Evidence based Strategies on how the use of community health workers will improve access to health care for individuals.

The purpose of this document is to outline the benefits of utilizing Community Health Workers to increase access to health care and guide organizations/agencies to partner with the Florida Community Health Workers Association and local community health worker networks.

OMH Efforts on CHW Use

1. Many of the CTG grantees utilize CHWs to implement their programming in their local communities.
2. Training CHWs on health screening procedures to improve health screening capacity for underserved communities across the state.
3. Providing grant writing training to community-based organizations that employ CHWs to improve the health of Floridians.
4. Encouraging the use of CHW lead self-management education programs across the state.
5. Promoting workforce development opportunities that diversify the health care and public health workforce and bring more CHW and health care professionals to communities in need through programs such as the National Health Service Corps and Nurses Corps.
6. Data collection, motivational interviewing, communication, and telehealth trainings will be given to CHWs in 2023.

Use of Community Health Workers to Improve Health care Access

1. **Facilitate health care and social service system navigation.**
    a. CHWs "advocate and liaise between their patients and a variety of healthcare and human service organizations (Rural Health Information Hub – Community Health Workers Toolkit)."
    b. CHWs are trained to have strong knowledge of specific diseases, the healthcare system, and resources available in their community and work in tandem with clinically trained health professionals to improve outcomes for patients (Rural Health Information Hub – Community Health Workers Toolkit).
    c. An example of this is the Outer Cape Health Services Community Resources Navigation Program that works to train CHWs to connect clients to needed social, behavioral health, and substance use disorder services (Rural Health Information Hub – Models and Innovations).
    d. Conducting outreach to connect families to health insurance and primary care providers and Patient Centered Medical Homes (PCMH)
2. **Assist with lay care coordination.**
    a. "As a care coordinator or case manager, community health workers help individuals with complex health conditions to navigate the healthcare systems (Rural Health Information Hub – Community Health Workers Toolkit)."
    b. CHWs often support individuals by providing information on health and community resources, coordinating transportation services, making appointments, and

delivering appointment reminders (Rural Health Information Hub – Community Health Workers Toolkit).

c. CHWs often work with patients to develop a care management plan, serve as care transition coaches for patients discharged, and work with patients who have been recently diagnosed with chronic conditions to answer questions and assist in scheduling appointments (Rural Health Information Hub – Community Health Workers Toolkit).
d. An example of this is the Nurse Navigator and Recovery Specialist Outreach Program in Pennsylvania in which CHWs provide case management services to assist patients with substance use disorders and chronic diseases to navigate the health care system (Rural Health Information Hub – Models and Innovations).

3. **Connect individuals to health and human service resources, such as health insurance, food, housing, and other health information.**
    a. Community health workers help to address the social, non-clinical challenges affecting patients' health and care (Massachusetts Department of Public Health).
    b. "CHWs are trained to help patients deal with social, economic, and other barriers to accessing and benefiting from services (Massachusetts Department of Public Health)."
    c. An example of this is CHWs at Kentucky Homeplace that provide clients a variety of services such as access to medical, social, and environmental support services ranging from assistance with diabetic supplies, eyeglasses, and home heating assistance (Rural Health Information Hub – Models and Innovations).
4. **Assist individuals with understanding their health condition(s) and develop strategies to support their health and well-being.**
    a. Massachusetts and other states have demonstrated that CHWs add value to multidisciplinary care teams in multiple ways. CHWs improve health by helping patients engage more fully in their care, helping patients adhere to care plans, and helping patients control chronic conditions (Massachusetts Department of Public Health).
    b. CHWs provide services through outreach, education, advocacy, and social support that seek to improve access to preventive care by teaching clients and patients how to prevent, reduce risks for, and manage chronic diseases (Massachusetts Department of Public Health).
    c. "CHWs support patients to make healthier lifestyle choices, help patients access needed services, keep medical appointments, and increase adherence to treatment plans (Massachusetts Department of Public Health)."
    d. Providing education and information on services related to blood pressure, glucose, body mass index, the prevention and management of diabetes, cardiovascular disease, cancer, HIV/AIDS, maternal and children, mental health, etc.
5. **Deliver health information using culturally appropriate terms and concepts.**
    a. "CHWs come from the communities they serve, usually sharing identities, geography, or experiences with their clients/patients. This commonality allows

CHWs to be uniquely qualified to relate with and provide support to individuals in their community (Minnesota Community Health Worker Alliance)"

b. CHWs are skilled frontline staff that bridge communication and cultural gaps that are prevalent between the low-income, underserved patients they serve and clinical health professionals (Massachusetts Department of Public Health).
c. "Since CHWs typically reside in the community they serve, they have the unique ability to bring information where it is needed most. They can reach community residents where they live, eat, play, work, and worship (NIH – National Heart, Lung, and Blood Institute)."

6. **Advocate for local health needs, provide informal counseling and participate in self-management programs.**
    a. CHW's are especially well suited for self-management programs and ongoing support for adults with Diabetes and Hypertension. It is widely recommended that they are used for chronic disease care services (CDC)
    b. The limited availability of certified health educators makes CHWs a logical choice for the service (CDC)
    c. State Level support is an important factor in carrying out CHW supported self-management programs. State support can be given by
        i. Providing access to database of approved self-management programs
        ii. Providing funding for CHWs to attend self-management programs
        iii. Creating materials for organizations to training CHWs in the support of self-management programs
7. **Conduct home visits or meet with individuals outside of the clinical settings.**
    a. In their role CHWs provide home visits to assess needs, appointment support and reminders, health literacy education, advocacy, and assistance finding medical services (Massachusetts Department of Public Health).
    b. The Patient- centered Outcomes Research Institute funded research study showed that a CHW asthma home visit program helped people ages 5-75 with uncontrolled asthma to learn about and avoid triggers for their symptoms. They also missed fewer days of work or school and had fewer ER visits + improved quality of life than those who did not have visits.
        i. The PCORI funded implementation project expanded a CHW asthma home visit program to new regions in Washington State.
    c. **Participating in community outreach efforts. CHWs can help with outreach efforts and connect community with care by**:
        i. Facilitating referrals to self-management programs, food banks, churches, social workers.
        ii. Following up on referrals to ensure that appointments are kept, and patients are receiving provider recommended appropriate care.
        iii. Sharing linguistically appropriate health education materials for adults with low health literacy.
        iv. Conducting motivational interviewing to discover patient needs.

v. Providing appropriate referrals (e.g., to a church-sponsored gym for $5 per year).
vi. Facilitating relationships with social workers with the goal that they will visit clinical sites and assist
vii. Connecting patients to each other to provide ongoing personal support.
viii. Serving on local boards and maintaining a healthy and active relationship within the community.
ix. Providing patients with a directory of resources and actively updating and maintaining the directory

d. **CHWs and Patient Centered Outreach Research**
   i. Conducting outreach to connect families to health insurance and primary care providers and Patient Centered Medical Homes (PCMH)
   ii. Engaging nontraditional partners (i.e., patients, clinicians, policy-makers, organizational leaders, Community Health Workers [CHWs]) throughout the research process can further research priorities, enhance methodology, and accelerate translation to inform policy and practice and reduce disparities [1–3]. This essential spoke of the translational research wheel strengthens research activities through diverse stakeholder expertise and lived experience.
   iii. Community Health Workers represent an untapped workforce well situated to bridge the community with various health service
   iv. Because of their intimate connections with the community, CHWs hold the potential to serve as liaisons between investigators and target populations in PCOR.
   v. CHWs can engage hard-to-reach individuals within vulnerable communities, understand the context in which health problems exist, and serve as advocates for their communities' needs in research

e. State level support can be given by
   i. Using toolkits to help organizations understand how to create partnerships and develop
   ii. community-clinical linkages.
   iii. Creating and maintaining a robust resource list for CHWs to use in their outreach work (e.g., with
   iv. multiservice organizations and faith-based organizations) that helps communities engage in resolving their own health problems.
   v. Creating and supporting a statewide CHW network to share resources and increase engagement.
   vi. Improving access to mental health services, as this is an issue that often needs addressing, especially
   vii. as CHWs have limited ability to obtain referrals for mental health services or learn about resources in that field.
   viii. Working within an interdisciplinary care team to tailor resources to individual patients' self-management and education needs.

ix. Promoting preventive behaviors.
x. Having CHWs assist in providing community resources such as lists of resources for outreach (e.g., lists of mental and dental clinics)

8. **CHWs usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve, collaborate with the healthcare system, and play a key role in reaching the vulnerable and underserved.**
    a. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.
    b. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.
    c. CHWs as a member of the care delivery team also frees up resources and enables rural healthcare professionals to focus on more complex patients and issues.
    d. Supporting and advocating for families to improve communication and trust with healthcare and public health services.
    e. Assisting families and individuals for whom the primary language is not English with healthcare access and quality.
    f. Enabling health care providers to improve programs and communicate adequately with populations whose primary language is not English.

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