



Innovative Roles for CHWs in Community Health Centers

CHW Summit, April 23, 2024



This work is funded by the Federal Office of Rural Health Policy's Rural Public Health Workforce Training Network Grant

Objectives

Participants will

- Leave with a greater understanding of the unique integrated approach central to federally qualified health center (FQHC) operations
- Learn about the differing types of CHWs working within community health centers



Challenge

- Federally Qualified Health Centers (FQHCs) are hiring CHWs to address social drivers of health (SDoH) in their integrated medical, behavioral health and dental practices.
- There are multiple opportunities for CHWs to move beyond a general job description to specialization in areas such as population health/quality assurance, behavioral health, and school-health
- This innovation addresses workforce challenges in primary care, while also providing new career opportunities for those interested in joining the field of health care and gaining valuable experience

Introductions

- Matty Knowles CHW HOME program, PCHC
- Shane Gero-Lewis CHW HOME program, PCHC—largest health center in the state
- Yessenia Argudo, Downeast Program Manager. Maine Mobile Health Program—smallest health center in the state
- Lisa Tapert, Tapert Group

A Day in the Life of a CHW—Penobscot Community Health Care (PCHC) -- Housing, Outreach, Member Engagement (HOME) Program

- Average day
- Referrals
- Who receives services?
- Social Driver of Health screening
- Boundary setting
- Supervision
- Behavioral health services
- EMR
- Close



Program Brochure--PCHC

Goals of the HOME Program:

- Care management services to facilitate access to and maintenance of housing
- Support and strengthen coordination between primary care and behavioral health
- Decrease preventable hospitalizations and emergency room visits
- Reduce barriers to timely access to services



Care Management is a team of patients, providers, and community resources working together to identify needs and overcome barriers to achieve personal health goals through support, empowerment, and education.



For more information about
The HOME Program Team

Call us today at:
207.992.9200 EXT: 2258

Housing Outreach & Member Engagement (HOME)



Care Management
Bringing Our Patients
Medical and Social Support
into their Home!

Housing Outreach and Member Engagement (HOME)

WHAT IS THE HOME Program?

A Community Care Team
MaineCare Program

HOME services are a team-based, innovative, integrated, health home service model that is whole-person-oriented and designed to improve health outcomes and care experience.

HOME Program provider teams deliver comprehensive care management services to facilitate access to behavioral health care, medical care, and community-based social services, including housing.

Components of HOME Services:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care
- Individual and family support
- Referral to community and support services

Improved Health Outcomes:

People experiencing homelessness and unmet health-related social needs face obstacles to accessing health care services and managing their health conditions. HOME services provide supports and referrals to address these needs both before and after housing is obtained to support improved health outcomes and housing stability.

Improved Patient Experience

The roles of peer supports, community health workers, and housing navigators with training and lived experience are part of the HOME provider team. These roles are identified as valuable for successful outreach and health promotion.

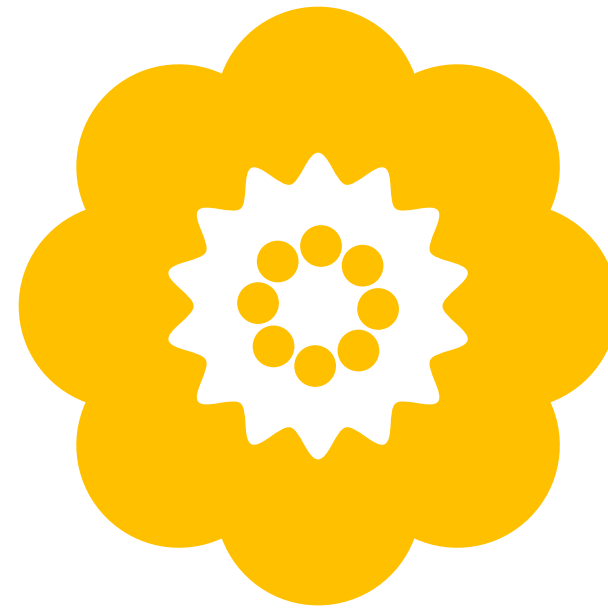
The HOME Program

The HOME Program Team at PCHC identifies and works with adult and youth clients with a history of homelessness

A Day in the Life of a CHW—Maine Mobile Health Program

A CHW- and patient-centered health center

- Average Day
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Program Brochure—MMHP

MAINE MOBILE HEALTH PROGRAM

A federally qualified health center supporting Maine's farmworkers, seafood processors, and their families



Our team collaborates on an integrated model of care that aims to be patient-centered, linguistically appropriate, and culturally sensitive.

We work to reduce health disparities and inequities of access by focusing on social determinants of health, community outreach and engagement, and advocacy.

WHO WE ARE:

A COMMUNITY NETWORK

MEDICAL PROVIDERS



COMMUNITY HEALTH WORKERS



BEHAVIORAL HEALTH PROVIDERS



ADMINISTRATIVE STAFF



WHO OUR PATIENTS ARE





MAINE MOBILE HEALTH PROGRAM
PROVIDING QUALITY, AFFORDABLE CARE
WHERE YOU ARE
WWW.MAINEMOBILE.ORG

WHAT WE OFFER

- Mobile primary care (preventative and acute)
- Referrals for dental, vision, and specialty care
- Prescription assistance
- Chronic disease management
- Brief interventions and long-term therapy
- Accompaniment
- System navigation
- Emergency case management
- Social and emotional support
- Health education
- Cultural brokering
- Interpretation
- Transportation
- Payment for care
- Connections to resources

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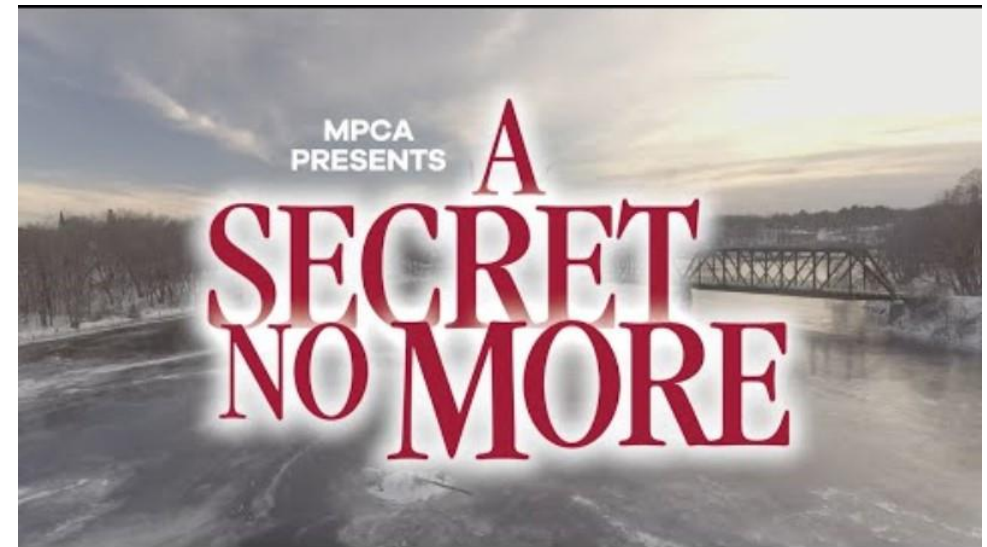
mepca.org

Interested in more information about careers in FQHCs?

Contact:

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