Support for Community Health Workers to Increase Health Access and to Reduce Health Inequities

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Significant health status and access-to-care issues are facing communities across the United States. Community health workers (CHWs) can assist in addressing many of these issues from a community-centered approach; however, their presence in the US health system is fragmented, and their potential contributions are poorly understood by many. To strengthen the position of CHWs, who are frontline members of the public health workforce and are uniquely positioned to address issues of health care access, quality, cost, and disparities, a comprehensive policy and practice changes are needed at all levels. These changes will allow CHWs to contribute fully and most effectively to health improvements across the country.

In 2001, the American Public Health Association (APHA) adopted Policy Statement 2001-15, "Recognition and Support for Community Health Workers' Contributions to Meeting Our Nation's Health Care Needs."[1] In this resolution, the Community Health Worker Special Primary Interest Group (CHW SPIG) articulated many issues facing the field and proposed an array of policy and practice recommendations to address these issues. The 2001 resolution has helped move many local and state level policy and practice decisions forward; however, there has been no consistent and comprehensive progress in fulfilling all the recommendations. Therefore, the CHW SPIG requests that policy statement 2001-15 be archived and that APHA adopt this updated resolution in its place. This resolution, incorporating lessons learned during the ensuing 8 years, seeks to articulate current challenges to CHW workforce development and to strengthen many of the 2001 policy statement recommendations.

Defining CHW Roles

One of the key recommendations from the previous policy statement that has been addressed is the development of a national definition of the CHW workforce. In 2006, the CHW SPIG of APHA, working with CHWs and their advocates from across the country, submitted a request for a CHW classification to the Bureau of Labor Statistics for inclusion in the Department of Labor 2010 Standard Occupation Classification revision. The CHW SPIG submitted the following CHW definition:

Community Health Workers (CHWs) are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs 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. CHWs also build 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.

The request was well received and in January 2009, the Office of Management and Budget officially published the 2010 Standard Occupational Classifications (SOC), which includes a unique occupational classification for Community Health Workers (SOC 21-1094).[2] This CHW Standard Occupational Classification will become part of the 2010 census, which will assist in obtaining a more accurate estimate of the size of the CHW workforce.

The Health Resources and Services Administration, Bureau of Health Professions' 2007 National Workforce Study of CHWs, provided the first comprehensive systematic attempt to estimate numbers of CHWs. The study estimated that, as of 2005, there were approximately 120 000 CHWs working in the United States.[3]

As stated in the 2001-15 Resolution, the CHW field is broad, but recently national organizations and statewide partnerships have been creating clear definitions and roles for CHWs. Many of these definitions, including the one approved for the 2010 SOC revisions, are based the 7 roles of CHWs as identified in the 1998 National Community Health Advisor Study[4]:

1. Bridging and providing cultural mediation between communities and health and social service systems

2. Providing culturally appropriate health education and information

3. Ensuring people get services they need

4. Providing informal counseling and social support

5. Advocating for individual and community needs

6. Providing direct service, such as basic first aid and administering health screening tests

7. Building individual and community capacity

Persistent challenges to a robust, responsive health care and public health system in the United States include health disparities, access to care, quality of care, and health care costs. CHWs are uniquely positioned—as liaisons between systems and communities and skilled as advocates, outreach workers, and care coordinators—to help mitigate these challenges. In fact, the Institute of Medicine (IOM), in its 2002 report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, recommended integration of trained CHWs into multidisciplinary health care teams using community-based, comprehensive approaches to best address these issues. In that report, the IOM urged "programs to support the use of CHWs . . . especially, among medically underserved and racial and ethnic populations should be expanded, evaluated and replicated."[5]p195

Unfortunately, CHWs have yet to be fully integrated into the US health care system and face many workforce challenges. This lack of integration prevents CHWs from realizing their maximum effectiveness to improve the health of individuals, families, and communities. Additional barriers that CHWs face are lack of sustainable funding for their work and lack of a standard core curriculum for professional training and certification.

Most CHWs rely on categorical grant funding, either public or private, to support their services and salaries. This kind of funding creates persistently low wages, high turn over, and low job security. Currently, most health plans do not reimburse for CHW services or recognize CHWs as reimbursable providers, which gives little incentive for organizations to create stable CHW positions. Moreover, many options for stable funding depend on documentation of training and certification.

Providing Training and Certification

There is currently no national standard for CHW training or professional certification. Most CHWs receive on-the-job training tailored to the specific program with which the CHWs are hired to work.[6] When CHW training occurs primarily at the employer level; the training may be comprehensive, or it may present only skills required to complete a single project. Increasingly, education programs for CHWs are being offered at community-based organizations and academic institutions. In areas where academic institutions are involved in designing and providing training for CHWs, the goal is usually to provide a program designed to meet the needs of many CHW employers and can provide opportunities for CHWs to develop skills to further their knowledge or careers. Completion of a standardized training program allows employers the knowledge that a job candidate has a basic level of qualification, and it allows CHWs to develop skills that can be used between several types of CHW positions or employers.[7] As the role of academic institutions increases with this field, it is important that efforts be made to generate guidelines to ensure that standardized core competencies be used. A standardized curriculum would help define this profession and determine a clear scope of practice compared with other health and social service professions. A clearly defined and structured educational training program would also validate the role of the CHW and enhance the credibility of the position. Several cities and states have developed formal training guidelines and certification programs, which have contributed to success in integrating CHWs into the health care workforce.

For example, in Minnesota, the CHW state-standardized curriculum is offered for credit only through the postsecondary educational systems. CHWs receive a certificate on completion of the curriculum that qualifies them to enroll for reimbursement under the Medicaid program; one of the only reimbursement models to date for CHWs.[6] In San Francisco, the CHW curriculum is offered at a local community college. CHWs who graduate from this program also receive a certificate that is a credential used for jobs in city and state health departments.[8]

More states are in the process of expanding training opportunities as a framework to support a certification process in the future. These practices and other collaboratively developed CHW training resources identified by the Community Health Worker National Education Collaborative, funded by the US Department of Education,[9] are valuable assets that contribute to the growth of the field. Certification recognizes and legitimizes the work of CHWs and may provide a potential reimbursement opportunity for CHW services. It may provide a better opportunity for third-party reimbursement.[7] Three states, Alaska, Texas, and Ohio, have active certification programs. The movement to certify CHWs at the state level began in 1999 with the passage in Texas of HB 1864; Ohio's version passed through legislation in 2003. Both certification programs have fully developed sets of regulations, but it may take several more years before the value of this process can be assessed.[10]

Improving Health Outcomes

A growing body of research indicates the effectiveness of CHWs in improving the quality of care and individual health outcomes. For example, a randomized controlled trial of a CHW intervention to increase insurance among Latino children in Boston found that children in the CHW intervention group were significantly more likely to be insured and to be insured continuously, compared with children in the control group.[11] Several studies of CHW programs have shown significant improvements in patients' use of prevention services, such as mammography and cervical cancer screenings among low-income and immigrant women.[12–15] CHWs also have proven positive effects on chronic disease management and treatment adherence, including significant impacts on healthy food choices and increased physical activity among patients with diabetes,[16] and clinical outcomes for diabetes, such as decreased hemoglobin A1C levels.[17]

In addition to improved health outcomes, CHWs can contribute to reduced health care costs by diverting care from emergency departments to primary and preventive care. In a study of primary care underuse among underserved men in Denver, Whitley and colleagues found that, because of the CHW intervention, care shifted from expensive inpatient and urgent care to less costly primary care services.[18] This shift resulted in a return on investment of $2.28 per $1 spent on the CHW intervention, for a total savings of $95,941 per year. In another service utilization study of patients with diabetes, Fedder and colleagues found that patients who received CHW services had a reduction in emergency room visits and hospitalizations, which resulted in an estimated gross savings to the hospital per CHW of $80,000–90,000 per year.[19]

Findings from these studies clearly demonstrate that CHWs can contribute significantly to improvements in community members' access to and continuity of care; screening and other prevention activities; and adherence to treatment for various conditions and diseases, as well as reduced health care costs. Adding CHWs to the patient–provider team has a beneficial effect on the quality of care for populations most in need.[2,4,20–25]

Integrating CHWs Into the Health System

This policy resolution is specifically related to CHWs' being integrated into the US workforce and their effectiveness in increasing health access and reducing health disparities; however, CHWs are critical to health services around the world. Studies of international programs have also demonstrated CHWs' effectiveness in improving access to health services and health outcomes. Many of these studies are included in the recently rereleased Cochrane Review of CHW research.[26]

Distinct from these research findings, CHWs, researchers, and funders at a 2007 national conference identified that a lack of common standards for research studies concerning CHWs has meant that research findings are often difficult to compare and replicate. The conference issued a proposed CHW research agenda and related recommendations offering a valuable roadmap to the creation of a greater body of research that provides a strengthened evidence-base for CHWs.[27]

The IOM's recommendations related to CHWs in Unequal Treatment[5] are consistent with the existing evidence base in the literature. When well integrated into multidisciplinary teams addressing chronic disease self-management, access, education, and follow-up, CHWs can improve health outcomes, decrease emergency department use, and improve the cultural competence of the services provided.

In pursuing Healthy People 2010 goals and in anticipation of pending 2020 goals, many health programs have turned to CHWs for their unique ability to serve as "bridges" between community members and health care and public health services.[28–31] In addition, successful programs to eliminate health disparities in various racial and ethnic populations are built on strengthening the links between health care providers and the community members they serve.[32]

Recent efforts to integrate CHWs into the health care workforce will affect health reform on local and national levels. In Massachusetts, the legislature recognized the contribution of CHWs to increasing access to care and reducing health disparities by including CHWs in Section 110 of its groundbreaking health reform law, Chapter 58, The Acts of 2006. CHWs were also integrated into wellness programs and initiatives, chronic disease management programs, and health insurance outreach and enrollment programs.33 An amendment to the health care reform bill required a CHW seat on the states' Public Health Council, which oversees the Massachusetts Department of Public Health,[30] and the Massachusetts legislature is currently considering House bill 247, "An Act To Establish A Board Of Certification Of Community Health Workers."[34]

Minnesota is changing the role of the CHW from an occasional add-on to the system to a formal component of the mainstream health care workforce. Minnesota has defined the CHW "scope of practice," developed a statewide standardized curriculum, and identified standards and competencies related to protocols for CHW reimbursement. In 2007, the state legislature authorized policy to support the direct reimbursement of CHWs (Statute 256B.0625. Subd 49 and 256D.03.Subd4).[35] In 2008, the Centers for Medicare and Medicaid Services (CMS) approved an amendment authorizing Medicaid payments for CHWs.

The 2009 State Children's Health Insurance Plan (SCHIP) reauthorization contains CHW language in Section 302, Outreach and Enrollment.[36] The 2009 SCHIP reauthorization contains provisions allowing states to use Medicaid funding for CHW programs to conduct outreach, enrollment, and retention activities. Several other federal programs, including Healthy Start, the Ryan White Care Act, and the Maternal and Child Health Bureau's program for children with special needs, acknowledge the importance of case management function which parallels the role of CHWs.

Recommendations

Despite these recent advances in workforce development and a growing recognition of CHWs' abilities to affect health disparities, access to care, quality of care, and health care cost containment, much work remains to be done. Full integration of CHWs into the health and human services systems will require further vigorous effort to support CHW workforce development; through training, certification, and sustainable funding; and to strengthen community-based organizations employing CHWs in outreach and education efforts. APHA, therefore,

1. Asks that all public health and human service professional organizations support and promote a distinct occupational identity for CHWs as acknowledged in the 2010 Department of Labor SOC 21-1094, including support for the growth and development of the recently established American Association of Community Health Workers, and acknowledging the term CHW as an umbrella occupational category embracing multiple titles such as "outreach worker."

2. Asks public health and healthcare advocates and policymakers to integrate CHWs and CHW language into local and national healthcare reform legislation and related dialogues and initiatives.

3. Invites public health and health care industry officials to engage in a campaign to raise awareness of CHWs and their potential to improve access to care, eliminate health disparities, improve quality of care, and control the cost of care.

4. Urges private and public policymakers to engage CHWs in creation of common definitions and nationally recognized standards of core competencies for CHW practice, based on an updated understanding of core CHW roles as first captured in the National Community Health Advisor Study.[4]

5. Encourages employers of CHWs and academic institutions to support strong initial and continuing CHW education and capacity building for CHWs, implemented in a manner allowing multiple points of entry into practice, not limited to completion of college- or university-based education.

6. Urges that standards and qualifications for certain job titles such as "patient navigator" explicitly acknowledge the capacity of well-qualified CHWs to serve in such positions.

7. Urges researchers and funders to create common standards for research studies concerning CHWs to make studies more comparable and replicable and to create an evidence base for the CHW field which is comprehensive, coherent and useful for public policy.

8. Urges employers and funders to recognize CHWs' contribution to the public health and healthcare infrastructure by compensating CHWs at competitive wage levels at or above a locally determined living wage and providing employee benefits comparable to those received by other health professionals.

9. Calls on leading volunteer CHW programs to carefully evaluate career advancement opportunities for CHWs, including the possibility of paid CHW employment, and, as possible, integrate paid CHWs as CHW supervisors.

10. Urges federal agencies to promote a broad and consistent approach to care coordination, case management, outreach and related roles in federal health initiatives.

11. Urges state, federal and tribal governments and private insurers to provide direct reimbursement for CHW services as an integral part of the Medicare, Medicaid, SCHIP, and tribal health programs.

12. Urges employers to support CHW career development and formation of state and local CHW networks and associations for purposes of mutual support, advocacy, and professional development.

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