

Identifying Workforce Needs and Opportunities for Expanded Scope of Practice: A Community Health Worker Program Case Study

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- **Baylor Health Care System**
 - Largest not-for-profit health system in North Texas
- **Baylor Community Care**
 - Primary care service line for the uninsured (high utilizers)
 - 6/7 practices are Patient Centered Medical Homes
- **Problem**
 - Patient volume outweighs capacity of primary care physicians
 - Additional navigation and education needed to augment ‘traditional’ Patient Centered Medical Home services
 - Limited budget

- **CHW is a trusted peer***
 - Has a close understanding of the ethnicity, language, socio-economic status, and life experiences of the community served
 - Helps patients **navigate** medical, behavioral, and social services
 - Provides culturally appropriate and accessible health **education** and information
- **Certification program in place for 12 years**
 - 1999 – Texas House Bill 1864 established the Promotor(a) Program Development Committee
 - 2001 – Senate Bill 1051 directed the Texas Department of State Health Services (DSHS) to develop a training and certification program for promotores (CHWs)
 - 2001 – Certification program implemented

* Rosenthal E. L. WN, Brownstein J. N., Johnson S., Borbón I. A., De Zapien J. G. (1998). Summary coordination by E. Koch. Rural Health Office. Retrieved January 20, 2010, from [Context Link]. A summary of the national community health advisor study: Weaving the future. A policy research project of the University of Arizona. Summary coordination by E. Koch. Tucson, AZ: University of Arizona, Rural Health Office. 1998; <http://www.rho.arizona.edu/Publications/CAH.aspx>.

- “Generalist”, skills-based training
- 160 hour program via DSHS approved entities building competencies in:
 - Communication skills
 - Service coordination
 - Advocacy
 - Organizational skills
 - Interpersonal skills
 - Capacity-building
 - Teaching skills
 - Knowledge base
- 20 hours of continuing education/2 years

<http://www.dshs.state.tx.us/mch/chw.shtm>

Why CHWs at Baylor Community Care?



- Built trust quickly with disenfranchised patient population
- Informed other PCMH team members of patient reality
- Cost-effective
- CHW certification solidified relational skills (vs task focus of Medical Assistant type role)

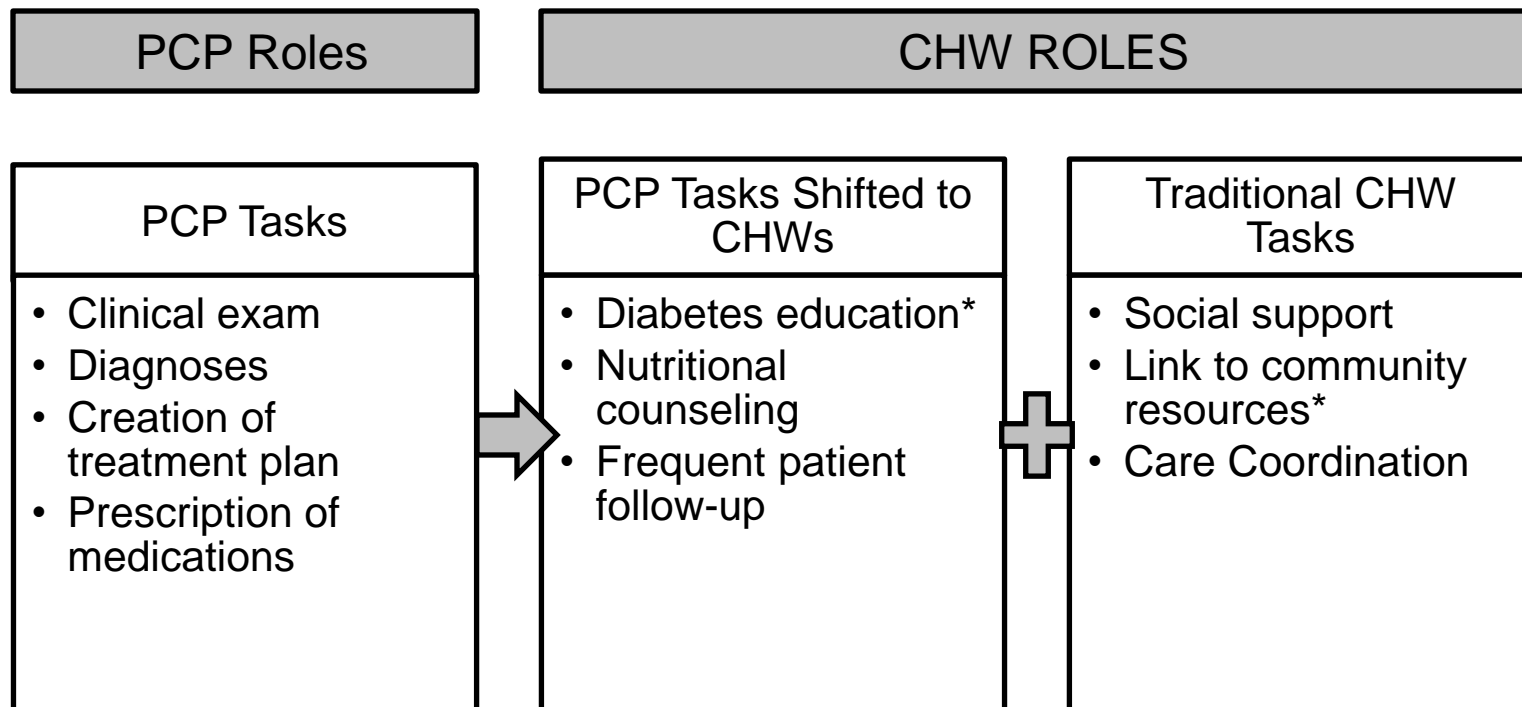
Diabetes Equity Project*

- Embed CHWs in PCMHs
- Adapt Community Diabetes Education (CoDE) Program
- Leverage software for data capture and communication
- Scaled to 7 sites

Community Care Navigation

- Hospital to primary care navigation
- Reduce barriers to effective care (meds, transportation, appts)
- Leverage software for data capture and communication
- Scaled to 4 sites

CHW as PCMH Team Member



- Licensed personnel (RNs, CDEs, SWs) handle more complex cases.
- CHW oversight by licensed program manager (RN or SW) and program Medical Director. Patient specific direction taken from PCP.

- Unique CHW/Patient relationship is the cornerstone of the intervention
- CHW competency is a must have
 - Training/certification
 - Clearly defined protocols and procedures
- EMR access facilitates model acceptance and effectiveness
- Outcome tracking and communication
- Relationships, relationships, relationships

- CHWs inform medical management
 - “The CHWs help surface what are the big barriers... is it that the person is really depressed, or is this person afraid of insulin?”
- CHW role needs to be well defined and supported
 - “We shouldn’t put the CHWs in situations where they feel they need to make clinical decisions. That’s our job.”

Thank You!



Questions?

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