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Project on Community Health Worker Policy and Practice

Occasional Paper No. 2: Commentary on Indiana CHW Workforce Assessment

This paper was prepared in part under a contract between the Indiana State Department of Health (ISDH) and Community Resources LLC of San Antonio, Texas.
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Summary: Two workforce surveys were conducted for the State of Indiana in the Summer and Fall of 2012, one addressed to CHWs and the other to current and potential employers and funders of CHWs. Response from CHWs was quite high, and a significant number of hospitals responded to the employer survey. Respondents show significant interest in standardizing the CHW occupation through credentialing, and many see potential roles for CHWs in new structures such as patient-centered medical homes (PCMH), although most CHWs currently work in projects focused on a specific health issue, with mental health prominent among these issues. Some employers remain concerned about liability issues in employing CHWs; this should be addressed in designing certification standards and procedures.

Introduction

With the leadership of the ISDH, the Indiana Community Health Worker (CHW) Coalition was formed in the Spring of 2012. In order to understand the CHW workforce in Indiana, Coalition members decided to conduct an assessment of the workforce through two online surveys, one of CHWs in English and Spanish and a second survey of CHW employers, funders, and those with a potential interest in working with CHWs. ISDH staff, who support the Coalition, worked with Community Resources LLC (CRLLC) to conduct the online surveys developed in coordination with broad representation of 155 Coalition members. The assessment findings were presented at

a statewide conference on October 15, 2012 to Indiana CHW Coalition members and their supporters. The following commentary provided by the CRLLC team, is provided to highlight key survey findings and supplement the presentation; it focuses on presenting the data in the context of the evolving CHW field in the United States.

In addition to the commentary in this paper, the survey methods and the bulk of the findings are presented in an Appendix highlighting the findings from each component of the surveys (CHW, CHW Employer/ Payer, and Potential CHW Employer/Payer surveys). A data set combining the English and Spanish language CHW surveys was provided to the State along with a data set combining employer and potential employer survey data.

Assessment survey response rates

CHW Survey

The number of responses to the CHW instrument was very encouraging with a total of 330 answering the English instrument and 20 answering the Spanish language instrument. This likely reflects a high level of interest, active networking by CHWs and encouragement from employers. The pattern of responses to the CHW assessment instrument, however, suggests that despite a clear definition in the opening pages of the survey instrument, a significant number of individuals completed the survey who are not CHWs according to this definition.

One indicator of this is the pattern of education levels, which is in general higher than might be expected. Massachusetts experienced a similar pattern in their CHW survey, which also enjoyed a high response rate. There are several possible explanations for this, which may merit further investigation in Indiana:

(1) Surveys generally, and online surveys in particular, may intimidate individual CHWs with lower levels of conventional education and a number of CHWs may lack routine access to computers in order to take an online survey (for this reason hard copies were offered as an alternative). We do not know how many individuals may have held back from responding for these two reasons and the degree to which this may impact the representativeness of the sample of CHW respondents.

(2) Hiring of CHWs in Indiana may tend to favor individuals with higher education levels due to the lack of widely-accepted CHW training programs or other CHW certification. We have seen employers in other states require a Bachelor's degree for CHW jobs simply because they perceive no other basis for judging an individual's qualifications.

(3) Without widespread recognition or acceptance of the CHW as a distinct occupation, improved understanding perpetuates complexities in better reaching and assessing the CHW workforce.

Employer/Payer Survey

There were a total of 82 respondents to the Employer/Payer survey including 49 Employer/Payers and 24 potential employer/payers. In contrast to the CHW response to the survey, the number of respondents was somewhat disappointing. The gross numbers may reflect a generally low level of awareness among potential employers; they simply do not know about CHWs or are not yet aware of the relevance of CHWs to their operations, even though Indiana had had a Medicaid waiver for a prenatal care coordination program for a number of years.. Prior to this initiative, there had never been an attempt to bring employers or CHWs together, nor (as in most states) had there been any concerted effort to educate providers or payers about CHWs. Indeed, this experience suggests that many CHWs were similarly aware that they were part of a larger workforce. It is fair to anticipate that further surveys in future years will elicit greater response.

Characteristics of respondents

Though the numbers of respondents was limited, there were some encouraging aspects to the composition of the group. A substantial percentage of these respondents were from hospitals. Also the percentage responding who are part of patient-centered medical homes (discussed below) seems to suggest further investigation may be fruitful, including possible inclusion of CHWs among Indiana's accountable care organizations (ACOs), which are more complex in financial and policy terms. It was notable that the employer respondents are relatively experienced with CHWs: 70% have worked with CHWs for more than five years. These organizations could form the basis of an assertive employer voice in Indiana. It may be

worthwhile to investigate why less experienced health care entities, including local health departments, did not respond to the survey in greater numbers.

Urban/rural employment patterns also merit further investigation. CHWs in urban areas of Indiana are more likely to be employed full time, whereas rural CHWs reported working part time and as volunteers. One implication of this may reflect a need for improved health care access in rural communities nationwide. Increasing the pool of employable CHWs in rural Indiana who can work full time with compensation may aid job creation and increase access to preventive health care services[1].

Highlights of survey findings

CHW Definitions

The authors have learned from experience in policy campaigns in Texas, Massachusetts and other states that defining the parameters of a field to policy and health finance professionals means determining a core of knowledge and skills that any worker claiming to be a CHW must have mastered, as well as arriving at a common understanding of a scope of practice and related parameters for this occupation.

There are many examples of other professions, e.g., nursing, where the range of tasks and skills within the defined profession can be quite wide. Even with this variance, the concept or idea of what a 'nurse' is or does in general allows for sufficient shared understanding for all kinds of funders, health plans, health planners, and other professionals as well as clients and patients to discuss. Nationally, CHWs have not yet reached this point.

Key to understanding this workforce is the recognition and validation of a distinct form of *expertise* in CHWs. Clinicians and administrators looking at health-related occupations tend to rely on the extent of clinical training to define and classify the occupation. While some exposure to clinical content is important, the CHWs contribution needs to be viewed in the context of a

[1] After completion of the research reported here, the Centers for Medicaid and Medicare Services announced new Medicaid rules effective January 2014, authorizing payment for preventive services delivered in community settings by non-licensed personnel.

distinctive scope of practice and a distinct set of core competencies (see below) that overall are not clinical in nature.

Definitions of "CHW" commonly refer to membership or close connection with the community served. Naturally, "community" can mean much more than a geographic construct. But it has been interesting to note that Indiana's CHWs perceive their "community" or "peer" relationship to those they serve more commonly on the basis of geography or race/ethnicity (52% and 40% respectively) than on the basis of socioeconomic status or shared experience with a particular health condition (27% and 26% respectively). This difference was even more marked among employers (55% and 55% vs. 14% and 17%). However, employers were more likely (69%) than CHWs (27%) to think in terms of language preference other than English as key to connectedness. This may have to do with the fact that employers deal on a daily basis with the operational challenges of language differences in actual provision of care.

CHW Scope of Practice

The range of health/social issues addressed by Indiana CHWs (per the assessment) and the most important CHW activities are comparable to findings in other states, including diabetes, nutrition, tobacco control, mental health issues and women's health..

Unfortunately, the definition of a scope of practice for CHWs has lagged behind other developments nationally. To date only New York and Minnesota have attempted to promulgate scopes of practice, and both would probably be considered "sketchy" compared to similar definitions for other professions. It could be argued that clear communication with providers, payers and other health professions cannot be achieved in the long run without a CHW scope of practice. The New York policy initiative applied a rigorous "functional job analysis" technique which produced a richly detailed picture of what CHWs actually (or potentially) do (available on request if further investigation is pursued). An early attempt at definition in the San Francisco Bay Area in the 1990s found clear distinctions in roles and skill sets between what they termed the "Clinical CHW" and the "Community Health Outreach Worker."

It is of note that 44% of employers responding to the survey were somewhat or very concerned about liability issues. In the authors many years of experience in this field, we have never heard of an organization being found liable for harm to a client/patient resulting from actions of a

CHW, but this concern persists. This concern will need to be addressed in discussions of credentialing and in preparation of CHW *supervisors*.

CHW Core Competencies

Related to Scope of Practice much discussion in the CHW field has focused on Core CHW Competencies as first defined in the National Community Health Advisor Study (Wiggins, Rosenthal et al., 1998). The policy initiatives in Texas, Ohio, New York, New Jersey and Massachusetts have all adopted some variation on these themes with the state of Texas fully adopting the skills as presented in the National Community Health Advisor Study. More background documents on these activities are available if this direction is further pursued.

CHWs and Patient Navigators (PNs)

The authors recommend dealing early and directly with the ongoing confusion of definitions between CHW and PNs. The term PN was coined by Dr. Harold Freeman at Harlem Hospital in the early 1990s, and it has been brought to the forefront by the Patient Navigator Act (2005) and its reauthorization in the Affordable Care Act (2009). PNs are most often associated with cancer diagnosis and treatment, but they have proven to be effective in other chronic conditions.

The authors suggest Indiana stakeholders adopt a stance that patient navigation is a role or function, and not a distinct occupation, considering the following distinctions:

- PNs are assigned to specific patients; CHWs are often not, depending on their role
- PN duties are a subset of potential CHW duties
- Many PNs are CHWs, but PNs may have another occupational background (RN, MSW); this is a legitimate program design choice
- A nurse navigator can also find other employment as a nurse, as a CHW should be able to take CHW positions other than that of a PN

Both CHWs and non-CHW PNs can complement the care continuum via "warm hand-offs" from preventive screening through follow up. Note the similarity in qualities of PNs with those of CHWs in the following statements from documents co-authored by Dr. Freeman:

> The most important role of [the PN] is to assure that any woman with a suspicious finding will receive timely diagnosis and treatment. The Navigator accomplishes this most effectively through one-on-one contact with the patient ... to eliminate barriers … the [PN] should [be]: culturally attuned to the … community being served, able to communicate, sensitive and compassionate… very knowledgeable of the environment and system ... highly connected and allied with critical decision makers within the system, especial the financial decision makers.
>
> Note: No particular level of formal education is required. [2]

[Navigators are selected largely on the basis of being] "dedicated people from the community" [that are] "sensitive to and can communicate with the population served."[3]

Actual CHW position descriptions

It appears that CHW compensation in Indiana is comparable to other states, but it is of interest that few employer respondents provide no compensation at all, and 24% say they pay more than $15 per hour. This could be investigated further, including patterns in rural vs. urban areas.

The authors have collected numerous examples of CHW job descriptions and position announcements, most of which are very limited in detail. We have noted that a number of employers have published a series of different job announcements with different duties, all using the same position title, suggesting that they consider "CHW" to be a larger category of worker. A review of actual position descriptions in Indiana (though not part of the present study) reportedly has revealed that variation is wide with regard to the level of training required for CHWs, but core roles and functions are similar.

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[2] Freeman HP et al. Breast Health Patient Navigator Resource Kit. Healthcare Association of New York State, September 2002

[3] Vargas RB, Ryan GW, Jackson CA, Rodriguez R, Freeman HP. Characteristics of the Original Patient Navigation Programs to Reduce Disparities in the Diagnosis and Treatment of Breast Cancer.
Cancer May 2008 (113:2) 426-433

Credentialing

Indiana CHW respondents appear to be quite interested (74%) in pursuing credentialing, and a substantial majority of employer/payer respondents (90%) also support credentialing. Findings from the employer/payer assessment suggest that employers/payers also are likely to support efforts toward CHW credentialing. The authors have been in policy discussions with state officials and health plans (in several states) that serve people with subsidized insurance about the possibilities of covering CHW services. In addition to requiring a definition of the occupation or profession of CHW, health plans universally stress the importance of having recognized standards of skills and qualifications, potentially extending to standards of training and credentialing. They do not appear prescriptive about what kind of credentialing, or who issues the credentials so long as it is officially accepted as a standard by the State. All three states that have passed CHW credentialing legislation have based the certification in statewide organizations or agencies with clear relevance and legitimacy in the health field. For a brief summary of the essentials of credentialing and the Texas and Ohio systems, please see CHRLLC publication, "Basics of CHW Credentialing."

The long-standing debate among CHWs, their colleagues and allies about the pros and cons of credentialing continues. One clear pattern is that *licensure is out of the question for CHWs.* There are forces in the culture of health care that may push for such an approach. However, three states (Massachusetts, New York and Virginia) have made formal determinations that licensure is not applicable because the unlicensed practice of CHW activities do not pose a significant risk of harm to the public. Of the other options for credentialing, *certification* has emerged as the most logical choice.

Job Quality

CHW respondents to the assessment rated "autonomy and independence" and a "flexible schedule" as important characteristics of a CHW position. These are common qualities of the work but are often difficult for employers to accept. Further exploration of these elements and other attributes that make the CHW role favorable such as salary and benefits are worthy of discussion with employers and funders as well as CHWs. Currently, approximately 80% employers report that they offer benefits to CHWs such as vacation and sick leave, whereas 60-

70% of CHWs reported receiving such benefits. It would not be surprising if respondent employers better attended to the needs of CHW employees.

What CHW financing opportunities seem to be of interest to providers and payers?

The pattern of sustainable CHW funding activity seems to be grouped in a few areas of innovation:

- Building on a solid evidence base for CHW effectiveness in traditional areas: e.g., chronic disease management, maternal and child health (birth outcomes); cancer screening and navigation
- "Hot-spotters" models – reducing costs by improving care for high utilizers (hot spotters); increasingly possible with improvements in information technology (IT). Also a major "win-win" is saving money by improving care rather than reducing benefits or limiting eligibility
- Patient-centered medical homes (PCMHs) and Health Homes
- Care transitions and reducing readmissions – a variation on "hot-spotters," mainly building on CHW success in redirecting high utilizers of emergency departments (EDs)

With a growing body of evidence suggesting that CHWs create significant financial return through savings in total cost of care, it is encouraging to see that half the Indiana employers responding to a question on funding of CHW positions reported use of internal budgets or "core funding" rather than (or in addition to) external grants or third-party payers.

CHWs in the Patient-Centered Medical Home (PCMH)

Findings of the employer/payer assessment indicate that many organizations are either accredited as PCMHs or pursuing such status. A significant percentage of respondents see potential roles for CHWs in the PCMH (35% of employers). Although the number of potential employers responding to these questions was too small for statistical significance, some of them also foresaw roles for CHWs in the PCMH. One employer respondent described the potential roles of CHWs in the PCMH as follows:

> Help ensure care coordination; help identify and build relationships with potential referral resources; assist with health benefits enrollment - - e.g., xxx Health Program; assist with health education efforts - both individuals, groups and communities; help identify parts of our Service Area that are particularly needy; increase individual and community awareness of services provided by a FQHC; assist consumers with accessing medications from pharmaceuticals companies; assist patients with navigating the healthcare and social services systems; help identify funding sources related to Outreach activities.

However, CHW respondents commonly (81%) reported their work to be focused on a specific health/social issue. One potential challenge to be resolved is to match CHW and employer expectations for *generalist* vs. *specialist* CHW skills in the PCMH setting, which by definition is patient-focused rather than condition-focused. It may be unrealistic for any one CHW to have detailed expertise in every health issue area their patients may face; the same holds true for primary care physicians. We are aware of discussion in Washington state about a hybrid approach with *generalist* CHWs embedded in the PCMH care team with *specialist* CHWs in areas like diabetes management who can "float," assisting multiple teams with concentrated support with specific patients.

The traditional focus on specific health/social needs may reflect the state's previous pattern of categorical funding, which limited comprehensive and transferable skills from one disease or population specific area to another. The ISDH's primary reason for undertaking this initiative is to align all workers under the CHW umbrella to allow for a common set of skills and competencies that can be transferred to any setting or population. Through such efforts as the recent merger of the Office of Primary Care and Rural Health with the Division of Chronic Disease Prevention and Control is one example of how the ISDH is approaching population-level health. Indiana intends to lay out a tiered or stacked CHW credential in which all CHWs will receive a core training with the option to add endorsements in specialty areas such as HIV, MCH, diabetes, mental health, etc. This will allow for greater connectivity with public health trainings and resources as well as prepare Indiana's frontline with evidence-based strategies to better respond to local needs.

Making the case for community health workers' relevance to PCMH accreditation standards. One of the authors (Rush) has reviewed the standards of the National Committee for Quality Assurance (NCQA), which is a common standard that states are using to score provider applicants to qualify for Patient Centered Medical Home (PCMH) accreditation. He has focused on performance "factors" (or indicators) under Elements of the medical home to which community health workers can be argued to contribute. In each area the PCMH is scored from 0 to 100 percent based on how many performance "factors" are present under each "Element."

Area 1: Enhance Access and Continuity
Element F: culturally and linguistically appropriate services (CLAS) - this focuses exclusively on language services, and as such the Study Team believes it deserves further refinement. Even though CHWs should not be pulled in as interpreters or translators without appropriate training, this is an area where we think they can contribute value.
Element G: the practice team - CHWs can add depth of understanding of the patient/family situation

Area 2: Managing the Patient Population
Element A: patient information; assuring the team has a complete picture, and patient/family are being candid
Element C: patient assessment
Element D: population management; this area emphasizes prevention in the patients for whom the PCMH is responsible

Area 3: Managing care
Element A: patient reminders
Element C: care management (care plan and follow-up)
Element D: medication management (reconciling and recording)

Area 4: Self-care support and community resources
Element A: self-care support
Element B: referrals to community resources

Area 5: Tracking and coordinating care
Element A: lab test follow-up
Element B: referral follow-up
Element C: coordination and care transition

A recent study for the RWJF Aligning Forces for Quality initiative, *Advancing Primary Care: Opportunities to Support Care Delivery Redesign in Practices Serving Medicaid and Racially*

and Ethnically Diverse Patients,[4] shows that the *top two* "areas of opportunity" for improvement of primary care for Medicaid patients are "Community Orientation" and "First Contact: Access," both areas in which a plausible case can be made for the value of CHWs.

Oregon's Patient-Centered Primary Care Program (PCPCP) sets standards distinct from the NCQA medical home standards. Multiple criteria in the PCPCP assessment could be met by primary care practices that are connected to chronic disease self-management teams or other outreach that include CHWs (for example the home visiting asthma team). Additionally, the Oregon legislature specified that Accountable Care Organizations (which they call "Coordinated Care Organizations") must indicate how they will employ "non-traditional health workers" and provides incentives for them to do so. These include CHWs as well as patient navigators.[5]

Vermont passed their state health care reform initiative in 2006 and subsequently participated in a CMS demonstration initiative (Multi-payer Advanced Primary Care Practice Demonstration) that led to the creation of the "Blueprint for Health" plan. Key to this model is the requirement that medical homes be supported by **community health teams**, and in addition to the RN leader, members of these teams can include community health workers. The teams are linked to medical homes and can be based in separate non-profits. There are public health specialists as part of these teams, and these teams are viewed as a "crucial link between primary care and community based prevention of chronic disease."

Accountable care organizations (ACOs) are more complex in many ways, but they may present even greater potential for CHW roles since they place a high value on reducing avoidable costs to maximize financial return, and ACOs inevitably balance the interests of payers and hospitals with those of primary and specialty care providers.

Workforce development and training opportunities

Interestingly, despite the generally high level of formal education among CHW respondents, almost half (47%) said they received the majority of their CHW education **on the job**. CHWs historically have been hired first and then trained. The link to communities they will serve is a primary hiring criterion, which dictates this approach to hiring. In addition, there have been

[4] RWJF, August 2012
[5] Oregon House Bill 3650, July 2011

insufficient jobs or job security (as well as low pay) in the field to motivate individuals to pursue training without having a position or invest in training that does not lead to a career ladder, a nationally recognized standard in the field of workforce development.

All of these factors persist, although the availability of positions and better pay levels are likely to increase. CHW training is available in a variety of settings within and across states. Some—such as Minnesota—have a state recognized core competency training that is available mainly through community colleges. Others—including Texas and Massachusetts—have established training centers primarily in community-based organizations, to enhance access for community members who may feel less comfortable in academic settings. Until recently in Massachusetts core competency training was offered free to CHWs and their employers because it was subsidized with public funding. The pressures of cutbacks are moving these centers in the direction of charging for the trainings.

Progress in Indiana

Looking at the relatively longer-term familiarity of CHW employers with CHW services, combined with the high interest among CHWs to respond to the survey, the survey assessment shows that there is a strong core of individuals and organizations in the state that support the role of CHWs. Also looking at the work and symposium that was held in the fall to review CHW assessment findings, it is clear that in contrast to many states Indiana has the knowledge and understanding of CHW roles coupled with a commitment to CHW leadership that should lead to the strong development of the field.