



Community Health Workers: A Front Line for Primary Care?

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OVERVIEW — Among the potential changes invoked in discussions on health system transformation, a need to revitalize primary care remains paramount. One way of doing this, most agree, is to move more in the direction of team-based care. Professionals such as physician assistants and nurse practitioners may be able to ease some of the physician's clinical care load, but some populations also need help accessing services and basic health education in a familiar setting. Enter the community health worker (CHW), known by many titles and playing a variety of roles, who comes from the community he or she is serving and therefore can interact with and effectively motivate clients. This paper examines what CHWs do, how they are trained, and the outlook for their incorporation into mainstream health care, as well as the challenges for developing the profession further.

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Transformation of health care delivery, while much discussed, has only been achieved in certain organizations, settings, or circumstances. Nevertheless, some themes and strategies have entered canonical thinking about the direction that delivery should be taking. Among these are team-based care, population health, and reduction of treatment disparities.

Improving population health and reducing disparities means beginning with access to care, and that in turn may mean thinking about the composition of a health care team. Some patients need help finding and navigating clinical and translation services, care coordination, and health education delivered in a community setting. Community and provider organizations across the country have found that adding the community health worker (CHW) to the professional team of physicians, nurse practitioners, physician assistants, social workers, and others can help to meet these entry-level needs.

Although CHW is the title that appears most often in the literature and has been recognized by the Bureau of Labor Statistics (BLS), such workers may also be known as community health advisors, *promotores/promotoras de salud*, patient navigators, lay health workers, peer health educators, or other titles. These professionals play a range of roles, discussed below, but ideally share basic characteristics, including a commitment to the community they serve and the organization they work for, an ability to interact effectively with both, and an ability to motivate clients.¹

DEVELOPMENT

While examples of community members helping and encouraging one another can presumably be drawn from many eras in human history, the first formal CHW program (then called the Community Health Aide Program) was funded in 1967 by the Office of Economic Opportunity. It targeted American and Alaska Indians, aiming to increase their understanding of basic health care principles and participation in their own health maintenance and care and to improve cross-cultural communication in the delivery of health care services. Responsibility for the program was soon transferred to the Indian

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Health Service, which changed the workers' titles to Community Health Representatives. Alaska remains a stronghold of CHW practice, which is not surprising given the isolation of many of its communities and the dearth of available providers.

The Community Health Worker National Workforce Study (NWS), conducted by the Health Resources and Services Administration's (HRSA's) Bureau of Health Professions in 2007, describes the development of the CHW workforce as moving from local attempts to address the persistent problems of the poor through special projects funded by short-term public and private grants, to state and federal initiatives, to general public policy recognition.² Recent evidence of the latter is found in provisions in the Patient Protection and Affordable Care Act of 2010 (PPACA), also discussed below.

DEFINITIONS AND ROLES

The NWS estimated that there were 120,000 CHWs in active practice in 2005. At that time, in the absence of a BLS Standard Occupational Classification (SOC) for CHWs, there was no way to do an actual count. BLS introduced an SOC for 2010, separating CHWs from health educators, but it still is not broken out separately in the 2012 BLS table of Community and Social Service Occupations or included in the Occupational Health Outlook. In fact, many CHWs working in the United States continue to include health education in their portfolio of responsibilities. According to the NWS, approximately two-thirds of CHWs are in paid positions. More than 80 percent are women.

The BLS SOC specifies that CHWs:

“Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs.”³

The NWS definition includes this summary sentence:

“Community health workers are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve.”⁴

A 2011 publication from HRSA’s Office of Rural Health Policy (ORHP), *Community Health Workers Evidence-Based Models Toolbox*, recognizes that CHW activities are tailored to meet the unique needs of their communities, but outlines their typical roles as follows:

- creating more effective linkages between vulnerable populations and the health care system;
- managing care and care transitions for vulnerable populations;
- ensuring cultural competence among health care professionals serving vulnerable populations;
- providing culturally appropriate health education on topics related to chronic disease prevention, physical activity, and nutrition;
- advocating for underserved individuals to receive appropriate services;
- providing informal counseling; and
- building community capacity to address health issues.⁵

In addition, CHWs play an important role in community-based research, serving as a bridge between outside researchers and community members.

RECRUITMENT AND TRAINING

Because being a member of a target community is integral to the CHW’s effectiveness, it is not surprising that networking and word-of-mouth are the most common recruitment methods. Former clients are often recruited as CHWs. Churches and local small businesses sometimes function as intermediaries. For example, the Congregational Health Network in Memphis is a joint venture among Methodist Le Bonheur Healthcare hospitals, city churches, and community health organizations. Parishioners serve as volunteer liaisons between their churches and the health system, offering patient navigation, health promotion, in-hospital support, and other services.

The NWS found that 21 percent of CHW programs required a high school diploma or GED, and 32 percent required a bachelor's degree. Requirements for subsequent training show wide variation; a 2009 literature review found that requirements range from five hours to six months.⁶ Employer-based training is often aimed at both enhancing existing skills and forming the competencies necessary to carry out a specific program.

Whether education requirements and some part of training should be standardized is much discussed in today's CHW programs. Some suggest that, because of the CHW origins as community members who share an environment with and are known to those they serve, academic training may have a distancing effect. Others suggest that, in order to move CHWs into the health care mainstream and make their services reimbursable by insurers, formal certification will be necessary. Researchers also have noted conflicting opinions on the part of CHWs themselves. On one hand, many want to remain somewhat independent from the health care system and more closely connected to their clients and communities. On the other hand, many are interested in recognition and acceptance—as well as payment—as professionals.⁷ Some program managers have expressed interest in having some kind of career ladder for CHWs.

As it stands now, three states—Alaska, Texas, and Ohio—require CHWs to be certified. North Carolina and Nevada have state-level training standards. A handful of other states have CHW training programs in community colleges. A national survey conducted by Bitá Kash and colleagues identified three trends in CHW workforce development:

- schooling at the community college level is identified with career advancement opportunities;
- on-the-job training improves standards of care, CHW income, and retention; and
- certification at the state level acknowledges professional standing and facilitates reimbursement.⁸

There is general agreement that, if CHW training is standardized, some training tailored to the particular mission, duties, and environment in which the CHW works will continue to be necessary.

PROGRAM FUNDING

The Center for the Health Professions at the University of California, San Francisco (UCSF), did an extensive analysis of CHW program funding in 2006. They identified four major funding models, as follows:

Charitable foundation or government agency grants or contracts are most common. They may be awarded to county clinics or other locally based organization to hire, train, and field CHWs. Such grants tend to be tied to a specific project, such as a family planning initiative, HIV/AIDS education, or prenatal health. They also tend to fund short-term projects. National-level funders in this category have included HRSA, the Centers for Medicare & Medicaid Services, the Centers for Disease Control and Prevention, and the National Institutes of Health, and the Robert Wood Johnson, W.K. Kellogg, and Annie E. Casey Foundations.

Appalachian Kentucky: Kentucky Homeplace

Kentucky Homeplace (KH) was conceived and developed by the University of Kentucky’s Center for Excellence in Rural Health as a demonstration in 14 eastern Kentucky counties where rates of cancer, diabetes, and heart disease were very high. Today its service network spans most of the state’s poorer and more rural counties, where people tend to be less educated and less likely to have insurance coverage. Clients’ incomes are generally in the range of 100 to 133 percent of the federal poverty level. The program is funded by the state.

KH employs CHWs with a mission to educate Kentuckians to identify risk factors, take preventive action, and become healthier people with the knowledge and skills necessary to access the health care and social services systems. CHWs are hired from the communities they serve and trained as advocates by KH.

First quarter 2012

Number of clients served	4,550
Value of medications accessed	\$6,545,606
Value of other services accessed	\$600,650

Most common diagnoses: Hypertension, high cholesterol, diabetes, mental health conditions, heart disease

Government general funds may include a line item for a CHW program, often housed in a county hospital or health department.⁹ States may be fund as well; for example, Kentucky Homeplace, a CHW initiative in 58 predominantly rural counties, receives the bulk of its operating funds from the state legislature (see text box).

Private sector organizations such as hospitals or health plans may employ CHWs directly or through contracts. An interesting example is the Blue Ridge Area Health Education Center (AHEC), which is paid by health care providers for interpretation services provided by AHEC interpreters who also function as CHWs.

Medicaid pays for CHW services in Minnesota (see text box, next page) and Alaska, though reportedly other states are looking at the model for its potential to avoid more expensive acute care services. While federal Medicaid rules do not recognize CHWs as providers eligible for reimbursement, CHW services may be incorporated

in a capitation rate, reimbursed on a unit basis under a Section 1115 waiver, or included under administrative costs for outreach and coordination activities.

Theoretically, employers or consumers themselves could pay for CHW services, but the UCSF study found no examples where this was occurring.

PROGRAM EVALUATION

Research on the effectiveness of CHW programs has been mixed. In part, this is a function of resources available to conduct evaluations. While CHW programs have increasingly been aware of the need to document their results for funders, they are seldom in a position to mount a sophisticated research protocol such as a randomized controlled trial (RCT). This is not unusual for small social welfare programs. One study by Tiffany Gary and colleagues, repeatedly cited in the literature because it was an RCT, looked at the effects of nurse case manager (NCM) and CHW interventions on risk factors for diabetes-related complications in urban African Americans. It found that combined NCM/CHW intervention may improve diabetic control in this population. However, the authors' conclusion was muted at best: "Although the results were clinically important, they did not reach statistical significance. This approach deserves further attention..."¹⁰

Most published evaluations of CHW programs use a pre-/post-test design and rely on participants' self-reporting of the intervention's results. They tend to show modest gains in the target variable, often a form of behavior such as frequency of exercise, seeking prenatal care, or obtaining tests or screenings. For example, a program known as *Salud Si!* sponsored by the Mariposa Community Health Center in Nogales, Arizona, used *promotoras* to identify and educate Mexican-American women of childbearing age on the benefits of exercise and a healthy diet (see text box, next page). Participants reported increases in fruit and vegetable servings per week and significantly reduced consumption of sodas. Similarly, a study of the effectiveness of CHWs in providing outreach and education for colorectal cancer screening in rural Kentucky found increased knowledge and willingness to discuss screening with a physician among the study population.¹¹

Standardizing Training in Minnesota: The CHW Alliance

Minnesota established a standardized CHW curriculum in 2003 through a partnership between the state and the Blue Cross and Blue Shield of Minnesota Foundation. In 2005, the CHW Alliance was formed, comprising CHWs in practice and representatives of state agencies, educational institutions, payers, and the health care industry. This group defined a CHW scope of practice and a credit-based course package to be offered statewide under the aegis of the Minnesota State Colleges and Universities system. In 2007, the state legislature authorized reimbursement for the services of trained and supervised CHWs under Medicaid. The Centers for Medicare & Medicaid Services subsequently approved state plan amendments incorporating this policy change.

A gain in knowledge of how to manage a condition or access health care services may also be what is sought. For example, a study by the Central Valley Health Policy Institute at California State University Fresno documented that 45 percent of a group of adult Latino residents of the county had insurance before an educational campaign and individual assistance by CHWs. The percentage rose to 70 percent following the intervention.¹²

Studies demonstrating CHW cost effectiveness are few, though in some cases (such as the Mariposa program) health outcomes show improvement sufficient to attract new funding. One program that did document savings was the Arkansas Community Connector Program, a three-year (2005–2008), three-county demonstration in which CHWs identified Medicaid-eligible people with physical disabilities and potential unmet long-term care needs. Those eligible but not enrolled for Medicaid were referred for enrollment. Those with unmet needs were informed of available long-term care options, including home- and community-based services (HCBS), and were connected to agencies providing such services. CHWs followed up and offered system navigation assistance. The intervention group, compared with a similar group of Medicaid participants who did not participate, was found to have spent less on Medicaid services; indeed, estimates are that Medicaid realized a return of 3 to 1 for each dollar spent on the program. The major driver seemed to be that program participants were more likely to use HCBS and to spend less on nursing home services than their counterparts in the other group.¹³

Arizona Border: Mariposa Community Health Center's Platicamos Salud

Platicamos Salud began with an outreach grant awarded by the Health Resources and Services Administration. It serves an almost entirely Hispanic population, some of which has an “undocumented” immigration status. A variety of programs serve some 5,000 clients per year. Funding was entirely grant-based until this year, when the health center committed to make the salaries of its patient navigators a part of its core budget.

Promotoras, hired from the community, must have a high school diploma or GED; they must also be licensed to drive and have access to a car. They offer individual

services, from help with children's health insurance enrollment to home-based education for reducing asthma triggers; community services such as citizenship classes, parenting seminars, health and fitness classes, and support groups; and operate a WIC program (a nutritional program; WIC stands for women, infants, and children). After two years' experience as a *promotora*, an employee is eligible to work as a patient navigator, a part of the medical team, or as a maternal/child health case manager. Teen facilitators are trained to work in programs aimed at their peers.

Denver Health had a similar experience with its Men's Health Initiative, in which CHWs engaged in outreach to poor men in Denver to increase their access to health services and to try to establish continuity of care. Service utilization, charges, and reimbursements for 590 men were analyzed nine months before and after interaction with a CHW. Participants increased their utilization of primary and specialty care office visits, while urgent care, inpatient care, and outpatient behavioral health care utilization all diminished. Analysts attributed the change to CHWs' success in assisting clients with establishing a medical home, selecting a primary care provider, system navigation, and case management. The return on investment (ROI) was calculated at 2.28 to 1.00, representing an annual savings of \$95,941. Unfortunately, the analysts went on to note, the lack of publicly funded insurance programs for poor men meant that most of the charges for their care remained in the "uncompensated" category.¹⁴

CHALLENGES

Sustainability and financing remain central issues for CHW programs. Some programs have established their value in the eyes of reliable funders; others have had a period of success and then come to the end of the grant money. The HRSA/ORHP *Evidence-Based Models Toolbox* urges CHW programs to incorporate an evaluation component from the very beginning, particularly with a goal of calculating ROI and demonstrating program effectiveness to community partners who may be willing to make financial contributions.¹⁵

Working toward CHW eligibility for third-party funding is a goal for some. It seems likely that taking this step would entail some form of CHW credentialing and/or certification, which may have the effect of limiting the scope of activities permitted to CHWs and reducing their ability to tailor their services to the needs of their communities. Certification could also conceivably lead to an expansion of CHW responsibilities, thus raising the scope-of-practice issues that have bedeviled other health professions trying to push their boundaries.

Another challenge raised by some CHW managers is liability. CHWs may encounter unstable or even dangerous domestic situations. Particularly in rural areas, they may have to travel long distances

In a Variety of Settings: Grand-Aides

The Grand-Aides program was started by Arthur Garson of the University of Virginia in response to the idea that grandparents offer primary care to their families all the time. The concept is to enroll lay people (not necessarily grandparents) to work under nurse supervision to accomplish the following:

- provide access to appropriate primary and chronic care,
- reduce congestion in hospitals and clinics by caring for people at home,
- educate patients in preventive and self-care,
- make care more affordable, and
- create paying jobs and a career ladder for mature adults who want to give back to their community.

Grand-Aides function as nurse extenders, focusing on the provision of medical care and counseling, to the exclusion of the social services portfolio that many CHWs offer. Grand-Aides obtain state certification as a nursing assistants, medical assistants, or CHWs.

The program was piloted in two locations, where a Grand-Aide and a nurse administered standard protocols by diagnosis. The pilot found that a significant percentage of the cases could have been treated safely and far less expensively at home. A larger pilot, expected to reach 10,000 adults and children, is now under way in Texas.

to interact with clients. Some programs require their CHWs to travel in pairs.

Where CHW responsibilities include system navigation and improving health access, the extent to which local providers are aware and supportive of the CHW program may determine whether CHWs are able to obtain appointments, services, and culturally sensitive care for their clients. Cultural and educational barriers may exist with respect to written materials as well as face-to-face communications.

OUTLOOK

PPACA provides some opportunities for expanded use of CHWs. Section 3502 directs the Secretary of Health and Human Services to establish a program to provide grants and/or contracts to establish “community-based, interdisciplinary, interprofessional teams” to support primary care practices. These teams are charged with responsibilities that CHWs could perform, though these workers are not explicitly mentioned. Section 5313, however, calls on the director of the Centers for Disease Control and

Prevention, in collaboration with the Secretary, to award grants to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.¹⁶

Project ECHO, a care delivery model developed by Dr. Sanjeev Arora at the University of New Mexico, seeks to treat chronic, common, and complex disease in rural and underserved communities by connecting local primary care physicians with specialists at the University for real-time consultation and education. The program trains and employs CHWs to carry out patient education and disease management functions at the local level. Project ECHO recently received a Health Care Innovation Award from the U.S. Department of Health and Human Services, which will finance program expansion in New

Mexico and Washington. The Department of Veterans Affairs is rolling out a version of Project ECHO at VA medical centers around the country. Dr. Arora reports that he is in consultation with health care organizations in the United States and abroad to further replicate Project ECHO.¹⁷ Proliferation of this model may aid in making CHWs more mainstream.

There is widespread agreement that CHWs can be effective in promoting healthy behavior, easing health system access and managing illness in a way their clients are receptive to and comfortable with. The UCSF researchers cited earlier found consensus among those working with CHWs that the value of their services is far greater than their cost.¹⁸ That conviction is not yet shared by most payers. Policymakers may resist the idea of adding another category of compensable providers. Given a shortage, or at least maldistribution, of other primary care providers, CHWs able to demonstrate cost effectiveness may address some concerns over health care cost and access.

ENDNOTES

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