2019

# Community Health Worker's Perceptions of Integration into the Behavioral Health Care System

Juliette Swanston Jenkins
*Walden University*

# Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Juliette Swanston Jenkins

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Anne Hacker, Committee Chairperson,
Public Policy and Administration Faculty

Dr. Linda Day, Committee Member,
Public Policy and Administration Faculty

Dr. Frances Goldman, University Reviewer,
Public Policy and Administration Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2019

Abstract

Community Health Workers' Perceptions of Integration into the Behavioral Health Care System

by

Juliette Swanston Jenkins

MSN, University of Maryland

BSN, University of Bridgeport

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy and Administration

Walden University

May 2019

## Abstract

Mental illness in the United States is a major public health problem. According to the Substance Abuse and Mental Health Services Administration, in 2017, 18.9% of adults in the United States had a mental illness. The purpose of this study was to gain insight into the perceptions held by community health workers (CHWs) regarding their integration into the behavioral health care system in Maryland. Using a social constructivism paradigm and phenomenological approach, a purposive sample of 11 CHWs who supported patients with behavioral health conditions in 17 counties in the state were interviewed. Howlett, McConnell, and Perl's five stream confluence policy process theory and Lipsky's street level bureaucracy theory provided the foundation to explore the perceptions of the CHWs about their integration into the behavioral health care system; the problems, policies, processes, and programs that impacted their ability to be integrated into the behavioral health team; and their function as a street level bureaucrat to facilitate their integration. A deductive iterative coding approach was used, culminating in the identification of the following 6 themes: health system utilization of CHW behavioral health integration, official policy recognition of the CHW profession, accountability for CHW integration, CHW practice support, integrated health care team management of physical and mental health and behavior, and building the CHW profession. The social change implications of this study are that CHWs' integration into the broadly defined, integrated, physical and mental behavioral health team can support having a more cost-effective way toward having healthy people and communities because they link the community to health and social services and advocate for quality care.

# Community Health Workers' Perceptions of Integration into the Behavioral Health Care System

by

Juliette Swanston Jenkins

MSN, University of Maryland

BSN, University of Bridgeport

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Policy and Administration

Walden University

May 2019

# Dedication

This dissertation is dedicated to the expansion of the integration of behavioral health care into the delivery of patient-centered care in the United States health care system. I also want to dedicate this dissertation to all those who are living with behavioral health conditions and their families and others who provide support. It is my hope that our healthcare system evolves so that behavioral health is given parity with physical health to improve access to integrated, patient-centered, quality health care.

Acknowledgments

First and foremost, I want to thank God for enabling me to earn my doctorate and still have a reasonable portion of my physical, mental, and emotional health. I want to thank my husband, George Jenkins, who has been an academic widower for the last six years. He was a pillar of support throughout my pursuit of my doctorate. I also want to express my appreciation for my son, Dyami' Jenkins; his wife, Michelle; my son, Brahn Jenkins; his wife, Fatma, and my grandson, Isaac. Although my time was often limited, they made my time away from school work some of the most carefree and enjoyable moments. A special thanks goes to Brahn for supporting me through my graphic and computer technology challenges during this experience. In addition, I want to thank God, my sisters, and my church family and friends for their prayers and encouragement throughout my studies. For this, I appreciate you and give you a special thank you. I want to also acknowledge my parents who were champions of education, and I can imagine their pride in this accomplishment, if they were still here.

I want to thank the community health workers who took time out of their busy schedules to contribute their perspective of their role and its integration into the behavioral health team, which was critical to this study. A special acknowledgement goes to my colleagues who passionately journeyed with me as dedicated champions for improving public health across the United States and globally, leading up to the completion of my dissertation.

Finally, I want to express my sincere gratitude to my dissertation committee chair, Dr. Anne Hacker, who demonstrated scholarly excellence in guiding me through my

doctoral journey and helping expand my vision for my future scholarly pursuits. I also want to thank my committee member, Dr. Linda Day, and the university research reviewers, Dr. Frances Goldman and Dr. Hector Antunez, for their meaningful insights regarding my dissertation.

Table of Contents

List of Tables

List of Figures

# Chapter 1: Introduction to the Study

## Introduction

Transitioning to the community after a behavioral health hospitalization can be a challenge. Having community health workers (CHWs) integrated into the behavioral health care team is critical to people being able to effectively manage their behavioral illness in their community. Without the support of a family member or other advocate, such as a CHW, persons with behavioral illnesses are at risk of being rehospitalized within 30 days of discharge (Heslin & Weiss, 2015). This risk creates an emotional, social, and economic burden on the person with the behavioral illness, their family, the behavioral health care system, and the community.

The transition of a patient from a structured, behavioral health, inpatient setting to successful community living and preventing rehospitalization requires support from their family and/or health care or social services systems. A CHW can play a role in fostering behavioral health and provide a bridge between recipients of behavioral health care services, the community, and the health care system (HCS) to facilitate the management of care to prevent rehospitalizations for behavioral illnesses (Snyder, 2016). The cost of health care is high, the need for services is increasing, there are limitations in the health workforce, and there is some reluctance and/or inability to access behavioral health care in some communities (Institute of Medicine, 2003). A CHW is able to deliver culturally sensitive care and share their expertise with the behavioral health team. In addition, a CHW is also a less costly team member, compared to a community health nurse, to support a behavioral health team that already has a nurse (U.S. Department of Labor,

2019a, 2019b). In order to perform this role, the CHW would need to officially be a member of the behavioral health care team. Understanding CHWs' perceptions could provide clearer insight into how to make the CHW a viable member of this team.

Most of the literature regarding the role of a CHW predominantly reflected the research, analysis, and perspectives of public policy leaders, researchers, administrators, clinicians, and academicians regarding CHWs and not CHWs themselves. Understanding and engaging CHWs in a dialogue about their roles and associated policies and programs is a foundation that would facilitate CHWs being accepted as viable team members that could make major contributions to the behavioral health team and community (Maes, Closser, & Kalofonos, 2014). Maes et al. (2014) suggested that an ethnographic study of CHWs, policy makers, and supporters of CHWs should be performed. The foundation of understanding all perspectives on CHWs could facilitate the building of relationships that support the integration of CHWs into behavioral health teams.

Having CHWs share their perceptions of being integrated into the behavioral health system could provide insights into needed policies and possible processes to make this occur. Leaders, in consultation with CHWs, could develop and/or identify existing practical policies that facilitate the integration of CHWs into the behavioral health systems and share this information with other organizations or systems. Other systems and entities could possibly leverage this knowledge gleaned to truncate the exploratory process to determine what steps they need to take in their organizations and systems to facilitate CHW integration into the behavioral health team and support making their communities healthier.

In this chapter, I provide the background for this study with a description of the literature that demonstrates the nature and scope of the issue of the integration of CHWs into the behavioral health system. CHWs' role in the community and outpatient setting to prevent readmissions for mental illness and substance use disorder (SUD), also known as behavioral illnesses, is also addressed. The composition of the behavioral health care team, including CHWs, that may effectively support the prevention and management of mental illness and SUD in community and outpatient settings needs to be documented in the literature so that others seeking to integrate CHWs into the behavioral health system could leverage this information.

In this study, I used a phenomenological approach, which involved searching for understanding of the essence of experiences. I took into consideration the environmental, social, and political factors as well as HCS roles that would impact or be impacted by the integration of CHWs into the behavioral health system. The styles of building relationships, negotiating and compromising for CHWs, policy makers, and contributors were considered in obtaining insight into the integration of CHWs into the behavioral health care team (see Maes et al., 2014). In addition, I explore the policy process and the mechanisms and procedures that need to be established, including the lessons learned, for use by other HCSs to efficiently and effectively establish similar teams tailored to their environment.

The social change implications of this study are that the contributions of CHWs as a member of the behavioral health care team can be leveraged, allowing for task shifting from highly trained professional team members to CHWs, as appropriate. This

leveraging could improve access to primary and secondary preventive behavioral health care in the community and prevention of initial admissions and readmissions, which are costly. This could reduce the tremendous economic burden and stress on the HCS as well as the financial, social, and other challenges for patients, their families, and their communities. In addition, the integration of CHWs into the behavioral health system will impact the other members on the health care team. Preventing mental illness and reducing the need for readmissions for people living with mental illness and SUD through the integration of CHWs into the behavioral health system could be a less costly way to improve the status of the social determinants of health in communities and could also reduce public's share of the costs to support the HCS and public health.

## Background

Mental illness in the United States is a major public health problem. According to the Substance Abuse and Mental Health Services Administration (SAMHSA; 2018), in 2017, 11.2 million adults, 18 years old or older, in the United States had serious mental illnesses (SMI). In addition, 19.7 million people, 12 years old or older, had a SUD, and 3.1 million adults had a co-occurring SMI and a SUD (SAMHSA; 2018). Heslin and Weiss (2015) indicated that hospital stays for mood disorders and schizophrenia were discharged to home or self-care almost 89% and 78% of stays, respectively; however, with non-mental illness/SUD, only 62% were discharged to home or self-care. A similar trend was noted with referrals to home health care.

Hospital stays with a principal diagnosis of schizophrenia or mood disorders had 1.0–1.6% referrals to home health care, whereas non-mental illness/SUD hospital stays

had 14.1% referrals to home health care (Heslin & Weiss, 2015). Even more compelling, Heslin and Weiss (2015) stated that the rate for readmissions of patients with schizophrenia and mood disorders within 30 days of an initial hospitalization was 12.6%. This rate was 46% higher than the 8.7% rate for non–mental illness/SUD stays (Heslin & Weiss, 2015). These readmissions created an economic burden on the HCS.

Insurance companies and hospitals alone cannot tackle this economically urgent dilemma by restricting spending. The needs of the community must be anticipated into the future to achieve cost containment. A community is a collection of people with varied features who are connected socially, share mutual perceptions, and participate collectively in geographical locations or environments (MacQueen et al., 2001). It will take the community, in collaboration with the HCS, to create a remedy for evolving into a healthy community that plays a role in the prevention of behavioral illness and readmissions (Standley, 2016).

CHWs can play a key role in primary and secondary prevention to prevent illness and avoid readmissions of people with behavioral health illnesses. Facilitating the transition of CHWs into the behavioral health system, in collaboration with the HCS, should be explored. According to the Centers for Disease Control and Prevention (CDC, 2019), primary prevention is the avoidance of the development of a disease or condition, which would reflect a healthy community, which is the ultimate goal. Secondary prevention is the early detection and treatment of an illness or disease to reduce its impact (CDC, 2019). Secondary prevention can be useful in preventing readmissions for behavioral health illnesses.

Evidence of the implementation of processes that support CHWs functioning at their greatest capacity on a physical and mental behavioral health team is still needed. The existing scholarly literature in the field addresses capacity building through team-based, integrated, interprofessional training of the health workforce (Fricchione et al., 2012; Sapag, Herrera, Trainor, Caldera, & Khenti, 2013; Swartz, Kilian, Twesigye, Attah, & Chiliza, 2014). Wennerstrom, Hargrove, Minor, Kirkland, and Shelton (2015) discussed the development of CHWs' capacity through training and functioning in an integrated physical and mental behavioral health team. They revealed that further work is needed to refine and test a care team model that utilizes CHWs to their full potential. However, how the health care system can change to support CHWs to fully use their skills on these teams has not been adequately addressed in the literature. With this study, I addressed the interprofessional delivery of team-based, integrated, physical and mental behavioral health care services that include CHWs as a member of the team. CHWs' integration into the team could facilitate the addition of client input along with the team members to support a more cost-effective way to deliver patient-centered care.

Mental illnesses and SUDs are creating an increasingly heavy burden on the United States with community needs for care outpacing the supply of an adequately prepared level and type of health workforce and service delivery models (Lake & Turner, 2017). Without adequate community supports to successfully foster mental health, prevent hospital admissions, and facilitate successful transitions from hospitals back to the community, the HCS is being challenged to improve the scope and quality of their behavioral health and SUD services and reduce health care costs. To address these

challenges, the 21st Century Cures Act (2016) dedicated numerous titles to address various aspects of mental health, SUD, and associated criminal justice system involvement.

## Problem Statement

The problem addressed in this study was the need to provide community supports to prevent mental illness and/or support clients living in the community with mental illness to effectively manage their health to prevent hospitalizations. In the event that they are hospitalized, there needs to be support for successful transition from the hospital to the community and stabilization in the community to prevent rehospitalizations. There is also a need in the community to understand how to prevent mental illness or to intervene early to prevent mental health crises. This early intervention could reduce medical costs. One viable alternative to address this need is to utilize CHWs as part of the behavioral health team. However, the integration of CHWs into the behavioral team has been slow to be implemented effectively. In this study, I explored the perceptions of CHWs related to their integration into the behavioral health care system and their capacity to improve access to care through the delivery of behavioral health services. In addition, the study was based on the roles of the interprofessional, integrated health care team in the outpatient practice setting. Themes that contributed to the capacity to deliver behavioral health services were identified.

Primary and secondary preventive services are not readily accessible to the community to facilitate the prevention of admissions and the readmissions for behavioral health illnesses (Kripalani, Theobald, Anctil, & Vasilevskis, (2013). Fricchione et al.

(2012) noted that researchers have not indicated the particular team roles, such as physicians and nonphysicians, specialists, generalists, and CHWs, that are the most effective and efficient in improving access to behavioral health services. This information could possibly be used to quickly put mechanisms in place in outpatient and community settings to address the increased need for primary and secondary prevention of behavioral illnesses.

According to the U.S. Department of Labor, Bureau of Labor Statistics (2019a), a CHW is a person who "assists individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health." (para. 1). Section 5313 of the Patient Protection and Affordable Care Act (2010) requires the director of the CDC to administer grants for CHWs. The CHWs are to provide services in their community to medically underserved populations to foster positive health behaviors and outcomes and improve the health of the community (p. 634). This law further indicates that CHWs are to be the liaison between the community residents and the HCS. While the literature focused predominantly on the role of CHWs with medical conditions, there were examples of CHWs providing support for behavioral health services. These examples indicated that CHWs have the ability to support the unmet needs in the community for primary and secondary prevention services for substance use, psychosocial, psychological, mental, and neurological disorders (Matumba, Ginneken, Paintain, Wandiembe, & Schellenberg, 2013; van Ginneken et al., 2013). These types of services have the potential to provide support that is needed to

prevent readmissions for behavioral health care services. Brooks et al. (2018) emphasized a growing body of evidence on the value of using CHWs and the movement toward them having the capacity to work on more than one type of health condition, which results in better-integrated, less-fragmented services, an increase in efficiency, streamlining of communication, and less frustration for the patient and the CHW. However, the authors noted that the emphasis is on medical conditions and not behavioral health.

## Purpose of the Study

The purpose of this study was to describe CHWs' perceptions of their integration into the behavioral health care team in the state of Maryland. As frontline workers, CHWs are in the position to use their clinical expertise, understanding of the needs of service recipients, and how they align their values with the organization's priorities to make decisions; these decisions can then be evaluated to determine if they are appropriate (Vinzant & Crothers, 1996). In addition, CHWs could refer patients to the behavioral health care team when a crisis may be imminent, which could lead to improving access to services and preventing readmissions. The integration of CHWs into the behavioral health care team to perform secondary prevention of behavioral illness could minimize the use of limited resources while improving access to behavioral health services. This integration can also support administrators in considering this information in recruiting and/or training staff with the necessary skillsets to support the capacity building of mental health care services delivery. The first step was to determine the existence of an outpatient, team-based, behavioral health care delivery model that uses CHWs who are

integrated into the HCS in Maryland.

## Research Questions

The three research questions that guided the inquiry into the participants' perceptions of their integration into the behavioral health care system were:

Research Question 1: What are the perceptions of CHWs related to their integration into the behavioral health care team?

Research Question 2: How do problems, policies, politics, programs, or processes impact CHWs' ability to be integrated into the behavioral health team?

Research Question 3: How do CHWs view their function as a street level bureaucrat (SLB) to support integration into the behavioral health care team?

## Theoretical and Conceptual Frameworks

I used the five stream confluence model (5SCM) developed by Howlett, McConnell, and Perl (2015) as the theoretical framework in this study. This model, which is an expansion of Kingdon's (1984) multiple streams approach (MSA), provided me with a thorough foundation through which to explore the evolution of the policy process. It consists of five streams or paths through the policy process, including problems, policies, politics, processes, and programs, and are appraised in the context of one of the five streams being predominant in their influence on the process. Once the appraisals are completed, stakeholders consider how new programs need to be integrated into existing ones to develop a policy recommendation for decision making. Stakeholders collaboratively make the final policy decision. Once the decision is made, the policy is ready for implementation, which is the culmination of Howlett et al.'s

(2015) 5SCM. This policy is then passed on to an implementation organization.

A SLB is one who has a level of independence in performing their duties in interacting with the public and, therefore, influences the policies of the organization for which they work (Lipsky, 2010). The implementation organization establishes programs, policies, and processes in preparation for the SLB to implement. Lipsky's (1980) SLBs are the people on the front line of the delivery of services who are expected to implement the policies that politicians and government leaders have developed. The policies and regulations allow the SLB a range of discretion in implementing the policies, which can create challenges in consistency of administering the laws. The CHW functions in a SLB role, which made this theoretical framework relevant to my analysis of the CHWs' perceptions in this phenomenological study.

Social constructivism takes into consideration each individual's personal experience and the meaning they ascribe to the experiences and interactions (Patton, 2015). This study was grounded in the social constructivism paradigm. Since Kingdon (1984) developed the MSA, there have been modifications to this framework that expanded on the MSA to bring further clarity (Zahariadis as cited in Sabatier, 2014). The 5SCM that Howlett et al. (2015) created is a refinement of the MSA. This theoretical framework was appropriate for this study because it provided the conceptual foundation for agenda setting, policy formation, decision making, and policy settlement, leading to policy implementation and organizational systems change recommendations in this study.

Howlett et al.'s (2015) 5SCM identified an increased level of analysis, adding process and program streams to Kingdon's (1984) MSA, which included problem, policy,

and political streams. This model introduced the concept of stream dominance. It means that several streams may occur concurrently, while a stream could influence the flow, dynamics, and interactions of the other streams, reflecting their interdependency and change (Howlett, et al., 2015). These changes have occurred in organizations with community health programs that successfully implemented the Patient Protection and Affordable Care Act (2010) related to CHWs in the primary and secondary prevention of readmission of persons with behavioral illnesses; therefore, I determined that the 5SCM was appropriate to guide the analysis of this study.

The 5SCM suppositions provided me with the opportunity to determine what systems changes are needed to integrate CHWs into the HCS to support the delivery of primary and secondary behavioral health services and also showed the skills and activities necessary to address challenges and to effectively execute the change. The key concept that I investigated was the CHWs' perception of how they are integrated into the behavioral health care team. I anticipated that the CHWs' perceptions could provide insights into what indicators could be used to determine the successful integration of CHWs into a behavioral health team.

Lipsky's (1980) SLB theoretical framework played an additional role in the policy implementation process. Since they are on the front line, SLBs are in one of the best positions to provide feedback on the policy that had to be implemented. They are able to share their experiences with discretionary leeway, which can result in feedback to indicate whether a policy needs to be more specific or allow the SLB more discretion to be responsive to the needs of the population that they serve (Lipsky, 1980). Conversely,

Cooper, Sornalingam, and O'Donnell (2015) indicated that with the decrease in public services, SLBs might be in the position of rationing services to the disadvantaged or an increasing workload.

The Patient Protection and Affordable Care Act (2010) set the foundation for policy change related to community health and the role of CHWs and called for the escalation of the use of CHWs in the HCS. The 5SCM can be used to address government and policy changes, which have to occur to integrate CHWs into the behavioral health system. These modifications needed to be explored to thoroughly demonstrate the dynamics that occur with government and policy changes; therefore, Howlett et al.'s (2015) model continued to be an appropriate framework for this research study with these adjustments. The major proposition for this study was that CHWs will be able to describe how they are integrated into the behavioral health team and that their descriptions could be used to determine what policies leaders need to address to facilitate full integration. In turn, this integration could provide support to the behavioral health team, which would allow the team to focus on more complex issues. This proposition will be discussed in more detail in Chapter 2.

## Nature of the Study

I used a qualitative approach with a phenomenological design in this study. My efforts focused on understanding the roles and involvement of select individuals in the integration of the CHW into the behavioral health care system to facilitate access to services. In order to focus on the CHWs' experiences, I used bracketing. Bracketing is the putting aside of personal perspectives and beliefs to glean themes and patterns of

behavior and their impact on the integration effort and the individuals involved (Patton, 2015). These phenomena could then used to provide insight into other organizations planning to pursue the integration of CHWs into their HCS.

## Definitions of Terms

There are various terms related to HCSs and public health that are intricate, multifaceted, and necessary to understand the integration of CHWs into the HCS. I defined several key concepts that were pertinent to this study as follows:

*Behavioral health*: Substance use and mental health (SAMHSA, 2017).

*Bidirectional integration*: Addressing the need for behavioral health services in primary care settings and the need for primary care services in the behavioral health setting (SAMHSA and Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions, n.d.).

*Community-based worker (CBW):* A CHW focused on the management of chronic disease with people at risk for health disparities (Kim et al., 2016).

*Community health worker (CHW):* "A frontline public health worker who is a trusted member of and/or has an usually 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." (American Public Health Association, 2019a, para. 2).

*Health care system (HCS)*: An organization or a group of organizations that coordinate health care services to provide quality care to persons, as necessary (World Health Organization, 2016, para. 1).

*Integrated care team*: A diverse, interprofessional, healthcare team that collaborates to provide integrated, coordinated, health care services in the planning and implementation and evaluation of a thorough treatment plan to address patients' biological, psychological, and social needs (American Psychological Association, 2017).

*Population health*: The health outcomes of a group and how the health outcomes are distributed among the group (Institute for Healthcare Improvement, 2014).

*Primary prevention*: The avoidance of the development of a disease or condition, which would reflect a healthy community, is the ultimate goal (CDC, 2019).

*Psychiatric readmission*: "An admission to an inpatient psychiatric or acute care hospital within 30-days of discharge from an eligible inpatient psychiatric admission" (Centers for Medicare & Medicaid Services, 2016, p. 9).

*Public health*: The protection and fostering of people's health and the communities they live, learn, play, and work in (American Public Health Association, 2019b).

*Secondary prevention*: The early detection and treatment of an illness or disease to reduce its impact (CDC, 2019). It occurs when those at risk for developing a disease are identified and intervention occurs to minimize the possibility of developing the disease or to minimize progression (Tandon, 2012).

*Serious mental illness (SMI)*: Adults with a mental, behavioral, or emotional illness that restricts their ability to perform one or more main life activities (SAMHSA, 2018).

*Social determinants of health*: Social, physical, cultural, and social surroundings that impact the health status of individuals and communities (U.S. Department of Health and Human Service [DHHS], 2017).

## Assumptions

Assumptions in qualitative research are related to factors that are beyond the control of the researcher but that need to exist in order for the research to be pertinent to the problem (Simon, 2011). I made a few assumptions for this study. In order for CHWs to have perceptions about their role related to their integration into the behavioral health care team, they needed to have experience working with such a team and associated patients; therefore, I assumed that CHWs selected for interviews in this study had experience working with behavioral health care teams and recipients of behavioral health care team services. Another assumption was that CHWs needed to function in a CHW assignment for at least 12 months to allow time to develop their perception about their integration. My interview questions were deliberately opened-ended to draw information from the participants about their lived experience as CHWs. Social constructivism allows for open-ended questions that allow the interviewee the flexibility to discuss the interactions among people and related to practices in the organization (Patton, 2015). I also assumed that this study was grounded in the social constructivism paradigm and was flexible in allowing the participants to expand on areas to give

meaning to the phenonmenon of integration of CHWs into the behavioral health system. Using this interpretation of the paradigm was a critical part of the study in seeking the CHWs' perceptions. My final assumption was that the confidentiality of interviews was critical for the CHWs to feel comfortable providing honest responses to the questions. I took care to ensure anonymity of the CHWs' comments and shared how I would go about doing so with the study participants before they agreed to participate in the study.

## Scope and Delimitations

The scope of a study describes what will be included in the research and what will not be included as part of the study (Simon & Goes, 2013) and is defined by the problem, methodology, conceptual framework, and research methodologies. The research problem that was specifically addressed in this study was the integration of CHWs into the behavioral health system. I specifically selected this problem because it is an area in which there is limited use of CHWs in the United States (see National Academy for State Health Policy, 2018). Readmissions of people with behavioral health disorders were higher for people with behavioral health conditions than for those with medical conditions (Heslin & Weiss, 2015). In addition, Heslin and Weiss (2015) indicated that this population is not referred for home health services upon discharge from the hospital at the same rate as their medically ill counterparts. The results of this study provided general insights into how to successfully integrate CHWs into a HCS and specific information related to the integration of CHWs into a behavioral health team.

## Limitations

A limitation is an aspect of a study that is beyond the researcher's control and

creates a vulnerability in the study (Simon, 2011). One of the limitations of the qualitative phenomenological methodology is that as the researcher, I had to separate my personal experience with the problem being studied. This separation allowed for the perspective of the participants to be fully reflective of their experience related to the problem. Interview questions were carefully articulated to minimize the possibility of introduction of bias (Miles et al., 2014). Epoché was used, which required me to put aside personal experiences and look at the phenomenon with a fresh perspective (see Patton, 2015). Another method to manage personal bias that I used was triangulation, where I looked at different sources for validation of the findings (see Miles, Huberman, & Saldana, 2014). The participants had the opportunity to review their transcripts of their interviews and add information, which was another way to ensure that their statements and perspectives were accurately reflected. Determining if and when I, as the researcher, should share my perspective with the participants being interviewed was also a challenge in negating bias. The measures taken to address these limitations were that I restrained myself from making comments relating to my personal experience or knowledge about the problem. However, when the participants expressed frustration, I sought to clarify what their frustration was about or nodded to express that I understood their frustration during the interview. No other situations arose making it appropriate for me to express empathy or to share my perspective or experience. Another challenge was finding enough people who had experienced the phenomenon and were willing to be interviewed.

Using an interview as a data collection procedure can create ethical issues. One particular ethical concern was the issue of confidentiality. All participants were

explicitly informed about the purpose of the interview, who the information was for and how it will be used, what the content of the interview would be, how the responses from the interview would be handled, and how confidentiality would be managed. The participants were given this information in advance and at the time of the interview, allowing them to ask questions (see Patton, 2015, pp. 497-498).

## Significance

Secondary prevention occurs when those at risk for developing a disease are identified and intervention occurs to minimize the possibility of developing the disease or to minimize progression (Tandon, 2012). CHWs could play a critical role in the primary and secondary prevention of behavioral health conditions, particularly related to preventing relapses to acute mental illness. The CHW could be instrumental in supporting the secondary prevention of mental illness and positively influence the status of the determinants of health. As members of the health care team, they can support the HCS to provide more cost-effective, quality care in the community (Bielaszka-DuVernay, 2011).

## Summary

In this chapter, I introduced the topic of study, which was the perceptions of CHWs regarding their integration into the behavioral health care system. The research problem of the need for better access to quality behavioral health care was discussed and a brief background and problem statement were provided. The purpose of the research was to understand the phenomenon of integration of CHWs into the behavioral health system to identify organizational and policy changes that are needed for this to occur.

The research questions as well as Howlett et al.'s (2015) 5SCM and Lipsky's (1980) notion of the SLB were identified as the theoretical framework for the study The data collection and analysis plan were also presented. I discussed the nature of the study, including the rationale for the design, key concepts, and a summary of the methodology. In addition, the definitions of terms, assumptions, scope, and delimitations were described. Finally, the limitations and significance of the study closed out this chapter. The next chapter includes a detailed review of the extant literature on the topic.

# Chapter 2: Literature Review

## Introduction

The management of SMI continues to be a public health challenge in the United States. A chronic SMI occurs when adults 18 years old or older have been diagnosed with mental, behavioral, or emotional conditions, other than developmental and SUDs, for a prolonged period that meets or restricts one or more major life activities (SAMHSA, 2014). The stigma associated with a SMI has been met with silence in addressing mental illness in our country, until it becomes a crisis. Accompanying this crisis is the financial burden on the HCS and the community as well as the human suffering that comes with not effectively managing this illness. The failure to address this problem impacts the United States' ability to build healthy communities. In this chapter, I explore the literature search strategy; the theoretical foundation and perspective for the study; and key concepts that provide the context for readmissions of persons living with mental illness and SUDs, training and support of CHWs, and integration of CHWs into community systems. The chapter also includes the legislative mandates of the Patient Protection and Affordable Care Act (2010) related to the integration of CHWs into the behavioral health care team in an effort to change HCSs.

Howlett et al. (2015) developed a refinement of Kingdon's (1984) MSA, which is the 5SCM. I used this model as the theoretical foundation for this phenomenological study to analyze the organizational change that occurred in one community with the integration of the CHW. Howlett et al. expanded Kingdon's MSA to go beyond agenda setting and use of the problem, policy, and political streams. Kingdon indicated that

agenda setting was not complete until all three existed simultaneously; however, Howlett et al. added appraisals to address the complexities of agenda setting and completion of policy development by adding two additional streams: process and program streams. In addition, Howlett et al. introduced the concept of a particular stream being predominant among the streams, depending on the nature of the policy being developed. Finally, unlike Kingdon's MSA, Howlett et al.'s 5SCM culminated in a policy ready to be passed on to an implementing organization to execute the policy. Because of this expansion of the policy development process, I used this theoretical foundation to enhance the understanding of CHWs' perceptions of their role in the behavioral health team.

The results of this literature review presented me with insight into the salient issues that impact the integration of CHWs into the behavioral health care team. I reviewed how the various roles participate in or with the behavioral health care team to integrate CHWs into the team. In addition, the CHWs' perceptions of leaderships' roles in ensuring organizational policies are being implemented to support the integration of the CHWs into the behavioral health care team's efforts were explored. I also searched the literature to inform the application of Howlett et al.'s (2015) 5SCM in this study.

## Literature Search Strategy

The databases I used to search the literature were Academic Search Complete, Business Source Complete, EBSCO, ProQuest Central, Sage Premier, Google Search Engine, and Dissertations and Theses at Walden. The terms used to search each of these databases were: *health policy, public policy and administration, the garbage can model, Kingdon, multiple streams, mental health, mental illness, stigma, public health,*

*community health workers,* and *interprofessional health teams.* There was extensive extant literature on the role of the CHW related to various medical conditions; however, there was limited research on the use of CHWs related to behavioral health disorders and applying an expanded MSA theoretical framework model that goes beyond agenda setting into policy to apply to this research topic (see Howlett et al., 2015). Therefore, I used the limited research on CHWs and behavioral health disorders and the MSA and complimented it with literature on the use of CHWs working with populations suffering from conditions other than mental health disorders to inform this study. Some of the disciplines that I explored were economics, medicine, nursing, psychology, public health, social work, sociology, social science, and training, which have relevance for the research problem being studied (see Shaffritz, Russell, Borick & Hyde, 2016).

## Theoretical Framework

The theoretical framework served as the foundation for the critical analysis of the readmission of patients with SMI and facilitated the exploration of the role that CHWs can play to prevent these rehospitalizations when integrated into the behavioral health care team to support the team in managing patients' care in the community. In this study, I used the 5SCM (Howlett et al., 2015) as part of the theoretical framework for this study as well as for the execution of the policy process. Specifically, this model addressed the setting of an agenda, which is the initial step in the policy process that can then set the stage for policy decisions. In addition, I used the street level bureaucracy theory model (Lipsky, 2010) as a theoretical framework for this study. This model addressed the role

of workers who provide services directly to citizens in the community and how they influence the execution of policy through their discretion in making decisions.

**Evolution of the Five Stream Confluence Model (5SCM)**

In this section, I describe the evolution of the MSA to the policy development process in Howlett et al.'s (2015) 5SCM. The concept of streams in the policy making process, which began with the garbage can model is discussed (Cohen, March, & Olsen, 1972) and is followed by Kingdon's (1984, 1989, 2011 ) MSA, which remained limited to three streams in the policy-making process: problems, politics, and policy. Research from the literature using Kingdon's MSA is also reviewed. I also describe Howlett et al.'s exploration of the possibility of the expansion of the MSA by increasing the complexity and the number of streams for the policy development process, culminating in the 5SCM.

**Garbage can model.** The garbage can model exists when there is organized anarchy in which preferences are problematic, technology is unclear, or participation is constantly changing (Cohen et al., 1972). In these situations, four streams will be apparent: problems, solutions, participants, and choice opportunities (Cohen et al., 1972). Cohen et al. (1972) further explained that the preferences are problematic because they are based on unpredictable and vague preferences. The unclear technology is associated with the organization's members not being clear on how it operates (Cohen et al., 1972). Finally, fluid participation is reflected by the inconsistency of time spent on problems and the audiences and the leaders who make decisions (Cohen et al., 1972). The assumption is that there are problems waiting to be solved and solutions waiting to find problems

(Cohen et al., 1972). While business is conducted, decisions are made through a chaotic process, and this results in problems and solutions randomly being put on the agenda as important and to be addressed, removed or ignored, or left dormant with constant changes of decision-makers, thus the characterization of the garbage can model (Kingdon, 2011).

**Multiple streams approach MSA.** In the face of the chaos of the garbage can model, Kingdon (1984) sought to create a conceptual framework that could bring clarity through a process that addresses how, when, and who should address problems and with what solutions. Kingdon created a simpler version of the policy process, using one of the same streams as the garbage can model, the problem stream; however, the MSA focused only on developing an agenda (McBeth, Jones, & Shanahan, 2014). The foundation of the MSA is the identification of problems, policies, and politics as processes that must converge to make it possible for change to address problems (Kingdon, 1984).

Subsequent to the development of the MSA, all three aspects of the policy process were acknowledged when Kingdon (1989) focused on the decision-making process in Congress. At this time, Kingdon clearly reiterated that there are three steps in the policy process, setting the agenda, identifying the alternatives, making a decision about what alternatives to implement, respectively. The MSA oversimplifies the policy process by not considering that individual streams, once combined, may evolve into different problems, calling for different policies to address this and politics may change based on this change (Howlett et al., 2015). This activity is performed to set an agenda and identify alternate specifications for policy change through the identification of problems and possible solutions as well as a strategy to sell it (Zahariadis as cited in Sabatier,

2014). Zahariadis further discussed two important factors contributing to a situation being defined as a problem, which are how government officials learn about issues impacting a population and how the problem is presented to them. Officials may learn about a problem by signs that indicate that there is a problem, events or situations that draw their attention, and feedback about how existing programs are functioning. When situations are such that there needs to be a change, they are considered to be problems; however, how this happens requires more understanding of this process.

There are many factors that convert situations into problems, such as there being a violation of human rights or other values or a perception that the situation is not acceptable when compared to how it is managed in other countries. There are also factors that may remove situations as problems and replace them with other problems. In addition, the political stream influences how high or low a problem is on the governmental agenda according to the national mood and elections (Mettler and Sorelle as cited in Sabatier, 2014). There are visible participants in the agenda setting process that are influential in a situation being converted into a problem (Kingdon, 1984).

Kingdon (1984) also identified other characteristics that are influential in prioritizing problems, referring to them as alternative specifications, such as unknown communities of specialists (i.e., policy experts, academics, and researchers) with contributions that may be considered in the policy process. The policy stream involves consensus building and a prolonged process of business people willing to take risks for innovation and realign policies and partners to push their policy agenda (Kingdon, 1984).

The point at which the problem, politics, and policy processes converge is known as the policy window (Kingdon, 1984). This is a time when it is possible for a policy to be established or changed; however, Kingdon's (1984) initial presentation of the MSA did not demonstrate that it was taken into consideration that the policy process is iterative and not simply a convergence of the streams followed by the making of a decision. Subsequent authors discussed expansions of the MSA model that did capture the iterative nature of the policy process (Howlett et al., 2015).

The MSA has been used as a theoretical framework in various studies in the literature, demonstrating how public policy issues can be addressed. Kubiak, Sobeck, and Rose (2005) used the MSA to assess barriers to HCSs integrating mental health and SUD services and concluded that the MSA went beyond identifying the problem, politics, and policy. They found that exploring the streams was useful in ordering tactics to facilitate the movement of issues closer to change. In addition, the MSA analysis was helpful in highlighting areas that need particular emphasis (Kubiak, et al., 2005).

The MSA approach is a theoretical framework that can be used in uncertain situations; the policy process fits in this category (Zahariadis as cited in Sabatier, 2014). Kingdon (2011) discussed the MSA in the context of health care reform, interviewing 247 people in various aspects of the fields of health and transportation from 1976 to 1979. He selected these two areas because they were broad in scope, allowing for variations in policy agenda items, potential for policy change, and finally, there were big contrasts in the functions of the policy area in terms of organizations, congressional committee jurisdictions, and functions (Kingdon, 2011). The interviewees were staff and

researchers from the Executive Office of the President, consultants, political appointees and civil servants in departments, interest groups, journalists, academics, and consultants (Kingdon, 2011). The author concluded that the politics and policy streams were more favorable for health care reform and had a higher level of prominence during Obama's administration compared to Clinton's administration. Kingdon also noted that change occurs rapidly and in massive ways that were reflected with the implementation of health care reform. This is contrary to the description that the author used in 1984, indicating change occurs gradually and in increments.

In another study, Kusi-Ampofo et al. (2015) used the original Kingdon (1984) MSA to analyze the health policy process that occurred to successfully change Ghana's HCS in 2003. The HCS transitioned from strategy that the government subsidized to what was perceived as a more economically efficient and effective cash payment strategy. However, there was a problem with access to health care deteriorating for the population that was not able to pay for health care with cash, making Ghana a less healthy country. Kusi-Ampofo et al. (2015) found that Kingdon's (1984) MSA with the policies, politics, and problem stream converged and opened a window for this health care payment policy change to occur. New politicians were elected in 2000 making the political environment to a health care payment system change. The new government officials passed the law to implement the National Health Insurance Scheme. This law provided the universal coverage that created better access to care for the Ghanaian population regardless of the ability to pay. The authors in this case study found that Kingdon's (1984) original three stream MSA was adequate to reflect the policy change that occurred in Ghana.

The MSA (Kingdon, 2011) identified the three streams but it does not reflect the analysis of the interaction of the streams, that could inform what changes should be made. Kusi-Ampofo et al., (2015) used the original Kingdon (1984) framework to demonstrate the existence of certain key factors that create a situation ripe for the policy process to be implemented to facilitate change. It also seems to be ideal when studying the policy process for the development, implementation, and evaluation of legislation. In addition, the study of the implementation of the Patient Protection and Affordable Care Act (2010) and the establishment of the use of CHWs to prevent readmissions of patients with mental illness and SUD lends itself to analysis of the policy process with the use of Kingdon's (1984) theoretical framework. It can also serve to help public health officials and health care providers to discern when there are opportunities when HCSs changes are feasible. This is particularly important as scholars and leaders seek to leverage opportunities to make the HCS more effective and efficient. This includes leading change of public policy that will support improvement of the status of the social determinants of health in our communities.

Kingdon's MSA is evident in the writings of Dower et al. (2006) and Balcazar et al. (2011). The problem stream is that the health care needs of the American population have changed creating challenges for the existing HCS to meet these needs. The health care workforce is not adequate to meet the health care needs. The policy stream is the proposal that the use of CHWs is a more cost effective and efficient way to facilitate access to care and to foster improved public health. In addition, there is legislation that authorizes the use of CHWs. The political stream is that the existing health workforce is

not adequate to address the health care needs in its current state, and there are limited resources to support the HCS. The three streams impact the ability for the HCS to change. The three streams are aligned, making it feasible for the HCS to make a cost-effective adjustment to meet the population's healthcare needs and improve public health. The policy development process is ever changing because of policies, which could be legislation, or federal, state and local policies, politics, and problems that arise or are determined to be worthy of being on the policy agenda (Kingdon, 2011). The concepts and phenomenon that are demonstrated in this study are that with the Kingdon (2011) theoretical framework approach, analysis is limited to each triple stream individually setting the agenda from the triple streams and the resultant decision without reflecting the interaction of the streams as Kusi-Ampofo et al. (2015) described.

**Advanced multiple streams models.** Kingdon's (2011) MSA only addressed the agenda phase of the policy development process, keeping the paths of problems, policies, and politics separate which oversimplified the policy development process, over-simplifying its complicated nature. Howlett et al. (2015) described four additional policy-making models using multiple streams: the three-into-one tributary model, the three streams – two stages model, the four-stream model, and the 5SCM. They went beyond the agenda phase to focus on the policy formation and decision-making stages of the policy process.

***Three into one tributary model.*** Howlett et al.'s (2015) first model, the 3 into 1 tributary model, involved assessing the implications for combining the three streams, problem, policy, and politics, into a consolidated policy-making process rather than

addressing them separately. Combining them helped to look at a problem from a different perspective, yielding different options for problem solving that informs and limits authoritative decision-making and the use of government resources to execute policy (Howlett et al., 2015).

The benefit of this model is that the convergence of the three streams allows for the problem to be studied from a different perspective. This may result in clarity on what the real problem is and identification of flaws in approaches chosen to solve a problem due to inaccurate perceptions of the problem. However, the politics of the problem gets lost in the combining of the streams, causing insular development of solutions to a problem. This can result in solving a problem outside of the context of politics. This often controls whether and how politicians want a problem to be identified and/or addressed. It could also be a case of politics creating urgency for a problem to be identified and how it will be addressed. This is due to the need for politicians to be perceived by their constituents as solving problems. The execution of this three into one tributary model often results in addressing the policy stream again after this model is implemented (Howlett, et al., 2015).

***Three streams-two-stage model.*** The second model that Howlett et al. (2015) proposed is the three streams–two-stage model. It starts with Kingdon's (1984) problems, policies, and politics streams. The three streams converge, and the problem remains the same, with the addition of a process stream. It allows for agenda setting, modifying the problem, and exploring options for solving the problem. The outcome from these streams is policy settlement with one or more decisions being made. This may

create opportunities to focus on details of various problems in a semichaotic unintentional way, which may haphazardly be solved, the garbage can model (Cohen et al., 1972). In addition, it is unrealistic to think that a problem will remain the same with politics and discovery of new information (Cohen et al., 1972; Howlett et al. 2015). Therefore, this model may not be a realistic approach. However, Howlett et al. indicated that it shows promise as a suitable model since it goes beyond the agenda-setting phase into the policy development and decision-making phase.

***Four-stream model.*** Howlett et al.'s (2015) third model is the four-stream model. This model consists of problem, policies, politics, and choice opportunity themes, which were first discussed in the garbage, can model (Cohen et al., 1972). The benefit of this model is that it moves the policy development process beyond agenda setting into the realm of policy development and decision-making. Kingdon (1984) only addressed the multiple streams approach. It allows for understanding of problems more fully, related to the dynamics between problems and processes and the discovery of new information, which sometimes occurs independently when new information is discovered. It also permits streams to move independent of each other. It is not clear how the four streams will communicate among themselves to respond effectively to excellent opportunities. If the process includes negotiations, the definition of the problem may evolve into a modified or different problem. A model is needed to reflect the relationships among the streams (Howlett et al., 2015).

***Five stream confluence model.*** Howlett et al.'s 5SCM takes the multiple streams from three separate streams to five streams. Program and process are two new streams

added to this model, making it possible for all five streams to be active at the same time. It expands the policy making process to go beyond setting the agenda to include policy formulation and decision-making. This model provides four opportunities for the convergence of the streams. In addition, it allows for the integration of the streams as well as the dominance of a particular stream. This can cause the remaining streams to go in its direction or be nested within the dominant stream to help explain. The model provides an opportunity for communication, through convergence, which may change the composition and or the flow of the model. Streams may be nested in each other depending on the dominant stream and the need to identify all aspects of a policy making process. Most importantly, the five stream confluence model can accommodate the complexities and the unpredictable changes that occur in the policy making process.

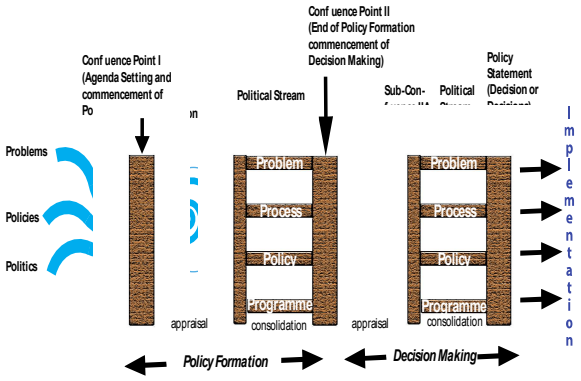



*Figure 1*. Five stream confluence model of the policy process theory. Adapted from "Forum Sections: Theoretically Refining the Multiple Streams Framework Streams and Stages: Reconciling Kingdon and Policy Process," by M. Howlett, A. McConnell, & A. Perl, 2015, *European Journal of Political Research*, *54,* p. 427. Copyright 2014 by John Wiley and Sons. Reproduced with permission.

Figure 1, Howlett et al.'s (2015) 5SCM, demonstrates the complexities in the policy development process including the five streams, appraisal phases, policy development, decision-making and production of a policy(s) for an implementation organization to put into practice. It shows the potential for more detailed analysis of the dynamics between streams and their impact on each other. This additional analysis, with further refinement, should be explored for the possibility of guiding the policy process toward the change being sought (Howlett et al., 2015).

**Street Level Bureaucracy**

The SLB theory (Lipsky, 2010) revealed the role bureaucrats play in providing direct services to the public. There is official policy that guides the performance of the service providers in a bureaucracy. However, within the policies of the bureaucracy, there is flexibility in how much initiative a bureaucrat can use to implement their responsibilities to influence the outcomes for the population they serve. Gaede (2014) demonstrated how physicians' proactive use of discretion, within policy guidelines of the bureaucracy on behalf of the patient population they served in South Africa, can make a difference in the patient outcomes related to the services provided. Integrating the CHW into the mental health care team is an example of application of the street level bureaucracy theoretical framework by using discretion to facilitate better patient outcomes. Task shifting from physicians and other professional team members to CHWs in the behavioral health care system is an example of SLBs using their discretion to positively impact the outcomes of the population they serve.

The role of the SLB is critical in the implementation of policies that come from the policy development process (Lipsky, 2010). The policy development cycle ends with the production of policy that needs to be implemented (Howlett et al.'s, 2015). The policy is transitioned to an organization to implement the policy. The implementation organization then develops a program with policies and processes designed to execute the intent of the policy. The policy and its associated processes should be explicit enough for the SLB to understand their role in the implementation of the policy. However, there are usually procedural gaps in implementation that leave the public service SLB with room for using their discretion in implementing the policy (Lipsky, 2010). This discretion creates room for variability from bureaucrat to bureaucrat. It also puts the SLB in the position to impact the implementation of policy, which is dependent on the scope of the discretion with their role and this ultimately impacts the access of the public to government rights and benefits. Health workers are included among SLBs (Vinzant & Crothers, 1996).

When there are financial cutbacks, the roles of the SLB are challenged, not only from the management perspective but from the community they serve as well. Management's need for budget cuts often are directed toward the SLB, some of which may be due to lack of clarity of the scope of their work. From the public's perspective, services are being cut and their direct contact with the source of the services is the SLB. This may create an environment of conflict between the priorities of management and the SLB such as reducing productivity and adversely impacting an organization's ability to implement policies (Erasmus, 2014). However, if management understands what the

SLB experiences and their desire for advancement coupled with the need for productivity, they can reward the activities that support the organization to be more productive while providing opportunities for the advancement of SLBs (Lipsky, 2010).

The interaction between the SLB and the public can strongly impact the public's perspective of the populations being served. For example, in some cases, the SLB could be influential in removing the stigma that is experienced by the way SLBs treat the population they serve. This puts the SLB in the position of being a model in how to treat the public and can impact policy (Lipsky, 2010).

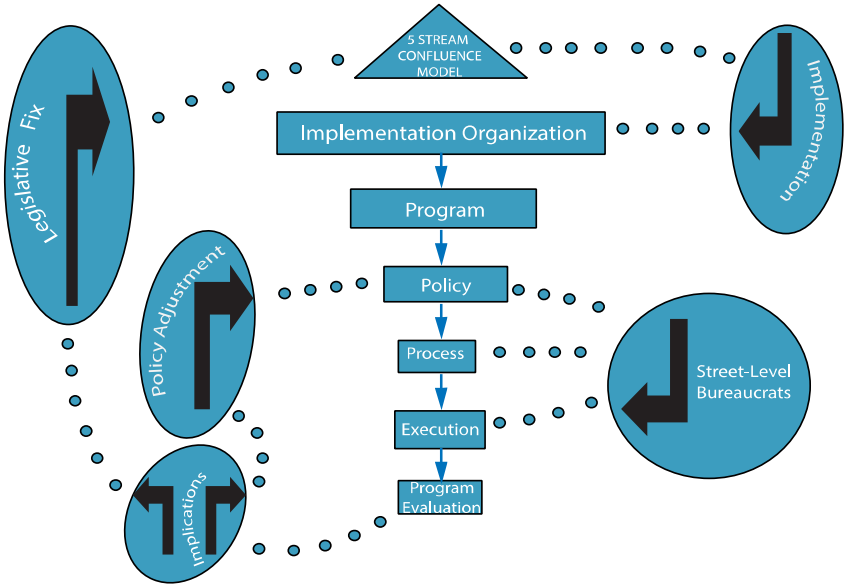



*Figure 2.* Conceptualization of policy implementation after completion of five stream confluence policy process theory and street level bureaucracy theory.

Figure 2 depicts the policy implementation process after the 5SCM (Howlett et al., 2015) policy is generated and delivered to an organization to implement. It also shows the implementation organizations' sharing the policy and using results from the

execution of Lipsky's (2010) SLB model to inform the policy implementation process. The policy implementation organization uses this information to determine the implications for policy revisions which could involve adjusting the policy or pursuing a legislative fix. The 5SCM represents the problem, policies, politics, processes and program streams, settlement of dominance of streams, and the whirlwind of decision making which results in a final policy decision. The SLB theoretical framework takes the final policy decision from the 5SCM process and establishes an operational program and associated policies, processes, execution, and evaluation. The evaluation takes insights from execution of the implementation process to discern if changes are needed in operational implementation or legislative fixes. If needed changes are within the legislative authority, then the implementing organization can make adjustments to program policy. If a legislative fix is needed, then the policy development process will be triggered. Communication occurs across all the phases and among entities, organizations and individuals executing the process. The use of the 5SCM on a continuum with the street-level bureaucrat theoretical framework provided the foundation for a model of how policy can be developed, executed, evaluated, allowing for evidence-based adjustments to be made.

## Literature Review and Key Concepts

The review of the literature reflected concepts of the 5SCM, which showed how multiple streams such as problems, processes, policy, program, and political streams that influenced the making of a policy decision can create confluence points that reconfigure the dominant stream (Howlett et al., 2015). In this case, the policy and the process of

providing people with mental conditions and SUDs with treatment created another problem of high costs that do not improve the quality of care. This creates a confluence point where the streams need to be appraised again to determine what stream should be predominant to make a decision about how to address this concern.

The theoretical concept of the SLB (Lipsky, 2010) is that policies may be made at top levels of an organization or system (e.g., legislation, federal and state level government, HCS). However, it is the worker interacting and providing services directly to the populations they serve, the SLB, who has discretion related to how policies are implemented. This puts CHWs, who are SLBs, in the position of having discretion related to certain services they can provide, in keeping with policy, when the details of the service are implemented (Lipsky, 2010). The role of the CHW and the impact it has in the implementation of policy in an integrated behavioral health care team was explored.

Based on the 5SCM (Howlett et al., 2015) and the street level bureaucracy (Lipsky, 2010) theoretical frameworks, several key areas of interest were considered related to readmission costs for treatment of SMI and utilizing the CHW to positively impact patients through their work in the community. They are cost and cost effectiveness, the role of CHWs, training of CHWs, and integration of health care teams. These evolved through the review of the literature regarding hospital readmissions to the hospitals for the same mental health disorder and the associated cost were repeatedly mentioned (Agency for Healthcare Research and Quality, 2014; Dower, Knox, Lindler, & Neil, 2006; Snyder 2016). The integration of the CHW into the behavioral health system

was explored in the context of preventing rehospitalizations for behavioral health conditions. The consideration of these key areas of interest helped answer the three research questions that this study was designed to answer. For example, this study sought to understand the CHWs' perceptions of their integration into the behavioral health team and how problems, policies, politics, processes and programs impact their integration. Furthermore, how CHWs functioned as SLBs, in an effort to advocate for clients, the community, and the health care team, was also explored.

It is unclear how the current administration may impact the evolution of these concepts. The Department of Health and Human Services funds various programs to support the training and development of CHWs (MHP Salud, 2014). In 2017 and 2018, the media and the U.S. Congress were discussing and debating the repeal and replacement of the Patient Protection and Affordable Care Act of 2010 as it relates to health care services. Changes to the provisions in the Patient Protection and Affordable Care Act of 2010 could affect integration of the CHWs into the HCS. Although several resolutions have been put forth, according to Congress.Gov, the official source of federal legislation, no legislation has been passed as of May 25, 2017 to repeal or replace the Patient Protection and Affordable Care Act of 2010 (Library of Congress, 2017). This legislation has been one of the main catalysts that facilitated the gradual evolution of the CHW role and the further integration of CHWs into the HCS. The Department of Health and Human Services implemented the CHW provisions in the Patient Protection and Affordable Care Act (2010) in compliance with the legislation. The possibility of Congress repealing and replacing the Patient Protection and Affordable Care Act (2010)

began soon after the presidential inauguration in February 2017 and could impact the findings and implications from this study. The results of a possible repeal and replacement may be contrary to the integration of CHWs into the HCS.

**Readmission and CHW Costs**

The hospitalization of a person for a serious mental illness or substance use is very costly. In 2011, there were almost 3.3 million adult readmissions in the United States across Medicare, Medicaid, privately insured and uninsured populations associated with approximately $41.3 billion in hospital costs (Hines, Barrett, Jiang, & Steiner, 2014). Among the uninsured patients aged 18-64, readmissions for mental illnesses, such as mood disorders, schizophrenia and other psychic disorders, as well as substance-related disorders including alcohol-related disorders account for these costs. These cost the federal budget $165 million of $433 million budget allocation, or 37% of funds. Readmission rates were from 10.4 to 16.0 per 100 admissions. For Medicaid patients 18-64 years of age, $832 million of $2.1 billion dollars or 40% of funds were spent on mental illness or substance use diagnoses. The readmission rates for these diagnoses ranged from 18.5 to 26.1 per 100 admissions (Heslin & Weiss, 2015).

In 2012, initial admissions for patients with mood disorders and schizophrenia or SUDs are four times more likely to be followed by a readmission within 30 days of discharge for the same principle diagnoses. Specifically, 60.1 % of patients were readmitted with a principal diagnosis of mood disorders and 70.3 % of patients were readmitted with principal diagnosis of schizophrenia or SUDs. Costs for readmissions for mood disorders and readmissions for any cause ($7,100 and $7,200 respectively) were

higher than initial admissions for mood disorders ($5,800). Hospital stays for mood disorders and schizophrenia were 39% and more than 100% longer, than hospitalizations for any cause, 6.6, 10.4, and 4.8 days, respectively (Heslin & Weiss, 2015).

Some of the skepticism about the utilization of CHWs is the uncertainty of the source and amount of payments for their services and whether they are cost effective and can produce positive health outcomes. Vaughan, Kok, Witter, and Dieleman (2015) reviewed and synthesized the literature on this topic. The review consisted of a methodical review of the value of CHWs and what impacts their ability to function effectively with community providers. They reviewed 32 published primary studies and four reviews from 2003 to July 2015, using a data extraction method. These included economic evaluations, costs and benefits of a single intervention or program and cost data. They looked at CHWs from provider, health or broader societal perspectives. Limitations are that cost and cost effectiveness analyses were not being done methodologically or consistently using similar analyses. Also, there are various types of roles in which CHWs functioned along with their training and skills and ability. This made it even more difficult to make the case for the cost effectiveness of using CHWs although anecdotally there is evidence that the CHW are efficient in low and middle-income countries, particularly with tuberculosis. Evidence for effectiveness with reproductive and maternal child health and malaria was weaker. Vaughan et al. (2015) recommended that more attention be given to comprehending costs and cost-effectiveness from both a societal and governmental perspective. They also suggested that CHWs be

integrated into the national HCS in all aspects such as related to hiring, being managed and supported, and career development (Vaughan et al., 2015).

CHW roles have been discussed in the U.S. literature for over 50 years (HRSA, 2007). Some of the progress made in recent years related to training CHWs and integrating them into the HCS can be attributed to the Patient Protection and Affordable Care Act (2010) legislation (Allen, Escoffery, Satsangi, & Brownstein, 2016). In this provision, there is a mandate for the CDC to integrate CHWs into academic institution training and care delivery sites in the community. An illustrative example of the uncertainty of situations in the policy development process and the policy agenda, in particular, is the most recent presidential election in 2016. President Donald Trump and President Barack Obama, under whose administration the Patient Protection and Affordable Care Act of 2010 was passed, have very different agendas.

The change in administration from the Democrat Party to the Republican Party may influence the findings of this study. Specifically, usually, Democrats are inclined toward domestic spending on health and social service programs and labor and oversight through regulations to ensure that legislation is implemented in keeping with the legislative intent. Republicans may be inclined toward the needs of businesses (Kingdon, 2011). Given this, the legislative language to support CHWs is from the Patient Protection and Affordable Care Act of 2010. Public policy support including financial support for CHWs will always depend on the political climate. The president released his budget request for FY 2018 and is still awaiting Congress' approval. In the FY 2018 DHHS budget, there are major cuts proposed for health workforce programs, which is

one of the sources of CHW training and health service delivery (2017a). Various DHHS operating divisions fund programs that support CHWs (MHP Salud, 2014).

CHWs can make a meaningful contribution and play a viable role on the mental health care team. Matumba et al. (2013) reviewed articles against predefined criteria related to the roles and effectiveness of lay CHWs in the prevention of mental, neurological, and substance use (MNS) disorders in low and middle-income countries (LMIC). Fifteen studies were reviewed, 11 of which were selected randomly based on the inclusion criteria. In 11 of the studies, primary and secondary prevention of MNS disorders were reviewed. Six LMICs, India, Pakistan, Bangladesh, South Africa, and Uganda were included in the study. There was evidence of effectiveness of lay CHWs in reducing the burden of MNS disorders such as depression and post-traumatic stress disorder.

Most of these studies had small sample sizes. The cases had an unclear or high risk of bias (Matumba et al., 2013). The gap in the literature was the need for comparable larger settings in LMICs to record indicators related to undesirable outcomes, processes for delivering care, reliability of interventions, and cost effectiveness. Although this research was conducted for LMICs, these findings can have implications for the United States, which is a high-income country with pockets of low-income populations. There is potential that the United States could glean some knowledge that might benefit the low-income populations.

**Training and Support of Community Health Workers**

There needs to be more consensus in the HCS on the role of CHWs and their integration into the healthcare team. An integrated approach is needed to train CHWs. Shah, Heisler, and Davis (2014) indicated that the Patient Protection and Affordable Care Act of 2010 provided an opportunity to establish a common framework for the integration of CHWs into the healthcare team, including more widespread use of CHWs. One way to do this is to integrate CHWs into medical and nursing training as roles are being learned. Wennerstrom et al. (2011) studied the development of training for a mental health outreach role for CHWs and case managers focused on reducing inequities in access to care and quality of services for posttraumatic stress disorder and depression post-Katrina New Orleans. CHWs along with leaders of community agencies, healthcare organizations, and academics collaboratively developed a CHW training program. The contributions CHWs made focused the training to include CHW activities such as collaboration with clinical teams, education, outreach, and the use of screening tools among other interventions. The study produced training with an intervention development approach that may be used to tackle post-disaster mental health disparities and enhance collaborative care. Integrated training of CHWs and medical and nursing students provides early exposure in their career, making integration of care an expectation rather than a burden or concern. There continues to be a need for continuous development and evaluation of such a training model to determine its effectiveness.

Language access for consumers of health care is critical to successfully practice primary and secondary prevention. Swartz et al. (2014) found diversity of language and

culture presents the need for front line caregivers to develop skills to deal with linguistic complexity. Failure to do so can adversely impact the ability of the professional mental health care provider and patient to communicate. Developing and using this skill set will create a workload to facilitate more effective communication. Addressing this challenge may be an appropriate task to shift from professional mental health care team members to non-professional mental health team members, such as CHWs. This conclusion supported Fricchione et al. (2012) in their discussion of the need for task shifting to improve access to health care, contributing to the health care team's ability to improve access to care.

The underutilization of CHWs is not unique to the United States. High-income countries (HICs) also do not utilize CHWs consistently across the healthcare system. Najafizada, Bourgeault, Labonte, Packer, and Torres (2015) reviewed literature on the types of health interventions that include CHWs in six HICs, specifically the United States, the United Kingdom, Australia, Spain, Netherlands, and Canada. General, specific, and themes of information were captured such as the type of CHWs, the geographic area, the population receiving services, the field of service of the CHWs and CHW training, accreditation and tasks, and recruitment. The author concluded the beneficial outcomes of CHW intervention are still underutilized. Another key observation that Najafizada et al. (2015) made was that CHWs need to be integrated into the larger social service and health systems for their potential impact to be realized. This is consistent with the conclusion in Balcazar et al. (2011) and Perry et al. (2014). It

revealed that there may be an opportunity for the United States to problem solve along with the HICs on how to integrate CHWs into the HCS.

**Integration of Community Health Workers into Community Systems**

In communities that have limited resources, CHWs can play a critical role to facilitate access to health care services. Vaughan et al. (2015) indicated that the use of CHWs in low-middle income countries has demonstrated that they are cost-effective in treating tuberculosis (TB). Population health can also be improved with the use of CHWs domestically. CHWs in North Carolina are integrated into the HCS. Their contributions have been recognized as positively addressing health concerns related to chronic conditions, such as diabetes, hypertension, and cancer, preventive health care like immunizations, maternal and child health, and infectious diseases such as TB and HIV/AIDS (Nelson, Money, & Petersen, 2016). Given this identified value, further insight is needed into how to integrate CHWs into the HCS.

Clarification is needed on multiple aspects of the integration of CHWs into the HCS. This includes the role of the CHW, education and certification for practice, supervision needed, publications with research that concentrate on results, payment for providing services, and the cost effectiveness of using CHW services. The use of community health workers is a possible option to improve access to health services in a HCS that has limited resources. What still needs to be known is how to classify CHWs so that their knowledge of the community and other capabilities that can benefit the communities they serve can be captured outside of the classification systems used for administrative staff and clinicians (Dower, et al., 2006). Sabo, Allen, Sutkowi, and

Wennerstrom (2017) acknowledge the progress that has been made in CHWs being recognized and present in the United States with the establishment of a Department of Labor Standard Professional Classification code for CHWs as a health profession. They also highlighted that the Patient Protection and Affordable Care Act of 2010 set forth legislative language for multiple major federal agencies to administer programs to prepare and support CHWs to impact individual and community health outcomes as a contributing member of the health care system.

Self-insured private employers and healthcare organizations need to become familiar with profit and cost savings that are achievable through the employment of CHWs. This may not require additional funds and may be feasible to do within current budgets. The value that CHWs bring is that they can interact with individuals and families, and communities, across levels of prevention to address health disparities and improve population health (Dower et al., 2006).

The CHW's relationships in their community make them an ideal member to integrate into a health care team that often is composed of persons of a different culture than the populations they serve. When integrated into the HCS, CHWs are able to build trust in the community so that the population becomes more willing to access the health care services that are available. The CHW filling this gap in the healthcare team allows the HCS meet the health care needs of the population and improve public health. However, doing this requires an infrastructure that supports and/or facilitates the existence and success with the use of CHWs (Balcazar et al., 2011; Bovbjerg, Eyster, Ormond, Anderson & Richardson, 2013).

There are various ways to build an infrastructure to support the integration of CHWs into the HCS. Balcazar et al. (2011) described three actions for a new paradigm for health in the US which is utilizing CHWs to the fullest extent possible. They recommended three action steps related to CHWs. First, the HCS needs to be made aware of the CHWs' ability to convey the viewpoint of the community regarding the HCS addressing their needs through their utilization in primary, secondary and tertiary care. Second, CHWs should be integrated into the entire health care delivery and population health programs. Third, CHW leadership needs to be engaged in setting a national agenda for CHW research and evaluation of the development of policy suggestions. Balcazar et al. agreed with Dower et al. (2006) that the integration of CHWs into the HCS could contribute to improving delivery of health care services. Integration of the CHW into the HCS can help fill a gap that can improve access to health care and improve public health. They also identified funding models similar to those that Dower et al. described and emphasized the importance of sustainable mechanisms for funding being put in place.

There are gaps in the health workforce that make it difficult to meet the existing population's mental health care and SUD needs in the community. Capacity building in global mental health is moving toward integrated, team-based mental health care and task shifting. However, there is a need for research on the roles of members of the mental health care team, other than physicians, to understand their functions and how they can contribute to the effectiveness of the team (Fricchione et al., 2012). This

recommendation supported the need to explore the use of CHWs with integrated, team-based mental health care and SUDs, and task shifting and the impact on patient outcomes.

The success of mental health care is often heavily dependent on understanding the culture of patients with mental health disorders and their community. Community Health Workers can bring their understanding of their community and the population that resides in it. Like Fricchione et al. (2012), Sapag, Herrera, Trainor, Caldera, and Khenti (2013) evaluated capacity building to strengthen the mental health workforce. Based on a literature review, the authors identified activities that are useful to integrate mental health and addiction services into primary care. Two of them are the use of interprofessional team-based care and strategies for health care providers to prevent stigma, such as developing cultural sensitivity. Their conclusions were consistent with Fricchione et al. (2012), who identified the need for educational institutions and practice settings to have processes to transition and sustain application of capacity building to partners within their country. In addition, Sapag et al. reinforced the value of team-based care along with Fricchione et al. Utilizing their expertise in understanding their community, CHWs have the capacity to foster such understanding in the integrated behavioral health care team, which could support it to be more effective in the delivery of care to patients with behavioral health conditions and their families.

The study of CHWs across the world can provide insights into how they can contribute to addressing particular health conditions in the United States. The United States could consider leveraging this information regarding CHWs, as it is relevant to its communities. Perry, Zulliger, and Rogers (2014) identified how CHWs positively

influenced improvement of malaria and tuberculosis control, children's nutrition, and women's health related to HIV/AIDS treatment. In the United States, CHWs contributed to chronic disease management including HIV infection, and cancer screening. Based on the evidence of CHWs' impact, Perry et al. concluded CHWs should evolve as a fundamental part of health systems, with the support of CHW stakeholders, as they seek to improve access to quality care and influence population health. This is consistent with the need to integrate CHWs into the healthcare team as members to make a meaningful contribution to health care delivery, as Balcazar et al. (2011) and Vaughan et al. (2015) described.

There are several roles that the CHW can play in support of the patient with a behavioral health condition and the integrated behavioral health care team who cares for them. Some key roles are the follow-up of patients upon discharge and communication with the health care team to seek assistance or provide feedback on the status of patients who they are treating. This is done to facilitate or reinforce follow-up care. The Minnesota Department of Health State Innovation Model (2016) identified factors influencing CHWs' roles and performance, patient satisfaction, and the status of financing of CHWs. The roles identified were coordination, referral and follow-up, feedback to medical providers, treatment adherence promotion, and documentation and recognizing social issues. These are key functions necessary in managing secondary prevention of mental illness, which is early detection and treatment of disease. While there were differing opinions about models of study and evaluation of CHWs, there was general agreement that there is value in CHW contributions to the health workforce

(Minnesota Department of Health, State Innovation Model; 2016). Many of these roles use the CHW's unique knowledge of the community and the population that the mental health care team is serving. Hynes, Buscemi, and Quintiliani (2015), on behalf of the Society of Behavioral Medicine Health Policy, recommends actions to overcome the barriers to CHW integration into the systems of care, reflecting the buy-in of the behavioral health profession for CHW integration. Rogers et al. (2018) reflects the recognition of the need for integration of CHWs into patient-centered medical homes.

Major changes are needed in the health care delivery system to integrate community health workers into the behavioral health care team. The health care teams need to change along with the systems that support them, making the change in how they operate possible. Balcazar et al. (2011) further described a new paradigm for health in the United States, which is utilizing CHWs to the fullest extent possible. However, doing this requires an infrastructure that supports and/or facilitates the existence and success of this change.

Health system leaders need to lead their organizations' transition to the full integration of CHWs on the health care team and provide the support and resources needed to be successful. Balcazar et al. (2011) recommended three action steps related to CHWs. First, the HCS needs to be made aware of the CHW's ability to convey the viewpoint of the community regarding the HCS addressing their needs through their utilization in primary, secondary and tertiary care. Second, CHWs should be integrated into the entire health care delivery and population health programs. Third, CHW leadership needs to be engaged in setting a national agenda for CHW research and

evaluation of the development of policy suggestions. Balcazar et al. agreed with Dower et al. (2006) that the integration of CHWs into the HCS could contribute to improving delivery of health care services. Integration of the CHW into the HCS can help fill a gap in the health workforce that can improve access to health care and improve public health. They also identified funding models similar to those that Dower et al. described and emphasized the importance of sustainable mechanisms for funding being put in place.

The value that the CHW can bring needs to be fully explored and explicitly communicated to patients, health care teams, HCS, and the community. Kim et al. (2016) examined the interventions that trusted CBWs, also known as CHWs, used in the management of chronic disease among people at risk for health disparities. This included the training to perform interventions, the implementation of the interventions, the achievement of anticipated results, and how CBWs are integrated into the current HCS. Their review revealed cost analyses from 61 studies, indicating that the CBW is effective in controlling blood pressure and cholesterol. Evidence was inadequate to conclude CBWs were effective in working with the prevention and management of mental disorders and determining whether the work of the CBWs was cost effective. Inconsistencies were found in the duration and intensity of CBW training. Further studies are needed to assess the effectiveness of CHWs working with the primary and secondary prevention of mental disorders and establishing a standard curriculum or minimum skill sets needed in addressing these conditions.

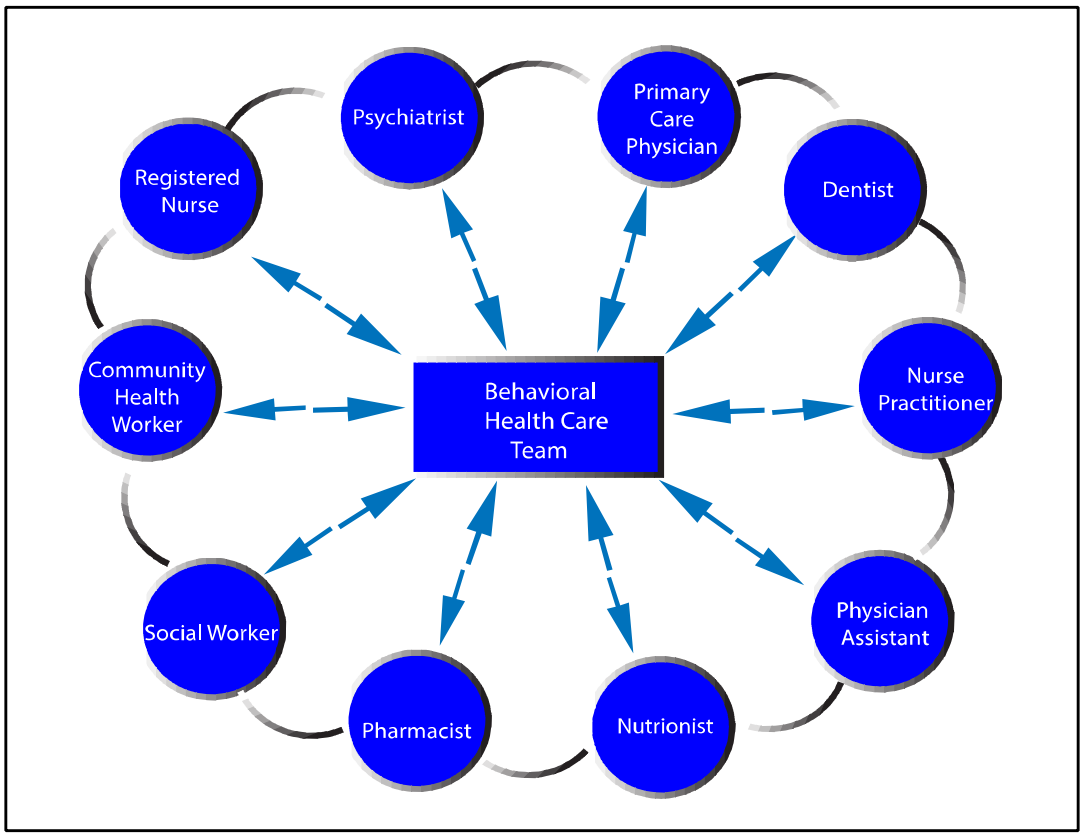



*Figure 3.* Integration of CHW's into the physical and mental behavioral health team.

In Figure 3, the square represents the behavioral health team. The integrated physical and mental behavioral health team consists of members who are working collaboratively with clients to manage their physical and mental health and associated behavior. The circles represent the many members that may be engaged in managing client care. It should be noted that the CHW is reflected as an integral member of the behavioral health team. The linkages between the circles reflects the current of communication that can pass through any of the team members, based on client needs.

The arrows represent the bidirectional communication and integration that occurs across the behavioral health care team.

Training processes such as evaluation of competencies and supervision of such approaches in more intricate detail is needed. CBWs, through their various intervening roles, link the community with the HCS to improve access to care. These interventions help build a relationship between the community and the HCS because of the CBWs' ability to communicate with the HCS. This contributes to the capacity of the HCS to deliver patient-focused integrated healthcare (Snyder, 2016). This type of work is not easily measured making evaluation of this activity difficult. While use of encounter forms are promising in terms of capturing this CBW workload, this data were seldom captured in the patient's medical record where impact can be demonstrated. This lack of documentation adversely impacts the ability to justify the need for CBW contributions and consequently justify payment for their services. Cost evaluation tools are needed to more systematically capture this type of information (Kim et al., 2016).

Due to variations in terminology regarding the CBWs' contributions, some information may not have been captured. Perhaps expansion of the terminology to describe CBWs' work would allow capturing more information about CBWs' contributions to team-based integrated care. Another limitation is that the role of the CBW was designed to improve access to health care services to vulnerable and underserved populations and therefore may not be applicable to middle/high-income populations. Kim et al. (2016) concluded the use of the CBW could help transition from a predominantly secondary and tertiary care delivery model to a primary prevention

model. Therefore, their use should be integrated into the HCS as an economical and more effective health care workforce among underserved, vulnerable low-income populations. This conclusion is consistent with Balcazar et al. (2011), Perry et al. (2014), and Najafizada et al. (2015), who also recommended the integration of the CHW role into the HCS. It is also noted that there are other partners outside of the health system who should be engaged in the dialogue about the integration of the CHW into the behavioral healthcare team. Elected officials, the business community, and members of the general public, particularly those with the greatest health risk should also be engaged in the discussion regarding integrating the CHW into the behavior health team in their community because this is about how to respond to the needs of the community (DeSalvo, O'Carroll, Koo, Auerbach, & Monroe, 2016).

## Summary and Conclusions

Kingdon's (1984) multiple streams theoretical framework was identified as evolving from the garbage model (Cohen, et al., 1972). The multiple streams model organized the garbage can model to make it more easily understood. However, some subsequent researchers including Kingdon (1989, 2011) sought to make the multiple streams framework more reflective of the complex nature of the policy development process. Kusi-Ampofo et al. (2015) adhered to Kingdon's original model. While Kingdon's (1989) original model was more organized that the garbage can model, it did not go beyond agenda setting to include the policy development process.

Howlett et al. (2015) made several iterations of the model for the purpose of facilitating the understanding of a public policy development phenomenon. They

reinforced the reality that Jones (1984) described, which is the planning, development, implementation, and evaluation of public policy is a very complex but necessary process. How the implementation of Howlett, et al.'s 5SCM addresses the policy development process and its appropriateness as a theoretical foundation, along with the SLB model (Lipsky, 2010), to guide the implementation of this research study was described.

The concepts that were explored in this study are readmission costs for treatment of serious mental illness and SUDs, the cost of CHWs, the role of CHWs, training of CHWs, and integration of CHWs into the HCS. It is known that readmissions for the treatment of SMI and SUDs are costly. However, it is mentioned several times that more insight is needed about how to methodically and consistently determine the cost and cost effectiveness of using CHWs. For example, a classification system other than those used for administrative staff and clinicians to address the distinct characteristics of the work of CHWs. There is a gap in the literature regarding the consistent application of feasible funding models to use for payment of CHWs.

The role of the CHW varies across the world and across communities. They are more commonly used in lower-middle-income countries and communities with limited resources. There is evidence that CHWs can be effective in the monitoring of some chronic diseases in the United States. CHWs have been used for mental illness, SUD, and neurological health care in addition to other chronic diseases such as diabetes and heart disease. CHWs have the unique insights about the community and its culture and the community trusts them since they come from and/or are knowledgeable about the communities in which they serve. The gap in the literature is the description of the

methods used to implement the use of CHWs in the HCS to deliver services related to behavioral health. Regarding the training of CHWs, more focus needs to be put on identifying commonly acceptable standards for training, practice, supervision, support, competencies, and career development for CHWs since it varies from organization to organization and state to state. There needs to be more engagement of CHW leaders to collaboratively lead the establishment of common standards regarding these areas. The need to cultivate and examine an integrated primary care and behavioral health team model that includes CHWs functioning at their fullest potential was identified. Some specific training activities that could make CHWs more effective such as collaboration with clinical teams, education, outreach, and the use of intervention development skills for readiness for emergencies were also noted (Wennerstrom, 2015). There is a gap in the literature about how leadership can evolve to provide strategic direction, common standards, economic viability, and advocacy for integration of CHW practice in the HCS.

There is a need to integrate the CHW into the behavioral health care system. Because of their relationship with the community, they are perfect members to integrate into the HCS. In this capacity, CHWs would be able to execute nonprofessional tasks, once appropriately trained, that skilled health professionals usually perform, to allow them to be available to address complex cases that require their expertise (Snyder, 2016). To facilitate integration, the HCS needs to be made aware that CHWs are able to effectively provide the perspective of the community. The CHW needs to be integrated into the entire health care delivery system. There is some guidance about how to integrate CHWs into the health care team for medical conditions (CDC, Division for

Heart Disease and Stroke Prevention (2019). However, there is a gap in the literature regarding the necessary steps that need to be taken for CHWs to be integrated into the behavioral health care system, practicing at their fullest capacity. I addressed the gap in the literature regarding identifying successful models of CHWs integrated into the HCS to support the delivery of mental health and SUD services in the community. In Chapter 3, the research methods used in this qualitative phenomenological study of CHWs' perceptions on their integration into the behavioral health care system as part of the delivery of health care services are discussed.

# Chapter 3: Research Method

## Introduction

The purpose of this study was to explore CHWs' perspectives regarding the integration of their role into the behavioral health care team. According to the Patient Protection and Affordable Care Act (2010), the purpose of integration is to provide a patient-centered approach to health care to address the majority of a patient's health care needs, including behavioral health, through community-based, integrated health care teams. This includes the delivery of care that is joined together with community-based training in prevention and treatment of the population that is being served to assist the behavioral health care team prevent and provide early treatment of behavioral illness (SAMHSA, 2019). Understanding this phenomenon would provide outpatient administration and clinical staff additional information on how they could expand their capacity to provide services that the community needs. Knowledge gleaned from the interviews could be used to revisit the processes that support the integration of the team and make necessary organizational changes. If there was not an organizational change or partnerships and collaborations that addressed the phenomenon, leadership of the organization may need to make the case for legislation or organizational policy that addresses the need for integrating CHWs into the behavioral health care system.

As clinicians working directly with clients, frontline workers are able to understand their clients' needs, use their clinical expertise, and conduct themselves in alignment with the organization's priorities to make decisions. As SLBs, their decisions can then be assessed to determine if they are pertinent (Vinzant & Crothers, 1996). This

capacity could include the CHWs performing primary and secondary prevention in the community by facilitating patients' adherence with their mental health care plans that the health care team develops in consultation with patients and their families. Furthermore, CHWs could refer patients to the behavioral health care team when there is an impending crisis, and this communication could facilitate access to behavioral health services and prevent readmissions.

With CHWs being integrated into the behavioral health care system, the use of constrained resources could be minimized through by using CHWs to perform secondary prevention of behavioral illness through identifying the need for and accessing behavioral health clinical advice and services. One of the critical steps in executing this research study was to identify CHWs who were working in an outpatient setting that integrates CHWs into the delivery of behavioral health care in a county in Maryland.

In this chapter, I discuss the research design used for this study and the rationale for selecting it. Then I describe the role of the researcher and the methodology used in this study in depth. Finally, I explain my data analysis plan, issues of trustworthiness, and ethical procedures.

## Research Design and Rationale

### Research Tradition

I used a phenomenological design, a qualitative research approach, in this study. This approach focuses on learning the personal experiences of the participants and their interrelationship with others and the meaning that the participant gives to these situations and interactions (Patton, 2015). Using the participants' descriptions, I identified themes

and patterns. Hermeneutical phenomenology was employed, which allowed me to seek to understand the context of lived experiences of the participants and interpret them. Using this type of phenomenology, researchers need to understand the participants' personal context and perspective on the topic being studied and the information the participant provides; researchers should not allow this information to limit their ability to get insight and clarity on what the participant is saying and how to interpret it (Patton, 2015). My rationale behind choosing this tradition was that my past experience of observing this phenomenon provided context that could assist me with a more thorough analysis of the phenomenon of integration of CHWs into the behavioral health care team.

**Research Questions**

I developed the following research questions to gain insight into the phenomenon of integration of CHWs into the behavioral health team:

Research Question 1: What are the perceptions of CHWs related to their integration into the behavioral health care team?

Research Question 2: How do problems, policies, politics, programs, or processes impact CHWs' ability to be integrated into the behavioral health team?

Research Question 3: How do CHWs view their function as a SLB to support integration into the behavioral health care team?

The two models that made up my theoretical frameworks, Howlett et al.'s (2015) 5SCM and Lipsky's (2010) SLB, are highlighted in the following subsections to reflect the alignment between the phenomenon under study, the research questions, and the integration of the theoretical framework to interpret the participants' lived experiences.

**Five Stream Confluence Model (5SCM)**

I used Howlett et al.'s (2015) 5SCM as part of the theoretical framework for this study. This model emanated from Kingdon's (2011) theory that described the policy development process as consisting of three streams: the policy, political, and problem streams. Howlett et al.'s model introduced two new phases into the policy development process for a total of five streams: the policy, political, problem, program, and process streams. Use of this model allows for the possibility of a more in-depth analysis of the subtleties among the streams and their effect on each other.

**Street Level Bureaucracy (SLB)**

Lipsky's (2010) SLB theory provided an additional theoretical lens through which I could fully explore the phenomenon of the integration of CHWs into the behavioral health team. Organizations provide official policy that guides the performance of bureaucrats when providing direct services to the community; however, within the policies of the bureaucracy, there is flexibility in how much initiative a bureaucrat can use to implement their responsibilities to influence the outcomes for the population they serve. Lipsky developed the SLB theory to provide the foundation for the role that the bureaucrat plays in delivering direct services to the public. Gaede (2014) demonstrated how physicians' proactive use of discretion, within policy guidelines of the bureaucracy on behalf of the patient population they served in South Africa, could make a difference in the patient outcomes related to the services provided. Integrating the CHW into the mental health care team is an example of an application of the SLB theory by using discretion to facilitate better patient outcomes. Task shifting from physicians and other

professional team members to CHWs in the behavioral health care system is an example of SLBs using their discretion to positively impact the outcomes of the population they serve.

**Integration of the Two Theories**

As previously mentioned, Howlett et al.'s (2015) 5SCM includes five streams: the problems, policies, politics, process, and program streams. Howlett et al. mentioned the possibility of the dominance of the streams changing after there is a convergence of the streams. This convergence of the streams also moves the policy process from agenda setting to policy formation to decision-making. Howlett et al. also indicated that after a series of convergences and movement through the policy process, a decision is made about what policy or policies will be implemented, then the implementation phase can begin.

Howlett et al.'s (2015) 5SCM focuses on the process for developing policy and ends before implementation; however, policies need to be implemented and the implementing organization needs to understand the policy process, how the policy evolved, and the intent of the policy makers to inform the implementation of the policy. I used the SLB framework to follow the 5SCM, starting with implementation of the policy. Direct care workers provide services on the front line and execute the policy that Howlett et al. (2015) described in 5SCM; however, due to the realities of the work environment (e.g., policy interpretation and limited time and resources) the SLBs inform the need for new policy or policy change through their execution of established policy.

## Role of the Researcher

My role as the researcher was that of an observer and participant, while also serving as the data collection instrument. As observer, I captured the essence of the descriptions of experiences related to the phenomenon by recording the interviews, taking notes, and transcribing the recordings accordingly. As a participant, I followed up on answers to questions for clarification but exerted effort to make sure that I did not ask leading questions. The participants interviewed had no personal or professional relationship with me such as an employee and supervisor relationship and/or instructor and student relationship. To ensure this, the process of screening for participants included language indicating the responsibility of the researcher and/or participant to disclose any such relationships.

I obtained informed consent from the CHWs who participated in the study. Miles et al. (2014) identified questions that should be asked of participants that can address many of the ethics issues that may arise. Both the participants and the researcher read and signed consent forms with mutually agreed upon conditions related to the interviews. Interviewees were also allowed to review the transcript of their interviews to ensure that what was captured accurately reflected what they intended to convey (see Miles et al., 2014).

Susceptibility to bias was monitored throughout the research process. I assessed my analytical biases by using tactics to verify the existence of bias in the analysis of the data, such as triangulating, seeking to understand outliers, and exploring surprises or discoveries (see Miles et al., 2014). Triangulation involved comparing the legislative

provision for CHWs in the Patient Protection and Affordable Care Act (2010) and state and local policy directives, analyzing data from the interviews, exploring opposing explanations in interviews, and referencing research findings in the literature. I also reviewed the responses across participants to determine if there were commonalities in themes across the various participants.

## Methodology

### Participant Selection Logic

The population used for this study was CHWs who supported some patients with behavioral health conditions. My initial intent was to use a screening process to get the best candidates for the study, creating a list of possible participants using purposive sampling criteria. The list would have only been used for screening purposes and the initial selections would not have made it to the final list to prevent the introduction of bias. However, due to the limited number of CHWs accessible for interviews, I selected participants from the CHWs who expressed their interest in participating in the study and met the participation criteria. Purposive selection is a sampling strategy that is used when there are a limited number of persons or sites that have the characteristics being studied (Maxwell, 2015). This is more likely to reduce the possibility of not getting a sample that represents the persons, activities, or important issues being studied (Patton, 2015). Another reason I used purposive selection was to ensure that the sample met the eligibility requirement necessary to implement this study (see Maxwell, 2015).

Criterion sampling was the type of purposive sampling I used in this study. Criterion sampling identifies specific criteria that will be used as a basis for selecting a

sample (Creswell, 2013). The criteria used for this study were CHWs: (a) at least 18 years old, (b) of any gender, (c) at least a high school diploma or general equivalency diploma, (d) actively working with a patient population that includes some patients with a behavioral health condition, (e) must speak English, (f) have at least 12 months of experience in an outpatient or community setting, and (g) interact with a behavioral health care team that is in an outpatient or inpatient setting. I determined that a sample size of 10 CHWs were needed. This size was based on the need to have a sample that was large enough for the phenomenon of integrating CHWs into behavioral health would be identified. In addition, this sample size seemed to be feasible in terms of time and access to people who meet the sample criteria as Miles et al. (2014) described. If saturation was not reached with the initial sample, additional participants would have needed to have been selected. The sample of 10 was adequate to reach data saturation from the participants' interviews.

**Instrumentation**

An interview protocol and a digital voice recorder were used for asking questions and capturing the answers during the interview. I developed the interview protocol based on review of the literature related to areas such as CHWs, behavioral health care team integration, workforce development, and training. One document that was used to inform the development of interview questions was the report that George Washington University researchers, Malcarney, Pittman, Quigley, Seiler, and Horton (2017) performed on behalf of the Department of Human Services. This report was written through a cooperative agreement with the DHHS, Bureau of Health Professions, Office of

Minority Health, and the National Center for Health Workforce Analysis. The document discussed the integration of the CHW into the health system and the associated management, competencies, and payment policies to support funding their work (Malcarney et al., 2015). This information was used to guide the development of the interview questions to ensure that the collected data was sufficient to answer the research questions.

Interview questions were developed and reviewed from the perspective of the interviewee to determine how the questions may be comprehended and how the questions may be answered (Maxwell, 2013). An interview guide was used to prepare for and guide the interview process to facilitate the readiness of the interviewer and interviewees for productive sessions. Two subject matter experts (SMEs) in policy development and administration of CHW workforce programs were used. These SMEs were requested to review the interview questions to ensure that they were clearly understandable and will yield the information that the researcher is seeking. These SMEs were persons who have worked with CHWs or have been involved in research or policy development related to CHWs in the private or federal sector. Once the SMEs provided feedback on the interview questions, and revisions were made, as needed, the process to collect data began after Institutional Review Board (IRB) approval (Maxwell, 2013).

**Procedures for Recruitment, Participation, and Data Collection**

Contacts were made with four organizations to request that my participant invitation be sent through their e-mail distribution so that interested CHWs could confidentially contact me if they met the participant criteria and were interested in

participating. The first contact was not responsive, the second contact allowed me to post my invitation to contacts in Maryland. This yielded two contacts. One person responded who did not meet the participant criteria. A second person responded indicating that there was one employee interested in participating in the study. However, when I contacted the person, she did not respond.

My third contact responded and yielded nine participants through their network. A final contact was made to another organization and yielded two more participants to reach a sample of 11. All of the CHWs in the sample came from the eastern state of Maryland. CHWs were practicing in urban, suburban, or rural areas.

Participants were prepared for the interviews by reviewing and signing a letter of consent to participate. The requirements for the participants was that they have worked actively as CHWs, with populations in the community who are at risk for or have an existing behavioral health condition. The participants had to have interacted with a behavioral health care team that is in an outpatient or inpatient setting. Most CHWs work in primary and secondary prevention of medical illnesses rather than behavioral health illnesses (National Academy for State Health Policy, 2016). However, CHWs, in supporting patients due to medical conditions, may also find that some of these patients also have behavioral health illnesses. The consent described the purpose of the study, what was trying to be accomplished, verified that they met the sample criteria and told each what they could expect and what was expected of them and their consent to be a participant in the study.

Information regarding the study was emailed to the CHWs through their supervisors. Participants interested in participating contacted me via e-mail. A preliminary contact via email or phone occurred to determine if the potential participants met the participant criteria, understood what the research was about, provided them an opportunity to ask questions, informed them that there will be anonymity of the participant and the organization with which they are employed, and documented permission for their participation in the interviews. The interview data were collected by in-person interviews with the CHWs. I was the interviewer and collected the data. Data collection occurred based on my availability and the availability of the interviewees. Nine of the 11 interviews were conducted at the site of their employment. Two interviews were conducted away from their employment site in agreement with their organization's expectation.

The length of the interviews was no more than 1 hour. There was no need to go for more than the anticipated hour duration. Data were recorded using a digital recorder. Participants were given the opportunity to review the transcripts from the interviews to verify that they reflected what they intended to convey. A revision was made to one participant's interview transcript upon request. Participants names were removed from the transcripts that were used for the study.

## Data Analysis Plan

The data analysis plan assisted in organizing the data to support the ability to analyze the data once collected. A deductive approach was used to initially develop codes prior to data collection. This involved using a preliminary coding framework that aligned

the theoretical frameworks, the research questions, the interview questions, and the primary and secondary codes. This coding approach allowed for the development of definitions that will allow for consistency in thinking about the phenomena throughout the study (Miles, et al., 2014).

The analysis of the responses to the interview questions started with a detailed description of the questions and the interviewee responses to them. Categorical aggregation, pattern establishment, and naturalistic generalizations were used to analyze the data. Categorical analysis is the gathering of instances from the data to determine relevant issues. Pattern establishment involves looking for commonalities among two or more categories. Analyzing the data to determine its applicability and incorporating specifics into categories to determine their representativeness was done carefully. It was important to avoid making generalizations when events or activities are nonrepresentative or erroneously concluding that processes are representative or transferable and drawing inaccurate conclusions (Miles et al., 2014).

Computer-assisted qualitative data analysis software, NVivo 12 for Mac, was used to assist in managing and analyzing data analysis of the data. It was used to code the data obtained from the interviews according to the preliminary codebook, emerging codes, and my research notes, and for analysis of the data. Discrepant cases were analyzed to determine if there were other categories of data that needed to be captured or explained to more accurately represent the data (Miles et al., 2014). One way I analyzed discrepant cases was to map the pattern codes that demonstrated themes and writing analytic memos that help document the thinking behind the code. The nature of the

analytic memos varied in that they were related to coding, theoretical frameworks, research question, interview questions, or a task. These analytic memos were then referenced to determine where discrepant cases fit in existing codes or could provide clarity on whether a new code was needed (Saldana, 2016).

## Issues of Trustworthiness

The researcher needs to ensure that the study is credible, transferable, dependable, and confirmable so that it can provide information modification and change for subsequent studies, where appropriate. Credibility is the determination of whether a study provides a genuine picture of the study participants and to the readers. One approach that was used to establish credibility was to disclose my biases, including past life experiences that may impact the questioning or could have been a factor in determining the methodology of the study (Creswell, 2013). Another way to establish credibility that was used was to do member checks to establish internal validity. The participants were given a chance to review their draft interview responses so they could verify the accuracy of the content in the transcript of the interviews and add additional information that they wanted to provide. Revisions were made to the interview responses based on the participants feedback to ensure that the interview accurately reflected what they wanted to convey.

Transferability is when the methodology and results of a study are such that they can be applied to other settings, populations or contexts. I sought to understand whether a repeat of this study by others would yield similar results (Miles et al., 2014). Thick description was used to provide details that a subsequent researcher could repeat the

study or make the determination regarding whether the research could be applied in their setting. In addition, the research needed to clearly indicate the theoretical foundations and their transferability (Creswell, 2013; Miles et al., 2014). It is noted that regional, economic, and ethnic variations may be such that generalizations may not be made from this study.

With dependability or reliability, Miles et al. (2014) indicated that if the process of a qualitative study is sensible and steady over time across researchers and methods, it is considered to be quality research and to have integrity. To ensure reliability, a dependable digital recorder was used to produce detailed field notes. An automated audio transcription service was used to transcribe the field notes. I reviewed the transcripts in detail to ensure that the content reflected the intended interview content as accurately as possible before sending it to the participant for review. Data quality checks were made to detect bias or deception (Creswell, 2013 and Miles et al., 2014).

Finally, confirmability addresses whether the research was done objectively and with the acknowledgement of any existing biases. Transparency in the entire research process was critical to be able to convey the entire research process. I was diligent about identifying my personal biases, assumptions, and feelings related to the research. The research process, which included the methodology and procedures, was documented and maintained so I could retrieve them, in keeping with the IRB regulations (Miles et al., 2014).

## Ethical Procedures

Before research was conducted, the IRB approved my proposal to ensure the ethical standards, federal regulations, and international guidelines were met (Approval # is 04-02-18-0411722). In addition, I obtained permission to use Howlett et al.'s (2015) 5SCM in this study (Appendix B). I obtained approval through the IRB to contact organizations to request them to send my research invitation to their e-mail distribution list. I sent my request for distribution of my participant to organizational representatives who the IRB approved. The contacts reached out to their network and I received contacts from the CHWs via e-mail. I shared the research invitation with the CHWs if they did not receive it.

The participants and I arranged for a mutually agreeable time and place to meet so that I could conduct the interview. I met all of the participants at their offices with the exception of two because of the organization's request that an alternative location be used, which was a location convenient for the participants at a local public library. All of the participants read and signed the consent form and a copy was made available to each of them. They agreed to be recorded and I informed them that the interviews would be confidential, only for my use for research. No interview went beyond 1 hour, as promised. The transcripts were sent to the participants for their review and changes were made, if requested. One participant made a clarification to her transcript which became the final version of her transcript. All of the participant transcripts were given numbers for identification purposes, removing the names of the participants for confidentiality. I thanked each of them for taking the time to contribute to my research at the end of the

interview and when I sent them the transcript for review. Participants were made aware that all transcripts and recordings will be retained for 5 years and will be kept confidential.

A Participant Invitation and the Consent Form for the Participant was used to recruit participants. The consent form included the background information, procedures, voluntary nature of the study, and risks and benefits of being in the study, payment, privacy, contacts who can answer questions, my signature, as the researcher, and the participant's signature, indicating consent for participation in the study.

An interview guide was used to guide the conduct of the research interview. This document contained the title of the study, a description of how the interviews will be conducted, the interviewer's script, and interview protocol. Appendix C shows the questions I asked during the interviews. No ethical issues or conflicts of interest were identified.

## Summary

In this chapter, the concept of SLB was introduced as frontline workers who work directly with clients, comprehend their needs, and use their expertise to implement their role in a way that is consistent with the organization's policies. The CHW, who is a SLB, also has the discretion to make decisions in their provision of services that could positively impact patient outcomes, which can be determined subsequent to their actions (Vinzant & Crothers, 1996). To determine the CHWs' perspective of what health care administrators need to do to integrate CHWs into the behavioral health team, CHWs who work in such a setting in Maryland were interviewed.

The research design and the rationale for its use were discussed. The 5SCM (Howlett et al., 2015) theoretical framework, which guides the policy development process, and the SLB theoretical framework (Lipsky, 2010), which reflects the front-line role, and decision discretion of the CHW, were described. The interrelationship between the two theoretical frameworks, in their respective roles was explored. The phenomenological approach was identified as the research tradition that was used (Patton, 2015). The role of the researcher was articulated as a participant and observer along with the precautions that were taken to manage any bias (Patton, 2015).

Finally, a criterion sampling type of purposive sampling strategy was identified used in this study with selection criteria. The sampling strategy was described as a convenience sampling based on the availability of a CHW sample. Four potential sources of the sample were identified, and two organizations were identified as the sources for the CHW sample. The criteria for selection of the sample was discussed, including the process for gaining access to the participants, their introduction to the study and what participation involved.

Chapter 3 described the research design and rationale for the chosen tradition, the role of the researcher, methodology, issues of trustworthiness, and ethical procedures needed to implement the study. Chapter 4 describes the results of executing the research activities discussed in chapter three. In addition, I interpret the study results, including the limitations of the study, recommendations, and implications for the study in this next chapter.

# Chapter 4: Results

## Introduction

My intent with this study was to investigate the perspectives of CHWs pertaining to their role being integrated into the behavioral health care team. The aim of the integration, as indicated in the Patient Protection and Affordable Care Act (2010), is to use a patient-centered, holistic approach to the delivery of care to address the preponderance of a patient's essential health care needs, with the inclusion of behavioral health, using community-based, integrated, health care teams. Community-based, integrated health care consists of the delivery of care that is joined through community-based training, prevention of illness, and treatment of the population that is being served (CITE). This helps the community and the behavioral health care team prevent and provide early treatment of behavioral illness. Awareness of this phenomenon may give hospital, outpatient, and community program administration and clinical staff additional insight into how their capacity to provide services that meet the needs of the community can be expanded. I used the information gathered from the interviews to reconsider the processes used to facilitate the integration of the CHW into the behavioral health team and recommend necessary organizational and business process changes toward integrated, community-based, behavioral health care delivery.

I designed the questions used in the CHW interviews to gather the participants' perceptions and insights on the phenomenon of their integration into the behavioral health team. The three key research questions that guided their development were:

Research Question 1: What are the perceptions of CHWs related to their integration into the behavioral health care team?

Research Question 2: How do problems, policies, politics, programs, or processes impact CHWs' ability to be integrated into the behavioral health team?

Research Question 3: How do CHWs view their function as a SLB to support integration into the behavioral health care team?

In this chapter, I discuss the setting of the research and describe the demographics and characteristics relevant to the study. The process used for data collection and data analysis are articulated. I also present evidence of trustworthiness and the study results in the chapter.

## Setting

In keeping with the IRB requirements, I sent the participant invitations to organization leaders who used their CHW e-mail distribution to share the invitation with supervisors in their organization. These supervisors made the CHWs in their organization aware of this research study. CHWs who were interested in participating in the study then contacted me directly and interviews were arranged for a time and place convenient for the participants. Although I did not inform the supervisors of who the potential participants were, it was apparent that many of the participants' supervisors were aware that they were being interviewed. It was difficult to determine whether the supervisor's awareness of their employee's participation had an impact on the participant's transparency during the interview. All of the 11 CHWs were interviewed

during their work hours, 9 in their office and two at the public library. The alternate location was used in keeping with the requirement of the CHW's institution.

## Demographics

I gave each participant a unique identification number to protect their anonymity. Table 1 shows the demographics related to the participants and characteristics relevant to the study. All of the 11 participants were female. They were from seven different organizations, 17 counties, and one county equivalent in a Maryland. In addition, one of the CHWs also provided services to two counties in two adjacent states. Almost half (i.e., 45%) of the CHWs had 2 or less years of experience and almost another half (i.e., 45%) had 5 or less years of experience, potentially reflecting the newness of the profession in the state or the movement of CHWs out of the profession. According to Ngugi et al. (2018), some reasons for CHW attrition to consider are uncertain financial sustainability, inadequate peer support, the need for more effective communication regarding expectations, and workload.

Table 1

*Demographic Data as a Percentage of Sample*

| Characteristics | Percentage of participants ($N$ = 11) |
|---|---|
| Years of service | |
| 1–2 | 45.45 |
| 3–5 | 45.45 |
| 17 | 9.09 |
| Roles | |
| Direct service only | 54.55 |
| Direct service and administration | 27.27 |
| Direct service and training | 18.18 |
| Populations served | |
| At risk for hospital readmission and behavioral health | 9.09 |
| At risk for hospital readmission and nursing home placement | 18.18 |
| Chronic disease | 18.18 |
| Communities in need of resources | 18.18 |
| Disabled and families | 9.09 |
| Homeless | 9.09 |
| Medicare beneficiary, county resident with 2 or more hospitalizations | 18.18 |

## Data Collection

I collected the responses for the interview questions from each of the 11 participants during individual interviews with each of them. A digital recorder was used to record the interview discussion. Participants were asked the six interview questions, and follow-up questions were asked of those whose responses did not touch on the

information in the follow-up questions. Interviews were held at the office location of 9 of the 11 research participants across Maryland. The interviews were held in their personal office space or in a conference room for privacy. Six of the interviews were held in the office spaces of the participants; of the six, two had their own office space, while four CHWs shared offices and the other occupant vacated the office during the interview. The five remaining CHW interviews were held in conference rooms. Two of the 11 participants were interviewed in a conference room in a local library. Their organization required their organization to do a full IRB approval for the interviews to be held on their property. Given time constraints, I opted to do the interviews with these participants in a location that was convenient for them, a library conference room close to their office. One of the 11 CHWs focused primarily on patients with behavioral health conditions, some of whom had medical conditions. The remaining 10 provided support to patients with medical conditions, some of whom had behavioral health conditions. With the interview of Participant 11, all of the themes were repeated; therefore, content saturation was reached.

Interviews were held for up to 1 hour, and only one encounter with each participant was needed to conduct their individual interviews. I captured the interviews using a digital voice recorder, then using an online transcription service to transcribe the recordings. I reviewed and revised the transcripts for accuracy and sent them electronically to each participant for their review and changes, which were made as requested. The interview transcripts reflected participant numbers and no names to protect their identity.

## Data Analysis

The first step in the data analysis process was to become reacquainted in detail with the qualitative software and revisit the preliminary coding framework. I developed the preliminary coding framework considering the alignment of the research questions; the theoretical framework for the study based on Howlett et al.'s (2015) 5SCM and Lipsky's (1980) SLB theory, and the interview questions. After my review of the transcripts from the interviews, it became apparent that the preliminary coding framework did not adequately address the emerging themes and needed to be reorganized for clarity of data analysis. Codes were defined and entered into the software and the interview transcripts were added as cases. I reviewed each interview again and coded the text according existing codes and emerging codes as they presented themselves in the interviews. Notes were taken as memory joggers throughout the analysis process. A revised codebook was generated based on this transcript review. Table D1 shows the revised coding framework, including the emerging codes. The cross-reference of data collection protocol lists the question numbers that were expected to yield data that fit into the parent and child codes. In addition, the codes were revisited and realigned to the theoretical framework. Codes were then put into categories and themes were identified based on participant quotes to note their importance.

Throughout the interviews, I took notes and reviewed participants' responses to note patterns in the data. The coding framework was revisited iteratively after all of the interviews were completed. The coding scheme was streamlined to simplify and clarify definitions of the codes and support distilling the essence of the participant responses to

the interview questions. These codes were entered into the NVivo software application. The interview transcripts were uploaded, and using the new coding scheme, I coded the question responses and established and defined emerging codes as content presented itself and was entered into the NVivo software. The responses were sorted according to their frequency for the codes, from the most frequently addressed to the least frequently addressed. Discrepant cases were noted and addressed in the descriptive narrative as they were found, and an explanation was given of how they were factored into the analysis.

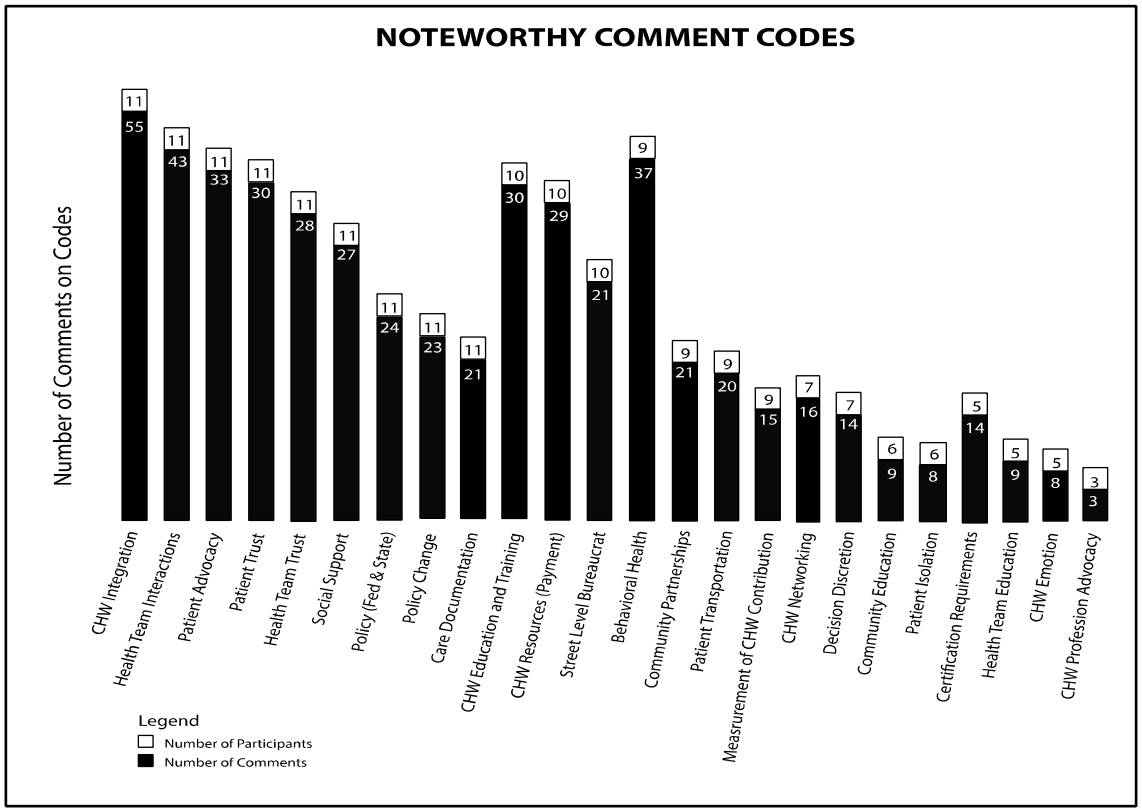



*Figure 4.* Noteworthy comment codes. Bar chart frequency of coded participant interview responses.

In Figure 4, the bar chart shows the noteworthy comments that the participants made that were coded accordingly. There were 25 codes that were addressed, 10 of which were emergent codes. Of the 25 codes, 15 of them had a frequency response of at least 20 comments. The 10 remaining codes had three codes with a frequency of responses from 10 to 15, three codes with a frequency of responses from five to 9, and three codes with a frequency of one to four responses. I included the less frequent comments because they had relevance to the theoretical framework or were noteworthy.

Subsequently, I reviewed all of the codes and the content of the references again for commonality and uniqueness of thoughts and ideas in order to ensure that the full scope of the perceptions were captured. Another critical analysis was then performed to analyze the content in the context of the 5SCM and the SLB model to glean insights on how the CHW integration into the behavioral health team may be facilitated to improve access to care. This inductively moved the data from the code level to larger representations of the data in categories and themes.

I explored the research questions related to the specific codes, categories, and themes that emerged from the interview data. According to Miles et al. (2014), pattern coding is used to group summations of data into lesser amounts of categories or themes. The responses to the interview questions were placed under codes, And the coded responses were placed in larger categories according to the association of the substance of the comments. Descriptions reflected both perceptions of enabling situations and situations that created barriers to CHWs integration into the behavioral health team. I then further analyzed the categories for commonality and developed themes, reflecting an

inductive process that ultimately resulted in the themes that were selected. Specific quotes were also identified to highlight their significance and to indicate themes. Through this inductive process, these themes constitute the comprehensive theme of system level change to integrate CHWs as a recognized member of the behavioral health care team. The specific and comprehensive theme is discussed in detail with illustrative participant quotes and paraphrases from the data in the discussion of results later in this chapter. While generally, the CHWs comments were consistent, there were a few areas where there were divergent opinions that required me to revisit the data to determine the underlying reasons. Two such areas were perceptions regarding CHWs being heard as a member of the integrated health care team and the level of discretion that they had in performing their work as SLBs.

## Evidence of Trustworthiness

In chapter 3, it was noted that it is important to stay objective and produce credible qualitative findings because there is often a suspicion that researchers will mold their findings to be consistent with their biases (Patton, 2015). I have practiced as a community health nurse, so I am familiar with the environments that the CHWs work in along with the challenges and the reward that comes with working with people in their home. However, I did not disclose my background with the CHWs during the interview so as not to bias their responses. I also have a background in public health policy which I also did not disclose. I also realized that there were some assumptions that I was at risk for making because of my background so I was careful to ask clarifying questions about what participants said to make sure I was not adding my interpretation to their statements.

I believe I was consistent with this until the interview with Participant 7. She had a patient who did not get a procedure he needed with a specialist, which she believed might have been avoided if the primary care physician was involved. She stated, "… I think having, especially with your primary care doctor, having them involved from head to toe literally, you know, is also helpful. Because then the primary care doctor's office would have followed up with that." I responded, stating "Right. Maybe" which pulled me out of my role of an objective researcher. Fortunately, this was at the end of the interview and the CHW responded saying, "Some of them around here would have." I noted this and reminded myself to stay neutral going forward, keeping this in mind when I analyzed the data. Also, triangulation was used across participant interviews with the participants reviewing the accuracy of their transcripts and also applying the theoretical frameworks to the analysis of the data. Most importantly, patterns of consistency or inconsistency of data from different sources or the same data from different sources were explored to come to reasonable explanations to support credibility (Patton, 2015).

Transferability is a way to determine if there is external validity in the conclusions of the study and whether they can be applied to other contexts. I captured extensive detail on the implementation of the research process in this study. This included the theoretical foundation and data analysis so that another researcher could determine through their review of the study whether findings would be applicable to their setting or could be replicated in their setting. I also made recommendations regarding past research and future settings where the findings could be used (Miles et al., 2014).

For dependability, I used the interview questionnaire in each interview. This was helpful to get the information that was needed across participants. Since the digital recorder was used, I was able to ensure that what the participants said was captured in the transcript. I also was flexible during the interview process and allow the participants to express some of their ideas regarding their perceptions. The coding process helped capture the specific examples that provided evidence of the perceptions that were expressed.

Finally, to support confirmability, I maintained my documents related to the methodology and procedures that were used in implementing my research process. I used mechanisms to manage my biases such as having the interviews reviewed by the participants. I also kept my biases in mind as I captured and analyzed the data from the interviews and prepared the research results. I focused on being transparent to communicate clearly the entire research process.

## Study Results

In this section, the results are discussed in detail. Table 2 highlights the results of the study showing the theoretical frameworks, categories, themes, and the associated research questions. Howlett et al.'s (2015) policy process theory using the 5SCM and Lipsky's (2010) policy implementation process using the SLB theoretical framework provided the structure for the discussion of the results. Each research question will be discussed with data to support the findings as well as discrepant cases/nonconfirming data, as applicable.

Table 2

*Categories and Themes*

| Theoretical frameworks | Categories | Themes | Research questions |
|---|---|---|---|
| Five stream confluence model | | | |
| Problems | Perceptions of CHW behavioral health integration<br>Community advocacy needs | Health system utilization of CHW behavioral health integration | 1 |
| Policies | Standardization of CHW training<br>CHW certification requirements | Official policy recognition of CHW profession | 2 |
| Politics | CHW payment policy<br>CHW profession advocacy | Accountability for CHW integration | 2 |
| Process | Integrated care communication/documentation<br>CHW contribution measurement<br>Community/organizational leadership/health care team education | CHW practice support | 2 |
| Program | Community behavioral health needs<br>Integrated health care teams | Integrated management of physical and mental health and behavior. | 2 |
| Street level bureaucracy model | | | |
| Decision discretion | Client advocacy and support<br>CHW networking<br>Partnership building | Building the CHW profession | 3 |

*Note.* This table shows the alignment of the two theoretical frameworks, the Five Stream Confluence Model (Howlett et al., 2015) and the Street Level Bureaucrat Theoretical Model (Lipsky, 2010), with the research categories, themes and associated research questions.

## Research Questions Results

Research Question 1 for this study: What are the perceptions of CHWs related to their integration into the behavioral health care team? This research question addresses identification of the problem, which is the problems stream (Howlett et al., 2015). The remaining streams will be addressed under Research Question 2. CHWs identified two categories under the problems stream. They were perceptions of behavioral health integration and community advocacy needs, as indicated in Table 2. The participant responses reflected the participants' perceptions which consisted of CHW integration enablers, CHW integration barriers, and community advocacy needs, which are discussed in detail below.

**Problem stream.** The problems stream is part of the process that policy makers use for agenda setting, which is an initial strategic appraisal. The agenda setting process consists of the problems, policies, and politics streams. It helps policy makers determine if and how to address the issue and get clarity and validate accuracy on their assumptions about the issue (Howlett et al., 2015).

***Perceptions of CHW behavioral health integration.*** The frequency of responses regarding perceptions of CHW behavioral health integration is 55 ($f$ = 55*)*. All of the participants perceived that there was a key role that CHWs could play when they are integrated into the behavioral health team. Some of the CHWs were directly involved as health care team members, supporting the team to address the needs of patients with behavioral health conditions. Some of the processes the CHWs described were enablers of the integration of CHWs into the behavioral health team. Other processes or lack

thereof were mentioned as barriers to CHW integration into the behavioral health team. Below is a summarization of comments and quotes from CHWs that illustrate their perceptions.

***CHW integration enablers.*** The CHWs provided several examples of activities and processes that enabled their integration into the behavioral health team. Some CHWs mentioned making referrals, transporting and/or attending behavioral health appointments with patients. Other activities mentioned were informing the team of circumstances in the patient's home that impact their behavioral health, direct interaction with the team on the progress of the client, both physically and mentally. In some cases, CHWs used assessment tools that let them know if patients need to be referred for further assessment of behavioral health care needs.

Participants 1, 3, and 10 described their enabling experiences working directly with their health care teams and how their direct interaction enabled them to support the client and assist the health care team to deliver the patient-centered care that was needed. Illustrative quotes were:

- Participant 1: "She [the patient] didn't have anyone who was…helping her at the mental health clinic. So, by…doing the blood pressure, getting to know her… I was able to…help her get back…to her therapist and being in her sessions."
- Participant 3: "My…team specifically focuses on clients that have mental health diagnoses…and [a medical illness]… I know which doctors or…nurse practitioners I need to reach out to in regard to my client's care."

- Participant 10: "We involve a community health worker, community health nurse and a community social worker [for behavioral health clients and]…alter the intervention based off of having an understanding that they have a behavioral health condition."

When asked to describe their integration as a CHW on the health care team treating a client with a behavioral health condition, some of the participants described their role as using an indirect approach. This seemed to be a function of the organization they worked in, the requirements of the grants under which they functioned, limitations of resources, and their perceptions. For example, participants five and nine indicated that they referred their clients with behavioral health conditions. Participant 5 stated, "[We were] not specifically a team where we all sat down, but we all work closely with [another] agency……compare notes…so…anybody else could pick up where we left off or they could answer one of the questions that we had." Participant 9 described her indirect involvement by stating, "When you are doing a home visit… you'll see that there is a mental health condition… We do a surface diagnostic and then do a referral to that [mental health] department … if the person gives the consent."

Participants 1 and 8 described patient trust in the CHW as another important enabler in the integration of the CHW into the behavioral health care team. Participant 1 stated, "Fortunately..., I knew her and once we kind of reconnected through the blood pressures, she off the bat, told people, told her family, and her therapist that she trusted me. So, the main issue, there was trust, confidentiality". Participant 8 also expressed the importance of patient trust by stating, "If they want to know about something, they can

call us. We let them know that we're there for them. That's what we're there for, is for them."

Health care team trust in the CHW is also an important factor in the utilization of the CHW as a member of the behavioral health team. Participant 10 shared her perception of how the health care team positively received her contributions after she shared information gleaned from a conference on suicide prevention in older adults with them. She stated, "I've gained the trust of our team...They've seen my abilities and know that I'm able to build the necessary relationships and act appropriately, connect them to the right resources, and act within my scope".

***CHW integration barriers.*** Despite the examples of CHW integration enablers, there were also several examples of integration barriers. The frequency of responses regarding perceptions of health team interactions was 43 ($f = 43$) and for health team trust, the frequency was 28 ($f = 28$). The CHWs expressed that there were barriers regarding the health care team accepting the integration of the CHW as a member of the integrated behavioral health team. This further emphasizes the magnitude of the CHWs' perceptions of the integration barriers, reflecting Howlett et al.'s (2015) problem stream as a predominant stream.

Below are illustrative quotes about the health care team's hesitancy to accept the CHWs as part of the health care team.

- Participant 2: "When we're dealing with patients that have anxiety or depression or schizophrenia, I don't think that a lot of the teams feel that we are [prepared], although we have training and continue to train."

- Participant 3: “You don't always get the respect...as a community health worker. They [the team] felt like it was, just a title that someone threw together and said, here you just do this and that's not it.”
- Participant 4: “In the beginning, they (health care team members) were a little like you don’t know what you’re are talking about…and then after you explained it more, like no, this person really didn’t want to share the information with you.”
- Participant 5: “I don’t think...a professional will accept a community health workers insight because... they’re the professional. Even though the CHW is the person that is seeing this day to day and... communicated well, they might, but I don’t think so.”
- Participant 6: “The…[health care team]…need[s] to be...open minded about …[CHWs]….Some of them think they know it all… but [they’re] not going to do what I can do. …[They’re] not going to deal with a… patient at their home.”
- Participant 10: “A lot of people are resistant to our program and our help because they’re not aware of the services that we can provide and sometimes they think we’re trying to sell something.”

There seems to be an understanding that there are contributions that CHWs can make, although not clarity on the distinction of the CHW role and how their services will be funded. This brings a hesitancy to continuously make referrals to CHW organizations without a known funder, bringing the issue of resources and scope of practice to the

forefront. These variations and discrepancies in perceptions regarding the CHW being integrated into the behavioral health team seems to be a function of the CHW, their organization, the terms and conditions of their functional description, the health care team, health care system, and the environment in which the CHW practices. However, there are situations in which the CHWs are integrated, but there is not consistency across organizations.

***Community advocacy needs.*** The frequency of responses regarding patient needs for advocacy in general was 33 ($f$ = 33). Some advocacy needs were called out specifically related to patient trust in the CHW with a frequency of 30 ($f$ = 30), social support with a frequency of 27 ($f$ = 27), and patient transportation with a frequency of 20 ($f$ = 20). The CHWs gave numerous examples that demonstrated the community's need for CHWs to be integrated into behavioral health care team to advocate for clients. Specifically, clients reveal their behavioral health needs to CHWs because of the trusting bond they establish with their clients in the community. A few illustrative quotes and paraphrased statements that reflect the data for this category are:

- Participant 1 does blood pressure screenings, stating, "That linked us to people who had depression, we were able to link them to resources of a therapist and had two who were…seen pro bono by the therapists and so it does lead from one thing to another."
- Participants 2 and 7 highlighted the gap that the CHW can fill by knowing the patient and their environment and the health care team to support the meeting of patient-centered goals to improve patient outcomes.

- Participant 3 stated, “We have a lot of clients that suffer from [mental illness]…Just changing doctors’ offices can give them anxiety. …This is just because they're anxious about going to another one or they can't afford to get the bus to another one”.
- Participant 5 stated, “Resources are always hard to find. Transportation is hard to find. Housing is a difficult thing…”
- Participant 8 said, “A client… thought I was following her around town…and she [the patient] couldn't understand that I wasn't, so the nurse and I made a visit to her home. The nurse referred her to the mobile crisis unit for them to go and evaluate her.” The CHW’s referral led the client to get the help she needed.
- Participant 10 indicated that they have a process in place in the event that the CHW encounters a patient when they did not already know that the patient has a behavioral health condition. She stated: “If …the initial enrollment visit is only scheduled with the community health worker and the community health nurse and the community social worker isn't involved, we're able to recognize when that community social worker needs to be involved.” The CHW has clear guidelines to guide them through this process.

The theme that evolved from the data that addressed this research question is the need for health system utilization of CHWs behavioral health integration. The CHWs expressed that the health care system has not fully accepted the role of the CHW and based on what the CHW is seeing in working with their clients, there is a need in the

community for integration of behavioral health and physical health and advocacy for clients. It should be noted that the CHW, using a patient-centered approach, is working with their client and the integrated health care team, to manage behavior related to physical and mental health conditions, to the extent possible. However, this is not always proactively and systematically done, depending on the organization and healthcare system in which the CHW works. This reflects a public policy problem, which belongs to the problem stream, which is predominant, and is one of the streams in Howlett et al.'s (2015) 5SCM. Consistent with being a predominant problem stream, this problem is addressed extensively in its pure form in the literature, seeking evidence-based solutions (Howlett et al., 2015). In 2015, the Maryland Department of Health and Mental Hygiene and the Maryland Insurance Administration, in response to 2014 Maryland legislation, created a stakeholder workgroup, studied the CHW public policy problem in detail, and reported their findings to the Maryland General Assembly (Maryland Department of Health and Mental Hygiene and Maryland Insurance Administration, 2015). The report reflects the work that Howlett et al. (2015) described as necessary in the agenda setting phase of policy formation, which is a strategic appraisal by policy makers which includes the problems, policies and politics streams. The purpose of the appraisal was to determine if and how to proceed, what the issues are, whether the notions regarding the problem are valid, culminating in setting an agenda. The Maryland General Assembly's response was subsequent legislation in 2018, which mandated the establishment of a Maryland CHW Advisory Committee to address CHW training accreditation and CHW certification. The responses to Research Question 2 will discuss this problem further in

the context of the four remaining streams, which are the policies, politics, process and program streams.

**Research Question 2**

Research Question 2 for this study: How do problems, policies, politics, programs, or processes impact CHWs' ability to be integrated into the behavioral health team? The remaining streams, which are part of agenda setting along with the problems stream, are the policies and politics streams mentioned under question one. These streams are addressed along with the two remaining streams, the process stream and program stream. During the process stream mechanisms to explore options and facilitate authoritative decision-making are established. Time frames for consideration and the general direction of how the stream will proceed is determined. Finally, the program stream establishes the processes to establish new methods to address the problem and integrate them with existing ones to address the problems (Howlett et al., 2015). Howlett et al.'s (2015) 5SCM's problems, policies, politics, process, and program streams revealed 14 categories and seven themes. As indicated in Table 2, the problem stream categories, perceptions of CHW behavioral health integration and community need for advocacy were already mentioned in question one with the evolving theme, which was the need for health system utilization of CHW behavioral health integration. The CHWs identified several policies, politics, processes, and program stream activities that would support addressing the problem stream categories mentioned above. These streams are discussed below with the categories and themes that were revealed from the interview

data. The problems, policies and politics streams are closely related because they are often tied to legislative and political action for them to occur.

**Policies stream.** The policies stream included two categories, standardization of CHW training and CHW certification requirement. The frequency of comments regarding federal and state policy and policy change were 24 ($f$ = 24) and 23 ($f$ = 23), respectively. Participants 1, 2, 8, 10, and 11 referenced the work being done in the State of Maryland, which is the legislatively mandated State of Maryland's CHW Advisory Committee. The Advisory Committee is charged with advising the Maryland Department of Health on policy related to the certification and training of community health workers (Maryland Department of Health, 2018). They identified that this work would assist them in contributing and being more integrated as a member of the behavioral health team. The Patient Protection and Affordable Care Act of 2010, known as Senate Resolution 3590 (2010) as well, was also mentioned as federal legislation that addressed the utilization of CHWs.

***Standardization of CHW training.*** The frequency of responses regarding CHW education and training was 30 ($f$ = 30). Participants 1, 2, 3, 4, 5, 10, and 11 specifically indicated that standardized training for CHWs should include behavioral health with examples such as mental health role playing, suicide prevention, de-escalation training, motivational interviewing, mental health first aid, opioid addiction, and shadowing CHWs in the field. Illustrative quotes reflecting CHW comments related to the need for standardized training are:

- Participant 2: "One of the policies that I feel would be integral in making sure that community health workers are part of the behavioral health team is the standardization of community health worker education and training."
- Participant 3: "De-escalation training has been a positive impact on my experience with the clients…Motivational interviewing is…a great training that…all community health workers should have."
- Participant 4: "CHWs need more advanced training with behavioral health like role playing, "so they can get a better understanding like culturally, of how to deal with individuals in that situation, whether it's like taking trips to a mental institution or just actually seeing it first-hand."
- Participant 5: "Sometimes when you go into a home, if you haven't been trained, you get overwhelmed, so you have to be trained well. It all goes back to training and education, I think."
- Participant 10: "It would be beneficial for all CHWs to have more of a health education background or at least kind of follow like a standard of certain courses so they have a thorough understanding of all, like major chronic conditions."
- Participant 11: "If the state rolls out a certification…then it would have to include some sort of recognized, evidence-based training in working with behavioral health clients if folks don't have the education background or the experience in that area."

It should be noted that although the eligibility requirement to participate in this study was a high school diploma or a general equivalency diploma, it was revealed that some of the CHWs had undergraduate and graduate degrees. As the Maryland CHW Advisory Committee addresses the standardization of CHW training, the varying education levels and types of training, that prepare CHWs for practice, needs to be considered in establishing the policies for accreditation of CHW training programs and the CHW certification process.

***CHW certification requirements.*** The frequency of responses regarding certification requirements was 14 ($f$ = 14). Several CHWs mentioned the work that is being done at the state level regarding developing regulations about the certification of CHWs. Some comments made were:

- Participant 4: "But as far as like certification that's developing, we're hoping to be compensated for that. So that's in the making now."
- Participant 6: "Well, we're all going to be certified, which is coming up hopefully soon, maybe next year that we're going to be certified and I think that's where people are going to actually see us as a part of this healthcare field."
- Participant 9: "We are still not recognized as the bridge between the patient and community as a community health worker in the state of Maryland. I know in other states we are already there, and they are already licensed."
- Participant 10: "It would be awesome…to get a certification for community health workers…just because sometimes people need you to have that formal

experience or background or title for them to kind of accept you for being knowledgeable. She further stated, "Understanding the scope of practice is extremely important."

- Participant 11: "Right now, I would say one of the major weaknesses is just the lack of certification. So, we don't have the name recognition or the recognition for the expertise that community health workers bring to interdisciplinary teams. She further mentioned "having the necessary licensure or whatever to work with folks who have behavioral health diagnoses" as a weakness.

Some more specific aspects of certification that were not mentioned were formal education requirements, frequency of certification, continuing education requirements. However, most comments were focused on education requirements, both formal and informal. Very few discussed the specifics regarding the scope of practice and the actual certification process. The State of Maryland Department of Health and Mental Hygiene report on Workforce Development and the Minnesota Department of Health Office of Rural Health and Primary Care CHW Toolkit, among others, have provided some guidelines for the scope of practice for CHWs in their reports for the State of Maryland to consider (Maryland Department of Health and Mental Hygiene and Maryland Insurance Administration, 2015 and Minnesota Department of Health Office of Rural Health and Primary Care, 2016). The theme that evolved from the policies stream categories of standardization of CHW training and CHW certification requirements was official policy recognition of the CHW profession.

**Politics stream.** The politics stream of Howlett et al.'s 5SCM included two categories, CHW payment policy and CHW profession advocacy. The frequency of responses regarding CHW resources was 29 *(f = 29*) and the frequency of responses regarding profession advocacy was 3 *(f* = 3). While the CHWs had numerous comments on payment policy that would provide for resources to pay for CHW services beyond continuously competing for grant funding. However, it is noted that few of the CHWs addressed the concept of advocacy for the CHW profession. These two categories were captured under the politics stream because they were considered to have a strong political component.

***CHW payment policy.*** As mentioned above, frequency of responses on the CHW resources (payment) code was 29 *(f = 29*). The 11 CHW participants came from seven different organizations. All of the organizations had some type of grants and were funded through various sources during their existence such as not for profit organizations, federal, state, and local government organizations, private practices, and health systems with inpatient, outpatient, and community services. Three organizations obtained resources through partnerships from organizations that received grant funding for a CHW workload and had them fulfill that aspect of the requirements of the grant. For one organization, resources came from the State for their work, but their referrals came through a partnership from the health system that serves their local community. Two other organizations used some of their own funds to support their CHWs with supplemental funding from a federal grant for one organization and from a non-profit agency for another. Finally, one organization received funds from the state Department

of Health and Mental Hygiene and the Health Services Cost Review Commission to fund their CHW program. Based on these various models of funding, it reemphasizes the critical role that partnerships play in the funding for and integration of CHWs into the health care system and the behavioral health team.

A critical policy to the successful integration of CHWs into the health care team is payment policy that will pay for the cost of CHW services. Of the seven organizations that were represented in the participant sample, only one of them was partially funded through a local hospital and two others were seeking local hospital funding. Below are some illustrative quotes or paraphrased comments from the research participants.

- Participant 2: "Right now we are grant funded, so we get money from governments, whether it's city, county, state. We have had a federal grant. So that process..., we're still working on, but we also have private donors and foundation funds." She further stated, "We don't necessarily want to be 100 percent grant funded. We want to have a constant stream of money coming in to support the services."
- Participant 7: "We have numerous partners. We are partnered with hospitals, FQHCs (federally qualified health centers), health departments, private practice and what we do benefits our partners, but it also helps to increase and improve health outcomes for their patients."
- Participant 9: "They (the hospital) will be the best one to give the financial support that we need because we're doing the jobs that they cannot do. You prevent the patient from going back to be readmitted, because every patient

they get readmitted, they lose funds, they lose their support…We are still fighting for it."

- Participants 11: "…Funding is definitely a barrier for community-based health care and… we will need the state to do more in the future if we want to expand this model across the state because I personally think it's very beneficial and to keep it going, we're going to need more funding."

The uncertainty of sources of funding and the individual organizations seeking funding to stay viable can be labor intensive and requires establishing various partnerships. The Maryland House Bill 856 and Senate Bill 592 mandated the establishment of a stakeholder workgroup to make recommendations on the development of the CHW workforce. The Workgroup determined that it is premature to make a recommendation regarding reimbursement, beyond suggesting that a group of CHW stakeholders who potentially will be retaining the services of CHWs, continue to generate more specific guidelines for reimbursement of CHWs from various private and public payment sources (Maryland Department of Health and Mental Hygiene and Maryland Insurance Administration, 2015). This will require the exploration of partnerships among payors, and health care teams to develop innovative models for practice and payment of CHWs.

***CHW profession advocacy.*** Some of the CHWs raised the concept of advocacy for the CHW profession not only by CHWs but by other partners and professions. In addition to the frequency of 3 ($f = 3$) for CHW profession advocacy responses, the frequency of responses for community partnerships was 21 ($f = 21$), the frequency of

responses for health team education about CHWs was 9 (*f = 9*). Below are some illustrative quotes and paraphrased comments that address these codes.

- Participant 2: "So our first experience working with a …somatic…or behavioral health care team…we were partnered with county mobile crisis teams." The counties in seeking funds advocated for the CHW profession by having a specific role for them in their grant.
- Participant 7: "It was our partner who…wrote the first grant because of the Affordable Care Act, [asking] 'What can we do with CHWs?'... The first go round they focused on oral health. The second go round [they] focus on behavioral health."
- Participant 11: "I think advocating for the profession is huge…That begins a soon as we enter someone's home, we're immediately explaining this is what we do…This is how we can help you." She further stated, "I think at the hospital level, [we need to be] advocating for a seat at the table as experts in our own community field." It was also noted that CHWs need to advocate for a place at the table when working with hospitals. She also indicated that there is value in other professions advocating for the CHW profession by stating, "When we're interacting with other organizations who may not be familiar with what community health workers do, …our clinical social worker does a good job of advocating for us and our expertise and speaking to how we can contribute."

These examples demonstrate that there is some value and perhaps some accountability not only for CHWs but for other professions to advocate for the integration of CHWs into the behavioral health team because of the value their impact on client outcomes through their contributions. However, the low frequency of 3 ($f = 3$) for comments on CHW profession advocacy seems to reflect that there is limited focus, expectations, or existence of CHW profession advocacy by CHWs, and other professions and partners, or others. Yet, several CHWs have indicated that this has been one of the more successful ways of obtaining funds to help them to integrate into the behavioral health team. The theme that evolved from the CHW payment policy and CHW profession advocacy was accountability for CHW integration.

The policies and politics streams are closely related and intertwined. The categories associated with the policies stream were standardization of CHW training and CHW certification requirements. The overarching theme for these categories was identified as official policy recognition of the CHW profession. The categories listed under the politics stream were CHW payment policy and CHW profession advocacy. The theme that evolved from these categories was accountability for CHW integration. These categories and themes are tied to collaborative legislative and political deliberation and partnerships for action to occur to address the CHW profession's role and concerns.

**Process stream.** The process stream establishes mechanisms to explore options and facilitate authoritative decision-making and time frames for considerations and sets forth the general direction of how the stream will proceed. This could be the establishment of a body that will convene and manage the process to move forward in

addressing the policy issue. This includes developing policy and establishing a decision-making process that will focus on the strategic agenda for an issue. The process stream examines options for policy decisions (Howlett et al., 2015). The legislatively mandated Maryland CHW Advisory Committee convened in October 2018. They meet every other month and are charged with advising the Maryland Department of Health on policies and procedures related to training and certifying CHWs. (Public Health - Community Health Workers – Advisory Committee and Certification Act, MD Senate Bill 163, § 441, 2018). The work that the Advisory Committee is performing is consistent with implementing the process stream.

***Integrated care communication/documentation.*** The categories that the participants addressed are integrated care communication/documentation, CHW contribution measurement, and community /healthcare team education. The frequency of responses regarding integrated care communication/ documentation was 21 ($f = 21$). The CHWs' comments addressed the importance of verbal and written communication with the health care team and clients regarding the delivery of CHW support. These comments discuss mechanisms that CHWs use to document the support they provide clients. It also addresses how they communicate with the patient and/or health care team to provide patient-centered informed support that meets the client's health care goals in collaboration with the team. Examples are described below.

Participant 2 indicated that her organization was community-based and not initially connected with a health care facility, which was difficult, but they subsequently developed a bi-directional referral system. The hospital would make a referral through

the system and the CHW would provide an update on their visits with the client. However, the feedback on what the hospital was doing related to the client was not communicated back to the organization. She stated, “It was fine as long as they were making referrals, so we weren't getting the feedback and that took again, like two and a half years for them to understand we need the information just like they do.’’

Participant 3 described the chart system that her organization uses. The team documents in the chart and may flag another member of the team if they need them to act on something related to a client. For example, if a client does not have an address but a team member knows the places where the client frequently visits, they can document that in the chart. She stated, “So when we have those clients that do fall out of care that need engagement or have certain diagnoses that need attention, I’m able to locate them fairly quickly and get them that vital information.”

Participant 4 mentioned that the CHWs document so that the team can see what they are doing. A review is done at the end of the month and if a patient has not been in touch with the health care team, a root cause analysis is done to determine why the client is not following up with their care.

Participant 5‘s organization has a data system which she described. She stated, “We put all of our consumers in the data system, so we can tell you how many community health workers we had as far as consumers.” They are able to reference the initial assessment of the patient with the current assessment for comparison as well as all of the resources or referrals provided to determine follow through or improvement. She emphasized that it is important for the hospital to share at least a diagnosis, in addition to

the demographics, and contact information so the CHW can follow through and have an idea of what they might find on their first visit.

Participant 6 stated that her new manager is training the CHWs on how to notate medical records to make sure that patients have a goal and try to reach that goal. Epic allows us to look up the patient's background before visiting them at the bedside. She stated, "I need more open communications with the people I work with on the healthcare team."

Participant 7 describes her active role with the behavioral health care team as well. She stated: "…When I get a referral, …I always have signed releases on both ends and I always ask permission [regarding restrictions in communication] and communicate…with whoever …referred me to let them know I've assessed, and this is our goal."

Participant 8 described their documentation of the support they provide their clients as a CHW. She stated, "We have a whole chart that gets filled out and the face sheet of the client. When we finish with that, the nurse gets it back when we finished visiting him to look over it to see."

Participant 9 raised the need for accessible online technology that interfaces with other organizations to complete the large amount of paperwork that is needed. It is time consuming to spend time working with a patient, complete the paperwork and then later find out that another agency is working on the same thing if the patient does not tell you or does not know that someone else is also working on the same thing. This is time that could be spent with someone else.

Participant 10 mentioned that they use a documentation system. The data analysts and program manager of the team look at the information and identify needs for coordination and report data to the local hospital and their other funding organization. Participant 11, from the same organization, stated, "they use a different documentation system from the hospital, but the goal is for all of them to be on the same system… This will give the CHWs access to the hospital documents and the hospital will be able to see…[activities] in the CHW program."

***Measurement of CHW contributions.*** The frequency of comments regarding measurement of CHW contribution is 15 ($f$ = 15). Based on the CHWs' responses, there are variations in the measurement and documentation of CHW contributions across the several organizations. Examples are:

- Supervisory review of CHWs' work varies across organizations. After the initial visit, subsequent supervisory reviews may vary according to organization policy and/or grant requirements (e.g., 30 days or 60 days). For example, in one organization, every three months, the CHW's workload is assessed for how many patients they have, how many are active, services provided and/or not provided, and how many patients passed away. They also track the number of referrals made, to what departments, whether patients followed through with the referral or want to discontinue services.
- Three organizations mentioned monitoring readmission rates of clients for decreases with the use of CHWs. If there is a patient that is not consistent about following up on their treatments and services, the CHW does a root

cause analysis of why the patient's engagement in care is not as expected. One organization mentioned that the CHWs' supervisors, in collaboration with the vice president, look at all the reports and readmission rates. For another organization, after the CHW completes their first visit, the RN reviews the documentation to ensure that the CHW reviewed the patient's information and made the necessary referrals to ensure they are in the best Medicare health insurance and drug programs and to see if there are other resources that would be helpful. Readmission rates were tracked as well.

- Two organizations described CHWs performing an initial assessment at the beginning of their treatment, setting goals, and evaluating progress and accomplishments in collaboration with the client so goals can be met. They are used to measure the impact of the CHW in facilitating integration and continuity of care, patient progress and the CHWs' performance. In addition, the CHW checks with the patient to determine if they did the activities that they agreed on and provides assistance where they can when the client has not taken action as agreed.
- Two organizations mentioned meeting measures that are associated with the grants that are funding the delivery of CHW services (e.g., blood pressure screenings, referrals, client support).
- One organization mentioned measuring program performance using guides to assess the performance of grants in the State of Maryland Health Enterprise Zones in consultation with a local university. Health Enterprise Zones are

adjacent geographic areas which exhibit quantifiable and substantiated health disparities and poor health (Maryland Health Improvement and Disparities Reduction Act of 2012). Areas assessed included CHW interventions, time spent, and patient outcomes.

- Another organization tracked its data through a statewide health information exchange, which covers Maryland and Washington, DC (Chesapeake Regional Information System for our Patients, 2019), using a healthcare data integration engine. It inputs their data and is able pull out data on the patients they serve rather than the general community population.
- One organization retained a university to help them develop a way to take the tremendous amount of data that they have and convert it into information that funders can use to make informed decisions.

Finally, one organization uses a tool called the patient activation measure (PAM). The PAM is a tool to determine how active a patient is engaged in their own health care management which can support the use and effectiveness of a patient centered care model (Hibbard, 2005). The CHW administers the PAM upon intake of the patient and administers the PAM at the end of the CHW intervention and use the scores as a measure of whether the patient made progress. Data was entered into a documentation system and a data team analyzes the data. In addition, information such as the client enrollment and graduation date, contact notes, care plan, and goals that were met and not met are also captured and a data team is reviewing, analyzing, and interpreting this information along

with the program manager for the CHWs and report it back to the funding organizations. The prevention of readmissions of high utilizers are used to calculate resources saved.

Based on CHWs' responses, there are variations in the measurement and documentation of CHW contributions across the seven organizations. The data elements, systems, processes, and procedures to measure CHW contributions to improved patient outcomes varies across the seven organizations where the participants work. There were common data elements that were collected, and activities implemented across some of the organizations such as readmission rates, collaborative assessment and setting goals, monitoring and evaluating progress toward agreed upon goals, and facilitating access to resources.

***Community/organizational leadership/health care team education.*** The frequency of responses regarding community education was 9 ($f = 9$) and the frequency of responses related to health team education was 9 ($f = 9$). In order to have the community and other professions advocate for the use and integration of CHWs into the behavioral health care team, they have to be educated and informed about the role of the CHW. They need to understand who CHWs are, what they do, including their scope of practice, who they work with, why what they do is important to the client, the health care team, and the community. They also need to know what they can do to help CHWs further their integration into the health care team. This education needs to evolve from the members and leadership of the community, the health care system, including CHWs, governmental agencies, and elected officials. They are the ones who should negotiate and partner regarding how the community can best be served, in the context of the

requirements/constraints and flexibilities of the community organizations, businesses, the health care system organizations and institutions that train the health workforce (DeSalvo et al., 2016).

The process stream had three categories, integrated care communication/ documentation, CHW contribution measurement, and community/health care team education. The CHWs expressed the need for two-way written and verbal communication with the integrated behavioral health care team. They also described variations in measuring CHWs' contributions. Finally, they emphasized the need for the community and the health care team to be educated on the role of the CHW. This information could help clients, the community, and the health care team understand how the CHW supports collaborative management of integrated, client-centered, quality physical and mental behavioral health care. The theme that evolved from these categories is CHW practice support.

**Program stream.** The program stream looks at needed mechanisms for introducing policy changes and how to make adjustments to integrate them into existing policies and systems (Howlett et al., 2015). The frequency of responses regarding behavioral health was 37 ($f = 37$) and as previously mentioned, the frequency of responses related to CHW behavioral health integration is 55 ($f = 55$). Two categories were identified in the participants' comments, community behavioral health needs and integrated health care team.

***Community behavioral health needs and integrated health care teams.*** The participant's provided several examples in which they were working with patients with

physical conditions and discovered behavioral health conditions. Also, patients with behavioral health conditions were often seen to address medical conditions. This gives credence to the importance of having CHWs prepared to have encounters with clients that address both physical and mental health conditions and associated behavior. The theme that evolved from these categories is the integrated management of physical and mental health and behavior.

**Research Question 3**

Research Question 3 for this study: How do CHWs view their function as a SLB to support integration into the behavioral health care team? This research question addresses how CHWs conduct themselves as SLBs. A SLB functions within the policies and job description for their position. However, there are gray areas where the employee can use decision discretion to execute their roles. This discretion may be exercised to manage workload or to function within limited resources such as social services (Lipsky, 2010).

**Decision discretion.** CHWs are SLBs and experience pressures to serve many clients with limited resources. With time and resource constraints, CHWs may use decision discretion to adjust their workload to make it more manageable and accommodate clients' needs, in keeping with their organization's policy. This could come in the form of optimizing resources, automating activities, and/or managing or adjusting client expectations (Vedung, 2015). However, the review of CHW roles, across various states and the ones that the Maryland Department of Health and Mental Hygiene and Maryland Insurance Administration (2015) identified in the Final Report to the

Maryland General Assembly, leaves flexibility regarding how some of the roles will be implemented. The three categories that participants identified were client advocacy and support, CHW networking, and partnership building. These are some activities that CHWs would perform as part of their regular duties. However, it is the intensity, steadfastness, and consistency with which the CHW works with their clients to prevent or address issues which reflects examples of decision discretion. The theme that evolved from these categories was building the CHW profession.

Decision discretion is often used to provide support to populations and CHWs identified that they could perform as SLBs, although some of the CHWs were hesitant to identify any functions. Of the 11 CHWs, seven of them gave examples of how they can use decision discretion. The remaining four did not offer examples of decision discretion as a SLB. Participant 9 emphasized that she tries to follow policies since they exist to protect her, the agency, and the client. Several specific examples of decision discretion are discussed below.

***Client advocacy and support.*** The frequency of responses regarding client or patient advocacy, transportation, and isolation were 33 ($f = 33$), 20 ($f = 20$), and 8 ($f = 8$), respectively. The extent to which a CHW goes to advocate for their clients may vary, which is a reflection of exercising decision discretion. Participant 1 indicated that because funding was cut, CHWs were laid off. Some of these CHWs opted to volunteer due to their commitment to serve the population. This reflects the level of commitment to support their clients that is found in the CHW population. She also addressed client advocacy by indicating that it would be helpful to have a source to go to when she has a

sense of the resource that the patient needs related to behavioral health. This reflected her willingness to use her discretion in helping her client get the help that he/she needed related to behavioral health. Participant 2 emphasized the need to know what resources are available as well to advocate for patients.

Participant 3 indicated her commitment to advocating for her clients to the fullest extent possible, including having resources for transportation for patients. She stated, "We know these clients, we know their needs and we know what works for them and I think that (we are)...the voice for them."

Participant 6 emphasized that CHWs perform work that other members of the health care team are not doing in terms of client advocacy and support such as shopping for groceries. Her comment highlighted that there is a broad range of activities that the CHW can perform and therein lies the decision discretion that the CHW has in their day-to-day work.

Participants 5 indicated that sometimes clients need someone they can talk with about various things like a medical visit or just have someone to ask and truly listen to how they feel. This is something that the CHW can do and could lead to referrals to address concerns. Participant 8 acknowledged that some of their clients suffer from loneliness and once identified, have benefited from having volunteers checking on them to see how they are doing.

***CHW networking.*** The frequency of responses regarding CHW networking was 16 ($f = 16$). Networking is an opportunity for CHWs to exchange information and ideas and problem solve to help them be effective in their practice. Below are quotes and

paraphrased comments from the participants. CHW networking can lay the foundation for advocating for the CHW profession. Information may also include updates on the state level activities regarding the CHW professions. Participant 4 indicated that she is part of the Maryland Community Health Workers Association and this is a chance to meet CHWs from different areas of the state working with various health conditions such as mental health and infectious disease.

Participant 5 also mentioned the value of CHW networking when she discussed the importance of sharing what they learn as they identify problems and inform the community and the team, so they know how to handle similar situations. She also mentioned that updates just to keep CHWs aware of new policies or to give them a heads up about what may be coming out is important. There needs to be a way to keep in touch because there are differences in how CHWs work depending on their setting and their organization and they need to share ideas.

Participant 9 mentioned that one way she networks is online. She stated, "…I go online and research…which way as a community health worker that I can help."

***Partnership building.*** The frequency of responses regarding community partnerships was 21 ($f = 21$). Partnership building is critical for CHWs to effectively perform their duties. As previously mentioned, most of the CHWs are funded through partnerships. In addition, these partnerships are also helpful for problem solving and health policy and program planning, execution and evaluation.

Participant 2 described her organizations first experience with CHWs working in the community was through a partnership with a grantee of the Maryland Department of

Health. They partnered with a mobile crisis team focused on working with behavioral health and SUD clients to prevent rehospitalization or divert them from being hospitalized. This first experience led them to opportunities with other organizations working with a mobile crisis team.

Participant 7 indicated that her organization belongs to a multi-organizational alliance across three states with numerous public health partners, such as hospitals, health departments, private practices, federally qualified health centers, and other community organizations. The work that her organization does benefits their partners and assists in improving health outcomes.

Participant 8 mentioned the partnership that they have with their local medical center from which they receive their referrals. Participant 9, who is from the same organization, indicated that when she comes across something that she has questions about implementing a policy, she brings it to her partnership team where they talk about what is not working or something needs to improve.

***Scope of practice clarity.*** The frequency of responses regarding scope of practice clarity was 2 ($f = 2$). Although only two CHWs explicitly mentioned scope of practice clarity, it is discussed because it raises a level of complexity for the CHW education accreditation and certification processes. There may need to be consideration of levels of CHW scope of practice based on types and levels of education and training preparation, roles, specialization, and experiential backgrounds. In addition to the recommendations of the Maryland Department of Health and Mental Hygiene and Maryland Insurance Administration (2015) and others, the actual practice as a CHW provides insight into

gaining clarity regarding the scope of practice. Participant 10 explicitly mentioned scope of practice three different times. She indicated the need for local policies to identify or define the CHW's scope of practice and certification process more. She also highlighted the importance of understanding the CHWs scope of practice.

Participant 11 offered a perspective on how to distinguish the roles of the nurse, social worker, and the CHW by stating, "the nurses deal more with the clinical condition of the patient, …the CHW [is] dealing with the social needs, and then the social worker is dealing with more of the behavioral health focus." Finally, she mentioned that part of building trust with the health care team is showing them that she is able to act within her scope of practice. The Maryland Workgroup on Workforce Development for Community Health Workers addressed the scope of work for CHWs and their report was submitted to the Maryland General Assembly (Maryland Department of Health and Mental Hygiene and Maryland Insurance Administration, 2015).

## Summary

In this chapter, six aspects of implementing the research were discussed. The aspects included: (a) the setting that impacted participants experience at the time of the study; (b) participant demographics and characteristics relevant to the study; (c) the data collection process, including any variations from the plan or unusual circumstances encountered; (d) the details of the data analysis process, including discrepant cases and how they were factored into the analysis; (e) evidence of trustworthiness through credibility, transferability, dependability, and confirmability; and (f) the study results.

The three research questions that guided this study and the details of the associated responses were discussed including the categories and themes that were yielded from the results. The responses to these three questions yielded 14 categories and six themes. The three questions and high-level summaries of responses are below:

**Research Question 1**

Two of the categories were identified in the responses to question 1. They are perceptions of behavioral health integration and community advocacy needs. The research participants perceived that the CHW integration into the behavioral health team allows them to make meaningful contributions to patient-centered integrated health care. They described enablers to the integration of the CHW into the behavioral health team such as direct communication with the health care team, keeping them aware of the status of the patient and seeking assistance of the health care team, as needed. Other enablers were described as having assessment tools available to use and making referrals to members of the health care team and for social support such as social services. They also accompany and/or transport or arrange for the transport of patients to behavioral health appointments. CHW roles may interact directly or indirectly with the behavioral health team. Other enablers are having the trust of the client and the health care team as they provide support to the clients and having the access to link clients to necessary resources (e.g. transportation, health care providers, social services, housing, etc.).

Barriers to integration of the CHW to the behavioral health care team are the hesitancy of the health care team to accept CHWs as members of the team because of funding constraints or lack of understanding of the CHW role and how they will function.

This puts CHWs in the position of having to prove their value to the health care team by showing them what they can do to earn respect and be fully utilized. Lack of certification was a factor that CHWs attributed to the lack of the integrated health care team accepting them. Two of the CHWs were not optimistic that health professionals will allow the CHW to be full participating members of the health care team, despite the CHW being in the position of seeing the patient in their environment and may have the most current information about the patient.

Also, some CHWs indicated that they did not have adequate written, verbal, or face-to-face communication with the health care team or potential clients which sometimes resulted in duplication of efforts or prevents the CHW from adequately preparing the CHW and the client for working collaboratively. This was also noted as a response under Research Question 2. Variations in perceptions related to communication, resources, and utilization to the integrated behavioral health team vary based on the organization in which the CHWs function. Community advocacy needs were also highlighted in response to Research Question 1, demonstrating the importance of a trusting relationship with clients, allowing the client to accept the advocacy support to facilitate client access to care that they need whether it be behavioral or medical health care.

One theme evolved from the data that addressed Research Question 1, health system utilization of CHW behavioral health integration. The health care system has not fully accepted the role of the CHW and based on what the CHW is seeing in working with their clients, there is a need in the community for integration of behavioral health

and physical health. It should be noted that the CHW, using a patient-centered approach, is working with their clients and the integrated health care team, to manage behavior related to physical and mental health conditions.

**Research Question 2**

I found nine categories in the responses to question 2. The policies stream included two categories, standardization of CHW training, and CHW certification requirements. The politics stream included two categories, CHW payment policy and CHW profession advocacy. The process stream had three categories, integrated care communication/documentation, CHW contribution measurement, and community/organizational leadership/ health care team education. The program stream had two categories, community behavioral health needs and integrated health care teams.

The CHWs identified several policies, politics, problems, programs and processes that would support them to contribute more as a member of the behavioral health team. The policies and politics are closely related because they are tied to legislative and political action for them to occur. The codes that were identified related to policies and politics were: (a) standardization of CHW training, (b) CHW certification requirements, (c) CHW payment policy, and (d) CHW profession advocacy.

Comments on these codes referred to the State of Maryland legislation that required the State of Maryland to establish a CHW Advisory Committee to oversee the accreditation of CHW training programs and certification of CHWs that is being implemented (Maryland Department of Health, 2018). Participants expressed that this process, once fully implemented, would assist them in being a more active member of the

behavioral health team. They mentioned some areas that standardized training should include to adequately prepare CHWs to function as members of a behavioral health care team. They also mentioned the importance of the certification requirements for CHWs to address the practice qualifications and standards for CHWs practicing in areas that require special expertise, such as behavioral health. One participant highlighted the importance of the scope of practice, which is noted as critical to inform the training curricula and accreditation standards for CHW training programs, certification requirements and practice standards that must be adhered to practice as a CHW.

The participants described how their organizations are paid for the CHW services they provide. All of the participant's organizations functioned under a grant. CHWs are not directly funded through state or federal healthcare reimbursement programs and therefore do not have ongoing sources of funding. However, the CHW organizations perform CHW functions through grants with other organizations. Some of the types of organizations that fund CHW's services include their organization's funds, indirect or direct federal, state, and county funding and funds from private donors, foundations and other not for profit organizations. are getting state and federal funds. Therefore, currently, payment for CHW services is dependent on community partnerships. It is believed that the certification of the CHW at the state level may better position CHWs for State reimbursement. An example of a partnership that is under development in the state is also highlighted and may be a promising model, although there are also other models throughout the state.

In addition to the policy and political issues mentioned above, several problems and processes were identified as barriers to the CHW's integration into the behavioral health team. These are the need for: (a) advocacy for patients, (b) community, organizational leadership, and health care team education; (c) advocacy for the CHW profession; (d) measures of CHW contributions; and (e) integrated care communication and documentation support inclusion. The critical nature of the CHW's ability to build trust with their clients so that they are able to advocate for them is highlighted. The community's need for the CHW's advocacy in navigating the health care and social system and CHWs' success in advocating for clients along with the challenges that CHWs face in their advocacy efforts were described.

The education of the health care team and the community were identified as critical in the promotion of the CHW profession to be integrated into the health care team. Four aspects of the promotion of the CHW profession were identified: (a) getting the local legislators, hospitals, and advisors to see the importance and distinct contribution of CHW role; (b) campaigning so the community is aware of the valuable role that the CHW can play for them in their community; (c) delivery of CHW services to the community so that they can experience the role in action; and (d) CHWs performing their role with the integrated health care team as a critical way to educate the health care team about the CHW role.

The measurement of CHW contributions and documentation were discussed, showing variations across organizations. These variations were noted on what and how information was collected and documentation on the CHW activities and patient

outcomes and the methods used to collect this information, which could be manual or automated, integrated or not integrated across systems. There were some commonalities in the data that were collected as well as methods and types of data collection and analysis that were unique to some of the organizations. Four themes evolved from the data that addressed Research Question 2. They were: (a) official policy recognition of the CHW profession, (b) accountability for CHW integration, (c) CHW practice support, and (d) integrated management of physical and mental health and behavior.

**Research Question 3**

The participant responses to this question aligned with the street level bureaucracy model (Lipton, 2010) with CHWs bringing clarity to their role based on situations with which they were faced and the judgement they exercised. The last three of the 14 categories were identified when responding to this research question. The participants identified client advocacy, CHW networking, and partnership building as areas in which they would be able to use decision discretion in their role as a CHW. Participants were consistent in expressing that their priority was client advocacy. They provided examples of how they used or would use their judgement and foresight in advocating for and supporting their clients, even more so when resources were available. There is a Maryland CHW Association which provides a forum for CHWs to network beyond their immediate working environment. This could be an opportunity for CHWs to share experiences where they used decision discretion that yielded positive patient outcomes or CHW performance.

Partnership building is identified as an area where CHWs can use their discretion

and be alert for opportunities for CHWs to work collaboratively with others to acquire resources, share ideas, and facilitate CHW integrations. The responses to this question yielded one theme, building the CHW profession. In chapter 4, processes used for data collection and data analysis were articulated, evidence of trustworthiness was discussed, and the study results were presented in the context of the research questions. Chapter 5 provides an interpretation of the findings, limitations, and recommendations of this study and the implications for social change.

# Chapter 5: Discussion, Conclusions, and Recommendations

## Introduction

The purpose of this research study was to gain insight into the phenomenon of CHW integration into the behavioral health team from the CHW perspective and identify transformations or adjustments that are needed to make it a reality. I used a phenomenological approach as the design for this study. Through participant interviews, insight was sought from CHWs about their experiences with being integrated into the behavioral health care system to promote access to health care and social services. In an effort to identify the data in their pure form, bracketing and theme analysis were used (see Patton, 2015). I conducted this study to focus on the need to support patients with mental illness in transitioning back to the community after a hospitalization and preventing rehospitalization. In addition, there was a need in the community to know how to prevent or detect mental health crises early.

The CHW's existence in the community, working with clients to prevent or address impending mental health crises, in collaboration with the behavioral health system, could lower the cost of health care services. The use of the CHW as part of the behavioral health team and a community advocate for mental health is a practical option to address this need. Based on the research participants' interviews, the key findings of this study were revealed through six themes. They were the need for (a) health system utilization of CHW integration, (b) official policy recognition of the CHW profession, (c) accountability for CHW integration, (d) CHW practice support, (e) integrated

management of physical and mental health and behavior, and (f) building the CHW profession.

## Interpretation of Findings

According to the participants, official recognition through the state as a profession will be helpful for CHWs to be accepted as a profession in the state. The State of Maryland CHW Advisory Committee has convened, as mandated by Maryland Senate Bill 163, Chapter 441, to advise the state on the certification and training of CHWs (Maryland Department of Health, 2018). The National Academy for State Health Policy (2018) surveys the states regarding their activities related to CHW training, certification, financing, roles, and scope of practice. They reported results in the State Community Health Worker Model, which revealed that 15 of the 50 states have reported that they have begun to address the role of the CHW. This varies from as little as defining the role of the CHW, convening advisory boards, performing studies, voluntary certification, conditional certification, mandatory certification, identification of the certifying body, and financing of CHWs (National Academy for State Health Policy, 2018). The decision about certification and accreditation programs for CHWs in the state of Maryland is pending the work of the Advisory Committee and the regulations that evolve from the state based on their recommendations (Maryland Department of Health, 2018).

Consistent with the literature review, which identified mental illness as a public health challenge, the participant CHWs were seeing clients with mental illness in their caseload. They also acknowledged the stigma of mental illness resulting in some of their clients not seeking help for their mental illness. In fact, some of the CHWs attended

appointments with their clients to support them in getting the behavioral health care they need.

The categories and themes that evolved from the content of the interviews were aligned with the Howlett et al.'s (2015) 5SCM and Lipsky's (2010) SLB model, previously described in Chapter 2 (see Table 2). Howlett et al.'s 5SCM includes five streams that occur when addressing policy development and implementation: the problem, policy, politics, program, and process streams. Using the streams of Howlett et al.'s 5SCM, the problems for CHWs were that they perceive that the health system has not fully accepted them as a profession and the community needs CHW advocacy to facilitate access to the HCS and social services to foster a healthy community. The policy needed is for the state of Maryland to determine how CHWs will function within the state in terms of certification and training accreditation. The politics associated with CHWs were the determination about who will be accountable for oversight and advocacy for the CHW profession, if any. For example, one state has the CHW certification under the state board of nursing; however, many of the functions that the CHW performs are associated with social services.

One of the major political issues that the CHWs raised was a payment policy for CHWs, keeping in mind that integration of CHWs is adversely impacted by having to depend on an unsteady flow of funding when depending on grants. Some states have provisions for reimbursement of CHWs in certain cases (National Academy for State Health Policy, 2018). The program that the CHWs described in their comments was

integrated health care teams with both behavioral health and physical health care integrated as part of the same team.

Processes identified by CHWs that need to be put in place to support CHW practice were care communication/documentation, CHW contribution measurement, and community/health care team education. The dominant streams are the problems, policies, and politics streams, which are actively reflected with the work of the State CHW Advisory Committee (Maryland Department of Health, 2018). There is evidence from across the state of the program and processes streams being tackled at the organizational level (i.e., CHWs are working; they are getting paid most of the time; they are working as members of integrated health care teams, although not fully integrated; they communicate and document on the care and interactions they have regarding their clients, although in some cases it is two-way with the HCS; they have various ways to measure their contributions, and they educate the community/healthcare team, although not consistently across the state). However, there are many complexities and interactions among these activities.

One of the complexities is that the role of the CHW not only plays a role in addressing the community's need for advocacy and access to health and social services, but it also plays a socio-economic role in the communities from which they come by providing employment opportunities. These employment opportunities could also lead to higher salaries as becoming a CHW would lead to the possibility of pursuing careers that would result in even higher salaries, such as nurses, socials workers, and other careers. In assessing the certification of CHWs and accreditation for their training programs, the

economic implications need to be considered as well. Certifications usually come with a fee and education requirements with tuition that may be costly and block persons from becoming certified or maintaining certification. These are the kinds of complexities and unpredictable situations that the 5SCM allows to be explored during the policy making process (Howlett et al., 2015).

The need to explore complexities is consistent with Howlett et al.'s (2015) 5SCM, which shows how various activities can disrupt the flow of the streams while decision making is pending or in process until the decision is made. Some examples of these disruptions are not having feasible policy options, loss of political interest, addressing the policy is constitutionally illegal (Howlett et al., 2015). It also demonstrates what Howlett et al. (2015) described as an opportunity for more detailed analysis of the interactions between and among the streams and how they affect each other. This information could possibly be used to shape the change that is wanted.

Once the policy and political decisions are made, implementation can take place. In the meantime, CHWs are in the position to use decision discretion within the framework of their employment situations. In alignment with Lipsky's (2010) SLB model (2010), the participants were asked about areas in which they believed they could exercise decision discretion in their role as CHWs. They identified client advocacy, CHW networking, and partnership building, demonstrating the relevance of the SLB model in this study.

The CHW interview comments were consistent with the findings of Shah et al. (2014) and Wennerstrom et al. (2011) in that the CHWs were already interacting with

healthcare teams and their work in the community involved working with mental health clients. In addition, several of the CHWs mentioned participating in training focused on mental health; however, none of the training was noted to be done simultaneously with medical and nursing students as Wennerstrom et al. described. The Federal Advisory Committee on Training in Primary Care Medicine and Dentistry (2014) also emphasized the importance of an inclusive integrated health workforce training and delivery site training. They identified CHWs as essential team members in the integrated cost-effective health care delivery of medical, dental, and behavioral health services to foster health equity. Wennerstrom et al. (2015) further highlighted the areas for training to prepare CHWs to provide services related to mental health. The CHWs in this research mentioned experiencing and/or being educated in the areas that Wennerstrom et al. (2015) mentioned, which were education, outreach, collaboration with health care teams, and the use of intervention development skills for readiness for emergencies.

Swartz et al. (2014) highlighted the importance of language diversity and cultural sensitivity and awareness in the delivery of mental health care. This is a role that the mental health care team can task shift to CHWs who have these skill sets. The participants noted that they come from the community they serve and, therefore, have the unique ability to communicate and build trusting relationships with their clients. This also supports Fricchione et al.'s (2012) results in their discussion regarding task shifting improving access to care.

The responses of the CHWs demonstrated that there are organizations that have established processes to use CHWs in the HCS to deliver mental health services. The

Maryland CHW Advisory Committee, which convened in October 2018, is also in the process of identifying acceptable training and practice standards (Maryland Department of Health, 2018). According to some of the CHWs interviewed, readmission costs are one of the criteria measured in some of the organizations that employ or use CHWs.

Regarding leadership and CHW support, the American Public Health Association (2019a) has a CHW section that states,

> Seeks to promote the community's voice within the health care system through development of the role of Community Health Workers (including Promotores de Salud, Community Health Representatives, Community Health Advisors and related titles) and provides a forum to share resources and strategies. (para.1)

The National Association of Community Health Workers (2019) seeks "to unify the voices of community health workers and strengthen the profession's capacity to promote healthy communities." ("Our Mission", para. 1). This organization was launched in April 2019 at its first national meeting. It is envisioned that this organization will be a unifying body for the profession and serve as a voice and resource regarding CHW policy, practice, leadership and evaluation, providing technical assistance, mentorship, and other support to evolving groups (National Association of Community Health Workers, 2019).

One of the CHW participants expressed the need for advocacy for the profession. She noted one of her experiences with a social worker advocating for CHW participation and recognition. Both of these organizations, based on their purposes, may be helpful in advocating for the CHW profession; however, given that the goal of this study was for the CHW to be part of an integrated behavioral health care team, it seems that advocacy

from members of the integrated mental and physical behavioral health care team may be more effective in getting team utilization of the CHW from that team.

## Limitations of the Study

My initial intent for identifying a sample of participants was to screen a few participants based on the participation criteria. If those candidates met the criteria for participation, then another set of participants would have been selected to participate in the sample. However, only 11 participants came forward indicating they met the criteria to participate after I sought to recruit participants through four organizations. Therefore, there may have been selection bias.

Another limitation was that participants came from 14 counties and one county equivalent in Maryland; therefore, it may not be possible to extrapolate the results to the remaining counties in the state. All of the CHWs in the sample came from Maryland so that the results may not be able to be generalized to other states. The research participation criteria only required participants to have a high school diploma or a general equivalency diploma. Since education beyond this level was not required or addressed in the interview questions, the impact of higher CHW education levels on the integration into the behavioral health team was not addressed.

## Recommendations

The following recommendations are based on the literature review and the research participants' perceptions of what is needed to support CHWs to serve their communities in the fullest capacity in their role. I urge CHW oversight/advisory bodies,

organizations, HCSs, and teams committed to the full integration of CHWs into behavioral health to use collaborative partnerships to implement these recommendations:

- Establish official policies to recognize the CHW profession with an explicit scope of practice as well as standardized CHW training accreditation and CHW certification requirement processes that include behavioral health.
- Consider how CHWs initially entering the profession with an advanced degree will ensure that their practice will reflect the intent of the CHW role being one that requires an intimate familiarity with the community, culture, and language of the populations they serve.
- Establish a repository of promising practices, lessons learned, models, methodologies, tools, and organizational behavior used across Maryland to support CHW practice and integration to include the following areas:
    - Documentation of evidence of the value that CHW contributions make to the HCS to improve patient outcomes.
    - A confidential, automated, unified care documentation mechanism to support integrated physical and mental behavioral health care delivery and communication that includes CHWs.
    - Methods for on-going, sustainable, CHW cost and payment/cost reimbursement.
    - Innovative partnering to make resources available for CHW use to support their clients, such as transportation and clinical resources.
    - Community, organizational, and healthcare team leadership education.

- Leverage the promising practices of existing policies, programs, processes, and infrastructure across organizations within Maryland and elsewhere in the literature, as relevant, to institute or make known existing pilots or models in the state pertaining to sustainable, CHW cost and payment/cost reimbursement.
- Engage and educate the community, including the businesses, community members, organization leaders, political officials, health profession organizations, and HCS leaders and teams in the advocacy for the integration of the role of the CHW and how it supports them and the public's health.
- Support CHWs and their professional organization to foster professional collaborations to advance the recognition, utilization, and compensation of the CHW, including being hired, managed, supported, and provided with career development.
- Engage CHW leadership in setting a national agenda for CHW research and evaluation of the development of policy suggestions.

Researchers interested in expanding the body of knowledge regarding CHWs practicing at their fullest capacity into integrated physical and mental health and behavior teams should consider studying the following:

- Impact of the CHW education accreditation and CHW certification policies on CHWs functioning at their fullest capacity in supporting the integrated health care team in achieving client goals.

- Identify/develop and evaluate CHW costs and cost effectiveness methodologies that can effectively support sustainable CHW payment/cost reimbursement.
- Assess the differences in the scope of practice of the CHW based on the level of education and experience.
- Engage CHW leadership in setting a national agenda for CHW research and evaluation of the development of policy suggestions.

## Implications

This study has potential impact for positive social change for communities, the HCS, CHWs, individuals, families, and the public's health. It highlights the challenges that CHWs experience in their efforts to effectively deliver services to their clients and how CHWs perceive they can become official members of the HCS. The official inclusion of the CHW in the HCS could provide a single point of contact for the team who has an awareness of the client's needs. The CHW is also able to advocate for the client or provide the support or guidance to the client to advocate for themselves. Finally, the CHW is also able to reinforce the plan of care and goals that the integrated patient-centered behavioral health care, including the client, established and communicate the need for consideration of adjustments.

When individual member's health and social service needs are being addressed, it can relieve the burden on other family members and positively impact the health of the family unit. It can also prevent the deterioration of the client's health which could lead to hospitalization, which is costly to hospitals, insurers, tax payers and overburdens the government in the subsidization of health care programs. The use of CHWs in this

manner could allow for task shifting for the behavioral health care team, allowing the health workforce to focus on more complex tasks and responsibilities aligned with their level of expertise and compensation. Organizations in turn will be using their health workforce more efficiently and cost effectively. In addition, the CHW can support the health care team and their clients to ensure that the client's needs are understood and that linguistically and culturally sensitive care is delivered to minimize barriers to appropriate treatment.

The use of the CHW could also facilitate the education and monitoring of health in their community through health education and screening programs which could improve the health of the community. This could help to identify persons at risk for illness (e.g., blood pressure screening or depression or suicide screening) and provide referrals to appropriate programs. From a societal public health policy perspective and social change, use of the CHW as a way of health care delivery for those in need for integration services is a cost-effective method for the delivery of services to facilitate having a healthier population. Utilization of CHWs in the community as a way of fostering primary prevention and early detection of illness is an investment in moving the health care system to be proactively healthy which is a less costly health care alternative.

Consideration needs to be given to changing the concept of the behavioral health team from either mental illness and/or SUD to an integrated team that addresses behavior related to physical and mental health, including SUDs to facilitate access to care and ongoing monitoring and treatment, as needed. Goodrich, Kilbourne, Nord, and Bauer (2013) advocated for this concept in their description of the evidence-based mental health

collaborative care model across settings which stresses proactive collaboration among primary care providers and mental health care providers, and specialists, involving coordination of care with community resources beyond primary care. This does not preclude the importance of the unique practices of each of these clinical practices or any other clinical specializations. However, it emphasizes that it is behavior that the client and the health care team are collaboratively managing for the clients and in turn the community to be as healthy as possible.

The use of Howlett et al.'s (2015) 5SCM policy development process and Lipsky's (2010) SLB model using decision discretion were relevant to CHW integration into the behavioral health system. The use of four of Howlett et al.'s five streams were reflected in the Maryland's activities related to deliberations regarding development of the CHW workforce. The first three streams of the 5SCM, which are problems, policies, and politics, are used to perform a strategic appraisal of a policy issue. In 2014, legislation was passed in Maryland convening a workgroup to analyze and make recommendations about CHW workforce development in the state (Maryland Department of Health (2018). The workgroup submitted a report reflecting their strategic appraisal to the Maryland General Assembly in 2015 (Maryland Department of Health and Mental Hygiene and Maryland Insurance Administration).

Howlett et al.'s (2015) fourth stream in the 5SCM is the process stream. During this stream, a method is established to determine how to proceed to make an authoritative decision regarding a policy issue. Maryland legislation was passed in 2018 to establish a Maryland CHW Advisory Committee to address matters related to CHW education

accreditation and certification policy. The committee convened in October 2018 and deliberations are underway (Maryland Department of Health, 2018). The final stream that Howlett et al. described was the program stream. This is when there is consolidation of ideas and stakeholders interested in the policy issue to ensure that all policy alternatives have been explored and to determine what the final policy should be regarding development of the CHW workforce. The completion of this stream is pending the completion of the work of the advisory committee during the process phase. Howlett et al.'s 5SCM should continue to be relevant for future research as the policy development process for the CHW profession is still underway and it is a very complex policy to be developed.

## Conclusion

CHWs need training and certification that prepares them for the populations they serve. CHWs support clients who have complex or multiple health conditions, many of which involve known and unknown physical and mental conditions, exhibited in the clients' behavior. The contributions of CHWs need to be included among health workforce members whose services are compensated through federal, state, and local government and private HCS reimbursement methods. Consequently, integration of care needs to go beyond the usual professions to include CHWs as a member of the health care team consisting of members working and communicating with each other and clients to collaboratively manage physical and mental health and associated behavior.

The CHW profession provides an opportunity for trained members of communities, of various economic situations, to enter the workforce to serve their

communities. Their personal experience of coming from the community they serve gives them the unique and necessary skill sets to understand and relate to members in the community. This study has served to provide perceptions of CHWs regarding their experiences as CHWs and their integration into the behavioral health team. It revealed that CHWs are in the community and meeting their communities' needs for advocacy for health care and social support. Specifically, there is a community need for integrated management of physical and mental behavior. There are clients with behavioral health conditions in the populations they serve as a regular part of their workload as they work with patients with medical conditions whether they are involved in primary, or secondary prevention activities. The challenges that CHWs face and the recommendations to address them to facilitate their integration into the behavioral health care team need to be given serious consideration to move the HCS forward in addressing the reality of community needs and how their role can contribute.

Some of the challenges are official recognition of CHWs as a profession through State regulations for CHW certification and training accreditation, which is underway, and accountability for CHWs in terms of profession advocacy, oversight, and payment/reimbursement policy. Finally, elucidation is needed on the roles of the health system members, including CHWs, the community, and the government in CHW integration into the behavioral health team. Our health care delivery and training programs need to prepare health care team members to deliver integrated care for physical and mental health and the associated behaviors.

The CHW should be a key team member who can facilitate the integration process in consultation and collaboration with the behavioral health care team, provided that they have HCS support. The CHW profession has the potential to provide career opportunities in the communities where CHWs live, which otherwise would not be available. Given these factors, integrating CHWs into the behavioral health team supports individuals, families, communities, organizations, and our society. The social implication is that CHWs' integration into the broadly defined integrated physical and mental behavioral health team could support having a more cost-effective way toward having healthy people and healthy communities.

The variations in the level of integration seems to be a function of the CHW, their organization, the terms and conditions of their functional description, the health care team, health care system, and the environment in which the CHW practices. This study and the literature show that there are essential components, promising practices, lessons learned, and models that exist globally, in states across the United States, and in Maryland that facilitate CHW integration into the behavioral health system. However, our country's health needs, health care costs, the accountability of HCS and other systems and infrastructure that support community and population health, along with progress that has been made thus far and that is underway is moving the integration of CHWs from a potentiality to a reality. It is time for CHWs to become official members of the team for integrated physical and mental behavioral health and to function to their fullest capacity. There appears to be insight into the problems impacting the full integration of CHWs into the HCS. Problems, policies, politics, process and program

changes, and supports required for this to occur seem to be known. There are activities on many fronts related to the integration of CHWs into the behavioral HCS. The government, HCS, the community and systems that support it, health profession educators and workforce, including CHWs, among others are taking action to move this integration forward. They seem to be primed to move the health care system to more effectively and efficiently utilize bidirectional primary care and behavioral health models of care to facilitate clients' and the communities' adoption and maintenance of healthier behaviors through the use of CHWs.

# References

Advisory Committee on Training in Primary Care Medicine and Dentistry. (2014, December). *Training health professionals in community settings during a time of transformation: Building and learning in integrated systems of care* (Annual Report No. 11). Rockville, MD: Author.

American Psychological Association. (2016). *Integrated health care.* Retrieved from http://www.apa.org/health/integrated-health-care.aspx

American Public Health Association. (2019a). *Community health workers.* Retrieved from https://www.apha.org/apha-communities/member-sections/community-health-workers

American Public Health Association. (2019b). *What is public health?* Retrieved from https://www.apha.org/what-is-public-health

Balcazar, H., Rosenthal, E. L., Brownstein, J., N., Rush, C. H., Matos, S., & Hernandez, L. (2011). Community health workers can be a public health force for change in the United States: Three actions for a new paradigm. *American Journal of Public Health, 101*(12), 2199-2203. doi:10.2105/AJPH.2011.300386

Baumgartner, F. R. (2016). John Kingdon and the evolutionary approach to public policy and agenda-setting. In N. Zahariadis (Ed.), *Handbook of public policy agenda-setting* (pp. 53-68). Cheltenham, England: Edward Elgar Publishing.

Bielaszka-DuVernay, C. (2011). Vermont's blueprint for medical homes, community health teams, and better health at lower cost. *Health Affairs, 30*(3), 383-386. doi: 10.1377/hlthaff.2011.0169

Bovbjerg, R. R., Eyster, L., Ormond, B. A., Anderson, T., & Richardson, E. (2013). Integrating community health workers into a reformed health care system (Grant Report No. 2012 SRC 102). Retrieved from http://www.urban.org/research/publication/integrating-community-health-workers-reformed-health-care-system/view/full_report

Brooks, B. A., Davis, S., Frank-Lightfoot, L., Kulbak, P. A., Poree, S., & Sgarlata, L. (2018). *Building a community health worker program: The key to better care, better outcomes, & lower costs.* Chicago, IL: Community Health Works.

Bureau of Labor Statistics. (2017). *Occupational employment and wages, May 2017: 21-1094 community health workers.* Retrieved from https://www.bls.gov/oes/2017/may/oes211094.htm

Cairney, P. (2015). Kingdon's multiple streams approach: What is the empirical impact of this universal theory? *Policy Studies Journal, 44,* 37–58. doi:10.1111/psj.12111

Centers for Disease Control and Prevention. (2019). Prevention. Retrieved from https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf

Centers for Disease Control and Prevention, Division for Heart Disease and Stroke Prevention. (2019). Community health worker toolkit. Retrieved from https://www.cdc.gov/dhdsp/pubs/toolkits/chw-toolkit.htm

Centers for Medicare and Medicaid Services. (2016). Measure methodology. Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html

Centers for Medicare and Medicaid Services. (2019). Accountable health communities model. Retrieved from https://innovation.cms.gov/initiatives/ahcm/

Chesapeake Regional Information System for our Patients. (2019). CRISP. Retrieved from https://www.crisphealth.org/

Cohen, M., March, J., & Olsen, J. (1972). A garbage can model of organizational choice. *Administrative Science Quarterly, 17*(1), 1–25. Retrieved from http://journals.sagepub.com/home/asq

Cooper, M. J., Sornalingam, S., & O'Donnell, C. (2015). Street-level bureaucracy: An underused theoretical model for general practice? *The British Journal of General Practice*, *65*(636), 376–377. doi:http://doi.org/10.3399/bjgp15X685921

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications.

DeSalvo, K. B., O'Carroll, P.W., Koo, D., Auerbach, J. M., & Monroe, J. A. (2016). Public health 3.0: Time for an upgrade. *American Journal of Public Health, 106*(4), 621-622. doi:10.2105/AJPH.2016.3030

Dower, C., Knox, M., Lindler, V. O., & Neil, E. (2006). *Advancing community health worker practice and utilization: The focus on financing.* San Francisco, CA: National Fund for Medical Education.

Erasmus, E. (2014). The use of street-level bureaucracy theory in health policy analysis in low- and middle-income countries: A meta-ethnographic synthesis. *Health Policy and Planning, 29*(suppl_3), iii70-iii78. doi:10.1093/heapol/czu112

Feeney, B. C., & Collins, N. L. (2014). A new look at social support: A theoretical perspective on thriving through relationships. *Personality and Social Psychology, Inc*, *19*(2), 113-147. doi:10.1177/1088868314544222

Fricchione, G. L., Borba, C. P. C., Alem, A., Shibre, T., Carney, J. R., & Henderson, D. C. (2012). Capacity building in global mental health: Professional training. *Harvard Review of Psychiatry*, *20*(1), 47–57. doi:10.3109/10673229.2012.655211

Gaede, B. M. (2014). Civil servant and professional: Understanding the challenges of being a public service doctor in a plural health care setting in rural South Africa. Retrieved from http://www.repository.up.ac.za/bitstream/handle/2263/45907/Gaede_Civil_2015.pdf?sequence=1

Goodrich, D. E., Kilbourne, A. M., Nord, K. M., & Bauer, M. S. (2013). Mental health collaborative care and its role in primary care settings. *Current Psychiatry Reports*, *15*(8), 383. doi:10.1007/s11920-013-0383-2.

Guetterman, T. C. (2015). Descriptions of sampling practices within five approaches to qualitative research in education and the health sciences. *Forum: Qualitative Social Research*, *16*(2), 1-18. doi:10.1177/1558689816674564

Health Resources and Services Administration, Bureau of Health Professions. (2007). Community health worker national workforce. Retrieved from https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/communityhealthworkforce.pdf

Herweg, N., Huß, C., & Zohlnhöfer, R. (2015). Straightening the three streams: Theorising extensions of the multiple streams framework. *European Journal of Political Research*, *54*(3), 435-449. doi:10.1111/1475-6765.12089

Heslin, K. C. & Weiss, A. J. (2015). Hospital readmissions involving psychiatric disorders, 2012. *Healthcare Cost and Utilization Project Statistical Brief 189.* Retrieved from http://hcup-us.ahrq.gov/reports/statbriefs/sb189-Hospital-Readmissions-Psychiatric-Disorders-2012.pdf

Hibbard, J. H., Mahoney, E. R., Stockard, J., & Tusler, M. (2005). Development and testing of a short form of the patient activation measure. *Health Services Research*, *40*(6 Pt 1), 1918-1930. doi:10.1111/j.1475-6773.2005.00438.x

Hines, A. L., Barrett, M. L., Jiang H. J., & Steiner, C. A. (2014). Conditions with the largest number of adult hospital readmissions by payer, 2011. *Healthcare Cost and Utilization Project Statistical Brief 172.* Retrieved from http://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf.

Howlett, M., McConnell, A., & Perl, A. (2015). Forum section: Theoretically refining the multiple streams framework streams and stages: Reconciling Kingdon and policy process theory. *European Journal of Political Research, 54*, 419–434. doi:10.1111/1475-6765.12064

Hynes, D. M., Buscemi, J., & Quintiiani, L. M. (2015). Society of Behavioral Medicine (SBM) position statement: SBM supports increased efforts to integrate community health workers into the patient-centered medical home. *Society of*

*Behavioral Medicine Health Policy*, *5*(4), 483-485. doi:10.1007/s13142-015-0340-1

Institute of Medicine. (2003). *The future of the public's health in the 21st century*. Washington, DC: National Academies Press.

Jones, C. O. (1984). *An introduction to the study of public policy* (3rd ed.). Belmont, CA: Wadsworth, Inc.

Kane, S. (2016). The health policy process in Vietnam: Going beyond Kingdon's multiple streams theory. *International Journal of Health Policy & Management, 5*, 435-437. doi:10.15171/ijhpm.2016.45.

Kangovi, S., Mitra, N., Turr, L., Huo, H., Grande, D., & Long, J. A. (2017). A randomized controlled trial of a community health worker intervention in a population of patients with multiple chronic diseases: Study design and protocol. *Contemporary Clinical Trials*, *53*, 115–121. doi:10.1016/j.cct.2016.12.009

Kartika, T. (2017). Innovative community health worker strategies: Medicaid payment models for community health worker home visits. *National Academy for State Health Policy*. Retrieved from https://nashp.org/wp-content/uploads/2017/11/CHW-Home-Improvement1.pdf

Kim, K., Choi, J. S., Choi, E., Nieman, C. L., Joo, J. H., Lin, F. R.,…Han, H. (2016). Effects of community-based health worker interventions to improve chronic disease management and care among vulnerable populations: A systematic

review. *American Journal of Public Health*. Advance online publication. doi:10.2105/AJPH.2015.302987

Kingdon, J. W. (1984). *Agendas, alternatives, and public policies*. Boston, MA: Little, Brown and Company.

Kingdon, J. W. (1989). *Congressmen's voting decisions.* Ann Arbor, MI: University of Michigan Press.

Kingdon, J. W. (2011). *Agendas, alternatives, and public policies* (Updated 2nd ed.). Glenview, IL: Pearson Education.

Kripalani, S., Theobald, C. N., Anctil, B., & Vasilevskis, E. E. (2013). Reducing hospital readmission rates: Current strategies and future directions. *Annual Review of Medicine, 65*, 471-485. doi:10.1146/annurev-med-022613-090415

Kubiak, S. P., Sobeck, J., & Rose, I. (2005). "It's not a gap, it's a gulf": An analysis of barriers to integrated treatment for those with co-occurring disorders using Kingdon's multiple streams framework. *Best Practices in Mental Health, 1*(2), 19-33. Retrieved from: https://ezp.waldenulibrary.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=18489484&site=eds-live&scope=site

Kusi-Ampofo, O., Church, J., Conteh, C., & Heinmiller, B. T. (2015). Resistance and change: A multiple streams approach to understanding health policy making in Ghana. *Journal of Health Politics, Policy & Law*, *40*(1), 195-219. doi:10.1215/03616878-2854711

Lake, J., & Turner, M. S. (2017. Urgent need for improved mental health care and a more collaborative model of care. *The Permanente Journal, 21,* 17-024. doi:10.7812/TPP/17-024

Library of Congress. (2017). Congress.gov. Retrieved from https://www.congress.gov/search?pageSort=documentNumber:desc&pageSize=250&q={%22congress%22:%22115%22,%22subject%22:%22Health%22,%22bill-status%22:%22law%22}&_=1496091809067

Lipsky, M. (2010). *Street level bureaucracy: Dilemmas of the individual in public service*: *30th anniversary expanded edition* (2nd ed.). New York, NY: Russell Sage Foundation.

MacQueen, K. M., McLellan, E., Metzger, D. S., Kegeles, S., Strauss, R. P., Scotti, R., … Trotter, R. T. (2001). What is community? An evidence-based definition for participatory public health. *American Journal of Public Health*, *91*(12), 1929–1938. doi:10.2105/AJPH.91.12.1929

Maes, K., Closser, S., & Kalofonos, I. (2014). Listening to community health workers: How ethnographic research can inform positive relationships among community health workers. *American Journal of Public Health. 104*(5), e5-e9. doi:10.2105/AJPH.2014.301907

Malcarney, M., Pittman, P., Quigley, L., Horton, K., & Seiler, N. (2017). The changing roles of community health workers. *Health Services Research, 52*(S1), 360-382. doi:10.1111/1475-6773.12657

Maryland Department of Health. (2018). *Community health workers in Maryland.* Retrieved from https://health.maryland.gov/mhhd/Pages/Community-Health-Worker.aspx

Maryland Department of Health and Mental Hygiene and Maryland Insurance Administration. (2015). *Final report to the Maryland General Assembly*. Retrieved from https://mmcp.health.maryland.gov/Documents/communityhealthworkersJCRfinal6-15.pdf

Maryland Health Improvement and Disparities Reduction Act of 2012, Md. Stat. Senate Bill 234 §§20-1401-1407

Maryland State Archives. (2018). Maryland manual online: A guide to Maryland and its government. Retrieved from https://msa.maryland.gov/msa/mdmanual/26excom/html/10comhealth.html

Matumba, B. B., Ginneken, N. V., Paintain, L. S., Wandiembe, S. & Schellenberg, D. (2013). Roles and effectiveness of lay community health workers in the prevention of mental, neurological and substance use disorders in low- and middle-income countries: A systematic review. *BMC Health Services Research, 13*(1), 1–23. doi:10.1186/1472-6963-13-412

Maxwell, J. A. (2013). *Qualitative research design: An interactive approach* (3rd ed.). Thousand Oaks, CA: Sage Publications.

McBeth, M. K., Jones, M. D., & Shanahan, E. A. (2014). The narrative policy framework. In P. A. Sabatier & C. M. Weible (Eds.), *Theories of the policy process* (pp. 225-266). Boulder, CO: Westview Press.

Mettler, S. & Sorelle, M. (2014). Policy feedback theory. In P. A. Sabatier & C. M. Weible (Eds.), *Theories of the policy process* (pp. 151-181). Boulder, CO: Westview Press.

MHP Salud. (2014). Guide to grant opportunities and resources for promotora programs. Retrieved from http://mhpsalud.org/wp-content/uploads/2013/11/Guide-to-Grant-Opportunities-and-Resources-for-Promotora-Programs.pdf

Miles, M. B., Huberman, A. M. & Saldaña, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Minnesota Department of Health, Office of Rural Health and Primary Care. (2016). *Community health worker (CHW) Toolkit: A guide for employers.* Retrieved from: http://www.health.state.mn.us/divs/orhpc/workforce/emerging/chw/2016chwtool.pdf

Minnesota Department of Health, State Innovation Model. (2016). *Community health workers: A review of the literature.* Retrieved from http://www.health.state.mn.us/divs/orhpc/workforce/emerging/chw/index2.html

Morse, S. W. (2014). *Smart communities: How citizens and local leaders can use strategic thinking to build a brighter future* (2nd ed.). San Francisco, CA: Jossey-Bass.

Najafizada, S. A. M., Bourgeault, I. L., Labonte, R., Packer, C., & Torres, S. (2015). Community health workers in Canada and other high-income countries: A scoping review and research gaps. *Canadian Journal of Public Health, 106*(3), E157-E164. doi: 10.17269/CJPH.106.4747

National Academy for State Health Policy. (2018). *State community health worker models.* Retrieved from http://www.nashp.org/state-community-health-worker-models/

National Association for Community Health Workers. (2019). *What we do.* Retrieved from https://nachw.org/about/

National Conference of State Legislatures. (2011). Affordable Care Act: A brief summary. Retrieved from http://www.ncsl.org/research/health/the-affordable-care-act-brief-summary.aspx

Ngugi, A. K., Nyaga, L. W., Lakhani, A., Agoi, F., Hanselman, M., Lugogo, G., & Mehta, K. M. (2018). Prevalence, incidence and predictors of volunteer community health worker attrition in Kwale County, Kenya. *BMJ Global Health*, *3*(4), e000750. doi:10.1136/bmjgh-2018-000750

O'Sullivan, E., Rassel, G. R., & Berner, M. (2008). *Research methods for public administrators* (5th ed.). New York, NY: Pearson Longman Publishing.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health*, *42*(5), 533–544. doi:10.1007/s10488-013-0528-y

Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

Patton, M.Q. (2015). *Qualitative research & evaluation methods* (4th ed.). Thousand Oaks, CA: SAGE.

Perry, H., Zulliger, R., & Rogers, M. M. (2014). Community health workers in low-, middle-, and high-income countries: An overview of their history, recent evolution and current effectiveness. *Annual Reviews of Public Health, 35*, 399-421. doi:10.1146/annurev-publhealth-032013-182354

Pittman, M., A. Sunderland, A. Broderick, and Barnett, K. (2015). Bringing community health workers into the mainstream of U.S. health care. *NAM Perspectives.* Discussion Paper, National Academy of Medicine, Washington, DC. doi:10.31478/201502c

Public Health - Community Health Workers – Advisory Committee and Certification Act, MD Senate Bill 163, § 441 (2018).

Rogers, E. A., Manser, S. T., Cleary, J., Joseph, A. M., Harwood, E. M., & Call, K. T. (2018). Integrating community health workers into medical practice. *Annals of Family Medicine, 16*(1), 14-20. doi:10.1370/afm.2171

Rudestam, K. E., & Newton, R. R. (2015). *Surviving your dissertation: A comprehensive guide to content and process* (4th ed.). Thousand Oaks, CA: SAGE.

Sabatier, P. A. & Weible, C. M. (Eds.) (2014). *Theories of the policy process.* Boulder, CO: Westview Press.

Sabo, S., Wennerstrom, A., Phillips, D., Haywoord, C., Redondo, F., Bell M. L., & Ingram, M. (2015). Community health worker professional advocacy: Voices of

action from the 2014 National Community Health Worker Advocacy Survey. *Journal of Ambulatory Care Management, 38*(3), 225-235. doi:10.1097/JAC.0000000000000089

Saldaña, J. (2016). *The coding manual for qualitative researchers*. (3rd ed.). Thousand Oaks, CA: SAGE.

Sapag, J. C., Herrera, A., Trainor, R., Caldera, T., & Khenti, A. (2013). Global mental health: transformative capacity building in Nicaragua. *Global Health Action*, *6*. doi:10.3402/gha.v6i0.21328.

Shaffritz, J. M., Russell, E.W., Borick, C.P., & Hyde, A.C. (2016). *Introducing public administration.* (9th ed.). New York: N.Y.: Routledge.

Shah, M., Heisler, M., & Davis, M. (2014). Community Health Workers and the Patient Protection and Affordable Care Act: An opportunity for a research, advocacy, and policy agenda. *Journal of Health Care for the Poor and Underserved*, *25*(1), 17–24. doi:10.1353/hpu.2014.0019

Simon, M. (2013.). Assumptions, limitations and delimitations. Retrieved from http://dissertationrecipes.com/wp-content/uploads/2011/04/AssumptionslimitationsdelimitationsX.pdf

Simon, M. K. & Goes, J. (2013.). Scope, limitations and delimitations. Retrieved from http://www.dissertationrecipes.com/wp-content/uploads/2011/04/limitationscopedelimitation1.pdf

Snyder, J. E. (2016). Community health workers: Roles and opportunities in health care delivery system reform. Retrieved from https://aspe.hhs.gov/system/files/pdf/168956/CHWPolicy.pdf

Standley, S. D. (2016). *A hospital: Reaching out and helping heal communities.* Paper presented at the 64th Annual Design & Construction Conference & Tradeshow, Westlake, OH. Retrieved from http://web.a.ebscohost.com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?vid=1&sid=aa7dd4e3-79d4-4f39-bcc4-888ef78b33ef%40sessionmgr4001&hid=4112

Substance Abuse and Mental Health Services Administration. (2014). *National behavioral health quality framework.* Retrieved from https://www.samhsa.gov/data/national-behavioral-health-quality-framework

Substance Abuse and Mental Health Services Administration. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health.* Retrieved from http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2016). *2015 National Survey on Drug Use and Health: Methodological summary and definitions.* Retrieved from https://www.samhsa.gov/data/sites/default/files/NSDUH-

MethodSummDefsHTML-2015/NSDUH-MethodSummDefsHTML-2015/NSDUH-MethodSummDefs-2015.htm

Substance Abuse and Mental Health Services Administration. (2017). *Behavioral Health Barometer: United States, Volume 4: Indicators as measured through the 2015 National Survey on Drug Use and Health and National Survey of Substance Abuse Treatment Services.* HHS Publication No. SMA–17–BaroUS–16. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.

Substance Abuse and Mental Health Services Administration. (2018). *Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health* (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

Substance Abuse and Mental Health Services Administration. (2019). *Behavioral health treatment and services.* Retrieved from http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf

Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration Center for Integrated Health Solutions (n.d.). *Glossary: Bi-directional integration*. Retrieved from https://www.integration.samhsa.gov/glossary

Swartz, L., Kilian, S., Twesigye, J., Attah, D., & Chiliza, B. (2014). Language, culture, and task shifting: An emerging challenge for global mental health. *Global Health Action, 7*, 23433. doi:10.3402gha.v7.23433

Tandon, N., Shah, J., Keshavan, M. S., & Tandon, R. (2012). Attenuated psychosis and the schizophrenia prodrome: current status of risk identification and psychosis prevention. *Neuropsychiatry*, *2*(4), 345–353. doi:10.2217/NPY.12.36U.S.

21st Century Cures Act, 42 U.S.C. § 1001 (2016).

U.S. Department of Health and Human Services. (2017a). HHS FY 2018 budget in brief - HRSA

Retrieved from https://www.hhs.gov/about/budget/fy2018/budget-in-brief/hrsa/index.html

U.S. Department of Health and Human Services. (2017b). Healthy people 2020. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

U.S. Department of Labor. (2019a). Occupational employment and wages, May 2018: 21-1094 community health workers. Retrieved from https://www.bls.gov/oes/2018/may/oes211094.htm

U.S. Department of Labor. (2019b). Occupational employment and wages, May 2018: 29-1141 registered nurses. Retrieved from https://www.bls.gov/oes/2018/may/oes291141.htm

van Ginneken, N., Tharyan, P., Lewin, S., Rao, G.N., Meera, S.M., Pian, J., Chandrashekar, S., & Patel, V. (2013). Non-specialist health worker interventions

for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries. *Cochrane Database of Systematic Reviews*. *11*(CD009149). doi:10.1002/14651858.CD009149.pub2

Vaughan, K., Kok, M. C., Witter, S. & Dieleman, M. (2015). Cost and cost-effectiveness of community health workers: Evidence from a literature review. *Human Resources for Health. 13*(71), 1-16. doi:101186/s1296-015-0070-y

Vedung, E. (2015). Autonomy and street-level bureaucrats' coping strategies. *Nordic Journal of Studies in Educational Policy. 2015*(2), 28643. doi:10.3402/nstep.v1.28643

Vinzant, J., & Crothers, L. (1996). Street-level leadership: Rethinking the role of public servants in contemporary governance. *The American Review of Public Administration. 26*(4), 457-476. doi: https://doi.org/10.1177/027507409602600405

Wennerstrom, A., Hargrove, L., Minor, S., Kirkland, A., Shelton, S. R. (2015). Integrating community health workers into primary care to support behavioral health service delivery: A pilot study. *Journal of Ambulatory Care Management, 38*(3), 263-272. doi:10.1097/JAC.0000000000000087

Wennerstrom, A., Vannoy, S. D., Allen, C. E., Meyers, D., O'Toole, E., Wells, K. B., & Springgate, B. F. (2011). Community-based participatory development of a community health worker mental health outreach role to extend collaborative care in post-Katrina New Orleans. *Ethnicity & Disease, 21*(301), S1-45-51. doi: f4a4a7aa04304a90911a72a906cd4abe

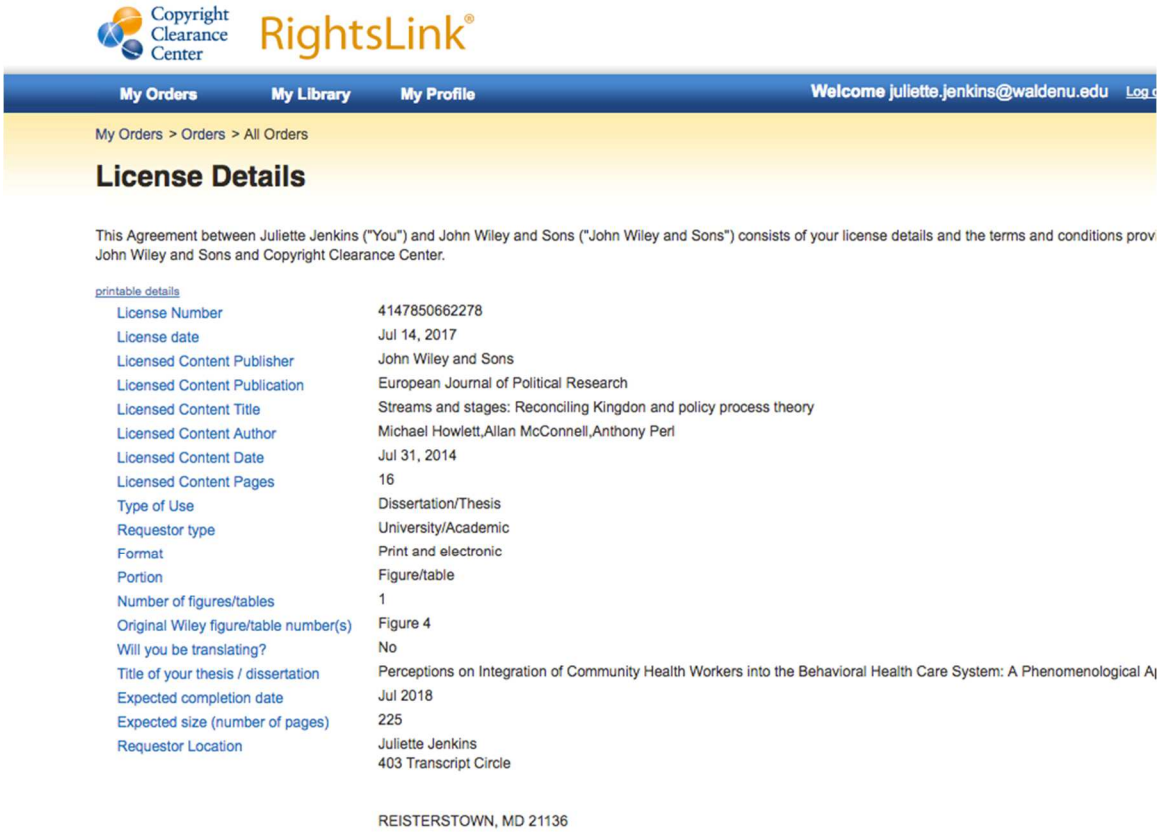
Workgroup on Workforce Development for Community Health Workers Act, MD House Bill 856, Chapter 259 (2014). Retrieved from https://legiscan.com/MD/bill/HB856/2014

Workgroup on Workforce Development for Community Health Workers Act, MD Senate Bill 592, Chapter 181 (2014). Retrieved from https://trackbill.com/bill/maryland-senate-bill-592-workgroup-on-workforce-development-for-community-health-workers/646982/

World Health Organization (2016). Health systems. Retrieved from http://www.who.int/topics/health_systems/en/

Zahariadis, N. (2014). Ambiguity and multiple streams. In P. A. Sabatier & C. M. Weible (Eds.), *Theories of the policy process* (pp. 25-58). Boulder, CO: Westview Press.

# Appendix A: Approval to Use Five Stream Confluence Model Figure



Copyright Clearance Center RightsLink®

My Orders | My Library | My Profile | Welcome juliette.jenkins@waldenu.edu | Log

My Orders > Orders > All Orders

## License Details

This Agreement between Juliette Jenkins ("You") and John Wiley and Sons ("John Wiley and Sons") consists of your license details and the terms and conditions prov
John Wiley and Sons and Copyright Clearance Center.

printable details

| | |
|---|---|
| License Number | 4147850662278 |
| License date | Jul 14, 2017 |
| Licensed Content Publisher | John Wiley and Sons |
| Licensed Content Publication | European Journal of Political Research |
| Licensed Content Title | Streams and stages: Reconciling Kingdon and policy process theory |
| Licensed Content Author | Michael Howlett,Allan McConnell,Anthony Perl |
| Licensed Content Date | Jul 31, 2014 |
| Licensed Content Pages | 16 |
| Type of Use | Dissertation/Thesis |
| Requestor type | University/Academic |
| Format | Print and electronic |
| Portion | Figure/table |
| Number of figures/tables | 1 |
| Original Wiley figure/table number(s) | Figure 4 |
| Will you be translating? | No |
| Title of your thesis / dissertation | Perceptions on Integration of Community Health Workers into the Behavioral Health Care System: A Phenomenological A |
| Expected completion date | Jul 2018 |
| Expected size (number of pages) | 225 |
| Requestor Location | Juliette Jenkins<br>403 Transcript Circle<br><br>REISTERSTOWN, MD 21136 |

Appendix B: Interview Questions

**Research Study:** A Phenomenological Study of the Integration of Community Health Workers into the Behavioral Health System.

**Description of the Project:** A phenomenological qualitative approach will be used to identify themes that contribute to understanding the policies, and roles that are involved in integrating CHWs into the behavioral health team.

**Questions:**

1.The Affordable Care Act supported the escalation of the use of CHWs. What local policies do you feel would support the CHWs to contribute more as a member of the behavioral health team?

2. Please describe, a situation in which you were integrated as a community health worker with a health care team that was addressing the needs of a patient with a behavioral health condition.

> Follow-up Prompt: What interactions did you have, with whom, how and about what, related to the patient's care?
>
> Follow up Prompts: What were your perceptions and feeling about these interactions related to you being accepted as a contributing member of the team and what were the reactions to your suggestions for change?
>
> Follow-up Prompts: What factors do you think influenced how health team members interacted with you to integrate you in patients' behavioral health care and why?

3. Describe if and how resources were made available to pay the cost of CHWs and their integration into the behavioral health care team?

Follow-up Question: If resources were made available, what was the source of the funds (e.g., receipt of new resources, reallocation of resources from another program, business process improvement)?

Follow-up Question: What were the processes put in place to measure the contributions of CHWs and the impact on health care delivery costs?

4. What do you think the strengths and weaknesses of the CHW role are?

5. Describe changes in policies or processes that could be made in the integration of the community health worker that could positively impact patient outcomes and the effectiveness and efficiency in the behavioral health care team?

Follow-up Question: What is your assessment of the contributions you have made or could make to advance the full integration of CHWs into the health care team that is addressing the needs of patients with behavioral health conditions and provide examples that support your conclusions.

Follow-up Question: What do you believe the health care system is doing and could do (e.g., legislatively, politically or organizationally) to advance the full integration of CHWs into the health care team that is addressing the needs of patients with behavioral health conditions?

Follow-up Question: What worked and what needs to be improved in the integration process at the organization, team, individual team members and patient levels?

6. CHWs are street level bureaucrats, which are persons implementing policy through interaction with the public, while using their judgment or policy discretion in the delivery of services. How do you perceive you can change policy related to integrating CHWs into the health care team through your role as a street level bureaucrat (i.e.,)?

## Appendix C: Legislation Pertaining to Community Health Workers

Retrieved from

https://msa.maryland.gov/msa/mdmanual/26excom/html/10comhealth.html

Maryland Senate Bill 163 by Senator Shirley Nathan Pulliam (D): In collaboration with the Advisory Committee, the Maryland Department of Health is to adopt regulations establishing the process for accrediting community health worker training programs, as well as initial regulations for the certification of community health workers.

Retrieved from

https://legiscan.com/MD/bill/HB856/2014

Maryland House Bill 856 by Senator Shirley Nathan Pulliam (D): Required the Department of Health and Mental Hygiene and the Maryland Insurance Administration to establish a specified stakeholder workgroup on workforce development for community health workers; requiring the workgroup to conduct a study and make recommendations; requiring the workgroup to submit a report to specified committees of the General Assembly on or before June 1, 2015; etc.

Retrieved from

https://trackbill.com/bill/166aryland-senate-bill-592-workgroup-on-workforce-development-for-community-health-workers/646982/

Maryland Senate Bill 592 by Senator Verna Jones-Rodwell (D): Requiring the Department of Health and Mental Hygiene and the Maryland Insurance Administration to establish a specified stakeholder workgroup; requiring, to the extent practicable, at least 50% of the membership of the workgroup be composed of individuals who are directly involved in or represent an institution or organization that is directly involved in the provision of nonclinical health care; requiring the workgroup to conduct a study and make recommendations on or before June 1, 2015; etc.

Retrieved from

https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

Senate Resolution 3590 Public Law 111–148 111th Congress: The Patient Protection Affordable Care Act (2010): Requires the implementation of numerous provisions with the intent to "expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and curb rising health care costs" (National Conference of State Legislatures, 2011).

Retrieved from

https://www.congress.gov/114/plaws/publ255/PLAW-114publ255.pdf

House Resolution 34 Public Law 114-255 114th Congress: 21st Century Cures Act (2016): Requires the implementation of numerous provisions to reform the mental health system, including addressing mental health, substance use disorders, and the criminal justice system.

# Appendix D: Table D1- Revised Coding Framework

Table D1

*Revised Preliminary Coding Framework*

| | Code name | Code description | Interview question number | Research question number | Theoretical framework |
|---|---|---|---|---|---|
| 1. | Community health worker integration perceptions (5PRCCHWI) | Interprofessional healthcare team that collaborates to provide integrated, coordinated health care services in the planning and implementation and evaluation of a thorough treatment plan to address patients' biological, psychological, and social needs (American Psychological Association, 2017). | 2, 3, 4, 5, 6 | 1, 2 | 5SCM process stream |
| 2. | Em - Perceptions of health care team Interactions (CHWIPI) | Perceptions of CHW or other health care team member's Interactions related to CHW integration. | 2 | 1, 2 | 5SCM process stream |
| 3. | Em - Advocacy for patient | A CHW taking action to facilitate a patient's access to services. | 6 | 1, 2, 3 | SLB |
| 4. | Patient trust in CHW | Establishing a trusting relationship as a critical | 2 | 1, 2, 3 | SLB |

| | | | | | |
|---|---|---|---|---|---|
| | | characteristic of the role of the CHW with the patient. | | | |
| 5. | Em - Health care team trust in CHWs | Health care team members and their trust in the contributions that CHWs can make | 2 | 1, 2 | 5SCM process stream |
| 6. | Em - Social support - (SLBDDSS) | Provision of emotional, instrumental, or informational support (Seeman, 2008). | 2 | 1, 2, 3 | SLB |
| 7. | Policy (5PLCY) | Affordable Care Act 2010-CHW provision (5PLCYACA) Policy change (5PLCYC) | 1, 5, 6 | 1, 2 | 5SCM policy stream |
| 8. | Em - CHW documentation | Mechanisms that CHWs use to document the support that they provide patients. This may include sharing their documentation and having access to documentation of other health care team members, working toward the goal of integrated patient-centered services. | 5 | 1, 2 | 5SCM process stream |
| 9. | CHW education and training | CHW education and training needs to be standardized. | 1, 5, 6 | 1, 2 | 5SCM problem stream |

| | | | | | |
|---|---|---|---|---|---|
| 10. | Resources for CHWs (5PRBR) | Resources to support the integration of CHWs into the health care team to improve access to care. | 3 | 1, 2 | 5SCM problem stream |
| 11. | Policy change (5PLCYC) | Policy changes that would support community health workers to contribute more as a member of the behavioral health team. | 1, 5, 6 | 1, 2 | 5SCM policy stream |
| 12. | Street level bureaucrat policy implementation (SLBFPI) | CHW feedback on being Street level Bureaucrats and implementing policies/activities to integrate them into the behavioral health team. | 2, 3, 4, 5, 6 | 1, 2, 3 | SLB |
| 13. | Behavioral health | Working with patients with behavioral health conditions and health care team members who serve them. | 1, 2, 5 | 1, 2 | 5SCM program stream |
| 14. | Em - Community partnerships | Identification and/or use of community partnerships to facilitate the integration of the CHW role into the behavioral health team. | 2 | 1, 2, 3 | SLB |
| 15. | Patient transportation resources | Provisions for patient transportation to appointments to receive health care services. | 2, 3, 4, 5, 6 | 1, 2 | 5SCM problem stream |

| | | | | | |
|---|---|---|---|---|---|
| 16. | Measurement of CHW contribution | How CHW contributions are measured. | 3 | 1, 2 | 5SCM process stream |
| 17. | Em - CHW networking | Meeting and engaging with other CHWs for support, exchanging ideas, and problem solving. | 5, 6 | 1, 2, 3 | SLB |
| 18. | Decision discretion | The flexibility in how much initiative a bureaucrat can use to implement their responsibilities to influence the outcomes for the population they serve, within the policies of the bureaucracy. | 5, 6 | 1, 2, 3 | SLB |
| 19. | Education of the community | Educate the community on how CHWs can advocate, support and educate the population and facilitate communication in the community and between patients and the health care team to support the delivery of culturally appropriate and effective health care delivery. | 1, 2, 3, 4, 5, 6 | 1, 2 | 5SCM Process stream & SLB |
| 20. | Em - Patient isolation | Patient does not have resources, communication, or access to services. | 2 | 1, 2 | 5SCM problem stream |

| | | | | | |
|---|---|---|---|---|---|
| 21. | Certification requirements | Procedures for the CHW to become certified by the State to practice as a CHW. | 2, 3, 4, 5, 6 | 1, 2 | 5SCM problem, policy, process streams |
| 22. | Education of the health care team | The need for the Health Care Team to understand the role of the CHW and how they can help support patients, the health care team, and the health of the community. | 1, 2, 3, 4, 5, 6 | 1, 2, | 5SCM problem stream |
| 23. | Em - CHW emotions | Emotions that CHWs express about their experience in their role as a CHW. | 2 | 1, 2, 3 | 5SCM problem stream & SLB |
| 24. | CHW scope of practice | Standards of practice to establish guidelines and expectations in the implementation of the CHW role. | 2, 3, 4, 5, 6 | 1, 2 | 5SCM problem, policy, process streams |
| 25. | Em - Advocacy for the profession | Making the role, capabilities, contributions and value that the CHW brings known in the community and the health care system. | 1, 5, 6 | 1, 2 | 5SCM problem, policy, process streams & SLB |
| 26. | Education of patients | Make patients aware of the CHW role and how they are able to support them. | 2 | 1, 2 | 5SCM process stream & SLB |

| | | | | | |
|---|---|---|---|---|---|
| 27. | Systems change | Changes in the business processes to support the implementation of the policy. | 3, 4, 5, 6 | 1, 2 | 5SCM process stream |
| 28. | Political | Legislation impacting CHWs | 1, 5, 6 | 1, 2, | 5SCM political stream |
| 29. | Political agenda | Political agenda of the health care system | 1, 5, 6 | 1, 2 | 5SCM political stream |
| 30. | Problem | Factors that adversely impact CHWs in becoming integrated into the behavioral health care system. | 1, 2, 3, 4, 5, 6 | 1, 2, 3 | 5SCM problem stream |
| 31. | Process | Processes put in place to implement the program that integrates CHW with the health care team to support community access to health care. | 1, 2, 3, 4, 5, 6 | 1, 2 | 5SCM process stream |
| 32. | Program | The mission, vision, goals, objectives, actions and/or expected outcomes that will support the integration of the CHW role into the health care system to support community health. | 1, 5, 6 | 1, 2 | 5SCM program stream |

*Note.* Table D1 shows the revised preliminary coding framework which includes the code names and descriptions, and associated interview questions, research questions and theoretical frameworks. Also shown in Table D1, there are 32 codes in the codebook. Of the 32 codes, 10 evolved as emergent (Em) codes. All of the eleven participants addressed eight of the codes with high frequencies of responses. Five of these eight codes were emergent codes.