Community Health Worker Common Indicator Summit

Executive Summary of Proceedings

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The CHW Common Indicator Summit was made possible by grants from the Cambia Health Foundation and Social Venture Partners of Portland, OR.

Brief Summary

Community Health Workers (CHWs) have made important contributions to communities and health and social service systems in the US for decades.[1,2,3] Since the passage of the Patient Protection and Affordable Care Act (ACA), interest in the CHW model has grown.[4,5] However, policy makers and health system leaders are asking for more systematic study to achieve a strong evidence base before making long-term investments in the CHW workforce.[6,7] This document summarizes the steps taken at the recent CHW Common Indicators Summit held in Portland, OR, on October 2-3, 2015. Building on work conducted by the Michigan Community Health Worker Alliance (MiCHWA), and under the auspices of the Oregon CHW Consortium, staff from the Multnomah County Community Capacitation Center (CCC) organized the two-day Summit to make progress on identifying a set of common process and outcome evaluation indicators that can be used by CHW programs around the US, and potentially around the world. The 16 CHWs, researchers, evaluators and program staff from five states who participated in the Summit brought both substantial experience measuring the process and outcomes of CHW programs, and new and fresh perspectives to the work. Participants reviewed MiCHWA's common indicators work as well as CHW program and evaluation work from their states and engaged in processes leading to consensus on the following proposed list of process and outcome indicators.

Introduction

Background on Community Health Workers

Community Health Workers, trusted community members who participate in training so that they can promote health in their own communities, have played crucial roles in communities and health care systems around the world for decades.[1,2,3] The CHW model grows out of natural helping and healing relationships that exist in all human communities. CHW programs have been supported by a variety of grants for many years and there is a growing body of research documenting their efficacy (see below).[8,9] However, there was little systematic recognition by the health care system in the US until the passage of the ACA in 2010, which highlighted CHWs' actual and potential roles.[10]

Since the passage of the ACA, interest in CHWs has grown rapidly.[3,11,12] However, most CHWs and their programs remain reliant on short-term grant funding, which makes their programs, employment and success in empowering individuals and communities unsustainable.[13] In response, CHW-related organizations, health and human services employers, some health plans and many states have been studying and implementing various actions with the goal of sustainably integrating CHWs into health care and human service systems. These include pursuing legislation, changes in administrative rules, and new training programs and payment mechanisms that apply to some but not all CHW activities and CHW programs.[14,15] These actions may have positive impacts; however, many policy makers and health system leaders are asking for more systematic study to achieve a strong evidence base before making long-term investments in the CHW workforce and programs. Alongside CHWs' current and future pursuits of new legislation, administrative rules, and payment mechanisms, the existence of a strong evidence base can hopefully lead to even greater advances in the CHW field.

The Need for Common Indicators

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The body of academic and organizational literature and reports about CHWs and CHW programs in the US has been developing since the 1960s, and has increased exponentially since the turn of the millennium.[2] Countless studies, including a growing number of "gold standard" randomized trials, document outcomes of CHW programs.[16,17,18] Some progress has been made on furthering systematic evaluation of CHW programs. Notably, one chapter of the landmark National Community Health Advisor Study[3] focused on evaluation of CHW programs. The National Community Health Worker Evaluation Toolkit, produced by the University of Arizona Office of Rural Health, made other substantial contributions to the field. CHW evaluators have recommended development of a common set of evaluation indicators and measures to foster identification of the unique contributions of CHWs to successful program outcomes and to strengthen the economic case for CHWs through pooled analyses.[3, 6, 21, 22]

However, the development of the evidence-base regarding CHW programs has been hampered by three primary factors. One factor is the dearth of studies that include measures of the processes by which CHW programs achieve their outcomes. Even those that describe CHW activities or interventions often do not document the unique contributions of CHWs, including *how* they address the social determinants of health or other non-clinical indicators. Employers may question why they should hire CHWs, specifically, and may hire other professionals and call them CHWs because they work with community members.

A second factor is that most CHW evaluations are short-term (in line with their short-term funding bases). CHW programs, often developed using community-based participatory research (CBPR) approaches, take time to develop, fully implement and evaluate over a long enough time to measure sustained individual or community outcomes. To date, no government or private funders have been willing to fund the kind of longitudinal studies that have coalesced support for programs like the Nurse-Family Partnership.

A third factor is variation among CHW programs. One of the reasons CHWs are so effective is that they respond in unique ways to the unique needs of diverse individuals and communities. They address a wide array of health issues and social concerns in a range of contexts from clinic to community.[19] This strength can become a weakness when evaluating CHW programs, since it is challenging to measure program processes and outcomes in such a way that data can be aggregated to create a more comprehensive picture of CHW programs' processes and effects.

Preliminary Studies Conducted by MiCHWA

To help fill this evaluation knowledge gap, MiCHWA launched the CHW Evaluation Common Indicators Project, with a pilot grant from the Vivian A. and James L. Curtis School of Social Work Research and Training Center at the University of Michigan.[6,20] The goal was to create a common set of evaluation indicators and measures to capture the unique contributions of CHWs to successful program outcomes and their added value to health care and human services systems. During 2014-2015, this project conducted key informant interviews with national CHW experts, Michigan-based focus groups with CHWs, and, informed by the first two activities, developed and implemented a survey of evaluation activities with Michigan-based CHW programs. Currently, the data are being analyzed to identify commonalities and gaps in process and outcome measures, including who and how data are collected. The anticipated outcome of this effort is a set of common evaluation measures and, possibly a recommended tool that can be used by CHW programs nationwide to better characterize and evaluate the work and impact of CHWs. The ultimate aim will be to support efforts to achieve sustainability of CHW programs

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and systematic evaluation of their impact on the health of underserved populations. The Common Indicators Summit was a logical next step in expanding this process beyond Michigan.

The Common Indicators Summit

Building on work conducted by MiCHWA, staff from the Multnomah CCC of the Multnomah County Health Department, Portland, OR, organized a two-day summit to make progress on identifying common process and outcome indicators. The summit, which was held in Portland, OR, on October 2-3, 2015, brought together 16 CHWs, researchers and evaluators, and program staff from five states.

Summit Participants

CHWs, CHW program managers, and CHW program evaluators attended the Summit from academic, health system, public health and other organizations from five states. The Summit was planned by a subgroup of the eventual participants representing each of these sectors, using a participatory approach. It was hosted by the Community Capacitation Center of the Multnomah County Health Department, Portland, OR. *A list of Summit participants is located in Appendix 2.*

Objectives of the Summit

In advance of the Summit, the facilitators and a subgroup of the eventual participants established a set of objectives, using a participatory planning approach, as follows.

By the end of the Summit, participants will:

1. Be familiar with work we have already done to identify common indicators for CHW practice;
2. Be familiar with the process and outcome indicators we are currently using in a representative sample of our CHW projects;
3. Identify similarities, differences and gaps in our process and outcome indicators;
4. Develop a plan for identifying a set of common indicators that we can all commit to using in our CHW evaluation and research work; and
5. Build support for one another to strengthen our CHW work.

Key Features of the Summit

Popular education was the philosophy and methodology used in the summit. Also referred to as empowerment and Freirian education, popular education creates settings in which people most affected by inequities can share what they know, learn from others in their community, and use their knowledge to create a more just and equitable society. Popular education and the CHW model grow out of many of the same historical roots and share key principles, such as the ideas that people most affected by inequity are the experts about their own lives, and that experiential knowledge is just as important as academic knowledge.[21]

Using popular education in the summit meant that facilitators made an effort to create an atmosphere of trust, balance participation and power around the room, actively elicit all voices, and come out of the summit with a workable action plan. In order to achieve these goals, facilitator used techniques such as dinámicas (social learning games), negotiation of group agreements, group evaluations, and shared meals.

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Day 1 included an introduction to the MiCHWA Common Indicators Project and its major findings to-date, followed by discussion and questions from Summit participants. Common themes regarding the unique contributions of CHWs included ability to provide social support, build empowerment, trust and relationships, health promotion, and system navigation. The importance of conceptualizing contributions beyond the medical model was also emphasized in the discussion, including the importance of incorporating an ecological framework and models of care and well-being that go beyond curing disease. This means measuring processes and outcomes that are important for CHWs and their communities, beyond those outcomes valued by health systems. This framing influenced deliberations that followed. Participants shared information about example programs from their states and compared similarities and differences in programmatic context. The first day ended with a review of potential common process and outcome indicators based on a summary of the results of the MiCHWA Program Evaluation Survey that was completed by Summit participants prior to the Summit. Participants reviewed, compared and discussed indicators and data collection and analysis processes, identified gaps and considered implications for the work of the Summit.

Day 2 began by reviewing existing indicators and discussing possible additions useful in a variety of ecological levels, with an emphasis on the importance of measuring social determinants of health and the practice and policy context in which CHWs work. This process continued throughout the day, leading to refinements in the list of proposed process, outcome and output indicators. The second half of the day was devoted to developing an initial action plan for continuing the Summit's work, including necessary steps, potential partners and settings for further planning, and next step leads among Summit participants and others.

Proposed Process Indicators

1. Workforce capacitation/support (level of CHW)
    a. Involvement of CHWs in decision making process
    b. Level of social support the organization provides for the CHW
    c. Value of CHW to the organization and acceptance of CHW
2. Frequency of enactment of 10 core roles (level of community member/participant/client)
3. Trust/satisfaction with CHW relationship (level of community member/participant/client)
4. Referrals made (level of community member/participant/client)
    a. CHW facilitated connections at all levels
    b. Connections to resources, organizations, and policy makers (level of systems)
5. The extent to which CHWs are part of the policy-making process
    a. CHWs teaming with systems, organizations and policy making bodies
    b. Degree are CHWs are integrated into health care teams

Proposed Outcome Indicators

1. CHW satisfaction with their job
2. Participant food, water, transportation, and security
3. Participant access to health and social services
4. Participant knowledge, attitudes and behaviors
5. Participant social support
6. Participant empowerment
7. Participant civic engagement
8. Participant quality of life/satisfaction with life

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9. Policy and systems change (increased fabric of social capital in area, e.g. number of parks)

A Plan for Moving Forward

Much was accomplished in the two-day summit held in Portland. But now the real work begins. We have a concrete set of action steps to undertake. Progress will depend on consistent leadership from MiCHWA and the CCC, and commitment from all partners to follow-through on the tasks to which they have committed. Hopefully within the near future, we will identify funding to allow us to reconvene at regular intervals to assess progress and plan for the future. If these goals are achieved, then we have a realistic hope of establishing a set of common process and outcome indicators for the CHW field.

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Appendix 1: Summit Schedule at a Glance

Day 1

Group Agreements (9:30-10:15am)
Opening Activity (10:15 to 10:45am)
Introduction to the Michigan Common Indicators Project (10:45-11:15am)
Break (11:15-11:30am)
Programmatic context (11:30-12:15pm)
Lunch (12:15-1:00pm)
Dinámica (1:00-1:15pm)
Programmatic context cont. (1:15-3:30pm)
Debrief Context Setting (3:30-3:45pm)
Process and Outcome Indicators (3:45-4:45pm)
Planning for Day 2 (4:45-4:55pm)
Day 1 Evaluation (4:55-5:00pm)

Day 2

Introduction (9:30-9:50am)
Dinámica (9:50-10:00am)
Creating a proposed list of process and outcome indicators (10:30-12:30pm)
Lunch at the PSU Farmer's Market (12:30-1:30pm)
Dinámica (1:30-1:45pm)
Coming up with an action plan (1:45-4:00pm)
Final thoughts (4:00-4:30pm)
Day 2 Evaluation (4:30-4:45pm)
Closing Dinámica (4:45-5:00pm)

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Appendix 2: List of Participants

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