Community Health Worker/Peer Workforce: Recruiting and Hiring for Social Determinants of Health Screening

Best Practices Guide and Findings from COVID-19 Pandemic

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

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INTRODUCTION AND PURPOSE

In 2020, the COVID-19 pandemic *emphasized* the value of lived expertise[1] that Community Health Workers (CHWs) and Peer Specialists (Peers) workforce bring to the table as health centers addressed systemic inequities that lead to significantly worse COVID-19 outcomes for vulnerable communities (i.e. Black adults are nearly 2x more likely to die from COVID-19).[2,3] As our public health community continues to eliminate COVID-19-related disparities and health inequities in general, we can draw upon lessons learned and practices from health centers who have been successful in hiring, training, integrating, and retaining CHWs/Peers, with lived experience, to pave the way for our future work in addressing and eliminating social determinants of health disparities that impact our most vulnerable communities.

Health centers emphasizing lived experience in their hiring and responsibilities for CHW and Peer positions, can achieve *multiple benefits* of maximizing meaningful engagement with target populations and empower the voices of people with lived experience in the health center environment, while supporting employment and economic opportunity in often hard to employ communities.

Through the HRSA-funded National Health Center Training and Technical Assistance Partnership program,[4] MHP Salud, the Corporation for Supportive Housing (CSH), and the National Health Care for the Homeless Council (NHCHC) conducted research to develop *Best Practices* on the successful integration of Community Health Workers or Peer Specialists with Lived Experiences within Federally Qualified Health Centers (FQHCs or health centers).

In this guide, we share best practices in **1)** recruiting, hiring, providing professional development, **2)** integrating the CHW role, and **3)** retaining CHWs and Peers with Lived Experience in an effort to maximize their role in screening for Social Determinants of Health (SDOH). These practices and findings are based on interviews and research, focused on the CHW and Peer role in SDOH screening and addressing related disparities, like impacts of COVID-19.

[1] By *Lived Experience* we refer to the shared characteristics, culture, language, and/or experiences that frontline health workers possess, which allows these frontline health workers to more effectively communicate, educate, and support patients.
https://www.sprc.org/livedexperiencetoolkit/about#:~:text=Lived%20experience%20is%20defined%20as,representations%20constructed%20by%20other%20people.%E2%80%9D

[2] https://covidtracking.com/race

[3] https://www.kff.org/other/state-indicator/covid-19-deaths-by-race-ethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[4] https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/national-training

COMMUNITY HEALTH WORKERS

A **Community Health Worker (CHW)** is a trusted member of the community who empowers community members through education and connections to health and social resources. They have proven to be successful at increasing health outcomes for their communities they serve because they have a deep understanding of the people they serve. Furthermore, CHWs are widely known to improve the health of their communities by linking their neighbors to health care and social services, educating about disease and injury prevention, working to make health services more accessible, and by mobilizing their communities to create positive change.[5]

Over the years, CHW's access and insight into their communities have supported successful health initiatives across the globe. Their understanding of cultural preferences, language, and local resources allow them to be effective at addressing emerging health challenges in any geographic location of any cultural make-up, and across various age groups.[6,7]

In these communities, access to health services is often restricted due to factors such as economic status, language, race/ethnicity, gender, age, or geographic location. Individuals who live within these areas often have trouble obtaining a vehicle, affording, or accessing public transportation, and finding culturally appropriate health information. These barriers impact one's ability to maintain a healthy lifestyle because it prevents them from finding affordable fresh foods, keeping appointments with health professionals, having the knowledge to adopt healthier habits, and applying for health care and services.[8]

What makes CHWs uniquely qualified to provide support in these communities is their ability to build strong relationships, speak the language, and empathize with complex life situations. These qualities allow CHWs to successfully connect individuals to community resources, organizations, and government programs that often provide free or low-cost services. Further, CHW programs are known to be cost-effective for the community at large. Multiple ROI (return on investment) analyses have shown positive returns for every $1 spent on CHW programs.[9]

[5] https://mhpsalud.org/our-chw-initiatives/community-health-workers/
[6] Ibid.
[7] https://www.apha.org/apha-communities/member-sections/community-health-workers
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1615805/
[9] https://mhpsalud.org/programs/community-health-workers-roi/

With the appropriate resources, training, and support, CHWs will provide a variety of social and economic benefits while also improving the health of their communities by:

- Linking their neighbors to health care and social services
- Educating their peers about disease and injury prevention
- Working to make community resources more accessible
- Mobilizing their communities to create positive change through targeted outreach and customized programming[10]

While CHWs are known by many different titles (i.e., health educators or navigators; peer support specialists), f or the purposes of this publication, we will use the term CHW or Peer to refer to those health workers who are trusted members of the community and use those qualities in their service. ***Peers with Lived Experience*** has traditionally referred to non-clinical staff, who have lived experience with mental health and substance use disorders and provide enabling services and support to patients battling mental health and/or substance use disorders. Based on their shared experiences with mental health and/or substance use disorders, *Peers* can build rapport, educate, and support their patients (much like CHWs do in their roles, addressing other health disparities).[11]

Additionally, when we refer to CHWs or Peers with *Lived Experience*, we are referring to frontline healthcare professionals/workers who may have lived experiences (i.e., experienced homelessness, from the same neighborhood, or recovering from addiction), which allows these health care staff to be successful in delivering care and services to their patients/clients

CHWs or Peers from the community bring *Lived Experiences* that allow them to empathize with patients and connect them to resources. Given the alignment of roles, skills, and responsibilities that CHWs and Peers share, we encourage expanding their roles and responsibilities as integral members of the health care team. In addition, in this guide, we share responses, best practices, and tools to help expand the CHW and Peer roles in Screening for SDOH in health centers and alike organizations.

Community Health Worker Profession

The CHW profession has seen substantial growth in recent years because of the unique ability of this workforce to make health services more accessible and mobilize communities to create positive changes. Key to the successful implementation of the CHW role is the expertise and knowledge of the community that CHWs bring to the role.[12]

The Bureau of Labor Statistics (BLS) reports that the CHW profession is expected to grow at a rate *much faster* than the national average of all other occupations from 2018 - 2028.[13] As of 2019, there were an estimated 58,950 CHWs employed nationally.[14] This is a 7% increase from

[10] Ibid.
[11] https://www.mhanational.org/what-peer
[12] https://www.cdc.gov/dhdsp/pubs/docs/chw_evidence_assessment_report.pdf
[13] Community and Social Service Occupations : Occupational Outlook Handbook: : U.S. Bureau of Labor Statistics (bls.gov)
[14] https://www.bls.gov/oes/current/oes211094.htm

2017, in which 54,760 CHWs were employed.[15,16] The BLS expects the CHW profession to grow 18.1% by 2026.[5] This means that over 10,000 jobs should be available within this profession. In addition, salaries for CHWs are increasing to a median of $19.41 per hour, or $40,360 annually.[2,17] **Growth in both the number of positions and in wages for these roles, provides further evidence of the effectiveness and value of CHWs across the nation.**

Factors such as recruiting, hiring, onboarding, and providing continuous professional development have proven to be successful strategies to support and strengthen the CHW profession as it continues to grow. Efforts to recruit and hire well-qualified individuals are not only beneficial for laying a strong foundation for a CHW program, but also contributes to reducing CHW attrition. Providing opportunities for professional development is an essential part of building capacity among the CHW profession, and creating greater CHW employment opportunities, due to the transferability of their skill set.[18,19,20]

Value of CHWs and Peers

What makes CHWs uniquely qualified to support vulnerable and marginalized communities are their ability to build strong relationships, speak the language, and empathize with complex life situations. Often, these qualities come with *lived experience*, or being from the communities that CHWs are serving (i.e., their peers). CHWs—or Peers—bring their experiences into their profession as a way to deliver better care.

Integrating CHWs and Peers in Health Center Care Coordination

The *integration* of CHWs and Peers in clinical settings can develop *proactive care teams* who work together to improve patient outcomes. Some examples of the CHW and Peer role in clinical/health care settings include:

- Creating connections between vulnerable populations and healthcare systems.
- Supporting cultural understanding and sensitivity among healthcare professionals serving vulnerable populations.
- Advocating for underserved individuals and communities to receive appropriate services.
- Providing culturally appropriate health education on topics related to chronic disease prevention and healthy living.
- Supporting individualized goal setting, implementation of self-management plans, and long-term self-management support.
- Providing informal counseling, health screenings, and referrals for identified SDOH needs.

[15] https://www.bls.gov/oes/2017/may/oes211094.htm
[16] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/community-health-workforce.pdf
[17] https://chwtraining.org/core-register-online-training/
[18] https://www.mchip.net/sites/default/files/mchipfiles/07_CHW_Recruitment.pdf
[19] https://nachw.org/chw_resources/capacity-building-and-training-needs-for-community-health-workers-working-in-health-care-organizations/
[20] https://poverty.umich.edu/10/files/2018/03/chrtlapedis.pdf

- Helping patients navigate health care and social systems (e.g., providing assistance with enrollment, appointments, referrals, transportation to and from appointments, and interpreter services at appointments).
- Educating health system providers and stakeholders about community health needs.
- Collecting data and relaying information to policymakers to inform policy change and program development.[21,22]

Given that CHWs and Peers are a growing profession that encompasses a wide range of responsibilities, these roles are often integrated *differently* across health centers. For example, in some health centers, CHWs and Peers are well integrated into their organizations, with CHWs and Peers working alongside medical practitioners (i.e., on clinical care teams). Whereas other health centers might have their CHWs and Peers delivering most services as outreach workers or health educators out in the community (i.e., health fairs, health education talks, home care.) As such, a **commonly reported barrier to CHW and Peer integration is, because this unique role works mostly out in the community, there are limited opportunities for cross-team collaboration and bonding.**

"Our community health workers are typically out in the community and as a result were not completely integrated."

Health center respondent

"Care coordination improved when CHW/Peer Specialists teamed up with clinical teams to provide training for migrant workers."

Health center respondent

For example, as it relates to initial actions health centers took to reduce the spread of COVID-19s, many health centers actually sent non-essential or non-clinical staff (i.e., CHWs/Peers) *home* to work. However, despite working remotely or from home, over this past year, CHWs and Peers

[21] https://2ow7t71bjuyu4dst8o28010f-wpengine.netdna-ssl.com/wp-content/uploads/2019/08/CHW-Clinical-Integration.pdf
[22] https://mhpsalud.org/programs/who-are-promotoresas-chws/the-chw-landscape/

continued to provide education and "outreach" (sometimes virtual) to their communities.[23] We can understand this phenomenon, in large part, due to the need and value of CHWs and Peers in delivering COVID-19-related education and access to resources. However, it still highlights that, as CHWs and Peers continue to become essential staff who are necessary to deliver equitable care, health centers must still find ways to keep these staff members well-integrated into their care teams/health centers.[24]

One CHW/Peer Specialist described a sense of feeling like there was not enough physical space for them in the health center.

Additionally, one respondent described how COVID-19 has created additional attention for the CHW and Peer Specialist role because of their integration into contact tracing and vaccination efforts.

Another common challenge to integrating CHWs into a [clinical] care team is often *misunderstanding* the CHW or Peer role. This role may share commonalities in the expectations and job duties that another role holds (i.e., Case Managers). **However, CHWs and Peers remain distinct from other care team members because they are peers to the patients.** Although they may perform similar tasks in their jobs, CHWs and Peers have different capabilities.[25]

Some guiding principles to help mitigate these barriers include:

- Promoting respect for CHWs and Peers among team members to strengthen clinical outcomes.
- Educating all members of the clinic on who CHWs and Peers are, what they do, and how they are an integral part of the team.
- Incorporating CHW core competencies into program design, including advocacy and community-based work on social determinants of health.
- Involving CHWs and Peers in integration planning and implementation at all system levels.
- Providing opportunities for CHWs and Peers to share their unique understanding, perspectives, and value of the community with the organization and team.
- Including CHWs and Peers in regular team meetings.

[23] https://mhpsalud.org/community-health-worker-resources/
[24] https://nachw.org/wp-content/uploads/2021/01/CBWA-Advancing-CHW-Engagement-in-COVID-Updated-2021.pdf
[25] https://mhpsalud.org/portfolio/making-the-case-for-community-health-workers-on-clinical-care-teams-a-toolkit/

- Providing CHWs and Peers access to electronic health records and integrating CHW and Peer notes into the patient record for improved continuity of care.[26]

Overall, CHWs and Peers serve as integral members of the health care team, by supporting the patient-centered goals and interventions. Every profession within an organization has a defined scope of work and it is important for all professions, including CHWs and Peers, to understand the parameters and expectations of their position. Having a clear understanding of each team member's contribution and integrating all care staff into the clinical team, ensures patients are served to the best of the organization's ability. As health centers continue to address COVID-19-related disparities, and other important health inequities, it is important to provide training and support to all health center staff, to ensure the CHW or Peer role(s) is well defined and understood.

SOCIAL DETERMINANTS OF HEALTH

Social Determinants of Health (SDOH) is the concept that where an individual lives, works, learns, plays, worships, and ages affects their overall health. Barriers to, or lack of access to resources reinforce health risk factors. Examples of SDOH include, but are not limited to:

- Housing/Utilities
- Transportation
- Literacy and language
- Food
- Social support
- Race / ethnicity
- Education
- Health coverage
- Financial security
- Neighborhood safety[27]

Equitable social and physical environments are key to good health, yet we know that barriers remain in our communities. We also know that social constructs (commonly accepted systems and assumptions in a society, like access to community resources, public education, or living wage) and individual inter-sectionalities (like race/ethnicity, religion, gender, sexual orientation, occupation, etc.) affect these determinants. This means, that often, individuals or communities who have marginalized identities, face the most challenging disparities related to their health and wellbeing.

[26] https://nachw.org/chw_resources/capacity-building-and-training-needs-for-community-health-workers-working-in-health-care-organizations/
[27] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Health Centers and SDOH Screening Overview

The Uniform Data System (UDS) is a national system of data where FQHCs report on patient outcomes, services delivered, and other important metrics on the nation's most vulnerable populations.[28] In the 2019 UDS report, among 1,385 FQHCs**, more than 70% reported collecting data on individual patients' social risk factors** *outside* of the data reportable in UDS. Among health centers who screen for patient social risk factors (i.e., SDOH), 36% use Protocol for Responding to and Assessing Patients' Assets Risks and Experiences (PRAPARE), the most commonly used SDOH screening tool.[29] Other commonly used SDOH screening tools include:

- Recommended Social and Behavioral Domains for Electronic Health Records[30]
- Well Child Care Evaluation Community Resources Advocacy Referral Education (WE CARE)[31]
- Centers for Medicare & Medicaid (CMS) Accountable Health Communities (AHC) Screening tool[32]

Screening for these determinants is **critical for health centers to assess population health, understand the social measures that affect the health of their patients, and collaborate with community partners to address the barriers affecting health.** Regardless of what tool(s) health centers use, one of the most important factors when choosing a social needs screening tool is **ensuring that the data collected and reported is meaningful and actionable for health center providers and staff**. Moreover, the SDOH screening tool should consider intended population or setting, total number of questions, social health domains covered, and domain-specific measures used. For health centers interested in the SDOH screening tool implementation process, we recommend "PRAPARE Implementation and Action Toolkit," as it also a HRSA-funded project, and includes extensive research and findings for health centers.[33]

70.69%

Nine hundred and seventy-nine (979) (70.69%) community health centers replied "Yes"

22.82%

316 (22.82%) replied "No, but we are in the planning stages to collect this information"

6.49%

90 (6.49%) replied, "No, we are not planning to collect this information"

[28] https://bphc.hrsa.gov/datareporting/reporting/index.html
[29] https://www.nachc.org/research-and-data/prapare/
[30] https://www.nap.edu/initiative/committee-on-the-recommended-social-and-behavioral-domains-and-measures-for-electronic-health-records
[31] https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/poverty/Pages/practice-tips.aspx
[32] https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

[33] https://www.nachc.org/research-and-data/prapare/toolkit/

Among health centers who screen for patient social risk factors (i.e., SDOH):

36.26%	355 use Protocol for Responding to and Assessing Patients' Assets Risks and Experiences (PRAPARE)
5.31%	52 Reported that they use the Recommended Social and Behavioral Domains for Electronic Health Records (EHRs)
4.08%	40 use the Accountable Health Community Screening Tools
3.88%	Lastly, 38 use the Well Child Care Evaluation Community Resources Advocacy Referral Education (WE CARE)
22.68%	Two hundred and twenty-two (222) do not use a standard screener but rather use independent or specific condition screeners such as PHQ-2,9 SBIRT or custom-built assessment tools.

CHW and Peer Role in Addressing SDOH

CHWs and Peers with lived experience are uniquely qualified to address the SDOH needs of their communities. They know how to *reach* individuals "where they are at," and can more effectively *connect* their community to services.[34] As such, input and feedback from CHWs and Peers can be beneficial in determining the key SDOH domains affecting the communities they serve. CHWs and Peers perform essential activities for organizations implementing programs that address SDOH, such as:

- Leading community needs assessment and collecting data that could aid in the selection of final SDOH domains.
- Providing referrals to a service for a community member to address SDOH needs (i.e., providing a family facing food insecurity a referral to a local food bank).
- Attending an appointment with a community member or providing transportation to an appointment.
- Providing ongoing communication and/or social services.
- Providing follow up through phone call, home, telehealth or office visits. [35]

[34]https://2ow7t71bjuyu4dst8o28010f-wpengine.netdna-ssl.com/wp-content/uploads/2020/08/Community-Health-Workers-Improving-Social-Determinants-of-Health.pdf
[35] https://mhpsalud.org/social-determinants-of-health/

HEALTH CENTER WORKFORCE INTERVIEWS AND FINDINGS

Overview of Methodology

Information and data for this guide was informed by facilitated focus groups/listening sessions conducted in January 2021. A focus group/listening session guide (see *Appendix 1*) was created to direct the conversation around **1)** hiring CHWs and Peers, **2)** their integration into Health Centers, and **3)** involvement with SDOH screening.

The focus groups/listening sessions were conducted via telephone and/or video conference and ranged between 30–60 minutes. Five sessions were conducted across three occupational categories, including:

- Health center staff who worked as CHW or Peers, or their supervisions
- Health center administrative staff
- Workforce specialist group (i.e., national organizations who support CHW training and/or certifications)

Each group consisted of three to four respondents, with a total of 16 respondents. The respondents represented a mixture of rural and urban community health centers (see *Appendix 2* for complete list). We also conducted a few one-on-one interviews, to accommodate health center staff who wanted to participate, but had schedule conflicts (i.e., could not attend focus group sessions). These one-on-one interviews were conducted with community health center representatives (n=2) and one person who provides national CHW training and certification.

The analysis involved finding qualitative themes by examining video/audio recordings of these interviews/focus groups and supplementing that analysis with notes taken by the moderators.

Focus Group/Listening Sessions Cohort Description

Recruitment efforts involved advertising, via NTTAP networks (i.e., during SDOH-related webinars or learning collaboratives; emailing health center representatives that our NTTAPs serve), netted 32 respondents who filled out the registration form (Google Form questionnaire). In the registration form, we asked specific questions about SDOH screening tools currently being used by health centers, and whether health centers had established CHW programs.

Among those who registered (n=32) to participate in a focus group/listening session, 59% (n=19) indicated their health centers currently screen for SDOH and 25% (n=8) indicated that they were unsure if their health center used screened for SDOH.

Among those who registered (n=32), only about half (n=16) were actual able to participate in a focus group/listening session (low participation was primarily due to last minute scheduling conflicts, as most participants were health center staff).

During the focus groups/listening sessions, most participants indicated their health center was using the PRAPARE tool. Other tools mentioned included the Accountable Health Community Screening Tool, Self Sufficiency Matrix (SSM), or a customized combination of tools.

CHW and Peer Hiring Best Practices

During the focus groups/listening sessions, participants overwhelming described the most the *prominent* qualification for hiring CHWs and Peers was that they had a connection to the community being served. This approach aligns well with overall hiring recommendations for this profession. For example, when hiring CHWs or Peers, health centers benefit when hiring staff who are *culturally familiar* with and representative of the population being served. Common qualifications for hiring CHWs and Peers often includes: networking skills, knowledge of local resources, lived experience, and similar cultural or linguistic qualities to those in the community.[36]

> *A workforce specialist respondent noted that in CHW and Peer roles, lived experience could be a more critical qualification than educational background. The professional background of CHW and Peer respondents before coming into their current role varied. For example, one CHW/Peer reported coming from within the health center system where others came from external positions like teaching, engineering, or personal fitness.*

However, many participants still mentioned common barriers to hiring CHWs or Peers. One commonly reported challenge is finding qualified applicants for these roles (i.e., speaking language of community or direct experience in the community). This challenge was noted as especially challenging for rural health centers and those serving special populations (i.e., migrant farmworker communities). Additionally, the COVID-19 pandemic was noted as further exacerbating technological barriers, impeding typically in-person hiring processes, and other practices typically done in-person.

[36] https://mhpsalud.org/tips-for-recruiting-and-hiring-community-health-workers-as-employees/

Lastly, a prominent barrier mentioned to hiring CHW or Peer roles included a lack of knowledge or understanding of about the scope of this role (i.e., not familiar with terminology or what the job entails).[37] Again, these barriers are common for many health centers who are hiring, training, and integrating CHWs or Peers. To address these issues, some recommendations include:

- Reaching out to community organizations, including the state or local CHW associations to broaden the reach outside of traditional online job postings.
- Utilizing CHW and Peer staff networks and community partners as a resource to identifying potential candidates (i.e., word of mouth).
- Conducting education outreach to inform the community on the CHW and Peer Specialist role while concurrently advertising open positions.

SDOH Screening Tools

As mentioned, there are several tools available to health centers and organizations interested in improving how they measure and monitor the SDOH needs of their patients (see *Appendix* 2 for a complete resource list). These tools can help health centers focus on a range of SDOH, including housing, finances, environment, or other factors.[38]

During the focus groups/listening sessions, participants shared how their health centers were implementing SDOH tools, including discussing what staff members were engaged in screening is the data is integrated into Electronic Health Records (EHRs) and how the data collected is used to provide whole person care and linkages to resources. There was a lot of variety in how health centers mentioned these SDOH screening processes are facilitated at their organizations. This is likely the result of different workforce demographics (i.e., some health centers have completely bilingual staff, while others struggle to hire bilingual staff needed to communicate with patients), resource availability (i.e., ability to provide paper versus electronic screening processes; number of staff available to support SDOH screening), and administrative standards that vary across health centers (i.e., how patient data is integrated into their EHR systems).

However, most participants did mention that when integrating SDOH screening into the clinical space, there is a general *workflow* that includes collecting SDOH metrics/data, identifying patient needs, and connecting patients to resources to address those needs. Some health centers mentioned integrating SDOH screening tools/questionnaire data directly into patients' EHR. This integration allows multidisciplinary care teams to share patient health data and use that collective information to deliver better care to patients.

[37] https://2ow7t71bjuyu4dst8o28010f-wpengine.netdna-ssl.com/wp-content/uploads/2020/08/Workforce-Development-and-Retention-of-Community-Health-Workers-Project.pdf
[38] https://mhpsalud.org/portfolio/chws-social-determinants-health/

SDOH
Workflow

There was a clear desire from other participants to incorporate SDOH screening results into care planning as an ideal goal to set a course for integrated care and improvement to health outcomes. It was emphasized that the lived experience of CHWs and Peers in this process provided a vital component to the screening process.

In cases where SDOH screening was conducted by staff with the lived experience (i.e., CHW roles) *and* this data was integrated into the EHR, participants shared that these staff members were often *more* involved in the clinical care and were able to utilize their skills as frontline staff with lived experiences to aid practitioners in patients' provision of care. This an important example of the invaluable contribution CHWs and Peers bring to their health centers and patients they served.

Health center participants also noted challenges related to SDOH data collection and patient privacy, especially when patients felt questions were invasive. These concerns are valid, and important, especially since the data collected will be used to help patients address determinants impacting their health—therefore, if patients do not feel comfortable answering SDOH screening questions, health center staff end up with incomplete information that is necessary to help deliver better care. Integrating health center staff, like CHWs or Peers, into the SDOH screening and data collection process can help address issues of mistrust among patients, especially when the CHW or Peer staff member shares important experiences or characteristics with patients (i.e., being able to screen in the preferred language of the patient). CHWs and Peers with lived experience can also communicate, to their patients, why SDOH data collection is important and how the data can be used to help provide a better understanding of the social conditions that contribute to poor health. This intentional integration of CHW or Peer staff allows health centers to more effectively address patient needs, connect patients to appropriate health and social services, and create opportunities to improve social systems affecting health.

SDOH Data Collection and Usage

SDOH data can be used to provide better patient-centered care and allow health centers to move away from a *one-size fits all* approach to the delivery of care. During focus groups/listening sessions, participants described how SDOH data can also be used to improve connections to social service programs (i.e., via referrals). Additionally, health centers often use SDOH data to examine *gaps* in the delivery of care (i.e. needing to integrate a case manager to explain how to navigate treatment options suggested by their physician) and areas for improvement to amplify the continuum of care after patients are discharged. Additionally SDOH data is used to build partnerships with local community-based organizations to serve patients and or the community. SDOH data can also be linked to other health data in a patient's EHR to better achieve health outcomes (i.e. SDOH data indicated food insecurity and patient is battling with poor nutrition).

Linkages to Resources or Partnerships for Satisfying Identified SDOH Needs

Health center participants described difficulties identifying and maintaining up-to-date referrals to local resources to address the patients' SDOH needs. COVID-19 intensified these challenges, as many community resources closed, temporarily or permanently, and new patient referrals are taking longer to get into the system (i.e., patients have to wait weeks or months to get these appointments). To alleviate these barriers, participants noted utilizing CHW and Peer networks and their connections to the community to locate more immediate resources. Several participants also indicated they were utilizing updated online resource platforms.

It was also suggested that providing CHW and Peer training around SDOH screening best practices was a useful tool to alleviate barriers in data collection and/or follow-up care. Participants noted receiving training support for CHW and Peer professional development from community colleges, state-wide CHW associations, Primary Care Associations (PCAs), and other community workforce organizations.

> *"It's not enough to make the referral, determining if action was taken and the social determinant is addressed is what will have impact on the health outcomes."*

COVID-19 PRACTICAL CONSIDERATIONS

In effort to reduce the spread of COVID-19, health centers in urban and rural communities needed to respond quickly to adapt how they engaged with their patients and broader community. The role of the CHWs and Peers as navigators, educators, and advocates uniquely equips this workforce to provide culturally informed care that empowers and educates their peers/patients, especially during a period of time when information and connections are key to quality care.

Dialogue during the focus groups/listening sessions revealed broad expansion of and role changes for CHWs and Peers, such as employing them as frontline staff for COVID-19 testing or vaccination efforts Additionally, as trusted members of their communities, CHWs and Peers were essential in providing COVID-19-related education, information, and referrals, including dispelling fears and translating information in a way that made sense to their patients/community (this was especially important for those serving migrant farmworker patients). CHWs and Peers also provided essential follow-up care with patients to ensure they had sufficient amounts of medications and prescriptions, especially when supplies were low, or appointments were temporarily cancelled. Technology was also described as an important tool for CHWs and Peers, especially to deliver care during COVID-19 (i.e., telehealth).

CHWs and Peers started using—or increased their use of—technology to facilitate virtual outreach for appointments, wellness checks, and provide hands-on technology training for patients shifting to telehealth. Again, while these roles—educating, navigating, and connecting patients to care—are typical to the CHW and Peer roles, COVID-19 was a catalyst to expanding and evolving the scope of these roles.

As mentioned earlier, misunderstanding the CHW and Peer role can be a barrier to effectively integrating these staff members into health centers and clinical care teams. Health centers can improve their coordination of care by including CHWs and Peers in team huddles or regular meetings and allowing CHWs or Peers to share important factors that may impact patients' ability to follow-up on prescribed care by their providers.[39] Additionally, health center participants described how COVID-19 brought additional attention to the CHW and Peer role because of their integration into contact tracing efforts, dissemination of information, and supplies.

During focus groups/listening sessions, health center participants shared that patients were reluctant to respond to SDOH screening questions due to fearing that revealing these gaps in their housing or economic conditions might create *greater* challenges for their family stability. For example, one of the participants noted that due to COVID-19, SDOH screening transitioned over-the-phone screening, and this transition made it difficult for CHWs to build that rapport with patients.

[39] https://mhpsalud.org/portfolio/healthcenters-chws/

However, again since CHWs and Peers are trusted members of their communities, these roles were essential in facilitating SDOH screeners among patients who were very concerned about their socioeconomic situations Participants did note that when CHWs and Peers spend additional time building rapport and trust with the patient, and providing solutions (i.e., referrals, vouchers), their patients were more likely to open up about their situations and allow CHWs/Peers to help provide follow-up care.

Building on the communication inroads achieved this past year in response to COVID-19, CHW and Peers are continuing outreach into their communities to support broad COVID-19 efforts, including:

- Pivoting to working remotely and facilitating telehealth visits.
- Providing virtual screenings for SDOH.
- Shifting to COVID-19 vaccination assistance.
- Evaluating outcomes for COVID-19 efforts.

COVID-19 has reinforced the need for partnership across the public health and social service sectors, especially to address health inequities related to COVID-19.

CHW HIRING, CERTIFICATION AND PARTNERSHIPS

Training and CHW and Peer Certification

Statewide CHW associations and community-based organizations are setting standards for CHW certifications in healthcare and other social services.[40] These certification programs and training opportunities supports CHW professional development and helps meet the growing demand for CHW-like roles n in the public health sector. While health centers often approach CHW and Peer hiring and training differently, national, or statewide certifications and training helps develop a workforce from which health centers can more effectively hire.

For the development of up-to-date SDOH resources and tools, health centers can connect with housing and service providers including Continuums of Care, Community Action Partners (CAP), Area Agencies on Aging (AAA), and/or behavioral health service providers.

One of the most striking new types of partnerships developing in communities is the connection among community colleges, statewide health and human service agencies, health centers and statewide training associations. In several of the communities participating in the focus groups, the health center and local service partners were identified as working closely with community colleges

[40] https://www.ruralhealthinfo.org/toolkits/community-health-workers/4/training/certification

to develop training or certification programs that respond to local conditions, skill development, and hiring gaps. As more states legislate for CHW standards and certification, they recognize the need to have local access points and tailored content.

CASE STUDY

Generations Family Health

Generations Family Health Center, Inc. (GFHC) is a 501(c) (3) not-for-profit, Federally Qualified Health Center that has been serving eastern Connecticut since 1984.

GFHC provides medical, dental, behavioral health and chiropractic services as well as enabling services for care management and support for people of all ages. Accredited by the Joint Commission, and National Committee for Quality Assurance (NCQA), recognized as a level 3 Patient Centered Medical Home (PCMH) practice, their mission is to provide quality care that is affordable, accessible and sustainable for everyone regardless of ability to pay. They employ bilingual, culturally competent staff who work closely with clinicians and community partners to assure that patients/families/caregivers have an advocate to help navigate the healthcare system.

Judith Gaudet, Systems of Care Director, provided extensive time and detail helping us to understand the vital role of CHW and Peers at GFHC, where she has been for 19 years. Gaudet began as an office nurse, moving up through the ranks in various positions to her current role. Part of her success as a leader is to facilitate mentorship and professional development, support Gaudet received to advance in roles at GFHC.

Key Program Components

The Systems of Care (SoC) Department initially grew out of the Connecticut Department of Social Services Shared Savings Program (PCMH+). GFHC developed a team of Care Coordinators, whose focus was on highest risk patient populations in efforts to decrease utilization and improve health outcomes. In 2018, the model proved to be successful and pulled in community health workers, formerly of the Health Education Department.

At the onset, GFHC recognized the need for not overtaxing existing staff, but to create new roles and hire targeted talent to fill them across various departments. The restructure created one department working in tandem with the care teams to address whole person care. Currently they

employ 28 Community Health Worker staff, with various titles: **Care Coordinators** work with highest risk patients, those who need a higher level of assistance over a longer period. **Care Facilitators** engage in similar tasks and specialty referrals, though the patients they serve are not considered high risk and require short-term assistance. **Outreach Workers** provide much of their community-based care and services to general and special populations. Targeted activities of the CHWs are based on risk stratification and the needs of a specific population, including those experiencing homelessness, migrant farmworkers, and children with special healthcare needs. In her words, Judith described how they work to provide enabling services that close the gaps, thus forming a "great circle of care."

Recruiting CHWs

Recruiting tools highlighted include social media, community websites, Indeed.com, and job fairs. Established relationships with community networks are great sources for hiring referrals.

Hiring of CHWs

GFHC conducts thorough interviews to assess the candidate's capacity to respond to questions, gauge their knowledge of GFHC and their understanding of the position/role, as well as their comfort with community interactions. Resumes are reviewed but are less important than interactivity with potential candidates. Other important factors include job specific qualifications, language and cultural fit, knowledge of community resources and hiring location. CHW job descriptions indicate educational credentials are 'preferred' but not mandatory. Judith is a strong proponent of using the probationary period effectively to gauge proper fit, providing needed training and feedback during this period to ensure staff have the tools and are gaining confidence in their new position.

Integration of CHWs

A supportive environment for Systems of Care staff was created and subsequently medical care teams increased their understanding of team member roles, fostering trust to allow CHWs to contribute valuable care plan details. Currently, the organization has integrated its medical and behavioral health care services. Care Coordinators lead the Integration meetings, asking what they can do to 'get the ball rolling' on a client's case and helping to consolidate and prioritize needs for the team. This value-add encourages the medical providers to rely more heavily on the skills and experience of the CHWs.

SDOH Screening by CHWs

To jumpstart the SDOH screening process, GFHC created forms within the EHR to document the SDOH assessment, care completed and referrals to community resources. The GFHC team has the capacity to go back into the system to produce usable needs, referral and results data to improve patient health outcomes. GFHC is exploring a national web-based screening and tracking platform,

UniteUS, which contains all local community resources, allows tracking of outgoing referrals, and generates information back from the service provider about referral outcomes.

Outcomes and Impact of CHW Efforts

As evidenced by the examples below, GFHC believes strongly in the impact of CHWs to support improved outcomes.

1. **A1C blood glucose control:**

   In an example of clinical care coordination, a Community Clinical Integration Project had 32 Hispanic individuals ages 18-39, all of whom had uncontrolled diabetes. A risk analysis was conducted to identify barriers to access, language differences, and cultural habits and diets. As the team worked with patients, they offered A1C testing, access to follow up appointments, and diabetic kits including cookbooks and glucometers. Of these 32 patients, 48% showed improvement in their A1C control. GFHC expanded the methodology using the same practices with their migrant farmworker population. In 2018, 2019 and 2020, respectively, the goals for uncontrolled diabetes in their migrant farmworker population declined over time, 36%, 15.48% and 11.6%. These improved results were achieved using the staff, services and their coordination across the clinical care team. The project again expanded to become a 2020 HRSA performance improvement project.

2. **Homelessness and Medication Management**:

   A patient experiencing homelessness contacted the outreach worker and their supervisor to let them know his backpack containing clothing and medications had gone missing. Within a day, the CHW utilized community connections to arrange for the delivery of medication to the patient's friend's house, as well as a replacement of his clothing and shoes.

3. **Migrant Farmworker COVID-19 Testing and Vaccinations:**

   Through a local farm partnership, GHFC CHWs were able to use telephonic enrollment of migrant farmworkers to schedule COVID-19 vaccinations. An agreement with a local transit company provided full-day shuttle runs to transport seniors from a congregate living setting to the vaccination site. The result was that 175 migrant farmworkers and 113 seniors received their COVID-19 vaccinations in the month of February.

Best Practice Recommendations for CHW and Peer Connections to SDOH screening.

- Obtain buy-in from senior management and demonstrate that the return on investment comes in improved outcomes and quality of health/life for patients. Through GFHCs Patient Centered Medical Home status, they have increased awards and value-based payments, thus

allowing them to use that funding to support the Systems of Care staff salaries. Despite this reinvestment, they still identify SDOH gaps for patients.

- Incentivize health centers to utilize the *community resource tracking* platforms and integration into the electronic health record as a means to coordinate care and track outcomes.
- Provide on-going cross training for all positions within CHW programs. All staff need to be on the same page and be well informed.

It was abundantly clear that the caring culture of Generations Family Health Center keeps them moving forward in a positive way in order to meet the myriad needs of their patients.

CONCLUSIONS, RECOMMENDATIONS, NEXT STEPS

Limitations and Recommendations

Some limitations inherent in the hiring and integrating of CHWs within health centers include:

- Lack of understanding of the CHW/Peer specialist role and qualifications.
- Pre-hiring certification vs. on-the-job training/certification.
- Funding/financial - programs are primarily grant-funded, which are often time-limited.
- Disconnect between insurance reimbursement, certification and lived expertise.
- The continued need to promote livable wages for CHWs and Peers.

Based on these findings, the following recommendations are *Best Practices* in hiring and integrating those with lived experience into health center CHW and Peer programs:

Recommendations	
Hiring and Recruitment	● Consider low barrier hiring practices and methods for recruitment. ● Utilize community based/neighborhood organizations to amplify the job opportunity. ● Be consistent in language (CHW, peer specialist, promotoras, etc.) and use definitions for better explanation of roles. ● Consider the representation of your patient population (i.e., Is finding someone who is bilingual important?) ● Work with other social organizations to see if you can have shared CHW or Peer employment.

Integration and Training	● Provide continued or on-the-job training and avoid specific training as pre-hiring requirement. (Some trainings may be important to prioritize such as trauma informed care, motivational interviewing, or how to handle conflict). It is important to equip employees with tools they may not be familiar with encountering. ● Collaborate with universities, community colleges, local and state CHW programs that offer peer support training and certification. ● Build partnerships with local social service programs so when SDOH needs are identified the CHW/peer can link the patient to care. ● Provide training on data entry. ● Be inclusive with the CHW and Peers in health team huddles to provide a different perspective some providers may not have. ● Value the knowledge and lived experience the CHW and Peer bring, through equitable pay. ● Provide training for supervisors (including human resources, C-Suite and other staff) responsible for supervision to CHWs and Peers that prepare supervisors for meeting the needs and providing appropriate support to those with the lived experience.
SDOH and Resource Referrals	● Work with local social service organizations to provide a "warm hand-off" for referrals – these helps ensure that patients receive the resources needed, especially if trust is a concern. ● Ensure resources and referrals (i.e., locations for food banks) are up-to-date and culturally informed (i.e., bilingual) ● Integrate SDOH screening tools and collected data into EHR systems and care teams to enhance care coordination and referral tracking

Next Steps

We recognize there are additional efforts needed to address gaps in promoting CHWs and Peers with lived experiences among SDOH screening and data collection efforts. Chiefly, these include:

- Continuing to raise up the voice of lived expertise among CHW and Peers through publications and national webinars.
- Exploring issues regarding hiring and qualifications of CHWs.
- Promoting understanding of the CHW role and their integration into medical care teams.
- Expanding SDOH screening activities and strengthening connections to community resources.

RESOURCES

SDOH Screening Tools and Community Health Worker Resources

- PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences)
- Social Needs Screening Toolkit
- Accountable Health Communities Health-Related Social Needs Screening Tool
- WE CARE (Well-child care visit; Evaluation; Community resources; Advocacy; Referral; Education)

- **Community Health Worker and Peer Learning Collaborative Resources**

HRSA Disclaimer

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APPENDICES

APPENDIX I: Interview Questions and Guide

Interview Script

Hello, and welcome to today's focus group. My name is _____ (moderator name) with _____ (moderator organization) and I will be facilitating today's focus group. This is _____ (observer name) with _____ (observer organization) and they will be observing today's focus group and taking notes. To guarantee that your responses are documented correctly, are you okay with us recording this session today? *(If "yes" begin recording and ask each participant to restate their name, organization, and consent to capture on tape, if "no" do not record).*

We would like to thank you for taking the time to participate in our Strengthening the CHW and Peer Specialist Workforce project. Today we will be asking a series of questions to understand better the CHW, Peer Specialist, and/or other roles with lived experience employed in your Health Center. When we refer to "CHWs/Peer Specialists with lived experience(s)," we mean trusted members of the community with the personal connection to social and health determinants, such as homelessness, diabetes, or substance use. Today's information will be used to develop a national resource that will be disseminated to all health centers. Information you share may help to shape the resource, but we will not identify you by name or Health Center.

We would now like to run through some housekeeping items:

- This focus group will last up to an hour.
- There are no right or wrong answers and feel free to share your opinion even if it differs from what others have said.
- Please be respectful of everyone's answers.
- Everyone should participate and only one person speaks at a time

Do you have any questions before we get started?

Questions for CHWs/Peer Specialists

Hiring/Integration

This first set of questions will focus on your thoughts and experiences about your current role as a CHW or Peer Specialist.

1. Please describe the process in which you found and eventually came into your current role.
    a. Probe (Ask if not being addressed in responses): If any, what types of resources did you utilize in finding your position?
    b. Probe (Ask if not being addressed in responses): Discuss any personal or professional experience that affected your ability to obtain a role as a CHW or Peer Specialist?
2. To what extent is lived experience a factor when your Health Center hires people into CHW or Peer Specialist roles?
    a. Probe (Skip if this is not a factor for all participants): What strategies, if any, does your Health Center use for hiring people with lived experience into these roles?
3. How integrated do you feel within your Health Center?
    a. Probe (Ask if not being addressed in responses): What, if anything, helps you to feel integrated within your Health Center?
    b. Probe (Ask if not being addressed in responses): Have there been any barriers to your integration within your Health Center? If so, please elaborate.
    c. Probe (Ask if not being addressed in responses): How has COVID-19 affected your integration into your Health Center?

SDOH Screening

This next set of questions will focus on social determinants of health screening within your Health Center. According to the Centers for Disease Control and Prevention, social determinants of health are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. Social determinants of health screening is the process of collecting this information from patients, typically through surveys, to better understand their condition.

4. From your perspective, is social determinants of health screening being conducted in your Health Center? If so, how? (Skip to end if "no" from all participants)
    a. Probe (Ask if not being addressed in responses): If applicable, please describe how screening for social determinants of health has been integrated into your role.
    b. Probe (Ask if not being addressed in responses): Can you tell me about any other positions that are screening for social determinants of health in your Health Center?
5. If applicable, please describe any barriers to screening for social determinants of health in your Health Center.

    c. Probe (Skip if no participants mention barriers): Are there any ways your health center has tried to alleviate these barriers?
6. From your perspective, how has COVID-19 affected the social determinants of health screening process in your Health Center?

That concludes our focus group. Thank you for sharing your thoughts and opinions with us.
Questions for HR or C-Suite Staff

Hiring/Integration

This first set of questions will focus on your Health Centers experience employing CHWs or Peer Specialists.

1. Describe your Health Center's process for hiring CHWs or Peer Specialists.
    a. Probe (Ask if not being addressed): To what extent is lived experience a factor when your Health Center hires CHWs or Peer Specialists?
    b. Probe (Ask if not being addressed): Describe any barriers your Health Center has experienced in hiring CHWs or Peer Specialists.
    c. Probe (Ask if not being addressed: Has your Health Center used any partnerships to assist in the CHW or Peer Specialist hiring process? If so, please elaborate.
2. Please describe any ways that CHWs or Peer Specialists are currently integrated within your Health Center.
    a. Probe (Ask if not being addressed in responses): Has your Health Center experienced any barriers to integrating CHWs or Peer Specialists? If so, please elaborate.
    b. Probe (Ask if not being addressed in responses): Has COVID-19 affected the integration of CHWs or Peer Specialists within your Health Center? If so, how?

SDOH Screening

This next set of questions will focus on social determinants of health screening in your Health Center. According to the Centers for Disease Control and Prevention, social determinants of health are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. Social determinants of health screening is the process of collecting this information from patients, typically through surveys, to better understand their condition.

3. Is social determinants of health screening being conducted in your Health Center? If so, how?
    a. Probe (Ask if not being addressed in responses): If applicable, how has your Health Centers integrated CHW or Peer Specialists into the social determinants of health screening?

b. Probe (Ask if not being addressed in responses): How does your Health Center use social determinants of health screening data?
c. Probe (Ask if not being addressed in responses): Can you tell me about barriers, if any, your Health Center has experienced in screening for social determinants of health?
d. Probe (Ask if not being addressed in responses): If applicable, describe how COVID-19 affected the social determinants of health screening process at your Health Center.

4. Tell me about any best practices your Health Center has utilized to facilitate screening for social determinants of health.

That concludes our focus group. Thank you for sharing your thoughts and opinions with us.

Questions for Workforce Training and Certification Organizations

Hiring/ Integration

This first set of questions will focus on your organization's connection to hiring and integrating CHWs or Peer Specialists within health centers.

1. Does your organization assist individuals looking to obtain a role as a CHW or Peer Specialist? If so, please elaborate. (Skip to questions 2 if "no" from all participants)
    a. Probe (Ask if not being addressed in responses): To what extent is lived experience a factor when an individual is looking for a CHW or Peer Specialist role?
    b. Probe (Ask if not being addressed in responses): Can you describe any specific examples of how your organization helps individuals obtain a CHW or Peer Specialist position?
2. Does your organization assist other organizations with the process of hiring CHWs or Peer Specialists? If so, please elaborate. (Skip to questions 3 if "no" from all participants)
    a. Probe (Ask if not being addressed in responses): Can you describe any specific types of assistance you offer to guide organizations in hiring CHWs or Peer Specialists?
    b. Probe (Ask if not being addressed in responses): Can you tell me about any barriers you have noted among health centers in hiring CHWs or Peer Specialists?
3. What is your perspective on how CHWs or peer specialists are integrated into health center care teams?

SDOH Screening

The following set of questions will focus on social determinants of health screening and CHWs or Peer Specialists. According to the Centers for Disease Control and Prevention, social determinants of health are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. Social determinants of health screening is the process of

collecting this information from patients, typically through surveys, to better understand their condition.

4. Can you tell me about any gaps in knowledge you have identified among health centers regarding social determinants of health screening?
5. Does your organization provide CHW or Peer Specialist training on social determinants of health screening? If so, what are some areas of focus? (Skip to COVID-19 section if "no" from all participants)
    a. Probe (Ask if not being addressed in responses): If applicable, can you discuss any social determinants of health screening tools highlighted in training? (e.g., PRAPARE)

COVID-19

This final section is focused on the effect of COVID-19 on CHW or Peer Specialists training conducted by your organization.

6. If applicable, please discuss how COVID-19 has affected CHW or Peer Specialist training in your organization.
    a. Probe (Ask if not being addressed in responses): Can you elaborate on any additional CHW or Peer Specialist training you have implemented related to COVID-19?
    b. Probe (Ask if not being addressed in responses): Have you modified any existing CHW or Peer Specialist training because of COVID-19? If so, please elaborate.

That concludes our focus group. Thank you so much for coming and sharing your thoughts and opinions with us.

APPENDIX II

List of Health Centers Engaged in Focus Groups/Listening Sessions:

Arnold School of Public Center for Community Health Alignment
Blue Ridge Health Services
Cape Cod Community College
Community Medical Centers, Recovery Center
Crosswalk Community Outreach
Family Health La Clinica
Generations Family Health Center, Inc.
Golden Valley Health Centers
Greater Portland Health
Health Care Collaborative of Rural Missouri
Healthcare for the Homeless-Houston
Heartland Health Centers
La Clinica
Live Well Community Health
Maine Access Immigrant Network
MCD Public Health
Outer Cape Health Services
ResourceCare
Shackelford County Community Resource Center
SIHF Healthcare
South Carolina Community Health Worker Association
Sunrise Community Health
The Providence Community Health Centers
Umemba Health, LLC
White House Clinics
Willie Mae Stokes Community Center