Concepts of Teamwork and Collaboration Applied to the Community Health Workers as Part of the Primary Care Team

Cathy Franklin, DNP, RN, FNP-C
East Boston Neighborhood Health Center
East Boston, MA.
Disclosures

NO

DISCLOSURE
Objectives

- Review the history and evidence related to patient outcomes regarding:
  - Primary care
  - The community health worker (CHW) movement
- Review concepts related to teamwork and collaboration
- Apply concepts of collaboration and teamwork to a model that describes CHWs as members of the primary care team
History of Primary Care

Time Line...

- **1920**: Concept of Primary Care Coined in the Dawson Report
- **1960’s**: Credentialing for a new specialty of family practice conceived
- **1967**: AAP introduces the concept of “Medical Home”
- **1978**: Declaration of Alma-Ata
- **1996**: IOM Report: Primary Care: America’s Health in a New Era
History of Primary Care:

Time Line

2002
The Future of Family Medicine Project

2007
Joint Principles of PCMH released

2008
Safety Net Medical Home Initiative

2010
Patient Protection and Affordable Care Act passes

2012
IOM Report: Primary Care and Public Health: Exploring Integration to Improve Population Health
Outcomes in Primary Care

- **2005**: Major systematic review demonstrates that primary care improves the health of individuals and communities, reduces health disparities, and lowers total costs of health (Starfield, Shi, Macinko, 2005)

- **2012**: Patient Centered Primary Care Collaborative Report
  
  Largest report to date on outcomes of PCMH projects across the United States demonstrating reduced costs and improved outcomes:
  
  - Reduced ED visits and hospitalizations
  - Improved management of chronic illness
  - Improved patient experience (Nielsen, Grundy, Nace, 2012)
Community Health Workers

• “…frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served…”

• Serve as a liaison, link, or intermediary between health/social services and the community to:
  ◦ facilitate access to services and
  ◦ improve the quality and cultural competence of service delivery

• Building 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
  ◦ Advocacy

APHA, 2009
National Call for CHWs
Improve the Nation’s Health

- IOM (2010): Recommended CHWs as part of their strategic plan to prevent, control, and reduce the impact of hypertension
- PPACA (2010): Identified the need to encourage CHW engagement in health promotion and improving health outcomes for the medically underserved
- CDC (2011): Policy Brief: Addressing Chronic Disease through CHW’s
CHWS

- Predominantly reflects the ethnic background - live in the communities they serve
- Over 85,000 paid and volunteer CHWs in the United States

- Titles include:
  - Lay health workers
  - Volunteer health workers
  - Community health agents
  - Promotorar de salud
  - Care Coordinators
Outcomes of CHW Interventions
Vulnerable and Underserved Populations

- Improved health promotion and prevention such as:
  - Vaccination compliance
  - Maternal child health
  - Cancer screenings

- Improved management of chronic illnesses such as:
  - Asthma
  - Diabetes
  - Heart disease

- Cost savings

Viswanathan, 2009; NE CEPAC, 2013
History

Community Health Workers:

Time Line...

- **17th Century**
  - First Evidence

- **1950’s**
  - Village health volunteers reported in Thailand & Latin America

- **1966**
  - Earliest note of CHW in US as an intervention to address poverty

- **Mid 70’s-80’s**
  - Private grants fund special health promotion & access

- **1990’s**
  - National conversation about standardized training for CHW’s; various state bills unsuccessfully passed
## History

### Community Health Workers:

#### Time Line

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>Texas becomes 1st state to require HHS agencies to use CHWs and require training &amp; certification</td>
</tr>
<tr>
<td>2006</td>
<td>Massachusetts CHWs assist over 200,000 residents to enroll in state’s first universal healthcare plan &amp; gain access to primary care</td>
</tr>
<tr>
<td>2008</td>
<td>Minnesota CHWs granted reimbursement for broad spectrum of interventions</td>
</tr>
<tr>
<td>2010</td>
<td>Patient Protection and Affordable Care Act passes</td>
</tr>
<tr>
<td>2014</td>
<td>States with CHW Organizations: Arizona, Colorado, District of Columbia, Florida, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Mexico, New York, North Carolina, Oregon, Rhode Island, Tennessee, Utah, Virginia, Washington, Wisconsin</td>
</tr>
</tbody>
</table>

---

*Note: This timeline is a representation of significant events in the history of community health workers (CHWs) in the United States.*
CHW National Workforce Study

Five Models of Health Care Delivery:

1. Member of the care delivery team
2. Navigator
3. Screening and health educator provider
4. Outreach-enrolling-informing agent
5. Organizer

HRSA, 2007
CHW Activities
Defined by 2007 Workforce Study

Six key areas of CHW activity identified as follows:

1. Creating linkages between communities and the healthcare system
2. Providing health education and information,
3. Assisting and advocating for underserved to receive appropriate services
4. Providing informal counseling
5. Directly addressing basic needs
6. Building community capacity in addressing health issues

HRSA, 2007
CHW Workforce Profile

- Approximately 67% of the CHW workforce are paid and employed by a variety of organizations
  - Approximately 27% of which can be categorized as ambulatory health care organizations
- Approximately 33% are volunteers deployed by:
  - Grassroots community
  - Faith based
  - Advocacy organizations

HRSA, 2007
States with CHW Training/Certification Standards

Current Status

- **Laws/Regulations Establish CHW Certification Program Requirements**
  - Statute Creates a CHW Advisory Board, Taskforce, or Workgroup to Establish Program Requirements
- **No Law; But Has State-led Training/Certification Program**
- **Pending Legislation**
- **Medicaid Payment for Certified CHW Services**
- **None**

*AK does not have a state-run CHW training program, but statutorily provides community health aide grants for third-parties to train community health aides.*

Last updated: 3/16/2015

Astho, 2015
States Implementing CHW Strategies

- CDC sponsoring program in 50 states to reduce the risk factors associated with childhood and adult obesity, diabetes, heart disease, and stroke with focus on healthy environments in workplaces, schools, and in the community.
  - 23 of the states are using CHWs to reduce health disparities in chronic illnesses through the provision of:
    - Training in health coaching for chronic disease self management
    - Development of core competencies and certification
    - Access to electronic health record (EHR) systems to facilitate follow-up with patients, communication with providers on the care team, and the referral of patients to community resources.
    - Exploration of financing mechanisms to sustain programs

- HRSA Office of Rural Health Policy published its CHW Evidence-Based Models Toolbox for CHW program models and training

CDC, 2014; HRSA, 2011
National Call
Teamwork and Collaboration

- **IOM (2001) in *Crossing the Quality Chasm***
  Increased development of interdisciplinary teamwork and team training as part of the redesign of the health care system

- **WHO (2010) in *Framework for Action on Interprofessional Education & Collaborative Practice***
  Put forth an action agenda, described as an “urgent challenge,” to integrate interprofessional education and collaborative practice into service, education, and health policy globally in order to strengthen health systems based on primary care.

- **Interprofessional Education Collaborative (IEC) (2011)**
  Introduced core competencies for interprofessional collaborative practice

- **IOM (2012) Primary Care and Public Health: Exploring Integration to Improve Population Health***
  Call for establishment of community based interprofessional teams to support primary care providers in PCMHs
Outcomes of Interprofessional Teamwork and Collaboration

- Improves patient outcomes
- Improves access to healthcare.
- Healthcare workers who serve as part of a team have higher job satisfaction than those who do not

Archer et al., 2012; Davenport, et al., 2007; Raab et al., 2013; Zatzick, et al., 2014
Terminology…

- **Team**: “a group of people working together to achieve common purpose for which they hold themselves mutually accountable” (Scholtes, et al., 2003)

- **Interprofessionality**: “…a cohesive practice between professionals from different disciplines. It is the process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/family/population”

  **Contrasted with:**

- **Multidisciplinarity**: a process whereby multiple disciplines work on the same project in an independent and parallel fashion reflecting a lower degree of collaboration on the spectrum (D’Amour and Oandasan, 2005)
Terminology

- **Teamwork** creates the environment that supports collaboration

- **Collaboration**: exchange between professionals “which values the expertise and contributions that various healthcare professionals bring to patient care”

- Collaboration requires two constant and key elements:
  1. Construction of collective action that addresses the complexity of client needs and
  2. Construction of a team life that integrates the perspectives of each professional where each member experiences respect and trust

D’Amour and Oandasan, 2005
Assumptions of Effective Teamwork

- **Shared understanding** of roles, norms, values, and goals of the team; shared responsibility and commitment

- **Cooperation**: Working together that recognizes and respects involvement and contributions of all members

- **Interdependence/Egalitarianism**: All members contribute to the relationship

**Synergy**

Outcomes achieved are greater than the effect of any one team member alone

Gage, 1998; Rice, 2000; Scholtes et al., 2003
Integrating CHWs into the PCMH: Lessons learned in promoting teamwork from the literature

Shared understanding of roles, norms, values, and goals of the team

- Clarification of role and scope of practice
- Recruitment of CHWs for leadership & communication skills
- Education of all team members re: role expectations
- CHW training in skills & PCMH
- Agreed upon protocols/workflow maps
- Administrative Support:
  - Organizational champions
  - Technology and other resources
  - Infrastructure support

CDC, 2014; Franklin et al., 2015; Matiz et al., 2014; Salant, et al., 2014; Wennerstrom et al., 2015
Integrating CHWs into the PCMH: Lessons learned in promoting teamwork from the literature

Cooperation/Interdependence/

Egalitarianism:

- CHWs part of planning
- Co-location
- Systems for ongoing Communication
  - Team huddles
  - Team meetings
  - Team building exercises
  - EHR access

CDC, 2014; Franklin et al., 2015; Matiz et al., 2014; Salant, et al., 2014; Wennerstrom et al., 2015
Commonalities of Models
All Assumptions for Effective Teamwork identified

- CHWs were part of the primary care team
- Patients who were recipients of CHW interventions were members of either a community health center, public health clinics, or academic center primary care clinic
- CHW interventions included the management of a chronic disease — Type II diabetes and asthma
CHW as Part of Healthcare Teams

Studies from Literature that Exemplify Teamwork

Teams were comprised of a CHW and one or more of the following:

- Nurse
- Physician
- Dietitian
- Social worker
- Psychologist
- Nursing Director
- Medical Assistant
- Project coordinator

Franklin et al., 2015; Wennerstrom, 2015
East Boston Neighborhood Health Center

Care Navigator

• 2011
• Community HealthCorps Member: (Division of AmeriCorps)
• Serve as Volunteers for 11 months full time (1700 hours)
• Often a gap year prior to grad school
• 9 Care Navigators integrated into each primary care/health center team at the health center
• Clear role: May not perform employee duties or fill in for an absent employee

• Receive an Education Award
  ◦ $5645
• Receive a living allowance
  ◦ $14,000 1st year
  ◦ $20,000 2nd year
• Loan Forbearance while serving
East Boston Neighborhood Health Center

Care Navigator: Role

- Assistance and guidance in navigation of the health care system for high risk populations:
  - Immigrant
  - Illiterate
  - Disabled
  - Veterans

- Advocacy, empowerment, and care coordination for patients with medical & non-medical needs

- Information about community resources, e.g.:
  - Housing & Shelter
  - Heating
  - Child care
  - Exercise, Food
  - Heating
  - Legal Services
  - Substance Abuse
  - Rape Crisis

- Provide escort for patients to appointments

- Tutoring
East Boston Neighborhood Health

CHW Role

- WIC Program
  Provides nutrition education & outreach materials to patients in the Family Medicine, OB, and Pediatric clinics, at local agencies & advocacy groups.

- Asthma Program
  Coming Soon to Pediatrics
  Massport Funded grant for residents of East Boston and Winthrop
  Home assessment and environmental action plan
  Medication adherence, medical appointments
Summary and Conclusions…

- Primary Care will be at the hub of access within PCMHs
- CHW interventions have demonstrated important significant clinical outcomes, reduced health disparities, and reduced costs
- Patient care can no longer be delivered in silos. Effective teamwork and collaboration are essential for all healthcare team members
- The integration of interprofessional teamwork and collaboration with primary care workforce redesign that integrates CHWs sits on the brink of bridging the gap between primary care and public health
Summary and Conclusions

Integrating CHWs into Primary Care teams presents an opportunity to:

- Improve access
- Reduce health disparities
- Increase cultural competence of the primary care team
- Improve cost savings
- Improve patient satisfaction
- Improve primary care team job satisfaction
- Improve management of chronic illnesses
- Promote the overall health of individuals, families, and communities thereby strengthening of the healthcare system overall
Cathy Franklin can be contacted at East Boston Neighborhood Center franklic@ebnhc.org
References

References


References


