

The Changing Roles of Community Health Workers

Take Away Points

- Community Health Workers (CHWs) are valuable members of health care teams given their connection to communities and potential to address social determinants of health and disparities.
- The shift of CHW employment settings from community based organizations to health systems urges the need of development of competencies that relate to CHWs' ability to integrate into health systems while maintaining their unique identity.

The Issue

The roles and activities of Community Health Workers (CHWs) are tailored towards meeting the unique health needs of the community. Due to their shared life experiences and deep understanding of community needs and resources, CHWs may have trust of the community and the ability to address social determinants of health where the health care system may fall short. Growing evidence suggests that CHWs can achieve positive health outcomes, particularly among low-income and minority populations. New Medicaid rules that allow reimbursements for CHW preventative services have led to questions surrounding the standardization of the CHW profession. Due to this change, it is increasingly important to understand the variations in CHWs' roles and how these variations relate to management, health system integration and to the competencies CHWs should have in different roles.

Source

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This study sought to determine 1) the range of settings in which CHWs are working as well as employers' hiring preferences, 2) what experts believe are the keys to successful CHW integration into health systems, and 3) if current CHW competency lists are consistent with employers' hiring perspectives.

Study Methods and Design

To address the first aim, a database of programs that employ CHWs was developed through a range of data collection techniques, including key informant interviews; for the second aim, key informant interviews were analyzed; and for the third aim, a comparative analysis of CHW competency lists was conducted. Between January-May 2015, the program database used in aim one was created by reviewing the literature, searching conference presentation topics (2014-2015) for relevant topics and performing internet searches using keywords related to CHW integration into health systems. Two specific job titles were excluded (patient navigators and health educators) as well as programs that carried out health activities with practitioners (e.g., nurses, social workers) other than CHWs. To supplement information, semi-structured interviews were conducted with 24 CHW employers and thought leaders who were identified based on consultations with experts and through the literature review. Interviews covered perceived changes in employment and keys to successful integration of CHWs. The database was further populated by pulling publicly available information from program websites followed by surveys sent to program contacts to validate and supplement information gathered. The search yielded 117 programs; 76 met inclusion criteria and were surveyed, 19 responded (25%). Four variables included on that survey

were the focus of this analysis: (1) primary site of intervention, (2) leading organization, (3) funding source, and (4) preferred hiring qualifications. Finally, CHW competency lists were identified on state websites or on affiliate websites; nine competency lists from eight states were identified.

Key Findings:

- **Program Characteristics:** Out of 76 programs analyzed, 57 (75%) provided services in home and community settings; 13 (17.1%) were based in a non-hospital clinical setting (e.g., physician’s office, school-based health center); and 6 (7.9%) were based in a hospital.
- **Leading Organization:** 44 programs (58%) led by clinical providers and health plans, in which hospitals/health systems led 24 programs. Community based organizations (CBOs) and other non-profit entities led 29 programs, while health/social agencies led 7 programs. Contrary to database results, most interviewees assumed that CBOs continue to be the leaders in most programs.
- **Funding Source:** CHW program funding is reliant on short-term grants and contracts: most were funded by federal health or social agencies (27, 35.5%) followed by private foundations (21, 27.6%), state or local health agencies (15, 19.7%), and health system entities (15, 19.7%); 9 programs (11.8%) were funded by multiple sources.
- **Hiring Qualifications:** Almost half the programs (37, 48.7%) required community membership or familiarity of CHWs and 5 (6.6%) required “peer” status (e.g., being diabetic for work in diabetes prevention). While 27 (35.5%) required training or certification, 17(22.4%) required language skills and 8 (10.5%) had a minimum education requirement. Interviews echoed database findings. Those employers hiring CHWs directly are more likely to require training/education.
- **Types of Integration:** In 41 programs (53.9%), CHWs were “direct hires,” or members of a larger team of health professionals. Seven (9.2%) programs had “community partner” arrangements with CHWs employed by an external entity. CHWs were external “informational resources” for 9 programs (11.8%), with no formal partnership, and 21 (27.6%) were “independent,” where CHWs were connected to the health care system through referrals only.
- **Successful integration of CHWs into the health systems:** Majority of the informants (16, 66.7%) expressed the need for established communication channels for CHWs and other providers about patient care, 10 (41.7%) considered transfer of expertise between CHWs and other providers an important factor, and 13 (54.2%) highlighted the importance of CHW autonomy.
- **CHW competencies:** All informants emphasized importance of establishing and standardizing CHW competencies. Nine competency sets were found, with a high degree of consistency across them. Two needs were identified: 1) lack of competencies that CHWs need to successfully integrate into health systems, and 2) lack of competencies that reflect CHWs’ unique identity and contribution.

Limitations Convenience sampling was used and therefore results may not be reflective of all CHW programs, strategies, or competency models.

Final Thoughts

The emerging value based payment models can increase the use of CHWs since employers are increasingly identifying key tasks that are not in themselves reimbursable but contribute to improved health if delivered through a cost-effective and efficient model.