TEAM UP Role Development – Community Health Worker (CHW) / Family Partner (FP) Role

Updated – February 2020

I. Context

The TEAM UP clinical model includes a role for a Community Health Worker (CHW) or Family Partner (FP) that is integrated into primary care - Pediatrics and Family Medicine - and works with the care team to address the basic needs and provide support for the behavioral health issues of patients and families. The CHW/FP role has been developed over the course of the initiative through an iterative and collaborative process. Throughout the development process, the guiding principle has been to create a common, shared framework for the role that it consistent across all TEAM UP health centers and flexible enough to fit the local environment. TEAM UP seeks to build upon this common framework in order to further develop out standards for the role and identify methods to quantify and assess the impact of the role on the delivery of care across TEAM UP health centers.

Goal of memo: Outline the guiding principles, core competencies, and required experience for the CHW/FP role as articulated through the development process to date, as well as highlight areas for further development of the role as identified in a preliminary assessment undertaken in Cohort 1 CHCs.

II. Guiding Principles

Outlined below are the central principles guiding the TEAM UP approach to development of the CHW/FP role. Our goal is that:

- The role <u>works well for the CHWs/FPs</u> and is rewarding and fulfilling;
- The role <u>works well for patients, the care team, and the health center</u>; and
- The role is <u>sustainable long term</u>.

These principles serve to ensure the CHW/FP role is consistent with a patient- and family-centered approach to care, takes into consideration enhanced care team wellness and job satisfaction, and can be maintained as an integral role on the care team. In addition, specific principles have been outlined related to TEAM UP's broader team-based care approach within which the CHW/FP role sits.

- TEAM UP adopts the core tenants of the Patient-Centered Medical Home clinical model.
- The clinical delivery and staffing model for TEAM UP is a team-based care model, where various licensed and non-licensed staff work together as a team to deliver all services, including visit-based care and care management and coordination.
- All care team members will strive to work at the top of their scope of practice and will collaborate with other care team members to ensure that the children and families receiving care have a seamless experience.

III. Considerations

The following are some of the major assumptions underlying TEAM UP's approach to development of the CHW/FP role, particularly in relation to the variability that may exist across participating health centers.

- Health centers may have previous experience with a particular version of the CHW role and currently employ staff that will function in this role for TEAM UP.
- The potential candidate pool is likely to vary among health centers.
- Human resources, hiring, and on-boarding processes are likely to vary among health centers.

© 2022 TEAM UP for Children

IV. Scope of Work and Core Competencies for the CHW/FP Role

The CHW/FP scope of work as articulated during Phase I of the TEAM UP initiative includes the following activities:

- Parent coaching and support, including outreach to and engagement with families to promote healthy development and access to care and services
- Linkage to basic needs resources and community services
- Care coordination to help with multiple appointments, different sites of care, etc.
- Screening and support for referrals, such as Early Intervention, stepped up care, etc.
- Population Health Management, such as outreach to families lost to care or with care gaps
- Engagement in community outreach events to promote public health messages and describe services available in Pediatrics

This scope of work is supported by trainings in the following evidence-based strategies:

- Motivational Interviewing
- Problem Solving
- Family Engagement

In addition to outlining the CHW/FP scope of work, core competencies for the CHW/FP role were established in Phase I of the TEAM UP initiative. These core competencies were developed in alignment with the 10 Core Competencies for Massachusetts Community Health Workers as identified by the Massachusetts Board of Certification of Community Health Workers.

Overview of CHW Core Competencies:

Outreach
Initiate and maintain trusting relationships with children and families
Conduct home visits and site visits to community partners
Individual and Community Assessment
Conduct preliminary screening and assessments of child and family
Assess for barriers to accessing services
Help children and families identify their goals, personal strengths
Assist in the development and implementation of care plans
Effective Communication
Be respectful and culturally aware during all interactions
Meet and collaborate with care team members to provide comprehensive services
Provide emotional support and education to children and families to support wellness and foster resiliency
Cultural Responsiveness and Mediation
Describe different aspects of community and culture and how they influence health beliefs and behaviors
Advocate for and promote the use of culturally and linguistically appropriate services and resources
Education to Promote Healthy Behavioral Change
Provide education and support to promote healthy behavior change
Promote efforts to prevent injury and disease through risk reduction
Care Coordination and System Navigation
Support children and families to effectively navigate the health care environment and access community resources and services
Assist the child, family, and care team in coordinating services through transitions in care, referrals to specialty services, and follow up visits

Support caregivers in accessing self-care and other supportive resources
Use of Public Health Concepts and Approaches
Gain and share information about health topics that are relevant to children and families
Use data and evidence-informed practice to support children and families and care team members in reaching their health goals
Utilize a quality improvement framework to evaluate work and identify areas for on-going performance improvement
Advocacy and Community Capacity Building
Encourage children and families to develop organizational and leadership skills needed to advocate for care and services
Build and maintain community networks and participate in activities to build further capacity for services within the community
Documentation
Provide organized and appropriate documentation of activities and rendered services that effectively communicates with children and families, and other care team members
Professional Skills and Conduct
Comply with all applicable Massachusetts laws and ethical standards
Observe the scope and boundaries of the CHW through close collaboration with other care team members

V. CHW/FP Required Skills and Expertise

The following table outlines the minimum required skills for the CHW/FP role as originally defined during Phase I of the TEAM UP initiative. In addition, preferred and optional skills were identified to support health centers in determining the expertise required to meet the needs of their particular patient population and guide job description development and hiring practices.

Overview of CHW/FP Skills and Expertise

	Minimum Required Skills	Additional Preferred Skills	Additional Optional Skills
Cultural Representation			
Bilingual	X		
Bicultural	X		
Previous Experience (consider requiring as many as possible across the cohort of CHWs)			
With children and families	X		
In the school system		X**	
Lived experience		X**	
In a health care setting		X	
In behavioral health		X	
Training/Certification			
Community Health Worker	X*		
Medical Assistant			X
Medical Interpretation		X*	
High School Equivalency	X		
On-going Training as needed		X	
Other			
College-level education			X
Computer skills	X		
Writing skills	X		
Reflective emotional capacity	X		

[Type here]

* Certification can be acquired after hire
** Prioritized Skills

VI. Phase I Role Assessment

During Phase I of the TEAM UP initiative, participating health centers and the BMC Implementation Team embarked on a two-step process to support further development of the CHW/FP role. The first step focused on skills development for the CHW/FP role, while the second step focused on undertaking a qualitative assessment of the role conducted through a series of individual meetings with CHWs/FPs from across the participating health centers.

The questions utilized and information collected in those meetings are summarized in great detail within the CHW Role Development Data Gathering Summary linked within Section VIII. The findings summarized below are organized into five areas of role development:

- Integrating training into your work – preparing you with the tools and skills to be successful in your work
- Team-Based Care – understanding everyone's role on the team
- Daily Activities – how you do your work each day
- How You Organize Your Work – tracking your work and the families you serve
- Population Health Management – services for the whole population that your health center serves

Summary of Key Findings from CHW/FP Role Assessment

	Key Findings
Integrating Training into Your Work	• There is universal interest in using a **Problem Solving** intervention. The problem solving focus seems a perfect fit for the role, especially for navigation episodes that have a set pattern or workflow, like IEPs. There is also general interest in developing care planning skills in a manualized approach: e.g. assessment, action plan, reassessment, etc. • CHW/FPs are using **MI** and have found this training to be immediately helpful, particularly in the fast-paced environment of primary care. • Opportunities for **meeting other CHWs to network for resources** have been very helpful.
Team-Based Care	• While it has needed development over time, overall all CHWs/FPs have a solid understanding of their role and responsibilities and feel it is well-defined. All CHWs self-describe their role citing at least some components of TEAM UP's core competencies for the CHW role, including helping families **access basic needs resources**, **care coordination** to help with multiple appointments, and supporting **referrals**, such as Early Intervention. The unique nature of this role – integrated into pediatrics and focused on behavioral health care – has taken time to develop fully. As this continues, health centers appear to be conducting on-going informal trainings to reinforce the role and its responsibilities. • Overall, CHWs/FPs feel the care team understands their role, particularly the BHCs. There is some variability amongst PCPs, particularly in accessing CHWs for tasks that could be handled without them (e.g. written information for resource needs). • In general, there is a good understanding of the CHW/FP role among patients and families. Codman FPs introduce themselves as the 'Family Support Team', which seems to work well. Patients do not always understand the limitations of their role and capacity. • CHW/FP skills and contributions are generally well utilized; this has improved as the role has developed over the length of the initiative. • The most fulfilling and satisfying part of the work is when CHWs/FPs are able to directly help a family, for example, coordinating care so that a child who is suffering can receive all the services they need, partnering with families, earning the family's trust, coaching caregivers and seeing that coaching internalized by the caregiver.

	• Challenges include fast pace of primary care (not having enough time for a family that needs a deeper dive), barriers and limitations in the system (e.g. housing, school system, emergency shelters), and families who are suffering and having a difficult time. • Every CHW/FP has a combination of clinical supervision and administrative supervision. Clinical supervision is provided by a behavioral health clinician, and each health center has a mechanism for CHWs/FPs to review difficult cases and receive peer support. There is not consistent meeting time with PCPs, but CHWs/FPs do have access to PCPs through informal meetings and huddles.
Daily Activities	• CHWs/FPs have anywhere from 1-5 visits per day, or **5-25 visits per week**. The majority of these are Warm Hand-Offs (WHOs), follow-up visits, or off-site visits at home or at a community agency. Some CHWs/FPs expressed a desire to expand their ability to meet with patients off-site. • In addition to visits, CHWs/FPs speak to about 5-10 patients by phone or text each day, or **50 per week**; at times can be as high as 15-20 per day. • CHWs/FPs receive requests in a variety of ways, including WHOs, referrals in the EMR, staff messages, telephone encounters or actions in the EMR, scrubbing providers' schedules, morning huddles, and emails. CHWs/FPs receive about **10-45 new discrete requests (referrals, actions, etc.) per week**. • CHWs/FPs estimate that **more than half** of the patients and families they serve **require more than one contact or touch** to fully address the issue at hand. On average this are 2-5 touches in total, but complex families can require many more contacts. • For patients who need on-going contact, the CHW/FP generally maintains regular contact until they reach a natural endpoint. On average contact is on-going for 3-6 months. • CHWs/FPs estimate that **more than half** of their patients are **high-risk**, as defined by having multiple complex needs, more social and behavioral health issues, co-morbid chronic medical health issues, DCF involvement, and urgent risk for homelessness. • On average, CHWs/FPs carry about **25-50 active patients** at a time. The CHW/FP may additionally be monitoring 20-25 patients after more intense support has wrapped up. When covering for a vacant position, the CHW/FP can carry up to 80 active patients at a time.
Organizing Your Work	• Two of the three health centers use the EMR to track daily visits. This is in part used to document how the CHW/FP has spent their time. • CHWs/FPs at every health center have some mechanism to track daily work and remind themselves about follow-up activities (EMR in-basket or Reach, with duplicate documentation in the EMR. Reach shows all active patients, and actions can be set – to email, text, call, etc. – within a defined timeframe.) • Each CHW/FP has a mechanism to track their active patient panel, however there is variability both within and between health centers. For some, this takes the form of a personal tracking system; others use functionality built into the EMR, such as assigning themselves to the care team. • All CHWs/FPs document in the EMR, both in visits and telephone encounters in the patient's record and through staff messages. • All CHWs/FPs have multiple avenues to communicate with other members of the care team, including through the EMR, staff meetings and clinical supervision, verbal updates, huddles, etc. Not all health centers have formal reserved time to meet with providers, nonetheless there are multiple informal mechanisms to review patient care with other team members. • All CHWs/FPs have multiple weekly meetings, including but not limited to clinical supervision, clinical department meetings (e.g. Pediatrics department), discipline meetings (e.g. Behavioral Health meeting), and care team meetings. Some also attend meetings within the community that are valued as a mechanism to stay abreast of community issues.

Population Health Management	• There are some emerging activities that are geared towards the entire population. This includes preventive touches at 2 weeks and 18 months, and as part of universal screening. • There are a number of activities that are geared towards all members of a specific high-risk population of patients. This includes families with DCF involvement, Early Intervention referrals, children with co-morbid chronic disease (asthma or diabetes) and social needs.

Findings from this assessment were utilized to guide discussion and planning across the participating health centers during the December 2017 Steering Committee Meeting (then referred to as the CQI Meeting) with the goal of developing a plan of action to address identified needs and gaps within the CHW/FP role. More detail on this work, as well as links to worksheets outlining individual health center CHW/FP workflows, can be found in the CHW/FP Role Development Summary linked within Section VIII.

The primary deliverable for come from the work in Phase I to further development of the CHW/FP role was the creation of the CHW Mini Manuals which can be accessed via a link within Section VIII. These manuals were developed in response to perceived needs identified during both steps of the process: skills development and the qualitative assessment. The manuals operationalize key aspects of the CHW/FP role within each of the core clinical workflows of the TEAM UP model.

VII. Areas of Opportunity and Recommendations from Phase 1

There remain many opportunities for further advancement and operationalization of the CHW/FP role during Phase II of the TEAM UP initiative based on the findings of the qualitative assessment. Outlined in the table below are the recommendations and areas of opportunity that will inform efforts moving forward for TEAM UP. Many of these opportunities pertain to optimizing EMR functionality used by CHWs to track and document their work with families.

A primary area of interest in the advancement of the CHW/FP role is the opportunity to quantify and assess the impact of the CHW/FP on care delivery within the integrated setting. This was born out in the work of Phase I and has been raised in multiple collective forums including the 3rd Annual TEAM UP Symposium. This memo and these recommendations are meant to serve as a jumping off point in discussions through Phase II of the initiative to articulate next steps in the process of advancing the CHW/FP role and developing an action plan for moving the work forward.

Summary of Recommendations from CHW/FP Role Assessment

	Recommendations
Integrating Training into Your Work	Consider developing a brief, single-episode intervention that aligns with PSE, a problem-solving intervention. This could focus on patient-centered, actionable goal setting (e.g. SMART goals). This would also likely help in building skills in how to address resistance and is a natural fit as a simplified approach to care planning. The intervention could serve as a template for documentation in the EMR. It would be helpful to create an accompanying documentation policy to set consistent standards.
	Consider offering additional disease-specific trainings on common chronic medical diseases in childhood, for example asthma and type 1 Diabetes.
Team-Based Care	Overall there is a strong understanding of the CHW/FP's role and responsibilities. On-site coaching through the role-focused supervision can further enhance the CHW/FP role within the care team.
Daily Activities	There is significant variability in how CHWs/FPs receive requests. For each health center, consider standardizing the way of using the EMR to communicate requests (e.g. all requests converted to telephone encounters to track all requests in a centralized place).
	Consider further developing mechanisms to support CHWs/FPs in doing off-site visits, either at the patient's home or at a community agency.

[Type here]

Organizing Your Work	While each CHW/FP uses some mechanism to track active patients and follow-up activities, there is significant variability in the tracking mechanism. For each health center, consider setting organizational standards for how active patients will be identified and how follow-up activities will be tracked. It is strongly recommended that the EMR be the tool utilized to track all patient care activities.
Population Health Management	With the emergence of ACOs, it is likely that long-term sustainability of the CHW/FP role would improve with proactive integration into the population health programming for which the ACO is responsible. Examples include 1) outreach to engage patients in primary care and address gaps in preventive care to achieve **quality** goals, and 2) engaging with high-risk patients and families with high utilization of emergency, hospital, and/or specialty care to achieve **efficiency** goals. We recommend formulating a plan to develop and integrate population health functions into the CHW/FP role.

VIII. Supporting Documents

Care Coordinator Role Memo vF 03.2016

CHW Role Development Data Gathering Summary

CHW/FP Role Development Summary

CHW Role Development Memo 9.30.19

CHW Mini Manuals

IX. References

The following resources have been used to guide TEAM UP's work in developing the CHW/FP role to date.

Project Launch Family Partner Role:
http://www.ecmhmatters.org/ForProfessionals/Documents/Toolkit/BPHC_PowerPoint_Project_Section_1_FINAL.pdf

Massachusetts Board of Certification of Community Health Workers Core Competencies for Community Health Workers:
http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/dhpl/community-health-workers/ma-board-of-certification-of-community-health-workers.html