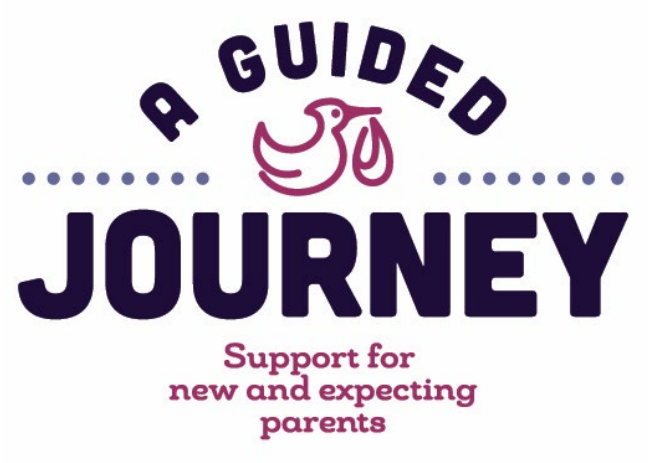


# COMMUNITY HEALTH WORKERS
## ADDRESSING HEALTH DISPARITIES IN MECKLENBURG COUNTY

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CARE RING


CARE RING

# IN PARTNERSHIP

*Disclaimer: The findings and conclusions in this presentation are those of the author(s) and do not necessarily represent the views of Mecklenburg County or Care Ring.*

# KEY DEFINITIONS

- **Health disparities** refer to differences in health and health care between groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion [1]
  - A health care disparity typically refers to differences between groups in health insurance coverage, access to and use of care, and quality of care [1]

1. Kaiser Family Foundation. (2021, May 11). Disparities in Health and Health Care: 5 Key Questions and Answers. https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/

# KEY DEFINITIONS

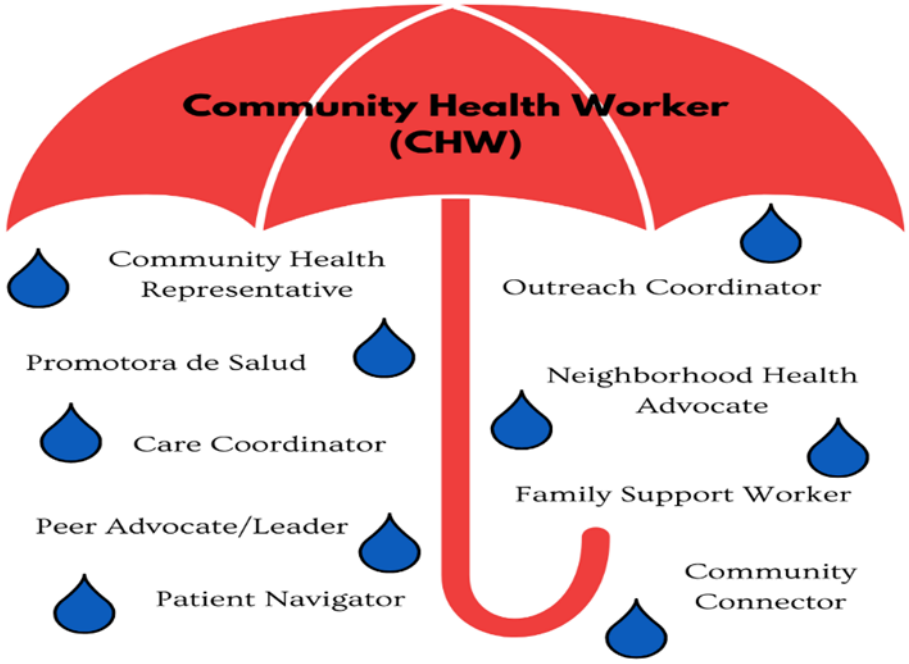
- A **community health worker (CHW)** is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery [1]
  - A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy [1]

***Adapted definition***

- A frontline public health worker who is a trusted member of and/or has an intimate understanding of the community served. This relationship enables the CHW to serve as a bridge or link between health and social services to facilitate better access to care by improving the quality and cultural competence of service delivery

1. American Public Health Association. (n.d.). Community Health Workers. https://www.apha.org/APHA-Communities/Member-Sections/Community-Health-Workers

# CHW INCLUDES A RANGE OF NAMES



# CHW SCOPE OF WORK

- Cultural Mediation
- Health Education and Information
- Service Coordination and Navigation
- Coaching and Social Support
- Advocacy
- Individual and Community Capacity
- Direct Service
- Individual and Community Assessments
- Outreach
- Evaluation and Research

# SCOPE OF WORK VARIES BY SETTING

- Hospitals and health systems
- Community-based organizations
- Local health departments
- Refugee Camps
- Faith-based organizations
- Homeless shelters
- Food Pantries

# BACKGROUND

- The COVID-19 pandemic has drawn new attention to and compounded existing disparities in health and health care, where minoritized and socioeconomically disadvantaged groups have borne a disproportionate burden of severe illness, hospitalization, and death [1,2]
- These disparities differ between groups and stem from broader inequities linked to social, economic, and/or environmental disadvantage that inhibits an individual from achieving the highest level of health [3]

1. Kaiser Family Foundation. (2020, October). Race, Health, and COVID-19: The Views and Experiences of Black Americans. https://files.kff.org/attachment/Report-Race-Health-and-COVID-19-The-Views-and-Experiences-of-Black-Americans.pdf
2. Pressman, A. R., Lockhart, S. H., Shen, Z., & Azar, K. M. J. (2021). Measuring and promoting SARS-CoV-2 vaccine equity: Development of a COVID-19 vaccine equity index. Health Equity, 5(1), 476-483. https://doi.org/10.1089/heq.2021.0047
3. Centers for Disease Control and Prevention. (2022, March 3). Health Equity. https://www.cdc.gov/chronicdisease/healthequity/index.htm

# BACKGROUND

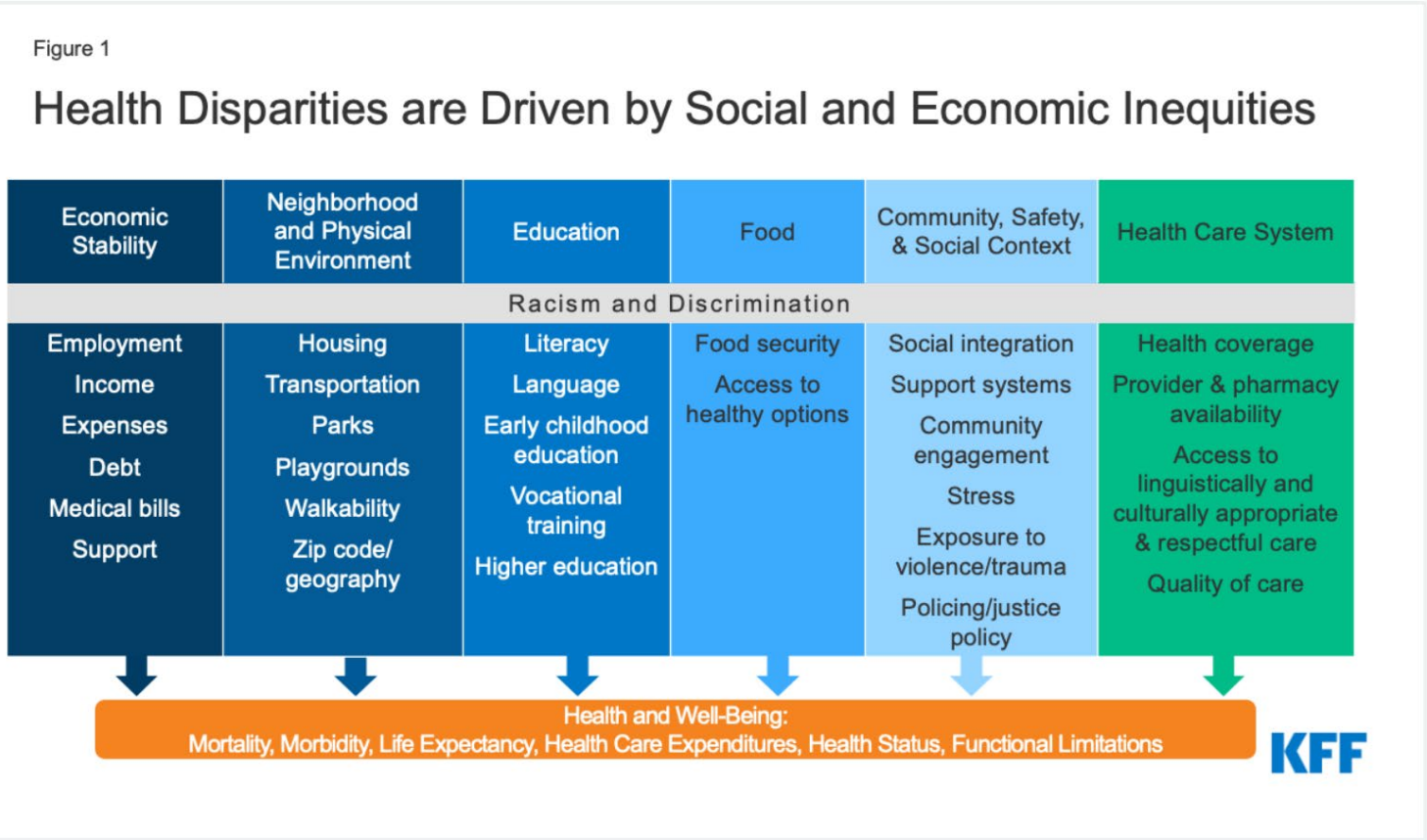



**Figure 1: Health Disparities are Driven by Social and Economic Inequities**

Kaiser Family Foundation. (2021, May 11). Disparities in Health and Health Care: 5 Key Questions and Answers. https://www.kff.org/racial-equity-andhealth-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/

# BACKGROUND

- Infant Mortality
- Pregnancy-Related Deaths
- Prevalence of Chronic Conditions
- Overall Physical and Mental Health Status

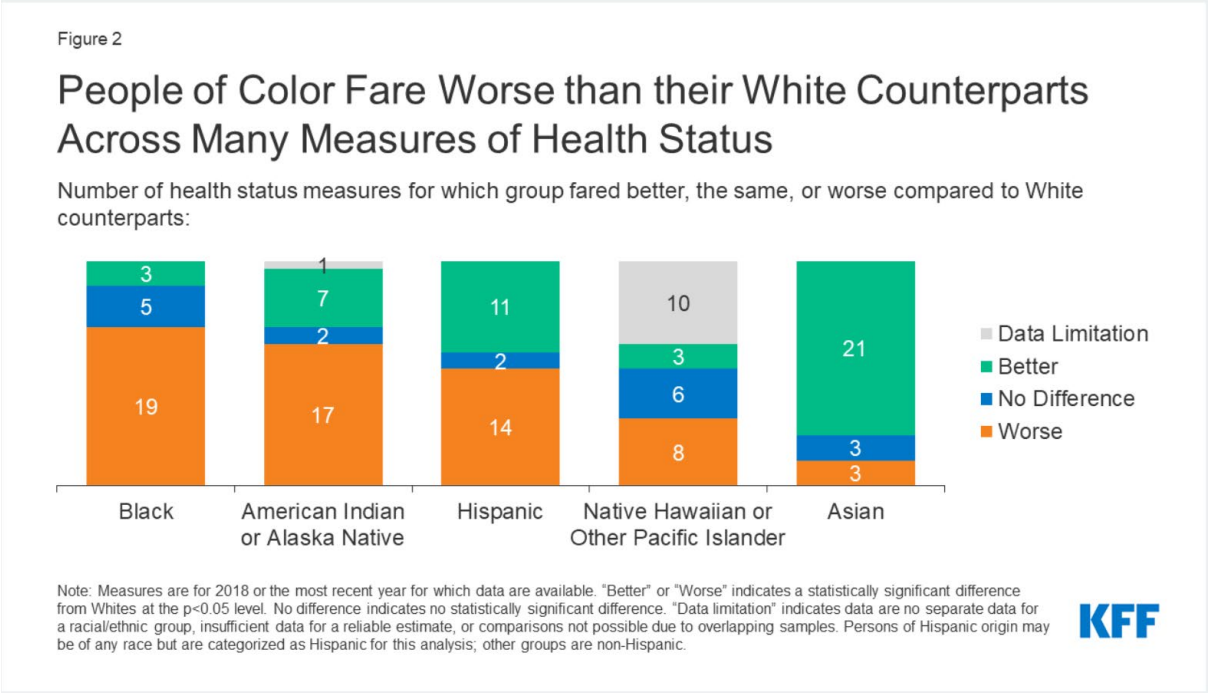



**Figure 2: People of Color Fare Worse than their White Counterparts Across Many Measures of Health Status.**

Kaiser Family Foundation. (2021, May 11). Disparities in Health and Health Care: 5 Key Questions and Answers. https://www.kff.org/racial-equity-andhealth-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/

# BACKGROUND

- Data from the National Center for Health Statistics show that maternal deaths in the first months of the pandemic increased by 33% and was even higher in Black and Hispanic women [1]
- While COVID-19 was listed as the secondary cause of death, other direct causes point to diabetes in pregnancy (95.9%), high blood pressure (39.0%), and other pregnancy-related conditions (48.05) [1]
  - Other factors influence pregnancy-related health outcomes, such as: race and ethnicity, age, and socioeconomic factors, such as income level, educational attainment, medical insurance coverage, access to medical care, pre-pregnancy health, and general health status [2]

1. Thoma ME, Declercq ER. All-Cause Maternal Mortality in the US Before vs During the COVID-19 Pandemic. JAMA Netw Open. 2022;5(6):e2219133. doi:10.1001/jamanetworkopen.2022.19133
2. Maternal, Infant, and Child Health. Maternal, Infant, and Child Health | Healthy People 2020. https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Maternal-Infant-and-Child-Health/determinants#:~:text=Determinants%20of%20Maternal%2C%20Infant%2C%20and%20Child%20Health&text=These%20include%20race%20and%20ethnicity,health%2C%20and%20general%20health%20status. Accessed July 22, 2022.

# BACKGROUND

- Community health workers (CHWs) have received national recognition for reducing health disparities in underserved and minority communities across the United States
- Recently, CHWs have played a vital role on health and social care teams by bridging the gap of community and clinical needs while combatting the CV-19 pandemic
- Their role and rapid response highlight the many ways CHWs help serve our communities as it relates to addressing high priority public health issues and health care needs in the Charlotte-Metro community.

# BACKGROUND

- In 2021, Mecklenburg County Health Department leaned into how health systems can integrate social care (i.e., services that address health-related social risk factors and social needs) into clinical and community settings by implementing *A Guided Journey*
- This program was launched as part of Mecklenburg County's priority funding to address health disparities among mothers and families in designated public health priority areas
- Using the **CHW model**, the programs links women to prenatal and postpartum care and other supportive services as an effective strategy to improve maternal child health disparities and outcomes in Mecklenburg County

# OVERVIEW OF CHW MODELS

There are several types of CHW program models that vary based on the services provided, the patients and community members served, and the overall goals of the health program [1]

A. Promotora de Salud/Lay Health Worker Model
   - ✓ CHWs are members of a target population with specialized training to provide health education

B. Member of Care Delivery Team Model
   - ✓ CHWs work alongside medical professionals to address health issues

C. Care Coordinator/Manager Model
   - ✓ CHWs help patients with complex health conditions navigate healthcare systems

D. Screening and Health Educator Model
   - ✓ CHWs deliver screenings and health education to a priority population

E. Outreach and Enrollment Agent Model
   - ✓ CHWs are responsible for providing outreach and enrollment to a priority population

F. Community Organizer and Capacity Builder Model
   - ✓ CHWs promote community action and build community support for new activities

1. Rural Health Information Hub. (2020, September 8). Module 2: Community health worker program models - RHIhub toolkit. https://www.ruralhealthinfo.org/toolkits/community-health-workers/2/program-models

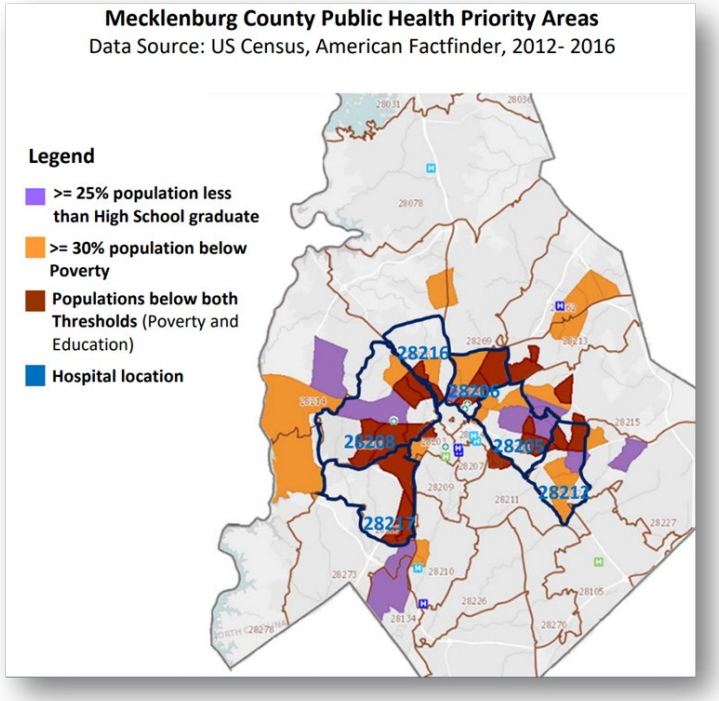
# CARE RING'S APPROACH

- A healthy pregnancy is one of the best ways to promote healthy families in Mecklenburg County
- Early and regular prenatal and postnatal care is an important step

# A GUIDED JOURNEY OVERVIEW

- Team Makeup
  - Program Director
  - Program Supervisor
  - 8 Community Health Workers
- Components
  - A Compliment to Nurse-Family Partnership
  - Bilingual
  - Culturally Competent
  - Priority Health Zip Codes (28205, 28206, 28208, 28212, 28216, and 28217)
- Goals and Outcomes
  - Prenatal
  - Postpartum
  - Early Childhood

# MECKLENBURG COUNTY PUBLIC HEALTH PRIORITY AREAS




- 28205
- 28206
- 28208
- 28212
- 28216
- 28217

People with less education and income tend to live in neighborhoods that lack access to nutritious foods and safe places to exercise. In addition to facing increased advertisements of tobacco, alcohol and high-calorie foods, residents of low-income neighborhoods may also be exposed to risk factors that increase their chances of chronic diseases later in life.

# NURSE FAMILY PARTNERSHIP

- Nurse Family Partnership (NFP) serves low-income pregnant individuals with previous live births who are at risk for poor birth or child health outcomes
- The nurses work with the families until the child turns two
- NFP offers more in-depth clinical approaches to address maternal child health disparities
- NFP home visits occurs:
  - Once a week for 4 weeks
  - Every other week until delivery
  - Once a week after delivery until 6 weeks post-partum
  - Every other week until the child is 22 months

# A GUIDED JOURNEY

- A Guided Journey (AGJ) is a maternal and child health program supported by the Mecklenburg County Community Health Worker Initiative, aimed to support pregnant women and women who are at least three months postpartum with linkage to community resources, medical home and education
- The CHW works with the families until the child turns three
- AGJ focuses on social determinants of health
  - Economic Stability
  - Neighborhood and Physical Environment
  - Education
  - Food
  - Community, Safety, and Social Context
  - Health Care System
- The CHW lives and work within the community served
- AGJ home visits occurs once monthly (or more depending on the need until the child is 36 months)

# DIFFERENCE BETWEEN NFP AND AGJ

## NFP

- Works with the family until the child turns two
- Focuses on clinical approaches
- Home visits occurs:
  - Once a week for 4 weeks
  - Every other week until delivery
  - Once a week after delivery until 6 weeks post-partum
  - Every other week until the child is 22 months

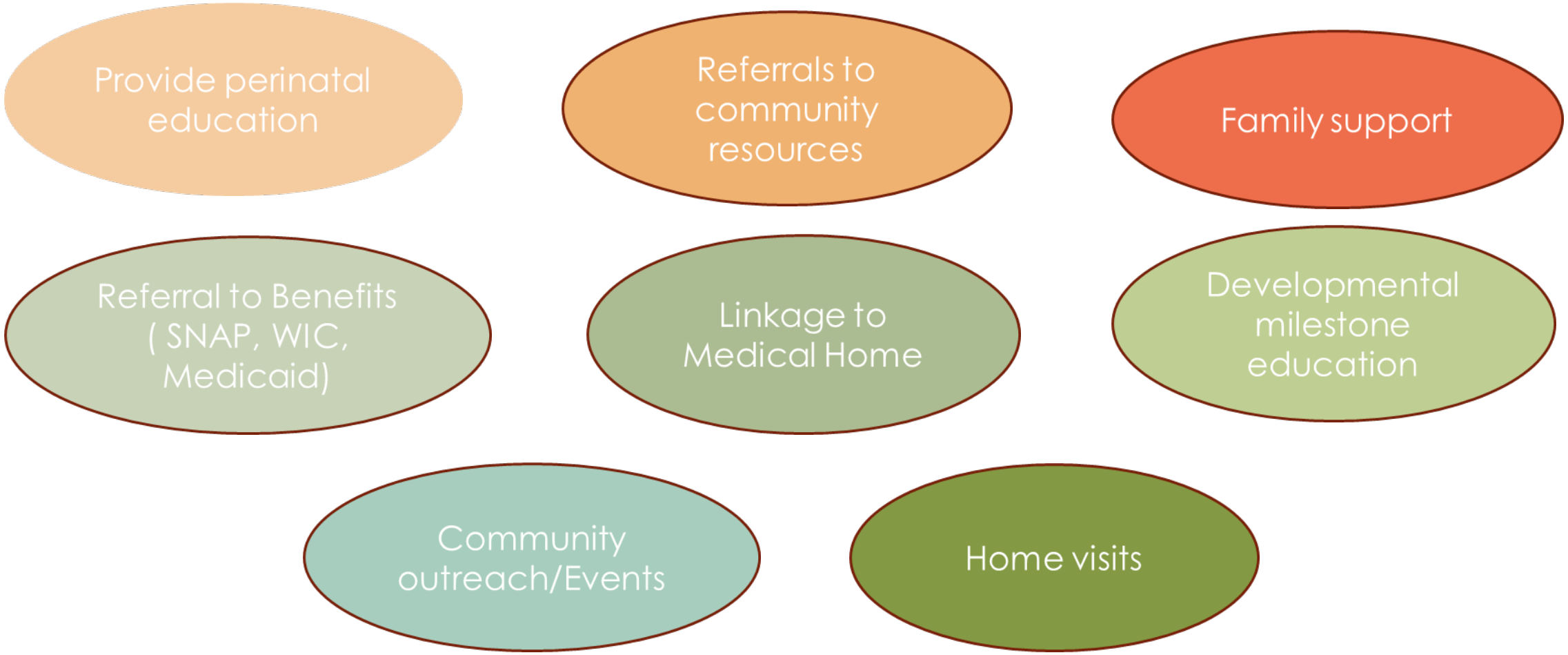
## AGJ

- Works with the family until child turns three
- Focuses on community approaches
- Home visits occurs:
  - Once monthly (or more depending on the need until the child is 36 months)

# ELIGIBILITY REQUIREMENTS

- Women who are pregnant or are at least three months post partum
- Income is 200% below federal poverty guidelines
- Resides within Mecklenburg county or the priority zip codes

# WHAT OUR CHWS DO



# PROGRAM OUTCOMES

| MEASURE | ACTUAL | STATE |
|---|---|---|
| % of Care Plan with at least One Goal Completed | 80% | N/A |
| % with Medical Home | 83% | 43%[2] |
| % Completing Postpartum Visit within 6 Weeks of Delivery | 86% | N/A |
| % Reporting Ever Breastfeeding | 85% | 73%[2] (LOW-INCOME) |
| % Screened for Postpartum Depression | 96% | N/A |
| % of Healthy Birth Weight Births | 93% | 90.7%[2] |

**Notes:**

- **55% of moms were uninsured and 42% have Medicaid**
- **68% received food assistance referrals**

# REFERRAL

- A referral can be made by scanning the QR code on our program flyer or calling (704) 248-3744
- Client can self refer into the program
- Agencies can also refer clients by completing the printed referral form or by using the QR code



# COMMUNITY ENGAGEMENT

# QUESTIONS