

COMMUNITY HEALTH WORKERS/PROMOTORES IN CHRONIC CARE: A DISCUSSION PAPER

Community Health Works put out this informal discussion paper in November, 2006, to promote discussion among CHWs and their allies on the long-standing issue of sustainability and credentialing for health workers. Community Health Workers is the partnership of San Francisco State University and City College of San Francisco.

In the US, the role of community health workers (or *promotores*) was developed within the community health center movement in the early 1960s. Over the next four and a half decades, CHWs have been used in thousands of health programs, overwhelmingly in the health safety net. Many of these are documented in the NIH CHID database.¹ About half of CHWs work in clinic settings for health departments and community based organizations, while half work in community outreach settings.²

The roles CHWs play fall on a *continuum* from broad community health functions to narrow “go-fer” functions. Some CHWs carry out community organizing to create healthier community conditions; others organize public health functions such as needle exchanges or dental screenings; others carry out interventions with individuals, for example, providing social care management for persons with chronic conditions; still others have circumscribed roles such as tracking down and bringing in patients to care.³ This paper addresses the role of CHWs in chronic care management.

Despite their significant long-term presence in the health safety net and numerous evaluations, CHWs have never broken through their marginalized position within the health workforce. Permanent sustainable support for their role exists only in relatively small pockets of the overall US health system.⁴

In contrast, in the international arena, community health workers have been widely recognized as a “lynchpin” of health teams. Most recently the role of CHWs has been articulated in the extensive writings of Paul Farmer, MD, professor at Harvard University and a founder of Partners in Health. Dr. Farmer’s group has articulated a team-based biopsychosocial model of care relying on CHWs as the backbone of health teams. Small numbers of physicians and nurses work in teams with large numbers of health workers. This staffing pattern extends high-quality care on a cost-effective basis, achieves notable rates of adherence and excellent health

outcomes. Contrasted with a strictly medical care model, it builds *community development* and *self-determination* in health care in marginalized communities. This community-based care model has been replicated and evaluated by the Partners in Health group in Haiti, Peru, Rwanda, Mexico, Russia, in the US in Boston. The model has been employed in a range of disease-specific conditions including HIV and tuberculosis.⁵

In this paper we make the argument that CHWs should also be recognized as lynchpins of the health system here in the US. The reasons for their success in the international arena apply equally within the health safety net in the US. In our opinion, the PIH biopsychosocial model can be readily adapted here. This is already being done in a small number of leading asthma programs in the US.⁶

When the issue of children's asthma gained visibility in around the year 2000, CHWs were pressed into service in programs all across the country, in roles ranging from case management to community organizing. Together with the New York City Department of Public Health, Community Health Works co-hosted east coast and west coast meetings on the role of CHWs in the asthma epidemic.⁷ Taking place in 2003, the two meetings drew some 200 people.

In 1992, 1997, 2004, and 2006, Community Health Works carried out systematic labor market surveys on CHWs work statewide and regionally in the Bay Area.⁸ These surveys surfaced a number of objections to the wider use of CHWs, and misconceptions of their role. This section will address some of these issues, including quality of care; scope of practice and supervision; quality assurance; and cost effectiveness.

CHWs FOCUS ON THE SOCIAL ASPECTS OF MEDICAL/SOCIAL CARE

Community health workers/promotores:

- Reinforce health education messages in clear non-technical language;
- Help families learn the self-management skills needed to follow treatments;
- Provide “accompaniment” or social support from peers;
- Help families navigate the healthcare system and overcome system barriers;
- Do home environmental assessments and help families minimize asthma triggers;
- Help families access information and referrals;
- Provide care in language and with cultural references familiar to the patient and family;
- Inform the rest of the healthcare team about the family's social, emotional, and economic situations, so that the clinical professionals can better tailor

- their interventions.
- Advocate for services and social change to better meet community needs. For example, asthma CHWs may organize their constituencies on issues such as clean air and healthy housing.

QUALITY OF CARE

One objection to the wider integration of CHWs is that their incorporation may lead to giving low-income people watered-down care by less-qualified providers. We believe this objection is based on a misunderstanding of the CHW role.

Particularly in some rural areas of resource-poor countries that suffer a critical lack of licensed health professionals, community health workers/promotores have functioned as the only healthcare providers—as “barefoot doctors”.⁹ *That approach is not what is being proposed here.*

In contrast, in the Partners in Health model advocated by Paul Farmer deploys CHWs working side by side with clinicians and registered nurses, providing adjunct care in chronic conditions. **The licensed health professionals carry out essential clinical tasks**, including diagnosis, treatment, development of care plans and implementation of clinical procedures. Their impact is multiplied and made much more effective by working closely with teams of CHWs who coordinate the social aspects of care. **CHWs do not substitute for the clinical role of licensed health professionals.** Rather, by assuming responsibility for the social and routine aspects of chronic care, CHWs extend how many people can be reached. Additionally, CHWs are peers, concordant with the people they serve in language, ethnicity, educational background and class background. They possess a first-hand knowledge of community realities and resources. Their interventions are made effective by the power of peer relationships.

In traditional clinical models without CHWs, rushed health professionals must focus on pressing clinical tasks, and the social aspects of chronic care are left unaddressed. As a result, quality of care suffers and too often patients are not assisted to master self-management skills and overcome social complicators. The work of CHWs frees clinicians and nurses to focus on the clinical tasks they were trained for.

SCOPE OF PRACTICE AND SUPERVISION ISSUES

A second objection to the wider use of CHWs is that they may drift out of their scope of practice and begin to advise on issues that are beyond their competence.

This is a real issue that must be addressed. Because they frequently gain the deep trust of patients and their families, CHWs/promotores are sometimes asked by families to advise or assist with medical and social issues that are beyond their scope and training. It is important, then, that CHWs' preparation should include a clearly delineated scope of practice that can guide them on when they need to call in another team member. Publications that can inform scope of practice guidelines include *The Final Report of the National Community Health Advisor Study: Weaving the Future*;¹⁰ and YES WE CAN's *Managing Children's Asthma: A Community Focused Team Approach, Volume 3: Community Health Worker Manual*.¹¹

For their contributions to be realized, CHWs need to be fully integrated onto care teams, rather than operating in isolation. Like other team members, they need supportive supervision and regular team case conferences. These are venues to update clinical staff on what CHWs have learned about the family's progress and how to tailor the care plan appropriately, and for CHWs to tap the clinical expertise of licensed health professionals.

Asthma CHWs may encounter very challenging issues in mental health, addiction, domestic violence or very poor housing conditions. In these complex situations, in addition to support from their supervisors, CHWs need to have access to skilled consults that can listen and advise. This is both to effectively handle challenging situations, and to avoid burnout.

In some of the most effective clinic-based asthma program models, CHWs/promotores are based in the clinic, have daily contact with the rest of the healthcare team, and participate in weekly case conferences. In other program models, they may be based at another community agency, have a CHW supervisor as their primary contact, and have much less frequent contact with the physicians or others providing the clinical asthma care. When CHWs do not have daily face-to-face contact with the healthcare team, to facilitate their full integration onto care teams, the program must build alternate structures such as regular case conferences.

Because quality of clinical care is a very real issue in asthma, some projects have pursued the idea that CHWs could advocate alongside families for better medical care. However two large program evaluations have found that CHWs alone are not able to influence improvements in quality of clinical care. Medicine is a hierarchical field and there is a wide social distance between clinicians and community health workers. CHWs simply do not have the standing to influence clinicians to change how they practice medicine.¹²

ASSURING CHW/PROMOTOR(A) COMPETENCE: CERTIFICATION, CREDENTIALING, AND RELATED ISSUES

A third objection to the wider use of CHWs is that there is at present no way to assure their competence. Asthma CHWs are working with a potentially life-threatening condition, and assurance of competence is therefore a serious issue.

Before beginning this discussion of credentialing, we want to note that *licensure* is off the table for CHWs. Licenses—required to use a title and to work in licensed positions—occurs only in health professions that carry out invasive procedures capable of doing great bodily harm.¹³ As CHWs do not work in this capacity, licensure *per se* will not become an issue.

Many of the skills and personal qualities needed to be an excellent CHW/promotore can be learned on the job and through life experience. Conversely, success in “book learning” often does *not* confer job effectiveness as a CHW.

The French sociologist Pierre Bourdieu made the helpful distinction between two social functions of credentialing: first, the *legitimate* function of attesting to competence; second, the often *sub rosa* function of restricting labor competition or monopolizing a niche in the labor market by requiring a credential that is not truly related to the ability to perform job-related duties. In the second case, the credential in essence functions as a gatekeeper to preserve advantaged labor market positions through exclusion.¹⁴ This distinction points up that CHWs and their allies can embrace the need for a method that will *attest to competence*, without having to swallow a credentialing mechanism that would exclude many competent health workers or even change the class/race make-up of the field, undermining the very strength of CHWs as peer health workers.

Veteran CHWs have often been suspicious of college-based training programs. Higher education—including community college—is not an avenue that is open to all low-income community people. It is common in the health workforce that college credentials are set as a requirement by state legislatures and other officials. This can easily function to exclude working CHWs who may have high levels of competence, but little formal schooling; or to skew the eligibility of new entrants into the field of community health work. Requirements for a college credential may exert pressure on a field currently composed of low-income women of color, toward a more white and middle class labor force composition. The challenge is to find a mechanism that will assure competence without excluding the very people most suited to work as peer educators. To work with this issue, CHWs and their

organizations should have a leading voice in shaping the way credentialing is implemented.

What would a good credentialing method look like? What follows is a round-up of some of the credentialing methods now in use, identifying their strengths and weaknesses. This section will end with our recommendation on CHW credentialing.

- **Certification of the agency, not the individual.** Examples: Partners in Health internationally; Women, Infants and Children (WIC), Family PACT and Comprehensive Perinatal Services Program (CPSP) in California. In CPSP, for example, the *agency* is approved by the California Department of Health Services to act as a program site. The agency then bears the responsibility to assure that its health workers are properly trained and supervised.

One strength of agency-based credentialing is that it enables organizations to hire CHWs based on the strength of their abilities and experience, rather than on their educational backgrounds or other criteria such as immigration status. A second strength is that it allows agencies to be flexible about how training and skill assessment is to be accomplished. Some agencies may run their own training programs, while others--in localities where there is a college-based certificate--may support their CHWs to take this training. In terms of attesting to competence, some agencies may use a simple skill checklist filled out by the supervisor, while others may use a more elaborate **competency-based performance examination**. This is a scenario-based practical exam, similar to those used by medical and nursing schools. Such examinations are rigorous yet democratic, because they test practice rather than book learning alone.¹⁵

A weakness of the “certify the agency” approach is that the individual CHW does not have a portable credential that can transfer from one topical focus or employer to another.

- **State-administered exam and certification process.** Examples: Texas and Ohio. In Texas, several experienced community health workers sit on the board that oversees the exam. In Ohio, by contrast, the process is overseen by the Board of Nursing, and includes no community health worker members or advisors. The Ohio process requires criminal background checks and immigration papers, and thus excludes some of the very individuals who are best suited to the job because of their knowledge as peers. In our opinion, any state-administered certification process should be developed by a diverse panel. The panel must include a strong role for CHWs and representatives of their organizations.

An exam should certify everyone with the needed skills and qualities, without unnecessarily excluding individuals for reasons unrelated to job duties. Often these exclusions rest on punitive policies, not job-related competencies. For example, immigration policies have saddled many community members with criminal records for simply moving from place to place; and a punitive drug war policy has resulted in many community members having criminal records for small-scale non-violent drug offenses. Policies that unfairly stigmatize many community members should not constitute a reason to deny employment.

- **Certification of the individual through a college certificate AND state exam.** Some state certification processes combine two qualifications: successful completion of a college certificate, as preparation for sitting an exam. For example, first-level drug and alcohol counselors must first complete some 30+ units in a community college program that is credentialed by a state body. Once the students have this preparation, they qualify to sit an exam. In the drug and alcohol field, there is a trend toward hiring only those who have obtained their state certification.
- **National exam administered by an independent organization.** The National Asthma Educator Certification Board, an independent organization, offers one such (voluntary) exam to credential certified asthma educators. Their goals—to standardize the training and evaluation of asthma educators and to enable their reimbursement for asthma education—are shared by the authors of this report. To date two states are reimbursing asthma educators.¹⁶

In our view, a majority of the board made an unfortunate decision to gear the exam toward a heavily clinical scope of practice that suits the test for clinicians, nurse practitioners, nurses and respiratory therapists. Even very senior and experienced CHWs/promotores are unlikely to be able to pass. The reason has nothing to do with the competence of the CHWs to function as CHWs, but goes to the exam's extremely rigorous content in a medical area outside the CHW scope of practice. In this case, the exam does nothing to provide a vehicle for assuring proficiency in CHW competencies, and worse, it may serve to de-legitimize CHWs.

- **College-based CHW/promotore training or certificate programs.** Nationally there are numerous certificate programs for CHWs/promotores, many of them based in community colleges.¹⁷ While this can certainly be one important approach to assuring CHW competency, it should not be the required or only avenue. Many excellent CHWs have developed their skills through volunteer, life, and on-the-job experience, and have learned topic specific asthma information through worksite trainings. These CHWs should not be required to complete a certificate program to continue working, and in some cases, would not be able to take time off to do so. Certificate programs can be one excellent

point of entry into the field or mechanism to assure competence, but they should not hold a monopoly as the only gateway to enter the field.

- **Hiring entity that allows for multiple points of entry.** Example: The San Francisco Department of Public Health has multiple points of entry into its employment track for community health workers, and multiple avenues for advancement once employed. It considers completion of the City College of San Francisco CHW Certificate Program, but also considers work experience. San Francisco's "both/and" approach on life experience and college achievement might be used as a model.

Recommendation on credentialing CHWs: After considering a number of ways to credential CHWs, we think that "certify the agency, not the individual," is the best approach under current conditions. Unlike state certification of individual CHWs, this method has been used by many large programs over many years, without creating exclusion and confusion.

If conditions were to change, and CHWs were able to consolidate strong statewide organizations, then they might consider developing a performance-based exam to certify individuals. However such an approach takes considerable funding, state-level organization, and ability to influence the policy process. In our view "certify the individual" may not be realistic at this time.

COST EFFECTIVENESS:

A fourth objection to the wider use of CHWs is that they are an overly expensive add-on during a period of budgetary constraint. Sometimes program using CHWs are referred to as "Cadillac models," unrealistic and unsustainable. (Paul Farmer reports that this dialog has an exact counterpart in debates in the international health community: Is a community-based approach to treatment for HIV/AIDS or multi-drug-resistant TB "too expensive?")

In the case of children's asthma, there are two main responses to this argument. The first takes the argument on its own terms, looking at cost effectiveness. Early cost studies from existing asthma programs indicate that chronic care approaches to asthma using community health workers are cost effective, and additional cost studies are currently under way.¹⁸ These programs use population management to target higher intensity services such as CHW support to those patients at elevated risk of asthma exacerbations. Such programs have proved cost neutral or cost saving for a number of reasons:

- Teams including CHWs/promotores rationally reconfigure routine chronic care duties toward less-expensive providers. This frees the more expensive clinically

trained professionals to focus on clinical diagnosis, treatment, and management.

- Although participation in a specialized asthma management program generally lasts for no more than six months, it teaches patients and families how to continue to manage the disease. Thus, savings from reduced hospitalizations and emergency department visits continue after program completion.
- CHWs' social interventions can often forestall serious and costly medical problems. For example, at the SF General Hospital Pediatric Asthma Clinic—a program with optimal medical care—currently virtually the only reason children are hospitalized is when there is a system navigation problem that did not get caught early enough, as when a family is not able to re-supply their child's medicine in a timely way¹⁹. Since system navigation is exactly the kind of assistance CHWs provide, this simple troubleshooting intervention is an effective way to prevent hospitalizations that cost over \$19,000 for each for a child on Medi-Cal. Northern California Kaiser Permanente shows that through care management, the need for hospitalization and emergency department use can be all but eliminated.

Quite apart from cost-effectiveness arguments, there is another response to the position that a community-based health care is a “Cadillac”, too expensive. This is a social justice argument, that quality care is a human right. As Joia Mukherjee and Paul Farmer say, “distribution of limited resources for health has been determined more by markets than by rights.” “We keep hearing that we live in ‘a time of limited resources.’ Yet the wealth of the world has not dried up—it has simply become unavailable to those who need it most.”²⁰ National standards of chronic care in asthma call for the provision of self-management support, and CHWs are widely seen as essential to this, particularly in diverse communities. Would the proponents of the “Cadillac” argument say that sub-standard care is the only realistic option?

Care management using a team approach is more just, more effective and more cost effective than usual practice, which too often comes down to providing rescue care over and over and over again. In the international arena, community-based care strategies have proved themselves far superior in the control of HIV/AIDS and TB and other conditions. The same conclusions have been reached in children's asthma, right here in California. Far from being a “Cadillac” model, team-based care is highly efficient, effective and just, because it puts the fruits of scientific progress at the service of those with the greatest need.

SUMMARY:

In the US as well as internationally, CHWs/promotores can serve as lynchpins of primary care and public health teams. It is important to work through concerns about their use, and to develop credentialing and reimbursement mechanisms that will promote their permanent integration into the US health workforce.

--This draft discussion paper was written by Jeni Miller, PhD, and Vicki Legion, at Community Health Works, the partnership of San Francisco State and City College of SF, with valuable input from Cindy Tsai. It is a work in progress. Send feedback to vlegion@sfsu.edu. Our website is www.communityhealthworks.org

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¹ <http://chid.nih.gov>

² Community Health Workers: Who They Are and What They Do, HEB, Vol 24 (4) 510-522, August 1997, Keiser, S, (under submission), 2006.

³ This continuum was articulated by Diana Bermudez, consultant for The California Endowment.

⁴ Note that the Blue Cross Foundation of Minnesota commissioned the UCSF Center for Health Professions to write a report on CHW sustainability (forthcoming).

⁵ www.pih.org contains extensive documentation and peer-reviewed study results.

⁶ Thyne S. et al., The Yes We Can Urban Asthma Partnership: A Medical/Social Model for Childhood Asthma Management, J. of Asthma (forthcoming 2006); Odessa Brown Children's Clinic, Seattle Washington, and others.

⁷ At the National Asthma Coalition Conference sponsored by the American College of Chest Physicians, and the American Public Health Association meetings.

⁸ The Emerging role of the CHW in California, Results of a statewide survey and SF Bay Area focus groups, SFSU/CCSF, 1992; Community Health workers: Who They Are and What They Do, HEB, Vol 24 (4) 510-522, August 1997; Keiser, S, (under submission), 2006.

⁹ David Werner's book *Where There is No Doctor*, translated into some 60 languages, is a handbook for CHW "barefoot doctors" who fill a role similar to mid-level providers here in the US. To our knowledge, the only place within the US where CHWs play this role is community health advisors in remote Alaskan villages.

¹⁰ Rosenthal, Wiggins, Brownstein, Johnson, et al. *The Final Report of the National Community Health Advisor Study: Weaving the Future*. 1998.

¹¹ Tsai, Ellinger, Miller. *Managing Children's Asthma: A Community Focused Team Approach, Volume 3: Community Health Worker Manual*. 2004.

¹² The two programs are ZAP Asthma (program evaluation on the CDC website) and the NY City Children's Asthma Initiative.

¹³ Per Dr. Leonard Finnochio, the California Healthcare Foundation.

¹⁴ *Reproduction in Education, Society and Culture*, Pierre Bourdieu and Jean Claude Passeron, 1990.

¹⁵ The YES WE CAN Toolkit contains one such performance examination for asthma CHWs.

¹⁶ Maria Elena Alioto, personal communication, Oct. 10, 2006.

¹⁷ Such as the one we are affiliated with at City College of San Francisco, directed by Alma Avila.

¹⁸ *Safe and Effective Approaches to Lowering State Prescription Drug Cost: Best Practices Among State Medicaid Drug Programs*, 1999. Rossiter, Louis F., Outcomes Research and Disease Management Come to State Medicaid Programs, Medicaid Outcomes Trust, July 1999, Volume 4, Issue 1. Kreger, M., Thyne, S., Kao, C., Colon-Hopkins, C., Brindis, C., Cost-Effectiveness Study of San Francisco General Hospital Pediatric Asthma Clinic, 2006, preliminary data. See the California Asthma Among the School Aged Initiative (CAASA), funded by The California Endowment, 2001-2004; and the Childhood Asthma Initiative in California, funded by the First Five Commission, 2000-2005. See also Kattan, M., Stears, S.C., Crain, E.F., Stout, J.S., Gergen, P.J., Evans III, R., et al. Cost Effectiveness of a Home-Based environmental Intervention of Inner-City Children with Asthma. *Journal of Allergy and Clinical Immunology* 2005; 116: 1058-63.

¹⁹ Different insurance companies have inconsistent formularies. If a clinician prescribes a medication that does not align with the formulary of a particular company, then filling the prescription will be stalled.

²⁰ Joia Mukherjee and Paul Farmer, *Infectious Diseases in Social Injustice and Public Health*, ed. Barry S. Levy and Victor W. Sidel, Oxford University Press, 2006, p. 232 and 234.

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