

Community Health Worker Clinical Integration Toolkit

Incorporating CHWs into Care Teams and Clinical Processes: **Strategies**

MHP Salud

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About MHP Salud

MHP Salud is a national nonprofit organization with 40+ years of experience improving health and well-being in communities through community-based, person-centered Community Health Worker (CHW)/Promotor(a) de Salud programs.

Our Mission

We serve communities by embracing the strengths and experiences of individuals and families, engaging them to acheive health and well-being.

Our Vision

Our populations and their communities will enjoy health without barriers.

Acknowledgements

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Introduction

With a long history of successfully and effectively addressing health-related needs, Community Health Workers (CHWs) can fill the gaps in services that many health care organizations experience in reaching hard-to-reach populations. For instance, six published studies on CHW interventions on the prevention and management of diabetes have shown significant positive outcomes, including changes in HbA1c levels and improved self-reports of dietary changes. In addition, six studies of CHW interventions focused on cervical cancer prevention reported positive outcomes, including a significant increase in the number of patients receiving a Pap smear and a larger change in the number of patients ever having a Pap smear.1 These outcomes support the effectiveness of CHWs in prevention and disease management within Care Teams.

The purpose of this toolkit is to illustrate different strategies for incorporating CHWs within Care Teams. Additionally, it will provide real-life case studies from various health entities throughout the nation to support the success of the implementation of these strategies.

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Making the Case for Community Health Workers Toolkit-Overview

Making the Case for Community Health Workers is a toolkit that provides a solid foundation of who CHWs work with, what they do, and how valuable CHWs are to organizations and the communities they serve. CHWs serve a function on a Care Team that is not available through other team members or sources.

Their work not only improves the individual practice of a clinician, but also improves the way a team works together and the way a healthcare organization serves the community; this leads to an overall improvement in the community's health. It is advised that Clinical Teams review this information as it explores the impact CHWs have on health outcomes, service delivery, cost of care, and cost-effectiveness.

Roles of CHWs in Clinical Settings

The incorporation of CHWs in clinical settings has the potential to develop proactive care teams that can work together to improve patient outcomes.[1]

Some examples of CHW roles in clinical settings are to:

- Create connections between populations and healthcare systems.[2]
- Support person-centered care among healthcare professionals serving different populations.[3]
- Advocate for individuals and communities to receive appropriate services.[2]
- Provide person-centered health education on topics related to chronic disease prevention and healthy living.[3]
- Support individualized goal-setting, implementation of self-management plans, and long-term self-management support.[3]
- Provide informal counseling, health screenings, and referrals.[2]
- Help patients navigate health care and social systems (e.g. provide assistance with enrollment, appointments, referrals, transportation to and from appointments, and interpreter services at appointments).[3]
- Educate health system providers and stakeholders about community health needs.[2]
- Collect data and relay information to policymakers to inform policy change and development.[2]

Overall, CHWs serve as integral members of the Health Care System by supporting the Care Team's patient-centered goals and interventions.[3] Every profession within an organization has a defined scope of work, and it is important for all professions, including CHWs, to understand the parameters and expectations of their position. Having a clear understanding of each team member's contribution ensures patients are served to the best of the organization's ability.

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3. Case Management Society of America (2017). Community Health Workers: A Key Role on the Collaborative Care Team. Available at: https://www.cmsatoday.com/2017/06/20/community-health-workers-a-key-role-on-the-collaborative-care-team/ (Accessed August 8, 2018).

Principles for Integrating CHWs

- Promote respect for CHWs among team members to strengthen clinical outcomes.
- Educate all members of the clinic on who CHWs are, what they do, and how they are an integral part of the team.
- Incorporate CHW core competencies into program design, including advocacy and community-based work on social stressors.
- Involve CHWs in integration planning and implementation at all system levels.
- Provide opportunities for CHWs to share their unique understanding, perspectives, and value of the community with the organization and team.
- Include CHWs in regular meetings with the full team (and more frequently with supervisor).
- Provide CHWs access to electronic health records and integrate CHW notes into the patient record for improved continuity of care.

References

Association of State and Territorial Health Officials (2018).Community Health Worker Integration: Issues and Options for State Health Departments- ASTHO (PDF), Available at: www.astho.org/community-health-workers/ (Accessed August 9, 2018)

Additional Benefits CHWs Bring to Clinical Settings and Care Teams

Act as a link to collaborate with community-based organizations, including:

- Social service providers
- Legal, housing, education, and employment sources of information
- Food pantries
- Community development organizations

Additionally, they can offer educational sessions that can help improve the patient's health status, such as:

- Healthy eating and food demonstration workshops
- Health, wellness, and physical activity workshops
- Financial literacy workshops

References:

Association of State and Territorial Health Officials (2018).Community Health Worker Integration: Issues and Options for State Health Departments- ASTHO (PDF), Available at: www.astho.org/community-health-workers/ (Accessed August 9, 2018)

Case Studies for Integrating CHWs into Care Teams Overview

To illustrate successful innovative strategies for integrating CHWs into Care Teams, selected health organizations throughout the nation will be showcased in real-life case studies. With over 45 years of combined experience, these organizations have demonstrated the ability to effectively use CHWs:

- Missouri Primary Care Association - Missouri, US
- Finger Lakes Community Health- New York, US
- Benton County Health Services- Oregon, US
- Family Medicine Health Center - Idaho, US

Acknowledgement

MHP Salud would expresses our great appreciation to all of the contributors of this toolkit. Thank you for your willingness to give your time so generously and provide in-depth insight into the success of your CHW programs. Undoubtedly, your contributions will be a great asset to other health organizations wishing to start or strengthen their CHW clinical integration.

CHWs and Electronic Health Record Data Entry

Electronic Health Records (EHRs) are electronic platforms that contain individualized health records for patients. Typically, these records include a patient's medical history, diagnosis, treatment plans, immunization dates, allergies, radiology images, pharmacy records, and laboratory and test results.[1] EHR systems can share patient information electronically across state and national health care organizations and agencies, pharmacies, laboratories, and third-party billing organizations.[2,3] The effective transmit of EHRs expands communication among these entities and minimizes medical errors; and ultimately, enhances the quality, safety, and efficiency of patient care.[4]

According to the Office of the National Coordinator for Health Information Technology, these advantages include:

- Providing accurate, current, and complete information about patients at the point of care,
- Providing quick access to patients' records,
- Ensuring security and privacy when sharing electronic information with patients and other medical and health professionals,
- Improving patient and provider communication,
- Improving health care convenience,
- Helping health care providers improve productivity and efficiency,
- Reducing costs through decreased paperwork, improved safety, reduced duplication of testing, and improved health.[5]

Electronic Health Record data platforms are an important tool for all Frontline Health Workers (FHWs), including CHWs, nurses, midwives, pharmacists, physician assistants, and doctors. FHWs are commonly the first and only point of contact for individuals seeking healthcare services.

They are responsible for providing interventions to meet the community healthcare needs and act as a bridge between healthcare resources and the community.[6] Their role in the community's health demands reliable and effective data collection methods such as EHRs. Paper surveys have been used for many years to collect health data, but they may present problems such as frequent errors, storage costs, and double data entry issues.[3] In an effort to improve data collection and entry processes, health care providers and other organizations developed electronic data collection methods. These methods are much faster, relieving the need to collect data on paper and then transfer the results into a computer database. Additionally, these methods have reduced the risk of transcription error and increased data accuracy.[7]

Because CHWs play an essential role in improving a community's health, the data collection tools and methods they use should be reliable and efficient. Many CHW-led organizations are opting for EHR platforms to improve participant outcomes and achieve organizational goals. According to the Office of the National Coordinator for Health Information Technology, FHWs, including CHWs, using these platforms can:

- Better healthcare by improving all aspects of patient care, including safety, effectiveness, patient-centeredness, communication, education, timeliness, efficiency, and access.
- Improve health by encouraging healthier lifestyles in the entire population, including increasing physical activity, improving nutrition, reducing behavioral risks, and expanding the use of preventive care.
- Increase efficiencies and lower health care costs by promoting preventive medicine and improved coordination of health care services, as well as by reducing waste and redundant tests.
- Strengthen clinical decision making by integrating patient information from multiple sources.[5]

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Case Study: Success in Using Electronic Health Record Data Entry Platforms with your Community Health Workers in Missouri Primary Care Association

Introduction

Missouri Primary Care Association (MPCA) is a non-profit organization with the mission to be Missouri's leader in shaping policies and programs that improve access to high-quality, community-based, and affordable primary health services for all Missourians. To this end, the Missouri Community Health Worker Program was started with the purpose to:

- Improve patient engagement in care with a focus on preventive, chronic disease management, and self-management services.
- Serve as an integral part of the care team serving as a liaison between care team and patient when the patient is outside of the four walls of the health center.
- Assess and address patients' social stressors using the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) tool.
- Connect patients to needed community-based services.
- Reduce potentially avoidable emergency room visits, admissions, and readmissions for preventative acute and chronic conditions such as diabetes.

The program received funding in spring 2016 and began implementation in fall of the same year. The program included 19 Missouri Federally Qualified Health Centers (FQHCs) in the start but by July 2018, that number grew to include 26 out of 29 FQHC grantees in Missouri. The project was able to maintain approximately 50 CHWs throughout the program.

Challenge: Missouri PCA strives to improve access to high-quality, community-based, and affordable primary health services for all Missourians through partnerships with local health clinics. However, they noticed the need for a more comprehensive tool that better captured the work of CHWs and examined social stressors within the communities they served. They also encountered some resistance from providers and other care team members because they were unaware of the value and potential CHWs can provide by engaging patients in their own care.

Strategy: The health centers working with the MPCA invested in Electronic Medical Record (EMR) template additions, CHW structured documentation within EMR, and hiring of CHWs. MPCA also invested in mapping and data validation from health center EMR/practice management systems to Azara Data, Validation, and Visualization System (DRVS) and invested in social stressor mapping that connected to DRVS. These systems assisted in the successful implementation of CHW programs. The next step was to develop a training work plan that focused on the following nine areas:

1. Complete CHW training program (for CHWs in need of formal CHW training).
2. Use the PRAPARE tool to assess social stressors. (Required)
3. Connect patients with community-based services. (Required)
4. Improve patient engagement in preventive, chronic disease management, self-management services. (Required)
5. Include three measures, one from each category: cancer screening, preventive, and chronic disease control/ management derived from UDS Electronic Clinical Quality Measures (eCQM). (Required)
6. Implement strategies to reduce avoidable emergency room visits and hospital admissions. (Required)

In addition, the training could be enhanced by selecting one of the three options below:

7. Increase screening, brief intervention, and referral to treatment (SBIRT) for identification of Substance Use Disorder.

8. Improve patient engagement for pregnant women by increasing adherence to prenatal services.

9. Provide CHW Continuing Education.

It was important to evaluate the CHW's performance. This was completed through quarterly reviews of qualitative, PRAPARE tool and CHW encounter/interventions reports that captured patient stories, successes and barriers to implementation, training/technical assistance needs. Included as well were the most common social stressor needs derived through the PRAPARE assessments. It was also important to review successful referrals to outside organizations and patient follow through, e.g., kept appointment, visited food pantry, etc.

Conclusion: The overall performance of CHWs improved after implementation of the program. This is evident as quarterly reports have shown a larger number of patients being served, higher number of PRAPARE assessments completed, and successful referrals made. Overall knowledge and acceptance of the value CHWs bring to care teams also improved. Many providers expressed that CHWs are invaluable to their daily practice, and they cannot imagine working without them.

Best Practices: Setting the programmatic purpose, goals, CHW functions and expected outcomes of your CHW program should be one of the first steps you take as an organization. Having these guidelines established will help create strategic partnerships with Medicaid, state health departments, managed care organizations (MCOs), regional CHW organizations, hospital associations and CHW peer learning networks. These connections help to display health center efforts, achievements in population health and determine success in a value-based payment environment. All these factors have been instrumental in ensuring CHWs become an integral member of the care team, subsequently engaging patients in care and increasing planned chronic and preventive visits by assessing and addressing patients' social stressors. Establishing a CHW peer learning network was also helpful in making networking, training and technical assistance available for CHWs.

Lessons Learned: It's imperative that any organization looking to integrate CHWs and their supervisors into EMR/EHR invest in training and technical assistance. It is critical for them and other members of the care team to have a firm understanding regarding team-based care and effective patient engagement techniques.

Angela Herman-Nestor, MPA, CPHQ, PCMH-CCE, Quality and Performance Improvement Manager. Missouri Primary Care Association. Questionnaire Responses. Thursday, October 25, 2018.

CHWs Participating in Care Team Daily Huddles

A huddle is a short, stand-up meeting lasting less than 10 minutes. These meetings are typically used at the start of each workday in a clinical setting. The main purpose is to discuss patient processes to be performed during the day. Additionally, it serves to actively manage the quality, safety, and effectiveness of services provided.[1] Routine huddle meetings contribute to an interdependent team culture, improved relationships, and the delivery of safe and reliable patient care.[2] Huddle meetings should involve all team members that can offer valuable input to clinic flow and patient needs, such as providers, medical assistants, nurses, social workers, case managers, etc. Every day, more clinics are opting to include CHWs in these meetings as they offer expertise in the dynamics and needs of the patients. Additionally, they provide invaluable insight into their health behaviors that can help clinicians to determine the best possible treatment decisions.[3]

Overall, these gatherings serve to unite all health workers on the care team. Each member's skills and knowledge are valued and considered so the team can provide better support to patients on understanding their health conditions, establishing health goals, and taking actions to improve their health and well-being.

Additional resources on how to run a huddle meeting:

- **Team Huddle Agenda, A Daily "Stand Up" Meeting** http://www.emergenceconsulting.com/wp-content/uploads/2015/08/Team-Huddle-Agenda.pdf
- **The Team Huddle: A Meeting Tip that will Simplify your Company's Life** https://appfluence.com/productivity/team-huddle-tips-ideas/
- **6 Tips to Successfully Conduct the Daily Huddle** https://status.net/templates/daily-huddle/

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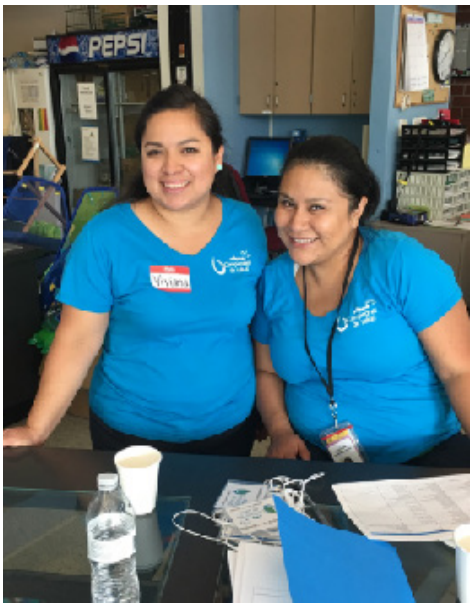
Case Study: Success in Integrating Community Health Workers in Huddle Meetings in Benton County Health Services

Introduction

Community Health Centers of Benton and Linn Counties (CHC) is a Federally Qualified Health Center (FQHC) in Willamette Valley, Oregon. Organizationally integrated with the Benton County Health Department, the CHC serves low- income, rural and homeless populations in Benton and Linn counties. They understand how physical health, mental health, and oral health all affect each other and are committed to helping each person achieve their personal health goals and lead a happier, healthier life. CHC's Health Navigation Program began in 2008 with one grant-funded, part-time CHW. This program aids the community in making the best health care decisions for their lifestyle, current situation, and conditions. Community Health Workers, in the role of health navigators, work in several settings including 10 primary care teams and 3 schools. The success of the program is evident in the growth they have experienced by increasing the number of CHWs from one to 28.

Challenge: Benton County Health Services strives to provide well-rounded services to every patient by incorporating CHWs in the clinical care team as Health Navigators. However, some medical professionals were hesitant to include non-medical professionals without formal medical training in the patient care team.

Strategy: Introducing CHWs to the care team included formal training for CHWs, and providers received a presentation that covered CHW roles, responsibilities, scope, limitations, and strengths. Providers were also engaged in discussions to determine how CHWs would be used within the care team, which set a strong foundation in developing a more cohesive team dynamic. An essential component to developing this team dynamic is providing extensive training to



Community Health Workers Viviana Gonzalez and Analuz Torres Giron are ready for the crowds to arrive for the Garfield Swim Day and Health Fair.

CHWs. This training lasts about 6 months and includes shadowing a CHW, having side-by-side training, and transitioning to individual work. Participation in team huddles begins on day one to allow CHWs to see the dynamic of the interactions and learn from providers.

As important as it is for CHWs to understand the clinical setting, it was just as important for the providers to understand how CHWs contribute to patient health outcomes. This understanding helped alleviate some of the initial hesitancy in integrating CHWs within the Care Team. However, it took almost two years of trust building and improved outcomes for CHWs to be considered an essential and valued member of the team.

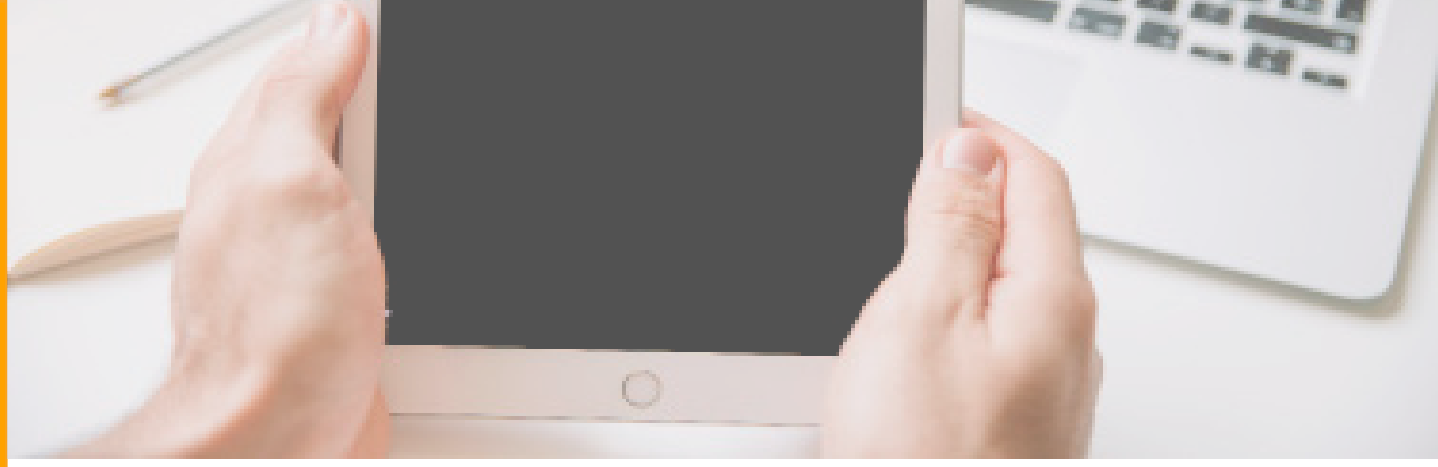
Conclusion: Providers and care teams have been able to see the value CHWs bring to the care team. They have a unique ability to connect with their community and build relationships in ways that can't be done within a 20-minute visit. Additionally, CHWs feel they have an open line of communication with providers where they can discuss things like patient health literacy, patient compliance with provider instructions and patient needs or current life situations due to the trust they built. As a result, CHWs are respected members of the team and the value they bring to patient care has been expressly recognized.

Best Practices: Though CHWs are being integrated into the clinical team, they still spend a large portion of their time in the community they are serving. Thus, it is important to have a set time for formal team huddles. This simple but important point will enable the CHW to be present more often and facilitate a seamless integration into the care team.


Clinical Community Health Worker Jesus Guzman gets ready to talk with clients about healthy eating and active living at a health fair.

Lessons Learned: It is crucial for the clinical staff and CHWs to take the time to understand how to work with each other. Sometimes it can be difficult for other professionals to receive input from CHWs because they do not understand the value of the knowledge the CHW contributes. It is equally detrimental when a CHW does not know how to interact with other members of the clinical team - e.g. protocols to follow, language, cultural appropriateness, etc. Unfortunately, the integration of CHWs into primary care will not be successful when the CHW does not fully understand their role and the clinical staff does not understand how to effectively use them. Having a knowledgeable supervisor, a provider champion, and clearly defined roles and expectations are critical to successfully integrating CHWs into a primary care home.

Kelly Volkmann, Health Navigation Program Manager. Benton County Health Services. Personal Interview and Questionnaire Responses. Wednesday, November 7, 2018.



CHWs Utilized in Telehealth

Telehealth, also known as e-health (electronic health) or m-health (mobile health), is the use of electronic information and communication technologies to enable virtual access to health care. This type of innovation commonly uses computers and mobile devices to perform video conferencing, instant messaging, streaming media, store-and-forward imaging, among other features.[1]

Telehealth is a platform used to overcome barriers such as geographic, financial, and/or workforce specific issues; it also provides patients with remote access to the health care team, including physicians, nurses, pharmacists, and CHWs.[1]

Overall, the main goals of telehealth are to:

- Make health care accessible to individuals living in isolated communities
- Increase access to services for individuals with mobility, time, or transportation challenges
- Provide easier access to health care specialists
- Improve communication and coordination of care between the health care team and patients
- Motivate patients to achieve self-efficacy regarding their health
- Provide support for patients' self-management of health care[2]

The integration of CHWs into telehealth technology can assist health care entities to reach their goals by positively impacting patients' health.[3] Additionally, it has been demonstrated that CHWs can incorporate telehealth with person-centered programs and increase access to high-quality care.[4]

CHWs can contribute in the following ways:

- Educate patients on how to use mobile devices or computers and access patient portals [2]
- Provide health education and resources (videos, fact sheets, interactive activities, etc.) [2]
- Send email, text, or phone reminders when patients need to be seen by the care team [2]
- Collect field-based health data [5]
- Increase communication between the patient and provider [5]

In conclusion, integrating CHWs into clinical processes using telehealth approaches improves the quality of care provided, the efficiency of services, and the capacity for program monitoring. [5]

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Case Study: Success in Using Telehealth with Community Health Workers to Bridge Patients to Health Services in Finger Lakes Community Health

Introduction

Finger Lakes Community Health (FLCH) is a Federally Qualified Health Center that provides services to patients of all incomes, ethnicities, and walks of life in the Finger Lakes region. This health center strives to bring a new standard of health care through education, technology, and preventive care. FLCH is an early adopter of telehealth technology, which provides a bridge for patients who cannot travel to visit a provider and connects patients with appropriate services through remote education, training, specialist consultations, and diagnosis via real-time video conferencing technology.

Furthermore, FLCH has an outstanding CHW program and possesses almost three decades of CHW experience. At present, this program consists of 23 CHWs assisting patients in accessing care, chronic condition self-management education, short-term intervention in acute or emergency cases, and prenatal and post-partum services.

Challenge: FLCH discovered many individuals were not visiting FLCH centers due to individuals fears, limited transportation, and language differences.

Strategy: After identifying barriers preventing individuals from visiting health centers, FLCH explored innovative ways to reach patients at their location and provide appropriate health services. FLCH established telehealth technology as one strategy to connect patients to needed health care services. CHWs play an essential role in providing support to access health care services; therefore, they have been incorporated as key components of this strategy. Two FLCH CHWs are involved in telehealth and their main duty is to perform outreach activities to reach individuals in the community who are in need of their services. Each CHW is equipped with a laptop computer installed with Synchronous, a live-video conferencing system supported by the Cisco platform. This service is readily available for CHWs and patients to connect to medical providers in real time. During the first video visit established with the provider, the patient is assessed to determine if the health services needed can be performed from a distance or whether a physical visit to the clinic is required. If telehealth is feasible, subsequent video appointments and appropriate follow-ups are scheduled for these patients.

To successfully implement this strategy, CHWs receive in-depth training on the use of the otoscope, stethoscope, blood pressure cuff, and oral camera. CHW training encompasses general computer processes and internet connection troubleshooting as well as simulated calls to assess their ability to successfully utilize the telehealth technology.

This telehealth initiative has been active for six months and is planned to continue for 12 to 24 more months as a pilot program. This time frame will allow FLCH to address any issues that may arise and make necessary changes for the betterment of the program.

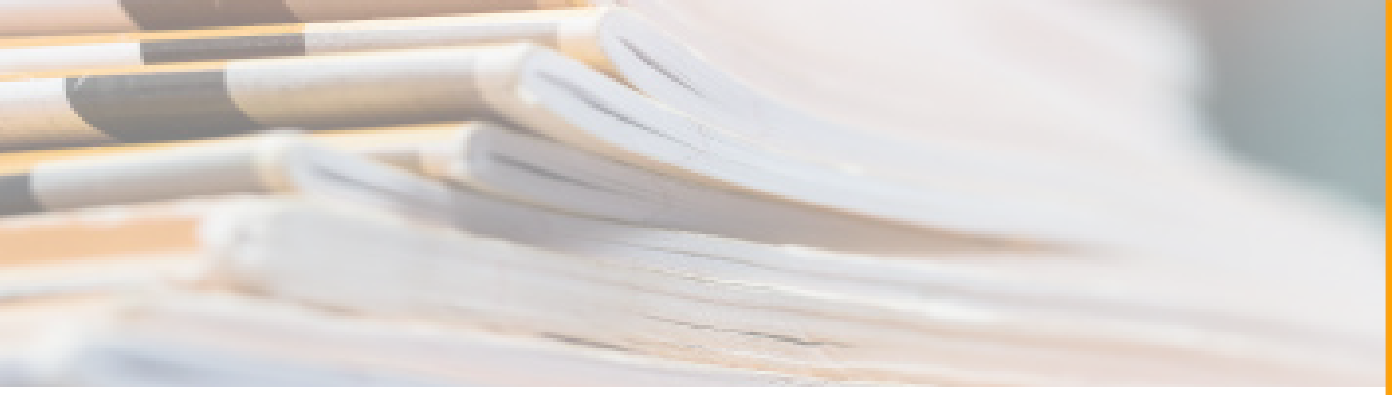
Conclusion: The integration of telehealth in FLCH has positively impacted patients, clinical team, and the overall health care system. Patients have been able to overcome barriers and receive care from the FLCH clinical team at their location, reducing the time, effort, and cost of travel to a health center. The clinical team has expanded services to remote areas of the community, increased direct patient interactions, and strengthened their network to other health specialists in the nation. The health care system has been positively impacted by the improved health care access and health outcomes, increased resource utilization, and enhanced the clinical team's cost and time efficiency.

Best Practices: A successful integration of CHWs into a new strategy such as telehealth requires health center leadership and care team members to be onboard and informed. In FLCH, the Chief Executive Officer, Chief Medical Officer, medical providers, and other members of the clinical team received appropriate information in regards to the CHWs' specific role, duties, and expectations in this strategy. In response, they supported the integration and encouraged the program to launch.

It is incredibly important to ensure all CHWs participating in telehealth are properly trained. This will produce trust among other members of the clinical team and will ease their integration into this service. FLCH provides intense training with multiple assessments and simulated calls to assess CHWs telehealth mastery competence. At present, CHWs have successfully worked alongside the entire clinical team.

Lessons Learned: FLCH serves rural communities, where adequate internet connectivity is difficult to obtain, restricting CHWs' effective use of telehealth technology. Therefore, to ensure success, it is important to identify and address connectivity issues prior to implementing telehealth in these communities.

Beverly Sirvent, Director of Agricultural Program and Sirene Garcia, Director of Special Programs, Finger Lakes Community Health. Questionnaire information. Thursday, November, 15, 2018.



Impact of Using CHW-Collected Data in Clinical Decision-Making

Collecting reliable and timely health data is essential for addressing health issues. Meaningful health information is used to formulate interventions that improve the health of patients. Reliable and timely health data becomes a necessity when emergent diseases or other health threats arise, and actions need to be made to prevent or treat these health issues. CHWs can offer support to clinical decision-making by providing data obtained while performing health care services to patients such as health education, referrals to health services, support groups, follow-ups, etc.[1] Additionally, CHWs can analyze social stressors and use collected data to connect patients to community resources, assist with care coordination, and improve provider-patient communication.[2]

Overall, the inclusion of CHWs into care teams allows clinical health professionals to use the health information collected by CHWs to improve patients' access to and quality of care.[3]

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Case Study: Success in Using Data Collected by Community Health Workers for Clinical Decision-Making in Family Medicine Health Center

FAMILY MEDICINE HEALTH CENTER

Introduction

Family Medicine Health Center (FMHC) is a FQHC located in Ada and Canyon counties in Idaho. This center prepares broadly-trained family medicine physicians and encourages them to work in Idaho's underserved and rural areas and serves low-income, uninsured, disabled, and other vulnerable populations in a Patient-Centered Medical Home. FMHC has a Community Health Worker program composed of six Community Health Workers (CHWs) and a Community Outreach Program Manager. This program started four years ago in 2014, with one grant-funded CHW from the surrounding community whose goal was to identify and increase the farmworker population's access to services. By 2015, the CHW program started to increase its presence among this community. Consequently, the health center incorporated an outreach program with a new group of certified CHWs serving as Enrollment Counselors or Navigators. Their impact and value were shown with a gradual increase of agricultural workers served: from 16 in 2014 to 618 in 2018, as reported in the UDS (Uniform Data System).

Challenge: FMHC is determined to better the health and quality of life of all patients. Nonetheless, they have recognized patients may face barriers to good health associated more with social or economic factors. Therefore, it is important to implement interventions that focus on these factors to help patients achieve overall health and wellness and an improved quality of life.

Strategy: CHWs in FMHC are trained and equipped to assess patients' social stressors, such as their economic stability, physical and social environments, education level, employment status, housing, health care access, and other important factors that may act as barriers to good health and a balanced quality of life. Gathering this type of data is essential to design health programs that can effectively overcome patients' barriers to good health. This data is collected after a medical provider consults the patient and identifies the need for a personal assessment.

Thereafter, the provider completes a Social Rx referral form, which is transferred to the CHW team. The Social Rx form is a fast-tracking tool that includes 24 questions to assess a patient's social needs. These questions inquire about transportation, housing, employment, nutrition, physical activity, sexual activity, social isolation, smoking, interpretation needs, and other issues. Each question is linked to an observation term, which allows CHWs to connect patients to the appropriate department and clinical team members to receive help and support.

Results: Based on the data collected by CHWs through the Social Rx tool, the clinical team is able to identify the specific social needs of every patient screened. At present, this tool has been used with a small percentage of the patient population. Nonetheless, this collected data has given the clinical team the ability to take a glance at the overall needs of the community they are serving. This data was reported in the Resources Patient Needs graphic. The graphic portrays a visualization of all the different barriers or needs patients face in their journey to good health.

Based on these results, the CHWs and clinical team discovered that the findings did not correspond to the needs expressed by patients. For example, only 3% of the screened patients identified as smokers. However, clinical studies and anecdotal information from CHWs identified smoking-related health issues as a major barrier to good health among patients. These findings raised concern and a priority to understand the low-reporting of smoking from patients. As the Care Team looked deeper, they found that the smoking question included in the Social Rx assessment may not have addressed all the types of tobacco use such as cigarettes, e-cigarettes (vapes), chewing tobacco, cigars, orbs, strips, sticks, hookah, etc. In response, FMHC partnered with the Central District Health Department of Boise, Idaho. This department emphasizes decreasing risk factors for chronic disease, improving quality of life, and increasing the years of healthy living among residents. Through this partnership, they started a smoking cessation program that included nicotine replacement therapy (NRT), tobacco education, and counseling. NRT is considered the first step of this program. During their initial NRT visit, medical doctors or pharmacists provide patients with a free two-week supply of tobacco cessation products such as patches, gums, and lozenges. If needed, patients have the opportunity to obtain up to two and a half months of additional tobacco cessation products. Next, patients are referred to the CHW team, where they complete innovative screening forms such as 3 A's and R Protocol and participant information forms. These forms allow the CHW team to assess the participant's tobacco use and offer appropriate continuous support.

This support includes tobacco cessation resources such as free evidence-based classes, telephone- and- web-based counseling, and a mobile application that contributes to the patient's quit journey.

Conclusion: The Tobacco Cessation program was designed using CHW-collected data and has proven successful in lowering smoking rates. Within the first six months of implementation (July 2018 to December 2018), these rates decreased by .5% from 21.9% to 21.4%. During the same time frame, the percentage of patients formally counseled on smoking cessation increased 16.9% from 29.8% to 46.7%. The successof this program demonstrates the value of CHW-collected data. What started as a CHW program goal soon became an organizational goal and a clinical measure.

Family Medicine Health Center CHW Department
Top left: Luis Lagos, Diane McKinnis, Marcial Angulo
Bottom Left: Jeanie Levinski, Martha Madero, Cinthya Hererra-Buitrago

Furthermore, this program has given more revenue to the CHW program at FMHC as the health center is monetarily compensated for each patient screened. Undoubtedly, CHW-collected data is valuable for clinical decision-making as it has the power to identify needs to construct initiatives that produce a positive change among patients.

Best Practices: It is important to always share CHWs' successes to all members of the health center including leadership and upper management of different departments. This communication will ensure better acceptance, trust, and support of CHWs' work. In the end, the whole clinical team is working toward the same goal: improving patients' health and quality of life.

Lessons Learned: To prevent confusion in regard to CHWs' roles and duties among other members of the clinical team and/or patients, it is important to define the CHWs' scope of work. Additionally, developing an evaluation to assess CHW performance can be helpful to improve the quality of the programs implemented.

Luis Lagos, Community Outreach Program Manager. Family Medicine Residency of Idaho. Personal Interview. Wednesday, October 23, 2018.

Conclusion

These case studies illustrate how successfully integrating CHWs into clinical functions that include EHR data input, telehealth, team huddles, and clinical decision-making can lead to improved patient outcomes. They also highlight the importance of having an established process for integration that is inclusive of other team members.

It is important to note that this is a long-term investment that can enhance the organization's overall goals. It is a process that will take time, effort, and resources to establish successfully. Nonetheless, the positive impact it will make both internally and externally will be immeasurable. For more information on integrating CHWs into clinical settings, please see the included resource list or contact MHP Salud at info@mhpsalud.org.

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