



A Policy Brief for the Medical Homes DC Area Health Education Center

Leaders Among Us: Developing a Community Health Worker Program in Washington, DC

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“A community health worker program would be a natural complement to other local health policies designed to expand access to high-quality primary care among low-income District residents.”

Low-income residents of Washington, DC are in poorer health and have less access to regular medical care than more affluent residents. A citywide community health worker program could increase primary care visits among low-income residents, improve their health and reduce potentially avoidable emergency department visits and hospitalizations. Community health workers (CHWs) are well-trained community members whose backgrounds are similar to those they serve, and who provide health education, links to health services, and support in managing health conditions. CHWs serve communities with cultural, linguistic, or economic barriers to health care services. A growing body of research suggests that CHW programs improve access to primary and preventive care, reduce emergency department overcrowding, and are cost-effective.

A citywide CHW program could be integrated into the Medical Homes DC Area Health Education Center (AHEC), part of the DC Primary Care Association. The Medical Homes AHEC would coordinate the training and placement of CHWs in community health centers, hospitals, emergency rooms, and managed care organizations. The program should start on a modest scale, training and employing 10 to 15 students in the first year. Starting small will allow the program to devote adequate time to recruitment, curriculum development, job development, obtaining feedback and buy-in from healthcare providers, and fund-raising for ongoing program support. A citywide CHW program would cost an estimated \$900,000 over the first five years.

I. Introduction

“We want someone who looks like us and talks like us to show us how to be healthier.”

—Community leader in Dayton, Ohio²

Low-income residents of Washington, DC, have poorer health and less access to primary care than do more affluent city residents. They have high rates of chronic diseases such as asthma, diabetes, and hypertension; high rates of hospitalizations for conditions that could be treated and managed in a primary care setting; and they are less likely to be insured and have a regular doctor than are higher-income residents. These poor health measures point to a clear need for better access to high-quality primary care.³

The District needs a strategy to reach people disconnected from primary care services. Individuals without a regular source of primary medical care are likely to go without care, make an emergency department visit for issues handled more effectively in a primary care setting, or be hospitalized for health conditions that become acute in the absence of regular care. A citywide community health worker program would complement other city efforts to increase access to and utilization of primary care.



Figure 1. The Vision: What a Citywide Community Health Worker (CHW) Program Would Look Like and Accomplish

1. **A citywide network of CHWs would provide an array of services that increase residents' access to and usage of primary care.** CHWs would reach residents who face cultural, economic, or linguistic barriers to accessing health care. The program could focus specifically on Medicaid and DC Healthcare Alliance patients.
2. **Common activities of CHWs would include:** providing information on health issues, including common diseases and the importance of primary care; helping individuals sign up for Medicaid and the Alliance; providing information on where people can go for health care; promoting continuity of care by helping individuals keep their appointments, receive lab results, and secure referrals; providing informal counseling and support; and communicating with providers about the needs and circumstances of neighborhood residents.
3. **CHWs would share a common core training to ensure a baseline set of competencies.** CHWs would be trained in communication skills, confidentiality, cultural competence and health issues, and they would have a thorough understanding of the health and social service resources in a community. In addition, CHWs would receive supplemental training to allow them to specialize if interested.
4. **CHWs would be drawn from the neighborhoods they serve, or share similar backgrounds with their clients.** This helps ensure maximum cultural competence, awareness, and sensitivity to needs and concerns of neighborhood residents.
5. **The CHW job would be stable and provide adequate wages. Training would be structured to provide CHWs with skills appropriate to continued advancement and career mobility.** Job training would also be structured to ensure accessibility by low-income residents who may not have significant formal education.
6. **The CHW program would be funded by a combination of public, private, and philanthropic sources.** The program would not rely solely on time-limited grants. Hospitals, community health centers, insurance companies, managed care organizations, the DC Department of Health, and other stakeholders would all contribute to the program or directly employ CHWs as appropriate. Educational institutions, community-based organizations, and others would also make contributions, perhaps in-kind.
7. **Funding for the program would include an evaluation component,** which would allow for feedback and continuous program improvements as well as provide measures of the program's effectiveness.

Community health workers (CHWs) provide health education and outreach to individuals in low-income and medically underserved communities and link them to medical care and other social services. CHW programs are in place throughout the country and refer to CHWs by a variety of names, including *promotoras*, outreach advocates, lay health workers, and peer health promoters. This brief defines a community health worker as “an individual that is indigenous to his/her community and agrees to be a link between community members and the service delivery system.”⁴

The roles and duties of CHWs vary across programs, but they all serve individuals with cultural, linguistic, or economic barriers to health care. For instance, individuals may be uninsured, distrust doctors, or be unfamiliar with how the health system works. CHWs are able to communicate more effectively with low-income and minority individuals than most professionals in the health care system because they provide services within the cultural, linguistic, and value systems of the community.

The city is already home to several CHW programs (or programs with CHW-like components), operated in community health centers, community-based organizations, the Department of Health, and the DC Area Health Education Center. The programs help people enroll in public health insurance programs, provide health education and screening, and offer logistical and social support. Some are “generalist” programs, while others focus on specific neighborhoods, populations or diseases.

These CHW programs are funded by a variety of sources, although predominantly by federal and local government grants and philanthropic awards. Many programs are funded by time-limited grants, and sustainability is a constant concern.

These programs do good work, but they are limited by funding constraints and are thus limited in scope. Many neighborhoods and residents remain disconnected from CHWs and primary care services. Entrepreneurial and committed directors and staff have developed programs, but not within the context of an agreed-upon set of goals and methods for CHWs. The city and its partners now have an opportunity to develop a CHW program in the context of a citywide effort to increase access to and utilization of primary care.

II. Background

A. Research on the Effectiveness of CHW Programs

A growing body of research suggests that CHWs are successful in increasing access to health care and improving health outcomes. They are also cost-effective. Although the research does not support definitive conclusions, it does offer support for the effectiveness of CHWs.⁵

A number of studies suggest that CHWs are successful in increasing access to care, especially for those in need of cancer screening and managing chronic illnesses.⁶ For example, participants in a CHW program focused on hypertension in a low-income Baltimore neighborhood had significantly lower blood pressure three years after the intervention started.⁷ Two other studies found that CHWs significantly increased follow-up visits for patients with high blood pressure.⁸ Families and children receiving an intensive set of CHW services significantly improved their asthma-related quality-of-life measures and reduced their asthma-related use of urgent health services.⁹ A review of research on the effectiveness of CHWs in helping people with diabetes found several promising results. Patients were generally satisfied with their contacts with CHWs; patient knowledge about diabetes and self-care increased; and patients showed positive behavioral change and improved physiological measures.¹⁰ The Division of Diabetes Translation within the U.S. Centers for Disease Control and Prevention has recommended greater support for integrating CHWs into health care teams and programs serving people with diabetes.¹¹

There are relatively few studies that evaluate the financial impact of CHWs on health care organizations and no consistently used methodologies. Thus, comparing programs and generalizing results is difficult, although the results do suggest that CHW programs can save money by reducing emergency room visits, hospitalizations, and other urgent care in favor of increased primary and preventive care.

A study of Denver Health patients assessing the return on investment of CHWs concluded that the CHW program saved \$2.28 for every \$1 invested in the program.¹² Denver Health is the major safety net medical provider in Denver, Colorado, with an integrated network that includes a hospital, school-based health centers, and community health centers. CHWs provided health education, assistance with enrollment in public health plans, referrals, system navigation, and care management. The study compared the medical utilization of patients

before and after contact with a CHW, finding that primary and specialty care visits increased after patients were visited by a CHW, and more expensive urgent and inpatient care use declined.

An evaluation of CHWs in Baltimore serving diabetes patients in the Medicaid program found the program to be cost-effective as well. In that program, CHWs helped arrange medical appointments, checked to ensure patients were looking after themselves properly, determined Medicaid eligibility, and offered general social support. Comparing health care usage before and after contact with a CHW, the study found that emergency room visits declined by 38 percent, hospitalizations declined by 30 percent, and Medicaid reimbursements declined by 27 percent.¹³

Presbyterian Hospital in New York City successfully used CHWs to redirect nonacute emergency department (ED) patients into primary care, and also achieved cost savings. To reduce ED overcrowding, nonacute patients were treated at the ED but met with a CHW before returning home. CHWs made follow-up primary care appointments, educated patients about primary care, reminded patients of appointments, and followed up after appointments. Over a three-year period, the broken appointment rate at the hospital's primary care centers for ED referrals dropped from 50 percent to 15 percent. Patient volume at the primary care centers also increased. Nonacute adult ED visits declined by 42 percent. (However, as with most of the other studies, the lack of a rigorous evaluation with control and experimental groups means that the reported changes cannot be conclusively attributed to the CHW intervention.) Because of the reduction in volume, the ED was able to close one of its triage units and reduce its staff size, saving \$250,000. It also benefited financially from the decrease in the number of "self-pay" ED patients and from increased Medicaid reimbursement, since CHWs encouraged patients to apply for Medicaid.¹⁴

The Health Plus managed care organization, also in New York City, employs 35 full-time CHWs earning \$38,000 per year, plus benefits. The organization has committed \$3 million per year to the program, which provides a wide variety of services to primarily Medicaid patients and other low-income individuals. Although Health Plus has not published a study of its CHW program, the health plan has determined it to be a cost-effective investment, with the savings achieved through CHW services exceeding the program cost.¹⁵

B. The Local Context

Several policies and programs are in place in the District to increase access to health care. A citywide CHW program could build on and leverage these investments. For a relatively modest incremental investment, a citywide CHW initiative could increase the effectiveness of existing programs.

1. Health Care Financing

The District government is committed to financing health care for its low-income residents, most of whom have some form of insurance, either Medicaid or the locally funded DC Health Care Alliance. The city government spends approximately \$1.2 billion per year on Medicaid in combined federal and local dollars, and approximately \$100 million on the Alliance.

The city has phased in several insurance expansions for low-income residents during the past several years. The Medicaid program is by far the largest insurer of low-income residents, with between 135,000 and 140,000 individuals enrolled, including children, working-aged adults, senior citizens, and people with disabilities.

In 2001, the city created the DC Health Care Alliance when it closed DC General Hospital as an inpatient facility. The Alliance, with approximately 31,000 enrollees, pays for health care services for uninsured District residents with annual incomes below 200 percent of the poverty line and who are ineligible for Medicaid. It primarily serves low-income, working-aged adults without children.

A citywide CHW program could improve the delivery of care for Medicaid and Alliance enrollees—and reduce public expenditures—by increasing primary care use and reducing potentially avoidable hospitalizations.

2. Medical Homes DC

Medical Homes DC is a major effort to expand the reach and improve the quality of primary care services for low-income and uninsured District residents. It is an initiative of the DC Primary Care Association in partnership with the District government, community health centers, the Brookings Institution, RAND Corporation, and others. The project was launched in 2003 with a \$2.5 million federal grant to the DC Primary Care Association from the Health Resources and Services Administration within the U.S. Department of Health and Human Services. The District government has committed \$15 million to the project over three years, and local and national foundations have also made major contributions.

The goal of Medical Homes DC is to strengthen and expand the current network of community health centers, and dramatically increase the number of low-income and uninsured District residents who have and regularly use a medical home. A medical home is a primary care provider where a patient's health history is known, where he or she will be seen regardless of ability to pay, and where he or she routinely seeks non-emergency care. Medical homes are integrated with one another and with support services, as well as with hospital emergency departments and discharge systems.

Medical Homes DC is working to improve the capacity of community health centers. Nine health centers received grants in 2005 to begin capital planning to upgrade their facilities. Training and technical assistance programs are helping health centers reach higher financial and managerial standards and improve their clinical practices.

A citywide CHW program would be a natural complement to the efforts of Medical Homes. As Medical Homes helps health centers improve their services and expand their capacity to provide high-quality primary care, the CHW program would steer more individuals into primary care settings.

3. DC Residents' Views of Health Care Access and CHWs

In early 2006, low-income District residents took part in a series of focus groups on how they view their health care options and how effective they think CHWs would be in improving access to health care.¹⁶ Findings from the focus groups echo what other research shows: many complex, interrelated barriers deter residents from accessing health care in general and from receiving primary or preventive care and finding a medical home, in particular. Focus group participants discussed the following barriers to care:

- **Lack of insurance, limited finances, and scheduling conflicts.** Lack of money and insurance are significant barriers, especially for Hispanics and men in general. Time and scheduling conflicts are also barriers; participants reported that health care visits were often during working hours and sometimes took several hours.
- **Fear and mistrust of the medical system, a lack of understanding of the importance of primary care, and negative health care experiences.** Fear of finding out something is wrong also appears to be a major barrier, especially among blacks. This fear is often coupled with a general mistrust of the medical community, sometimes based on previous negative experiences with doctors and other healthcare staff. A lack of awareness about the importance of preventive and primary care also appear to be a factor, especially among Hispanics and men in general. Some participants admit that procrastination plays a role, and for others, health care is just not a priority.
- **Lack of knowledge of the health care system, especially among Hispanics.** Many Hispanics are unaware of the health care providers and programs available to them. Some also find it difficult to locate Spanish-speaking providers.

A community health worker program on its own cannot address all these problems. However, several of these barriers should be fairly straightforward to address. For example, CHWs can provide information about health insurance programs and the location of different types of health services, direct people to insurance enrollment locations, or perhaps take applications for public health insurance themselves. Other barriers such as fear, mistrust of the medical system and a lack of understanding about primary and preventive care are more challenging, requiring a long-term effort. CHWs should understand these various barriers and be offered

strategies and tools to address them. In particular, to address the fear and mistrust identified in the focus groups, CHWs must develop strong relationship-building skills and credibility with neighborhood residents.

Focus group participants were generally enthusiastic about CHWs and thought they could play a positive role in their communities. Their reactions can inform how a citywide CHW program is developed and implemented.

- Participants stressed that CHWs should be well-trained, knowledgeable, and professional. They should be personable and committed to their jobs and to improving the health of their community.
- Participants' responses suggest that it may take time for a CHW to build trust in the community. Therefore, job retention among CHWs will likely be critical to a successful program.
- Ideally CHWs should be members of the community they serve, with the same or similar linguistic, racial-ethnic, or cultural background. At the very least, they should understand the community with whom they are working.
- Ensuring confidentiality is critical. Measures to protect confidentiality may need to be even more visible when the CHW is a fellow neighborhood resident.

Finally, given that several focus group participants reported discourteous treatment when seeking medical care or that health professionals failed to listen to them, CHWs can educate medical providers about the views and experiences of patients.

III. Laying the Foundation for a CHW Program in Washington, DC

Most CHW programs are emphatic that existing CHWs be involved as much as possible in program and curriculum design. Therefore, individuals currently working or volunteering as CHWs in the District should be engaged to discuss the ideas and issues raised in this brief.

A citywide CHW program should begin small, perhaps on a pilot basis in the first year. The program will need to identify instructors, develop a curriculum, obtain feedback on curriculum and program design from multiple stakeholders, identify job placements, develop selection criteria for incoming CHW students, develop recruitment strategies, and raise funds. Operating the program on a modest scale, with a cohort of 10–15 students in the first year, would keep the workload manageable. In subsequent years, the program could expand to two or possibly three training cohorts of about 12 students each per year.

A. What CHWs Do

CHWs can carry out some or all of the following direct services, depending on client and community needs:

- Facilitate enrollment in eligible health programs
- Increase access to primary and preventive care
- Teach concepts of prevention
- Teach or provide information on available levels of service (such as primary care, urgent care, and hospitalization) and when and how to access each
- Increase participation in screening for common diseases and conditions, such as high blood pressure
- Facilitate appointment-keeping
- Increase compliance with prescribed regimens
- Connect residents with social services as appropriate
- Provide informal counseling and social support
- Advocate for strategies to meet the health needs of the community

In addition, CHWs can offer valuable assistance to the health care system and the larger community, by:

- Assessing individual and community health needs, and
- Educating institutions about community norms, needs, culture, and strengths

See Appendix A for a detailed summary of the core roles of CHWs as laid out by the National Community Health Advisor Study.

B. Required Skills and Competencies

To carry out the above tasks, CHWs must possess a defined set of skills and competencies. The broad areas of skills and competencies include:

- Communication
- Cultural competence
- Interpersonal skills and relationship building
- Sound knowledge base of the community, specific health issues, and health and social service systems
- Service and resource coordination
- Capacity-building for community residents
- Advocacy

These skill and competency areas reflect those identified by the National Community Health Advisor Study. (See Appendix B for an outline of skills and competencies.) Within these broad areas, the District may identify additional skills that will be required for local CHWs. For example, programs have incorporated competencies such as data collection, ethics and legal responsibilities, and personal safety.

Focus group participants identified several key competencies important to them, including professional demeanor, a solid knowledge base of health issues and the health care system, excellent interpersonal skills, dependability, and clear and effective communication.

Surveys of health care providers have yielded similar priorities. A survey in Northern California of providers who employ CHWs identified multicultural competence, community outreach, and communication or conflict resolution skills as the most important skills for CHWs.¹⁷ A Massachusetts survey arrived at similar conclusions: supervisors of CHWs said the most valuable skills among CHWs were communication and relationship-building, along with knowledge of the communities they serve.¹⁸

C. Qualities to Look for in Recruiting CHWs

At their best, CHW programs identify individuals who are already natural assets in their communities and help to develop their skills and leadership. Community health workers should be outgoing and friendly, connected to and trusted in the communities they serve, and committed to the well-being of their neighbors and the neighborhood overall.

Although some CHW skills can be taught, such as intake, insurance enrollment, and case management, personal qualities that candidates bring to the job are equally, if not more, important. The National Community Health Advisor Study developed the following list of qualities most relevant for recruiting and hiring CHWs:

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| <ul style="list-style-type: none"> • Connected to the community (a community member or possessing shared experience with community members) • Strong and courageous (healthy self-esteem and the ability to remain calm in the face of harassment) • Friendly, outgoing, sociable • Patient • Open-minded, nonjudgmental • Motivated and capable of self-directed work • Caring | <ul style="list-style-type: none"> • Empathic • Committed and dedicated • Respectful • Honest • Open, eager to grow, change, and learn • Dependable, responsible, and reliable • Compassionate • Flexible and adaptable • Desire to help the community • Persistent • Creative and resourceful |
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D. Educating Health Care Providers about CHWs and Integrating CHWs into Health Care Settings

The Pew Health Professions Commissions called CHWs “integral yet often overlooked members of the health care workforce.” Their incorporation into the health care delivery system, the Commission argued, “offers unparalleled opportunities to improve the delivery of preventive and primary care to America’s diverse communities.”²⁰

CHWs are underused in the health care system, in part because many health care professionals do not understand who they are or what they do. There is no standard definition of the role of a CHW and no consistent certification or credentialing system, in direct contrast to the highly professionalized health care arena. Some health care professionals are skeptical about the skills and abilities of lay health workers. In addition, CHWs conduct much of their work off-site and in the community, making their contributions less visible. Much more work is needed to educate health care providers about the role and functions of CHWs and the evidence of their effectiveness in multiple health care settings, including community health centers, emergency departments, and managed care organizations.

Locally, community health centers support the work of CHWs, which is naturally aligned with the centers’ mission to provide health care to underserved populations. However, important questions of job structure and roles in health centers must be addressed, as well as how to fund CHW positions.

Other health care providers, such as hospitals, emergency departments, and managed care organizations, may be unfamiliar with CHWs, or may support them in theory but are unsure how CHWs would be integrated into their organization, or whether the investment needed to create a new position is worth it. CHW program proponents must provide these employers with information on the benefits of CHWs and discover how best CHWs could meet the organization’s needs and fit into the organizational structure. Providing examples of how other hospitals and MCOs have used CHWs to increase primary care use would be helpful, as would showing how CHWs have helped to reduce more expensive treatment of acute episodes and emergency room or hospital visits.

E. Creating a Home for the Program

There needs to be a central entity to track and coordinate the work of CHWs to ensure maximum coverage and minimize duplication of services. The most appropriate candidate for this role is the Medical Homes DC Area Health Education Center (AHEC), part of the DC Primary Care Association. One of the primary goals of the Medical Homes DC AHEC is to improve the health status of medically vulnerable residents through educational initiatives; managing a CHW program is a natural fit with this mission.

The most significant tasks in managing a CHW program are to coordinate the training and job placement of CHWs and to evaluate the training program and the performance of CHWs. The Medical Homes DC AHEC should also track:

- Providers employing CHWs and basic information on CHWs, such as their number, services provided, and geographic areas or populations covered.
- Health outreach and education programs carried out by other organizations, including the DC Department of Health and community-based organizations, to ensure collaboration when appropriate and to avoid service duplication.

F. Supporting and Enhancing the Medical Homes DC Program

Community health centers are expanding their capacity through the Medical Homes DC project by improving their facilities and internal operations. However, increasing the capacity of health centers does not guarantee that residents will use them, especially if residents do not understand the value of primary care or are accustomed to going without care or using emergency departments.

Expanding primary care usage will require greater outreach and education on the importance of primary care and more effectively connecting individuals to services—exactly the role of CHWs. In addition, research shows that effectively redirecting individuals from emergency

departments into primary care requires a strong primary care system to absorb the new patients. A CHW program and Medical Homes DC are therefore mutually supportive: they strengthen the primary care safety net while drawing more people in for needed services.

IV. Creating a Training Program and Curriculum

The ultimate goal of a training program should be to develop a group of motivated and energized CHWs who are competent and confident they can make a change in their communities for the better on health issues. Typically, there are no formal education requirements to enter CHW training. More important is that students be able to learn new information and skills, and possess the qualities outlined above. That said, the training curriculum for CHWs must be thorough and comprehensive to ensure that CHWs are well equipped to meet the high standards expected of them by community residents and providers, and to function effectively as members of the primary care team.

A. Core Training

The core curriculum should build the skills and competencies that CHWs are expected to master: knowledge of common health conditions, the health care system, health and social service resources (especially for low-income people), communication and interpersonal skills, and advocacy skills. The curriculum design process should engage multiple stakeholders, including health care providers, educational institutions, insurance companies, the DC Department of Health, and existing CHWs. Programs that have the most fully developed curricula have all engaged CHWs very intimately in the curriculum design.

All CHWs in the network should receive the same core training to ensure a baseline set of competencies. The curriculum should accommodate the needs of adult learners with minimal formal education, including heavy use of practicum and work experience opportunities. Several training programs across the county can act as models, as they have very consciously developed teaching methods suitable for adult learners.

Project Jumpstart in Arizona strove to design an entry-level program of study that validates the competencies that CHW students deploy in their communities, instead of focusing on academic competencies that are irrelevant to a CHW's work. Curriculum developers tested the curriculum with current CHWs and revised elements on the basis of participants' feedback and recommendations. The curriculum favors practicum-based learning over classroom learning wherever possible. Students are encouraged to draw upon their real-life experiences and apply them to learning activities.²¹ Similar to the Arizona program, the curriculum for the Minnesota Community Health Worker Project minimizes the use of standardized tests and essays, cognizant of students' test-taking anxieties and language barriers. It instead uses performance-based evaluations such as role-plays. Classes are co-taught by a community college faculty member and a CHW.²² In San Francisco, the Community Health Works project developed "learning teams" among the students as a strategy to improve retention. The learning teams required students to work together on class projects, and had the added benefit of providing another venue for the students to practice their communication skills.²³

B. Supplemental Training

In addition to the core curriculum, CHWs should have the option of specialized training in health issues such as diabetes and HIV/AIDS, in working with specific populations, or in managerial or supervisory skills. Content and design of this additional training should be responsive to the learning needs of the CHWs, meeting the design criteria outlined above.

C. Credentialing

Program administrators should consider creating a credentialing process for CHWs. Developing a state-recognized credential would offer assurance that CHWs have a standardized set of competencies. Currently Alaska, Texas, Indiana, and Ohio have statewide credentialing systems, and

several other states are considering it. Although some have expressed concerns about negative effects of credentialing (discussed below), states are increasingly moving toward adopting standards that define the roles and skills of CHWs.

The District would need to establish a credentialing body, which could be housed within the DC Department of Health. Before credentialing is instituted, however, a consortium of stakeholders (community health centers, educational institutions, hospitals, insurance companies, the DC Department of Health, existing CHWs) should determine which skills and competencies are needed to gain a CHW credential. In turn, the skills and competencies necessary for credentialing must be reflected in the CHW curriculum.

In Texas, legislation created the credentialing program, which includes a committee appointed and supported by the state with oversight responsibilities for training and credentialing CHWs. Texas CHWs must complete training that covers the eight core skills and competencies identified in the National Community Health Advisor Study, and receive at least 20 hours of knowledge and skill-building for each core competency.²⁴

The Indiana program focuses on maternal and child health. There, CHWs operate as part of a prenatal care coordination team, which also includes a nurse and a social worker. Because the CHWs are credentialed and operate under the guidance of certified care coordinator, the state allows CHW services to be reimbursed under Medicaid. CHWs must complete a training program approved by the state Department of Health, attend a one-day review, and pass a certification test conducted by the Department of Health.²⁵

The Ohio program also focuses on maternal and child health. The state passed legislation on CHW credentialing in 2003, and approved final regulations in 2005. Unlike other states, CHWs in Ohio are overseen and credentialed by the state Board of Nursing.²⁶

Credentialing, by standardizing the roles and skills of CHWs and offering formal recognition of CHW skills, provides numerous benefits. It opens up the possibility of new reimbursement streams, such as Medicaid. It advances the legitimacy of CHWs in the highly professionalized health care arena and ensures better quality of care. It assures both employers and those served by CHWs that CHWs have mastered basic competencies. It validates the work that CHWs do and offers opportunities for professional growth, especially if the training program is designed to provide skills that are applicable in further study in the health care field.

There are also a number of concerns about formalizing CHW training and practices. The underlying question is whether it is possible to take an informal, community-based practice and standardize it through an official training and credentialing program, while still retaining the benefits of the community-based lay health worker.²⁷ For instance, it is possible that potential or current CHWs, who may have limited experience or success with the formal education system, would be intimidated or alienated by training requirements. In addition, current CHWs may not be interested in or have the time to take the classes necessary for credentialing. In Texas, the state exempts volunteer CHWs from credentialing requirements, as well as CHWs who can document more than 1,000 hours of practice. Application fees or tuition could also be a barrier, in which case scholarships, organizational underwriting, or other assistance could be offered. In general, most agree that involving CHWs in designing the credentialing process is critical to minimize any negative effects.²⁸

D. Community College Involvement

CHW training is increasingly being offered through community colleges. Community colleges are well positioned to participate in CHW training: they offer open-admissions policies, low tuition, and are accustomed to working with nontraditional adult students. Training programs affiliated with community colleges can offer college credit, which can help place CHW students on a trajectory for further education in health care if they are interested.

In the 1990s, Community Health Works in San Francisco was the first program in the country to offer a college-credit-bearing, CHW certificate program. The certificate is jointly sponsored by City College of San Francisco and San Francisco State University and consists of 17 semester credit units (equal to about 435 classroom hours). Full-time students can complete

the certificate in one year, and working students usually complete the program in three to four semesters. In addition to the generalist certificate, students can also complete specialty certificates in such areas as drug and alcohol counseling or HIV/STD.²⁹

The Arizona Health Sciences Center (part of the University of Arizona), the Arizona Area Health Education Centers, four community colleges, and numerous community-based organizations worked together to create a 16-credit certificate program to be taught at community colleges. The University of Arizona tested and validated the program with the four community colleges and produced a curriculum resource book that can be used or adapted by other institutions.³⁰

In Minnesota, the Blue Cross and Blue Shield of Minnesota Foundation funded research on the employment and training of CHWs in the state, and convened policymakers, health care providers, and educators to identify the range of existing and potential use of CHWs. The foundation funded the Health Education Industry Partnership, a project of the Minnesota State Colleges and Universities system, to develop a standardized accredited CHW training program offered through community colleges. The program is 11 credits, and is available at four community colleges and a nonprofit training provider.³¹

The Community Health Worker - National Education Collaborative (CHW-NEC) was recently funded by the U.S. Department of Education's Fund for the Improvement of Post-secondary Education to develop CHW community college curricula for use by 15 "adapter institutions" around the country. The goal is to establish best practices in curriculum design, instructional methods, and evaluation of CHW training programs that serve nontraditional adult students.³²

In the District, a CHW program could form a partnership with the University of the District of Columbia (UDC) and develop a CHW certificate. UDC is the only public institution of higher education in the District and functions as both a state university, offering four-year and post-graduate degrees, and as a community college, offering associate degrees and certificates. Establishing a new credit-based program at UDC would likely take a year or two, and program managers would need to ensure that faculty are comfortable with and competent in using teaching methods appropriate for non-traditional adult learners.

V. Employment Opportunities for CHWs

Ideally, CHWs would be employed by the provider entity at which they are based, including hospitals, emergency rooms, community health centers, and managed care organizations. The provider/employer would be responsible for CHW wages. Especially for community health centers, however, the addition of one or more staff people to their payroll is not a trivial matter. The funding strategy for a CHW program must therefore ensure that, at least for the first few years, health centers and perhaps other providers receive supplemental funding to offset the costs of additional employees. In the long-term, a well-run CHW program should result in improved health outcomes for patients and more efficient clinical operations, with fewer missed appointments and better care coordination, which should in turn result in cost savings that will help healthcare providers offset the wages and benefits paid to CHWs.

The provider/employer would also be responsible for all employment-related administrative duties for their CHWs, including supervision, performance reviews, employment records, enrollment in employee benefit programs, and tax matters.

The network of providers and CHWs may wish to develop a uniform evaluation process by which job performance is assessed, and by which promotions and raises are awarded. This would be especially helpful if the network develops a range of CHW positions (for example, CHW I, II, III, discussed below). The CHW wage and benefits scale should also be relatively uniform.

A. Addressing CHW Job Quality and Advancement Opportunities

High turnover, poor morale, high error rates, low productivity, and increased recruitment and training costs are all potential results of failure to ensure that CHW jobs are “good” jobs. Good jobs are jobs that:

- Pay a living wage (or provide incremental steps toward a living wage), with benefits and manageable hours
- Provide clear job descriptions and expectations
- Provide effective supervision and performance review
- Reward performance with raises, promotions, and other recognition, and
- Create opportunities for advancement and professional growth, including continued education and training

Taking affirmative steps to ensure job quality for CHWs will yield benefits for CHWs, for employers, for clients, and for the community as a whole. CHWs are likely to stay in the job longer and perform better if they are paid a living wage, are given clear expectations, quality supervision, and access to training and advancement opportunities. Employers benefit from the increased job satisfaction, reduced turnover, and higher productivity that ensue. Clients benefit as well. Focus group participants stressed that longevity and continuity of the CHWs were important factors in establishing trust with local residents. Clients also benefit from higher morale and increasing skill levels of advancing CHWs. Communities benefit from more stable wage earners, a solid system of service delivery, and improved health of residents.

The quality of supervision is a critical yet easily overlooked aspect of job quality. A challenge particular to CHWs is that much of the work takes place in community settings away from an office. The supervisor of a CHW must be committed to the concept of community outreach and understand the nature of a CHW’s day-to-day activities. One option is to recruit CHW supervisors from the ranks of CHWs, or require experience with community outreach among supervisors.

Supervisors must be prepared to work with individuals who may have limited formal education or work experience. Supervisors may also need to act as mentors or coaches, helping CHWs adapt to workplace communication styles and office practices. At the same time, supervisors must recognize (and help other staff recognize) that CHWs are highly skilled in other, less formal settings, and not devalue them because their working styles and activities are different from other health care professionals.

On a macro level, CHWs in the District should consider forming a CHW network or association. CHW networks are in place in other cities and states across the country with the general goal of developing a collective voice for the profession and advancing the field. CHW networks allow CHWs to share resources and information, create opportunities for peer mentoring and educational offerings, raise awareness of the profession in the health care system, and advocate for public policy changes that support the work of CHWs.

1. Structuring Career Advancement

CHWs should have options for professional growth and advancement. One option is to create several levels of CHWs, such as CHW I, CHW II, and CHW III, that enable CHWs to gain increasing amounts of education, practicum and work experience as they progress beyond entry-level CHW work. The higher levels would have greater responsibility and pay. A CHW I, for example, would have successfully completed core curriculum training. A CHW II might have expertise in specific topic areas, such as HIV/AIDS, maternal and child health, diabetes, or asthma. A CHW III could be a supervisory or managerial position. Such a system, however, depends on employer needs, making employer input critical.

Another option is to advance to other positions in health care or public health fields. Training programs (especially if offered at community colleges) could provide courses that develop skills applicable to future studies. For example, Community Health Works in San Francisco has developed an articulated pathway from City College (which awards the CHW certificate) to San Francisco State. From the CHW generalist certificate, a student can complete an associate’s degree or transfer to San Francisco State for a bachelor’s or master’s degree. The transfer agree-

ment recognizes 12 units of CHW program credits in the health education major at San Francisco State.³³

VI. Building an Evaluation Component into the CHW Program

A CHW program should be able to assess its practices and outcomes to better inform future refinements, expansions, or adjustments. In addition, any program must be able to measure its progress to demonstrate to funders and other stakeholders that the program is meeting its goals.

A multilevel, ongoing evaluation process should be built into the program design. Outcomes to measure include health status, access to care, and health care utilization among clients; curriculum content; student outcomes in the classroom and workplace; and the costs and benefits of the program.³⁴

There are several resources to aid in designing an evaluation. The National Community Health Advisor Study offers an evaluation framework for CHW programs, and a spin-off document, the *Community Health Worker Evaluation Toolkit* was designed as a resource to help CHWs plan and participate in evaluations.³⁵ Finally, the CHW– National Education Collaborative is developing best practices for evaluating community college CHW training programs.

VII. Funding a Citywide CHW Program

A CHW program that follows the general parameters outlined above—with experienced trainers, a thoughtful curriculum design process, and a job placement system—would cost an estimated \$900,000 for the first five years. For an average cost of less than \$200,000 per year, the city and its partners can develop a program that will enhance the effectiveness of its other health care programs by improving access to and utilization of primary care services.

Adequate and stable funding is critical to build and maintain a successful program. Foundation or grant funding is essential to launching and supporting the program, but the program will need a wider array of investors if it is to be sustainable. Other supporters should include health care providers, managed care organizations, insurance companies, the District government, and educational institutions. Their investment could take a number of forms. They could support the development of a uniform training curriculum, underwrite training costs, provide training space or equipment, and employ CHWs directly.

The District government should play a prominent role in supporting a citywide CHW program. The Medicaid program could support CHWs by using funds designated for outreach and education, and it may be possible to create waivers so that additional CHW services are reimbursable. Medicaid and the DC Health Care Alliance could require managed care organizations serving enrollees to conduct community-based outreach and education according to the CHW model. With the addition of a relatively small investment in a community health worker program, the city can leverage its investments in Medicaid and Alliance coverage to increase primary care usage, reduce emergency department and hospital visits, and gain better health outcomes.

Other potential funding streams within the Department of Health include the primary care block grant and the maternal and child health block grant. There is also a role for other city agencies. The Department of Employment Services could use workforce development dollars to pay for training, and the Income Maintenance Administration could use its TANF dollars to support training for welfare recipients.

Universities and community colleges can also support the program. Their contributions may be in-kind, in the form of assistance with curriculum development or classroom space. If they themselves are conducting the training, they could offer or facilitate access to scholarships and financial aid if necessary.

VIII. Conclusion

A citywide community health worker program in Washington, DC, holds tremendous potential to improve the delivery of primary care to low-income District residents. Over time, a CHW program could improve health indicators, increase utilization of primary care, reduce potentially avoidable emergency department visits and hospitalizations, and reduce health care costs. The high rates of chronic disease and avoidable hospitalizations in parts of the city point to a clear need for better access to high-quality primary care.

Community health workers would link medically underserved residents to primary care services, and ensure patients keep appointments, follow up on screenings, and better manage chronic diseases. They would provide health education, and offer informal counseling and social support. Ultimately, CHWs could become powerful promoters of health, wellness and disease prevention in their communities.³⁶

A CHW program is a logical complement to the other policies and programs the District government, the DC Primary Care Association, and others have put into place to improve access to high-quality primary care. This brief offers ideas for how a program could be structured, organized, and funded. The next step is for a broad array of stakeholders to come together, discuss options, and agree on specific ideas for launching and sustaining a citywide CHW program.

Appendix A. Core Roles of Community Health Workers as Defined by the National Community Health Advisor Study³⁷

Core Role 1: Bridging/Cultural Mediation Between Communities and the Health and Social Service Systems

Educating community members about how to use the health care and social service systems. CHWs help community members get the services they need and help systems operate more smoothly by teaching people where and when to seek services. For example, CHWs teach people when they need to see a doctor and when they can safely treat an illness at home.

Gathering information for medical providers. The trust many CHWs establish with their clients enables them to collect information that is often inaccessible to other health and social service providers. When this information is passed on, with clients' permission, to medical personnel, it can lead to more accurate diagnoses and treatment, thereby improving health outcomes.

Educating medical and social service providers about community needs. CHWs can help health and social service systems staff become more culturally competent. The information that CHWs pass on can be used in a variety of ways. It can bring about actual changes in the services the system offers and changes in how services are offered. Clinic hours have been changed, triage practices adapted, and toys added to waiting rooms due to CHW education efforts. As a result of learning about cultures and practices in a community from CHWs, changes in provider attitudes and beliefs may occur.

Translating literal and medical languages. CHWs facilitate patient-provider communication. Sometimes, bilingual CHWs translate for clients. They may also translate letters and correspondence from health and social service agencies. Perhaps most important, CHWs "translate" medical and other terminology into lay language, teaching clients how to follow medication or other treatment regimens.

Core Role 2: Providing Culturally Appropriate Health Education and Information

Teaching concepts of health promotion and disease prevention. In a classic public health mode, CHWs focus on helping people stay healthy and intervening so that existing problems do not worsen. For example, CHWs stress the importance of screening tests and regular medical check-ups, thus increasing the likelihood of early detection of health prob-

lems. Many CHWs also make health education culturally accessible by using empowering and interactive adult education methods.

Helping to manage chronic illness. Another focus of health education by CHWs is management of chronic illnesses such as diabetes and hypertension. One program offers a “Cooking Class Support Group” for Latina women with diabetes. The women participate in an interactive class, do exercises geared to their ability level, and prepare appropriate nutritious meals.

Core Role 3: Assuring That People Get the Services They Need

Case finding. Because of their close contact with community members, CHWs are in a unique position to recognize as-yet-undiagnosed symptoms of illness or health needs and connect people to the health care system. Case finding is the first step in assuring that people obtain needed services.

Making referrals. CHWs refer clients to a broad range of health and social services, including clinics, hospitals, welfare offices, food banks and churches.

Providing follow-up. CHWs promote continuity of care by providing follow-up. Examples include tracking pregnant women to make sure they get prenatal care or physically locating people who need lab results but lack a telephone.

Core Role 4: Providing Informal Counseling and Social Support

Providing individual support and informal counseling. Conditions of poverty, unemployment, discrimination, and isolation in many of the communities where CHWs work mean that the coping resources of individuals are stretched to the limit. Relatives and friends who face many of the same obstacles may be unable to offer support in times of need. Under these conditions, the supportive relationships that CHWs build with their clients are crucial.

Leading support groups. CHWs conduct a wide range of support groups, including groups for homeless people, cancer survivors, and support and education groups for young people.

Core Role 5: Advocating for Individual and Community Needs

Advocating for individuals. At a basic level, CHWs act as advocates or spokespersons for clients. This function is related to their work as literal and medical translators. CHWs also can serve as intermediaries between clients and sometimes immobile bureaucracies. CHWs often help clients resolve problems with erroneous or overdue bills for health and other services.

Advocating for community needs. CHW advocacy for community needs may involve specific issues such as improvement of conditions in a migrant labor camp.

Core Role 6: Providing Clinical Services and Meeting Basic Needs

Providing clinical services. In the U.S., the CHW role in providing clinical services is minimal compared to CHW roles in the developing world. Yet, especially in remote areas, CHWs in the U.S. do provide needed basic services, thus making them accessible. In Michigan’s Camp Health Aide Program, CHWs are trained to provide first aid to migrant farmworkers who often live far from population centers.

Meeting basic needs. Before they can share specific health information, CHWs often must ensure that people have the basic determinants of good health: enough food, adequate housing, and employment. When resources exist, CHWs help people meet basic needs by referring them to or taking them to appropriate agencies.

Core Role 7: Building Individual and Community Capacity

Building individual capacity. CHWs increase the capacity of individuals to protect and improve their health by sharing valuable information about how to prevent illness. They also teach people concrete skills essential to maintaining good health, such as how to pre-

pare traditional foods with less fat. A very important way CHWs build individual capacity is by actively helping clients to change their behavior.

Building community capacity. According to the CHW model developed and promoted by the World Health Organization, one of the CHW's primary responsibilities is to bring about community participation in health. CHWs help communities assess their own needs and then act on meeting them. In one community, for example, CHWs helped families form support groups that later advocated with the school system for program changes.

Appendix B. Core CHW skills identified by the National Community Health Advisor Study³⁸

1. Communication skills

- Listening
- Use language confidently and appropriately
- Written communications

2. Interpersonal skills

- Counseling
- Relationship-building

3. Knowledge base

- Broad knowledge about the community
- Knowledge about specific health issues
- Knowledge of health and social services system

4. Service coordination skills

- Ability to identify and access resources
- Ability to network and build coalitions
- Ability to provide follow-up

5. Capacity-building skills

- "Empowerment." Ability to identify problems and resources to help clients solve problems themselves
- Leadership

6. Advocacy skills

- Ability to speak up for communities and withstand intimidation

7. Teaching skills

- Ability to share information one-on-one
- Ability to master information, plan and lead classes, and collect and use information from community people

8. Organizational skills

- Ability to set goals and plan
- Ability to juggle priorities and manage time

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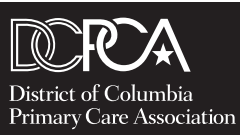
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