



Stakeholder Health

Transforming Health Through Community Partnership

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Community Health Workers

“Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional health workers.”
— World Health Organization



Community Health Workers

TABLE OF CONTENTS

- 2. Overview: Community Health Workers
- 5. Community Health Workers and Health Systems: Emerging Trends. A Conversation with Kevin Barnett, Grace Damio and Carl Rush
- 12. Richmond, Virginia: Community Health Workers in Public Housing
- 14. Washington, DC: a Trim, a Shave, a Blood Pressure Check
- 17. Community Health Workers Associations
- 18. Links for Community Health Workers



Overview:

Community Health Workers

By Molly Miller

A recent study by the Centers for Disease Control and Prevention found that the uninsured rate from January to March of 2015 stood at 9.2 percent - the lowest uninsured rate the country has seen in 50 years! This is great news for individuals who did not previously have health insurance, as it vastly improves the affordability of health care and reduces reliance on the emergency room as a form of primary care.

However, this increase in the number of individuals with health insurance has also increased the demand for health care services, with a recent study by the Commonwealth Fund projecting that primary care providers will see an average increase in the number of office visits of 1.34 visits per week. This could mean trouble for an already over-stretched primary care system.

As of April 2014, the United States and its territories had 6,087 Primary Care Health Professional Shortage Areas (HPSAs), which means that "primary medical professionals in contiguous areas are over-utilized, excessively distant or inaccessible to the population under consideration." The large number of HSPAs means that, while patients may be able to



afford health care, they may not be able to easily access high-quality health care.

To solve this issue, health policy experts are looking into a variety of solutions for decreasing shortages **including fast-track medical programs** for students interested in becoming primary care physicians. However, the solution to closing the gaps in primary care provision

may already exist in the form of Community Health Workers.

Who are Community Health Workers?

The World Health Organization provides the following widely accepted **definition of community health worker**:

"Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional health workers."

While this definition may provide a vague answer to the question of who community health workers actually are, it does so intentionally in order to create a space for the layperson to im-

pact the health of his or her community. In one state community health workers may have a professional certification while in another they receive only informal training. Some community health workers may focus on providing direct medical care while others may focus more on health education.

However, the common thread is that all community health workers, no matter where they are located, are deeply embedded in their community. This gives community health workers the opportunity to get to know their clients in a way that a 15-minute appointment with a primary care physician doesn't allow. This provides the opportunity to better understand potential social and environmental impacts on the client's health.

What can Community Health Workers do?

Community health workers can provide a variety of **health and social services including, but not limited to**:

- Connect vulnerable populations to appropriate health care providers
- Coordinate care for clients who are transitioning between health care providers (that is, from a primary care physician to a specialist or from an in-patient hospital setting to a home care setting)
- Help clients in determine their eligibility for, and enroll in, various health insurance and social service programs (Medicaid, Medicare, WIC, SNAP, etc...)

- Train health care providers in cultural competencies related to the vulnerable populations they serve
- Provide culturally appropriate health education
- Advocate for clients to ensure they receive the proper health and social services
- Provide informal counseling, interpretation, and translation services to clients
- Build community capacity to address specific health issues

What value do Community Health Workers provide?

Most services provided by community health workers are not direct medical services. But they are all vital to reducing patient burden placed on primary care physicians, especially in HSPAs and rural areas. Having an individual in the community who can travel to a client's home and check their blood glucose levels or provide health education and counseling regarding chronic disease management can prevent unnecessary visits to a primary care physician. This saves time for the client and allows the physician to keep appointment slots open for patients who truly need to see a doctor.

Due to the large variation in program design and purpose, it is hard to measure the overall impact that community health workers have on the health care system. However, some randomized trials have shown the positive impact community health workers can have on patient outcomes.

One study found that patients who were assigned a community health worker upon hospital admission—to serve as a liaison between the patient and the patient care team and help the patient create a post-hospitalization action plan—were approximately 12 percent more likely to complete a post-hospitalization primary care follow-up than those patients who did not receive the intervention. Additionally, patients receiving the community health worker intervention had only 38 readmissions compared to 45 readmissions among the control group, with the intervention also significantly decreasing recurrent readmissions from 40 percent to just over 15 fifteen.

While this study represents only one community health worker intervention, it demonstrates the usefulness of integrating community health workers into the patient care team. Patients who have an advocate who can explain medical jargon in terms that a layperson can understand are more likely to follow the doctor's orders, stay out of the hospital, and appropriately use health care facilities when needed.

The full benefit of robust community health worker programs is still being explored, but the existing body of research demonstrates that community health workers have the potential to serve as a vital part of the health care system.

Photo: Creative Commons

CHWs & Health Systems: Emerging Trends

A CONVERSATION WITH KEVIN BARNETT, GRACE DAMIO, AND CARL RUSH

Kevin Barnett is a Senior Investigator at the Public Health Institute. Grace Damio is a public health nutritionist and Director of Research and Training at the Hispanic Health Council. Carl Rush serves as a core team member of a policy center on CHWs at the University of Texas – Houston School of Public Health. All three have been engaged in Community Health Workers issues for many years. (For their bios, [click here](#).) Stakeholder Health’s Molly Miller and Tom Peterson recently caught up with them to get a sense of emerging trends.

Stakeholder: What are some of the best or most innovative ways hospitals are using community health workers to improve the health of the communities surrounding them? And what are some barriers and misconceptions that might keep hospitals from using them?

Rush: There doesn’t seem to be any systematic data gathering about what hospitals specifically have been doing. But I’ve been hearing a number of examples – particularly under community benefits funding. Partnerships are forming between

hospitals and organizations in the community to engage in large-scale population health initiatives to improve health. It depends on what you mean by community health because there are some interesting approaches with safety net hospitals that still have large percentages of uncompensated care involving community health work in care coordination or redirecting individuals into more appropriate sources of care, from the emergency room in particular.

Barnett: Other than a few exceptions, hospitals have not engaged community health workers or promotoras in any substantive manner. Where they have engaged them, they’ve come to the issue in looking at the kinds of challenges most relevant to them. So a good number of hospitals engage with community health workers to help with the enrollment process as part of the Medicaid expansion.

As they have looked at the kinds of issues people face related to readmission – as CMS has established penalties around readmission – it has brought to light that there are issues people confront post-discharge that now have financial implications for the hospitals.



Then there is the broader issue – where we have a good amount of evidence relating to chronic disease, pregnancy, and other related issues that are easily defined and which involve substantial additional costs if these conditions are not well managed. There are numerous examples where hospitals have reduced admission and utilization for things such as asthma, cardiovascular disease, and other conditions.

So, they come to the issue with the focus on how can we solve this immediate problem? They don't come with the perspective, at least automatically, of how community health workers will help us begin to solve some of the larger drivers of poor health in the community. That, in many instances, is down the road.

Damio: That description resonates with our experience as a local agency. We've partnered for decades with one local hospital, and they've done every combination of referring to our programs, funding our programs, or hiring their own staff to be part of our programs. So we have active with that hospital some partnership in cancer work with community health workers, a decades-long partnership in prenatal case management, a decades-long partnership in breastfeeding peer counseling, and then a very rigorous randomized-control trial on diabetes peer counseling.

Several of these have a lot of evidence behind them. The breastfeeding work was impressive to a second city hospital. They got a Kellogg grant to build in the expansion of the program to work with their population and their hope is that

they'll convince their hospital to actually pick-up support as the grant goes away in a few years. That said, it is issue-based, some around health promotion and some around chronic disease management. The background issue is that funding is in jeopardy as hospital funding gets cut.



A close colleague and ally from a local hospital recently said to me, “We’re so interested in this topic but what we’re really trying to do is find the right model.” And I said, “We have models that we’re working with you on and we’ve actually done research on them.”

I’ve heard that more than once from people who either are well-intentioned but don’t see what’s right in front of them or who are looking to create the groovy new thing and want to be the one who found and brought in the right model.

So, slipping into the barrier question, it’s interesting how the rigor within the community that has some evidence-base behind it isn’t necessarily seen for what it is. And the idea is that we’ll find something Georgetown did and adapt it.

Stakeholder: So you all have been working with this for a long time, and there are evidence-based models where community health workers have been working well with hospital systems. Why isn’t this catching on all over the country?

Rush: Part of the uncertainty many hospitals feel is related to the fact that the community health worker has such a broad

scope of practice. It does not overlap a lot with clinical occupations. They do so many different things at an individual patient level as well as a community population level. Folks have difficulty pigeon-holing them. Also, many feel a sort of common sense constraint – they’re looking for a source of support, particularly a sustainable one through a third party payer to support these positions.

I’m seeing, to some extent, a growing interest, not just among hospitals but also among health plans. For example, when looking for a dedicated funding stream to fund these positions they finance them out of their operating budget on the basis of internal return. There still aren’t a lot of examples of that, but there is a growing number. Some fairly prominent health systems are jumping in saying, “Let’s look at how our system needs improving and see where the community health workers fit in that.” This is a bit of a departure from what Kevin was pointing out, looking at an immediate problem and then casting about for a solution to that.

We see another barrier in some systems: I’ve heard direct quotes from folks who say, “Community health workers simply aren’t part of our model.” They don’t want to hear any more about it. Thankfully, that’s relatively few. But a lot of folks in these systems are so steeped in the medical model and the modus operandi for the community health worker is simply not based on the medical model, nor is their expertise in the domain of clinical knowledge and clinical training. They don’t quite know how to wrap their heads around that. So that

takes a little bit of cultural shift on the part of a lot of these organizations.

Stakeholder: What are some things you all have seen as systems have been able to overcome that bias towards just a clinical model?

Rush: Some systems are simply experiencing, especially with low-income patients, some serious barriers with communication. I’m talking about the barriers that result from power differentials between patient and provider, mistrust of institutions, and other things like that.

A second major current is recognizing a need for better communication, more continuous communication, with patients to deal with issues like care transitions, readmissions, adherence to treatment for chronic disease and that sort of thing. But also coming to respect much more the importance of social determinants and recognizing that most of their workforce is not well equipped to deal directly with them.

Damio: The diabetes peer counseling model we developed in Hartford has 17 home visits and the peer counselors were completely community based. They were integrated into a clinical health care team and conferred in face-to-face meetings once a week, but from the field, from the client’s homes. From that, it became obvious to the provider that there were major gaps in health care going on during the visit, that they needed internal care coordination. They needed cultural competence training within their own institution. And the relevance of what the

community health workers produced was pretty stellar in terms of the reduction of HbA1c.

It really was a full, rigorous, community-based model – well integrated, but on the outside dealing with social determinants. Everything from lack of access to pharmaceuticals, to depression not being well-managed, to not knowing how to manage glucose in the home, to educational issues. Many things are going on within the home setting and creating an effective interface. Unfortunately, it was a study that ended and there wasn't funding to continue. But the hospital saw not only the benefit of what the peer counselors did but also the bigger picture within their institution of needed changes.



Barnett: Clearly, one of the biggest obstacles to the substantive engagement of community health workers is our fee-for-service system. But with the growing volume of managed care, of capitated contracts for Medicaid, we're still largely operating in a fee-for-service system. The only real

entry-point that makes any financial sense for hospitals operating in that arena is through looking at ways to manage uninsured and underinsured patients coming into their emergency room.

That was some of the earliest work – around Emergency Department diversion. Now, with the notion of beginning to be at-risk for the populations that are insured and that a growing

number of people who are being insured are under the Medicaid expansion or are lower-income people with Silver and Bronze plans, it now is becoming important to look at creative models and look at the concept of how team-based care needs to be expanded significantly beyond the clinical arena as we see that the drivers of poor health are within that larger community context.

A number of communities in Ohio and Michigan are testing of the concept of the hub model of community health workers. In essence, a separate 501(c)(3) organization contracts with multiple providers and payers. Because they are based in a specific geographic community and are independent and able to contract with those entities they have more of a capability to look at strategies to address some of the drivers of poor health. These may be poor indoor conditions in housing that contribute to the exacerbation of asthma conditions, or broader issues around food access and food insecurity, safety, or other issues that the sector needs to begin to address.

This hub model offers the potential for hospitals to partner with entities that are doing this. Some hospitals are contracting with an external entity to do this for them. I'm most interested in communities where they're thinking about community health workers serving multiple providers and payers.

Rush: Picking up on that, a number of states have engaged community health workers as part of their design for their SIM strategy. There seem to be two main approaches, and sometimes they are taking both. The SIM plan may address

community health workers as a part of a redesign strategy, but it also may be separately considered as part of a workforce strategy under the SIM plan. So the plan may not address the role of community health workers directly in the redesign of health systems, but they may be an important element of workforce strategy.

One of the strengths behind the community hub model is that it allows the hub to draw funding from, or to bill, a number of different entities, such as the Housing Authority, depending on the services being rendered.

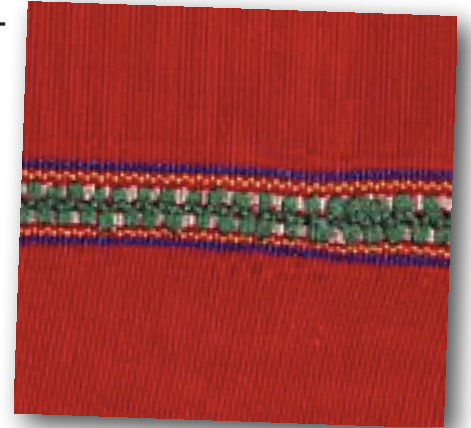
Back to the uninsured and uncompensated care, early on, and more or less on their own, several hospitals in the Houston area started applying this approach, mainly emergency room diversion. Almost immediately they began to see dramatic financial return in terms of reducing uncompensated care and the net return over the cost of the program. Employing community health workers has had a return on investment of around 3-to-1. The CHRISTUS system, in one of the regions in Southwest Louisiana, had a return of something like 15 to 1. So they're certainly convinced of the financial benefit.

Stakeholder: So is emergency room diversion by using community health workers the low-hanging fruit for many health systems?

Rush: I think that's appropriate. A couple of more sophisticated models have grown up as well, not explicitly hospital-centric, but out of New Mexico is really driven by the health plan that sees similar returns. They engaged a couple of pro-

vider networks with supplemental care coordination fees and employing community health workers to get to high utilizers. This is similar to the hotspotting model used in New Jersey, which is in multiple hospitals and partnerships. And they're high on the concept out of Camden.

Now, they've gone even farther as a community partnership in terms of being able to pull information from schools and law enforcement and a variety of things in terms of targeting interventions in the highest priority census tracts to address some social determinants directly and identify people at risk, rather than waiting for them to show up.



Barnett: The inclination is to see community health workers as doing something mysterious, that we don't understand, and somehow they have connections to people because they come from those communities that today will help doctors and clinical teams get more patient compliance. It's a simplistic way of interpreting it, but it's often the way that it's viewed.

The truth is, there are complex dimensions of knowledge, experience, and understanding of leadership qualities that are needed in order to be effective. Understanding the interactions between the social and physical environment and family and culture and ways in which that plays out in communities, you don't just give that job to anybody. Going forward, we need to look at community health workers as providing the

off-ramp out of the body shops we have created for just providing acute medical treatment to illnesses – many, if not most, of which are preventable. So they provide that off-ramp of the medical expenditure super-highway into the communities where health is actually created and, in that sense, are in a position to provide leadership and to help us begin to impact health.

So the low-hanging fruit is all of these people who are ending up in our emergency rooms who offer the potential to bankrupt not only our health delivery system, but our larger economy, with more and more people acquiring preventable diseases like diabetes. It's important to understand that there are some strong feelings within the community health worker community to say, "Don't undermine what is most important about our potential contributions by simply having us be medical service navigators."

Damio: I would also mention that it was also interesting within the SIM discussions because the original thinking was that the community health worker would be based within the clinical setting and largely play a navigator role. An enormous amount of, not just pushback, but strong input that was given shifted the thinking with the complexity of the role and why it needs to be in more of a community setting.

When the requirements were rolled out, the discussion came up: does the community health worker have to be in a community setting? Many thought, no, they can be in a clinical setting and still be effective; we're not going to force that. I said

that if they're in a clinical setting they are much more likely to be bound to a navigator role and not get beyond that. We didn't have enough people saying that for it to be fully built into the language of the plan. When people learn what a community health worker is, there is a mindset to first think of that navigator role, and that's so limited. They think, really, dump the person into an advanced practice network or an FQHC, and within the FQHC the idea is that they're in the community. A lot gets lost with that kind of thinking.

Rush: Grace brings up the important point. It's not so much where their base is – as in where they're supposed to be spending most of their time – as it's whether they have the flexibility to work where they're needed. Sometimes that's intervening and being present during discharge discussions. But it's also doing home visits and so on. This can be uncomfortable for those used to managing people in a clinical setting – that all of a sudden they're not there a lot of the time. This requires a certain organizational maturity and a supplemental set of supervisory skills to be able to oversee a workforce that may not be physically present in the institutional setting a lot of the time.

Another trend, there's a lot of discussion in the trade press recently about integration of behavioral health in both the primary care setting and the hospital setting. This is where community health workers show tremendous potential. They seem to gravitate naturally towards certain techniques that are helpful in dealing with folks with behavioral health issues.

And to sort of put a ribbon on this point about the safety net hospitals, there seems to be an appreciation for some intangible things that community health workers bring, including anecdotally a fair amount of impact on patient satisfaction and loyalty and things like that. There was a short demonstration with community health workers, mostly in pediatric departments. When the state funding ran out, three of the four hospitals participating kept those community health workers on the payroll without a distinct means of support.

When the one here in San Antonio, Christa Santa Rosa Hospital, experienced an across the board staff cut not long after that, the head of one of the departments that employed the community health workers put one of those positions on the block and the CEO came down and said, “You will not eliminate that position.”

Stakeholder: Is it your experience that if hospitals will try them, they’ll like them?

Rush: It can be that, but with a certain proviso of making sure they do it right, with clear guidance that they are making sure that they hire the right people. In many ways that’s more important than the training. And making sure the pieces are in place to integrate them into the organization, which can be jarring for an organization with an established culture.

Damio: The use of the community health worker services needs to be somewhat seamless for the other providers so that it doesn’t feel like a burden or something that’s too peripheral. Otherwise they just forget about it or think it’s a nuisance.

And that means communication systems and sharing of information and ways to get updates and even the referral process need to be carefully and elegantly designed to fit their needs.



When we did a care coordination process with the Children’s Hospital, the pediatric leader that envisioned it said at one of our planning meeting, “This might feel like heresy, but I’m more concerned about provider satisfaction than patient satisfaction.” And he only meant it in the sense that it needed to be well-integrated into the practice or it wasn’t going to work, so that’s one.

Barnett: We can’t just drop community health workers into a team context where there’s not a clear and in-depth understanding of their contributions. We hear all too often from community health workers that they don’t have a ready ear and a perspective among other members of the team to integrate the value of what they have to offer as part of that process. So as we look at engagement and community health, it’s important to think about what kind of training is needed for other members of the team to optimize contributions.

Reaching Public Housing Residents in a Personal Way

By Les Gura

For the past seven years, a growing initiative in Richmond, Virginia, has improved health services in the city's six large public housing developments by connecting residents not just with a weekly visiting nurse practitioner, but perhaps more important with a community advocate.

The advocates are residents of the housing complexes themselves. They receive training for some basic services—taking blood pressure and blood sugar, giving cardiopulmonary resuscitation—but their role is far deeper.

“They really are the faces of their community,” says Amy Popovich, RN, MSN and program director of the Resource Centers in the Richmond public housing developments. “They navigate people to medical homes and medical and community resources. And they do it in such a way that is very relatable and

pertinent to the people who they're serving in the community.

“It's different and better than what the medical professional world does,” Popovich says.

“They speak the same language and oftentimes have been there

themselves. They're open and sharing stories to give people hope. They let their people know they can make these changes in their lives as well.”

A model for others

The Resource Centers are funded through a collaboration of agencies: Richmond City Health District, the City of Richmond, Richmond Development and Housing Authority, Community Foundation, Richmond Memorial Health Foundation, Virginia Health Care Foundation, VCU Health and Bon Secours Health System, Inc.

One goal is to improve health in Richmond public housing in many ways—to reduce the prevalence of chronic disease such as hypertension and diabetes, as well as reduce sexually transmitted infections and teen pregnancy. A second goal is helping public housing residents learn new skills, find jobs or better employment, and perhaps leave public housing.

Popovich says the advocates, because they are part of the public housing world and now in stable jobs, offer a model to others. The six women who are community advocates, she says, “have been able to leave federal and state resources and programs, provide for their families, take care of their own health and get a primary care doctor.”

Community advocates bring results

The results of having these community advocates—in addition to the nurse practitioner, nurses and support staff for the six



LaTasha Melton, Community Advocate



Left to right- (all CAs except Denise Wise, CA Supervisor) Patrice Shelton, Shikita Taylor, Kimyatta Moses, Brenda Kenney, Denise Wise, Melissa Hayward, Stephanie Carrington, LaTasha Melton, and Camila Borja.

Resource Centers—have been startling. Popovich says last year brought 3,000 visits to Resource Centers representing more than 2,000 patients.

One health result? Statistics show that teen pregnancy from 2008 to 2014 dropped 40 percent in the city of Richmond. Popovich

says that can at least partly be credited to the work of the Resource Centers and their teams. Not only do the centers distribute condoms and information about sexually transmitted infections, but the advocates are there to provide role model support and coaching for teenagers.

Listening, connecting, supporting

Patrice Shelton, the community advocate for Hillside Court, was a longtime Walmart employee, but had been unemployed for about three years when the opportunity arose for her as an advocate. It's a role she says is natural.

"I am a question person," she says. "So if I'm not understanding something, or I'm in a room of people and they don't understand and are too shy, I'm quick to ask. My passion is for

elderly people and kids. People who can't speak for themselves."

She says the key to her job is listening.

"We make sure we are all ears, even if it has nothing to do with the job,"

Shelton says. "Stress affects your mental health, and talking it out sometimes eases stress. Part of my job is just to sit and listen to them."

Shelton also is able to help connect residents of her development, as well as anyone else who happens to stop by, with resources they might need beyond health checks.

"We try to find places that will help you with a car payment or utilities or rent," she says. "If you don't have insurance we'll help you get it. We'll try to get you a primary care doctor (as opposed to having to use only the clinic or having to go to an emergency room). My thing is a one-stop shop, very changeable to what the community needs."

That attitude is what makes the community advocates such an effective tool in the battle to improve health, Popovich says.

"Advocates serve as peer and mentorship support. People may come into one of our centers just to talk with an advocate over where they are in life," Popovich says. "It's more than just numbers; they serve as a support system to the community."



Stephanie Carrington, Community Advocate

A Trim, a Shave, a Blood Pressure Check



By Les Gura

Talk to Duane Johnson (pictured above) about doing blood pressure checks and diabetes screenings for patrons of M&S Barber Services, the shop he owns in Washington, D.C., and you get history.

Not just about the five years his shop has provided the service, thanks to training and support from MedStar Health, the Maryland-based health care system that created the Hair, Heart and Health program. Rather, Johnson talks about the

role barbershops have traditionally played in medicine, dating to medieval times. The traditional barber pole, he notes, points to a past in which barbers performed surgery, primitive though it might have been.

It was a natural, Johnson says, for barbershops to be invited to participate in the Hair, Heart and Health program, and there's a crucial reason why he considers it an honor to participate.

"I do it as a human being, as a Christian, as somebody that's concerned not only about the monetary proceeds of the barber shop, but just being able to give back anything," he says. "This is a program that's a need. And we need more programs like this in the community."

About Hair, Heart and Health

MedStar Health began the Hair, Heart and Health program as a way to provide outreach to several largely minority and poor neighborhoods in Washington, D.C. After an initial grant expired, MedStar Health, a 10-hospital nonprofit system that includes MedStar Georgetown University Hospital, conducted a community health needs assessment in 2012 for Washington, D.C., one of its key service areas.

Christopher King, MedStar's assistant vice president for community health, says the assessment found that African-American men are a difficult-to-reach population and many are unaware of their health status. The assessment prompted MedStar to renew and broaden the Hair, Heart and Health

program, which it did partly through a grant from Astra-Zeneca HealthCare Foundation.

“We wanted to focus on prevention, have it be culturally tailored, housed in a neighborhood setting and targeted to a specific population,” King says. “That’s why we felt the barber-shop is a great place.”

There are now four barber-shops participating in Washington D.C. neighborhoods. At M&S, Johnson and three barbers were trained to conduct the screenings themselves; the other shops use patient navigators brought on by MedStar to perform the screenings. But the decision to be screened arises through what King says is the most important part of the program—the age-old tradition of barbers and their patrons chewing the fat.

“Barbers have conversations with patrons about health and well-being. It goes beyond screening,” King says. “They’re having conversations about health, about mental health and about connecting to services in the community. And through peer-to-peer interactions, information is disseminated by a trusted source.”



Numbers point to need

High blood pressure, or hypertension, is a problem in the African-American community, as is the prevalence of diabetes.

According to the American Heart Association, more than 40 percent of non-Hispanic African-Americans have high blood pressure. Statistics show that high blood pressure also develops in African-Americans earlier in life than it does for whites.

Statistics from the Office of Minority Affairs of the U.S. Department of Health and Human Services show that African-Americans are twice as likely to be diagnosed with diabetes as non-Hispanic whites, and also are more likely to suffer complications from diabetes such as end-stage renal disease.

The grant from AstraZeneca allowed the Hair, Heart and Health program to begin a three-year period of testing in which MedStar Health will gather data to study the effectiveness of the program.

In addition to linking patients to a primary care provider, MedStar is studying whether Hair, Heart and Health is identifying new cases of undiagnosed hypertension and diabetes.

“As we strive to provide impactful health services in community-based settings, more research is needed to identify what works and what doesn’t work. The model is being rigorously evaluated and we are tweaking it as we go,” King said,

“so this can evolve to an evidence-based program that is worthy of replication in other communities.”

A new kind of barber service

“We’ve actually physically saved two or three lives with this program,” Johnson says, a touch of pride in his voice. “These guys came in and their readings were so high we immediately called an ambulance and they were transported to the hospital.” Doctors, he says, later told him that if the men hadn’t been taken in that soon, there was no telling what might have happened.

Although those were unusual cases, Johnson happily points to the many shop regulars who now get their pressure taken, with all of the data duly recorded according to federal privacy laws and shared with any of the patrons’ providers as requested.

“We make a big to-do about that program. We take so much pride in helping that we requested literature to give to people and it was provided to us,” he says. “We sold it as a new barbershop product, ‘We’ve got to take your blood pressure.’ A lot of people didn’t take it seriously at first, but as they see the constant awareness and information here, they’ve taken us a lot more seriously. We just went and ran with it.”

The broader message of reaching a population that struggled with high blood pressure and diabetes is crucial, Johnson says.



“Everybody in America is suffering some kind of ailment, like cancer, diabetes. As African-Americans, it affects us the most,” he says. “This has been a great opportunity to introduce and educate and to make aware, and being funded by MedStar, what could be better?”

King says one of the most encouraging things about the program is that it has reached even beyond what was envisioned because of the conversations taking place in the shops.

“Men are talking more about their health,” he says, “and through community resource guides that were developed by the staff, patrons are connected to medical and nonmedical services, such as housing assistance or legal help or access to fresh foods. All of these support holistic well-being.”

Photo: Barber Pole, Broken Sphere, Creative Commons

Community Health Worker Associations

By Molly Miller

As community health workers become more integrated into modern health care systems, a new form of organizing for better health care is emerging in the form of Community Health Worker Associations. Much like community health workers themselves, community health worker associations vary in their structure and purpose. Despite this, community health worker associations collectively provide the opportunity for community health workers to share best practices related to their work as well as an opportunity to develop much-needed "soft skills", including advocacy.

Where Do Community Health Worker Associations Exist?

Community health worker associations do not currently exist in every state where community health workers are employed. States with active community health worker associations include:

- **Arkansas**
- **Indiana**
- **Massachusetts**



- **Michigan**
- **New Mexico**
- **Ohio**
- **Oregon**
- **Rhode Island**

What Do Community Health Worker Associations Do?

Community health worker associations fill a variety of roles for community health workers. First, they help to professionalize the occupation of community health worker by providing training and, in some states, formal certification programs for community health workers. For example, the **Community Health Worker Association of Rhode Island provides an optional Community Health Worker Certification**, that is optional but endorsed by the Rhode Island Department of Health, which allows community health workers to develop new skills or brush-up on best practices. On the other hand, some state associations offer ad hoc trainings to improve community health worker skills surrounding specific health topics.

In addition to providing training, community health worker associations often provide opportunities for community health workers to meet with each other and share best practices during annual conferences. These conferences provide community health workers and community health worker ad-

vocates with the opportunity to learn more about the impact that they can have on specific health issues, share best practices with other community health workers in their state, and learn more about how to navigate a constantly changing health care system.

Finally, community health worker associations can provide a clearinghouse for job opportunities in the community health worker field, which is vital to recruiting new talent into the community health worker network.

While community health worker associations do not operate as unions, they provide the tools that their members need to advocate for themselves when speaking with potential employers, navigating health care systems, and legislative bodies in their respective states.



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Links: Community Health Workers

By Molly Miller

Reports and Articles

Uta Lehmann and David Sanders (2007), “Community health workers: What do we know about them?” - In this report, produced by the World Health Organization, the authors explore the feasibility and effectiveness of community health worker

programs on the global level, with a focus on the impacts that community health worker programs have had in areas with significant shortages of health care workers such as Latin America, Asia, and Sub-Saharan Africa.

E. Lee Rosenthal, J. Nell Brownstein, Carl H. Rush, Gail R. Hirsch, Anne M. Willaert, Jacqueline R. Scott, Lisa R. Holderby and Durrell J. Fox (2010), “Community Health Workers: Part of the Solution”, Health Affairs – This journal article explores the potential that community health workers have on ensuring adequate access to primary care services in under-served areas in a post-Affordable Care Act America.

Prabhjot Singh and Dave A. Chokshi (2013), “Community Health Workers – A Local Solution to a Global Program”, The New England Journal of Medicine - This journal article explores the current impact that community health workers are having in the United States and globally. Additionally, this article explores next steps for building up the community health worker occupation and ensuring that community health workers become and remain an integral part of the health care system.

Videos

Blue Cross and Blue Shield of Minnesota, “Critical Links: Community Health Workers” – This video explores the impact that community health workers in Minnesota have had on the state’s health care system, particularly with reaching vulnerable populations.

Oregon Community Health Worker Association, “Together, We Support Community Health: The Power of CHWs” – In this video, we hear from community health worker supervisors regarding the impact that their employees are having on health education and improving community health outcomes.

Resources

American Public Health Association Community Health Worker Section – The Community Health Worker section of the APHA provides networking opportunities for community health workers who attend the APHA Annual Conference as well as additional learning resources for section members hoping to improve their skills.

Rural Assistance Center Community Health Worker Toolkit – This toolkit provides organizations who are interested in starting a community health worker program with the steps and resources needed for such a program to be successful. Available resources include tips on program models, training approaches, program implementation, developing sustainability plans, monitoring and evaluation, and sharing best practices.

