



A SUMMARY OF
THE NATIONAL COMMUNITY HEALTH ADVISOR STUDY



Weaving the future

A Policy Research
Project of the University
of Arizona
Funded by the
Annie E. Casey
Foundation

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A Policy Research Project of The University of Arizona
Directed by E. Lee Rosenthal, MPH, and Funded by
The Annie E. Casey Foundation

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1. Overview

Who Are CHAs and Why Do We Need Them?

Community Health Advisors (CHAs) help individuals and groups take greater control over their health and their lives. They promote healthy living by educating about how to prevent disease and injury and by helping community residents understand and access formal health and human service systems. CHAs are able to achieve these results because they have specialized training and share experience, language or culture of the communities they serve.

CHAs work within and as a complement to health care delivery systems. Paid and volunteer CHAs are typically based in community clinics, nonprofit organizations, and public health departments, although increasingly they are also found in for-profit environments. As the diversity of the U.S. population increases, and as the rate of change in health systems accelerates, the opportunity to expand the CHA role grows.

Finally, CHA employment provides jobs to local residents, opportunities to learn about health careers, role models for under- or unemployed individuals, and leadership training.

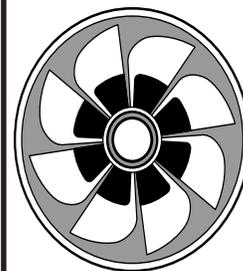
Introduction to the National Study

The National Community Health Advisor Study (Study) identifies steps to be taken to strengthen outreach services delivered by paid and volunteer Community Health Advisors (CHAs) throughout the United States. The Study, funded by the Annie E. Casey Foundation, began contacting people in the CHA field in late 1995, and in early 1996 a multi-disciplinary team of staff and consultants began work. The Study focused on issues that must be addressed to build the capacity of CHA programs to carry out their work in a manner that can be more easily recognized and reimbursed.

The term “Community Health Advisor” (CHA) is used in the Study to encompass an array of health practitioners known nationally and internationally by many different titles. Some other names for these practitioners are: Lay Health Advocate, Promotor, Outreach Educator, Community Health Representative, Peer Health Promoter, and Community Health Worker. In the Study’s national survey, which included respondents from more than 150 programs, 66 distinct (although often similar) titles for CHA were identified. These varied titles reflect the diversity of the field, diversity that contributes to CHA programs’ success in meeting the needs of culturally distinct communities. We have chosen to use the term “CHA” in this report. It was selected as a hybrid linking a wide array of CHAs serving in U.S. programs.

Goals of The National Community Health Advisor Study

The purpose of the National Community Health Advisor Study is to provide guidance to policymakers and practitioners on a number of areas that could improve the overall status of the CHA field. The Study incorporates the perspectives of CHAs as practitioners. Through its recommendations, the Study aims to strengthen the CHA profession itself, as well as its capacity to serve communities in need *and* enhance the health and human service systems on which they depend.



“... CHA’s not only identify and link people needing health or support services, they also coordinate clients’ relationships with multiple service systems.”

Scope of this Summary

This summary of the National Community Health Advisor Study covers the findings and recommendations from information collected directly from CHA practitioners and program managers over a period of 12 months during 1996 and 1997. Our findings cover four areas of inquiry:

1. What are the core roles of CHAs as health promotion practitioners? What competencies are considered by CHA practitioners to be essential to performance of CHA roles?
2. What measures should be used to evaluate the impacts of CHA programs?
3. What development issues confront CHA practitioners individually and as a field? What approaches can strengthen the CHA field to establish its role in health delivery systems?
4. How are CHA programs adapting to changes in the health care system? What are the most pressing opportunities and challenges?

All the recommendations made by the Study's Advisory Council are included in this Summary. They follow each of the four sections that identify steps to strengthen services delivered by paid and volunteer CHAs. The Study recommendations are also listed in this overview and again at the end in a tear-off section for easy reference.

Highlights of the National Study

CHA core roles and competencies. The Study identified a set of core roles played by CHAs, along with competencies that CHAs and program managers define as necessary foundations for CHA work. These identified roles and competencies could be used to set CHA recruitment, training, and practice goals and may help to improve program effectiveness locally.

Evaluation of CHA programs. CHAs impact a wide spectrum of health issues from individual and family health outcomes to community health indicators. However, there are numerous obstacles to rigorous, multi-site evaluation of CHA programs. A product of the Study is a four-part framework to guide CHA programs in formulating evaluations of their own programs.

CHA Career Development. Limited understanding of the CHA role by other health service professionals sometimes causes CHAs to be pushed beyond their training. In some other settings, CHA skills and training can be underutilized for the same reason. Strategies to promote CHA career paths, to improve recognition of qualities and skills required to perform CHA work, to develop clear program and agency standards, and to strengthen networks between CHAs and programs will enhance development of the CHA field.

CHA roles in changing health systems. While strongest in nonprofit and public health programs, CHA programs are emerging as important players within managed care programs. CHAs play critical roles linking managed care and communities by helping with outreach, patient education about managed care systems and health issues, and providing follow-up services. Increased emphasis on self-care creates opportunities for CHAs to use their special skills and abilities in ways that have great value to community members and those who finance health care.

Background on Community Health Advisors

Benefits of CHA Programs

CHA outreach and education services in underserved communities have shown remarkable effectiveness in linking individuals with the health care system, with insurance coverage, and with sources of continuous, appropriate medical care. Benefits of these activities include:

- Reduction of emergency room visits, hospital visits, length of time in a hospital, and the number of complications for certain illnesses.
- Greater availability of cost-effective, culturally competent home and clinically-based services compared with other services which may be unavailable or cost more.
- More focus on individual needs associated with health care delivery such as help obtaining non-medical services that reduce barriers to medical care for some people.
- Greater trust between client and the health care delivery system that promotes improved timely use of medical services and better compliance with medical care providers' treatment instructions.

In many programs, CHAs not only identify and link people needing health or support services, they also coordinate clients' relationships with multiple service systems. For clients who need extra social or logistical support to maintain their efforts toward defined goals, CHAs can be a valuable and cost-effective way to maintain connection with clients who are at the highest risk of dropping out of a complicated system.

The Number of CHAs

The most comprehensive documentation of CHA programs in the U.S. is found in the Centers for Disease Control and Prevention's (CDC) CHA database, which contains profiles of over 200 programs representing more than 10,000 CHAs. Despite CDC's updates of the database, the growth in CHA programs appears to be outpacing CDC's efforts, which depend on the voluntary self-registration of programs. According to estimates of the national Peer Helpers Association, there are also an estimated 50,000 school-based programs and 900 university-based programs (Tyndal, 1997), primarily made up of volunteer CHAs.

With no complete list of CHA programs available, it is not possible to firmly establish the total number of CHAs in the U.S. The lack of a common definition of CHAs and CHA programs also contributes to the difficulty of determining the number. From comparison of CHA programs identified through the Study and the CHA programs in the CDC database, we estimate that the CDC database, although newly updated, includes no more than one-third of all CHA programs (not including campus-based programs). If true, there would be an additional 400 CHA programs in the U.S. The median number of CHAs per program reported in the Study's survey is six CHAs. Multiplied by 400 programs this would mean that there are at least an additional 2,400 CHAs than are represented in the CDC database. Using these assumptions, there are approximately 12,500 CHAs throughout the U.S., with approximately 25% estimated to be volunteers. The estimated number of volunteer CHAs is based on similar findings in both the CDC CHA program database and the Study's own survey, both based on non-random samples.

Examples of CHA Programs

There are a number of exciting examples of CHA programs that have been successful helping people access health care, learn better self-management of chronic conditions, and in the process save medical costs. The following example was drawn from a program evaluation reported in a child development journal:

▣ *Pediatric Pathways to Success.* The goal of Boston City Hospital's *Pediatric Pathways to Success Program* is to support high-risk infants and families and address issues of high-cost prenatal drug exposure and premature births among the 1,700 babies delivered at Boston City Hospital (BCH) in the 1990s. Program methods include establishing therapeutic relationships, educating new parents about child development, and providing information support at pediatric visits during a child's first six months. At the core of Pathway's multi-disciplinary team are a primary care clinician and a family health advocate (a CHA). The family health advocate provides family support, community-based referrals and case management. Pathways cites the development of a special relationship between the family health advocate and family as a cornerstone of the project's success.

Evaluation of 97 Pathways infants compared them to 98 other infants born and cared for at BCH. The Pathways infants were less likely to have emergency room visits than the other infants (1.47 to 5.34), and made more visits to their pediatric clinicians for illness (327 to 168). There were 18 Pathways hospitalizations compared to 33 for the other group, and Pathways hospitalizations were shorter (3 days rather than 4.6 days). The total cost savings for the Pathways group compared to the other group was \$164,075. After the costs of the program are deducted, this represents a net saving of \$7,169 to the health care system. (These figures include startup costs, which have decreased over time).¹

The following program is profiled in the Study's chapter on CHAs and the Changing Health System:

▣ *Maternity Care Coalition.* The Maternity Care Coalition (MCC) in Philadelphia is a nonprofit advocacy and service organization working to reduce infant mortality. MCC has contracted with local health plans to provide varied services. Under these contracts, MCC's CHAs conduct outreach to identify pregnant women. They make home visits and provide case management to pregnant and postpartum women and their newborns.

¹ Source: *Enhancing Pediatric Primary Care for Low-Income Families: Cost Lessons Learned from Pediatric Pathways to Success*. Margot Kaplan-Sanoff, Ed., Thomas W. Brown, and Barry S. Zuckerman, M.D., in *Zero to Three*, National Center for Clinical Infant Programs, June/July 1997

1. Overview

Another program example, from the Harrison Institute's "*Leadership Brief on Preventive Health Programs*," details some unanticipated impacts on families in addition to results that were intended:

■ **Comprehensive Health Investment Project.** Comprehensive Health Investment Project (CHIP) of Virginia is a nonprofit organization with over ten program sites around the state of Virginia. CHIP is an intensive home visiting and support program that has established contracting relationships with three health plans. Its program goal is to establish and maintain mother and child relationships with a "health home" or consistent primary care clinician. CHAs maintain regular weekly or bi-weekly contact with families over a period of months. CHIP client outcomes recently included a 20% improvement in child immunization rates to 91%; over 30% of mothers were employed (130% improvement); AFDC enrollment was reduced by 35%; child use of private MD/HMO was 85% (a 44% increase); and mother's use of private MD/HMO was 61% (a 39% increase). Further analysis by the University of Alabama showed that hospitalizations and emergency room use by CHIP children declined over the 2 year evaluation period, and the cost of providing CHIP services to children and families declined as well.²

CHA programs focused on chronic conditions prevalent in defined populations have demonstrated success using culturally sensitive, empowering self-management approaches. The following program evaluation, also outlined in the "*Leadership Brief*," demonstrates the effect of these principles in practice.

■ **Latino Health Access Project (LHA).** Latino Health Access Project (LHA) Santa Ana, CA. Doctors in a managed care plan refer diabetic Latino enrollees to LHA, where CHAs, called Promotoras, team-teach a 12-week series of classes. The free classes are "prescribed" by the doctors and conducted in Spanish by Promotoras who are themselves people with diabetes and graduates of the program. The participatory classes train individuals with diabetes and their families to understand, prevent and manage this condition. A critical product of this program is its ability to help participants change their beliefs about the disease, which is a prerequisite for effective self-management.

In light of growing interest in CHA work in communities and with health care systems, the National Community Health Advisor Study was undertaken in 1996 to 1997 to explore and define how CHAs view their work and their field. Following are highlights from the Study's report.

Core Recommendations

Responding to Challenges in the Community Health Advisor Field

As the U.S. population grows increasingly diverse, the demand for accessible health care services takes on new meaning. Familiar barriers to care, such as cost and transportation, are exacerbated by the growing influence of language and cultural barriers. Overcoming these barriers demands that those who deliver health promotion information and health care services find responsive and creative solutions.

CHAs possess many of the needed qualities and skills to bridge the gap between health services and communities. However, fragmentation in the CHA field, linked to multiple funding sources, prevents the field from functioning in an optimal way. The gap between need and availability is too wide.

² *Community Health Workers: A Leadership Brief on Preventive Health Programs*, Harrison Institute for Public Law at Georgetown University Law Center and Codman Square Health Center. (Washington DC, 1997)

Recognizing that CHA program staff alone cannot address the challenge of sustainability, the National Community Health Advisor Study explores a number of areas affecting the overall status of the field. Its recommendations help develop the depth and breadth of CHA roles and identify issues that must be addressed to enhance and strengthen those roles.

Recommendations on CHA Core Roles and Competencies

1. **Adopt and Refine CHA Roles and Competencies.** Disseminate and track use of the Study’s proposed core roles and competencies lists and the validate lists with stakeholders.

CHA Core Roles and Competencies

————— **Roles** —————

▣ Cultural mediation between communities and health and human services system.	▣ Advocating for individual and community needs.
▣ Informal counseling and social support.	▣ Assuring people get the services they need.
▣ Providing culturally appropriate health education.	▣ Building individual and community capacity.
	▣ Providing direct services.

————— **Competencies: Skills** —————

▣ Communication skills.	▣ Interpersonal skills.	▣ Advocacy skills.
▣ Knowledge base.	▣ Service coordination skills.	▣ Organizational skills.
▣ Capacity building skills.	▣ Teaching skills.	

————— **Competencies: Qualities** (partial list) —————

▣ Relationship with community being served.	▣ Empathy.	▣ Personal strength and courage.
▣ Desire to help community.	▣ Persistence.	▣ Respectfulness.
	▣ Creativity / Resourcefulness.	

Recommendations on CHA Evaluation Strategies

2. **Promote a Comprehensive CHA Research Agenda.** Target a CHA research agenda promoting analysis of CHAs’ roles in various settings including MCOs, Welfare Reform, CHA cost-benefit analysis. Conduct a multi-site CHA program evaluation.
3. **Develop CHA Evaluation Guidelines and Tools.** Refine the evaluation framework developed as a part of the Study and create an evaluation “tool kit” for programs.
4. **Establish a CHA Evaluation Database.** Create a database containing a list of evaluators, evaluation tools, and findings.

Recommendations on CHA Career Advancement

5. ***Establish a National CHA Certification.*** Develop a CHA certification based on refined CHA core roles and competencies; link to other certifications such as those being explored by front-line human services professionals.
6. ***Create Academic Linkages for CHA Training.*** Establish academic pathways for CHAs who choose to continue in school and link CHA training to academic credit.
7. ***Establish CHA Core Curriculum Guidelines and Develop Supervisor Training.*** Develop and disseminate CHA curriculum guidelines nationally to guide CHA training. A related project is the development of CHA supervisor training guidelines.
8. ***Establish Multi-Program CHA Training and Support Centers.*** Develop regional and state-based training centers to provide core CHA training complementing program-specific training.
9. ***Develop Best Practice Guidelines for Programs.*** Develop guidelines for management and practice for CHA programs in various settings including Managed Care Organizations (MCOs).

Recommendations on CHAs in the Changing Health Care System

10. ***Educate Managed Care Organizations and State Medicaid Agencies about CHAs.***
Provide information and training about CHAs to MCO staff and Medicaid administrators who coordinate funding in MCOs.
11. ***Prepare CHAs and CHA Programs to Compete in the Changing Health System.***
Educate CHAs about special issues related to use of MCOs; create educational materials and trainings to help CHA programs develop needed infrastructure to work with managed care.
12. ***Build Sustainability for CHAs and CHA Programs Through Financing Mechanisms and Public Policy.*** Work to identify and allocate permanent public revenue sources to sustain CHAs through regulatory and public policy change, and work to build support within the private sector for direct services and CHA field infrastructure.

Recommendation on CHA Leadership Development

13. ***Establish Coordinated Leadership in the CHA Field.*** Form a national association or similar organization to provide leadership in the CHA field; CHAs should play the key role in governing such an organization. One proposed role for the organization is to oversee coordinated implementation of projects recommended by the Study.

2. Methodology and Study Participants

The Study's research agenda was shaped by two groups with strong interest in broadening CHA services in the U.S. The first, a Federal Technical Advisory Committee, which formed to look at ways to strengthen the CHA field, is based at the U.S. Department of Health and Human Services. The other is composed of individuals working with the New Professionals Special Primary Interest Group of the American Public Health Association, which is dedicated to enhancing the role of CHAs in the U.S. Our agenda was further refined by an active Advisory Council, formed for the Study, that was composed of a majority of CHA members as well as other individuals drawn from the two groups mentioned above.

The Study emphasized collection of data from established youth and adult CHA programs and individual CHAs covering four specific issue areas.

Study Issue Areas
<ol style="list-style-type: none">1. CHA core roles and competencies.2. Evaluation strategies for CHA programs.3. CHA career and field advancement.4. The role of CHAs in the changing health system.

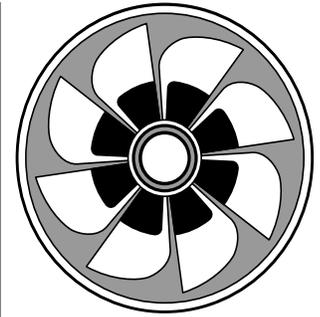
We used a participatory action research approach, which is a process by which we actively engaged the subjects of research (CHAs) in the process of gaining and creating knowledge, rather than relegating them to the role of passive "subjects" only. Central research methods included CHA discussion groups and a survey, which solicited CHA opinions on pressing issues confronting the field.

Advisory Council

The 36-member Advisory Council was composed primarily of CHAs who were representative of key CHA networks and programs throughout the country. It also included CHA program supervisors and CHA advocates from the public and private sector. The Council's role was to refine the Study's agenda, interpret the data gathered, and develop the Study's recommendations. The members of the Advisory Council brought a lens to the data that was based on members' firsthand experience in the field and their understanding of issues facing CHAs nationwide.

Research Methods

Qualitative and quantitative Study research methods included literature review, a survey questionnaire, one-on-one interviews, site visits and discussion groups (group interviews and focus groups) conducted either in conjunction with site visits or convened specifically for the Study. A special interdisciplinary meeting



“...we actively engaged the subjects of research (CHAs) in the process of gaining and creating knowledge.”

2. Methodology and Study Participants

was convened for the evaluation section of the Study, and special discussion groups for the career development section were also conducted. In addition to the core Study data, the section on the role of CHAs in the changing health system drew heavily from targeted telephone and personal interviews with CHAs, program managers, and managed care executives from 19 cutting edge programs, including three sites that had also been included in the Study's broad data-gathering effort.

Initial research and literature review. An extensive preliminary outreach phase, designed to collect information from practitioners and researchers, helped us expand the pool of CHAs and programs to be included. We requested unpublished program evaluations, CHA training curricula, and other relevant materials. In addition, we reviewed published literature.

Discussion groups. In the context of the Study, "discussion group" means both CHA group interviews conducted during site visits and CHA and supervisor focus groups. Approximately half of our site visits were in urban settings and half were in rural areas. Most site visits included a formal directed group interview with CHAs. We conducted three cross-program focus groups with CHAs - two in conjunction with CHA regional conferences and one convened just for the Study. More than 100 CHAs participated in Study discussion groups.

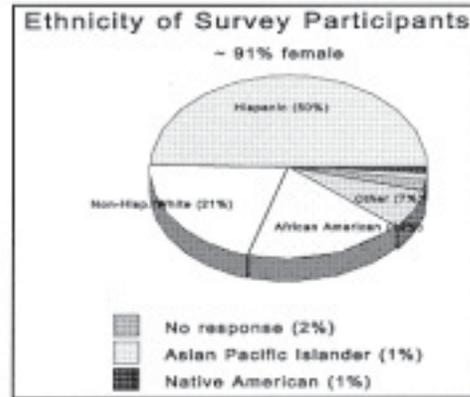
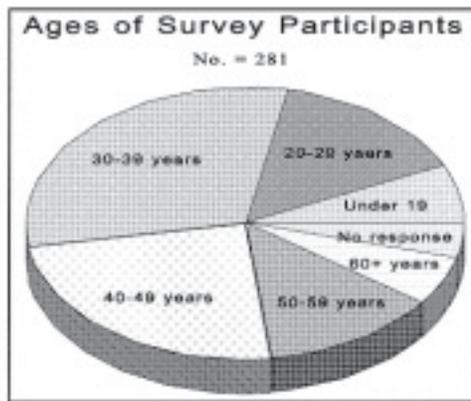
Survey. An eight-page survey questionnaire for CHAs and CHA supervisors covered the four core areas of the Study and included questions designed to elicit a general description of the CHA program for which the respondent worked as well as their opinions about pressing issues facing the field.

We originally hoped to conduct a random survey. However, upon attempting to define the universe of CHAs and CHA programs, it became apparent that it would be impossible to identify all of them. Instead, we chose to seek a *convenience* sample of CHAs. Our primary goal was to achieve geographic diversity through participation of a significant number of CHAs from different regions of the country and from a broad spectrum of programs.

Because of the empirical limits of the survey, the advisory Council used qualitative data as the primary source on which it based its assessments. We used survey data to supplement and validate the conclusions that were based on the site visits, interviews, and discussion groups.

Profile of survey participants. Our review of the literature on CHA programs demonstrated that most information has been reported from the perspective of program administrators and supervisors. Our survey sampling strategy was designed to give voice to the experience and knowledge of the individuals who are working to serve their communities as CHAs. We collected information on both the respondents and their programs.

A total of 281 CHAs and program supervisors working in 31 states and the District of Columbia completed the survey. The greatest representation was of programs from the southwestern U.S. Eighty-two percent of the respondents were currently working as CHAs. Two thirds of respondents had worked as CHAs or CHA supervisors for less than three years, and one third had worked for three years or more.



More than half of the survey respondents (53%) said that the CHAs in their program are the same ethnicity as the population served, while another 37% said this was true in some cases, but not all. A smaller percentage of supervisors (43%) are the same ethnic/racial group as the CHAs in the program.

Populations Served by Survey Participants

Respondents reported that 27% of their programs serve rural areas, 29% serve urban areas, and 38% serve both urban and rural areas. CHA programs in our sample serve an ethnically diverse population, with the majority serving Hispanics (85%).

Hispanic	85%	Non Hispanic White	69%
African American	60%	Asian/Pacific Islander	42%
Native American	41%		

CHA Services and Outreach Sites

Respondents provided services related to over 50 health concerns. Almost half of the programs provide services in the area of HIV/AIDS (48%) or cancer (40%). Many programs also focus on women's health (21%), or more specifically prenatal care and maternal health (32%). Domestic violence is also a concern for 26% of CHA programs. Twenty-six percent (26%) of programs provide advocacy services with regard to poverty, housing, food and employment resources.

Homes	74%	Community Centers	72%
Schools	66%	Worksites	40%
Clinics/hospitals	67%	Religious organizations	50%
Shelters	35%	Migrant labor camps	24%

3. Core Roles and Competencies

Purpose of the Core Roles and Competencies Section

The primary objectives of this section of the Study were (1) to identify the *core roles* that Community Health Advisors play in their communities and the health care system, and (2) to determine the *core competencies* they need to be most effective.

The lack of a “standard definition and conceptualization of who [CHAs] are and what they do” (Witmer, 1995) is one of the principal barriers to an expanded role for CHAs within the health care system. This barrier must be overcome to allow CHA services to grow as one of the most effective ways to address intractable health problems plaguing communities today. Most of these — infant mortality among African Americans, asthma among poor children, diabetes in Native American and Latino communities, violence among inner-city youth — are the result of environmental, social, and economic conditions. “Traditional medical services have had little success in addressing these determinants of health.” (JAMA, October, 1996)

For many reasons, managed care organizations (MCOs) are increasingly motivated to address the basic determinants of health. Many are looking to CHAs, who can “reduce the geographic, social and cultural distance between the service and its target population, . . . can concentrate upon the sorts of changes that may influence the true nature of the health problem, and can achieve aims within acceptable costs.” (World Health Organization, 1987) A working consensus about the roles and competencies of CHAs will help facilitate their integration into the health care system and thus enhance its ability to address the basic determinants of health.

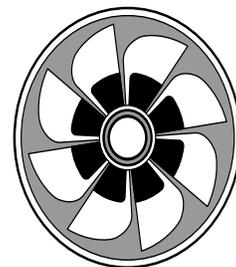
Core Roles and Competencies: Research Questions and Definitions

▣ *What are the core roles of CHAs within communities and the health care system?*

Role. We define “roles” as the functions that CHAs serve in communities and the health care system. For example, CHAs provide health education. The concept of roles includes the *responsibilities* of CHAs and the *activities* CHAs carry out.

▣ *What are the core competencies CHAs need to be optimally effective in these roles?*

Competency. We define “competency” as something that a person is capable of doing *or being*. Included in our definition of competencies are both *skills* and *qualities*. In this context, “qualities” mean personal characteristics or traits that can be enhanced but not taught. Patience, compassion, and persistence are examples of qualities. The word “skills,” on the other hand, is used to describe abilities gained through study or practice.



“ . . . a lack of role definition can also lead to failure to recognize and best utilize the unique skills of CHAs.”

Core Roles and Competencies: Findings

The task of defining the roles and competencies of Community Health Advisors must be approached with care. Strict adherence to a list of roles and competencies could rob the CHA model of its responsiveness to the unique needs of individuals and communities. In contrast, a lack of role definition can also lead to failure to recognize and best utilize the unique skills of CHAs.

A number of other studies of the roles and competencies of CHAs are currently being conducted or have recently been completed. The consistency of results from those studies along with the results of this Study lends credence to the belief that, despite the wide variety of CHA programs, there is a core of roles and competencies that cross programmatic, geographic, racial/ethnic and other lines.³ In this Study, we identified seven core roles, eight “skill clusters,” and a long list of common qualities.

Seven Core Roles of Community Health Advisors in the United States

Summary of Findings Seven CHA Core Roles

- | | |
|--|--|
| ▣ Cultural mediation between communities and health and human services system. | ▣ Advocating for individual and community needs. |
| ▣ Informal counseling and social support. | ▣ Assuring people get the services they need. |
| ▣ Providing culturally appropriate health education. | ▣ Building individual and community capacity. |
| | ▣ Providing direct services. |

Core Role 1: Bridging/Cultural Mediation Between Communities and the Health and Social Service Systems

CHAs play an important role as bridges and mediators between the communities in which they work and the health care system. This role corresponds to four functions, which are outlined below.

- ▣ ***Educating community members about how to use the health care and social service systems.***
CHAs help community members get the services they need and help systems operate more smoothly by teaching people where and when to seek services. For example, CHAs teach people when they need to see a doctor and when they can safely treat an illness at home.

³ The Community Health Training and Development Center (CHTDC) in San Francisco recently conducted a statewide survey of 185 agencies employing CHAs to collect information about core tasks and other topics. The survey found that “the majority [of CHAs] provide health education, information, referrals, translation services and advocacy for their communities.” The five skill areas respondents felt were most important for training programs for CHAs are: communication skills, interviewing, counseling, advocacy, and referral skills. According to supervisors who responded, the greatest asset of CHAs is their relationship to the community. Agency directors and supervisors in this survey identified roles and skills very similar to those identified by the CHAs in our study.

3. Core Roles and Competencies

- ▣ **Gathering information for medical providers.** The trust many CHAs establish with their clients enables them to collect information that is often inaccessible to other health and social service providers. When this information is passed on, with clients' permission, to medical personnel, it can lead to more accurate diagnoses and treatment, thereby improving health outcomes.
- ▣ **Educating medical and social service providers about community needs.** CHAs can help health and social service systems staff become more culturally competent. The information that CHAs pass on can be used in a variety of ways. It can bring about actual *changes in the services the system offers* and *changes in how services are offered*. Clinic hours have been changed, triage practices adapted, and toys added to waiting rooms due to CHA education of providers. As a result of learning about cultures and practices in a community from CHAs, changes in provider attitudes and beliefs may occur.
- ▣ **Translating literal and medical languages.** CHAs facilitate patient-provider communication. Sometimes, bilingual CHAs provide literal translation from one language to another. They may also translate letters and correspondence from health and social service agencies. Perhaps most importantly, CHAs “translate” medical and other terminology into lay language, teaching clients how to follow medication or other treatment regimens.

Core Role 2: Providing Culturally Appropriate Health Education and Information

CHAs make health education physically accessible by taking it directly into the community. This may involve handing out pamphlets on street corners, conducting door-to-door outreach, facilitating on-going health education classes, or presenting information at community meetings. Two functions associated with this role appear below.

- ▣ **Teaching concepts of health promotion and disease prevention.** In a classic public health mode, CHAs focus on helping people stay healthy and intervening so that existing problems do not get worse. For example, CHAs stress the importance of screening tests and regular medical check-ups, thus increasing the likelihood of early detection of health problems. Many CHAs also make health education culturally accessible by using empowering and interactive adult education methods.
- ▣ **Helping to manage chronic illness.** Another focus of health education by CHAs is management of chronic illnesses such as diabetes and hypertension. One program offers a “Cooking Class Support Group” for Latina women with diabetes. The women participate in an interactive class, do exercises geared to their ability level, and prepare appropriate nutritious meals.

Core Role 3: Assuring That People Get the Services They Need

CHAs do not stop at simply putting people in contact with services. Often, they go much further to make sure the services are actually obtained. For example, one outreach worker described his role as “going all the way . . . to get this person to the right place to get the services they need.” Three functions associated with this role are outlined below.

- ▣ **Case finding.** Because of their close contact with community members, CHAs are in a unique position to recognize as-yet-undiagnosed symptoms of illness or health needs and connect people to the health care system. *Case finding* is the first step in assuring that people obtain needed services.
- ▣ **Making referrals.** CHAs refer clients to a broad range of health and social services, including clinics, hospitals, welfare offices, food banks and churches.
- ▣ **Providing follow-up.** CHAs promote continuity of care by providing follow-up. Examples include tracking pregnant women to make sure they get prenatal care or physically locating people who need lab results but lack a telephone.

Core Role 4: Providing Informal Counseling and Social Support

A plethora of literature has demonstrated the importance of social support in preventing mental health problems and improving physical health outcomes. Respondents affirmed that CHAs help protect mental and physical health by providing social support via two primary functions.

- ▣ **Providing individual support and informal counseling.** Conditions of poverty, unemployment, discrimination and isolation in many of the communities where CHAs work mean that the coping resources of individuals are stretched to the limit. Relatives and friends who face many of the same obstacles may be unable to offer support in times of need. Under these conditions, the supportive relationships that CHAs build with their clients are crucial.
- ▣ **Leading support groups.** “Leading support groups” is among the ten most common CHA activities according to the survey. A wide range of CHA-led support groups were mentioned in our site visits. Examples include a support group for homeless women, support and health education groups for young people, cancer survivor support groups, and a cooking class for diabetic women.

Core Role 5: Advocating For Individual and Community Needs

- ▣ **Advocating for individuals.** At a basic level, CHAs act as *advocates or spokespersons* for clients. This function is related to their work as literal and medical translators. CHAs also can serve as *intermediaries* between clients and sometimes immobile bureaucracies. CHAs often help clients resolve problems with erroneous or overdue bills for health and other services.
- ▣ **Advocating for community needs.** CHA advocacy for *community needs* may involve specific issues such as improvement of conditions in a migrant labor camp.

Core Role 6: Providing Clinical Services and Meeting Basic Needs

- ▣ **Providing clinical services.** In the U.S., the CHA role in providing clinical services is minimal compared to CHA roles in the developing world. Yet, especially in remote areas, CHAs in the U.S. do provide needed basic services, thus making them accessible. In Michigan’s Camp Health Aide Program, CHAs are trained to provide first aid to migrant farmworkers who often live far from population centers.

3. Core Roles and Competencies

☞ **Meeting basic needs.** CHAs with whom we spoke stressed the fact that, before they can share specific health information, they often must assure that people have the basic determinants of good health: enough food, adequate housing and employment. When resources exist, CHAs help people meet basic needs by referring them to or taking them to appropriate agencies.

Core Role 7: Building Individual and Community Capacity

CHAs can help promote the community participation and empowerment that can result in substantial, long-lasting changes in health status. They do this by building capacity in both individuals and communities.

☞ **Building individual capacity.** CHAs increase the capacity of individuals to protect and improve their health by sharing valuable information about how to prevent illness. They also teach people *concrete skills* essential to maintaining good health, such as how to prepare traditional foods with less fat. A very important way CHAs build individual capacity is by actively helping clients to change their behavior.

☞ **Building community capacity.** According to the CHA model developed and promoted by the WHO, one of the CHA's primary responsibilities is to bring about *community participation in health*. CHAs help communities assess their own needs and then act on meeting them. We heard several examples of CHA involvement in bringing about community-wide change. In one community, CHAs helped families form support groups that later advocated with the school system for program changes.

Core Competencies of Community Health Advisors - Skills and Qualities

All our data suggest that the combination of qualities, skills and knowledge CHAs need to be effective in their roles does not fit neatly into a traditional competency-based framework. One of the few defining characteristics of CHAs that has been widely agreed-upon over time and throughout the world is *membership in the community in which they work*. Though community membership can be defined in various ways, none of the definitions of "community membership" is analogous to what have traditionally been defined as competencies. While it can imply a number of concrete skills, community membership is essentially a characteristic or quality.

For readers of this Study, information about "qualities" (included in this summary and further detailed in the full report) will probably be most useful for *recruiting and hiring* CHAs. The skills outlined can serve two purposes. First, the skills list can be used to determine the basic content of CHA training courses. Second, these measurable skills could serve as the basis for the development of a CHA certificate of competence. Study participants have provided valuable guidelines that, although not definitive, point the way toward a competency profile that is holistic and true to the nature of CHA work.

Core Skills of Community Health Advisors

There is marked correspondence between responses to the survey questions and responses to similar questions used in discussion groups. Based on both the qualitative and quantitative data, we developed eight "skill clusters" that respondents felt are necessary for CHAs working in a variety of situations.

Cluster 1: Communication Skills. Virtually all respondents agreed that to work effectively as a CHA, people need good communication skills. Listening skills were seen as essential for a variety of functions. Ability to use written language and explain health concepts using appropriate language were also considered of strong value.

Summary of Findings

Core Skill Clusters of CHAs

Note: Skills are in order of response rate.

1. **Communication Skills**
 - Listening.
 - Use language confidently & appropriately.
 - Written communication.
2. **Interpersonal Skills**
 - Counseling.
 - Relationship-building.
3. **Knowledge Base**
 - Broad knowledge about the community.
 - Knowledge about specific health issues.
 - Knowledge of health and social service systems.
4. **Service Coordination Skills**
 - Ability to identify and access resources.
 - Ability to network and build coalitions.
 - Ability to provide follow-up.
5. **Capacity-Building Skills**
 - "Empowerment" - Ability to identify problems and resources to help clients solve problems themselves.
 - Leadership.
6. **Advocacy Skills**
 - Ability to speak up for individuals or communities and withstand intimidation.
7. **Teaching Skills**
 - Ability to share information one-on-one.
 - Ability to master information, plan and lead classes, and collect and use information from community people.
8. **Organizational Skills**
 - Ability to set goals and plan.
 - Ability to juggle priorities and manage time.

Cluster 2: Interpersonal Skills. The qualities of *friendliness and sociability* are also interpersonal skills that were seen as important for CHAs. Two additional types of interpersonal skills were seen as essential: ability to work as part of a team and ability to work appropriately with diverse groups of people. The ability to understand and respect a variety of perspectives is essential to CHAs' role as mediators between communities and the health care system.

Cluster 3: Knowledge Base. According to CHAs and their supervisors, CHAs need at least three types of knowledge to be optimally effective. First, CHAs need broad *knowledge about the community*. This involves understanding of community norms, needs, problems and dynamics. Some urban CHAs used the term "street smarts" to describe the community knowledge CHAs need. *Knowledge about the specific health issues* the CHA addresses is critical, as well as the ability to find information that the CHA does not know, since CHAs are often asked about a variety of issues. Finally, *knowledge of local service systems and resources* is fundamental to helping assure that people get services they need.

Cluster 4: Service Coordination Skills. At its most basic level, this skill begins with knowledge - knowing what services are available, where they can be located, agency hours of operation, and who is eligible. CHAs also must develop an active referral network to be of assistance to clients, and this involves *the ability to network and build coalitions*. Appropriate use of a referral network depends on the CHA understanding the limitations of his or her role and when he/she needs to refer to other providers.

3. Core Roles and Competencies

Cluster 5: Capacity-Building Skills. One of the two sub-categories within this cluster is defined as *empowerment skills*. Empowerment is related to assessment in that CHAs must be able to help people identify their own problems. Many CHAs emphasized the need to “work with the ideas of the people.” Along with identifying problems, CHAs work with clients to identify strengths and resources. To do so, CHAs must view clients as capable people, not as victims. CHAs must then walk the “fine line between enabling and empowering,” according to one CHA supervisor.

Qualities of Community Health Advisors

In discussion groups, we initially asked about “qualities and skills” at the same time to allow respondents to answer in their own terms. The majority of responses cited qualities and not skills. Even after further probing, participants still tended to emphasize qualities over skills. One explanation for the emphasis on qualities is that CHAs may not recognize all the skills they possess. They are often regarded by other health and social service workers as “unskilled” and may have internalized this view. Alternately, CHAs may know what they are able to do, but not think of these abilities as “skills,” *per se*. Another explanation is that adaptive qualities such as patience, a desire to learn and grow, and respect for the opinions of others are “competencies” most needed in their work. This does not obviate the need for skills. It simply means that both kinds of competencies must be taken into account, though they may be used in different ways.

The list of “qualities” below will probably be most useful for recruiting and hiring CHAs.

Qualities of Community Health Advisors

1. Connected to the community (a community member or possessing shared experience with community members).
2. Strong and courageous (healthy self-esteem and the ability to remain calm in the face of harassment).
3. Friendly/outgoing/sociable.
4. Patient.
5. Open-minded/non-judgmental.
6. Motivated and capable of self-directed work.
7. Caring.
8. Empathic.
9. Committed/dedicated.
10. Respectful.
11. Honest.
12. Open/eager to grow/change/learn.
13. Dependable/responsible/reliable.
14. Compassionate.
15. Flexible/adaptable.
16. Desires to help the community.
17. Persistent.
18. Creative/resourceful.

CHA Core Roles and Competencies: Recommendations

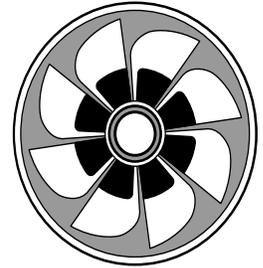
Recommendation: We recommend the adoption of the preceding core roles and competencies by those working in the CHA field. We also recommend that practitioners and researchers further refine and validate these roles and competencies. We recommend that the Study’s outline of roles and competencies be used in concert with a community needs assessment when designing CHA programs. CHAs may not play all seven roles, depending on the assessment and other factors. Competencies include both the *qualities* and the *skills* that CHAs need in order to be effective. While competencies do not correspond directly to roles, many competencies are useful in a variety of roles.

4. Evaluating CHA Services

Purpose of the Evaluation Section

For this section of the Study we sought to assess CHA program evaluation practices and collect data that could help develop effective and usable program evaluation tools. There is informal consensus among community-based health practitioners that CHA programs can bring about changes in the people and communities they touch. Yet lack of concrete data on program effectiveness has hampered efforts to advocate for these programs.

This section includes an evaluation framework based on the Study data and our research in the evaluation field, developed by staff and the advisory council. We offer the framework as a preliminary model that can be used by CHAs and programs in designing their own evaluations. A summary of the framework is at the end of this section. We hope this framework will be refined and used by programs in developing evaluation measures, for discussion, and as a tool for information-sharing across programs.



“... Much of the daily work that CHAs do and the positive changes their clients achieve are difficult to track, and are not tracked by current program evaluations.”

Background on Evaluation

Evaluation consists of constantly asking meaningful questions, gathering information, summarizing responses, reporting information, and fine-tuning plans. This study looks at two types of evaluations relevant to CHA programs: process evaluation and outcome or impact evaluation. Both process and outcome data lend programs greater credibility for their activity reports or funding proposals.

Process evaluation is aimed at understanding the internal dynamics of program operations and identifying areas for improvement. Process evaluations are concerned with what was done, when it was done, who did it, and to whom, how often it was useful, and how well it was done.

Outcome evaluation is aimed at determining program effects on short-term, intermediate, and long-term objectives, such as changes in health status or disease prevalence. Have the number of deaths due to heart attacks dropped? Are inappropriate uses of hospital emergency rooms decreasing? An outcome evaluation might ask whether a program has changed participants' behaviors or attitudes: *e.g.*, did a curriculum to prevent tobacco use change the perceptions of preteens about smoking?

Evaluating CHA Services: Research Questions

- ▣ *What types of data, methods, and process and outcome measures are now used in CHA program evaluations?*
- ▣ *What are the barriers to evaluating CHA programs?*
- ▣ *How can these barriers be overcome?*
- ▣ *Are CHA programs using any common evaluation elements or formats?*

4. Evaluating CHA Services

There are few rigorous evaluation studies of CHA programs. We did an extensive review of the published literature related to CHA evaluations. Additionally, we reviewed evaluation instruments currently in use, obtaining many of these through personal contacts at national meetings as well as through outreach to more than 40 published researchers evaluating CHA programs. The outreach was undertaken in collaboration with the University of New Mexico School of Medicine CHA evaluation project funded by the Robert Wood Johnson and Henry J. Kaiser Family Foundations' Opening Doors program.

In the fall of 1996, a meeting of CHAs, program administrators and evaluators from the field was hosted in conjunction with the University of New Mexico to review our research and data and to develop our evaluation framework. The framework was based on a conceptual model created by Eng and Young in 1992. Its components also draw from our review of literature and existing evaluation instruments.

Evaluating CHA Services: Findings

Many CHA programs do not assess their practices and outcomes. These programs often lack feedback to shape later decisions about which activities should be continued, refined, expanded, downsized, or even discontinued. Without such information, program managers have difficulty informing their partners and stakeholders whether their investment has been effective in achieving their organizational or programmatic goals.

Barriers to Evaluation of CHA programs

Evaluation of CHA programs is complex and poorly understood. We found that not all programs collect outcome or process data. Modestly funded community-based programs often do not know what data to collect or how to manage it; nor do they always understand the benefits of collecting data. One strength of CHA programs is their ability to adapt to community needs and to incorporate changes as they receive feedback. However, program changes complicate evaluation by altering the processes that are being measured. Conducting outcome evaluation is challenging for much the same reason: programs frequently take on issues that were not part of their original plans.

- ▣ ***CHA programs lack resources for evaluation training and implementation.*** Quality evaluation takes training and time. CHA programs, like other community-based health promotion and disease prevention efforts, often lack the staff expertise and resources to design and conduct evaluations. Often programs lack specific, measurable goals and objectives or program planners fail to define appropriate outcome measures. Community need for services may consume staff efforts and leave no time for evaluation.
- ▣ ***The nature of CHA interactions with clients does not always lend itself to easy documentation.*** Much of the daily work that CHAs do and the positive changes their clients achieve are difficult to track, and are not tracked by current program evaluations. This may be because the essential living skills CHAs teach and the support they provide are not seen as important subjects for data collection.
- ▣ ***There are few methods and little opportunity to measure long-term effects.*** CHAs acknowledge that measurement of long-term effects of community-based interventions has been difficult. Short-term funding of CHA programs may prevent the assessment of even intermediate program effects.

- ***Evaluation paperwork is perceived to take time away from time spent with clients.*** Programs frequently use forms as data collection instruments and CHAs perceive the paperwork required as a significant barrier to doing their work. While forms can capture valuable information, many programs are funded by multiple funders, each of which imposes different reporting requirements. Also, many of the effects that CHA services have on clients and community cannot be captured by quantitative instruments.
- ***Some evaluation measures can violate client confidentiality and are perceived as invasive.*** CHAs felt strongly that privacy issues could be a significant barrier to evaluation. A CHA who worked with juveniles indicated that he did not document certain client information because it would adversely affect the youths if presented in court. Instead, he kept that information “in my head.”
- ***There is limited opportunity to document services that are beyond the scope of the program.*** One CHA put it this way: “I could think of one thing that I did with a very young mother that had no life skills. I took her to the motor vehicle department...I got her an ID... I took her to a bank...things like that...but you don’t always record it...and sometimes you do [things] without realizing how important an effect you’re having on that person’s life.”

Overcoming Barriers to Evaluation of CHA Programs

CHAs and program staff shared several ideas for alleviating evaluation barriers. In summary, frequent ideas were as follows:

- Program goals and objectives should be clear and measurable.
- Interviewers who gather data for the evaluation component of programs should be matched to the experience and culture of the target population.
- Administrators should ensure that CHAs have opportunities for evaluation education.
- Non-CHA staff should engage in two-way communication with CHAs about program activities, goals, and evaluation. CHAs should be involved in planning all aspects of the program including evaluation.
- Short and intermediate outcomes should be measured.
- Outside evaluators could be employed to corroborate program self-evaluation. Methods to document expenses (costs) and savings (benefits) associated with delivering CHA services should be developed.
- Innovative qualitative data collection methods should be developed.

A strong theme among CHAs was that current evaluation methods and practices are inadequate to truly capture the real work and impact of what they do. One said, “It’s almost as if they don’t care about the quality of care, just the quantity of care. ... I understand the need to account for the number of visits or classes, but that doesn’t factor in the impact we have on the people.”

CHA Perceptions of the Need for Program Evaluations

One purpose for conducting discussion groups at CHA program sites was to solicit CHAs' thoughts on program evaluation and their involvement in evaluating their own programs.

- ***CHAs are aware that program evaluation is important.*** CHAs recognized that positive evaluation results gave them credibility. They felt that program evaluation not only highlights their accomplishments but also documents the numerous tasks they perform.
- ***Evaluation feedback during program implementation allows modification of methods.*** CHAs repeatedly stressed that evaluation helped them “determine what works and what doesn't.” For example, one group of CHAs learned that they had a better turnout for flu immunizations when they delivered notices door-to-door instead of just posting them.
- ***Evaluation increases awareness that CHAs have been effective in creating changes.*** CHAs were aware that their teaching had an impact. For example, following nutrition classes taught by CHAs, they noted that their clients were now cooking their traditional foods like turnip greens without using fat.
- ***Some CHAs do not have an impact on program evaluations.*** CHAs involvement in evaluation varied among programs. Some CHAs reported they were not part of evaluation planning. Other CHAs reported that they do not receive program feedback. Some CHAs reported that supervisors had not asked for their evaluation opinions, while others felt that their suggestions were discounted. Another group of CHAs lamented that while they spent considerable time collecting data and preparing reports, the reports appeared to have little impact on program planning or operations.
- ***CHAs provide feedback through data collection and process evaluation.*** Many CHAs felt that they did contribute to program evaluation, primarily through their data collection and process evaluation efforts.

There are numerous methods for evaluation of CHA programs. Five program evaluation methodologies are discussed in the Study's full report. The following program is one which represents a strong effort to ensure that CHAs are fully involved in the evaluation process.

Example: Kentucky Homeplace Project (KHP)

One of KHP's evaluation approaches was to train the project's CHAs in evaluation methods and involve them in developing data collection instruments. As a result, data collection methods and instruments have changed significantly over the life of the project.

KHP's outcome objectives are to increase use of appropriate services and decrease use of inappropriate, costly health services. Because CHAs kept clients out of nursing homes and reduced the number of client visits to hospital emergency rooms, KHP could show that it saved Kentucky's health care system \$935,000 during one year. KHP documented the number of clients it linked to free health care, services, goods, and transportation. Also, KHP documented another outcome—how it helped clients solve their own problems.

Evaluating CHA Services: Recommendations

More sensitive, practical, and inexpensive instruments for both qualitative and quantitative evaluation must be developed to monitor CHA program activities and measure program effects on clients, CHAs, communities and health care systems. Effective coordination of evaluation will allow CHA programs to continue to grow, improve, and build their credibility with funders and the communities they serve. Our recommendations for evaluation fall under two goals.

Goal: Demonstrate effectiveness and improve sustainability of CHA programs by funding evaluation efforts.

Recommendation 1: Make evaluation essential. Funding for CHA programs should be sufficient and should support evaluation training for CHAs and other staff. Funding periods should be long enough to allow effective program implementation and evaluation.

Recommendation 2: Promote a CHA research agenda. Fund research that:

- a) Identifies outcomes of effective CHA programs in terms of health outcomes or access to care and links them to best practice guidelines.
- b) Refines and emphasizes cost/benefit analysis methodology.
- c) Identifies appropriate roles for CHAs in changing health care systems by examining current roles and determining the elements most effective in achieving defined outcomes.
- d) Identifies appropriate roles for CHAs within welfare reform.
- e) Conducts multi-site evaluations using a common evaluation framework and develops and tests measurement instruments for reliability and validity.

Goal: Simplify and generalize CHA program evaluation methods.

Recommendation 3: Develop CHA evaluation guidelines and tools. Fund, refine, and disseminate the Study's evaluation framework along with culturally and linguistically appropriate training materials and tools to CHA practitioners.

Recommendation 4: Create a CHA evaluation database. Create and maintain a database on evaluation topics such as CHA evaluation instruments, program results, and a directory of experienced CHA evaluators and practitioners who could mentor others.

Recommendation 5: Recognize CHAs as partners in CHA program evaluation. CHAs, other program staff, and community members should be equal partners in the design, implementation, analysis, and dissemination of program evaluations.

Evaluation Framework

The Study's CHA program evaluation framework summarized on the following two pages offers a menu of evaluation options from which individual programs can choose.

4. Evaluating CHA Services

NCHAS EVALUATION FRAMEWORK FOR COMMUNITY HEALTH ADVISOR PROGRAMS (SUMMARY VERSION)

A. Individual (Impact on the CHA/Client/Family)

Concept	Process Measures	Concept	Outcome Measures
How similar are CHAs to the client target population?	Correlation between CHAs and clients (race/ethnicity and life experience) *	What effects does working in the CHA program have on CHAs?	Changes in health knowledge, attitudes, beliefs, practices and behaviors Personal changes - self-esteem, self-efficacy
Are CHAs culturally competent, well trained?	No. of CHAs completing training.	Does working as a CHA have an impact on the CHA's health status?	Changes in health status measures (e.g. blood pressure, birth weight morbidity and mortality).
What is the level of CHA commitment to job/community?	Length of time serving as a CHA in program.	Does the CHA program have effects on clients?	Changes in health knowledge, attitudes, beliefs, practices and behaviors Personal changes - self-esteem, self-efficacy.
What specific CHA interactions with clients are measurable? What kinds of services do the program's clients need?	No. of visits, referrals, contacts, screens; no. of special referrals; no. and types of assistance and advocacy efforts provided.	Is the health status of clients affected by CHA contact?	Changes in health status measures (e.g. blood pressure, birth weight morbidity and mortality.)
		Are clients receiving more appropriate health care or treatment after seeing CHAs?	Changes in level of treatment and care.

B. Program/Organizational Relationships

Concept	Process Measures	Concept	Outcome Measures
Management-program planning framework.	Existence of strategic and action plans, timelines, quarterly/annual reports.	Management-program planning.	Met timeline objectives, submission of quarterly/annual report.
Management-recruitment and retention of CHAs.	No. of CHAs recruited; no. of new hires; types of benefits/incentives/salary.	Management-recruitment and retention of CHAs.	Years of CHA service to program, annual turnover of CHAs and administrators, employee satisfaction with program and benefits, etc.
Management-training and preparation of CHAs.	Set curriculum; modifications of curriculum with CHA input; no. CHAs trained; no. of inservices.	Management- training and preparation of CHAs.	Curriculum revisions, no. of inservices offered per year.
Ongoing management.	Use of action plan; match between curriculum and services; attendance at staff meetings; development of marketing plan/activities.	Ongoing management.	Updated and completed annual action plans, no. of staff meetings with ≥ 80% attendance by CHAs, client satisfaction with services, production of marketing materials.
Are the services in demand and relevant to the community?	Aggregate no. of clients contacted and receiving services, direct assistance, referrals, education; no. of CHA client appts. kept; no. of referrals kept; percent of staff time for services and activities.	Are the CHA services offered those that are needed and relevant to the community?	Improved health status indicators, improved health outcomes, decreased inappropriate service use, increased service utilization (appropriate), no. of clients completing referrals/training, services.

* Core measures are those highlighted.

Framework concept is adapted from Eng, J., Young, R., "Lay Health Advisors as Community Change Agents," in *Family and Community Health*, 15 (1):24-40, 1992.

C. Community/Agency Relationships

Concept	Process Measures	Concepts	Outcome Measures
Are the services responsive to changing community needs and perceived as needed by other agencies?	No. of regular meetings of agency to examine policies, practices related to population served; no. of service delivery negotiations in process.	Service delivery - Are referral resources to and from the CHA program used?	No. of networks, no. of referrals (to and from CHAs), no. of issues, no. of agencies that referred to CHAs and no. of agencies to which CHAs referred clients.
		Service delivery - Are there reductions in barriers related to access to health services?	Practice changes related to access (hours, translators); policy changes (i.e., insurance, referral).
		Service delivery - Have services been expanded?	No. of new resources and new specialized programs and services.
		Service delivery - Are CHAs part of local health delivery system(s)? (legitimacy)	Payment sources; direct reimbursement; formal relationships with medical service providers.
Is the CHA program developing visibility and working in partnerships with other local agencies and coalitions?	No. of collaborative planning activities (e.g. writing grants for new resources); evidence of diverse participation in coalition by: CHAs, CHA coordinators, agencies, and policy makers; evidence of negotiations/discussions among financial intermediaries/policy makers.	Is the CHA program effectively developing visibility and working in partnerships with other local agencies and coalitions?	Coalitions formed (with operational structure and decisions made). Local and State policy maker leadership is supportive of CHAs. Policy supporting CHAs work is considered or enacted locally. Media attention to CHA work. Cross agency collaboration (training, dual roles).
Are CHAs acting as agents of community empowerment? Contributing to community capacity? Are CHAs acting as community change agents?	Percent of CHA time spent in community meetings; evidence of skill building in training/activities; evidence of community visiting/critical reflection; evidence of genuine participation, collaboration, supportive leadership; evidence of advocacy efforts (at agency regulatory level, city/tribal government).	Are CHAs taking leadership in coalitions or partnerships? Are community members (or CHA clients) developing leadership in coalitions or partnerships? [Community competence]	Decision making role for CHAs: in interagency coalitions, CHA coalitions, local politics. Active citizen participation. Involved leadership. Social network. Sense of community. Ability to leverage resources. Skill based in community.

D. External Linkages

Concept	Process Measures	Concept	Outcome Measures
Are CHAs participating in networking at state, regional, national, international levels?	Evidence of state/regional/national meetings with CHA coordinators and CHAs in decision making roles; Evidence of advocacy efforts (at agency, national coalition, state/national legislature)	Are CHAs developing their leadership at state, regional, national, international levels?	CHA-initiated changes in decision making for advocacy strategy. Program CHAs in elected or leadership roles in CHA network(s). Changes (increases) in leadership role in interagency activities.
		Is the CHA field gaining visibility and legitimacy at the state, regional, national and international levels?	Public and private policy changes related to CHA reimbursement, certification, standardization. Public funds for training and support. Increased public and private funding for CHA programs, training and conferences.

5. Community Health Advisors: A Career in Development

Purpose of Career Development Section

Initially, our intent to explore CHA career advancement was focused on the needs of individual CHAs. Early meetings with Study participants played an important role in broadening our scope from individual career development to the overall advancement of the field. For example, CHAs in New Mexico told us that not only low wages, but lack of job security caused by dependence on “soft” grant monies were among their greatest concerns. We realized that the Study should address the issue of CHAs as an occupational group. It became apparent that development of centralized CHA training centers and core training guidelines would be a key to addressing many of the needs raised by individual CHAs.

This section analyzes factors that affect CHAs’ capacity to function as full partners in health and human service teams. The obstacles we identified affect CHAs’ ability to represent and advocate for community needs while working with medical care teams. When CHA needs as workers are better addressed, they will be able to better contribute to the important goal of promoting the public’s health.

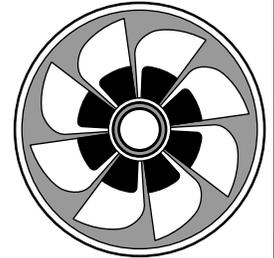
Research Questions

- *What general issues confront the CHA workforce and what are the challenges CHAs face as members of the health care team?*
- *What approaches can assist CHAs to establish a firm and understood role within the health care system and in relationship to the communities they serve?*
- *What can CHAs learn from strategies developed in other fields to enhance their status and effectiveness?*

CHA Career Development - Findings

CHAs in the Workforce

As members of the communities they serve, CHAs tend to be from the low-income and other at-risk communities that are the target of most U.S. public health interventions. A parent of a child with asthma, a person in recovery from an addiction, a former sex worker, or a formerly homeless person may be good candidates for paid and volunteer CHA roles. Many of these characteristics are rarely seen in a positive light on the job market, making CHA positions a unique entry point into the workforce and of special interest from an employment and training perspective.

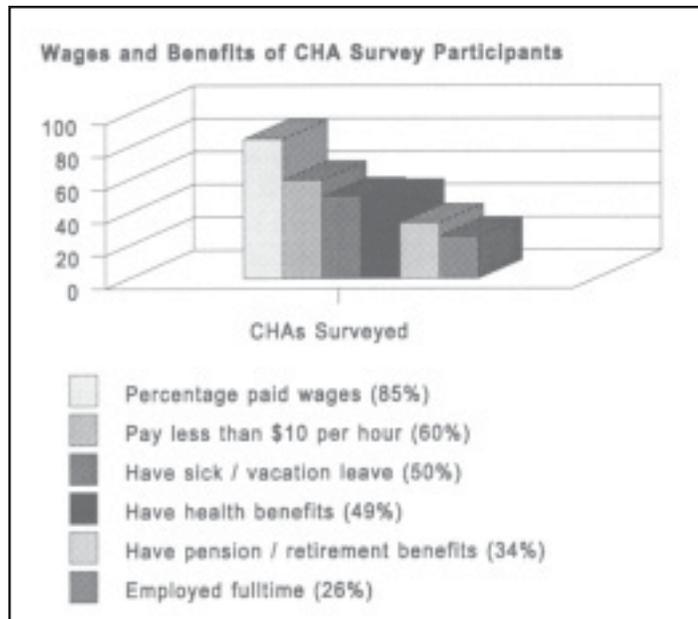


“When CHAs’ needs as workers are better addressed, they will be able to better contribute to the important goal of promoting the public’s health.”

While some individuals remain CHAs long term, others become CHAs as one step in a career path, hoping that this will help to prepare them for other roles in health and human services. Young CHAs whom we interviewed saw the CHA position as a part of their education as well as a job. They were looking toward the future as they gained valued skills and experiences. In contrast, many older CHAs suggested that this role was not a part of a career path but that they had “arrived.” Efforts to advance the field must accommodate the needs of those CHAs wishing to stay in their role, those undecided about their goals for the future, and those who plan to move on to other roles.

CHA Wages and Benefits

The value of CHA jobs as entry points for people from at-risk communities must be juxtaposed against the often part-time nature of the work and lack of benefits and job security. The average wage range reported in our survey for paid CHAs is \$7.90 to \$10.90 per hour or \$16,432 to \$22,672 for *full time* work annually. The poverty level for a family of four is \$15,550. It should be noted that the median number of hours worked among CHAs in our survey was only 20 hours per week. Wages were reported far outside the range in both directions. Five and one-half percent of survey respondents reported that CHAs earn less than \$5.00 per hour. However, 17% reported CHA earnings over \$15.00 per hour.



Career Advancement

We identified a number of agency practices that support CHA career advancement. An internal career ladder to the supervisory role in CHA programs is not uncommon; 15% of CHA survey respondents indicated they have some supervisory role. Other practices identified include efforts to provide academic support. Both CHAs and program supervisors saw lack of funding and lack of opportunity for advancement within the job as the two greatest obstacles to CHA career advancement.

Training of CHAs

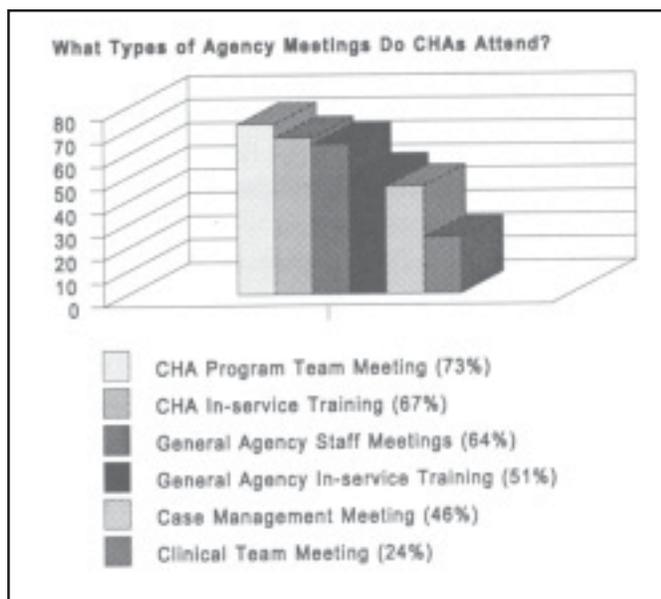
CHAs are exposed to a variety of types of training as they prepare for the CHA role. Eighty-three percent of survey respondents indicated they got formal “on-the-job” training. The second most common type of preparation was “experience on the job,” reported by 79%. School-based training was mentioned by only 21%. Respondents believed the best ways to prepare for work as a CHA are *life experience and observing other CHAs*. From site visits we learned that one area of responsibility taken by CHAs advancing *in* the job was the coordination of training and in-service presentations for new CHAs.

Most Commonly Cited CHA Training Topics

<i>Health Topics (50%)</i>	<i>Skill Building (50%)</i>
<p>Examples: Cancer, Breast health, Domestic violence, Diabetes, Lead, Hypertension, Prenatal care issues.</p>	<p>Skill topics addressed in descending order:</p> <ol style="list-style-type: none"> 1. CHA role / confidentiality. 2. Counseling and support techniques. 3. Orientation to health and human services. 4. Clinical services / screening services / examining patients. 5. Health education techniques.

Relations of CHAs with Others in the Health Care Workforce

While included in the workforce of many health care agencies, CHAs are at other times cut off from the health care team. Most CHA staff contact is with other CHAs. One prominent theme of the discussion groups was a feeling of being under-recognized for their contribution to the health care system. Several CHAs spoke of being left out of decision-making and service teams. Based on observations made during site visits as well as CHAs' own comments, the physical appearance of CHAs on the job may be a contributing factor. CHAs' casual dress style, which enables them to move freely in communities, may mislead medical care providers and the community about their professionalism and the importance of their work. Combined with the flexible schedule that is required to accommodate home visits and community events, this may add to distance between CHAs and other health care workers.



Validation and Professionalization of the CHA Role

CHAs and supervisors were asked their perceptions about CHA professional status, the introduction of training standards and CHA certification. Eighty-one percent of respondents saw the CHA role as professional, regardless of whether they were working in paid or volunteer programs. CHAs emphasized the value of their training to themselves and to their families. A majority of respondents (79%) support the development of CHA training standards.

CHAs want recognition of CHA training to contribute to a more respected role in their work as CHAs or in other jobs. Many felt that a credential might help them gain respect from medical professionals. However, many acknowledged that other professionals would not necessarily recognize a certificate. In the survey, 71% said they supported certification for CHAs.

Volunteer and Paid Community Health Advisors: Anticipating Change

Although there are many volunteers throughout the health and human services field, very few other occupations include both paid and volunteer persons who are members of the profession and who are equally committed to work in their field. One field that does is the Emergency Medical Technician (EMT) field. EMT volunteers play a critical role as a part of a *continuum* of emergency medical services. Volunteer EMTs work primarily in rural areas where there are few paid EMTs and in more urbanized areas during evenings and weekends when coverage by paid EMTs can be limited. Although these two groups work together, tension has been noted between the two groups that may even affect the quality of their work.

Generally, volunteer and paid CHAs do not work in the same CHA programs, although there are exceptions. In addition to volunteer CHA programs linked to traditional health promotion providers, there are many church and school-based peer health programs that have volunteers.

Today, little tension appears to exist between paid and volunteer CHAs. However, with increasing moves toward professionalization of the field, tensions are likely to mount as the two groups seek to define their roles. According to economic theory, a voluntary segment of a workforce can hold down the pay scale of employed workers. In the case of CHAs, one could argue that this economic principle is not threatening as long as volunteer and paid CHAs serve in different communities, or as long as they are not seen as interchangeable or as substitutes for one another. Unity in the CHA field can be promoted by working to articulate the distinct roles of volunteer and paid CHAs before conflicts begin.

Youth Community Health Advisors

The Study looks briefly at the special needs of youth CHAs, particularly within the sphere of career development and advancement issues. Youth face many of the same issues as adult CHAs related to a poor understanding of their role by those outside the immediate bounds of their programs. They appear at times to be caught between the worlds of school and clinic, which are often poorly linked to each another. For many youth CHAs, their work provides a unique introduction to the health care field that may impact their long-term career choices. The Study makes several recommendations for strengthening the role of youth CHAs including forging stronger bonds between schools and health care agencies. It is also recommended that youth be exposed to as many health professions as possible while serving as CHAs, and that they are encouraged to take advantage of all opportunities for learning such as participating in the design and implementation of program evaluation. (In the full report, this Chapter contains a special supplement on youth issues developed by Roberta Rael, *et al.*)

CHA Career Development Themes

The following themes emerged from discussion groups with CHAs from around the country.

CHA commitment is significant, and community change is an important reward of CHA work. CHAs, both paid and volunteer, expressed a high commitment to their communities. CHAs spoke of the 24-hour commitment that was required when serving as a CHA. CHAs spoke of a sense of belonging in their communities that kept them motivated. Some CHAs expressed concern that professionalization of the field may negatively affect their roles in communities, allying them more with the health care system than with their communities.

The CHA role is demanding and without boundaries. One of the strongest messages from discussion groups was that the CHA role is demanding and lacks clear boundaries. There are several aspects to this lack of boundaries.

Many things are expected that are not in the job description. CHAs are sometimes asked by both medical professionals and by community members to do more than they feel prepared for. CHAs spoke of expectations from fellow community members that extended far beyond their own perceived sense of their role. Often the limits to a CHA's role is not clearly defined.

CHAs' own personal boundaries are sometimes threatened, and CHAs at times are in danger. Several CHAs spoke of being in dangerous situations. CHAs are often in remote areas or conflict-ridden city neighborhoods. CHAs can be exposed to wild dogs, street violence and domestic violence during home visits. To reduce such risks, some CHAs work in pairs or carry portable telephones to stay in contact.

Community members and CHAs are not separated by clear boundaries. CHAs take their work home. "Our job is not just in the clinics." People may knock on the door of a neighborhood CHA at any hour. CHAs and CHA supervisors mentioned difficulties posed by CHAs facing challenges similar to their clients. Such blurred boundaries contribute to tension on the job.

The importance of crossing boundaries. On the positive side of fluid boundaries, CHAs spoke of being able to cross agency boundaries as needed and to work with staff in multiple settings. This could be a valuable asset in a fragmented health care system. CHAs also spoke of access to a wide referral network, which allows them to better serve their communities.

Professional Advancement Strategies from Other Fields

To explore possibilities to strengthen the role of individual CHAs and the field as a whole, we researched the history of several related fields. We identified four levels of career advancement strategies.

Four Levels of Professional Advancement Strategies

- 1. Promoting individual advancement.**
- 2. Promoting recognition of preparatory training and curriculum.**
- 3. Targeting program and agency practice.**
- 4. Facilitating individual and agency inter-program and interdisciplinary networks.**

Level 1: Promoting Individual Advancement

The primary individual advancement strategies uncovered by our research were individual credentialing or certification, state licensure, requirements to complete internships or apprenticeships, and registration and tracking of individuals practicing the occupation. In the CHA field none of these practices is formally in place on a broad scale.

Credentialing. The Advisory Council for the Study had a strong interest in CHA credential development that influenced the direction of our research. Several professions offer relevant models of credentialing. For example, the position of Child Development Associate (CDA) has been developed by the child care industry. However, no notable increase in child care workers' salaries is associated with this credential. Of greatest interest is the multi-faceted approach to granting the CDA credential. In the early years of its administration, a peer-based field evaluation reduced dependence on written tests. The CDA credential also offers an example of how those currently in the field acquire a credential while those new to a field follow a different path.

On-the-job career advancement. Many CHAs enter their positions without previous formal professional or academic preparation. Given the entry-level status of this position, opportunities for CHA advancement are frequently envisioned solely in terms of CHAs moving beyond the CHA role. Such thinking does not address the costs of high turnover, which includes the costs of recruiting and training new CHAs, losing continuity in communities served, and losing the value of on-the-job training. For these reasons, on-the-job advancement opportunities should be nurtured.

Career advancement can be promoted by providing CHAs opportunities to specialize. CHA specialization falls primarily into two categories:

▣ **Management.** CHAs move into management functions, for example as a lead CHA with supervisory responsibilities or as an in-service training coordinator.

▣ **Specialization.** CHAs deepen their expertise in a selected health area, such as in cancer or HIV-AIDS issues or becoming a Certified Childbirth Educator while still serving as a CHA.

Career advancement into other professions. Although CHA training and the skills built on the job prepare individuals for service in many fields, they frequently have difficulty in moving into other roles. Contributing factors appear to be the lack of understanding of the CHA role and the patchwork approach to training, which is generally acquired without formal academic credit. Strategies to build external career ladders for CHAs include agency practices that enable CHAs to explore other professions and collaboration with academic institutions to provide academic credit and programs.

Level 2: Promoting Recognition of Preparatory Training and Curriculum

Standardizing basic training, combined with a self-definition of core tasks, are key steps in the process of professionalization. Many trainers and training institutions adhere to curriculum guidelines. A familiar example is the Red Cross, which certifies trainers who in turn train and certify individuals.

Overall, CHA training is decentralized and lacks a common set of standards or curricula. Most training is on-the-job. However, there are some CHA curricula and associated training programs that are available regionally and nationally.

Agency-based and training center approaches to CHA training. On-site training is valued by many agencies. During the training, many local health and human services providers serve as trainers, and important links are forged between CHAs, these individuals and their agencies. There are a small number of free-standing CHA training centers that assist existing CHA programs which are growing in popularity.

Level 3: Targeting Program and Agency Practice

Formal organizational standards such as minimum standards for site accreditation versus emphasis on “best practices” or “models that work” are two approaches at opposite ends of a spectrum. Both envision standards and guidelines at the program level.

Best practice initiatives highlight unique examples of *excellence*, seeking to promote high standards for a field. Highlighting best practices can have an important influence on practice. The federal Bureau of Primary Health Care (BPHC) runs a “*Models That Work*” initiative and competition. Several models in 1996 were CHA programs, including one of the five top winners.

Organizational standards are not widely practiced in the CHA field, but there are examples of CHA programs linked by standards. An example is the Community Health Representative (CHR) Program, which represents a joint effort initiated in 1968 between Native American Tribes and the Indian Health Service (IHS). The tribes select CHRs, who attend a three-week core training course from the IHS. While CHR programs use common training and coordination methods, local tribes ultimately control their CHR programs.

Franchising, where a local program takes its shape from a larger entity, is another way that organizational practices are standardized. In order to carry a franchise title, the agency must adhere to certain standards addressing areas such as management practices or the uniformity of services offered. The national child abuse prevention program, Healthy Families America (HFA), is an example of a franchise program that sets organizational standards. To be designated as a *Healthy Families America* program, local groups must prepare an extensive application to the national office according to program guidelines. After a review and a site visit, the organization is approved. Notably, there are many CHAs in the 150+ HFA programs who are called “Family Support Workers.”

Site accreditation usually sets *minimum* standards that an organization must meet. It is often a voluntary process that offers incentives such as greater public acceptance.

Level 4: Facilitating CHA and Agency Participation in Networks

Within a given field, networks of individuals and agencies are commonly the key to its advancement. In the context of such networks, fields become better defined, and peers have an opportunity to share approaches. Moving beyond networks, associations often begin because a group feels a need to advocate for its interests or those of its clients. Activities that associations often undertake include the creation of guidelines for professional training and practice, development of a common credential, and advocacy for increased funding for programs.

Existing networks in the CHA field. There are already an array of national, regional, state and local networks working to advance the CHA field. National CHA networks include the American Public Health Association’s “New Professionals” Special Primary Interest Group, the Perinatal Empowerment Resource Committee (POWER) of the National Healthy Mothers, Healthy Babies Coalition, and the National Association of CHRs (NACHR, pronounced “Nature”). State networks have been established in a number of states including New Mexico, New Jersey, and Oregon. There are numerous city-wide networks as well.

CHA Career Development Recommendations

As a result of the Study's findings, we defined four goals related to CHA career development. The 14 recommendations are abstracted below. Recommendations are steps towards reaching the goals.

Goal: Improve working conditions and future opportunities for CHAs.

We urge that career advancement issues confronting *individual* CHAs be addressed. Efforts should promote career development options for CHAs on-the-job and afford mechanisms to transfer CHA skills to other fields.

Recommendation 1: Establish a national CHA certification. Develop a CHA certification based on refined core roles and competencies; link to other certifications such as those being explored by front line human service professionals.

Recommendation 2: Create academic linkages for CHA training. Establish academic pathways for CHAs who continue in school and link CHA training to academic credit.

Recommendation 3: Assure wage and benefit rewards reflective of CHA contributions. Promote comparable pay scales that reflect the comprehensive nature of CHA roles. Like many professional roles, CHA jobs do not have clear boundaries such as hours of work or the walls of an office or hospital.

Recommendation 4: Develop CHA career paths within and outside CHA programs.

☞ **Internally:** Develop protocols for CHAs to take on increased administrative responsibilities or develop refined expertise in identified health and related areas. Work with CHAs to articulate which other responsibilities they wish to take on. Support CHA efforts to build skills and confidence.

☞ **Externally:** Circulate job postings for related work within the agency and in other agencies. Link CHA training to academic credits and certificates. Educate partner and other agencies about CHA roles and competencies.

Goal: Standardize approaches to CHA core training.

To improve the quality of services delivered by CHAs as well as the status of the workforce, training in the field should be coordinated and organized around a set of defined core roles and competencies specific to CHAs in the United States. Greater coordination of training would promote efficient use of resources.

Recommendation 5: Promote paid on-the-job CHA training. To emphasize the importance of CHA training and to assure that CHAs receive comprehensive training, we recommend that both paid and volunteer CHAs be paid for the time they dedicate to training.

Recommendation 6: Establish CHA core curriculum and guidelines. Develop and disseminate CHA curriculum guidelines nationally to guide CHA training. We recommend that guidelines be based on the core roles and competencies outlined in this Study.

5. *Community Health Advisors: A Career in Development*

Recommendation 7: Include community-specific training in basic CHA training. When establishing CHA training, assure that CHAs are exposed to the issues confronting the specific communities where they serve.

Recommendation 8: Establish multi-program CHA training and support centers. Develop regional or state-based training centers for core CHA training to complement program-specific training.

Recommendation 9: Develop CHA supervisor training. Develop training for CHA supervisors that emphasizes job coaching/mentoring skills. Call upon senior CHAs to assist in the development of training guidelines for CHA supervisors.

Goal: Delineate and disseminate program practice guidelines.

Clear criteria or program guidelines would aid health care administrators and providers to structure CHA programs that meet their needs while maintaining the integrity of the CHA model for outreach in managed care and other settings.

Recommendation 10: Develop best practice guidelines for CHA programs. Develop guidelines for management and practice for CHA programs in various settings. Elements should include recruitment of CHAs, supervision, program management, and community assessment.

Recommendation 11: Establish clear role delineation between paid and volunteer CHAs. Delineate the roles of both paid and volunteer CHAs. Attention should be given to potential integration of the roles of paid and volunteer CHAs. Projects that include volunteer and paid CHAs should be identified to disseminate lessons learned in these projects.

Recommendation 12: Clarify inter-agency CHA roles in health and human services. While serving clients, CHAs often provide outreach and related services for multiple agencies. We recommend development of memoranda of understanding to clarify and acknowledge inter-agency relationships and to provide CHAs with definitions of roles and responsibilities.

Recommendation 13: Create visibility for essential CHA roles and competencies. Develop a multi-faceted educational campaign aimed at increasing visibility of the CHA role, which is targeted to health and human services providers, communities where CHAs serve and the public at large. We encourage the CHA community to work closely with the press and media to achieve educational goals.

Goal: Strengthen coordination in the CHA community.

Throughout the country many networks of CHAs have formed or are forming. All levels of CHA networks (local, state, regional and national) strengthen the field and can help to strengthen one another. Together, these networks can provide leadership for the CHA field.

Recommendation 14: Strengthen local CHA networks & form a national CHA-led association. To develop the CHA field to its fullest potential, formal national leadership in the field must be firmly established. Many of the Study recommendations would benefit from coordinated implementation. Important leadership roles could include refinement of core roles and competencies, the development of curriculum/guidelines, coordination of a CHA national credentialing program, and the establishment of reimbursement streams for CHA services.

6. Community Health Advisors in the Changing Health System

Purpose of this Section

This section reports and analyzes changes in the health care system and the impact of those changes on CHAs and CHA programs. The health care sector has moved from payment for individual services to a managed care model. Those responsible for increasing access, containing cost and maintaining quality are focusing more on disease prevention and health promotion, as well as on efficient use of health care resources. CHA services can play an important role in accomplishing shared goals among managed care organizations, public health officials, Medicaid officials and consumers. However, shared goals require relationships that build on the strengths of each group.

CHAs Work in these Domains

- Public health programs (*ongoing*).
- Managed care settings (*emerging*).
- Publicly-funded health insurance (*ongoing and emerging*).

CHAs in the Changing Health System: Research Questions

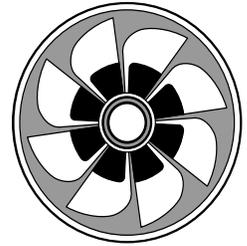
- What are the impacts of changes in the U.S. health system on CHAs and CHA programs?*
- In what types of program settings are CHAs working?*
- What are the opportunities for mutually beneficial interactions between CHAs and the changing health care system?*

Methods Used for this Section

To learn about changes in the health system and different CHA program models in this changing context, we chose to interview a sample of 19 programs in person and by telephone. Our sample included eight programs in managed care, nine in public health and two in publicly funded health insurance programs. We interviewed program directors and administrators as well as CHAs.

The programs we chose met the following criteria:

- CHAs working in the programs are recruited from the target community and are culturally and linguistically similar to those with whom they work;
- CHAs work from program sites located within target communities;
- The CHA role in the program is generally consistent with roles and competencies outlined in the Study, although some CHAs do not carry out all seven of the core roles described; and
- The programs have been in operation at least a year.



“...opportunities are related to CHA expansion into new areas such as managed care... At the same time, CHAs have developed an increasingly important role in public health programs.”

CHAs in the Changing Health System - Findings

The organization and delivery of health care services in the United States has changed dramatically in the 1990s. The traditional fee-for-service system of medical care has been replaced to a large extent by managed care.

With the rapid movement into managed care for Medicaid recipients, state Medicaid agencies, managed care organizations (MCOs) that contract with them, and Medicaid recipients have faced particular challenges. Many new MCO members have been confused by the enrollment process, the new rules and guidelines, and have perceived a lack of choices or inability to obtain care.

CHAs in the Changing Health System Summary of Primary Program Settings and Activities

Program Settings	Description of the Setting	Primary CHA Activities
Managed Care Settings	<ul style="list-style-type: none"> ■ For-profit and non-profit MCOs targeting underserved populations. ■ CHAs may be employees of an Managed Care Organization (MCO). ■ MCO may contract with a Community-Based Organization (CBO) for services of CHAs. ■ Partnerships of MCOs may contract with CBOs or finance program. 	<p><i>Services targeted to MCO members:</i></p> <ul style="list-style-type: none"> ■ Health education. ■ Explaining managed care system and appropriate use of health care. ■ Family support and advocacy. ■ Follow-up. ■ Referrals. <p><i>Few services targeted to the general community:</i></p> <ul style="list-style-type: none"> ■ Community-wide health education. ■ Community development activities that impact access and community health.
Publicly Funded Insurance Programs	<ul style="list-style-type: none"> ■ Medicaid and other state-funded insurance programs for the uninsured. ■ Includes the Children's Health Insurance Program (CHIP) funded by Congress in 1997. 	<p><i>Services targeted to eligible but not enrolled community members:</i></p> <ul style="list-style-type: none"> ■ Education about eligibility and assistance with enrollment ■ Follow-up. ■ Case management. ■ Referrals and advocacy for services..
Public Health Programs	<ul style="list-style-type: none"> ■ Wide variety of community-based health programs. ■ Administered by non-profit CBOs and public agencies. ■ Primarily targeted to underserved, often culturally and linguistically marginalized groups. 	<p><i>Services to program clients and the general community:</i></p> <ul style="list-style-type: none"> ■ Client-specific and community-wide education on a range of topics related to health. ■ Advocacy. ■ Case management and family support ■ Health needs assessment. ■ Referrals. ■ Follow-up. ■ Community development.

There have been a number of changes in publicly-funded health insurance programs. Most notably, with the passage of the federal children's health bill, a number of states are considering expansion of Medicaid eligibility. This comes near in time to another important change in Medicaid, the federal welfare reform act, which severed the tie between welfare eligibility and Medicaid enrollment. Now, families that are not eligible for welfare assistance (now called Temporary Assistance for Needy Families) may be eligible for Medicaid.

Although changes in the field of public health are perhaps not as marked as in other sectors of health care, public health has also been undergoing changes in the last decade, while prevention and health promotion efforts continue to be the top priority.

CHAs in Managed Care Settings

CHA services can be a key to successfully managing the care of high-risk and low-income populations. CHAs can inform new MCO members about how to use managed care and teach about prevention, health risks, and treatment protocols. CHAs can provide follow-up, counseling, referrals, and listen to new members and answer questions in their language.

We identified a variety of working relationships between CHAs and CHA programs and MCOs. Three arrangements for delivering CHA services in managed care settings that were identified include:

- managed care organizations directly hire CHAs;
- MCOs contract with community-based organizations to provide CHA services; and
- partnerships are formed between MCOs and community-based organizations or public health entities for joint funding of CHAs to conduct client and community-wide outreach, education, and support.

Managed Care Organizations Directly Hire CHAs

A number of MCOs hire CHAs directly. CHA responsibilities vary somewhat among MCOs but generally cover outreach to members in their homes, member education, health education, follow-up, tracking for preventive services, social support and referrals. In the full Study report, five MCO programs that directly employ CHAs are summarized.

One managed care organization, a nonprofit health plan, has operated an outreach program for Medicaid recipients staffed by CHAs and visiting nurses since the 1970s. The CHAs are considered highly effective by members and medical providers because they go into people's homes, act as patient advocates and address many of the social problems that prevent members from accessing medical care or staying healthy.

At another MCO, a for-profit health plan, CHAs make home visits to new mothers and new members. They help members choose primary care providers and explain how to use medical, dental and visual services. During home visits, they provide education and information and assist members to make appointments.

All five of the MCOs interviewed included in the Study that employ CHAs directly were very enthusiastic about the CHAs on their staff and felt that they made a real difference.

"The best way to reach clientele is on a personal basis. Sending out cards, letters---they were trashed and forgotten. A lot of people don't have telephone numbers or we don't know the telephone numbers. You need someone who has direct contact. You need someone who is street smart and knows community resources. So our plans send outreach workers to people's homes to educate members and provide follow-up. In the long run educated members save money."

- Barbara Fuller, Dayton Area Health Plan

MCOs Contract with Community-Based Organizations for CHA Services

Some managed care organizations contract directly with community-based organizations (CBOs) for local CHA services. CBOs such as community health centers, community-based coalitions, perinatal associations and others have a long history of providing street outreach, health information, referrals, and other services for community residents. Sometimes referred to as “safety net providers,” CBOs have experience, understanding of the community and an established track record providing service to community residents. We interviewed two CHA programs that contract with managed care to provide CHA services.

A nonprofit CBO serving low-income pregnant and postpartum women in Philadelphia contracts with MCOs to provide CHA services. Under the contracts, the CHAs conduct outreach to identify members who are pregnant. They make home visits and perform case management for women throughout pregnancy and the postpartum period.

A nonprofit CBO in New York City has a three-year contract with an MCO to provide CHA perinatal education and case management for MCO Medicaid members during pregnancy and the infant’s first year of life. The CHAs make home visits, provide health education and case management, and make referrals. The CHA program provides a statistical report to the MCO on a monthly basis.

Partnerships are Formed Between MCOs and CBOs and/or Public Health Entities for Joint Funding of CHAs

A third approach to incorporating CHAs in managed care is represented by partnerships between multiple MCOs and CBOs or public health departments. Participating partners jointly create programs and fund CHA services. We interviewed one program in this category.

The Solano County Community Health Outreach Project in California is a three year pilot program jointly funded by the Kaiser Permanente Health Plan and the Solano County Health Department. Three outreach teams - each composed of a public health nurse and four CHAs work in covered neighborhoods. The teams provide client services in accordance with a public health model, and perform community-wide outreach and education activities. They also support change efforts for individuals, families and neighborhoods. In one community, the team worked with residents to advocate for more accessible, convenient bus routes from the neighborhood to health care and other vital services.

CHAs in Publicly Funded Health Insurance Programs - Reaching the Uninsured

Publicly funded health insurance programs need community-based support to help people learn about eligibility, apply to enroll, and get information about the health care system and health prevention measures. CHAs are involved in outreach, education and enrollment for Medicaid, state-funded health insurance and other community health programs. These CHAs may work directly for the state, county or city or may work directly for community-based organizations. We interviewed two such programs.

Georgia’s “Right From the Start” program is a statewide program targeting children and families eligible for Medicaid but not enrolled. Right From the Start, administered by the Georgia Department of Human Resources, employs more than 140 CHAs (called outreach workers) statewide. Their mission is “to inform and educate the community, not just about the Medicaid program but also about other resources — from shelters, to teen pregnancy task forces to furniture, eyeglasses and clothing.” Outreach workers’ offices are located in high volume areas such as day care centers, shopping centers, health departments, public housing and teen clinics. At least a third of their time is spent working on weekends and at night.

Public Health Programs and CHAs

CHAs have worked successfully for over thirty years in public health and community health programs. We interviewed nine programs in this arena. While managed care focuses on the population enrolled in managed care health plans, public health agencies focus on the entire population. Historically, public health agencies primarily addressed infectious disease control, maternal and child health, clean water supplies, and sanitation. In the last several years, public health offices have increasingly taken on a multitude of other public health problems. These include HIV/AIDS, intentional violence, teen pregnancy, access to health care, and safe neighborhoods. Increased emphasis in public health on reaching the underserved in a culturally and linguistically competent manner should heighten the opportunities for CHAs.

Funding for CHA positions in public health comes from various places. The federal government is a large but fragmented source of funding. Federal funds support CHA work through a number of channels including annual block grants to the states from the federal Department of Health and Human Services (HHS) directed to particular health issues, Centers For Disease Control contracts and initiatives, other HHS national initiatives and the Indian Health Service. State public health funds often provide partial support for CHA services. Other sources of funding include hospitals, MCOs and community foundations.

Community health centers and other community-based sites often run CHA programs using a public health model. One such program is based at Codman Square Health Center, a community health center in Boston. In its generalist CHA program addressing a wide range of health issues, each CHA is responsible for a geographical area. The CHAs conduct home visits, which include both door knocking to locate new clients as well as follow-up visits to health center clients. They do community liaison work with a clinical team, which includes follow-up with patients who do not have telephones for lab results and other clinical information. Some do block organizing, which might involve starting block groups or working with existing neighborhood groups.

Findings: CHAs in the Changing Health System

What are the impacts of changes in the U.S. health system on CHAs and CHA programs?

The changes in the health care system in the 1990s create opportunities and challenges for CHAs. The opportunities are related to CHA expansion into new areas such as managed care and publicly funded health insurance programs. At the same time, CHAs have developed an increasingly important role in public health programs since the 1980s.

Four opportunities and five challenges stand out for CHAs and their programs at this time.

Opportunities

■ CHAs can support Medicaid managed care enrollees. CHAs can serve an important education, support and referral role for Medicaid clients who have enrolled in managed care in recent years. They improve access to care and help MCOs achieve performance measures for Medicaid members. In a competitive environment, they help MCOs reach their members and provide them with services they need.

6. Community Health Advisors in the Changing Health System

- ▣ **CHAs can provide important outreach and education to Medicare managed care enrollees.** Medicare is the single largest payer in the U.S. Health care system. CHAs can provide education and monitoring of health status to prevent exacerbation of disease and support the elderly to access the health services they need.
- ▣ **CHAs can perform critical outreach to uninsured populations.** There is new federal funding for expanded health insurance coverage for children. This funding requires community-based outreach activities, which CHAs can conduct.
- ▣ **The CHA role in accomplishing public health goals remains important.** CHAs continue to be needed in public health programs to help people access care, provide information about public health problems, community resources and self-care and preventive measures.

Challenges

- ▣ **Poor understanding of the value of CHA roles has led to inadequate support for CHAs.** Both public and private sector support for CHAs and CHA programs is primarily given on a program by program patchwork basis. Unless there is increased recognition of the contribution of CHAs, new opportunities in the changing health system may result in temporary increases in the number of CHAs without a lasting impact on the stability of the CHA field and CHA jobs.
- ▣ **CHA programs typically do not have the infrastructure in place that is necessary to work with potential contractors, such as MCOs.** Many CHA programs currently lack administrative systems, information and data collection systems that MCOs look for when they choose to enter into a contract. Without the capacity to accurately report on and bill for specific services, CHA programs may not be in a favorable position to begin negotiating with MCOs.
- ▣ **New opportunities can present threats to the integrity of CHA core roles and competencies.** As CHAs increasingly enter the world of managed care, conscious program criteria and standards are needed to promote and protect CHA services in this environment. Pressure to increase MCO enrollment or reduce cost has sometimes resulted in detrimental impacts on CHA programs due to lack of clarity about their roles and the standards by which CHA work should be measured.
- ▣ **Potential reductions in public spending and cost-containment efforts in managed care organizations may threaten CHA services or compromise quality.** Too often when there are fiscal constraints in the public sector, CHA programs are cut or reduced to the extent that they cannot adequately function. Managed care organizations protecting the bottom line may be unwilling to invest in CHAs or may cut essential services after starting CHA programs. Any decrease in Medicaid managed care capitation rates may unfavorably affect CHA programs.
- ▣ **Lack of organized CHA leadership means that CHA voices are often not heard, either as advocates for community interests, or for their own interests as practitioners.** Most health professions have professional associations that provide leadership, standards, and advocacy for members. There are a limited number of state or city CHA networks, a “New Professionals” Special Primary Interest Group of the American Public Health Association and some other national coalitions and groups that support CHA goals. However, these groups are no substitute for a CHA professional association.

CHAs in the Changing Health System: Recommendations

The advisory council for the Study developed three goals and six accompanying recommendations based on this section's findings and analysis.

Goal: Promote Sustainability for CHAs and CHA Programs in the Changing Health System

Recommendation 1: Develop sustainable financing mechanisms for CHA programs.

As CHA programs develop administrative capacity and are able to successfully negotiate with MCOs and other organizations for their services, stable, ongoing funding will be more feasible. In the meantime, the public sector must allocate permanent funding streams for CHAs who work in public health and publicly funded health insurance programs. The private sector, including managed care organizations and hospitals, should systematically fund CHAs whether through directly employing CHAs, contracting with community based organizations for CHA services, or by partnering with other entities to jointly fund CHAs. Non-profit foundations should not abandon their interest and commitment to CHAs at this time, but should make investments in infrastructure for the field. Private sources of ongoing program funding such as community benefits and assets from non-profit to for-profit health care conversions should be carefully explored.

Recommendation 2: Strengthen public policies in support of CHAs and CHA programs.

Use competitive contracting processes of state Medicaid agencies (*e.g.*, RFP, contracts) to encourage and promote CHAs as part of the managed care health team serving Medicaid clients. Similarly, use state public health agency RFPs and contracts with community organizations to promote the role of CHAs in public health programs receiving state dollars. Include explicit provisions in Medicaid expansion programs and state-funded efforts to utilize CHAs to provide community outreach and education.

Through a variety of methods, states can enact policy supportive of CHA services. Advocates should seek policy changes to enhance community-based outreach, diminish barriers to health care and encourage partnerships between managed care organizations and community-based CHA programs. Reform of federal funding policy for disease prevention should include the development of integrated rather than categorical funding for CHA health promotion and disease prevention programs. Another option for federal policy is to pass a National Community Health Advisor Act that includes funding for CHA programs, such as that proposed during the mid-1990's by Vermont Senator Bernie Sanders. Affirmative policy change should include funding to establish state or regional clearinghouses to provide information, training and evaluation assistance to CHA programs.

Goal: Build Linkages Among State Agencies, Managed Care Organizations and CHAs

Recommendation 3: Educate managed care organizations and state Medicaid agencies about the role and functions of CHAs in the health care system and build organizational capacity for working with CHAs and CHA programs. Provide training about CHAs to managed care organizations and state Medicaid agencies. Develop and distribute information to MCOs, state Medicaid agencies and other service providers information on CHAs in print and electronic format.

Recommendation 4: Prepare CHAs and CHA programs to compete in the changing health system. Train CHAs, CHA programs and community-based organizations about issues related to using and working with managed care and other areas of the changing health care system.

6. *Community Health Advisors in the Changing Health System*

Goal: Promote CHA National Organization and Leadership

Recommendation 5: Involve CHAs in planning and advocacy about the health system and their role. Involve CHAs in health system planning processes, especially in the area of services to low-income, at risk communities. Enhance the capacity of CHAs and CHA supporters to make presentations, network, understand how to advocate for policy in the changing health care system and participate in community health decision making.

Recommendation 6: Build capacity for a national CHA organization and coordinated CHA leadership and advocacy. Form a CHA-led national association or coalition to provide leadership in the CHA field, which would link CHAs with each other, represent their interests, strengthen the field and oversee the coordinated implementation of the Study recommendations. In addition, we note here the importance of CHAs linking beyond one another to consumer and civic associations, community coalitions and other local, state and national health reform groups. Such linking and outreach will improve CHA visibility and strengthen the negotiating position of CHA programs locally and nationally with health care payers.

7. Conclusion

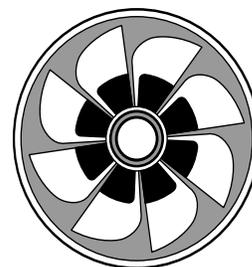
What is the Potential for the CHA Field?

CHAs now play a role in integrating service delivery in medically underserved communities, and could play an increasingly important role as more individuals from these communities enter insurance systems and managed care. However, CHA programs represent much more than simple placement of community members on the front lines between residents and health service systems. Development of this field promises to facilitate the real involvement of members of underserved communities in their community's health. CHA efforts can help communities become empowered to participate in setting and meeting a health promotion agenda locally. In order for this to take place, many of the steps outlined in this report must be fully implemented and we must identify the elements that prevent the field from becoming more sustainable.

Factors contributing to instability of the field

The foundation of instability of the CHA field is inadequate and intermittent funding for programs. CHA programs lack institutionalized funding and the reasons for this are complex. The issues that contribute to lack of a funding or revenue base for CHA services break down into four areas.

- **Characteristics of the U.S. Health Care System.** The U.S. health care delivery system is decentralized and emphasizes high technology medical solutions. The incentives in our systems have caused a focus on cure rather than disease prevention.
- **Assumptions About the Impact of "Institutionalization" on the CHA Role.** CHA advocates recognize the value of the community-based perspective that CHAs bring to their work. In an effort to protect this decentralized, community-specific approach, some CHA advocates may inadvertently resist efforts to build toward a more institutionalized approach to program and revenue development.
- **Challenges Evaluating CHA Service Impacts.** Documentation of program results and cost-savings is very difficult due to the short funding cycles of many grants, limited resources within programs, and the challenge of documenting problems that did *not* occur as a result of prevention efforts.
- **Lack of Coordinated Advocacy Efforts.** Almost all CHA programs are service delivery programs operating locally. Most CHA program managers are hard pressed to move beyond the day-to-day fund raising efforts to think strategically to develop broader-based stable funding sources. Since CHA programs address an extremely broad range of health issues and communities, these differences often obscure the common elements of programs that could lead to building united advocacy efforts.



“...CHA efforts can help communities become empowered to participate in setting and meeting a health promotion agenda locally.”

How Can CHA Potential Best Be Realized?

The process of carrying out the Study gave the staff, consultants and the Advisory Council a forum in which to review the issues confronted not only by individual CHAs and CHA programs but by the CHA field as a whole. We brainstormed together about the future of the field, and in the process began to identify important opportunities for coordinated efforts that could enhance it.

Our emphasis on the voices of CHAs themselves was perhaps our most critical decision. Asking those who serve in a field for guidance is based on the same principles that induce business leaders to ask those who work on the front lines to provide insight on what is needed to improve the product. It is clear that the CHA field must be defined and standards articulated in order to pave the way to better integration of CHA roles into health systems. However, we caution against taking these fundamental issues too far from the hands of CHAs themselves.

Many CHA practitioners are from the most disenfranchised communities in the country. One of the important assets CHAs offer health and medical systems are their connections in these communities and the impact they have in their communities through personal bonds of shared experience and trust. Part of the experience CHAs may share with other community residents is that of being perceived by those *outside* their immediate communities as voiceless or powerless.

Knowledge of CHA program effectiveness among policymakers and health care providers is likely to increase, given growing public attention to issues of outreach and cultural competence. There is a risk that well-meaning program directors or policymakers could unintentionally weaken the CHA model through efforts to bring CHA-type programs into widespread use as effective tools to promote community health. We urge thoughtful collaboration with CHA practitioners at all levels to promote the field.

Some Study recommendations are intended to safeguard existing practices in the field while others call for significant change building on emerging trends. The Council strongly believes that the Study's recommendations should not be implemented in isolation from one another. An example of such a linkage is the use of core role and competency definitions to inform the development of guidelines for the integration of CHAs into managed care settings.

A large community of individuals and organizations is already working to enhance the CHA field. That community includes CHAs and CHA program coordinators and the many public and private organizations that impact programs at the local level. The recommendations made in this report provide a road map for moving the CHA field ahead so that it may better serve communities in need while facing rapid change in the U.S. health care system. There is a need for an oversight body of some kind to implement and coordinate many of the Study's recommendations. If a national association or coalition is formed, we hope that it can play this oversight role in partnership with other appropriate entities. In partnership, both public and private funders seeking to support development of the CHA field can help to provide a mechanism through which a vision of the field as a whole can be realized. One starting place would be to support implementation of the Study recommendations by appropriate partners.

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CORE RECOMMENDATIONS

NATIONAL COMMUNITY HEALTH ADVISOR STUDY

A policy research project of the University of Arizona; funded by the Annie E. Casey Foundation*

“A policy idea is a proposal for some change.” - Steve Kelman - Making Public Policy

The National Community Health Advisor Study’s advisory council has made many recommendations for practice, policy, and research. What follows are selected Study recommendations aimed at developing an infrastructure to strengthen the CHA field. Implementation of the recommendations depends on actions being taken by Community Health Advisor (CHA) programs working together with support from public and private funders. We are hopeful that this set of recommendations will generate dialogue that will lead to their refinement and coordinated implementation.

CHA Core Roles and Competencies

1. **Adopt and Refine CHA Roles and Competencies.** Disseminate and track use of the Study’s proposed core roles and competencies lists and the validate lists with stakeholders.

CHA Core Roles and Competencies

Roles

- | | |
|--|--|
| ▣ Cultural mediation between communities and health and human services system. | ▣ Advocating for individual and community needs. |
| ▣ Informal counseling and social support. | ▣ Assuring people get the services they need. |
| ▣ Providing culturally appropriate health education. | ▣ Building individual and community capacity. |
| | ▣ Providing direct services. |

Competencies: Skills

- | | | |
|-----------------------------|--------------------------------|--------------------------|
| ▣ Communication skills. | ▣ Interpersonal skills. | ▣ Advocacy skills. |
| ▣ Knowledge base. | ▣ Service coordination skills. | ▣ Organizational skills. |
| ▣ Capacity building skills. | ▣ Teaching skills. | |

Competencies: Qualities (partial list)

- | | | |
|---|---------------------------------|----------------------------------|
| ▣ Relationship with community being served. | ▣ Empathy. | ▣ Personal strength and courage. |
| ▣ Desire to help community. | ▣ Persistence. | ▣ Respectfulness. |
| | ▣ Creativity / Resourcefulness. | |

CHA Evaluation Strategies

- 2) **Promote a Comprehensive CHA Research Agenda.** Target a research agenda promoting analysis of CHA roles in various settings including MCOs, and welfare reform. Conduct a multi-site CHA program evaluation.
- 3) **Develop CHA Evaluation Guidelines and Tools.** Refine the evaluation framework developed as a part of the Study and create an evaluation “tool kit” for programs.
- 4) **Establish a CHA Evaluation Database.** Create a database of evaluators, evaluation tools and findings.

CHA Career Advancement

- 5) **Establish a National CHA Certification.** *Develop a CHA certification based on refined CHA core roles and competencies; link to other certifications such as those being explored by front-line human services professionals.*
- 6) **Create Academic Linkages for CHA Training.** *Establish academic pathways for CHAs who choose to continue in school and link CHA training to academic credit.*
- 7) **Develop CHA Core Curriculum Guidelines and Supervisor Training.** *Develop and disseminate CHA curriculum guidelines nationally. A related project is the development of CHA supervisor training guidelines.*
- 8) **Establish Multi-Program CHA Training and Support Centers.** *Develop regional and state-based training centers to provide core CHA training complementing program-specific training.*
- 9) **Develop Best Practice Guidelines for Programs.** *Develop guidelines for management and practice for CHA programs in various settings including Managed Care Organizations (MCOs).*

CHAs in the Changing Health Care System

- 10) **Educate Managed Care Organizations and State Medicaid Agencies about CHAs.** *Provide information and training about CHAs to MCO staff and Medicaid administrators who coordinate funding in MCOs.*
- 11) **Prepare CHAs and CHA Programs to Compete in the Changing Health System.** *Educate CHAs about special issues related to member utilization of MCOs; create educational materials and trainings to help CHA programs develop needed infrastructure to work with managed care.*
- 12) **Build Sustainability for CHAs and CHA Programs Through Financing Mechanisms and Public Policy.** *Work to allocate permanent public revenue sources to sustain CHAs through regulatory and public policy change, and work to build support within the private sector for direct services and CHA field infrastructure.*

CHA Leadership Development

- 13) **Establish Coordinated Leadership in the CHA Field.** *Form a national association or similar organization to provide leadership in the CHA field; CHAs should play the key role in governing such an organization. One proposed role for the organization is to coordinate implementation of projects recommended by the Study.*

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For more information about the Study and implementation of its recommendations please contact: For copies - The Annie E. Casey Foundation at (410) 223-2890 / Publine, or Fax (410) 547-6624, Attn. Pub. Dept. To speak with Study staff contact E. Lee Rosenthal c/o University of Arizona, (520) 626-7946. E-mail: cha@ahsc.arizona.edu