Skills and Techniques for Community Health Workers Addressing the Needs of Dually Eligible Beneficiaries

Community Health Workers (CHWs) are trusted members of the communities they serve who partner with individuals to help them address their health and social needs. CHWs bridge gaps in care for complex populations by helping them navigate the health care system and connecting them to services.[1] In collaboration with members and the rest of the care team, CHWs may develop and execute care plans, support care management strategies, and link members to community resources.

CHWs play valuable roles on care teams. This brief describes the range of skills, competencies, and techniques that CHWs may use to meet individual needs and provide quality care. Providers and plans may find this information useful when integrating CHWs into care teams to provide more coordinated care to complex populations, including dually eligible beneficiaries.[2]

Skills, Competencies, and Techniques for CHWs

CHWs add value to care teams by providing a range of services, such as assisting with clinical duties, helping identify stable housing for an individual, and delivering culturally and linguistically competent health education. CHWs' specific roles and skills will vary based on the programs or settings they work in and members' needs and preferences. Some of the competencies and techniques CHWs rely on include:

- **Member engagement.** CHWs play an important role in building relationships and developing trust between the member and the provider or plan. CHWs rely on a number of approaches to engage members and establish relationships, including:
    - **Facilitating person-centered goal setting.** CHWs work closely with members to set meaningful, person-centered goals and develop measurable steps to achieve those goals.
    - **Helping members address challenges.** Members often experience challenges such as accessing providers and taking medications as prescribed. CHWs can teach members how to schedule doctor's appointments, identify reliable sources of food, and establish reminders to take medications. CHWs also help members build self-efficacy by supporting them with strategies on how to address challenges, rather than doing the tasks for them.
    - **Helping members access social services.** Individuals with complex needs often benefit from connections to social services; CHWs can refer members to these services and accompany them to appointments. Accessing social support services—such as transportation, housing, and employment assistance— can support goals within care

[1] The Network for Excellence in Health Innovation, *Community Health Workers: Getting the Job Done in Healthcare Delivery*. Retrieved from http://www.nehi.net/writable/publication_files/file/jhf-nehi_chw_issue_brief_web_ready_.pdf

[2] Note: Please check state regulations for specific guidance on the competencies for CHWs.

plans while improving an individual's quality of life and ability to reach additional care plan goals.

- **Coordinating care across the care team.** Through their close, trusting relationships with members, CHWs are well-positioned to identify unmet needs related to mental or physical health and communicate these needs to the rest of the care team. CHWs can also facilitate coordination between providers and the member.
- **Translation and health literacy.** To support the diverse populations they serve, many organizations employ CHWs from those diverse populations. Multilingual CHWs can help translate complex medical into straightforward terms in the member's language, which is particularly important for individuals with lower health literacy levels. This ensures members understand diagnoses and instructions from providers.[3]
- **Clinical assistance.** CHWs may help care teams by providing additional support performing clinical duties, particularly when caring for individuals with complex needs. CHWs can help clinical staff assess medical and social needs and provide ongoing updates. In addition, CHWs can be trained to help with:
    - **Documentation/Use of Electronic Health Records (EHR):** CHWs need to document their visits and interactions with members in accordance with regulations for privacy and confidentiality. As many CHWs do not have a clinical background, they may need training on the use of and requirements for EHRs.
    - **Chronic disease management**: With appropriate training and depending upon state regulations, CHWs can assess health status indicators, such as weight and blood pressure. They can also teach members to complete these assessments themselves, improving their ability to self-manage.
    - **Health education:** CHWs can deliver culturally appropriate and accessible health education and information and teach community members about preventing disease.[4] For example, the Centers for Disease Control and Prevention (CDC) engage CHWs to teach curricula focused on diabetes prevention.[5] As members of the communities they serve, CHWs can tailor education materials to the community and its available resources.
    - **Monitoring medication, supplies, and durable medical equipment:** CHWs can help members monitor their supply of medication or other medical supplies and help them order new supplies when needed.
- **Developing partnerships with local organizations and providers.** CHWs live in the communities they serve and can build networks and make referrals to local resources through existing

[3] Note: Please check state regulations for specific guidance regarding CHWs and translation capabilities.
[4] Centers for Disease Control and Prevention, *CDC's Division of Diabetes Translation Community Health Workers/Promotores de Salud: Critical Connections in Communities*. Retrieved from https://www.cdc.gov/diabetes/projects/pdfs/comm.pdf
[5] Centers for Disease Control and Prevention, *CDC's Division of Diabetes Translation Community Health Workers/Promotores de Salud: Critical Connections in Communities*. Retrieved from https://www.cdc.gov/diabetes/projects/pdfs/comm.pdf

relationships and community organizations. In addition, CHWs will often accompany members to appointments and develop partnerships with local providers.

Additional Resources

These resources provide additional information about skills, competencies, and techniques for Community Health Workers:

- **Camden Coalition COACH Manual:** Care teams in Camden Coalition's Care Management program include CHWs, who use a variety of strategies for member engagement. Their "COACH" model manual describes the staffing, training, and techniques used in their program.
- **New Mexico Department of Health Office of Community Health Workers, CHW Scope of Work:** This document lists the many roles CHWs may perform depending on their job, based on feedback from New Mexico CHWs, employers, and the results of state and national CHW workforce studies.

The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) seeks to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. This brief is intended to support health plans and providers in integrating and coordinating care for dually eligible beneficiaries. It does not convey current or anticipated health plan or provider requirements. For additional information, please go to https://www.resourcesforintegratedcare.com/