Q&A from webinar: Using community health workers to improve linkage and retention in HIV care

July 27th 2017

CHW Curriculum

Q: Is there a [standard] curriculum for CHW?
A: We are developing training curricula for CHWs and supervisors working in HIV care. Several topics focus on learning about HIV and sexual health and how to discuss these topics with clients. The curricula are expected to be ready by summer 2018.

Q: Will this curriculum be ready before May 2018
A: Our aim is to have the initial curricula on-line by summer 2018. Stay in touch, we will advise.

Q: Will slides [from the webinar] be available?
A: Yes, a link to slides and the recorded webinar are available on our website at http://cahpp.org/resources/webinar-chw1 .

Roles of a CHW

Q: Could you share [your CHW] job description?
A: A CHW job description can be found at http://cahpp.org/wp-content/uploads/2017/04/Multnomah-SPNS-Navigator-Housing-Case-Manager-Descriptions.docx . (This is part of a collection of resources for organizations who provide care to people living with HIV who are experiencing homelessness. You can find the toolkit at http://cahpp.org/project/medheart/resources .)

Q: Is it natural to have overlapping roles between the CHW and Medical Case Manager? (E.g., patient struggling to connect with Case Manager because of reliance on CHW as point person)
A: We experienced this at Multnomah County [Health Department HIV Health Services Center]. Clients tend to form a very strong bond with their assigned CHW. We have overcome this challenge by having regular (at least monthly) status update meetings that include the Medical Case Manager (MCM), the CHW, and the client. During these meetings, progress is discussed and planned and next steps are determined. We also have a final "graduation" meeting that involves the warm hand back from the CHW to the MCM. We give the client a certificate of achievement (which clients love because many have never completed anything) and a $5 Starbucks card.

Q: May you share more on how the CHW and MCM work together?
A: [At the Multnomah County Health Department HIV Health Services Center] the MCM work(s) with the CHW and client to set out the initial plan. The CHWs chart in the Electronic Health Record (EHR) and participate in daily huddles so there is an opportunity for regular communication/case consultation. The CHW has quite a bit of discretion in how they engage the client; however, the CHW consults with the MCM about hurdles and unexpected situations. Usually, the MCM is the link to the provider/nurse/medical assistant but, again, morning huddles provide an opportunity for team members to be on the same page and to respond to urgent situations. CHWs have access to regular clinical supervision as well as access to our mental health providers.

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Q. Are your patient navigators also patients in your clinic? Do they have some professional credentials?
A: At Multnomah County [Health Department HIV Health Services Center], we prefer that our navigators have at least a Bachelor's degree in a related field. However, we look at experience first and foremost. The credentials of our three current navigators are 1) Bachelor's degree and Certification in Addictions Counseling 2) Bachelor's degree when hired or just completed an MPH; and 3) no degree but some coursework in social work and significant lived and work experience—this navigator is our lead and is highly effective. All navigators have completed 96 hours of CHW training and are certified by the State [of Oregon]. We do not [currently] hire patients as CHW or as any other paid staff.

Q: How long do your CHWs follow clients?
A: It depends on the needs of the client. [At the Multnomah County Health Department HIV Health Services Center] the average length of follow-up is about 8-10 months. However, some [clients] have a need that is very specific and short-term—for example, a series of specialty appointments related to surgery or housing or legal issues. Some clients may receive a series of CHW interventions over time.

Q: Do your CHWs drive and are they computer/tech savvy?
A: [Multnomah County Health Department HIV Health Services Center] CHWs do drive clients on a limited basis. We tend to use cabs/taxis/Lyft etc. Our CHWs are very tech savvy. They all have work iPhones to access resources via the web while in the field. They all chart in the Electronic Health Record. They also have iPads so that they can chart in the field.

Q: Do you recommend allowing CHWs to have access to the EHR (Electronic Health Record) if they are patients at the clinic?
A: [At the Multnomah County Health Department HIV Health Services Center] we do not hire patients as CHW or as any other paid staff. We have a volunteer peer support program that is run by our Client Advisory Board. None of the volunteers have access to patient records. Also we are getting ready to integrate substance abuse peers into our clinic. The "peer" aspect will be that they are recovering alcoholics/substance abusers—because the Portland HIV community is so small, these peers will not be HIV+.

Q: Are there ever concerns about CHWs taking on tasks or working with populations for which they are not qualified? E.g., dealing with suicidal ideation if the CHW is expected to work independently in the field? Are CHWs protected by medical malpractice laws?
A: [The Multnomah County Health Department HIV Health Services Center] is not aware of any jurisdiction in which CHWs are protected by medical malpractice laws, and no, we would not be concerned about CHWs taking on tasks or working with populations for which they are not qualified. CHW job descriptions are the responsibilities of their employers, and CHWs are typically trained by their employers and coordinate with their supervisors and work colleagues to be prepared for their home and community-based work.

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CHW Certification and Training

Q: Where can I find certification courses in NYC?
A: CWHs are not [currently required to be] certified in New York.

Q: Can you share a little about the certification standards or curriculum for CHWs?
A: Oregon has a 96-hour training program that leads to [state] CHW certification. The Oregon certification website is at http://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCC/PSW-HCW/Pages/Community-Health-Worker.aspx

Q: Are you seeing any issues with inconsistencies in those training and certification standards?
A: There are significant variations in training standards among states. Texas, for instance, requires 160 hours of core curriculum training for certification, while Massachusetts requires 80 and Oregon, 96. Some states certify training programs, while New Mexico certifies individuals, as well as organizations, to deliver its state-approved curriculum. Similarly, there are variations in certification models, ranging from programs authorized by law and managed by state health departments, to programs operated without legislation by non-government organizations working in cooperation with state agencies and other stakeholders.

As noted in the webinar, there are [currently] no national standards for training or certification. What "issues" arise from this is a matter of perspective. We are concerned that while most states define CHW core competencies and use this as the basis for training and certification programs, sometimes CHWs are seen primarily in "medical extender" roles that don't take full advantage of their community connections and abilities to address non-medical issues that affect health. We recommend using the CHW Core Consensus (C3, available at http://www.chwcentral.org/sites/default/files/CHW%20C3%20Project.pdf) Project findings as the basis for defining core CHW roles and skills. It is the closest reference we have now for a national standard.

The most important concern to emphasize is that CHW leaders and state-based CHW associations are not reliably or consistently involved in efforts to develop and implement training and certification standards. This would be inconceivable for any other professional health care workforce. It is incumbent upon state officials, providers, policy makers, academics, and advocates to involve CHWs directly in developing policies and programs, to ensure that the integrity of the workforce is preserved as a professionalization effort moves forward.

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Integration of CHWs

Q: Can you describe the needs assessment process, particularly around adherence, the CHW's role, and any screening/assessment instruments they may use?
A: [At the Multnomah County Health Department HIV Health Service Center] we conduct a detailed psychosocial needs assessment at intake and then it is updated every 6 months. The MCM conducts this assessment. It is something that our clinic developed over time. The assessment is built into EPIC, our EHR. We also use a wide variety of other screening tools, like the DAST, AUDIT, PHQ2 and 9, VAT, etc.

Q: You mentioned "mistrust" and "power distinctions" being, I assume, the main barriers for PLWH not being in care. How was the information obtained?
A: [At the Multnomah County Health Department HIV Health Service Center] we have conducted periodic surveys and focus groups with patients who have not successfully engaged in care and who identified this as a problem.

Q: How do you work with other community case managers or workers that people are involved with, such as housing case managers, DV workers, etc. so that a person will not have so many competing service plans?
A: [At the Multnomah County Health Department HIV Health Service Center] we promote a high level of coordination between housing, other case managers, and the medical team. While the client and CHW may have a long-range plan, the CHW is working off a series of simple client driven goal plans that lead to the overarching long-range plan. The CHW helps the client to interface with housing, corrections, probation, treatment and other staff. Through this approach, plans generally dovetail with each other and the order of operations are prioritized.

Q: Would cultural mediation include language translation?
A: Cultural mediation [a CHW role] includes serving as a bridge between community members and organizations and health care providers, but it should not include language translation as a required job responsibility. In health care settings, that is the job of certified medical interpreters, which is a distinct field. Certainly, the ability to communicate with community members in their first languages – which is more difficult than translating conversations – is an important part of culturally responsive practice, which is a hallmark of CHW effectiveness. In fact, CHWs are often expected to translate in the course of their work, but this is not an appropriate application of how cultural mediation is defined as a CHW core competency.

Cultural mediation may include providing access to culturally and linguistically appropriate services, explaining culturally-based expectations or concerns patients may have to clinical providers, and explaining the "real world" challenges patients may face. Cultural mediation also includes serving as a navigator for patients/community members, helping them understand and access the complex and cultural unfamiliar and sometimes alienating worlds of health care settings. It also may involve helping to mediate power differentials between clinical providers and patients/community members. In this respect "culture" is a broadly inclusive concept.