Winning Policy Change to Promote Community Health Workers: Lessons From Massachusetts in The Health Reform Era

There is a national movement among community health workers (CHWs) to improve compensation, working conditions, and recognition for the workforce through organizing for policy change.

As some of the key advocates involved, we describe the development in Massachusetts of an authentic collaboration between strong CHW leaders of a growing statewide CHW association and their public health allies. Collaborators worked toward CHW workforce and public health objectives through alliance building and organizing, legislative advocacy, and education in the context of opportunities afforded by health care reform.

This narrative of the path to policy achievements can inform other collaborative efforts attempting to promote a policy agenda for the CHW workforce across the nation. (*Am J Public Health.* 2011;101:2211–2216. doi:10.2105/AJPH.2011.300402)

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THE PATIENT PROTECTION AND Affordable Care Act of 2010 (ACA) includes an array of public health provisions designed to expand access to preventive services, reduce the social and financial costs of chronic disease, and eliminate racial and ethnic disparities.[1] Although public discourse has focused on common elements between ACA and the 2006 Massachusetts health reform law,[2] there is less discussion about how both Massachusetts legislation and ACA specifically address the community health worker (CHW) workforce. CHWs are frontline public health workers, primarily hired for their shared background with and special understanding of the communities they serve. Formal educational attainment by CHWs varies, and most receive on-the-job training for this work. Increasing numbers also receive additional training specifically designed for CHWs.

The new national law explicitly defines CHWs as health professionals[3] and recommends engaging CHWs to "promote positive health behaviors and outcomes for patients in medically underserved communities."[3(USC 399V)] A provision of the 2006 Massachusetts law (Section 110) required the state department of public health (MDPH) to develop proposals for building a sustainable program to promote employment of the state's approximately 3000 community health workers.[4] This section of the Massachusetts legislation resulted from a campaign by the growing statewide CHW association and its public health allies who were seeking to improve recognition and sustainability of the workforce through organizing and policy change.

We describe the development of this collaboration—guided by strong, independent CHW leadership and voices—and how it succeeded in passing 2 pieces of state legislation: the 2006 health reform section and a subsequent law passed in 2010 requiring the MDPH to develop a board of certification for CHWs, designed to advance CHW workforce and public health goals. Five of the coauthors, representing the CHW association, MDPH, and the state public health association, were key players in some or all phases and events of the collaborative campaign described; direct experience is the source for much of the information and analysis in this essay. Principles drawn from collaborative dialogue and Kingdon's policymaking process frame the story of how the collaboration came together to enable successful actions. Kingdon asserts that policymaking requires the timely merging of 3 streams through a window of opportunity. Policy entrepreneurs must define a compelling problem to secure the attention of policymakers, they must offer a viable proposal to solve that problem, and they must take advantage of political dynamics to force action on their agenda.[5]

National health reform provides a policy window of opportunity[5] to integrate community health workers into our health system. The following elements of the Massachusetts campaign are essential to its success: (1) nurturing independent CHW leadership and organizational capacity as part of building a public health partnership, (2) defining CHW workforce issues as linked to politically salient problems (e.g., health reform), (3) building viable policy proposals that advance CHW workforce and public health goals, and (4) pursuing an advocacy strategy attentive to current political dynamics that expanded recognition and support for the field.

AUTHENTIC COLLABORATION AND SHARED COMMITMENT

Collaborative dialogue in policymaking brings together interdependent, diverse stakeholders to work out policy solutions to problems.[6] In authentic collaborations, all member groups strive to contribute in a balanced and reciprocal manner to decision-making in setting priorities and framing issues. If members of unorganized, relatively powerless groups such as community health workers are to participate as equal partners in collaborations, leaders must emerge and be nurtured.[7]

The collaborative dialogue in Massachusetts that resulted in a CHW policy agenda and

legislative successes emerged from a shared commitment among all partners to prioritize and promote CHW perspectives and interests while protecting the integrity of the field. This commitment, grounded in a social justice framework, sustained priorities and relationships through the inevitable tensions of a partnership.

CHW perspectives guided the collaboration in navigating difficult policy decisions. There is an inherent tension between promoting heightened professional status for CHWs and retaining the very characteristics that make CHWs distinctive and effective—their ties and orientation to communities they serve.[8] Without the organized leadership of CHWs in the Massachusetts policy advocacy campaign, we believe that certification legislation, for example, might have wound up imposing regulations and procedures that would prevent many effective CHWs from practicing.

ORGANIZATIONAL CAPACITY, LEADERSHIP, AND PARTNERSHIPS

Several factors supporting the emergence of CHW leadership were tied to the growing collaboration among CHW leaders and public and private sector allies.

Emerging CHW Leadership in Massachusetts

The increase in importance and size of this workforce was one contributing factor. The impetus for organizing from within the CHW workforce emerged in the early 1990s as the number of culturally diverse outreach staff grew. Their work was central to culturally appropriate public health interventions in underserved communities to reduce racial and ethnic inequities related to HIV/AIDS, sexually transmitted infections, asthma, and infant mortality. MDPH staff was in a unique position to monitor the emergence of this workforce because MDPH has been the largest single funder of CHWs, primarily through contracts with community-based service providers.[9]

Also in the 1990s, CHW training programs in Massachusetts began identifying standardized core competencies for the workforce. In 1993, the Boston Public Health Commission established the Community Health Education Center (CHEC), one of the first CHW training centers in the country. Subsequently, MDPH provided initial support for the Outreach Worker Training Institute at Central Massachusetts Area Health Education Center.[10] These and national settings provided forums for rising CHW leaders to advocate for improved working conditions, increased training opportunities, and recognition.

While beginning to discuss their working conditions, several impassioned, politically astute CHWs began to articulate factors that undermine the effectiveness of the workforce: low wages, limited training opportunities, and high turnover rates. Job security is limited by the short-term nature of categorical grants focused on specific diseases or populations. Job losses interrupt vital relationships between CHWs and the people they serve. The multiple roles that CHWs play as bridges between vulnerable communities and provider agencies are often misunderstood or underappreciated. While CHW activists grappled with these realities, some among them recognized that it was necessary to seek policy solutions in addition to working as change agents within their own organizations and communities.[11,12]

By joining coalitions seeking to reform managed care, these CHWs, in the 1990s, found opportunities to address CHW policy objectives in the context of broader health access policy battles.[13,14] Finding themselves often marginalized within coalitions, these CHWs ultimately became convinced of the importance of developing their own organizational capacity and power.

An additional influence on Massachusetts CHW leadership development among activists was their involvement in the national CHW movement. Regular communication with counterparts and supporters in other states at annual meetings of the American Public Health Association and national CHW Unity conferences helped emerging leaders lay the groundwork for organizing and policy work. This involvement created the context for defining a shared identity and core values for CHWs; outlining a code of ethics[15]; participating in research on the roles and impacts of CHWs; advocating for better compensation, training, and supervision; and devising policy initiatives to promote the workforce.[16–18]

Formation of a Statewide CHW Association

In the mid-1990s (Table 1), active collaboration between CHWs and MDPH staff was formalized, leading to both public and private funding. Together, CHW leaders, dedicated MDPH staff, and other advocates began to understand that a CHW-led, statewide organization was necessary for there to be a credible voice of the workforce promoting recognition, supportive policies, and stable funding. In 2000, this collaboration led to the formation of the Massachusetts Association of Community Health Workers (MACHW).[21] MDPH received federal funding from the US Health Resources and Services Administration Maternal and Child Health Bureau to support CHW network activities; develop MDPH definitions, contracting, and supervision policies; and conduct a statewide workforce survey.

From its inception, MACHW determined that its steering committee, which evolved into its board of directors, should be led by CHWs. MACHW's structure included a policy committee and a strategic planning process articulated policy priorities.[22] An additional key ally was identified in the Massachusetts Public Health Association (MPHA). MPHA was chosen by MACHW as its fiscal sponsor because of a shared vision of CHW leadership and state policy advocacy expertise, according to Lisa Renee Holderby-Fox, LSW, AS, Executive Director of MACHW (personal communication, December 1, 2010). The emerging partnership of MACHW and 2 key organizational allies was formalized and strengthened, laying the groundwork for a significant relationship with the Blue Cross Blue Shield of Massachusetts Foundation, which has provided funding for CHW-led policy initiatives since 2003.

The joint commitment to CHW leadership development served as the guiding principle for the partnership of MACHW, MDPH, MPHA, and other stakeholders. The collaboration has been essential to garnering resources, promoting strategic thinking, and increasing the ability to convene and build consensus among diverse stakeholders representing varying interests. With MACHW serving as the voice of the emerging profession, and with MDPH and MPHA providing technical assistance, the partners were positioned to influence health reform in Massachusetts.

TABLE 1—Timeline of Significant Milestones in the Community Health Worker Movement in Massachusetts

1990s	Community health workers (CHWs) start to organize networks in various regions of the state
1997	CHWs within the American Public Health Association's New Professionals Special Primary Interest Group agree to adopt the umbrella term *community health worker*
2000	Massachusetts Association of Community Health Workers (MACHW) forms
2000	Massachusetts Department of Public Health (MDPH) receives federal funding to support ongoing CHW network activities, develop CHW policies, and conduct a statewide survey about the workforce
2002	MACHW formalizes relationship with Massachusetts Public Health Association
2003	Blue Cross Blue Shield of Massachusetts Foundation first funds MACHW
2004	MACHW files legislation that would require MDPH to convene an advisory council, conduct a study and develop recommendations for building a sustainable CHW workforce
2005	MDPH releases report *Community Health Workers: Essential to Improving Health in Massachusetts*[9]
2006	Massachusetts health care reform law adopted with CHW provision[19]
2007	MDPH CHW Advisory Council convened
2008	CHW Board of Certification bill filed
2009	US Department of Labor recognized CHWs as a distinctive workforce[20]
2010	CHW Advisory Council report, *CHWs in MA: Improving Health Care and Public Health*, released to legislature[10]
2010	Patient Protection and Affordable Care Act of 2010 includes CHW language[1]
2010	CHW Board of Certification bill becomes law[19]

DEFINING THE PROBLEM AND LINKING POLICY OBJECTIVES TO REFORM

CHW leaders in Massachusetts understood that the problems facing their workforce also influenced their effectiveness in improving access to care and health outcomes in their communities. The challenge was to define issues in terms meaningful to policymakers grappling with large health system issues, including health care quality and unsustainable growth in health care costs. Health reform provided an opportunity to link the needs of an effective CHW workforce with overall health system needs; defining policy proposals that could simultaneously address both presented an additional challenge.

MACHW leaders, keenly aware of initiatives in other states to promote CHW workforce development, were determined to learn from them. They sought to take policy steps that would have sustained benefits for CHWs without compromising the qualities of practice that help distinguish CHWs from other health professions.[14,15]

In considering legislative action in 2004, MACHW leaders and supporters knew that they faced formidable challenges in the political environment. Because of massive state budget deficits, any proposal would have to be budget neutral. Few legislators knew who CHWs were or what they did; the term "community health worker" was not widely used. Literature reviews had identified preliminary research evidence for the positive impacts of CHWs on expanding access to care, increasing health knowledge, and contributing to behavior change, but few studies in the past had incorporated rigorous research designs.[23,24]

THE HEALTH REFORM AGENDA AND THE FIRST LEGISLATIVE VICTORY

In a pivotal planning session in late 2004, MACHW leaders, together with representatives from MPHA and MDPH, crafted what would become a winning legislative strategy.[14] They decided to introduce a bill in the 2005–2006 legislative session that would require MDPH to conduct a study of the CHW workforce—including activities, market dynamics, and evidence for CHW effectiveness in improving health and reducing disparities—and to develop recommendations for building a sustainable CHW workforce. They found, as chief sponsor, a champion of CHWs in the House of Representatives for whom the legislation was a top priority.

MACHW had grown and linked with regional CHW networks around the state. It became the locus for engaging groups and constituents in varied legislative districts to work on a campaign, educating CHWs about the bill and engaging in legislative tactics such as letter writing, calling and meeting with legislators, gaining endorsements from other organizations, circulating fact sheets, and participating in hearings.

The timing of these advocacy activities in late 2005 turned out to be critical. As the landmark Massachusetts health reform bill moved toward passage, it eclipsed action on many other legislative priorities. Health care financing committee leaders decided to incorporate the CHW bill into the larger health reform package as a health disparity provision, and it was signed into law as Section 110 of Chapter 58 of the Acts of 2006.[4]

The importance of community health workers to successful health reform had now been acknowledged in law. Furthermore, the legislation laid out the next steps advocates had envisioned as a way to build legitimacy for their case, requiring MDPH to convene an advisory council including representatives of key state agencies, health sector employers, insurers, health provider organizations, academics, CHW training programs, public health advocates including MPHA, and MACHW to carry out the law's mandated activities.

VIABLE PROPOSALS AND THE POLITICAL CONTEXT

In 2007, MDPH's commissioner convened the CHW Advisory

Council[10(pp76–78)] to review the national literature on CHW effectiveness, conduct a workforce study and employer survey, present financing options, and develop training and certification recommendations. As part of the investigation MACHW held regional forums to gather CHW input on issues such as certification.[10(pp101–103)]

The Advisory Council members heard regularly from MACHW leaders about the values and roles that defined CHWs and about the imperatives of strengthening opportunities for CHWs without erecting barriers to entry to the field for community members or otherwise eroding the characteristics that make CHWs distinctive and effective.

Advisory Council members closely monitored developments in health reform at the state and national levels. Massachusetts provided a model for national reform, and issues of cost and quality became prominent in the policy debate in the state as well as nationally. This provided an opportunity for the CHW Advisory Council to emphasize the effectiveness of CHWs in improving health outcomes, containing costs, and reducing disparities for the overall health care system. Meanwhile, an increasingly rigorous body of scientific research was being published demonstrating impressive CHW contributions as members of clinical teams, outreach and prevention workers, educators, and health system navigators.[25–29]

The 2010 release of the CHW Advisory Council's report to the legislature gave further political legitimacy to the potential role of CHWs in ongoing health reform.[30] It included a synthesis of recent rigorous effectiveness research and offered 34 specific recommendations for promoting CHW workforce development. It also included summaries of cost–benefit research to ground its recommendations in the economic realities of the national recession that had begun in 2008.[23(pp33–42, 84–98)]

THE POLITICAL DYNAMICS OF LEGISLATION FOR A BOARD OF CERTIFICATION

The Advisory Council made multiple recommendations to strengthen CHW professional identity, training, funding, and state infrastructure.[10(pp45–61)] The recommendation to establish a board of certification for CHWs emerged as the next viable policy step because it helped address the need for a more clearly defined field, and there was supporting infrastructure in place for it at MDPH.

CHW Advisory Council members, representing diverse and sometimes divergent stakeholder interests, had agreed that to promote CHW workforce development it was essential to clarify a scope of practice and to develop a certification process for CHWs and the organizations that trained them. Employers and insurers emphasized that certification was necessary to provide a basis for confidence regarding what services would be purchased under almost any of the payment options being considered by the Advisory Council. MACHW leaders embraced certification as a way to strengthen the workforce, provided that CHWs helped define standards and that training opportunities be expanded to avoid the risk of restricting access to this community-oriented, emerging profession. Their workforce goals were twofold: increased understanding and respect for the field and a desire for greater employment stability and opportunities for equitable wages.

Resources were needed for both research and advocacy efforts, and support came from The Boston Foundation, which funded the Community Health Worker Initiative of Boston through the SkillWorks program for workforce development and policy change.[31] Action for Boston Community Development (ABCD) led the initiative, and MACHW and MPHA staff were contracted to colead its Policy Committee, which expanded the collaboration to include ABCD, the Massachusetts League of Community Health Centers, and other community health organizations and advocacy groups.

CHW leaders, in close collaboration with MDPH, drafted legislation to establish a CHW Certification Board to be located within the MDPH Division of Health Professions Licensure and with a financing mechanism cost neutral to the state budget. The solid, longstanding partnership between MACHW and MDPH would prove to be essential in the swift passage of this legislation,[32] and the joint leadership of the advocacy strategy by MACHW and MPHA provided a coordinated team focus.

In cooperation with MDPH officials and MACHW's original legislative champion, the bill was introduced for the 2009–2010 session. It specified a comprehensive set of responsibilities for the certification board and ensured that CHWs would be involved in developing practice standards, training and continuing education requirements, grandfathering provisions for the current workforce, and establishing requirements for CHW training entities. It defined the composition of the certification board to include CHWs recommended by MACHW to the governor of Massachusetts.

LEGISLATIVE STRATEGY, EXTERNAL PRESSURE, INTERNAL INFLUENCE

Although there was no organized opposition to the Board of Certification legislation, to gain the attention of the legislature during a session dominated by dramatic debates over revenue and budget cutting proposals, the bill required strong advocacy from constituents and from legislators about its importance. The campaign to win passage of what would become Chapter 322 of the Acts of 2010 was promoted from outside the legislature by CHWs, employers, and other advocates led by MACHW, including the Policy Committee of the CHW Initiative.[33]

Using the venue of its annual "CHW Day at the State House," MACHW mobilized more than 100 CHWs and other supporters to provide legislators and their staff with information about CHWs and the need for certification. During the 2-year legislative campaign for the certification board, MACHW kept CHWs informed and engaged through a postcard campaign, regional meetings, e-mail updates, and Web-based factsheets. CHWs, their employers, and other stakeholders participated in bill hearings as well as meetings with key legislators. Concise messages and compelling CHW stories secured the support of many respected legislators. Interest in the legislation also increased when MDPH publicly released the CHW report at the State House and supported the bill.[19]

Key to the campaign to gain support for the legislation was collaboration with the bill's chief sponsor who worked closely with advocates and listened to the priorities of the workforce. A key advocacy message—the potential

contributions of CHWs to the improved quality of health services in a cost-effective manner—was not lost on many legislators who were concerned with containing health care spending as Massachusetts worked to address outstanding challenges in health reform.

Identifying and working directly with legislative champions who understood CHWs' contributions to improving health in underserved communities turned out to be pivotal when a powerful legislator decided to alter the legislation. An added amendment would have required mandatory licensure for CHWs and changed the original intent of the legislation, as well as the field itself. The intent had been to establish a voluntary process to certify achievement of standard competencies. MACHW acted swiftly to engage CHWs, stakeholders, and key legislators in efforts to remove the added language or withdraw support for the bill if the mandatory licensure language was retained. In the end, that added language was removed. Despite this challenge and the additional challenges of an overcrowded legislative agenda, supporters of the CHW certification bill accomplished a rare feat: passage of a law within 1 legislative session that also reflects the original intent of the CHW workforce.[19]

CONCLUSIONS

The Massachusetts experience described here is about the power of authentic collaboration, based on respect for the authority and necessity of CHWs to define their needs and determine the viability of different policy alternatives to advance the field. MACHW leaders built their organization and its capacity to lead policy change by engaging CHWs and other allies in health care, public health, charitable foundations, academia, and the legislature.

Health reform provided an important opportunity to advance the CHW and public health policy agenda, but the collaboration was poised to take action because of the preparatory work in organizing CHWs and forming strong partnerships. The Massachusetts experience offers valuable lessons for CHW leaders and supporters in other states involved now with implementing the Affordable Care Act. Health reform is crucially about improving the quality of health in this country and making sure that improvements in access and services reach everyone equitably. CHWs in Massachusetts, as elsewhere, have been guided by an abiding commitment to empowerment for underserved community members and by their own experiences of racism, sexism, and economic injustice. Public health advocates in other states should recognize the CHW workforce as an important ally in the effort to make health reform consistent with public health goals.

These Massachusetts campaign stories also illustrate the importance of understanding the legislative process and building advocacy power through effective cooperation with influential legislators and their staff and by organizing sustained outside pressure for desired policy change. In this work, experienced partners with shared goals are essential. In defining the problem, prioritizing and developing viable proposals, and analyzing the political landscape, CHWs have formed valuable collaborations within the state health department, the Massachusetts affiliate of the American Public Health Association, and others.

Foundation funding has enabled MACHW to build organizational capacity over time, but in-kind support from a host of partner organizations predated grant funding and provided a critical component of MACHW's resource base. CHWs have also received sustained financial and in-kind support for their membership building and educational work, as well as for advocacy. For other states, the lesson in the Massachusetts experience, as well in national health reform, is that policymakers were able to see the connection between successful health reform and integration of community health workers. Even in difficult economic times, funders and public health organizations should heed this lesson and support similar work in other states and nationally. ■

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