

Promoting Policy and Systems Change to Expand Employment of Community Workers (CHWs)

Session 6: Moving Policy and Systems Change Forward

Session Overview

The objectives for this session include:

- List at least five key strategy points and nine key stakeholder groups important to policy and systems change
- Describe what two leading states (Minnesota and Massachusetts) have accomplished in CHW policy and how they did it
- Discuss at least five important lessons learned from each of these states

Audio Transcript

In this session, we will build on the background covered in Sessions 1 through 5 by examining efforts at comprehensive policy change in two states that have successfully moved forward: Minnesota and Massachusetts.

We will first identify some common elements of the states' efforts and then look at each state's accomplishments and methods. Finally, we will attempt to distill some common lessons learned from the states' experiences.

Key Strategy Points

The key strategy points:

- Must address all four policy arenas
- Education and awareness effort needed first
- Need "Champions" in each stakeholder group
- CHW networks and associations need support
- Different stakeholders have different interests
- APHA policy statement contains other key principles

Audio Transcript

Leaders in Minnesota and Massachusetts found that to effect successful policy and systems change, they needed to address certain key strategy points. These included the four policy arenas discussed in previous sessions:

- Occupational regulation
- Workforce development
- Sustainable funding for CHW positions
- Standards for research and evaluation

In hindsight, leaders in both states acknowledged that the need for organized education and awareness efforts was greater than they had anticipated and that more attention to these efforts early in the process might have been productive.

Both states found that “champions” played an important role in working with and on behalf of each key stakeholder group.

Although leaders in both states have stated repeatedly that CHWs should play significant leadership roles in efforts to change policy and systems, they also learned that CHW networks and associations required to speak for the field need more support and time to develop than was initially anticipated.

We’ve mentioned before that different types of stakeholders are interested in different kinds of results from CHW activities. Although each of these two states had an open and transparent advocacy process, it became clear that each type of stakeholder was interested in certain kinds of evidence and not interested in others. Policy and system change efforts must include a wide range of measures and data in order to meet stakeholders’ interests. Efforts to change policies and systems must be equipped with a range of measures of results or return on investment and should be prepared to use these measures selectively.

And finally, certain key principles should be kept in mind when designing and implementing policy and systems change. These principles were captured in a policy statement on CHWs by the American Public Health Association in 2009. We will review them in a few moments.

Key Stakeholders

The key stakeholders include:

- Potential employers and their associations
- Third-party payers, including the state
- Workforce development, education agencies
- CHWs themselves
- Community leaders and interest groups
- Other professional associations
- Key legislators and staff

Audio Transcript

This slide and the next one list the main categories of stakeholders involved in change efforts in Minnesota and Massachusetts. Different parts of the process call for more prominent roles for certain kinds of stakeholders. For example, if state legislation is involved, legislators often want to hear from people directly affected, such as patients, clients, employers, and CHWs themselves, rather than researchers and executive branch officials. The list includes:

- Potential employers and their associations
- Third-party payers, including the state
- Workforce development agencies, including education provider organizations
- CHWs themselves
- Community leaders and interest groups
- Other professional associations
- Key legislators and staff

Differing Interests of Health Care Stakeholders

The kinds of results that may be of interest to stakeholders include:

- Cost control/reduction
- Reducing hospital admissions and ER visits
- Increasing primary care visits and revenue
- Increasing compliance
- Reducing disparities

Audio Transcript

The kinds of results that may be of interest to stakeholders include:

- Cost control and reduction
- Reducing hospital admissions and ER visits
- Increasing primary care visits and revenue
- Increasing compliance, including keeping appointments
- Reducing disparities

Again, the overarching goal of total cost control or reduction in costs is generally a concern at higher levels of state government or at the top administrative levels of provider organizations. In Minnesota and Massachusetts, the selective use of evidence helped persuade stakeholders to participate in policy change initiatives and decision makers to support the initiatives.

Stages of Stakeholder Development

Stages of stakeholder development include:

- Awareness
- Understanding
- Interest
- Perceived benefits
- Commitment
- Participation
- Leadership

Audio Transcript

The process in Minnesota and Massachusetts involved identifying stakeholders and moving them along a continuum of development from awareness to understanding, interest, perceived benefits, commitment, participation, and, finally, leadership. Some stakeholders may leap ahead in the process, but most will start at an early stage, such as awareness, and they must be cultivated at that stage before they can be asked to move to the next. For example, an employer who has never heard of CHWs may not be ready to take a leadership role in advocating for a policy change that might affect their organization in ways they don't understand.

Experience suggests that the greatest hurdle is in persuading stakeholders to sign on to an initiative after they have acknowledged credibility of the claimed benefits of CHWs. Anyone involved in processes of change has experienced a reaction such as, "That all sounds very good, but I'm really busy right now," or "..., but this is not among my top priorities."

Stages of Policy Change Process Common to Minnesota and Massachusetts

Let's review the pattern of common steps in the policy change processes followed by Minnesota and Massachusetts.

- Form core stakeholder group
- Collect workforce data, including employer return on investment, and produce report
- Use core group and report to build larger stakeholder group
- Build state CHW network as integral partner

Audio Transcript

Let's review the pattern of common steps in the policy change processes followed by Minnesota and Massachusetts.

In each state, a core stakeholder group was organized at the beginning of the process. This group was responsible for collecting CHW workforce data, obtaining funding to commission basic workforce surveys, or both. This basic background data was summarized in a brief report and then used by the core stakeholder group to recruit champions at higher levels in the public and private sectors into a larger, second-stage stakeholder group.

In parallel to the initial data collection effort, the core stakeholder group devoted early attention to cultivating participation from CHWs, including the statewide CHW network or association. This activity began earlier in the process in Massachusetts than in Minnesota, although individual CHWs were involved in the initiative from the beginning in Minnesota.

Stages of Policy Change Process Common to Minnesota and Massachusetts (Cont.)

Stages of the policy change process common to Minnesota and Massachusetts also include:

- Enlist pivotal leadership institutions
- Formal reports documenting CHW success and offering strategies for sustainability
- Establish educational pathways early in process
- Introduce major legislation and policy change after other pieces are in place

Audio Transcript

Once a larger stakeholder group was organized, one or more pivotal institutions in each state began to take a more visible leadership role. In Minnesota, this role was primarily played by the state college and university system, with strong support from the Blue Cross and Blue Shield of Minnesota Foundation, the Minnesota Department of Human Services, and the Minnesota Department of Health. In Massachusetts, the Massachusetts Department of Public Health took the lead with assistance from the Massachusetts Public Health Association, the Blue Cross Blue Shield of Massachusetts Foundation.

Both states produced important legislation, mainly through the advocacy efforts of the states' CHW associations. In Massachusetts, the process took the form of two separate legislative steps. The first recognized the CHW workforce and officially commissioned a report to the legislature, and the second took up occupational regulation of the field.

Massachusetts advocates also took advantage of a window of opportunity when the Legislature was considering statewide healthcare reform in 2006. In Minnesota, development of an educational pathway was an early priority; in Massachusetts, there were three recognized CHW training centers in the state already established when the policy initiative began.

Other Key Principles

The American Public Health Association has identified a few overarching principles as important in advocating for expanded roles for CHWs these:

- Include CHWs in the development of policies that affect them
- Minimize barriers of language, education level, citizenship status, and life experience
- Encourage contracting with community-based organizations for CHWs' services
- Incorporate the full range of CHW roles into positions

For more information, visit the following link:

<http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1393>

Audio Transcript

The American Public Health Association has identified a few overarching principles as important in advocating for expanded roles for CHWs. The first two have been addressed in previous sessions:

- Include CHWs in the development of policies that affect them
- Minimize barriers to CHW training and employment related to language, education level, citizenship status, and life experience

The third point concerns CHWs' ability to maintain their sense of accountability to their communities. One way to address this issue is to invite providers and other potential employers to contract with community-based organizations rather than employing CHWs directly. This way, the provider and the community-based organization can work out the provider's institutional needs in their agreement, and the CHWs can work out how best to achieve those needs in a way that is sensitive to the needs of the community.

The final point recognizes the tendency of past initiatives, especially short-term projects, to call on CHWs to perform narrowly defined interventions. As we learn more, we are realizing that we can maximize the benefits of CHW services only by cultivating CHWs' ability to exercise a full range of roles and competencies.

What Minnesota Did

Minnesota:

- Formed broad-based partnership including CHWs and other major stakeholders
- Developed standard, competency-based CHW curriculum
- Created CHW peer network for ongoing education and peer support
- Defined CHW scope of practice
- Used HEIP's Policy Council to lead policy change process

Audio Transcript

Minnesota's initiative was created by the Healthcare Education- Industry Partnership, which is led by officials of the Minnesota State Colleges and Universities system and now part of HealthForce Minnesota. The Healthcare Education-Industry Partnership's CHW Policy Council led the effort for adoption of all of the initiative's products. The council included all of the major stakeholder groups that might be affected by policy change.

In the early stages, after the background research studies were published, the initiative produced a statement of the scope of practice for the CHW and drafted a standard CHW curriculum to be implemented by community colleges and other post- secondary schools.

Its third major accomplishment, which has had ripple effects around the country, was a Medicaid State Plan Amendment authorizing Medicaid reimbursement for CHW services. This move required authorizing legislation, submission to CMS of the State Plan Amendment proposal, and, after approval by CMS, the publication of regulations for implementation.

And as in other states, Minnesota leaders placed emphasis on creating and supporting an autonomous peer network or association of CHWs to represent their interests.

Minnesota CHW Scope of Practice

The scope of practice for Minnesota CHWs as defined by the CHW Policy Council comprises five role categories:

- Bridge the gap between communities and health and social service systems
- Navigate health and human services system
- Advocate for individual and community needs
- Provide direct services
- Build individual and community capacity

Audio Transcript

The scope of practice for Minnesota CHWs as defined by the CHW Policy Council comprises five role categories:

- Bridge the gap between communities and the health and social service systems
- Help individuals navigate the health and human services system
- Advocate for individual and community needs
- Provide direct services
- Build individual and community capacity

These categories are similar to the range of CHW roles and functions discussed earlier in this series as a product of the National Community Health Advisor Study in 1998. Let's look at the details of each of these roles as defined in Minnesota.

The activities involved in the first role help clarify the term "bridging the gap," which is often used as shorthand in the CHW field with no explanation. "Bridging the gap" may include:

- Aiding communication between provider and patient to clarify cultural practices
- Educating community members on how to use health care and social service systems
- Educating the health and social service systems about community needs and perspectives
- Establishing better communication processes

The second role is probably the most widely understood by people with limited exposure to CHWs. Activities are:

- Increasing access to primary care through culturally competent outreach and enrollment strategies
- Making referrals and coordinating services
- Teaching people the knowledge and skills needed to obtain care
- Facilitating continuity of care by providing follow-up
- Enrolling clients in programs such as health insurance and public assistance
- Informing clients of, and linking them to, available community resources

The third role, advocacy, is generally less well understood than the first two roles, although it appears in virtually all definitions of the CHW occupation. Activities include:

- Articulating to others and advocating for community and individual needs
- Being a spokesperson for clients when they are unable to speak for themselves
- Involving participants in self and community advocacy
- Mapping communities to help locate and support needed services

The third and fourth points under this category may require elaboration. Simply advocating on behalf of clients and the community is generally not enough. Unless the CHW encourages community members to advocate for themselves and their community, further dependence is created.

The fourth role, Providing Direct Services, folds health information, education, and other services into a broad definition as “direct service,” including:

- Promoting wellness by providing culturally appropriate health information to clients and providers
- Educating clients on disease prevention
- Assisting clients in self-management of chronic illnesses and medication adherence
- Providing individual social and health care support
- Organizing and/or facilitating support groups
- Referring and linking to preventive services through health screenings and health care information
- Conducting health-related screenings

Finally, in their capacity-building role, CHWs cultivate the ability of individuals, families, and communities to improve their own health through:

- Building individual capacity to achieve wellness
- Building community capacity by addressing social determinants of health

- Identifying individual and community needs
- Mentoring other CHWs
- Seeking professional development, such as continuing education

CHWs are encouraged to go beyond conventional topics, such as nutrition and physical activity, and help communities understand and address the underlying social, economic, and behavioral determinants of health. This role category also addresses building capacity among CHWs themselves through professional development.

Minnesota CHW Curriculum

Core competencies courses (nine credit hours) in the Minnesota CHW curriculum include:

- Role, Advocacy, and Outreach
- Organization and Resources
- Teaching and Capacity Building
- Legal and Ethical Responsibilities
- Coordination and Documentation
- Communication and Cultural Competency

Audio Transcript

The Minnesota CHW core curriculum is offered through several community colleges and other post-secondary schools and consists of 14 credit hours, two of which are a capstone internship experience. Each curriculum component begins with a focus on the CHW's role in that topic area.

The majority of the curriculum relates to core competencies, paralleling those we discussed earlier. The courses are:

- Role, Advocacy, and Outreach
- Organization and Resources
- Teaching and Capacity Building
- Legal and Ethical Responsibilities
- Coordination and Documentation
- Communication and Cultural Competency

Minnesota CHW Curriculum (Cont.)

Health promotion competencies (three credit hours) in the Minnesota CHW curriculum include:

- Healthy Lifestyles
- Heart and Stroke
- Maternal, Child, and Teen Health
- Diabetes
- Cancer
- Oral Health
- Mental Health

The program also includes an internship of two credit hours.

Audio Transcript

In the knowledge base portion of the curriculum, the Minnesota partnership requires the following health topics, which it describes as "health promotion competencies:"

- Healthy Lifestyles
- Heart and Stroke
- Maternal, Child, and Teen Health
- Diabetes
- Cancer
- Oral Health
- Mental Health

Finally, candidates practice the competencies by completing an internship integrating multiple areas of learning.

Minnesota Medicaid Legislation (MS [256B.0625](#), subdivision 49)

The Minnesota Medicaid legislation:

- Allows payment for services of a CHW who has completed standard curriculum
- Requires CHWs to be supervised by specific types of Medicaid- enrolled providers
- Allows initial period of grandfathering based on prior experience
- Fiscal note to bill projected modest net cost savings

Audio Transcript

The 2007 legislation that led to Medicaid reimbursement for CHWs was quite simple. It expanded the list of services authorized under Medicaid to include services provided by a CHW who has earned a certificate from an approved curriculum, and it stipulated that CHWs must work under the supervision of an enrolled provider.

As often happens with such measures, the language of the original bill became embedded in an omnibus appropriation bill. The most significant point of the legislative process, however, may be the fact that fiscal note to this measure predicted that it would lead to a modest reduction in Medicaid spending.

With this authorization, the state Medicaid agency within the Minnesota Department of Human Services filed a proposed state plan amendment with CMS in September 2007. The amendment was approved in December 2007.

Covered CHW Services

CHWs may provide patient education and care coordination and must:

- Be supervised by a Medicaid-enrolled provider
- Have order signed by authorized professional
- Work under a documented care plan
- Provide services face-to-face
- Use an established health education curriculum

Audio Transcript

After receiving CMS approval, the Minnesota Department of Human Services published regulations governing the reimbursement process. One essential provision is that, although a CHW must apply for registration as a Medicaid provider and receive a Medicaid provider number, the CHW may not bill the Minnesota health care plan or the Medicaid fee- for-service program directly. Billing is controlled by the supervising provider.

Under this policy, billable services are limited to diagnosis- related patient education and care coordination, and they may be provided only on the basis of an order signed by an authorized clinical professional as part of a documented plan of care. Only face-to-face services are covered, but they may be provided in a group setting as well as individually. The policy requires that CHWs use an established curriculum in delivering health education. It is too early to determine whether this requirement limits CHWs' ability to provide needed services.

Lessons Learned in Minnesota

Leaders in Minnesota have identified a number of lessons learned, which include:

- Reach out and inform a wide circle of CHWs and other stakeholders
- Engage interested health professionals in discussions of CHW scope of practice and training requirements
- Legislative champions are vital, but one-on-one visits are also necessary with committee leaders
- Employer testimony is essential
- Employer and CHW testimony is essential

Audio Transcript

Leaders in Minnesota have identified a number of lessons learned, which we will look at on this slide and the next. They found that a major potential source of resistance is stakeholders who believe they have been left out of the process. As noted earlier, nurses in Minnesota were concerned about decisions on scope of practice and training of CHWs, and they were engaged in policy discussions from the beginning.

Even though the Minnesota policy proposals had the support of identified champions, leaders found it necessary to visit one-on-one with key legislative committee leaders. Obtaining buy-in from one legislator who was a nurse was considered a priority. Once she became familiar with the initiative, she became a champion for it within the Legislature.

When the time came to invite testimony, leaders determined that although the legislature should hear from a range of stakeholders, the testimony from CHW employers was essential.

Another lesson learned was that this type of policy change is not a short-term undertaking. Leaders have reflected that relationships begun in the early 2000s needed to be sustained.

Lessons Learned in Minnesota (Cont.)

Lessons learned in Minnesota include:

- Involve key state agencies as partners
- Furnish key research data to show budget impacts of policy change
- Build positive relationships with tribal governments that employ Community Health Representatives (CHRs)
- Partner with community colleges and other post-secondary schools to promote and offer credit-bearing CHW education
- Identity and awareness building is an ongoing priority

Audio Transcript

As noted earlier, the enabling legislation for Medicaid reimbursement was considered budget neutral. This conclusion could not have been made without the active leadership of the Minnesota Department of Human Services, which acted as a champion within the state government.

Minnesota is one of a number of states in which tribal governments play a significant role in health care. The Indian Health Service funds perhaps the largest single CHW program in the country, the Community Health Representative Program. Administration of Community Health Representatives differs in structure and style from one tribal government to another.

Leaders in Minnesota elected to focus CHW training in community colleges, believing that earning academic credits was important for CHWs. Priorities may differ in other states. Nonetheless, community colleges are accustomed to recruiting students in open enrollment for occupation-related education. However, they also assist students in finding jobs after graduation, and some colleges were not prepared to offer the CHW program until leaders could document a more viable job market. This may well be true elsewhere.

And finally, Minnesota has included in its current priorities a plan to conduct an awareness campaign for the CHW as an occupation. In hindsight, Minnesota leaders believe that such a campaign might have been valuable earlier in the process.

What Massachusetts Did

Massachusetts followed a similar, but not identical, path to state policy change and has produced some wide-ranging results. It has:

- Created active statewide CHW association
- Office of CHWs in state health department
- Policy mandate for state contractors
- 2006 state health care reform act:
 - Added CHW to state Public Health Council
 - Mandated report to legislature on CHW policy
 - Follow-up enrollment activity demonstrated value of CHWs
- Created CHW credentialing board

Audio Transcript

Massachusetts followed a similar, but not identical, path to state policy change and has produced some wide-ranging results. It has:

- Created a statewide CHW association
- Created a state office of CHWs in the Massachusetts Department of Public Health
- Established a policy mandate for state contractors to employ CHWs
- Secured significant language on CHWs in a 2006 state health care reform bill that:
 - Gave CHWs a role on the state Public Health Council
 - Mandated a report to legislature on CHW policy
- Passed a bill creating CHW credentialing board
- Demonstrated the value of CHWs through enrollment activity following passage of the reform bill

The 2006 Massachusetts Health Care Reform Act was the first major policy achievement concerning CHWs, and in many ways it was a pivotal one. Implementation of reform in Massachusetts required a massive enrollment effort that allowed CHWs to demonstrate concrete results. The report to the legislature mandated by the bill became a major symbol and a tool leading to the introduction of credentialing legislation, which was passed in 2010. This latter bill creates a credentialing board to recommend how CHWs should be credentialed.

Key Collaborations Yield Results

A 2000 grant from HRSA led to:

- Founding of Massachusetts Association of Community Health Workers
- Survey report on CHWs in the state, citing them as essential to improving health
- Amending state contracting policies to require vendors to train and supervise CHWs

Audio Transcript

The Massachusetts initiative was spurred by funding from HRSA in 2000, which produced three major results: the beginnings of a statewide CHW association, the production of a survey report that found CHWs to be essential to improving health, and the creation of an amendment to state contracting policies with requirements for CHW training and supervision.

Key Collaborations Yield Results (Cont.)

A 2003 partnership of:

- Massachusetts Department of Public Health
- Massachusetts Association of Community Health Workers
- Massachusetts Public Health Association

And support from the Blue Cross Blue Shield of Massachusetts Foundation.

Audio Transcript

Following these early achievements, the Massachusetts Department of Public Health, the new Massachusetts Association of Community Health Workers, and the Massachusetts Public Health Association formed an organized partnership, which received substantial and visible support from the Blue Cross Blue Shield of Massachusetts Foundation.

Health Care Reform Act Mandate

Convene statewide advisory council to investigate:

- Use and funding of CHWs
- Role in increasing access to health care
- Role in eliminating health disparities

Make recommendations for a “sustainable CHW program” – report to Legislature.

Certification recommendations introduced as new bill in 2009, passed in August 2010.

Audio Transcript

Let’s look in more detail at the first Massachusetts legislation concerning CHWs, Section 110 of the 2006 Massachusetts Health Care Reform Act.

Among other provisions, this section mandated that the state convene an advisory council to investigate the use and funding of CHWs in Massachusetts and their roles in increasing access to health care and eliminating health disparities. The council was then to make recommendations for policies leading to a sustainable CHW workforce, including provisions for training, certification, and financing.

The advisory council completed its study in 2009 and reported its findings and recommendations to the legislature in January 2010.

Between the study’s completion and its presentation to the legislature, the state’s CHW leaders began drafting legislation that would implement the council’s recommendations on certification of CHWs.

The Massachusetts CHW Advisory Council initially included 14 agencies named in the original legislation; others were later invited. The council consisted of 30 organizations and agencies, including the Massachusetts Department of Public Health, the state Medicaid agency, the insurance “connector” agency charged with key elements of insurance coverage expansion in the state, and the state Department of Labor. The organizations responsible for the three existing CHW core training programs in the state were also represented, along with the state Primary Care Office, the Massachusetts Hospital Association, and the Association of Health Plans.

Massachusetts leaders acknowledge that not all interest groups were initially receptive to participating in the initiative. The hospitals and health insurers, in particular, were initially not sure why they needed to be involved. Strong leadership from the state health department was crucial in securing their participation.

Lessons Learned in Massachusetts

Lessons learned in Massachusetts include:

- Key stakeholders must be involved, but MDPH was indispensable as convener and funder
- Infrastructure: Office of CHWs located in MDPH health care workforce division
- Legislation had practical and symbolic value
- CHWs need support and education to get involved in policy; legislation is not always their top priority
- Awareness campaign still needed

Audio Transcript

Leaders argue that the state health department's role in this process as convener was crucial to their long-term success.

Massachusetts is one of the first states to have an actual office of CHWs, located in the state health department's health care workforce division. As noted earlier, the state health department also used its clout as a prominent funder of health services to influence the inclusion of CHWs in the delivery of services and to encourage stakeholders to come to the table.

Legislation adopted in Massachusetts has had both practical and symbolic value. It has both helped to direct resources to actual policy change and attracted decision makers' attention to the fact that the inclusion of CHWs in legislation was a high priority for the state's political leaders.

In a sign of the times, one of the state's three CHW core training programs lost its funding in the same legislative session in which the CHW certification bill passed. Although development of the final certification policies and procedures will take several years to implement, the fact that they are under development will probably increase demand for CHW training. This outcome would demonstrate the interconnectedness of all areas of policy involving community health workers.

Leaders in Massachusetts came to recognize that CHWs as a group may need support and education to become involved in policy change. The state CHW association (called MACHW) had a very active executive director and a policy director involved in these policy initiatives.

And finally, as in Minnesota, Massachusetts leaders have concluded that an awareness campaign is a high priority. The advisory council report to the legislature recommended such a campaign.

Session Summary

The takeaways for this session include:

- Must address all four policy arenas
- Education and awareness effort will be required first
- Promote and support participation and leadership of CHWs
- Determine who your potential partners are

Audio Transcript

Take a moment to reflect on what you take away from this session. Here are some possibilities:

- Your initiative must address all four policy arenas discussed in Sessions 3 through 5, although you might not emphasize them all equally all of the time
- A broad and sustained education and awareness effort with potential stakeholders will be required as a first step
- As you move forward, it is vital to promote and support the participation and leadership of CHWs
- And finally, determine who are your potential partners and sources of assistance, both within and outside your state

Thanks for participating!