Community Health Worker Advancement: A Research Summary

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Executive Summary

In 2005, the Robert Wood Johnson Foundation awarded a grant to SkillWorks to apply the SkillWorks approach to career advancement to community health workers. SkillWorks: *Partners for a Productive Workforce* contracted with Jobs for the Future, a Boston-based consulting group focusing on economic and educational advancement for disadvantaged youth and adults, to recommend adaptations of the SkillWorks Workforce Partnership model. As the basis for these recommendations, SkillWorks asked JFF to conduct research on the challenges to and national best practices for the advancement of community health workers.

The research team employed several methods to learn about career advancement in the field of community health work and the analysis of the return on investment in terms of improved health care quality from improving career advancement opportunities for community health workers. These methods were:

- A focus group of Massachusetts and Boston-area experts;
- Interviews with local and national key informants; and
- A literature review on community health worker practices, education program designs and curricula, and evaluations.

Findings

Community health workers are an essential, if overlooked, part of the U.S. public health system. They work in diverse settings and under myriad titles to improve access to health care for underserved populations using culturally appropriate methods. Despite their importance, community health workers are often not well rewarded, and their job tenure is unstable. Well-defined career paths are lacking, as are systematic skills sets and credentials recognized across work settings and usable for higher education. As a result, turnover is high, with individuals leaving not only their jobs but also the field itself. Employers are constrained from investing more deeply in training and rewards, owing, among other factors, to third-party payer reimbursement arrangements and to dependence on grants for funding health outreach.

Employers typically choose between hiring from a community that is targeted to receive services or hiring an individual with education and experience in public health. It is not uncommon for a community health worker with a Master's in Public Health to be employed at the same job, at the same low rate of pay, with the same job insecurity as an individual with only a high school diploma. There are minimal career advancement opportunities, and to get ahead financially, a person must either leave the field altogether or move into supervisory or grant management positions.

The nature of the evidence available regarding advancement models for community health workers reinforces that this is an emerging field in the public health arena. There is little precise data on the size of the workforce, locally or nationally. There also are few evaluations of the impact of the work or evaluations of the impact of community health work education and training on health care outcomes. Contributing to the problem is the fact that there is no widely accepted definition of what community health workers do. In most parts of the country, the field is not regulated or licensed, nor is the position certified; efforts to apply such requirements have met with mixed reactions from both community health workers and their employers in some locations.

Introduction

This report summarizes the results of a scan of local and national educational programs and workforce advancement issues concerning community health work. The research was conducted for the Boston-based SkillWorks initiative, with funding from the Robert Wood Johnson Foundation. Its purposes were to:

- Clarify the challenges that community health workers face in the labor market; and
- Explore the feasibility of a variety of national and local approaches to addressing these challenges.

The findings supported the preparation of a Request for Proposals that aligns the advancement strategy proposed through SkillWorks with the most promising practices for intervening in the community health work labor market. The RFP adapts the SkillWorks model to the issues and challenges surrounding this sector in Boston.

SkillWorks capitalizes on the best practices and unique strengths of the city's workforce development system to help low- and moderate-income adults advance into family-supporting employment. It does so by building partnerships between Boston's employers and workforce development providers. SkillWorks is a five-year initiative led by thirteen local and national foundations, the City of Boston and Commonwealth of Massachusetts to improve the way that workforce development meets the skill development needs of low-income residents and of the region's employers.

SkillWorks utilizes a three-pronged model to improve the workforce development system for workers and employers:

- *Workforce Partnerships*, or intermediaries targeted to industry sectors or occupations to solve problems for workers and employers;
- *Capacity Building* of Workforce Partnerships through technical assistance; and
- *Public Policy Advocacy* for sustainable improvements in workforce development.

Community health workers are an essential, if often overlooked, part of our public health system. Though working in diverse settings and under myriad job titles, they are united by the goals of improving access to health care for underserved populations using culturally appropriate methods. Often, they are also representatives of these populations. Despite their importance, their work is often not well rewarded and their job tenure is unstable.

Research Methodology

The research team employed several methods to learn about career advancement in the field of community health work and to analyze the return on investment in terms of improved health care quality from improving career advancement opportunities for community health workers.

First, JFF and the SkillWorks Funders Group convened a focus group of state and local experts to explore the nature of the community health work labor market in Massachusetts and the challenges facing its workforce. Participants represented workers, education and training providers, state funders of community health workers, and provider organizations (including the statewide organization of community health clinics). *(See the Appendix for a list of participants and the meeting agenda.)* After learning about the SkillWorks model of workforce development, the participants responded to a series of questions in the following areas:

- Current labor issues in community health care, including the largest labor force challenges, distinctive labor markets within the community health work field, and potential skill shortages;
- Profile of community health workers and employers, including necessary skills, opportunity structures, and the role played by education in advancement; and
- Potential career ladders, including feasible components, current efforts, and likely intermediaries who might design and operate such projects.

Building on the findings from the focus group, JFF sought out key informants, both locally and nationally, to describe and assess education and training programs for community health workers, suggest evaluation criteria, and deepen our understanding in several areas, including job titles and tasks and the employment of community health workers in specific Massachusetts settings. These contacts were identified through inquiries with focus group members and from recommendations by initial informants. An interview protocol tailored questions to employers, community-based organizations, worker representatives, and researchers. In these discussions, JFF also asked informants to validate our emerging ideas for career ladders in community health work.

Finally, to identify promising advancement practices, JFF searched relevant literature on community health worker practices, education program designs and curricula, and evaluations of their impact. These were obtained through expert recommendations, Web-based queries, and the researcher's prior project experience.

A central concern of the Robert Wood Johnson Foundation for this initiative is the demonstration of "return on investment"— quantifiable benefits for employers, patients, workers, or others, particularly in the quality of health care. The research team also sought models for eval-

uating community health work practice and educational programs, including specific criteria or metrics that might be applied to the SkillWorks program. This was done both by consulting practitioners and users of community health work evaluation and by searching for academic literature and public health reports. Key sources of information on evaluation included Dr. Lee Rosenthal, author of the National Community Health Advisor Worker Study (1998), Dr. Jacob Tennenbaum, U.S. Bureau of Health Professions, HRSA, and Anne Willaert, Healthcare Education Industry Partnership.

The nature of the evidence available regarding advancement models for community health workers brought home that this is an emerging field in the public health arena. There is little precise data on the size of the workforce, locally or nationally. There are also few evaluations of the impact of community health work or evaluations of the impact on health care outcomes of education and training for community health workers. From the research, JFF learned the most widely accepted thinking in the field in two areas: promising practices and challenges for worker advancement; and the return on investment of community health work on access to health care for hard-to-reach populations.

What We Learned

Employment Status of Community Health Workers

While studies often consider Massachusetts something of a national leader in recognizing community health work as a distinct field, there is no formal, widely accepted definition of what community health workers do in this state. It is not a regulated, licensed, or certified position, nor do any health care regulatory bodies or health care or public health delivery bodies (e.g., community health centers, hospitals) mandate the use of community health workers.

What Community Health Workers Do

Community health workers are part of the public health system's strategy to increase access to health care for underserved populations, such as immigrants, limited English speakers, minorities, and residents of low-income neighborhoods. Community health workers serve as "culture brokers," providing culturally and linguistically appropriate information, resources, services, and advice to targeted groups, and, ideally, they help develop culturally relevant public health care programs (Love and Gardner 1992). Their role has grown steadily in the U.S. public health system since the 1960s, but their integration into clinical and service teams has been spotty, including in Massachusetts and Boston, as in the rest of the country.

Community health workers go by many job titles and perform a wide range of services to increase access to health care for underserved communities. The Massachusetts Department of Public Health recognizes over 40 job titles as falling into the community health worker category (Ballester 2005). Their roles include (Community Health Works of San Francisco 1997):

- Teaching community members the concepts of primary and secondary prevention;
- Linking hard-to-reach patients to needed services;
- Increasing access to preventive care;
- Facilitating patient appointment-keeping;
- Increasing patient compliance with prescribed regimens;
- Improving screening and early intervention for specific medical conditions; and
- Preventing unnecessary reliance on emergency department and specialty services.

In keeping with these tasks bridging underserved groups to mainstream health delivery resources, Massachusetts public health professionals seem to agree in large part that the role of community health workers is to link members of hard-to-reach groups to health care, behavioral health, and social service resources.

Where They Work

Community health workers perform their jobs within, and as a complement to, the health care delivery system. They may be based in community health centers; hospital emergency rooms, outpatient clinics, or specialized departments; non-profit community organizations; managed care organizations; and government or academic public health departments.

In Boston, community-based organizations and multi-service centers employ community health workers on grant-funded projects (e.g., smoking cessation, teen pregnancy prevention), often in small numbers and usually in a single specialty area. The Boston Public Health Commission, a unionized employer, employs a significant number of community health workers in multiple specialty areas; it, too, is primarily grant-funded. Several Boston hospitals employ community health workers as Patient Navigators in specialty departments or clinics (e.g., Massachusetts General Hospital's breast cancer treatment center). As a group, community health centers employ the most community health workers, both as generalists and in specialty areas.

In an apparent idiosyncrasy, the mental health and substance abuse treatment systems in Massachusetts do not employ community health workers to any significant extent. Recent legislation requiring all individuals having client contact in these systems to have at least a Master's degree precludes employment of people with the usual community health worker profile from providing health education or case management support. Within these systems, some community health workers provide outreach services, but their roles and opportunities for advancement are constrained by the Allied Health Professional Regulations (Funk 2005**)**.

Job Security

Community health work is poorly paid, unstable, and rarely provides fringe benefits. Starting salaries are about $9.50 per hour, regardless of experience or education. It is not uncommon for community health workers to provide education and referral services related to health insurance that they themselves do not receive from their employers.

The funding to hire community health workers comes from public health grants or from third-party payers, such as Medicare, but these sources do not cover their services in the clinical/patient care setting. Employers must build the cost of employing community health workers into the reimbursement rate for covered services, as an overhead expense. In tight budgets, community health workers are among the first to be let go, despite the likelihood that they contribute to revenue by increasing the number of patients from hard-to-reach populations.

In the public health setting, community health workers are integral to the patient outreach and education strategy for initiatives such as smoking cessation, teen pregnancy prevention, or HIV/AIDS education. Community organizations, multi-service centers, community health centers, and sometimes hospital departments apply to the Massachusetts Department of

Public Health, federal agencies (e.g., the federal Centers for Disease Control and Prevention or the U.S. Department of Health and Human Services), or foundations for multi-year or, at times, single-year, grants. Because grants are awarded through a competitive public procurement process, there is no assurance that a program will be operated by the same agency from year to year or grant to grant.

The consequence of these financing constraints is that community health workers have little job security and will often take a new job on a different grant for comparatively small increases in pay.

Hiring Criteria

Massachusetts has no licensing or accreditation standards for community health workers; employers set their own hiring criteria. Most national studies emphasize that community health workers should be knowledgeable about the communities they work with – and preferably be members of it and have strong ties to it. Personal qualities, such as cultural competence, warmth, and flexibility, tend to be rated more highly than knowledge or experience with health systems or conditions (Love and Gardner 1992).

In Boston, employers recruiting community health workers typically choose between hiring from the community targeted to receive services or hiring an individual with education and experience in public health. In the first case, workers with a high school diploma or GED often need training about the health care and behavioral health systems, social service resources, and specific health conditions. In the latter case, workers with Bachelor's degrees (or more) often need training in culturally competent interview, counseling, and education approaches for each community. In keeping with national norms, employers incline toward hiring from the target community and providing training on health issues and the service delivery systems. The premise is that it is easier to teach comparatively objective content than to teach a highly educated professional how to work within the cultural norms of various underserved communities.

Demand/Supply Issues

None of the employers or service agencies JFF spoke with reported having a hard time recruiting or hiring community health workers. Rather, the challenges are poor job retention and a lack of advancement opportunities. As a result of high turnover, institutional memory is lost to organizations interested in cultivating relationships with target communities or in building a community reputation for accessibility in key public health areas.

Little is definitively known about the number of community health workers in Greater Boston. This is partially attributable to the lack of consensus on what job titles are considered community health work, but also because they work in many different settings that are overseen by different regulatory bodies, none of which track employment statistics.

Nationally, the Centers for Disease Control and Prevention maintain the most comprehensive database on the employment of community health workers. In 1998 the CDC counted more than 10,000 individuals in 200 programs, a number that the National Community Health Advisory Study sponsored by the Annie E. Casey Foundation estimated reflected less than one-third of all community health programs (Rosenthal et al. 1998). This same study estimates that each program employs, on average, six community health workers.

Current Advancement Opportunities

It is not uncommon for a person with a Master's in Public Health to work side by side in the same job at the same rate of pay as a person with a high school diploma. Employers consider this to be a trade off between cultural competence and technical knowledge.

Within community health work itself, JFF heard a consensus among Boston advocates, employers, worker representatives, and policymakers that there is a lack of career advancement opportunities. To get ahead financially, a person must either leave the field or move into a supervisory or grant management position. Career advancement is available in related fields, such as social work or public health, and there is a great need for individuals with the cultural competence skills possessed by most community health workers in patient care and hospital administration positions.

The Education and Training of Community Health Workers

Several organizations in Massachusetts offer workshops and training sessions targeted at community health workers.

One of best-known, the Central Massachusetts Area Health Education Collaborative *Outreach Worker Training Institute*, is located in Worcester and thus not readily accessible to Boston-based workers or candidates. This program offers a 45-hour certificate course, with classes for three-hours per week over fifteen weeks. Participants can earn academic credit. The curriculum focuses on a range of competencies, including communication, community assessment, advocacy skills, environmental health, substance abuse, and mental health. It addresses most of the core competencies described by advocates as needed by community health workers, although it does not specifically cover the delivery systems for behavioral health, health care or social services.

In Boston, the Community Health Education Center at the Boston Public Health Commission provides a certificate with 55-hour, 15-session program in both substantive health areas and core skill areas, such as leadership, cultural competence, community organizing, and assessment. As with its counterpart program the OWTI, participants can earn academic credit in local universities and colleges. The program provides training and technical support to CHWs in 175 organizations across Metropolitan Boston, including hospitals, community-based agencies, and public health departments. The program also serves employees of the Boston Public Health Commission and its grantees. As with other area training programs, it is not able by

itself to address the English language literacy development and other remedial education needs of many community health workers that impede their participation in training. Some of Boston's better-known neighborhood health clinics, such as Codman Square Health Center or Dimock Community Health Center, have conducted well-regarded training programs for their staff, but none focus on advancement of community health workers.Boston-area community colleges offer health education certificate and degree programs in a variety of patient care, medical technician, and medical administration career tracks. However, Bunker Hill, Mass Bay, and Roxbury Community Colleges offer no courses on community health work or the public health field. The most relevant offering is Mass Bay's 16-credit certificate program in Medical Interpreting.

Return on Investment and Quality of Care

There is little formal evaluation of the impact of community health worker education on long-term outcomes in health care and its delivery. Some scholarly and professional literature discusses the impact of community health work on key health care outcomes, such as inappropriate uses of emergency room services (and associated hospital costs) or chronic disease management (e.g., for diabetes or asthma) (Frye 1998, Finneran 1994, Rosenthal et al. 1992). Evaluations have also demonstrated the value of community health workers in disease prevention and the control of hypertension (Butz 1994, Knobel 1992). The CDC, which has funded demonstration programs for educating community health workers in several Florida community colleges, is in the process of evaluating student outcomes (e.g., attaining raises or higher skilled positions), as is Minnesota's recently established Community Health Worker Project for training community health workers. Both initiatives are too new to adequately measure results for community health workers and their communities.

An example that informed our research was the evaluation framework of the National Community Health Advisor Study, which was developed to help monitor community health worker program activities and measure their effects on clients, workers, communities and health care systems. The framework, while not measuring the effects of education per se, is relevant to SkillWorks because it defines measures of program outcome in multiple areas: individual, organizational, and external, including the community and the wider policy environment (Rosenthal et al. 1998).

While JFF found examples of metrics in these areas for community health worker projects funded by federal agencies, statewide programs, and local initiatives, there is little consistency or standardization of practice. Based on interviews and literature, however, we found considerable interest from practitioners and funders for increased use and improvement of evaluation, and confirmation for the types of outcome measures we have proposed for the community health worker Workforce Partnerships.

Potential Solutions

Mapping the Field

The proposed SkillWorks Workforce Partnership continues a path marked by numerous other efforts to intervene and bring improvements to the labor market for community health workers. These include projects to "map the field" and bring clarity as well as recognition to those whose work and contributions have previously been poorly understood – or even classified as part of the same field. Some states, including California and Massachusetts, have conducted surveys of their community health worker labor force and its employers (Love and Gardner 1992, Ballester 2005). The most widely used example is the Annie E. Casey Foundation's National Community Health Adviser Study (Rosenthal et al. 1998). This report's definition of community health workers and their roles, along with recommendations for improving the field, have been used in many subsequent projects at both the state and national levels, including in Massachusetts. A further national effort to map the field and enumerate the community health work labor force was initiated in 2005 by the U.S. Health Resources and Service Administration (Siciliano 2005).

Improving the Job

The other major category of effort has focused on improving the job and, in some cases, providing support for advancement. This has extended to formal recognition and adoption of community health work by funders in government and third-party insurers; the creation of career ladders and standards for employment and advancement; and the creation of educational programs to support skill development and advancement of community health workers.

Certification

One approach to standardizing the field, upgrading the job, and improving community health workers' performance has been the establishment of standard competencies and certification for those demonstrating mastery of them. For example, in San Francisco's Community Health Works program, agencies or postsecondary institutions grant certification for demonstrated competencies and education. Certification is not a requirement for employment in the field, but certificate holders are eligible for higher salary ranks or they can substitute the certificate for required years of work experience.

In a few cases (Texas, Ohio, Alaska), statewide community health worker certification requirements have been adopted, not unlike those required for Certified Nursing Assistants. While such standards have the benefit of improved status and recognition for the work, as well as greater transferability of such status between jobs, they are controversial in Massachusetts and elsewhere. Advocates for community health workers fear that required certifications, particularly those requiring postsecondary credentials, would create barriers to entry as well as to advancement for some experienced workers who are knowledgeable about and trusted

by their communities. A further problem for establishing and monitoring certification is capacity: only two institutions are designated to certify community health workers for all of Texas.

Massachusetts has not yet adopted a statewide certification requirement, but several independent programs now offer certificates following a brief course of instruction. These programs have been valuable in building the skills of individual workers and enhancing the capacity and professionalism of the field. However, they do not serve all who could potentially benefit from education, nor do they involve partnerships leading to recognized degrees or credentials from postsecondary institutions.

Career Ladders

Practitioners and community health worker advocates describe two potential approaches to offering career ladders: "up and out" of community health work; and promotion tiers. Each approach presents opportunities for wage advancement and meeting employer skill shortages.

"Up and Out" refers to facilitating the access of community health workers to established health career tracks in areas such as patient care, clinical technician, or medical administration. Workers in these positions who are members of hard-to-reach communities are much sought after by the health industry, as they bring a culturally competent approach to working with patients who may have difficulty understanding and accessing mainstream health services.

Massachusetts employers do not have a promotional track career ladder in community health work that links increases in wages and responsibility to increases in skills, education, or competencies. Such a system does exist in other parts of the country, related to the adoption of certification standards and often involving union advocacy.

Higher Education-based Programs

Outside of Massachusetts, a number of states have developed programs based in higher education institutions – principally community colleges – and often partnered with agencies employing community health workers. A program with such partners established in Massachusetts could build on a growing track record and accompanying lessons.

These programs vary in a number of dimensions, including admission criteria; length and number of credit hours offered; recognition by employers and funding agencies; funding mechanisms; required or optional curricular content; points of entry; and granting of or articulation with postsecondary degrees or credentials. The Center for Sustainable Health Outreach, based in the University of Southern Mississippi and Georgetown University, set out to document such programs as of 2002, and identified 15 that offer courses, certificates, and/or degrees in community health work (Center for Sustainable Health Outreach 2002). More recently, the Fund for the Improvement of Post-secondary Education, a federal program,

funded a demonstration project to establish good practices in college-based community health worker education. Program officials and evaluators are looking for models of curriculum and instructional design, institutional climate, student retention, and sustainability of such programs.

Program Design Components and Rationale

Based on JFF's research into the challenges and promising practices for advancement of community health workers in Boston and nationally, we conclude that the easier strategy will be to link workers to career paths in related health care and administration occupations. More challenging – but strongly desirable – is a strategy to create a career ladder within community health work where there currently is none. A needed component of this latter strategy is to create an accessible, widely recognized education program that resides at one or more community colleges. However, that will only tackle half of the problem. A strong advocacy and employer engagement component will probably be needed to address the structural problems that inhibit the adoption of a community health work career ladder linking increases in skill, education, and experience to increased responsibility and wages.

Appendix

SkillWorks℠
PARTNERS FOR A PRODUCTIVE WORKFORCE

Community Health Workers Workforce Development Project
Stakeholder Focus Group
September 27, 2005

Attendees

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Community Health Workers Workforce Development Project

Stakeholder Focus Group

September 27, 2005

Agenda

Meeting Objectives:

- To introduce stakeholders to the SkillWorks model
- To gain insight into the current state of affairs for community health workers
- To hear stakeholder insights into how a career ladder model could work for community health workers, in order to assist with the development the RFP

I. Introduction
  - Purpose of the meeting
  - Introductions

II. Description of SkillWorks (PPT)
  - Goals
  - Use of intermediaries
  - Role of employers
  - Goals of RWJ project – career ladder development for community health workers

III. Questions for Stakeholders:

A. The current state of affairs
  - How do employers find these workers now?
  - What sort of training is available to them?
  - Where do entry-level community health workers typically go after the 1st job?
  - What are the barriers to workers getting ahead

B. Potential for career ladder development
  - What potential career ladders could you envision for entry-level community health workers? (draw a "map" on flip chart – start with one comment, have others add to it.)
  - Who are the likely intermediaries who would have the capacity to do this?
  - Who are the likely employer partners?

C. Need for career ladders from the employers perspective
  - What is the downside of the current way things operate from the employers' perspective?
  - Are there skill shortages at levels beyond entry-level that could be filled with a career ladder model?

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