Community Health Workers: An ONA Position Statement
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Position

Oregon Nurses Association supports the development and utilization of the Community Health Worker (CHW) in Oregon's evolving health care delivery system. This paper reflects the experience, views and recommendations of the Association.

Recommendations regarding the training of CHWs:

- Training is conducted in segments interspersed with clinical experiences to facilitate and solidify learning;
- Training includes content related to ethical conduct;
- Similar curricular requirements should be clustered to facilitate learning and achievement of competencies.

Recommendations regarding the CHW and the health care team:

- Work with stakeholders and the State of Oregon to ensure that Registered Nurses have authority to delegate, supervise, assess and evaluate CHW direct care activities with clients;
- Assignments of the CHW to clients is done in collaboration with the RN and other licensed personnel as directed by the individual plan of care;
- Evaluation of CHW services and outcomes is conducted by professionals such as the RN, physician, nurse practitioner, clinical nurse specialist, social worker or other licensed health care providers;
- Assignment of clients to CHW care is consistent with evidenced based recommendations;
- CHW oversight by the Oregon Health Authority is conducted in collaboration with the Oregon State Board of Nursing;
- CHW is accountable to the health care team.

Background/Context

With Oregon focusing on implementation of health care reform, new health care delivery teams and roles are evolving and opportunities are emerging from differing structures. Nurses will increasingly work in the community in teams that include both licensed providers and unlicensed workers to emphasize prevention, health promotion, and intervention in illness. One of the
emerging roles to support the outcomes of high quality, reduced cost and improved patient experience is the Community Health Worker (CHW).

In addition to the anticipated changes in health care delivery, it is expected that there will be increased access to health coverage and increased demand for services. The Oregon Healthcare Workforce Institute 2010 report estimates that 310,000 previously uninsured Oregonians will gain access to health coverage. The Patient Protection and Affordable Care Act identifies care coordination throughout its provision to improve quality and control costs to transform the health care delivery system (H.R. 3590, 2009). The purpose of the CHW role is to assist with the care coordination requirement due to the anticipated changes in health care delivery, increased access to health coverage and increased demand for services.

To accommodate increased demand and create a robust system of care, the CHW role has been developed to augment the licensed provider workforce, support patients in their communities, connect with individuals and families in a culturally appropriate manner and assist with coordination of services. A goal of this expanding workforce is to improve health equity and reduce health disparities.

Community Health Worker Roles

In 2007, the Community Health Worker National Workforce Study, under the auspices of the Health Resources and Services Administration Bureau of Health Professions, defined CHWs as “lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve” (HRSA, 2007, pp. iii).

CHWs have been identified by many titles, e.g., community health advisors, lay health advocates, promotores(as), outreach educators, community health representatives, peer health promoters and peer health educators. In 1998, the National Community Health Advisor Study (Rosenthal et al.), conducted by the University of Arizona, identified core functions of the role as offering interpretation and translation services, providing culturally appropriate health education and information, connecting needed care with resources, giving informal counseling and guidance on personal health behaviors, and advocating for the individual and the community’s health needs. Historically, CHWs come from the communities they serve and work at the grassroots level to build trust and vital relationships, thus making them effective cultural brokers between their community and systems of care. Most programs that utilize the CHW have directed their work toward the underserved in locations characterized by poverty and lower educational levels, e.g., inner cities, the U.S.-Mexico borders and rural areas.

Community Health Workers: An Evidence-Based Technology Assessment

The Agency for Healthcare Research and Quality (AHRQ) has published an evidence-based technical report related to CHW outcomes. The report is based on the concept that CHWs “...prompt individual and social change and thereby reduce health disparities in either access to care or outcomes of care (or both)” (AHRQ, 2009, pp. 118). The literature search in this assessment yielded a total of 1,076 articles; after full review, a total of 89 studies met inclusion criteria and were reviewed to answer the key questions. The key questions to be answered were:
What specific methods are used by CHWs to interact with clients, e.g., patients, families, and others?

What is the impact of the CHW on outcomes (knowledge, behavior, satisfaction, health outcomes, and health care utilization)?

What is known about the cost-effectiveness of CHWs for improving health outcomes?

What are the characteristics of training CHWs?

Are particular training characteristics of CHWs associated with improved outcomes for patients?

**CHW methods:** Among these studies, CHWs used 1:1 counseling, education, support, information on resources, transportation, and appointment reminders. Many interventions had multiple face-to-face counseling sessions in the home. Interactions with clients may have been brief (5 - 60 minutes), or meetings and interactions totaling several hours. Length of contact varied from 1 day to 2.5 years. CHW interaction intensity was classified by the number of 1:1, face-to-face, hourly sessions, or months of duration; typically, the CHWs had more high intensity interactions than low intensity. These interactions of the CHWs related to health promotion/disease prevention (11 studies), injury prevention interventions (3 studies), maternal/child health interventions (15 studies), cancer screening interventions (15 studies), and chronic disease management (13 studies).

**CHW outcomes:** Outcomes associated with CHWs were found in five domains: knowledge, behavior/behavior change, satisfaction, health outcomes and health care utilization. CHW impact on satisfaction and knowledge outcomes were absent or inconsistently reported in these studies. CHWs had a moderate impact on behavior and behavior change in some areas, but limited impact in workplace safety, diabetes, asthma. CHWs did not have impact on outcomes in health promotion with Latinas, injury prevention at home, smoking cessation, and asthma. The conclusion drawn from this review is that CHWs "...can, in some instances, yield greater positive changes in participant behavior than a range of alternatives (including no intervention, community intervention, usual care plus a newsletter...)" (AHRQ, 2009, pp. 117). The report concludes that CHW intervention may provide greater benefit in changing behavior when the behavior is easy to adopt, e.g., lower intensity CHW interventions.

**CHW and health care utilization:** The studies analyzed in this evidence base provide low and moderate evidence that CHW interventions increase some appropriate health care utilization.

**CHW training:** Few research studies were found in this key question area. If it was reported, improvement in knowledge and skill was found. However, few studies reported on training for "...cultural competence, recruitment and retention process skills, intake and assessment, and protocol delivery" (AHRQ, 2009, pp. 129). Because of this, the impact of the CHW on knowledge is unclear and substantial gaps in the information about training and of these projects is found.

In summary, this technical review provides a mixed evidence base for CHWs in the areas of client-based knowledge acquisition, behavior change and improved health outcomes in some diseases. However, additional studies have been conducted since this technology assessment which may provide evidence regarding the potential gains in the delivery of services by the CHWs and/or provide additional information on evidence for best practices related to training programs for CHWs.
State Approaches to Community Health Workers

Minnesota and Massachusetts have taken comprehensive approaches to develop policies and systems that build capacity for an integrated and sustainable CHW workforce. In 1999, Texas recommended that the state establish CHW certification standards for individual CHWs and for training programs. The state established a nine-person committee that included four certified CHWs to oversee the implementation process. A few other states – Indiana and Alaska – have linked some CHW curricula to state requirements; other states are exploring and/or are implementing possible credentialing of varying types and at various levels. Ohio has adopted a credentialing program in which the State Board of Nursing regulates the CHW certification process.

Community Health Workers in Oregon

Community Health Workers have been used in Oregon for many years to provide outreach and translation services. Generally they have worked with licensed health care providers such as Registered Nurses in county health departments. Oregon House Bill 3650 (2011) and Senate Bill 1580 (2012) created Oregon’s Health System Transformation, which seeks to fulfill the triple aim of improving patient outcomes and experiences, improving population health, and reducing costs by better coordinating health care for Oregon’s Medicaid population. This legislation identified and defined Community Health Workers, Peer Wellness Specialists and Personal Health Navigators. It directed the Oregon Health Authority to develop the criteria and descriptions of each type of Non-Traditional Health Care Worker (NTHW) to be used by Coordinated Care Organizations, as well as requirements for education and training. Additionally, these standards needed to meet Centers for Medicare & Medicaid Services (CMS) criteria in order for NTHWs to be eligible for Medicaid reimbursement. In order to implement this legislation, the state was granted a waiver from CMS. The waiver included several provisions related to community health workers including training 300 new CHWs by 2015 (OHP, 2012).

The roles are described in Oregon statute as:

- **Community Health Worker:**
  a) Has expertise or experience in public health;
  b) Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;
  c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;
  d) Assists members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness;
  e) Provides health education and information that is culturally appropriate to the individuals being served;
  f) Assists community residents in receiving the care they need;
  g) May give peer counseling and guidance on health behaviors; and
  h) May provide direct services such as first aid or blood pressure screening.

- **Peer Wellness Specialist** – individual who is responsible for assessing mental health service and support needs of the individuals through community outreach, assisting with
access to available services and resources, addressing barriers to services and providing education and information about available resources and mental health issues.

- Personal Health Navigator – an individual who provides information, assistance, tools and support to enable a person to make the best health care decisions in their own particular circumstance.

- Doula – birth companion who provides personal, nonmedical support to women and families throughout a women’s pregnancy, childbirth, and post-partum experience.

A report from the Non-Traditional Health Worker Subcommittee made the following recommendations (OHA, 2012):

- Certify 80 hour didactic and on-the-job training programs that cover core competencies and on-the-job contact hours with additional contact hours to cover supplemental training recommended for specific worker types;
- Require statewide oversight of training programs to review and approve curriculum, maintain a registry and/or certification records;
- Develop a statewide training advisory panel to provide guidance and to ensure workforce programs produce trained individuals with essential competencies who can easily move between organizations and within communities;
- Limit the cost of enrollment in training programs; and
- “Grandparent” individuals who also participate in an “incumbent worker” training.

And, most importantly:

- Provide supervision of the NTHW by a licensed health care professional, a licensed behavioral health professional or an individual with master’s level public health knowledge and competency.

In December, 2012, the new Non-Traditional Health Care Worker Steering Committee was chartered and began its work which includes developing a process for approving training programs, developing temporary administrative rules for the NTHW program, and creating an online registry for NTHWs who have completed a state certified training program and are therefore eligible for Medicaid reimbursement.

**Nurses and Community Health Workers**

The registered nurse must practice consistent with the requirements in Oregon State Board of Nursing Nurse Practice Act, OAR 851.045-0030, and delegation rules, OAR 851.047-0000. Registered nurses are accountable to the public for providing effective nursing care to health care consumers in a variety of settings across the continuum of health care. The RN functions as an essential member of the health care team that includes health care consumers and may include other licensed professionals, paraprofessionals, and assistive health care workers and caregivers. If a nurse is practicing where there is a CHW, there needs to be understanding and implementation of practice arrangements that are consistent with the experience, training and role of the CHW. Task delegation involves assignment of activities or tasks related to patient care to personnel who are capable of safe completion of the activity or task while the RN retains accountability for the outcome. For example, an RN cannot delegate responsibilities related to
making nursing judgments about a patient’s status, the impact of interventions or the care provided to a patient (ANA, 2012).

The CHW may be a partner to the nurse and the health care team by advocating for the individual or community plan of care. This would be done by informing and educating the team members about effective outreach, and by assisting the patient and family to implement goal-directed care plan activities. The nurse’s role-related actions with the CHW include teaching, coaching, delegation and supervision.

The CHW may collaborate with other health care providers about community health needs and the cultural relevance of wellness education, care, and prevention programs. Such collaborations can increase the effectiveness of health care teams within communities and improve health outcomes for community members.

**How Nursing Can Help**

Nursing and CHWs fulfill different roles under health care reform. The degree to which they have effective partnerships will predict the achievement of health outcomes and reduction of disparities in health care settings. In the practice setting, the RN and CHW will need to pay attention to occupational boundaries and intersections. This will be best accomplished through collaborative discussions between the CHW and RN, and among leaders of health care teams.

Nursing’s long history of advocacy for patients and health care systems is a strength and support for CHW development. By working to understand occupational boundaries and intersections in the practice setting, and by establishing formalized channels of communication and collaboration, nursing and CHWs may be able to secure a strong foundation for the emerging health care system that provides high-quality, accessible, patient-centered care.
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