

Strengths, Challenges, & Opportunities for Kansas Community Health Workers

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Strengths, Challenges, & Opportunities for Kansas Community Health Workers

Executive Summary

As part of its commitment to health equity for all Kansans, the United Methodist Health Ministry Fund commissioned research to better understand the role community health workers (CHWs) play in Kansas' health care system. The research, summarized in the following report, included a literature review, stakeholder focus groups and interviews, and an environmental scan of other states. Findings from the stakeholder focus groups and interviews expanded previous reports, and the results from the workforce study deepened the understanding of CHWs. **The study found that integrating CHWs into care teams results in better and more appropriate access to health care, improves health outcomes, addresses gaps and equity issues in our fragmented health care system, and delivers strong return on investment at both the organization and systems levels.** The report also found that systems questions – payment and credentialing – must be addressed in order to bring the benefits of CHWs to more patients and communities over the long run.

CHWs provide Diverse Services in Diverse Locations and have Diverse Backgrounds and Experiences. CHWs emerged as a profession in response to local needs. CHW staff and volunteers provide a variety of services in organizations and settings throughout urban and rural areas of Kansas. The current report highlights the growing breadth and depth of the CHW profession. Findings suggest that the profession is becoming more diverse in many ways, including services provided, education and/or training received, populations served, and the settings in which they serve. Such diversity is a strength as CHWs work to meet local needs.

Evidence of the Benefits of CHWs. A growing number of research studies and anecdotal examples suggest that CHWs provide: (1) financial return on investment, (2) improvements to health outcomes, and (3) support toward creating greater and appropriate access to healthcare services. Continued documentation of such benefits will add to a growing body of literature advancing knowledge and support of the role of CHWs.

- **Return on investment.** Comparatively speaking, CHWs represent a low-cost approach to extending the health and social supports provided by traditional health and human service providers. If CHWs can help alter their clients' or patients' use of higher cost services and supports, they can save the organization and the system unnecessary costs. It should be recognized that CHWs are part of a continuum of care – not a replacement for other services or therapies. Kim et al. (2016) found that integrating CHWs into the health care delivery system was associated with cost-effective and sustainable care.
- **Health outcomes.** Research shows that when CHWs work with clients and patients, their physical or mental health improves. A clinical trial in Philadelphia, PA targeted residents living in high-poverty neighborhoods who had two or more chronic diseases, such as diabetes, obesity, tobacco dependence, or hypertension. The individualized design of the trial led to improved chronic disease control, mental health, quality of care, and hospitalizations (Kangovi, 2017).
- **Healthcare accessibility.** Accessing healthcare can be a challenging and overwhelming process. CHWs act as a bridge to the formal healthcare system for their communities, especially for individuals who often avoid preventative and routine care or only access healthcare for emergencies. Blue Cross and Blue Shield of Minnesota Foundation found that CHWs bridge the gap between communities and health/social service systems by building individual and community capacity, advocating for individual and community needs, providing direct services, promoting wellness by providing culturally appropriate health information to clients and providers, and assisting in navigating the health and human services system (2010).

Community Health Worker Recognition. The field and practice of CHWs is complicated, in part, by their nontraditional positions being embedded in traditional health and human service systems. While those employers that include CHWs as part of their staff recognize their contributions, many have reservations about the positions due to a lack of formalized training and licensing. Recommendations from the literature for developing the CHW workforce include “professional identity” campaigns to promote awareness of CHWs and their benefits, developing networks or groups for CHWs to connect and develop the workforce, establishing guidance for evaluation research on CHWs, and using evaluation studies to shape policy for implementing CHWs into the healthcare system (Alvillar, Quinlan, Rush, & Dudley, 2011; Balcazar et al., 2011; Rosenthal, et al., 2010).

Funding for CHW Positions. CHW positions have traditionally been funded or supported through third party grants or contracts. While such options are available and useful, additional sustainable funding options are necessary for advancement of the CHW model. More sustainable funding options discussed by participants include Medicaid expansion, service reimbursement strategies, and other innovative and unique payment ideas. Integrating CHWs into a care team can also create new possibilities for funding. Through Medicaid, bundled payments or capitated rate structures may be possible when CHW services are integrated with other similar services (Lapidos et al., 2019).

Expanding the CHW Profession. There is currently not a well-defined career path for those interested in becoming a CHW nor are there clear opportunities for advancement in the CHW workforce. Emphasis on standardizing education and training, providing continuing education options, and outlining possibilities for additional advancement within health and human service organizations could support the expansion of the profession. Standardization of the profession creates a well-defined scope of practice with core competencies needed to do the job and provides opportunities for ROI through sustainable funding mechanisms for the profession (i.e., Medicaid reimbursement) (Rosenthal, et al. 2010; Alvillar et al., 2011). However, Gilkey, Garcia, and Rush (2011) argue that certification could create a divide between CHWs and their clients by requiring traditional professionalization. In either case, continuing education and compensation need to be considered in relation to establishing career advancement opportunities for those who wish to pursue them.

To ensure long-term success, broader implementation and sustainability of CHWs in Kansas, the report also highlights crucial steps that need to be taken to recognize the profession and to establish sustainable funding for CHWs, including:

- **Continue to collect data to demonstrate value:** work with CHW employers to document the return on investment CHWs provide from both a health and economic standpoint. This data is critical to building the case for long-term support of CHWs.
- **Demonstrate non-monetary value:** CHWs improve the trust between patient and provider as well as help address the social determinants of health for their patients/clients. Helping employers, providers, policymakers and payers understand the breadth of services CHWs can provide and the value of those services will help to better maximize the utilization of CHWs.
- **Standardize education and training:** Developing a certification process that provides a baseline level of education and training for those working as CHWs is needed for the profession’s sustainability and career pathways for CHWs interested in future opportunities.
- **Explore alternative funding:** CHW funding is largely dependent on grant funding, which is not sustainable for the long term. Establishing more sustainable funding through sources such as Medicaid/Medicare, service reimbursement, bundled payment options, and opportunities for cost sharing and other partnerships is critical to sustaining the profession going forward.

Introduction

The United Methodist Health Ministry Fund (UMHMF) partnered with Wichita State University's Community Engagement Institute (CEI) to expand research and evaluation support for the identification and defining of the Kansas Community Health Worker (CHW) workforce by gathering data to explore:

- How are organizations utilizing CHWs?
- Where are CHWs working? In what types of organizations and in what parts of the state?
- What are the current needs of CHW employers and/or of organizations utilizing CHWs?
- What recommendations do these organizations have for future initiatives concerning CHWs?

A Kansas Community Health Worker Workforce Assessment was conducted in 2016 and in 2018. These two assessments involved surveys of CHWs and employers of CHWs to learn more about where CHWs are employed, what types of services they provide and to whom, what training or education they have received and/or are interested in receiving, and the challenges they encounter in doing their work. This project is intended to expand upon what has been learned through these previous CHW Workforce Assessments by outlining additional characteristics of the CHW field including: location of CHWs in the state, scope of practice, type of employers, sources of funding, credentials, education and training, employers' perceived value and relevance, and to highlight future opportunities for the field.

Community health workers (CHWs) go by a variety of names, such as health navigator, promotor(a), advocate, and educator, but their important function remains the same regardless of their title: to serve as a bridge between community members and the medical and social services they need. CHWs engage in a variety of activities, such as providing assistance or guidance to community residents, culturally or linguistically appropriate education services, advocacy, coordination of care, and insurance enrollment (Brooks et al., 2014).

Historically, CHWs have been used in the United States since the early 1960s and have since expanded to provide more comprehensive services to various populations (HRSA, 2007). State and federal legislation, including the Affordable Care Act, have identified more specific roles for CHWs and have allowed for the funding of these types of services (Brooks et al., 2014). While there are numerous definitions of CHWs, this study has adopted the following definition from the American Public Health Association (2016):

A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.

CHW programs are beneficial in reducing health disparities for marginalized populations. Additionally, CHWs help with overall population health, enhance quality of care, and reduce the cost of medical services (Brooks et al., 2014). While CHW positions are often similar to other traditional medical services, CHW work settings and responsibilities provide a different scope of practice. The range of services a CHW provides varies by community, as local needs often determine the role of this workforce.

KANSAS CHW COALITION HISTORY

Through support and funding from the Kansas Department of Health and Environment (KDHE), CEI helped launch the Kansas Community Health Worker Coalition in 2016. Since then, CEI has operated as the backbone support for the coalition. This includes but is not limited to activities such as meeting scheduling and facilitation, support for the executive committee and four subcommittees, basic research and evaluation, and assistance in planning and executing the annual Community Health Worker Symposium. CEI also convenes a KDHE workgroup quarterly that spans multiple bureaus and programs at the state level. CEI staff represent the CHW Coalition in meetings and presentations across the state as needed. CEI believes in the value and impact of CHWs. Involvement and support since the beginning of the statewide CHW Coalition places CEI in a critical role to continue developing and supporting Kansas CHWs.

Methods

CEI utilized primary and secondary data to describe the current landscape of CHWs in Kansas. This report outlines the current characteristics of the CHW field, including information such as location of CHWs, scope of practice, type of employers, sources of funding, credentials, education and training, employer perceived value of relevance, and other relevant information.

This project utilized current workforce assessment survey data (summarized in Appendix A), data from KDHE funded projects such as the Kansas CHW Workforce Assessments, and primary data from focus groups and key informant interviews conducted with employers, philanthropies, and other CHW stakeholders.

FOCUS GROUPS AND INTERVIEWS

Staff from Wichita State University's Community Engagement Institute (CEI) developed protocols for the interviews and focus groups conducted for this project. Questions focused on employment and/or volunteer opportunities within individual organizations, funding sources, types of services provided by CHWs, benefits to organization due to CHW services, the populations CHWs serve, health issues CHWs encounter, any social needs or social determinants of health addressed by CHWs, CHW education or training required, and the current needs of the CHW workforce. Participants also answered questions addressing their hopes for the future of the CHW workforce, both within their organization and as a field, and their ideas for increasing both the size and capacity of the CHW workforce. The questions were designed to capture the unique contributions of this workforce in the Kansas healthcare and social service systems.

LITERATURE REVIEW

A literature review was conducted in order to build on the qualitative research methods undertaken as part of this work and to relate the findings to existing knowledge about CHWs and CHW programs. The review focused on five main topics: education and training, using CHWs in innovative ways, CHW value, CHW funding, and CHW integration into healthcare, mental health, and/or behavioral health care teams. Throughout the report, callout boxes “Looking to the Literature” highlight relevant literature as it relates to certain qualitative findings. For a full summary of the literature reviewed, please see Appendix C.

FOCUS GROUP PARTICIPANTS

Focus group participants included a variety of CHW employers and potential employers. About half of the organizations that participated in a focus group either currently employ CHWs or have employed them previously. Several of those that did not currently employ CHWs indicated that they plan to or would like to do so in the future. Several organizations have a large volunteer base of CHWs who are known as Promotoras de Salud (PdS).

Three focus groups were conducted in different locations across the state (Manhattan, Kansas City, and Wichita) with a total of 46 participants. Participants included representatives from healthcare facilities, Federally Qualified Health Clinics, health departments, rural and urban hospitals, federally funded programs, and professional associations. A full list of participating organizations is available upon request.

INTERVIEW PARTICIPANTS

Interviews were conducted with representatives from three foundations that are part of Kansas Grant Makers in Health. All three organizations were either currently funding CHW-related initiatives or have funded them in the past, specifically focusing on funding infrastructure support and/or CHW program startup costs. In general, CHWs funded by Kansas organizations focus on health equity, health outcomes, and health promotion, with the goal of closing service and needs gaps by connecting patients/clients to necessary services.

INTERACTIVE CHW PROGRAM MAP

CEI has developed an interactive map to demonstrate where CHW programs are located and have CHWs serving across Kansas. This map is soon to be launched on the Kansas CHW Coalition website at <https://kschw.org>. The map will be available to the public and will feature items including organizations with CHWs serving in each county, types of populations served, and services provided.

INDIVIDUAL CHW DIRECTORY

The individual CHW directory will be available to CHWs who are members of the Kansas CHW Coalition via the log-in portion of the website (<https://kschw.org>). When creating their own account, individual CHWs are able to choose what personal information they wish to have shared in the directory. The Kansas CHW Coalition has elected to allow only CHWs to have immediate access

to the directory for the purposes of contacting one another. CHW stakeholders will still need to locate and contact the CHW programs if they desire to get in contact with an individual CHW.

ENVIRONMENTAL SCAN OF OTHER STATES

CEI staff evaluated other states' strategies and pathways to credentialing, reimbursement, alternative funding methods, and identifying benefits to utilizing CHWs (found in Appendix B). Recommended actions based on approaches identified as helpful to Kansas CHW credentialing or payment modes are included in this report.

Findings

WHAT IS A COMMUNITY HEALTH WORKER?

For the purposes of this research, a community health worker was defined as a frontline public health worker who is also a trusted community member and/or is a person who deeply understands the community being served. The CHW is able to leverage this trust to serve as a liaison or intermediary between health and social services in the community, facilitating access to services and improving the quality and cultural competency of service delivery. A CHW helps build individual and community capacity to improve health outcomes via outreach, community education, informal counseling, social support, and advocacy.

OTHER NAMES FOR CHWS IN KANSAS	
Community Health Advisor	Home Visitors
Community Health Advocate	Patient Navigator
Community Health Educator	Promotores
Community Health Representative	Promotora de Salud
Health Navigator	Senior Companion
Health Promoter	Outreach Worker
Peer Educator	Care Guide

What is the difference between a care coordinator and a CHW?

While at first glance care coordinators and CHWs may appear to provide similar services, there are a few key differences between the two, the biggest of which is that care coordinators are not necessarily from the community they serve while CHWs are chosen because of their connection to the community. Care coordinators generally provide services via telephone while CHWs often meet with their clients in person. Both care coordinators and CHWs can assist with appointment making and reminders as well as with coordination of services. Care coordinators can provide advice on how to navigate systems while CHWs can go with clients to help directly address barriers to care and serve as an advocate for their clients. Care coordinators do not typically offer educational or client empowerment opportunities while CHWs do. CHWs also tend to provide more assistance with

other life issues related to the social determinants of health (e.g., transportation, child care, utilities, housing, etc.).

WHO ARE COMMUNITY HEALTH WORKERS?

What additional titles or terms are used to describe the job of community health workers?

As mentioned previously, the term “community health worker” is not always the title used to describe individuals who do CHW-like work. Other terms or titles include, but are not limited to clinical care coordinators, outreach coordinators, case managers, peer educators, and Promotoras de Salud (PdS). While they may not be referred to as community health workers, employers reported valuing the characteristics of employees whose word matches more closely with CHWs than with traditional care coordinators or case managers, noting that CHWs are usually trusted members of the communities they serve and can therefore better identify and connect with their patients/clients.

Where are community health workers employed?

Unlike other health related professions, CHWs do not need to be based out of health and social service facilities. While some CHWs serve in clinics, hospitals, health departments, and social service facilities, others are housed in faith-based organizations, neighborhood associations, or schools. In addition, some Emergency Medical Service (EMS) Systems are employing a similar profession called community paramedics. In these settings, the EMS reimbursement structure is modified so that payment is received regardless of patient transport, which allows for greater access to necessary care, including CHW services.

WHO DO COMMUNITY HEALTH WORKERS SERVE?

CHWs often, but do not exclusively, serve people who are underserved or otherwise disadvantaged for a variety of reasons. Some of the communities served by CHWs represented in this project include:

- Refugees
- Immigrants
- African Americans
- Hispanic or Spanish speaking populations
- Low-German speaking populations
- Elderly and aging populations
- Individuals who are homeless
- Specific communities of faith
- Patients who are newly diagnosed with a chronic condition or terminal illness

CHWs often reach these underserved individuals through targeted outreach and community events. They are able to work with patients outside the clinical environment, in places where patients might feel more comfortable – in their homes, in places of worship, or other non-clinical settings.

WHAT DO COMMUNITY HEALTH WORKERS DO?

Educate Clients/Patients

Most CHWs provide some form of education to address patient/client understanding. This can cover health-related topics such as diabetes management, chronic disease management, prenatal education, or even how to make healthier choices by engaging in exercise and physical activity. They may provide nutritional education to families, instruction on how to utilize social services through their local health departments (such as WIC), and connection for caregivers to obtain additional information or services as needed. CHWs are able to provide culturally appropriate health education and model healthy behaviors for their patients/clients.

Help with Compliance and Follow-up

CHWs help their clients make appointments (for medical and non-medical services) and provide appointment reminders. CHWs can determine whether their clients are going to their health appointments, and if they are struggling with attendance, CHWs can then help identify barriers and assist in removing or overcoming them.

CHWs accompany clients to doctor's appointments and help them navigate large treatment facilities. While some providers and/or clients prefer not to have CHWs in the exam or behavioral health appointment rooms, most appreciate the cultural liaison and interpretation services provided by the CHW.

CHWs also assist with client goals and provide guidance on adherence to medication and treatment guidelines. Medication and treatment guidelines are often complex and not easily understood by the client/patient. CHWs are skilled at navigating this complexity with patients through their relationships and understanding of a shared cultural community.

Some healthcare providers said they are more likely to rely on a nurse or a social worker, rather than a CHW, for patient education, follow-ups, and referrals. In part, they are more accustomed to relying on social workers and nurses. Some providers shared that they are uncomfortable working with individuals who are not licensed or trained. Conversely, one doctor at a Federally Qualified Health Clinic said he considers the CHW an extension of himself. Overall, focus group participants noted that awareness needs to be raised among providers that CHWs could potentially alleviate the burden of work on nurses and social workers, allowing them to practice more efficiently.

Provide Medical Services

While most CHWs do not provide medical services, those who do commonly provide blood pressure checks, blood sugar screenings, and have conversations with clients about the importance of preventative care appointments and screenings. One group of CHWs has started doing biometric screenings and has found there is interest and enthusiasm among CHWs around these screenings.

Increase Access to Care

The health foundations interviewed talked about how, as funders, they do not typically pay for direct services or medical equipment; they focus on increasing access to oral, behavioral, and health care.

They believe that the CHW profession matches well with that focus as CHWs help specific populations gain access to care they might not otherwise receive. One funder noted that CHWs act as a “cultural broker” for the community they are serving, providing needed interpretation and bridging access to services.

Refer to Additional Services

CHWs provide a link between primary care providers and other services, as CHWs are able to provide referrals to services that healthcare providers normally do not have the time to address. Many CHWs utilize 2-1-1 through United Way, referring to food banks/resources, housing, transportation, financial assistance, landlord problems, bed bug infestations, and local health department services, among others. In addition, CHWs are able to follow-up on whether clients were able to receive additional services from these referrals. Follow-up may reveal client frustrations and offer opportunities for CHWs to continue exploring other options for their clients. This is especially true for uninsured and underinsured clients.

CHWs who have access to electronic medical records (EMRs) are able to keep notes on what social services clients/patients are connected to, and through this shared documentation, providers can see and address these during visits. The referral systems across the entire CHW workforce are not consistent, and there is currently no formal connection between CHW programs. While referrals to services are tracked in individual programs, these programs do not share information with one another. Increased referral tracking and a system or process by which to share referral information among CHWs could be beneficial going forward.

Address Social Determinants of Health/Social Needs

Focus group participants mentioned that due to the intimate relationship established between CHWs and patients, they often have access to patients’ families. They can assess their homes and gain a broader understanding of factors that might contribute to poor health. As a result, most CHWs are working to address patients’ life issues, including assessing qualification for additional services, facilitating access to additional services and resources, and identifying the cultural barriers present in various circumstances. The list below describes some of the social needs addressed by CHWs that were mentioned by focus group participants:

- Signing up for a bank account
- Sharing locations for food bank and food pantry resources
- Maintaining or getting utilities restored (e.g., water, sewer, electricity, etc.)
- Obtaining free or reduced cost transportation, local transit, ride sharing, and/or bicycles
- Providing emotional and psychological support for people who are homebound
- Assisting with home maintenance or facilitating connections to those who can (e.g., heating ventilation and air conditioning, water heater, wheelchair ramp, etc.)
- Addressing language and cultural barriers between health and social service systems and the community they are serving

Social isolation can be detrimental to individual health. A participant shared that often one of the most important things a CHW can provide is a sense of community or connection for people who may feel otherwise isolated. Whether it be social isolation or another concern, after the primary

social needs are met, CHWs can assist with addressing other needs. Some of the additional needs CHWs address include:

- Accessing services in other towns when a patient lives in a small county or town
- Facilitating access to free or low-cost health, dental, and/or mental health care
- Identifying adverse childhood experiences (ACEs)
- Linking caregivers of patients/clients to counseling services
- Assessing patient/client for qualifying services and assisting with completion of required paperwork to access those services (e.g., enrollment for Supplemental Nutrition Assistance Program (SNAP), KanCare waivers)

One focus group participant shared an example of how addressing social needs led to addressing additional needs. A CHW had a patient who was wheelchair-bound and did not have a ramp to their front door that would allow them to easily leave the home. The CHW arranged for a ramp to be built, which then allowed the individual to better access needed services (improving physical health) and to better integrate into the community (improving mental health). Another participant stated, “By addressing the biggest or first [social] need an individual has can eliminate stress.”

Interviews with foundation staff also highlighted the role of CHWs in addressing social needs and social determinants of health. Most funded CHW programs focus on health equity, health outcomes, and health promotion work. Interview participants noted that CHWs work to provide needed services identified by their client by removing barriers or increasing access to those services. Some connections that CHWs help make, as mentioned during the focus groups, included facilitating access to transportation, housing support, childcare, food banks/pantries, vision care, and enrollment into insurance or other medical programs. One participant said, “Pushing someone to go to the doctor regularly is not going to solve all of their health problems if they are living in poverty, have bad housing, are unemployed, etc.”

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Looking to the Literature: What CHWs Do

CHWs in Philadelphia, PA applied a clinical trial targeting residents living in high-poverty neighborhoods who had two or more chronic diseases, such as diabetes, obesity, tobacco dependence, or hypertension (Kangovi, 2017). This specialized design included a single-blind randomized clinical trial where patients each set a disease management goal and were assigned to individual CHWs who provided six months of support tailored for the participant's goals. This individualized design led to improved chronic disease control, mental health, quality of care, and hospitalizations, showing this could be a useful approach for population health management in healthcare systems. CHWs in New Mexico delivered an intervention specifically aimed at addressing problems with underemployment, inadequate housing, food insecurity, and violence among primary care patients with depression (Waitzkin et al, 2011). These CHWs focused on helping patients resolve contextual problems that they identified to be likely contributing to the patient's depression by connecting them to useful local resources they were otherwise unfamiliar with. While their intervention improved conditions overall for the four highlighted areas, it was ultimately unsuccessful at significantly impacting depression directly. With that said, the intervention still provides useful insights regarding targeting specified needs of underserved local communities.

WHAT ARE NEW AND INNOVATIVE WAYS ORGANIZATIONS ARE UTILIZING COMMUNITY HEALTH WORKERS?

Worksite Wellness

Some CHWs are providing worksite wellness services where they conduct basic health screenings, including biometric screenings, and then link employees to appropriate services. Organizations that employ CHWs could offer to provide workplace screening events tailored for specific populations employed by corporations or businesses. For example, one idea might be a CHW providing screenings in a meat processing plant for non-English speaking workers.

Health Promotion

A new health promotion series is being offered for refugee populations. Over four class sessions, people who are new to the United States learn about the American healthcare system. They learn information about the emergency room and its proper usage. Medicaid information and education are provided. They have also created a pilot partnership with Wichita State University's international group to help refugees obtain the American equivalent of their degrees. Many refugees were professionals in their home countries, with degrees from local educational institutions. One particular success story involved an individual working to get their Master's in Social Work so they

can return and provide services through this same organization. They will then be able to work as a social worker in their own communities and in refugee camps.

Unique Partnerships

A CHW organization has created a partnership with the local Chamber of Commerce to conduct outreach to businesses in order to make the public more aware of their CHW services. This project will be expanded to include places of worship in the future.

In a local community center, CHWs run programs for young teens in English as a Second Language (ESL) classes. Businesses work together to provide a mentor program for young students to go through the job interviewing process, with the goal of eventually securing a job.

A few other examples of innovative partnerships between CHWs and their employers are:

- Senior Living and Senior Services
- Neighborhood Associations
- Kansas Department of Children and Families

WHAT EDUCATION AND TRAINING DO COMMUNITY HEALTH WORKERS HAVE/RECEIVE?

Education, Qualifications, and/or Experience

As outlined in the American Public Health Association (APHA) definition of a community health worker on the association's website, CHWs need to be a trusted member of the community they are serving and have similar lived experiences. Participants stressed the importance of CHWs being able to connect through language, culture, and personality. According to employers, finding the "right" people to fill the CHW positions is the first priority, followed by equipping those individuals with the tools, training, and resources to do the job.

CHWs benefit from some knowledge of healthcare and social systems along with an understanding of how those systems can change over time. CHWs need to not only have or quickly be able to develop trust with the communities they are serving, but they also need to be able to create strong working relationships with agencies and organizations in order to procure resources for their clients/patients.

A number of employers indicated that a high school diploma is their only education requirement; however, some do not even require that. They are most careful about hiring people who can connect with and engage the community. In short, providers stated that experience trumps education. Some providers assist CHWs with obtaining their GED or high school degree equivalent.

Some employers prefer individuals with bachelors or even masters degrees; however, there was also an awareness that as an individual's level of education increases, the level of trust within in the community may decrease. With higher levels of education also comes higher levels of pay, which can make these positions more expensive to maintain. Participants agreed that the education component for

"We need to value different ways of knowing."

the CHW workforce is complicated. The Kansas CHW workforce must consider the benefits of those with formal higher education as well as those with “street smarts.” One focus group participant noted, “We need to value different ways of knowing.”

There was a strong caution among participants to not create qualifications that would potentially eliminate CHWs who are already engaged in this work. For example, if the state were to require CHWs to be citizens as is required for social workers in Kansas, then groups of current CHWs may be left out. Some organizations provide support for their CHWs to obtain citizenship so they can be hired for pay and not work solely as volunteers; however, they would not want these individuals to be excluded from this work (even as volunteers) in the meantime.

Training

Few organizations reported requiring prior training for their CHWs. The communities served by the various CHW programs are different, so the necessary training and qualifications for CHWs in those programs will be different as well. Some organizations recommended a training similar to the health navigator training provided by the Community Care Network of Kansas or obtaining a Certified Nurse Assistant (CNA) license.

Participants shared that their intention is to have CHWs be “generalists” who can then obtain specialized training when needed. For example, if individuals need to have more training about diabetes management due to patients or clients having a high prevalence of diabetes, they can then obtain that training. The goal is to offer a framework and a network to support them in their work.

Participants provided several examples of orientation training they require for CHWs. Example formats include:

- CHWs are in training for four weeks and then complete three weeks of shadowing.
- CHWs learn core competencies and develop a basic understanding of mental health principles and how to work through the Medicaid/Medicare system. This process takes several months to complete.
- CHWs complete a certificate program such as the Metropolitan Community College (located in Kansas City, Missouri) CHW certificate or Promotora de Salud (PdS) certificate.

In addition to the above basic or training orientation, topic specific trainings mentioned by focus group participants included:

- Leadership training
- Nutrition education training
- Disease prevention through healthy lifestyles
- Certified Medical Translation courses (interpretation training)
- Arizona Self-Sufficiency Matrix (to identify and address social needs/social determinants of health)
- How to complete State Nutritional Assistance Program (SNAP) and Kansas Department of Children and Families forms
- Training on different stages of life including childhood, childbearing, and aging/elderly
- Healthcare related training such as medical terminology, CPR training, and how to take blood pressure
- Behavioral health related training such as trauma informed education, motivational interviewing, and tobacco cessation training

Professional Development & Support

During interviews, funders noted that professional development was identified as a need in the CHW profession. Barriers to professional development included a lack of money to attend (virtually or in person), time allowed to attend, and actual training resources that are available for CHWs. One funder has made it a priority to provide these opportunities. These learning opportunities have been focused on inputs, outcomes, and impact areas – teaching CHWs about what they are doing, what it means, and how to determine what is next. Some opportunities include information about self-care strategies. Others include time for CHW collaboration and networking support. One opportunity encouraged CHWs to assess their individual networks or the network they tap to get services for their clients/patients. This helps them identify their support systems and the people that they can refer to in a professional network. This funding has also supported the development of toolkits that provide processes and tools for implementation of CHW programs, understanding of where and what the needs are, outlining potential indicators and measures to show impact, and how to show the potential return on investment of CHWs.

Considerations for the Future

Currently there is no well-defined or clear pathway to the community health worker profession, not only in Kansas but in other states as well. (See Appendix B.) And without a structured curriculum or recognized training program, CHWs may not ever be able to be reimbursed through Medicare/Medicaid for the services they provide. Education and training can help standardize this work as well as increase pay, secure funding, provide opportunities for advancement within the CHW role, and/or learn skills to be promoted to other positions such as care coordinators.

Looking to the Literature: CHW Education & Professional Development

Many articles note that developing the CHW workforce is an important step in integrating this workforce into the healthcare system and that training and professional development are an important means of developing this workforce (CDC, 2015; Rosenthal et al., 2010). The American Association of Diabetes Educators (2009) and the CDC (2015) recommend training on specific diseases in order to complement CHW experience and skills. Other recommendations for developing the workforce include “professional identity” campaigns to promote awareness of CHWs and their benefits, developing networks or groups for CHWs to connect and develop the workforce, establishing guidance for evaluation research on CHWs, and using evaluation studies to shape policy for implementing CHWs into the healthcare system (Alvillar, Quinlan, Rush, & Dudley, 2011; Balcazar et al., 2011; Rosenthal, et al., 2010).

WHAT IS THE VALUE OF COMMUNITY HEALTH WORKERS?

Traditionally, CHWs have not been considered part of a health or mental health care team. As more providers transition to value-based care, the interest in finding alternatives to connecting with patients and clients have led to non-traditional care approaches. “CHWs are shown to bridge the gap between communities and health/social service systems by creating individual and community capacity, advocating for client/patient and community needs, providing direct services as need, promote wellness by providing culturally appropriate health information, and navigating health and human service systems” (Blue Cross and Blue Shield of Minnesota Foundation, 2010).

Looking to the Literature: Value of CHWs

Demonstrating both cost-effectiveness and changes in health outcomes is a powerful way to demonstrate the value of CHWs. Many articles and studies demonstrate the cost-effectiveness of integrating CHWs into the healthcare delivery system (Kim et al., 2016), specifically through return on investment (ROI). Determining how CHWs have an impact on specific health indicators can be challenging. Sinai Urban Health Institute (2014) recommends linking value-added services provided by CHWs to actual health outcomes provided by other types of providers. .

Monetary Value/Return on Investment

Several organizations agreed there must be a demonstrable return on investment for employing CHWs. One CHW employer mentioned a \$250,000 per year cost savings to hire CHWs versus care coordinators. Another participant emphasized that these savings should be shown to as many organizations as possible in order to create the business case for CHWs. Participants reported that their internal organizational data suggest the CHW model is effective. Participants mentioned they have seen a decrease in hospitalizations among patients whose care is monitored by a CHW. CHWs help clients and patients by increasing their adherence to treatments. In addition, CHWs assist patients in understanding the appropriate use of emergency rooms (i.e., not visiting the emergency room for non-urgent care needs). Patient intake data and post-intervention measurements also suggest the effectiveness of the CHW model. For example, a decrease in a diabetic patients’ A1C levels over subsequent visits with a CHW might be attributed to a CHW closely monitoring their care.

Outcome Data

Most foundations do not require any reported measures, values, or return on investment other than what the applicant states in their grant agreement. Foundation interviewees mentioned there are potential ways to measure CHW benefit, such as an increase in people enrolled in preventive programs, increase in people accessing care, decrease in emergency department visits, among other things. Measurable objectives that demonstrate improved access to care or improved health outcomes would help show the benefit of the CHW position. For example, a funded organization could review the number of diabetics whose A1C is higher than 10, connect them with a CHW, and

then show that two to three years later these same patients are stable, successfully managing their diabetes, actively improving the quality of their lives, etc.

One interview participant mentioned that they support a Federally Qualified Health Clinic and provide funding for the research costs associated with measuring return on investment for CHWs and their work with clients. This FQHC currently employs CHWs, but needed assistance funding this particular research project. The funder is focused on the results of the study, and the FQHC is responsible for funding the CHW positions through other means. Other foundations could consider funding similar opportunities to look at return of investment; however, these types of research projects would likely require a funding period longer than the typical one- to three-year grant provided by most foundations.

Access to Care

Organizations stated that CHWs add value beyond monetary or clinical outcomes. Many of the comments centered around the ability of CHWs to improve access to care through the trust they have established within the community. An example shared is that CHWs help patients overcome the fear of talking with providers and build trust between patients and providers. Further, CHWs have relationships in the community that allow them to “ask difficult questions and not be seen as authoritative compliance but rather as a trusted person.” CHWs have a high level of trust that they have earned from their patients, and one healthcare provider mentioned that as a result of that trust, the advice the patients receive from CHWs improves compliance with healthcare directives. The CHW is able to communicate with community members in a culturally competent and relevant way. For example, advice and guidance patients receive through the Hispanic volunteer Promotoras de Salud (PdS) helps support families’ nutritional practices in the community. As one participant said, “It is powerful to meet them in their community.”

Patients/clients report feeling heard, having a greater sense of belonging, feeling accepted in their community, and experiencing emotional and spiritual healing as a result of working with their CHW. As they act as a cultural intermediary, CHWs help remove prejudices and increase trust between providers and patients. In addition, participants share that CHWs are able to empower patients to be more self-sufficient. Patients in turn teach other individuals in their community to navigate the healthcare system, creating a “ripple effect.”

CHWs allow practitioners and providers to be more efficient and effective. Nurses, doctors, and social workers are able to practice at the “top of their scope.” The doctor can move on to the next patient while the CHW does follow-up work. This is difficult to quantify, but suggests the potential for increases in provider productivity and efficiency. Further, the information a CHW gleans from a patient gives the provider insight they would not normally receive from their frontline contact with the patient.

With an increased interest in telehealth and telemedicine (particularly in rural communities), one employer stated, “CHWs provide something that simple telemedicine cannot – telemedicine puts a monitor between the patient and the provider, which compromises trust.” Patients have shared that

the human presence helps increase the connection and builds trust. In a culture moving toward telemedicine, “connection remains especially important among certain cultures.”

WHAT BARRIERS OR CHALLENGES ARE FACED BY COMMUNITY HEALTH WORKERS?

While CHWs work in a variety of settings and with various populations, CHWs and CHW employers report experiencing similar challenges and barriers. These include, but are not limited to, locating resources, burnout, data collection, and funding for their positions. These barriers and challenges seem to be similar across the United States.

Locating Resources

CHWs participating in the focus groups mentioned that they often find it difficult to locate the needed resources for their patients/clients. They expressed that this is especially true when CHWs are not integrated into medical or mental health systems. Alternatively, some programs start with CHWs in the clinical setting with the intention of seeing patients/clients in their homes, but in some CHW employer organizations that has not yet transpired.

Although not unique to the CHW profession, it was mentioned that availability of resources and access to those resources are also barriers. In urban places, it is often easier to find access to resources like food and transportation. One example shared was how transportation in rural Kansas can be a huge barrier given many resources are more than an hour away. In rural Kansas, it is also difficult to find resources because they are so limited. Specifically, a patient might need a caregiver, but there is a limit on reliable caregivers, even if they have the funds to pay for one.

Burnout

Employers shared that burnout is a major concern among CHWs. Funding is often reactive to the largest health and social problems. Funding is typically available to help CHWs care for those who are already sick; prevention services are not a focus in most cases. Some CHWs are known to provide preventative services, but this not the norm. It is discouraging to CHWs to know there are individuals who could benefit from their services, but they are not able to serve them.

Due to their connection with the community, CHWs are often sought out by other community partners for project support without any financial support or compensation. Employers and CHWs expressed that they want to make sure CHWs are not being taken advantage of, intentionally or unintentionally.

Data Collection

Appropriate data collection is also a barrier. Disease prevention efforts are difficult to measure among those CHW programs that provide preventative services. For example, it is difficult to state with confidence what diseases did not occur or how many hospital readmissions were avoided; however, appropriate data collection can help identify areas where prevention can be supported. Many community organizations do not currently collect this type of data. The Kansas CHW

workforce and other partners/stakeholders could help determine what impact data to collect and how best to collect it.

Funding

Currently, many rural communities do not have the finances to hire for an additional position when they struggle to maintain their already established positions. According to one participant, many Kansas hospitals are operating in a negative margin, and they hardly have the capacity to maintain staff. Larger hospitals are utilizing CHWs as they see that their bottom-line could benefit, but in rural areas, not many hospital systems are utilizing CHWs. A few organizations mentioned that they did have individuals serving in a CHW role, but they were also serving in other roles, serving as a social worker, discharge staff, or nurse, in addition to the CHW job duties.

HOW ARE COMMUNITY HEALTH WORKER POSITIONS FUNDED?

Kansas CHW programs use a small number of funding options, including state and local foundations, national grants, and project funds. Several programs operate on a revolving budget of funding that is renewed annually or every few years. These are often project specific, and the services CHWs provide are directed by the funder. Some funds are so limited that only the volunteer coordinator receives a salary, and these programs then provide deliverables through their volunteer CHWs.

Most funders interviewed do not engage in long-term, ongoing support. They will often fund an organization to start a project or program and then require the organization to find a way to sustain the position through billing opportunities, finding other funders, and/or fitting it into their operating budgets. Many organizations have to utilize multiple funding options for CHW positions because they do not have a high (or existent) reimbursement rate. Funders hope to assist with developing sustainability plans and future reimbursement strategies. Funders also would like to see more investment from employers, especially if their target or high-risk populations could benefit.

Some of the CHW programs supported by local foundations are able to use their funding more broadly, defining their own work in the request for proposal. These sometimes offer funding for travel, compensation for a newly hired CHW position, support for development and enhancement of current opportunities, and integration of CHWs into existing structures. Focus group participants shared that when CHW startup programs are funded by grants, the programs often dissolve when that funding is no longer available. This makes the maintenance of a CHW position difficult when better salaried and more stable positions are available elsewhere. Some programs see the value of the services provided to patients and prioritize maintaining their CHW positions. One participant suggested state block grant funding, where an organization might receive a specific amount of money per CHW service, as a seemingly stable source of funding.

Looking to the Literature: CHW Sustainability

Establishing sustainable funding for CHW programs can be difficult, as discussed by focus group participants. Integrating CHWs into a care team opens up new possibilities for funding. Through Medicaid, bundled payments or capitated rate structures may be possible when CHW services are integrated with other similar services (Lapidos et al., 2019).

WHAT ARE YOUR HOPES FOR THE FUTURE OF COMMUNITY HEALTH WORKERS?

Conversations about the future of CHWs seem to focus on three key areas: integration, certification, and financing/funding sustainability. These three areas, while separate, are also related to each other. Better integration into care teams along with certification/credentialing provides a clearer path to those interested in the CHW profession. In addition, integration and certification begin to build a stronger base/case for more consistent funding, which will be key to the sustainability of CHW positions in organizations.

Integration Into Care Teams

Healthcare providers shared that some CHWs are integrated into health and mental health care teams where providers refer to CHWs; however, some providers are not ready to make this change or shift to full integration. There was a perception among participants that CHWs are sometimes seen as competition for care coordinators and other clinical staff.

Typically, providers do not hear about what happens after patients are discharged, and according to employers, CHWs could help address this problem by conducting follow-up. One participant noted, “For many providers, it is more comfortable to have a nurse or social worker do patient education and follow-up.” Unaddressed needs during follow-up puts added stress on the community served, and nurses and social workers are unable to practice at the top of their scope. Some rural hospitals have a care transition team, but again, the work usually falls to nurses.

Several hospitals agreed that they have a CHW role serving in their hospital, but they do not go into patient/client homes or environments. These “CHW-like roles” are not able to help with accessing resources or addressing issues outside the hospital setting. It was mentioned that, “Hospitals are providing great care inside but admit that it would be great to see the same level of care being provided outside of the hospital walls.”

CHW Certification

Participants believe that certification for CHWs could help make a compelling case for funding support. A possible explanation is that credentialing provides formal recognition of a professional achievement. This may increase the legitimacy of the CHW profession among healthcare professionals and social workers as the training shows an individual’s ability to manage a certain level of complex systems, services, and communities.

Employers stated that some providers do not understand the capability of those in CHW roles. Many CHWs have been utilized for marketplace navigation and advice on insurance, but remain untapped for the majority of their capabilities. One question participants said needs to be answered is, “What would make providers more comfortable utilizing community health workers?” If CHWs were to receive a certification and/or licensure, perhaps this discomfort would be minimized. The caution is that, by requiring formal licensure, individuals who are not legally able to become credentialed in the United States might be left out.

Funding

Medicare and Medicaid

Several organizations mentioned that Medicare pays a limited amount toward CHW work. There is a desire for the Managed Care Organizations (MCOs) to consider reallocating some of their funding to help support CHWs. In addition to Medicare, if Medicaid is expanded in Kansas, not only would more people be eligible for Medicaid, but more employers would be able to hire CHWs.

Reimbursement Models

Employers would also like to see reimbursement models through insurers. Even small reimbursements could help with sustainability for the profession. Having smart billing codes for CHW services or even a fee for service for CHWs who are connected to patients may increase sustainability as well.

There are also opportunities to be explored in bundled payment options where CHWs would be included in clinical and social services. Private insurance providers could also support the CHW role. Currently, CHWs do not universally receive competitive pay, which discourages career longevity. At this point in time, the medical culture is fee-for-service, which competes with the value-based system of CHWs.

340B Program

Hospitals mentioned the 340B Program, which provides safety net health providers the option to buy medications at a discounted rate. Certain pharmacies can then purchase the medications from the safety net health provider and share the profit with the pharmacy. This has reduced the costs of prescription medications and also helps provide assistance for the undocumented population. This is severely needed as they have treatment needs for chronic illnesses. The profit mentioned then enables the community hospitals to meet community needs and provide other services.

Partnerships/Shared Costs

While some larger communities have built strong partnerships among healthcare, social service systems, local health departments, and state agencies, focus group participants recommended that similar partnerships need to be developed in smaller communities. These partnerships could build the capacity to share the cost of hiring CHWs for their communities. Individual organizations do not currently have the financial capability to afford to independently pay for a CHW position. Many CHW-type services are provided by an existing employee who might function in multiple roles. One example might be a laboratory technician who also arranges transportation for clients or a secretary who also assists patients with insurance applications or marketplace navigation.

Some local and state private foundations are funding prevention efforts through the Promotoras de Salud (PdS). PdS serve mothers, helping them sign up for SNAP and showing them how to make

healthy, culturally appropriate meals. This helps prevent childhood obesity. This works well for specific programs that serve undocumented people where public funding is not an option. Supplemental funds also provide social support to volunteer PdS, such as help obtaining a GED, procuring citizenship support, and assisting with family health, which may provide a pathway to securing a funded CHW position or other paid employment in the future. These things help them to get hired in CHW positions later in life.

Looking to the Literature: Future of CHWs

A common debate in the literature is the extent to which CHWs should be “professionalized” and the need for standard certification. CHWs’ unique position as a member of the community positions them to serve communities in a manner that other healthcare professionals may not be able to. Many case studies and articles recommend that in order to sustain and move the profession forward, certification and standardized education are needed (CDC, 2015; Ingram et al., 2020; Rosenthal et al., 2010). Standardization of the profession creates a well-defined scope of practice with core competencies needed to do the job and provides opportunities for ROI through sustainable funding mechanisms for the profession (i.e., Medicaid reimbursement) (Rosenthal, et al. 2010; Alvillar et al, 2011). Gilkey, Garcia, and Rush (2011) argue that certification could create a divide between CHWs and their clients by requiring traditional professionalization. Rather, seeing CHWs as “experience-based experts” can be used to their advantage and to build partnerships with other healthcare professions, such as health educators who do have formal education.

Conclusion

The United Methodist Health Ministry Fund commissioned research on the Kansas Community Health Worker (CHW) workforce. This research involved gathering data through interviews and focus groups with those most closely connected to the CHW workforce: CHWs, employers of CHWs (including hospitals, health departments, and Federally Qualified Health Clinics), and funders of CHW programs. While findings confirmed data from previous reports, this study also helped deepen the understanding of the CHW workforce in Kansas and identify considerations for supporting and strengthening the Kansas CHW workforce.

CONTINUING TO COLLECT DATA TO DEMONSTRATE VALUE

Several participants mentioned that more CHW employers need to document their return on investment to get the attention of payers and funders. Relevant ROI data could result in securing additional funding and make it easier to convince new employers who might be interested in hiring CHWs.

ROI is one way to measure CHW benefit. CHWs also help increase access to care, with their patients/clients receiving necessary services they may not have received otherwise. CHWs can also

help improve health outcomes for those they serve through access to care, culturally appropriate health education, and follow-up to ensure compliance with medication and treatment instructions. To build the case for long-term support of CHWs, documenting the value of CHWs in terms of financial return on investment, increased healthcare accessibility, and improved health outcomes will be important.

DEMONSTRATING NON-MONETARY VALUE

In addition to the value CHWs bring through financial benefit and improved health outcomes, participants also talked about the value of CHW services that is not as easily measured or quantified. For example, CHWs improve the trust between patient and provider. They help address social needs or social determinants of health for their patients/clients, which healthcare providers are not often well-positioned to address. They are able to meet with patients/clients in non-clinical settings, in locations where patients/clients may feel more comfortable.

CHWs are an important part of the continuum of care. They are not meant to replace positions like nurses or social workers but rather to work in tandem with these other positions to contribute to the best possible health outcomes for their clients/patients. Helping employers and providers understand the breadth of services CHWs can provide and the value of those services will help to better maximize the utilization of CHWs.

STANDARDIZING EDUCATION AND TRAINING

Because CHWs serve diverse populations, they will continue to have varied needs related to education and training. In addition, CHWs themselves are diverse and come to the position with a variety of backgrounds, skills, and experiences. That being said, the core of their work as a CHW remains the same – serving as a trusted member of the community who can facilitate access to needed health and social services. With the core work of being the same, there is likely a foundational set of skills and knowledge that would be beneficial for all CHWs to have.

Kansas is one of several states exploring options for CHW certification. This certification process would provide a baseline level of education and training for those working as CHWs or interested in pursuing work as a CHW. CHWs could then take advantage of opportunities for additional specialized training and/or continuing education that could improve their work as a CHW, lead to advancement within the CHW field, or lead to another role within the healthcare system, such as care coordinator.

EXPLORING ALTERNATIVE FUNDING

Having data to document the value of CHWs and focusing on a standardized approach to education and training could help make the case for more and different types of funding to support the CHW workforce. Most CHW programs are currently funded through grants, which typically limit funding to one to three years. Continuing to explore more sustainable funding through sources such as Medicaid/Medicare, service reimbursement, bundled payment options, and opportunities for cost sharing and other partnerships will be important going forward.

About the Community Engagement Institute

Wichita State University's Community Engagement Institute is dedicated to improving the health of Kansans through leadership development, research and evaluation, organizational capacity building, community collaboration, and public health and behavioral health initiatives. The Community Engagement Institute maintains six centers with skilled staff who work directly with community coalitions, nonprofits, government entities, health and human services organizations, and support groups. The centers include:

- Center for Applied Research and Evaluation
- Center for Behavioral Health Initiatives
- Center for Leadership Development
- Center for Organizational Development and Collaboration
- Center for Public Health Initiatives
- IMPact Center

Want to know more about this report? Contact Alissa Rankin, Project Manager for the Center for Public Health Initiatives, at alissa.rankin@wichita.edu.

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Appendix A

The Kansas Community Health Worker & Employer Workforce Assessment consisted of two surveys – one for community health workers to complete and one for employers of community health workers to complete. Both surveys were conducted online, and the survey for community health workers was made available in both English and Spanish. The surveys were open during the months of September, October, and November of 2018. A total of 64 individuals completed the Community Health Worker Survey (42 in English, 22 in Spanish), and 29 completed the Employer Survey.

Key Findings from Community Health Workers

Where do they work?

- The majority of community health workers (CHWs) who responded to the survey indicated they work for a nonprofit organization.
- Most reported they are being paid full-time for their work as a CHW (as opposed to being paid part-time or volunteering their time).
- Most CHWs work as part of a team, with the most frequently mentioned team members including other CHWs, nurses, and doctors.

Who do they serve?

- More CHWs provide services for adults (18+) than for children/youth.
- The top groups CHWs assist or provide services for are people with low-income, people with no health insurance, immigrants, women and children, and people who are homeless.
- Forty percent of the CHWs indicated they serve more than 20 people per week.

What do they do?

- The top health problems or issues CHWs reported helping people with include diabetes, high blood pressure, and women's health.
- The top three tasks or jobs CHWs reported doing included: 1) connecting people with non-medical help and programs (e.g., social services), 2) connecting people with medical help and programs, and 3) helping people find the help they need.

What do they need?

- CHWs were most interested to receive training in the following areas:
 - How to use motivational interviewing
 - How to provide care for specific diseases (e.g., cancer, diabetes, etc.)
 - How to give first aid/CPR
 - How to train others to do CHW work
 - Leadership training
- They reported being most likely to use trainings provided in-person or at their job.
- In a list of possible challenges, the top identified challenge was: "I have too many people to help and there should be more people like me."

Key Findings from Employers of Community Health Workers

Who are they?

- Most CHW employers reported they were nonprofit organizations.
- Most reported having more CHWs who were paid than unpaid, and more working full-time than part-time. They also indicated the CHW positions are largely funded through grants.

Who do they serve?

- The top groups CHW employer organizations reported assisting or providing services for are people with low-income, women and children, people with no health insurance, faith community members, the general public, and immigrants.
- The approximate number of people served annually by CHWs at these organizations varied widely, from fewer than 50 to more than 10,000.

What do they think of CHWs?

- 100% of CHW employers agreed that CHWs have a vital role in healthcare.
- The top focus areas for CHWs according to employers are prevention/health promotion, accessing health services, and chronic disease management.
- Employers considered the most important CHW tasks to be: providing cross-cultural communication, helping clients gain access to non-medical services or programs, building both individual and community capacity, and providing culturally appropriate health promotion/education.
- Most employers indicate prior training is not required in order to be hired as a CHW, and nearly all offer training to those hired as CHWs at their organizations. These trainings are often provided by CHW supervisors or other CHWs.

What do they need?

- In a list of possible barriers to implementing a CHW program, the top identified barrier was a lack of stable funding.

Appendix B

Community Health Worker Certification in Other States

All certification data is derived from the National Academy of State Health Policy (NASHP, 2020).

No Certification

As of 2018, 23 states do not have certifications available nor do they have any documented movement toward this effort. These states are Alabama, Arkansas, California, District of Columbia, Georgia, Hawaii, Iowa, Idaho, Louisiana, Maine, Michigan, North Carolina, North Dakota, New Hampshire, Nevada, New York, Pennsylvania, Utah, Vermont, Washington, Wisconsin, West Virginia, and Wyoming.

Pursuing Certification

According to the National Academy of State Health Policy, 13 states identified they are currently in the process of developing or considering CHW certification systems. They are Colorado, Illinois, Kentucky, Mississippi, Montana, Virginia, and South Dakota. Connecticut is exploring options through a state mandated feasibility study. Delaware, Kansas, Maryland, and Nebraska each have a CHW coalition/association/collaboration that recommends certification. South Carolina has local certifications that are available, but no current statewide certification.

Two states reported having certificate programs through educational institutions, community organizations, or health departments, but no certification programs. Arizona has four voluntary certificate programs administered by community colleges and training centers. New Jersey awards a certificate of completion to those who complete their CHW training program. Certificate and training programs do not necessarily constitute certification.

Current Certification

States that currently offer certification are listed in the table below.

State	Available	Required or Mandatory For Practice	Required for Medicaid or Medicare Reimbursement	Education Program Completion is Incorporated into Certification System	SPA, Waiver, or other Law
AK	Yes		Yes		State Plan Amendment
FL	Yes				
IN	Yes				
MA	Yes				
MN	Yes	Yes			
MO	Yes	Yes		Community Colleges and other approved venues**	
NM	Yes			Department of Health	
OH	Yes			CHW Training Program**	
OR	Yes		Only certified CHWs can participate in Health Homes.		
RI	Yes				
TX	Yes		Yes		2 Certification Pathways – Training & Experience

**Educational certificate programs do not necessarily constitute professional certification.

Article Name	AUTHOR(S)	SUMMARY/KEY POINTS	SOURCE
Value Models/ROI			
Effects of Community-Based Health Worker Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations: A Systematic Review	Kim et al. (2016)	<p>This article catalogues a systematic review of studies in which the effect of Community-based Health Workers (CBHWs) was tested for chronic disease management and care among people who are at risk for health disparities. Evidence synthesized focused on types of CBHW interventions, the qualification and characteristics of CBHWs, and patient outcomes and cost-effectiveness of interventions.</p> <p>Results: Eight articles documented cost analyses and found that integrating CBHWs into the health care delivery system was associated with cost-effective and sustainable care. Interventions by CBHWs appear to be effective when compared with alternatives and also cost-effective for certain health conditions, particularly when partnering with low-income, underserved, and racial and ethnic minority communities.</p>	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4785041/
Recognizing and Sustaining the Value of Community Health Workers and Promotores	Jim Lloyd, Kathy Moses and Rachel Davis, Center for Health Care Strategies (2020)	<p>This study attributes cost savings for Community Health Worker (CHW) programs to lower-cost workforce as compared to licensed health care professionals. Two studies that show return on investment (ROI) are cited:</p> <p>1) CHWs and Promotores in the Salud y Vida program in South Texas, run by MHP Salud, provide health education efforts focusing on diabetes management. An evaluation of the program's 12-month diabetes self-management course showed improvements in participating patients' hemoglobin A1c levels while achieving a nearly 10 percent ROI from improved disease management.</p> <p>2) In New Mexico, Molina Healthcare's Medicaid managed care organization contracts with a community-based organization and the state university to use CHWs to identify individuals with complex medical and social needs in the community and connect them to needed resources. The program saved an estimated \$2 million in health care costs in one year across 448 patients, suggesting close to a 4:1 ROI.</p>	https://www.chcs.org/meda/CHCS-CHCF-CHWP-Brief_010920_FINAL.pdf
Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings	Sinai Urban Health Institute (2014)	In order to show evidence of improved health, these article overviews guidelines which stress the importance of linking value-added services often provided by CHWs to actual health outcomes that may be provided by other providers (page 102).	https://www.sinai.org/sites/default/files/SUHI%20Best%20Practice%20Guidelines%20for%20CHW%20Programs.pdf

<p>Community Health Workers in Minnesota: Bridging barriers, expanding access, improving health.</p>	<p>Blue Cross and Blue Shield of Minnesota Foundation (2010)</p>	<p>CHWs bridge the gap between communities and health/social service systems by building individual and community capacity, advocating for individual and community needs, providing direct services, promoting wellness by providing culturally appropriate health information to clients and providers, and assist in navigating the health and human services system.</p>	<p>http://s472440476.online.home.us/wp-content/uploads/2012/12/CHWsMNBcbcs.pdf</p>
<p>Funding</p>			
<p>How States Can Fund Community Health Workers through Medicaid to Improve People’s Health, Decrease Costs, and Reduce Disparities</p>	<p>Families USA (2016)</p>	<p>Methods to Fund CHWs via Medicaid: SPAs; Section 1115 Waivers; SPAs for Broader Medical Reimbursement; MCO Contracts, Other health system transformation efforts – report goes into methods and successful state examples</p> <ul style="list-style-type: none"> - Method chosen can either narrow or broaden scope 	<p>http://familiesusa.org/sites/default/files/product_documents/HE_HST_Community_Health_Workers_Brief_v4.pdf</p>
<p>Advancing the Profession and Sustainability of Community Health Workers</p>	<p>Lapedis, Kieffer, Rhenigans, Udow-Phillips (2018)</p>	<p>Explains fee-for-service payments and alternative payment models that can be used.</p>	<p>https://www.chrt.org/publication/advancing-profession-sustainability-community-health-workers/</p>
<p>Realizing the Value of Community Health Workers – New Opportunities for Sustainable Financing</p>	<p>Lapidos, Lapedis, & Heisler (2019)</p>	<p>Opportunities (closely related to value-based care): 2018 CHRONIC Care Act allows Medicare Advantage plans to offer nonmedical benefits that could improve well-being of chronically ill enrollees – could offer new opportunities for plans to cover CHW services Using Medicaid MCO contracts to deploy CHWs to help engage enrollees in care (Michigan and New Mexico are examples) Center for Medicare/Medicaid Services updated Medicaid managed care rules to facilitate access to high-value nonmedical interventions such as services that address SDoH, etc. – natural fit to integrate CHWs into this work</p> <p>Integrating CHWs into Medicaid related services is important key starting point for CHW financing – 40% of U.S. uses services. As part of a care team, bundled payment or capitated rate structure are options.</p> <p>Fee-for-Service Opportunities/Recommendations: Essential to establish billing codes to finance work of CHWs in fee-for-service environments; allow payers to reimburse CHW activities; BUT this comes with many barriers – oversight, clear benchmarks for evaluating outcomes, reimbursement rates must cover community work, rapport building, ongoing social support (<i>fee for service structure (and frankly just health care system in general) is not currently set up to support such</i></p>	<p>https://www.nejm.org/doi/full/10.1056/NEJMp1815382</p> <p>(see folder)</p>

<p>Recognizing and Sustaining the Value of Community Health Workers and Promotores</p>	<p>Jim Lloyd, Kathy Moses and Rachel Davis, Center for Health Care Strategies (2020)</p>	<p>activity); some states only want licensed CHWs to bill but could be barrier to participation by trusted community members.</p> <p>Similar reimbursement model could be applied to CHWs used by Peer Support Specialists</p> <p>Medicaid Managed Care regulations authorize the use of CHWs for services covered by managed care plans (MCPs), such as health education, navigation, and care coordination. Examples include: Minnesota – authorizes payment for services provided by CHWs; Michigan – MCP contract includes language requiring MCPs to design and implement CHW interventions to address beneficiaries’ SDOH; Oregon – One CCO uses Pathways Community HUB model which provides outcomes-based payments to CBOs and providers who deliver services to beneficiaries, while another MCP embeds CHWs within provider practices to provide additional care coordination services.</p> <p>Medicaid State Plan Amendments – States may develop a SPA with CMS to alter how their Medicaid programs are run in order to provide different services, implement innovative payment methodologies, or extend coverage to new groups of beneficiaries. Some SPAs expand how CHWs can provide services. California’s Health Home model is particularly relevant. This SPA supports care coordination for Medicaid beneficiaries with complex health needs, and includes a CHW option as part of the health home care team. SPAs around preventive services and targeted case management (TCM) are also possible, as modeled by several states.</p> <p>1115 Demonstration Waivers – DSRIP and similar resources can fund CHW programs. In Massachusetts, their DSRIP waiver covers infrastructure investment including workforce development initiatives to train more CHWs.</p>	<p>https://www.chcs.org/medica/CHCS-CHCF-CHWP-Brief_010920_FINAL.pdf</p>
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Interventions and Meta-Analyses

<p>Development and preliminary testing of a CHW- delivered, Spanish language, counseling intervention for heavy drinking among male, Latino day laborers.</p>	<p>Moore AA, Karno MP, Ray L, Ramirez K, Barenstein V, Portillo MJ, Pino HE. (2016)</p>	<ol style="list-style-type: none"> 1. Target population: Male, Latino day laborers who were at least 21 years old, were Spanish speaking, reported consuming more than 14 drinks per week or more than 4 drinks at least twice per week, were not currently in treatment for substance use disorder, were not planning to leave town in the next six months, and had access to a telephone for contact. 2. Intervention: Culturally adopted 3-session intervention that combined Motivational Enhancement Therapy (MET: structured feedback, decision rulers, exploration of positive and negative aspects of drinking) and 	<p>https:// doi .org/ 10.1016/ j.jsat.2015.11.003</p>
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		<p>Strength-Based Case Management (identification of service needs, barriers to service, personal strengths, and available resources) intervention. Delivered in Spanish by CHWs.</p> <ol style="list-style-type: none"> 3. Outcomes: Both the intervention and control groups reduced alcohol intake and improved AUDIT scores over time. There was no statistically significant differences between groups: however, at the six week follow-up, intervention group participants drank less and had lower AUDIT scores. The differences persisted at the 12-week follow-up but diminished at the 18-week follow-up. Within-group repeated analysis of variance (ANOVA) suggests significant change over time for drinks per week among intervention group participants but not for control group participants. 	
<p>Advancing mental health equality: a mapping review of interventions, economic evaluations and barriers and facilitators</p>	<p>Arundell, L.-L., Greenwood, H., Baldwin, H., Kotas, E., Smith, S., Trojanowska, K., & Cooper, C. (2020).</p>	<ol style="list-style-type: none"> 1. Metanalysis aimed at identifying studies of interventions seeking to address mental health inequalities, studies assessing the economic impact of such interventions and factors which act as barriers and those that can facilitate interventions to address inequalities in mental healthcare. 2. Overview: Systematic mapping method of studies focused on populations with mental health disorders and an intervention that focused on mental health inequalities. 3. Outcome: Of 128 studies that met inclusion criteria, 94 looked at interventions, 6 at cost-effectiveness, and 36 at barriers and facilitators. An existing taxonomy of disparities interventions was used. Most of the identified interventions focused on addressing socioeconomic factors, race disparities and age-related issues. The most frequently used intervention strategy was providing psychological support. Barriers and associated facilitators were categorised into groups including (not limited to) access to care, communication issues and financial constraints. 	<p>doi:10.1186/s13643-020-01333-6</p>
<p>Mobilizing community health workers to address mental health disparities for underserved populations</p>	<p>Barnett, M. L., Gonzalez, A., Miranda, J., Chavira, D. A., & Lau, A. S. (2018)</p>	<ol style="list-style-type: none"> 1. Target Population: Evaluates efforts from CHWs delivering evidence-based mental health interventions to underserved communities in the United States and in low- and middle-income countries. 2. Study Details: 39 trials were reviewed to characterize the background characteristics of CHW, their role in intervention delivery, the types of interventions they deliver, and the implementation supports they received. 3. Outcomes: Majority of trials found that CHW-delivered interventions led to symptom reduction. 	<p>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5803443/</p>

<p>Findings for a CBT support group for Latina migrant farmworkers in western Colorado</p>	<p>Hovey JD, Hurtado G, Seligman LD. (2014)</p>	<ol style="list-style-type: none"> 1. Target population: Female migrant farmworkers of Mexican descent from Montrose area in Colorado. 2. Intervention: Six-week support group-based intervention employing CBT techniques, including imaginal and in vivo exposure, assertiveness training, cognitive restructuring, and behavioral strategies (eg. Positive activity scheduling; coping skills. Emphasis on culturally valued interactions. 3. Outcomes: Migrant farmworker stress and depressive symptom scores were significantly reduced at post-treatment and improvements were maintained in follow-up. <ol style="list-style-type: none"> i. 83% of women achieved clinically significant baseline post-treatment change and end-state functioning for migrant farm-worker stress and depressive symptoms. 	<p>https://doi.org/10.1007/s12144-014-9212-y</p>
<p>Effect of the healthy MOMs lifestyle intervention on reducing depressive symptoms among pregnant Latinas</p>	<p>Kieffer EC, Caldwell CH, Welmerink DB, Welch KB, Sinco BR, Guzm.n JR. (2013)</p>	<ol style="list-style-type: none"> 1. Target population: Pregnant Latinas residing in Southwest Detroit who were 18 years or older and less than 20 weeks gestation at eligibility screening. 2. Intervention: 14 session social-support based healthy lifestyle intervention (Healthy MOMs), designed to empower pregnant women to develop knowledge and skills to reduce social and environmental barriers to healthy eating and regular exercise. Culturally linguistically tailored. 3. Outcomes: MOMs participants were less likely than control group participants to be at risk for depression at follow-up. Between baseline and follow-up, MOMs participants experienced a significant decline in depressive symptoms. From baseline to postpartum, there was a significant intervention effect among non-English speaking women only. 	<p>https://doi.org/10.1007/s10464-012-9523-9</p>
<p>Interconexiones: a pilot-test of a community-based depression care program for Latina violence survivors.</p>	<p>Nicolaidis C, Mejia A, Perez M, Alvarado A, Celaya-Alston R, Quintero Y, Aguillon, R. Proyecto (2013)</p>	<ol style="list-style-type: none"> 1. Target population is Spanish-speaking Latina women in the Portland, Oregon area who were at least 18 years old, had moderate to severe depressive symptoms, and a current or past history of intimate partner violence 2. Intervention: 12-week group abuse-sensitive depression care intervention and individual case management services based on principles of chronic illness management and cognitive behavioral therapy (CBT). Intervention was adapted to be multi-faceted and culturally-tailored to more fully meet the needs of Latina IPV survivors. Latino cultural values and strengths, social and feminist empowerment ideals, and existing community resources were integrated into treatment. Delivered by CHWs at a community-based agency. 3. Outcomes: There was a significant decrease in mean depression scores among participants. 	<p>https://pdxscholar.library.pdx.edu/cgi/viewcontent.cgi?article=1001&context=chla_fac</p>

<p>Addressing behavioral health disparities for Somali immigrants through group cognitive behavioral therapy led by community health workers.</p>	<p>Pratt R, Ahmed N, Noor S, Sharif H, Raymond N, Williams C. (2017)</p>	<ol style="list-style-type: none"> 1. Target Population: Somali women living in Minnesota who were 18 years or older, interested in attending a program to build positive mental health and felt they would benefit from the course. 2. Intervention: 8-session cognitive behavioral therapy model, Living Life to the Full that focused on building skills for positive mental well-being in the context of experiencing a wide range of stressors. Delivered to CHWs who were also Somali women at a local health drop-in center serving an urban community where many Somalis live. 3. Outcomes: Over time in the program, participants' mean happiness levels significantly increased and mean anxiety levels significantly decreased 	<p>https:// doi .org/ 10.1007/ s10903-015-0338-2</p>
<p>Influence of a community health worker Intervention on mental health outcomes among low- income Latino and African American adults with type 2 diabetes</p>	<p>Spencer MS, Hawkins J, Espitia NR, Sinco B, Jennings T, Lewis C, Kieffer E. (2013)</p>	<ol style="list-style-type: none"> 1. Target population: African American and Hispanic Target Population: African American and Hispanic adults living in either the Southwest or Eastside neighborhoods of Detroit, Michigan who had physician-diagnosed type- 2 diabetes without serious diabetes- related complications. 2. Intervention Overview: CHW-delivered healthy lifestyle and diabetes self-management program that included 11 group diabetes education classes, home visits (twice per month), and one clinic visit with participants and primary care providers. Diabetes education classes were culturally tailored in English and Spanish and delivered every 2 weeks at community locations. Content focused on stress reduction, physical activity, and healthy eating. The intervention used empowerment-based approaches, such as motivational interviewing, to support participants' goal setting and action plans. 3. Outcomes: Adjusting for demographics, diabetes-related emotional distress significantly decreased for both the intervention and delayed intervention groups. The PHQ-9 did not change significantly; however, the PHQ-2 showed a significant decrease in depression. The intervention effect was greater for Latinx participants than for African American participants. 	<p>https:// doi .org/ 10.1007/ s12552-013-9098-6</p>
<p>Results from a pilot promotora program to reduce depression and stress among immigrant Latinas.</p>	<p>Tran AN, Ornelas IJ, Kim M, Perez G, Green M, Lyn MJ, Corbie- Smith G. (2014)</p>	<ol style="list-style-type: none"> 1. Target population: Latina women, at least 18 years old, who lived in three North Carolina counties. 2. Intervention Overview: CHW-delivered intervention to improve mental health among Latinas that was developed within a community-based participatory framework. Intervention was linguistically and culturally tailored for recently immigrated Latinas and focused on mental health, stress, and coping skills. Included at least three contacts. 	<p>https:// doi .org/ 10.1177/ 1524839913511635</p>

		3. Outcome: Participants' depressive symptoms, perceived stress, and acculturation stressors significantly decreased over time in the intervention program.	
Systematic review of mental health CHWs as mental health practitioners in primary care: a multi- method study of an intervention to address contextual sources of depression	Waitzkin H, Getrich C, Heying S, Rodr.guez L, Parmar A, Willging C, et al. (2011)	<ol style="list-style-type: none"> 1. Target Population: Primary care patients at two Community Health Centers in New Mexico who met criteria for depression based on the PHQ. 2. Intervention Overview: CHW-delivered intervention to address problems in four contextual areas: underemployment, inadequate housing, food insecurity, and violence among primary care patients with depression. CHWs helped patients resolve contextual problems potentially contributing to depression via connecting them with resources. This intervention was delivered in medication treatment and/or referral from a psychiatric or psychological consultation as needed. 3. Outcome: There was not a significant intervention effect on depression. 	https:// doi .org/ 10.1007/ s10900-010-9313-y
Education and Professional Development			
Addressing Chronic Disease Through Community Health Workers: A Policy and Systems-level Approach	Centers for Disease Control and Prevention (2015)	Key Comprehensive Policies & Components: CHW Workforce development and training of CHWs should allocate specific resources, focus on core skills and provide competency-based education. This includes training on both disease-specific topics and core skill development. Following the hiring process, CHWs should be trained on skills specifically related to the population they serve. The training should bolster the skills of both CHWs specifically and also CHWs who supervise other CHWs.	https://www.cdc.gov/dhds/p/docs/chw_brief.pdf
Community Health Workers in Diabetes Management and Prevention	American Association of Diabetes Educators	Disease specific training: CHWs are natural helpers who are “particular individuals to whom others naturally turn for advice, emotional support and tangible aid. “A critical asset of programs that engage CHWs is that they build on already existing community network ties that contribute to the acceptance and sustainability of effective community programs.	https://www.diabeteseducator.org/docs/default-source/legacy-docs/_resources/pdf/CommunityHealthWorkerPositionStatement2009.pdf
Unequal Treatment: Confronting racial and ethnic disparities.	Smedly BD, Stith AY, Nelson AR. (2003)	This book covers how race and ethnicity remain constant predictors of the health care and mental health care that individuals receive. There are many aspects of the client/provider visit that have gaps that could be filled by CHW help. The disparities in care can be minimized by improving financing opportunities, providing care in individuals' communities, meeting the clients' needs through their own language, etc. Many policies can be created to increase quality of care for people of color.	https://www.nap.edu/catalog/12875/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care
Establishing Voluntary Certification of Community Health Workers in Arizona: A	Ingram M, Sabo S, Redondo F, Soto Y, Russell K, Carter H, et al. (2020)	Voluntary certification helps increase the professionalization of the CHW workforce. Using a standardized core set of competencies will provide show direction for hiring and developing on-site training and/or professional	https://pubmed.ncbi.nlm.nih.gov/32586328/

<p>Policy Study of Building a Unified Workforce</p> <p>Community Health Worker Employer Survey: Perspectives on CHW Workforce Development in the Midwest</p> <p>Creating the Conditions that Promote Community Health Worker Success</p>	<p>Chaidez V, Palmer-Wackerly AL, Trout KE. (2018)</p> <p>Wiggins N, Rosenthal EL,</p>	<p>development. A flexible approach to certification allows for CHWs to professionalize while still aligning with the populations they serve.</p> <p>An overview of the Nebraska statewide Community Health Worker Employer survey which received 240 responses from various clinical, community, and faith-based organizations across rural and urban settings in the Midwest. A large majority of the respondents were not current employers of CHWs but saw the need for employing them.</p> <p>The recommendations include defining the workforce by creating an accepted definition of CHWs, who is involved in that title, setting standards through competencies and certification, determining value and benefit, creating insurance and Medicaid reimbursement strategies and support organizations</p>	<p>https://pubmed.ncbi.nlm.nih.gov/28961658/</p> <p>https://journals.lww.com/ambulatorycaremanagement/Citation/2015/10000/Creating_the_Conditions_That_Promote_Community.2.aspx</p>
<p>Community Health Workers Can be a Public Health Force for Change in the United States: Three Actions for a New Paradigm</p>	<p>Balcazar H, Rosenthal EL, Brownstein JN, Rush CH, Matos S, & Hernandez L</p>	<p>In Balcazar, et al. (2011), the authors argue that CHWs have proven to be effective workers in the health care system and are well positioned to be part of health care teams and community-based public health programs. The qualities of the workforce provides an opportunity to integrate CHWS our health care system and to play an important role in moving the health care system to one that focuses on preventative services while being cost effective, addressing health inequities and the social determinants of health, and improving access to health care and other (i.e. early childhood, public health, etc.) services. The authors propose three key actions to promote this shift: 1.) Bring awareness to the profession of CHWs and the roles they bring, 2.) Integrate CHWs into health care teams and population health programming 3.) Conduct national CHW evaluation research and create policies to ensure sustainability of CHWs.</p>	<p>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC322447/?tool=pmcentrez&report=abstract</p>
<p>Community Health Workers: Part of the Solution</p>	<p>Rosenthal EL, Brownstein JN, Rush CH, Hirsch GR, Wallaert AM, et al. (2010)</p>	<p>The case study on how Massachusetts and Minnesota implemented policies that increased integration of CHWs into their care teams. This particular article shows how CHWs helped increase access to care that ultimately led to the release of recommendations on how to build the sustainable workforce. There is now a significant standard for advocacy and policy in order to raise awareness of the profession, training programs, and sustainability efforts. This led to standardization of educational curriculum which led to financing infrastructure. As a result of studying the results of what happened in these states, policy recommendations include:</p> <ol style="list-style-type: none"> 1. Sustainable financing – payment for services via Medicaid, CHIP, and other major funding streams 2. Workforce development resources (training and PD) 	<p>https://search-proquest-com.proxy.wichita.edu/docview/651813892/fulltextPDF/CB8A8E208AD54B54PQ/1?accountid=15042</p>

3. Certification and standardized training
4. Guidelines for common measures to be used in research and evaluation of CHWs

Recommendations for Developing and Sustaining CHWs

Alvillar M, Quinlan J, Rush C, Dudley D (2011)

The article recaps findings and recommendations from a CHW summit in 2010. They made three key recommendations: 1.) Training standards to clarify role and benefits of CHW role 2.) Reimbursement 3.) Local support networks to develop CHW, such as through education and other methods.

<http://doi.org/10.1353/hpu.2011.0073>

Professionalization and the Experience-based Expert: Strengthening Partnerships Between Health Educators and CHWs

Gilkey M, Garcia CC, Rush C. (2011)

CHWs are unique in the fact that they are “experience-based experts” rather than those with high levels of education. This is why the professionalization of CHWs is non-linear and often incomplete/patch worked (state-level). CHWs are often from the communities they seek to serve, which means that professionalization and higher levels of education may create a gap in their ability to work with members in their communities. Unlike health educators, CHWs’ experience is acquired through experience rather than certification and formal education, which means they can understand health in a context other health professionals cannot. Approaching CHWs as “experience-based experts” is likely better than traditional professionalization. The role of CHWs can be maximized by partnering with credential based (i.e., health educators) experts.

<https://doi-org.proxy.wichita.edu/10.1177%2F1524839910394175>