The Emergence and Future of Community Health Workers

What's your definition of CHW?

Community Health Worker Definition - APHA (1)
- The CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.
- This trusting relationship enables the CHW 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.

Community Health Worker Definition - APHA (2)
- The CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.
- APHA Policy Statement 2009-1, November 2009

What Is Distinctive About CHWs? (1)
- Do not provide clinical care
- Generally do not hold another professional license
- Expertise is based on shared life experience (and often culture) with people served

What Is Distinctive About CHWs? (2)
- Rely on relationships and trust more than on clinical expertise
- Relate to community members as peers rather than purely as clients
- Can achieve certain results that other professionals can't (or won't)
CHWs and Patient Navigators

What's the difference?

- PNs are assigned to specific patients; CHWs often not, depending on role
- PN duties are a subset of CHW duties
- PNs may have another occupational background (RN, MSW)
- PN is a role or function, CHW is a distinct occupation

Professionalization of CHWs

- Language is changing from "the CHW model" and "CHW programs" to "CHWs as part of the system"
- CHWs as front-line public health workers and members of clinical care teams
- Requires recognizing and valuing their unique expertise – they are not clinicians
- Not everyone is in favor of professionalizing CHWs

Is professionalizing a good thing?

- Will CHWs lose touch?
- Will employers “kill the goose?”
- Can CHWs balance accountability to community and employer institutions?
- Should CHWs emulate existing professions?
- What about volunteers?
- "Community membership" as a qualification: who is a CHW?

National milestones

- National Community Health Advisor Study (1998)
- State CHW credentialing in Texas and Ohio (2002-3)
- HRSA CHW National Workforce Study (2007)
- NUCC Provider Taxonomy code for CHWs (2007)
- Minnesota Medicaid State Plan Amendment (2008)
- OMB creates SOC code for CHWs (2009)
Emergence of CHWs

SUSTAINABILITY – NOT ON GRANTS!

“If we pull this off, we’ll eat like kings.”

Key Understandings

- Affordable Care Act does not offer specific help in sustainability
- Most payment sources have a hard time with the full range of possible CHW roles
- Interests of payers and provider/employers are often different (who pays? who benefits?)
- May need to let go of language like “CHW program” that isolates the CHW

Routes to sustainability

- Primary prevention and community development: long term investment in addressing social determinants
- Health care:
  - Help control costs
  - Help providers address accountability in new care/payment structures: outcomes, not units of service
  - Help increase productivity of scarce clinical personnel

Sustainability options in health care

- 3rd party payers: CHW activity as “services” rather than “admin”
- New payment structures
- Internal financing

Current payer interest in CHWs

- “Hot-spotters” – better care for high utilizers
- Chronic disease management
- Improving birth outcomes
- Cancer screening and navigation
- Patient-Centered Medical Homes
- Care transitions

Why CHWs in Patient-Centered Medical Homes (PCMH(?)

- Communication and trust
- Regular follow-up
- Management of chronic conditions
- Consider whole person/family
Emergence of CHWs

Patient-Centered Medical Homes NCQA Criteria (1)

Area 1: Enhance Access and Continuity
- **Element F**: culturally and linguistically appropriate services (CLAS)
- **Element G**: the practice team - CHWs can add depth of understanding of the patient/family situation

Area 2: Managing the Patient Population
- **Element A**: patient information; assuring the team has a complete picture, and patient/family are being candid
- **Element C**: patient assessment
- **Element D**: population management; emphasizes prevention

Policy and systems change

Goal: create “employer demand” for CHWs
- Raise awareness of CHWs and their potential
- Pursue policies in four areas:
  - Occupational regulation (agreement on skills standards)
  - Research and data standards (evidence of effectiveness and “ROI”)
  - Sustainable financing models
  - Workforce development (training capacity/resources)

NCQA PCMH Criteria (2)

Area 3: Managing care
- **Element A**: patient reminders
- **Element C**: care management (care plan and follow-up)
- **Element D**: medication management (reconciling and recording)

Area 4: Self-care support and community resources
- **Element A**: self-care support
- **Element B**: referrals to community resources

Area 5: Tracking and coordinating care
- **Element A**: lab test follow-up
- **Element B**: referral follow-up
- **Element C**: coordination and care transition

Everything is connected!

Key Strategy Points

- Must address all 4 policy arenas
- Education and awareness effort needed first
- Need “Champions” in each stakeholder group
- CHW networks and associations need support
- Different stakeholders have different interests
- APHA policy statement contains other key principles

Differing interests of health care stakeholders

- Cost control/reduction
- Reducing hospital admissions and ER visits
- Increasing primary care visits and revenue
- Increasing patient adherence
- Reducing disparities
- Building trust, satisfaction, loyalty
### Reality in legislative action

- Anything that looks like “new spending” is DOA
- Studies and task forces can be viable first steps – engage stakeholders
- Scope of practice is potential sticking point with other professions
- Cost control/reduction is always appealing

### Stages of Policy Change Process Common to Minnesota And Massachusetts (1)

- Form core stakeholder group
- Collect workforce data, including employer return on investment, and produce report
- Use core group and report to build larger stakeholder group
- Build state CHW network as integral partner

### Stages of Policy Change Process Common to Minnesota And Massachusetts (2)

- Enlist pivotal leadership institutions
- May need officially commissioned reports as an intermediate step
- Introduce major legislation and policy change after other pieces are in place

### OTHER KEY PRINCIPLES

- Include CHWs in the development of policies that affect them
- Minimize barriers of language, education level, citizenship status, and life experience
- Encourage contracting with community-based organizations for CHWs’ services
- Incorporate the full range of CHW roles into positions

### Employer Awareness Stages

Clueless: “What’s a CHW?”
Unclear: “Nice, but how does it fit my business?”
Well-intended: “Great – if we can just get a grant...”
True believer: “CHWs are essential to what we do.”

### Other national CHW initiatives (1)

- CDC CHW policy e-learning series
- OWH CHW leadership training
- DOL “apprenticeable trade”
- OMH Promotora/CHW initiative
- DOL occupational definition

Other national CHW initiatives (2)

- CDC CHW policy e-learning series
- OWH CHW leadership training
- DOL “apprenticeable trade”
- OMH Promotora/CHW initiative
- DOL occupational definition (cont’d)
Promoting Policy and Systems Change to Expand Employment of Community Health Workers (CHWs)

Course Description
This course is designed to provide state programs and other stakeholders with basic knowledge about Community Health Workers (CHWs), such as official definitions of CHWs, workforce development, and other topic areas. In addition, the course covers how states can become engaged in policy and systems change efforts to establish sustainability for the work of CHWs, including examples of states that have proven success in this arena.

The six-session course covers:
- CHWs' roles and functions
- Current status of the CHW occupation
- Areas of public policy affecting CHWs
- Credentialing CHWs
- Sustainable funding for CHW positions
- Examples of states successful in moving policy and systems change forward

The course sessions are self-paced. Completion time for each session is between 30–45 minutes. The user does not have to take each session in succession.

Recent state/local innovations with CHWs
- DE “Health Ambassadors”
- CHW Network of Buffalo (NY)
- Seattle-King County
- Medicaid 1115 waiver in San Antonio
- Oregon “CCO” legislation
- South Carolina Medicaid pilot

Link to CDC E-learning
http://1.usa.gov/Z0nNw8g.htm

Surge in state-level interest
In addition to established initiatives in AK, MA, MN, FL, NY, RI, IN, MI, OH, TX:
- New movements in AZ, IL, MS, NE, NM, OR, SC, WI
- Recent State investigations in AR, CA, DE, MD, MO, ND, UT, WA

CONTACT INFO
Carl H. Rush, MRP
Project on CHW Policy and Practice
U. Of Texas Institute for Health Policy
PO Box 5533
San Antonio, TX 78201-0533
(210) 775-2709
(210) 241-3983 mobile
carl.h.rush@uth.tmc.edu

carl.h.rush@uth.tmc.edu