Integrating Community Health Workers into your HCH

National Health Care for the Homeless Regional Training
Friday 9/23 8:30am Louisville, KY
Speakers

Julia Dobbins
NHCHC
Nashville, Tennessee

Sue Moore
Charles Drew Health Center
Omaha, Nebraska

Agenda

• CMS-CHW Project
• Hiring & Supervising a CHW
• Training a CHW
• CHW Integration & Support
• Funding & Sustainability
• Online Resource Guide for HCH
• Question, Answer, Discussion
Community Health Workers and HCH: A Partnership to Promote Primary Care

• Funded through the Centers for Medicare and Medicaid Innovation Center
• July 2012 – Project Begins
• February 2013 – Client Enrollment begins
• August 2014 – Client Enrollment ends
• June 2015 – Final data submitted
• September 2015 – Project ends
• March 2016 – Final reports submitted
CMS-CHW Project Snapshot

A total of 355 individuals were enrolled and completed the intervention which included establishing a medical home at the participating HCH sites.

There was a significant difference in the SF12 scores at the beginning of the intervention and the end. These results suggest that participating in the intervention was related to improved physical and mental health – even for individuals who did not complete the intervention.

There was a significant difference in the QOL scores at intervention start and last QOL scores reported. These results suggest individuals participating in the intervention had an improved sense of well-being in the areas of physical health, relationships, social and community participation, personal development, and recreation.
CMS-CHW Project Snapshot

- Thirty-two percent of participants met their health care plan goal.

- On average, hospital costs decreased from pre to post-intervention, insurance payments and uncompensated care costs also decreased.

- Inpatients days increased; specifically hospital ED visits increased. Results showed the decrease in costs and increase in inpatient days were both statistically significant. When examining just the participants who completed the intervention (met their health plan goal), hospital ED visits actually decreased significantly from pre to post-intervention.
Lessons Learned

What didn’t work?

• Checks and balances
• CHWs in the ED
  • Caseload of 25
• Paperwork overload
• Overworked supervisors
  • Boundary concerns
What did work?

HCH
+
CHWs=
Mission: Charles Drew Health Center, Inc. is dedicated to providing quality, comprehensive health care in a manner that acknowledges the dignity of the individual, the strength of the family, and the supportive network of the community.
Charles Drew Health Center, Inc.

- Located in Omaha, Nebraska (pop. 409k)
- Established in 1983
- Federally Qualified Health Center (FQHC)
- Health Resources and Services Administration (HRSA)
  - Bureau of Primary Health Care Uniform Data System (UDS) Report
- Joint Commission Accreditation
- 14 locations in addition to a mobile dental van
  - 12 medical service sites
    - Main location – houses primary medical, dental, behavioral health and administrative services
    - 2 Health Care for the Homeless
    - 4 School-Based Health Centers
    - 4 Public Housing Health Clinics
    - Clinic located near elderly housing
  - 2 professional locations
    - Call Center/Outreach/Fitness Center
    - Omaha Healthy Start/Fathers for a Lifetime
Charles Drew Health Center, Inc.

- FY 2015-16 FY CDHC served 10,202 unduplicated patients
  o Homeless 2,426 unduplicated (107 children)
- FY 2015-16 CDHC facilitated 37,308 patient visits
  o Homeless 4,782 visits (18 and over)
- 89% of all patients were below 100% poverty level
  o 92% of homeless
- 59% of all patients were uninsured
  o 85% of homeless
- Patients by Race/Ethnicity
  o Black/African American 44% (Homeless 27%)
  o White 30% (Homeless 63%)
  o Asian 14% (Homeless < 1%)
  o Unreported/refused 8% (Homeless 4%)
  o American Indian, Native Hawaiian, Pacific Islander, more than one race each < 1% (Homeless < 1%)
- Patients served by a language other than English
  o 12% (Homeless < 1%)
CDHC Programs and Services

- Programs and Services:
  - Medical
  - Behavioral Health
  - Dental
  - Pharmacy
  - Interpreter services – 23 languages
    - 16% speak a language other than English
    - 23 languages
    - 53% Karen speaking
    - 8,122 encounters last FY
  - WIC
  - Healthy Families - Dietician
  - Omaha Healthy Start
  - Fathers for a Lifetime
Community Health Workers

- National Health Care for the Homeless Innovation Challenge Grant
  - Community Health Workers and HCH: A Partnership to Promote Primary Care, CMS Health Care Innovation Award
  - 3 years – July 1, 2012 to June 30, 2015
- Goal: to improve health outcomes and quality of care while decreasing high Medicare, Medicaid, and uncompensated care costs produced by misuse of Emergency Department services.
  - Individual Health Care Plan Goal for enrollees
- Funding for 2 CHW’s
  - 15 CHW’s for 10 HCH sites nationally
- Partnership w/hospitals
  - CHI
  - UNMC
- Caseload
  - Began with 25 annually per CHW
  - Rolling caseload of 8
- CHW post grant
Hiring & Supervising a CHW

Sue Carson Moore, MPA
Director of Homeless & Public Housing Health Services
CHW - Finding the Right Person

• Traits
  o Compassionate
  o Independent
  o Trustworthy
  o Flexible
  o Dependable
  o Responsible
  o Resourceful
• Experience
• Is it better if the CHW has been in the client’s shoes?
• Does being in recovery play a role?
• Outgoing vs. Introvert
Skills – Hard vs Soft

• Hard skills
  o Degree – yes or no?
  o Computer proficient
  o Communication

• Soft skills
  o Communication
  o Non-judgmental
  o Empathy
  o Patience
  o “Street-smart”
    • Recognize manipulation
  o Ability to empower
  o Problem-solver
Interviewing

- Resume – hard skills/stability
- Conversation – soft skills/personality traits
- Asking the right questions
- Knowledge of the homeless
  - Who?
  - How?
- Comfort level for population/work environment
- Scenarios – instincts
  - Examples
- Read between the lines
- Making the decision
  - The Right Fit?
Training the CHW

- Tracking System
  - Internal
  - External
- Role/Expectations
- Boundaries
- Safety
- Working with Your Team
- Shadowing
- Building Client Trust
- Working with Community Partners
- Identifying Community Resources
- NHCHC Training Modules
Community Partnerships

- Community Partners are Essential for Success
- Why?
  - Valuable Resources
  - Time/Expertise
  - It Takes a Village
- Who?
  - Shelters/Treatment Centers
  - Specialty Services – Medical/Mental Health
  - Homeless Review Team (HRT)
  - Street Outreach
  - SSI/SSDI Outreach, Access, and Recovery (SOAR)
  - Housing Partners
  - Metro Area Continuum of Care for the Homeless (MACCH)
  - Department of Health & Human Services
  - Department of Corrections
  - Funding Partners
Supervision

- Building Trust
- Shared Calendar
- Allowing Independence
- Confidence in CHW’s Ability
- Weekly Check-in
  - Review Caseload
  - Provide Guidance
- Listen, Listen, Listen
- Monthly Reporting
- Accessible
- Identifying Burn-Out/Compassion Fatigue
Caseload

• What is the Right Number?

• Identifying When Caseload Too Small
  o Blocks of time on CHW calendar open
  o CHW is in the office a lot
  o Minimal information on weekly/monthly caseload documentation

• Identifying When Caseload Too Big
  o CHW is unable to attend appointments or complete necessary paperwork for client
  o Clients are falling between the cracks
  o CHW struggling to complete reports on time
  o CHW is showing signs of burn-out

• Include CHW in decisions regarding size of caseload based on high-level need clients
Burn-Out/Compassion Fatigue

Signs and Symptoms
- Irritability
- Emotional dumping
- Increase in absences
- Decrease in work quality
- Loss of compassion for the population
- Avoidance of clients
- Poor time-management
- Frequent illness
- Insomnia

Causes
- Large caseload
- Secondary trauma
- Poor boundaries
- Poor time-management
- Clients with high-level needs
- Working harder than your clients
- Difficulty locating existing clients
- Staff conflict
- Client deaths
Support/Self-Care

- Communicate with supervisor
- Time off/mental health day
- Do something for yourself you enjoy
- Hobbies
- Self-reflection
- Spend time with friends or family
- Intentional choices to reduce stress
  - Exercise
  - Good nutrition
  - Meditation
- EAP
Integrating the CHW into the Organization
CHW Workplace Needs

• **Tools**
  - Laptop or iPad for ease while traveling
  - Cellular phone
  - Business cards/flyers

• **Provide Work Area**
  - Private space to meet with clients confidentially
  - Space to decompress

• **Transportation**
  - Personal vehicles to transport clients
  - Public transportation
  - Mileage reimbursement
CHW - Part of the Team

• Educate Departmental and Organizational Staff Regarding CHW’s Role
  o Understand what the CHW can do
  o Understand what the CHW can’t do
  o Become part of the “huddle”

• Medical/Mental Health Providers
  o Encourage Providers to utilize CHW’s to assist with high-needs clients
  o “Warm Hand Off” (WHO) process

• Coverage with Flexibility
  o Flexible start/end times
  o Breaks
  o On the go – traveling position
    • Pros and Cons
CHW’s Role in Care Coordination

• Internal to the organization
  o Personal care management plan
  o Health goals (with the assistance of the Provider)
  o Medical referrals – assistance with obtaining medical records
  o Assistance understanding/completing forms and paperwork
  o Transportation
  o Connection with Behavioral Health therapist/Dental services
  o SSI/SSDI – assist in application process
  o Medicaid/Medicare/SNAP – assist in application process, approvals reported to billing department
  o Internal referrals
    • Omaha Healthy Start
    • Fathers for a Lifetime
  o Data reporting for Productivity/UDS
  o Documentation in EHR system
  o Referrals to external community partners
Care Coordination - External

- **External to the organization**
  - Advocate for patient at medical and social services appointments
  - Hospitals
  - Shelters/Homeless Treatment Programs
  - SSI/SSDI
  - Medicaid/Medicare
  - Douglas County General Assistance
    - Complex medical needs
    - Housing needs
  - Housing agencies
  - Social Services agencies
  - Douglas County Corrections
  - Federal probation
  - Community Alliance – mental health services
  - Lasting Hope – mental health crisis services
How Can I Help the CHW be Successful?

- Include CHW in Departmental Monthly Meetings
  - Allow time for discussing successes as well as challenges
- Assure their Safety
  - Is CHW making safe choices?
- Develop and Nurture Community Partnerships
  - Essential for the CHW’s success
- CHW Participation in:
  - Trainings/webinars
  - External meetings with community partners
  - NHCHC Conference & Symposium
- Provide Regular Positive Feedback on Performance
- Recognize and Acknowledge Burn-out and Take Steps to Assist CHW’s in Coping
Street Outreach

- 3-5 days per week
- 2 teams
- Seek homeless under bridges, camps, cars, flying signs, etc…
- Law enforcement and business owner referrals
- Build rapport
- ViSpdat if needed
- Provide basic supplies – water, snacks, hygiene kits, cold weather supplies
- Schedule appointments to CDHC medical clinic
- Provide referrals for housing/shelter
- Basic first aid
- Crisis intervention
### Street Outreach

<table>
<thead>
<tr>
<th>Charles Drew Health Center CHW’s</th>
<th>Visiting Nurses Association (VNA)</th>
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<tbody>
<tr>
<td>Heartland Family Service</td>
<td>Salvation Army</td>
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<tr>
<td>Community Alliance</td>
<td>Together</td>
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<td>Lutheran Family Services</td>
<td>United Health Care</td>
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<tr>
<td>Nebraska AIDS Project (NAP)</td>
<td>Council Bluffs Police Department</td>
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<td>Veteran’s Administration (VA)</td>
<td>Mercy Care Hospital</td>
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Homeless Review Team (HRT)

- Meets weekly – led by Community Alliance
- MACCH driven – follows HUD guidelines
- Goal: to obtain housing for the chronically homeless
- Review list of most vulnerable, chronically homeless (ViSpdat)
- Coordinate case management services
- Discuss open housing referrals
- Determine which individuals meet eligibility for available housing
- Determine which agency will assist with housing referral
### Homeless Review Team (HRT)

- Charles Drew Health Center, Inc.
- Community Alliance (mental health services)
- Shelters/Homeless Treatment Agencies
- Veteran’s Administration (VA)
- Visiting Nurses Association (VNA)
- Together
- Heartland Family Service
- Lutheran Family Services
- Salvation Army

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<tr>
<th>Region Six</th>
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<tr>
<td>Catholic Charities</td>
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<td>Douglas County Corrections</td>
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<td>Douglas County Mental Health</td>
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<td>Douglas County General Assistance</td>
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<td>Nebraska AIDS project (NAP)</td>
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<td>Metro Area Continuum for the Care of the Homeless (MACCH)</td>
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</table>
Funding the CHW/Sustainability

- Funding
  - Grants
  - Government Funding i.e. HRSA
  - Hospitals
- Revenue
  - Medicaid/Medicare
  - Health Insurance
- Lack of funding/insurance
  - Now what?
- How to fund or justify the CHW’s position
  - Productivity
  - UDS reporting
  - Converting non-paying patients to paying patients
  - Moving patients out of homelessness
Reporting Data

• Productivity reports
  - Enrolled
  - Outreach

• UDS
  - Case Management
  - Outreach Touches

• Patient Financial Services
  - Number of new paying patients

• EHR system
  - Document encounters in EHR in case management or social work note
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<tr>
<th>Date Exit Date</th>
<th>DOB</th>
<th>SS#</th>
<th>Outreach Location</th>
<th>CDHC Patient (Y/N)</th>
<th>VISPDAT</th>
<th>SSI</th>
<th>SSDI</th>
<th>Medicaid</th>
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<th>Other Income</th>
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<th>Referral Type</th>
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<td>Completed ViSpdat and assisted client in filing SSI/SSDI application</td>
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<td>1/12/16</td>
<td>Transport to main clinic for chest x-ray</td>
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<td>1/20/16</td>
<td>Pt came to clinic crying. He was distraught over his homelessness and feeling stuck. I encouraged and helped him with behavioral health.</td>
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<td>1/26/16</td>
<td>Spoke with Andrew from SOAR to ask for suggestion to facilitate approval for SSI app. appointments on 2/10.</td>
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<td>Assisted with med refills</td>
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<td>2/8/16</td>
<td>Informed client of his financial approval for chest scans on Feb 23</td>
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<td>2/10/16</td>
<td>Took client to his SSI consultation doctor appointment</td>
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<td>2/22/16</td>
<td>Client was approved SSI on hold, need green card before payments start.</td>
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<td>3/1/16</td>
<td>Took client to Immigration for green card</td>
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<td>3/25/16</td>
<td>Unsuccessful in getting a copy of green card, so SSI is denying him for medical, but will give him some payment for 1 year. Need to reapply for green card.</td>
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<td>3/29/16</td>
<td>Attempted to reapply for green card, but could only get an appointment</td>
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<td>Spoke to client about obtaining a duplicate green card. Tried to call Andrew @SOAR and called Gary at Friends of our Neighbors - LM</td>
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<td>4/4/16</td>
<td>Spoke to Gary at Friends of our Neighbors, he sent green card to Jennilee. I emailed Jennilee, but have not gotten a response back yet.</td>
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<td>4/8/16</td>
<td>Continuing to try to contact Jennilee for green card.</td>
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<tr>
<td>4/8/16</td>
<td>Found green card at Jennilee’s office. Gave to client, he is so happy!!</td>
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<tr>
<td>4/11/16</td>
<td>Met with client to let him know we will go to SSI tomorrow to show green card and get SSI approval again.</td>
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<tr>
<td>4/14/16</td>
<td>Transported client to SSI office, presented ID, answered questions, left with approval. He will receive back-pay check next week and monthly checks on May 1.</td>
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<tr>
<td>4/19/16</td>
<td>Asked to apply for Medicaid, made appt for tomorrow am.</td>
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<tr>
<td>4/20/16</td>
<td>Applied for Medicaid</td>
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<tr>
<td>4/22/16</td>
<td>Took client to CA for SSI check, to bank to cash</td>
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<tr>
<td>4/26/16</td>
<td>Took client to bank to open account for direct deposit of SSDI</td>
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<tr>
<td>4/29/16</td>
<td>Medicaid approved as of 4/1/16</td>
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<tr>
<td>5/2/16</td>
<td>Rcvd mail from SSI, helped explain his benefits and when he will get them.</td>
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<tr>
<td>5/4/16</td>
<td>Andrew spoke to client regarding SSI finalization. Helped with his bank account and activating bank card.</td>
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<tr>
<td>5/6/16</td>
<td>Took pt to see ortho at Immanuel and pick up Rx. He has hip replacement scheduled for 6/27.</td>
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<tr>
<td>5/25/16</td>
<td>Discussed upcoming surgery, will transport to this appt. on June 27, 16 @ 10:00 am. Got disability award letter, purchased a car and insurance will try and get a reasonable accomodation for OHA Section &amp; Housing</td>
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</table>
# Sample Reports-Outreach

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient Name</th>
<th>Unique</th>
<th>Contact Location</th>
<th>Type of Contact</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/9/16</td>
<td>Terry</td>
<td>1SFH</td>
<td>In-person</td>
<td>Clt approached CHW about scheduling clinic appt for diabetes. CHW assisted clt with scheduling appt.</td>
<td></td>
</tr>
<tr>
<td>8/10/16</td>
<td>Christopher</td>
<td>1CFH</td>
<td>In-person</td>
<td>Clt approached CHW at clinic to get assistance with his prosthetic leg. Looked up Hanger Prosthetics and had client call to schedule appt. Attempted to Schedule Medicaid taxi, clt didn’t know Medicaid #, told clt to meet with DHSS staff at shelter.</td>
<td></td>
</tr>
<tr>
<td>8/10/16</td>
<td>&quot;Richard&quot;</td>
<td>118th &amp; Cass</td>
<td>In-person</td>
<td>Street outreach: CHW met clt to assess needs and inform of CDHC services.</td>
<td></td>
</tr>
<tr>
<td>8/11/16</td>
<td>Christopher</td>
<td>76th &amp; Cass</td>
<td>In-person</td>
<td>Street Outreach. Met with clt, completed VI-SPDAT and scheduled appt for clt with Holly on 8/15.</td>
<td></td>
</tr>
<tr>
<td>8/12/16</td>
<td>Jesse</td>
<td>1CFH</td>
<td>In-person</td>
<td>CHW met with client to confirm that client is in transition since being released from jail 6/21. Wrote Documentation of Homelessness</td>
<td></td>
</tr>
<tr>
<td>8/15/16</td>
<td>Ernesto</td>
<td>1ODM</td>
<td>In-person</td>
<td>Clt approached CHW asking about CHAP program; CHW explained the program and gave clt contact info.</td>
<td></td>
</tr>
<tr>
<td>8/18/16</td>
<td>Linny</td>
<td>160th &amp; Center</td>
<td>In-person</td>
<td>Street outreach: Clt is sleeping in her car. Completed VI-SPDAT. Informed clt of CDHC services.</td>
<td></td>
</tr>
<tr>
<td>8/18/16</td>
<td>Thomas</td>
<td>1SFH</td>
<td>Phone</td>
<td>Clt called CHW from campground in Sarpy Co. Clt is a veteran so CHW took information and left voicemail for Amber King, VA outreach worker.</td>
<td></td>
</tr>
<tr>
<td>8/19/16</td>
<td>Rich</td>
<td>1CFH</td>
<td>In-person</td>
<td>CHW met clt at CFH clinic. Clt said he’s been homeless for 8 years, is 62 yr., has health problems, and no benefits. CHW scheduled appt to meet on 8/22.</td>
<td></td>
</tr>
<tr>
<td>8/24/16</td>
<td>Zach</td>
<td>SFH</td>
<td>In-person</td>
<td>CHW met with clt and completed referrals to Community Alliance Outreach and SOAR.</td>
<td></td>
</tr>
<tr>
<td>8/24/16</td>
<td>Fred</td>
<td>1SFH</td>
<td>In-person</td>
<td>Clt approach CHW about getting an appt for a med bd. CHW explained process and showed clt where CFH clinic is.</td>
<td></td>
</tr>
<tr>
<td>8/25/16</td>
<td>Weather</td>
<td>116th &amp; Yates camp</td>
<td>In-person</td>
<td>Street outreach. CHW met clt and scheduled appt for clinic.</td>
<td></td>
</tr>
<tr>
<td>8/25/16</td>
<td>Fausto</td>
<td>116th &amp; Yates camp</td>
<td>In-person</td>
<td>Street outreach. CHW met clt and scheduled appt for clinic for blood pressure medication.</td>
<td></td>
</tr>
<tr>
<td>8/25/16</td>
<td>Kelvin</td>
<td>woods near MO River</td>
<td>In-person</td>
<td>Street outreach: CHW provided info on CDHC services</td>
<td></td>
</tr>
<tr>
<td>8/26/16</td>
<td>Jeff</td>
<td>1 UNMC</td>
<td>In-person</td>
<td>CHW went to UNMC to visit clt at Holly’s request. Clt in-patient, having heart surgery tomorrow. Completed VISPDAT to refer clt to HRT and to GA for Primary Health Care. Will check in again next week.</td>
<td></td>
</tr>
<tr>
<td>8/26/16</td>
<td>Robert</td>
<td>CUMC</td>
<td>In-person</td>
<td>Clt is hospitalized after being assaulted. CHW checked in with clt to make sure he follows up with SFHC upon discharge and told clt about SFH housing opportunity.</td>
<td></td>
</tr>
<tr>
<td>8/29/16</td>
<td>Charles</td>
<td>1 SFH</td>
<td>In-person</td>
<td>CHW met with clt to discuss options for medications that CDHC pharmacy doesn’t have and assisted with calling NAP.</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Outreach Goal</td>
<td># Outreach Touches</td>
<td>% of Outreach Goal</td>
<td>Case Mgmt Goal</td>
<td># Case Mgmt</td>
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<tr>
<td>May-16</td>
<td>20</td>
<td>21</td>
<td>105%</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Jun-16</td>
<td>30</td>
<td>46</td>
<td>153%</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Jul-16</td>
<td>50</td>
<td>57</td>
<td>114%</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Aug-16</td>
<td>30</td>
<td>43</td>
<td>143%</td>
<td>15</td>
<td>18</td>
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<tr>
<td>Sep-16</td>
<td>30</td>
<td>0%</td>
<td>0%</td>
<td>15</td>
<td>0%</td>
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<tr>
<td>Oct-16</td>
<td>30</td>
<td>0%</td>
<td>0%</td>
<td>15</td>
<td>0%</td>
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<tr>
<td>Nov-16</td>
<td>30</td>
<td>0%</td>
<td>0%</td>
<td>15</td>
<td>0%</td>
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<tr>
<td>Dec-16</td>
<td>30</td>
<td>0%</td>
<td>0%</td>
<td>15</td>
<td>0%</td>
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</tbody>
</table>

*May-Employee started 05/19/16
*June-CHW was on vacation for a week this month
Success Story

• Harvey – 61 yr old
  o Learning disabilities and is illiterate
  o Living at shelter for about 2 years
  o Referred to CHW by his medical provider at the CDHC Homeless Clinic
  o History of hospital work in laundry for 15 years, strained his back and was let go from his job
  o Lost his job and his apartment
  o Became homeless
  o Struggled to gain employment as he cannot read or use a computer
  o Goals were set with CHW to obtain income, housing and healthcare
  o With CHW assist – applied for SSI, took patient to all appts., read and assisted in completing paperwork
    • Process took approx. 4 months – client APPROVED!
  o CHW assisted with application for Medicaid – APPROVED!
  o CHW assisted w/housing applications – APPROVED! Moved in one month later.
  o Harvey has been living in his own apartment for about a year now and still comes to our clinic to ask for
    CHW’s assistance in the annual recertification for Medicaid health coverage. He calls us his angels.
Resource Guide

Development
- Lessons learned
- Interviews
- Literature
- CHWs in other fields

Priorities
- CHW & HCH
- CHW Roles & Responsibilities
- Hiring a CHW
- Training CHWs
- Supervision of CHWs
- CHW Integration & Support
INTEGRATING COMMUNITY HEALTH WORKERS INTO PRIMARY CARE PRACTICE: A RESOURCE GUIDE FOR HCH PROGRAMS

1. CHWs and HCH
2. CHW Roles and Responsibilities
3. Hiring CHWs
4. Training CHWs
5. Supervision of CHWs
6. CHW Integration and Support

"Being a CHW has made me a better person in a very real sense. I’m more patient, understanding, and friendly in general – maybe it’s just doing a job I love.” — Community Health Worker

Introduction

In June 2015, the National Health Care for the Homeless (HCH) Council completed a 3-year pilot project funded by the Center for Medicare & Medicaid Innovation (CMMI) through a Health Care Innovation Award (HCIA). The project aimed to connect individuals experiencing homelessness who were also high users of hospital services with Community Health Workers (CHWs) in order to increase utilization of primary care and reduce unnecessary utilization of emergency services.

CHWs were employed by and stationed at Health Care for the Homeless projects. Partnering hospitals referred high utilizers to CHWs on an individual basis or the HCH project notified CHWs when a high utilizer was in the clinic (based on a high utilizer list shared by a partnering hospital). Over the course of 3 years, CHWs enrolled 355 high utilizers into the project. This project not only demonstrated the significant impact CHWs can have on improving the health of high utilizers but also served as a catalyst for ongoing efforts to integrate CHWs into primary care settings.
Questions