In line with our mission to advance the community health worker (CHW) model approach to build community capacity and leadership for health promotion and disease prevention, the PRC is engaged in disseminating policy efforts to reduce cardiovascular disease and diabetes, as well as those which promote the use of CHWs and other lay community leaders in this effort.

Current policy work around community health workers involves four core issues:

A. Definition and Scope of the Workforce
B. Reimbursement of CHWs
C. Workforce Development, Training and Credentialing
D. Research and Evaluation

A. Definition and Scope of the Workforce

Issue: Developing a standard definition of the CHW workforce and its practice

Why is this important?

- Understand the scope of work in the field as well as the current impact and utilization of CHWs
- Development of appropriate training and credentialing programs
- Incentivize states to initiate sustainable methods of reimbursement (i.e. Medicaid)

Complicated by:

- Use of different job titles (i.e. promotoras, community health educators, lay health advisors, etc.)
- Various roles of CHWs, as well as areas of focus and specializations within community health

Policy:

- 1998: National Community Health Advisory Study identified eight areas of CHW “core competencies”
- 2009: US Department of Labor established a Standard Occupational Classification of a CHW
- 2010: Patient Protection and Affordable Care Act addressed community health workers in several sections, including classification of CHWs as “health professionals” and as part of the “health care workforce.”

B. Reimbursement of CHWs
Issue: Establishing sustainable funding streams for reimbursement of CHWs

Why is this important?

- Development and sustainability of the CHW workforce
- State policymakers and Medicaid administrators view partnerships between state Medicaid agencies and CHWs as a strategic alliance

Complicated by:

- Prevalence of short-term and grant funding
- Reliance on multiple funding sources (i.e. federal, state and local government, private and nonprofit organizations, etc.)
- CHWs are not viewed as “billable providers” by federal government – more difficult to directly reimburse

Policy:

- 2001: State and federal representatives assembled in San Antonio, Texas to discuss policy options that integrate CHWs into programs such as Medicaid, Women Infants and Children, Food Stamps and Head Start
- 2007: Minnesota is first and only state to directly reimburse CHWs through Medicaid

C. Workforce Development, Training and Credentialing

Issue: Developing training and career development resources for CHWs, as well as integrating training and credentialing standards into the CHW workforce

Why is this important?

- Advance visibility and recognition of CHWs within the health system
- Expand job stability for CHWs
- Provide more opportunities for sustainable reimbursement through state Medicaid programs
- Improve skills and competencies for CHWs
- Ensure higher quality of care
- Build greater respect for CHWs among other professions

Complicated by:

- Loss of effective CHWs due to volunteer status or restrictions based on immigration status
- Barriers to training
- Tuition and credentialing fees create barriers for low-income CHWs
- Geographical barriers – trainings may take place in locations that are inaccessible for many CHWs
- Training programs may create barriers if they are not available in other languages or appropriate for CHWs with lower education or literacy levels
- How to incorporate the full range of community health worker roles and competencies within a training program
- Notion that training and credentialing takes away from “organic roots” of CHWs

Policy:

- 1998: National Community Health Advisory Study identified eight areas of CHW “core competencies”
- A number of states (including Arizona, California, Maryland, Massachusetts, Mississippi, New Jersey, New Mexico, New York, and Texas) have formed associations to promote and standardize the role of CHWs. Statewide credentialing: Texas and Ohio have the only formalized programs; Indiana and Alaska have standard requirements under specific programs
- Texas: First state to adopt legislation governing the utilization of CHWs
- 1999: CHW training and certification legislation passed

D. Research and Evaluation

Issue: Research and evaluation of CHWs (i.e. workforce, programs, models, etc.)

Why is this important?

- Distinguish “best processes” and replication for further studies
- Examine workforce and its practice
- Evaluate CHW programs

Complicated by:

- Lack of peer-reviewed journal
- Lack of systematic evaluation of CHW effectiveness and best practices, due to variety of topics, methodologies, and results discussed in the studies (HRSA)

Policy:

- Three states have passed bills mandating studies of state CHW workforce: New Mexico (2003), Massachusetts (2005), Virginia (2006).
- 2003: HRSA funded a number of national CHW programs
- 2005: Patient Navigator Outreach and Chronic Disease Prevention Act authorized $25 million for demonstration programs that provide patient navigator services to reduce health barriers and improve health care outcomes
- 2007: HRSA studied the CHW workforce and the factors that affect its utilization and development
- 2010: Patient Protection and Affordable Care Act provided grants to promote the CHW workforce through programs and research