Community Health Worker Labor and Curriculum Information

LABOR MARKET NEED

Community Health Workers (CHWs) have worked to improve the quality of health care delivery services, in order to reduce health disparities, for more than 60 years. (Balcazar et al, 2011). The US Department of Health and Human Services defines community health workers (CHWs) as: "… lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, promotores(as), outreach educators, community health representatives, patient navigators, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening." (USDHHS, 2007). CHWs improve consumer access to health insurance coverage, they model and encourage clients in healthy behaviors, they monitor health status, they educate consumers with basic information about disease prevention or reduction, they make consumers aware of resources to improve health. CHWs are trusted frontline public health workers. Because CHWs live in the communities they serve or are working in similar communities, they have a unique vantage point to understand and explain the health problems that members of their communities face and to identify and implement workable solutions. (American Public Health Association, 2009)

In 2002-2003, the need for CHWs in the Chicago metropolitan area was great. By now it is well documented that the need is not only local but national. In the past decade the use of CHWs by health care and social service providers has grown, and their effective contributions to the health system have been extensively described, for example, in managing chronic diseases such as hypertension and diabetes, improving birth outcomes, maintaining child wellness (US Department of Health and Human Services, 2007; Viswanathan et al., 2009; Rosenthal, Wiggins, et al., 2011). As a result, there has been an increasing recognition by health care and social service providers and by the government of CHW's important roles. At the federal level the U.S. Office of Management and Budget has approved a Standard Occupational Classification, 21-1094, expressly for CHWs (US Bureau of Labor Statistics, 2010). At least five states, including Massachusetts, Texas, Minnesota, Ohio, and Alaska, have also created occupational classifications for CHWs and have developed or are developing certification programs for CHWs. With the passage of the Affordable Care Act the Obama administration has raised the profile of CHWs by authorizing the Centers of Disease Control to promote the use of CHWs in

medically underserved communities. ACAC has allocated federal funds to expand community based care settings in which CHWs may work. (Patient Protection and Affordable Care Act, 2010; National Peer Support Collaborative Learning Network, 2012)

Government-generated estimates of the number of CHWs in the U.S. vary, ranging from 38,000 (US Department of Labor, Bureau of Labor Statistics, 2012) to 121, 000 (O*NET OnLine, 2012; US DHHS, Health Services Administration, 2007). The lower figure might not account for part-time CHWs, volunteer CHWs and CHW functions described in overlapping occupations, such as health educators or community and social service assistants. However, there is agreement that the projected growth rate for CHWs between 2010 and 2020 will be robust: 20% to 28%. This rate is higher than the projected national average for all occupations and places CHWs in the fourth fastest growing major occupational group, community and social service occupations (Lockard & Wolf, 2012). Illinois is the state with the third largest number of CHWs currently employed (after California and Texas), and the Chicago-Joliet-Naperville Metropolitan region has the largest concentration of CHWs employed of any metropolitan area in the U.S. Nationally, average hourly wages for CHWs are $18.02; in Illinois average CHW hourly wages are $17.99 (US Bureau of Labor Statistics, 2012). By the most conservative estimate there were at least 2,130 CHWs in Illinois in May, 2012 (US Bureau of Labor Statistics, 2012).

The need for CHWs has never been greater. Chronic diseases such as cardiovascular disease and diabetes, and communicable diseases such as HIV/AIDS and Hepatitis B continue to have a disproportionately high impact in the low income minority communities where CHWs live and work. Low income communities continue to endure higher infant mortality rates; the need for pre-natal care and education persists. Tobacco use and substance abuse also remain high. Millions of low income community residents need accurate, up-to-date information about disease prevention, to become familiar with current community and government resources (such as using SNAP and LINK at farmers' markets) . They also need help to gain access to health care services and navigate the insurance options to pay for them, a need which has become more acute as the Affordable Care Act is being implemented. The proposed curriculum at South Suburban College contains courses that address all of these issues; it will prepare CHWs with the requisite background knowledge and skills to educate, counsel and support clients and advocate for healthier communities.

CURRICULUM DEVELOPMENT

In August, 2002 a group of 25 health care professionals working in government agencies, health care organizations, non profit organizations, and universities came together in Chicago to discuss education, training and certification issues of CHWs, in order to advance their professional development. There were many issues to address: CHWs faced high job insecurity. Their work was often funded by short-term grants, and CHWs were rarely employed in a full time position with benefits. Each organization hiring CHWs had

their own training programs and did not recognize the value of CHWs' prior training and experience. A working group was formed, which began by concentrating on areas of study. (See Appendix ___ for names and affiliations of team members). The team agreed on eight core subject areas and developed detailed course descriptions for all courses in each subject area. The authors designed the curriculum to be widely inclusive of the different levels of knowledge, experience and personal goals of CHWs. The curriculum had three levels: a basic certificate, an advanced certificate and an Associate Arts of Science degree, which could enable a CHW to move from a city college AA program to a four-year college for a BA degree. Courses could be taken for credit or as non-credit courses. Instructors were required to establish learning goals, requirements and assessments for both credit and non-credit students. For example, non-credit courses could fit the interests of an aging CHW who wanted quality professional development with peers before retiring, but did not seek a certificate or degree. The curriculum was submitted to Richard J. Daley College, one of the colleges in the Chicago City Colleges system. ICCB approved the program at Daley College. Team members assisted in the recruitment of instructors and students. Teaching commenced in 2003. This Daley College curriculum became the basis for the proposed curriculum at South Suburban College.

The Chicago CHW Local Network (CCHWLN), an organization by and for CHWs and their allies, formed in 2003, With 800 members, it has become a leading voice for standardized CHW training recognized by employers across job sites and for the establishment of career ladders for CHWs who wish to advance their careers as health care practitioners in Illinois. The CCHWLN has been instrumental in bringing frontline CHWs together with other stakeholders to identify CHW roles and responsibilities, their educational needs and their views on certification, to learn about similar efforts in other states, and to develop policy. CCHWLN held a ground breaking conference to organize and advocate for CHWs in 2007 and has collaborated with employers and CHW research and advocacy organizations at subsequent forums in 2010 and 2011. The conferences served as springboards for CCHWLN to establish working groups of CHWs and health professional allies. The committees meet monthly to develop training programs and certification policies. CCHWLN also participates in a coalition of organizations, known as the CEED Alliance, to promote research describing and evaluating CHWs' work in many settings, to widen acceptance of CHWs by employers as important members of community health teams, and to advocate for CHW state certification (For an example of the coalition's work, see CEED's power point presentation to physicians and administrators on the value of CHWs).

Between 2011 and 2012 CCHWLN conducted seven focus groups of Chicago area CHWs and other stakeholders including CHW employers and supervisors, and CHW trainers. A cross-section of Latino/a (Hispanic), African-American (Black) and Euro-American (White) participated. Focus groups were conducted in English and Spanish based on the needs of the host organization. The focus groups were held in Cook and Lake Counties, in Chicago and the suburbs (Waukegan and South Holland) and in academic, community-

based organization (CBO) and healthcare settings. More than 100 people participated in this process. Through these focus groups with CHWs and stakeholders, the CCHWLN gathered information on CHW roles and responsibilities, core competencies, training, supervision and certification in order to facilitate the development of a statewide policy to recognize and advance occupational opportunities.

Focus group results revealed that CHWs tended to assume the roles and responsibilities of either case managers, outreach workers, health promoters, and/or educators. They also acted as researchers and advocates. CHWs strongly urged that their knowledge and experience be recognized, appreciated and validated by employers. They also wanted on-the-job-training to be portable across work settings. Finally, for those CHWs who desired to continue formal academic study for other health professions, a tiered academic program should be created, which includes a basic certificate followed by community college degree program, which could be applied towards a college program. The results echoed discussions at previous CCHWLN's previous conferences and forums (Stansell, 2011) and is consistent with other research. (Rosenthal, et al., 2011; Whitley et al., 2007)

Armed with the result CCHWLN reconvened the group of curriculum developers of the Daley College curriculum in 2012. The current working group has reviewed the focus group findings, reviewed CHW curricula at community colleges elsewhere (e.g., San Francisco and Minneapolis) and has since updated and revised the curriculum, which is now being presented to South Suburban College.