Family Strengthening Policy Center

Policy Brief

An Initiative of the National Human Services Assembly

NATIONAL HUMAN SERVICES ASSEMBLY

Community Health Workers:

Closing Gaps in Families' Health Resources

Policy Brief No. 14

Low-income families face multiple barriers to accessing timely, quality services necessary to protect their health. A wide variety of organizations have found community health workers can play a critical role in helping families manage their health.

Overview

On the frontlines. Families' sole linkage into health care. Speaking their language. Bridging cultures and navigating health and human service systems. The goal? Empowering families to manage their health. Community health workers do all this and more. Indeed, community health systems are increasingly using these paraprofessionals to reach low-income families with children.[1-3]

When parents have good physical and mental health, they have more energy and a greater ability to nurture their children.[4] Family health is also essential to family economic success. Just half of the US workforce has paid sick days for themselves; even fewer can tap paid leave when their children are sick.[5] Among low-income families, ill health can be common. For example, parents with family incomes below the poverty line experience high rates of health problems.

- 33 percent describe their mental health as poor.
- Only 37 percent indicate their health is excellent or very good.[4]

Low-income families face multiple barriers to accessing timely, quality services necessary to protect their health. The community health sector is among the social systems that should be in close contact with low-income families with children. However, many low-income families live in neighborhoods where health resources are limited.

Common community-level barriers include:

- Shortages of health professionals in low-income or rural communities.[6, 7]
- Inadequate safety net resources (such as community clinics providing primary care).[8, 9]
- Insufficient access to employer-provided or otherwise affordable health insurance coverage.[10, 11]

- Service fragmentation in community health and human service sectors.[9, 12]

A wide variety of public, nonprofit and corporate organizations have found community health workers (CHWs) can play a critical role in helping families manage their health (*see the textbox,* A Family-Strengthening Definition of Community Health Worker*, below*). Specifically, CHWs leverage their insiders' understanding of the families they serve to expand and enhance their health resources.[13] Only a small subset of CHWs provides medical care.

Facing an ever-diversifying demographic base, health and human service practitioners want to increase the use of CHWs.[1-3] Their experience indicates CHWs are particularly effective in reaching vulnerable and underserved families.[1, 14] These practitioner perspectives are mirrored by a growing research base that indicates CHWs increase underserved populations' access to health care.[15-17] (*See the section,* Are CHWs Effective?*, beginning on page 4*.)

Changes in public policies would help CHWs become a sustainable and highly effective component of health and human service delivery. Organizations serving families with children also can take steps to realize the potential of CHWs. (*See recommendations, which begin on page 7.*)

A Family-Strengthening Definition of *Community Health Worker*

In the context of strengthening families, ***community health workers*** **(CHWs) are trained paraprofessionals who serve as health and human service resource persons in the communities where they live and work.** As trusted members of the communities they serve, CHWs primarily assist isolated and vulnerable families. Key roles include:

- Helping families locate and connect to a full range of community resources.
- Providing culturally appropriate education and outreach to help families and communities take charge of their health and wellbeing.
- Delivering direct services – education, advocacy, social support and more – to vulnerable and underserved clients in their homes and community settings.

The Facts: Families at Risk for Ill Health

Low-income children and adults experience more illness, injuries and disabilities than middle- and upper-income groups.[18] Differences in health care access and conditions associated with socioeconomic disadvantage partially explain these health disparities.[19]

Health Care Access

Many low-income families face one or more barriers to getting quality, timely health care.[1, 4, 8, 9, 14, 15, 20, 21]

- Un- or underinsured.
- Limited means for out-of-pocket health care costs, including co-payments.
- Cultural and language differences with providers.
- Transportation difficulties.
- Lack of child care.
- Inadequate supply of primary care providers and specialists in neighborhood.
- Gaps in knowledge of how to access community-based care.
- Institutional bias.

- Isolation.
- Literacy deficiencies.
- Gaps in Medicaid coverage.

The problems low-income families currently encounter in accessing health care are likely to worsen because of:

- Recently adopted changes in Medicaid.[22]
- The erosion of employer-based health care coverage for low-wage workers.[11]
- Ongoing declines in federal per capita spending on the health care safety net. [9]

If the shortfall in community health resources worsens, there will be an increased need for CHWs who can advocate for low-income families and other underserved populations.

Other Barriers to Staying Healthy

Hazardous living and working conditions also undermine the health of low-income persons, as do gaps in knowledge, skills and resources necessary to maintaining healthy lifestyles.[19, 23] Thus, addressing the "health" needs of low-income families often requires coordinated delivery of services from multiple social systems. However, far too many "multi-agency" families encounter a fragmented service delivery system.[12]

- In particular, many health care providers lack connections to human services. Yet, hunger, inadequate housing, financial problems, unemployment and other socioeconomic circumstances also affect health. The lack of connections between sectors creates gaps in needed supports for families.[1, 9, 12]
- Within the health care safety net, coordinating services is difficult due to fragmented service delivery. (Community health centers, public hospitals and local health departments form the core of the safety net. Other organizations also contribute: clinics in schools or churches, private health care providers, hospital emergency departments and more.)[9]

Building Good Health Case Study: Environmental Health Along the Border

Farmworker Justice Fund (FJF)
US/Mexico border
http://www.fwjustice.org

Unclean water, inadequate sewage and trash collection systems, agricultural pesticides and industrial pollution endanger the health of millions of residents along the US/Mexico border. With local partners, FJF's Project Clean Environment for Healthy Kids has trained 170 CHWs/*promotores de salud* to educate their peers on both sides of the border. Since 1999 CHWs have educated nearly 20,000 residents about pesticide safety, lead poisoning, asthma and food- and water-borne illnesses. The project has also trained primary care providers how to recognize, treat and report pesticide-related illnesses. The FJF project received a 2005 Children's Environmental Health Excellence award from the US Environmental Protection Agency. The award recognizes extraordinary efforts to protect children from environmental health risks. Funding: US Environmental Protection Agency and Health Resources and Services Administration.

See additional case studies in Appendix B.

Case management services play an essential role in "aggregating or weaving together the diverse resources and services that families require."[12] Because of their relationships with clients and knowledge of the community, CHWs can aid case management when they have the necessary support to connect with other community-based workers.

Community Health Workers: One Strategy

The National Community Health Advisor Study in 1998 provided a practice-based examination of the major roles of CHWs in public health. It found that CHWs help create and improve linkages between individuals in need and community health and support services and also that these outreach and education services are particularly helpful for vulnerable groups. Yet, CHWs are not a cure-all for the health problems facing low-income families and their communities. The study authors concluded:

> *"CHWs, with their unique wisdom and skills resulting from shared experiences with the community they serve and complemented by quality training, can be a linking piece ensuring that all remain connected to, and enjoy the benefits of … [the] health care system."*
>
> – E. Lee Rosenthal, study director, et al[13]

Community Health Workers At-a-Glance

Who Coming from the communities they serve, CHWs are paraprofessionals who reach out to families and communities facing major barriers to accessing health and human services.

What CHWs link clients to services, improve clients' ability to manage their health and work to create conditions so community residents can be healthy. Health and human service agencies both rely on CHWs' generalist skills to help families with multi-agency problems.

Where Much of CHWs' hands-on work is in homes, the streets and other community settings, as illustrated in Figure 1. A wide range of organizations use CHWs – public health agencies, Medicaid and other public insurance programs, managed care organizations, community health centers, faith-based agencies, community-based organizations and human service agencies.

How CHWs work with individuals and families; some also strive to improve health on a community-wide basis. Specific duties often reflect the availability of health resources and community needs (*see Appendix A for a list of common CHW roles*).

Why CHWs create bridges to close gaps in families' health resources and overall community access to health care.[2, 3, 13, 14, 21, 24-26]

Are CHWs Effective?

A growing body of research is confirming what practitioners have known for years, that CHWs are effective in:

- Improving access to and use of health care, including preventive health and chronic disease management.
- Increasing health knowledge.
- Improving health indicators.[16, 24]

However, these results are not consistently achieved in all CHW programs. The most effective services appear to be in improving access to health care.[16]

In the landmark report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, the Institute of Medicine similarly concluded:

> *"Community health workers offer promise as a community-based resource to increase racial and ethnic minorities' access to healthcare and to serve as a liaison between healthcare providers and the communities they serve."*[15]

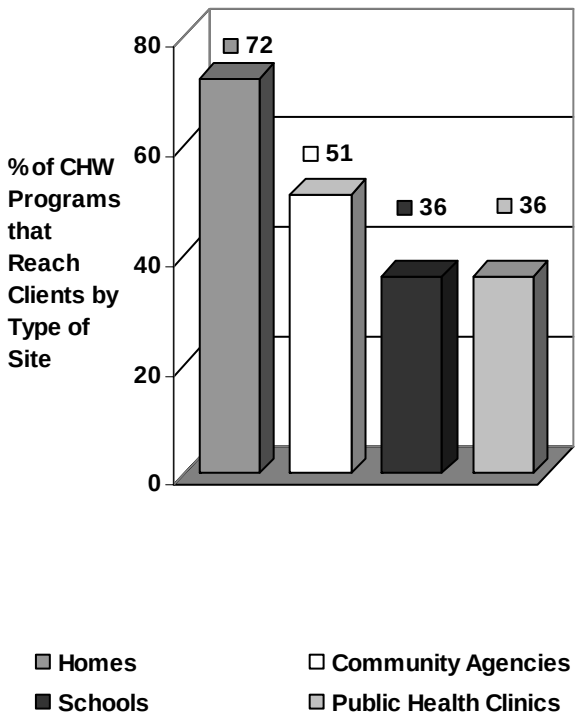
Studies and experience suggest CHW programs can achieve other results:

- Increase enrollment in health insurance programs.
- Initiate service development or expansion in underserved communities.
- Increase clients' use of community resources.
- Collect data to inform for policy.[3, 13, 17, 20, 21, 24, 28]

Many programs claim CHWs are cost-effective, but relatively few have conducted rigorous analyses.[21, 24] In one evaluation, a CHW program that helped Maryland Medicaid patients manage their diabetes generated a savings of more than $2,200 per patient per year. Related program impacts included a 40 percent reduction in emergency-room visits and a 33 percent drop in total hospital admissions, even as patients reported improved quality of life.[29] An analysis of another CHW program attributed overall cost-savings to lower nursing home admissions and reduced use of emergency departments.[30]

How have clients and other providers rated CHWs? In Alaska, patients of tribal community health representatives were generally satisfied with care provided.[14] In Minnesota, nearly 4 in 5 organizations using CHWs rated them as highly effective, and over 75 percent of all health and human service agencies indicated they were very or somewhat likely to expand the number of CHW positions in the future.[1]

FIGURE 1. Delivery Sites for CHW Services, Virginia, 2002[3]



Going from the Margins to the Mainstream

Despite positive outcomes, CHWs are underutilized in many community settings. Going to scale will require overcoming four critical challenges that are interrelated.

Inadequate funding keeps CHW programs from achieving their potential. Many available grants restrict CHW services to a specific disease (such as HIV/AIDs or diabetes). Because most clients need attention to multiple health-related issues, flexible funding for CHW services is needed. Programs

respond to this barrier by using a patchwork of grants and other resources, but funding instability precludes effective CHW programs from expanding. Also, in many low-income communities, local funding is often insufficient to sustain CHW programs; thus, when nonrenewable grants end, so too have successful CHW programs. [1, 13, 17, 21, 26, 31]

Within the health and human service sectors, CHWs often are not recognized as legitimate providers. [3, 13, 17, 21, 32] The diversity of CHW job titles and roles has contributed to this challenge.[33] Yet, the problem goes deeper: even in their home organizations, CHWs can be seen as outliers. Their work in community settings – sometimes at odd hours – makes them less visible to senior leaders and sets them apart from co-workers.[34]

The lack of direct reimbursement for CHW services by Medicaid and other programs serving low-income families compounds the first two challenges. [1, 21] Public agencies may resist direct reimbursement for CHW services until a standardized scope of practice for CHWs is established.[3] Gaining policy support may also require an outcome evaluation of CHW services from a national perspective. This evaluation could help make the case for stable funding and reimbursement and boost recognition of CHWs.[20]

The lack of accepted CHW standards – such as a definition, core competencies and scope of practice – impedes CHWs' ability to link families with a full range of community supports. [3, 17] Often, CHWs only receive program-specific or informal on-the-job training instead of a formal education and training program that would enable CHWs to undertake a broad set of CHW roles (*see Appendix A*).[2, 13] Due to variances in CHW programs, family service agencies in the community may be unsure how to have their programs interface with CHWs in helping families.[33, 35] In many states and

Building Good Health Case Study: Kentucky Families

Kentucky Homeplace
http://www.mc.uky.edu/RuralHealth/LayHealth/KY_Homeplace.htm

Cancer, heart disease, asthma and diabetes are common in rural Kentucky, yet access to primary and specialty care to manage chronic diseases is beyond the reach of many low-income residents. To help low-income residents advocate for their health needs, the Kentucky General Assembly in 1994 authorized the Kentucky Homeplace program (now housed in the Center of Excellence in Rural Health, University of Kentucky). Kentucky Homeplace currently employs 39 family healthcare advisors who visit low-income homes in 58 counties. The advisors assess family health needs, provide health education and help participants tap free or reduced-price medical services and prescriptions and other social services (such as vocational rehabilitation and Women's, Infants and Children (WIC) benefits). Beyond participating in community events and health fairs, the advisors work with other partners to address community-wide issues such as creating referral systems.

In 2005, staff served more than 15,000 clients, provided an average of 21 services/client and accessed medicines valued at $23 million. Funding: about $1.7 million/year from the state.

See additional case studies in Appendix B.

on the national level, CHWs do not have strong organizations to push for standards and advance the field.[33]

State Policies and Programs Seek to Turn the Tide

A growing number of states have adopted or are moving towards CHW standards for training and credentialing as a way to partially address these challenges. In fact, a 2005 review found a third of states sponsor some type of CHW training program. Three states – Alaska, Indiana and Texas – have established a statewide credentialing system.[36] Appendix C profiles these and other states' efforts.

The CHW Credentialing Debate

Both practitioners and others involved in the CHW field have advocated for using certification or credentialing as a way to move CHWs from an emerging to an established practice. Potential benefits of credentialing include:

- Advance perceived legitimacy within the health and human services communities.
- Improve outcomes related to CHW services.
- Help open the door for reimbursement for CHW services.
- Expand job opportunities for CHWs by making them a recognized provider.
- Offer assurances to current and potential CHW employers[a] that credentialed CHWs have basic competencies.[1-3, 26, 36]

The benefits that accrue from credentialing will depend on the inclusion of CHWs in planning and implementing a new system.[2, 34] Also, the experience of creating credentialing systems for child development associates (CDAs) – which did not yield the expected gains in pay and recognition[13, 34] – indicates additional strategies are necessary to bring CHWs from the margins to the mainstream. Other practitioners and experts believe the potential pitfalls of credentialing would outweigh the potential gains. A particular concern is that credentialing would lead to fewer CHWs who come from the communities they serve.[2,24,36,37] Negative outcomes are more likely to occur if CHWs are not directly involved in establishing the program.[2, 34] (*See Figure 2 on page 10 for strategies to minimize potential problems*.)

Policy Recommendations

As recommended by the Institute of Medicine in *Unequal Treatment*, CHWs are a promising practice that merits expanded use, accompanied by evaluation.[15] Both the institute and leading scholars in socioeconomic disparities indicate a comprehensive, multi-level strategy is necessary to improve the health of minority and low-income families.[15, 19, 23] In this context, CHWs are a critical component.

Federal and State Governments

To help CHW programs reach their potential, federal and state governments ought to *integrate CHW services into health and human service programs*.[17] Integration means:

- Amend statutes (or regulations) to recognize CHWs as legitimate providers and authorize their services in addressing a wide spectrum of families' health-related needs.

[a] In a survey of Minnesota health and human service organizations using CHWs, 90 percent said they saw some or a great need for formal CHW training programs. Among all respondents, only 30 percent indicated they were unlikely to send CHWs for standardized training because of finances or reliance on their own CHW training program (BCBS of Minnesota Foundation, 2003).

- Provide grants, contracts or reimbursement for CHW services to low-income families.
- Involve CHWs in health and human service teams serving low-income families.
- Increase the availability of CHW training and technical assistance for CHW programs.[14]

To minimize the administrative burden on all parties, it is important that public agencies work together to adopt common performance requirements and privacy standards.

Federal and state governments can *both authorize new programs and appropriate funding for existing programs to provide grants to initiatives using CHWs to provide information, education and linkages to a full range of family supports*. In the initial years, the grant program would support a limited number of sites, coupled with a rigorous outcomes evaluation (including cost analyses). As projects demonstrate success, program funding would increase to support additional CHW programs. Grants also would be structured so the share of local, private and foundation funding increases over time while providing some ongoing support as necessary for program sustainability. All grant funding should be contingent on performance standards, with technical assistance provided for under-performing sites with the potential to improve.[13, 17, 21]

The ability of CHWs to link families to health care depends on *increased federal support for the expansion of the community health center (CHC) system*, which is a core part of the health care safety net. Researchers have found CHCs deliver affordable and quality health care.[9] The recommended expansion would have the primary

Building Good Health Case Study: Youth CHWs

Latino Health Access[27]
Santa Ana (Orange County), CA
http://www.latinohealthaccess.org

Youth can be effective CHWs too. A unique community program of Latino Health Access, the Latino Children and Youth Initiative trains youth *promotores* to:

- Coordinate after-school activities for children and youth in high-risk neighborhoods.
- Educate peers about healthy behaviors, mental health and sibling care.
- Refer families to medical and mental health services.

The program not only strengthens families but builds local youth leadership.

CHW/*promotores* are an integral part of all Latino Health Access programs and receive extensive training. Beyond helping individuals and families, male and female *promotores* engage their communities in seeking policy and social change. For example, Latino Health Access is leading a community collaborative to address childhood obesity through policy changes in elementary schools, health care services, community programs, neighborhoods and the media. Funding: The California Endowment and other funding agencies.

See additional case studies in Appendix B.

benefit of improving health care resources in low-income communities. Inclusion of CHWs in planning new centers is essential to ensuring the proposed CHCs address the specific health and cultural needs of low-income families in the service areas.

State and Local Governments

State and local governments have four recommended actions to undertake. It is critical that they work closely with CHWs and family service agencies to accomplish the following.

1) Support CHW services by maximizing the use of Medicaid and SCHIP funds designated for outreach and education funds. (Federal regulations require Medicaid programs to provide outreach, enrollment and translation-interpreter services.)[3]

2) Request Medicaid waivers so additional CHW services are reimbursable. To develop an appropriate and feasible system, CHWs and their advocates must be actively involved in drafting the Section 1915 or Section 1115 waiver application.[21, 8]

3) Develop and adopt CHW standards, especially definitions and scope of practice.[3,13,25,26,36,38,39] Effective legislative or regulatory actions would both:

- Incorporate the broad range of roles identified in the National Community Health Advisory Study (*see Appendix A*). [13]
- Uphold the need for CHWs to be indigenous to the communities they serve.[26, 37]

A national community health organization should develop and disseminate a set of model standards for states. Appendix C summarizes how the Massachusetts Department of Public Health is using CHW standards in contracting.

4) Establish both training standards and credentialing requirements for CHWs.[13,21,38] Examining existing models would provide a head start in the development phase.

- Numerous training and education programs exist, including several with evaluations.[26, 36, 39, 40] New approaches also merit attention. In Minnesota, a coalition is standardizing CHW training in the state's college and university system (*see Appendix C*), and Community-Voices Miami (*see Appendix B*) is an example of a local training and certification program.
- Existing CHW standards and credentialing systems are summarized in Appendix C. The Texas system is an important model because it issues a certificate to current practitioners who document 1,000 hours or more of providing CHW services.[2, 41]

States ought to adopt strategies that will minimize potential negative consequences arising from CHW credentialing, which are profiled in Figure 2 and in Appendix C on state policies and programs.

It is also recommended that state and local governments:

- Require Medicaid and other publicly funded health and human service providers to use CHWs in community-based outreach and health education.[21, 25]
- Ensure CHWs have a seat at the table in developing or updating government plans for health and human services.[13] From disaster and flu epidemic plans to conventional strategic plans that guide agencies, CHWs can help assure such plans are feasible from a frontline perspective and do not overlook critical resources. Professional recognition would be an indirect benefit of involving CHWs in official planning processes.[26]

FIGURE 2. Potential Problems from CHW Credentialing and Options to Minimize[1-3, 13, 24, 26, 34, 36]

Potential Problems with Credentialing CHWs	Options to Minimize Potential Problems
Erosion of indigenous qualities that make CHWs effective (a critical asset for program success)	• Exempt volunteer CHWs from credentialing system but encourage organizations to adopt guidelines for volunteer CHWs • Encourage CHW programs to supplement formal training with education and training specific to the community served • Ensure CHW training builds upon CHWs' affinity with their home communities
Loss of highly effective CHWs due to immigration status or level or education, if these are required to participate in CHW training program and credentialing	• Create credentialing credits that currently practicing CHWs can obtain, such as on-the-job training, hours of service and other life experiences that contribute to effective service delivery
Credentialing fees and training tuition may be barriers for low-income CHWs interested in becoming certified	• Encourage organizations that use CHWs to underwrite fees; if only partial subsidies are provided, then organizations should supply information on tuition assistance and financial aid • Do not charge an application fee for credentials • Arrange for training scholarships • Link with transportation and child care assistance
Other unforeseen problems	• Involve practicing CHWs in developing and refining a new credentialing program

Opportunities for Public/Private Partnerships

Public-private partnerships (involving local and state governments, private foundations, CHW programs, other family service agencies and practicing CHWs) would work best to:

- Develop and test professional training programs for core CHW competencies through partnerships with community colleges, area health education centers and other institutions.[3, 14, 36] Specialized training is needed for CHW supervisors. Ideally, CHW training programs would enable participants to earn academic credits.[1, 13]
- Support initiatives to test and promote quality assurance and accountability systems for CHWs. Because many CHW services are delivered in community settings, such systems are essential to building recognition for these frontline workers and ensuring effective services.[33]

CHW Evaluation Tool Kit

For evaluations of CHW services to succeed, CHWs must play a role in evaluation design, implementation and analysis. The Community Health Worker Evaluation Tool Kit – a spin-off of the National Community Health Advisor Study – is a practical and useful guide to evaluating CHWs and CHW programs to quantify results.

The Annie E. Casey Foundation sponsored both the national study and the development of the evaluation tool kit. The complete tool kit is available online at: http://www.publichealth.arizona.edu/chwtoolkit.

- Educate health and human services administrators and practitioners about the benefits of using CHWs in service delivery and the need to support their efforts to link clients to a full range of community supports.[13, 25, 33, 40]
- Provide funding, technical assistance and policy support for CHW demonstration projects, especially those that will conduct rigorous cost-effectiveness analyses.[3, 21, 25, 36]
- Evaluate existing CHW programs – using the CHW evaluation tool kit (*see* CHW Evaluation Tool Kit) – and promote the adoption of best practices.[20, 21]
- Strengthen CHW associations/networks with funding and technical assistance so they can provide essential leadership on professional and community health issues at the national, state and regional levels.[13] For example, with support from the state public health agency, the Massachusetts Public Health Association has helped strengthen the state's CHW network.[42]

Family Service Agency Recommendations

The CHW outreach model is most effective when tailored to local circumstances and community needs.[15] For that reason, each family service agency must assess how CHWs can contribute, if at all, to program goals and objectives.[28] *Yet, all can advocate for CHW standards and stable funding streams for CHWs serving low-income and other underserved communities.*

Practice and research indicate that effective use of CHWs services entails:

- Integrating CHWs into service delivery.[3, 43] Information should flow both from the community to the service delivery system and back. Some

programs have found putting CHWs on teams with other providers, such as social workers and public health nurses, helps with integration.[33, 36]

- Connecting CHWs into networks of community family service agencies.[13, 35, 37, 40]
  - Ensure CHWs know about formal community resources and processes to access them, yet encourage continued use of their informal networks.
  - Introduce CHWs to other community-based workers providing family services.
  - Educate other community organizations and then develop formal agreements that define the inter-agency roles and responsibilities of CHWs as they help families connect with resources. Inter-agency communication systems and agreements must enable CHWs and other service providers to share client data in appropriate ways.[b]
- Ensuring that relevant senior officials in the organization understand their CHW program and can provide leadership on issues that hinder CHW effectiveness in the community.[33]
- Involving CHWs in the design, implementation and management of initiatives to enhance community health.[1]
- Hiring CHWs that have a strong affinity with the community to be served.[1, 14, 24, 26] In addition, Latino Health Access (*see page 8*) demonstrates the opportunity to engage youth in serving their families, peers and communities as CHWs.
- Improving CHW recruitment and retention by:
  - Developing career paths for the CHW field, including youth CHWs.[1, 13, 21, 25]
  - Paying CHWs living wages and benefits.[13,21,25,31]
  - Providing ongoing paid training, continuing education, supportive supervision and networking opportunities.[14, 25]
  - Reviewing policies regarding hiring persons who are former nonviolent drug offenders or in treatment for substance abuse. CHWs who have had these problems or are recovering from them could be particularly well equipped to reach out and serve families where drug or alcohol abuse exists.[33]

[b] For example, complying with state and federal (Health Insurance Portability and Accountability Act or HIPAA) standards has created some challenges to CHWs' ability to help clients get needed follow-up care after hospitalization (Hinton, 2006).

RESOURCES

American Public Health Association (APHA)
http://www.apha.org

APHA has a special interest group for CHWs. The group seeks to promote the community's voice within the health care system through development of the CHW role and to provide a forum to share resources and strategies.

Annie E. Casey Foundation (AECF)
http://www.aecf.org

With 55+ years of experience in investing in child and family wellbeing, the AECF website provides a broad collection of research- and practice-based publications on strengthening families. AECF sponsored the National Community Health Advisor Study and evaluation tool kit.

Center for Sustainable Health Outreach (CSHO)
http://www.usm.edu/csho/

CSHO provides support and technical assistance to CHWs and CHW programs. CSHO serves as a national point of contact for CHWs and CHW programs and

provides them with reliable, up-to-date information and assistance.

Centers for Medicare and Medicaid Services (CMS)
http://www.cms.gov

CMS assures health care security for Medicare and Medicaid beneficiaries by exercising federal oversight of the Medicaid and State Children's Health Insurance Program (SCHIP). Outreach and education funds from Medicaid and SCHIP can be used to support CHW services.

City Indicators: Diversity Data
http://www.cfah.org/programs/city_indicators.cfm

The Center for the Advancement of Health is creating this online resource of (sub)urban indicators of good health and quality of life that can be used to provide a scorecard of sustainability, opportunity and quality of life for various racial and ethnic groups and socioeconomic groups.

Community Health Worker Evaluation Tool Kit
http://www.publichealth.arizona.edu/chwtoolkit/

The tool kit is a practical and useful guide to evaluating CHWs and CHW programs and quantifying results.

CHW-National Education Collaborative
http://www.chw-nec.org/

This national community-of-practice website is part of an initiative to support the development of "college responsive programs" for CHWs across the nation.

Community Health Works
http://www.communityhealthworks.org

San Francisco State University and the City College of San Francisco developed the nation's first college-credit CHW program in the nation.

Community Voices
http://www.communityvoices.org

Involving eight learning laboratories across the nation, the Community Voices initiative aims to ensure the survival of safety-net providers and strengthen community support services.

Family Strengthening Policy Center, National Human Services Assembly
http://www.nassembly.org/fspc/practice/practices.html

With support from the Annie E. Casey Foundation, the Family Strengthening Policy Center (FSPC) seeks to describe practice-based approaches to strengthening families raising children in low-income communities and policy implications. Other relevant FSPC policy briefs include:

- *Introduction to Family Strengthening*
- *Strengthening Families by Increasing Access to Needed Benefits: The New Technologies*
- *Family-Centered Community Building*
- *Re-Establishing Normalcy: Helping Families Address the Long-Range Effects of Disaster through Case Management*

Health Resources and Services Administration (HRSA)
http://www.hrsa.gov

This federal agency provides national leadership, program resources and services needed to improve access to culturally competent, quality health care. HRSA support for CHWs includes the following.[c]

- Area Health Education Centers (AHECs) and Health Education Training Centers (HETCs) support community health education and CHW training programs. (For one example, go to: http://www.easternctahec.org/educationCHOW.html.)

[c] See also grant programs listed in *Directory of HRSA's Community Health Workers (CHWs) Programs* (Virginia Center for Health Outreach, 2002).

- Healthy Communities Access Program (HCAP) provides grant funding and technical assistance to consortia that coordinate and strengthen health services for the un- and underinsured in their communities. Consortia members include public and private health care providers along with social service, local government and other community-based organizations. However, grant support is time-limited with the expectation that programs become self-sustaining.

Minnesota Community Health Worker Program
http://www.heip.org/community_health_worker.htm

The project is a statewide coalition with public higher education, health care systems and major payers working to reduce cultural and linguistic barriers to health care, improve quality and cost effectiveness of care and increase the number of health care workers who come from diverse backgrounds.

Virginia Center for Health Outreach
http://www.vcho.cisat.jmu.edu/

The Virginia Center for Health Outreach (VCHO) supports CHWs and increases people's awareness of the use of CHW programs in Virginia.

APPENDIX A: COMMON CHW ROLES

Common roles filled by CHWs are described in Figure 3. These were adapted from the National Community Health Advisor Study by integrating the findings of more recent regional studies. A CHW's specific duties should reflect community needs.[26]

FIGURE 3. Common CHW Roles[1, 2, 13, 21, 24, 25]

Role	Description
Outreach Worker	• Finding persons in need of health and other vital services who are disconnected from community supports • Disseminating information • Reaching out to medically underserved communities
Connector	• Connecting clients in need to community supports • Building bridges between the health care system and community resources • Bridging cultural and/or language differences between clients and providers • Strengthening existing community networks
Case Manager	• Assessing needs • Making referrals • Setting up, managing and following up services from multiple providers
Navigator	• Educating community members about how to access community supports • Helping clients navigate health and social service systems
Advocate	• Seeking beneficial policy and social change • Helping individuals obtain needed health care and protect their rights • Alerting health and human service systems to important changes in communities and identify innovative and promising practices
Health Care Extender	• Translating between patients and health care providers • Educating individuals, families and communities so they have the knowledge and skills to avoid illness and injury and reduce other risks to wellbeing • Conducting basic health assessments and screenings (such as blood pressure) • Providing basic emergency care • Providing follow-up care • Providing informal counseling and social support
Other	• Building community capacity (for example, informing public health and community planning; participating in community advocacy efforts) • Providing social support to the homebound and those who are socially isolated • Transporting clients

APPENDIX B: ADDITIONAL CASE STUDIES

Community Voices-Miami (CVM)
Miami, FL
http://www.communityvoicesmiami.org

Integrating CHW services into the existing county health care delivery system is a core CVM strategy for improving the health of Miami's uninsured and underserved. Through a partnership with United Way of Miami-Dade County, Miami-Dade College, local health agencies, community centers and Jackson Hospital, CVM piloted and evaluated a CHW training curriculum and certification process. They also developed a peer support group for CHWs. Next steps include:

- Full-scale implementation of the evaluated training curriculum.
- CHW certification through the college.
- Development of CHW career tracks.
- A clearinghouse to help organizations integrate CHWs into service delivery.

The CHW project is part of a community-wide action plan to increase health care coverage and access, eliminate non-insurance barriers to health care, help the underserved access a full range of community services and make policy planning and changes that respond to community concerns. Funding: WK Kellogg Foundation, Annie E. Casey Foundation, Health Resources and Services Administration and regional community foundations.

Maternal Infant Health Outreach Worker (MIHOW) Program[44]
Kentucky, Louisiana, Mississippi, Tennessee and West Virginia
http://www.mihow.org
http://www.aecf.org/familiescount/national/2002/mihowp.htm

Giving children a positive start in life is possible through low-cost, parent-to-parent interventions for families struggling with poverty, low self-esteem and isolation. Developed by the Vanderbilt University Center for Health Services, community-based organizations in five states operate MIHOW projects. Sponsoring agencies train local women – mothers who are trusted locally for their energy, integrity, compassion and commitment to the community – to visit the homes of pregnant women and families with infants and toddlers. During the visit, parents talk to the MIHOW outreach workers about their concerns; learn about nutrition, health and child development; practice positive parenting skills and get referrals to medical and social services. MIHOW also provides case management and advocacy services. In some communities, participants and staff have developed new family-strengthening programs. In evaluations parent-participants report:

- Having deeper connections with their children.
- Obtaining more frequent and earlier prenatal care visits.
- Having better knowledge of how to access community resources.

To assure the provision of quality services, the Vanderbilt Center for Health Services launched an accreditation program to help all sites achieve MIHOW Standards of Practice.

MIHOW has received the Annie E. Casey Foundation Families Count Award (2002),[d] the Points of Light Foundation President's Award (2002), the Oscar van Leer Award (2001), and the Lamaze International Outreach Services Award (2000). Funding: Annie E. Casey Foundation, other funding agencies and foundations, Vanderbilt University and private donations.

[d] The award celebrates organizations that improve the odds for vulnerable children by helping them have what they need most – strong, capable and economically successful families.

APPENDIX C: SUMMARY OF STATE EFFORTS TO STRENGTHEN THE CHW MODEL

FIGURE 4. Selected State Policy and Program Initiatives Relating to CHWs

State	CHW Initiatives	Notes
	States that Credential CHWs	
AK[14, 36]	Community Health Aide Program (CHAP) established in 1964 • Aims to increase access to primary health care services for Alaska Natives in frontier communities with CHWs delivering some basic health services • Uses a distinctive and extensive training process with academic credit possible • Credentials CHWs as they complete each stage of training • Supports CHWs in remote villages with medical and instructor supervision and a community health aide manual that provides medical standing orders • Addresses the oral health needs of Alaska Natives in rural settings with a Dental Health Aide Program • Operates in partnership with Native health corporations, individual villages and the state; the federal Alaska Native Health Systems provides oversight	Established by state and federal legislation Unique in that the CHWs provide basic health (or dental) care services Funded by: Indian Health Service and the State of Alaska
IN[36]	Statewide program uses prenatal care coordination teams consisting of a registered nurse, a social worker and a CHW • Trains CHWs using a state-developed curricula and state-trained instructors at local agency sites • Credentials CHWs who meet criteria and pass a qualifying exam • Receives Medicaid reimbursement due to CHWs being paired with licensed providers, recognition of CHWs in the Administrative Rule of 1994 and limiting service to high-risk, Medicaid-qualified pregnant women	No state legislation Funded by: Indiana State Department of Health and Medicaid
TX[2, 21, 41]	*Promotor(a)* Program Development Committee commissioned to prepare a *promotor(a)* training and certification program • Identified ~30 existing programs using 300 CHWs/*promotores* • Recommended standardized curriculum guidelines and learning objectives so trained CHWs/*promotores* would have portable skills Currently, the state: • Certifies CHWs/*promotores*, CHW trainers and training institutions • Requires all paid CHWs/*promotores* to be certified • Mandates that state health and human service agencies have certified CHWs/*promotores* involved in helping recipients of medical assistance	Established by state legislation (HB 1864 in 1999; SB 751 and 1051 in 2001) New laws increased demand for certified *promotor(a)* training programs. By 2005, Texas had an estimated 700 certified CHWs/*promotores* Funded by: Texas Department of State Health Services

State	CHW Initiatives	Notes
	Other State Policies and Programs to Advance CHWs	
MA[25]	Interdepartmental CHW task force in the Massachusetts Department of Public Health • Surveyed CHWs and supervisors on services, workforce needs and integration into health care delivery • Supported the creation of a CHW network (through the Massachusetts Public Health Association) • Implementing a clear departmental policy on CHWs that requires contractors to meet program and training standards	The Massachusetts Department of Public Health has supported CHWs since the 1960s Funded by: state, Health Resources and Services Administration
MN[1, 45]	Minnesota CHW Project, a program of the Minnesota State Colleges and Universities' Health Education-Industry Partnership • Developing a standardized CHW training program • Recruiting students to reflect growing demographic diversity • Bringing together higher education, health plans, payers, government agencies and CHW employers, including health care providers • Sponsoring a policy council to advance the role of CHWs in health and human service sectors and to recommend policies and strategies to incorporate CHWs into care delivery systems	Funded by: Blue Cross and Blue Shield of Minnesota Foundation, Robert Wood Johnson Foundation
VA[3, 38]	Public-private committee (coordinated by the Virginia Center for Health Outreach) authorized to study and recommend ways to address the underutilization of CHWs • Inventoried CHWs and their roles in Virginia • Analyzed outcome studies on CHW efficacy • Identified ways to elevate the use and value of CHWs in health, human service systems • Studied quality measures relating to CHWs and community outreach for Medicaid and other contracted service providers • Considered a statewide core curriculum for CHWs employed by public agencies	Authorized by the Virginia General Assembly Funded by: Commonwealth of Virginia

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This series of policy briefs produced by the Family Strengthening Policy Center (FSPC) seeks to describe a new way of thinking about how to strengthen families raising children in low-income communities and how this approach can and should influence policy. The premise of "family strengthening" in this context, and as championed by the Annie E. Casey Foundation, is that children do well when cared for by supportive families, which, in turn, do better when they live in vital and supportive communities. The series describes ways in which enhancing connections within families and between families and the institutions that affect them result in better outcomes for children *and* their families.

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This brief reflects the findings and views of the Family Strengthening Policy Center, which is solely responsible for its content.

For more information or to access other family strengthening policy briefs, visit www.nassembly.org/fspc.

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