COMMUNITY HEALTH WORKERS:
AT THE HEART OF TRANSFORMING OHIO'S HEALTH CARE DELIVERY SYSTEM

A REPORT ON THE FINDINGS OF UHCAN OHIO'S
COMMUNITY HEALTH WORKER SURVEY

UHCAN Ohio

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A REPORT ON THE FINDINGS OF UHCAN OHIO'S COMMUNITY HEALTH WORKER SURVEY

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EXECUTIVE SUMMARY

The broad goal of health care reform, in Ohio and elsewhere, is improved population health, meaning improving the health of all people).[1]

In Ohio, like in many other areas of the country, health disparities exist for certain populations. Some of the highest chronic disease rates exist among African Americans, Hispanics, Asians, those of African descent, and rural populations. Reports like *Unequal Treatment,*[2] the Kaiser Family Foundation's State Health Facts on Minority Health[3] and Kaiser Monthly Update on Health Disparities[4] provide ample statistical documentation of continuing disparities. Like other states, Ohio is in the midst of reforming its health care delivery system with a focus on changing from paying for volume of health services to paying for value – better care at lower cost. As a result, healthcare providers, private and public insurance companies, and patients/consumers are looking for new models of delivering care that achieve this goal.

New models of care – such as the "patient-centered medical home" and other primary care with care management for patients with chronic health conditions – require an expanded workforce capable of improving the health of people who historically have had worse health outcomes because of non-medical barriers. This paper looks at community health workers (CHWs) as a workforce addition that can improve health outcomes for people in culturally and economically diverse communities.

CHWs are lay members of communities who work either for pay or as volunteers in association with local health care delivery systems in urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. They have been identified by many titles, such as community health workers, health advisors, navigators, lay health advocates, "promotores(as),"[5] outreach health educators, community health representatives, peer health promoters, and peer health educators[6] (for a full listing of their titles see Appendix A).

New models of care – such as the "patient-centered medical home" and other primary care with care management for patients with chronic health conditions – require an expanded workforce capable of improving the health of people who historically have had worse health outcomes because of non-medical barriers.

[1] See Ohio Office of Health Transformation, Ohio Application for State Innovation Model Test Assistance, July 7, 2014, at http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=e_p2kypH7G8%3d&tabid=138.
[2] Institute of Medicine, *Unequal Treatment,* March 2002, at http://www.iom.edu/reports/2002/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care.aspx
[3] http://kff.org/state-category/minority-health/
[4] At http://kff.org/disparities-policy/kaisers-monthly-update-on-health-disparities/
[5] Promotores (as). The terms *promotores* and *promotoras* are used in Mexico, Latin America, and Latino communities in the United States to describe advocates of the welfare of their own community who have the vocation, time, dedication, and experience to assist fellow community members in improving their health status and quality of life. Recently, the terms have been used interchangeably, despite some opposition, with the term community health workers. http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=55
[6] Community Health Worker National Workforce Study, U.S. Department of Health and Human Services, Human Resources and Services Administration, Bureau of Health Professionals, 2007, at http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf

The effectiveness of community health workers derives largely from their knowledge of the communities in which they work. This includes an understanding of the culture of the community and the ability to empathize with community members, as well as their ability and willingness to go into the community where their clients live, work, and play. Among those we surveyed, knowledge of the community was one of the skills most desired by organizations utilizing this workforce in Ohio. Knowledge of social services and medical services were also rated high on the list of skills respondents felt helped CHWs to better serve clients.

Recent studies about community health workers have drawn a connection between this workforce and addressing health disparities. According to "Outcomes of Community Health Worker Interventions," a study commissioned by the Agency for Healthcare Research and Quality, "A core component in recommendations to address health disparities is the involvement of the community, specifically the involvement of community health workers."[7] A large part of CHWs' success is in understanding the community, knowing where people live and go for help, and being willing to go into the community where the clients are located. UHCAN Ohio's report *Community Health Workers: At the Heart of Transforming Ohio's Health Care Delivery System* is intended to explore and describe the organizations that use CHWs and paint a picture of how they are currently being used. It is our hope that this report will contribute to the body of knowledge about this workforce in Ohio, be a resource to those who are considering new models of care, particularly those models designed to work in racial, ethnic, and rural communities, and support the expanded use of this workforce.

The Affordable Care Act (ACA) acknowledges the potential utility of CHWs by including a provision to expand the use of community health workers (Section 5313, as modified by Section 10501). This section "requires the Director of the Centers for Disease Control to award grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers." The provision, although currently unfunded, is a clear recognition from policy makers on the utility of this workforce.

With the implementation of the coverage provisions of the ACA on January 1, 2014, many more Ohioans already have coverage and are seeking care. This influx of more consumers into the health care delivery system, along with the move toward the patient-centered medical home (PCMH) model of team-based primary care and other transformational changes in Ohio, present a timely opportunity for broader discussion on the use of community health workers in Ohio.

The effectiveness of community health workers derives largely from their knowledge of the communities in which they work.

[7] Agency for Health Research on Quality, Outcomes of Community Health Worker Interventions, June 2006. http://www.ahrq.gov/research/findings/evidence-based-reports/comhwork-evidence-report.pdf

In 2013, UHCAN Ohio conducted a statewide survey to explore how the CHW workforce is being used in Ohio. The survey included questions to help us better understand the organizations that use CHWs in Ohio, the types of services CHWs provide, the types of training CHWs have, and the ways they are reimbursed for their services. We received 75 responses from organizations who are currently using community health workers across Ohio. Our survey showed that:

- Organizations in Ohio are using CHWs to perform a variety of services with a variety of populations. The services most widely performed by CHWs whose organizations responded to the survey are follow-up calls and health education, with forty responses each, followed by home visits, linkage to medical services, assistance with appointments, transportation, case management, accompaniment to doctor's appointments, linkage to non-medical services, health screenings, patient advocacy, linkage to behavioral health services, provision of behavioral health services, chronic disease self-management, and nutritional and exercise programs. Other services provided by smaller numbers of respondents include health literacy, language interpretation, personal care, homemaking, and medication monitoring.

- Ohio CHWs provide services in many non-traditional community settings. Thirty-four respondents said their community health workers perform their duties out of community-based organizations; thirty-three said they went to public housing units; thirty-five worked out of schools; twenty-nine worked in faith based organizations; eighteen worked in beauty shops and barber shops; forty-four worked in community health clinics; thirty one worked in shelters; twenty-five worked on the street; four worked in migrant camps; nineteen went to clients' work sites; and seventeen worked out of teen centers.

- While most programs used CHWs to work on maternal and child health issues, we found several organizations who use CHWs to deliver chronic disease self-management services and behavioral health services. Health departments, non-profit health providers, and community-based organizations all used community health workers for these services. For example, the Diabetes Partnership of Cleveland and the Central Ohio Diabetes Association use community health workers to deliver chronic disease self-management programs to persons living with diabetes. TriHealth in Cincinnati uses CHWs to work with patients on managing chronic conditions like hypertension and diabetes and to facilitate exercise and nutrition programs. Ohio organizations like Planned Parenthood send their CHWs out to the street, public housing units, schools, and shelters to provide family planning counseling, women's health education, prenatal care, smoking education, linkage to doctors, and follow- up care. Another exciting approach is hospitals working with faith and community organizations to deliver health services. Through its new CHW training program, Ohio State University Medical Center East is placing CHWs in community-based organizations for practicum experiences with the hope that these organizations will find permanent positions for them once they graduate. The CHWs at the Hospital Council of Northwest Ohio deliver services out of a variety of venues, including churches.

- Ohio has one of the only CHW certification programs in the country and was the first to connect this certification to its state Board of Nursing. There are six certified training sites at colleges and universities across the state of Ohio. Attendance at one of these programs allows a CHW to receive a certification from the Ohio Nursing Board. In addition, there are many programs that use CHWs who are trained in other ways.

- Organizations who responded use a variety of outcome measures to evaluate the success of CHW services. Some respondents used quantitative measures, such as the number of patients who kept appointments, number of patients that completed screenings, or number of patients served. Many of those surveyed used Pathways outcome measures.

- Among our respondents, reimbursement for CHW services was the biggest barrier to recruiting, hiring, and retaining community health workers. In Ohio, very few programs receive reimbursement from public programs like Medicaid, Medicare, and SCHIP.

- For example, none of the health departments or community health centers we surveyed were being reimbursed by Medicaid for CHW services. A few of those that responded received reimbursement from Medicare for their CHWs. Many CHWs in Ohio are funded by grants. For example, Columbus Public Health uses CHWs in their maternal and child health programs and these CHWs are paid for out of grant dollars. Managed care plans reported being able to pay for their CHWs out of capitation fees (per-member per-month or PMPM fees).[8] CareSource, one of the managed care plans that responded to the survey, has hired community health workers to go into the homes of patients and conduct evaluations that help guide treatment plans. These workers are staff of the managed care plan and are paid for out of capitation fees.

[8] Ohio's Medicaid Managed Care Plans are reimbursed under a payment model known as "capitation" (from the Latin word "head"). The capitation is a set fee paid to the plan by the state for each patient every month, regardless of how many (or few) health services the enrollee uses. Thus, the managed care plans are "at risk," because if the capitation rate is too low, they will lose money by providing services in excess of the revenues they receive. In turn for receiving this payment, the managed care plans must provide enrollees with all services required under their contract and achieve goals (metrics) established by the state. Several Ohio Medicaid Managed Care Plans are now employing community health workers out of the belief that doing so will help patients manage their health and avoid needing high-cost services (emergency department visits and inpatient hospitalization) for poorly controlled health conditions.

KEY FINDINGS

- Utilization of CHWs is an effective strategy to expand cultural diversity and increase cultural competency among Ohio's health care workforce. These health care workers perform a variety of services in a variety of settings that expand capacity to reach underserved and high risk populations experiencing the highest rates of health disparities.
- Many organizations across Ohio understand the importance of the CHW workforce, as evidenced by the number of programs already using them in Ohio.
- Reimbursement for CHWs is the biggest barrier to both retaining the current CHW workforce and to expanding the use of this workforce.
- Currently, few of the patient-centered medical homes (PCMH) being created are using CHWs.
- There are examples of programs in other states that have been successful in securing long term funding for CHWs. Other states like Vermont, New Jersey, New York, California, and Maryland have used Medicaid waivers and capitation fees to reimburse CHWs.

RECOMMENDATIONS:

- As public and private stakeholders develop new models of enhanced, patient-centered primary care (such as the patient-centered medical home), new reimbursement schemes should account for the need to employ CHWs as part of the care team, especially for practices working with racially and ethnically diverse and rural populations.

- In order to address the reimbursement issue, a study and report detailing strategies that have been used to create sustainable funding for community health workers (in Ohio and elsewhere) should be developed.

- The Ohio Office of Health Transformation should establish a task force to develop a plan for expanding the use of CHWs among public and private provider organizations and in new payment and delivery models to improve population health. The task force should address strategies for reimbursement and explore the role of CHWs in the new models of care that are being developed, including patient-centered medical homes and demonstrations such as My Care Ohio.

- This task force should be comprised of representatives from Ohio Community Health Workers Association, CHW training sites, the Ohio Department of Health, local health departments, community health centers, the Ohio Board of Nursing, the Ohio Health Disparities Collaborative (Workforce Development Committee), consumer advocacy organizations, hospitals, managed care plans, provider organizations, community and faith organizations, and other key stakeholders.

- Future discussions on expanding the use of community health workers should include:

  1. How to identify those organizations central to the communities where health disparities are the highest and strategies for partnering with them to place CHWs in these sites to provide relevant health services. Churches with health ministries, health clinics, community action agencies, and settlement houses are places to focus on.

  2. The training and certification that is needed for CHWs in certain settings. The Ohio CHW certification process is linked to the Ohio Board of Nursing and could be a strength in promoting the use of CHWs as part of PCMH teams. This training and certification can also be a strength in establishing a common training for this workforce. The current CHW certified training programs could be the basis for a standardized training program, and agencies could add relevant training for the services their populations need (e.g. chronic disease self-management training.

  3. How non-certified CHWs (e.g. promotores/as and peer counselors) are used, and how Ohio can create stable reimbursement for this important part of the CHW workforce

  4. How long term funding strategies for both certified and non-certified CHWs can be identified and implemented.

  5. How to create a pipeline that facilitates CHWs moving into higher level health care professions like nursing, physicians assistants and physicians.

Care coordination, when effective, can increase access, improve patients' health outcomes, and cut health care costs. As health care systems and the providers within them look to new models to coordinate care, CHWs, with their knowledge of the communities in which they work, can be a key resource.

INTRODUCTION

We surveyed health provider organizations, colleges and universities, and community-based and faith-based organizations to find out how community health workers were being used across Ohio and other information relevant to creating a statewide conversation on expanding the use of this workforce. In addition to the survey, we conducted phone interviews with several key organizations working with community health workers, including Ohio Community Health Workers Association, Ohio State University East, Community Health Worker training program, Community Health Access Project (CHAP),[9] Wright State University Department of Community Health, and, outside of Ohio, the Massachusetts Association of Community Health Workers.

The following sections discuss the findings from the UHCAN Ohio Community Health Worker Survey Report and key stakeholder organization interviews. This report includes information on the types of organizations that responded to the survey and/or participated in the interviews, the types of services the CHWs working for them provide, and the types of training and certification these organizations require their CHWs to have. It also includes a discussion on creating stable funding for CHWs and a set of recommendations for starting a statewide dialogue on expanding the use of community health workers.

Why are community health workers so important to Ohio's health care workforce, and why is it important to expand their use? Understanding health disparities and the role of care coordination are critical to reforming health care in Ohio in ways that lead to improved health outcomes and decreased health disparities. Care coordination is at the core of health care reform's goal of better population health. Effective care coordination for prevention, primary care, disease management, and follow-up care is essential if we are to see changes in chronic disease outcomes. According to a report by the U.S. Department of Health and Human Services, "Effective care coordination is a consumer-friendly, system-wide approach to care that seeks to improve patients' health, increase access to appropriate care, and reduce costs by placing the patient at the center of care. Consumer-friendly programs tend to use an expanded model of health care that addresses individuals' physical and behavioral health care needs within their family and home, as well as non-medical needs, such as food, safe housing, environment, and transportation."[10] Care coordination, when effective, can increase access, improve patients' health outcomes, and cut health care costs. As health care systems and the providers within them look to new models to coordinate care, CHWs, with their knowledge of the communities in which they work, can be a key resource.

Health disparities are differences or inequalities in the burden of disease and/or health conditions, mortality, health status, and access to care. In the United States, inequalities exist based on gender, age, race and/or ethnicity, sexual orientation, geography, education, and socio-economic position. Addressing health disparities requires addressing not only the health needs of individuals but also the social determinants of health: economic status, education, discrimination, and environmental factors. In Ohio, like across the country, racial and ethnic minority and rural populations experience higher rates of chronic disease. For example, Franklin County has one of the highest infant mortality rates in the country, with mortality rates for African American babies two and a half times higher than for white

[9] At http://chap-ohio.net/

[10] Community Health Worker National Workforce Study, U.S. Department of Health and Human Services, Human Resources and Services Administration, Bureau of Health Professionals, 2007, at http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf

If effective pipelines are created, this workforce could become some of our future nurses, physicians' assistants, and primary care physicians.

babies.[11] Ohio's Appalachian communities experience some of the highest rates of oral health diseases.[12] In Ohio and across the country, Hispanic populations had some of the highest uninsured rates and lowest rates of enrollment during the last Affordable Care Act enrollment period.[13]

Reaching hard-to-reach populations by reducing cultural and linguistic barriers and expanding the diversity among the health care workforce are two important reasons for expanding the CHW workforce here in Ohio. Persons who are familiar with the patient's environment, understand the health care delivery system, and who can relate to patients both culturally and linguistically will be invaluable in creating consumer- friendly models of coordinated care that address health disparities among Ohio's most vulnerable populations. Improving population health and reducing health disparities are two overarching goals of Ohio's recently funded State Innovation Model (SIM) Test Grant.[14] Increasing diversity among Ohio's primary care workforce is recognized as a leading strategy for reducing health disparities by the National Partnership for Action to End Health Disparities.[15] Community health workers, part of that nationally recognized diversified work force, can help bridge the cultural and linguistic gap for primary care physicians, hospital staff, and other medical staff working with hard-to-reach populations. In addition, if effective pipelines are created, this workforce could become some of our future nurses, physicians' assistants, and primary care physicians.

Promising population health practices include those that are linguistically and culturally competent, provide services in settings where people are comfortable, increase health literacy, address physical, behavioral, and social determinants of health, and link patients to needed medical and non-medical services.[16] Community health workers, trained health workers from the community in which they work, will increase the chances of success among these new population health initiatives and new models of care, such as patient-centered medical homes.

In Ohio, CHWs are most known for their work around maternal and child health, as part of the effort to improve infant mortality. Health departments, community-based health centers, and hospitals have used them for years to conduct home visiting programs, early childhood development education, prenatal care, linkage to services, and a host of other services to pregnant and parenting mothers and their young children.

Health departments and hospitals were found to be the biggest users of CHWs in this way. For example, Health Care Access Now's Pregnancy Pathways program uses CHWs to work with pregnant and parenting moms, as do organizations like the Cleveland Department of Public Health, MetroHealth Hospital in Cleveland, and the University of Cincinnati Hospital. While maternal and child health programs were the biggest users of community health workers, we found several organizations who use CHWs to deliver chronic disease self-management services, behavioral health services, health screening activities, and nutrition and exercise programs.

Training and certification of CHWs are linked to reimbursement, pay scales, and the types of services this workforce can provide. Ohio has a formal certified training program where CHWs can be trained at one of 6 college and university sites across Ohio and receive a certification through the Ohio Board of Nursing. The training sites are Chatfield College, Cleveland Institute of Community Health, Cincinnati State Technical and Community College, North Central State College, the Christ College of Nursing and Health Sciences, Community Health Worker Certificate Program, and the Ohio State University Colleges of Nursing. These training programs take approximately 6-9 months to complete. It is important to note that Ohio is one of the few states which has a certification program for its CHWs and the first to have a program that is certified by its board of nursing. A training developed by Dr. Harold Freeman[17] has also gained some support from Ohio provider groups. This training out of New York can be taken online or in person and provides a patient navigation certification. The training takes 2 days in person or can be completed on-line at a self-pace. Several managed care plans and community-based organizations in Northeast Ohio have used this training model to train their CHW staff.

[11] Greater Columbus Infant Mortality Task Force, *Final Report and Implementation Plan*, June 2014. http://gcinfantmortality.org/wp-content/uploads/2014/07/IMTF-2014-Final-Report-FINAL.pdf
[12] Ohio Department of Health, *Oral Health Isn't Optional! A Report on the Oral Health of Ohioans and Their Access to Dental Care*, July 2011. http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/health%20resources/reports/oralhealthisntoptionalreport.ashx
[13] U.S. Department of Health and Human Services, Survey Data on Health Insurance Coverage for 2013 and 2014, 2014. http://aspe.hhs.gov/health/reports/2014/InsuranceEstimates/ib_InsuranceEstimates.pdf
[14] On December 16, 2014, Ohio was awarded a $75 million, four-year State Innovation Model Testing Grant from Center for Medicare and Medicaid Services. The award letter and Ohio's SIM Test Application can be found at: http://www.healthtransformation.ohio.gov/CurrentInitiatives/EngagePartnerstoAlignPaymentInnovation.aspx
[15] National Partnership for Action to End Health Disparities, National Stakeholder Strategy for Achieving Health Equity, April 2011. http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286
[16] Betancourt, Joseph, Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches, Commonwealth Fund, October 2002. http://www.commonwealthfund.org/usr_doc/betancourt_culturalcompetence_576.pdf
[17] At http://www.hpfreemanpni.org/

As an alternative to Ohio's certification process through the Ohio Board of Nursing, we found that many organizations working with limited-English populations were likely to use CHWs who were not trained by either of the above programs. These organizations have developed training programs specific to the health needs of the populations they are working with. For example, the Ohio Hispanic Coalition uses promotoras, bi-lingual trained health outreach workers who provide a variety of health education, screening, and health navigation activities in Latino and immigrant communities. Asian American Community Services Inc. uses peer health educators to conduct hepatitis screenings, health linkage, and referral information. These organizations do not require their CHWs to have an Ohio CHW certification. In fact, those interviewed spoke to both the cost of CHW training being prohibitive and the effectiveness of their programs, because the CHWs they worked with were more likely to stay in the community than those who go through the certification process.

Finding money to pay CHWs is not easy. Many respondents cited lack of stable funding for CHWs as a major barrier to recruitment, hiring, and retention of CHWs and the continuation of the services they provide. In Ohio, very few programs receive reimbursement from entitlement programs like Medicare and Medicaid. Many CHWs in Ohio are funded by grants and capitation fees (per-member per-month fees). For example, Health Care Access Now in Cincinnati funds its Pregnancy Pathways program through a grant, and CareSource, a managed care plan serving the Medicaid population uses a capitated rate to pay for their community health workers. One promising program is the Medicaid Technical Assistance and Policy Program (MEDTAPP) grants that are funding CHW expansion. For example, The Ohio State University Hospital East in Columbus launched a training program for CHWs in January 2014 using MEDTAPP funding and is placing them in community settings.

Across the country, CHWs face the same barrier—lack of sustainable funding. There are a few examples of programs in other states that have been able to secure stable long-term funding for CHWs. For grant-funded programs, the US Health Resources and Service Administration (HRSA) is the largest federal funder for CHW programs and the most stable over long periods of time. Some states have been successful in developing strategies for reimbursing CHWs using capitation or per-member per-month fees. Vermont has a promising strategy for using per-member fees which allows CHWs who are part of one of their community care teams to be reimbursed by Medicaid, Medicare, and private insurance. New York and California have both adopted strategies that allow them to use Medicaid waivers in ways that allow for the reimbursement for CHWs.[18] For-profit disease management groups are using CHWs to assist with chronic disease self-management and are receiving reimbursements from private insurance companies for these services.[19]

Addressing health disparities requires addressing not only the health needs of individuals but also the social determinants of health: economic status, education, discrimination, and environmental factors.

[18] Vermont Department of Health, *Vermont Blueprint for Health Annual Report,* 2008. http://www.leg.state.vt.us/reports/2009ExternalReports/240386.pdf
[19] U.S. Department of Health and Human Services – Health Resources and Services Administration, *Community Health Worker National Workforce Study,* March 2007. http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf

METHODOLOGY

Unit of Analysis
The unit of analysis for the data was collected at the healthcare provider level in the State of Ohio. The research design, methods, data collection, and sampling techniques were designed to complement the unit of analysis.

Research Design
The main objective of this study was to explore facts about how community health workers' services are utilized by organizations, identify reimbursement strategies, and determine best practices. Research designs, including quantitative and qualitative, are used to connect or help develop certain assumptions about how the researcher will learn and what the researcher will learn during the inquiry (Creswell, 2003[20]). A qualitative data collection method was used in this study. Descriptive data was used to summarize the findings in this study.

Methods
The qualitative method used in this study was content analysis, which involves condensing and analyzing information from a variety of sources in order to draw meaningful conclusions.[21]

Data collection
An online survey questionnaire instrument was created using a template on the Survey Monkey™ website. The questionnaire was e-mailed to non-randomized participants identified for this study during the period August 2012 to December 2013. In addition, surveys were distributed at an Ohio Association of Community Health Workers general meeting, and telephone interviews were conducted using the survey questions with key organizations that were known to employ CHWs and provide training to them that did not respond to the survey.

Research Questions
To better comprehend best practices for CHW services that are used by organizations, a number of research questions were designed to understand current practices and identify alternative practices that could be recommended for future studies. The following questions include:

1. What credentials do CHWs have who are employed by organizations? What organizational personnel and administrative support are provided to CHW programs? What organizational personnel and administrative obstacles have impacted CHW programs?
2. Where do CHWs provide services?
3. How are CHWs or their employers reimbursed for their services?
4. What is the distribution of services provided by CHWs?
5. What output and outcome measures are commonly used for CHWs by organizations to evaluate CHW services?
6. What CHW skills or services are needed to better serve clients?

[20] Creswell, John, Research Design, Sage Publications, 2003, at http://isites.harvard.edu/fs/docs/icb.topic1334586.files/2003_Creswell_A%20Framework%20for%20Design.pdf
[21] Carol Busch, Paul S. De Maret, Teresa Flynn, Rachel Kellum , Sheri Le, Brad Meyers, Matt Saunders, Robert White, and Mike Palmquist, Content Analysis, Writing@CSU, Colorado State University, 1994 – 2012.

DEMOGRAPHICS

Seventy-five (75) participants provided data for the online survey. The description or type of organization that uses CHWs includes healthcare providers (n=30), health departments (n=15), health insurance entities (n=13), community-based organizations (n=16), faith-based organizations (n=3), patient-centered medical homes (n=3), mental health substance abuse agencies (n=6), and primary and secondary schools (n=6). The data on the type of organizations that use CHWs were collected to identify those organizations that are using CHWs (some respondents are classed in multiple categories). In addition, 11 phone interviews were conducted. 5 interview participants were community-based programs, 2 were hospitals, 2 were training sites (community colleges), and 2 were professional networks for CHWs.

PROVIDER ORGANIZATIONS SURVEY RESPONDENTS	NUMBER OF ORGANIZATIONS
Healthcare providers	30
Health departments	15
Health insurance entities	13
Community-based organizations	16
Faith based organizations	3
Patient-centered medical home	3
Mental health substance abuse agency	6
Primary and secondary schools	6

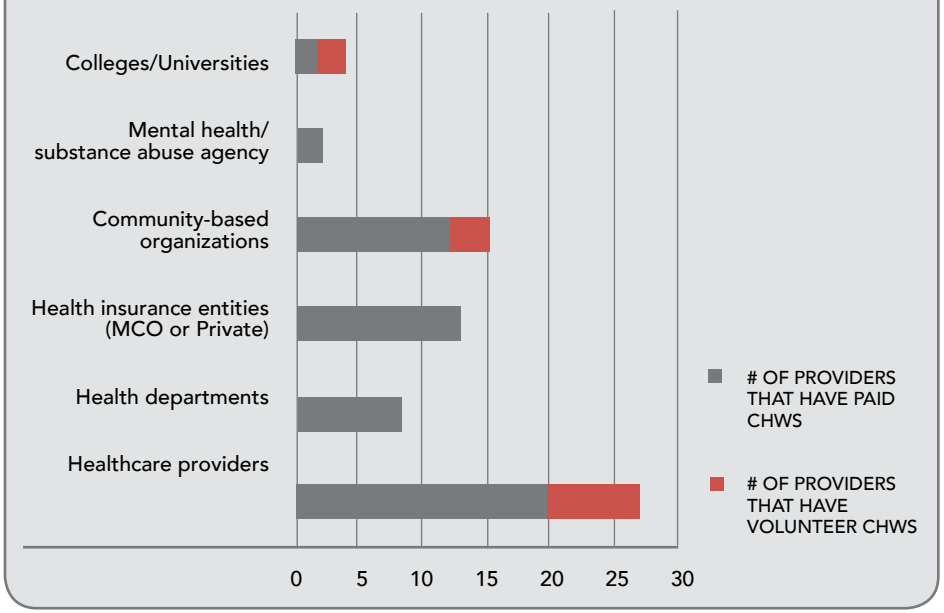
INTERVIEW SURVEY RESPONDENTS	NUMBER OF ORGANIZATIONS
Healthcare providers	2
Health departments	
Health insurance entities	
Community-based organizations	5
Faith based organizations	
Patient-centered medical home	
Mental health substance abuse agency	
Primary and secondary schools	2
Other (professional Networks)	2

RESULTS

Types of Organizations that use Community Health Workers

Our survey received good representation of responses across geographic regions in Ohio and across disciplines. Thirteen types of organizations responded to the survey, including public health departments, non-profits, for profits, community-based organizations, managed care plans, hospitals, health insurance companies, faith-based organizations, mental health providers, primary care providers, patient-centered medical homes, chronic disease organizations, colleges and universities, and primary k-12 schools. Hospitals, community-based organizations, community health centers, public health departments, and managed care plans were the most frequent users of CHWs, according to those who responded to our survey. Seventeen cities were represented in the survey results: Akron, Blue Ash, Canton, Cleveland, Cincinnati, Columbus, Dayton, Hamilton, Lima, Mansfield, Maumee, Springfield, Toledo, Warren, Westerville, Youngstown, and Zanesville. This report uses the responses of these organizations to paint a picture on how Ohio is using the CHW workforce.

TABLE 2. CHW PAID OR VOLUNTEER STATUS BY ORGANIZATION TYPE



Organization Characteristics

Data on CHWs by paid or volunteer status appear in Table 2. As described in Table 2, all provider organizations were found to employ paid CHWs. Health departments were the biggest employers of Ohio Board of Nursing-trained CHWs. Healthcare providers, community-based organizations, and colleges/universities were found to also use volunteer CHWs.

TABLE 1. CHWS' EDUCATION LEVEL BY ORGANIZATION TYPE

PROVIDER ORGANIZATIONS	ASSOCIATE DEGREE	BACHELOR'S DEGREE	CERTIFICATIONS	MASTERS	PHD
Healthcare providers	8	8	12	1	0
Health departments	6	6	9	3	1
Health insurance entities (MCO or Private)	1	2	7	1	0
Community-based organizations	7	7	9	0	0
Patient-centered medical home	2	2	0	0	0
Mental health/substance abuse agency	2	1	1	0	0
Colleges/Universities	1	1	0	0	0

Table 3 includes information on the types of knowledge organizations preferred CHWs to have. Health care providers, health departments, managed care organizations, community-based organizations, and patient-centered medical homes were found to employ CHWs with knowledge of the community being served, social service resources, community resources, and medical resources. Mental health and substance abuse agencies were found to employ CHWs with knowledge of the community being served, social service resources, and community resources. Colleges/universities were found to employ CHWs with knowledge of the community being served and social service resources. Colleges/universities did not report on CHWs' knowledge of community resources and medical resources.

TABLE 3. CHWS' JOB RELATED KNOWLEDGE BY ORGANIZATION TYPE

PROVIDER ORGANIZATIONS	COMMUNITY SERVED	SOCIAL SERVICES RESOURCES	COMMUNITY RESOURCES	MEDICAL RESOURCES
Healthcare providers	12	12	12	9
Health departments	6	3	5	4
Health insurance entities (MCO or Private)	4	4	5	3
Community-based organizations	11	11	10	8
Patient-centered medical home	1	1	1	1
Mental health/ substance abuse agency	1	1	1	0
Colleges/ Universities	1	1	0	0

Table 4 shows office skills held by CHWs as reported by provider organizations. All provider organizations were found to employ CHWs with knowledge of data entry skills. Healthcare providers, health departments, health insurance entities, community-based organizations, and colleges/universities were found to employ CHWs with knowledge of report-writing skills. Healthcare providers, health departments, health insurance entities, community-based organizations, and colleges/universities were found to employ CHWs with electronic medical record keeping skills. Mental health/substance abuse agencies did not report on CHWs' knowledge of electronic medical record skills.

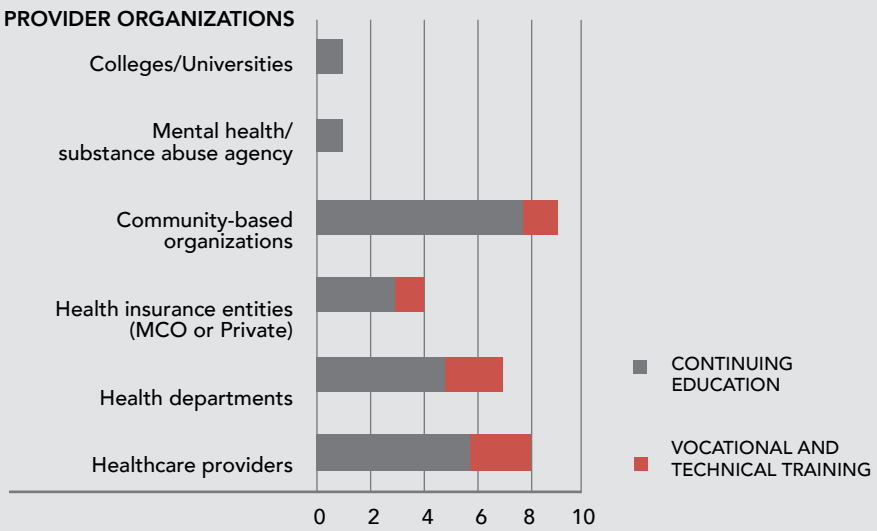
TABLE 4. CHWS' OFFICE SKILLS BY ORGANIZATION TYPE

PROVIDER ORGANIZATIONS	DATA ENTRY	REPORT WRITING	ELECTRONIC MEDICAL RECORD KEEPING
Healthcare providers	7	5	4
Health departments	6	3	1
Health insurance entities (MCO or Private)	2	1	1
Community-based organizations	6	4	1
Mental health substance abuse agency	1	0	0
Colleges/Universities	2	1	1

As shown in Table 5, all provider organizations reported providing CHWs with continuing education training. Healthcare providers, health departments, health insurance entities (e.g. managed care organizations or health insurance companies), and community-based organizations were found to provide vocational and technical training to CHWs.

Health departments, managed care organizations, community-based organizations, mental health/substance abuse agencies and colleges/universities were not currently reimbursed for CHW services. None of those responding to the survey said they were reimbursed by entitlement programs like Medicaid. Several of those interviewed who worked with elderly populations reported that they were able to receive reimbursement for homemaker and other services through Medicare and supplemental insurances.

TABLE 5. CHWS' TRAINING BY ORGANIZATION TYPE



Services provided by CHWs

Organizations in Ohio are using CHWs to perform a variety of services with a variety of populations. The services most widely performed by CHWs whose organizations responded to the survey are follow-up calls and health education, with forty positive responses each. Next, in order of frequency, were home visits, linkage to medical services, assistance with appointments, transportation, case management, accompaniment to doctor's appointments, linkage to non-medical services, health screenings, patient advocacy, linkage to behavioral health services, provision of behavioral health services, chronic disease self-management, and nutritional and exercise programs. Other services provided by smaller numbers of respondents include services to improve health literacy, language interpretation, personal care, homemaking, and medication monitoring.

Services frequently provided by CHWs were found to vary by organization type (which appears in Table 6). The top six types of services most provided by community health workers include follow-up calls, health education, home visits, linkage to medical services, health screenings, and patient advocacy. As described in Table 6, healthcare providers, health departments, managed care organizations, community-based organizations, and colleges/universities that employ CHWs were found to provide a set of core services which included health education, home visits, follow-up calls, links to medical services, assistance with appointments, and transportation. Mental health substance abuse agencies provide home visits, follow up calls, links to medical services, assistance with appointments, and transportation. Non-profit and for-profit health providers that employ CHWs used them to accompany patients to doctor visits, provide case management, link patients to social services, provide health screenings, and provide patient advocacy. Non-profit healthcare providers and health departments that employ CHWs were found to provide services that enroll patients into chronic disease related workshops and provide services that involve medication monitoring and compliance services. Community-based organizations that employ CHWs were found to provide services that involve medication monitoring and compliance services. Health departments, managed care organizations, and community-based organizations that employ CHWs were found to use them to accompany patients to doctor visits, provide case management, link patients to social services, provide health screenings, and provide patient advocacy. All provider organizations that employ CHWs provided services that link or refer patients to behavioral health services.

Managed care organizations, mental health substance abuse agencies, colleges/universities that employ CHWs did not report using them to provide chronic disease management. Mental health substance abuse agencies and colleges/universities that employ CHWs did not report using them to facilitate exercise or nutritional programs and language interpretation programs. Mental health substance abuse agencies and colleges/universities that employ CHWs did not report using CHWs to provide health literacy.

An example of Ohio organizations using CHWs that responded to the survey include Columbus Public Health, which uses community health workers to work with pregnant and parenting moms and children and Health Care Access Now who uses CHW's in their Pregnancy Pathways program. Other examples are the Diabetes Partnership of Cleveland and the Central Ohio Diabetes Association, both of which use community health workers to deliver chronic disease self-management programs to persons living with diabetes. TriHealth Hospital in Cincinnati uses CHWs to work with patients on managing chronic conditions like hypertension and diabetes and to facilitate exercise and nutrition programs. Ohio organizations like Planned Parenthood send their CHWs out to the street, public housing units, schools, and shelters to provide family planning counseling, women's health education, prenatal care, smoking cessation education, linkage to doctors, and follow-up care. The CHWs at the Hospital Council of Northwest Ohio deliver services out of a variety of venues, including churches. And finally, Ohio State University Medical Center East is placing CHWs in community-based organizations for practicum experiences with the hope that these organizations will find permanent positions for them once they graduate. Health Hubs have been created across the state and CHW's are used by these health hub programs and their partners organizations.

TABLE 6. FREQUENTLY PROVIDED CHW SERVICES BY ORGANIZATION TYPE

TYPE OF PROVIDER	NON-PROFIT HEALTHCARE PROVIDERS	FOR-PROFIT HEALTHCARE PROVIDERS	HEALTH DEPARTMENTS	HEALTH INSURANCE COMPANIES	MANAGED CARE ORGANIZATIONS	COMMUNITY-BASED ORGANIZATIONS	MENTAL HEALTH/ SUBSTANCE ABUSE AGENCY	COLLEGES AND UNIVERSITIES
Health Education	12	2	13		4	8	0	1
Home Visits	7	2	9		7	8	2	1
Follow Up Calls	12	2	8		5	10	2	1
Link to Medical Services	12	3	7		3	6	2	1
Assistance with Appointments	12	2	7		4	6	2	0
Transportation	11	1	7		4	6	2	0
Accompany Patients to Doctor Visits	5	1	8	3		7	1	0
Case Management	7	1	6	4		9	1	1
Link to Social Services (Non-Medical)	10	1	7	4		6	1	1
Health Screenings	10	1	7	1		5	0	1
Patient Advocacy	6	1	6	2		9	1	1
Link to Behavioral Services	5	2	6		3	5	1	1
Behavioral Health Services	4	2	6		2	6	0	0
Chronic Disease Management	7	1	4		0	4	0	0
Facilitate Exercise or Nutritional Programs	6	1	5		1	3	0	0
Language Interpretation	5	2	2		1	1	0	0

THE PLACES WHERE COMMUNITY HEALTH WORKERS PROVIDE SERVICES

Community-Based Organizations	34
Public Housing Units	33
Schools	35
Faith-based Organzations	29
Beauty/Barber Shops	18
Community Health Clinics	44
Shelters	31
On the Street	25
Migrant Camps	4
Clients' Work Sites	19
Teen Centers	17

CHWs employed by healthcare providers and health departments were found to provide services at their agency/organization, clients' homes, community events, faith-based organizations, community-based organizations, on the streets, primary care practices, patient-centered medical homes, health clinics, public housing units, schools, shelter centers, teen centers (excludes health departments), and at the barber shop. CHWs employed by health insurance providers were found to provide services at clients' homes, hospitals, and primary care practices. CHWs employed by community-based organization were found to provide services at their agency/organization, clients' homes, faith-based organizations, hospitals, community-based organizations, on the streets, primary care practices, health clinics, public housing units, and at the barber shop.

Evaluation/Outcome Measurements

Organizations who responded use a variety of outcome measures to evaluate the success of CHW services. Some respondents used quantitative measures, such as the number of patients who kept appointments, number of patients that completed screenings, or number of patients served.

This question received few responses from those surveyed. However, half of those interviewed reported that they used pathways outcome measurements, a model developed by the Community Health Access Project (CHAP) in Mansfield, in which outcomes are defined on a individual level and the focus is on problem resolution.[22] Responses for those that responded to this question, output and outcome measures used to evaluate CHW services are described in Table 7.

TABLE 7. PROVIDER ORGANIZATION CHW OUTPUT MEASURES

HEALTHCARE PROVIDERS	HEALTH DEPARTMENT	HEALTH INSURANCE COMPANIES	COMMUNITY-BASED ORGANIZATION	MENTAL HEALTH SUBSTANCE ABUSE AGENCY	COLLEGES/ UNIVERSITIES
No. of mothers registered for car seat class	Breast feeding rates	Cost of services	Scheduled and kept prenatal immunization scheduled appointments	Patient satisfaction	N/A
No. of car seats installed on-site	Pre-test and Post-test	Patient outcomes	Intake checklist		
% of patients utilized services	Birth outcomes		Breast feeding rates		
% of patients that completed screening	Patient satisfaction		Contraception rates		
Chart audits	Pathways		Service volume documentation		
Birth weight	Assessment tools		No. of women served		
Infant mortality			No. of women that received mammograms		
% of barriers that are removed to deliver care			No. of women signed up for health insurance and received healthcare		
Improved patient knowledge from education workshops, training and outreach initiatives			Age and stage questionnaire (ASQ)		
Pathways			Birth outcomes Quality Improvement (QI) reports Prenatal care Cultural competence Patient outcomes Patient satisfaction Pathways assessment tools Focus groups Computer based outcome system Improved patient knowledge Blood glucose levels		

[22] Community Health Access Project, *Pathways: Building a Community Outcome Production Model*, 2010. http://chap-ohio.net/press/wp-content/uploads/2010/09/PathwaysManual1.pdf

Preferred Skills

Knowledge about community resources and electronic medical record keeping were the most desired skills for CHWs. Healthcare providers, health departments, and community-based organizations that employ CHWs indicated that those skills that are needed to better serve clients should include knowledge about the community being served, social service resources, data entry, and knowledge about medical resources.

Training

Ohio has one of the only CHW certification programs in the country and was the first to connect this certification to its state Board of Nursing. There are six certified training sites at colleges and universities across the state of Ohio. Attendance at one of these programs allows a CHW to receive a certification from the Ohio Nursing Board. In addition, there are many programs that use CHWs who are trained in other ways.

Board of Nursing-certified community health workers were used the most among the organizations that responded to the survey. Health departments were the biggest employers of Ohio Board of Nursing-certified CHWs. Community-based organizations and managed care plans were found to use alternate methods for training CHWs, like their own curriculums or the Dr. Harold Freeman training. Chronic disease groups were likely to have additional certification programs to train their CHWs to provide chronic disease self-management services specific to the chronic disease they worked with. For more information go to www.nursing.ohio.gov.

Reimbursement for Services

Lack of reimbursement for CHWs is the biggest barrier to both retention of current CHWs and to expanding the use of this workforce. All of the organizations that responded to the survey and participated in the interviews employed CHWs. It is clear that these organizations believe compensation for CHWs is necessary or preferable to obtain the documented benefits of employing CHWs – in other words, a best practice. Employing CHWs with a living wage is made possible by the Healthcare provider or other employing organization's ability to bill for CHW services and/or find grant funding. Because Ohio currently has no mechanism to bill for CHW services through state and federal entitlement programs (e.g. Medicaid, Medicare)[23] or private insurance, many Ohioans from among at-risk populations and communities where health disparities are highest cannot benefit from the services of CHWs.

A report commissioned by the National Center for Chronic Disease Prevention and Health Promotion Division for Heart Disease and Stroke Prevention outlines several examples of states and programs that have been able to secure long term funding for CHWs.[24] The most stable long-term funding strategies we found include grant funding: Health Resources and Services Administration (HRSA) is the biggest federal funder over longer periods, using per-member fees;[25] Vermont has a promising strategy for using per-member fees paid by Medicaid, Medicare and private insurance companies, and Medicaid waivers are used in New York and California.[26] Finally, for-profit disease management groups are using CHWs to assist with chronic disease management and receiving reimbursements from private insurance companies.

In addition, several recent developments suggest that funding for CHWs may be improving. The Affordable Care Act acknowledges the potential utility of CHWs by including a provision to expand the use of Community Health Workers (Section 5313, as modified by Section 10501).

Among those we surveyed knowledge of the community was one of the most desired skill.

[23] Ohio Medicaid managed care plans pay for community health workers from their capitated rate. See footnote 8.
[24] National Center for Chronic Disease Prevention and Health Promotion – Division for Heart Disease and Stroke Prevention, *Addressing Chronic Disease through Community Health Workers: A Policy and Systems-Level Approach; A Policy Brief on Community Health Workers,* 2011. http://www.cdc.gov/dhdsp/docs/chw_brief.pdf
[25] U.S. Department of Health and Human Services – Health Resources and Services Administration, Community Health Worker National Workforce Study, March 2007. http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf
[26] Vermont Department of Health, *Vermont Blueprint for Health Annual Report,* 2008. http://www.leg.state.vt.us/reports/2009ExternalReports/240386.pdf

And the newly created CMS rule could be the beginning of the creation of funding streams for this workforce. According to the new CMS rule,[28] beginning January 1, 2014, state Medicaid agencies can "reimburse for preventive services provided by professionals that may fall outside of a state's clinical licensure system, as long as the services have been initially recommended by a physician or other licensed practitioner."[29]

Implications

Community Health Workers part of that nationally recognized diversified workforce, can help bridge the cultural and linguistic gap for primary care physicians, hospital staff and other medical staff working with hard-to-reach populations.

Many organizations across Ohio understand the importance of the community health worker workforce, as evidenced by the number of programs already using them in Ohio. CHWs are already providing core services which enhance the effectiveness of Federally Qualified Health Centers (FQHC), hospitals, and public health departments as well as community programs and federally qualified health centers.

Ohio could benefit from expanding the use of this workforce. CHWs could significantly improve the capacity of PCMHs, FQHCs, hospitals and others providing health care services to Ohio's at risk populations by bridging cultural and linguistic gaps. They could also help to diversify Ohio's medical workforce.

The volume or depth of services provided by CHWs is influenced by a number of factors, including training, providers' commitment to job-related acquired knowledge, job-related skill sets, access to continuing education, vocational or technical training, and, most of all, funding.

Future polices based on the Affordable Care Act mandate to expand the CHW workforce could open up funding mechanisms for CHWs. For example the new CMS rule has implications for creating a Medicaid reimbursement stream for CHWs in Ohio. Implementing this new rule could allow the Ohio Office on Health Transformation to include reimbursement for CHW services as part of the services Patient Centered Medical Homes can receive reimbursement for. There are programs across the country that have been successful in creating sustainable funding for CHW programs and could be resources in helping Ohio create stable funding for this workforce. A report from the National Fund for Medical Education, "Advancing Community Health Worker Practice and Utilization; Focus on Financing," provides examples of programs across the country who have created sustainable funding resources and provides funding models for states that are interested in creating sustainable funding for CHWs.[30]

Conclusion

Ohio has many systems in place that can support the expansion of CHWs. For example, many of our health departments, hospitals, and community health organizations are already using CHWs. We already have training sites and a certification process in place. Ohio has identified and is attempting to impact several priority health issues, such as infant mortality, where disparities have been identified that could benefit from expanded use of community health workers. In addition, Ohio has just received a State Innovation Model Test Grant to "reset the basic rules of health care competition so that the incentive is to deliver better care and keep people as healthy as possible."[31] One of the two payment models being tested is the "patient-centered medical home" model of primary care, which is an ideal vehicle for community health workers.

It is our hope that this report will fuel a more formal statewide conversation on how to incorporate community health workers into existing and new models of care that are being developed and how to create sustainable funding for them.

[27] Patient Protection and Affordable Care Act, 42 U.S.C., Sections 5313 and 10501.
[28] Centers for Medicare & Medicaid Services, *Medicaid and children's health insurance programs: essential health benefits in alternative benefit plans, eligibility notices, fair hearing and appeal processes, premiums and cost sharing, exchanges: eligibility and enrollment; final rule,* 78 Fed Reg 42160, § 440.130 July 15, 2013. http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf
[29] Community Health Worker Health Disparities Initiative, National Institutes of Health, at http://www.abcardio.org/articles/cms_rule.html.
[30] National Fund for Medical Education, Advancing Community Health Worker Practice and Utilization; Focus on Financing, 2006. http://futurehealth.ucsf.edu/Content/29/2006-12_Advancing_Community_Health_Worker_Practice_and_Utilization_The_Focus_on_Financing.pdf
[31] Ohio SIM Test Grant Application, at http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=e_p2kypH7G8%3d&tabid=138 page 3.

RECOMMENDATIONS

Recommendation 1: CHWs should be part of all Ohio primary care teams serving patients who could benefit from CHWs' services, particularly those from racial, ethnic and rural populations.

Recommendation 2: As public and private stakeholders develop new models of enhanced, patient-centered primary care (such as the patient-centered medical home), new reimbursement schemes should account for the need to employ CHWs as part of the care team for practices whose patients could benefit from CHWs.

Recommendation 3: In order to address the reimbursement issue, a policy brief outlining some of the strategies that have been used to create sustainable funding for community health workers in other states should be developed and provided to the Ohio Department of Medicaid, Ohio Office of Health Transformation, Ohio policy makers, and made publicly available.

Recommendation 4: The Ohio Office of Health Transformation and the Department of Medicaid should establish a committee to develop a plan for implementing a Medicaid reimbursement strategy for Ohio CHWs and explore their role in new models of care, including patient-centered medical homes. This committee should be comprised of representatives from Ohio Community Health Workers Association, CHW training sites, Ohio Department of Health, local health departments, community health centers, Ohio Board of Nursing, the Ohio Health Disparities Collaborative (Workforce Development Committee), consumer advocacy organizations, hospitals, managed care plans, provider organizations, community and faith organizations, and other key stakeholders.

Recommendation 5: Existing community-based programs should be utilized to house community health workers (e.g. churches, community action agencies, Head Starts, community health centers, and public health departments).

Recommendation 6: Managed care plans, insurance companies, and hospitals should look for and support models and projects that place more community health workers in community settings and add them to PCMH teams. Stronger partnerships are needed between hospitals, managed care plans, private insurance companies, and community and faith programs.

Recommendation 7: Future discussions on expanding the use of community health workers should include:

- How to identify those organizations central to the communities where health disparities are the highest and strategies for partnering with them to place CHWs in these sites to provide relevant health services. Churches with health ministries, health clinics, community action agencies, and settlement houses are places to focus on.
- What training and certification is needed for CHWs in certain settings. The Ohio CHW certification process is linked to the Ohio Board of Nursing and could be a strength in promoting their use as part of PCMH teams. This training and certification can also be a strength in establishing a common training for this workforce. The current CHW certified training programs could be the basis for a standardized training program, and agencies could add relevant training for the services their populations need (e.g. chronic disease self-management training) once hired.
- How non-certified CHWs (e.g. promotores/as and peer counselors) are used, and how Ohio can create stable reimbursement for this important part of the CHW workforce.
- How to identify and implement long-term funding strategies for both certified and non-certified CHWs.
- How to create a pipeline for CHWs to move into other higher level medical professions (e.g. nurses, nurse practitioners, physicians assistants and physicians).

APPENDICES

APPENDIX A:
Titles Used by Community Health Workers
(In descending order of frequency of use)

Certified Community Health Worker
Case Manager
Community Health Advocate
Community Health Educator
Outreach Worker
Community Care Coordinator
Community Worker
Outreach Specialist
Home Visitor/Support Worker
Community Health Advisor
Patient Navigator
Community Health Aide
Helper/Supporter
Promotores(as)
Patient Advocate
Health Coach
Peer/Teen Educator
Lactation Consultant/Specialist

APPENDIX B:
Comments from survey participants on ways to better address the needs of patients/clients

More opportunities to have educational sessions for the clients.

Continued blurring of the lines between physical health and behavioral health.

Updated/current contact information for members.

Relationship building.

More cultural competency training, and more education opportunities.

Providing more community health workers on low income housing sites.

More resources.

Funding for specific issues and problems that we have identified.

A better understanding from the higher-ups.

Direct location in the community, not agency whose interests are not centered on the client.

This is an excellent program; no need to reinvent the wheel.

More housing programs for low income people; this would help eliminate year or longer waiting lists.

I feel that we advocate very well for our clients/ members.

Uniformed training in patient navigation for the advocates.

More streamlined communication and processes between local health partners.

Time management; we address issues that are all, sometimes, a level 1 crisis mode.

Developing trusting relationships.

More flexibility in scheduling with clients.

More incentives.

Provide coordinated care service delivery teams.

Integrate CHWs into the Public Health culture - not just isolated pockets.

They need to obtain a better understanding of their personal health and what they can do to improve their own health.

Let the CHWs run the program.

Transportation.

Majority are very low income. Literacy and transportation are significant issues. Many cannot pay for services which puts burden on programming sustainability.

Better understanding from the providers of who CHWs are and what they do.

Funding and our services valued by funders.

Additional funding to assist programs in being as effective as possible.

Need additional CHW capacity.

Conduct more preventative health education awareness sessions.

APPENDIX C:
Resources for Further Reading

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