Community Health Workers: Wages, Skills and Roles

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Introduction

Community Health Workers (CHWs) are an important and growing part of the healthcare, public health and social services workforce. They serve as liaisons to the community, connect patients to services and providers, identify community health needs, and support the prevention and management of chronic disease. By conducting outreach for health organizations and health providers, CHWs help individuals and communities practice and maintain healthy behaviors. CHWs typically provide information about available resources, are a source of support and informal counseling, become advocates for individuals and community health needs, and collect data that help to identify needs. CHWs are particularly well suited to understand and communicate with patients and other providers about the relevant social and economic factors that are increasingly understood to play a vital role in health outcomes. In this way, CHWs help to assure that high quality and cost-efficient care is accessible to vulnerable populations, which serves to reduce health disparities.

In an assessment of CHW standards across the states, the Community Health Worker Core Consensus (C3) Project (2016) finds that CHWs' roles include cultural mediation between individuals and communities and the healthcare system, culturally appropriate health education, care coordination, coaching and social support, advocacy, outreach, capacity building, and assessment and evaluation. As frontline public health workers, CHWs bring critical knowledge about the community to other members of the care team. It is not surprising then, that CHWs' role is recognized in the Patient Protection and Affordable Care Act and that CHWs are increasingly part of new models of care, including patient-centered team-based care and Accountable Care Organizations (ACOs). Yet, like in many direct healthcare occupations in which women of color predominate, CHWs receive wages below that commensurate with the multiple sets of skills required to do their work.

The Massachusetts Association of Community Health Workers (MACHW) commissioned this brief to document the skills required of CHWs in their work, the current wage rate, and the consequences of low wages. MACHW was founded in 2000 as a collaboration between CHW leaders and the Massachusetts Department of Public Health. Since its founding it has helped progress a legislative and policy agenda that has produced a better understanding of the CHW workforce in the context of health reform in Massachusetts.

This brief provides a short description of the workforce, an analysis of CHW wages, a discussion of the skill set required of CHWs, the role of CHWs in the context of patient-centered care and accountable care organizations, and an explanation of the financial and other costs of turnover when wages are low.

The Majority of the CHW Workforce is Comprised of Women of Color

There are just over 3,000 CHWs working in the state. Workers responding to a 2016 Massachusetts Statewide CHW Workforce Surveillance Survey conducted by researchers at the University of Massachusetts Medical School with the Massachusetts Department of Public Health indicate that 42% are non-Hispanic white, 29% Hispanic, 19% non-Hispanic Black, and 4% non-Hispanic Asian. As in most healthcare professions, CHWs are disproportionately female (80%). About half of CHWs are multi-lingual. Sixty percent of CHWs are 35 years and older and 60% have at least three years of experience as a CWH.

CHWs earn 70% of the Average Wage in Massachusetts

In 2016, according to the U.S. Department of Labor, community health workers in Massachusetts earned an average hourly wage of $20.86. The average wage for all occupations in Massachusetts was $29.95 in 2016, 29% higher than a CHW's wage. Individuals working in similar occupations like health educators, on average earn higher wages than CHWs. Table 1 below depicts the hourly mean wages and employment level of individuals working in similar occupations in the Massachusetts healthcare industry in 2016.

Table 1: Comparison of Wages between CHWs and other Similar Occupations in Massachusetts (2016)

Occupation	Hourly Mean Wage	Employment
All Occupations	$29.25	3,459,910
Health Educators	$28.51	6,830
Substance Abuse and Behavioral Disorder Counselors	$21.89	11,970
Mental Health Counselors	$21.65	12,610
Community Health Workers	**$20.86**	**3,130**
Rehabilitation Counselors	$19.16	5,810

Source: U.S. Department of Labor, Bureau of Labor Statistics (BLS). (2016). Occupational Employment Statistics. Tables for May 2016 Massachusetts.

Average wages can be skewed by high wage earners, so to get a better sense of the typical wage, we also report median wages. The median wage is the point where half of the employees fall below the wage point and half fall above it. According to the U.S. Department of Labor, the median hourly wage for CHWs in Massachusetts is $19.42 as of 2016. Real median hourly wages for CHWs have grown 4% since 2012. The growth rate in CHW real median wages is very similar to all occupations in Massachusetts.

Median Annual Earnings are under $40,000 for at Least Half of CHWs in Massachusetts

There are no contemporary national data surveys that collect information on annual earnings for CHWs. But according to the Massachusetts Statewide CHW Workforce Surveillance Survey of 2016, employers reported annual earnings for CHWs with a median of $34,220 and CHWs reported their annual earnings resulting in a slightly higher median of $35,040, with the vast majority of employers (84%) reporting that CHWs work full time (at least 30 hours a week).

To put these wages into context, we use the MIT Living Wage Calculator for Massachusetts. A living wage for a single adult in Massachusetts is $13.39 or approximately $27,851 in annual earnings for a full time, year-round worker. However, we know that the CHW workforce is predominately women of color who likely support children. The living wage for a single adult with 2 children is $32.98 or approximately $68,600 in annual earnings for a full time, year-round worker. Additionally, living wages differ across the

state. For example, a living wage for a single adult with two children living in Boston is $34.51 compared to $29.40 for those living in Franklin County.

CHWs Earn More in Clinical Settings

The U.S. Department of Labor provides data on median hourly wage by employment setting. The average hourly wage of Massachusetts-based CHWs that work for hospitals (about 10% of CHW employment) is $23.31 an hour. For those who work for local governments (about 14% of CHW employment) it is $20.29 an hour and $17.54 for those in outpatient care for individual or family service organizations (about 29% of CHW employment). The difference in wages does not necessarily reflect differences in skill levels but rather differences in funding sources and organizational types. Wages are lowest at community-based organizations because funding sources tend to be grants that have time limits and are less resourced than the operating funds of a hospital, for example.

The Demand for CHWs is Expected to Grow Twice as Fast as All Occupations

The U.S. Department of Labor's Occupational Outlook Handbook predicts that over the next ten years, there will be a 16% increased demand for CHWs (and health educators) nationally, compared to a 7% total increase for all occupations. As the demand grows, without a corresponding increase in wage growth, it will become more difficult to recruit, hire and retain CHWs.

CHWs Have an Important Skill Set Shared by Other Mid-Level Occupations

Community health workers can work under many job titles, including community advocates, health promoters, and patient navigators. They develop trust and a deep familiarity within their community, usually made up of hard-to-reach populations. In so doing they create a linkage between community members and healthcare and community-based services. CHWs must connect to and communicate effectively with patients and community members as well as with health providers. To assist with prevention and management of chronic disease, they need to listen actively and relate well to people. CHWs must also be familiar with several computer programs, including the use of electronic health records, which assist in communicating as well as sharing resources and information with individuals, communities and healthcare providers. Despite the fact that some CHWs have no college experience, the required skill set is comparable to many occupations that require college degrees and beyond. Because CHWs are key to assuring that marginalized or vulnerable community members have access to or use healthcare resources available to them, they also must often be able to translate, educate, provide support, and advocate for individuals as well as assess community health needs.

Community Health Worker Core Consensus (C3) Project (2016) provides a list of skills and detailed subskills required of CHWs. Those skills include: communication; interpersonal and relationship building; service coordination and navigation; capacity building; advocacy; education and facilitation; individual and community assessment; and outreach.

We also looked to the O*NET Resource Center to examine the most important skills that they identify what a CHW needs to possess to do his or her job, in order to compare wages of workers with these same sets of skills. O*NET, developed through the U.S. Department of Labor's Education and Training Administration, provides detailed information on over 1000 occupations, including the kinds of knowledge, skills and abilities required. The specific set of the most important skills assigned to CHWs include:

- Active Learning
- Active Listening

- Coordination
- Critical Thinking
- Reading Comprehension
- Service Orientation
- Social Perceptiveness
- Speaking

This specific bundle of skills is shared with several other occupations. This includes many types of nurses and several types of doctors. Predictably, it also includes educators and mental health professionals. Not as immediately evident, this bundle of skills is also required of administrators and managers, supervisors of emergency personnel, clergy and coaches. Table 2 provides an illustrative list of detailed occupations that rank this skill set as highly important.

Table 2: Detailed Occupations that Share High Ranking in Importance Skill Set with CHWs

Detailed Occupation	Median Hourly Wage[(1)]
Clergy	$ 28.32
Clinical Nurse Specialist	$ 40.58
Education Administrators, Elementary and Secondary School	$ 49.83
Emergency Management Directors	$ 34.80
Financial Managers, Branch or Department	$ 58.46
First-Line Supervisors of Office and Administrative Support Workers	$ 28.54
Municipal Fire Fighting and Prevention Supervisors	$ 39.00
Neurologists	$ 90.47
Nurse Practitioners	$ 54.78
Psychiatrists	$ 83.85
Sales Managers	$ 63.82
Special Education Teachers, Middle School	$ 32.28
Sports Medicine Physicians	$ 90.47

[(1)] Median hourly wages are in 2016 $ for Massachusetts

Method: Using the O*NET database on skills by occupations, the top eight most important skills for CHWs were matched to all other occupations. The list of occupations above is an illustration of the types of occupations that have the same eight skills among their most important.

Further the sets of personal characteristics that O-NET provides that will affect how well someone can perform the job of a CHW include dependability, integrity, cooperation, adaptability/flexibility, and independence. And while these traits are important, they are also very hard to measure and as such may not be fully remunerated.

CHW Role is a Unique Contribution to Patient-Centered, Team-Based Care

Primary care settings are shifting to a patient-centered, team-based care model. These settings call for the unique contribution of CHWs in addressing the social and economic determinants of health. For example, because of their shared lived experience, CHWs may know why patients might not be able to adhere to providers' instructions, including being able to afford prescribed medications or specific diets, and then work with patients and other care providers to address these barriers. CHWs will see a greater demand for cultural mediation as it is translated into practice among clinical staff. The non-clinical role

of the CHW enables facilitates more effective clinical interventions. CHWs will also be called upon to do more technical work in terms of insurance enrollment and using Health IT systems.

Patient-centered, Team-based Care
Patient-centered, team-based care requires a cultural shift within healthcare settings. In the past, care was organized around the provider; now practices are shifting to team-based care where healthcare professionals work collaboratively to meet the needs of patients, families and communities. Team-based care is expected to improve patient experience and lead to better health outcomes. One particular challenge in setting up a practice based on team-based care is defining roles for each healthcare professional. This has been challenging for all those involved, including CHWs, especially as their role in the healthcare setting is expanding.

Expanded Roles for CHWs on a Care Team[1]

- Provide guidance on service delivery within the care team.
- Collect data and conduct assessments, which had traditionally been done by clinical staff, in a culturally competent manner.
- Build bridges between a community's cultural norms and the healthcare services available to them.
- Provide in-person assistance for enrolling in health insurance.
- Utilize Health IT systems to improve coordination with the care team.

There is Preliminary Evidence that the CHW Role Enhances Accountable Care Organization (ACO) Goals
CHWs' direct work with patients to educate them and promote prevention and management of chronic disease has led to improved health outcomes, according to the Centers for Disease Control and Prevention. These positive outcomes align with the goals for Accountable Care Organizations (ACOs). Additionally, the work of CHWs has resulted in cost savings by reducing hospital readmissions and unnecessary emergency room visits (Islam, et al., 2015).

An ACO is an administrative and service delivery model designed to provide a system of coordinated care by grouping together doctors, hospitals and other providers. The two primary goals of an ACO are to improve health outcomes and reduce healthcare costs. The ACO model puts emphasis on preventative care, population health, management of chronic disease, and the social, economic and environmental determinants of health.

The Patient Protection and Affordable Care Act (PPACA) recognizes CHWs as an important health occupation for reducing costs and improving health outcomes. There is some evidence available that links the contribution of CHWs to cost savings and improved health outcomes that include:[2]

- Reductions in spending for Medicare and Medicaid populations
- Improved clinical outcomes, including glycemic control and medication adherence
- Improved health outcomes by assisting with chronic disease management and prevention
- Increased insurance enrollment among the uninsured
- Reduced hospital readmissions and emergency room visits resulting in cost savings

[1] Islam, et al., 2015; Payne, et al., 2017.
[2] Balcazar, et al., 2011; Felix, et al., 2011; Islam, et al., 2015; Massachusetts Department of Public Health, 2015; and the National Center for Chronic Disease Prevention and Health Promotion, 2015.

- Improved birth outcomes and maintaining child wellness

Wages and Employee Turnover

Turnover can be costly for employers in terms of hiring and training costs but in direct care situations it can also negatively affect the quality of care. Data on turnover among CHWs is scarce. However, we do know that a substantial portion of CHWs is relatively new to the field in Massachusetts. The Massachusetts Statewide CHW Workforce Surveillance Survey found that 40% of respondents indicated that they had been a CHW for fewer than three years. At the other end, a smaller share is highly experienced, with 22% indicating they had been doing this work for 11 years or more; this suggests a high level of turnover in the profession.

Other data on frontline healthcare workers on the lower-end of the wage scale find that turnover is high. For example, using national survey data from the Census Bureau in 2005 and 2006, Smith and Baughman (2007) look at female direct care workers (hospital aides, nursing home aides and home health aides) who are employed in the same occupation over the year. They find 60% stayed in their occupation, while 33% switched occupations and the rest left the labor force. A study of community mental health workers among 42 mental health agencies in Ohio found a turnover rate of 26% of workers in 2011, with agencies with higher pay and smaller size having lower rates (Bukach et al. 2017).

Turnover costs to employers include those associated with advertising, interviewing, vetting, and training new employees with the sets of skills required to perform the job. One particular quality that CHWs bring, and is hard to replace, is the specific relationships with patients and communities that are built over time. One important goal of integrating CHWs into the health delivery system is to enhance the team's capacity to reach the most vulnerable and hard-to-reach populations; high turnover rates make this more difficult. There can also be costs associated with productivity losses and compromised patient outcomes when experienced care workers leave the field and disrupt the continuity of care provided among a team of healthcare providers (Seavey 2004). One systematic review found that high levels of turnover of nursing home staff was associated with decreases in the quality of patient care (Bostick et al. 2008).

Studies that look at turnover of direct care workers find a variety of factors contribute to voluntary quitting or expressing intention to leave, including burnout, job dissatisfaction, inadequate supervision, lack of career advancement, other employment opportunities, and pay (e.g. Hayes et al. 2012). At the same time, care workers often enter their profession because they are committed to serving those they care for and this devotion makes some workers reluctant to leave, which is one reason why employers pay them less than their skills levels or value of their work are worth (Folbre 2002).

Together, studies on healthcare support workers, like CHWs, suggest that pay levels commensurate with skills provided, in addition to other workforce supports mentioned above, may help reduce the level of turnover in the profession, especially in relationship to how CHWs are integrated into care teams and see their work as valued.

Conclusion

Increasingly healthcare services are being seen as best provided by teams of providers that bring varied and complex sets of skills. Further, creating the social and physical environments that allow for good health are viewed as critical ways to reduce health disparities and improve short and long-term health outcomes. Community health workers, by the nature of their work, provide an invaluable link in understanding and navigating the social and economic determinants of health for under-served and

vulnerable populations as part of a larger, comprehensive healthcare team. And despite their vast skill set and personal attributes, CHWs receive considerably lower pay than those in occupations that require the same sets of skills. Additionally, CHWs with families to support likely do not earn a living wage. The CHW skill set is only growing in importance as they are integrated into patient-centered care teams and are seen as an important component of the work of accountable care organizations. Massachusetts can anticipate an increased demand for CHWs, which is only made higher by large turnover rates of low-paid direct care workers.

In order to maintain and attract CHWs, the evidence provided in this brief all points to the need for boosting wages for CHWs in Massachusetts.

SOURCES

Balcazar , Hector, E. Lee Rosenthal, J. Nell Brownstein, Carl H. Rush, Sergio Matos, and Lorenza Hernandez. (2011). "Community Health Workers can be a Public Health Force for Change In the United States: Three Actions for a New Paradigm" in *American Journal of Public Health*, 101(12):2199-2203.

Bukach, A. M., Ejaz, F. K., Dawson, N., & Gitter, R. J. (2017). Turnover among Community Mental Health Workers in Ohio. *Administration and Policy in Mental Health and Mental Health Services Research*, *44*(1), 115+. Retrieved from http://link.galegroup.com.ezproxy.lib.umb.edu/apps/doc/A477104828/HRCA?u=mlin_b_umass&sid=HRCA&xid=90e9268b

Bostick, Jane, Marilyn J. Rantz, Marcia K. Flesner, C. Jo Riggs (2008)Systematic Review of Studies of Staffing and Quality in Nursing Homes**,** Journal of the American Medical Directors Association , Volume 7, Issue 6, 366 - 376

Community Health Worker Core Consensus Project. (2016). "The Community Health Worker Core Consensus (C3) Project: 2016 Recommendations on CHW Roles, Skills and Qualities." http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/chw/c3_project_brief_roles_and_skills.pdf, accessed 2/15/18.

Castle, N. G., & Engberg, J. (2005). Staff turnover and quality of care in nursing homes. Medical Care, 43(6), 616-626.

Centers for Medicare and Medicaid Services. (2017). Accountable Care Organizations at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/, accessed 1/5/18.

Commonwealth Corporation and Centers for Labor Markets and Policy, Drexel University. (2016). "Characteristics of Workers and Jobs in the Massachusetts Health Care Industry." Prepared for the Commonwealth of Massachusetts, Office of the State Auditor.

Felix, Holly C., Glen P. Mays, M. Kathryn Stewart, Naomi Cottoms, and Mary Olson. (2011). "The Care Span: Medicaid Savings Resulted when Community Health Workers Matched Those with Needs to Home and Community Care" in *Health Affairs*, 30(7):1366-74.

Folbre, Nancy. 2002 *The Invisible Heart: economics and family values*. NYC: The New Press.

Hayes, Laureen J. Linda O'Brien-Pallas, Christine Duffield, Judith Shamian, James Buchan, Frances Hughes, Heather K. Spence Laschinger, Nicola North, Nurse turnover: A literature review – An update International Journal of Nursing Studies, Volume 49, Issue 7, 2012, pp. 887-905.

Islam, Nadia, Smiti Kapadia Nadkarni, Deborah Zahn, Megan Skillman, Simona C. Kwon, and Chau Trinh-Shevrin. (2015). "Integrating Community Health Workers within Patient Protection and Affordable Care Act Implementation" in *Journal of Public Health Management Practice*, 21(1):42-50.

Massachusetts Department of Public Health. (2015). "Achieving the Triple Aim: Success with Community Health Workers." March 2015.

Massachusetts Department of Public Health Community Health Worker Advisory Council. (2009). "Community Health Workers in Massachusetts: Improving Health Care and Public Health." December 2009. http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/legislature-report.pdf, accessed 2/15/18.

Massachusetts Institute of Technology. (2018). "Living Wage Calculator." http://livingwage.mit.edu/, accessed 2/15/18.

National Center for Chronic Disease Prevention and Health Promotion. (2015). "Addressing Chronic Disease through Community Health Workers." April 2015.

Office of Survey Research, Center for Health Policy and Research. (2016). Massachusetts Statewide CHW Workforce Surveillance Survey. PowerPoint Presentation, Massachusetts Department of Public Health and the University of Massachusetts Medical School.

O*NET OnLine. (2017). Summary Report for Community Health Workers. https://www.onetonline.org/link/summary/21-1094.00, accessed 01/17/18.

O*NET Resource Center. (2016). O*NET 22.1 Database. Sponsored by the U.S. Department of Labor at https://www.onetcenter.org/.

Payne, Julianne, Sima Razi, Kyle Emery, Westleigh Quattrone, and Miriam Tardif-Douglin (2017). Integrating Community Health Workers (CHWs) in Healthcare Organizations in *Journal of Community Health*, 42:983-990.

Schottenfeld, Lisa, Dana Petersen, Deborah Peikes, Richard Ricciardi, Hannah Burak, Robert McNellis, Janice Genevro. (2016). "Creating Patient-Centered, Team-Based Primary Care." Prepared for the Agency for Healthcare Research and Quality, U.S. Department of health and Human Services, March 2016.

Seavey, Dorie 2004 The cost of Frontline Turnover in Long-Term Care. Institute for the Future of Aging Services. Retrieved at http://www.leadingage.org/sites/default/files/Cost_Frontline_Turnover.pdf, January 10, 2018.

U.S. Census Bureau. (2018). Quickfacts Massachusetts. https://www.census.gov/quickfacts/MA, accessed 1/9/18.

U.S. Department of Labor, Bureau of Labor Statistics. (2017). Occupational Outlook Handbook. "Health educators and Community Health Workers." https://www.bls.gov/ooh/community-and-social-service/health-educators.htm#tab-6.

U.S. Department of Labor, Bureau of Labor Statistics. (2016). Occupational Employment Statistics – May 2016 Occupational Employment and Wage Estimates, Massachusetts.

University of Massachusetts Medical School, Center for Health Policy and Research (2016). Massachusetts Statewide CHW Workforce Surveillance Survey: Report of Baseline Survey Results, unpublished powerpoint.