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Top 10 Things You Need to Know to Run Community Health Worker Programs: Lessons Learned in the Field

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Community health workers (CHWs) are laypersons who work one to one with individuals to improve health outcomes and healthcare system use.[1] They have many different titles: lay health worker, outreach worker, health advocate, promotora de salud, navigators, and guides. Typically, CHWs work with complex, less adherent, underserved people to increase engagement and treatment plan adherence.[2] CHWs improve chronic disease outcomes, self-management skills, disease prevention, and pregnancy outcomes, as well as decrease utilization and hospital admissions.[3–8] Maintaining excellence in CHW programs is key to producing high performance in CHWs individually.[9]

Since 2004 we have led multiple programs using CHWs to work with individuals with various social and medical needs, including programs directed toward individuals with sickle cell disease (SCD). Some programs were created to assist individuals with particular diseases, whereas other programs focused on social or demographic characteristics. Across programs, many logistical and organizational challenges presented themselves repeatedly. In this perspective we discuss the top 10 lessons we learned through our experience, including key considerations for program design; the hiring, training, and supervising of CHWs; and the essentials of aiding CHWs in assisting their clients. We intend for these lessons to be a primer for establishing a well-functioning CHW program.

Lesson 1: Determining a Program's Approach

The first step is to design the CHW program. There likely will be a goal or target population in mind, such as working within a specific demographic, social need, or disease. Having clear program objectives will aid in determining what CHW skill set is needed. CHWs are not homogeneous; there is variability in the skills of CHWs, and a certain type of CHW will need to be selected based on the objectives of the program. Given specific program needs,

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CHWs can be broadly placed into distinct categories, each with attendant advantages and disadvantages.

A peer meets the classic definition of a CHW,[1] shares the targeted condition/disease or experiences of the targeted population, and typically assists with education and advocacy. Peer-type CHWs often are the most successful because of the credibility that stems from a shared identity with their clients. Many peer CHWs are not well educated or technically trained and may require a significant amount of training or professional development. The goal of programs using peer CHWs is that CHWs retain credibility as they obtain additional training and develop skills that could "corrupt" their clients' ability to identify with them.

Nonclinical CHWs may or may not share the targeted disease, experiences, or population identity, but they have credentials or training that qualify them to improve care or health outcomes for the population. They may have completed specific courses or programs. The credibility of these CHWs may be questioned by their clients when they first meet, and the CHWs may need to work harder than peer CHWs to gain the trust or a sense of shared goals with their clients.

CHW as a term is sometimes applied more widely to other navigator positions, which do not fit the layperson definition of CHW. Other types of this position include clinical CHWs, who typically have a clinical background and usually are nurses. They are qualified to assist with system navigation and to provide medical advice and supporting treatment plans. Their cultural distance from their clients may be great. Typically, they are hired by a health system and not given a specific caseload. They may or may not be told to retain clients once they provide a specific service. Often, they are given a system-focused mission such as cost reduction, utilization reduction, or efficiency enhancement that puts them in inherent conflict of interest with their clients. They are the least conflicted when their role is primarily to enhance clients' access to healthcare system resources.

Insurance CHWs may have no health training at all but instead have a business background or credential. They typically bring to their job financial or business skills and experience with providing services to the public. They usually assist clients with accessing and enrolling in health insurance plans and gaining an understanding of the various plans to make the best enrollment choice. They refer medical questions to other experts and do not give advice about matters that are unrelated to financing medical care. They require some training specific to the organization that hires them.

CHW Other is a category that is reserved for miscellaneous professionals who interact with patients to improve their health outcomes. They may have a more defined role, such as a wellness coach, and often are housed in or employed by community organizations. Their primary function is to seek relationships with individuals who determine a need for them and may not be formally referred to them. They also may work with individual clients on a fee-for-service basis.

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Lesson 2: CHW Services and Roles

It is imperative that the job skills of a CHW match planned job roles. Mission creep in CHW roles seems a convenient proposition but is unattractive, especially if it results in unskilled workers performing tasks that require special skills. By determining the services that CHWs should provide, the required skill set for those services, and the type(s) of CHWs required, programs gain a search strategy for CHWs that is appropriate to its goals. For efficiency and to provide timely assistance to the greatest number of clients, it is critical that clearly defined services be established and clear boundaries be placed around service limits when recruiting, training, and marketing. Boundaries around service types should be based on thorough assessments of available versus unavailable community assets. CHWs should help enable better health outcomes for clients, usually by empowering them. If CHWs complete tasks for their clients instead of with them, then clients will not learn essential skills.

Lesson 3: Referral Process

Clients are enrolled in CHW programs through a referral process. One of the first decisions to be made in the referral process is to determine who may refer clients. Some programs may limit the referral process by only allowing physicians to refer clients, whereas others may encourage any member of the healthcare team to refer clients. Having a clear referral process is essential to understand the goals of the CHW and to track the outcomes of CHW interventions.

CHWs should not connect with patients until the referral is received and reviewed by the CHW supervisor. It is essential to route referrals through the CHW supervisor because the CHW supervisor should be the conduit through which the medical team channels client concerns and priorities. Referrals being appropriately routed avoids poorly planned encounters, lacking the benefit of planning with the CHW supervisor. Outreach to patients when armed with limited information is problematic for CHWs, and poorly planned consultations may lead to confusion for CHWs and supervisors.

The next step is determining what information is needed in the referral. We developed a referral process that collects basic demographic information, medical information, referral reason, explanation of services requested, and perceived adherence barriers. The referral process can be integrated into an electronic medical record, and much of the referral can be auto-filled in the record. During CHW morning meetings (“huddles”) the CHW supervisor reviews and assigns new referrals (see lesson 7).

Lesson 4: CHW Hiring

Once the program has been designed, including CHW skill set, services provided, and the referral process, CHWs must be hired. Finding well-qualified CHWs can be challenging. CHWs vary in their educational background; some CHWs have a high school or General Education Development diploma, whereas others hold college degrees. Some colleges offer courses or certificate programs for CHWs.

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The skill set needed by CHWs should be determined by program goals. Fundamentally, CHWs must be able to assess clients, determine approaches that will be useful in working with clients, and adapt appropriately. Many required skills, such as organizational or computer skills, can be taught; however, teaching skills such as rapport building with individuals across a wide spectrum of social classes or races, is more challenging. It also can be a challenge to recruit individuals with ideal interpersonal skills. Identifying those individuals by speaking with community members is essential; community members will have an idea of personality types that will work best within their community.

Lesson 5: CHW Training

Training CHWs is a multilayered process and includes a wide range of education that complements CHW skill sets. CHWs require extensive training because of the various roles they play. Peer-type CHWs, for example, may not have experience in the medical field or in an office setting and as such the following training model should be considered: behavioral skill building, technical and organizational skill training, and guidance in adapting to a professional workplace. These core skills are important to help CHWs successfully negotiate professional workspaces and be integrated into the healthcare team. CHWs also may require training regarding preventive medicine, the healthcare system, the importance of primary care, patient-centered medical home concepts, community resources, and the interaction of health and daily life. This training reinforces the underlying program drivers—improving adherence and health outcomes. Program-specific training is required and varies based on program target and location. In our case, training in the basics of SCD, how it affects a person’s health, and its impact on daily life was essential.

Training for CHWs is ongoing. Initially, CHWs require several weeks of knowledge, attitude, and skill building, which may be best accomplished by a 2-week session of intensive training. Subsequently, full-day or half-day continuing educational training sessions should be conducted as part of ongoing CHW education.

When hiring an experienced CHW, an assessment of his or her existing skills is necessary. Depending on the person’s baseline skill set, a modified curriculum should be developed that includes at least refreshers on all training modules because there may be differences in approach and technique among programs.

CHWs also have the ability to grow within their roles. As CHWs gain experience, they may begin to take on additional tasks, including training other CHWs, supervising CHWs, and assisting in program design. With these additional responsibilities, CHWs should receive commensurate increases in pay and title.

Lesson 6: CHW Skill Reinforcement

It is important to require CHWs to use their newly acquired skills in supervised sessions so that they become comfortable with them. Consider how we reinforced skills for our peer-type CHWs who had poor or nonexistent a priori computer skills: To increase computer proficiency, we introduced a step-by-step process to support the CHWs as they incorporated computer use into daily workflows. Initially, CHWs operated using handwritten notes. Once

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they were comfortable taking notes, CHWs were required to enter client information into an electronic data collection system. CHWs initially worked from printed copies of data spreadsheets, but they were gradually encouraged to use computers or tablet devices for notes, data collection, and documentation. This step-by-step approach allowed CHWs with little to no computer experience to learn how to use technology.

Lesson 7: CHW Supervision

CHWs are an integral part of the team-based approach to medicine. For CHWs to function at a high level, the team needs a dedicated CHW supervisor. This supervisor must meet with CHWs regularly and be able to provide support and guidance. This role may be played by a senior CHW, which helps to ensure that CHWs are addressing the priorities of the medical team and communicating relevant information to the providers.

The work that CHWs perform occurs primarily in the community. Overseeing their work without restricting time with clients requires striking a careful balance. Morning rounds or huddles are critical to assist CHWs in preparing for the day and week. Rounds provide an opportunity to discuss outstanding issues or concerns because CHWs need support to appropriately prioritize patient needs. Huddles help teams establish plans and goals and allow reinforcement of and accountability for the previous work period's activities while ensuring that the most up-to-date information regarding clients is available. These meetings are much like daily provider huddles in patient-centered medical home care delivery models.[10–12] Huddles provide regular opportunities for CHW learning and feedback, planning interventions for clients, and addressing workflow and communication issues.[10,11] Huddles create opportunities for collective problem solving and team building and ensure awareness of integrative care delivery. CHWs also receive checklists and instruction in and reinforcement of core skills during these meetings.

It is important to discuss regularly all clients; otherwise, clients with less urgent concerns or those who are less vocal about their needs may become marginalized. CHWs may be unfamiliar with the autonomy associated with their role and may not be skilled at balancing their workload. Vulnerable clients may clamor for attention and consume too much time. Supervisors reviewing all clients' needs regularly with CHWs will help avoid overconsumption of time and ensure that CHWs have regular contact with all clients. The summary of each client's progress should be recorded in the medical record, ensuring continuous communication with care teams.

Likewise, CHWs should be present during healthcare team meetings. During these meetings, providers, social workers, case managers, and CHWs can discuss some of the more challenging cases. These team-based care conferences can develop CHW care plans further.

Lesson 8: CHW Caseloads

There are no specific guidelines for the development of CHW caseloads.[13] Caseloads vary based on the intensity of the CHW intervention. There are highly intense research programs that have as few as 10 cases per CHW. Historic data suggest that optimum caseloads are between 10 and 30 clients if comprehensive care is provided[14–17]; however, with increasing

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efficiency pressures, requiring more care to a larger population with the same resources, caseloads exceeding this range have become common.[18–20] In our experience, CHWs have managed caseloads with as many as 59 clients. Such large caseload involved only a few clients requiring intense intervention; most clients were less labor intensive.

Lesson 9: CHWs Should Empower Clients and Build Coping Skills

A large part of the CHW role is assisting clients in obtaining services and navigating the healthcare system. The CHW should not do the clients' work; rather, CHWs should encourage self-management and effective self-care for clients with chronic medical conditions. CHW programs promote client self-management by providing health education, interventions, and training. By promoting self-management, CHWs ensure that clients are better suited to care for themselves, rather than relying on CHWs' support. The ultimate goal of CHW programs is to aid clients in building their coping skills and independence. Once these skills are developed, clients will be better able to find solutions to barriers to medical care.

Lesson 10: Client "Graduation"

Endpoints for CHW interventions are important. If clients need short-term, clearly definable services, it may be easy to complete and finish providing care. Although necessary, it is much more challenging to determine endpoints for the provision of supportive services.

It also is essential to determine a cease point if clients refuse to meet learning or skill goals. If clients continually rely on CHWs for their needs and do not fend for themselves, the program must determine a point at which to stop providing services. Periodic summary meetings (described above) are key for helping make this determination. It is challenging to develop protocols for determining endpoints for assisting clients. Often, decisions are made on a case-by case-basis, considering services needed, the amount of time required, and client intellectual capacity. It is essential for the CHW supervisor to make these decisions in consultation with the medical team and that all team members, including the CHWs, agree that termination of services is the appropriate resolution. It should be reinforced to both the medical team and the CHW that the inability to achieve the initial goal for the client is not a failure of the CHW. Some goals may be outside the client's capacity or the CHW's scope of work.

Clients attaining incremental increases in adherence or self-management skills should be rewarded. When goals have been met, simple diplomas or certificates of completion are helpful.

Conclusions

CHWs play key roles in comprehensive healthcare delivery. Clients may be more likely to relate to members of their own community. The care of individuals with SCD is complex and often fraught with disparities in access to care as well as care delivery, challenges with adherence to care, and successful navigation of the healthcare system. Peer-type CHWs are the most successful, but they require the most professional development. The insights of

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CHWs into the personal lives of clients, potential barriers or facilitators to medical care, and understanding healthcare knowledge attained and self-management skills developed are critical in well-functioning healthcare teams. CHWs relay crucial information to the medical team, and by incorporating their assessments into individualized care plans, medical teams are better able to care for patients. Ultimately, more personalized care plans will improve health outcomes and decrease preventable healthcare utilization.

References

1. American Public Health Association. [Accessed June 20, 2016] Community health workers. http://www.apha.org/apha-communities/member-sections/community-health-workers
2. Viswanathan M, Kraschnewski J, Nishikawa B, et al. Outcomes of community health worker interventions. Evid Rep Technol Assess (Full Rep). 2009; 181:1–144. A1–2, B1–14. passim. [PubMed: 20804230]
3. Rosenthal EL, Brownstein JN, Rush CH, et al. Community health workers: part of the solution. Health Aff (Millwood). 2010; 29:1338–1342. [PubMed: 20606185]
4. Behforouz HL, Farmer PE, Mukherjee JS. From directly observed therapy to accompagnateurs: enhancing AIDS treatment outcomes in Haiti and in Boston. Clin Infect Dis. 2004; 38(Suppl 5):S429–S436. [PubMed: 15156434]
5. Cooper LA, Hill MN, Powe NR. Designing and evaluating interventions to eliminate racial and ethnic disparities in health care. J Gen Intern Med. 2002; 17:477–486. [PubMed: 12133164]
6. Gary TL, Bone LR, Hill MN, et al. Randomized controlled trial of the effects of nurse case manager and community health worker interventions on risk factors for diabetes- related complications in urban African Americans. Prev Med. 2003; 37:23–32. [PubMed: 12799126]
7. Gibbons MC, Tyus NC. Systematic review of U.S-based randomized controlled trials using community health workers. Prog Community Health Partnersh. 2007; 1:371–381. [PubMed: 20208216]
8. Burns ME, Galbraith AA, Ross-Degnan D, et al. Feasibility and evaluation of a pilot community health worker intervention to reduce hospital readmissions. Int J Qual Health Care. 2014; 26:358–365. [PubMed: 24744082]
9. Rowe AK, de Savigny D, Lanata CF, et al. How can we achieve and maintain high-quality performance of health workers in low-resource settings? Lancet. 2005; 366:1026–1035. [PubMed: 16168785]
10. Bodenheimer T, Laing BY. The teamlet model of primary care. Ann Fam Med. 2007; 5:457–461. [PubMed: 17893389]
11. Rodriguez HP, Meredith LS, Hamilton AB, et al. Huddle up! The adoption and use of structured team communication for VA medical home implementation. Health Care Manage Rev. 2015; 40:286–299. [PubMed: 25029511]
12. Nielson, M.; Olayiwola, JN.; Grundy, P., et al. The Patient-Centered Medical Home's Impact on Cost and Quality: Annual Review of the Evidence, 2012–2013. Washington, DC: Patient-Centered Primary Care Collaborative; 2014.
13. Happell B, Hoey W, Gaskin CJ. Community mental health nurses, caseloads, and practices: a literature review. Int J Ment Health Nurs. 2012; 21:131–137. [PubMed: 22034873]
14. Intagliata J. Improving the quality of community care for the chronically mentally disabled: the role of case management. Schizophr Bull. 1982; 8:655–674. [PubMed: 7178854]
15. Kanter J. Clinical case management: definition, principles, components. Hosp Community Psychiatry. 1989; 40:361–368. [PubMed: 2714749]
16. Mueser KT, Bond GR, Drake RE, et al. Models of community care for severe mental illness: a review of research on case management. Schizophr Bull. 1998; 24:37–74. [PubMed: 9502546]
17. Fedder DO, Chang RJ, Curry S, et al. The effectiveness of a community health worker outreach program on healthcare utilization of west Baltimore City Medicaid patients with diabetes, with or without hypertension. Ethn Dis. 2003; 13:22–27. [PubMed: 12723008]

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18. Hromco JG, Moore MW, Nikkel RE. How managed care has affected mental health case management activities, caseloads, and tenure. Community Ment Health J. 2003; 39:501–509. [PubMed: 14713057]

19. King R, Le Bas J, Spooner D. The impact of caseload on the personal efficacy of mental health case managers. Psychiatr Serv. 2000; 51:364–368. [PubMed: 10686245]

20. Muir-Cochrane E. The case management practices of community mental health nurses: “doing the best we can. Aust N Z J Ment Health Nurs. 2001; 10:210–220. [PubMed: 11703271]