

Recommendations for Developing and Sustaining Community Health Workers

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Summary: This report provides recommendations for the development and sustenance of community health workers. These recommendations are a result of the San Antonio Community Health Worker Summit held January 2010. Recommendations include defining the workforce, training standards, evaluating financial benefit, strategizing Medicaid reimbursement, and creating support networks.

Key words: Policy, patient navigator, community health worker, *promotora*, community health educator, lay health worker, workforce development.

Intent of Report

This report summarizes the findings and recommendations for developing the Community Health Worker (CHW) workforce from the San Antonio CHW Summit held January 22, 2010. In this report, the term *CHW* is intended to be inclusive of various job titles including but not limited to the following: *Promotores*, Patient Navigators, Lay Health Advisors, and Peer Educators. At the summit, we identified individuals with common interests in workforce development and opened an active discussion regarding CHWs' development and sustainability. Based on these interactions we propose state and national recommendations for CHW workforce development. In addition, we provide brief local recommendations. Most of our recommendations can be applied generally to all those who may be considered a CHW, although some are group-specific.

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Summit Description

Various organizations and institutions from the South-Central Texas Region gathered at the San Antonio CHW Summit to discuss sustainability strategies for the CHW workforce. The University of Texas Health Science Center at San Antonio (UTHSCSA) Patient Navigation Research Program (PNRP) sponsored the summit. The PNRP is funded by the National Cancer Institute (NCI) and is a research project to determine if patient navigation can adequately address health disparities in cancer prevention, diagnosis, and treatment for low-income and other medically underserved populations. As interest and the list of sponsors grew, the focus of the summit shifted from strictly including patient navigators in cancer prevention to the CHW workforce in general. Co-sponsors included the South Central Area Health Education Center, Community Resources LLC, Northwest Vista College, UTHSCSA Institute for Health Promotion and Research, and The Health Collaborative. The summit was attended by 65 participants, including CHWs and other health policy leaders in the community.

Presenters provided background information on CHWs for those who are familiar and those who were unfamiliar with the workforce. Carl Rush, MRP, from Community Resources LLC, presented “Getting on The Same Page,” where he defined roles of CHWs, outlined federal interest in the workforce, public policy with regards to CHWs, and options for financing CHW positions. Joan Cleary, MBA, vice president of the Blue Cross and Blue Shield of Minnesota Foundation, provided the keynote address, and summarized the Minnesota experience of successfully creating a Medicaid reimbursement policy for services provided by CHWs. The Minnesota program allows for sustainability of CHWs as a workforce, and paints a success story that other states can emulate.

Subsequently, CHW supervisors and program coordinators presented descriptions of successful CHW programs. Panel members included Jennie Quinlan, MPH and Sandra San Miguel, who discussed UTHSCSA projects involving CHWs. These included the PNRP and the navigation program sponsored by *Redes En Acción*. Otila Garcia and Lourdes Rangel discussed their successes in diabetes prevention and management at the Gateway Community Health Center in Laredo. Kimberly Camp, RN, MSN, Director of Community Care Management at CHRISTUS Health, described the integration of CHWs in the emergency department at CHRISTUS Spohn hospital in Corpus Christi. In the discussion period, participants’ questions ranged from negotiating the need for CHWs with administrative staff to equitable compensation for CHWs.

Participants interacted with CHWs from successful programs in a small group discussion period. Each discussion group was encouraged to interact with the CHW about their experiences in the field; the following questions were provided to facilitate the discussion: (1) How do you define CHW/*Promotor(a)*/Navigator? What do they do? (2) How can they help your organization? (3) What do you want/need to know? Summaries of each small group discussion were then presented to all summit participants. Paula Winkler, MEd, Director of the South Central Area Health Education Center and Carl Rush, MRP of Community Resources LLC, led the interactive discussion. Results from these discussion groups were then synthesized into more discrete recommendations (see below).

Evaluation

At the summit's close, attendees provided feedback regarding the summit. Part one of the evaluation contained seven open-ended questions and part two contained seven statements that respondents were to evaluate on a four-point scale (see appendix). Forty evaluations were returned by the 65 participants; a response rate of 61.5%. Notes from the small group discussions were also collected as well as a *Compromisos* card. The *Compromisos* card contained commitments that summit attendees made regarding the development of the CHW workforce. These commitments ranged from educating people about the workforce to hiring CHWs. Summit attendees were invited to meet once a month for the next six months. Participants at these follow-up meetings discussed obstacles and potential solutions for workforce development. Based on the surveys, small group discussions, and follow-up meetings we propose the following recommendations for developing the CHW workforce.

National/State Recommendations

Define the CHW workforce. Defined job descriptions can standardize roles in the field, determine compensation, and create cohesion among the workforce. Defining the CHW workforce, specifically who they are and what they do, is vital to the success of integrating CHWs into models of care. A universal definition will provide a basis for a workforce identity campaign and assist employers in setting standards for their employees regarding their functions, standards of pay, and an understanding of the benefits of CHWs. According to the American Public Health Association (APHA):

A Community Health Worker, (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the 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. A 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.^{1[p.1]}

Although this definition is wide-ranging, there are often others who do similar work but are referred to by different titles. Common terms that refer to individuals who do similar work are *promotores*, lay health advisors, and community health educators, among many others. Individuals who perform comparable work but without a consensus on the definition or title lack a clear identity. Various job titles are used by different organizations, which can lead to confusion and a lack of cohesion among the workforce. A common definition will allow CHWs to be seen as a single recognized profession. We believe that the variety of local definitions will further fragment CHW identity. Therefore, policy development at a national level should occur to standardize the workforce.

Create training standards for patient navigators. Standardized training will clarify roles and benefits of employing Patient Navigators. While patient navigators do not

currently undergo standard training, their roles are more accepted within the medical community. Patient navigation is a function and not a separate occupation; navigators may also be nurses, social workers and CHWs. Community Health Workers' roles may include navigation but are not limited to those functions. The NCI PNRP Fact Sheet defines patient navigation as follows:

Patient navigation in cancer care refers to the assistance offered to healthcare consumers (patients, survivors, families, and caregivers) to help them access and then chart a course through the healthcare system and overcome any barriers to quality care. A patient navigator can be a registered nurse or a social worker who functions as a "guide." Navigators help their patients move through the complexities of the healthcare system—getting them more timely treatment, more information about treatment options and preventive behaviors.^{2(p.1)}

Patient navigators are not limited to cancer care, but this definition describes the multiple facets of the health care system that navigators must master to assist their patients. Currently, lack of accepted training standards leads to variation in definitions and duties of navigators on a site-specific basis. Because of the varied backgrounds, we propose a standard training for all those who fill the role of patient navigator is created and implemented. Standardized training programs with common outcome metrics will elevate professional certification and recognition of the patient navigator workforce.

Evaluate the financial benefit of integrating CHWs into existing systems through cost/benefit analyses. Demonstrated financial benefits will be critical to developing a sustainable workforce. To fully realize the financial impact of CHWs within an organization, evaluating their cost-effectiveness is imperative for the sustainability of the workforce. In Minnesota, policymakers succeeded in creating a financially sustainable reimbursement system for CHWs serving Medicaid recipients. Blue Cross Blue Shield of Minnesota Foundation funded a research project evaluating CHWs by the University of California San Francisco. The findings were used to gain the Medicaid reimbursement in Minnesota. There are similar on-going efforts in other states, but most programs rely on grant funding to employ CHWs. In some cases, CHWs volunteer their services. As part of the efforts in Texas and nationally to create a sustainable workforce, research and evaluations of CHWs programs should be reviewed in terms of financial benefits. While a few studies have reviewed the financial benefit of integrating CHWs into their care models,^{3,4,5} more research regarding the cost effectiveness of CHWs is needed. Cost-benefit analyses should be performed and distributed nationally to all those who may benefit from the employment of CHWs. A national effort to show the financial benefit of CHWs is essential to the progress of local programs.

Pursue strategies for reimbursement of CHW services from major third-party payers (Medicaid, SCHIP, and Medicare). Because of the lack of Medicaid reimbursement in most states, patients most in need have no access to CHW assistance. Successful strategies to integrate Medicaid reimbursement in specific states should be shared. Currently, while employment of CHWs is predominantly funded through a variety of mechanisms, Medicaid reimbursement may encourage more employers to maintain CHWs in health care systems. While the Minnesota experience demonstrates that

Medicaid reimbursement for CHW services is possible, different strategies will likely need to be tailored according to state law and policy. Successful strategies to integrate Medicaid reimbursement in specific states should be shared to serve as templates for emulation.

Local Recommendations

Local recommendations are focused on outreach, education, and creating local support networks of those interested in the development of the CHW workforce. Early efforts should include educating employers about CHWs. Many employers are unaware of CHWs' activities and potential benefits. Education in conjunction with evidence of cost effectiveness will likely encourage the creation of permanent positions. Another step to grow and strengthen the workforce, identified by attendees at the San Antonio summit, is the need for an employer network. Local support is central to the overall goal of workforce sustainability; otherwise, CHWs will remain in temporary positions. The recommended employer network should consist of those who employ CHWs, those who may have an interest in employing CHWs, and those who want to learn more about employing CHWs. Current efforts to cultivate a CHW network are underway and a social networking site for CHWs was recently launched (healthworkernetwork.ning.com). This site is a social/professional network for the CHW workforce in Texas to interact and exchange information. A website is currently under construction to house a database of local resources commonly accessed by the workforce. Resources include assets provided by or to the community to assist with basic needs that arise during times of difficulty. A resource can be anything from affordable childcare to utility assistance to reasonably priced medical services.

Conclusion

While we believe that integrating CHWs into mainstream health care services will be beneficial to the community and to health care organizations, national studies of the cost effectiveness of patient navigators, CHWs, and *promotores* are still needed. Major efforts are still needed to gain widespread acceptance of a common definition of CHWs, but this awareness will benefit both employer organizations and the CHW workforce itself. State policies for Medicaid reimbursement of CHW services will be beneficial in efforts to address persistent health disparities.

Notes

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