

Alachua County
American Rescue Plan
State and Local Fiscal Recovery Funds

Closing Health Care Disparities with
Community Health Care Workers and
Improving Health Care Communications

Alachua County 2022 Recovery Plan

Closing Health Care Disparities with Community Health Care Workers and Improving Health Care Communications

Table of Contents

Executive Summary	3
Uses of Funds	4
Promoting Equitable Outcomes	5
Goals and Measures	6
Community Engagement	7
Healthcare Communications	8
Use of Evidence	9
Project Inventory	10

Executive Summary

In response to the COVID-19 Pandemic, the Federal government has provided Alachua County funding through the American Rescue Plan – State and Local Fiscal Recovery Funds. One category of funding, Social Determinants of Health: Community Health Workers or Benefits Navigators (3.14) is addressed through this plan Closing Health Disparities with Community Health Care Workers. Additionally, the plan to Improving Health Care Communications, falls under Category Social Determinants of Health: Other (3.12), focuses on better understanding how strategic, effective, and engaged communication can address the barriers that face people who experience health inequity. The COVID-19 Pandemic has adversely impacted these existing inequities creating further economic and social detriments. The project requests a total of \$500,000.00 in funding for the two-year project period.

Community Health Workers (CHWs) are locally based, culturally competent lay health care workers who are uniquely situated to provide ongoing behavioral support to a cohort of patients in conjunction with the broader health care team. According to the Centers for Disease Control, CHWs have been shown to improve health in a wide range of chronic conditions, such as cancer, diabetes, cardiovascular disease, multiple medical comorbidities, and mental health. The root of their effectiveness relies on their close connection to the community, ability to influence patient behaviors, and effective interaction with the larger health care team. CHWs are powerful drivers of decreased costs, especially among patients with high starting health care costs and among underserved and minority populations.¹

Closing Health Disparities with Community Health Care Workers will partner with local educational institutions and social service agencies to train and deploy CHW's, as they work toward required service hours and certification. An outreach support team will be put in place to develop further partnering and growth of the community's resources to ensure a comprehensive network is accessible to those for which these services are intended. The goal of this effort is to positively impact the health and recovery of those served.

A collaboration with the University of Florida's Center for Gender, Sexualities, and Women's Studies is tasked to better understand how strategic, effective, and engaged communications can address the barriers that face people who experience health inequities. The goal of Improving Health Care Communications is to enhance communication capabilities to build trust with residents who are most affected by the factors that lead to health inequity, while also providing new written documents and visual communications dedicated to ending health inequity.

These two programs will specifically target disproportionately impacted communities within Alachua County by providing Community Health Care Workers who belong to the service demographic, live in the area of need, and are motivated to serve their community. Health communication plays a significant role at all levels of disease prevention and health promotion. By improving health communication, it will allow people to more easily understand and act on health information. Accordingly, this positively impacts the economic well-being and recovery of those individuals served.

¹ www.cdc.gov/pcd/issues/2020/19_0316.htm

Uses of Funds

The overall strategy of this project is two pronged; deploy CHW's to address health inequities and disparities, especially those exacerbated by Covid and improve communications to establish and build trust with those individuals impacted. ARPA funding is used to employ the CHW's and staffing for the needed administrative structure which oversees implementation. Employee recruitment will focus on employing individuals living in the impacted communities thereby directly addressing economic recovery from the pandemic. After receiving certification, these individuals will provide services to address health concerns, thereby improving overall public health.

Establishment of a Program Administrator position. This position will oversee the Program and additionally facilitate discussions between organizations about current needs of community, develop a Resource Platform or maintain information on the current platform, identify organizations and providers to participate in referral tool/platform, bridge the city and county programs, facilitate communication to and between agencies and provider networks, coordinate language assistance needs, determine/develop transportation options, dental supply distribution coordination, research and apply for grants to maintain sustainability.

Establishment of a Community Mentor/Training Co-Facilitator position. This position will recruit and refer for training potential Community Health Worker candidates and can provide support for in-person training using the approved Community Health Worker curriculum. This position will also provide support to the candidates during completion of their service hour requirements. The local agency will provide mission-specific training.

Training Coordinator/Lead Facilitator

This position is responsible for continuous quality improvement related to the in-person CHW training curriculum including updating materials to reflect ongoing community needs, ensuring that all training sessions apply best practice standards for health literacy and cultural sensitivity, and ensuring that CHW trainees are comprehending material in a manner that sets them up to pass the CHW certification exam. This individual is the lead in content delivery during all training workshops and works with the community mentor to make sure they are competent in the training program to ensure that they can support CHW candidates in the field as it relates to utilizing skills attained during the training process.

Salaries for Community Health Care Workers. The program would pay the salaries of the Community Health Care Workers as plans for sustainability are implemented, i.e., direct billing for services. The project expects to work closely with CareerSource which will contract with the various agencies employing the CHW's for reimbursement of wages paid.

Training Materials and Certification Test Fees. The program would pay for Community Health Care Worker training materials and test fees. Testing fees could potentially be covered by Workforce Innovation and Opportunity Act if the candidate(s) are qualified.

Promoting Equitable Outcomes

Equity intersects issues of race, economic class, nationality, literacy, and language. To achieve greater equity and inclusion, the County needs to acknowledge and commit to responding to the linguistic and literacy diversity of its residents, especially those identified as limited English proficient speakers (LEP). The COVID-19 pandemic revealed inequities in information and services to non-English speakers, resulting in negative health outcomes and economic

disenfranchisement. These issues have been exacerbated by historic disparities impacting immigrants, refugees, Puerto Rican monolingual-Spanish speaking neighbors, and lower-literate community members in the County.

There are approximately 37,700 speakers of languages other than English who reside in Alachua County (14% of the population). In the County, 11% of the population is foreign-born, the largest percentage being from Asia, followed by Latin America, Europe, and Africa. Race, gender, ethnicity, and income are issues that intersect and collectively impact community members' lived experiences. This indicates that many foreign-born individuals are people of color who are positioned to experience racial and linguistic discrimination simultaneously, while also experiencing bias due to potential issues related to documentation. Additionally, it is notable that there are more than 5,000 foreign students at the University of Florida and Santa Fe College combined (2018 figures). Of these, 4,000 were graduate students, many with children and spouses who are LEP speakers.

While many programs funded by ARPA will specifically target disproportionately impacted communities, underserved and hardest-hit communities will continue to face significant barriers in learning about potential relief as a result of multiple issues such as language and communication challenges including speakers of other languages, disabilities, and the intersection of these issues within families and communities. Formal immigration status, country of birth, and potential lack of official documentation also may limit qualifications for programs and increase fear and reluctance.

Data that follows supports the need to respond to tens of thousands of County residents who speak languages other than English. Data comes from the US Census, World Population Review.com, School Board of Alachua County, and the Rural Women's Health Project (RWHP):

- 37,719 speakers of languages other than English (14% of the Alachua County population)
- 7.5% Spanish speakers (ages 18-64)
- 4% speak Asian or Pacific Island languages

According to the School Board of Alachua County, there are 800 non-English speaking children (ELL) in Alachua schools, 80+ families in migrant education with monolingual Spanish or indigenous speaking parents, and 80 Spanish-speaking out of school youth served by Migrant Education. The Combined Communications Center received 397 requests for the language line between September 2020 and April 2021. The majority were Spanish speakers followed by Mandarin, Vietnamese, and Tagalog. The local Salir Adelante survey of Latinas found that the leading barriers for Latinx immigrant women accessing health-protective services included: immigration stressors, access to health resources, and employment. Participants identified insurance status, English proficiency, and discrimination as barriers to health and social services.²

The residents of the eastern portion of Alachua County, as represented by Zip Codes 32609 and 32641, are more likely to be low-income and Black than the county average and, especially, when compared to ZIP codes in some western parts of the county (Zip Code 32605 used for comparison). The health disparities experienced by residents of this area are severe and persistent. Black residents of Alachua County are more likely to die of diabetes and stroke than White residents. An estimate of years of potential life lost was 5,748/100,000 population for Whites and 9,967/100,000 for Blacks. Eastside residents are more likely to use the emergency department than other residents. They are also twice as likely to make an avoidable visit to the emergency department than the average resident in Alachua County and almost three times more likely to use the emergency department than people who live in Zip Code 32605.

² Rural Women's Health Project, Salir Adelante, 2020)

As health care systems work to reduce the use of emergency departments for non-emergencies, one strategy that has proven to be effective is the integration of Community Health Workers (CHWs). There is evidence to suggest that CHW-led program interventions targeting overuse of emergency medical services can be beneficial to the patient and the institutions that serve them. For example, a program focusing on patient education and outreach on community health services reduced unnecessary emergency department use up to 80% (Society for Academic Emergency Medicine). Another study found that providing intensive case management decreased EMS use by 32% (Health Leaders). A further study targeting low-socioeconomic urban patients with heart failure found that patients who received a CHW had a 75% decrease in Heart Failure (HF)-related ED visits, an 89% decrease in HF-related readmissions, and a significant decrease in inpatient cost for HF-related visits (pubmed.gov). Numerous studies conducted over a decade have shown that CHWs improve patients' outcomes.

Goals and Measures

Goal #1

Improve the economic well-being of citizens disproportionately impacted by Covid-19 by offering training, certification, and employment opportunities to residents of impacted areas to become a Certified CHW.

Goal #2

Provide health related services to improve health outcomes and reduce the inappropriate use of emergency services for residents in the impacted areas.

Hiring Measure

A minimum of 10 trainees will be hired by local agencies for employment (part time or full time) in a role consistent with their CHW training in years one and two.

Training Measure

A minimum of 10 community members from high disparity zip codes in the county will complete the entire training program in year one and in year two.

Certification Measure

A minimum of 10 trainees will complete the 500-hour requirement and sit for the CCHW certification exam with a minimum of 5 receiving full certification in year one and a minimum of 10 receiving full certification in year two.

Patient/Client Engagement Measure

Specific engagement metrics will be dependent on the agency in which trainees are hired. Expected engagement numbers will be 100-500 clients per CHW per year for a total program goal of 1,000-5,000 clients per year. Other agency specific metrics will be established by the hiring agency. Those metrics will be detailed during the agency application process with the expectation that each agency collect and report data.

Outcome #1

A minimum of 20 individuals will achieve certification and gainful employment, which through the implementation of a sustainability plan will be able to continue their work after the project concludes.

Outcome #2

The impacted areas will benefit from sustained and improved access to healthcare services provided and coordinated by the CHW program resulting in reduced costs to the County and other stakeholders by lessening the demand for emergency health related expenses.

Community Engagement

Community Health Care Workers are, by definition, engaged in the community. CHWs usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. The roles and activities of community health workers (CHWs) are tailored to meet the unique needs of the communities they

serve. That role depends on factors such as their education, training, lived experience, and experience working with specific populations.

CHWs may take on many tasks, such as creating connections between vulnerable populations and healthcare providers, helping patients navigate healthcare and social service systems, managing care and care transitions for vulnerable populations, and determining likely eligibility and enrolling individuals in health insurance plans. Further, CHW's ensure and promote cultural competence among healthcare providers serving vulnerable populations, educating healthcare providers and stakeholders about community health needs, providing culturally appropriate health education on topics related to chronic disease prevention, physical activity, and nutrition. CHW's also advocate for underserved individuals or communities to receive services and resources to address health needs. CHWs' potential to connect with community members on a more personal level and in community spaces where patients spend most of their time facilitates the effective provision of services, as well as links to other social services and supports. For this reason, CHWs play an especially crucial role in making health more equitable for populations experiencing disproportionately poor outcomes.

Healthcare Communications

This component of the initiative is designed to ensure that CHW candidates are trained in a manner that promotes health literate communication, cultural humility and sensitivity and also ensures that both synchronous and asynchronous forms of communication meet best-practice standards for effective health communication. Dr. Laura Guyer, an expert in healthcare communication and community engagement, will provide ongoing supervision of the CHW curriculum and training as well as overseeing the development or outsourcing of health education materials that would be used to support CHW-based initiatives. Educational materials may include audio-visual as well as written mediums. Dr. Guyer has decades of experience in overseeing such activities and will be a tremendous asset in fulfilling this important aspect of the program.

Use of Evidence

Community health workers (CHWs) have been acknowledged participants in healthcare systems since the 1960s and their impact in health care has been a topic of research for years.³ Consequently, there is ample evidence of how CHWs can be an effective member of a community's medical and social support infrastructure and several evidence-based practices have been developed.

³ pubmed.ncbi.nlm.nih.gov/7625495/

According to the CDC’s 2014 Policy Evidence Assessment Report: Community Health Worker Policy Components, there are many elements of successful Community Health Worker programs that have proven to have a significant impact and are considered best practices and should be considered when creating policies. ⁴

Table 1. CHW policy component evidence quality and evidence of public health impact assessment results

Evidence-based policy component description (short description)	Quality Score ¹	Impact Score ²	Evidence Category ³
CHWs provide chronic disease care services (<i>Chronic Care</i>)	40	40	Best
Inclusion of CHWs in team-based care model (<i>Team-based Care</i>)	33	33	Best
Core competency CHW certification (<i>Core Certification</i>)	29	28	Best
CHWs supervised by health care professionals (<i>Supervision</i>)	28	26	Best
Standardized core CHW curriculum (<i>Standard Core Curriculum</i>)	26	28	Best
Medicaid payment for CHW services (<i>Medicaid</i>)	25	22	Best
Specialty area CHW certification (<i>Specialty Certification</i>)	21	28	Best
Inclusion of CHWs in development of their certification requirements (<i>Certification Development</i>)	21	24	Best
Standardized specialty area CHW curriculum (<i>Standard Specialty Curriculum</i>)	23	17	Promising Quality
Defined CHW scope of practice (<i>Scope of Practice</i>)	21	12	Promising Quality
Inclusion of CHWs in development of their standardized curriculum (<i>Curriculum Development</i>)	20	24	Promising Impact
Private insurers cover and reimburse CHW services (<i>Private Insurers</i>)	11	4	Emerging
Educational campaign about CHWs (<i>Campaign</i>)	7	8	Emerging
Grants and/or incentives to support CHW workforce (<i>Grants</i>)	7	4	Emerging

¹ The Quality Score assesses the level of evidence quality for the overall evidence base based on the study types used, the sources authoring the evidence, and the amounts of evidence derived from practice, theory, and research. This score ranges from 1-40, with 40 being the highest level of quality.

² The Impact Score assesses the level of evidence of public health impact related to the use of the component, as suggested by the overall evidence base. Impact level is based on actual or suggested outcomes related to health, equity, efficiency, and transferability. This score ranges from 1-40, with 40 being the highest level of impact.

³ Component evidence categories include: Best, whose components have higher levels (a score greater than 20) of both quality and impact; Promising Quality, whose components have higher levels of quality but lower levels of impact; Promising Impact, whose components have higher levels of impact but lower levels of quality; and Emerging, whose components have lower levels of both quality and impact.

Evidence from many successful CHW inclusive programs shows the positive impact that CHWs can have on the health of diverse populations and varied health conditions.

- The IMPaCT program model from the Penn Center for Community Health Workers was tested in 3 randomized trials and has been proven to improve “chronic disease control, mental health, and quality of care while reducing total hospital days by 65%” and had a “\$2:1 annual return on investment to payers.” ⁵
- The Personalized Support for Progress CHW model for women with depression results showed 46% of the participants were visited at least monthly and the program revealed a 30% reduction in total charge amounts and a reduction in the frequency of “high-cost encounters such as emergency department visits and inpatient encounters related to labor and delivery.” ⁶
- A study conducted at CareMore Health in Tennessee, evaluated how complex care management was effective when caring for high-need, high-cost Medicaid patients. In this study, CHWs were included as part of the care team for the patients enrolled in the Complex Care Management group versus the Usual Care group. The results from the 12-month intervention yielded fewer inpatient admissions, specialist visits, and

⁴ Policy Evidence Assessment Report: Community Health Worker Policy Components (cdc.gov)

⁵ About IMPaCT - Penn Center for Community Health Workers (upenn.edu).

⁶ Demonstrated health care cost savings for women: findings from a community health worker intervention designed to address depression and unmet social needs - PubMed (nih.gov)

lower total medical expenditures per member per year.⁷

- A 2019 review of nine studies funded by the Patient-Centered Outcomes Research Institute (PCORI) found that CHWs are important components regarding the mitigation of health inequities. The studies selected for review examined the CHWs and their impact of various health issues and their effectiveness with “diverse ethnic, racial, linguistic, socioeconomic, and geographic backgrounds.” The results of this review found that CHWs can “improve patient outcomes, increase access to primary care, reduce avoidable hospital and ED utilization, and generate savings for payer and providers across a wide variety of patient population, conditions, and settings.”⁸
- The Colorectal Cancer Male Navigation Program implemented by University Health System in San Antonio increased the life expectancy for participants by 6 months when compared to non-participants. The program also yielded a net health care savings of \$1,148 per participant.⁹
- The Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, found that CHWs operate as a community-based resource that can increase access to healthcare for racial and ethnic minorities. They recommended the support of CHWs to be included as part of a multi-disciplinary team, act as language interpreter where needed, and that their use should be “expanded, evaluated, and replicated” especially in the setting of the underserved.¹⁰
- A 3-year Pilot by Geisinger Health System implemented in 5 Pennsylvania counties incorporated CHWs, or Community Health Assistants (CHA), to connect patients with resources that would mitigate the negative impacts the Social Determinants of Health (SDOH) they were experiencing. In three years, they assisted “16,000 individuals and closed 24,000 ‘care gaps’.”¹¹

Many national health initiatives, and their state-level efforts, have incorporated CHWs as an integral part of the program implementation and evaluation. Some of those initiatives are:

- The Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) is a program in the CDC’s Division for Heart Disease and Stroke Prevention.
- The CDC’s Racial and Ethnic Approaches to Community Health (REACH)
- Several programs in the CDC Division of Diabetes Translation
- The CDC’s Diabetes Prevention Program (DPP)
- The National Diabetes Education Program (NDEP)
- Several programs under the Division of Cancer Prevention and Control: National Comprehensive Cancer Control Program (NCCCP), National Breast and Cervical Cancer Early Detection Program (NBCCEDP), and Colorectal Cancer Control Program (CCCP).

Many States including New Mexico, Maryland, Minnesota, Massachusetts, and Illinois have successfully passed and implemented legislation to include CHW infrastructure in their health care systems with various focus on everything from relaxing the requirements for CHW certification to the inclusion of CHWs in the contracts with state Medicaid MCOs.¹²

⁷ Impact of Complex Care Management on Spending and Utilization for High-Need, High-Cost Medicaid Patients (ajmc.com)

⁸ Advancing Health Equity Through Community Health Workers and Peer Providers: Mounting Evidence and Policy Recommendations - Families Usa

⁹ <https://pubmed.ncbi.nlm.nih.gov/25168070/>

¹⁰ <https://www.ncbi.nlm.nih.gov/books/NBK220358/>

¹¹ Geisinger Health System Deploys Community Health Workers to Address Social Determinants of Health | Playbook (bettercareplaybook.org)

¹² https://www.cdc.gov/dhdsp/docs/chw_brief.pdf

Example: The expansion of Medicaid under the Affordable Care Act created significant challenges to New Mexico because of its poverty rate and shortage of health professionals. A collaboration with the University of New Mexico and the New Mexico Medicaid system resulted in the wide use of CHWs to address Social Determinants of Health for the patients attending targeted clinics including a Federally Qualified Health Center. The CHWs helped the patients understand their benefits, engage with their Primary Care Physician, and gain transportation to appointments. The CHWs also educated the health team on SDOHs and how they were affecting their patients as well as what resources were available that could be incorporated into their patients' plan of care. The results of the CHW intervention and improvements in patient outcome and cost of care led to the state's Medicaid Division directly investing into the model and the incorporation of CHWs as a required component within the contracts of state Medicaid with MCOs. Since three of the four MCOs in New Mexico are national, the CHW model has been deployed in 12 states and has garnered interest from the Agency for Healthcare Research and Quality (AHRQ), the Health Resources and Services Administration (HRSA), and the Centers for Medicare and Medicaid Services (CMS).¹³

The implementation of the Closing Health Disparities with Community Health Care Workers program will incorporate many of the evidence-based practices regarding the CHW curriculum, certification, supervision, inclusion into medical team, provision on chronic disease care services, and educational campaigns about the acceptance and inclusion of CHWs in the community's medical and social service landscape. The evaluation of the Closing Health Disparities with Community Health Care Workers will include best practice strategies and considerations regarding evaluation measures, data collection, and data evaluation that are like those proposed and/or used in the *Rural Community Health Workers Toolkit*, the *University of Arizona's Community Health Worker Evaluation Tool Kit*, and the *Community Health Worker Assessment and Improvement Matrix*.¹⁴

¹³ Diffusion Of Community Health Workers Within Medicaid Managed Care: A Strategy To Address Social Determinants Of Health | Health Affairs

¹⁴

https://www.usaid.gov/sites/default/files/documents/1864/CHW_AIM_Updated_Program_Functionality_Matrix_2018_508_final.pdf and other resources available through the CDC. <https://www.cdc.gov/evaluation/resources/index.htm>

<https://www.ruralhealthinfo.org/toolkits/community-health-workers>

<https://azprc.arizona.edu/sites/default/files/CHWtoolkit/toolkit.htm>

PROJECT INVENTORY

Project Identification Number:

To be determined

Project Name

Closing Health Care Disparities with Community Health Care Workers and Improving Health Care Communications

Funding amount

\$500,000.00 (estimated \$250,000.00 annually)

Project Expenditure Category

Social Determinants of Health: Community Health Workers or Benefits Navigators (3.14)

Social Determinants of Health: Other (3.12)

Estimated Budget

Expense Description	FY2023	FY2024
Program Administrator (1 FTE)	\$80,000	\$80,000
Community Mentor/Training Co-Facilitator (1 FTE)	\$80,000	\$80,000
Training Coordinator/Lead Facilitator (\$75 hour, 30 hours per Cohort, 2-4 Cohorts annually)	9,000	9,000
Community Health Care Workers (not including funding from other agencies)	\$75,000	\$80,000
Training Materials and Certification Testing	\$1,000	\$1,000
Agency Specific Health Care Communications Materials	\$5,000	\$0
Total Project Budget	\$250,000	\$250,000

***End of Report**