The New England Comparative Effectiveness Public Advisory Council

An Action Guide on Community Health Workers (CHWs): Guidance for Organizations Working With CHWs

September 2013

Completed by:

The Institute for Clinical and Economic Review

Introduction

About this guide

Evidence from clinical effectiveness reviews is critical to judgments that patients, clinicians, and health insurers must make about treatment choices and coverage policies. Yet that evidence is often not translated in a way that is helpful to inform healthcare decisions. This document is a companion policy guide designed to help organizations working with community health workers (CHWs) make use of the results from a recent report titled, "Community Health Workers: A Review of Program Evolution, Evidence on Effectiveness and Value, and Status of Workforce Development in New England" developed by the Institute for Clinical and Economic Review (ICER). This report formed the basis for the deliberations and votes of the New England Comparative Effectiveness Public Advisory Council (CEPAC) – an independent body that meets in a public, transparent forum to provide objective guidance on how information from evidence reviews can best be used by regional decision-makers to improve the quality and value of healthcare services.[1] The report pulls together the best available evidence on the effectiveness and value of CHWs from the published literature, findings from interviews with expert stakeholders, new survey results benchmarking the use of CHWs in New England, and public testimony.

CEPAC held its meeting on CHWs on June 28, 2013, bringing together policy experts from around the country to inform the deliberations. We have developed this action guide in order to provide a user-friendly overview of the CEPAC findings and an associated list of specific evidence-based action steps and resources that organizations can use to improve patient outcomes and the overall value of CHW services.

This guide provides information that may be helpful in various ways for organizations considering the employment of CHWs. It summarizes evidence-based best practices that organizations may wish to adopt or reinforce. It delineates possible quality indicators for high-quality CHW programs that may be used in discussions with payers. It provides background on key state policy matters related to the training and certification of CHWs that provider organizations may wish to influence. And it describes policy experts' experiences and perspectives on options for reimbursement. Information is provided in the following areas:

- *Certification and Training*
- *Recruitment*
- *Care team Integration and CHW Supervision*
- *Pairing*
- *Patient Interaction*
- *Funding*
- *Evaluation*

[1] For more information on CEPAC, visit: http://cepac.icer-review.org/

Organizations Working with CHWs

I. Training and Certification

1. Training

While training programs are traditionally focused on specific diseases or conditions, many policy experts believe that current training focused on core competencies is crucial. Development of core skills will translate across conditions and patient communities. Advanced training will provide specialized education in specific disease states establishing knowledge beyond a generalized skill set for CHWs.

Examples of New England-based training opportunities focused on core competencies include programs at the Southwestern Connecticut Area Health Education Center (AHEC) and at the Boston Public Health Commission. These programs provide 48-55 hours of training in areas such as leadership skill development, cross-cultural communication, and self-management health education. Community Health Innovations of Rhode Island offers a 15-week training course with 3-hour weekly sessions and 1 weekly group session. Field experience or an internship is commonly part of the generalized curriculum.

Minnesota utilizes a statewide competency-based training program for CHWs. For high school graduates or those with a GED, accredited schools offer a 14-credit course consisting of 9 credit hours in core competencies in advocacy and outreach, 3 hours in the health promotion of healthy lifestyles, health promotion competencies and 2 credit hours for 72-80 hours of supervised experience in a practical internship. This standardized curriculum is part of the system approved by the Minnesota legislature and the Centers for Medicare and Medicaid Services (CMS) allowing CHWs to become billable Medicaid providers. The curriculum is available for purchase through the Minnesota State College and University System (for more information, contact Ann Willaert at anne.willaert@southcentral.edu, or visit the following website: http://s472440476.onlinehome.us/wp-content/uploads/2013/05/FAQchw.pdf).

Additional available training resources are listed in Table 1 and Table 2 on below and on the following page.

Table 1. Training Programs Outside of New England.

Minnesota	
	Minnesota Community Health Worker Alliance: Education http://mnchwalliance.org/explore-the-field/education-2/
Texas	
	Texas Department of State Health Services – CHWs: Training Information http://www.dshs.state.tx.us/mch/chw/training.aspx

Table 2. New England Training Programs.

Connecticut	
	Center for the Study of Cultural, Health, and Human Development at the University of CT – Family Development Credential http://www.familydevelopmentcredential.org/Plugs/How_to_Earn_Credentials.aspx
	Central AHEC, Hartford CT – Community Health Worker/Patient Navigator Program http://www.centralctahec.org/CHW-PN-Training.aspx
	Southwestern AHEC, Trumbull CT http://www.swctahec.org/
Maine	
	Portland, ME, Public Health Division – Minority Health Program http://www.portlandmaine.gov/hhs/phminority.asp
	University of New England – Interprofessional Education Collaborative http://www.une.edu/wchp/ipec/index.cfm
Massachusetts	
	Bunker Hill Community College – Community Health Worker Certificate Program http://www.bhcc.mass.edu/programsofstudy/certificateprograms/humanservices/communityhealthworkercertificateprogram/
	Community Health Education Center of the Boston Public Health Commission http://www.bphc.org/programs/chec/Pages/Home.aspx
	Mass Bay Community College – Associate degree in Liberal Arts, Community Health Option http://www.massbay.edu/uploadedFiles/Second_Level_Pages/Academics/Curriculum-Sheet-SSPS-Liberal-Arts-Community-Health-Option-AA.pdf
	Mass Bay Community College – Certificate program in Community Health http://www.massbay.edu/uploadedFiles/Second_Level_Pages/Academics/Curriculum-Sheet-SSPS-Liberal-Arts-Community-Health-C.pdf
	Lowell Community Health Center http://www.lchealth.org/CHEC.shtml
	Outreach Worker Training Institute of the Central MA AHEC http://www.cmahec.org/index.php?option=com_content&view=article&id=46&Itemid=59
New Hampshire	
	No training programs identified; please contact your local AHEC for updated information (see page 7).
Rhode Island	
	Community Health Innovations of RI – CHW Certificate Course http://chi-ri.org/programs/certificate/
	Community Health Worker Association of Rhode Island http://www.chwassociationri.org/index.html
Vermont	
	No training programs identified; please contact your local AHEC for updated information (see page 7).

2. Certification

Certification of CHWs is important for the standardization of training and education programs across different regions and states. Certified CHWs can achieve increased recognition from healthcare teams, provider organizations, and payers. While a certification process suggests a requirement for a uniform level of knowledge and skills, it is important for states to recognize the work history of current, experienced CHWs and to create a low cost, easily accessible road to certification to encourage ideal CHW candidates. While professional certification is not currently required in New England for CHWs, states are working toward establishing a certification process. In Massachusetts, a law was passed in 2010 creating the Board of Certification for CHWs. The Board began meeting in July 2012, and is working to create a program of certification for CHWs.

Some states outside of New England, such as Minnesota and Texas, already have certification or credentialing programs in place. In Texas, there is no application fee for certification, and the sole requirement of applicants is to complete a 160-hour CHW training program, approved by the Department of State Health Services (DSHS) or to have provided at least 1000 hours of CHW services in the last 6 years, with verification by a supervisor. In Minnesota, CHWs may provide diagnosis-related patient education services with Medicaid reimbursement if the following major requirements are met:

- Completion of an accredited CHW training program with receipt of certification
- Enrollment in the Minnesota Health Care Programs as a participating provider
- CHW supervision by an APRN, physician, certified public health nurse or dentist who is an eligible Billing Provider

Other requirements are detailed on the Minnesota Department of Human Services website (please see link below).

In Oregon, CHWs are utilized as part of integrated care teams known as "coordinated care organizations" (CCOs) under a Centers for Medicare and Medicaid Services (CMS) Innovation Award (Oregon.gov, 2013). The state legislature is currently considering a bill to establish a health workers commission that would identify training and education requirements for CHWs and other health professionals. Established by the Oregon Health Authority, the Non-Traditional Health Worker Subcommittee has made recommendations regarding training, supervision and registration for CHWs (Angus, 2012). In December 2012, a Steering Committee began working towards implementation, along with establishment of an online registry for certified CHWs eligible for Medicaid reimbursement (Miyao, 2013). Currently in Oregon, the Home Care Commission provides training opportunities and maintains a registry of qualified Homecare Workers. After completion of 20 additional hours of core safety and skills training, Homecare Workers and Personal Support Workers receive Professional Development Recognition. These select individuals are now eligible for free certification training as a Community Health Worker under the Oregon Health System Transformation Initiative (Oregon.gov, 2013).

More information may be found at the following links:

Minnesota Department of Human Services:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357

Texas Department of State Health Services:
http://www.dshs.state.tx.us/mch/chw.shtm

II. Recruitment

Experts agree that CHWs maximize their impact when they have the respect of patients and a deep understanding of their social and environmental context. Therefore, it is important to recruit CHWs from within the communities they will serve. For some organizations, standard hiring and recruitment strategies may not capture the unique characteristics or qualities important to the role of a CHW. Organizations wanting to begin working with CHWs may consider partnering with community-based organizations, local aid groups, and religious or cultural organizations that are particularly well-placed to recruit CHWs to ensure that the appropriate individuals are selected for the job.

Resources are provided below to help employers identify local organizations in their state with whom they can collaborate to recruit and deploy CHWs.

1. Area Health Education Centers

Area Health Education Centers (AHECs) are designed to increase the number of health care providers and improve the quality of care in rural and underserved areas. Each local AHEC typically operates as an independent not-for-profit agency, working closely with local community groups and health professional training programs to enhance workforce development, which may include activities in the following areas:

- Training and recruitment of students from minority or underserved communities into health careers through direct outreach and community engagement;
- Placement of students into community-based clinical settings in underserved areas;
- Promotion of interprofessional education and team-based care;
- Facilitation of training, continuing education, and career service programs for health professionals in topics or areas relevant to the needs of the local community, particularly in rural or underserved areas.

Table 3 on the following page provides website links and contact information for each local AHEC in New England.

Table 3. Area Health Education Centers (AHECs) in New England.

Connecticut	
CT AHEC Program - Program Office at the University of Connecticut	http://www.publichealth.uconn.edu/cphhp-services.html
Central AHEC	http://www.centralctahec.org/central-ct-ahec.aspx | 860-920-5149 | info@centralctahec.org
Eastern CT AHEC	http://www.easternctahec.org/ | 860-465-8281 | bond@easternctahec.org
Northwestern CT AHEC	http://www.nwctahec.org/ | 203-758-1110 | nwctahec@nwctahec.org
Southwestern CT AHEC	http://www.swctahec.org/ | 203- 372-5503 | mseguinot@swctahec.org
Maine	
Eastern Maine AHEC	http://www.pchcbangor.org/ | 207-404-8000
Northern Maine AHEC	http://www.nmcc.edu/ | 207-768-2700 | lbuck@nmcc.edu
Western Maine AHEC	http://www.fchn.org/ | 207-779-2575 | krogers@fchn.org
Massachusetts	
Massachusetts AHEC Network	http://www.umassmed.edu/ahec/index.aspx
Berkshire AHEC	http://www.umassmed.edu/ahec/centers/berkshire.aspx | 413-447-2417 | ccohen@berkshireahec.org
Boston Area AHEC	http://www.umassmed.edu/ahec/centers/Boston_AHEC.aspx#youth_to_health | 617 - 534-5258 | BAHEC@bphc.org
Boston University AHEC	http://www.bumc.bu.edu/busm-ahec/boston-university-area-health-education-center/
Central Massachusetts AHEC	http://www.cmahec.org/ | 508-756-6676 | jlcalista@cmahec.org
Merrimack Valley AHEC	http://glfhc.org/site/programs-and-services/merrimack-valley-ahec/ | 978-685-4860
Pioneer Valley AHEC	http://www.umassmed.edu/ahec/centers/Pioneer_Valley.aspx | 413-750-2079 | pvahec@springfieldcityhall.com
AHEC of Southeastern Massachusetts	http://www.umassmed.edu/ahec/centers/Southeastern_ma.aspx | 508- 583-2250 | lmarschke@healthimperatives.org
New Hampshire	
NH AHEC	http://tdi.dartmouth.edu/initiatives/area-health-education-center
Northern NH AHEC	http://www.nchcnh.org/AHEC.php | 603-259-3700
Southern NH AHEC	http://www.snhahec.org/ | 603-895-1514 | psmith@snhahec.org
Rhode Island	
RI AHEC Network	http://med.brown.edu/ahec/
Northern RI AHEC	http://northernriahec.org/ | 401-356-4077 | info@northernriahec.org
Central RI AHEC	http://www.saintjosephri.com/ | 401-456-3000
Southern RI AHEC	http://www.southernriahec.org/ | 401-874-2768
Vermont	
Vermont AHEC	http://www.uvm.edu/medicine/ahec/?Page=about.html&SM=aboutussubmenu.html
Northeastern Vermont AHEC	http://www.nevahec.org/ | 802-748-2506 | contactus@nevahec.org
Champlain Valley AHEC	http://www.cvahec.org/ | 802-527-1474 | feedback@cvahec.org
Southeastern Vermont AHEC	http://www.svahec.org/ | 802-885-2126 | info@svahec.org

2. Professional Associations

Some New England states have professional associations of CHWs that are working to expand leadership and training opportunities for CHWs and build recognition of the workforce. These professional associations, though not yet in every state, have made efforts to collaborate at a regional level and may provide a helpful resource when trying to recruit CHWs. Table 4 below provides links with information on each professional CHW association in New England.

Table 4. Professional CHW Associations in New England.

Connecticut	Community Health Worker Association of Connecticut https://www.facebook.com/CHWACT
Massachusetts	Massachusetts Association of Community Health Workers http://www.machw.org/
Rhode Island	Community Health Worker Association of Rhode Island http://www.chwassociationri.org/

3. Community-based Organizations

Community-based organizations work directly with local communities and often provide health, education, and social services for vulnerable population groups. These organizations are well situated to recruit CHWs or connect individuals to CHW resources. Table 5 below and on the following pages provides examples of community-based organizations in each New England state, as well as links to other resources with a more comprehensive list of non-profit and community organizations operating in the region.

Table 5. Community-based Organizations in New England.

Regional	
New England AIDS Education and Training Center	NEAETC provides training and education for nurses, nurse practitioners, physicians, physician assistants, social workers, dentists as well as other health care providers. It offers multiple educational opportunities including clinical consultation and skills building with the goals of enhancing competency in HIV prevention and care, and improving services for people living with HIV infection. http://www.neaetc.org/
Connecticut (For a more comprehensive list of community-based organizations in CT, including non-profits, educational organizations, libraries, and faith-based organizations, refer to the Office of Contract Compliance's list.)	
Hispanic Health Council	Provides culturally-relevant direct service programs to the Latino population in a variety of areas, including breastfeeding, parenting support, diabetes, migrant farm worker health, etc. http://www.hispanichealth.com/hhc/
International Institute of Connecticut	Provides a broad range of services to immigrants and foreign-born persons, including English classes, job training, refugee resettlement, interpretation, and connection to food and housing services. http://www.iiconn.org/about.html
Hartford Communities that Care, Inc.	Focused on violence and drug prevention through coordination and collaboration of direct services, fostering community partnerships, education, and promotion of healthy lifestyles. http://www.hartfordctc.org/about_us.htm
Hartford Gay and Lesbian Collaborative	Provides mental and clinical health services, education, support groups, etc., tailored to the LBGTQ communities, particularly for young people living with HIV/AIDS. http://www.hglhc.org/
CAUSA, Inc.	Membership organization of several Latino community service organizations in CT. Members agencies work in the areas of elderly care, child care, HIV/AIDS, housing and economic development. http://www.causainc.org/

Connecticut, continued	
Khmer Health Advocates	Provides culturally-appropriate direct health services to Cambodian refugees living in CT and MA through use of CHWs, including health consultations, mental health evaluations, and long-term psychotherapy. Also provides training and education opportunities in outreach work in Khmer-English interpretation, cross-cultural care, and mental health. http://www.khmerhealthadvocates.org/
Maine	
Maine Migrant Health Program	Maine's only farmworker health organization that works to link agricultural workers to healthcare resources and services. MMHP uses mobile medical units to bring primary care to migrant workers, and also provides outreach, case management, interpretation, and other services. http://www.khmerhealthadvocates.org/
El Centro Latino de Maine	Provides advocacy and access to services and information for the Latino population of Maine. http://www.elcentrolatinome.org/
Mano en Mano	Works with a diverse group of populations to provide educational and affordable housing opportunities, remove barriers to health and social services, and advocate for social justice. http://www.manomaine.org/about
Goodwill Industries of Northern New England	Provides a range or programs and services, including direct clinical services, case management, and support services for underserved populations. http://www.goodwillnne.org/programs/workforce-solutions/americorps/
Immigrant Legal Advocacy Project	Provides free or low-cost information and legal assistance to low-income Mainers. http://www.ilapmaine.org/
Maine Equal Justice Partners	Non-profit legal aid provider that's focused on poverty alleviation and finding solutions for low-income Mainers. http://www.mejp.org/content/our-mission
Massachusetts (For a more comprehensive list of community-based organizations in MA, please visit the Executive Office of Labor and Workforce Development website: http://www.mass.gov/lwd/labor-standards/das/cbos).	
Boston Centers for Youth and Families	Offers community programming including pre-school, school-aged and adult education, family literacy, youth employment, violent prevention, and senior activities for the Greater Boston Area. http://www.cityofboston.gov/bcyf/
Roxbury Multi Service Center	Services provided include case management, in-home therapy, therapeutic mentoring, family stabilization, tutoring for grades 1-5, and a nurturing program. http://www.roxmulti.org/
Fair Housing Massachusetts	Provides free legal counseling and accepts housing discrimination complaints, while also providing general education and outreach services to community groups, service providers, landlords, and others. http://www.massfairhousing.org/about-us
Twin Cities Community Development Corporation	Membership organization led by the resident and business communities of Fitchburg and Leominster, which works to invest and organize communities around issues such as quality housing, healthy neighborhoods, and good jobs. http://www.twincitiescdc.org/
Health Imperatives	Works directly with vulnerable population groups to reduce health disparities by providing a range of direct services, including family planning, emergency domestic violence/sexual assault resources, and nutrition and home visiting programs. http://www.healthimperatives.org/
La Alianza Hispana	Provides direct programs and services to the Latino population of Massachusetts, including elder care, family support services, language support and workforce training, and adolescent education. http://laalianza.org/index.php?option=com_content&view=category&layout=blog&id=41&Itemid=54

New Hampshire	
Bhutanese Community of New Hampshire	Provides essential services to the Bhutanese population of NH to help individuals access basic resources, community base services, and information related to various jobs, skills and health trainings. http://www.bhutanesecommunitynh.org/Default.aspx
NH Catholic Charities	Social service organization providing a range of services such as adoption and maternity resources, immigration support and casework, and counseling. http://www.nh-cc.org/what-we-do.aspx
New Hampshire Children's Trust	Lead agency focusing on the elimination of child abuse and neglect in the state. Utilizes evidence-based prevention strategies and provides training, technical assistance, resources, evaluation and accreditation support to direct service programs. http://www.nhchildrenstrust.org/
New Hampshire Family Voices	Works directly with parents and caregivers for children with special needs, providing one to one phone assistance, educational materials, a Lending Library and quarterly newsletter. NH Family Voice participates in several projects, each with a specific focus on different ways to help families become informed, experienced, self-sufficient advocates for their children and themselves. http://nhfv.org/
Rhode Island	
Progreso Latino Inc.	Progreso Latino multi-service organization serving the Latino and immigrant populations: Adult Education & Workforce Development, Citizenship Preparation & Civic Engagement, Computer Literacy, Early Childhood Education, Financial Literacy & Volunteer Income Tax Assistance, Health Education & Wellness Services, Immigration and Social Services, Job Development, Native Literacy, Spanish Language Senior Citizens Group, Trainings for New Entrepreneurs, and Youth Development Services. http://www.progresolatino.org/
Silk Road Center	Provides education, health, culture, language and other social services for the Chinese and Asian communities of RI. http://www.silkroadcenter.org/Home/adult-chinese-class-1
Dr. Martin Luther King Jr. Community Center	Provides education, social, and recreational services and programs to persons of all ages and cultures, including daycare, teen and senior services. http://www.mlkccenter.org/
Dorcas International Institute of Rhode Island	Provides educational and social services to immigrant and refugee populations in Rhode Island. http://www.diiri.org/
Children's Friend	Provides culturally-relevant services to RI's most vulnerable children and their families. http://www.cfsri.org/
Laotian Community Center of Rhode Island	Provides social services and cultural programming/events for the Laotian community of RI. http://www.rilaocenter.org/
Vermont	
Pathways to Housing, Vermont	Works with vulnerable populations in Vermont to provide peer support, and home-based and community services to prevent homelessness. http://pathwaystohousing.org/vt/
Association of Africans Living in Vermont	Provides a range of services to all immigrant or refugee populations, including referral case management, cross-cultural training, language interpretation, etc. http://www.africansinvermont.org/
Vermont Family Network	Provides support, referrals, and services to children and families of VT, particularly around development disabilities, early childhood development, and mental health. http://www.vermontfamilynetwork.org/about-vfn/

4. Community Action Agencies

Community Action Agencies (CAAs) are non-profit private and public organizations established under the Economic Opportunity Act of 1964 to provide direct support to individuals living in poverty. CAAs are each governed locally and therefore provide a range of services, with most delivering programs in the following areas: service coordination; emergency services (e.g. food pantries, domestic violence, homeless shelters); education; food and nutrition; family development (e.g. case management, counseling, etc.); training and development; income management; transportation; and health care.

To search for CAAs by state, please visit: http://www.communityactionpartnership.com/index.php?option=com_spreadsheets&view=search&spreadsheet=cap&Itemid=188

5. Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are community organizations that encompass a range of health programs serving vulnerable populations, including:

- Community Health Centers, which provide services to federally designated underserved areas or populations;
- Migrant Health Centers, which provide services to migrant or seasonal agricultural workers;
- Health Care for the Homeless Programs, which provide primary, preventative, and substance abuse services to homeless individuals and families; and
- Public Housing Primary Care Programs, which provide services to public housing residents and their adjacent communities

For a comprehensive list of FQHCs searchable by state, county, or zip code, please visit the Health Resources and Services Administration (HRSA) website: http://findahealthcenter.hrsa.gov/Search_HCC.aspx.

6. Public Health Agencies

Public health agencies are another important resource for organizations and states to consider working with to develop and deploy the CHW workforce. Public health departments have made many significant contributions to the CHW workforce in New England, and may be important partners when launching new programs or looking to recruit CHWs for the first time.

Table 6 on the following page provides a list of public health agencies operating in each New England state with links for more information. This list is not exhaustive, and there may be additional government agencies or departments that may serve as valuable resources.

Table 6. Public Health Agencies in New England.

New England
Region I (New England), Office of the Assistant Secretary for Health, U.S. Dept. of Health and Human Services http://www.hhs.gov/ash/rha/region1/index.html
Connecticut
Office of Health Care Access, Connecticut Department of Public Health http://www.ct.gov/dph/cwp/view.asp?a=3902&q=277344
Maine
Office of Health Equity, Maine Center for Disease Control and Prevention, Maine Dept. of Health and Human Services http://www.maine.gov/dhhs/mecdc/health-equity/index.shtml
Minority Health Program, Portland Public Health Division, Health and Human Services Dept. http://www.portlandmaine.gov/hhs/phminority.asp
Massachusetts
Office of Community Health Workers, Division of Primary Care and Health Access, Massachusetts Dept. of Public Health http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/primarycare-healthaccess/healthcare-workforce-center/comm-health-wkrs/
Community Health Education Center, Boston Public Health Commission http://www.bphc.org/programs/chec/Pages/Home.aspx
New Hampshire
Office of Minority Health and Refugee Affairs, New Hampshire Dept. of Health and Human Services http://www.dhhs.state.nh.us/omh/index.htm
Bureau of Community Health Services, New Hampshire Dept. of Health and Human Services http://www.dhhs.state.nh.us/dphs/bchs/index.htm
Rhode Island
Division of Community, Family Health, and Equity, Rhode Island Dept. of Health and Human Services http://www.health.ri.gov/programs/communityfamilyhealthandequity/index.php/
Vermont
Division of Community Public Health, Vermont Dept. of Health and Human Services http://healthvermont.gov/admin/cph/cph.aspx
Office of Minority Health and Health Disparities, Vermont Dept. of Health and Human Services http://healthvermont.gov/local/mhealth/minority.aspx

III. Care Team Integration and Supervision

The resources below provide guidance for organizations looking to better integrate CHWs into the care team, including information on how to define the role of CHWs and appropriately train supervisors. The individual integration plan will vary by each agency or organization, but the following resources are provided as guidance for organizations looking to incorporate CHWs into their care team, or to benchmark best practices.

1. A Clear, Concrete Role for CHWs

The individual duties and responsibilities for CHWs will depend greatly on the setting in which they work, as well as the communities they serve. CHWs may operate under numerous job titles, including but not limited to:

- Community Health Educator
- Enrollment Worker
- Family Advocate
- Family Planning Counselor
- Family Support Worker
- Doula
- Health Advocate
- Health Educator
- HIV Peer Advocate
- Outreach Worker
- Outreach Educator
- Patient Navigator
- Peer Advocate
- Peer Leader
- Promotor(a)
- Promotor(a) de Salud
- Street Outreach Worker

Sample Job Descriptions, Duties, and Responsibilities for CHWs

The following are examples of job descriptions that other states or organizations have used when hiring CHWs.

STATE OF MINNESOTA: http://chw-nec.org/docs/minnesota/handouts.pdf

"Community Health Workers (CHWs) are members of the community they serve. They build relationships and trust at the grassroots level and bridge the gap between individuals, families and communities with health and social services. CHWs are paraprofessionals who have graduated from an approved CHW training curriculum*, they work in clinical and community facilities to provide health and social service linkages. CHWs teach community members and providers the knowledge and skills needed to understand, give and receive appropriate care and service options for all Minnesotans."

*Note: not all states have standardized training curriculums in place, and it is at each state or individual program's discretion to require training for CHW employment.

Table 7 on the following page provides a sample job description with roles and responsibilities for CHWs from Minnesota.

Table 7. State of Minnesota Roles and Responsibilities for CHWs.

Role 1: Bridge the gap between communities and the health and social service systems A. Educate community members about how to use the healthcare and social service systems B. Educate the health and social service systems about community needs and perspectives C. Gather information D. Communicate with identified populations E. Improve the quality of care by aiding communication between provider and patient to clarify cultural practices
Role 2: Promote wellness by providing culturally appropriate health information to clients and providers. For example: A. Health promotion and disease prevention B. Assist in client's managing their chronic illness
Role 3: Assist in navigating the health and human service system A. Connect with people needing services B. Make referrals and coordinate services C. Teach people the knowledge and skills needed to obtain care D. Facilitate continuity of care by providing follow-up E. Manage paperwork (e.g. help with application for public assistance)
Role 4: Advocate for individual and community needs A. Articulate and represent needs of community and individuals to others B. Be a spokesperson for clients when they are unable to speak for themselves C. Involve participants in self and community advocacy
Role 5: Provide direct services A. Link to community resources to meet basic needs B. Provide individual social and health care support C. Organize and/or facilitate support groups D. Refer and link to preventative services through health screenings and healthcare information
Role 6: Build individual and community capacity A. Build individual capacity to achieve wellness B. Build community capacity by addressing social determinants of health C. Identify individual and community needs D. Mentor other CHWs – capacity building E. Seek professional development (continuing education)

Source: Community Health Worker National Education Collaborative, http://chw-nec.org/docs/minnesota/handouts.pdf

PATIENT CENTERED MEDICAL HOMES:

Opportunities under the Patient Protection and Affordable Care Act for the development of patient-centered medical homes may create a natural setting for the work of CHWs. The core services that health homes are set out to deliver closely align with the roles and duties of CHWs.

Table 8 on the following page provides a list of core activities identified by the NY State Department of Health that can be performed directly by or supported by a CHW within the medical home, as well as a sample job description for a CHW working within a medical home.

Table 8. CHW Sample Scope of Responsibilities.

Comprehensive care management	
Performed directly by CHW	**Supported by CHW**
Consult with primary care physician and/or any specialists involved in the treatment plan.	Complete a comprehensive health assessment and reassessment, including medical, behavioral, rehabilitative, and long-term care and social service needs.
Conduct client outreach and engagement activities to assess ongoing emerging needs and to promote continuity of care and improved health outcomes.	Complete/revise an individualized patient-centered plan of care with the patient to identify patient's needs and goals and include family members and other social supports as appropriate.
	Consult with multidisciplinary team on client's care plan, needs, and goals.
	Prepare client crisis intervention plan.
Care coordination and health promotion	
Performed directly by CHW	**Supported by CHW**
Coordinate with service providers and health plans, as appropriate, to secure necessary care; share crisis intervention and emergency information.	Conduct case reviews with interdisciplinary team to monitor/evaluate client status and service needs.
Refer client to services to support care plan/treatment goals, including medical, behavioral health care, patient education, self-help/recovery, and self-management.	Coordinate with treating clinicians to ensure that services are provided and to ensure changes in treatment or medical conditions are addressed.
Advocate for services and assist with scheduling of needed services.	Crisis intervention, revise care plan/goals as required.
Monitor, support, and accompany the client to scheduled medical appointments.	
Comprehensive transitional care	
Performed directly by CHW	**Supported by CHW**
Follow up with hospitals/ED upon notification of a client's admission and/or discharge to/from an ED, hospital/residential/rehabilitative setting.	Facilitate discharge planning from an ED, hospital, residential, and rehabilitative setting to ensure a safe transition/discharge and that care needs are in place.
Notify/consult with treating clinicians, schedule follow-up appointments, and assist with medication reconciliation.	Link client with community supports to ensure that needed services are provided.
Follow up post-discharge with clients and their families to ensure client care plan needs/goals are met.	
Patient and family support	
Performed directly by CHW	**Supported by CHW**
Consult with client/family/caretaker on advanced directives and educate on client rights and health care issues, as needed.	Develop/review/revise the individual's care plan with the clients and their families to ensure that the plan reflects individual's goals, education, and support for self-management.
Meet with client and family, inviting any other providers to facilitate needed interpretation services.	
Refer clients and their families to peer supports, support groups, social services, and entitlement programs as needed.	
Referral to community and social support services	
Performed directly by CHW	Supported by CHW
Collaborate and coordinate with community-based providers to support effective utilization of services based on client/family need.	

Source: Zahn D, et al. Making the Connection: The Role of CHWs in Health Homes, 2012. http://www.chwnetwork.org/media/122708/making-the-connection-chw-health-homes-sept-2012.pdf

Sample CHW Health Home Job Description

"The Community Health Worker (CHW) will be an integral member of an interdisciplinary health home care management team. The CHW will work closely with health home patients, care managers, other care management team members, health care providers, social services providers, and community partners to effectively manage the care of designated health home patients."

Table 9. Sample CHW Health Home Job Requirements and Qualifications.

Requirements
Conduct patient outreach and engagement activities to designated health home patients, including face-to-face, mail, electronic, and telephone contact.
Conduct outreach and engagement activities that support patient continuity of care, including re-engaging patients in care if they miss appointments and/or do not follow up on treatment.
Conduct initial and periodic needs assessments, including assessing barriers and assets (e.g., transportation, community barriers, social supports); patient and family or caregiver preferences; and language, literacy, and cultural preferences.
Assist patients in completing patient consent forms.
Support the development and execution of patients' care plans, including assisting patients in understanding care plans and instructions and tailoring communications to appropriate health literacy levels.
Promote patient treatment adherence through assessing patient readiness to make changes; assisting patient in making changes to daily routines; identifying barriers; and assisting patients with developing strategies to address barriers.
Provide informal counseling, behavioral change support, and assistance with goal setting and action planning.
Assist patients with navigating health care and social service systems, including arranging for transportation and scheduling and accompanying patients to appointments.
Assist care managers in monitoring and evaluating patients' needs, including for prevention, wellness, medical, specialist, and behavioral health treatment; care transitions; and social and community service needs.
Identify available community-based resources and actively manage appropriate referrals, access, engagement, follow-up, and coordination of services.
Coordinate patients' access to individual and family supports and resources, including resources related to housing; prevention of mental illness and substance use disorders; smoking cessation; diabetes; asthma; hypertension; self-help/recovery resources; and other services based on individual needs and preferences.
Provide support for chronic disease self-management to patients and their families.
Coordinate access to the basic determinants of health (e.g., food, clothing, shelter, income, utilities).
Use health information technology to link to services and resources and communicate among team members, providers, and patients and their families/caregivers.
Collect and report on data for program evaluation.
Provide information on patients to care managers, other care team members, and providers.
Manually and/or electronically document activities and patient information and interventions in patient-tracking systems, care management software programs, and other program systems.
Qualifications
Direct experience with or knowledge of population or community to be served.
Excellent oral communication skills.
Ability to establish positive, supportive, and trusting relationships with and among patients and colleagues and to work collaboratively and effectively within a team.
Ability to develop, adapt, and execute outreach plans.
Knowledge of and ability to facilitate use of the health care system (e.g., primary care and specialty care linkages; appointment scheduling; laboratory and pharmacy services; medical interpreters; eligibility requirements; renewal/recertification; benefits; managed care).
Knowledge of available social services and resources.
Health education skills, knowledge of health promotion/wellness, knowledge of chronic disease prevention and management, and knowledge of health condition-specific treatment or management.
Ability to collect and document data and information.
Must be able to quickly develop proficiency in patient-tracking systems and care management software.
Identify and apply appropriate role definition and skilled boundaries.

Source: Zahn D, et al. Making the Connection: The Role of CHWs in Health Homes, 2012. http://www.chwnetwork.org/media/122708/making-the-connection-chw-health-homes-sept-2012.pdf

2. Supervision of CHWs

CHWs should be supervised by a member of the staff who has a clear understanding of their role. Experts have recommended that CHWs meet regularly with their supervisors, and that organizations have a clear supervision structure in place for CHWs. Health insurers who are known to reimburse CHWs require that they receive supervision in their work.

CHW supervisors in the clinical setting may include, but are not limited to:

- Physicians
- Certified Nurse Practitioners
- Physician Assistants
- PhD Psychologists
- PsyD Psychologists
- Licensed Social Workers
- Licensed Professional Counselors
- Dentists

3. Training of the Healthcare Team to Work with CHWs

For CHWs who are employed within a healthcare organization, it is essential that they be appropriately oriented to the entire care team to help clarify their roles. Doing so ensures that everyone on the care team understands the scope of the CHW position and how their role complements the work of other members on the care team. Ideally, CHW integration begins with a process of role definition for all team members, assuring that CHWs are viewed in the context of their unique potential contributions. Clinical supervisors may have little prior experience working with CHWs and may not understand how to maximize the potential of CHWs in the care team. Training is therefore needed not only for the CHW, but for the entire clinical team on how to effectively work with CHWs.

Training for CHW supervisors can take place internally through the employer or through an outside education organization, like an AHEC. CHW supervisor training programs vary in duration and focus on equipping clinical and program staff with supervision strategies needed to support CHWs in their unique role. There are some training programs in New England for CHW supervisors, with most being run through local AHECs. For example, the Outreach Working Training Institute at the Central Massachusetts Area Health Education Center provides courses for CHW supervisors. The course is 18-hours and focuses on Employment Laws and Regulations, Leadership and Management, Problem Solving and Decision Making, Fostering Effective Job Performance, and more. For more information, visit: http://www.cmahec.org/index.php?option=com_content&view=article&id=46&Itemid=59.

The Boston Public Health Commission's (BPHC) CHW supervisor training takes the form of a 2 part workshop over the course of 1.5 days, or 10 hours. This training focuses on the key roles and responsibilities of CHW supervisors, including hiring, CHW orientation/training, performance standards, goal setting, and discusses best practices for supervision. The workshop emphasizes the unique role of CHWs and ways their supervision differs and relates to other members of the staff. Program participants learn new ways to support their CHW staff, discover strategies and techniques to hold staff accountable, resolve conflict, and provide constructive feedback. Registration costs $75.00. For more information, visit the BPHC website (http://www.bphc.org/chec) or call 617-534-5181.

IV. Target Patient Populations

The scope of CHW engagement can either be structured broadly, encompassing multiple patient conditions and communities, or narrowly, where CHW services are targeted to a more focused patient population. Some states and organizations have adopted a more comprehensive approach where all patients are required to have access to care teams with CHWs without any specific requirements for eligibility. This is the case in some health systems in Vermont, where multi-disciplinary Community Health Teams are available to all patients in a given practice with no requirements in place for eligibility, referral, prior-authorization, or co-payments. In many other states in New England an incremental approach has been adopted in which CHW services are targeted to a more focused patient community. In this model health insurers may limit the target population that CHWs work with to the frail, disabled, dual eligibles, or other patient groups that are at the highest risk of expensive medical treatment. For these patient groups, successful care will very likely require outreach and assistance from health care workers who know the community and can reach these patients in a way that traditional health care teams often cannot.

V. Pairing between Patients and CHWs

CHWs gain respect and trust from their patients by demonstrating an understanding of the patient's cultural and socioeconomic environment. This connection is achieved, in part, by pairing CHWs with their patients based on knowledge of an individual's specific condition or disease, shared race or ethnicity and often, primary language. Across New England organizations utilize language, race/ethnicity, and shared residence in the community to connect patients with CHWs. Other attributes that can create a bond between patients and CHWs are shared occupations (e.g., farmworker) and same or similar cultures.

While policy experts believe that many of the above characteristics are important to establishing trust between patients and CHWs, skills in empathetic listening and in motivation are critical to the success of any CHW. Shared experiences, cultures and ethnicity will create a bridge, but establishing a long-term relationship will depend on CHWs understanding the social, cultural and economic realities of their patients.

VI. CHW and Patient Interactions

CHWs have many opportunities to engage with their patients, and these may occur in a variety of environments such as the patient's home or a local clinic or community center. The structure of the interaction between CHWs and patients may incorporate numerous elements including telephone calls, individualized mailings, group meetings, and home visits. Three key elements of CHW interactions include: 1) significant, extended face-time with patients, and often, families; 2) individual visits in the home or clinic; and 3) active engagement with patients to plan for future care. The amount of one-to-one patient or one-to-one family time is extremely important to the success of any CHW intervention. Oftentimes CHWs are the only member of the clinical care team able to spend significant face-time with the patient, which can support the uptake of health messaging and adherence to treatment.

One best practice approach to patient interaction has been at the PACT Project at Partners In Health. There, community health workers use a "CHW facilitator's guide" to inform interventions with patients in the home. This guide contains evidence-based and field-tested conversations and exercises that CHWs can use to impact patient adoption of health promoting behavior based on individually tailored care plans. Patients receive varying intensity services based on their personal risk profiles and level of motivation for change. (Heidi Behforouz, MD, personal communication, July 2013).[2] In addition, PACT CHWs track and document what they do during each interaction on handheld devices that then sync with a web-accessed database. The program manager regularly queries the data base to understand the intensity and impact of the interventions with enrolled clients and periodically reprioritize the care plans.

For socially isolated and geographically dispersed populations, some programs are making use of telemedicine to connect patients to resources. For example, a partnership between academic, clinical, and community partners in Connecticut and California collaborated to provide geographically dispersed older Cambodian-Americans with linguistically appropriate medication therapy management by utilizing videoconferencing and a care team of pharmacists and CHWs (Center for Technology and Aging, 2011). During this intervention CHWs performed home visits and completed a web-based medication assessment to document the patient's condition, medication status, and drug therapy problems, which achieved significant time-savings for the pharmacist. The CHW then operated the teleconferencing software and provided medical interpretation services during the pharmacist's remote consultation. CHWs can help patients prioritize what to discuss with healthcare professionals who are pressed for time. Individual visits help make the intervention more patient-centered and lead to an individualized plan or course of treatment based on the patient's unique needs and goals.

For populations whose interactions with the health system are made most difficult by stark differences in language and culture, an individualized approach can prove crucial to improving the patient's experience and adherence to treatment. Khmer Health Advocates uses CHWs to serve older Cambodian-Americans, many of whom are refugees and victims of torture and trauma, by immersing themselves in the community and gaining a comprehensive understanding of each patient's individual situation (Khmer Health Advocates, 2013). Under this model, CHWs accompany patients to physician appointments, perform home visits, and complete regular check-ins in order to catch issues early on before they develop into more complex or life-threatening situations.

VII. Funding and Reimbursement

Financially sustaining CHW initiatives is one of the most significant challenges faced by organizations engaged in CHW interventions. The majority of funding remains through grants that expire and are disruptive to a program's impact. Grant funding also makes it difficult to fully integrate CHWs in care teams or expand the generalist model for CHWs. The temporary nature of grant support also makes data collection inconsistent, as programs often have to change focus or innovate to secure additional funding, making it difficult to document the long-term impact of CHWs and specific interventions.

One policy approach to creating a more sustainable model is to include a clear expectation that CHWs should be included in new care models being developed as part of large delivery system innovations. In Oregon, for

[2] For more information, e-mail Dr. Heidi Behforouz at HBEHFOROUZ@PCHI.PARTNERS.ORG

example, legislative language requires that CHWs be included in the care delivered by new Coordinated Care Organizations (CCOs), the delivery system unit through which funding will flow under the state's evolving health care reform initiative. Requiring that CHWs be included by provider organizations receiving global capitation budgets is one way to provide for relatively stable funding, at least in the short term.

Short of formal requirements of this type, other creative mechanisms need to be developed. Providers and health insurers that have explored fee-for-service payment mechanisms have confronted obstacles due to the rigid nature of the billing structure and the lack of codes for CHWs and supportive services. New mechanisms are therefore needed, but policy experts are nearly universally agreed that whatever mechanism is developed to fund CHWs in the current health care environment will need to be cost-neutral or cost-saving. This is why more robust evidence on clinical and economic outcomes is so essential to move the field forward. It is also why creative approaches to budgeting are needed, such as re-examination of entire budgets for home care services, visiting nursing, and case management, along with novel approaches to blending payment through global budgets and quality incentives from payers to provider groups. For example, Blue Cross Blue Shield of Massachusetts introduced the Alternative Quality Contract (AQC) in 2009 that provides enhanced payments to providers who perform well on a broad set of quality measures. These types of innovative payment models may provide opportunities for providers to align delivery reform initiatives with new mechanisms to reimburse CHWs. Nevertheless, policy experts believe that reimbursement through cost-neutral bundled payments by itself will not be the only answer, and that for the foreseeable future funding through additional grant opportunities and private-public partnerships will continue to serve an important role.

Examples of how some organizations are using opportunities under payment reform to reimburse CHWs are provided in Table 10 on the following page.

Table 10. Reimbursing CHWs as Part of the Care Team.

State	CHW Integration	Funding Structure
Vermont	Many patient centered medical homes in the state have incorporated CHWs as part of a new model for team-based care called the Community Health Team. CHWs work with the care team to assist patients by identifying their needs, connecting them to services, and helping schedule physician appointments. CHWs with experience in health coaching work to help patients establish their own self-management goals, as well as make home visits and attend physician appointments as necessary.	State law requires that health insurers partially fund Community Health Teams. Insurers provide a total of $350,000 per each Community Health Team annually which serves a general population of 20,000 ($17,500 per year for every 1000 patients), with shares paid to a single existing administrative entity in each Health Service Area. This combined funding covers the salaries of the core team, but the specifics on how the funding is allocated is decided locally.
Oregon	Oregon received a CMS State Innovation Model Grant (SIM) to further develop its Coordinated Care Organization (CCO) model, which will focus on patient-centered and team-based care. Under this waiver, "non-traditional health workers" including CHWs, are approved as members of the healthcare team, and serve the patient in a variety of ways, including navigation, home visits, referrals, etc.	CHWs working as part of CCOs receive Medicaid reimbursement primarily through bundled or capitated payments. When CHWs are providing direct services (e.g. health promotion, care coordination, etc.) they must work under the supervision of a licensed health professional to receive reimbursement. CHWs and other non-traditional health workers involved in population management activities, including outreach, education, etc. are sometimes paid through a CCO sub-contract with a community – based organization. Doulas are reimbursed according to individual agreement achieved between a provider and CCO. Payments to providers, hospitals, or birthing centers are typically enhanced when a doula is utilized, in which case the FFS claim for delivery is billed with a modifier.

Sources:
National Academy for State Health Policy: http://www.nashp.org/med-home-states/vermont
Oregon Health Authority: http://www.oregon.gov/oha/amh/rule/NTHW-BriefwithRules.pdf

VIII. Evaluation

There are many different ways to identify and evaluate the impact of CHW interventions. While CHWs have the potential for broadly-reaching influence on service delivery and partnership within the community, many organizations will initially evaluate individual CHW performance and outcomes directly associated with their interventions. Before developing an evaluation framework for CHWs, several areas require clarification by your organization (Mirambeau, 2012). Important questions to address are listed in Table 11 on the following page.

Table 11. Sample Evaluation Framework

Description of CHW Intervention A. What are the responsibilities of the CHWs? B. Who is being served or coming into direct contact with the CHWs? C. What is the nature of the interactions between CHWs and their patients? D. What are the expected changes among the patients served?
Important Program Components to Evaluate A. Client-level outcomes B. Healthcare utilization C. Costs D. Community capacity
Association between CHW interventions and Intended Outcomes A. Identify and/or modify existing data sources B. Explore validated and reliable measurements C. Conduct interviews D. Prepare for program limitations and barriers

Source: Mirambeau AM. CDC Evaluation Coffee Break: evaluating community health worker programs, 2012. Available at: http://www.cdc.gov/dhdsp/pubs/docs/CB_November_2012.pdf.

Other aspects of CHW interventions to consider prior to development of evaluation procedures include the variety of activities and responsibilities performed by CHWs, the myriad of perspectives and interests of different stakeholders, and the timeframe for assessment (Rush, 2012). The National Community Health Advisor Study (Rosenthal, 1998) and the University of Arizona have proposed similar frameworks for CHW evaluation, outlining different levels of impact (Mirambeau, 2012). These serve as an initiation point in the following sections.

1. Individual CHW Performance

Areas of focus for CHW evaluation include knowledge and beliefs, skills, work status and quality of life. For varying perspectives and observation, CHWs may be evaluated by their supervisors and by their patients; CHWs may also conduct self-evaluations to provide insight into their personal and professional growth. Within the University of Arizona's Community Health Worker Evaluation Tool Kit, several reliable and professionally utilized evaluation forms are presented, with permission, as examples of the kinds of data an organization may collect about its individual CHWs. General descriptions for some of these tools are listed in Table 12 on the following page.

Table 12. Sample CHW Evaluation Approaches.

Type of Form	Specific Areas for Evaluation
Direct Observation Form	1. Introduction to group (preparation, attire, punctuality) 2. Presentation style (body language, comfort/enthusiasm with topic) 3. Ease and knowledge of subject material (factual information, questions answered) 4. Patient interactions (encourage discussion, active listening) 5. Evaluation of strengths and identification of areas for improvement
Direct Interview with CHW	1. Describe impact on patient satisfaction and access to resources 2. Describe efforts to follow-up on health-related problems and obstacles encountered 3. Suggest changes to training for future CHWs
CHW Evaluation by Patient	1. Overall performance of CHW (punctuality, preparation, knowledge) 2. Assessment of program curriculum (topics, visual aids, time of sessions) 3. Most effective/least effective parts of program

2. CHW Program Assessment

CHW program assessment is essential for measuring how specific CHW interventions impact patient health outcomes, healthcare utilization, and costs. Areas of focus for program evaluation may include the following (Mirambeau, 2012):

- Patients and Families
  - Health status
  - Access to and utilization of health services
  - Access to and utilization of community resources
  - Provision of social support
- Program performance
  - Training
  - Organization and management
  - Service delivery
  - Costs and benefits

Specific best practice indicators may include those listed in Table 13 on the following page.

Table 13. Sample Best Practice Indicators.

CHW Activities	Process Indicators	Outcome Indicators	Impact
Improving access and appropriate use of services • Case finding/outreach • Patient reminders • Resource/referral	• # of visits • # of appointments made • # case-finding chart review • # enrolled • # patients served • # assessed/screened • # referrals made	• Changes in knowledge • Satisfaction w/CHWs • Self-management • Medication compliance • Lifestyle changes (smoking, dietary habits) • Biometrics (blood pressure, cholesterol)	• Reduced morbidity and mortality • Reduced costs • Reduction in health disparities
Risk Reduction • Health education • Informal counseling	• # of education sessions • # enrolled in education sessions • # completing program • # and type of material disseminated		

Source: Mirambeau AM (2012). CDC Evaluation Coffee Break: evaluating community health worker programs. Available at: http://www.cdc.gov/dhdsp/pubs/docs/CB_November_2012.pdf. Adapted from Nemceck MA, Sabatier R. Public Health Nurs. 2003:20(4):260-270.

Economic evaluation is a crucial part of the framework for CHW program assessment. While current evidence supporting the value of CHWs has significant limitations, demonstration of CHW programs as cost-neutral or cost-saving is imperative for sustainability. Inclusion of economic outcomes in overall program evaluation provides a means for establishing monetary value and accountability, while allowing an organization to assess resource allocation (University of Arizona, 1998). The University of Arizona's Community Health Worker Evaluation Tool Kit provides a primer on conducting cost-benefit analysis for CHW programs: https://apps.publichealth.arizona.edu/CHWToolkit/PDFs/FRAMEWOR/COSTBENE.PDF.

Several barriers exist to the evaluation of CHW programs including a paucity of resources for training and implementation, few long-term evaluation opportunities, and perception of evaluation processes as detrimental to patient interactions (impact on confidentiality, difficulties with documentation) (Rosenthal, 1998). To minimize the impact of these barriers, organizations working with CHWs should involve them in program development and management, including creation and establishment of evaluation protocols.

For organizations conducting research on CHW interventions, evaluations should include comparisons with relevant control or "comparison" groups to avoid the limitations of case studies and single arm cohort studies. Ideally, control groups will be composed of demographically- and clinically-comparable patients not receiving CHW services. Patient-centered outcomes may better capture patient quality-of-life, productivity, and other measures important for understanding the full scope of CHW impact. The durability of any impact on patient outcomes or costs should be measured, either by extending the duration of follow-up for a comparative study or at a minimum conducting an "extension" study of patients receiving the CHW intervention. The purpose of either of these designs would be to assess whether clinical and functional benefits continue at the same rate over time, and to ascertain whether programs continue to produce reliable estimates of cost-offset and potential savings to the provider.

Many resources are available through the Internet, and in different languages. Table 14 below provides links to some important example evaluation tools.

Table 14. Sample Evaluation Tools.

The University of Arizona Rural Health Office and College of Public Health – Community Health Worker Evaluation Tool Kit	https://apps.publichealth.arizona.edu/CHWToolkit/
Rural Assistance Center – Module 6: Measuring Program Impact	http://www.raconline.org/communityhealth/chw/module6/
Global Health Workforce Alliance - Community Health Worker Assessment and Improvement Matrix (CHW AIM): A Toolkit for Improving Community Health Worker Programs and Services	http://www.who.int/workforcealliance/knowledge/toolkit/54/en/index.html
The University of Arizona, The Mel and Enid Zuckerman College of Public Health – National Community Health Advisor Study	http://crh.arizona.edu/publications/studies-reports/cha
CDC - Promoting Policy and Systems Change to Expand Employment of Community Health Workers (CHWs)	http://www.cdc.gov/dhdsp/pubs/chw_elearning.htm

IX. Conclusion

CHWs can play an important and unique role as part of healthcare teams. As members of the community, CHWs focus on education and health system navigation for their patients, providing a bridge to appropriate healthcare utilization. Organizations working with CHWs are positioned to play a crucial role in the effective deployment of the workforce through the development of evidence-based strategies for CHW recruitment, training, care team integration, and evaluation. Provider groups have the opportunity to be vanguards in testing new global payments and models for team-based care to support the long-term sustainability of CHWs.

While the research on the effectiveness and value of CHWs is often narrow in scope and focused on short-term outcomes, there are important opportunities for provider groups and other organizations to apply evidence-based best practices based on expert knowledge, regional survey data, and the published literature that make up this guide. Utilization of the best available evidence will assist employers and other organizations working with CHWs in establishing high-quality CHW programs which have the potential to positively impact the health of patients both in New England and across the nation.

Additional Resources

CDC e-learning module: Promoting Policy and Systems Change to Expand Employment of Community Health Workers (CHWs) http://www.cdc.gov/dhdsp/pubs/chw_elearning.htm	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.
U.S. Dept. of Health and Human Services, Health Resources and Service Administration (HRSA), Office of Rural Health Policy (ORHP): CHWs Evidence-Based Models Toolbox http://www.hrsa.gov/ruralhealth/pdf/chwtoolkit.pdf	Identifies promising practice models and evidence-based practices for using CHWs in rural communities.
Rural Assistance Center: CHW Toolkit http://www.raconline.org/communityhealth/chw/	The CHWs Toolkit is designed to help rural communities evaluate opportunities for developing a community health worker program, and to provide resources and best practices developed by successful community health worker programs. Through eight modules, the toolkit offers tools and resources to develop and implement programs for using CHWs in local programs.

X. References

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