COUNTY OF MONTEREY
HEALTH DEPARTMENT

ICCS
Institute for Community Collaborative Studies

Prevention First Monterey County 1305 Project

Key Informant Interview Report:

Initial Findings on Provider & Community-Based Organization's Use of Community Health Workers and the Diabetes Self-Management Education Program & National Diabetes Prevention Program in Monterey County

INSTITUTE FOR COMMUNITY COLLABORATIVE STUDIES

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Purpose

The Prevention First Monterey County (PFMC) 1305 Project's scope of work provided an opportunity for more in-depth analysis of the utilization of Community Health Workers (CHWs) through collection of additional data using Key Informant Interviews (KIIs). The KIIs were conducted as a follow up to the Quality Improvement Processes in Monterey County's Health Care System (QIPMC) survey in order to further assess how medical providers utilize Community Health Workers (CHWs) to support the National Diabetes Prevention Program (NDPP) and monitor/educate residents of Monterey County on hypertension.

Since the PFMC project developed and conducted an additional survey of non-medical community based organizations (Monterey County's Community Based Organization's Diabetes & Hypertension (MCCBO)), the KIIs were expanded to include community-based organizations that utilize CHWs and/or provide lifestyle intervention programming related to diabetes and/or hypertension. The KIIs were also expanded to assess CHW utilization in Diabetes Self-Management Education (DSME) programs within medical and non-medical organizations.

The information collected by the KIIs is expected to inform the PFMC project about the utilization and scope of CHW activities in Monterey County related to diabetes and hypertension prevention and self-management, in support of – Years 3 and 4 project activities to promote – the expanded use of CHWs and lifestyle intervention programming.

Methodology

KII Questions

KII questions were developed utilizing language from the PFMC project's scope of work activities and follow-up questions to the QIPMC and MCCBO surveys, e.g., elaborating on the current utilization and possible expansion of CHWs to assist in the management of diabetes and hypertension, as well as integration of CHWs within organizations (i.e. data collection, CHW scope, recruitment, requirements, etc.).[1]

PFMC project leadership at the California Department of Public Health (CDPH) and project evaluators at UC Davis reviewed the draft KII questions and provided feedback for additional questions. The KII questions were generalized to incorporate both hypertension and diabetes to maximize data collection on organizations' efforts to prevent and treat these two chronic

[1] See Appendix A for full list of KII questions

diseases. The key informant questions were also designed to assist in developing partnerships in the next phase of the project.

Participants

KII participants were selected based on QIPMC and MCCBO survey responses to the CHW, lifestyle intervention, and self-management sections of the surveys, as well as from word of mouth. All but two of the organizations chosen for the KIIs participated in the surveys; however, for some of the organizations, the interviews were conducted with different individuals than those who responded to their organization's respective survey.

A total of 14 interviews were conducted, representing 12 organizations (5 medical & 7 non-medical) serving the residents of Monterey County. Additionally, one of the hospital interviews included seven hospital residents who shared their insights. All KII participants are important partners as their responses will be incorporated into planning for years 3 and 4 Learning Action Networks.

Scheduling, Conducting & Documentation

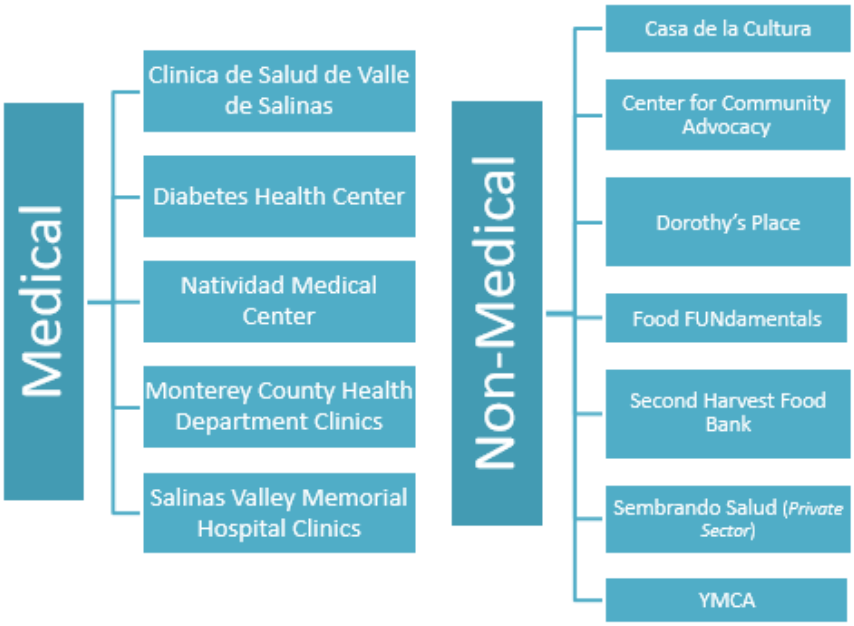
Scheduling of KIIs was done by sending a "Request for Interview" email to potential participants which included a brief background of the project, reference to the QIPMC or MCCBO survey someone in their organization completed, and interview logistics (i.e., approximate number of questions, amount of time expected for the interview, options for in-person or phone interview, and the overall timeline for completing the interviews. Follow up emails were sent to confirmed participants that included a general definition of a CHW, their organization's responses to the QIPMC or MCCBO survey, and the KII questions.

Interviews were either conducted in person at the interviewee's location of operation or over the phone. Interviews included introductions and participants were provided with a briefing on the purpose for the interview within the scope of the project and how the information would be used in future project planning. Participants were asked (and all provided) permission to record the interview, although one was not ultimately recorded). All of the recorded interviews were transcribed and included with the interviewer's notes.

Interview notes were analyzed for key ideas and themes which were summarized in two matrices, one for the medical interviews and one for the non-medical interviews and included a list of recommendations. The KII data and recommendations will be included in a

comprehensive report[2] and used in formulating content and activities for Years 3 & 4 of this project.

Figure 1: List of Key Informant Interview Organizations



Key Informant Interview Findings

Each of the following sections includes responses to KII questions by topic areas, i.e., definition of a Community Health Worker, qualifications and recruitment, utilization and scope, evaluation and data collection, role in clinical-community linkages, payment structure, challenges, and training development.

What is a Community Health Worker?

For purposes of the PFMC project KIIs, the American Public Health Association's definition of a Community Health Worker (CHW) is used as a general description as follows:

> *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. A CHW also builds individual and community capacity by*

[2] The comprehensive report will include findings from the QIPMC Environment Scan report, the MCCBO survey and this KII report.

increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.[3]

CHWs are known by a variety of names, including: community health advisor, outreach worker, community health representative, promotora/promotores de salud (health promoter/promoters), patient navigator, navigator promotores, peer counselor, lay health advisor, peer health advisor, and peer leaders. This definition was provided in the surveys and to the interviewees prior to the KIIs. Interestingly, KII participants provided widely varying definitions of CHWs used among organizations and provided insight into the various perspectives of what Promotores(as) are (and do) in comparison to CHWs. According to MHP Salud, Spanish-speaking CHWs that work with the Latino population are known as Promotores(as).[4] The KIIs suggest that the role of CHWs and Promotores are viewed differently; for some organizations Promotores(as) are described as being *unpaid volunteers* with closer *links to the community* than the clinical system, in comparison with CHWs who are reported to be viewed by other organizations as paid members of a patient's clinical support team. An example of a CHW within a clinical support team was found by one organization interviewed who stated that they consider their Medical Assistants to be CHWs.

Qualifications & Recruitment

Among KII participants, an individual's desire to help others and various interpersonal skills were the most valued qualifications for being a CHW. Participants stated that having a *passion for wanting to make a difference in someone else's health* and a *willingness and desire to help others* was more important than educational achievement. In addition to wanting to help others, a key qualification that KII participants identified was proficiency in Spanish and English in order to address the needs of Monterey County's Latino(a) population. It should be noted that there was also an expressed need for people who spoke Mixteco, Trique, Oaxacan and other indigenous, as well as some Asian languages. Other skills that local organizations wanted to see in their CHWs included having *a deep understanding of the community, understanding of cultural factors, communication skills, knowledge of social determinants of health,* and *social work skills*.

Generally, the KII participants agreed that if a potential CHW candidate had the desire to help others, was (Spanish) bilingual, and had good interpersonal skills they would be acceptable to be trained to meet the organization's needs. Some of the types of trainings organizations are reported to offer include *standard safety & privacy (HIPAA) training, Covered California enrollment training, motivational interviewing,* and training in *trauma, ethics, professional boundaries, first aid/CPR,* and *diabetes and nutrition information*.

[3] American Public Health Association, 2016
[4] MHP Salud, 2014

Respondents' thoughts on educational background varied. One interviewee stated, "If you start putting down educational requirements, you're leaving out many members of the community and the community knowledge, and the cultural and linguistic knowledge and compassion and I would think that would be self-defeating" (personal communication, August 31, 2016). Although educational attainment was not prioritized as the most important qualification for CHWs, it was recognized that having a degree or experience in the medical field or in social welfare would be very helpful as a factor in determining what kind of work an individual would or could be assigned to do within the organization. Some of the potential candidates included students enrolled in community colleges or *undergraduate programs, and in pre-med or allied health* degree programs. The only instance where it was indicated that some sort of educational background or credentialing was required was in the case of health screenings. One organization indicated that the administration of glucose testing at health fairs and other community outreach events has to be conducted by a medical professional such as a Medical Assistant (MA) or Nurse Practitioner (NP).

Only two out of the ten organizations had a formal job description for CHWs (one of which provided a copy) and two others were in the process of developing them. The others reported that their organizations did not have a formalized job description for CHWs because they *used Medical Assistants (MAs)* for this role, their *CHWs were unpaid volunteers* or they did not have CHWs at this time.

The primary ways that CHWs are being recruited is through "*in reach*" (internal organizational) searches for interested candidates, academic connections, directly from the community or through community organizations such as:

- *Center for Community Advocacy,*
- *Lideres de Campisino,*
- *Salud Para La Gente,*
- *Second Harvest Food Bank's Promotora program*, or
- *Health Care Connections* (a national organization).

Some of the KII participants discussed working with *vocational programs* and *college internship programs* as a means to recruit CHWs including local educational institutions such as Hartnell Community College (nutrition and food safety students) and California State University Monterey Bay (CSUMB). Other means of recruitment include by word-of-mouth, online, participating in food bank pick-ups, and through community members participating at local trainings/events being conducted in schools and neighborhoods.

Utilization & Scope

Part of the KII asked about the provision of patient self-management programs (e.g., the National Diabetes Prevention Program (NDPP), the Diabetes Self-Management Education (DSME) program, and other hypertension self-management programs). Only one of the organizations (currently using CHWs) is currently offering an accredited NDPP program, and one additional organization is offering a prevention program called *5 Steps to Preventing Diabetes*. Four other organizations are offering nutrition and healthy cooking classes as a means of supporting prevention efforts. Three other organizations are currently offering DSME programs.

Participants were asked if their organization screens patients/clients for chronic diseases. Half (6 out of 12) of the organizations indicated that they provide health screening for diabetes and high blood pressure while the other half either do not or only worked with patients/clients after they have already been diagnosed. One organization specified that they provide health screenings at community outreach events. An additional organization that does not do formal screenings, mentioned using risk assessment tools from the Centers for Disease Control & Prevention (CDC) or the American Diabetes Association (ADA) to assess participants' program eligibility.

When asked in what capacity CHWs work with patients/clients, the most common responses are education and support, such as *assisting with self-management*, *answering questions, and providing resources*. Other job functions mentioned include *attending health fairs* and *tracking patients/clients*. Two of the organizations that currently offer DSME programs are also in the planning stages for incorporating CHWs into this work and anticipated the following responsibilities: *addressing patient's daily stressors, problem solving and goal setting, phone call/text support, home visits, screening for depression, referral to other necessary providers, involvement in support groups, assisting in medication management, encouraging physical activity, assisting in housing, meals and other health services,* and *bridging language barriers and cultural beliefs.* Some of the resources organizations provide to their patients/clients include *glucose meters and test strips, blood pressure monitoring*, information on *financial assistance* and *sliding scale* payment options, *educational materials,* referrals to *social worker counseling, focus groups,* as well as *"replenishing willpower"* at each encounter. One organization offers *free membership* to their facilities where there is gym equipment available to use, while another offers *specialized meals that support a healthy diet* while living with diabetes. One other organization refers clients to a participating *clinic to provide medical assistance and management support*.

Evaluation & Data Collection

KII participants were also asked about data collection as a means of measuring the effectiveness of their CHWs. Over half of (7) organizations tally the number of patients/clients served by their CHWs, but only a few were able to provide examples of the data they collect at the time of the interviews. One organization indicated that they only track information from physician interactions, so effectiveness for this organization can only be shown at the clinic level and would not incorporate the CHW contributions. In order to measure effectiveness, one organization utilizes program participants' *weigh-ins* and *self-reported physical activity* information. Another means of measuring the success of the CHWs facilitating various programs is through *pre and post-tests to check for knowledge gained by program participants,* which 3 organizations stated they administer. For the organization that reported doing health screenings at community events, their success is measured by tracking how many people came in for treatment after receiving a screening result showing follow-up treatment is recommended. Participants also noted i*mproved medication compliance, improved blood pressure, improved A1C, weight loss* and *patient satisfaction* as indicators of CHW effectiveness.

Role in Clinical-Community Linkages

According to Vision y Compromiso, "Promotores and Community Health Workers are liaisons (links) between their communities and health and social service providers."[5] The role of CHWs as a link between the clinical system and the community is widely discussed as a means of bridging care and support for patients/clients. KII participants were asked what role they think CHWs could play in increasing community-clinical linkages with responses including *helping patients/clients navigate the medical system, helping the medical system understand individual and community barriers*, and helping both the community and the medical system *address social determinants of health.* Examples of ways in which CHWs can assist the health care system in supporting patients and the factors that affect their health was through providing *knowledge of local resources to support referral*, *providing patient education*, and *collecting data on social determinants and entering that data into the patient's electronic health record*. One organization expressed a desire for physicians to *ask about their patients about food security and give referrals to the local food bank*. Participants also felt that CHWs could be beneficial in their role if patients/clients are able to utilize them as a source of knowledge (i.e., *being a wealth of information for clients to utilize in order to meet their needs, bringing health education to the job site*), encouragement (i.e., *facilitating support groups, peer-to-peer counseling*), and organization (i.e., *follow-up calls, teaching patients/clients how to comply with medical instructions, helping with coordination of care, bringing clinic services to the job site*).

[5] Vision y Compromiso (2016)

Payment Structure

Payment structure is a clear concern for organizations interested in utilizing CHWs (as indicated through both the surveys and the KIIs). One organization interviewed was in the private sector, so their CHW services were paid for by the company. Only two organizations indicated that services provided by their CHWs are reimbursed (through participant fees), but it should be indicated that one of the organizations reimbursement for services was not in connection with chronic disease prevention or management. Another interviewee reported that their organization had been reimbursed in the past for Covered California trainings that their CHWs conducted, but believed funding for this purpose had ended. An additional issue mentioned is that there is no mechanism (e.g., code number) to bill insurance carriers for CHW services. This aspect of medical billing would need to be resolved to help promote the use of CHWs in the medical setting. However, there is hope that this may change for Medi-Cal patients/clients in the near future due to an approval from the Central Coast Alliance for Health (CCAH) to begin reimbursement for NDPP programming. Although some organizations use donations or grant funding for CHWs, grant funding is not considered sustainable. Not having ongoing and consistent funding is a barrier for the expansion of CHWs for medical providers as well as community-based organizations throughout the county.

KII participants attributed less reliability (i.e., not showing up on a regular basis) and less availability for training and presentations to the fact that CHWs are unpaid volunteers and often have other obligations such as work and family that come before their volunteer work. It is clear that the financial barriers do not only affect the medical system, but also the CHWs themselves and in turn the communities they serve.

Challenges

In addition to payment and reimbursement issues participants report barriers for patient's utilization of CHWs including patient's *lack of interest* in or *denial of being at risk*, *lack of family support* for their health care needs, *(possible) lack of trust* in CHWs because they are *not seen as medical professionals, patient's personal beliefs in current health fads*, and *too many needs with too little resources*. One participant also mentioned that patient's competing priorities such as *housing, safety, and food access that may trump their ability to focus on their health*.

Additional barriers (and concerns) of medical organizations include lack of structure around CHW *job descriptions, objectives, professional training, scope of practice* and *employment status* (specifically for the unpaid volunteers), as well as a plan to address the balance between being beneficial and *not adding more work for the other medical personnel*, being *able to work together*, maintaining *confidentiality*, and concerns about whether or not they are *cost saving for the organization*.

Finally, barriers *for* CHWs were also mentioned including their *knowledge base and training, ability to work with challenging personalities, confidence to lead a class or group facilitation, being timely, having enough time to meet the requirements of the position with limited funding, burn-out/depression,* and *immigration status*.

Training Development

The KII participants were asked about the types of formats and locations for a potential future CHW training program in Monterey County. All of the participants believed that *face-to-face* training was important, although six of the participants indicated that they could see a *hybrid of face-to-face and online training* being effective. One participant indicated that they would only want to see the *online format used for refresher courses*. However, there is concern about *access to computers and internet* for some potential candidates. One participant indicated that a mobile application might be more effective than an online platform due to the wide use and ability to use smart phones. Other training issues include the availability of *training in Spanish* and inclusion of a *combination of social work and health skills*, *motivational interviewing*, *role playing, navigating the health care system, knowledge of Monterey County resources,* and *professional objective writing skills*.

Seven of the participants indicated that the trainings should be held *in the community* (i.e., *community centers, affordable housing common areas, at elementary or middle schools, churches,* or *in agriculture fields)* to ensure that they were *convenient for participants* and representative of the community within which they and patients/clients live. Salinas was specified as a preferred location over Monterey by two organizations. Four participants indicated a preference for trainings to be held in an institution of higher education such as *Hartnell Community College* or *CSUMB*. These respondents felt that people might be more *comfortable being trained in an academic setting*. Other ideas for the development of CHW training opportunities include providing ongoing *continuing education* and an *annual forum for CHWs to come together to learn about new information and developments in the field which would also include breakout sessions on specific health topics*.

Conclusion

The KIIs garnered valuable information about the utilization of CHWs and lifestyle intervention programming in Monterey County. There is clearly a need for a generally agreed upon definition of the role and functions of CHWs. Generally, participants believed that there was a need for this kind of position in the spectrum of patient and community care and there was support for the development and guidance on how to make it a reality. Although, the KII participants believed in

the value of CHWs in theory, there were concerns about the logistics of incorporating this new role into their already complex systems.

There is evidence of CHW effectiveness in other parts of the US, but it would be key to tailor the development of CHWs in Monterey County to the needs of the local population. Additionally, patient services and needs do not end at county lines and it was indicated by one participant that there is a need to work together with the surrounding counties to serve the populations in need. Increasing CHW utilization across the county and region, specifically in regards to diabetes and hypertension prevention and self-management, could prove to be very beneficial for the medical system, the patients/clients, CHWs, and the community as a whole.

Recommendations

The following recommendations are based upon feedback provided in the KIIs which focus on adding more formal organizational structures for the utilization of CHWs in Monterey County:

1. Develop a standardized and locally relevant definition of a CHW
2. Develop a locally relevant job description and potential scope of work within an organization and in the community
3. Clarify roles and expectations between unpaid volunteer CHWs and paid CHWs
4. Increase engagement of [or provide other incentives for] unpaid volunteer CHWs as a means to address reliability concerns
5. Develop sustainable funding or payment structures for CHW utilization
6. Collect and analyze data on the effectiveness of CHWs in clinical settings to provide evidence in support of CHWs
7. Develop effective procedures for introducing CHWs to physicians and other medical personnel as well as with patients/clients to ensure trust is established
8. Develop procedures for ensuring that CHWs communicate accurate (e.g., nutritional) information from providers to patients/clients
9. Formalize connections between medical organizations and CBOs with local community colleges and CSUMB for recruitment of CHWs
10. Develop a career tract for CHWs as an incentive for choosing this field of work

Specific recommendations for CHW utilization include:

1. Utilize CHWs in the facilitation of patient/client support groups and individual care support
2. Expand CHWs work to include collaboration with pharmacists to assist patients/clients in medication management
3. Connect CHWs to food banks, housing organizations, and mental health resources to broaden their ability to address patient's needs

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Appendix

Appendix A: Key Informant Interview Questions

1. Please tell me a little bit about yourself, your role in your organization and in what capacity you work with CHWs. *(If additional people are included in the interview, please request name and position title.)*
2. What educational background and/or experience are required before becoming a CHW in your organization? Is there any requirement by certification programs for a prerequisite of GED or diploma?
3. Does your organization have a formal job description for Community Health Workers (CHWs)? If so, would you be willing to share it with us?
4. What languages do your organization's CHWs speak? What languages are needed in your communities?
5. How does your organization recruit individuals for CHWs positions?
6. *Scope in which CHWs are used/Current utilization of CHWs:*
    a. Is your organization providing self-management programs?
    b. Does your organization screen patients/clients for chronic diseases? If so, for which are they screened, e.g., diabetes, high blood pressure or others?
    c. In what capacity do CHWs work with patients, especially for high blood pressure control efforts or diabetes self-management education? Are they assigned to work with adults diagnosed with high blood pressure (or diabetes)?
    d. What resources does your organization provide to support adults with high blood pressure or diabetes?
7. *Data to show CHWs' effectiveness:*
    a. Does your organization tally the number of patients that CHWs serve annually? If so, can you share the number of patients your CHWs served in 2015? If your organization does not currently collect this information, would you be interested in determining their contributions more systematically?
    b. How does your organization determine the effectiveness of CHWs services for patient/client education and support (especially for self-management)?
        i. For example, what specific goals do you hope CHWs accomplish as they work with patients?

ii. Are any of these goals measured? If so, which are measured and how are they being measured?

c. Does your organization collect patient/client data related to services provided by CHWs? If so, what type of data is collected?

d. How is this data used to determine effectiveness of CHWs' services, e.g., does the data demonstrate an improvement in how diabetes or hypertension patients are managed or if your patient's conditions have improved (their high blood pressure controlled or risk for diabetes reduced)?

8. What role do you think CHWs could play in increasing community-clinical linkages, i.e., between residents and clinics and CBOs and medical providers?
9. If your organization has received payment for CHW activities, what is the payment structure for charging for CHW activities that are compensated, e.g., charge by the visit, by the hour, etc.?
10. What types of challenges do CHWs encounter while working with patients and how are CHWs supported to address or overcome these challenges?
11. Are there any controversial issues that might limit the utilization or expansion of CHWs in the local healthcare system?
12. What format for a CHW training program would be most useful in our region, e.g., face-to-face instruction, online classes or a combination of online and face-to-face instruction?
13. What locations would be most convenient for face-to-face trainings: CSUMB, MCHD, Community Colleges, hospitals, clinics, other locations?
14. Do you have any success stories or data you would be willing to share about the utilization of CHWs in your organization?
15. Is there anything else you would like to add that we haven't already discussed?