

FOCUS POPULATION: INDIVIDUALS EXPERIENCING EQUITY GAPS
INTERVENTION STANDARDS

Developed under guidance from the Practice Transformation Taskforce (PTTF) as part of the Connecticut State Innovation Model Initiative

Program Description and Objective:

Description: The equity gap intervention will focus on:

- 1) Reducing health equity gaps through standardizing certain elements of the care processes to be more culturally and linguistically appropriate; and,
- 2) Developing processes in the primary care practice to identify individuals experiencing gaps in their health outcomes who would benefit from more culturally attuned care interventions and connect them to those interventions

The standardization of certain elements of care will include the re-engineering of care processes to optimize performance and minimize sub-population specific barriers in the care pathway. The culturally specific interventions will include:

- Use of a community health worker who has culturally and linguistically sensitive training to educate individuals about their condition and empower them to better manage their own care,
- Producing translated and culturally appropriate educational materials

For the first wave of Advanced Network and FQHC participation in CCIP, the intervention should focus on sub-populations defined by large race and ethnic populations, specifically White, Black, and Latino. The intervention should be further limited to diabetes, hypertension and asthma, as these conditions are likely to be included in the SIM Core Quality Measure set. The Advanced Network or FQHC may propose an alternative area of focus based Advanced Network or FQHC individual demographics and performance data.

The primary purpose of the intervention is to develop these skills with a focus sub-population and condition so that these same skills can then be applied to other sub-populations and conditions. It is expected that the Advanced Networks and FQHCs will examine their performance with smaller sub-populations such as Southeast Asian or Cambodian populations and adopt similar methods to close health equity gaps.

Objective: Narrow the specific gap in care identified and maintain improvement. The community health worker will support the initial improvement and long-term maintenance of health outcomes for the sub-population identified through the provision of culturally sensitive medical education about their condition, behavior change education to promote a healthy lifestyle, and identifying and connecting the individual to needed support services.

High-Level Health Equity Gap Intervention Design:

1. Create a more culturally and linguistically sensitive environment
2. Establish a CHW workforce
3. Identify individuals who will benefit from the culturally attuned supportive services of a CHW
4. Conduct a person-centered needs assessment
5. Create a person-centered self-care management plan

6. Execute and monitor the person-centered self-care management plan
7. Identify process to determine when an individual is ready to transition to self-directed maintenance

Standards

1. Create a more culturally and linguistically sensitive environment

- The identified practices provide culturally and linguistically appropriate services informed by the root-cause analysis conducted around the identified health care disparity.
 - Practices provide interpretation/bilingual services as necessary
 - Practices provide printed materials (education and other materials) that meet the language needs of the individual and are comprehensible to all individuals

2. The network establishes a CHW workforce

- The network determines the best strategy for incorporating community health workers and the community health worker field supervisor(s) into the primary care practices. Options include:
 - Employ the CHWs/CHW field supervisor within the practice
 - Employ the CHWs/CHW field supervisor at one or more hubs in support of multiple practices
 - Contract with community organizations for CHW/CHW field supervisor services
- The network documents process for how CHWs will be made available to individuals across the network
- The network establishes the appropriate case load (individuals to team ratio) for the CHW¹
- The network establishes training protocols on:
 - Identifying values, principles, and goals of the CHW intervention
 - Redesigning the primary care workflow to integrate the CHWs work process
 - Orienting the primary care team to the roles and responsibilities of the community health worker
- Network ensures training is provided:
 - To all primary care team members involved in the CHW intervention
 - On an annual basis to incorporate new concepts and guidelines and reinforce initial training
- The network develops and administers CHW training protocols or ensures that CHWs have otherwise received such training:²
 - Person-centered assessment and support
 - Disease specific training informed by endorsed training protocols³
 - Outreach methods and strategies
 - Effective communication methods
 - Health education for behavior change
 - Methods for supporting, advocating, and coordinating care for individuals

¹ Optimal ratios should be determined by the network based on local needs

² CT is expanding access to CHW education and training so it should be easier to recruit CHWs with basic competencies; training in role/function specific competencies will need to be undertaken by the network.

³ The disparity gap being addressed will determine the type of disease-specific training

- Public health concepts and approaches
- Community capacity building (i.e.; improving ability for communities to care for themselves)
- Safety training protocols geared at maintaining safety in the home
- Basic level of behavioral health training, so the community health worker can recognize behavioral health needs

3. Identify individuals who will benefit from CHW support

- Network identifies individuals who will benefit CHW support by developing criteria that assesses:
 - The individual is part of the focus sub-population for intervention
 - Lack of health status improvement for the targeted clinical outcome
 - Presence of social determinant or other risk factors associated with poor outcomes
 - Health literacy and/or language barriers

4. Conduct a person-centered needs assessment

- To understand the historical and current challenges with self-care management to inform the person-centered self-care management plan, the network conducts a person-centered needs assessment that includes:
 - Preferred language
 - Family/social/cultural characteristics
 - Behaviors affecting health
 - Assessment of health literacy
 - Social determinant risks
 - Personal preferences and values
- Network defines the process and protocols for the CHW to conduct the person-centered needs assessment⁴

5. Create a self-care management plan

- The CHW and the individual and their natural supports⁵ collaborate to develop a self-care management plan that includes the following features:
 - Incorporates the individual's preferences and lifestyle goals
 - Establishes health behavior goals that will improve self-care management and are reflective of the individual's stage of change⁶
 - Establishes social health goals that will improve self-care management and are reflective of needs/barriers identified in the person-centered needs assessment
 - Identifies actions steps for each goal and establishes a due date⁷

⁴ Should identify where the person-centered needs assessment should be conducted which should be determined by the patient and the timeframe within which it should be completed post CHW intervention enrollment

⁵ Natural supports include but are not limited to, family, clergy, friends, and neighbors

⁶ Stage of change refers to the Prochaska's stages of change model that categorizes how ready an individual is to change their behavior. Stages include: pre-contemplation (not ready), contemplation (getting ready), preparation (ready), action, and maintenance

⁷ See Appendix F for examples from other programs

- The network defines a process and protocols for the CHW to create the person-centered self-management plan including location and timeframe for completion⁸

6. Execute and monitor the person-centered self-care management plan

- The network establishes protocols for regular CHW led care team meetings that establish:
 - Who is required to attend⁹
 - The frequency of meetings
 - The format for the meetings (i.e.; via conference call, in person, etc.)
 - A standardized reporting structure on the individual's progress and risks¹⁰
- The network establishes protocols for monitoring individual progress on the person-centered self-care management plan the includes:
 - Establishing key touch points with the individual for monitoring and readjusting of the person-centered self-care management plan, as necessary
 - Establishing who, in addition to the CHW, will be involved in the touch points
 - Developing a standardized progress not that documents key information obtained during the touch points
- The network modifies its process for exchanging health information across care settings to accommodate the role and functions of the CHW support¹¹
- The network develops a process and protocols for connecting individuals to needed community services (i.e. social support services) which include:
 - See Community Consensus Linkages Process and Guidelines

7. Identify process to determine when an individual is ready to transition to self-directed maintenance

- The network develops criteria to evaluate when the individual has acquired the necessary education and self-care management skills to transition to self-directed maintenance that includes:
 - Collaborating with the individual to assess their readiness to independently self-manage their care
 - Assessing improvement on the relevant clinical outcomes
 - Assessing achievement of individual identified care goals

⁸ The network should determine where the self-care management plan should be completed which should be determined by the patient and a timeframe for completion post needs assessment should be established

⁹ Best practice suggests the following attendees: CHW, CHW field supervisor, key members of the primary care team, including the primary care provider

¹⁰ The intention of this report is to provide the team with an update, but also to alert the team to any key areas of concern that the broader team might be able to address

¹¹ The network should have agreements with necessary care providers about exchanging information; establish the type of information to be shared (consider needs assessment self-care management plan and patient progress notes ;timeframes for exchanging information; and, how the organization facilitates referrals