**Community Wellness Grant (CWG), Minneapolis Health Department (MHD)**

Community Clinical Linkages (Strategy 2.8)

***Volunteers of America (VoA) CHW Pilot: Developing a community-based CHW model for diabetes and heart disease self-management and prevention***

CHW MANUAL

DRAFT: Jul 9, 2016

*NOTE: Some sections have been directly excerpted from:*

*Penn Center for Community Health Workers:* [*http://chw.upenn.edu/tools*](http://chw.upenn.edu/tools)

*Pathways:* [*https://innovations.ahrq.gov/sites/default/files/Guides/CommHub\_QuickStart.pdf*](https://innovations.ahrq.gov/sites/default/files/Guides/CommHub_QuickStart.pdf)

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1. **PROJECT OVERVIEW AND GOALS**

Adding CHWs to the Volunteers of America (VoA) team at Minneapolis Public Housing high-rises aims to address social factors impacting residents’ health. The project also aims to improve communication and linkages with residents’ clinical providers, improve residents’ disease self-management skills, and improve residents’ health. The project goals are:

(1) 1:1 connection w/ clients on health issues;

(2) improve connections with community resources and medical systems; and

(3) provide CHW facilitation of group health education

1. **CHW ROLE**

In general, the VoA CHWs will provide social support, navigation and advocacy to high-risk patients in order to help them reach their health goals. This includes conducting referrals, reinforcing health education messages, assessing need for medication management support, improving linkages to clinical teams including community pharmacists, and providing group education.

VoA CHWs will:

* Carry a caseload of residents for 1:1 visits and utilize identified Pathways to serve them
* Lead group health sessions supporting residents’ self-management of their chronic conditions (for example: Diabetes Prevention Program, Chronic Disease Self-Management Program, Health BINGO, etc.)
* Help coordinate, and assist residents and staff, at on-site events (for example: blood pressure checks, medication management education, etc.), including some events featuring Community Paramedics and/or Community Pharmacists
* Conduct introductory and ongoing visits and calls with residents to set health goals, support them in reaching the goals, and connect them with resources they need
* Enter progress notes into resident record (Access Database), and collect required data to track outcomes for this pilot CHW project
* Support residents in seeking help if medical issues arise
* Coach residents to get the most out of their doctor’s appointments
* Attend important doctor appointments with residents
* Attend VoA staff meetings, multidisciplinary care team meetings, Healthy Living Advisory Committee meetings, and Pilot Project Team meetings

**3. ORIENTATION AND TRAINING SCHEDULE**

Orientation and training includes:

1. VoA Corporate Orientation (Policy Book and Training Manual topics):
* Organizational information
* Employment and work site information
* Contracts and funding
* Service delivery issues and skills
* Service provision
* Continuous Quality Improvement
* Staff orientation and training (orientation, first year, ongoing)
1. VoA Supervisor Orientation (Bill and Carrie) (general welcome, overview of the job and the team, orientation to the Database; general logistics)
2. Community Wellness Grant CHW Pilot Project Orientation (Carrie, Megan, Lara and Jared) (CWG CHW manual, evaluation measures and data collection)
3. Shadowing with VoA Social Service Staff (about 2 weeks) (one-on-one observation of staff delivering services and documenting in the Database; meeting VoA staff; use of VoA Referral Form when needed; CHW practice visiting residents on their own)
4. Topic-specific training

|  |  |  |  |
| --- | --- | --- | --- |
| **Date/Time** | **What?** | **Who?** | **Where?** |
| 6/13: three hours | VoA Corporate Orientation | CHWs | 600 18th Ave N, (VoA Corporate Offices) |
| 6/14 | VoA Supervisor Orientation | Bill, Carrie and CHWs | 311 University Ave NE (Bill’s office?) |
| Approx 6/27 | Orientation to the Pilot—overview of the Manual | Carrie and CHWs (Megan available if-needed) | 1314 44th Ave N (Carrie’s office) |
| Approx 6/27 | Orientation to the Pilot Evaluation—the Database and other data collection | Carrie, Megan, Jared and CHWs | 1314 44th Ave N (Carrie’s office) |
| (SEE BELOW) | On-site orientation and shadowing | Carrie, on-site supervisors, CHWs | (SEE BELOW) |
| CHW1: weekly day/timeCHW2: weekly day/time | One-on-one Supervisor check-ins | Carrie and CHW1Carrie and CHW2 | 1314 44th Ave N (Carrie’s office) |
| Tuesday mornings, 9:15-11:30 | Weekly VoA Team meetings | Bill, Carrie, VoA staff and CHWs | 311 University Ave NE |
| Every-other Thursday, 2:00-3:00 pm (starting 6/23) | Bi-weekly Pilot Project Team meetings | Carrie, Megan and CHWs, (Lara and Bill as-needed) | 1314 44th Ave N (Carrie’s office) |
| Every two months, Thursday, 2-3:30 (July; Sept; Nov) | Bi-monthly Pilot Advisory Committee meetings | Bill, Carrie, CHWs, Lara, Megan, Vish, and Advisory Cmte members | 311 University Ave NE |
| TRAININGS |
| 6/23/2016, 1-4 pm | MN Dept of Health Hypertension Training | Carrie, CHWs, Megan | Hilton Minneapolis North, 2200 Freeway Blvd, Minneapolis |
| TBD | National Diabetes Prevention Program Lifestyle Coach Training |  |  |
| TBD | Chronic Disease Self-Management Program Training (TENTATIVE) |  |  |
| TBD | Diabetes Self-Management Program Training (TENTATIVE) |  |  |

1. **LOCATION ASSIGMENTS AND SHADOWING SCHEDULE**

| **Building (# of Residents)** | **Social Svc Staff Contact** | **CHW (w/ Schedule)** | **Shadowing Schedule** |
| --- | --- | --- | --- |
| Cedar High Apartments (550 residents)* 1611 S 6th Street
* 1627 S 6th Street
* 620 Cedar
* 630 Cedar
 | Mahdi Nur952-945-4190mnur@voamn.org | Somali-speaking | First 2 weeks |
| 2121 Minnehaha Ave(James R. Heltzer Manor)(100 residents) | Carrie Harris612-220-2549 carrie.harris@voamn.orgAhmed Bani952-945-4180abani@voamn.org | Somali-speaking | First 2 weeks |
| 1815 Central Ave NE (Parker Skyview)(330 residents) | Terri Trombley952-945-4192ttrombley@voamn.org |  | First 2 weeks |
| 2415 N 3rd St(Lynway Manor)(60 residents) | Terri Trombley952-945-4192ttrombley@voamn.org |  | First 2 weeks |
| 600 18th Ave N(Lyndale Manor)(240 residents) | Angie Akenson952-945-4182aakenson@voamn.org |  | First 2 weeks |

1. **1:1 CASELOAD APPROACH**
* The Pilot project expects to serve 30-40 residents on a 1:1 caseload by December 2016, divided among 2 CHWS.
* A resident is considered on a caseload if they complete an initial CHW intake visit and at least one other 1:1 visit with the CHW. (Social Service referrals with no CHW visits, or only an initial visit, will also be tracked).
* CHWs will receive referrals to the 1:1 approach from VoA Social Service staff in the buildings; Social Service staff will use CHW Referral Form (SEE APPENDICES) to make referrals; CHWs will also recruit residents for the 1:1 approach at Group and On-Site Events (see below).
* CHWs will follow a standard approach for 1:1 visits to set goals, provide support, and connect residents to resources:
	+ Completing an initial visit checklist
	+ Identifying resident goals, and Pathways that will support them in reaching their goals
	+ Regular meetings of CHWs and their supervisor will be held to discuss appropriate Pathways to use, and recommendations for next steps, for each resident
	+ Coach residents to get the most out of their doctors’ appointments (SEE ALSO, PENN PAGE 23)
	+ Attend important doctor appointments with the residents (SEE ALSO, PENN PAGE 24)
	+ Because a strong start is crucial, CHWs will make three 1:1 in-person visits within the first month after an initial visit for residents on their caseload. After the first month, CHWs will make contact with residents on their caseload every week, with at least one 1:1 in-person visit per month.
	+ CHWs will set-up regular office hours when residents can drop-in to talk.

***Initial Visit***

* Before the initial visit with a resident, CHWs will review notes in the database and get information from VoA staff who made the referral about the resident’s needs.

***Supervisor Check-ins***

* CHWs will check-in their supervisor regularly (at-least bi-weekly) to review their caseloads, determine which Pathways to use, and discuss approaches and next steps for individual residents. The CHW supervisor will listen to CHW experiences with residents, and support CHWs in their efforts.
* CHWs will participate in VoA staff meetings, including once-a-month there is case consultation where CHWs can gain additional insight about how to best serve residents.

***Pathways***

* Pathways serve as accountability tools to document resident engagement with the services, connection to interventions and to measure outcomes.
* Implementing each Pathway includes: providing standardized education to the patient (and family members), identifying and eliminating barriers, confirming appointments are kept and documenting completion of a Pathway. Although the defined Pathway is usually related to health, it can also relate to an improvement in employment, education, housing, or other social condition that affects health status. VoA Social Service staff are also available to assist residents to make progress on these social conditions impacting their health.
* Pathways to consider in serving residents (outcome in parentheses):
* Medical referral (confirmation of kept appointment)
* Social service referral (confirmation of kept appointment)
* Education—for example, asthma, depression, diabetes, and other conditions (verified patient understands information presented)
* Medication assessment and medication chart (verified with primary care provider that medication chart was received)
* Medication management (verify with primary care provider that client is taking medications as prescribed)
* Medical home (confirmation of kept appointment)
* Smoking cessation (client has stopped smoking/using tobacco products)
* Behavioral health (client kept three scheduled appointments)
* Health insurance (follow-up 2-6 weeks after application to confirm acceptance or denial)
* Employment (client has found consistent source of steady income and is employed over a period of three months)
1. **WEEKLY BLOOD PRESSURE CHECK EVENTS**
* CHWs will help coordinate and assist residents and staff at on-site blood pressure check events weekly at every building.
* NOTE: CHWs and their supervisor are attending a CHW High Blood Pressure training on 6/23/2016. After the training the project team (including CHWs) will determine how to incorporate the approaches into the Pilot.
1. **GROUPS AND OTHER EVENTS**
* The project goal is to provide at least one additional event or group activity at each building before Dec 31, 2016. (For example, having Community Pharmacists on-site for a medication management brown bag, having Community Paramedics visit buildings)
* The Project Team will help determine and plan these events, including helping identify partner Community Pharmacists and Community Paramedics to include.
* The Project Team is considering offering the Diabetes Prevention Program, the Diabetes Self-Management Program, and/or the Chronic Disease Self-Management Program (and potentially others, like Healthy BINGO). CHWs will be trained in the group programming they are expected to lead.
* The group activities will be open to everyone in the building, and CHWs can do specific outreach to their 1:1 caseload to help them make it to the groups as well. (For example, call them the day before the group to remind them it’s happening)
* The goal is to have groups meet at the same time each week on a regular schedule; this has worked well in the past.
1. **DOCUMENTATION, DATA COLLECTION AND PRIVACY**

***Documentation***

* VoA Social Service Staff utilize an Access database (the Database) to record their visits with residents.
* CHWs will be shown the Database and oriented to the data fields they need to fill-in at orientation. They will receive additional training on entering data into the Database during the two-week shadowing training, and throughout the Pilot.
* It’s important that CHWs input resident information in the way they have been trained so that the Project Team can gather data to describe the Pilot activities, and the outcomes residents experience.
* Forms can be scanned and entered into the resident record in the Database
* Information in the Database falls under the following tabs:
	+ Demographic Report
	+ Contacts: family and case managers
	+ Long-term case: Free text fields include: recommendations (services and supports recommended by VoA MN staff), summary of support plan (services accepted by client), issues at referral/intake, health and safety (services/supports needed to keep the person healthy or safe), person’s choices (what does the person want help with? Supports requested), reassessment) (Includes date fields for open/closed and assessment/reassessment dates)
	+ Service log: Brief description of each encounter
	+ Service history or healthcare: Includes services list, for example “home health aide,” and free text for how often?, name of agency/worker/relative/friend, phone #, past/present?, insurance/MA #s, doctors/clinics with address, phone and fax #s, preferred hospital, health care directive and who has copy, and medications list
	+ Risks and screens: Health and other risk factors drop down includes: memory, cognition, developmentally disabled, medical issues, housekeeping, chemical dependency, other chronic diseases, $1,000 or less, personal hygiene, hospitalizations/nursing home, nutrition, language/cultural issues, mental health, illiteracy, vulnerable adult, 80 years or older, isolation, previously homeless—comments can be entered for each category
	+ Financial
	+ Progress notes
	+ Documents (scanned)

***Data Collection for Community Wellness Grant Evaluation Measures***

* CHWs will input data about all residents on their caseload into the Pathways Log, and Excel file created for the Pilot (include: Pathways used, dates opened and closed, completion of Pathway (Yes/No), date completed, reason the Pathway was closed (if it wasn’t completed), and codes for the medical, social and health services the CHW has linked residents to.
* A survey will be developed to measure resident satisfaction with the services. It will be administered by someone other than the CHW, and will be conducted at 3- and 6- months after the resident is added to a caseload.
* Data will also be gathered on the weekly blood pressure check events (# in attendance, follow-up, linkages to other services, etc.) (EVALUATION TOOL TO BE DEVELOPED)

***Privacy***

* HIPAA is covered in CHW certification training, and supported by regular practices of the VoA Social Services team (use of VoA’s “Consent for the Release of Information” form). DHS HIPAA training is available if needed. (SEE ALSO, PENN manual that provides clear day-to-day instructions for how CHWs comply with data privacy requirements.)
1. **RESOURCES, REFERRALS AND COMMUNICATION WITH OTHER AGENCIES**
* CHWs are responsible to know community resources that help fill VoA residents’ needs. VoA Social Services has a list to start with, and the team regularly shares group emails regarding community resources to add to the CHWs’ knowledge of what’s available, and how to connect residents to these resources. CHWs will email the Team to ask for ideas and assistance from their colleagues when residents need resources the CHWs are not familiar with.
* CWG-funded (and other) clinics can refer patients living in the five Pilot highrises to VoA CHW services. Clinic staff will follow their clinic’s Release of Information process and forms, and contact (via phone or fax) Bill or Carrie at VoA. VoA Pilot staff may develop a referral form that can be shared with clinics for them to use to access VoA CHWs for their patients.
* VoA CHWs will obtain a list of the residents’ clinical providers as part of their initial assessment. When agreed upon with the resident, and when it will assist residents to meet their health goals, VoA CHWs will attend clinic visits with residents to: (1) listen to education messages; (2) provide support; (3) clarify/understand clinical goals; and (4) identify ways the CHW can assist the resident in reaching goals.
* If a resident served by a VoA CHW also has CHW and/or other care coordination support at their primary care provider, the VoA CHW will discuss roles with the other CHW/care coordination staff to assure residents get the support they need, and to avoid duplication. Many clinic-based care coordinators may not provide in-home visits, and this may be a role VoA CHWs can fill.
* VoA CHWs can use this SAMPLE SCRIPT as a template for reaching out to residents’ medical providers (from PENN manual):
	+ “My name is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and I’m a Community Health Worker with the Volunteers of America. I work in Minneapolis Public Housing high rises. My job is to provide high-risk residents with intensive support in order to help them reach their health goals. I am working with (RESIDENT NAME) to help him/her reach his/her goals of (RESIDENT’S GOALS). In order to reach this goal s/he has told me s/he will need to work on the following areas (LIST PATHWAYS AND OTHER IDENTIFIED AREAS). I will be providing support with these goals and may be contacting you if we run into medical questions along the way. Please let me know if I can be of help. My cell phone # is \_\_\_\_\_\_\_\_. Please do not hesitate to call if you need help in conducting outreach to the resident or have any questions.”
* CHW Supervisor, Carrie Harris, is available to speak to or meet with clinics as needed to help forge closer partnerships and relationship with them.
* CHWs are responsible for getting residents medical help if issues arise from home
	+ If a medical issue arises (for example, a resident’s blood pressure is above 200, their blood sugar is above 300, the resident is not feeling well, has a problem with medications, or is unclear about some messages from their medical providers) this is ALWAYS the most urgent thing the CHW needs to take care of. The CHW will drop whatever else they are doing for the moment, and focus on the medical issue. There are a few things they will do:
		- The CHW WILL NOT tell the resident what to do (for example, go to the ER or don’t go to the ER), but WILL offer to support them with whatever they think they should do. The CHW will remember that they are not a clinician.
		- The CHW will notify their supervisor, or other VoA Social Services Staff if their Supervisor is not available.
		- In an emergency situation, the CHW will call 911.
		- The CHW will offer to get in-touch with a doctor. CHWs will never give residents the doctor’s pager or cell phone #, but WILL use three-way calls with the resident. The CHW will use their training to explain the situation to the doctor: Situation (who they are, where they are); Background (resident’s name, Date of Birth, major medical conditions); Assessment (what is happening?); Request (what resident needs). The CHW will stay with the resident or in-touch with the resident as they contact a clinical provider. If they cannot contact the provider, they will contact their supervisor.
		- If a resident has a psychiatric crisis (suicidal, or other threats of harm to self or others) or a domestic violence issue, CHWs will do the following:
			* THE CHW WILL STAY ON THE LINE OR STAY WITH THE RESIDENT. If the CHW is on the phone, they will ask the resident to tell them where they are. The CHW will also ask the resident to get to a safer location where they are not alone.
			* The CHW will make a three-way call to their Supervisor.
			* The CHW will call the suicide hotline/domestic violence hotline with the resident.
1. **SAFETY**
* Being a CHW can be a challenging job. The most important principle of this VoA Project is THE CHW’S SAFETY COMES FIRST!
* If CHWs ever feel uncomfortable in any situation, or if safety concerns arise at any level, they will leave right away and call the lead building social service staff or their supervisor. (Tricks for leaving quickly will be shared at orientation.)
* Bed bugs are an issue at the buildings the VoA CHWs will be working in. Guidance on how to work in this environment will be covered at orientation and include:
	+ CHWs will not sit down in residents’ apartments. They will keep in-apartment meetings brief, and remain standing. CHWs will meet with clients 1:1 in common areas of the buildings.
* CHWs will invite a colleague to attend a visit/meeting with them if that will make a situation more safe or comfortable for them.
* If a CHW has a scheduled visit with a resident, the resident doesn’t answer the door, and the CHW is worried about the resident, the CHW will call for a “Health and Safety Check”: 612-342-1585. Building staff will come and open the door to check on the resident.
* CHWs will find a neutral and safe place for 1:1 client visits. For example, a quiet private place in the common areas of buildings.
* If a CHW realizes early on that they know a resident personally, are related to the resident, or live in a 1-2 block radius of the resident, they will not accept the resident on their caseload.
* If a resident behaves inappropriately or makes the CHW feel uncomfortable or unsafe, the CHW will report this to their Supervisor immediately. The resident’s participation in The Pilot may be terminated.
* CHWs will never enter a client’s car or give them a ride in a car, however short a distance.
* Any violation of the Safety Rules will result in immediate disciplinary action (verbal warning, then written warning, then Human Resources involvement). The VoA Social Service staff will have a Team discussion of any safety violation to understand why it happened and how to prevent others. CHWs will report to their supervisor any breaches of safety.

Volunteers of America

**CHW REFERRAL SCREENING FORM**

REVISED (JUN 17, 2016)

Person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Resident name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Building and unit #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VoA Social Service NOTES:

If **ANY “CHW REFERRAL”** box below is marked, please fill-out the information above and give this form to a VoA Community Health Worker. The CHW will then contact the resident.

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Do you have diabetes or hypertension (high blood pressure)?
 | YES | NO | DON’T KNOW |
| 1. Do you have prediabetes (at-risk for developing diabetes)?
 | YES | NO | DON’T KNOW**CHW REFERRAL**for prediabetes screen |
|  | If **“YES”** to **ONE or BOTH** above, **move on to question #3**. | If **“NO”** to **BOTH** ABOVE, **STOP—no CHW referral** |  |
| 1. Do you feel your condition(s) is/are under control?
 | YES | NO**CHW REFERRAL** | DON’T KNOW**CHW REFERRAL** |
| 1. Does your doctor feel your condition(s) is/are under control?
 | YES | NO**CHW REFERRAL** | DON’T KNOW**CHW REFERRAL** |
| 1. In the last 6 months, have you been to the Emergency Room for this/ these condition(s)?
 | YES**CHW REFERRAL** | NO | DON’T KNOW**CHW REFERRAL** |
| 1. In the last 6 months have you seen a primary care provider, and feel like you have a good relationship with them?
 | YES | NO**CHW REFERRAL** | DON’T KNOW**CHW REFERRAL** |