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Hispanic Health Council

Policy *brief*

Addressing Social Determinants of Health through Community Health Workers: A Call to Action

Hispanic Health Council

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This policy brief was produced by the Hispanic Health Council in partnership with Southwestern AHEC and a panel of Community Health Worker Policy Research Experts.

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- P. 13, Hispanic Health Council, DIALBEST Study, part of the Center for Eliminating Health Disparities Among Latinos (CEHDL, funded by NIH Minority Health and Health Disparities Institute. 2005-2011
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DESIGN

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INTRODUCTION

Community health workers (CHWs) have a unique understanding of the experience, language, culture, and socioeconomic reality of the communities that they serve. They apply this unique understanding to make a distinctive contribution to improving health outcomes. A body of evidence indicates that CHWs play an important role in improving health through enhancing clinical outcomes and by addressing the social conditions that impact health status, called social determinants of health (SDOH). Currently, CHW services* are supported through a patchwork of largely vulnerable grant funding in most areas of the country. However, a combination of factors present the potential for development of a sustainable financing system for CHW services sustained through healthcare funding. These factors include evidence of CHW impact and return on investment, changes in federal regulations on funding of preventive healthcare services, and healthcare innovation initiatives utilizing various payment reform models.

As part of its Community Health Insurance Reform for the People (CHIRP) II project, the Hispanic Health Council (HHC) sought to develop evidence-based policy recommendations that would promote widespread support for community-based CHW services with sufficient resources to address SDOH. The goal of these recommendations is to promote healthcare policy, specifically related to CHW services, which will best serve the needs of members of communities most affected by health inequities. With grant support from the Connecticut Health Foundation, the HHC convened a group of CHW policy experts to conduct policy research and analysis to inform development of these policy recommendations.

*Note: Throughout this document, the term "services" is used to refer to the diverse activities performed by CHWs that are described within the report.

POLICY RECOMMENDATIONS

The Hispanic Health Council and its expert policy research panel developed a total of 20 recommendations in seven broad CHW policy categories, as listed below:

1. Payment of Community Health Worker Services

Recommendations:

No. 1 Healthcare payment methods should reward improved outcomes, rather than volume, and should address the underlying health risks of the population, including SDOH.

No. 2 Payments for CHW services should cover the full range of services needed to be effective in improving health outcomes for high-risk populations, including addressing SDOH. Funding should be adjusted to meet the health and SDOH needs of the population of focus for each specific intervention (see Community Health Worker Caseloads section, page 10-11).

2. Community Health Worker Caseloads

Recommendations:

No. 3 CHW services should support full performance of CHW roles, including addressing SDOH. Therefore, employers should structure CHW job duties to provide sufficient time for: 1) significant, extended face-time with clients, and often, families; 2) individual visits in the home and/or clinic; and 3) active engagement with clients to plan for future care.[1]

3. Community Health Worker Recruitment

Recommendations:

No. 4 CHWs should be selected based on their unique understanding of the experience, language, culture, and socioeconomic needs of the community they will serve, among other qualities and characteristics. (For a list of research-based qualities and characteristics, see Wiggins and Borbon, 1998.) [2]

4. Community Health Worker Training

Recommendations:

No. 5 Curricula should include education on health issues, SDOH, and health inequities, as well as training to develop specific skills, such as communication and service coordination.

No. 6 Training programs should use the principles and techniques of popular education (also known as empowerment or Freirian education, in honor of the Brazilian popular educator Paulo Freire).[3]

No. 7 Training programs should involve experienced CHWs in designing and conducting CHW training.

No. 8 Training programs should prepare and support CHWs to perform the full range of CHW roles.

No. 9 CHWs should be trained in data collection and documentation in electronic health records.

5. Reflective and Trauma-Informed Mentoring and Supportive Supervision of Community Health Workers

Recommendations:

No. 10 The supervisor to CHW ratio should facilitate high quality administrative and clinical supervision.

No. 11 Training for CHW supervisors is crucial, and should include training in popular education and the unique roles and needs of CHWs.

6. Integration of Community Health Workers into Care Teams

Recommendations:

No. 12 A CHW champion should be designated within the organization to help ensure that the role of CHWs is valued, understood and supported.

No. 13 Training for all members of the healthcare team should be conducted to establish a thorough understanding of the history and current status of the CHW profession ***before*** bringing a CHW onto the team.

No. 14 Adequate time should be allocated to provide an intensive orientation for the CHW to the organization.

No. 15 CHWs should be included in care team meetings and empowered to provide insights about their participants/the community during and between meetings.

No. 16 CHW services should be documented as part of the electronic health record, to facilitate sharing of their work with other team members, and tailoring their support to individual needs.

7. Documenting the Effects of Community Health Worker Services on Social Determinants of Health

Recommendations:

No. 17 CHWs should be trained to collect data while completing participant services.

No. 18 Indicators of CHW work should be systematically documented, including process, health outcomes and social outcomes measures related to the SDOH, in alignment with the Connecticut adaptation of the CHW Common Indicators Project.[4]

No. 19 Regular process and impact evaluations of CHW services should be conducted for continuous quality improvement and continued program support and sustainability of the CHW services.

No. 20 CHWs should be involved in developing evaluation methods and outcomes in order to contribute to their professional growth and to build more valid and reliable measurements.

CONCLUSION

Historically, CHWs have addressed SDOH through a variety of services, from helping people meet their basic needs, to organizing communities to address the underlying causes of adverse health outcomes. A service design that optimally supports CHWs in addressing SDOH would incorporate all seven areas of policy recommendations included in this report: funding, caseloads, recruitment, training, supervision and mentoring, integration into care teams, and monitoring/ evaluation.

Also highlighted in this report is the importance of:

- The word *community* in Community Health Worker:

  As emphasized by the World Health Organization,[5] the community context of CHWs is important to full execution of their role; community immersion enables CHWs to successfully address SDOH at individual and community levels.

- Regular process and impact evaluation of the results of the CHW's work:

  Documentation of the work of CHWs facilitates validation of their essential functions, including their impact on SDOH. Continuous review and sharing of the impact of CHW work enables quality improvement and facilitates continued CHW funding support.

It is critically important to take these evidence based recommendations into account in the redesign of funding for CHW services, to assure CHWs are able to make an optimal contribution to addressing SDOH.

INTRODUCTION

Community health workers (CHWs) have a unique understanding of the experience, language, culture, and socioeconomic reality of the communities that they serve. They apply this unique understanding to make a distinctive contribution to improving health outcomes. A body of evidence indicates that CHWs play an important role in improving health through enhancing clinical outcomes and by addressing the social conditions that impact health status, called social determinants of health (SDOH). Currently, CHW services are supported through a patchwork of largely vulnerable grant funding in most areas of the country. However, a combination of factors present the potential for development of a sustainable financing system for CHW services sustained through healthcare funding. These factors include evidence of CHW impact and return on investment, changes in federal regulations on funding of preventive healthcare services, and healthcare innovation initiatives utilizing various payment reform models.

As part of its Community Health Insurance Reform for the People (CHIRP) II project, the Hispanic Health Council (HHC) sought to develop evidence-based policy recommendations that would promote widespread support for community-based CHW services with sufficient resources to address SDOH. The goal of these recommendations is to promote healthcare policy, specifically related to CHW services, which will best serve the needs of members of communities most affected by health inequities. With grant support from the Connecticut Health Foundation, the HHC convened a group of CHW policy experts to conduct policy research and analysis to inform development of these policy recommendations.

This report provides background information on CHWs and SDOH, and 20 policy recommendations related to seven elements of CHW service design needed to optimally support CHWs in addressing SDOH:

1. Payment of community health worker services
2. Community health worker caseloads
3. Community health worker recruitment
4. Community health worker training
5. Reflective and trauma-informed mentoring and supervision of community health workers
6. Integration of community health workers into care teams
7. Documenting the effects of community health worker services on social determinants of health

In the development of this report, we drew on multiple sources which are cited in endnotes. We drew heavily on findings from the Community Health Worker (CHW) Core Consensus (C3) Project.[6] The project's final report provides a national, contemporary look at CHW roles in the US, and the competencies needed to fulfill those roles. The findings are intended to serve as a starting point for developing a common understanding of CHW roles and services among a range of stakeholders from employers to policy makers.

BACKGROUND

Community Health Workers (CHWs)

The Connecticut State Innovation Model (SIM) program, a federally funded initiative to support the development and implementation of healthcare service delivery and payment reforms, identified CHW services as a key component of the future healthcare system. It established a CHW Advisory Committee to develop recommendations with respect to the training, promotion, integration and certification of CHWs. The CHW Advisory Committee approved this definition:

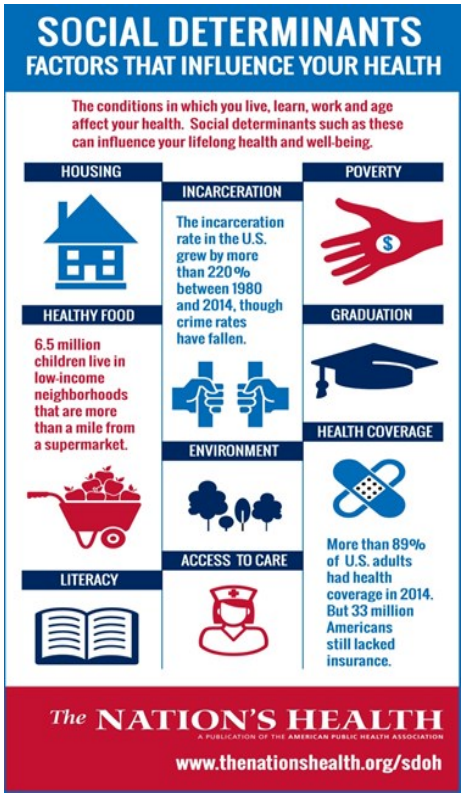
> "A ***Community Health Worker*** is a front line public health worker who is a trusted member of, and/or has a unique understanding of the experience, language, culture, and socioeconomic needs of the community served. A CHW serves as a liaison/intermediary between individuals, communities and health and social services to facilitate access to care, improve the quality and cultural responsiveness of service delivery, and address social determinants of health.
>
> CHWs build individual and community capacity by increasing health knowledge and self-sufficiency through a range of culturally appropriate services such as: outreach and engagement; education, coaching, and informal counseling; social support; advocacy; care coordination; basic screenings and assessments; and research and evaluation."[7]

Social Determinants of Health

Social Determinants of Health (SDOH) are "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[8] The five key areas of SDOH include economic stability, education, social and community context, healthcare, and neighborhood and built environment.[9] Social and community context includes less tangible social determinants, such as social support and social networks, respect and dignity, and freedom from racism, bias and stigma.

A 2002 analysis estimated the contribution of various factors to premature death. This analysis concluded that lack of medical care contributed only 10% to premature deaths, while behavior, social circumstances and environmental exposures – that is, SDOH -- together contributed 60% to premature deaths,[11] as shown in Figure 2.[12]

Figure 1: Social Determinants: Factors that Influence Your Health [10]



Community Health Worker Contribution to Addressing Social Determinants of Health

Community health workers' unique lived experience, qualities, and skills enable them to address factors lying outside the medical system, both at the individual level by helping to meet basic needs, and at the community level by organizing communities to identify and solve their own most pressing health issues.

A number of studies have evaluated the effectiveness of CHWs in improving clients' health. Studies have documented

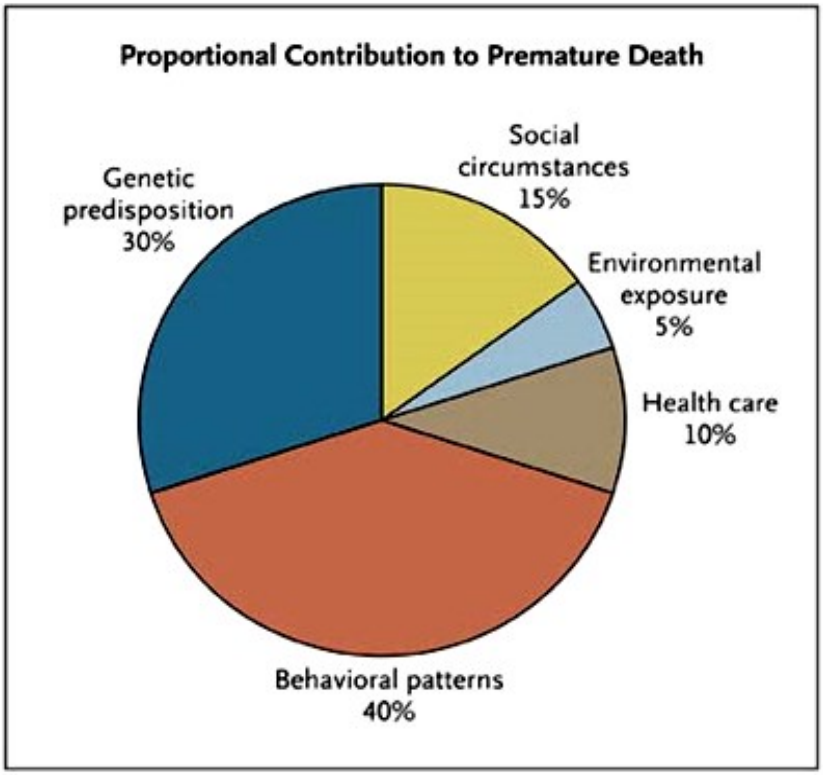


Figure 2: Proportional Contribution to Premature Death [12]

improvements in diabetes management, asthma control, blood pressure, and other areas; however, not all CHW interventions have produced significant improvements. According to one study, interventions were most likely to produce significant improvements when each CHW received at least 40 hours of training, visited participants in their home or community to help address SDOH, interacted with each participant in-person for at least one hour, and shared a community, ethnicity or health condition with most participants.[13]

Other studies demonstrated that when CHWs help participants improve control of their healthcare conditions, the participants have less need for expensive hospital care. Some interventions have yielded a positive return on investment; that is, the savings from reduced healthcare utilization exceeded the cost of the intervention. These interventions specifically focused on individuals with poorly controlled conditions who were most likely to require hospital care in the absence of an intervention.[14,15]

The World Health Organization's definition of CHWs and profiles of some of their work highlights the importance of the community-based context of community health workers. The definition states: "Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily part of its organization...." WHO also emphasizes "…there is overwhelming consensus that community participation is a vital constituent of successful and sustainable CHW programs throughout the world."[16]

POLICY RECOMMENDATIONS

1. Payment of Community Health Worker Services

Recommendations:

No. 1 Healthcare payment methods should reward improved outcomes, rather than volume, and should address the underlying health risk of the population, including SDOH.

No. 2 Payments for CHW services should cover the full range of services needed to be effective in improving health outcomes for high risk populations, including addressing SDOH. Funding should be adjusted to meet the health and SDOH needs of the population of focus for each specific intervention (see Community Health Worker Caseloads section, page 10-11).

Traditionally, most healthcare providers have received a fee for every covered service that they provide. This fee-for-service system creates an incentive to provide more billable services. In an effort to contain costs, payers limit the set of services that are billable; in particular, payers often deny coverage for new services and strategies, such as CHW initiatives.

Some states have implemented payment for CHW services, but still within the fee-for-service payment structure. For example, Minnesota and Pennsylvania Medicaid programs pay fee-for-service for CHW services, using standard billing codes. Connecticut payers do not cover these services.

Minnesota's CHW reimbursement standards read as follows: "CHW services providing patient education for health promotion and disease management are covered if provided under the supervision of a physician, dentist, advanced practice registered nurse (APRN), certified public health nurse (PHN) or mental health professional." Minnesota pays for self-management and education, when under supervision. Medicaid Managed Care Organizations (MCOs) must cover these services.

Medicaid is the largest source of funding for CHW services in Pennsylvania, followed by federal grant categorical funding. CHW programs at behavioral health organizations are funded primarily through Medicaid. MCOs consider CHW expenditures as clinical care costs. Pennsylvania provides Medicaid coverage for peer support specialists (PSS) in the behavioral health field, and some PSS providers are considered CHWs. The Pennsylvania Department of Human Resources oversees PSS.

While Medicaid fee-for-service payment for CHWs in Minnesota and Pennsylvania may be a step in the right direction, these programs only pay for a limited portion of the CHW scope of work: the payment covers only one or two of the diverse CHW roles. Therefore, the effectiveness of CHWs can be hampered, or CHW initiatives can become unsustainable, as CHWs are only paid for a portion of what they do.

Some payers are beginning to implement alternative payment methods that reward providers for improving health outcomes and containing costs. Value-Based Payment (VBP) is a strategy used by purchasers to promote quality and value of

healthcare services. The goal of any VBP program is to shift from pure volume-based payment, as exemplified by fee-for-service payments to payments that are more closely related to outcomes. The Center for Medicare and Medicaid Services states that these programs are important because they're helping payers move toward paying providers based on the quality, rather than the quantity of care they give patients.[17] The alternative payment methods used in VBP programs allow providers flexibility to invest in services that help meet quality and cost goals. Payments made under these alternative arrangements may be adjusted to reflect the underlying health risks of the population. That is, a provider would be paid more to care for a patient panel that is expected to need more services and would be paid less to care for a patient panel that is expected to use fewer services.

Health inequities rooted in SDOH result in worse health outcomes for people of color and people with low socioeconomic status and increased direct and indirect healthcare costs.[18] Payments can be adjusted to reflect this higher risk. Massachusetts Medicaid is in the process of implementing risk adjustment for SDOH. For example, Medicaid recipients who have unstable housing (3 or more addresses in a year) have higher healthcare costs than those with stable housing. Massachusetts adjusts its capitated payment rates to reflect these higher costs.

The outcome-based focus and flexibility of the VBP provide opportunities for payment of CHW services.

2. Community Health Worker Caseloads

Recommendations:

No.3 CHW services should support full performance of CHW roles, including addressing SDOH. Therefore, employers should structure CHW job duties to provide sufficient time for: 1) significant, extended face-time with clients, and often, families; 2) individual visits in the home and/or clinic; and 3) Active engagement with clients to plan for future care.[19]

CHW service models (including staff and caseloads) should take into account the time necessary for adequately addressing specific health and SDOH needs of the population of focus. CHWs may often find that two home visits are initially needed to focus exclusively on addressing SDOH, such as access to food, housing and transportation. Only after those immediate needs are addressed can the CHWs and participants focus on the participants' medical needs.

CHW employers could use a caseload estimator tool to calculate an appropriate caseload, given the health and SDOH needs of the population of focus and the time required to meet them. It should also be taken into account that working through an interpreter can increase the amount of time required for a visit by approximately 50%. A caseload calculator is provided in Figure 3 on the next page. It is provided as an Excel spreadsheet in Attachment 1, to allow for tailoring caseloads to specific CHW job descriptions and organizational characteristics (e.g. paid time off, number of meetings, etc.).[20]

Figure 3 Caseload Estimator

1. Employer Job Standards		
Total weekdays	260	Days per year
Paid holidays	12	Days per year
Paid vacation days	15	Days per year
Average paid sick days	10	Days per year
Work days per year	223	Days per year
Hours worked per day	7	
Total work hours per year	1,561.00	

2. CHW job requirements		
a. Administrative time		
Weekly meeting time (case review, staff meetings, supervision, etc.)	5	Hours per week
Weekly meeting time per year (rounded)	260	Hours per year
Other **annual** paid administrative time (training, conferences, annual meetings)	24	Hours per year
Administrative time per year	289	Hours per year
Remaining work hours	**1,272.00**	

c. Participation in Community Meetings/Advocacy Activities		
Meetings per month	1.00	Meeting
Hours per meeting, incl. travel	2.50	Hours
Total hours per year	**30.00**	Hours
Remaining work hours	**1,242.00**	

c. Home visits		
Time in home	1.5	Hours per visit
Travel time - roundtrip	0.75	Hours per visit
Follow-up	2	Hours per visit
Documentation time	0.25	Hours per home visit
Time required per home visit	4.5	Hours per visit
Average number home visits per client	6	Number of visits
Time required for home visits per client	27	Hours per client

d. Phone calls to client		
Call duration	0.3	Hours per call
Follow-up	0.3	Hours per call
Documentation	0.03	hours per call
Total time per call	0.63	Hours per call
	0.05	Hours per call
Average number of calls per client	10	Number of calls
Time required for phone calls per client	0.5	Hours per client

c+d Total time per client - visits and phone calls	27.5	Hours per client

e. Annual Case load

Remaining work hours divided by time per client	**45.16364**	**Clients served**

3. Community Health Worker Recruitment

Recommendations:

No.4 CHWs should be selected based on their unique understanding of the experience, language, culture, and socioeconomic needs of the community they will serve, among other qualities and characteristics. (For a list of research-based qualities and characteristics, see Wiggins and Borbon, 1998.)[21]

It is important to carefully select individuals who are knowledgeable about and sensitive to the needs of the community and participant population being served, and who will be identified as peers. They should be comfortable speaking in team meetings, and have, or be willing to be trained in the necessary skills and knowledge, including communication skills, to work in both the healthcare and community settings.

4. Community Health Worker Training

Recommendations:

No.5 Curricula should include training to develop specific skills, such as communication and service coordination, as well as education on health issues, SDOH, and related disparities.

No.6 Training programs should use the principles and techniques of popular education (also known as empowerment or Freirian education, in honor of popular educator, Paolo Freire).[22]

No.7 Training programs should involve experienced CHWs in designing and conducting CHW training.

No.8 Training programs should prepare and support CHWs to perform the full range of their roles.

No.9 CHWs should be trained in data collection and documentation in electronic health records.

Addressing SDOH requires high quality training to meet general and specific competencies depending on the role that the CHW plays. Effective training programs can significantly increase CHWs' ability to improve health and eliminate inequities by addressing SDOH. A team of researchers in Portland, Oregon evaluated and identified best training practices.[23] Their recommendations of best practices are summarized as follows:

- **Curriculum components**
  Curricula should include training to develop specific skills, such as communication and service coordination, as well as education on health issues, SDOH, and related disparities.[24] Per the C3 report, specific health topics covered in training will depend upon the needs of the communities, the CHW and the employer. Motivational interviewing and mental health first aid are often included as part of basic skill development training.

- **Popular education**
  Training programs should use the principles and techniques of popular education (also known as empowerment or Freirian education, in honor of popular educator, Paolo Freire). Popular education incorporates and emphasizes the value of the experiential knowledge of CHWs, while also providing concrete techniques for building capacity and community. As noted above, CHWs bring a unique understanding of the experience, language, culture, and socioeconomic needs of the communities served. Effective training approaches

incorporate this unique understanding into the training process using the principles of popular education. Culturally centered curricula based in popular education can make a particularly meaningful contribution to CHWs' own empowerment, and thus to their ability to work in empowering ways in communities.[25]

- **Involvement of experienced CHWs**

  Training programs should involve experienced CHWs in both designing and conducting CHW training. Experienced CHWs have firsthand knowledge of the skills, qualities, and information that are essential to success as a CHW, and can communicate this knowledge to new trainees.

- **CHW Roles**

  Training programs should prepare CHWs and support them to perform the full range of CHW roles. Per the C3 Report, these roles include:[26]

  1. Cultural mediation among individuals, communities, and health and social service systems
  2. Providing culturally appropriate health education and information
  3. Care coordination, case management, and system navigation
  4. Providing coaching and social support
  5. Advocating for individuals and communities
  6. Building individual and community capacity
  7. Providing direct service
  8. Implementing individual and community assessments
  9. Conducting outreach
  10. Participating in evaluation and research

CHW Training Programs in Connecticut *

- CHW core competencies are recognized nationally as the foundational basic skills for CHWs to perform their work.[27] Capital Community College, Gateway Community College and Housatonic Community College each offer a CHW course including the core competencies and Mental Health First Aid through their Continuing Education Divisions. The course is 120 hours in length, and includes a 50 hour required internship. This course format has been approved for four college credits by Charter Oak State College, which provides online degree programs and college credits for alternative learning sources. The cost of the training ranges from $1,500 - $1,799. The course offerings were developed in 2014 and should be updated to include the C3 recommendations.

- Southwestern Area Health Education Center (SWAHEC), a member of the Connecticut AHEC Network, provides Core Competency Training based on the updated C3 standards. The training is 80 hours in length, and includes Mental Health First Aid certification. SWAHEC can include fieldwork assessments of the students upon completion of the training to provide guidance and feedback for further experiential learning.

- Other organizations in Connecticut have developed curricula to train their CHWs, for ongoing service provision and/or CHW research studies. Some of these curricula have: a) used evidence-based content adherent to

professional guidelines; and b) produced results indicating evidence of their effectiveness. Their content and CHW intervention results have indicated the evidence-base of the curriculum used.[28,29]

- Trainings in specialty topics are available both in-person and on-line.

*A resource list for CHW training available in Connecticut is provided through the following link: https://CHWResourcesct.org

5. Reflective and Trauma-Informed Mentoring and Supervision

Recommendations:

No.10 CHW supervision should be well structured with a supervisor: CHW ratio that supports both administrative and clinical supervision of high quality.

No.11 Training for CHW supervisors is crucial, and should include training in popular education and the unique roles and needs of CHWs.

The quality and nature of CHW mentoring and supervision is strongly linked to CHWs' job satisfaction, productivity, retention, and ability to build capacity and address the social determinants of health.[30] Because CHWs come from communities most affected by inequities, it is highly likely that CHWs have experienced historical, personal and/or vicarious trauma. Large percentages of CHWs come to their positions with little formal education and/or past job experience. They may be immigrants and/or speak English as a second language; they may also be in recovery from addiction. For all of these reasons, many CHW programs have found that the model of supervision that works best for CHWs is a model that comes from the social work field. In this model, supervision is divided into two parts: administrative and clinical. Administrative supervision deals with things like billable hours, getting to work on time, and filling out time sheets correctly. Clinical supervision helps the worker to develop both personally and professionally, and to manage experiences that can trigger past trauma. Supportive supervision is also a two-way process. The expectation is that both the supervisor and the worker will learn from their mutually supportive interactions.[31] Healthy Families America, which advocates a model similar to the CHW model, has long recommended a worker to supervisor ratio of 5:1.[32]

Topics covered in administrative supervision

- Acceptable standards for task performance
- Adherence to norms and guidelines
- Requirements for documentation
- Administrative requirements of organization
- Professional goal-setting and career advancement

Topics covered in clinical supervision

- Integration of CHW into organization/team (clearly define CHW's role, provide mechanism for CHW to provide feedback to broader team and run interference within the organization)
- Case consultation and problem-solving
- Professional goal-setting and career advancement

6. Integration of Community Health Workers into Care Teams

Recommendations:

No.12 A CHW champion should be designated within the organization to help ensure that the role of CHWs is valued, understood and supported.

No.13 Training for all members of the healthcare team should be conducted to develop a thorough understanding of the history and current status of the community health worker profession *before* bringing a CHW onto the team.

No.14 Adequate time should be allocated to provide an intensive orientation for the CHW to the organization.

No.15 CHWs should be included in care team meetings and empowered to provide insights about their participants/the community during and between meetings.

No.16 CHW services should be documented as part of the electronic health record, to facilitate sharing of their work with other team members, and tailoring their support to individual needs.

CHWs have a unique understanding of the experience, language, culture, and socioeconomic reality of the community being served. They apply this unique understanding to make a distinctive contribution to improving health outcomes. CHWs achieve success through reinforcing clinical guidance and through addressing the SDOH by providing social support for the myriad of situations that their participants encounter.[33] Employers need to apply a deliberate process to facilitate successful integration of CHWs into healthcare teams and to optimize the contributions of CHWs. It should be noted that many CHWs are located in community-based organizations and settings from which they are well positioned to be fully integrated into clinical care teams in the communities they serve. Below, we provide recommendations for healthcare practices when integrating a CHW into a care team: (Adapted from MHP *Salud*: 9 Tips to Integrate *Promotores (as) into Health Center Care Teams.* *http://mhpsalud.org/portfolio/nine-tips-for-integrating-promotoresas-into-health-center-teams/*)

Supportive infrastructure

Create the infrastructure needed to empower and support the CHW, initially and continuously, i.e., pre- and in-service trainings and reflective/supportive supervision. Staff should also understand that the non-clinical community expertise of the CHW makes a unique contribution to supporting both the participant and the work of the team. Ongoing professional development for the healthcare team is highly desirable. It is essential that all members of the team develop a thorough understanding of the history and current status of the CHW profession *before* bringing a CHW onto the team.

CHW champion

Identify a CHW champion within the organization who will help ensure the role of CHWs is understood and supported.

CHW orientation to the organization

Allocate adequate time to provide an intensive orientation for the CHW to the practice. Introduce them to everyone from the front desk staff to the administration. The CHW needs to understand the processes; both within the healthcare setting, as well as outside the healthcare setting, when being incorporated as part of the heath care team. Be sure to provide orientation to the community served by the organization.

CHW support within the clinical setting: supportive supervision

- If the CHW is supervised within the clinical setting, provide a supervisor for the CHW who is supportive and provides guidance as the CHW adapts to a clinical environment, and on an ongoing basis afterward. Regular supervisory meetings are needed for problem solving difficult cases, tracking accomplishments, and identifying areas and opportunities for needed professional development. The supervisor must also support the CHW in balancing in-clinic duties and community-based work.
- The CHW will often be based within the community served, and therefore trained and supervised by a community-based organization. In this case, assign a point person who will provide guidance and facilitate their work, in coordination with the healthcare supervisor, when they are working onsite in the clinical setting.

Building the care team

- Ensure that the CHW is included and empowered to actively participate in frequent team meetings, to build a communicative and cohesive healthcare team.
- Be sure to provide a mechanism for the CHW to provide insights about the community to the healthcare team, and the healthcare staff.

Electronic health record (EHR) accessibility

Provide the CHW with access to the EHR to document their work, and a way to tailor their support to individual needs, and collect data while completing home visits and other provided services.

Evaluation

Regular process and impact evaluations of the results of the CHW's work is important to share with both the CHW and the organization's leadership, for continuous quality improvement and continued program support and sustainability for the CHW services. Involving CHWs in developing evaluation methods and outcomes will contribute to their professional growth and result in more valid and reliable measurements.

7. Documenting the Effects of Community Health Worker Services on Social Determinants of Health

Recommendations:

No.17 CHWs should be trained to collect data while completing participant services.

No.18 Indicators of CHW work should be systematically documented, including process, health outcomes and social outcomes measures related to the SDOH, in alignment with the Connecticut adaptation of the CHW Common Indicators Project.[34]

No.19 Regular process and impact evaluations of the results of CHW services should be conducted for continuous quality improvement and continued program support and sustainability of the CHW services.

No.20 CHWs should be involved in developing evaluation methods and outcomes in order to contribute to their professional growth and to build more valid and reliable measurements.

The body of peer-reviewed literature assessing outcomes of CHW programs is substantial and growing. However, the multiplicity of indicators tracked has made it impossible to aggregate outcomes of CHW programs at the national level or to develop a fuller understanding of how CHWs achieve these outcomes. To fill this gap, in 2014 members of the Michigan CHW Alliance (MiCHWA) began a process aimed at developing a common set of evaluation indicators and measures to capture the contributions of CHWs to successful program outcomes and their added value to healthcare and human services systems. In 2015, they were joined by members of the Oregon CHW Consortium, who organized a summit to develop a proposed list of process and outcome indicators for CHW practice.

The CHW Common Indicators (CI) Project comprises over 45 CHWs, researcher and program staff from around the country. Further development of the list of indicators, and measures to assess those indicators, is on-going. The list below is an adaptation for Connecticut, based on the preliminary CI list (http://www.michwa.org/common-indicators-project-2).[35]

Process indicators

- Referrals made: CHW-facilitated connections to resources, organizations, and policy makers
- Participant trust/satisfaction with CHW relationship
- Degree to which CHWs are integrated into healthcare teams
- Involvement of CHWs decision-making process
- Frequency with which CHWs enact 10 core roles[36]

Health outcome indicators

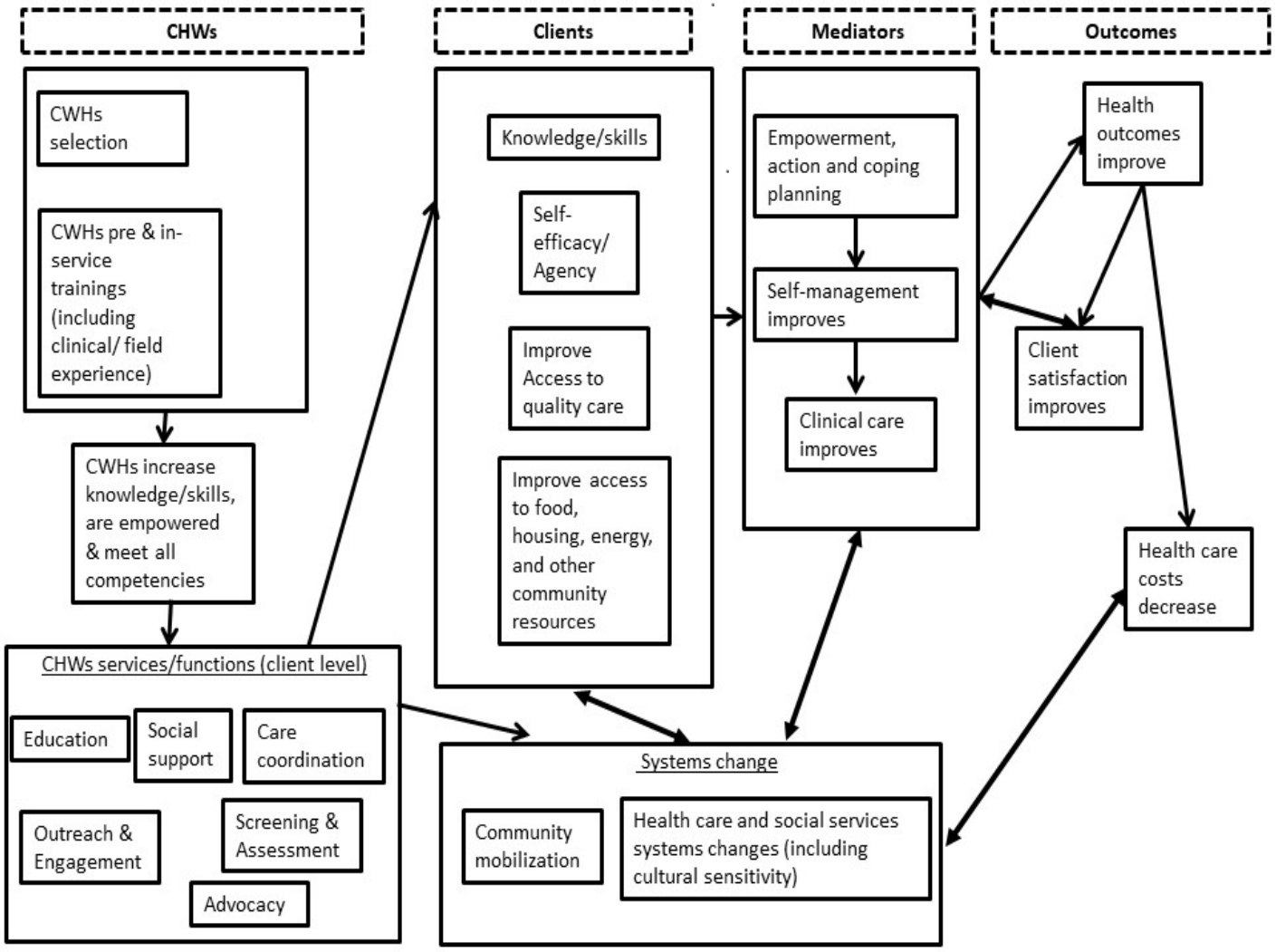
- Participant self-reported health - possibly through use of the SF-36, a 36-item short form survey developed by RAND Health, and commonly used by MCOs and Medicare for routine monitoring and assessment of care outcomes in adult patients[37]
- Participant clinical health indicators (e.g. diabetes control (HbA1c), asthma control, blood pressure, BMI, etc.)
- Participant utilization of health services (increased primary care use, decreased emergency visits and inpatient hospital visits)
- Participant total cost of care
- Participant access to healthcare services

Social outcome indicators

- Participant access to food, water, transportation, and security
- Participant knowledge, attitudes and behaviors
- Participant access to social services
- Participant social support
- Participant empowerment
- Participant civic engagement
- Participant quality of life/satisfaction with life
- Policy and systems change

Our panel developed a Program Impacts Pathways Diagram[38] to guide the selection of process and impact indicators of CHW services (see Figure 4 on next page). Please note that, in this diagram, CHW training is assumed to follow the recommendations provided above, including use of popular education methodology, which leads to empowerment.

Figure 4. Program Impact Pathways Analysis for Hypothetical CHW Chronic Disease Management



Program Impact Pathways analysis for hypothetical CHW chronic disease self-management program. Monitoring indicators can be mapped to each solid box. (Wiggins et al. (2,3,23,31)., Kieffer et al. (4), Pérez-Escamilla et al. (28,29), Pallas et al. (38)

Issues that need to be considered for scaling up CHW services

The global literature indicates that the ability for states or countries to scale up CHW services relies heavily on embedding them as part of well-developed healthcare and social service platforms. Although civil society organizations and the academic sector have played an important role in developing diverse cost-effective CHW prototypes, it is only when governments provide the financial resources to cover the cost of high quality training opportunities and salaries for the CHW workforce that their services can be scaled up and sustained. Although different countries developed varied architectures for their CHW programs, common challenges that they have faced include: (i) adding additional tasks to existing workers without carefully planning the impact of that decision on both the CHW employees and the outcomes; (ii) not having budget lines or stable reimbursement mechanisms specifically tied to CHW training, services and supportive supervision; and (iii) having weak monitoring & evaluation management information systems.[39] Add a final sentence: "Avoiding these pitfalls is crucial to successful scaling of CHW programs at the state and national level.

CONCLUSION

Historically, CHWs have addressed SDOH through a variety of activities, from helping people meet their basic needs, to organizing communities to address the underlying causes of adverse health outcomes. A service design that optimally supports CHWs in addressing SDOH would incorporate all seven areas of policy recommendations included in this report: funding, caseloads, recruitment, training, supervision and mentoring, integration into care teams, and monitoring/evaluation.

Also highlighted in this report is the importance of:

- The word *community* in Community Health Worker:

  As emphasized by the World Health Organization,[5] the community context of CHWs is important to full execution of their role; community immersion enables CHWs to successfully address SDOH at individual and community levels.

- Regular process and impact evaluation of the results of the CHW's work:

  Documentation of the work of CHWs facilitates validation of their essential functions, including their impact on SDOH. Continuous review and sharing of the impact of CHW work enables quality improvement and facilitates continued CHW funding support.

It is critically important to take these evidence based recommendations into account in the redesign of funding for CHW services, to assure CHWs are able to make an optimal contribution to addressing SDOH.

ENDNOTES AND REFERENCES

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Appendix 1. Caseload Estimator

1. Employer Job Standards

Total weekdays	260.00	Days per year
Paid holidays	12.00	Days per year
Paid vacation days	15.00	Days per year
Average paid sick days	10.00	Days per year
Work days per year	223.00	Days per year
Hours worked per day	7.00	
Total work hours per year	1,561.00	

2. CHW job requirements

a. Administrative time

Weekly meeting time (case review, staff meetings, supervision, etc.)	5.00	Hours per week
Weekly meeting time per year (rounded)	260.00	Hours per year
Other **annual** paid administrative time (training, conferences, annual meetings)	24.00	Hours per year
Administrative time per year	284.00	Hours per year
Remaining work hours	1,277.00	

b. Participation in Community Meetings/Advocacy Activities

Meetings per month	1.00	Meeting
Hours per meeting, incl. travel	2.50	Hours
Total hours per year	30.00	Hours
Remaining work hours	1,247.00	

c. Home visits

Time in home	1.50	Hours per visit
Travel time - roundtrip	0.75	Hours per visit
Follow-up	2.00	Hours per visit
Documentation time	0.25	Hours per visit
Time required per home visit	4.50	Hours per visit
Average number home visits per client	6.00	Number of visits
Time required for home visits per client	27.00	Hours per client

d. Phone calls to client

Call duration	0.30	Hours per call
Follow-up	0.30	Hours per call
Documentation	0.03	Hours per call
Total time per call	0.63	Hours per call
Average number of calls per client	10.00	Number of calls
Time required for phone calls per client	6.30	Hours per client

c+d Total time per client - visits and phone calls	33.30	Hours per client

e. Annual Case load

Remaining work hours divided by time per client	37.45	**Clients served**