REGULATORY FRAMEWORKS FOR

COMMUNITY HEALTH WORKER PROGRAMS

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EXECUTIVE SUMMARY

Health reforms in recent years have opened up the door to greater use of Community Health Workers (CHWs) due to their role in working with higher-risk populations. CHWs have the ability to decrease costs and improve patient outcomes in the communities they serve. As a result, providers, payers, and state policymakers are taking steps to incorporate them into their health delivery systems.

For leaders seeking to bring CHWs into their organizations, twelve components have been identified that, when incorporated, can contribute to a successful program with positive outcomes.

For policymakers seeking to pave the way for greater CHW use, current state policies have been identified. Although each state's approach to CHW standards varies, there are some common themes and similarities across states. States that have enacted legislation regarding certification tend to have more requirements, such as supervision of CHWs and mandatory certification. There are other factors that vary across all states regardless of legislation, such as the hours required or administration of training. Some of the decisions policymakers will need make when developing standards include whether to require certification and the organization(s) that should create and administer the training.

PATIENT INTERACTION

Patient empowerment
Health education
Psychosocial intervention
Early intervention
Care coordination

ORGANIZATIONAL STRUCTURE

Training
Clinical oversight
Team participation
Evaluation

COMMUNITY RELATIONSHIPS

Link to community resources
Community bond
Workforce development

INTRODUCTION

The Community Health Worker (CHW) role is not a new concept; CHWs have been active both in the U.S. and around the world for more than six decades, increasing access to health care services.[1] However, the enactment of the Patient Protection and Affordable Care Act (ACA) and the establishment of the Triple Aim have sharpened the focus on CHWs as valuable partners in health care. Not only does the ACA define CHWs as members of the health care workforce, it also created many opportunities to integrate them into the delivery of care in order to improve population health and reduce health disparities. CHWs are able to help achieve the goals of the Triple Aim—to increase quality results and decrease the cost of care—by providing tailored support to high-cost, high-need patients. Providers, payers, and policymakers are increasingly becoming aware of the value CHWs provide and are taking steps to incorporate them into programs and legislation. A review of research reveals some key components that can lead to a successful CHW program as well as indicators that policymakers should consider.

WHAT IS A COMMUNITY HEALTH WORKER?

Community Health Workers (CHWs) are considered to be the "frontline public healthcare workforce" and the most versatile members of the health care community.[2] CHWs are most often found in underserved or underprivileged communities with health barriers spanning social, religious, language, cultural, value, and resource access issues. They are trusted and trained members of the community in which they live and serve to convey health messages, promote healthy behaviors, and increase the general health of the community. By creating a sense of familiarity, trust, and comfort with patients, they are able to provide support consistent with patients' values and needs and engender healthy behaviors.

Although the roles and functions of CHWs will vary based on location and setting, they generally fill non-clinical roles and often care for patients in programs for weight management and obesity, diabetes, cardiovascular health, smoking cessation, cancer, reproductive health, asthma, care navigation, psychosocial support, or self-management. They provide support with scheduling appointments, educating patients on disease-specific protocols and care management, addressing potential racial or ethnic barriers to care, providing minor emotional support, and linking patients with primary care physicians and community resources such as housing, meal preparation, transportation, or substance abuse treatment.

Many studies have shown that CHWs improve outcomes for patients with chronic conditions,[3] reduce 30-day hospital readmissions,[4] improve mental health,[4] increase linkages to primary care,[4] decrease hospital costs,[5] and increase patient and provider satisfaction.[6] Estimated health cost savings associated with CHWs range from $2.28 to $4.00 for every $1.00 spent.[7] These findings suggest that incorporating CHWs more fully into the delivery system could lead to both improved health and lower costs.

Community Health Workers

A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker 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.

A community health worker also builds 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."

- American Public Health Association
www.apha.org

BENDING THE COST CURVE

The Triple Aim established an industry-wide goal to improve the U.S. health care system by 1) improving the experience of care, 2) improving the health of populations, and 3) reducing per capita costs of health care.[8] Hospital readmissions are increasingly used as an indicator of health systems' quality, and they are also a significant cost driver. A study of pediatric hospitals between 2003 and 2008 found that nearly 20 percent of admissions and one quarter of inpatient expenditures were accounted for by a very small group of patients who were readmitted to the hospital at least four times within one year.[9] Most of these readmissions could have been avoided.

Many hospital readmissions are caused by lack of communication with patients and patient knowledge of appropriate follow-up care,[10] but mental health[11] and other psychosocial factors also influence preventable readmission rates. In addition, when tied to complicated medical conditions, factors such as race, ethnicity, language proficiency, age, socioeconomic status, place of residence, and disability may also be predictors of readmission risk.[12]

The Centers for Medicare and Medicaid Services (CMS) has identified eight essential strategies to prevent or reduce hospital readmissions for diverse populations, many of which are relevant for any population (See Figure 1).[12] Such services are typically outside the scope of work for traditional providers who generally lack the time, training, and community linkages to provide such support. However, CHWs are trained to provide these services and are well-positioned to assist in this role.

Figure 1: Essential strategies to prevent or reduce hospital readmissions in diverse populations

DISCHARGE AND CARE TRANSITIONS	PATIENT EDUCATION
• Provide support scheduling appointments • Communicate with patients about the importance of early follow-up	• Address cultural factors that may inhibit medical direction non-adherence, provide education on disease self-management • Facilitate trust with patients by demonstrating respect for culture and beliefs
LINK TO PRIMARY CARE	**SOCIAL DETERMINANTS**
• Provide referrals to primary care	• Link individuals to community resources such as housing, meal preparation, transportation or substance abuse treatment • Improve social support through family-centered care and health information technology
LANGUAGE BARRIERS	**MENTAL HEALTH**
• Interpret or assist with interpretation services	• Support and encourage coping mechanisms
HEALTH LITERACY	**CO-MORBIDITIES**
• Conduct screenings to ensure the providers are aware of the patient's level of literacy • Ensure educational materials and instructions are at a level of understanding	• Use multi-disciplinary disease management teams • Focus on the full spectrum of the patient's health

CHW MODEL FRAMEWORK

There are many variations of CHW models used in the U.S. and around the world. Because these models typically focus on a specific objective such as health promotion, care coordination, or health management, fundamental differences exist in their program designs. A number of papers have studied the effectiveness of CHWs and the programs in which they are placed, but little has been done to identify the core elements of an effective CHW program.[13] Nevertheless, a review of existing literature, including current program results and the Centers for Disease Control and Prevention (CDC) recommendations, reveals many important elements that contribute to an effective CHW program. Each element falls under three categories: patient interaction, organizational structure, and community relationships (See Figure 2). Each category represents critical high-level components that should be defined in all CHW programs.

Figure 2: CHW program categories and underlying elements

PATIENT INTERACTION

- Patient empowerment
- Health education
- Psychosocial intervention
- Early intervention
- Care coordination

ORGANIZATIONAL STRUCTURE

- Training
- Clinical oversight
- Team participation
- Evaluation

COMMUNITY RELATIONSHIPS

- Link to community resources
- Community bond
- Workforce development

Patient Interaction

The interaction between patient and CHW is the main driver of program success. It is the resulting patient outcomes from the CHW-patient relationship that determine whether the program is working. Some specific elements within the CHW scope of work that have demonstrated improvement in patient outcomes include patient empowerment, health education, psychosocial intervention, early intervention, and care coordination.

Patient Empowerment

For patients with chronic conditions, the ability to effectively self-manage their disease is very important. When taught techniques that allow them to problem-solve their conditions and manage potential issues, patients' confidence in their own care increases. Patients who are more knowledgeable, skilled, and confident about managing their care are much more likely to have better health outcomes and lower health care costs than patients who lack the confidence and skill.[14,15] One of the defining characteristics of a CHW is the ability to empower patients and engage them in their own care. Not only does it give the patients responsibility and accountability for health outcomes, it also prepares them to manage their own care after the end of the transition program.

HEALTH COACHING EMBODIES THE FAMILIAR ADAGE "GIVE A MAN A FISH, AND HE EATS FOR A DAY. TEACH A MAN TO FISH, AND HE EATS FOR A LIFETIME."

Source: American Academy of Family Physicians http://www.aafp.org/fpm/2010/0900/p24.html

Health Education

Health education is the vehicle to patient empowerment. While patient empowerment gives patients the tools and confidence to manage their conditions, education gives them the facts and knowledge about the condition, its symptoms, and triggers. It explains things clearly, in a culturally appropriate manner that helps patients understand how to access care, what their medication needs are, and how to monitor glucose or other levels

prior to making decisions about their care. Often times, education alone does not improve outcomes; however, when coupled with self-management and empowerment principles, results are more favorable.[16]

Psychosocial Factors

Literature has repeatedly shown evidence that social and environmental factors have an impact upon physical health and the ability of individuals to manage their health.[17] In addition, many associations have been made between mental health illness and chronic conditions.[18] Individuals with such challenges may not only be coping with anger, fear, frustration, and sadness of having a chronic condition, but also trying to balance other life stresses.

A story, recounted by Thomas Bodenheimer, MD in the *Journal of the American Medical Association*, tells of a patient with a history of obesity, diabetes, high blood pressure, and high cholesterol. He was also inconsistent at adhering to medical instructions. When attempting to improve compliance, the man was asked what he saw as his main problem. Instead of indicating a medical condition, the patient cited family challenges.[16] In order to improve health outcomes, sometimes individuals need to first address non-medical challenges. CHWs are trained to provide such support, offering coaching and helping patients access community resources that can assist them further.

Early Intervention

A smooth transition between care settings is critical to improving patient outcomes. Lack of communication and poor information exchange at the time of transition is often cited as one of the causes of adverse events shortly after discharge.[19,20] To mitigate such challenges and ensure a smooth hand-off, transitional care teams—including CHWs—should engage with the patient in the hospital well before discharge.

Once at home or in the community, patient outcomes increase if both in-person and telephonic follow-up is provided. Although a personal connection is formed through home visits, it is not necessary for all follow-up to occur in-person; research shows that interventions involving both in-person and telephonic follow-up result in the best outcomes.[21]

"[THE CHWs'] ROLE IS CRITICAL BECAUSE THEY HELP IMPLEMENT THE PATIENT'S HEALTH CARE PLAN, AND HELP PATIENTS BETTER UNDERSTAND THEIR CONDITIONS TO ACHIEVE A PATH OF GOOD HEALTH."

- Illinois State Representative Robyn Gabel

Source: http://bit.ly/29zu4Ne

Care Coordination

One of the barriers to a smooth care transition is coordination of care. A timely follow-up appointment can decrease the risk of re-hospitalization, but too often patients don't receive consistent follow-up care for multiple reasons. Either patients lack the transportation to get to their appointment, they don't understand the purpose of the appointment, or primary care physicians have little or no information about the patient's hospitalization.[22,23] In addition, individuals with chronic or complex conditions are often receiving care from multiple providers, increasing the complexity of coordination needs.

Care coordination provided by a CHW is an important element to bridging the gap after hospital discharge. CHWs can facilitate follow-up appointments and transportation when needed, support implementation of the patient's care plan, and effectively convey the patient's needs to licensed clinicians.

The use of technology can improve the quality of patient interventions and increase CHW performance and retention.[24] Assessment software allows CHWs to leverage the license of nursing supervisors to create care plans or monitor a patient's progress and risk of readmission. Organizations should consider giving CHWs access to EHRs, as it allows care teams to follow the progress of patients more easily and increase communication among team members.[25]

Organizational Structure

Although patient interaction is the driver of a successful CHW program, the foundation for success is created by ensuring CHWs have the tools and support needed for success. The program structure can create an optimal work environment that not only increases CHW productivity and job satisfaction, but also increases the effectiveness of the program and individual workers.[26]

Important structural elements include training, oversight, and team participation, and evaluation.

Training

To grow both personally and professionally and be an effective worker, CHWs should possess certain core skills. Not only should they be taught skills that apply across all populations, but also the skills that apply to the specific population being served. A comprehensive training program will clearly define the individual's role and ensure that the necessary skills have been taught and are ready to be applied in the care setting.

Training should also be provided to all staff and leadership within the organization to raise awareness of how CHWs fit into the operational and organizational structure. Such education can help all employees understand how best to utilize and work with CHWs, alleviating what many CHWs report as a barrier to becoming integrated into the organization.[1]

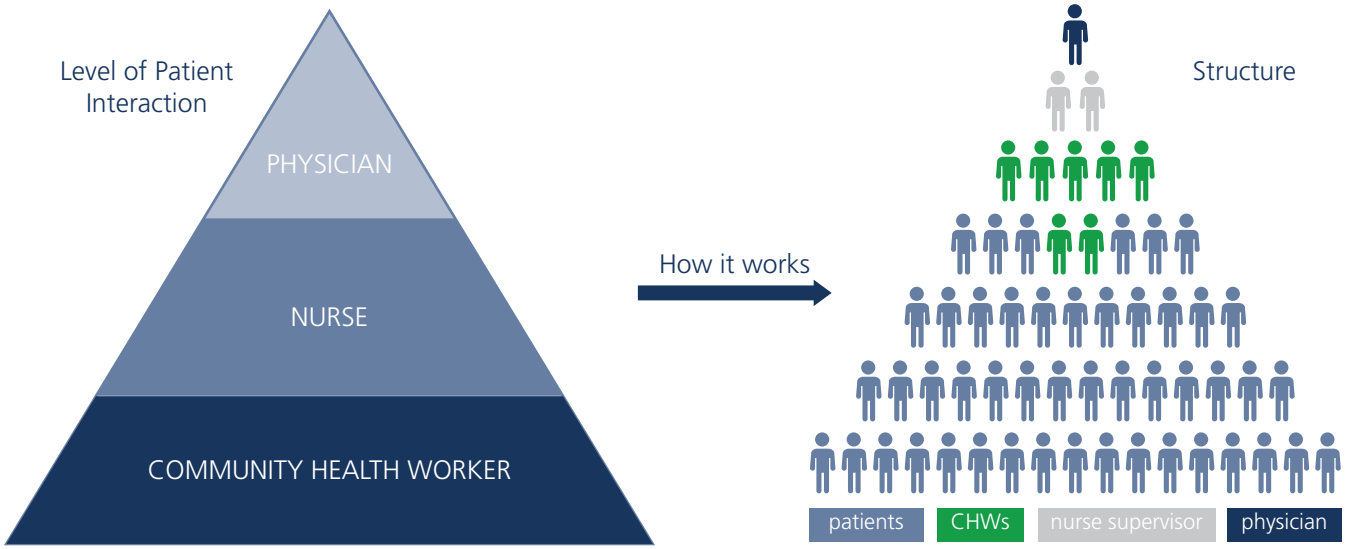
Team Participation

Team-based care is an effective model in which health professionals collaborate with the patient, family, and other care workers to achieve the patient's health goals. Each member of the team has a defined role and responsibility. CHWs are well-positioned to be a part of this care team due to their ground-level involvement with the patient's care. They can convey the patient's needs to the physician and provide motivation to the patient in carrying out the agreed-upon care plan. Such collaboration gives confidence to the CHW and demonstrates their role's value to all involved.

Clinical Oversight

As an important member of the care team, the CHW should also be supervised by a licensed health worker. Effective and supportive supervision increases morale and productivity as well as allows the physicians' and nursing supervisors' skills to be leveraged.[26] The supervisor can oversee the care of multiple patients through regular communication with CHWs. By monitoring and discussing patient progress, the supervisor can easily adjust the level of care if needed. As seen in Figure 3, patients receive the majority of quality interactions from the CHW who serves them with a greater level of support, a moderate amount from nurses who monitor the clinical outcomes, and physicians on an as-needed basis.

Figure 3: Licensed clinician leverage through CHW oversight



Evaluation

Because each organization has unique needs and circumstances, an evaluation component is important to a CHW program. In order to determine best practices and make necessary adjustments, there must be a way to determine how well the program is working and where improvement is needed.

Community Relationships

The CHW's unique connection to the community is unmatched by other health care workers. Such connections allow CHWs to provide more effective care to the populations they serve.

Link to Community Resources

One of the most essential functions of CHWs is to connect patients to available community resources, such as housing, meal preparation, transportation, substance abuse support, and other resources. These are often the resources that patients lack, and by connecting to available community assets, CHWs further enable them to remain in their homes and out of the hospital. CHWs serve as a liaison between communities and health and social service systems, and can thus help build community capacity and advocate to fill gaps in community needs.

Community Bond

The ability to connect on a deeper level with patients is another characteristic that makes CHWs valuable. When they come from a common background, CHWs are able to understand the challenges and barriers to improved health, and as such gain a greater level of trust with the patients. This "common bond" model has been implemented in many countries, and has proven to be effective in making broad community changes.

For example, in Jamkhed, India, village health workers—common villagers with low levels of education, but still very capable—were able to impact the belief system of the community and persuade community members to alter behaviors and take greater responsibility for their health. Within three years, the health of the whole community began to improve. While Jamkehed provides an extreme example, similar principles apply in the context of American sub-cultures. When patients and health workers are able to relate to one another, trust and influence grows stronger—enabling CHWs to have a greater impact on patient outcomes.

Workforce Development

CHWs programs often provide a mechanism for workforce development that has far reaching effects on the individual worker and the health care sector overall.

Since December of 2012 Temple University has been graduating CHWs from a formal training program sponsored by the university. The median annual income of the first graduating class before the program was $9,000. After graduation, students averaged $35,000 annually in addition to full time benefits packages.[27] Today, the Bureau of Labor Statistics reports that 80% of CHWs earn between $22,570 and $62,880 per year.[28]

Additionally, CHWs are encouraged to remain active in their careers through continuing education and networking events. The sense of community with similar associates provides an external source of support, further increasing job satisfaction.[1] Increased interest and involvement in health care may also prepare workers for future careers as health care professionals.

CHW REGULATION AND CERTIFICATION CONSIDERATIONS

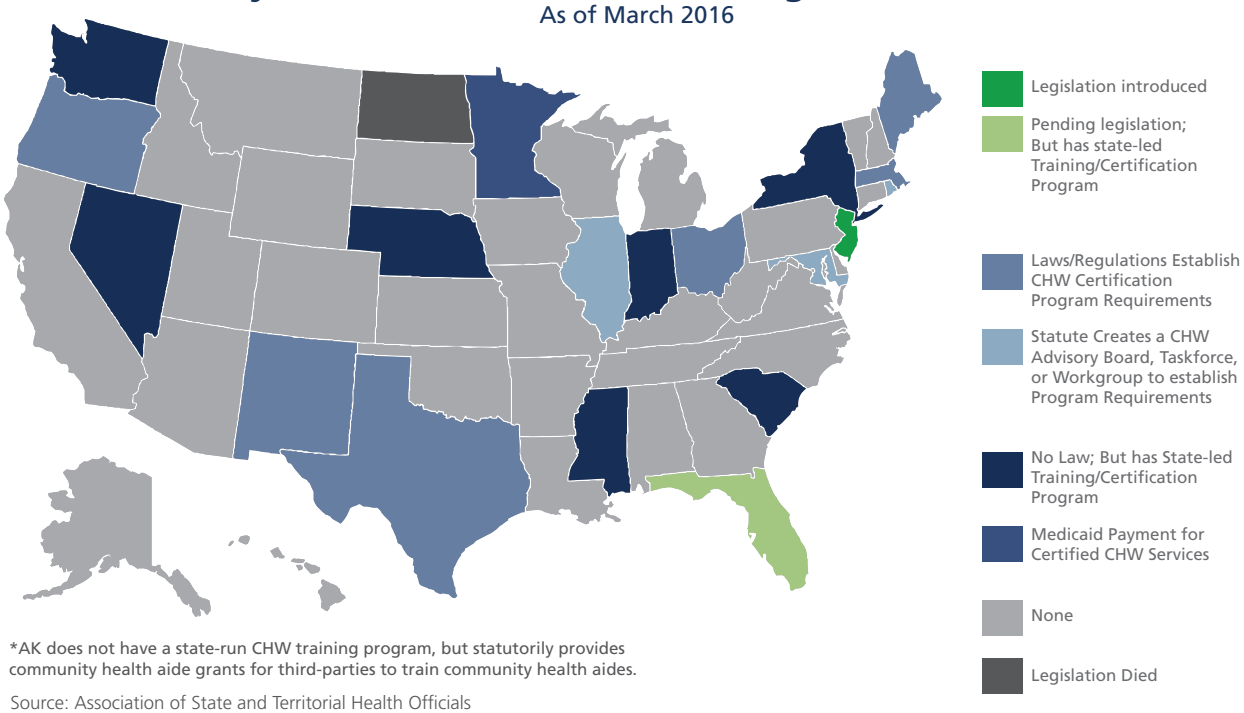
Despite CHWs' increasing use and support, the workforce remains fractured, and there are still many challenges to overcome. Training is inconsistent, qualifications vary, and funding mechanisms are few. However, many states are beginning to decrease these barriers by developing supporting policies and programs. Some of these initiatives include advisory boards and workgroups, certification or training programs, and Medicaid funding (See Figures 4 and 5).[29]

Although each state's approach to certifications and standards is unique, there are some general trends. States generally define CHWs' scope of work as health workers who educate and assist individuals in accessing community health and other services. States who offer training and certification programs generally offer it on a voluntary basis; however, Texas and Ohio require certification. The number of hours required for certification varies a great deal from 40 hours of training (Kentucky) to 160 of training (Missouri). In addition, some states require thousands of hours of relevant

Figure 4: State CHW initiatives

Community Health Workers (CHWs) Training/Certification Standards

As of March 2016



*AK does not have a state-run CHW training program, but statutorily provides community health aide grants for third-parties to train community health aides.

Source: Association of State and Territorial Health Officials

Figure 5: State CHW training and certification standards

Community Health Workers (CHWs) Training/Certification Standards

Statutory & Department Program Requirements

State		IL	FL	IN	ME	MD	MA	MN	MS	NE	NJ	NM	NY	NV	OH	OR	RI	SC	TX	WA
Year of Enactment		'14	–	'13	'15	'14	'10	'07	'12	–	–	'14	'10	'13	'03	'11	'11	'12	'99	'11
Department or Agency Responsibilities	Dept. of Health/Public Health	•		*	•	•	•		*	*	•	•	*	*		•	•	*	•	*
	Dept. of Human Services							•												
	Board of Nursing														•					
Scope of practice described		•		*		*	•	*	*	*		•	*	*	•	•	•		•	•
Core competencies established		•		*		*	•			*		+		*		+			+	*
Health professional supervisor required								•							•	+		*		
CHW Advisory Board/Taskforce/Workgroup established		•		*		•			*		•	•				+	•	*	•	
Continuing education required							•					•			•	+			+	*
Board of CHW Certification to Recommend Standards							•					•							+	
University-run certification program								•												
Background/criminal checks required												•			•	+				
Age requirements established				*			•					+			•	+			+	
Out-of-state certifications accepted							•													
Fees collected to support program							•					•			•					
Complaint/disciplinary proceedings established							•					•			•	+			+	
Possession of certification documentation required							•					•							+	
Certification Renewel Period	Two years				•		•					•			•				+	
	Three years															•				

+ Information in regulations. * Does not have legislation, but is Department-established.

Source: Association of State and Territorial Health Officials

Figure 6: CHW certification standards state comparison

CHW program standards comparison: Ohio and Rhode Island		
	Ohio	**Rhode Island**
Certification Requirement	Required	Voluntary
Certification Board	Ohio Board of Nursing	Community Health Worker Association of Rhode Island (CHWARI) provides certification; Rhode Island Department of Health endorses and supports certification
Training provider	State colleges; private companies	CHWARI; State college in collaboration with CHWARI
Training requirements	100 hours of classroom instruction; 130 hours of field instruction	30 hours of classroom instruction; 80 hours of field instruction
Continuing education requirements	15 hours every 2 years	Available, but not required
Oversight requirements	Must be supervised by a registered nurse	No requirement
Core Competencies	1. Health care 2. Community resources 3. Communication skills 4. Individual and community advocacy 5. Health education 6. Service skills and responsibility 7. Individual needs throughout the eras of a lifetime	1. Advocacy 2. Current workforce issues 3. Working with children and families 4. Communication skills 5. Cultural competency

work experience in addition to the training module (Massachusetts). Continuing education is generally 20-30 hours across states for a bi-annual certification renewal, and supervisory oversight is required in about half of the legislation-enacted states. Figure 6 showcases the certification standards and requirements in two states—Ohio and Rhode Island.

As states continue to experiment with various regulatory frameworks, health care stakeholders may encourage the development of successful CHW programs through cross-sector partnerships. Payers, such as Medicaid Managed Care Organizations (MCOs), have an opportunity to work with providers in the ambulatory, acute, and post-acute care settings to establish effective programs.

Certification and Licensure Efforts

Most states have not enacted legislation regarding certification requirements. As a result, states that do have a training or certification program generally only offer them on a voluntary basis. However, states who have enacted certification legislation usually include some type of requirements for some or all CHWs. For example, Texas requires training for CHWs receiving compensation, but not for volunteer CHWs. There are still a number of states in the process of developing certification competencies, standards, and requirements.

There are both advantages and disadvantages to requiring certification, which state policymakers should consider when deciding whether to require certification

Figure 7: Advantages and disadvantages of mandatory CHW certification

ADVANTAGES	DISADVANTAGES
• Provides recognition of the CHW role • Establishes a minimum standard of competencies or skills • Establishes clinical oversight requirements • Establishes a professional value to the employer • Substantiates an individual's commitment to the role • Potentially increases access to funding • Improves collaboration with the health care community	• Creates barriers to entry for some who may have the desired background • Eliminates the individual "grassroots" feel • May limit the role the CHW can play • Requires state or other funding to establish and run a certification program • Increases a burden that isn't currently required—employers are not requiring it

(See Figure 7).

Licensure, however, is not currently a requirement in any states. Because CHWs provide assistance and care through a role that is non-clinical in nature, the need for licensure is generally beyond the scope of provided services. Non-clinical tasks do not require licensure even if they support care provided by clinical professionals.[30]

Training

Among the states who offer training, the agency or organization providing the program varies. Roughly half the states offer training through community colleges, state colleges, or universities; one-quarter offer training through state agencies; and one-quarter through community organizations. State agency and higher education administered programs are more likely to be supported by the state, but higher education programs are not necessarily regulated by state standards.[31]

Factors state policymakers should consider when deciding where to house training programs include:[31]

- States with school-based training programs report enhanced opportunities for CHWs to advance in their careers and pursue additional professional schooling.
- State with on-the-job training at the organization level, whether supported by the state or not, have achieved better health outcomes due to specialized training and better retention levels, translating to higher productivity.

CONCLUSION

Barriers still exist for CHWs to achieve full entry into the health care system, but more states are beginning to develop standards and requirements. Some standards are common across many states while others vary quite widely. As additional states begin to set certification standards and other requirements, there are some key considerations they will need to take into account.

As providers and payers consider incorporating CHWs into their organizations, they should create or consider a program that incorporates many of the patient interaction, organizational structure, and community relationships key elements. Although not reviewed as a package, each element individually has demonstrated a positive impact on patient outcomes. As such, payers and providers that are willing to work together to dedicate the necessary resources are likely to be rewarded with improvements in the patient populations they serve.

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