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Defining the Role of the Community Health Worker within a Federal Healthy Start Care Coordination Team

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Abstract

Introduction—Federal and state policies often require utilization of evidence-based home visiting programs. Measurement of specified interventions is important for tracking program implementation and achieving program outcomes. Thus, the Strong Beginnings program worked to define community health worker (CHW) interventions, a core service of the program to improve maternal and child health.

Methods—A workgroup consisting of CHWs, supervisors and other program staff was created in order to develop and define specific CHW interventions within a nurse or social worker care team. Basic interventions were first compared to the nurse or social worker care coordinator home visiting interventions by risk topic. The evaluator then grouped each CHW intervention into categories per risk domain using thematic analysis and assigned a CHW core function or role based on literature review findings. The workgroup confirmed the results. The workgroup then continued discussions to further enhance CHW interventions per risk domain once the general structure was created.

Results—The workgroup identified seven core functions and 28 maternal and child health risk topics to be addressed by the CHW. The process resulted in a detailed document of program interventions that the CHWs use to guide care.

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Conclusions—The process helped CHWs feel more valued with their role in team care. The specified interventions will help others understand the CHW role within the care team, ensure consistent interventions are delivered across program partners, provide a foundation to better understand how specific CHW contributions are related to health outcomes, and support program sustainability.

Keywords

Community Health Worker (CHW); Home visiting; Care coordination; Federal Healthy Start Program

Introduction

Many federal Healthy Start programs utilize community health workers (CHW) as part of their intervention service delivery. The American Public Health Association defines a CHW as “a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker 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” (American Public Health Association Community Health Workers Section 2009). The Grand Rapids federal Healthy Start program, Strong Beginnings, teams CHWs with registered nurses or licensed social workers from Michigan’s Medicaid-sponsored Maternal Infant Health Program (MIHP), a home visiting program designed to serve all Medicaid-eligible pregnant women and infants. The MIHP nurse or social worker care coordinator conducts comprehensive risk screening and delivers service through protocol-driven plans of care for care coordination, health education and referrals determined by specific risk factors. Under rigorous examination, MIHP has shown success with increased utilization of prenatal care and well child visits and decreased risk for preterm birth and infant low birth weight among women who enroll in the program before their third trimester of pregnancy and receive 3 or more contacts (Meghea et al. 2013b; Roman et al. 2014).

Yet statewide, only about 30% of eligible women participate in MIHP (Roman et al. 2014) and racial and ethnic disparities in infant mortality persist. The infant mortality rate for Blacks in the Strong Beginnings’ service area is more than double the White infant mortality rate (Michigan Department of Community Health 2015). Thus, Strong Beginnings enhanced the MIHP model by adding the unique skills of a CHW to facilitate access to services, improve the quality and cultural competence of service delivery (American Public Health Association Community Health Workers Section 2009) and address social determinants of health for African American pregnant women and infants enrolled in the program. Many African American women enrolled in the program were found to have higher psychosocial and medical risks than other Medicaid-eligible pregnant women and infants (Meghea et al. 2013a).

In the Strong Beginnings interdisciplinary model, the CHW enriches team care through their knowledge of the community they serve (American Public Health Association Community Health Workers Section 2009) and provides team-based care management or care

coordination, health education, and referrals in conjunction with the nurse or social worker. Functionally, the addition of the CHW also allows services to be more concentrated through an expanded visit schedule and smaller caseloads. The CHW aims to provide bi-weekly prenatal visits and weekly visits for the first 6 weeks after birth followed with bi-weekly visits until the infant is 6 months old; and then monthly until the child is 24 months old. In addition to CHW care, the MIHP nurse or social worker care coordinator can provide up to 9 visits during pregnancy and typically up to 9 visits after birth until the infant reaches 12 months old. In order to allow the CHWs to follow the intense visit schedule, the CHW client caseloads are significantly less at 30–35 clients per provider compared to the nurse or social worker care coordinator at about 60 to 80 clients. The CHWs are managed by the same supervising staff as MIHP nurses and social workers. The CHWs are also required to complete 126 h of certificate training issued by a local community college (Michigan Community Health Worker Alliance 2016b) in addition to other education related to program needs.

The challenge is determining how the CHW and MIHP care coordinator complement each other's care and work together as a home visiting team without duplication. When Strong Beginnings began in 2005, the CHWs were expected to deliver specific curriculum with women. However, over time, other evidence-based education materials and strategies were added to the repertoire of CHW intervention. The CHWs began to mix interventions based on their level of comfort with the material, experience, and general availability. Thus, the difference in care between the CHW and the nurse or social worker care coordinator became confusing, and the value of integrating a CHW within the care team was unclear without defined CHW interventions (Findley et al. 2014; Swider 2002). Moreover, the lack of standardized CHW interventions made it difficult to evaluate CHW care across multiple provider agencies and quantify CHW contributions to health outcomes (Arvey and Fernandez 2012).

Given recent federal and state policies requiring the utilization of evidence-based home visiting programs, the growing interest in adding CHWs to medical and public health services in the United States, and federally funded work to improve the local perinatal system of care within the Strong Beginnings service area, rigorous evaluation of the CHW team model is essential (Bovbjerg et al. 2013; Patient Protection and Affordable Care Act H.R. 3590 (111th) 2010; State of Michigan 96th Legislature Regular Session of 2012 House Bill No. 5572 2012). Thus, Strong Beginnings sought to clearly define the role and specific interventions of the CHW within the care coordination team to standardize care across multiple partner agencies and create a foundation for a subsequent comprehensive evaluation of CHW contributions to maternal and child health outcomes.

Methods

A workgroup consisting of three CHWs, three program supervisors who manage CHWs and MIHP care coordinators from each partner agency, one community educator, one program evaluator and two other program staff was created to define specific CHW interventions. Given the team model, the work group reviewed the MIHP program organizing framework that specified nurse and social worker interventions for established risk domains and

determined the framework could also be used as a method to organize and distinguish CHW interventions. The MIHP risk domains included: family planning, pregnancy health, food and nutrition, housing, transportation, social support, smoking and secondhand exposure, alcohol, drugs, stress/depression, abuse/violence, asthma, diabetes, hypertension, interconception health, infant health, infant safety, feeding and nutrition, general development and family, social support, parenting and childcare (Michigan Department of Health and Human Services 2017). For each risk domain, the workgroup first developed a general list of existing CHW curriculum materials and other intervention strategies compared to the pre-existing plan of care to be followed by the nurse or social worker.

Once the general list of CHW interventions were created for each domain, the evaluator grouped each CHW intervention into categories per risk domain using thematic analysis to document the frequency of common themes in the materials and determine core functions embedded in the current program model. Next, a literature review was done to identify common CHW core functions or roles in a broad range of CHW programs. Case management and care coordination (Fishman et al. 2015; Matos et al. 2011; Michigan Community Health Worker Alliance 2016a; Rosenthal et al. 2016), community-cultural liaison (Fishman et al. 2015; Matos et al. 2011; Michigan Community Health Worker Alliance 2016a; Rosenthal et al. 2016), peer support (Money et al. 2011), health promotion and health coaching (Fishman et al. 2015; Matos et al. 2011; Michigan Community Health Worker Alliance 2016a; Rosenthal et al. 2016), self-management/problem solving and capacity building (Rosenthal et al. 2016; Tang et al. 2014), home-based support (Fishman et al. 2015; Matos et al. 2011; Michigan Community Health Worker Alliance 2016a), outreach and community mobilization (Fishman et al. 2015; Ingram et al. 2012; Matos et al. 2011; Michigan Community Health Worker Alliance 2016a; Rosenthal et al. 2016), system navigation (Fishman et al. 2015; Ingram et al. 2012; Matos et al. 2011; Michigan Community Health Worker Alliance 2016a; Rosenthal et al. 2016), health education (Ingram et al. 2012; Krieger et al. 2005; Tang et al. 2014), chronic disease management (Kyounghae et al. 2016), risk screening (Ingram et al. 2012; Rosenthal et al. 2016), participatory research and community assessments (Fishman et al. 2015; Matos et al. 2011; Michigan Community Health Worker Alliance 2016a; Rosenthal et al. 2016), and doula support during birth (Kane Low 2006) were identified and considered. The evaluator then assigned a CHW core function or role as defined in literature to each intervention category. The workgroup, then, reviewed the findings and worked to achieve consensus on core functions for the maternal and infant health home visiting team model.

Once the general structure was created, the workgroup continued discussions: (1) to further enhance CHW interventions per core function or role for each risk domain; (2) to identify the differences and overlap between the MIHP care coordinator and CHW interventions; (3) to determine additional CHW roles that fit well with nurse or social worker care; and (4) to decide if and what additional risk domains the CHW should address. The workgroup made decisions based-on how well the roles, interventions, and risk domains fit with client needs informed by CHW workgroup members, coordination of care with the MIHP nurse or social worker, program goals and funder requirements. This evaluation project was reviewed by Michigan State University's Institutional Review Board.

Results

Using thematic analysis, the literature review, and iterative group discussions, the workgroup identified seven CHW core functions. From thematic analysis and literature: (1) risk screening; (2) personal goal setting, later specified as self-management and problem solving; (3) health education; and (4) referrals and system navigation were identified as CHW core functions within care coordination. Based on further discussions, the workgroup added core functions which included: (5) peer support; (6) collaboration with the MIHP nurse or social worker; and (7) community outreach and mobilization. Given the CHW's close understanding of the clients they serve and ability to intensely work with a client, the workgroup felt peer support was a unique aspect of CHW care that is ingrained in all facets of care and enhances services the most but was not concluded from the thematic analysis. Collaboration with the nurse or social worker was also considered an important program expectation across all care but similarly was not a specific result of the thematic analysis. Community outreach and mobilization was also added as a core function to account for CHW work within the community rather than services delivered as part of the care team. Descriptions of each core function are described in (Table 1).

The workgroup also delineated 28 topics of risk or risk domains to be addressed by the CHW which are presented in (Table 2). The majority of risk domains were the same risks addressed by the nurse or social worker care coordinator. However, a few topics were explicit to CHW care such as the personal goals and care transition at birth. The personal goal topic was developed in order to capture any additional goals beyond program focus that a client may want to achieve while enrolled. Further, as hospital visits by MIHP nurses and social workers are not reimbursable, interventions for the care transitions at birth area of care were specific given the CHW's ability to complete a visit in the hospital to ensure the infant had a car seat to go home, next medical visits were scheduled for both the mother and infant, the infant had a safe place to sleep at home and other needs before hospital discharge after birth. A hospital visit is expected to be completed if the CHW is notified of the birth in time.

The number of interventions identified for each specified core function varied by risk topic or domain and ranged from 1 to 21 specified interventions. In general, self-management and problem solving interventions were aimed to empower the woman with achieving self-improvement for health and wellness within their everyday life and included goal setting and action plan development, identifying barriers and problem solving, and promoting communication skills for describing health concerns with the medical provider. Health education interventions comprised of specific curriculum materials to support goal setting and action plan development. The workgroup identified specific curriculum for the CHW that enhances, not duplicates, education provided by the nurse or social worker care coordinator using the Florida State University Partners for a Healthy Baby Curriculum (The Florida State University Center for Prevention & Early Intervention Policy) and other materials or strategies. The extra education also allows the CHW to offer peer support throughout the topics. With knowledge of the specific CHW education, the nurse or social worker can either prepare the client that the CHW will go into more detail about a specific topic or use her materials to reinforce what was already provided by the CHW depending on how discussions fall within the visit schedule between the CHW and care coordinator.

Referrals and system navigation included assisting clients with adhering to medical appointment schedules, providing referrals to community resources as needed, assisting with supportive engagement into services, and accompanying clients to the referral source upon request. An example of CHW interventions listed per core function for the family planning risk domain is reported in (Table 3).

Essentially the interventions listed for each core function across the risk domains direct the CHW to work closely with the woman on developing, setting and managing health and wellness goals within their everyday life and use peer support to coach and assist the client with overcoming barriers to reaching their goals. The CHW will use risk screening to help monitor care needs and provide comprehensive health education to support personal goal setting work. Although referrals are also an expectation of the MIHP nurse or social worker, both CHW and care coordinator will address all referral needs no matter who is providing intervention at the time. However, through peer support, the CHW will assist with engaging the client into referral completion if needed and help with time consuming referrals such as applying for Section 8 Housing. Within the team model, the role of the MIHP nurse or social worker is to complete comprehensive assessments to determine specific risk and assist the woman with achieving health goals by providing basic education, facilitating connections to other health and human services, coordinating care among service providers and monitoring for the need to make care adjustments based on previously established plans of care (Michigan Department of Health and Human Services et al. 2017). The MIHP nurse or social worker is also the lead in the team based care.

Overall, this process resulted in a detailed document of CHW program interventions that the CHWs will use to guide their care per risk topic. The listed interventions are considered required interventions unless specially noted to be provided as needed. However, the CHW may provide additional care.

Conclusions

The workgroup's knowledge and appreciation of CHW care was essential for reviewing and determining specific actionable CHW interventions. The detailed document clearly defined the role of the CHW within the care team. The defining process also created a better nurse and social worker understanding how CHW services complement their care especially among the program supervisors participating in the workgroup who had experience working as a MIHP care coordinator. The process also helped CHWs participating in the workgroup feel more valued with their role in care.

The results have limitations. The detailed intervention document is specific to maternal and child health programs. CHWs are often used in other areas of health such as cancer screening and chronic disease management (Kyoungah et al. 2016) which could be adapted but may not directly translate from maternal and child health interventions. Further, the workgroup found that CHW roles are not always defined with mutually exclusive tasks in literature. For example, coaching on problem solving was identified as a CHW task for case management and care coordination, home-based support, and health promotion and health coaching which made it difficult to identify specific core functions or roles during the

process (Matos et al. 2011; Michigan Community Health Worker Alliance 2016a). Thus what the workgroup defined as care coordination interventions because it matched MIHP terminology for the nurse or social worker within the interdisciplinary team, another group could define as health promotion or home-based support.

The program's CHWs are now utilizing the created document as a checklist for care based on risk. Each intervention was assigned a unique code to simplify CHW documentation of intervention delivery which is captured in the program's electronic database per encounter. The documentation will allow the program to evaluate specific care delivered by the CHW, and its relation to program outcomes. The specified interventions are also a valuable source for staff training and will help ensure consistent intervention is delivered across program partners. Early use of the defined interventions has already identified additional training needs among the CHWs. Next steps are to conduct an implementation study to better understand how the CHWs are delivering interventions with fidelity to the Strong Beginnings model and, then, a comprehensive evaluation of the program. It is hoped the clearly defined roles and specific interventions creates a foundation for evaluating and understanding specific CHW contributions to care and health outcomes which is essential for future scaling-up of services and sustainability of program funding (Findley et al. 2014; Pallas et al. 2013). The knowledge learned from evaluating CHW contributions could support similar home visiting programs with development and implementation of CHW care and support potential reimbursement for specific services provided by a CHW within home visiting. Additional knowledge could also help create other CHW integrated care models within the system of care for further population health improvements (Balcazar et al. 2011).

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Significance

There is an abundance of literature that generally defines the work of a community health worker (CHW). However, little is known about the specific interventions CHWs provide particularly within a home visiting nurse or social worker team for maternal and child health. This article explains the process a local federal Healthy Start Program took in order to define specific CHW interventions that complement existing nurse or social worker care coordination and standardize services across multiple partnering agencies.

Table 1

The description of each community health worker core functions identified by the workgroup

CHW core function	Description
Peer support	Use experiential knowledge to build trust and engage women and their families in improving health and using health resources. Provide emotional support, information and advice, practical assistance, and help in understanding events or information. Serve as a role model
Care coordination	
Risk screening	Conduct screening for personal mastery, trauma, health literacy, and provide continuous monitoring of depression/stress, use of family planning method(s), and breastfeeding. Use results of Community Health Worker screening and comprehensive risk assessments conducted by the MIHP care coordinator to direct care
Self-management and problem solving (goal setting)	Help the woman to develop attainable self-improvement goals and action plans for behavior change, overall health and wellness based on risk factors or required risk topic. Coach problem solving to assist client with identifying and addressing personal life barriers to achieving goals. Promote communication skills for describing health concerns and improving medical provider and patient interactions. Provide support for the client to call their medical provider's office with medical questions and concerns between appointments. Encourage adherence to MIHP care coordinator intervention, medical care and psychosocial treatment. Celebrate achieved goals with the woman
Health education	Provide specific curriculums to promote health and well-being based on client risk or required risk topic
Referrals and system navigation	Assist the woman with adhering to medical appointment schedules in regards to the specified risk (i.e. chronic disease, prenatal care, and infant care). Provide referral(s) for additional health and community resources, especially for basic needs. Assist the MIHP care coordinator by providing supportive engagement throughout the referral process, including accompaniment if requested
Collaboration with MIHP care coordinator	Collaborate with the MIHP care coordinator on care, notify care coordinator of any new risk or change in risk, case conference and partner on interventions as much as possible
Community outreach and mobilization	Inform and assist the community members with accessing available resources and health services, particularly services offered through Medicaid; and participate in health fairs that provide information about community services and promote health

CHW Community Health Worker, *MIHP* Maternal Infant Health Program

Table 2

Risk domains to be addressed by the community health worker identified by the workgroup

Risk domains	
Mother	
1	Abuse/Violence ^a
2	Alcohol ^a
3	Asthma ^a
4	Barriers to service
5	Basic needs ^a (food, housing, transportation)
6	Breast health
7	Breastfeeding ^a
8	Care transition at birth
9	Diabetes ^a
10	Drugs ^a (illicit or misuse)
11	Family planning ^a
12	Hypertension ^a
13	Interconception/postpartum health care ^a
14	Nutrition ^a
15	Other chronic disease
16	Periodontal disease
17	Personal goals/personal mastery
18	Prenatal health care ^a
19	Smoking/secondhand smoke ^a
20	Social support ^a
21	STDs, sexually transmitted disease and HIV/AIDS, human immunodeficiency virus/acquired immunodeficiency syndrome
22	Stress/depression/trauma ^a
Infant	
23	Family, social support, parenting and child care ^a
24	Feeding and nutrition ^a
25	Infant development ^a
26	Infant health care ^a
27	Safety ^a
28	Substance exposed infant ^a

^aDomain is also specified for the nurse or social worker care coordinator by the Maternal Infant Health Program. However, the care coordinator will address other concerns as needed

Table 3

Example of MIHP nurse or social worker and community health worker interventions per core functions for family planning

Family planning domain		CHW interventions
MIHP Nurse or social worker interventions		
Care coordination		
1	At each visit, assess for willingness to utilize post-delivery family planning method using motivational interviewing strategies and techniques	<p>Self-management and problem solving</p> <p>1 Use the reproductive life plan form to help the woman identify</p> <ul style="list-style-type: none"> • If she would like more children and how many? • How long she plans to wait until her next pregnancy? • If she used birth control before and how did she feel about it? • Does or will she have insurance coverage for birth control? • Which birth control method does she plan to use? • Where will she get birth control? • What would she do if she found herself pregnant again before planned? • Has she discussed birth control choice with partner? • Does she have a doctor for annual check-ups or regular medical care? • Where does she see herself in two years? • How would an unplanned pregnancy affect her plans? • What can you do today to help her achieve her goals? <p>2 Help identify what the woman's health plan will cover, and options if she wishes to change coverage</p> <p>3 Encourage the woman to discuss plan, potential side effects of method choice, and how method choice may affect breastfeeding with her physician</p> <p>4 Provide support for the woman to call her physician's office with any questions or if experiencing side effects as needed</p> <p>5 Teach techniques to stay on track with reproductive life plan (share plan with partner, provide tips on how to remember to take chosen contraceptive as needed, etc.)</p> <p>6 Provide number for pill reminder texts as needed</p> <p>7 Monitor for barriers to achieving plan and assist with overcoming barriers</p>

Health education

- 1 Review family planning methods available
- 2 Inform regarding Family Planning Clinics

A number of education materials are listed in the intervention document. In general, the materials include types of contraception available, effectiveness and pros/cons of each, general anatomy, common myths, and importance of birth spacing. CHWs are also instructed to use contraception kits that include examples of contraception methods and models to show where and how the different methods are placed or used in the body

Referral/system navigation

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Family planning domain			
1	Review how to access reproductive health services and encourage beneficiary to arrange for appointment with local Title × family planning provider or medical care provider	1	Assist with enrollment into health care coverage for family planning as needed
		2	Encourage completion of 6–8 week postpartum check-up to initiate family planning
2	Assist with an application for health care coverage, if indicated	3	Assist with establishing a medical home as addressed in the interconception/postpartum domain
		4	Encourage annual well women preventative check-ups

CHW Community Health Worker, MIHP Maternal Infant Health Program