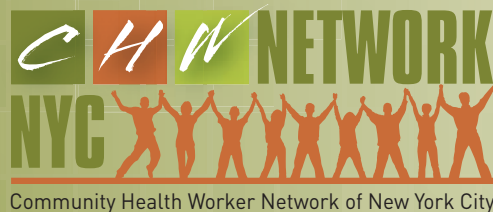




The New York State Community Health Worker Initiative



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Contents

EXECUTIVE SUMMARY	1
INTRODUCTION	3
History of Community Health Workers	3
Evidence for Community Health Workers	3
KEY ISSUES FOR STANDARDIZING THE COMMUNITY HEALTH WORKER FIELD	8
Defining Community Health Workers	8
Determining the Training and Certification Standards for Community Health Workers	9
KEY ISSUES FOR FINANCING COMMUNITY HEALTH WORKERS	12
Current State Funding for Community Health Workers	12
Moving Forward: New York State CHW Financing Considerations	12
Potential for Federal Funding for Community Health Workers	16
CONCLUSION	18

“Helping people is in my spirit so getting trained as a community health worker was an amazing, life-changing moment. We have power because we have resources and knowledge, but we want to share it. I meet families that need services and you know that services are there but they feel powerless. You work together with families to find the light at the end of the tunnel.”

MARIA MURPHY

CHW
Bronx Lebanon Hospital Center, New York, NY



Executive Summary

Many New Yorkers face significant barriers to accessing and using health care and social services. This is particularly true in low-income communities and among racial, ethnic, political, economic, and marginalized populations. Community Health Workers (CHWs) have a unique ability to address existing barriers in both community and clinical settings. Known by many different titles,¹ CHWs are frontline public health workers who are trusted members of the community they serve and function as liaisons between health and social services and communities to facilitate access to services as well as build individual and community capacity. CHWs help community residents understand the root causes of their conditions and develop strategies to address these injustices. CHWs share common racial and ethnic backgrounds, cultures, languages, and life experiences with the communities in which they live and serve, therefore, have the necessary trust to engage residents and help them take positive action to improve their health.

Numerous studies have shown that CHWs can improve health outcomes, address disparities, and reduce the use of resource-intensive services by helping high-need populations access and navigate fragmented health and social service systems, make positive changes in their behaviors, and adhere to complicated treatment regimens. Despite this evidence and an estimated 11,000 CHWs in the State, the CHW workforce in New York does not have a standard scope of practice, core competencies, training and certification, or sustainable funding streams. This inconsistency in how CHWs are defined, trained, deployed, and financed contributes to an inefficient use of resources, instability to the CHW field, and transient financing.

There is a growing recognition in New York and across the country that there needs to be sustainable financing for CHWs; therefore, standardizing the workforce is necessary. Efforts to regulate sectors of the CHW field are now underway in several states, but these vary greatly in their ability to embrace the whole CHW field in those states. Only Minnesota has established

“ Oftentimes, the mainstream service providers aren’t able to engage the highest risk, hardest to reach clients because they aren’t aware of the complex daily realities of their lives, and don’t take the complete situation of a client into account when creating treatment plans. We tend to see those clients falling through the cracks because their values and culture are not understood as a critical component to consider. CHWs help bridge that divide and create an enhanced continuum of care.”

JESSICA WALKER
EXECUTIVE DIRECTOR
AIDS Family Services, Buffalo, NY



¹ CHWs are called by many names, including case workers, community follow-up workers, community health advocates, community health advisers, community health aides, community health outreach workers, community health representatives, community health specialists, counselors, family health promoters, family support workers, health advisors, health facilitators, health information specialists, health promoters, health liaisons, health specialists, outreach workers, outreach specialists, patient navigators, peer counselors, peer educators, peer health advisors, peer health educators, peer workers, promotores/as, public health aides, public service aides, social worker assistants, addiction treatment specialists, HIV/AIDS educators, HIV/STD prevention counselors, HIV risk assessment/disclosure counselors, mental health aides, nutrition assistants, pre-perinatal health specialists, volunteers, women’s health specialists.

Executive Summary (continued)

a financing stream, including Medicaid reimbursement, to sustain CHWs statewide regardless of the health-specific focus of their work.

The New York State Health Foundation (NYSHealth) is investing in a statewide CHW initiative in partnership with CHWs statewide, the Community Health Worker Network of NYC, the Community Health Worker Association of Rochester, and the Heilbrunn Department of Population and Family Health in the Mailman School of Public Health at Columbia University. The goal of the initiative is to establish sustainable financing for the CHW workforce in New York State. The objectives of the initiative are to:

- ▶ Establish core competencies and a standard scope of practice for CHWs;
- ▶ Implement a statewide training and certification process for CHWs; and
- ▶ Identify and secure stable financing streams and mechanisms for CHWs.

The purpose of this report is to provide background to this important CHW initiative. In it we summarize the state of the CHW field, illustrate the emerging evidence supporting use of CHWs, and highlight opportunities to advance the field in New York.

“ I have been in and out of the hospital. She (the CHW) was the first to come to my home. There’s a connection. She listens and she’s there, always comes prepared and with the little packages. ”

CHW CLIENT



Introduction

HISTORY OF COMMUNITY HEALTH WORKERS

CHWs first emerged more than 300 years ago when particular members of communities—“natural helpers”—assumed the role of helping other community members with health-related issues.^{2,3,4} In the 1950s, a few studies described community-based outreach and education programs by CHWs. During the 1960s and early 1970s, CHWs were primarily deployed in low-income communities to address poverty-related issues, such as linking community residents to employment and education opportunities. Beginning in 1973 through 1989 there was an increase in funding, evaluation, and published studies of CHW projects. In the 1990s, the need to standardize training for CHWs received greater recognition and numerous CHW-related bills were introduced at the national and state levels, although none passed. In the 2000s, legislation was introduced in several states and many passed. A Patient Navigator bill was signed into law as a major piece of legislation at the Federal level addressing CHW activities.⁵ The 2007 National Workforce Study of CHWs conducted by the Bureau of Health Professions of the Health Resources and Services Administration estimated that there were approximately 120,000 CHWs working in the United States as of 2005, including an estimated 11,000 CHWs in New York.⁶

EVIDENCE FOR COMMUNITY HEALTH WORKERS

The evidence base for CHWs is growing.⁷ An emerging body of research shows that CHWs can improve health outcomes, address health and health care disparities, and reduce health care costs by helping vulnerable and underserved populations access and navigate fragmented health and social services, make positive changes in their behaviors, and adhere to complicated treatment regimens.^{8, 9, 10, 11, 12, 13, 14, 15, 16} For example,

“CHWs are frontline workers who work directly with the patient and advocate extensively on behalf of the patient. A CHW has the ability to connect with people and is the link between the patient and the health care provider. They allow our organization to reach the minority HIV/AIDS community because we are all from the community, we look like our clients, and we can relate to them.”

LUCIA COLINDRES-VASQUEZ

CHW AND ASSOCIATE DIRECTOR
OF PREVENTION SERVICES
AIDS Community Health Center of Rochester
Rochester, NY

² Rosenthal E.L., Wiggins N., Brownstein J.N., et al. “The Final Report of the National Community Health Advisor Study: Weaving the Future.” Tucson, AZ: University of Arizona, 1998.

³ Fendall N.R.E. “The Barefoot Doctors: Health Workers in the Front Line.” *The Round Table: The Commonwealth Journal of International Affairs* 264. 1976:361-9.

⁴ Perez, L & Martinez, J. “Community Health Workers: Social Justice and Policy Advocates for Community Health and Well-Being.” *American Journal of Public Health*, 98, 1:11-14, 2008

⁵ U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Professions, “Community Health Worker National Workforce Study,” U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Professions Web site, <http://bhpr.hrsa.gov/healthworkforce/chw/default.htm>, accessed May 10, 2010.

⁶ Ibid.

⁷ Viswanathan M., Kraschnewski J., Nishikawa B., et al. “Outcomes of Community Health Worker Interventions.” Evidence Report/Technology Assessment No. 181 [Prepared by the RTI International—University of North Carolina Evidence-based Practice Center under Contract No. 290 2007 10056 I.] AHRQ Publication No. 09-E014. Rockville, MD: Agency for Healthcare Research and Quality. June 2009.

⁸ Office of Management and Budget. Federal Register. January 21, 2009; 74(12):3923.

⁹ Rosenthal E.L., Wiggins N., Brownstein J.N., et al. “The Final Report of the National Community Health Advisor Study: Weaving the Future.” A policy research project of the University of Arizona funded by the Annie E. Casey Foundation. University of Arizona, 1998.

¹⁰ Allen J.K., Scott L.B. “Alternative Models in the Delivery of Primary and Secondary Prevention Programs,” *Journal of Cardiovascular Nursing* 18, no 2 (2003):150-156.

¹¹ Becker D.M., Yanek L.R., Johnson W.R., Jr., et al. “Impact of a community-based multiple risk factor intervention on cardiovascular risks in black families with a history of premature coronary disease,” *Circulation* 111, no 10 (March 15, 2005):1298-1304.

¹² Perez, M., Findley, SE., Mejia, M., Martinez J., [2006]. The Impact of Community Health Worker Training and Programs in New York City. *Journal of Health Care for the Poor and Underserved* 17.1 Supplement 26-43.

¹³ Brownstein J.N., Bone L.R., Dennison C.R., et al. “Community Health Workers as Interventionists in the Prevention and Control of Heart Disease and Stroke,” *American Journal of Preventative Medicine* 29, no 5S1 (2005): 128-133.

¹⁴ Brownstein J.N., Chowdhury F.M., Norris S.L., et al. “Effectiveness of Community Health Workers in the Care of People with Hypertension,” *American Journal of Preventative Medicine* 32, no 5 (2007): 435-447.

¹⁵ Hill M.N., Han H.R., Dennison C.R., et al. “Hypertension Care and Control in Underserved Urban African American Men: Behavioral and Physiologic Outcomes at 36 Months,” *American Journal of Hypertension* 16, no 11 (2003): 906-13.

¹⁶ Lewis S., Dick J., Pond P., et al. “Lay Community Health Workers in Primary and Community Health Care,” *Cochrane Database of Systematic Reviews* 1, (2005): CD004015.



Introduction (continued)

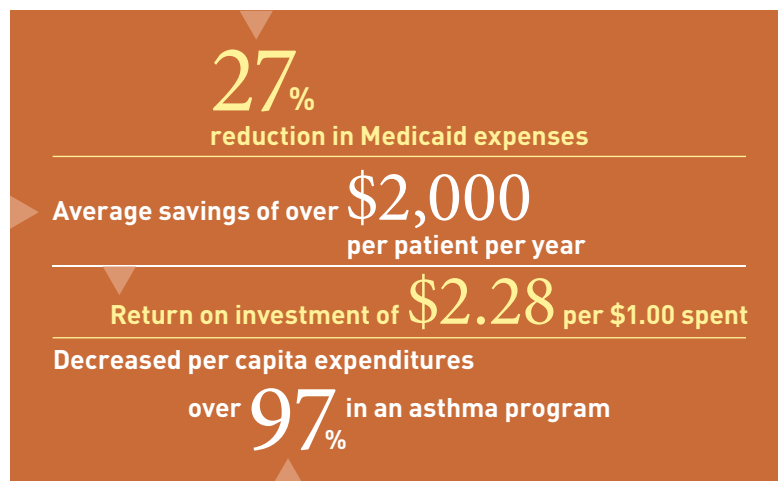
a number of studies of CHW programs have shown significant improvements in patients' use of prevention services, such as mammography and cervical cancer screenings among low-income and immigrant women.^{17, 18, 19, 20, 21} A randomized controlled trial of a CHW intervention to increase insurance coverage 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 to children in the control group.²² Other studies also have shown that CHWs increased healthy food choices and increased physical activity among patients with diabetes,²³ and clinical outcomes for diabetes, such as decreased A1C levels.²⁴

In addition to improved health outcomes, CHWs contribute to reducing health care costs by decreasing unnecessary or avoidable emergency department (ED) utilization²⁵ and hospitalizations. An evaluation of

“ CHWs worked as part of a team to help women who were pregnant and for five years after they gave birth. They were part of the care planning meetings with nurses, dieticians, and diabetes educators, and they helped keep patients on track. A dietician would give the patients nutrition counseling and CHWs helped patients follow up nutrition issues and helped them get to appointments and with parenting. CHWs can get into homes, which the other team members could not. They got to know the patients better because they could see where they were coming from and what they need. CHWs were able to develop trust and connect with patients. The position was so important because they can devote time to people to encourage them and follow up. ”

KERRY MIHALKO

FORMER CHW SUPERVISOR
AT CHAUTAUQUA OPPORTUNITIES, INC.
Chautauqua County, New York



¹⁷ Anderson M.R., et al. The Effectiveness of Mammography Promotion by Volunteers in Rural Communities. *American Journal of Preventive Medicine* 18, no 3 (2000): 199-207.

¹⁸ Crump, S.R., et al. "Abnormal Mammogram Follow-Up: Do Community Lay Health Advocates Make a Difference?" *Health Promotion Practice* 9, no 2 (2008): 140-148.

¹⁹ Mock J, et al. "Effective Lay Health Worker Outreach and Media-Based Education for Promoting Cervical Cancer Screening Among Vietnamese American Women," *American Journal of Public Health* 97, no 9 (2007): 1693-1700.

²⁰ Weber B.E., Reilly B.M. "Enhancing Mammography Use in the Inner City: Randomized Trial of Intensive Case Management," *Archives of Internal Medicine* 157, no 20 (1997): 2345-2349.

²¹ Martinez, J., Frye, L., & Perez L., Community Health Workers in the Black Community: Building Trust, Alleviating Pain, and Improving Health Access. Health Issues in the Black Community San Francisco: Jossey-Bass, 2009.

²² Flores G., et al. "A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children," *Pediatrics* 116, no 6 (2005): 1433-1441.

²³ Babamoto K., et al. "Improving Diabetes Care and Health Measures Among Hispanics Using Community Health Workers: Results from a Randomized, Controlled Trial," *Health Education and Behavior* 36, no 113 (2009): 113-126.

²⁴ Gary T.L., et al. "Randomized Controlled Trial of the Effects of Nurse Case Manager and Community Health Worker Interventions on Risk Factors for Diabetes Related Complications in Urban African Americans," *Preventive Medicine* 37, no 1 (2003): 23-32.

²⁵ Michelen, W., Martinez, J., Lee, A., & Wheeler, D. P. "Reducing Frequent Flyer Emergency Department Visits." *Journal of Health Care for the Poor and Underserved*, 17: 59-69. 2006.

Introduction (continued)

the impact of CHWs on health care utilization of African-American Medicaid patients in Maryland with diabetes with or without hypertension showed a 40% reduction in ED visits, a 33% reduction in ED admissions to hospitals, a 33% reduction in total hospital admissions, and a 27% decrease in Medicaid reimbursements. The CHW program produced an average savings of \$2,245 per patient per year and a total savings of \$262,080 for 117 patients.²⁶ A CHW intervention among underserved men in Denver, Colorado found that the CHW intervention shifted care from costly inpatient and urgent care to primary care services. This shift resulted in a return on investment of \$2.28 per \$1 spent on the community-based intervention for a total savings of \$95,941 per year.²⁷ Another evaluation of a community-based asthma management program showed a decrease in per capita expenditures from \$735 to \$18 (a 97.6% reduction), a reduction in ED visits from 60 to 10 (an 83.3% reduction) and an overall reduction in asthma-related visits from 1.5 to 0.25 per person after the CHW intervention.²⁸



²⁶ Fedder D.O., et al. "The Effectiveness of a Community Health Worker Outreach Program on Healthcare Utilization of West Baltimore City Medicaid Patients with Diabetes, With or Without Hypertension," *Ethnicity and Disease* 13, no 1 (2003): 22-7.

²⁷ Whitley E.M., et al. "Measuring Return on Investment of Outreach By Community Health Workers," *Journal of Health Care for the Poor and Underserved* 17, no 1 (2006): 6-15.

²⁸ Beckham S., Kaahaaina D., Voloch K.A., Washburn A. "A Community-Based Asthma Management Program: Effects on Resource Utilization and Quality Of Life," *Hawaii Medical Journal* 63, no 4 (April 2004): 121-126.

NATIONAL SUPPORT FOR COMMUNITY HEALTH WORKERS

American Public Health Association (APHA)

APHA has had a CHW Special Primary Interest Group for over 20 years. In 2009 APHA recognized this group by accepting them as the CHW Section. In 2009, APHA also issued a policy statement titled “Support for Community Health Workers to Increase Health Access and to Reduce Inequities” (Policy Number 20091).

Centers for Disease Control and Prevention (CDC)

The CDC has provided leadership in documenting and acknowledging the role of CHWs. CDC’s Division of Diabetes Translation report titled *Community Health Workers/Promotores de Salud: Critical Connections in Communities* stated “Across the scope of CDC’s diabetes programs, many ties link communities to health care systems through which runs a common thread—including and honoring the advocacy and teaching skills of community members in the role of CHWs.”²⁹

Department of Labor (DOL)

In its publication of the 2010 Standard Occupation Classification revisions for the Department of Labor, the Executive Office of the President included a unique occupational classification for Community Health Workers,³⁰ which will be used in the 2010 census.

Health Resources and Services Administration (HRSA)

HRSA has a history of supporting the role of CHWs. HRSA funded the Community Health Workers National Workforce Study, a comprehensive national study of the CHW workforce released in 2007 and funds a national Patient Navigator program. HRSA mandates that all of its Area Health Education Centers use CHWs for outreach to community members.

Institute of Medicine (IOM)

In its 2002 report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, IOM recognized that CHWs “offer promise as a community-based resource to increase racial and ethnic minorities’ access to health care and to serve as a liaison between healthcare providers and the communities they serve.” The report also asserts that CHWs are effective as, “a strategy for improving care delivery, implementing secondary prevention strategies, and enhancing risk reduction” and recommends integrating trained CHWs into multidisciplinary health care teams.³¹ In its 2010 report *A Population-Based Policy and Systems Change Approach to Prevent and Control Hypertension*, the IOM recommends the CDC Division for Heart Disease and Stroke Prevention (DHDSP) should explore ways to make increased use of community health workers.³²

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²⁹ Centers for Disease Control and Prevention. Community Health Workers/Promotores de Salud: Critical Connections in Communities. Retrieved from <http://www.cdc.gov/diabetes/projects/comm.htm>, accessed April 29, 2010.

³⁰ Office of Management and Budget. Federal Register. January 21, 2009; 74(12):3923.

³¹ Snidely B.D., Stith A.Y., Nelson A.R., eds. “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” (Washington, DC: Institute of Medicine, 2002), p.17-18.

³² Institute of Medicine, A Population-Based Policy and Systems Change Approach to Prevent and Control Hypertension. Institute of Medicine Web site, <http://www.iom.edu/Reports/2010/A-Population-Based-Policy-and-Systems-Change-Approach-to-Prevent-and-Control-Hypertension/Report-Brief-Prevent-and-Control-Hypertension.aspx>, accessed May 10, 2010.

NATIONAL SUPPORT FOR COMMUNITY HEALTH WORKERS

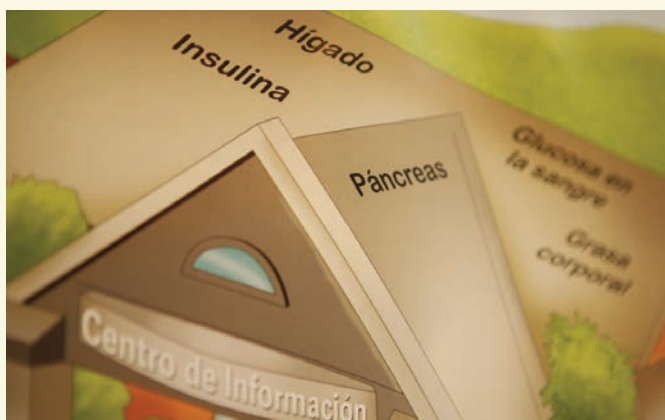
National Heart, Lung and Blood Institute (NHLBI)

In its Hypertension Awareness and Control Programs, NHLBI recommends a strategy of training and using CHWs as: 1) trainers of others; 2) to educate community members; and 3) to work as a member of a health care team to help improve adherence to clinical and educational recommendations.

United States Congress

The newly enacted Patient Protection and Affordable Care Law, defines CHWs as members of the “Health Care Workforce” and lists CHWs as “Health Professionals.” In addition, the law determines that funds granted under sec. 399V, subsection (a) shall be used to support CHWs to provide outreach, promote positive health behaviors, support enrollment in health insurance, identify and enroll underserved populations to appropriate health care agencies and community-based programs, and provide home visitation services regarding maternal health and prenatal care. Funding for the use of CHWs in underserved communities through the CDC also was included.

The use of CHWs has been promoted by numerous other state and national agencies and organizations, including Aetna, the American Association of Diabetes Educators, American Diabetes Association, American Heart Association, American Hospital Association, American Medical Association, American Nurses Association, National Coalition of Ethnic Minority Nursing Organizations, National Conference of State Legislatures, New York State Department of Health.



“ I came to the US about 17 years ago. I spoke no English and had no money. I worked at a factory 13 hours a day for almost nothing and tried to learn English. I spent the next two years trying to learn new skills and figuring out how to access health and social services in a new country. Finally, I met a CHW who showed me how to navigate and receive the services I needed. I wanted to help other people the same way she helped me. I volunteered as a CHW for two years. I tutored disabled Spanish-speaking children learning English at the library. Then I found a job at an agency helping people get jobs. I worked there for five years helping community members learn the rules of the game. This is a job but I get to help people. That’s amazing! Now I supervise eight CHWs, and I look for that passion when I am hiring new CHWs.”



ROMELIA CORVACHO

CHW SUPERVISOR
Bronx-Lebanon Hospital Center, New York, NY

Key Issues for Standardizing The Community Health Worker Field

DEFINING COMMUNITY HEALTH WORKERS

In 2006, the Community Health Worker Section (CHW Section) of the American Public Health Association, working with CHWs and their advocates from across the country, submitted a request for a Community Health Worker classification to the Bureau of Labor Statistics for inclusion in the Department of Labor 2010 Standard Occupation Classification revision. The request was approved, and in January 2009, the Executive Office of the President's Office of Management and Budget published the 2010 Standard Occupational Classifications (SOC) with a unique occupational classification for Community Health Workers (SOC 21-1094).³³ The CHW SOC is part of the 2010 census, which will enable a more accurate count of the CHW workforce. The CHW definition (APHA-CHW Section) is as follows:

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.

Many CHW definitions, including the one approved for the 2010 SOC revisions, are based on the seven roles of CHWs as identified in the 1998 National Community Health Advisor Study.³⁴ These roles are:

- ▶ Bridging/cultural mediation between communities and health and social service systems
- ▶ Providing culturally appropriate health education and information
- ▶ Assuring people get health and social/economic services they need
- ▶ Providing informal counseling and social support
- ▶ Advocating for individual and community needs
- ▶ Providing direct service, such as basic first aid and administering health screening tests
- ▶ Building individual and community empowerment capacity

CHWs also play other important roles, including:

- ▶ Community organizing and advocacy for social justice and equality

“Community health workers are best capable to do primary prevention. We should take their capacity and strengthen it and make them do what they do better. A patient may not tell me he is depressed because his best friend died and he is 26 and doesn't want to admit that he's depressed because it makes him less of a man. But he would tell a community health worker that.”

KATHLEEN T. GRIMM

CO-DIVISION CHIEF
University Internal Medicine/Pediatrics,
SUNY Buffalo,
Buffalo, NY

³³ Office of Management and Budget. Federal Register. January 21, 2009; 74(12):3923.

³⁴ Rosenthal E.L., Wiggins N., Brownstein J.N., et al. "The Final Report of the National Community Health Advisor Study: Weaving the Future." Tucson, AZ: University of Arizona, 1998.

Key Issues for Standardizing The Community Health Worker Field (continued)

- ▶ Helping patients and community members navigate complex health and social service systems and understand and manage their conditions
- ▶ Conducting outreach to difficult-to-reach populations
- ▶ Supporting or leading prevention efforts
- ▶ Coordinating care for people with specific diseases and conditions, such as diabetes, asthma, pregnancy, and HIV/AIDS
- ▶ Facilitating enrollment in health coverage programs
- ▶ Helping people address broader cultural, environmental, and lifestyle issues that impact their health

Critical Roles for CHWs in the Changing Health Care Delivery System

The health care landscape is in the midst of tremendous transformation. With those changes has come greater recognition that the U.S. needs a better way to deliver health care, one that produces better outcomes for patients. The Patient-Centered Medical Home (PCMH) has emerged as the predominant model for improving the delivery system. The PCMH model indicates that it takes a team of professionals and others to offer and coordinate the precise care and services that a patient needs. Because of their unique roles as bridges between health care and community-based services, CHWs can be vital members of PCMH teams. A number of PCMH pilots across the country have already incorporated CHWs into their teams.

DETERMINING THE TRAINING AND CERTIFICATION STANDARDS FOR COMMUNITY HEALTH WORKERS

Currently, there are no national or New York standards for CHW training or certification, although 17 other states have some form of training or certification program. This lack of standardization in New York creates fragmentation in the CHW field and inhibits sustainable financing. There are several issues that must be addressed in order to establish standards.

Training

CHWs require specific training that enables them to play their multifaceted roles. The success of CHWs is based on attributes they bring to their work that make them unique and effective, including their leadership as “natural helpers,” abilities as community liaisons, and the trust they instill in their peers. Therefore, CHW training must build upon these strengths while still ensuring that CHWs acquire expertise in a set of core competencies that include but transcend knowledge and technical expertise on health and health care. Recommended core competencies include:

- ▶ Communication skills – verbal and non-verbal, observation, documentation, negotiation, and conflict resolution

“ CHWs have the power to make changes in people’s lives for the collective empowerment of communities. But the role of CHWs is more than what people think. In order to promote democracy and human rights, people’s basic needs have to be addressed. If I am sick, I will not care about the outcome of elections. People have to be healthy and well fed and well housed. Their basic needs have to be met in order for them to fully participate in a real democracy and to make it a functional democracy. CHWs help meet those needs.”

BAKARY TANDIA

CHW, AFRICAN SERVICES COMMITTEE
New York, NY



Key Issues for Standardizing The Community Health Worker Field (*continued*)

- ▶ Interpersonal skills—relationship-building, trust, empathy, compassion, and personal and professional boundaries
- ▶ Informal counseling—behavior change, goal setting, maintenance and relapse prevention, and disease management
- ▶ Service coordination skills—home visiting, system navigation, linking to services, and case management
- ▶ Capacity-building skills—strength-based approach, community organizing, and individual and community empowerment
- ▶ Advocacy skills—health and social service systems
- ▶ Technical skills—adult learning, pedagogy, facilitation, and group presentations
- ▶ Organizational skills—identifying strengths, planning, outreach, time management, prioritizing, and safety

Rather than promoting a single standard curriculum, we will work with CHWs and stakeholders to develop statewide curricula standards for New York. In that way, different certifying entities could use their existing resources to meet the standards. CHWs recognize the individual and organizational maturity required of institutions to adapt to their specific training needs, both in content and methods, and are eager to advance a supportive relationship.³⁵ Standards also would help define the CHW profession and articulate a clear scope of practice compared with other health and social service professions. This approach mirrors that of several cities and states, which have developed formal CHW training guidelines that are linked with certification.

Certification

In addition to establishing standards for CHW training, New York must establish some type of certification that verifies that individual CHWs have the knowledge, skills, and competencies required to be a CHW. This is essential for securing third-party reimbursement for CHWs, especially through State Medicaid, which requires some type of certification to apply for reimbursement. There are multiple options for certification, all of which will be explored through this initiative, including college-supported, community-based, legislative regulation, and self-regulation through a guild model.³⁶ In addition, there could be advanced or content-specific certifications as supplements to the basic certification, including chronic diseases, maternal health, violence prevention, prisoner reintegration, teen pregnancy interventions, sex-worker outreach, or substance use outreach.

“ I was first trained as a *promotora* as a teenager in Nicaragua. We were trained in popular education and focused on literacy but many other issues came up—health, food, housing, job issues. I saw that it worked, not only with literacy but with a lot of health issues. I saw that people learned and changed. When I moved to New York, I became a volunteer for a literacy program. Again, I saw the same dynamic. So many needs came up that I started making referrals. I became a CHW without even knowing what that meant. Empowerment came easy for me because I don’t have to make decisions *for* people. It’s a collaborative effort with families to help them move forward. ”

MARIA GUEVARA-FRIEDMAN

CHW PROGRAM DIRECTOR
Northern Manhattan Perinatal Partnership, Inc.
New York, NY

³⁵ Catalani, Caricia, Sally Findley, Sergio Matos and Romelia Rodriguez. 2009. “Community Health Worker Insights on Their Training and Certification.” *Progress in Community Health Partnerships: Research, Education, and Action*. 3(3), Fall: 201-212

³⁶ In a guild model, CHWs would join local CHW networks or associations that review their background, experience, and training and accept into the association only those passing the agreed upon statewide standards.

Key Issues for Standardizing The Community Health Worker Field (*continued*)

It is important, however, that the form and implementation of a formalized certification must be structured to avoid limiting the utility of the CHW model. By definition, CHWs come from a wide variety of cultural, societal, linguistic, and experiential backgrounds. Therefore, the certification process must be developed accordingly. There are many pitfalls to avoid. As examples:

- ▶ A certification test only offered in English would eliminate or hinder the certification of CHWs who, like the populations they serve, primarily or only speak languages other than English.
- ▶ An academic “testing” model would disadvantage those with limited experience taking tests or who have limited literacy.
- ▶ A certification that disallows individuals with criminal backgrounds would eliminate the certification of CHWs who are often the most effective with particular difficult-to-reach community members, such as substance users and sex workers.
- ▶ A certification that bars CHWs based on immigration status would exclude CHWs from certain immigrant communities becoming certified, including those from communities that suffer high burdens of poor health and health disparities and could benefit greatly from CHWs.
- ▶ A certification that requires extensive medical knowledge would limit the number of CHWs who could achieve certification, even though CHWs are not health care providers and, therefore, should not be required to possess the same level of knowledge as other health professionals.

LESSONS FROM OTHER STATES: CHWs Leading the Initiative

Based on the experience of other states, it is essential that CHWs play a leadership role in defining their scope of practice. When CHWs are engaged and lead efforts to define scope of practice, certification, and financing models, then the core elements of the field are not only captured they are also embraced by CHW practitioners and the communities they serve.

For example, in Texas an Advisory Committee was formed to establish the certification requirements. The Advisory Committee was heavily weighted toward professional and academic representatives. The certification requirements that were established were onerous and the costs of training were expensive. In addition, language and literacy barriers were not adequately addressed, and financial incentives or improved employment opportunities based on the credential were not offered. These issues prohibited the participation of a large cohort of existing CHWs throughout the state. The Texas CHW credentialing legislation was passed in 2001. As of 2007, the 13 certified training programs have produced approximately 500 certified CHWs in the state. Only half of those who obtain the credential get re-credentialed, indicating a low actual demand for the credential even among those who already have it.³⁷

³⁷ Harris A.M., McArthur K., Huang C., et al. “The Houston Community Health Worker Survey: Unanticipated Effects of Certification.” Proceedings from the Third International Community-University Exposition, Victoria, Canada May 2008, pp. 105-109.

Key Issues for Financing Community Health Workers

In New York, CHWs are financed through a patchwork of funding sources,³⁸ including operations or project budgets of State and local government agencies and departments, Medicaid and commercial health plans, community health centers, hospitals, community-based organizations, faith-based organizations, and employers. Most CHWs working in New York rely on multiple sources of funding and, in particular, time-limited, categorical contracts and grants from government agencies, foundations, and charitable organizations. Unlike Alaska and Minnesota, CHWs are not recognized as reimbursable providers and, therefore, are not directly paid for by third-party reimbursement. This reliance on “soft” funding creates instability in the field, contributes to high turnover and low wages, and leaves high need communities vulnerable to a loss of services and support.

CURRENT STATE FUNDING FOR COMMUNITY HEALTH WORKERS

The New York State Department of Health’s Bureau of Family and Community Health has a CHW program that offers CHW-support to communities with high rates of infant mortality, teen pregnancy and birth, and births to low-income women and single parent households and with low rates of prenatal care. Hospitals, county health departments, or community organizations request funding from the State to offer CHW programs, and the State supports training of the CHWs using a state-approved training program. CHWs provide outreach, education, referrals, follow up, case management, advocacy, and home visiting services. Currently, there are 23 State-funded programs in 19 counties.

The State Department of Health’s AIDS Institute has funded community health centers to support outreach to persons living with HIV/AIDS and to promote adherence to anti-retroviral therapy for those diagnosed as HIV positive. The CHW-led programs help people living with HIV/AIDS with various social and health issues. The AIDS Institute does not mandate any particular training, except for agencies seeking funding for their Community Follow-up Program, which requires that CHWs hired for the program take a training offered by private training programs.

“ Her communication skills and the way she cares not only for me but also my family. I consider her a family member. She talks to the entire family. She knows my sons. When she comes to my home, I feel she’s a part of the family.”

CHW CLIENT

MOVING FORWARD: NEW YORK STATE CHW FINANCING CONSIDERATIONS

There are several important considerations for developing financing for CHWs.

Compensating Appropriately

Although compensation will vary by geographic region, employment setting, program type, and level of certification, compensation needs to recognize the full value that CHWs provide to the communities they serve and the health care system. Various methods must be considered, including capitation, fee-for-service, and pay for performance as well as emerging payment structures for Patient-Centered Medical Homes and shared service models.

³⁸ Dower C., Know M., Linder C., O’Neil E. “Advancing Community Health Worker Practice and Utilization: The Focus on Financing,” (San Francisco: National Fund for Medical Education, 2006).

Key Issues for Financing Community Health Workers *(continued)*

Paying for Community-Based Work

As stated, CHWs do not easily fit into traditional health care reimbursement models. Much of their value lies in the work they do in communities and particularly the trust they earn as part of the communities they serve. Therefore, financing for CHWs must account for their unique roles and not be limited to services provided in clinical settings.

Supporting Development and Certification

It will be critical to establish funding streams for the ongoing development of the field and individual CHWs. In Texas, the cost of CHW training and certification was shifted from the employer to the individual CHW. This shift contributed to the low rates of certification. Funding needs to include financial support to CHWs for training, certifying, and re-certifying. This is particularly important in areas where there may be limited access to CHW services, such as rural communities.

Funding for Ongoing Evaluation of CHWs

In order to sustain the support for CHWs, their contribution needs to be consistently evaluated and communicated. Entities such as government agencies, foundations, and CHW employers should ensure that CHW programs are continuously evaluated for health and social outcomes, cost-effectiveness, and return-on-investment and share those findings broadly.

Linking Certification and Financing

Lessons from other CHW certification efforts in other states, such as Texas and Ohio, illustrate the importance of recognizing that financing does not automatically follow establishing statewide certification. Although both states have state-specific certifications, neither has achieved third-party reimbursement. For that reason, this initiative will work with payers to secure sustainable financing while developing and implementing a certification. This will ensure that a certification is developed that payers perceive as valuable enough for payment and that the funding mechanisms are in place to support the certification process when it is launched.

Embedding CHW Payment in New Payment Models

With the passage of federal health reform, a shift toward episodes of care payments, a frenzy of Patient-Centered Medical Homes efforts, and the advent of efforts to develop Accountable Care Organizations, New York and other states will continue to experiment with new payment models that support better quality care and outcomes. New York has already begun the implementation of Ambulatory Patient Groups, a new episode of care-based payment methodology for most Medicaid outpatient services. Grants under federal health reform will test additional quality-driven payment methods. Because CHWs play an important role in achieving positive health outcomes, it is critical that CHWs and their roles be included as these new payment methods are being developed and implemented.



Key Issues for Financing Community Health Workers (*continued*)

COMMUNITY HEALTH WORKER PROGRAMS IN OTHER STATES

Currently, 17 states have some type of CHW standards: Alaska, Arizona, California, Connecticut, Florida, Indiana, Kentucky, Massachusetts, Mississippi, North Carolina, New Mexico, Nevada, Ohio, Oregon, Texas, Virginia, and West Virginia. Only Minnesota and Texas have state certification for all CHWs. The CHW programs in the remaining 15 states are population- and health condition-specific or are not statewide.^{39, 40, 41, 42}

EXAMPLES OF OTHER STATES' CHW STANDARDS

MINNESOTA: The Minnesota CHW training and certification process was developed by a coalition of stakeholders, including representatives of CHWs, academia, and the health-care industry.

Through this coalition, Minnesota defined a standard CHW scope of practice, developed a statewide standardized curriculum, and identified standards and competencies related to protocols for CHW reimbursement. CHWs receive a certificate upon completion of the curriculum, which qualifies them to enroll as providers under the Medicaid program.⁴³ Based on the recommendations from this process, in 2007 the state legislature authorized the direct reimbursement of CHW services, including home visiting and health education.⁴⁴

TEXAS: In 2001, Texas implemented a system of credentialing CHWs. The credential is voluntary for CHWs who do not receive compensation for their services and mandatory for those who are financially compensated for the services they provide. The credentialing was based on eight areas of "core competencies" identified in the 1998 National Community Health Advisor Study. Applicants for credential must demonstrate that they have successfully completed an approved training program or equivalent experience. CHWs must complete a required 20 hours of continuing education and must renew every two years. There is no fee for either the original application or for renewal. In May 2001, the Texas Health and Human Services Commission began requiring health and human services agencies to use certified CHWs "to the extent possible" in health outreach and education programs to residents on medical assistance.

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³⁹ Harris A.M., McArthur K., Huang C., et al. "The Houston Community Health Worker Survey: Unanticipated Effects of Certification." Proceedings from the Third International Community-University Exposition, Victoria, Canada May 2008, pp. 105-109.

⁴⁰ May M., Kash B., Contreras R. "Community Health Worker (CHW) Certification and Training: A National Survey of Regionally and State-Based Programs," Southwest Rural Health Research Center Web site, http://srph.tamhsc.edu/centers/srhrcc/PDF/CHW_cert_final.pdf, accessed May 11, 2010.

⁴¹ Community Health Worker National Educational Collaborative. "Key Conditions for Opening Doors: Developing Community Health Worker Education Programs," Community Health Worker National Educational Collaborative Web site, <http://www.chw-nec.org/pdf/guidebook.pdf>, accessed May 6, 2010.

⁴² Goodwin K., Tobler L. "Community Health Workers: Expanding the Scope of the Health Care Delivery System." Proceedings from the National Conference of State Legislatures, April 2008.

⁴³ Willaert A. "Minnesota Community Health Worker Workforce Analysis: Summary of Findings for Minneapolis and St. Paul," [Mankato, MN: Healthcare Education Industry Partnership, 2005].

⁴⁴ Minnesota Statutes of 2007, Section 32 Supplement Section 256B.0625 Subdivision 49, <http://www.mnchwinstute.org/MNCHWLegislation.asp>, accessed May 11, 2010.

Key Issues for Financing Community Health Workers (*continued*)

COMMUNITY HEALTH WORKER PROGRAMS IN OTHER STATES

EXAMPLES OF OTHER STATES' CHW STANDARDS (*continued*):

KENTUCKY: Started in 1994, the statewide Kentucky Homeplace Program is operated by the University of Kentucky and provides training and supervision for 35 CHWs who work with underserved families in 58 predominantly rural counties. The program includes rigorous screening to hire local residents who understand the difficulties of obtaining care in rural Kentucky. CHWs are trained using a 140 hour curriculum, starting with two weeks of intensive training followed by additional training after starting work.^{45, 46}

ALASKA: Alaska created two health service-specific certification programs: Community Health Aide/Practitioner and Dental Health Aide/Practitioner certifications. These programs provide basic care in remote villages under medical and dental supervision, including management of some prescription drugs. The training requires 520 hours of instruction and is more clinical in nature since the practitioners provide more direct clinical care than typical CHWs.

INDIANA: In 1994, the Indiana Medicaid Program authorized trained and supervised CHWs to be reimbursed for home visits to high-risk pregnant women. The State health department created its own curriculum, and certification is awarded upon completion of an approved training program that adheres to that curriculum. Trainers were required to be State-certified registered nurse care coordinators.

MASSACHUSETTS: With leadership from the Massachusetts Association of Community Health Workers, the State legislature recognized the contribution of CHWs by including CHWs in its health reform law. Section 110 of Chapter 58 of the Acts of 2006 required the Massachusetts Department of Public Health to conduct a workforce study and to develop recommendations for a sustainable CHW program for the Commonwealth, which were released in January 2010. Recognizing the importance of CHW leadership, the law mandated inclusion of CHWs on the Community Health Worker Advisory Council that was responsible for the study. CHWs also were integrated into wellness programs and initiatives, chronic disease management programs, and health insurance outreach and enrollment programs.⁴⁷ 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, and the Massachusetts legislature is currently considering a bill to establish a board of certification for CHWs.⁴⁸

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⁴⁵ Goodwin K., Tobler L. "Community Health Workers: Expanding the Scope of the Health Care Delivery System." Proceedings from the National Conference of State Legislatures, April 2008.

⁴⁶ Schoenberg, N., Campbell, K., Garrity, J., et al. "The Kentucky Homeplace Project: Family Health Care Advisers in Underserved Rural Communities," *Journal of Rural Health* 17, (2001): 179-186.

⁴⁷ Massachusetts Legislation, Chapter 58 of the Acts of 2006, "An Act Providing Access To Affordable, Quality, Accountable Health Care." Section 110, Section 104. <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>. Accessed December 31, 2009.

⁴⁸ Massachusetts Legislation, Chapter 1 of the Acts of 2007, "An Act Further Revising The Membership Of The Public Health Council." <http://www.mass.gov/legis/laws/seslaw07/sl070001.htm>. Accessed December 31, 2009.

Key Issues for Financing Community Health Workers (*continued*)

COMMUNITY HEALTH WORKER PROGRAMS IN OTHER STATES

EXAMPLES OF OTHER STATES' CHW STANDARDS (*continued*)

OHIO: In 2003, Ohio initiated a certification program that is regulated by the State Board of Nursing. A “certificate to practice” is awarded after completion of an approved training program. Training programs must include at least 100 hours of didactic instruction and 130 hours of clinical instruction, which may be done in a community-based setting. Ohio provides an “endorsement” of CHWs holding similar certifications from other states. CHWs renew their certification every two years and require 15 hours of continuing education and a \$35 fee.

POTENTIAL FOR FEDERAL FUNDING FOR COMMUNITY HEALTH WORKERS

There are several ways that the federal government is funding and promoting CHWs, including:

Federal Health Reform Initiatives:

- ▶ The Patient Protection and Affordable Care Act contains several provisions that directly include CHWs. The Law authorizes:
 - ▶ The creation of the National Health Care Workforce Commission. The provision includes CHWs in definition of health professionals. (Section 5101)
 - ▶ Awards through Centers for Disease Control and Prevention to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of CHWs. (Section 5313)⁴⁹
 - ▶ Area Health Education Centers to conduct and participate in interdisciplinary training that involves health professionals, including CHWs. (Section 5403)
- ▶ Although they do not mandate the use of CHWs, CHWs could play an important role in the implementation of the following provisions: Hospital Readmission Reduction (Section 3025) and Community Health Teams in Support of Patient-Centered Medical Homes (Section 3502)–

Centers for Medicare and Medicaid Services (CMS):

CMS has taken several steps to support the use of CHWs, including:

- ▶ Demonstration Projects to Promote Primary Care: Funding demonstration projects in 20 states help divert emergency room visitors to primary care. Most of the sites include CHWs in their projects.

⁴⁸ U.S. Congress, Affordable Health Care for America Act of 2010, P.L.: 111-148, Sec. 399V, Grants to Promote Positive Health Behaviors and Outcomes. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf, accessed June 25, 2010.

Key Issues for Financing Community Health Workers (continued)



- ▶ Every Diabetic Counts program: To assist Medicare beneficiaries in controlling their diabetes and improving their health, the CMS included the Every Diabetic Counts program in select Quality Improvement Organization Program's 9th Scope of Work Prevention. Under this funding, CHWs work with Certified Diabetes Educators to provide diabetes self-management education.
- ▶ Some states have received Medicaid waivers authorizing Medicaid payments for CHWs for certain programs and services.⁵⁰

State Children's Health Insurance Program (SCHIP): On February 4, 2009, President Obama added a CHW definition into the SCHIP reauthorization law and authorized the use of Medicaid funds for CHW programs to conduct outreach, enrollment, and retention activities.⁵¹

Health Resources and Services Administration (HRSA): Through the Patient Navigator Outreach and Chronic Disease Prevention Act of 2005,⁵² HRSA's Bureau of Health Professions has \$25 million for fiscal years 2006-2010 for a national Patient Navigator program. The federal health reform act reauthorized this program through 2015. This program provides support to health care providers each year and defined CHWs as the preferred model for Patient Navigator projects.⁵³

⁵⁰ Dower C., Know M., Linder C., O'Neil E. "Advancing Community Health Worker Practice and Utilization: The Focus on Financing," San Francisco: National Fund for Medical Education, 2006.

⁵¹ U.S. Congress, Children's Health Insurance Program Reauthorization Act of 2009. P.L.: 111-3. 123 Stat. 38. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ003.111.pdf%20%A0, accessed December 31, 2009.

⁵² U.S. Congress, Patient Navigator Outreach and Chronic Disease Prevention Act of 2005. P.L.: 109-18. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_public_laws&docid=f:publ018.109.pdf, accessed April 29, 2010.

⁵³ Community Health Worker Section Newsletter Winter 2009. American Public Health Association Web site, http://www.apha.org/membergroups/newsletters/spignewsletters/comm_work/winter09/default.htm#{E3327E60-F728-49D0-863D-E1ECEE9D9ED7}, accessed April 29, 2010.

Conclusion

The U.S. and New York are struggling to reorganize the health care system toward a more rational system that places patients at the center of their care; emphasizes pro-active preventive, primary, and community-based care; and produces quality outcomes for the patient and the overall system. This is in contrast to the current system that emphasizes reactive, clinically-based acute/“sickness” care and produces visit volume rather than health and wellness. Because of their unique roles as a community “insider” and as a bridge between communities and health care and social service systems, well trained and qualified CHWs are an important part of the solution to this challenge.

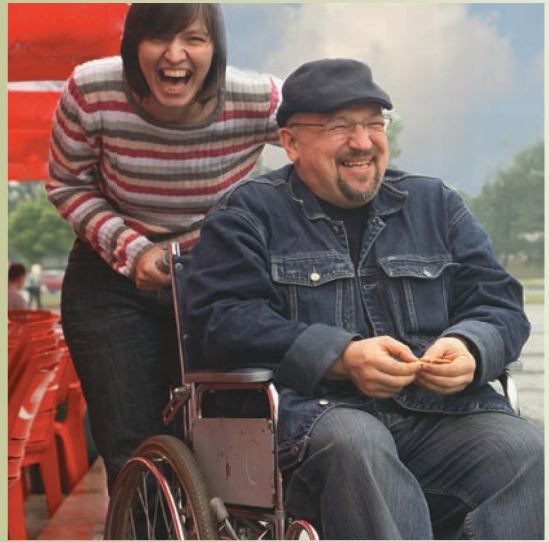
Several states have been exploring ways that CHWs can be established as a stable part of the health care team. New York has the opportunity to be a leader among other states to promote CHWs. Through this initiative and the tremendous efforts of CHWs and their supporters throughout the State, New York can emerge as one of the first states to not only develop standardized statewide certification that is embraced by CHWs, their employers, and payers, but to secure sustainable financing for this valuable workforce. That will position the State to meet the challenges before it and help create the system of health care that will help all New Yorkers live longer, healthier lives.

“To me, the CHW is the army we need to manage chronic disease, especially for those who are not in control. I think there is a huge fit for CHWs in secondary prevention perspective across all of our programs. Really, the Chronic Care Model supports activated people capable of managing their own conditions. I would think that the CHW is an essential part of the activated team that supports people to manage their own disease and engage with the health care system.”

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“I needed help with this problem [tooth decay];
and now I’m getting it. I have medicine and
appointments with a dentist.”

CHW Client