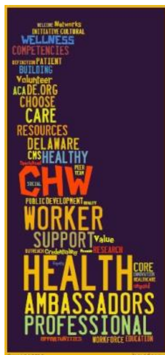
STATE OF DELAWARE
Delaware Health and Social Services, Division of Public Health



Community Health Workers:
Improving the Health and Quality of Life for Delawareans
Forum Summary

EXECUTIVE SUMMARY

Nationally, seventy-five percent of today's health care spending is on chronic disease management. As a state, Delaware spends more than the national average on health care at a level and rate of growth that is unsustainable. Moreover, Delaware remains relatively unhealthy overall, with a growing burden of chronic disease and behavioral health, and persistence of underlying unhealthy behaviors. Thus Delaware is positioning to transform its health system, with the goal of improving the health of Delawareans, improving the patient experience of care, and reducing health care costs. The new system will be one that is more person-centered, team-based, coordinated, and integrated than the one today. It will also require a workforce that is broader, more diverse, and more geographically distributed with a heightened focus on prevention and wellness. Delaware's transformed workforce will include a broad range of professional, para-professional and lay health care workers who will function as collaborative, interdependent members of health care teams, going beyond treating patients to truly including Delaware families and communities in all aspects of health and health care. It will be more empowered, better integrated, and more nimble, requiring new and more clearly defined career trajectories; one that includes community health workers.

Community health workers (CHWs) will play an integral role helping individuals overcome some of the social, economic and education obstacles that threaten adherence to their care plans. As "cultural translators" CHWs will serve as the bridge between individuals and the community, and between individuals and providers. Therefore, on March 31, 2014, 64 key stakeholders from health, social and community services organizations, health care and state government convened to explore the workforce implications for CHW. Interdisciplinary teams of practitioners and health policy experts discussed the scope of practice for CHWs and the core competencies and workforce preparation they would need.

Stakeholders agreed that CHWs should provide services including: outreach; culturally relevant and linguistically appropriate health education and information; home environment, family needs assessments and other select assessments under the direction of a licensed health practitioner for services outside of the clinical needs; direct service and monitoring; informal education, counseling and social support; management of referrals and connections to needed resources and services; navigating, coordinating, bridging and providing cultural mediation between communities and health and social service systems; advocating for and collaborating with individuals, families and communities to address needs and build individual and community capacity.

Stakeholders agreed on ten core competencies that all CHWs should possess.

Core Competencies of Community Health Workers	
11. Outreach Methods and Strategies 12. Client and Community Assessment 13. Effective Communication 14. Cultural Responsiveness and Mediation 15. Education to Promote Healthy Behavior Change	16. Coordination and System Navigation 17. Use of Public Health Concepts and Approaches 18. Advocacy and Community Capacity Building 19. Writing and Work-based Communication 20. Professional Skills and Conduct

Four key findings emerged from the Community Health Workers Forum.

- Encourage the formal adoption of a standard definition of "community health worker", including core competencies and a common scope of practice.

- Establish a statewide infrastructure for standardized training and continuing education. Academic institutions and health care organizations should work closely with each other to design curricula for core competencies and continuing education. Administration of approved training may be conducted by academic institutions or health care organizations. Any curricula designed for CHWs will require prior approval by Department of Education, the regulatory body for education and training institutions in Delaware, as a prerequisite for certification.

- Further discussion is required for the credentialing of community health workers. The Department of Education, Department of Health and Social Services and the Department of State's Division of Professional Regulation should be included in these discussions to determine the appropriate state entity to provide oversight for certifying prerequisite courses for credentialing and for recertification or Continuing Education Units to be granted.

- Develop a financial sustainability plan through the widespread adoption of payment models that reward value (versus volume). Most importantly create a financial structure that recognizes the community health worker as an important member of person-centered, interdisciplinary care teams who identifies and addresses the barriers outside of the clinical setting that hinders many Delawareans' ability to fully engage in achieving optimum health.

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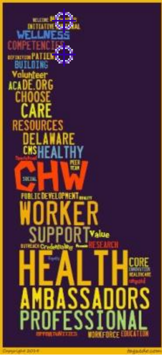

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INTRODUCTION

A highly coordinated health system is critical for addressing the nation's chronic disease burden, which accounts for about 75 percent of today's healthcare spending. With the implementation of the Affordable Care Act (ACA) there are delivery system reforms to create greater accountability of health care providers in achieving quality and health outcomes. Financing reforms are shifting reimbursement from a volume-based system to one that is value-based. As we look to streamline the nation's health system and create greater cost efficiencies, there is mounting evidence that investments in effective community-based prevention programs[1] are yielding savings on a magnitude of more than 5 to 1.[2] Recent changes to Medicaid regulations that allow reimbursement for preventive services by 'otherwise qualified health professionals', also offers an exciting opportunity to staff community-based prevention programs with a broad array of health professionals.

Currently there are several initiatives in Delaware serving patient populations who have, or are at risk of having, various health conditions are underway, including those insured by Medicaid. These initiatives incorporate what would, potentially, be considered 'otherwise qualified health professionals' as members of the health care team. Moreover, Delaware has taken a more holistic approach to health promotion and disease prevention as evidenced by "Healthy Neighborhoods" in the State's Innovation Model Plan. It "integrates communities with their local care delivery systems, and better connects community resources with each other. Integration will be achieved through dedicated staff and a Neighborhood Council of community organizations, employers, and providers (including care coordinators and community health workers who lead care coordination in the community and across clinical settings). These connections will be reinforced with a set of common goals to ensure providers and community organizations share a focus on health, wellness, prevention, and primary care".[3]

The State's Innovation Model Plan has proposed an integrated, coordinated approach to health service delivery in which the CHW plays an important role within the health care team. (Please refer to the graphic below.)

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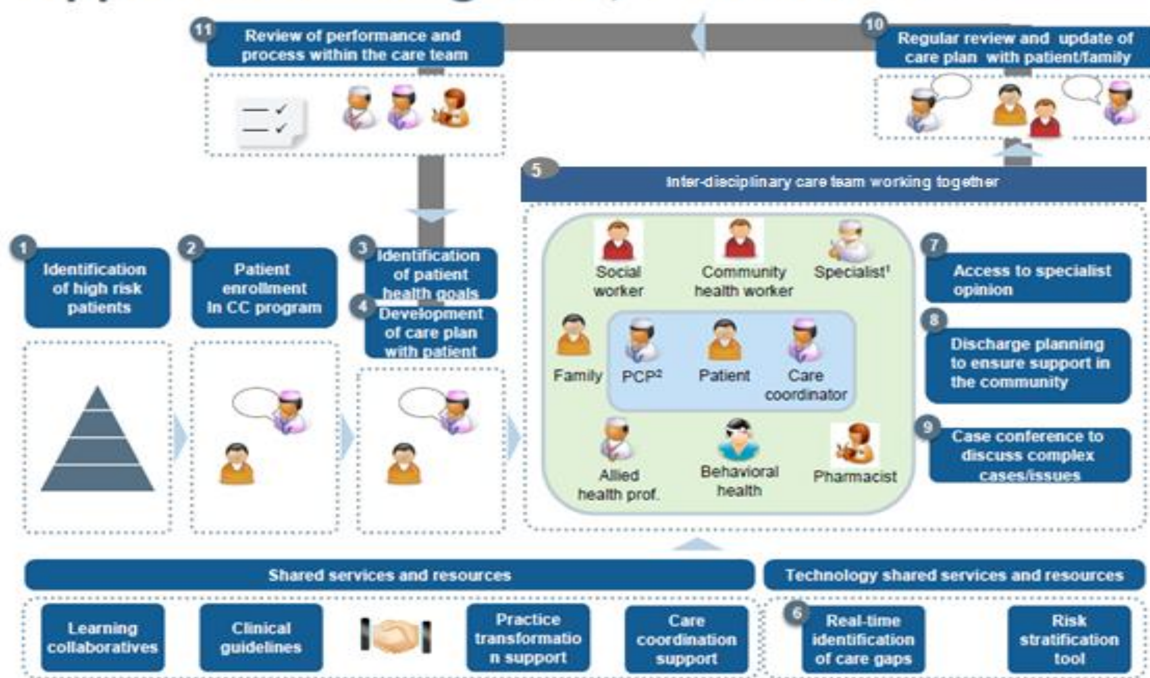
[1] New York Academy of Medicine and Trust for America's Health. *A Compendium of Community-Based Prevention Programs* (2013) Retrieved from http://www.tfah.org/assets/files/Compendium_Report_1016_1131.pdf

[2] Trust for America's Health. *Prevention for a Healthier America: Investment in Disease Prevention Yield Significant Savings and Stronger Communities*(July 2008)Retrieved from http://www.tfah.org/reports/prevention08/Prevention08Exec.pdf

[3] Delaware Health Care Commission. Choose Delaware: Delaware's State Innovation Model Plan. (December, 2013) Retrieved from http://dhss.delaware.gov/dhcc/cmmi/files/choosehealthplan.pdf



Informed by the *State Innovation Model (SIM) Plan* and the CMS regulations, with support from Delaware's Secretary of Health and Social Services, Rita Landgraf; Dr. Karyl Rattay, Director of Public Health; and Steve Groff, Director of Medicaid, 64 key stakeholders from health, social and community services organizations, health care and state government convened on March 31, 2014, to explore the workforce implications for Community Health Workers (CHW). Six interdisciplinary teams of practitioners and health policy experts discussed the scope of practice for CHWs and the workforce competencies and preparation they would need. Each group addressed the following questions:

1. What services will CHWs provide and where?
2. What work structures and levels of supervision will be required?
3. What are the linkages between CHW, primary care and specialty care teams?
4. What core competencies will be required for CHWs?
5. What type of training, continuing education and credentialing will be needed:
6. Will or should existing CHWs be grandfathered into future the workforce structure?

What follows is a summary of the day's discussion which identifies obstacles and challenges that must be considered in future plans.

SCOPE OF PRACTICE

A variety of definitions exist for community health workers and their roles in the field of public health. Although these definitions provide different variations of job functions, each definition expresses the integral role they play as part of the health care team and their importance to promoting overall health in the community. The following definitions are examples of such variations:

1. **American Public Health Association (APHA)**: "A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and

cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."[4]

2. **Bureau of Labor Statistics (BLS):** "Community health workers "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. Excludes 'Health Educators' ".[5]
3. **Health Resources and Services Administration (HRSA):** "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. They have been identified by many titles such as community health advisors, lay health advocates, 'promotores(as),' outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening."[6]
4. **Affordable Care Act (ACA)**: A community health worker is "an individual who promotes health or nutrition within the community in which the individual resides- by serving as a liaison between communities and healthcare agencies; by providing guidance and social assistance to community residents; by providing culturally and linguistically appropriate health or nutrition education; by advocating for individual and community health; by providing referral and follow-up services or otherwise coordinating care; and by proactively identifying and enrolling eligible individuals in Federal, State, local, private or nonprofit health and human services programs."[7]

The table below offers comparisons the definitions described above and illustrates the differences in terms of services provided.

Comparison of CHW Definitions by Services Provided*

Services Provided	APHA	BLS	HRSA	ACA
Serves as a link between communities and health/social service agencies	X			X
Facilitates access and information to services and resources	X	X	X	
Improve/provide culturally competent/appropriate education and service delivery	X		X	X
Enhance community residents' ability to effectively communicate with healthcare providers				X
Offer interpretation and translation services			X	X
Build individual and community capacity	X			
Conduct outreach and health education	X	X	X	X
Provide informal counseling and social support on health behavior	X	X	X	
Advocate for individual and community health	X	X	X	X
Provide services such as first aid and blood pressure		X	X	X
Provide referral and follow-up services or otherwise coordinating care				X
Identify and enroll eligible individuals in Federal, State, local, private or nonprofit health and human services programs.				X

* *Adapted from information obtained from the CMS Center for Medicare and Medicaid Innovation.*

What services will CHWs provide and where?
General consensus among the participating stakeholders was that CHWs should provide the following services: outreach; culturally relevant and linguistically appropriate health education and information (e.g. behavior models, lifestyle coaching, and reinforcing instructions given by a providers); assessments including: home environment assessments, family needs assessments and select assessments under the direction of a licensed health practitioner for services outside of the clinical needs; direct service and monitoring (e.g. basic first aid and administering health screening tests); informal education, counseling and social support(e.g. lactation support and counseling); managing referrals and connections to resources to ensure people get needed services; navigating, coordinating, bridging and providing cultural mediation between communities and health and social service systems; advocating for and collaborating with individuals, families and communities to address their needs; and building individual and community capacity.

Although described in numerous ways, stakeholders recommended that CHWs have the freedom to provide services in safe and diverse settings, including where people live, learn, work, play, and worship. It is important that CHWs be able to meet people “where they are” to build trust and rapport. As a cultural mediator between an individual and the community, and between individuals and providers, having partnerships with community organizations, federally qualified health centers (FQHCs) and health care practices were strongly encouraged.

What work structures and levels of supervision will be required?
CHWs are “cultural translators” or intermediaries– that are a bridge between an individual or family and community resources; therefore the structure or organization for which they would work could vary depending on the needs of the population or community they serve, and the managerial and fiscal capabilities of the supervising organization. CHWs could work in a health care system (e.g. ACO, PCMH, FQHC, insurers), as well as other sites, including but not limited to, community or senior centers; and faith-based organizations.

Stakeholders agreed that CHW must be able to work independently, managing their time and priorities well. Because CHWs do most of their work in the field they will have limited direct supervision. Most likely a CHW should report directly to a project field supervisor based on the structure of the organization by which they are employed. More supervision would be required in the early stages of employment, with less direct supervision as they gain more experience.

What are the linkages between CHW, primary care and specialty care teams?
CHWs can play a critical role on the healthcare team and in helping individuals overcome some of the social, economic and education obstacles that threaten adherence to their care plan. Consequently, verbal and written communication is critical; not only with the healthcare team, but with the individual and, when appropriate, their family. Verbal communication at team meetings and written communication through the electronic medical record (EMR) informs other healthcare team members about urgent and emergent needs requiring immediate attention as well as general compliance status and challenges. Because they also serve as the cultural translators between communities and health and social service systems they advocate for and collaborate with individuals and families. Culturally appropriate verbal, written and even visual communication helps to ensure the individual’s needs are addressed.

WORKFORCE DEVELOPMENT

A growing number of job titles are used to describe the “otherwise qualified health professionals” are gaining greater attention with the implementation of ACA. Examples of the workers that are being included on health care teams are: health care navigators, care coordinators, health coaches, system navigators, community health outreach workers and *community health workers.* Across the country conversations are being held to establish core competency requirements for these newer members of the care team.

What core competencies will be required for CHWs?

Unlike Care Coordinators who operate in a clinical setting to assist patients in navigating the health system and coordinating appropriate medical care, CHWs work in the community with individuals, families and the community. They "coordinate", or link individuals and families to needed health, public health, and human services. They also play an important role in helping individuals and families "navigate", or steer through systems enabling greater access to health and human services as a means to eliminate racial, ethnic, and socioeconomic health disparities among vulnerable and underserved communities. The American Public Health Association (APHA), the States of Massachusetts, Maryland and Texas are just a few examples of organizations or government agencies that have established skill competencies for community health workers. There are great similarities among all of them. Stakeholders at the March forum identified competencies Delaware's community health workers should demonstrate. Ten of them mirrored those created by the State of Massachusetts[8] (http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/dhpl/community-health-workers/ma-board-of-certification-of-community-health-workers.html). They are:

Core Competencies of Community Health Workers	
1. Outreach Methods and Strategies 2. Client and Community Assessment 3. Effective Communication 4. Cultural Responsiveness and Mediation 5. Education to Promote Healthy Behavior Change	6. Coordination and System Navigation 7. Use of Public Health Concepts and Approaches 8. Advocacy and Community Capacity Building 9. Writing and Work-based Communication 10. Professional Skills and Conduct

Problem solving, public speaking, time and stress management, foreign language and computer skills were additional competencies that emerged.

What type of training, continuing education and credentialing will be needed?

Community health workers typically have deep roots or shared life experiences in the communities they serve. They share similar values, ethnic background and socio-economic status and usually the same language as the people they provide services to. Stakeholders agreed that in developing this workforce, training of some nature would be required; however, they also felt strongly about not placing educational barriers between a dedicated community member, who knows and understands the community and the job of community health worker. Consequently, stakeholders generally agreed that a high school diploma or GED was a certificated foundation on which other competencies and training would be built. Candidates with higher levels of formal education in fields such as allied health, social work or education could also be drawn upon.

As adult learners, current and potential CHWs have accumulated a reservoir of life experiences, rich in resources for learning. They are able to direct their own learning, and generally are problem-centered with interest in immediate application of knowledge. Therefore training for CHWs should be action oriented, experiential and project-based and include the core competencies, medical terminology, disease specific education, and CPR. Practicum experiences can provide CHW candidates opportunities to practice skills in a community, with individuals and families they would typically work with. Because many CHWs do work communities that are culturally, ethnically and linguistically diverse, foreign language training was also considered to be helpful. Lastly, in order for CHWs to maintain skills, obtain new ones or upgrade expertise for future career options, continuing education and refresher courses should also be made available.

Certification provides career mobility and professionalism, and is a mechanism being used by numerous other occupations. Thus the development of a certification process is recommended. Core competencies may be

[8] http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/dhpl/community-health-workers/ma-board-of-certification-of-community-health-workers.html

verified by certified training institutions such as community colleges, universities, vocational schools, proprietary institutions or through continuing education units (CEUs) granted by professional associations. Hours of practicum experience or years of experience are also factors to be taken into consideration.

Will or should existing CHWs be grandfathered into future the workforce structure?
CHWs are an emerging occupation, and many individuals are already engaged in this work without formal "community health worker" training. Hence a grandfathering process is recommended for a limited period of time so that individuals who have blazed the trails, and currently are in the field have the opportunity for certification. Their years of experience should be taken into account, along with an assessment process to evaluate core competencies.

CONCLUSION

Four key findings emerged from the Community Health Workers Forum.

- Encourage the formal adoption of a standard definition of "community health worker", including core competencies and a common scope of practice.

- Establish a statewide infrastructure for standardized training and continuing education. Academic institutions and health care organizations should work closely with each other to design curricula for core competencies and continuing education. Administration of approved training may be conducted by academic institutions or health care organizations. Any curricula designed for CHWs will require prior approval by Department of Education, the regulatory body for education and training institutions in Delaware, as a prerequisite for certification.

- Further discussion is required for the credentialing of community health workers. The Department of Education, Department of Health and Social Services and the Department of State's Division of Professional Regulation should be included in these discussions to determine the appropriate state entity to provide oversight for certifying prerequisite courses for credentialing and for recertification or Continuing Education Units to be granted.

- Develop a financial sustainability plan through the widespread adoption of payment models that reward value (versus volume). Most importantly create a financial structure that recognizes the community health worker as an important member of person-centered, interdisciplinary care teams who identifies and addresses the barriers outside of the clinical setting that hinders many Delawareans' ability to fully engage in achieving optimum health.