The Houston Community Health Worker Survey: Unanticipated Effects of Certification

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We share in this paper the results of an evaluation of community health worker (CHW) utilization in Houston, Texas from May to August 2007. We present the state of the field in a diverse city; identify challenges, including certification; and discuss community-based solutions.

Background and Significance

Promotores, or community health workers (CHWs), are trained lay persons who share ethnicity, language, experience, and/or socioeconomic status with the community to which they provide health-related services. Research has shown that CHWs can help overcome healthcare barriers and inefficiencies. CHWs can assist members of medically underserved communities navigate the healthcare system (Swider 2002; Reinschmidt et al., 2006), increase disease screening (Hunter et al., 2004) and preventive care (Nguyen et al., 2006), improve disease management (Norris, 2006), and reduce the overall cost of care (Whitley, Everhart, & Wright, 2006).

CHWs primarily work with people who are marginalized from the mainstream healthcare system, often by poverty, age, or cultural tradition. They provide services that range from interpretation to health education to community advocacy. The roles that CHWs fulfill are likely to expand in the future, due to demographic trends, such as an aging population and increasing immigration; the growth of care management technology that will broaden what can be done by paraprofessionals in patients' homes; and increasing demands for cost-effective interventions.

Studies such as the Community Health Workers National Workforce Study (2007) have provided a comprehensive overview of the state of the field in the United States. This research project is designed to complement those studies through a case study of Houston, Texas, a diverse city in a state that has been in the vanguard of the CHW movement. As a mature model of CHWs' integration into the healthcare system, Houston can be viewed as a bellwether for the profession in the United States as a whole. This paper reports one of our results: the challenges and opportunities that credentialing has presented for Houston's CHWs and the organizations that employ them.

CHW Demographics and Reimbursement

In Texas, the CHW workforce is 68% Hispanic/Latino(a), 18.5% Non-Hispanic White, and 10.7% Black/African-American (Health Resources and Services Administration (HRSA), 2007). Texas mirrors the nation in that CHWs are mostly female between the ages of 30 and 50 (ibid). Approximately two-thirds (67%) of U.S. CHWs are in paid positions (HRSA, 2007). Of those who are paid, experience is the biggest predictor of pay (ibid).

CHW Credentialing in the United States

The lack of standards for the education, training, and certification of CHWs has been cited as limiting CHWs' ability to receive payment for their services (Kash, May, & Tai-Seale, 2007). Without such standards, it is argued, employers, insurers, funders, third-party payers, and community members cannot evaluate the competence of CHWs and the value of their services (Dower, Knox, Lindler, & O'Neil, 2006).

Currently, only Alaska, Ohio, Indiana, and Texas have state-required certification, although several states are moving in that direction (Kash, May, Tai-Seale, 2007). Of these states, only Texas and Ohio certify "generalist" CHWs. Alaska and

Indiana certify only "specialist" CHWs, who are highly skilled and serve targeted populations. Alaska's certified health aides (CHAs) serve the state's Native population; the program has evolved over more than 50 years and partners with federal agencies and tribal governments. Alaska's CHAs receive Medicaid reimbursement (ibid). Indiana certifies CHWs working for maternal and child health programs. They also have been able to secure Medicaid reimbursement. Ohio implemented its state certification program, administered through the Board of Nursing, in 2004.

CHW Credentialing in Texas

Texas' certification and training program is the result of a process that was based upon the principles of community-based participatory research, and which is a good example of community-campus partnership.

History. In 1999, a committee was formed to explore certification of CHWs in Texas. The committee's 15 members were two CHWs, two members of the public, two employees of the Department of Health, seven representatives of higher education, one representative of the Workforce Commission, and one representative of a border-health advocacy group. The committee's charge included program evaluation and the issue of Medicaid reimbursement for CHW services (HB 1864, 1999).

The committee met monthly for two years. They reviewed existing curricula and training programs and visited 30 Texas programs that, together, employed over 300 CHWs. To ensure that the proposed certification curriculum was realistic and representative of CHWs' work, community meetings were held in four towns around the state. More than 150 people commented at the meetings, most of whom were CHWs. Other stakeholders who participated were from higher education, government, and community advocacy groups (Nichols, 2005).

Certification requirements. In 2001, legislation was passed based on the committee's recommendations (Texas Department of State Health Services, 2001). Certification was required for all CHWs who receive compensation for their services, and state health and human services agencies were directed to attempt to use certified CHWs for patients who receive medical assistance (SB 751, 2001; SB 1051, 2001).

Texas' certification program is administered by a nine-member advisory committee that is composed of four certified CHWs; two citizens; one instructor who has trained CHWs; and two professionals who work with CHWs in a community setting (Nichols, 2005). State-certified training programs must follow guidelines that are intended to provide portable skills, a common base of knowledge, and certain basic skills. Coursework consists of160 hours, with a focus on eight competencies and minimum objectives in each competency: Advocacy, Interpersonal Relations, Capacity Building, Communication, Knowledge, Organization, Teaching, and Service coordination (Nichols, 2005).

Grandfather provisions require ≥1000 hours of experience over 12 months. The special needs of adult learners who may not be legal citizens are considered when certifying training programs, and precedence is given to settings with a history of working with CHWs, where they are more likely to feel safe, comfortable, valued, and respected (Nichols, 2005). Recertification is biannual, and requires 20 hours of continuing education credit. There is no application fee for certification, and the state conducted several promotional workshops to distribute applications and information about the certification process.

State of certification. As of November 2007, 13 training programs are certified (originally 14; one program has elected not to recertify). Over 500 CHWs have completed certification. Harris County has by far the most certified CHWs (Texas Office of Primary Care, 2007). However, as of December 2005, only 52% of CHWs who were due for re-certification had re-certified, and the numbers of recertifications and certifications have been falling (CHW Advisory Committee, 2005).

Purpose

We conducted a systematic evaluation of CHW utilization in Houston, Texas from May to August 2007. The purpose of the semi-structured interview study was to identify the organizations that support CHWs; the purpose and scope of the work conducted by CHWs; and the operational support of CHW programs, including funding, program evaluation methods, "best practices," and barriers to service delivery. This article focuses upon an unexpected finding from the study. We were surprised to discover that many practicing CHWs have experienced Texas' credentialing program as a burden, rather than a benefit.

Methods

The research methodology for this project was qualitative, consisting of semi-structured interviews. The interviews were held in accordance with The Methodist Hospital Institutional Review Board guidelines. We conducted 32 interviews, representing 11 organizations−8 nonprofit and 2 governmental. Twelve of the respondents were program managers. The rest of the interviewees were practicing CHWs. All but one of the interviewees was female.

The study followed a non-probability, snowball sampling procedure for identifying the organizations and the interviewees. The sample was derived from lists provided by individuals within organizations that trained CHWs for state

certification. Those contacted were asked if they could refer us to another organization that supported CHWs.

In-person interviews were arranged through phone or email communication with program coordinators and CHWs. Interviews were conducted at the organization or CHWs' offices, and ranged from 30 to 60 minutes. Based on feedback and requests from participants, interviews were neither video nor audio recorded. Written notes were taken, including quotes when possible, and two (female) interviewers were present at almost all interviews to ensure the maximum accuracy in data recording.

Interview questions addressed CHWs' goals, outreach methods, service topics, training status, funding, and evaluation. Additional questions aimed at CHWs' motivations, barriers, and definition of community.

The limitations of this project included the compressed data collection period (a summer fellowship), which sometimes hampered scheduling interviews. A longer collection period would have allowed for the inclusion of interviews with CHWs who were unable to participate during the study period. Secondly, the lack of consistency in naming CHWs was a barrier to identifying potential participants. Most organizations that employed staff members who fit the definition of a CHW did not refer to them as CHWs, so there was no job title that could be asked for when calling an organization in which the researchers did not know the name of a CHW. This may have introduced bias into the sample, perhaps skewing it toward state-certified CHWs.

Results

This paper focuses upon the issue of certification. Certification was repeatedly raised as a perceived barrier, both by CHWs and by program directors. Six of the organizations interviewed employ a mix of certified CHWs and uncertified CHWs. The two government agencies have fully certified CHW staffs. However, all of the organizations provide internal training for CHWs that focus on program-specific skills, as well as requiring continuing education.

Two of the organizations studied were certification-granting institutions, as well as CHW employers. Both program directors cited two requirements as onerous. Training programs must create their own curricula, and must revise their curricula every two years. "People view their community as too unique… [there's] a problem with lack of sharing," states a director. A trainer suggests that, "[We] could make use of the expertise of each organization. Instead of [us] organizing everything, [we] should make use of the resources and infrastructure that is already there." Both directors said that collaborative learning of organizations should be the focus in strengthening the CHW curriculum and certification efficacy.

Barriers cited by the CHWs themselves included limited class availability, cost of courses, and literacy issues. The two-year recertification requirement was viewed as daunting by some CHWs, while others found that the continuing education classes available were not challenging or interesting, given the level of training they already received through their organizations. Language was also viewed as a barrier in the certification process. There is limited bilingual access to the training classes. And, if a training program provides a bilingual translator, the language is almost always Spanish.

Another barrier is the requirement that CHWs must apply for recertification before their current certificate expires. This became a problem for one of the organizations interviewed. A newly hired director of a program that was being revived wanted to employ certified CHWs from the community but was unsuccessful because those who had previously been certified had forgone the opportunity to apply for recertification. As a CHW states, every time new CHWs are hired because previous ones lost their certification, CHWs "need to reestablish a level of trust with the community."

The majority of interviewees agree that there are benefits to certification. They cited heightened credibility, quality, recognition and acceptance as potential benefits. But the steps for institutions, instructors, and CHWs to obtain and maintain certification were also cited as drawbacks. Most CHWs interviewed linked the challenge of certification to the lack of job opportunities and stability. They did not see a financial benefit to certification.

Discussion and Conclusions

The development of Texas' CHW certification process was community-based and respectful of the tension that CHWs' feel as members of communities who are also interested in acceptance and reimbursement by the healthcare system (Dower et al., 2006). In many ways, it is an exemplary example of a community-campus partnership. However, in practice, it appears to be failing to meet the needs of the people whom it was intended to serve.

Most importantly, certification does not appear to increase pay. The national workforce study found that experience, not certification, was the biggest predictor of pay in Texas (HRSA, 2007). Texas' original legislation mandated exploration of Medicaid reimbursement for CHWs. That initiative appears to have lost momentum. In addition, the state requirement that paid CHWs be certified has no enforcement associated with it, and so has not had much impact outside of state agencies.

The shift from employer, program-specific, and community-based training to a broader, uniform approach to CHW education seems to have created challenges for CHWs. This study found that certification results in cost-shifting to

individual CHWs, who traditionally come from socioeconomically disadvantaged backgrounds. It is clear from our interviews that certification's costs in both time and money are perceived as barriers by CHWs.

The dynamics of the Advisory Committee are also a consideration. The Advisory Committee is heavily weighted toward professional and academic representatives. It may be difficult to get a truly representative and participatory experience from the group because of its uneven power dynamics. Possible ways of making the committee more participatory include holding the meetings in communities, rather than in the state capitol, and making the work less policy-level and academic. Perhaps a presentation from a successful group of CHWs at each meeting that solicits their practical feedback would be helpful.

The training requirements for certification are long and somewhat undefined. Elements such as service coordination, advocacy, and communication are very important, but it is not clear that it is appropriate for every community to spend so much time on each of them. Texas deliberately has no curriculum model, in order to remain open to individual community experience. However, this means that the curriculum has to be rewritten by every instructor. The weakness of this approach is that there is no source of best practices available and no statewide organization where CHW instructors or program directors can learn from one another. While every community is different, a great deal can also be learned from others' experiences.

Finally, recertification was cited by our respondents as a barrier. The Advisory Committee has responded to this barrier by providing extensions. Unfortunately, this option is not well-publicized; the authors were unable to find it on their website (which is in English). In addition, recertification is a challenge for CHWs because there are a limited number of CHW instructors and very few organizations offering continuing education. This is especially difficult for CHWs in rural areas. Even in Houston, a large urban area, there is only one organization that offers continuing education, and that only on an occasional basis.

Houston provides insights into the lived experience of Texas' CHW certification process. As other states consider certification, this study can serve both as an exemplar of a community-based partnership between academia and grassroots healthcare providers and as a source of insights into the difficulty of creating a system that is responsive to the needs of all the stakeholders involved in CHW credentialing.

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