Appendix 5-A
Community Health Workers and Patient Nagivators

Indiana Department of Health

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Background
Community health workers (CHWs) are non-clinical public health workers who often live and work in communities about which they are knowledgeable. CHW is a designation that can also include community health advisors, lay health educators, or promotores de salud. CHWs connect individuals with healthcare services, thereby decreasing barriers to healthcare. A CHW serves in a distinct role from other healthcare professionals, and patient navigation may be one component of a CHW's responsibilities. Patient navigators, also known as patient advocates, help guide patients through the healthcare system and provide support to improve follow-up and adherence. Patient navigation was designed to help decrease disparities in cancer care.

CHWs and patient navigators may provide transportation for patients to get to healthcare provider offices and may also provide informal counseling and social support, which can improve patient outcomes.

CHWs are often used in healthcare systems the following ways:

- As direct members of the healthcare delivery team
- As a patient navigator connecting people with needed services
- To offer screening and health promotion activities
- To provide outreach and assistance with enrolling in benefits
- In an organizing capacity and as a patient advocate

There is strong evidence that patient navigators can improve rates of cancer screening, especially breast cancer screening. CHWs have been identified as a promising practice for addressing social determinants of health in rural communities by increasing care coordination and linking populations to healthcare and other social services. CHWs have also been found to improve management of chronic diseases as well as decrease barriers for patients trying to access different health services.

Purpose
Most CHWs live in the communities they serve and therefore can bring information where it is needed most. CHWs can serve as frontline agents of change, helping to reduce health disparities in underserved communities. They augment and extend clinical and administrative roles in healthcare settings.

CHW-specific work activities include:

- Culturally appropriate health promotion and health education
- Assistance in accessing medical services and programs

Assistance in accessing non-medical services and programs:

- Translation
- Interpreting
- Counseling
- Mentoring
- Social support
- Transportation

Related to work activities, employer-reported duties:

- Case management
- Risk identification
- Patient navigation
- Direct services

Among the many known outcomes of CHW services are the following:

- Improved access to health care services.
- Increased health and screening.
- Better understanding between community members and the health and social service system.
- Enhanced communication between community members and health providers.
- Increased use of health care services.
- Improved adherence to health recommendations.
- Reduced need for emergency and specialty services.

Description of proposal and funded activities

1. Describe in what sectors of your organization will add CHWs.
2. Describe how many people you expect to assist.
3. Describe what populations will your program is intended to help.
4. Describe the CHWs scope of practice that reflects required competencies across the sites they will serve.
5. Define an appropriate scope of practice based on education, duties, accountabilities, and responsibilities.
6. Describe what role CHWs will play in coordination with other staff and the community.
7. Describe the training opportunities that will be required and/or optional for CHWs.
8. Describe how efforts will be sustained after the grant ends.

Eligible groups to receive funding

- Hospitals looking to engage CHWs to carry out nonclinical tasks, such as ensuring patients get to their medical appointments or fill their prescriptions.
- Healthcare systems looking to engage CHWs to address social determinants of health.
- Public health researchers working with practitioners to analyze how to engage CHWs for

specific populations.

- Community organizations seeking to bridge the gap between the healthcare system and the people they serve.

Health equity statement (required):

Describe populations disproportionately impacted by the specific topic area and how applicant will address these populations specifically.

Please refer to the General Grant Guidance for additional details.

Metrics and evaluation of funded activities

Measures to be collected regularly and submitted monthly to the Indiana Department of Health (IDOH):

1. Demographics:
    a. Number of individuals served by race (Black/African American, American Indian/Alaska Native/Native Hawaiian/Other Pacific Islander, Asian, Caucasian/White, etc.)
    b. Number of individuals served by ethnicity [Hispanic/Latin(a/o/x), other].
    c. Number of individuals served by gender/gender identity (males, females, those who prefer not to answer)
    d. Number of members of the LGBTQ+ community served
    e. Age ranges served
    f. Number of individuals served with a primary language other than English
    g. Number of unique individuals served that meet at least one of the following criteria:
        i. Current active enrollment in MEDICAID/ HIP; or
        ii. Current active enrollment in SNAP/Food Stamps; or
        iii. Current active enrollment in TANF; or
        iv. Residing in a household at or below 200% of poverty per the HHS Poverty Guideline as noted in the HHS Poverty Guidelines for 2022 (Poverty Guidelines | ASPE (hhs.gov))
    h. Additional factors, including but not limited to education level, disability, substance abuse, mental illness, etc.
2. Health Equity: Please share progress made toward achieving your health equity goals (as defined in your Health Equity Statement)
3. Participation: Number of unique individuals served
4. Program Area Metrics:

a. CHWs and Training Opportunities
    i. Number of CHW employed by your program to date
    ii. Number of CHW earning additional certifications
    iii. Number of CHW who were offered training
b. Referrals
    i. Number of referrals to medical services made
    ii. Number of individuals provided with translation services
    iii. Number of referrals to transportation services made
    iv. Number of referrals to food resources made
    v. Number of referrals to rent and/or utility assistance made
    vi. Number of referrals made to other community resources
c. Screenings
    i. Number of individuals provided with health screenings
    ii. Number of medical and/or social determinants of health risk screenings performed.
d. Education and Outreach
    i. Number of educational events facilitated by CHW(s)
    ii. Number of outreach events facilitated by CHW(s)
    iii. Number of individuals educated by your program (regardless of enrollment status)
    iv. Topic(s) your program covered during educational sessions
e. Healthcare Services
    i. Number of individuals provided with community linkages
    ii. Number of home visits completed.
    iii. Number of direct healthcare services provided by CHW(s)

Provide a plan for how you will evaluate the program over your grant project period.

*The above measures may be altered at any time at the discretion of the Health Innovation Partnerships and Programs Division of IDOH.

References (data sources, etc.)

- https://www.nhlbi.nih.gov/health/educational/healthdisp/role-of-community-health-workers.htm
- https://www.aha.org/system/files/2018-10/chw-program-manual-2018-toolkit-final.pdf