Toolkit for Training and Utilization of Community Health Workers in Subsidized Housing

CLINICAL SCHOLARS

A Robert Wood Johnson Foundation program

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ABOUT

This toolkit provides insights to help address Social Determinants of Health (SDoH) challenges faced in Subsidized Housing through providing Community Health Worker training, resident education, and support.

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Executive Summary

The goal of Health Engagement Leading to Prevention (HELP) is to achieve a safe environment for seniors, people with disabilities, and formerly homeless individuals.

HELP addresses barriers to wellness for residents of subsidized housing by providing Community Health Worker (CHW) training, resident health education, and direct CHW support to address social determinants of health (SDoH) challenges. We are demonstrating the value of our model through data collection and evaluation with the intention to bring HELP to other low-income housing systems.

Our pilot began in Arrowhead Apartments in Asheville, North Carolina, which is comprised of a combination of senior citizens, disabled individuals and formerly homeless individuals. This type of subsidized housing facility, featuring senior independent living, is not uncommon in the US. The residents here are on limited budgets, have a higher prevalence of chronic disease and are at greater risk for a shortened life expectancy. Due to this confluence of SDoH issues, these residents often utilize emergency medical services disproportionately and uncontrolled physical and mental health issues can lead to eviction. Many residents receive and/or are eligible to receive services from social services and healthcare organizations. The wicked problem is the numerous barriers for resident access to community resources, including social service, healthcare, transportation, and health education programs. So, though eligible for services which may impact health and ability to remain independent in the community, many residents are not connected.

These barriers to engagement with community resources are both simple and complex–solutions may seem simple, but due to funding streams and siloing of service lines, vulnerable individuals can fall through the cracks, where individuals who could live independently with modest support instead are evicted and transitioned to nursing facilities or institutionalization. Others may need a higher level of care and also fall through the cracks at a time they need support the most. Our team has assisted several vulnerable individuals with housekeeping and care coordination, which previously may have led to eviction due to the condition of their apartment and more costly care needs, but with simple yet intentional support, eviction was averted. After repeated lease violations issued by the property manager, several residents were eventually provided information by the Service Coordinator at Arrowhead to request HELP's assistance to engage "Everyday Details," which provides supportive cleaning services by the team.

As another example, a married couple that was struggling with health issues and unable to shop and clean for themselves reached out to the Service Coordinator and were then connected to our team to receive shopping assistance, housekeeping assistance and general support through their difficult situation. Without this help, this couple would have had continued deterioration of their health status until requiring more costly health services and residential support.

Our current approach to address these issues has been interagency collaboration with service coordinators, nurses, doctors, social workers and the Arrowhead manager and staff. Additionally, we have worked towards sustainability of the project by training individuals at Arrowhead to become CHWs who report and work alongside the community nurse and other trained CHWs. **The result has been better outcomes for this hard-to-serve population and less need for eviction and infractions than when agencies are working in isolation.**

Planning

We conducted needs assessments through initial interactions with residents of Arrowhead Apartments. There were several surprising findings from the survey:

- Residents were issued evictions due to infractions which could be easily corrected with minor support
- Residents were not able to maintain the cleanliness of apartments due to uncontrolled mental health conditions and physical limitations
- A number of residents did not have primary care providers or needed transportation to get to medical care

Our initial plan was to connect resident needs to resources. We did not want residents to continue to fall through the cracks. We developed a Community Health Worker training program in order to train residents from the apartment complex to become community health workers and support other residents. We developed regularly scheduled educational programs, contracted cleaning services, connected residents to mental health care services and provided transportation services. Our ultimate goal was to utilize CHWs to identify needs, be the eyes and ears of the team and connect clients to resources.

Project Team

Shuchin Shukla, MD, MPH*: Medical Director

Kathey Avery, RN, BSN, CN, CTTS*: Project Lead & Community Nurse

Frank Castelblanco, RN, DNP*: Medical oversight and outreach

Kevin Rumley, MSW, LCSW, LCAS: CHW training and support

**Clinical Scholars Fellows pictured*

Key Skill Sets

Desire and ability to advance community work and to have a holistic approach to patient care. Interventions are aimed at individuals, families, and groups within the communities we serve. Community nursing focuses on managing and preventing diseases, as well as on educating our community about maintaining well-being. So that means to improve health outcomes you use health knowledge as well as critical thinking skills, team-building, motivation skills, and coalition building to expand the infrastructure required to monitor and manage diseases and at the same time work on all of the factors contributing to those diseases.

Trust-building is important, that's where CHWs and members from the community come in. Interestingly, during the pandemic in addressing vaccine hesitancy, we saw and read example after example worldwide where a key to getting people to get the vaccine was talking about it with someone they knew and believed—in their churches, from their neighborhood, speaking their language. There has to be a good structure of clinical support to partner, consult, and assist, and sometimes even be willing, when necessary, to meet the client where they are thereby easing access

to care. In getting to know the residents, we found frequently that they were eligible for a variety of services and assistance but not utilizing them. Early on, we were able to communicate the importance of linking to medical and mental health experts and getting proper diagnoses and treatment plans in place. Lastly, following through and following-up until the residents' needs are met is imperative.

Easing access to services as residents require action and timely problem-solving to meet their needs. It entails having services on contract, to call to pick up medications for them, or provide rides to doctor's appointments. An example is our CHW supervisor accompanying a resident to treatment appointments, facilitating as needed. As the community nurse Kathey Avery is the primary care coordinator and requests an appointment for a primary care physician visit. If the resident does not have a primary care provider, she establishes a resident with one for assessments to get diagnoses in place. It's also providing healthy food items and basic needs items.

Engagement is a key word in our project title (HELP) for a reason. We want to instill ownership and empower residents to take responsibility for their health and take an active part in maintaining and improving it. Health education is tailored to individuals, or focused on ailments and conditions most prevalent among residents, as determined by interviews and surveys. Our team creates education which is interactive, participatory, and to emphasize benefits that HELP can provide or facilitate. We take into consideration residents' time, knowledge, and experiences, so they feel more seen, heard, and involved. We also encourage them to engage in their wider living community, though the pandemic has put limits on that. Whenever possible, for instance, if another resident can provide a needed task, we contract with them to do it, both building bonds within the community and providing needed extra income. One resident, Eugene, received a small monthly stipend from our funding for collecting trash from residents who have mobility issues and taking it to the dumpster.

Stability and feeling safe in one's living situation are so important to health and being able to maintain it. So, we took on that "revolving door syndrome" first with early and ongoing tobacco cessation education and support initiatives. And quite quickly we found another issue of urgency to remedy – and cause for evictions: Hoarding and unclean, unsafe individual apartments. Key in this has been informing the management team's perspective from an infraction, eviction, even law enforcement solution, to one which refers residents to primary care services and other resources. Again, during the pandemic this has been a huge measure in keeping people housed and safe.

Measurable health improvements: We keep a lot of data to document individual changes as well as markers that indicate a healthier living community overall, prevention efforts and impact, such as participation in education outreach, and getting feedback from participants about their main takeaways. All this is with an eye to promoting aging in place, and reducing causes for eviction, and reliance on crisis and emergency care.

*"**Together**, we can make sure Arrowhead residents **do not fall through the cracks**."*

– Kathey Avery, project lead

Funding

Initial funding of $315,000 to initiate the project was received through the RWJF Clinical Scholars Program. Subsequent funding to establish the nonprofit which will fund the Institute For Preventive Healthcare & Advocacy is being provided by Buncombe County and several foundations.

Community Partnerships

- Arrowhead Apartments: housing complex for the project
- Asheville Buncombe Institute for Parity Achievement (ABIPA): financial sponsor and community partner
- Mountain Area Health Education Center (MAHEC): medical oversight and community partner
- Buncombe County Health and Human Services (HHS): referral for services and partner
- Transportation and Cleaning entities: Capital Xpress Transportation Services and Bio-One Cleaning Services to support housing residents
- Mission Health Partners: Accountable Care Organization for referrals and follow through

*"Training residents to support one another provides a **sustainable model to achieve better health** to remain in place."*

– Kevin Rumley, MSW, LCSW, LCAS

Concept Map: Our Logic Model

Project work

Strategies

HELP has two main components: direct services and health education to the residents and, for sustainability, training of embedded community health workers who are actually part of the Arrowhead community by our community nurses. This is an interdisciplinary project involving a support system of medical providers, community nursing, social work, housing providers, transportation and cleaning services, and, most importantly, community health workers. The fundamental goal is to improve the health of vulnerable residents at our pilot site, and to prevent unnecessary and preventable eviction or hospitalization.

Embedding CHWs in residence at the facility is a key component. The CHWs in collaboration with the Arrowhead services manager as a HELP liaison create ongoing, consistent, direct linkage between our community nurse and LPN/CHW and the residents. Response can be just a phone call or text away. The presence of those resident CHWs at the Arrowhead site where they can see and talk with fellow residents serves as a constant reminder of HELP and its initiatives, as well as a better chance for an early notification about health issues or other concerns. Additionally, it is a source of income and skills-building for the CHWs themselves. They are paid monthly through RWJF funding for Clinical Scholars and going forward through grant and contract funding. Lastly, they assist with tasks such as: distributing fliers for the monthly engagements, aid in the set-up of events, hold monthly dinners to provide social interactions and help to determine education and screening events for the residents and their well-being.

- Engaging with Community Members using HELP's "Door to Door" nursing approach through the COVID-19 pandemic. We have met, identified and trained two residents and the Service Coordinator to become Community Health Workers embedded in Arrowhead Apartments to assist the project lead Kathey with addressing the on-going needs of the residents. This team was able to distribute masks, educational materials and food items.
- Collecting and reviewing Health and Wellness Assessments by an interdisciplinary team to continuously understand resident needs.
- Provide coordinated individualized services and support including a range of social, medical, and other services.
- Educating local government, other health agencies and the public about best practices and potential policy options to strengthen systems.

Outcomes

Only about 10 of Arrowhead's 116 residents require little or no care assistance and support, or only one-time limited assistance such as Ms. J, who is in her late 70s, and used our transportation service briefly during the time she got an eye survey, and is now back, independent, and driving her car again. There are senior citizens who mainly need a little help from time to time to pay rent or utilities. The residents started their own community garden to provide healthy food items, and have dinners using the food they grew during the summer months.

Evictions over the last three years are down drastically, according to Arrowhead management. Partly this is because of the moratorium over the past two years during COVID, but partly, too, from HELP intervention on residents' behalf. (Some have left on their own, notably to live where they can smoke. Another consideration: a strategy of non-renewal of leases.) This keeps residence from having an eviction on their records.

Social Determinants of Health Addressed at Arrowhead Apartments

Before a senior resident will be able to move into an apartment, they will have to fill out quite a bit of paperwork and provide proof, so the apartment manager can determine what their costs would be if the senior decides that they want an apartment at that building. Many senior homes offer low-cost senior living since many seniors are receiving Social Security or disability as their primary or only form of income.

Housing: Arrowhead is a senior independent, living environment, retirement home, located in Asheville, North Carolina at 100 Cheerio Ln. It offers residents independent living options as well as a variety of amenities and services.

Transportation: Seeing the need for transportation, HELP now has Capital Express who can take residents to doctor's appointments, COVID vaccine clinics, banks, and grocery stores. One example is one young African American resident who is disabled and has a diagnosis of schizophrenia. He was missing getting injectable medication Treatment at MAHEC Psychiatry clinic because he could not understand the importance and make decisions on his own to get to his appointment. As the Community Nurse Kathey set up the appointments the CHW/LPN picks up the injections from the pharmacy and takes them to the MAHEC clinic. Capital express has taken this resident to 17 appointments in 2021. The CHW in residence helps remind him of his appointments along with the CHW/LPN calling him. When there was road work being done and this resident could not access the bus to get to his GED classes, Capital Express took him to his classes.

Food: CHW Ava has cooked for residents who have disabilities and need the extra help, along with cooking for holiday events. HELP provided fresh fruits and vegetables every month. Other organizations bring food, but some things are not nutritious. Our residents recognize and comment on getting too many "pasta boxes" that aren't healthy for them. The residents also started their own community garden. Several of the residents sit in their chairs aligning the garden using safe distancing and socialize and work in the garden. They have a table in the hallway for other residents to share the food.

Health Education: The chronic disease assessment below provided by Dr. Ameena Batada at UNC-A helped Kathey to develop health education content either individually and for HELP's monthly community engagement outreach. Nutritional food is also provided at these monthly engagements. During the COVID-19 lockdowns, the HELP team provided health education, PPE, and healthy food items right to the residents' doors.

Evaluation and dissemination

The evaluation plan included contracting with Dr. Ameena Batada, MPH Professor & Evaluator, University of North Carolina University Asheville. The initial components included resident surveys and in-person interviews. COVID-19 however limited in-person interviews but the surveys were initiated pre-pandemic and continued throughout the project. "*Though we had a number of metrics we planned to follow among residents over time, it was challenging for the team to collect data because of the disruptions in communication created by COVID*." – Dr. Batada

Arrowhead Chronic Illness Survey

An initial survey of twenty-two participants completed the Chronic Illness survey distributed May 2021. The purpose of the form was to collect data in regard to the types of chronic illnesses residents of the Arrowhead community have been diagnosed with and if they are taking any medications for certain conditions. In total, there were thirty-five chronic illnesses listed on the form from which participants were able to check off. **31 out of 35 chronic illnesses listed had been checked off by participants (n=22).**

Process Evaluation

Process Evaluation Tools include program records, health surveys, and chronic illness surveys.

Metric	Description	People Served / Reached
# Receiving COVID supplies and education at home (Education Materials)	Door-to-door distribution of COVID PPE, related supplies, and tailored education based on specific needs determined by our community nurse from analysis of residents' completed chronic ailments surveys, management's recommendations, and CHW observations and interviews.	116+
# Participating Consistently	Attending events or educational programming or personally being seen at least once every 3 months	38
# Attending Monthly Community Engagement Events	Attending monthly community engagement activities on a variety of topics, employing social distancing measures and limiting 3-6 people in the commons area at a time for presentations for several months and later reformatted again to accommodate remodeling being done at the facility. Topics included: ■ Smoking cessation ■ Glucose and blood pressure checks ■ Chronic diseases ■ Preventive health education: controlling hypertension, overall health gains from regular dental care, managing arthritis and joint pain, and recognizing depression and other mental health issues	8-30
# Participating in Smoking Cessation through HELP	Because Arrowhead is a smoke-free facility and infractions can lead to eviction, we worked with residents on smoking cessation education	11

Education and Advocacy

Education is central to the project. Initially we focused on training residents how to stay safe during COVID and distributed masks, supplies and food. Additionally, our lead and community nurse trained residents from Arrowhead apartments to be Community Health Workers. As COVID eased we provided health screenings and educational sessions with providers from MAHEC to include mental health services.

Kathey Avery, the project lead, underwent policy development training provided by RWJF. Our team developed a patient advocacy policy. Our lead met with local politicians and administration from our county's health and human services to discuss how to improve services and connections for residents from Arrowhead and the community.

- Website: Avery Health Education and Consulting
- Website: Institute for Preventive Healthcare and Advocacy (IFPHA)
- Facebook: Institute for Preventive Healthcare and Advocacy (IFPHA)
- The Urban News – Multicultural Newspaper Publication for Asheville, NC: Institute for Preventive Healthcare and Advocacy monthly articles
    - Example: What does the African American community mean to you?

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INSTITUTE FOR PREVENTIVE HEALTHCARE & ADVOCACY

What is Community to You?

BY KATHEY AVERY, RN, BSN, FOUNDER AND CEO

Where are the African American/Black Communities in Asheville?

The definition of community: a social group of any size whose members reside in a specific locality, share government, and often have a common cultural and historical heritage; people living in one particu-

One person said when she talked to the 18-30 years old during a church outreach program about the jobs they wanted, they said, "no weekends, nights, day shift only."

Lessons learned

The project was disrupted by COVID but we pivoted to meet resident needs as best as we could. In doing so we have learned the following:

- Individuals may have long-term trauma from COVID
- Residents' mental health needs increased
- Our team's capacity varied due to COVID clinical requirements
- Our partners had a good deal of turnover

Challenges & Successes

The project's long-term sustainability was important to the team so as not to interrupt services and more importantly relationships and trust that had been established. The project lead, Kathey Avery, founded the Institute For Preventive Healthcare and Advocacy (IFPHA), a non-profit which will continue the work initiated.

Arrowhead residents, who mostly live alone, experienced a good deal of anxiety, depression and trauma as a result of COVID. We provided screenings with mental health professionals who provided direct care and referrals for services.

The Great Resignation affected our project. We trained several CHWs and invested with several partner agencies to train staff. We contracted with service coordinators and due to COVID and other circumstances there was a fair amount of turnover. At the beginning of our pilot there had been tremendous turnover of managers because of the complexity of the tenants at Arrowhead but the work of our team and the CHWs being in place has greater helped lessen this turnover to establish stability.

Shifts in Thinking

The project began with the concept of aging in place by creating a better support system. We have trained CHWs. Their collaboration with the managers and service coordinators have proven to be successful. We continue to lead in that manner however with the creation of IFPHA, our clinical and community partnerships are even more pivotal to our success in reaching outside of Arrowhead Apts. Western North Carolina is extensive and looks quite different than Arrowhead apts., but it still needs just as much help. Partnerships with DHHS, Foundations, other health agencies and NC Care 360 have been essential in order to ramp up the work and reach communities that have limited resources.

Key Learnings:

- Relationships are important
- The ability to pivot quickly is required to be successful
- Western North Carolina and Asheville are politically different but both have people in need
- Effective critical conversations are a developed skill
- Mental Health is an important part of overall health
- Some residents have a lot of "stuff"

Recommendations

The wicked problem of preventing people falling through the cracks began in Asheville NC and now supports WNC region's residents to obtain access to health care, food and other supplies, rental assistance, and additional resources, focusing on trust and relationships. The wicked problem is by no means solved but ideally this toolkit can serve as a guideline for the challenges and our approaches to them.

Getting Started

The wicked problem is prevalent in every community to some extent. Our team has developed extensive partnerships, initially locally and now regionally. These partnerships developed at the speed of trust and are key to our growth and success. These relationships must be developed at all levels from the individuals doing the on the ground work to those who are in board meetings so as to have everyone working for the same goals. Using a collective impact model, our team needed to network with community members, organizations, and institutions who work toward advancing equity by learning together, aligning and integrating our actions to achieve population and systems level change.

Our team was made up of busy clinicians, community leaders and administrators. One recommendation would be to allocate more time for all team members because a project of this magnitude requires a fair amount of time commitment as well as passion for the work.

Best Practices

In the beginning, our team developed several carefully thought-out plans with knowledge and expectations that we could be flexible once we started. These plans quickly shifted due to COVID and we pivoted quickly to meet resident and community needs. The community told us what we needed to know:

- Trust is earned
- Education is essential
- Basic needs must be met first
- Coping skills can be taught
- Relationships are everything
- Clinical community connections!

*"I know that we **CAN improve quality of life and prevent premature death**, and even save money doing it, with tools that currently exist—we just need to implement it! **HELP/IFPHA show us the way.**"*

– Dr. Shuchin Shukla

Appendix

NC Department of Health and Human Services, *Community Health Workers in North Carolina: Creating an Infrastructure for Sustainability*, Final Report and Stakeholder Recommendations of the NC Community Health Worker Initiative, May 2018. https://www.ncdhhs.gov/media/2054/download

Healthy People 2030, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, provides a wealth of data and highlights the importance of addressing the social determinates of health (SDOH)—those historical inequities—by making "Social and Physical Environments that Promote Good Health for All" as one of four overarching goals for the decade. https://health.gov/healthypeople