- Reduction in hospitalization for ambulatory sensitive conditions and 30-day re-hospitalization for any reason.
- Improved patient-provider communication.
- Improved service experience.
- High level of satisfaction with CHW services – would recommend to family and friends.
- Proportion of CHW clients who have reached short-term and long-term goals.
- Client encounters documented in EHR within 72 hours of completion of the contact.
- Proportion of CHW clients who have maintained or improved clinical indicators for chronic disease.
    - % of patients screened for BMI and % of patients with out of range BMI who have a documented follow up plan.
    - % of patients screened for tobacco use and % of active tobacco users who receive cessation intervention.

- % of patients with hypertension with most recent BP < 140/90.
- % of patients with Diabetes with most recent A1C > 9%.

CHW Standard Work:

Daily Work

- Check EHR inbox for new referrals.
- Check calendar in planner for who is due for follow up
- Look at open cases in caseload registry - check in on notes, review goals
- Make follow up contact - phone call or in person
- Address follow up tasks.
- Document care given.
- Use NCCARE360 to generate referrals, as needed, and/or connect clients with resources using other avenues.

Weekly Work

- Attend 1-2 community outreach events
- Check on NCCARE360 referrals made and address any rejections or closed cases not resolved
- Attend weekly 1:1 CHW Supervision meeting
- Review and ensure EHR charting for prior week is up to date.

Monthly

- Attend CHW Program Team meeting
- Attend CHW Peer Learning meeting
- Prepare monthly report of activities for CHW Supervisor

Twice Monthly

- Prepare for and attend Clinical Case Consult meeting with physician, CHWs, CHW Supervisor, and other clinical team members (LCSW, RN, Pharmacist)
- Complete 1 hour of training (online module or presentation, attend presentation, read article/book, etc)

As Needed

- Send Patient or Direct Messages to Providers in EHR
- Contact Providers by Phone
- Pick up resources for clients e.g., pick up Ensure at MHP and delivery, make food box deliveries, pick up medication from pharmacy
- Attend clinic appointments with clients
- Attend Home Based Primary Care (HBPC) Team meeting

1. New Provider Referrals:
    a. Reach out to new clients the same day or next day to make an appointment and do an initial appointment. In the case that you are not able to reach the client by phone, make arrangements for a home visit within a 1-2 wk time period.
        i. As needed, reach out to providers for more information about the referral.
        ii. Send a message to the referring provider about the plan for the initial visit.
    b. At initial appointment:
        i. Introduce the program
        ii. Establish goal for work together (may carry over until subsequent visits, as needed, based on level of connection/trust established)
            1. Review goals PCP is recommending
            2. Identifying goals important to them
            3. Assessing readiness to make changes/address goals
        iii. SDOH screening to identify needs that CHW can start addressing (may carry over until subsequent visits, as needed, based on level of connection/trust established)
        iv. Complete medication review – record names, doses, and timing of medications patient is taking.
        v. Assess client's openness to working with you - focus on building relationship
        vi. Assess client capacity and preference for CHW support, e.g., would they prefer to follow up on information provided by CHW or have

more support from CHW in making connections, providing resources

vii. Set up a plan for next connection AND attending upcoming provider visit - by telehealth or in person

c. Document visit
d. Send message to provider with an update on the result of the initial contact
e. Within 1 week of the initial visit:
    i. Connect in person or by phone to:
        1. Share resources for/engage them in achieving goals
        2. Share resources/address medication issues/needs
        3. Share resources/connect with social/community resources to address SDOH needs

2. <u>Follow Up Contact:</u>
    f. Reach out to clients by phone or in person
        i. Assess for SDOH needs at the moment - short check in
        ii. Ask open ended questions:
            1. How are you doing with your wellbeing?
            2. How are you doing with your goals?
            3. How can I support you?
        ii. Give them the floor and listen so they can express their needs - let them guide the conversation
        iii. Assess if they are experiencing any barriers to achieving the goals they set
            1. If so, discuss how to best address them - brainstorm ideas with client IF they are not clear themselves
        iv. Respond as appropriate: for example, address needs they identify, support plans to overcome barriers to achieving goals, etc.
3. <u>Post Contact Work:</u>
    g. Ensure EHR documentation is up to date - complete all documentation by the end of the week.
    h. Investigate resources for client needs.

i. Communicate with providers and other clinic staff as needed, including patient messages, phone calls/text messages, scheduling, triage nurses, and monthly CHW summary note.
j. Plan for follow up visits, e.g., create a list of questions, pull together resources, etc.

4. Closing a Case:
    a. Conditions under which to close a case:
        i. If client has met goals and demonstrates capacity to engage in and advance their health, including client assessment of their confidence to be on their own
        ii. If client decides they no longer want the service
        iii. If client demonstrates a low level of readiness for achieving goals after a 3-month period of CHW engagement
    b. Closure process: as needed and every 3 months
        i. Evaluate need for continued services
            1. Status of achieving goals
            2. Level of readiness to achieve goals
            3. Level of engagement with CHW services, e.g., not taking CHW calls
            4. Level of confidence in being on their own
        ii. If the decision is to continue services, make a note of this in the in the EHR.
            1. As appropriate, adjust and/or set new goals.
        iii. If the decision is to close the case, make a note of this in EHR, change the status of the client to inactive, and inactivate the CHW diagnosis code on the problem list.
        iv. Clients who have been inactivated may become active again based on their and/or the provider request.

CHW Supervision:

1. Each CHW will meet 1:1 with CHW Supervisor weekly to address:
    a. Overall experience of managing current caseload
    b. Provide support and problem-solving partnership related to any challenge and barriers

c. Identify program improvement needs
d. Provide accountability for maintaining program service standards, e.g., response times, documentation, scope of practice, etc.
e. Identify professional development and training needs

2. Quarterly, CHW Supervisor and CHW will review together a report with the following information as a way to identify strengths and ongoing development needs:
    k. Client caseload
    l. Performance on goals
    m. Timeliness of follow up on new referrals, timeliness and completeness of documentation, NCCARE360 follow up, and 3-month case status review.
    n. Client and provider satisfaction survey results
    o. Professional development/training completed by the CHW over the past quarter, barriers to professional development and training and identify training needs/interests for the next quarter.
    p. As needed, a plan for additional training and/or support will be developed to ensure CHW has capacity to fulfill their role and deliver high quality care.

<u>Training and Professional Development:</u>

- Foundational CHW Curriculum training at Community College within the first year of employment.
- Complete all required employee training.
- Complete required CHW specialty training.
- Monthly NC AHEC CHW ECHO.
- Annual competency assessment.