Rural Evaluation Brief

March 2011 • Y Series - No. 1

NORC WALSH CENTER FOR RURAL HEALTH ANALYSIS
http://walshcenter.norc.org

Rural Health Research Center
UNIVERSITY OF MINNESOTA
www.sph.umn.edu/hpm/rhrc/

Promising Practices for Rural Community Health Worker Programs

Alycia Infante, MPA, Alana Knudson, PhD, Alexa Brown, BS

Community health workers (CHWs) have made important contributions to improving the health of underserved populations in rural communities. While there are many ways to characterize the scope of their activities, the Health Resources and Services Administration's (HRSA) Community Health Workers National Workforce Study defined CHWs as "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."[1] CHWs expand access to health services in areas where transportation barriers, provider shortages, stigmas, and other challenges prevent people from receiving basic care. They play a number of roles in the community—from outreach worker to resource coordinator to health educator—depending on the needs of the target population.

Recognizing the value of CHW programs in rural communities, the HRSA Federal Office of Rural Health Policy funded rural communities to implement CHW programs as part of the 330A Outreach Authority program. The 330A Outreach Authority program focuses on reducing health care disparities and expanding health care services in rural areas. One of the lessons learned from the experiences of the 330A Outreach Authority grantees—and the literature on rural CHW programs, more generally—is that there is a need to identify promising practices for rural CHW programs to guide program development, implementation and sustainability.

A growing body of literature has demonstrated the effectiveness of CHW models in improving health education and other outcomes in underserved populations. However, little is known about the CHW strategies that are most effective in rural communities. Rural communities are developing CHW programs from the ground up, despite the fact that other programs may have promising practices and tools that could be easily adapted.

Key Findings

- This project identified six rural CHW models in the literature and in practice: promotora, member of the care delivery team, care coordinator, health educator, outreach and enrollment agent, and community organizer and capacity builder.
- The 330A Outreach Authority grantees offer promising strategies in the areas of program implementation, evaluation, and sustainability.
- Liabilities for CHWs include transporting clients in their own vehicles and conducting outreach activities in remote areas.
- An empowerment approach to evaluation, where CHWs are involved in the evaluation design and learn the results, is most effective.
- Key sustainability strategies for CHW programs are to develop a consortium of community partners that can lend resources and time, and investigate the feasibility of different fiscal sustainability models such as third party reimbursement for CHW services.
- Identifying promising practices for rural CHW programs will be important as CHWs continue to play an expanding role in rural health initiatives.

Identifying promising practices for rural CHW programs—and making this information accessible to other rural communities—will help to facilitate the replication of programs that are supported by research and/or experience.

Findings for this issue brief are based on a literature review of rural CHW programs and feedback from six 330A Outreach Authority grantees that implemented rural CHW programs. This project culminated in the development of a toolkit of rural CHW resources highlighting identified promising practices. The toolkit is available on the Rural Assistance Center (RAC)[2] website, www.raconline.org.

Purpose of the Project

The purpose of this project was to identify promising practices for rural CHW programs that help rural communities learn from the experiences of their peers and access tried and tested tools and approaches. The study focuses on reviewing the experiences of rural CHW programs in the field to identify "model" programs —those that are frequently implemented in rural communities with positive outcomes—and promising practice resources that may benefit rural communities. The project is timely in light of recent policy activity related to CHWs, including the recognition of the role of CHWs in the Patient Protection and Affordable Care Act (ACA) and the U.S. Department of Labor's inclusion of a Standard Occupational Classification for CHWs.

Methodology

The methods for this project included: (1) discussions with the HRSA Federal Office of Rural Health Policy staff and a review of 330A Outreach Authority grantee applications to identify those utilizing CHWs; (2) a review of the applications for the seven 330A Outreach Authority grantees found to be utilizing CHWs; (3) a review of the literature on rural CHW programs; (4) semi-structured telephone interviews with 330A Outreach Authority grantees that have implemented CHW programs; and (5) the development of a toolkit that contains resources on promising practices used in rural CHW programs.

In the first phase of this project, HRSA Federal Office of Rural Health Policy staff identified seven 330A Outreach Authority grantees that implemented CHW programs in rural communities. We reviewed the grantee applications, which contained information about grantees' strategies for developing rural CHW programs; conducted a review of the literature on rural CHW programs; and developed a grantee interview protocol. The protocol covered a range of topics about rural CHW programs, including the use of evidence in designing their programs, program curricula, recruitment and hiring approaches, liability issues, evaluation activities, and sustainability plans. Six of the seven grantees participated in a one-hour telephone interview; one grantee declined to participate. During the interviews, the grantees provided resources, templates, and promising practices for inclusion in the CHW toolkit. Interviews were completed between August and October 2010.

In the second stage of the project, we reviewed findings from the interviews and compiled toolkit resources from the literature. Additionally, the National Rural Health Association disseminated a call for promising practices on rural CHW programs through its listserv. The final toolkit is organized in eight areas: 1) introduction to CHWs; 2) CHW program models; 3) CHW training approaches; 4) implementation of CHW programs; 5) sustainability; 6) measuring and evaluating CHW programs; 7) disseminating CHW resources and promising practices; and 8) rural CHW program clearinghouse. The toolkit was designed in a question and answer format. Resources are provided for each topic area. RAC designed the toolkit in an electronic format on their website, www.raconline.org.

This project represents the first effort to identify promising practices for rural CHW programs. While the initial intention was to develop a toolkit of evidence-based resources and tools, this was not possible. Findings from a review of the literature and discussions with the grantees illustrate that often the approaches used by rural CHW programs are not rigorously evaluated because of a lack of time, funding, and other necessary resources. Additionally, there is not an existing body of literature on evidence-based rural CHW programs. Thus, the toolkit is a compilation of promising practices rather than evidence-based practices. It provides useful information, tools, and resources to rural communities that may wish to design and implement their own CHW programs. Future research will be needed to validate rural CHW program approaches. Several key themes emerged from this project and are described in the following sections.

CHW Program Models in Rural Communities

The literature review and interviews revealed CHW program models that are frequently implemented in rural communities and have contributed to positive outcomes.

Promotora Model. In the promotora model, CHWs are members of the target population that share many of the same social, cultural, and economic characteristics. They are trusted members of their community who are effective at building relationships. They serve as the bridge between diverse populations and the health care system. The scope of their activities ranges from providing culturally appropriate services to serving as a patient advocate, educator, mentor, outreach worker, and translator. The promotora model has been applied in Latin America and in the U.S. to reach Hispanic communities, in particular. It has been used widely in rural communities to improve the health and wellness of migrant and seasonal farm workers and their families as well as residents of border communities.

Member of Care Delivery Team Model. As a member of the care delivery team, CHWs provide direct health services in collaboration with a medical professional. They measure blood pressure, blood glucose, and heart rate and provide basic first aid and medication counseling. CHWs may work alongside a team comprised of a physician, nurse, allied health worker, or physician's assistant to deliver health education or screening services while the provider conducts a medical exam. This model is often used when CHWs work with providers in a mobile clinic setting.

Care Coordinator/Manager Model. As a care coordinator or care manager, CHWs help individuals with complex health conditions to navigate the health care system. They liaise between the target population and an array of health and social service organizations. They may support individuals by providing information and resources, coordinating transportation, and making appointments and delivering appointment reminders. Additionally, CHWs may work with patients to develop a care management plan and use other tools to track their health goals over time. For example, in one program, CHWs served as a care transition coach for rural elders that were discharged from home health services.

Health Educator Model. CHWs may also serve as a health educator, improving patient knowledge on prevention, nutrition, physical activity, chronic disease management, and environmental health. CHWs conduct educational programs in a variety of settings, including communities, agricultural worksites, processing plants, canneries, and colonias (rural communities along the U.S./Mexico border). Health education materials are often provided in multiple languages.

Outreach and Enrollment Agent Model. The outreach and enrollment agent model is similar to the health educator model with additional outreach and enrollment responsibilities. As outreach and enrollment agents, CHWs provide services in hard-to-reach rural areas. They conduct intensive home visits to deliver psychosocial support, promote maternal and child health, conduct environmental health and home assessments, offer advice, and make referrals. They also help individuals apply for government benefits and other programs.

Community Organizer and Capacity Builder Model. As community organizers, CHWs promote community action and garner support and resources from community organizations to implement program activities. CHWs may also motivate their communities to seek specific policy and social changes. They build relationships with public health organizations, grassroots organizations, health care providers, faith-based groups, universities, and government agencies to develop a more coordinated approach to serve their target population.

> *"We developed our [community health worker] model based on the community's needs."*
>
> *–330A Outreach Authority Grantee*

The CHW program models are not mutually exclusive. CHWs may conduct health education as well as outreach and enrollment activities—or serve as a member of the care delivery team and a community organizer. The scope of each CHW's activities is dependent upon their training and skills, program resources, and the unique needs of the target population.

Recruiting and Hiring Rural Community Health Workers

In some cases, CHWs are volunteers at health centers or organizations and receive a stipend or gift certificate rather than a salary for their efforts. In other cases, they are full- or part-time employees of a health center or organization. CHWs are recruited from within a variety of different clinics and organizations and/or the broader community through word of mouth and advertisements at work sites, social events, and schools. CHWs that provide clinical services often have a college degree or a certification from an academic institute or other state-level CHW program. However, some programs also hire CHWs with a high school diploma. Other programs have no academic requirements. Common skills required are outreach experience, fluency in English and Spanish, strong communication and interpersonal skills, and experience speaking to groups. Many programs also require their CHWs to be trusted and highly connected members of the community who share many of the same social, cultural, and economic characteristics as the target population. One grantee noted: "We try to [hire] people from the communities; they understand the communities better than we do because they are out there."

Training Rural Community Health Workers

Rural CHW programs have adapted existing materials from the Centers for Disease Control and Prevention (CDC), states, and academic institutions to create their own training curricula. When developing their programs, grantees have also utilized resources from the Community Health Worker National Education Collaborative, Community Health Works, the National Center for Farmworker Health, and Migrant Health Promotion. Depending on the population served, CHW programs have translated materials from these sources or modified them to reflect the scope of their programs. Common training areas include screening recommendations, risk factors, insurance eligibility and enrollment, ethics, communication skills, health promotion, and disease prevention and management. The grantees commented that their CHWs also attend cultural competency trainings to ensure that they deliver culturally appropriate services.

Liability Issues in Rural Community Health Worker Programs

CHWs play a number of roles that involve providing basic services, conducting home visits and assessments, and traveling to hard-to-reach areas to serve their target populations. Given that risks may be associated with these activities, rural CHW programs must assess their liabilities. Grantees identified transportation as a key liability issue in their programs. One grantee noted: "We do not allow our promotoras to transport participants because there is no way to cover that liability." Some rural CHW programs have considered acquiring insurance to cover other liabilities (e.g., injury on assignment). Grantees discussed the importance of discussing CHWs' scope of work, and some noted that they instruct CHWs to discontinue a home appointment or education session if they feel uneasy. Grantees also provide CHWs with safety kits containing pepper spray, insect spray, sunscreen, phone cards, and other resources when conducting outreach activities in rural and frontier communities.

> *"Community health workers have to come from the community and be of the community."*
>
> *–330A Outreach Authority Grantee*

Making the Case for Rural Community Health Workers: Program Evaluation Strategies

Given the diversity of CHW programs, there is no single evaluation design that will meet the needs of every program. Several different toolkits have been developed to guide the evaluation of CHW programs.[3,4] The toolkits include information about using logic models, applying different evaluation approaches and processes, measuring program costs and benefits, and presenting evaluation results. They also provide worksheets, examples, and evaluation case studies of different CHW programs.

A common theme from the CHW evaluation resources available in the literature is the value of utilizing an empowerment approach to evaluation. Findings from the interviews and the literature suggest that the most effective evaluations are those that are developed in collaboration with CHWs. CDC's handbook for enhancing CHW programs indicates that "evaluation of CHW programs is effective if the evaluation design

and data collection methods are developed with—and discussed, modified, and accepted by—the CHWs."[5] Grantees also highlighted the importance of including CHWs in the evaluation process and discussing the results with CHWs.

> *"I think the promotora community health worker model is absolutely key to long-term health and decreases in health disparities. We just need to find a way to fund it long enough to allow those outcomes to be clear."*
>
> *– 330A Outreach Authority Grantee*

Rural CHW programs have used a variety of program evaluation strategies to demonstrate the effectiveness of their activities. Some hired an external evaluator while others assigned an internal staff member to serve as an evaluator or quality coordinator. Grantees are collecting qualitative and quantitative data from their CHW programs using individual encounter forms, group education session documents, clinic reports, and case management reports. Common outcome measures for grantee evaluations of CHW services are patients' blood glucose levels and blood pressure. Process measures include the number of clients receiving education, the number of community education programs facilitated by CHWs, and the number and types of topics presented by CHWs at community presentations. In addition, some of the grantees solicited feedback from their consortia or boards of directors to identify program strengths and weaknesses.

A few grantees noted that they are trying to develop a business case for CHW activities, but are a few years away from having adequate data to demonstrate outcomes. No other business case analyses were identified in the literature. One grantee is conducting a cost effectiveness analysis of their program by comparing the cost of the infrastructure needed to conduct CHW activities to the value of the program. Another grantee is evaluating the differences in productivity and outcomes between voluntary part-time and paid full-time CHWs.

Grantees described challenges in conducting their program evaluations. First, grantees are collecting outcomes measures that are self-reported, which introduces bias into the data. Second, grantees have limited resources to conduct rigorous evaluations and typically work with smaller partner organizations that also lack resources to contribute to evaluation efforts. Finally, some programs rely on their CHWs to collect the data for the evaluation, although they have little training in this area. Grantees noted that they need more information on best practices for recording information, documenting the effectiveness of their activities, and analyzing data.

Sustainability Strategies

Rural CHW programs are developing sustainability strategies to continue their work post-grant. The grantees' most common sustainability strategy is to develop a consortium of community partners that advocate for the program. The majority of the grantees developed a consortium, network, or steering committee to guide the program and its sustainability and share promising practices and new ideas. Creating a sense of ownership for the CHW program among the public and private stakeholders in the community has helped grantees to identify new opportunities to sustain their activities. For example, community organizations provided facilities for CHW trainings, transportation services, and other in-kind resources. Additionally, another grantee commented that they are trying to expand their network. While this grantee belongs to numerous coalitions of social services organizations and medical agencies, they are striving to partner with organizations that focus on the social determinants of health, such as housing projects and legal aid groups.

CHW programs are also investigating viable fiscal sustainability models. One potential model is to seek third-party reimbursement for services provided by CHWs. For example, one of the 330A Outreach Authority grantees is a community health center (CHC) that contracts their CHWs out to other clinics in the rural community. This financial model has helped the CHC collect revenue for their CHW services. Another grantee is developing a similar relationship with their local fisherman's association, given that migrant workers in the community need translation, health care, and social support services. In other rural programs, Medicaid has reimbursed CHWs' health education services.

> *"If people on the ground don't understand what you are doing and why, you are never going to get great data."*
>
> *– 330A Outreach Authority Grantee*

Sustainability is also contingent upon having adequate space and staff to continue the program over time. One grantee discussed that they have outgrown the space in their CHC and cannot expand their program until they move into a larger facility. Another grantee commented that even well-funded programs have to maintain a

dedicated program coordinator to supervise, train, and mentor the CHWs. Given the time that it takes to train a CHW coordinator, staff retention is a key sustainability issue. The grantee noted: "Living in a small town, our candidate pool for positions it not huge; it's [about] finding the right people."

Health reform may offer new opportunities for sustaining rural CHW programs. The ACA recognizes CHWs as members of the health care work force and allows Congress to allocate funding to establish a federal grant program to support the use of CHWs in medically underserved areas. Future grants could be made available to health departments, clinics, hospitals, federally qualified health centers, and other private organizations for promising programs using CHWs.

Rural Implications

The 330A Outreach Authority grantees commented that there are some unique benefits to implementing a CHW program in a rural area. Grantees commented that, in rural areas, "people are used to being self-sufficient because there are not a plethora of services available;" "people know how to make things work without electric or roads" and "the mentality is 'let's do this for ourselves.'" Also, "people are connected in a rural community." Grantees reported that there is a deep sense of community; people know one another and organizations from the public and private sectors have a history of collaborating to create solutions that will benefit their communities. For these reasons, another grantee expressed that "it might be easier [to implement a CHW program] in a rural community." Finally, a few grantees commented that rural CHW programs are more likely to be successful in the long term because "rural populations are much more stable; they come to rural areas and they stay."

Identifying promising practices for rural CHW programs will be important as CHWs continue to play an expanding role in rural health initiatives. This project and toolkit help to build knowledge on CHW strategies that work well in rural communities and disseminate promising approaches. Identifying promising practices for rural CHW programs is particularly important in light of recent policy activity at the national level. The ACA's recognition of the role of CHWs and the U.S. Department of Labor's creation of a Standard Occupational Classification for CHWs may change the landscape in the future—with CHWs playing an expanded role in the improvement of health in rural communities.

References

1. Community Health Worker National Workforce Study. March 2007. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions: 2.
2. Rural Community Health Workers Toolkit. 2010. Rural Assistance Center Online. www.raconline.org
3. The Community Health Worker Toolkit. 1998. University of Arizona. Office of Rural Health and College of Public Health. Accessed January 7, 2011 https://apps.publichealth.arizona.edu/CHWToolkit/
4. Evaluation Toolkit. 2009. Migrant Health Promotion. Accessed January 7, 2011 www.migranthealth.org
5. "A Handbook for Enhancing Community Health Worker Programs: Guidance from the National Breast and Cervical Cancer Early Detection Program" (Part I), 29. Accessed January 7, 2011 www.cdc.gov/cancer/nbccedp/training/community.htm

This study was funded under a contract with the Health Resources and Services Administration Federal Office of Rural Health Policy (ORHP), DHHS, Contract Number HHSH25020090012C. Under this contract, the NORC Walsh Center for Rural Health Analysis and the University of Minnesota Rural Health Research Center are conducting evaluations of the six grant programs established under the 330A Outreach Authority. The project described in this brief was conducted in the first year of the four year evaluation project. The conclusions and opinions expressed in this report are those of the authors; no endorsement by NORC at the University of Chicago, the University of Minnesota, HRSA, ORHP, or other sources of information is intended or should be inferred. The Walsh Center for Rural Health Analysis is part of NORC at the University of Chicago. For more information about this project or the Walsh Center and its publications, please contact Michael Meit at (301) 634-9324 or meit-michael@norc.org.