Center for PUBLIC POLICY & ADMINISTRATION
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CPPA

Community Health Workers in Utah

An Assessment of the Role of CHWs in Utah and the National Health Care System

Prepared for the Utah Department of Health, Heart Disease and Stroke Prevention Program

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EXECUTIVE SUMMARY

Overview

Community health workers (CHWs), also known as promotoras or patient navigators, have received considerable attention for their potential to improve access to and the quality of healthcare. The National Heart Disease and Stroke Prevention Program (NHDSP) in the Centers for Disease Control and Prevention (CDC) outlined evidence based or practice based priority strategies on which states should focus their efforts. In addition, passage of the Patient Protection and Affordable Care Act (PPACA) in 2010 promoted the use of CHWs and similar occupations. Together these two events prompted the Utah Department of Health's Heart Disease and Stroke Prevention Program (HDSPP) to assess the role CHWs play in Utah. HDSPP contracted with the University of Utah's Center for Public Policy and Administration (CPPA) to conduct a literature review, a nationwide survey, and a Utah-specific survey on current practices and impacts of programs utilizing the services of CHWs.

Literature Review

The literature review assessed the cost effectiveness and outcome effectiveness of CHW programs and interventions. Findings from this literature review indicate that there is a general need to increase consistent, standardized measurement of outcomes and cost effectiveness of CHW programs. The impact of CHWs on economic and health outcomes has been widely researched, but is not easily generalized due to the variety of CHW programs and interventions, the variety of roles filled by CHWs, and inconsistent methodologies utilized in analysis. However, the literature generally points to cost savings and improved health outcomes in target populations that are served by CHWs. These findings were used to inform the creation of the national survey tool.

National Assessment

The purpose of the national assessment was to establish a context for the Utah CHW assessment, and to begin to formulate a baseline understanding of the roles and environments in which CHWs work. Additionally, information obtained through this survey on the funding, legislation, training, and other issues related to CHWs can be used to plan for future actions in Utah. Finally, recommendations were solicited from the interviewees on how best to promote an increased role for CHWs, should Utah pursue this course of action.

Findings from the national assessment indicate that CHWs work in a variety of roles, including outreach and education, patient navigation and health screening, and their work is applied in a variety of settings. The individuals interviewed in the national assessment indicated the CHW is typically a member of a care delivery team or part of a health care continuum whereby lay workers are supervised by or coordinated with a clinically trained supervisor. CHWs may be employed for pay or may be volunteers, and many paid CHW positions are funded through grants. A number of states are studying alternatives to grant funding in an attempt to ensure the fiscal sustainability of CHW services in the long term. Furthermore, to strengthen and validate the profession, many of those contacted are looking at developing training and certification standards, as well as exploring other means of increasing awareness and inclusion of CHWs into mainstream health care systems.

Utah Assessment

Findings from the Utah assessment indicate that CHWs work in a variety of settings, though the number of community based or nonprofit agencies responding to the survey that engage CHWs (24 respondents) was double that of any other type of organization that engages CHWs. Additionally, the majority of individuals interviewed in the Utah assessment (60%) indicated that CHWs within their organization typically work directly with clinical professionals.

Responses suggest that, on average, CHWs each perform five of the seven roles of CHWs as categorized by the National Community Health Advisor Study (Rosenthal, et al., 1998). The most common role is "providing culturally appropriate health education and information," and the least common is "providing direct services." CHWs most commonly serve racial and ethnic minorities (especially Hispanic/Latino populations), followed by pregnant women, individuals with disabilities, and individuals with specific diseases (especially diabetes and high blood pressure). A GED or high school diploma was the minimum education level required most often, and most entities represented by respondents provide training for their CHWs. In response to a question on what the role of the Bureau of Health Promotion (BHP) should be with respect to CHWs, it was suggested that the BHP should provide and support training and licensing for CHWs in Utah, as well as be a champion and coordinator of CHW efforts in the expansion of preventive care.

The majority of CHWs engaged by respondents' organizations are paid, with full-time positions being more common than part-time positions, and the greatest number of CHWs with annual earnings of $22,000 to $25,999. A slight majority (56%) of the respondents' organizations provide benefits to their full-time CHWs, while only a few (15%) provide benefits to their part-time CHWs. Over a third of entities provide no benefits. The most common funding source for CHW positions was federal grant categorical funding, and less than a third of respondents' agencies employs CHWs under core operating budgets. In response to a question on policy or system changes that would make it easier to sustain CHW services on an ongoing basis respondents most frequently made comments on securing or increasing funding sources for CHWs. Respondents felt it was not only important to generate more federal and state funding for sustainability, but it was also important to secure funding to expand the capabilities and practices of CHWs in the community. In addition, changes to the billing scheme for CHWs could facilitate an expansion of services and workforce sustainability. Respondents suggested that BHP should play a central role in increasing, and in some cases administering, funding streams for CHWs.

Recommendations

In furthering the CHW profession, it is of primary importance to work with CHWs themselves, stakeholders, and partners in determining what specific approach would be best in Utah. There were several recommendations made by interviewees in the national assessment that stood out as to how it would be best to approach expanding and developing the role of CHWs: 1) Establish an association or network of CHWs to serve as "the voice of CHWs, build professional identity, and train, unify, and advocate for the profession"; 2) Seek out or establish sustainable funding sources; and 3) Establish standardized training or certification.

ACKNOWLEDGEMENTS

Thank you to Carl Rush of the University of Texas Institute for Health Policy, and Gail Hirsch, Director of the Office of Community Health Workers within the Massachusetts Department of Public Health. Mr. Rush and Ms. Hirsch took time from their very busy schedules to provide insights on CHWs as well as review the national and state assessment tools used, and provide suggestions on whom we should contact in a number of states.

UDOH staff members who took the time from their own positions to review the Utah survey tool and provide input:

- Karen Coats
- Tania Charette
- MaryCatherine Jones
- Dulce Diez
- Nicole Bissonette
- Rebecca Giles

Thank you as well to the members of the community and individuals in the target population who provided feedback on the survey.

- Jessica Martinez, Molina Healthcare of Utah
- Victor Arredondo, American Heart Association
- Kathy Froerer, Utah Association of Local Health Departments
- Jorge Arce-Larreta, Alliance Community Services

Thank you to all respondents to both the national and state-wide surveys.

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OVERVIEW

Community health workers (CHWs), also known as promotoras or patient navigators, have received considerable attention for their potential to improve access to and the quality of healthcare. The CHW workforce emerged in the United States in the 1960s as an attempt to expand access to care among underserved populations (Witmer, Seifer, Finocchio, Leslie, & O'Neil, 1995). Since that time, CHWs have become recognized as significant public health figures in the reduction of racial and ethnic disparities in health care (Perez, 2011). Studies have demonstrated that CHWs play key roles in high-priority health care issues, such as the management of chronic illnesses, reduction of health care costs, and improvement of access and continuity of health insurance coverage(Balcazar, Rosenthal, Brownstein, Rush, Matos, & Hernandez, 2011).

The National Heart Disease and Stroke Prevention Program (NHDSP) in the Centers for Disease Control and Prevention (CDC) outlined priority evidence based or practice based strategies on which states should focus their efforts. In addition, passage of the Patient Protection and Affordable Care Act (PPACA) in 2010 promoted the use of CHWs and similar occupations. Together these two events prompted the Utah Department of Health's (UDOH) Heart Disease and Stroke Prevention Program (HDSPP) to assess the role CHWs play in Utah.

The CDC strategies encourage grantees to promote system changes that will integrate and sustain the role of CHWs and other health care extenders within health care settings (Centers for Disease Control and Prevention, National Heart Disease & Stroke Prevention Program, 2010). Specific strategies suggest taking action to:

- *Promote reimbursement for self-management support provided by pharmacists, CHW, and other health extenders;*
- *Promote use of pharmacists, dentists, case managers, CHW, and other health extenders to improve health outcomes; and*
- *Promote linkages between patients, community resources, and health care systems.*

Even with the growing awareness of community health workers, recognizing CHWs frequently presents a problem for organizations. The jobs and roles of CHWs are as varied as their titles.

To help distinguish the unique role that CHWs fill, The National Community Health Advisor Study (Rosenthal, et al., 1998) categorized CHW functions into the seven core areas highlighted below. In reviewing these roles the key component that emerges is the cultural understanding that is unique to CHWs:

- Cultural mediation between communities and the health and social services system (how to use these systems, increase use of preventive care and decrease urgent or emergency care);
- Providing culturally appropriate health education and information (prevention related information, managing and controlling illnesses such as diabetes and asthma);
- Assuring that people get the services they need (case finding, motivating and accompanying patients to appointments and follow-up care, making referrals and promoting continuity of care);
- Providing informal counseling and social support (individuals and groups, to improve mental and physical health);
- Advocating for individual and community needs (serve as intermediaries between clients and bureaucratic entities);
- Providing direct services (basic first aid, administering some health screening tests);
- Building individual and community capacity (facilitate health behavior change; act as community leaders to bring about community-wide change).

One sign of the growth of this occupation is the creation of a new occupational classification code for CHWs (21-1094) in the 2010 Standard Occupational Classifications (SOC)[1] by the Bureau of Labor Statistics in the US Department of Labor's. Employment data is not available yet for this code from either BLS or the Utah Department of Workforce Services; however, it will be a useful tool in future years. CHWs are defined as performing the following roles:

> *Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs. Excludes "Health Educators" (21-1091). Illustrative examples: Peer Health Promoter, Lay Health Advocate.* (Bureau of Labor Statistics, 2010)

[1]**The Occupational Employment Statistics (OES) program produces estimates based on three years of data to help reduce sampling error. For example, May 2011 data is based on data from panels November 2008, May 2009, November 2009, May 2010, November 2010, and May 2011. In 2010, the Standard Occupational Classification (SOC) system was revised from the 2000 SOC version. The OES program created a hybrid version of occupations until three full years of data collected under the new 2010 SOC. The Community health workers (21-1094) was one of the new occupations added to the 2010 SOC. Currently, community health workers are classified under occupation code #21-1798 – Community and Social Service Specialists, All Other. The May 2012 data (expected to be released early in 2013) should be the first sets of estimates with the full conversion to the 2010 SOC.**

LITERATURE REVIEW

A literature review was conducted to inform the creation of the national assessment survey tool. This review provides a summary of the history, use and impact of CHWs.

The CHW workforce emerged in the United States in the 1960s, working to expand access to care among underserved populations (Witmer, Seifer, Finocchio, Leslie, & O'Neil, 1995). Since that time, CHWs have become recognized as significant public health figures in the reduction of racial and ethnic disparities in health care (Perez, 2011). Studies have demonstrated that CHWs play key roles in high-priority health care issues, such as the management of chronic illnesses, reduction of health care costs, and improvement of access and continuity of health insurance coverage (Balcazar, Rosenthal, Brownstein, Rush, Matos, & Hernandez, 2011).

The American Public Health Association defines CHWs as, "frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served" (American Public Health Association, 2009) CHWs are known by a variety of names, including community health advisor, lay health worker, community health representative, promotora/promotores de salud, and patient navigators, to name a few (National Center for Chronic Disease Prevention and Health Promotion, 2010). Regardless of the job title they use, all CHWs share a core element of community connection. The majority of CHWs live in the communities where they work and understand the social and linguistic context of community members' lives (National Center for Chronic Disease Prevention and Health Promotion, 2010). CHWs are uniquely situated to provide education, social support and advocacy to community members while also educating health care providers and administrators about cultural relativity and competence.

The purpose of this review was to assess the cost-effectiveness, as well as outcome effectiveness, of CHW programs and interventions. Several systematic reviews have been conducted on the topic, but many focus on particular subpopulations or health issues. This review will provide a broad understanding of the current role and impact of the CHW workforce in the greater health care field.

METHODOLOGY FOR LITERATURE REVIEW

Three inclusion criteria were established for the literature review: articles had to describe work of CHWs within the United States; articles had to be written post 2000; and the articles needed to meet the APHA definition of CHWs. In summary, the APHA defines CHWs as individuals who carry out functions related to health care delivery and are part of the community served or have an established relationship with the community served.

The PubMed database was used to locate published articles on the effectiveness of CHWs. The key words *community health worker*, *promotora*, *promotores de salud*, *patient navigator*, *lay health worker*, and *lay health advisor* were used to identify articles reporting outcomes effectiveness and cost effectiveness on CHW programs and interventions. Bibliographies of included articles were also searched for relevant articles. A list of 73 articles was identified, which was reduced to 37 articles after full-text reviews. The articles included in this review fall into three broad categories: research findings and implications from CHW interventions, systematic review, and commentary.

SUMMARY OF FINDINGS

Recognition of CHWs as vital components of the health care system is growing. As members of the communities they serve, CHWs can effectively link patients and individuals to community and health care resources in culturally and linguistically appropriate ways. The impact of CHWs on economic and health outcomes has been widely researched, but is not easily generalized due to the variety of CHW programs and interventions, the variety of roles filled by CHWs, and various methodologies used in analysis. However, the literature generally points to cost savings and improved health outcomes in target populations that are served by CHWs.

The following summarizes the findings from the literature review. The full literature review including all citations and an annotated bibliography can be found in Appendix 1: Literature Review.

FINDINGS AND IMPLICATIONS FROM CHW INTERVENTIONS

Analysis of the individual studies revealed that CHWs are used primarily in chronic disease management, but also in immunizations, women's health, and insurance enrollment initiatives. Outcomes associated with programs utilizing CHWs are improved health, improved patient knowledge, and improved patient health behaviors. In some studies, CHWs are shown to be cost effective components of targeted interventions and programs.

The statistically significant findings from the research reviewed suggest that CHWs have a positive impact on patient health knowledge and behavior, clinical outcomes, and improved health care utilization. However, the quality of research examining the cost effectiveness of CHWs is relatively low and does not have a consistency in methodology that would facilitate comparison between studies. There are several reasons for this inconsistency, including a lack of data reflecting long-term impacts, preferences of individual researchers on cost inclusion, and the wide variety of CHW functions and interventions (Rush, 2012).

While there are a number of studies analyzing the impact of CHWs on health outcomes and health care costs, many of the studies are not generalizable to the national population and report scant information on program design, CHW characteristics, and economic impact. There is a general need in the literature to increase consistent, standardized measurement of outcomes and cost effectiveness of CHW programs. Furthermore, as the majority of CHW programs rely on short-term financing, the establishment of standardized recruitment, training and evaluation for CHW programs is essential for securing sustainable financing and expanding the workforce.

SYSTEMATIC REVIEW OF PREVIOUS FINDINGS

The assessment of the impact of CHWs is not a new topic of inquiry, thus many of the articles gathered in this literature search were previously conducted systematic reviews. A total of 14 systematic reviews included in this review covered the following topics: chronic disease management, work with targeted populations, screenings, training and certification, and economic impact and financing.

The variety of programs analyzed and outcomes measured make it difficult to draw generalized conclusions on the impact and effectiveness of CHW interventions. However, general conclusions can be drawn on the state of the literature, and broad indications for the CHW workforce can be gathered as well. Furthermore, all systematic reviews note that despite the issues with cross-comparison and generalization of research findings, evidence suggests that CHW interventions can be effective at reducing health care utilization costs as well as program costs for individual institutions.

STATUS OF THE LITERATURE

A primary issue within the current literature on CHW programs and interventions includes a lack of standardized outcome measurements and lack of control comparisons. As a result, uniform conclusions about the effectiveness of programs on patient knowledge and behavior, clinical outcomes, and cost effectiveness as compared to standard forms of care cannot be made. Furthermore, there is an overall lack of information on cost or cost effectiveness data on CHW programs and interventions. Standardization of cost measurements and effectiveness analysis would establish a threshold from which CHW programs can be compared and investigated.

Another key issue within the current literature is the lack of information provided on CHWs themselves. Several of the systematic reviews reported a lack of descriptive data on CHW recruitment, training and reimbursement policies, as well as a lack of information on the backgrounds and demographics of CHWs. Furthermore, the interventions involving CHWs are poorly described within the majority of published articles. Understanding who CHWs are and how they work can facilitate workforce growth and development, and also allow cross-comparison and evaluation of programs utilizing CHWs in similar functions and capacities.

Key Points: Literature Review

- **Defining the scope of practice, establishing training and certification standards, and establishing payment guidelines are essential steps in the development of the CHW workforce.**
- **The Patient Protection and Affordable Care Act (PPACA) offers a viable path toward CHW integration into the health care system through Accountable Care Organizations (ACO) and Patient Centered Medical Homes (PCMH).**
- **The economic information currently available captures only short-term impacts of CHW programs.**
- **Not all economic impact assessments are comparable, as researchers account for different costs across varying CHW programs and functions.**
- **Program-specific economic assessments may be more useful for individual organizations employing CHWs.**

IMPLICATIONS FOR THE CHW WORKFORCE

Community health worker roles vary according to the goals and purpose of each program and intervention. However, common roles include: culturally appropriate health promotion and health education, assistance in accessing medical and non-medical services and programs, patient care and support, translation and interpretation, counseling, transportation, and case management. Given the wide range of activities performed by CHWs across an extensive variety of programs and initiatives, it is difficult to pinpoint what elements of CHW participation are important in producing successful patient outcomes. Documenting strategies for CHW recruitment, training and supervision, as well as process evaluation procedures, can help identify these essential elements and foster their development.

A second issue facing the development of the CHW workforce is sustainable funding. The majority of programs utilizing CHWs rely on short-term funding streams from grants and government agencies. The formation of sustainable funding is essential to the advancement of the CHW workforce. Several factors must be addressed when considering sustainable financing: clarification of CHW roles

in health care, establishment of common payment and reimbursement policies, adequate and appropriate supervision mechanisms, and increased data collection for analysis and evaluation of program impact, and return on investment.

EXPERT COMMENTARY

Seven of the articles included in the review were categorized as commentary and included recommendations from working groups, policy briefs and individual researchers. The commentaries discuss a variety of subjects related to CHWs, the most common being training, integration into the current health care system, financing and evaluation of financial benefit.

Key recommendations given on the incorporation of CHWs into the current health care model include: define the workforce's scope of practice; establish training and certification standards; and establish payment guidelines.

According to the commentaries, the Patient Protection and Affordable Care Act (PPACA) creates an ideal opportunity for CHW integration. The Accountable Care Organizations (ACO) and Patient Centered Medical Homes (PCMH) promoted within the PPACA offer CHWs a potential entry point into health care models being developed. Furthermore, the incorporation of CHWs into ACOs and PCMHs can facilitate Medicaid financing and coverage by commercial insurance providers.

Another significant recommendation provided in the selected commentaries was to evaluate the financial benefit of CHWs. Current methods used to analyze the economic impact of CHWs include caveats resulting in very limited economic information that is comparable across studies or generalizable. New forms of economic assessment that capture costs for tailored CHW interventions, such as budget impact analysis, may yield more useful information for individual organizations. Furthermore, most economic analyses conducted on CHWs are done within brief time periods and capture only short-term impacts; longer periods of data collection are required to capture the long-term impacts of CHWs on patient outcomes, program costs, and health care utilization.

DISCUSSION

Recognition of CHWs as vital components of the health care system is growing. As members of the communities they serve, CHWs can effectively link patients and individuals to community and health care resources in culturally and linguistically appropriate ways. The impact of CHWs on economic and health outcomes has been widely researched, but is not easily generalized due to the variety of CHW programs and interventions, the variety of roles filled by CHWs and various methodologies applied in analysis. However, the literature generally points to cost savings and improved health outcomes in target populations that are served by CHWs.

NATIONAL ASSESSMENT

The purpose of the national assessment was to establish context for the Utah CHW assessment, and to begin to formulate a baseline understanding of the roles and environment in which CHWs work. The information collected informed the design of the Utah state CHW assessment. Additionally, information obtained through this survey on the funding, legislation, training, and other issues related to the CHWs can be used to plan for future actions related to CHWs in Utah. Finally, recommendations were solicited from the interviewees for Utah as it begins to explore and ascertain the role of CHWs in health care services. The following summary outlines the findings of a survey of informants in 10 states regarding the role that CHWs play in their states.

METHODOLOGY FOR NATIONAL ASSESSMENT

To develop the national assessment, a literature review was conducted to identify and examine other studies of CHWs. Based on this review a national assessment survey tool was developed. To obtain additional insights, Carl Rush of the University of Texas Institute for Health Policy, who is a national expert on CHWs, reviewed the tool and provided input. The final assessment tool was submitted for review to the UDOH/HDSPP team in early-February and was approved for use.

The national assessment covered the following topical areas with each contact:

- Broad overview of the services CHWs provide in the state
- Association or network of CHWs in the state
- Financing of CHW services
- Certification and training programs and requirements
- Legislation
- Initiatives in the state
- Recommendations for Utah

HDSPP selected the initial audience from their knowledge of the CHW field. The target audience was further developed through identifying states with active CHW communities as well as one state chosen for its proximity to Utah, and similar demographic composition and political environment. The target audience was narrowed to ten states which HDSPP felt were of most interest based on the development of the CHW workforce, public health environment and/or overall proximity. Within each state, if there was a CHW association or network, the executive director of the organization was contacted. In those states where there is no association or network, the best contact was identified through referrals from other states and/or internet searches. Phone interviews were conducted with representatives; one state completed an on-line version of the survey that had been sent so she could see the topics that would be covered. In addition, published information on topics related to interviews was reviewed in cases where additional information was deemed useful.

SUMMARY OF FINDINGS FROM THE NATIONAL ASSESSMENT

Findings from the national assessment indicate that CHWs work in a variety of roles, including outreach and education, patient navigation and health screening, and their work is applied in a variety of settings. The individuals interviewed in the national assessment indicated the CHW is typically a member of a care delivery team or part of a health care continuum whereby lay workers are supervised by or coordinated with a clinically trained supervisor. CHWs might be volunteers or might be employed for pay, with many paid CHW positions supported through grant funding. A number of states are studying alternatives in an attempt to find more sustainable sources

of funding for CHW services. Furthermore, to strengthen and validate the profession, many of those contacted are considering developing training and certification standards, as well as exploring other means of increasing awareness and inclusion of CHWs into mainstream health care systems.

SUMMARY OF NATIONAL ASSESSMENT BY TOPIC

Summarized below are responses by topic. The assessment tool and detailed responses by state are included in Appendix 2: Attachments from the National Assessment. Following the detailed responses, some issues are noted as items that may be of value for follow-up at a later time.

BROAD OVERVIEW OF THE ROLE CHWs SERVE

The jobs and roles of CHWs are as varied as their titles. Typical functions include:

- Outreach and education
- Health screening
- Informal counseling
- Referral
- Advocacy
- Interpretation
- Insurance and benefits enrollment
- Health promotion

In addition, they help individuals navigate the health care system, arrange for transportation, and respond to other needs. Their work is applied in a variety of settings, both rural and urban, in hospitals, clinics, community health organizations, and working directly in communities where CHWs are needed most, including making home visits. CHWs may be clinically trained or may be lay workers, but the individuals interviewed indicated the CHW is typically a member of a care delivery team or part of a health care continuum whereby lay workers are supervised by or coordinated with a clinically trained supervisor. In Texas, the largest employer of CHWs is a Medicaid contractor which has CHWs working in enrollment and benefits education. Currently, the state of Texas is studying the desirability and feasibility of employing CHWs in the public health care arena. In addition to working in more broad-based jobs and roles, CHWs also perform disease specific work in many states. CHWs focus on working with cancer patients or those with chronic diseases such as diabetes. CHWs not only help patients with managing and understanding their health care needs, but also help people make healthy lifestyle choices, access healthy food and exercise facilities.

Along with the variety of services that CHWs perform, pay and funding sources for their work varies. CHWs might be employed for pay, or might be volunteers. Many CHW positions are funded through grants and other temporary sources. A number of states are studying alternatives in an attempt to find more sustainable sources of funding for CHW services. In Texas, CHW employment is tracked through the state certification system, thus reliable information about CHW employment is available in Texas. Approximately 70% of certified CHWs work in paid positions; 10% are unemployed; and the remaining 20% are volunteers. A study in Massachusetts found that use of CHWs is increasing in both the public and private sector; however, CHWs have not been fully integrated into mainstream health care systems, wages tend to be low, and turnover is high. The lack of predictable, long-term funding is a source of the problem of employment stability for CHWs.

To strengthen and validate the profession, many of those contacted are looking at developing training and certification standards, as well as exploring other means of increasing awareness and inclusion of CHWs into mainstream health care systems. With respect to training, several interviewees indicated that there is strong support within their states for developing a standardized, state-wide curriculum that covers core concepts and roles shared by CHWs working in diverse jobs and organizations. Another step that many states are working on in order to advance the profession is to increase stakeholder and peer support for the profession. To do this, some states have attempted to promote CHWs through education and by bringing people together in meetings or conferences. Some interviewees described partnerships and stakeholders as critical to building the profession and helping states meet their goal of improving patient care and health system efficiency. Partnerships may be between similar types of agencies, for example in Kentucky community organizations work together to ensure that people have access to the services they need. Alternately, partnerships may be more broad based, between diverse agencies such as clinics, schools, and health plans, and may be focused on broad goals such as expanding the role of CHWs.

Key Points: National Assessment

- **CHWs work in a variety of roles, including outreach and education, patient navigation and health screening.**
- **The national assessment indicated the CHW is typically a member of a care delivery team or part of a health care continuum.**
- **Many paid CHW positions are funded through grants.**
- **A number of states are studying alternatives to grant funding in an attempt to ensure the fiscal sustainability of CHW services in the long term.**
- **To strengthen and validate the profession, those contacted are looking at developing training and certification standards, as well as exploring other means of increasing awareness of CHWs and including CHWs in mainstream health care systems.**

ORGANIZATION TYPES THAT ENGAGE CHWs

Table1 summarizes the types of organizations or agencies that engage CHWs in the 10 states that were contacted. Respondents were asked to indicate all organizational types; most states marked more than one. Community based organizations and health departments were indicated by all 10 individuals interviewed. Public outpatient health institutions were mentioned by 9 of the 10. Faith based organizations and inpatient facilities were mentioned by 8 out of 10. The range of numbers of organizations noted by each state respondent was from 4 to 11 (including other) with an average of 7, indicating wide use of CHWs in the states contacted. It should be noted that due to the methodology of the national assessment, in which only one individual was contacted per state, it is possible that the interviewee was unaware of some of organizations in which CHWs are employed.

Table 1. Summary of Organization Types that Engage CHWs

Type of Organization	Number of States That Engage CHWs in These Organization Types
Community based organizations	10
Health departments	10
Public outpatient health institutions	9
Faith based organizations	8
Inpatient facilities	8
Other	7
Educational institutions	6
Private providers	6
Advocacy organizations	5
Health plans or insurers	5
Mental health agencies	5

CHW ASSOCIATIONS AND NETWORKS

Seven of the states represented by interviewees in this survey had at least one CHW association or network (the three states that reported having no association or network were Idaho, Mississippi, and Wisconsin). CHW associations range from local to state-wide. The associations may focus on specific health issues, such as cancer, or a broad range of issues that CHWs address. They also focus on needs of CHWs such as education, or attaining sustainable funding. Overall, the goals of the associations or networks include education, training or certification, connecting CHWs across the area or region, connecting CHWs with other health care industry stakeholders, and taking measures to advocate for and strengthen the profession. Others are formed around goals such as decreasing barriers to health care access for specific groups, and increasing the use of preventative care and screenings.

One example of a broad, state-wide association is the Massachusetts Association of Community Health Workers. As stated by Gail Hirsch, Director of the Office of Community Health Workers within the Massachusetts Department of Public Health, CHW associations serve as "…the voice of CHWs, build professional identity, and train, unify, and advocate for the profession."In their advocacy for the profession, for example, the Massachusetts Association of Community Health Workers was instrumental in helping to pass two pieces of state legislation related to CHWs: a study of sustainable funding, and establishment of a board of certification for CHWs.

Other state-wide associations or alliances mentioned in the interviews include the Kentucky Homeplace Program, which focuses on increased use of preventive care; the Minnesota CHW Alliance, which focuses on education, employment, and CHW leadership development; and the New Mexico Community Health Worker Association, which provides training, and is working on a certification program for the state.

Two associations that address more specific areas of the health field and CHW work are the REACH Coalition in Arizona, and Cancer Patient Navigators of Georgia. The REACH Coalition is focused on improving care for patients with cervical cancer, in part by providing training to CHWs working in this area. The mission of the Cancer Patient Navigators of Georgia is to "educate and share best practices among patient navigators in Georgia… [to] reduce barriers and increase access to services specifically related to cancer." (Cancer Patient Navigators of Georgia, 2012)

In Texas, there are several local or regional networks and associations including the South Texas Promotora Association, at least one organization in El Paso and two in Lubbock. It was proposed that the Texas Public Health Association bring the groups together to form one statewide organization, but there has been resistance because promotoras and CHWs have chosen to identify as differentiated from one another. This is a regional issue: people in the eastern part of Texas refer to these workers as CHWs, but individuals in the western part prefer the term promotora(s).

In contrast to formal associations, some organizations define themselves as networks, such as the Arizona Community Health Outreach Workers Network (AZCHOW). AZCHOW's mission is to "provide a forum to inform and unite culturally diverse CHWs of all disciplines to strengthen the professional development of the field through resource sharing and collaborative opportunities with community, government, health and educational institutions." (Arizona Community Health Outreach Workers Network)Other groups that identify as networks include the Georgia Community Health Worker Network, which focuses on decreasing barriers to care for all groups, and the Minnesota CHW Peer Network, which focuses on trainings and education.

To formalize the role of state and local CHW associations and networks further, the American Public Health Association (APHA) has created a CHW section. The section's website states, "The Community Health Workers (CHW) Section seeks to promote the community's voice within the health care system through development of the role of CHWs (including Promotores de Salud, Community Health Representatives, Community Health Advisors and related titles) and provides a forum to share resources and strategies"(American Public Health Association, 2012). The goals of the section are: policy development that supports CHWs, leadership development, and membership engagement. On the APHA CHW section's website, 27 national, state, or regional CHW associations or Community Health Representatives (CHR) Area Associations are noted. The section will meet in conjunction with the APHA annual meeting October 27-31, 2012. A list of all the CHW networks and association identified from the APHA website and during interviews is included in Appendix 2of this report.

FINANCING OF CHW SERVICES

Interviewees indicated that CHWs in their state are financed primarily through grant funding. Most states mentioned the use of private foundation grants, though only two mentioned specific grants. Kentucky used an Anthem Foundation grant for the "I DO" diabetes program; Massachusetts obtained a grant from the Blue Cross Blue Shield of Massachusetts Foundation to fund an insurance enrollment and maintenance program. Grant funding through federal sources, such as the National Institutes of Health (NIH), funded programs in Georgia and Idaho, and the Health Resources and Services Administration (HRSA) funded a program in Georgia. Unfortunately, funding from grant sources is typically temporary which may make the CHW services and programs challenging to sustain over time.

Insurance was also mentioned as a source of funding for CHW positions. Although most interviewees did not go into the specifics of how insurance funding of CHWs works, a few respondents gave details. In New Mexico, insurance was mentioned as the primary source of CHW funding, specifically Molina Healthcare. According to their website Molina Healthcare "arranges for the delivery of health care services or offers health information management solutions for nearly 4.3 million individuals and families who receive their care through Medicaid, Medicare, and other government funded programs in 15 states" (Molina Healthcare, 2012). A similar model of insurance company financing of CHW services through Medicaid was mentioned in Minnesota. Per Joan Cleary, of the Minnesota CHW Alliance, "The majority of Medicaid patients in the state are funded through private insurance, so through this mechanism private insurance funds services provided by CHWs."

Two other models of insurance funding were mentioned—directly funding a program or employing CHWs as core or administrative staff of the insurance company. In Georgia, United Healthcare[2] funds an American Cancer Society patient navigator program in the hospital setting. In Texas, CHWs are employed directly by insurance companies out of their core operating budgets as an administrative cost. The respondent in Texas, Beverly MacCarty, from the Texas Department of State Health, said that "Insurance companies have found this to be an effective method of increasing savings in other areas." Finally, an effort is under way by the community paramedic program in Idaho to receive compensation from insurance companies.

Medicaid serves as a source of funding for CHWs in some states although the funding method varies. The respondent from Minnesota indicated that Minnesota and Alaska are the only two states to currently have Medicaid funding for CHW services; however, the respondents from Massachusetts, New Mexico, and Wisconsin indicated that CHWs in their state also receive some funding through Medicaid. The difference in the information received may be due to the way in which CHWs are reimbursed by Medicaid in the state. In Minnesota and Alaska, CHWs are able to bill Medicaid directly if they meet certification and other eligibility requirements (Goodwin & Tobler, 2008). CHWs in the other three states receive Medicaid funding for their services by first going through a doctor, a health system, or a program that uses bundled payments for CHW services. Under this model the health plan or doctor receives capitated payments from Medicaid, which is then used to employ or contract for CHW services (Dower, Knox, Lindler, & O'Neil, 2006).

In addition to the interviews, several articles identified the use of Medicaid funding for CHW services. A 2006 report commissioned by the Blue Cross and Blue Shield of Minnesota Foundation on financing models for CHW services lists the major funding models for Medicaid reimbursement of CHW services, with examples of the funding models provided. The report, "Advancing Community Health Worker Practice and Utilization: The Focus on Financing" (Dower, Knox, Lindler, & O'Neil, 2006), can be accessed from the Center for Health Professionals website: http://futurehealth.ucsf.edu/. Since 2006, many pilot programs and studies have been funded through Medicaid administrative funds in order to examine the cost-effectiveness of CHWs. One such study examined the effectiveness of CHWs in reducing Medicaid long term care spending, concluding that they can be effective. More importantly for the purpose of this report, the authors suggest that programs such as the pilot program in the study, and others that reimburse or employ CHWs for services through Medicaid funding are now more feasible, as "The Affordable Care Act provides state Medicaid programs with increased flexibility to expand coverage for home and community-based services, along with new sources of federal funding to develop Community Health Worker programs" (Felix, Mays, Stewart, Cottoms, & Olson, 2011). Pilot programs are typically financed through short-term allocations of funds, so they do not create sustainable funding sources; however, they may lead to the adoption of permanent programs with sustainable funding such as Medicaid.

Four respondents were aware of CHW positions being funded by providers through their core operating budgets (Georgia, Minnesota, Massachusetts, and New Mexico). In Georgia, one private cancer practice was noted as employing CHWs out of the operation's core budget[3]In Massachusetts, the PACT program and health centers around the state were known to finance the work of CHWs through core operating budgets to save costs and enhance productivity of other workers. In Minnesota the interviewee was aware of one hospital that pays for CHW

[2] Our contact believed that it is United Healthcare who funds this program; though she said it may be a different insurance company.

[3] A second was at one point doing the same but our contact could not confirm whether they continued to fund CHWs out of the core operating budget.

services through their core operating budget. BetteJo Ciesielski, of the New Mexico CHW Association, identified two programs in New Mexico that finance CHWs work through core operating budgets: Presbyterian Hospital South Valley, and First Nations Community HealthSource.

The interviewee from Kentucky mentioned a program, the Kentucky Homeplace Program, which receives state funds for programs.

CERTIFICATION AND TRAINING

Six of the states included in this survey have no certification requirement for CHWs. Among the other four, Kentucky, Minnesota, and Texas have conditional certification requirements, and Massachusetts has established a board in order to develop certification regulations and requirements. Conditional certification requirements are those that are not required of all CHWs, but under certain conditions are required. Nine of the ten states have some sort of training program, though some are very limited in their scope and availability. Idaho currently does not have any CHW training programs; according to the Idaho contact, April Dunham, Mountain States Group has the capacity to provide general training to CHWs, but she is not aware of anyone taking advantage of that opportunity.

According to Gail Hirsch, of the Massachusetts Department of Public Health, the idea of the Massachusetts legislation is "…to create validation for, and recognition of the skills CHWs possess." To do this, CHW training programs need to consistently cover core concepts and competencies to "…increase understanding of the role and scope of CHWs and to allow them to move more easily from one job to another." The Massachusetts Association of Community Health Workers strongly advocated for these goals in passing the CHW Certification Board legislation, as do many CHW associations nationwide.

Training programs vary from broad and comprehensive programs that are highly accessible, to disease-specific and limited availability programs. Examples of broad, accessible programs include training programs in New Mexico and Texas. Perhaps the most accessible are the three training programs in New Mexico. The New Mexico Community Health Workers Association training program is open to anyone who is interested. Project ECHO offers disease-specific training via teleconference, which makes these types of trainings accessible to CHWs throughout New Mexico, without the need to travel. Additionally, CHW training is available through some of the state's community colleges. Perhaps the most standardized state-wide training program is in Texas, where certification is required for any CHW in a paid position. The training will cover, at a minimum, the same eight core competencies regardless of what organization is providing the training. The coursework is covered through classroom work and on-the-job-training. CHWs who qualify can also attain certification through grandfathering based on experience. The eight core competencies are: 1) communication; 2) interpersonal skills; 3) service coordination; 4) capacity building; 5) advocacy; 6) teaching; 7) organization; and 8) knowledge base.

In Minnesota, certification requirements are conditional. CHWs must be certified to be eligible to bill Medicaid for their services. Those who are not certified may work in the state but their services are not reimbursable through Medicaid. The certification training curriculum is standardized and will soon be available online in addition to being offered at post-secondary institutions, making the program more accessible. This certification requires CHWs to have a high school diploma or GED and to complete a placement test prior to enrollment in the program. CHWs who complete the program receive 14 college credits which can be applied toward other degrees, providing an additional benefit to CHWs seeking to advance their careers through completion of a post-secondary degree.

In Kentucky, certification is also required conditionally. Only those CHWs working in the Homeplace Program are required to have a certificate. To earn the certificate, CHWs in Kentucky must have a high school diploma or GED, complete minimal training in a standardized curriculum, and take continuing education throughout their career. The training covers both core concepts and disease-specific topics.

CHW training has been more limited in Wisconsin where no certification is currently required. Available training programs have been limited to one day conferences and focus primarily on cancer-related topics. Arizona, Georgia, and Mississippi also have training programs that focus primarily on disease-specific training as opposed to broad training, some through on-the-job training, through community colleges, or through church volunteer programs. In Mississippi there is currently work being done to develop a certification that would focus on core skills rather than be disease-specific.

LEGISLATION

Of the ten states contacted, four have passed legislation regarding CHWs (Massachusetts, Minnesota, New Mexico, and Texas). Legislation varies by state but often covers issues such as mandating a study of CHWs in the workforce, making recommendations for the use and funding of CHW positions and CHW certification. Additionally, the state of Minnesota passed a law permitting Medicaid reimbursement of CHW services. See Table 2 for a summary of legislation passed in respondent states.

No legislation has been passed in Arizona, but there is currently a statewide committee forming to work on policy change. In Georgia, the Network would like to focus on passing legislation in the next session. The contact at the Idaho Department of Health and Welfare's Heart Disease & Stroke Prevention expressed low expectations for the likelihood of pursuing or passing legislation on the issue in Idaho, saying the Department of Health does not have the capacity to pursue legislation and the political climate there would not be conducive to passing legislation on the issue.

Legislation has been passed in other states, but is not included in this review. One recent summary of CHW legislation available online from the Michigan Community Health Worker Alliance can be found at http://www.ssw.umich.edu/chw/legislation/CHW%20Overview%20&%20Policy.pdf.

Table 2. Summary of Legislation Passed in Respondent States		
State	**State Legislation Passed**	**Summary of Legislation's Purpose**
Arizona	No	
Georgia	No	
Idaho	No	
Kentucky	No	
Massachusetts	Yes	2006: Legislation passed requiring a study the CHW profession; make recommendations on how to increase the role and sustainability of CHWs 2010: Legislation passed convening a board to develop a program for certification of CHWs. (Board not yet appointed at time of interview.)
Minnesota	Yes	2007: Legislation passed permitting Medicaid reimbursement of CHW services. CHWs must be graduates of accredited Minnesota CHW curriculum program and supervised by approved Medicaid Enrolled Provider.
Mississippi	No	
New Mexico	Yes	2003: Legislation passed initiating a study of CHWs workforce. 2011: Legislation passed requesting that the Department of Health create an office of community health workers, and statewide certification for CHWs.
Texas	Yes	2001 - Legislation passed requiring that state health and human services agencies use certified promotores, to the extent possible, for recipients of medical assistance. CHWs that receive compensation for their services must be certified.
Wisconsin	No	

INITIATIVES

In addition to legislation, a number of states have also implemented initiatives to promote the use of CHWs. Some of the initiatives include raising awareness, researching the role of CHWs, designing certification programs, and working to establish more sustainable funding sources for CHWs services. Initiatives to raise awareness of CHWs were mentioned most often (six respondents), followed by efforts to create policy change (three respondents). Other initiatives mentioned include efforts to implement or expand access to training and certification, and to identify CHWs and research their effectiveness.

Approaches to raising awareness include educational workshops about CHWs, outreach to politicians and government officials, local promotion of the effectiveness and efficiency of CHWs, and building awareness of CHWs through conferences. Policy change was mentioned as a general topic, but was specifically discussed in regards to improving reimbursement of CHW services and health care reform. The PPACA was described as a potential means to improve employment opportunities for CHWs.

Another initiative described was the US Department of Health and Human Services' creation of the HHS Promotores de Salud Initiative in 2011 "to promote utilization of promotores de salud as a means of strengthening outreach and education on the availability of health services and insurance coverage to underserved Hispanic/Latino communities" (US Department of Health and Human Services. Office of Minority Health).

In Idaho, a state with some political, demographic, and regional similarities to Utah, there is currently an initiative underway to align Medicaid health home work with multi-payer medical health homes. This National Committee for Quality Assurance (NCQA) patient-centered medical home pilot program is a state-wide effort that will include the Idaho primary care association, IMA, state government offices, private doctors, and hospital systems. It is hoped that eventually 50 clinics will be involved. This project is currently in the beginning phases.

RECOMMENDATIONS

Recommendations were solicited in regard to initial steps that Utah should take when considering the role that CHWs could play in the state. Representation of key stakeholders was recommended most often (six respondents), followed by building the leadership skills of CHWs and identifying champions for CHWs (four respondents), and forming an association or other state-wide CHW organization (three respondents). Respondents also emphasized the importance that any initiative needs to be grassroots, or bottom-up, with CHWs involved from the beginning. Several described the importance they believed establishing a credentialing process and standardized education had played in their own states. It was also recommended that Utah consider hosting a statewide summit or meeting involving CHWs and stakeholders to identify and discuss steps toward an expanded role for CHWs in the state as well as other topics. Full recommendations can be found in Table 3 below, as well as in the detailed state summaries included in Appendix 2.

Some of the recommendations may be more applicable to Utah than others. For example, while the contact in Mississippi felt that legislation was critical to advancing policy for the benefit of the CHW profession, the contact in Idaho felt that legislation would not be a good first step for Utah. The experiences with CHW-related legislation efforts in Idaho may be more applicable to Utah than those of Mississippi.

In addition, some of the recommendations are substantiated by the existence and expansion of successful programs and initiatives. For example, building CHW leadership or developing a champion for the cause was the second most frequent recommendation (four respondents) for developing the role of CHWs in Utah. The US Department of Health and Human Services' Office on Women's Health has a new initiative called the Women's Health Leadership Institute, which was implemented with the purpose of CHW leadership development (US Department of Health and Human Services. Office on Women's Health, 2011). The design of this program is based on a successful pilot program, began in 2006, called the Border Women's Health Promotora Institute, and run by the Mariposa Community Health Center in Arizona(The University of Arizona. Arizona Prevention Research Center).

Table 3. Recommendations for Engaging CHWs in Utah

State	Recommendations
Arizona	Form a statewide organization with good leadership that includes representatives from all regions of the state.
Georgia	CHW pilot programs should be in areas of greatest need, which tend to be disadvantaged communities, where CHWs can help individuals to overcome barriers and close the gap between the disadvantaged and adequate health care. Focusing efforts on these kinds of projects also tends to produce impactful success stories that can be used to build support for programs.
	Credentialing is important for career-building, and requires standardized training. It will also help people to learn more and understand what a CHW does.
Idaho	A legislative solution was not seen as appropriate for Idaho. Need to consider your environment in creating an approach.

Table 3. Recommendations for Engaging CHWs in Utah	
Kentucky	None mentioned.
Massachusetts	CHW leadership is a critical issue in furthering the profession. CHWs frequently are members of populations that are not typically empowered, so efforts to build leadership skills of CHWs are very valuable.
	Emphasized the importance of both grassroots action stemming from CHWs themselves, as well as a champion within the Department of Health who educates and informs all Health Department programs about the benefits of incorporating CHWs into health systems.
	Develop a CHW association in Utah. Identification and inclusion of key stakeholders is critical, including those from the Health Department, the community, and academia.
	Seek foundation money or grants in order to hold a summit or event of some sort to bring people together to start a discussion of what steps CHWs would like to take in Utah.
Minnesota	Look for opportunities to integrate the role of CHWs into state health care reform efforts.
	Work on education and the establishment of a standardized curriculum is a major starting point in expanding the role of CHWs. This will tend to lead stakeholders to get into more workforce development issues, because it is important to support a viable job market for those who complete the training. An integrated approach is very important. Sustainability should be kept in mind during planning efforts.
	Involve CHWs in activities related to developing the profession in the state. Since it may be difficult to find CHWs that are able to take time away from their jobs to take leadership roles, identify organizations that employ CHWs who would be willing to support their employees' in getting involved in these efforts.
	A large stakeholder meeting or summit may be a good way to initiate efforts and develop an agenda to work toward an expanded role for CHWs in the state. Broad-based partnerships are also important.
Mississippi	Utah Department of Health should identify organizations in the state that engage CHWs and work with CHWs themselves to help them self-identify and self-define their scope of practice.
	Strongly encouraged working through the legislative process, believing that legislation is the most impactful method to make relevant policy changes.
New Mexico	Start an association as one of the first steps in getting started on developing policies and advocating for CHWs. The New Mexico association has brought together a number of stakeholders who have effectively worked together to help promote the CHW model.
Texas	Identifying champions for the role of CHWs both in and out of the health department is important. State certification has been positive for Texas and Beverly believes many other states are following suit. It is crucial to allow the approach – whether incorporating a statewide certification or starting an association – to form from the ground up.
Wisconsin	Involve American Cancer Society in Utah in development efforts since they have been active in promoting the role of patient navigators in other states.
	Involve nursing schools in the state as a way to recruit help for trainings, find volunteer CHWs or interns, and educate future nurses about CHWs.

UTAH ASSESSMENT

From the literature review and national assessment of the role of CHWs, it is apparent that a significant amount of research has been conducted on their work, and CHWs play an important and diverse role in the delivery of services in other states. Little is known, though, on their role in Utah. The state assessment that will be discussed in this section collected information to build base knowledge on the role of CHWs in Utah. Specifically, input was solicited on a variety of areas including:

- What type of organizations engage CHWs and whether CHWs are volunteers or paid;
- What populations are targeted and in what areas of the state;
- What role or function do they serve;
- How are services funded;
- Is there a required education level and is training received; and
- What kind of policy or system changes might make it easier to sustain CHWs?

Given the UDOH's Bureau of Health Promotion role of promoting the health of Utah citizens and supporting the services provided by Utah's health system, the information collected could provide insights on the role the Bureau could play. The data was collected using an online survey tool. The following summarizes the survey methodology, the results, and discusses the findings.

METHODOLOGY FOR UTAH ASSESSMENT

CPPA developed a state assessment on CHWs based on data gathered from the national assessment and the literature review. Questions the survey was designed to answer include who engages CHWs, what populations are targeted, how services are funded, what policy or system changes might make it easier to sustain CHWs, and more. Gail Hirsch of the Massachusetts Department of Health graciously agreed to let us use two questions from the Massachusetts Department of Public Health CHW Workforce Survey of 2008. One question was on earnings (Question 5) and the other on the role or function that CHWs serve (Question 9). Input on all of the survey questions was received from Carl Rush, University of Texas' Institute of Health Policy, and Gail Hirsch. The survey was then sent to the following UDOH staff for review:

- Karen Coats
- Tania Charette
- MaryCatherine Jones
- Dulce Diez
- Nicole Bissonette
- Rebecca Giles

Suggested changes were incorporated as appropriate. It was then programmed in the online survey software, Qualtrics, Inc., and tested by CPPA staff. The survey was then pre-tested by the following individuals in the target population. Suggestions received resulted in minor changes to the survey based on the input.

- Jessica Martinez, Molina Healthcare of Utah
- Victor Arredondo, American Heart Association
- Kathy Froerer, Utah Association of Local Health Departments
- Jorge Arce-Larreta, Alliance Community Services

On June 1, 2012, the survey was made live and it was taken off-line on July 7, 2012. The survey link was forwarded to almost 200 individuals and/or organizations. In addition, it was forwarded to others using what is called a "snowball sample" – the survey is sent to the known target population and they are asked forward it to others as appropriate. Just as a snowball collects snow as it rolls, the survey collects additional respondents as it is forwarded. For example, some individuals agreed to forward or discuss the survey with individuals within their network. One such person was Melissa Zito of UDOH. She presented the survey to the Native American Tribal Leaders and the Urban Indian Organizations. In addition, the last questions on the survey solicited ideas on whom else the survey should be sent to. On an ongoing basis, the suggested entities were reviewed to determine if they had already completed the survey; if not, the link was forwarded. Finally, individuals who received the survey were asked to forward it to other organizations that might engage CHWs.

The following summarizes the number of responses.

- 114 individuals accessed the survey
- 88 individuals responded to some or all questions
- 67 completed the entire survey (although some questions may have been skipped)
- 26 individuals viewed the survey but did not complete any questions

Given the snowball sampling approach, an accurate response rate cannot be calculated. Based on the initial target population of 200, a 44% response rate can be calculated using 88 respondents whether in the initial pool or not.

Since response rates by question varied, the number of respondents to each question is noted as "n." For simplicity, the term "entities" is used to refer inclusively to all types of organizations and agencies targeted in the survey including state agencies, nonprofits, faith-based organizations, and more. If a specific organizational type is being addressed, it will be explicitly stated. Finally, the term CHW is used to refer CHWs as well as promotora(s).

SUMMARY OF FINDINGS FROM THE UTAH ASSESSMENT

Findings from the Utah assessment indicate that CHWs work in a variety of settings, though the number of community based or nonprofit agencies responding to the survey that engage CHWs (24 respondents) was double that of any other type of organization that engages CHWs. Additionally, the majority of individuals interviewed in the Utah assessment (60%) indicated that CHWs within their organization typically work directly with clinical professionals. Responses suggest that, on average, CHWs each perform five of the seven roles of CHWs as categorized by the National Community Health Advisor Study (Rosenthal, et al., 1998). The most common role is "providing culturally appropriate health education and information," and the least common is "providing direct services." CHWs most commonly serve racial and ethnic minorities (especially Hispanic/Latino populations), followed by pregnant women, individuals with disabilities, and individuals with specific diseases (especially diabetes and high blood pressure). A GED or high school diploma was the minimum education level required most often, and most entities in the sample provide training for their CHWs. In response to a question on what the role of the Bureau of Health Promotion (BHP) should be with respect to CHWs, it was suggested that the BHP should provide and support training and licensing for CHWs in Utah, as well as be a champion and coordinator of CHW efforts in the expansion of preventive care.

A plurality of CHWs engaged by respondents' organizations are paid, with full-time positions being more common than part-time, and the greatest number of CHWs earning annually $22,000 to $25,999. A slight majority (56%) of the respondents' organizations provide benefits to their full-time CHWs, while only a few (15%) provide benefits to their part-time CHWs. Over a third of entities provide no benefits. The most common funding source for CHW positions was federal grant categorical funding, and less than a third of respondents' agencies employs CHWs under core operating budgets. In response to a question on policy or system changes that would make it easier to sustain CHW services on an ongoing basis, respondents most frequently made comments on securing or increasing funding sources for CHWs. Respondents felt it was not only important to generate more federal and state funding for sustainability, but it was also important to secure funding to expand the capabilities and practices of CHWs in the community. In addition, changes to the billing scheme for CHWs could facilitate an expansion of services and workforce sustainability, and there is a need to maintain adequate salaries for the CHWs. Respondents suggested that BHP should play a central role in increasing (and in some cases administering) funding streams for CHWs.

Key Points: Utah Assessment

- **CHWs typically work directly with clinical professionals.**
- **The most common role is "providing culturally appropriate health education and information."**
- **The most commonly served populations are racial and ethnic minorities (especially Hispanic/Latino populations), followed by pregnant women, individuals with disabilities, and individuals with specific diseases.**
- **Average annual earnings range from $22,000 to $25,999.**
- **The most common funding source for CHW positions was federal categorical funding grants.**
- **Securing or increasing state and federal funding sources for CHWs would help sustain CHW services.**
- **Changes to the billing scheme for CHWs could facilitate an expansion of services and contribute to workforce sustainability.**

SUMMARY OF UTAH ASSESSMENT BY TOPIC

Summarized below are responses by type and topic. Survey results of quantitative questions are discussed first, followed by qualitative results. The assessment tool, verbatim comments, and full responses to open-ended questions are included in Appendix 3: Attachments from the Utah Assessment.

SUMMARY OF QUANTITATIVE SURVEY QUESTIONS

As noted previously, the survey questions addressed general topics of who engages CHWs, what populations are targeted, how services are funded, and what policy or system changes might make it easier to sustain CHWs. The following sections summarize responses by question. An overview of each question is provided, followed by a chart summarizing the data. Topics covered in the survey included:

- What role or function do CHWs serve;
- How are services funded;
- Is there a required education level and is training received; and
- What kind of policy or system changes might make it easier to sustain CHWs?

ORGANIZATIONAL TYPE

The survey queried respondents on their organization type, prompting them to mark more than one type if appropriate. Of the 88 respondents, over 101 organization types were marked. "Community based or nonprofit organizations" (CBO) were the most common (30%), followed by state and local health departments (18% and 16% respectively). Of these 88 organizations, 80 indicated that they engage CHWs. Not surprisingly, CBOs comprised a majority of respondents that engage CHWs (29%) followed by local health departments (18%) and state health department (15%).

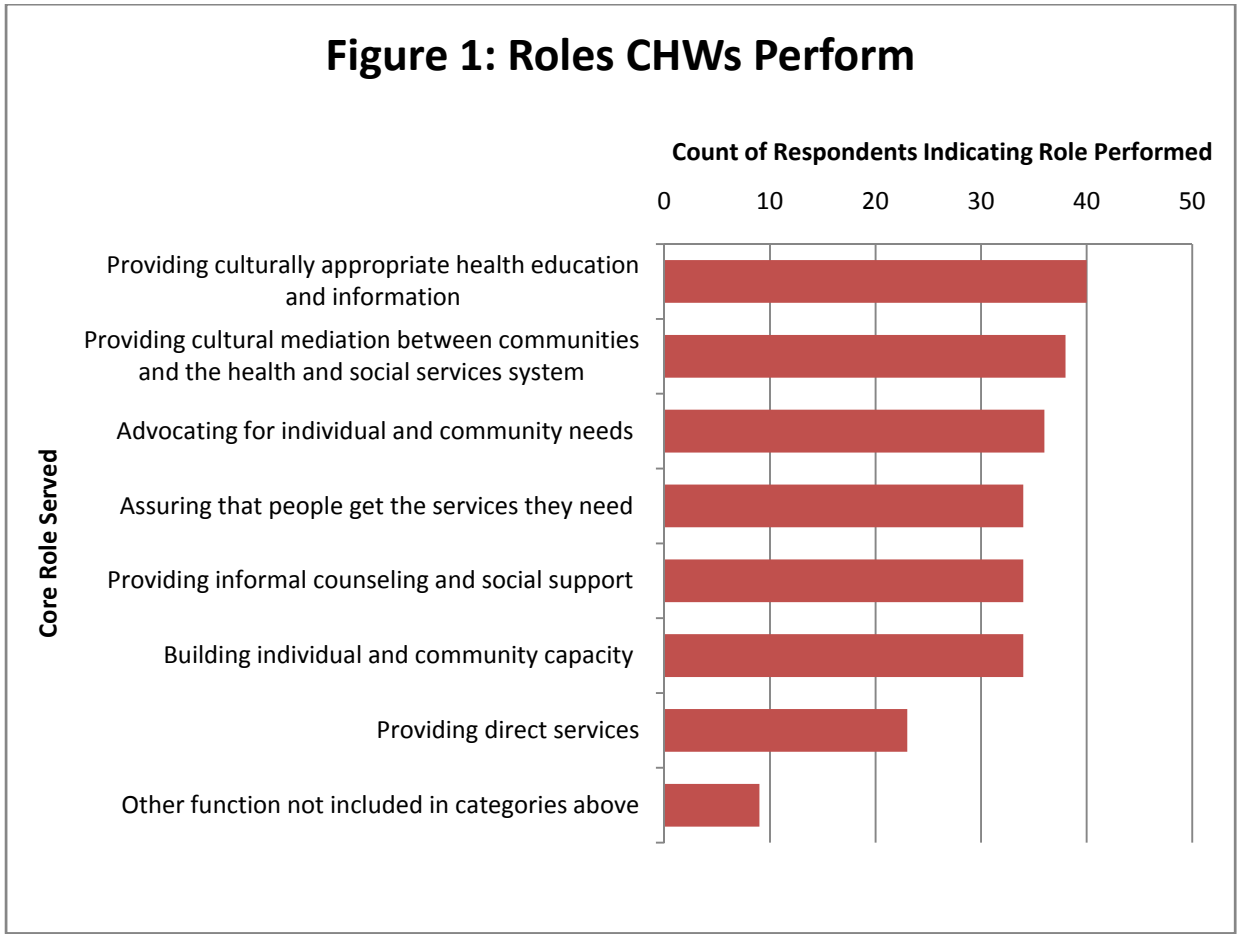
Since the survey was distributed broadly it was assumed that not all entities responding would engage CHWs at present. This was the case with 17 agencies (20%) indicating that they do "not engage CHWs or employees serving in similar capacities." These respondents were asked to respond to a follow-up question: "Is your organization considering or interested in engaging CHWs in the future?" Of the 17 respondents, seven indicated "yes" and 10 respondents indicated "no."

Table 4: Please indicate what type of organization you work for. You may select more than one type of organization.

Organization Type	Number and Percentage of Total (n=88)		Number and Percentage that engage CHWs (n=80)	
	Count	%	Count	%
Community based or nonprofit organization	29	33%	24	30%
State health department	18	20%	12	15%
Local health department	16	18%	14	18%
Institution of higher education, such as junior college or university	8	9%	7	9%
Mental health agency	7	8%	5	6%
Other government agency (local government, association of governmental entities, etc)	5	6%	4	5%
State agency not health (DWS, DSAMH, etc)	4	5%	3	4%
Other entity medically related	3	3%	0	0%
Health care system	2	2%	2	3%
Inpatient facility such as a hospital or care center	2	2%	2	3%
Public outpatient health institution such as a community health center	2	2%	2	3%
Faith-based organization	1	1%	1	1%
Health plan or insurer	1	1%	1	1%
Other	1	1%	0	0%
Private provider including a primary care provider or physician office	1	1%	0	0%
Educational institution such as a K-12 school or day care	0	0%	0	0%

FUNCTIONS AND POPULATIONS SERVED BY CHWS

A CHW may provide a wide array of services in the community. The National Community Health Advisor Study categorized their roles into seven core areas (Rosenthal, et al., 1998). Survey respondents were asked to indicate the roles CHWs currently perform for their agency. The 52 respondents to this question marked over 240 functions or roles performed by CHWs, demonstrating that CHWs in Utah serve multiple functions for each agency (see Figure 1). The three most common roles were each marked by over 35 respondents. The most common function noted was "providing culturally appropriate health education and information," which includes providing information on prevention as well as managing and controlling illnesses such as diabetes and asthma. This was followed closely by "providing cultural mediation between communities and the health and social services system" which includes helping individuals understand how to use these systems, increasing their use of preventive care and decreasing urgent or emergency care. The third most common role was "advocating for individual and community needs" by serving as intermediaries between clients and bureaucratic entities. The full definitions of roles used in the survey can be found in Question 9 of the State Assessment tool in Appendix 3. Since respondents indicated on average almost five core roles, and therefore, counts were high for any given role compared with the others, additional analysis looking at differences by role (e.g. cross-tabulations) did not reveal noteworthy findings.

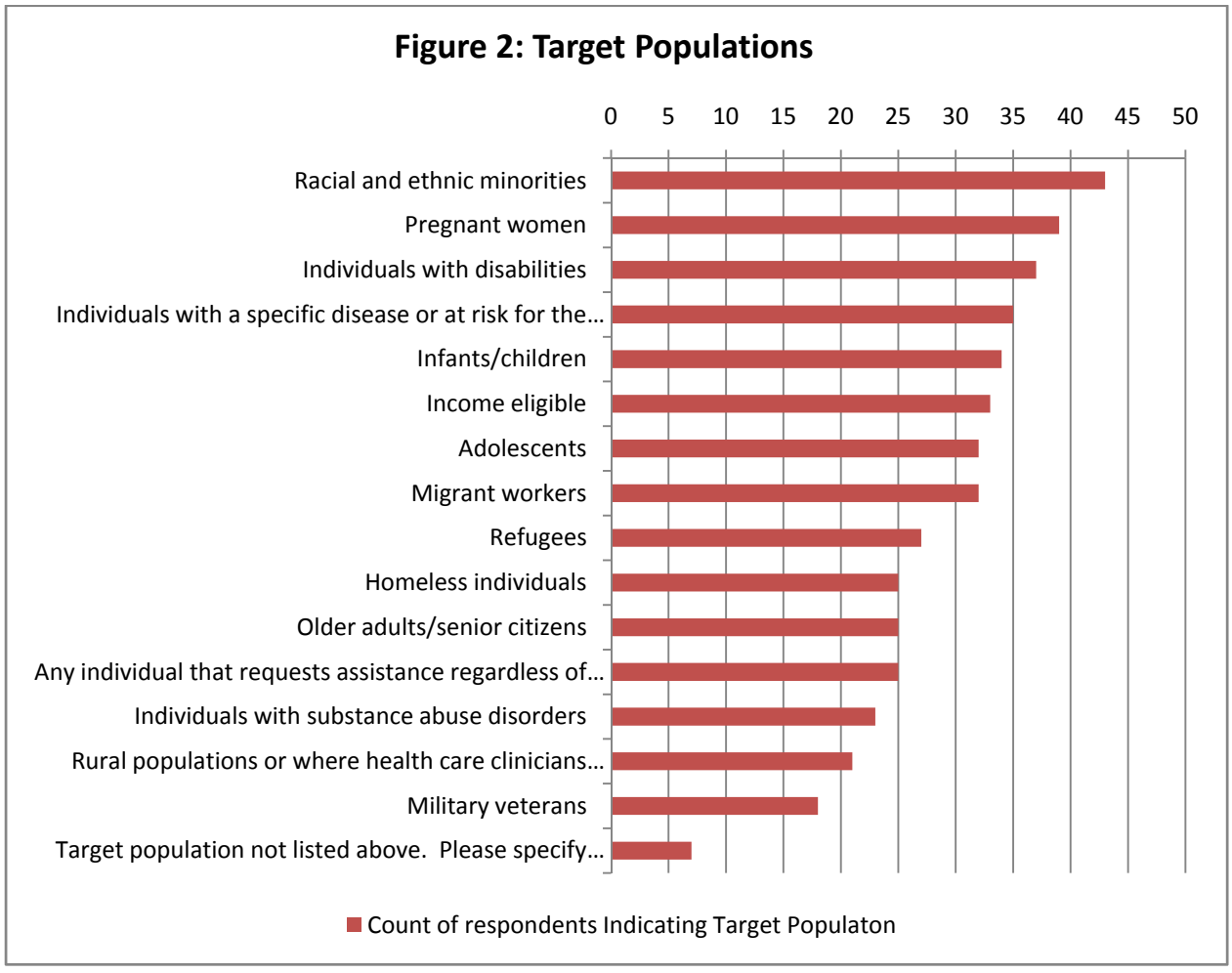


In performing these roles, CHWs frequently work with clinical professionals (see Table 5). This can take many forms, including clinical professionals referring patients to CHWs for services (such as education), or the CHW referring an individual to a doctor after health concerns have been identified.

Table 5: Do CHWs within your organization work directly with clinical professionals? For example, do clinical professionals refer patients to CHWs for services such as diabetes education or do CHWs report specific information to clinical professionals?

Response Categories	Response Count (n=50)	Percentage
Yes	30	60%
No	20	40%
Total	50	100%

In addition to serving many roles, CHWs in Utah provide services to a very diverse target population (see Figure 2). Utah CHWs most commonly target racial and ethnic minorities (43 of 49 respondents) which is not surprising given CHWs' original role in the U.S. of reducing racial and ethnic disparities in health care. Pregnant women, individuals with disabilities, and individuals with a specific disease or at risk for the disease are populations targeted very frequently as well (39, 37 and35 respondents, respectively).



Follow up questions were asked when respondents indicated that their organizations targeted two specific populations: racial and ethnic minorities, and/or individuals with a specific disease or at risk for the disease. As noted previously, the first group was the largest target population. The follow up question revealed, the vast majority of respondents indicated CHWs target Hispanic/Latino populations (83%). This is followed by American Indians/Alaskan Natives, Blacks/African Americans, and Pacific Islanders/Hawaiian Natives populations. Table 6 summarizes this information. Table 7 includes data on individuals with a specific disease or at risk for the disease served by CHWs. Diabetes was cited most frequently, followed by populations with, or at risk for, high blood pressure, heart disease, and mental health conditions.

Looking at the data for the two target populations together, the two findings correlate. CHWs' historical role has been to improve access to and quality of health care services to racially and ethnically diverse communities. The two most commonly targeted racial populations in Utah are Hispanics/Latinos and American Indians/Alaskan Natives. These two populations also have a higher prevalence of diabetes than other racial/ethnic groups. Hispanic/Latino Americans are 1.7 times more likely to be diagnosed with diabetes than non-Hispanic White Americans. In addition, members of the American Indian population are generally more than twice as likely to have diabetes as non-Hispanic White persons (Utah Department of Health, 2012). Thus, the survey results suggest that CHWs have been targeting Utah communities with a higher prevalence of diabetes.

Table 6: Please indicate specific racial and/or ethnic populations your CHW target. Mark all that apply. (n=41)

Response categories	Response Count	Percentage
Hispanics/Latinos	34	83%
American Indians/Alaskan Natives	20	49%
Blacks/African Americans	15	37%
Pacific Islanders/Hawaiian Natives	15	37%
Asian Americans	10	24%
Other: Serve all or do not target populations	5	14%
Refugees and foreign students	3	7%
White/Non-Hispanic	1	2%
Total number of times target populations marked	103	

Table 7: CHWs affiliated with your organization focus on individuals with a specific disease or at risk for the disease. On what specific diseases do CHWs focus? (n=34)		
Response categories	**Response Count**	**Percentage**
Diabetes	20	59%
High blood pressure	14	41%
Heart disease	13	38%
Mental health conditions	12	35%
High cholesterol	10	29%
Cancer	8	24%
HIV/AIDS	8	24%
Asthma	6	18%
Other	6	18%
Child health and development issues	5	15%
Obesity/Nutrition	3	9%
Pregnancy/Breastfeeding	2	6%
Total number of diseases marked	107	

FUNDING

To gain an understanding of how CHW services are funded, respondents were asked to indicate the funding sources that are currently being used to support their program. The 49 respondents marked over 117 sources, ranging from1 to 7 out of a total of 11 possible, and an average of 2.4 (see Table 8). 20 entities did not mark a source of funding for CHW services although the respondent indicated their entity does engage CHWs.

Federal categorical grants are the most common source of funding, with 67% of the respondents indicating this response; followed distantly by Medicaid, state sources, and "other" sources, which were each indicated as funding sources used by 29% of respondents. Looking closer at the 13 state sources specified, seven were UDOH and four were Department of Human Services. Local government sources were noted as "local match to state dollars," county funds, Community Development Block Grants (CDBG), and fees. Responses to the "other" category included four that use federal funding, "DCFS," "corporate sources," "United Way Dixie" and the "University of Utah, School of Pharmacy." Additionally, three respondents who marked "other funding sources" indicated that the CHWs their agency engages are either unpaid volunteers or interns, or are paid by another entity.

Looking at the relationship between the number and types of funding sources by the role or service provided, there does not seem to be a link between specific funding sources and any given services that CHWs provide. Rather, each type of funding source is generally used to fund the various services that CHWs provide. One exception to this trend may be "direct services." A lower percentage of CHWs provide this service than other services (as noted in Figure 1), yet a higher average number of funding sources (3.0 funding sources)are used to fund this service compared to the overall average number of funding sources used to provide services (2.6 funding sources). Also worth noting is that the CHW service of "providing culturally appropriate health education" draws upon a slightly lower than average number of funding sources (2.4 funding sources).

Table 8: To gain a better understanding of how CHW services are funded, please indicate the funding sources your agency currently uses to support your CHW program. Please mark all that apply. (n=49)		
Response Categories	**Response Count**	**Percentage**
Federal grant categorical funding	33	67%
Medicaid	14	29%
State, please specify:	14	29%
Other sources, please specify	14	29%
Funding from a private foundation or entity	12	24%
Local government, please specify:	9	18%
Research grant or contract	7	14%
Program fees	7	14%
AmeriCorps/Vista	3	6%
Medicare	2	4%
Health plan/insurance	2	4%

An additional question related to funding asked if the organization employed any CHWs under their core operating budget (i.e., funding not received specifically for that purpose). The rationale being that funding for CHWs would result in cost savings, revenue generation, or other outcomes valued by the organization, such as educating a client on chronic disease management to avoid higher cost services or an emergency room visit. Of the 46 respondents to the question, 30% (14 respondents) said that they did fund CHWs out of core budgets (see Table 9). Looking at the organizational type indicated by these 14 respondents (3 of which indicated more than one organization type), five were community based organizations, four were with state entities, and two each were local health departments, local government entities, and public outpatient health institutions. Funding sources of these 14 entities were examined in closer detail to attempt to identify common trends between agency funding sources and payment for CHW services from core operating budgets. Due to the small pool of entities (14), however, and great variation in their funding sources, no significant conclusions could be drawn. Aside from this lack of apparent pattern, it is interesting to note that none of the respondents affiliated with an institution of higher education, such as a junior college or university indicated that their agency funds CHWs out of core operating budgets.

Table 9: Does your organization employ any CHWs under your core operating budget (i.e., not funding you receive specifically for that purpose), on the basis of cost saving, revenue generation, or other outcomes valued by the organization. (n=48)		
Response categories	**Response Count**	**Percentage**
Yes	14	30%
No	32	70%
Type of Government Entity		**Count Indicating Employ CHW Under Core Operating Budget**
Community based or nonprofit organization		5
State health department		4
Local health department		2
Public outpatient health institution such as a community health center		2
Other government agency (local government, association of governmental entities, etc)		2
Inpatient facility such as a hospital or care center		1
Mental health agency		1
Note: other organizational types not included since they did not indicate funding CHWs from core operating budgets.		

ORGANIZATIONAL TYPE AND ENGAGEMENT OF CHWS

Like many other types of workers, CHWs can be engaged by entities in a variety of ways. Respondents indicated that their entities engage CHWs most commonly as paid employees (49%) followed by volunteers (37%), independent contractors (26%), and interns or students enrolled in a service learning class (26%). Responses are summarized in Table 10. In the "other" category (13 responses), respondents' comments show that the relationships are often complicated. For example, comments indicated more complex engagement arrangements with CHWs such as partnerships: "Our consortium partners … pays for promotoras," or "HRSA funded patient navigation projects with American Indians." and "Our promotoras are placed in our clinic by a CBO, Holy Cross Ministries, who employs them"; indirect engagement: "We contract with agencies that use CHWs"; and limited engagement arrangements: "Stipend for project activities in a grant." Full responses are provided in Appendix 3: Attachments from Utah Assessment.

Table 10: Does your organization engage CHWs in any of the following ways? Please mark all that apply. (n=87)

Response Categories	Response Count	Percentage
Paid employees	43	49%
Volunteers	32	37%
Independent contractors	23	26%
Interns and/or students enrolled in service learning classes	23	26%
Other, please specify	13	15%
AmeriCorps and/or Vista workers	8	9%
Our organization does not engage CHWs or employees serving in similar capacities.	17	20%

To help further define the contribution of CHWs to entities in Utah, respondents were asked to provide an estimate of the total numbers of hours worked per month by all CHWs affiliated with their entity. The 42 entities responding indicated that CHWs worked over 21,500 hours per month, with a monthly average of 518 hours per agency, and a range of 3 hours to 4400 hours per month.

Table 11: Summary of CHW hours worked

Total number of hours worked by all CHWs engaged by respondents (n=42)	21,500 hours/month
Average hours CHW work per month by agency	518
Range of average hours per month	3-4,400

Historically, CHWs have often been engaged as part of a research or pilot project (as was noted in the literature review and the national assessment). This appears to continue to be a prevalent means for employing CHWs in Utah, with 34% of respondents indicated that CHWs are employed or engaged as part of a pilot program or research project.

CHW COMPENSATION AND BENEFITS

Excluding those who indicated that their agency only engages CHWs as volunteers, respondents were asked a series of questions regarding the number of CHWs that receive payment, how much they earn, and whether benefits are provided. Twenty-four respondents indicated their entity employed one or more fulltime CHW.

Together, these entities paid an average of 11.7 full-time workers with a range of 1 to 55 workers. In addition, 37 respondents indicated employing one or more part-time CHW. On average, these entities employed 7.3 part-time workers, which includes those working only a few hours a week or month. (see Table 12)

The average number of paid full-time CHWs per respondent (11.7 excluding outlier) is higher than the average number of paid part-time CHWs per respondent (7.8 excluding outlier); however, some respondents had more part-time CHWs than full-time. Notably, universities used part-time CHWs but not full-time CHWs. Mental health agencies, and other government agencies, used more part-time than full-time CHWs.

Table 12: Summary of CHWs employment and benefits for entities that provide payment to CHWs

	Full-time	**Part-time**
Average number of paid CHWs by entity**	11.7 (n=24)	7.3 (n=37)
Range of CHWs**	1-55 (outlier of 500)	1-55 (outlier of 500)
Estimated number of CHWs that receive payment **	281	270
Average number that receive earnings by entity	31.2 (n=25)	20.3 (n=38)
Range	1- 500	1- 500
Estimated number of CHWs that receive payment	781	770
Estimated number that received benefits (n=39)	31	6
** Excludes outlier of full-time employed of 500 and part-time employed of 500		

Table 13 summarizes the earnings information for CHWs, as provided by respondents. Looking at the relationship between compensation paid by role of the CHW, CHWs providing direct services are more likely to be paid. Similarly, comparing the numbers of CHWs in paid positions by role of the CHW, the average number of full or part-time paid CHWs (18.1 and 9.7, respectively)providing direct services is higher than for any other category of roles or services provided by CHWs. The average number of paid full-time CHWs by role ranged from 10.1 to 18.1, with an overall average of 13.3 CHWs; for paid part-time workers, the average was 5.8 to 9.7, with an overall average of 7.4 CHWs. CHWs providing "culturally appropriate health education" were also more likely to be in paid positions.

Table 13: Estimated number in earning categories

Earnings	**Total respondents indicating staff in salary range**	**Minimum/ Maximum # employed in range by an entity**	**Total employed in the earnings range**
Less than $9.00 per hour (less than $18,000 per year full-time annualized salary)	3	3/40	47
$9.00 - 10.99 per hour ($18,000-21,999 per year)	9	1/25	54
$11.00 - 12.99 per hour ($22,000-25,999 per year)	15	1/21	132.7
$13.00 - 14.99 per hour ($26,000-29,999 per year)	13	1/11	66
$15.00 - 19.99 per hour ($30,000-39,999 per year)	17	1/250	327
$20.00 or more per hour ($40,000 or more per year)	13	1/250	328
$15.00 - 19.99 per hour ($30,000-39,999 per year) excluding outlier of 250	*16*	*1/22*	*77*
$20.00 or more per hour ($40,000 or more per year) excluding outlier of 250	*12*	*1/20*	*78*

With respect to benefits, the majority of respondents indicated that full-time CHWs received benefits (56%) but only 15% indicated that part-time CHWs receive benefits. In contrast, 38% of respondents indicated that CHWs do not receive benefits.

Table 14: Do CHWs receive benefits (n=39)

Response categories	Response Count	Percentage
Full-time CHWs receive benefits	22	56%
Part-time CHWs receive benefits	6	15%
CHWs do not receive benefits (Marking this excludes other responses to this question)	15	38%

Of the 32 entities that engage volunteers, 19 indicated the average number of volunteers affiliated with their organization. Of these, the respondents engaged a total of 172 volunteers on either a part-time or full-time basis. The average number per agency was 9 volunteers with a range from 1 to 35.

EDUCATIONAL REQUIREMENTS AND TRAINING PROVIDED

Given that a key component of CHW roles per the APHA "is an unusually close understanding of the community served," it is not surprising that the minimum education level required by the largest percentage of respondents is a GED or high school diploma (43%), followed by "no educational requirement" (27%). Of course, the CHWs could have a higher level of education than the minimum requirement (See Table 15).

Table 15: What is the minimum education level required for CHWs engaged by your organization? (n=49)

Response categories	Response Count	Percentage
No educational requirement	13	27%
GED/high school diploma	21	43%
Associate degree	6	12%
Bachelor degree	8	16%
Master degree or above	1	2%

Almost all of the CHWs engaged by organizations receive some type of training, with 51 of 52 entities responding that training is provided (see Table 16). Fifty respondents indicated over 117 training categories. The most common types of training provided are structured in-house training (78%) and "on-the-job training by shadowing others" (68%). These are followed distantly by "training provided by an educational institution just as a junior college" (34%).

Table 16: What training is provided? Please mark all that apply. (n=50)		
Response categories	**Response Count**	**Percentage**
Structured in-house training	35	70%
On-the-job training by shadowing others	34	68%
Clinic based training	17	34%
Training provided by an educational institution such as junior college	10	20%
Conferences/workshops*	7	14%
Trained by partner agency(ies)*	6	12%
Program specific*	6	12%
Other, please specify	2	4%
*Categories created based on responses to "Other"		

PRIMARY ROLE OF RESPONDENT

The survey respondents were asked to describe their position within the entity that they represent (see Table 17). The majority of the 88 respondents were in management positions including 37% executive directors or senior managers and 18% managers or supervisors. This was followed by outreach/education staff or coordinators (9%).

Table 17: Please indicate your primary role in your organization (n=88)		
Response categories	**Response Count**	**Percentage**
Executive director or senior manager	33	38%
Manager or supervisor of CHWs and/or other staff	16	18%
Outreach/education staff or coordinator	8	9%
Clinical staff, for example nurse or other licensed medical clinician	6	7%
Other	5	6%
Program Manager	5	6%
Service Provider	5	6%
Administrator, such as human resources and/or trainer	3	3%
Administrative assistant	3	3%
Case Manager	2	2%
Researcher/Professor	2	2%

Respondents were asked to indicate what counties they provided services in and an option was provided to mark "all counties in Utah." As summarized in Table 18, the most commonly marked county was Salt Lake County (55%), followed by Davis (20%), Weber (16%), and Summit and Wasatch Counties (14% each). The top three counties noted are among the four largest counties in Utah so these results are not surprising. In contrast, Summit and Wasatch are the 10th and 13th largest counties.

No respondents specifically indicated providing CHW services in 10 counties: Carbon, Emery, Grand, Juab, Millard, Piute, Rich, Sanpete, Sevier, and Wayne. It may be that there are CHWs working in these counties, but that those entities employing them did not respond to the survey. These counties also are likely covered by the entities of the eight respondents marking "all counties in Utah."

Table 18: To gain a better understanding of where CHWs work within Utah, what counties does your agency use CHWs to provide services? Please mark all that apply. (n=49)

Counties	Response Count	Percentage	Counties	Response Count	Percentage
All counties in Utah	8	16%	Uintah	3	6%
Salt Lake	27	55%	Beaver	2	4%
Davis	10	20%	Box Elder	2	4%
Weber	8	16%	Duchesne	2	4%
Summit	7	14%	Garfield	2	4%
Wasatch	7	14%	Iron	2	4%
Utah	6	12%	Kane	2	4%
Tooele	5	10%	Daggett	1	2%
Washington	5	10%	Morgan	1	2%
Cache	4	8%	San Juan	1	2%

SUMMARY OF COMMENTS ON POLICY, CHWs AND THE BUREAU OF HEALTH PROMOTION'S ROLE

Three of the survey questions were open-ended, meaning they provided an opportunity for respondents to provide their input without constraint. The questions invited input on three topics: policy or system changes to sustain CHWs services; the role the Bureau of Health Promotion should play with respect to CHWs; and additional thoughts. A summary of comments is provided here, and verbatim comments are included in Appendix 3.

POLICY OR SYSTEM CHANGES TO SUSTAIN CHW SERVICES

With respect to policy or system changes that would make it easier to sustain CHW services on an ongoing basis (question 16), respondents most frequently made comments on securing or increasing funding sources for CHWs. Respondents felt it was not only important to generate more federal and state funding for sustainability, but also to secure funding to expand the capabilities and practices of CHWs in the community. Many respondents mentioned that relying too heavily on grant funding is a concern, and that state and federal dollars would be useful at a local level. In the words of one respondent, "suffice it to say that all of our programs are dependent on a lot of state and federal funding. Should that funding be discontinued, so would our programs." In addition, changes to the billing scheme for CHWs could facilitate an expansion of services and workforce sustainability. Several respondents mention that billing codes in Medicaid and grants that link services together across programs would facilitate CHW integration and patient management. Respondents also felt that maintaining adequate salaries for the CHWs was important, as many of these individuals need income to support themselves and families. In the words of one respondent, "People do not need to be volunteers forever; they need to support their families as well." One respondent also mentioned the capacity to offer fringe benefits.

Two respondents explicitly mentioned that it would be useful to have a state-wide recognition for licensed CHWs. Furthermore, several other respondents emphasized the importance of being sure that CHWs have "foundational information and skills consistent with best practices and core standards." This training could be offered through a certificate or associate's degree obtained at an institution of higher education. Of course, as one respondent indicated, "Caution has to be taken because when standards are put in place, the ethnic communities become marginalized or excluded by the standards/policies." In other words, CHWs' link to the communities is a key aspect of CHW services, and a poorly designed training and certificate program could jeopardize this link.

A few respondents stated that increasing the CHWs services offered to targeted communities, such as the under-insured and uninsured, would enhance the CHW workforce. One respondent stated that partnering with private hospitals and clinics could provide an effective venue through which CHWs can emphasize preventive medicine.

BUREAU OF HEALTH PROMOTION ROLE WITH RESPECT TO CHWs

One of the last questions on the survey, asked respondents to provide input on the role the Bureau of Health Promotion should play with respect to CHWs given the Bureau's mission of promoting the health of Utah citizens and supporting services provided by Utah's health system (question 20). Comments addressed a number of areas including training of CHWs, promoting the role of CHWs, funding, and promoting collaboration and innovation across organizations.

The most common response was that the Bureau of Health Promotion (BHP) should provide and support adequate training for CHWs in Utah, increasing their expertise and competencies "on topics relevant to the positions they hold." These comments were followed by remarks stating that BHP should provide strong leadership in the establishment of standards and policies for CHWs working in Utah. This includes the creation of a state licensing program for CHWs and the administration of CHW subcontracts to organizations wanting to use CHWs in their programs. Several respondents stated that placing direction and oversight within BHP will ensure that the CHW workforce is adequately, properly and consistently trained.

Another frequent response was that BHP should be a strong champion and coordinator of CHW efforts in the expansion of preventive care. There were several strategies on this topic mentioned by respondents, including updating CHWs on what resources are available to them and on outreach projects for targeted populations, providing professional support to the CHW network, and promoting and advertising the purpose, abilities and successes of CHWs across Utah communities. Several respondents suggested that BHP foster collaboration and innovation across organizations utilizing CHWs, including health care providers, local communities, and local health departments.

Respondents also indicated that BHP should work to increase and secure funding streams for CHW projects, as well as administer the funding that goes to programs utilizing CHWs. In addition to securing and administering funding, BHP can play a strong role in the collection and analysis of data on the effectiveness and impact of CHWs in health promotion. One respondent stated that BHP could "evaluate their role and effectiveness in other states and determine how we could benefit from providing funding and training for these workers" in Utah.

ADDITIONAL THOUGHTS OR COMMENTS REGARDING CHWs

The additional comments provided by 21 respondents reflected general themes in the survey (question 22). Respondents highlighted the important role that CHWs can or do play. As one person states, "CHWs who are bi-/multilingual and bi-/multicultural can be indispensable as cultural brokers when working with specific communities, especially certain immigrant/ethnic groups." Unfortunately, as another indicates, CHWs are "highly valued and under-utilized."

Respondents did indicate that the functions served by CHWs/promotoras are frequently called by a different name. Despite some confusion over the label used, the role is seen as important. Weber Human Services is partnering with other entities to integrate physical health into the mental health setting, focusing on an

individual's whole health in a health home concept. Relating the work to what CHWs perform, "We hope to impact people having a better life, cut costs to emergent facilities, and promote quality health to avoid high cost physical health services as people age."

Respondents also noted that CHWs could be a valuable addition to their existing approach to providing services. A few additional respondents want to be involved in one way or another. One specifically mentioned that "Utah Colleges of Applied Technology … statewide network would welcome the opportunity to provide this level of training."

DISCUSSION & RECOMMENDATIONS

Collaboration and Stakeholder Input

CHWs work in a diverse range of settings and institutions. As such, it is difficult to account for the unique needs and concerns of CHWs in various roles and organizational types. Therefore, it is important to collaborate with stakeholders in planning and strategizing to expand the role and development of the CHW profession in Utah. Input from the other states suggests that the UDOH help those interested in helping with this expansion, including CHWs themselves, assemble to discuss how to increase the effectiveness of CHWs. The findings from the Utah assessment indicate that overall the respondents would support this.

Another benefit of assembling stakeholders and other key health care industry representatives is to increase support for and to advance the profession. To this end, some states included in the national assessment have used meetings as educational opportunities to build support and understanding for the CHW profession. Establishing an association or network of CHWs in Utah may serve as a useful tool for bringing stakeholders together around a common issue and encouraging collaboration. As stated by Gail Hirsch, Director of the Office of Community Health Workers within the Massachusetts Department of Public Health, CHW associations serve as "the voice of CHWs, build professional identity, and train, unify, and advocate for the profession." In the national assessment it was strongly emphasized that the establishment of an association or network should be grassroots, but the Department of Health could play a key role in identifying a champion – or champions – and stakeholders and supporting and encouraging these individuals or entities in their efforts. Interviewees described partnerships as critical to building the CHW profession and helping states meet their goal of improving patient care and health system efficiency. The contacts established through the state assessment may serve as a starting point in identifying and reaching out to stakeholders interested in working together to further the role of CHWs in Utah.

Funding

As noted in the literature review, national assessment, and Utah assessment, significant issue facing the development of the CHW workforce is sustainable funding. The majority of programs utilizing CHWs rely on short-term funding streams from grants and government agencies. The formation of sustainable funding is essential to the advancement of the CHW workforce. The Utah assessment respondents noted the same concerns with current lack of sustainable funding.

A number of states are studying alternatives in an attempt to find more sustainable sources of funding for CHW services. For one, payment of CHWs from core operating budgets may provide a sustainable source of funding for CHWs; however, it is not commonly used. Utah should look for ways to promote employment of CHWs under core operating budgets as a way to reduce overall costs for entities. Another potential source of sustainable funding is Medicaid.

The national survey identified states that use Medicaid funding streams, both direct reimbursement and capitated payments in which a health plan or doctor receives payments from Medicaid, which it uses to employ or contract for services of a CHW. Additionally, the Patient Protection and Affordable Care Act (PPACA) has created opportunities for use of Medicaid for CHW services. The Accountable Care Organizations (ACO) and Patient Centered Medical Homes (PCMH) promoted within the PPACA offer CHWs a potential entry point into health care models being developed. In return, the incorporation of CHWs into ACOs and PCMHs can facilitate Medicaid financing and coverage by commercial insurance providers.

Several factors must be addressed when considering sustainable financing: clarification of CHW roles in health care, establishment of common payment and reimbursement policies, adequate and appropriate supervision mechanisms, and increased data collection for analysis and evaluation of program impact and return on investment.

Measurement

As noted in the literature review, there is a general need to increase consistent, standardized measurement of outcomes and cost-effectiveness of CHW programs. This can impact issues related to the advancement of the CHW profession including development of sustainable funding. Both the literature review and the national survey revealed that many efforts are under way to study CHWs, taking place in the academic realm, in national, state and local government programs, and nonprofit and community based organizations. Some standardized measures have begun to emerge, such as the seven core roles of CHWs, however, other areas of measurement have yet to achieve reliable, consistent measurement. Respondents to the Utah CHW survey suggested that the Bureau of Health Promotion in the Utah Department of Health take an active role in collecting data and assessing the work that CHWs do. In doing so, the BHP should attempt to identify and use methods of data collection and measurement that are consistent with any emerging national standards and best practices. As one example, even with the growing awareness of CHWs, recognizing CHWs frequently presents a problem for organizations. Therefore, the BHP should play an active role in adopting and promoting awareness of standardized titles and definitions of roles that CHWs play in health care in Utah in order to facilitate recognition of CHWs. The Bureau of Labor Statistics in the US Department of Labor created a new occupational classification code for CHWs in 2010. This can be used to standardize definitions of CHW roles for evaluation purposes.

Information that should be collected using standardized measures includes:

- Information to facilitate understanding of who CHWs are and how they work can facilitate workforce growth and development, and also allow cross-comparison and evaluation of programs utilizing CHWs in similar functions and capacities.
    - Descriptive data on CHW recruitment, training, supervision, evaluation, and reimbursement policies
    - Information on the backgrounds and demographics of CHWs
- Information on interventions programs and goals to understand the variation in CHW roles (CHW roles vary according to the goals, purpose, and design of each program and intervention).
- Information to pinpoint what elements of CHW participation are important in producing successful patient outcomes.
- Information to capture both the short and long-term impacts of CHWs, using cost and benefit measures that are comparable across different CHW programs and functions.
    - New forms of economic assessment that capture costs for tailored CHW interventions, such as budget impact analysis, may yield more useful information for individual organizations.

CHW Training and Certification

To strengthen and validate the profession, many of those contacted in the national survey were looking at developing training and certification standards, as a means of increasing awareness and inclusion of CHWs into mainstream health care systems. Some states have legislated certification and training standards. These create validation for, and recognition of the skills CHWs possess. In some cases, standardized training has facilitated the building of sustainable funding streams, such as Medicaid reimbursement. CHW training programs need to consistently cover core concepts and competencies to increase understanding of the role and scope of CHWs and to allow them to move more easily from one job to another. National survey interviewees indicated that there is strong support within their states for developing a standardized, state-wide curriculum that covers core concepts and roles shared by CHWs working in diverse jobs and organizations. Many also found topical trainings useful for CHWs working with specific populations.

The role of state health departments in CHW training and certification varies across those states interviewed. In some cases, the health department oversees the trainings and ensures that they meet the established training requirements and maintain a record of those CHWs who have completed the trainings or certification requirements. In other areas, training has been developed and provided by institutions of higher education, which may be helpful in establishing a training curriculum in Utah. The accessibility of trainings should be taken into consideration if any state-wide training or certification is pursued.

CHW Workforce: Special Concerns

CHWs have become recognized as significant public health figures in the reduction of racial and ethnic disparities in healthcare, and studies have demonstrated that CHWs play key roles in high priority health care issues, such as the management of chronic illnesses, reduction of health care costs, and improvement of access and continuity of health insurance coverage. As such, not only the CHW workforce, but the health care system as a whole can benefit from efforts to validate, expand, and sustain their roles. Through these efforts, though, the unique qualities of CHWs that makes them so effective need to be identified and preserved.

CHWs' link to the communities they serve is a key aspect of CHW services. In reviewing CHWs' seven core roles the key component that emerges is the cultural component which is unique to CHWs. As such, training, certificate, and other CHW program elements need to be designed so that they do not jeopardize this link. Additionally, national survey respondents recommended building the leadership skills of CHWs and identifying champions for the promotion of the profession. These leaders can then act as representatives of CHWs in protecting their interests and meeting their needs.

It was strongly emphasized that efforts to build the CHW profession in Utah should be grassroots and must be supported by CHWs themselves. Thus, the identification of specific strategies to move forward should be done in conjunction with partners, stakeholders, and CHWs.

WORKS CITED

Cancer Patient Navigators of Georgia. (2012). *Cancer Patient Navigators of Georgia*. Retrieved July 14, 2012, from http://www.gacancerpatientnavigators.org/

American Public Health Association. (2012). *APHA: Community health workers*. Retrieved July 11, 2012, from American Public Health Association: http://www.apha.org/membergroups/sections/aphasections/chw/

American Public Health Association. (2009, November 10). *Support for community health workers to increase health access and to reduce health inequities*. Retrieved April 25, 2012, from Policy Statement Database: http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1393

Arizona Community Health Outreach Workers Network. (n.d.). *About*. Retrieved July 14, 2012, from AZCHOW: http://azchow.org/about/

Balcazar, H., Rosenthal, E. L., Brownstein, N., Rush, C. H., Matos, S., & Hernandez, L. (2011). Community health workers can be a public health force for change in the United States: Three actions for a new paradigm. *Am J Public Health, 101* (12), 2199-2203.

Bureau of Labor Statistics. (2010, March 11). *Standard Occupational Classification: 21-1094 Community health workers*. Retrieved August 6, 2012, from Bureau of Labor Statistics: http://www.bls.gov/soc/2010/soc211094.htm

Centers for Disease Control and Prevention, National Heart Disease & Stroke Prevention Program. (2010, Fall). *Strategies for States to Address the "ABCS" of Heart Disease and Stroke Prevention.* Retrieved August 6, 2012, from CDC National Heart Disease and Stroke Prevention Program: http://www.cdc.gov/DHDSP/programs/nhdsp_program/docs/ABCs_Guide.pdf

Dower, C., Knox, M., Lindler, V., & O'Neil, E. (2006). *Advancing Community health worker Practice and Utilization: The Focus on Financing.* San Francisco, CA: National Fund for Medical Education.

Felix, H. C., Mays, G. P., Stewart, M. K., Cottoms, N., & Olson, M. (2011). Medicaid Savings Resulted When Community health workers Matched Those With Needs To Home And Community Care . *Health Affairs, 30* (7), 1366-1374.

Goodwin, K., & Tobler, L. (2008). *Community health workers: Expanding the Scope of the Health Care Delivery System.* National Conference of State Legislatures.

Molina Healthcare. (2012). *About Molina*. Retrieved July 11, 2012, from Molina Healthcare: http://www.molinahealthcare.com/abtmolina/Pages/abtmolina_home.aspx

National Center for Chronic Disease Prevention and Health Promotion. (2010). *Addressing chronic disease through community health workers: A policy and systems-level approach.* Policy brief on community health workers, Centers for Disease Control and Prevention, Washington, DC.

Perez, L. (2011). *Community health workers in the US and Florida: Reducing costs, improving health outcomes and creating a pathway to work.* Collins Center for Public Policy. Tallahassee, FL: Collins Center for Public Policy.

Rosenthal, E. L., Wiggins, N., Brownstein, J. N., Johnson, S., Borbon, I. A., Rael, R., et al. (1998). *The final report of the national community health advisor study: Weaving the future.* Funded by the Annie E. Casey Foundation, A Policy Research Project of the University of Arizona.

Rush, C. H. (2012). Return on investment from employment of community health workers. *J Ambul Care Manage, 35* (2), 133-137.

Sebelius, K. (January, 19 2012). *2012 Poverty Guidelines, Federal Register Notice*. Retrieved July 19, 2012, from U.S. Department of Health and Human Services: http://aspe.hhs.gov/poverty/12fedreg.shtml

The University of Arizona. Arizona Prevention Research Center. (n.d.). *Capacity Building and Training*. Retrieved July 16, 2012, from Arizona Prevention Research Center: http://azprc.arizona.edu/projects/capacity_building_training

US Department of Health and Human Services. Office of Minority Health. (n.d.). *HHS Promotores de Salud Initiative*. Retrieved July 16, 2012, from The Office of Minority Health: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=207.

US Department of Health and Human Services. Office on Women's Health. (2011). *Women's Health Leadership Institute* . Retrieved July 16, 2012, from http://www.whli.org/

Utah Department of Health. (2012, July 20). *Relevant Population Characteristics for Diabetes Prevalence*. Retrieved August 6, 2012, from IBIS-PH Indicator Report Related Indicators - Diabetes Prevalence: http://ibis.health.utah.gov/indicator/related/PopChar/DiabPrev.html

Witmer, A., Seifer, S. D., Finocchio, L., Leslie, J., & O'Neil, E. H. (1995). Community health workers: Integral members of the health care workforce. *Am J Pub Health, 85* (8), 1055-1058.