El Centro Family Health

Health Planning Network Report

Report prepared for

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TABLE OF CONTENTS

INTRODUCTION

This report summarizes work performed for Taos Community Foundation to assess the potential usefulness of a Community Health Worker (CHW) program as a part of a comprehensive continuum of care for mental health and substance abuse clients in Taos County. What specific gaps exist here that could be positively addressed by a CHW program? What barriers might impede or prevent its implementation? What community strengths or qualities would support a program such as this? What next steps must be taken to further explore the idea? Building on the groundwork laid throughout winter and spring 2012 by members of a planning network, Taos Community Foundation and i2i Institute worked together to develop an inquiry plan and to gather information specific to this community's needs. This report includes both relevant contextual information and an analysis of findings, and concludes with community recommendations and questions for further study.

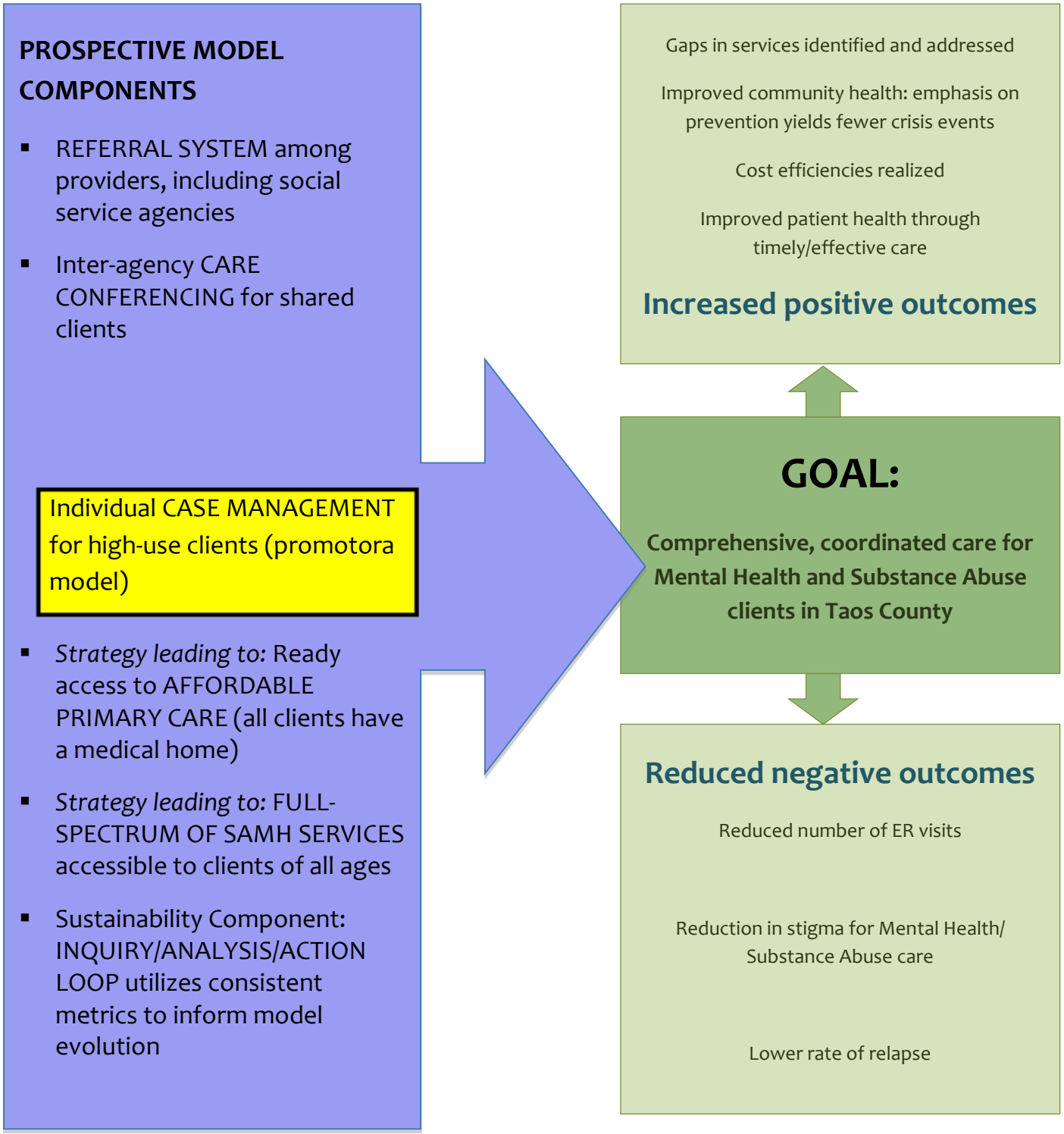
BACKGROUND

In January, 2012, i2i Institute was invited to join El Centro Family Health Center as evaluator for their Network Planning Grant. The network of engaged professionals sought to identify needs and address gaps in services for mental health and substance abuse clients in Taos County; working cooperatively, the members hoped to envision and aim toward creating a comprehensive continuum of care to replace the fragmentation, duplication, and disconnection that characterized the existing system.

Representatives from El Centro Family Health Center, Tri-County Community Services, Holy Cross Hospital and other organizations gathered on four occasions to take a frank look at community strengths, specific barriers (those faced by clients as well as those of an organizational or community-wide nature), and pressing needs with respect to creating a comprehensive, coordinated system of care. They discussed the importance of contextual factors and acknowledged the inseparable connection of mental and physical health. The group discussed recent efforts to address fragmentation in care delivery and to build collaborative systems, and examined the varying success these efforts met.

Using input from participants as well as information from current medical and public health literature, i2i Institute distilled the network's ideas into a graphic representation of prospective model components (see figure 1, below). Other communities had met some success in reducing rates of ER use, improving overall health outcomes, and increasing cost efficiencies by combining services that addressed the health care consumer holistically, and Taos County seemed ripe to begin exploring these innovative solutions.

Figure 1


PROSPECTIVE MODEL COMPONENTS
REFERRAL SYSTEM among providers, including social service agencies
Inter-agency CARE CONFERENCING for shared clients
Individual CASE MANAGEMENT for high-use clients (promotora model)
Strategy leading to: Ready access to AFFORDABLE PRIMARY CARE (all clients have a medical home)
Strategy leading to: FULL-SPECTRUM OF SAMH SERVICES accessible to clients of all ages
Sustainability Component: INQUIRY/ANALYSIS/ACTION LOOP utilizes consistent metrics to inform model evolution
GOAL:
Comprehensive, coordinated care for Mental Health and Substance Abuse clients in Taos County
Increased positive outcomes
Gaps in services identified and addressed
Improved community health: emphasis on prevention yields fewer crisis events
Cost efficiencies realized
Improved patient health through timely/effective care
Reduced negative outcomes
Reduced number of ER visits
Reduction in stigma for Mental Health/ Substance Abuse care
Lower rate of relapse

Working collaboratively, the group identified three areas of inquiry to guide model development.

AREAS OF INQUIRY TO GUIDE MODEL DEVELOPMENT

(1) Inventory existing Taos County MH/SA resources and usage patterns

- Snapshot of current situation affords baseline for comparison and helps identify local trends.
- Assembling provider information will identify prospective network members

(2) Identify local heavy users; examine their needs

- Lack of prevention and timely, effective care results in overuse of medical resources and poor client outcomes.
- Heavy users account for much greater percentage of medical costs.
- Focusing on needs of heavy users will identify critical gaps in care delivery system.
- Making it better for those with the highest needs improves things for everybody.

(3) Focus on prior efforts in Taos County or elsewhere; identify local barriers/facilitators to effectiveness

- Examination of local projects will point out regionally relevant considerations.
- Models effective elsewhere can be tinkered with to address local needs.

El Centro leadership confirmed their desire to focus on high utilizers of the hospital emergency room as a primary source of data. The group concurred that ER data would track those clients with the most urgent and persistent needs, and a close examination would likely reveal critical gaps in the care delivery system. In response, i2i Institute drafted a list of questions to guide group inquiry, and identified a resource list of knowledgeable people, relevant documents, and related databases to consult.

The line of inquiry seemed relatively straightforward, but problems arose as the group sought more specific sources of data. County-wide, data collection on health care is conducted through a variety of methods, systems, and software programs to serve a wide range of individual, program-specific needs and intentions. Even so, there is frequently no consistent protocol intra-agency, and limited understanding of or commitment to the use of community-level data to inform a comprehensive planning effort for the future. While we could access general demographic data and figures for general health care use, numbers of ER visits, and total costs billed, specifics about diagnoses, insurers, follow-up, and other relevant information went uncollected or irretrievable. Efforts to acquire even a baseline picture of mental health and substance abuse care in Taos County yielded little quantitative data and relied heavily on personal report.

One crucial fact contributed to the complexity of this inquiry. Mental health and substance abuse are health issues that cannot be separated from other aspects of patient health and well-being. Providers repeatedly expressed their perception that mental health and substance abuse issues often co-occur with a range of other physical health concerns, and are often linked as well with contextual factors regarding housing, employment, domestic and other relationships, food security, availability of transportation, and various other basic needs. Addressing mental health and substance abuse issues

can't be done in a vacuum. Providers are accustomed to referring clients for outside services whenever feasible, but their capacity to do this is necessarily limited by the time, information, and other resources available to them. Many providers expressed regret at not being able to include or follow-up on these essential services, and remarked at how frequently these contextual factors prevented their clients from accessing their mental health or substance abuse appointments or successfully following through on their course of care. Similarly, patients who present at the emergency room with pain issues, traumatic injuries, and other symptoms may in some cases be dealing with a mental health or substance abuse related origin for those complaints.

At this point in the project, El Centro experienced two personnel changes that significantly impacted the project. The part-time Project Coordinator (who had assumed responsibility after a previous Coordinator left the agency) faced a conflict with another project and resigned her post. The Behavioral Health Services Director, under whose aegis the grant was written and who was the primary federal contact at El Centro, retired his position and traveled out of the country. The new BHS Director entered with a full plate of duties, and this project necessarily took back seat to more immediate and pressing demands.

In their absence, and in an effort to continue the work that had already been done, Taos Community Foundation agreed to accept responsibility for future project coordination and proposed a slight shift in direction. Rather than plan toward a comprehensive model, TCF suggested refocusing attention and selecting the one model component most likely to be effective in meeting the specific needs that rural, diverse Taos County presents. The idea of Community Health Workers had been around for some time, and had been successfully implemented in at least one area program. Judging from the diverse needs the mental health and substance abuse care community seemed to present, the flexibility and relationship-based approach of the CHW model suggested a positive match. El Centro agreed, and TCF, with support from i2i Institute, took the lead in exploring the model and polling the community for input regarding needs, strengths, and barriers.

FOCUS ON COMMUNITY HEALTH WORKERS (CHW)

COMMUNITY HEALTH WORKERS: AN OVERVIEW

Community Health Workers play an important role in rural, and increasingly in urban, communities worldwide. They serve as adjunct to and often liaison between the services of medical professionals and the health care needs of community members. The specific roles of CHWs can vary widely, however. Generally speaking, CHWs create "more effective linkages between vulnerable populations and the health care system" (HRSA) by establishing one-on-one relationships of greater intimacy and trust than providers may have time, resources, or training to pursue.

TYPES OF COMMUNITY HEALTH WORKERS

The following information is taken from the HRSA OFFICE OF RURAL HEALTH POLICY's COMMUNITY HEALTH WORKERS EVIDENCE-BASED MODELS TOOLBOX

PROMOTORA DE SALUD/LAY HEALTH WORKER

CHWs are members of the target population that share many of the same social, cultural and economic characteristics. As trusted members of their community, promotoras provide culturally appropriate services and serve as a patient advocate, educator, mentor, outreach worker, and translator. They are often the bridge between the diverse populations they serve and the health care system.

MEMBER OF CARE DELIVERY TEAM

CHWs render direct health services in collaboration with a medical professional. They may measure blood pressure and pulse and provide first aid care, medication counseling, and health screenings, among other basic services.

CARE COORDINATOR/ MANAGER MODEL

CHWs help individuals with complex health conditions to navigate the health care system. They liaise between the target population and a variety of health, human, and social services organizations. They may support individuals by providing information on health and community resources, coordinating transportation, and making appointments and delivering appointment reminders.

HEALTH EDUCATOR

CHWs deliver health education to the target population related to disease prevention, screenings, and healthy behaviors. CHWs may teach educational programs in the community about chronic disease prevention, nutrition, physical activity, and stress management, and also provide health screenings.

OUTREACH AND ENROLLMENT AGENT

Similar to the health educator model with additional outreach and enrollment responsibilities. In this model, CHWs conduct intensive home visits to deliver psychosocial support, promote maternal and child health, conduct environmental health and home assessments, offer one-on-one advice, and make referrals. They also help individuals to enroll in government programs.

COMMUNITY ORGANIZER AND CAPACITY BUILDER MODEL

CHWs promote community action and garner support and resources from community organizations to implement new activities. CHWs may also motivate their communities to seek specific policy and social changes. They build relationships with community/regional organizations to develop a more coordinated approach to serving their target population.

In reality, most CHW programs mix and match elements of all these models, choosing those most appropriate to their specific populations and communities. Whether working to provide maternal/child health advice, diabetes education, asthma prevention education, support for those experiencing depression, or any of the other distinct areas of focus, research indicates that it is crucial to craft a clear description of the roles and boundaries of CHWs. The position must be equally well understood by the CHWs and by the medical providers alongside whom they work. Although employing CHWs as a part of a continuum of care is in some ways a step outside the conventions of medical training, their value,

contributions, and limitations must be appropriately acknowledged and respected for the program to be successful.

RESEARCH DESIGN, RESULTS AND DISCUSSION

In examining the potential advantages and pitfalls of a CHW program for MH/SA clients in Taos County, i2i Institute took three independent angles of inquiry. We conducted a literature search to identify model components, appropriate populations, and success rates of different types of CHW programs worldwide. Using information gathered both from the literature and from discussion with network members, we developed and distributed three surveys to determine which services would be of the greatest value for the Taos County community. Finally, we conducted key informant interviews of local MH/SA service providers as well as with personnel at local programs that utilize a CHW model. What are the specific needs we have as a community here in Taos County? What works and, just as importantly, what doesn't in a model like this for our community? What barriers, challenges, and strengths exist? And, finally, what recommendations can be drawn from the research to guide future inquiry and action?

LITERATURE SEARCH

Although the Community Health Worker concept has been employed under various names for centuries, the growing fragmentation of health care services and recognized disparities in health care among diverse populations in recent years have caused policy makers and health care system implementers to take a closer look. In some states, formal programs to train CHWs and official recognition granted their roles has validated the work and contributed to more rigorous recruitment and more extensive employment. Federal and state agencies and forward thinking foundations have taken a proactive role in assessing the effectiveness of existing CHW programs. The results of those studies are mixed, however, pointing to—in some cases—the need for more rigorous approaches to experimental design, and in others a different way of tracking the success of CHW interventions.

A thorough review of the outcomes of CHW programs was commissioned by the U.S. Department of Health and Human Services (HHS) and prepared in 2009 by RTI International's Evidence-based Practice Center. Essentially an examination of studies published in English between 1980 and November 2008, the review considered 53 studies and came to a guarded conclusion. "CHWs can serve as a means of improving outcomes for underserved populations for some health conditions," the authors state. "The effectiveness of CHWs in numerous areas requires further research that addresses the methodological limitations of prior studies and that contributes to translating research into practice." Citing "limited or insufficient data" and "low strength of evidence" in reference to most of the interventions, the study indicates the importance of integrating both creative and comprehensive data tracking (using both quantitative and qualitative methods) when designing a CHW model.

Clearly, CHWs are no general panacea. Directly attributing behavioral change, health outcomes, or economic benefit to a single component of a more comprehensive health care delivery system has proven difficult to do, especially through quantitative methods. (Using CHWs without professional intervention to address mental health or substance abuse issues, in the name of isolating variables, would be irresponsible and counterproductive.) Still, research on CHWs is in its awkward adolescence,

as programs try to sort out problems in implementation and use evaluative feedback to improve program effectiveness.

The relatively intimate nature of the relationship between CHWs and the clients they serve requires a degree of flexibility and an occasionally ad-hoc response to complex situations program implementers insist is an essential quality of the intervention. This may inadvertently result in muddy data, but for on-the-ground implementers dealing with complex human needs and interactions, the alternative—a strict protocol of scripted solutions or an entrenched curriculum—may not suffice. Still, one prominent stumbling block that arose in multiple programs concerns the lack of clarity regarding the role CHWs were intended to fulfill. Health care professionals, in particular, have been slow to warm to the unique position CHWs occupy, often resorting to efforts to enlist them as support staff for their own medically-oriented tasks. A case study in London evaluating the introduction of CHWs to community mental health teams for older adults concluded that "managers must ensure role clarity when non-professional workers are introduced into multidisciplinary community teams." (McCrae 2008) Clarity regarding expectations and boundaries can support CHWs own sense of value as well as ease turf issues with medical personnel.

Although many citations can be found for CHWs in a variety of settings and health issues, there is not an extensive body of literature addressing CHWs specific to MH/SA issues. "The use of promotoras in the mental health field is relatively new in the U.S.," claims a report from the University of Florida College of Nursing. "Results demonstrate that promotoras empower community members to promote mental health and prevent exacerbation of individuals' mental illness. Promotoras collaborate closely with key leaders in their communities and can successfully deliver mental health promotion, early interventions and chronic disease management." Still, "lack of systematic training and promotoras' own mental health burdens are acknowledged in the literature as substantially important factors contributing to their effectiveness in mental health" (Stacciarini, 2011).

Many insist that formal training, however, must take a back seat to other qualities. Excellent communications skills, an empathic nature, the ability to advocate successfully for their clients, a knack for navigating the health care field, and the capacity to enlist the client in self-advocacy all are mentioned in the literature as essential traits. "Rather than a specific training credential," states a 2011 white paper from the Institute for Healthcare Improvement, "it is most critical that CHWs respond to the particular needs of the target population... The unique attributes of CHWs as trusted, accessible, and resourceful peers make them a valuable member of an interdisciplinary health home team" (Craig, 2011).

The report also suggested that CHWs might be most suited to work with individuals whose most prominent medical needs arise from "social instability or lack of social support," as distinguished from those with "medical frailty or complexity" or chronic mental health issues.

The latter point raises an interesting question with applications to the Taos County community. Are some MH/SA clients better served by the skill set of CHWs than others? What specific needs would best be addressed by a CHW implementation?

One of the few case studies to examine the role of CHWs (identified in this case as promotoras) for patients in primary care treatment for depression was conducted by Taos resident Howard Waitzkin, M.D., Ph. D., Distinguished Emeritus Professor at the University of New Mexico. The study was implemented in a primary care clinic in northern New Mexico. Promotoras were employed to address contextual factors in depression, including underemployment, inadequate housing, food insecurity, and

violence—factors common to many in Taos County, as well. The program focused primarily on service coordination duties for the promotoras, enlisting their help in an effort to "reduce social risk factors for stressful life events" and thereby reduce the incidence of depression. Clients received professional medical care (Rx and Dx) concurrently; a comparison group at a different clinic received the medical care but did not receive promotora services (Waitzkin, 2011).

Dr. Waitzkin et al. (2011) employed a multi-method evaluation for this case study, measuring quantitative changes in health outcomes as well as gathering ethnographic data through interviews with stakeholders. Unexpected challenges in implementation involved changes in infrastructure at the clinics, turf issues with medical assistants, and uncertainty regarding the extent of the promotoras' roles, and may have led to less favorable results. "Our research led to mixed findings," the authors write. "The project showed that the promotora model for depression care can achieve implementation at CHCs and can generate perceptions of value among a wide cross-section of stakeholders. Despite the favorable observations from the ethnographic evaluation, the quantitative assessment did not reveal a statistically significant impact of the promotora intervention on depression, the key targeted outcome."

Despite the inconclusive evidence, the study is an important contribution to the literature and of considerable value to Taos County professionals considering a similar implementation. We were able to interview Dr. Waitzkin and ask him specific questions about the experience and his suggestions for future programs. His input, along with that of the other local professionals we interviewed, will be considered in section three of the research.

POINTS RAISED BY LITERATURE SEARCH

- Clarity of role seems crucial to success. What role would Taos County CHWs be most likely to play?
- CHWs need to bring a skill set that emphasizes personal qualities—empathy, good communication, the ability to encourage and motivate others, and openness to developing a relationship with clients based on mutual respect and trust—as well as specific field-related training. How would CHWs be recruited, selected, and retained? What qualifications would be essential?
- It is important to match the intervention with an appropriate population. What portion of TC's MH/SA clients would be aided by a CHW program? How would they be selected?
- Training is a tricky issue: not too little, not too much. Best practices for CHWs require them to maintain flexibility but implement appropriate tools. What training should CHWs receive?
- CHWs must fit in to the team. How to assure an appropriate fit and team-member buy-in?
- Program evaluation can be problematical. How can appropriate data collection and analysis be built into the program design to provide ongoing feedback as well as measure program effectiveness?

SURVEYS

Searching the literature provided ample information about programs in other locales, but to understand the needs specific to Taos County, we needed an instrument able reach a wide section of local stakeholders in a short period of time, and elicit from them specific and pointed responses. We turned to a survey to accomplish this.

Working from information gathered in the network meetings, i2i Institute designed three separate surveys with coordinated questions to address three groups: medical and mental health professionals, including physicians, counselors/therapists, nurses, social workers, and others; providers of community services; and consumers of mental health and substance abuse care. The surveys were crafted to ask community-specific questions that protected the identity of respondents, and all respondents were assured anonymity. They were available both as paper copies and in a web-based version that i2i Institute created using the Survey Monkey tool.

In consultation with Taos Community Foundation and other local experts, i2i Institute developed extensive lists of representative organizations and individuals to approach for each of the first two categories. TCF and i2i worked in tandem to identify key personnel in each organization, and contacted them by email and follow-up phone calls and personal visits. This personal engagement doubled as an opportunity to inform community members about the project and to informally gauge their response. (A complete list of those contacted follows in the appendix.) Organizational contacts were encouraged to share the survey with other Taos County providers, both within and outside their offices. All three surveys asked respondents to rank the value of various services to consumers with mental health or substance abuse concerns.

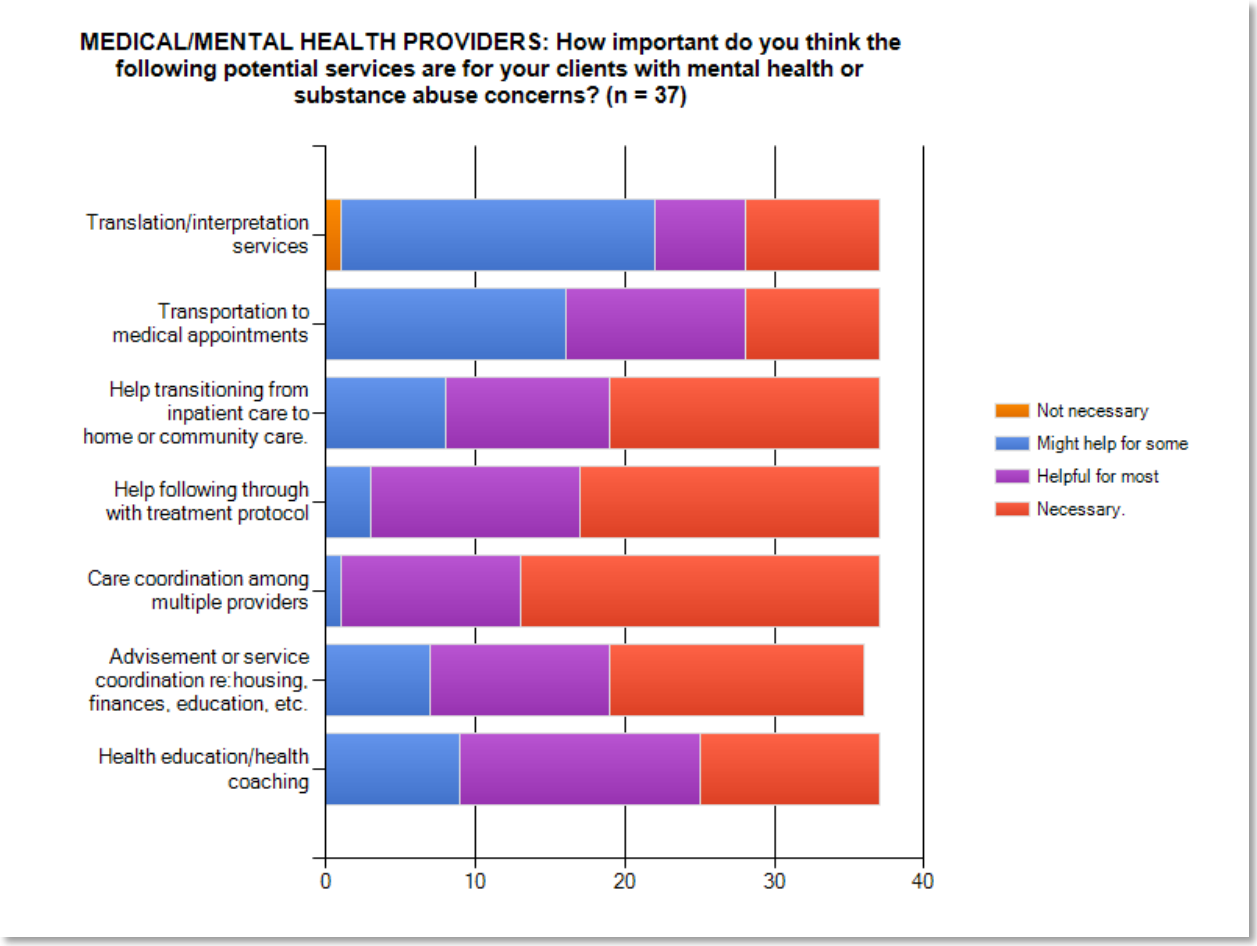
MEDICAL/MENTAL HEALTH PROVIDERS

Forty medical/mental health providers were approached with the request to participate, and the response was largely enthusiastic. A total of 36 surveys were collected from that group. The largest percentage of respondents (42.9%) self-identified as counselors/therapists, and 17.1% as social workers. The remaining respondents included clinical and school psychologists, physicians, pharmacists, substance abuse counselors, and nurses. Nearly 9 in 10 respondents (88.9%) provide direct services to clients with mental health or substance abuse concerns.

As seen in figure 2, below, the service most frequently identified as necessary by providers (64.9%) was *care coordination among multiple providers*, followed by *help following through with treatment protocol* (55.6%). Providers also reported that *help transitioning from inpatient care to home or community care* is a necessary service in the area (50.0%/18). Just under half of respondents (45.7%) recognized *advisement and service coordination regarding housing, finances, employment, etc.* as necessary.

The survey comments confirmed the emphasis providers placed on the need for care coordination, but made clear that this coordination must occur not on the patient level but at the level of professionals. One respondent echoed a common sentiment, remarking that s/he could do a better job serving clients with MH/SA concerns “if I knew how to access/collaboration with PCPs and others. Feels disjointed.” Others responded with the hope that “care coordination was simpler and streamlined in this community,” and that “the services I provide could be included in an overall medical wellness plan.”

Figure 2



Regarding mental health and substance abuse concerns, providers reported that what Taos County needs most is facilities for inpatient rehabilitation and treatment centers, (34%), followed by cooperation and collaboration among professionals (24%), financial support (24%), and quality services (20%). A complete inventory of comments can be found in the appendix.

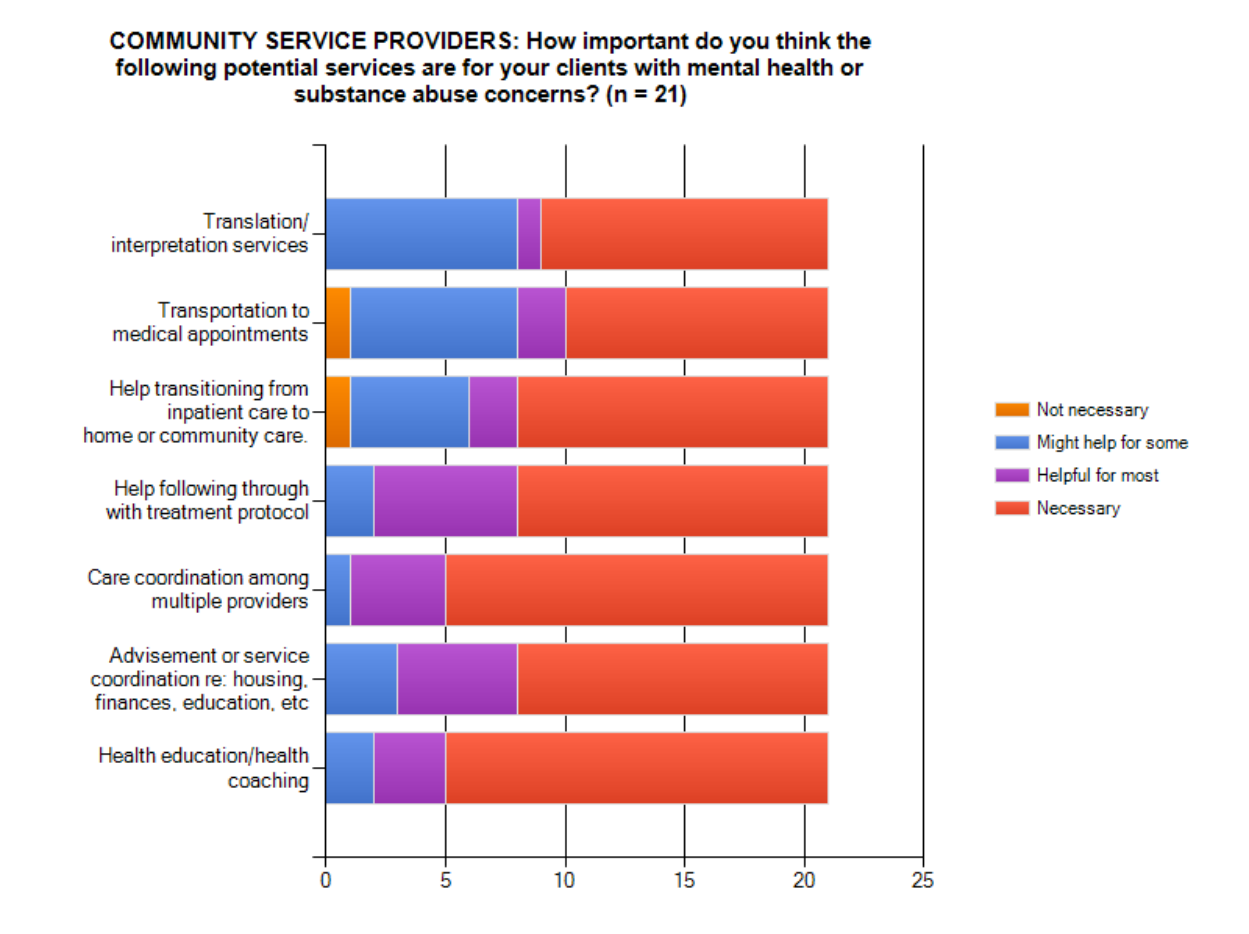
COMMUNITY SERVICE PROVIDERS

The community service provider survey showed a different emphasis. A total of 14 area organizations were approached, and 21 surveys collected. Surprisingly, 100% of respondents indicated that they work with clients with mental health or substance abuse concerns. Half reported always knowing how to proceed when they suspect MH/SA involvement; 45.5% checked “sometimes”. Two thirds (68.2%) regularly screen clients for MH/SA issues, while the remaining one third (31.8%) do not. All of the respondents request formal permission of their clients currently in care to exchange information with their medical/mental health care provider.

Figure 3 provides results of the community provider surveys. In comparison to the other groups, community service providers were much more willing to mark services "necessary." *Health education/health coaching* was seen as necessary by 76.2% respondents, equal to the number who judged *care coordination among providers* necessary. Following close behind were *advisement and service coordination regarding housing, finances, employment, etc., help following through with treatment protocol*, and *help transitioning from inpatient care to home or community care* (each 61.9%). *Transportation to medical appointments* and *translation/interpretation services* were seen as valuable but rated "necessary" or "helpful for most" by fewer respondents.

Community service providers, like medical providers, emphasized the need for collaboration and communication, but their responses tended to skew more toward the need for more and better training and a more comprehensive knowledge base regarding MH/SA services and best practices. "I wish I were better trained on best practices to identify and support families/individuals with mental health and substance abuse," wrote one respondent. Another called for "more coordination and connection with different organizations." Taos County most needs "in-patient facilities," "adolescent services," "quality providers," and "community support and resources," respondents wrote.

Figure 3

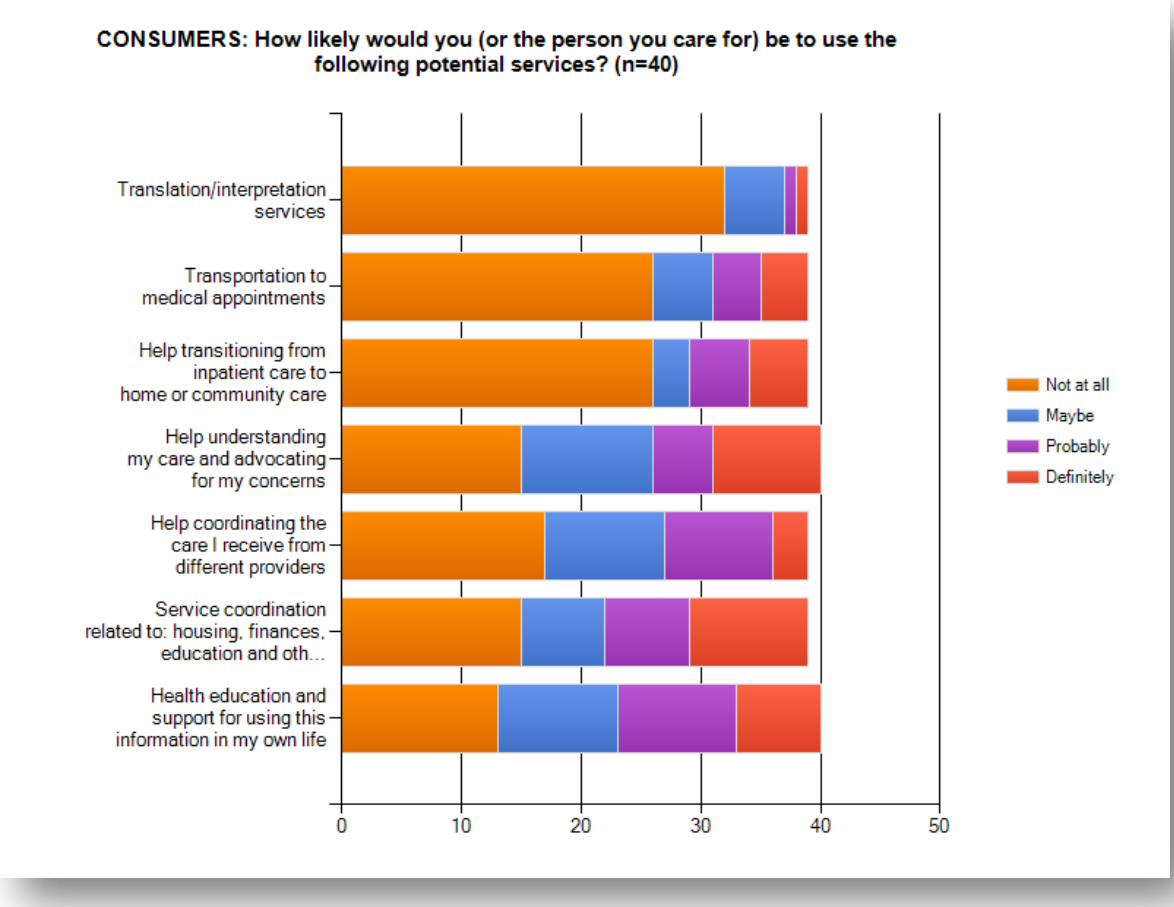


CONSUMERS

Consumers of MH/SA services responded to a similar survey, worded to pertain to their experience. Eleven different health care organizations were asked to share the survey with their clients, and six agreed and complied. A total of 41 responses were collected. Over half (56.1%) of respondents currently receive or have in the past received professional care to address mental health or substance abuse concerns. 31.7% of survey participants report that they provide support for someone receiving professional care for mental health or substance abuse concerns.

Participants were asked to rank how likely they (or the person they care for) were to use some potential services. (Regarding translation services, it is important to note that the survey was not made available in Spanish.) Figure 4 provides results of this survey.

Figure 4



The majority of participants agreed that they were **not likely** to use:

- Translation/interpretation services: 82.1%
- Transportation to medical appointments: 66.7%
- Help transitioning from inpatient care to home or community care: 66.7%

However, among the services that consumer's recognized as **"definitely" likely to use**, we found:

- Help understanding their care and advocating for their concerns: 22.5%.
- Service coordination relates to housing, finances, education and other life's concerns 25.6%.
- Health education and support for using this information in their lives 17.5%.

When asked "what would help you the most with regard to your MH/SA needs," comments were widespread but fell into a few general categories. These are depicted in table 1, below.

Table 1

The one service that would help me the most, related to mental health or substance abuse concerns, is:	Percentage
Quality and affordable service	56%
Service Coordination	16%
Education	6%
None- n/a	20%

Several mentioned the need in Taos County for inpatient/outpatient detox care and rehab services. Additionally, a significant number mentioned that they needed "someone to talk to," or "Someone who can listen to my fears and mixed emotions and might be able to help me deal with it."

It is illustrative to examine the differences that arise between consumers' impressions—service coordination for contextual concerns, and health education and support are the two most important categories—and the medical providers' responses, which rank interagency care coordination and help following through with treatment protocol as the most pressing concerns, with health education/health coaching a distant fifth. Community service providers may offer an interesting vantage, privy to the concerns of both medical providers and the consumers. Though the group of respondents was small (N=24), they clearly understood both the need for health education and the need for care coordination among multiple providers. Although CHWs are more frequently associated with medical organizations, a community service organization—not explicitly medical—might be considered an appropriate home for

a program employing them, provided adequate medical support was provided clients and a robust communication took place between the CHWs and the medical personnel.

The surveys suggest other conclusions as well. While comments from community service providers mention the paucity of MH/SA providers who are comfortably bilingual, the need for translation/interpretation services ranks lowest on the list of needed services for all three groups. (Note: The survey was not made available in Spanish, nor were extensive efforts made to engage members of Taos County's monolingual Spanish-speaking population.) Similarly, though providers pointed to transportation as an important need and several consumers mentioned it in their comments, the prospect of transportation to/from medical appointments did not merit an enthusiastic response. And, while need is acknowledged for help transitioning from inpatient care to home/community care, it is limited to a smaller portion of the population and does not seem as widespread a need as the others. Surely these needs exist, but CHW programs trying to address issues that affect the greatest numbers might be more effective focusing on the four remaining needs.

QUESTIONS RAISED BY THE SURVEYS

- Where is the middle ground between what medical providers believe is most valuable and what consumers want?
- Should a CHW program try to serve a small but clearly identified portion of the MH/SA care community, or should it address larger issues experienced by greater numbers?

KEY INFORMANT INTERVIEWS

To gain more in-depth information about potential program implementation, i2i Institute conducted lengthy interviews with eight area professionals: two primary care physicians also active in research regarding mental health and substance abuse; four program directors (a pharmacist, two mental health services directors, and a director of a maternal-child health home visiting program), a community outreach specialist, and a social worker. Most of these were conducted face-to-face and recorded for accuracy, but two took place via email exchanges. Most of the informants had some experience with CHW interventions.

The following trends emerged from close analysis of the interviews:

- There is a common consensus that it's important to move toward "patient-centered care" from our current model of "doctor-centered care." "One-on-one, doctor-patient care is one of the least-efficient, potentially expensive, and some say dangerous ways to deliver health care. It's very antiquated, and very awkward," one physician remarked. A good community health worker model would be of enormous benefit to everyone; it would cut costs, reduce redundancy, and improve care.
- The relationship between CHW and client is most successful when it is characterized by trust and longevity. CHWs provide a liaison between the medical community, social services, and families based on the relationship model. "Sometimes, a misperception can arise from the medical community that a home visitor or promotora is going to be able to 'fix' the client," a program

director said. Medical providers may expect immediate positive outcomes, but nothing happens that quickly. “We’re trying to address lifelong habits and behaviors,” she confirmed.

- Turf issues can form a formidable barrier to success. These can take place on the level of the agency, with friction arising between medical professionals and CHWs over roles and boundaries; but it is equally onerous interagency, with competing entities and various regulatory agencies. Informants alluded to a history of distrust and hampered communication. Getting agencies to work together was perceived to be a major challenge.
- Most of the informants talked far more about employing CHWs as a method of improving overall community health than about the use of CHWs specifically for mental health/substance abuse. They view general community wellness and prevention as the more-important topic. “Why is this conversation just about mental health?” asked one program director. “It should be about how CHWs can help create a community culture of health.” Another pointed out that everyone would benefit by saving money, time, ER visits, and the “aftermath” of having an unhealthy population. If everyone could agree on how to get it together, he believes, it would benefit every service provider, as well as the entire community. As one informant put it, “It’s bigger than behavioral health and substance abuse.”
- There is general agreement that there needs to be a standard, baseline training that fits everyone’s needs, allowing individual specialty areas to be pursued from there. A less comprehensive or rigorous medical training would need to be coupled with training in other aspects of client interaction. A director of a successful and long-running program emphasized that “hiring the right personnel is key. Having a higher professional level of people is good, especially for a start-up model. You need a really strong, diverse team, so you can focus on the holistic client.” She recommended that programs focus first on building relationships with providers. “You need support from all providers so they know what you’re doing, why to refer to you, and why not.”
- Finally, funding—on all levels—is a necessary element of success. For CHW programs to succeed they must be “free or no cost ... [and provide] cultural and linguistic compatibility,” confirmed a physician. Community health workers must have adequate pay and benefits, and programs must have a level of financial security that will permit them to support their employees and plan into the future. That said, informants were in general agreement that the model could create cost efficiencies and help reduce overall health costs.

QUESTIONS RAISED BY THE INTERVIEWS

- Is it possible to design an effective CHW program that is not field-specific? What would the goals be for such an intervention?
- Should a CHW program be housed by a single agency, or should it be independent and offer services to clients of multiple provider agencies?
- How can turf issues be addressed? Is there an effective way to encourage interagency collaboration on this issue?
- Where might funding be found?
- Should the CHW intervention be viewed as an ongoing relationship between the CHW and client? Can it be effective if it spans a short time?

RECOMMENDATIONS-NEXT STEPS

CONCLUSIONS, AND QUESTIONS FOR FURTHER STUDY

A broad look at points raised by all data collection strategies supports a few major conclusions.

The use of CHWs in MH/SA care does appear to have merit, particularly when approached as a relationship-based intervention trading on trust and addressing the comprehensive psychosocial needs of the individual in care. Questions concerning clarity of role, selection criteria, training content and procedures, team fit, and agency affiliation should be pursued further.

There is a pressing need to improve communication between providers, both individually and organizationally. These are community-wide issues that can best be addressed by a coalition of dedicated members. The interest and dedication exist, but the awareness of this is hampered by a pervasive lack of trust.

Mental health and substance abuse care in Taos County presents multiple gaps. The lack of adequate adolescent care, inpatient care, and affordable detox/rehab care are serious issues that can't be remedied by a one-size-fits-all solution. It will take concerted effort to find a way to address these issues, too.

It is important to examine data collection systems and to consider actions to improve collection and facilitate sharing. Meaningful evaluation strategies are critical to obtaining useful feedback for program improvement and for assessing efficacy and community need and use. What questions should we be asking, now and in the future? What would it help to know? An increased awareness of this issue might result in low- or no-cost improvements that could help tremendously down the road.

There is a wealth of experience, intellect, passion and commitment here in our community. How can Taos County tap that as a resource—collectively, and individually—to move forward with this idea?

APPENDIX A: REFERENCES

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APPENDIX B: SURVEY AND RESULTS

Survey 1: Medical/Mental Health Providers (36 survey responses)

1. ***I am a: ☐ physician (8.6%) ☐ counselor/therapist (42.9%) ☐nurse practitioner (8.6%) ☐R.N. (5.7%) ☐ Social worker (17.1%) ☐ other: (20.0%)*** _____
   35 answered/1 skipped

2. ***I provide direct service to clients with mental health or substance abuse concerns.***

   ☐ Yes (88.9%) ☐ No (11.1%)

36 answered

3. ***I provide administrative or other support to mental health or substance abuse health care providers.***

   ☐ Yes (51.4%) ☐ No (48.6%)

35 answered/1 skipped

4. ***How important do you think the following potential services are for your clients with mental health or substance abuse concerns? Please check the appropriate box.***

Service	Not necessary	Might help for some	Helpful for most	Necessary
Translation/interpretation services	2.8%	**58.3%**	13.9%	25%
Transportation to medical appointments	0.0%	**44.4%**	30.6%	25.0%
Help transitioning from inpatient care to home or community care	0.0%	19.4%	30.6%	**50.0%**
Help following through with treatment protocol	0.0%	8.3%	36.1%	**55.6%**
Care coordination among multiple providers	0.0%	2.8%	33.3%	**63.9%**
Advisement or service coordination re: housing, finances, education, etc.	0.0%	20.0%	34.3%	**45.7%**
Health education/health coaching	0.0%	25.0%	**44.4%**	30.6%

5. ***I could do a better job serving clients with mental health or substance abuse concerns if:***

29 answered/5 skipped

Responses for cooperation/collaboration:

- Cooperation.
- Coordinated crisis response for youth.
- collaboration between medical community and other institutions
- Collaboration with town and county officials for coordinating of service, ex jails, etc.
- Less territorial behavior and more concern for patient care and substance abuse treatment programming in the detention center.
- A serious attempt by law enforcement to stem the distribution and use of illegal substances.

- Cooperation and collaboration between providers

Responses for facility

- In-patient rehab facility, group homes for mentally disabled.
- Treatment center options for poor in- patient.
- A residential facility for rehabilitation. Halfway house might be helpful.
- In patient services.
- Residential treatment, transitional housing.
- more outpt and inpt programs available. more substance abuse counselors available.
- local inpatient services..both mental health and substance abuse....!!!!
- An inpatient facility
- facility 30 day program
- Housing and transitional housing services like shelter + care, transitional housing for those going to or coming from inpatient treatment, medical detox, inpatient treatment here in Taos, and respite housing for mental health crises

Responses for Financial

- more therapists that take Medicaid
- services and funding
- collaboration between medical community and other institutions
- All payors to consider mental health and substance abuse as a chronic condition like diabetes.
- More afforable BH (sliding scale)
- More resources for middle class income that can't afford insurance but don't qualify for state help.
- The lack of flexibility and desire to change how we practice mental health. Therapists do not want to add more work if they are not paid, even if it helps improve the quality of care

Responses for Services:

- Less structured services for people who are not structured.
- Access to all services and supports to continue to access care.
- local inpatient services..both mental health and substance abuse....!!!!
- Programs dealing with court committed clients.
- Competent providers who put clients needs first and entity & personal pockets second or third.
- Education. Many people I have come across in the community are unfamiliar mental health issues and treatments. As far as substance abuse many are in denial about their use and very defensive when addressed.
- I had regular consultation with medical providers
- if I had more education in how to help them.
- if I had access to BH specialists proximity and operationally.

6. With respect to mental health and substance abuse concerns, what Taos County needs most is:

- facilities for inpatient rehabilitation and treatment centers, (34%),
- cooperation and collaboration (24%),
- financial support (24%)

- quality services (20%).

7. Something vital to add? Please feel free to write in the space provided below.

- Working in social services concerning mental health and substance abuse it is painfully evident that so many are left without options for care due to no coverage with insurance. This needs to be addressed.
- Substance abuse is a problem that cannot be treated by just anyone who has a masters degree in mental health counseling or social work, or in a related medical field, because there is not enough training included in these various degree programs to allow for a clear understanding of substance abuse disorders or the techniques necessary to successfully treat the problem. Therefore I am asking that only those who are clearly educated in this area be called upon to provide services.
- The answers to these questions varies depending in the type and/or severity of mental health or substance abuse issues a person has. Those with severe mental health or substance abuse concerns would likely rate a necessary in all categories above. The populations I work with most prevalently do not fit in that category.
- Substance abuse services need to be better funded through increases at the state and federal level and through corporate grants.
- good health training.
- Collaboration, collaboration, collaboration!
- Taos County has a very large number of direct service providers, but the criminal justice, healthcare, social services, behavioral health, etc. systems are not coordinated. These systems are what we need.
- I am hoping that a collaborative mental health group will develop and will be able to work in a collaborative manner to ensure or clients need's are being met in the most effective way.

Survey 2: Community Service Providers (22 Survey Responses)

1. ***Some of the clients I serve are dealing with mental health or substance abuse concerns.***

   ☐ ***Yes (100%)*** ☐ ***No.*** **(0.0%)**

2. ***If I suspect mental health or substance abuse involvement with a client I serve, I***

☐ always (50%) ☐ sometimes (45.5%) ☐ never (4.5%) know how to proceed.

22 answered

3. ***I regularly screen clients for mental health or substance abuse issues.***

   ☐ ***Yes (68.2%)*** ☐ ***No (31.8%)***

22 answered

4. ***For clients currently under care for mental health or substance abuse concerns, I***
   ☐ do (100%) ☐ do not (0.0%) request formal permission to exchange information with their medical/mental health provider.

19 answered, 3 skipped.

5. ***How important do you think the following potential services are for your clients with mental health or substance abuse concerns? Please check the appropriate box.***

Service	Not necessary	Might help for some	Helpful for most	Necessary
Translation/interpretation services	0.0%	40.9%	4.5%	**54.5%**
Transportation to medical appointments	4.5%	36.4%	9.1%	**50.0%**
Help transitioning from inpatient care to home or community care	4.5%	27.3%	9.1%	**59.1%**
Help following through with treatment protocol	0.0%	9.1%	31.8%	**59.1%**
Care coordination among multiple providers	0.0%	4.5%	22.7%	**72.7%**
Advisement or service coordination re: housing, finances, education, etc.	0.0%	13.6%	27.3%	**59.1%**
Health education/health coaching	0.0%	9.1%	18.2%	**72.7%**

6. ***I could do a better job serving clients with mental health or substance abuse concerns if***

19 answered, 3 skipped

- There were more appropriate services in the community.
- There were more wrap around services for adolecent clients who have no place to go after the successfully complete treatment foster care.

- my agency could be reimbursed for continued care and care coordination efforts.
- More professional trainings in Taos.
- INSURANCE COVERED MORE SERVICES
- We had training.
- There was collaborative care.
- we attended a training session.
- I were better trained on best practices to identify and support families/individuals with mental health and substance abuse.
- I knew what options they have regarding services.
- If I had more links onto substance abuse programs
- there were a concerted effort to bring all the services together to have a safe network.
- if I had a full working knowledge of what services are provided and who provides them.
- if all the services above were in place.
- if I knew all the resources/supports available in the community, especially in regards to substance abuse.
- there was good communication between agencies.
- Clients disclosed information to me
- More coordination and connection with different organizations.

7. With respect to mental health and substance abuse concerns, what Taos County needs most is

21 answered, 1 skipped

- Adolescent services.
- CCSS
- Substance abuse programs for teens Many more regular foster homes
- an adolescent detox
- Engagement in healthy alternatives - starting from early age with incentives for parental involvement.
- IN-PATIENT FACILITIES
- IN-PATIENT FACILITIES
- Collaborative care and standardized protocols.
- Standard policies.
- Knowledge re: services
- Transportation to and from support groups outside of Taos due to stigmas and small communities.
- Community support and resources.
- More links to mental health and substance abuse programs
- Reinforcement from the community to provide support for individuals, children and adult family members for education and intervention.
- communication with multiple providers.
- Low cost or no cost health care and counseling services.
- Quality providers and also services that take Medicaid and for undocumented and Spanish speaking .
- Quality providers that take Medicaid or sliding scale for undocumented people. More access
- Quality providers, Spanish speakers.
- Quality counselors, therapists. Services for Spanish speaking clients.
- Needs more Spanish speaking counselors and therapists
-

Something vital to add? Please feel free to write on the back of this sheet.

- We need Spanish speaking counselors, especially for couples counseling. We need culturally sensitive therapists, counselors, etc.

Survey 3: Consumer (41 surveys completed)

1. ***I currently receive or have in the past received professional care to address mental health or substance abuse concerns. ☐ Yes (56.1%) ☐ No (43.9%)***

41 answered.

2. ***I am related to or provide support to someone receiving professional care for mental health or substance abuse health concerns. ☐ Yes (31.7%) ☐ No (68.3%)***

41 answered

3. ***How likely would you (or the person you care for) be to use the following potential services? Please check the appropriate box.***

Service	Not at all	Maybe	Probably	Definitely
Translation/interpretation services	**82.1%**	12.8%	2.6%	2.6%
Transportation to medical appointments	**66.7%**	12.8%	10.3%	10.3%
Help transitioning from inpatient care to home or community care	**66.7%**	7.7%	12.8%	12.8%
Help understanding my care and advocating for my concerns	**37.5%**	27.5%	12.5%	22.5%
Help coordinating the care I receive from different providers	**43.6%**	25.6%	23.1%	7.7%
Service coordination related to: housing, finances, education, & other life concerns	**38.5%**	17.9%	17.9%	25.6%
Health education and support for using this information in my own life	**32.5%**	25.0%	25.0%	17.5%

40 answered/1 skipped

4. ***The one service that would help me the most, related to mental health or substance abuse concerns, is:***

30 answered, 11 skipped

- Alcoholics Anonymous
- Service coordination
- Getting my meds and talking to someone about my problems.
- Understanding the sources available.
- Health education
- More affordable rehab centers for substance abuse.
- Affordable mental health appointments.
- Better services for compulsive gambling /gambling addiction.
- Coordination of agencies for the benefit of clients.
- Better coordination between agencies to better assist the patient/client.
- Improved ER response to mental health needs.
- Get to the appointments quickly when I need them.

- Service coordination.
- Very satisfied with my care.
- Money.
- My meds.
- Health education.
- Other services in the Taos vicinity.
- Service coordination related to housing, finances, education and other life concerns.
- Therapy
- Support/therapy for my teen.
- Someone to talk with.
- Counseling
- Someone who can listen to my fears and mixed emotions and might be able to help me deal with it.
- They need lots of help.

5. ***With respect to mental health and substance abuse concerns, what Taos County really needs is:***
   - A hospital with a psych unit!!!
   - Detox Outpatient Options
   - more services
   - I don't think anything everyone here are really nice and helpful.
   - Government officials who respect their jobs and their residents, who are not hypocrites in what they do and the services they provide (the who you know, not what you know mentality)
   - An affordable rehab center for substance abuse.
   - In-patient treatment for drug rehab.
   - Better insurance for community, not just those who work. Universal health care.
   - More mental health services specifically focused on "process" addictions - specially gambling.
   - In patient rehabilitation and resources.
   - More services for people who require them.
   - Long term rehabilitation (in-patient) substance abuse.
   - Financial support/awareness.
   - 24 hour transportation and service.
   - Unknown.
   - Help with payments.
   - Nothing.
   - Support, financial and many others.
   - A.A /N.A 24 hour safe house.
   - No comment at this time.
   - After work hours.
   - 24 hour support / 24 hour transportation
   - Public transportation.
   - unable to answer this.
   - More help.

Something vital to add? Please feel free to write on the back of this sheet.

- Current statistics on "problem" or compulsive gambling are inaccurate. This problem is largely ignored and hugely underfunded. Most stats are gathered /provided by and funded through parties primarily interested in maintaining legalized gambling (eg) counselors and therapists need more information on the physiological impact of slot gambling in particular, which some studies suggest mirror the neurological effects of cocaine.
- So very thankful for Tri-County and the support /therapy given to our family.

APPENDIX C: KEY INFORMANT INTERVIEW PROTOCOL/RESULTS

We interviewed eight area professionals:

- Tracey Garcia, Behavioral Health Services Director, El Centro Family Health
- Kim Hamstra, director, Tri-County Community Services
- John Hutchinson, pharmacist and director of CATCH, Collaborative Action for Taos County Health
- Jay Swoboda, MD, Taos Veterans Administration Clinic
- Kathy Namba, former director of Taos First Steps (home visiting for first-time families)
- Howard Waitzkin, PhD, MD, researcher

Below are notable trends and highlights from the interviews.

Notable Trends:

- There is a common consensus that it's important to move toward "patient-centered care" from our current model of "doctor-centered care." "One-on-one, doctor-patient care is one of the least-efficient, potentially expensive, and some say dangerous ways to deliver health care. It's very antiquated, and very awkward," one physician remarked. A good community health worker model would be of enormous benefit to everyone; it would cut costs, reduce redundancy, and improve care.

- The relationship between CHW and client is most successful when it is characterized by trust and longevity. CHWs provide a liaison between the medical community, social services, and families based on the relationship model. "Sometimes, a misperception can arise from the medical community that a home visitor or promotora is going to be able to 'fix' the client," a program director said. Medical providers may expect immediate positive outcomes, but nothing happens that quickly. "We're trying to address lifelong habits and behaviors," she confirmed.

- Turf issues can form a formidable barrier to success. These can take place on the level of the agency, with friction arising between medical professionals and CHWs over roles and boundaries; but it is equally onerous interagency, with competing entities and various regulatory agencies. Informants alluded to a history of distrust and hampered communication. Getting agencies to work together was perceived to be a major challenge.

- Most of the informants talked far more about employing CHWs as a method of improving overall community health than about the use of CHWs specifically for mental health/substance abuse. They view general community wellness and prevention as the more-important topic. "Why is this conversation just about mental health?" asked one

program director, herself engaged in the field. “It should be about how CHWs can help create a community culture of health.” Another pointed out that everyone would benefit by saving money, time, ER visits, and the “aftermath” of having an unhealthy population. If everyone could agree on how to get it together, he believes, it would benefit every service provider, as well as the entire community. As one informant put it, “It’s bigger than behavioral health and substance abuse.”

- There is general agreement that there needs to be a standard, baseline training that fits everyone’s needs, allowing individual specialty areas to be pursued from there. A less comprehensive or rigorous medical training would need to be coupled with training in other aspects of client interaction. A director of a successful and long-running program emphasized that “hiring the right personnel is key. Having a higher professional level of people is good, especially for a start-up model. You need a really strong, diverse team, so you can focus on the holistic client.” She recommended that programs focus first on building relationships with providers. “You need support from *all* providers so they know what you’re doing, why to refer to you, and why not.”

- Finally, funding—on all levels—is a necessary element of success. For CHW programs to succeed they must be “free or no cost ... [and provide] cultural and linguistic compatibility,” confirmed a physician. Community health workers must have adequate pay and benefits, and programs must have a level of financial security that will permit them to support their employees and plan into the future. That said, informants were in general agreement that the model could create cost efficiencies and help reduce overall health costs.

- A respondent stated that the initial vision for CATCH was to be the “home,” for the pool of CHWs in Taos County (it was supposed to be its own 501c3, for community health). Respondent would love to see the next evolution of CATCH be that – to become the community-wide hub for CHWs.

How does (did, might) your program employ a community health worker model to serve your clientele?

- **El Centro Family Health:** “Teaching good eating habits, smoking cessation, risk reduction and relaxation techniques are only a few of the reasons we utilize our CHWs.”

- **Tri-County Community Services:** Uses Comprehensive Community Support Workers (CSWs), who all receive a 20 hour, statewide CCS training before they begin working with clients. They’re mandated to provide CCS for chronic mental health. They have to have all the training annually. Rely heavily on these CSWs to provide essential services across the region; bringing care to people where they need it, and helping to coordinate their care across sectors. And they’re especially effective in this model – letting clients talk to someone who has “been there” (peer support specialists).

- **Collaborative Action for Taos County Health:** Used promotoras for a short time (6 to 9 months). Built the model around diabetes, and tried to integrate both inpatient and outpatient elements. Focused on "care without walls."

- **Taos VA** Hasn't really worked with CHWs as such; but thinks the model is a no brainer, and that there should be no end to what can be done in a rural community, with technology and a little bit of structure. Although no direct CHW experience, when he did his residency at UNM, they had a full team (nurses, midlevels, docs, etc.) and that included members of the team doing home visits, going into communities.

- **FIRST STEPS:** FS not a true promotora model, as the home visitors have professional degrees and years of experience working in related fields (nursing, education, etc). They are a liaison between the med community, social services, and families based on the relationship model. "All of our home visitors have been trained and are expert at making everyone feel comfortable." Heart of the model is trust established between HV and parent.

What makes this model effective, as opposed to (or in addition to) an office-centered care delivery system? (i.e., what are the special advantages this offers in terms of serving the clients' needs?)

- "I know that our CHW's are able to go out into the community/homes of patients. This has proven to be a plus to our patients who often feel more comfortable in their own environments and are better able to make the changes that benefit their health, both mentally and physically."

- Respondents were clear that a *good* community health worker model would be of enormous benefit to everyone; would cut costs, reduce redundancy, and improve care – it's just a question of getting the agencies to work together.

- "From the healthcare provider standpoint, there's a certain comfort with knowing that patients who are homebound, or difficult to communicate with, or that were high-risk or recently discharged from the hospital, that we had that lifeline out there. So some of the helpful information [CHWs] brought back was that they could tell us about their living situations, they could basically say, were they organized, they could speak a little bit about their literacy or their ability to navigate the system."

  Also points out that *everyone* would save money, time, ER visits, and the "aftermath" of having an unhealthy population. If everyone can agree on how to get it together, it would benefit every service-provider, not to mention the entire community.

- "One-on-one, doctor-patient care is one of the least-efficient, potentially expensive, and some say dangerous ways to deliver health care. It's very antiquated, and very awkward."

Anyone who's out there where the patients are is totally invaluable, gets a better and more effective perspective. And CHWs cut down on the "burden of needing to go to the doctor," and respect some people's reluctance to travel to healthcare facilities (due to both privacy and health concerns, e.g.).

- Puts everybody on neutral ground. Meeting clients in their homes takes away the professional onus; HV has to hold the content knowledge and at the same time help the client to create their own drive, desire, solutions, healing. "Clients are experts in their own homes, and can feel that." ... The trusting relationship is key. "When you're allowed into a home, it connotes openness to change. Clients are more active in their healing process."

- Improved access, free or no cost, cultural and linguistic compatibility.

What are the challenges specific to this model? (In addition to general issues, what challenges might be specific to Taos?)

- Do not have enough CHW's to meet the needs of all our patients. This more we can reach out to patients and give them the extra attention the more likely they are to reach their personal health goals and be educated in how to do so.

  Barriers would likely be the risk involved with entering the homes of patients. Bad cell service in some of the rural areas create a high risk, if the CHW is unable to reach help or help is unable to reach them.

- "Communication, of all of us. And I'm guilty of this, too. I think all of us putting our agendas down, and coming in and saying, 'Does everybody hire their own? Do we have where all of us pool and it becomes an honest collaboration (which I would love to see)? Otherwise what we're doing is, if you're physically ill you go there; if you're mentally ill you come here; and you belong to me, you belong over there because you have diabetes; as wide open as this town is, we don't join. And until that happens it's gonna be real political – and the losers are gonna be the folks that need our services."

  On a community level, getting people to access services despite the possible stigma of people knowing that they're doing so. (Some people park at Albertson's and walk to TCCS so that no one sees their car there.) So sensitivity to people's fear that "everyone will know," since it's such a small community. ("And they will know." We can't pretend they won't.)

- -Competing entities and various regulatory agencies.
  -Medical practices are not necessarily designed (practically or physically) to accommodate that – hence the idea of having a 'pool' of workers based somewhere else.
  -People aren't always open to letting others in their homes.
  - CHWs have a very specific kind/amount of knowledge, and they need to know their limits, and know when to ask for advice.

- Suspects that most providers don't necessarily agree with him re: CHWs as a no-brainer; probably this mentality needs to be incorporated into medical training from the beginning.
  - People (consumer)'s adherence to the 1:1 doctor visit
  -Trust

- Sometimes, misperception from the medical community that HV or promotora is going to be able to "fix" the client. Medical providers expect immediate positive outcome, but nothing happens that quickly. "We're trying to address lifelong habits and behaviors."

- Turf issues with current providers, although the needs are so great that I think most providers would welcome the extra support and improved access. [In our study], funding limitations led to an inability to hire enough CHWs to cross cover for each other and to assure a large enough N for adequate statistical power; it wasn't clear if lack of statistical significance in the quantitative part reflected the N and lack of consistent follow due to the serious illness and consequent absence of one of the CHWs. To avoid that type of problem, enough CHWs including backup support would be very helpful.

What factors are most critical in successfully implementing a community health worker program?

- Uniform training; Agency/office agendas being put aside for the greater good; Creation of a joint mission/joint team; Person leading the effort who is not linked to any of the organizations involved, but whose responsibility is to the community; Trust across agencies; Being able to bill CHW services to funders.

- Depends on the practice/focus area. Home visits were ideal for their diabetes model, because they needed eyes and ears in the home; in some cases, having a CHW *in* a medical practice to assist with care coordination/additional education is the right model.

  It would be great to have a "pool" of CHWs with the same baseline training (CPR, BLS, etc), then some could get special training based on community needs.

Data collection. Have to be able to defend it to community, providers, and funders, so finding good tools and methods for tracking success is essential.

- "Hiring the right personnel. Having a higher professional level of people is good, especially for a start-up model. You need a really strong, diverse team; not just nurses, but also educators, etc., so you can focus on the wholistic client." Early focus should be on building relationships with providers. Need support from ALL providers so they know what you're doing, why refer, why not.

- -Telehealth
  -Creation of a community that's willing to do things a little differently, get out of their silos. Community health workers are a natural lubricant to help de-silo providers and consumers alike.
  -Not clinic-specific CHWs, but community-specific CHWs or even problem-specific (baseline training with specialty areas).

- Adequate pay and benefits for the CHWs; Buy-in by providers, especially to void turf issues.

What are the most valuable services you offer (could offer) through this program?

- "In my opinion some of the most valuable services we offer with our CHW program is education. In my experience educating patients in their medical issues or in preventative techniques has been a major contributor to their making positive health/life changes."

- Anyone who's out there where the patients are is totally invaluable, gets a better and more effective perspective. If primary care providers were given the time/methodology to interact with those people out "doing the work," doctors could focus more on being educators (not just 1-1 providers). CHWs cut down on the "burden of needing to go to the doctor."

- "Home visitors are there to share in the joys. It's not just about service coordination, teaching, problem solving. It's also about giving joyful response to clients and stories and successes." "What clients want is someone to listen to them as they try things out. In reflective practice, the HV will turn it around to the client and ask them to look at solutions and find appropriate ones for themselves."