Community Health Workers: Connecticut

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Connecting students to careers, professionals to communities, and communities to better health

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Background

Community health workers (CHWs) have been recognized as an integral part of community-based healthcare. According to the American Public Health Association, a CHW is defined as a frontline worker who is a trusted member of and/or has an unusually close understanding of the community served. This relationship enables the CHW to serve as a liaison between health and social services and the community to facilitate access to services and improve quality and cultural competency of service delivery.

The CHW workforce in CT is poorly understood. CHWs are known by different names, have diverse job titles and responsibilities, and may not be connected to other CHWs in their own communities or in the state. Consequently, the capacity of CHWs to improve health of CT's most vulnerable communities has not been fully realized. Southwestern AHEC, Inc. (SWAHEC) seeks to improve that understanding and propel the CHW workforce in CT forward.

Community Health Worker and Employer Surveys

In 2012, SWAHEC distributed two surveys to CHWs and their employers to better understand the characteristics of CHWs in CT, as well as their roles, met and unmet training needs, and employment status. Employers were asked about funding mechanisms in place for CHWs that they employ, as well as attitudes about the use of CHWs.

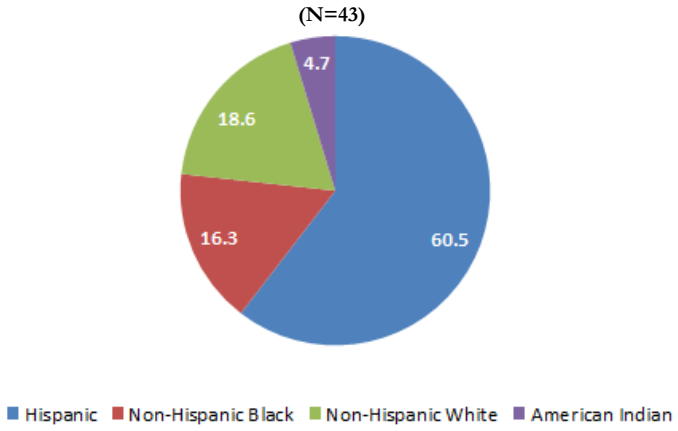
A total of 43 CHWs completed the CHW survey and 97 employers of CHWs responded to the employer survey. This report summarizes the findings of these surveys, and includes the following major sections: Community Health Worker Characteristics, Health Care Employer Characteristics, Training, and Reimbursement.

CHW Characteristics

Gender, Age, and Race/Ethnicity

The majority of CHW respondents were women (95.4%). The average age of CHWs was 44.6 (SD=11.2) with an age range of 26 to 67 years. The racial/ethnic breakdown of CHWs can be seen in the figure to the right. The majority of CHWs surveyed were Hispanic (60.5%), followed by non-Hispanic white (18.6%) and non-Hispanic black (16.3%).

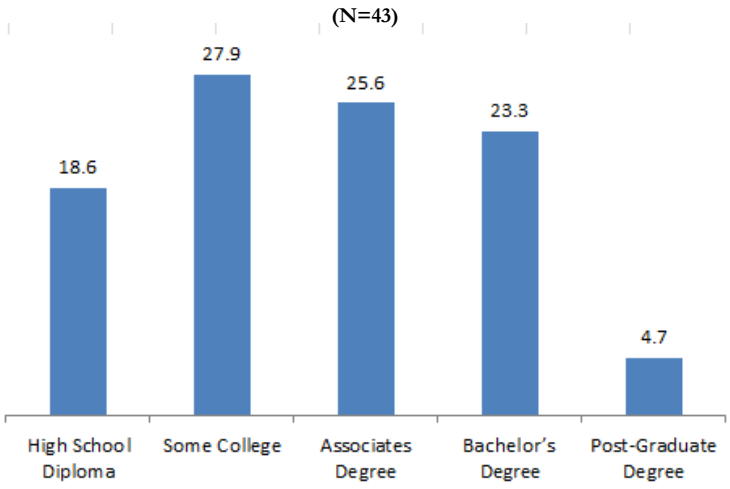
Race/Ethnicity of CHWs (%)



Education

The majority of CHW respondents had at least some college education (53.5%) which is slightly higher than educational attainment for CHWs nationwide. The proportion of CHWs in CT who had a college degree or more was 28%.

Educational Attainment of CHWs (%)

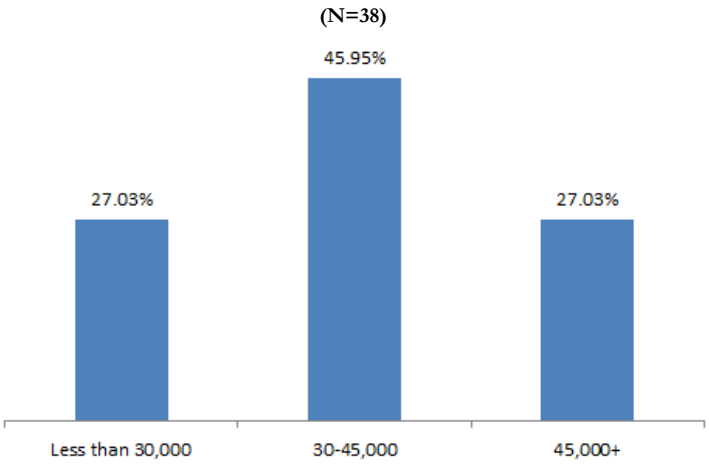


Wages

Of the 38 CHWs who responded to employment status, 35 (92.1%) were full-time. Of those who indicated they were employed full-time and reported a salary range, 27% earned less than $30,000 per year. The majority, 46%, earned between $30,000 and $45,000 per year. The remaining 27% earned more than $45,000 per year.

There was a relationship between education and salary; CHWs who reported higher education were generally in higher salary categories (data not shown).

CHW Salaries, Full-Time Employees (%)



What do CHWS do?

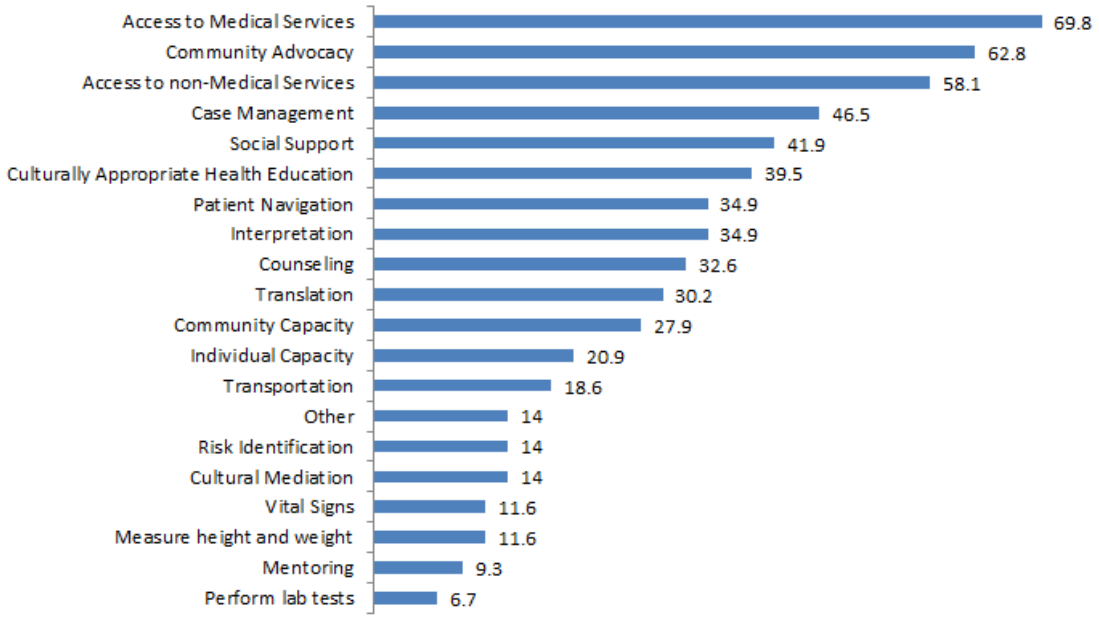
CHWs in CT (N=43) had diverse job duties. The most common activities included assistance with access to medical services (69.8%), community advocacy (62.8%), assistance with access to non-medical services (58.1%), case management (46.5%), and providing social support to community members (41.9%). Other activities, which highlight the diversity of CHW duties, included performing lab tests, risk identification, and providing transportation to clients. The figure below shows activities reported by CHWs.

In their own words...

It's the best job you can have if you enjoy helping individuals regardless of their background. This position is very rewarding.

-CHW

Activities of CHWs in CT (%)



**multiple responses allowed, so percentages do not sum to 100%*

Job Titles

Despite substantial overlap in the roles and responsibilities of CHWs, they are known by many different names. Some of the job titles CHW respondents identified:

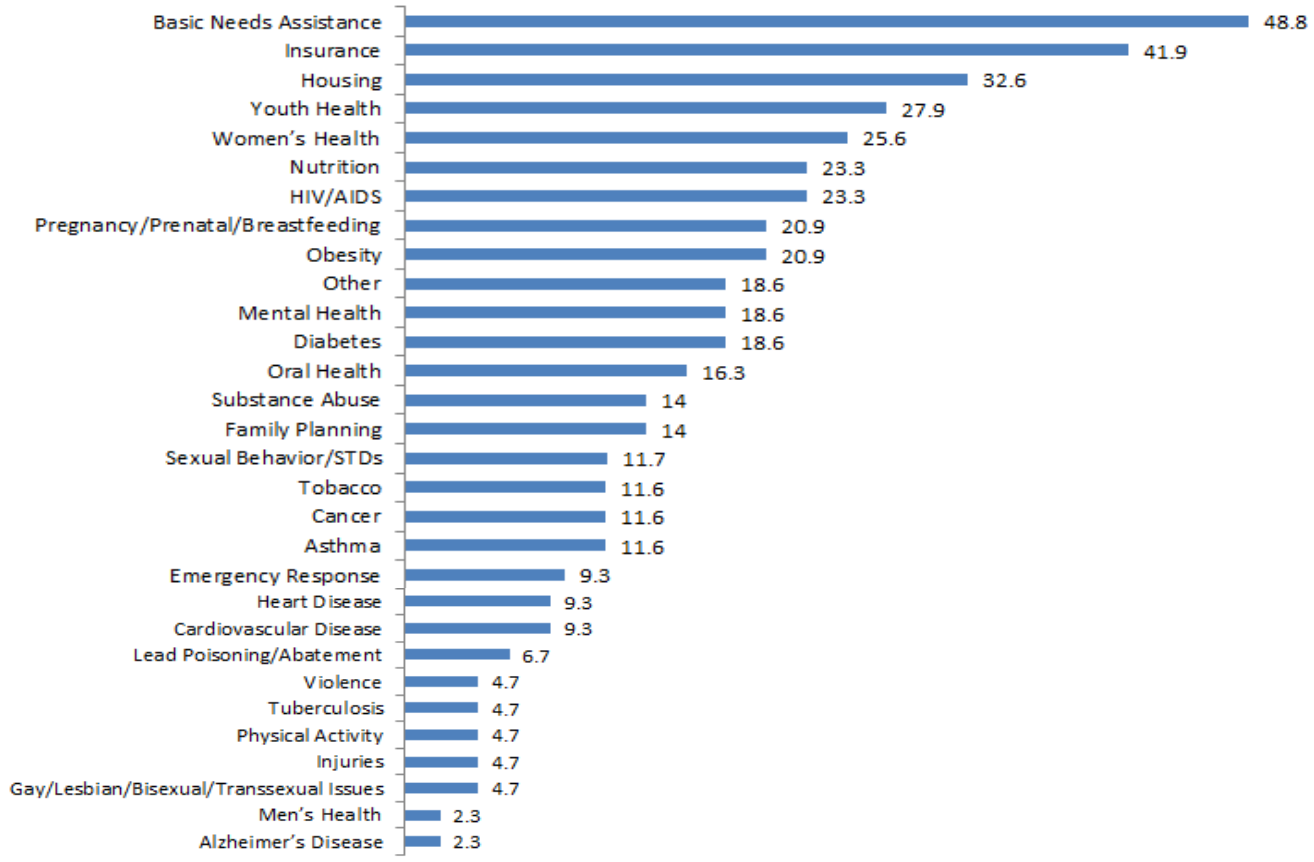
Case manager	Outreach specialist	Community health representative
Community care coordinator	**Outreach worker***	Promotor de salud
Community health educator	Patient navigator	**Community health worker***
Community worker		

**represent titles that were most frequently selected by respondents*

What do CHWS do? Cont'd

Basic needs assistance (48.8%) and insurance (41.9%) were identified as key areas for CHW involvement in CT (N=43). Other services include housing-related assistance, women's health, diabetes, cancer, among many others. The complete list of health/wellness issues addressed by CHWs can be seen in the figure below, and illustrates the diversity of CHWs in the state.

Main Issues (%)



**multiple responses allowed, so percentages do not sum to 100%*

Job Satisfaction & Security

Of the CHWs surveyed (N=43), the majority (92.5%) were satisfied with their job as a CHW. However, 47.5% did not feel secure in their job, and identified the following obstacles facing CHWs in CT:

- Lack of stable funding (55.8%)
- Lack of understanding about CHW's contributions to the community (46.5%)
- Lack of training resources (41.9%)
- Lack of standard definition of who CHWs are (37.2%)
- Hostility/competition from other health care workers (18.6%)
- Lack of acceptance by other health care workers (14.0%)
- Other (6.7%)
- None (6.7%)

**Note: multiple responses possible, so items do not sum to 100%*

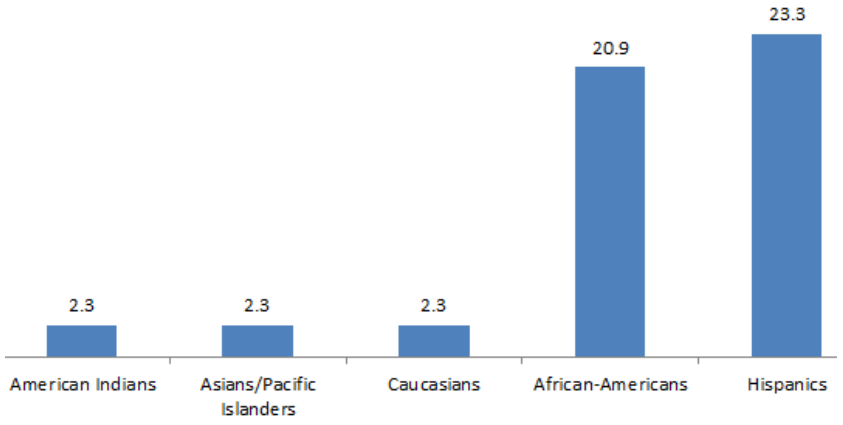
Target Populations

CHWs in CT (N=43) worked with many different groups. Of those who reported working with a specific gender, 23.3% indicated targeting women and 14% indicated targeting men.

A large proportion of CHWs served minority populations, particularly Hispanic (23.3%) and African-American (20.9%). In addition, 23.3% of CHWs targeted immigrants 9.3% targeted migrant workers. The uninsured were targeted by 16.3% of CHWs, and 20.9% of CHWs targeted homeless individuals. Lesbian, gay, bisexual and transsexual individuals were reported as targets for 9.6% of the surveyed CHWs. Almost half (48.8%) of CHW respondents reported no specific target population, and 7% indicated other populations. Note that the percentages do not sum to 100% because this item allowed for multiple responses.

Racial/ethnic groups targeted by CHWs (%)

(N=12)

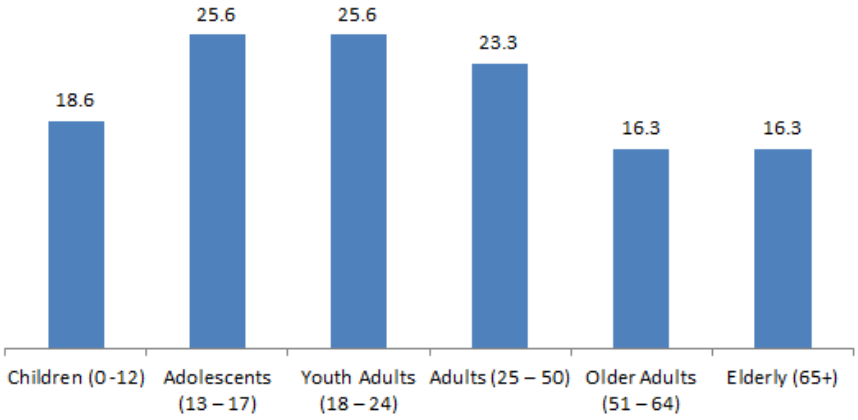


Age Groups

CHWs (N=43) worked with all age groups, spanning from children (18.6%) to the elderly (16.3%). The most common age group for CHWs to target was adolescents between ages 13 and 17 and young adults between ages 18 and 24, an important target for prevention education and outreach for various infectious diseases and preventable chronic conditions.

Age groups targeted by CHWs (%)

multiple responses allowed, so percentages do not sum to 100%



Training of CHWs: Employer Perspective

The CHW survey and the employer survey revealed a number of insights into the expectations of employers regarding CHW skills and the training of CHWs in Connecticut.

Required Skills for CHWs

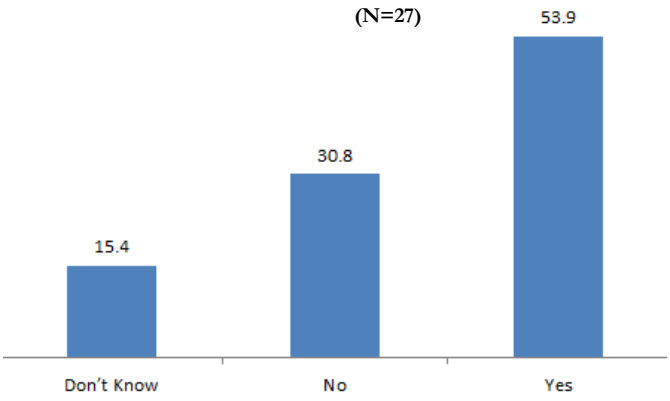
Employers surveyed (N=32) expected CHWs to have specific skills, as seen in the table to the right. The items in bold are skills required by more than 50% of employers surveyed. Highlights include communication skills, interpersonal skills, knowledge of the community, and confidentiality skills.

Skills required for employment	
Communication Skills	**96.9%**
Interpersonal Skills	**90.6%**
Confidentiality Skills	**75.0%**
Knowledge of the Community	**75.0%**
Organizational Skills	**68.8%**
Bilingual Skills	**65.6%**
Advocacy Skills	**62.5%**
Knowledge Base of Health	**59.4%**
Coordination Skills	**56.3%**
Teaching Skills	40.6%
Capacity Building Skills	31.3%
Other Skills	15.6%
No Skills Required	0%

Training

When asked whether they would like CHWs to have more training, the majority of employers (53.9%) indicated that they would like their CHWs to have more training. Of the remaining respondents, 15.4% were satisfied with the level of training that their CHWs currently have, and 30.8% were unsure if additional training would be beneficial.

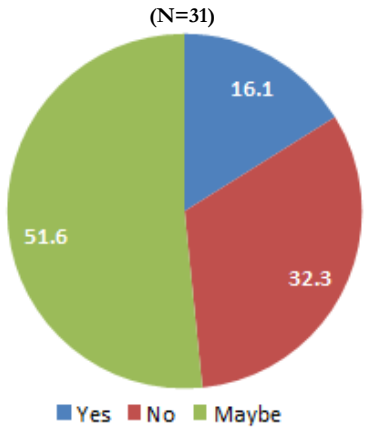
Desire More Training for CHWs (%)



Support for Training

However, the employer survey indicated that while employers expected CHWs to have a certain skill set, and thought training would be beneficial, most were reluctant to subsidize additional training for CHWs. Of the 31 respondents, 16.1% indicated that their organization would provide resources to cover the cost of additional training for CHWs, whereas 32.3% indicated they would not consider such a policy. The remaining 51.6% of respondents indicated that they would consider providing resources to cover the cost of additional training.

Willing to Provide Financial Assistance for CHW Training (%)



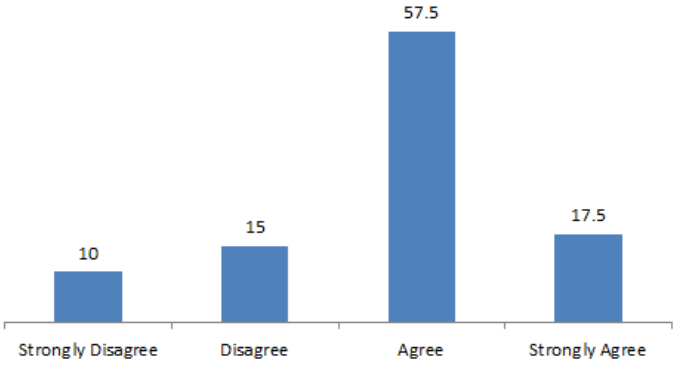
Training of CHWs: CHW Perspective

The CHW survey revealed that 54.8% of CHWs received training prior to becoming a CHW.

An overwhelming majority of CHWs indicated they would benefit from more training. Only one respondent said they would not benefit from more training. The figure below shows how well-trained CHWs felt for their current position, and indicates that while the majority agreed or strongly agreed that they felt well-trained for their job as a CHW, a significant proportion (25%) did not feel well-prepared.

I was well-trained for my job as a CHW (%)

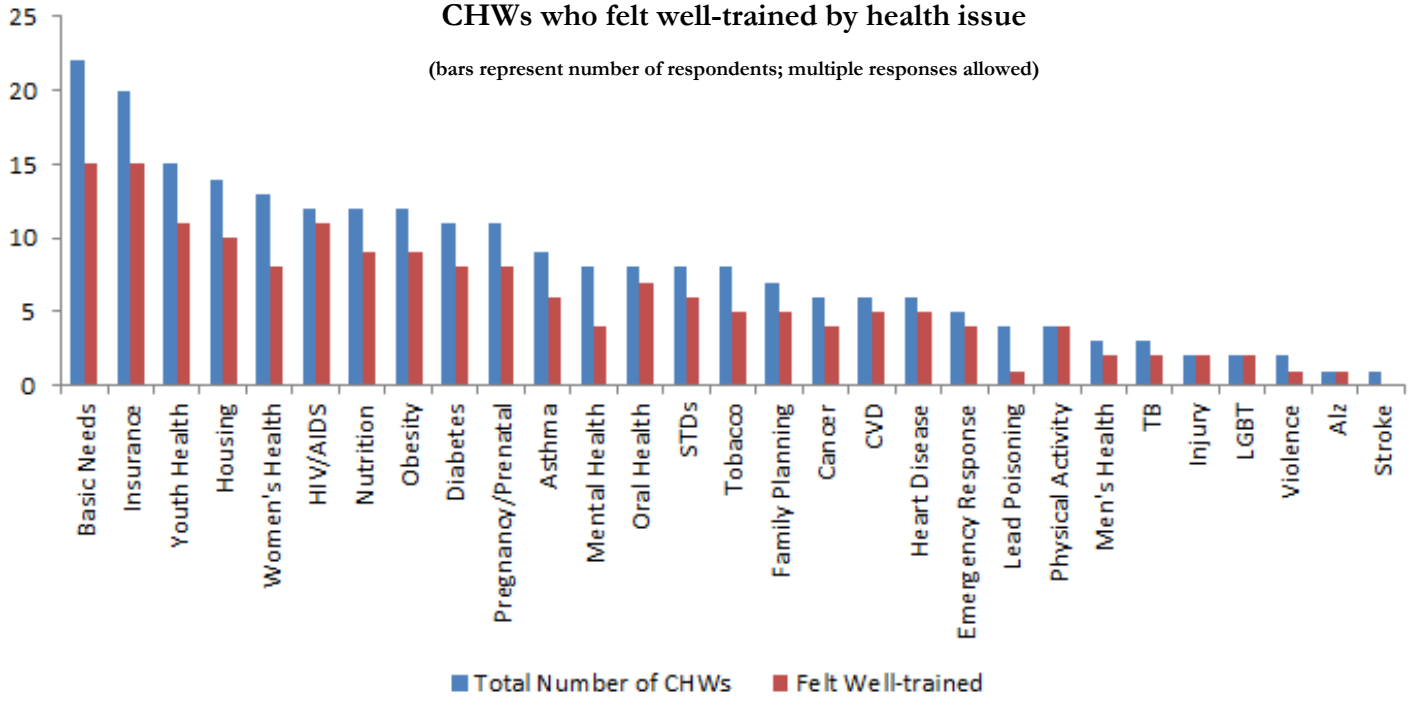
(N=40)



The graph below examines how well-trained CHWs felt in relation to the health issue they work in. The definition of well-trained was adapted from a survey question that asked CHWs to rate how well-trained they feel they are trained for their current position using a Likert scale. A response of 1 (not trained enough) or 2 was defined as not feeling well-trained, whereas a response of 3, 4 or 5 (extremely well-trained) was defined as feeling well-trained. Important to note is that CHWs did not rate training specifically for the categories represented.

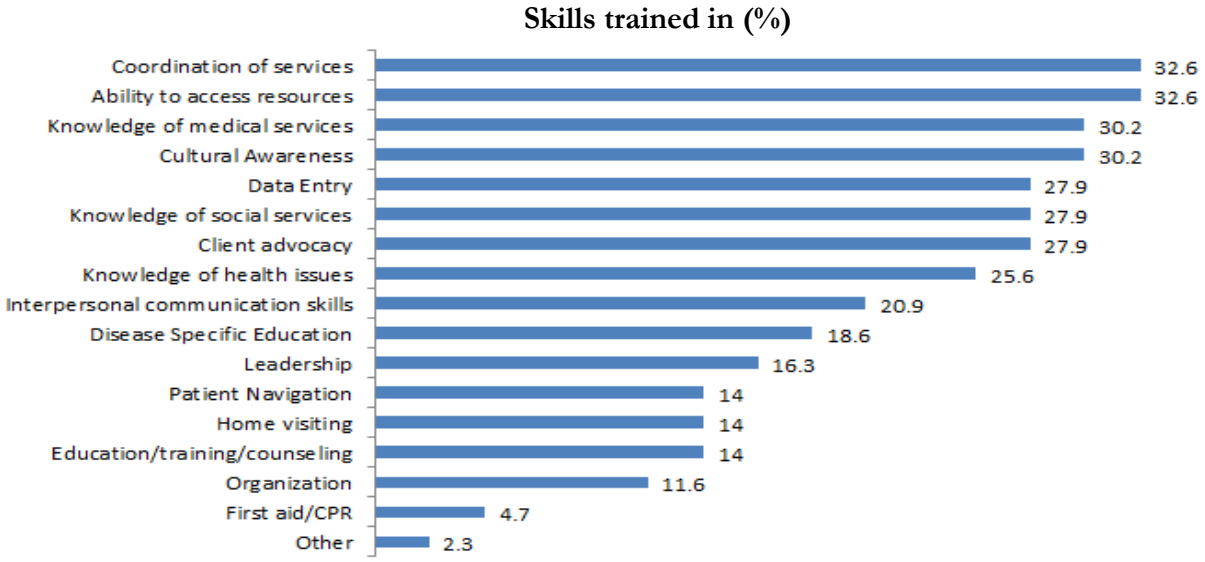
CHWs who felt well-trained by health issue

(bars represent number of respondents; multiple responses allowed)



Training of CHWs: CHW Perspective Cont.

Those who received training did so in a number of areas, including client advocacy, first aid, and home visiting. The types of training can be seen in the figure below (N=43)



Most training (N=43) was delivered on-the job (37.2%), via multiple short trainings in specialty areas (34.9%), and via off-site training programs (27.9%). Other training styles included classroom instruction, comprehensive skills training, mentoring, and online training.

There is some sentiment among the CHWs surveyed that the first steps have been taken. The state government and organizations working to improve the health of the state are challenged to move beyond those first steps and further support the CHW workforce.

In their own words…

Though I think [the course I was offered at Gateway] was an important first step…its weakness lies in its orientation toward PN [Patient Navigator] in the hospital more than out in the community.

-CHW

I feel there should be a standard training program in place for new CHWs and a yearly training refresher and update, similar to Covering Kids (which has been very beneficial), but specific to the screening and application process. Advocating for clients with DSS is a significant challenge as it is extremely difficult to reach anyone.

-CHW

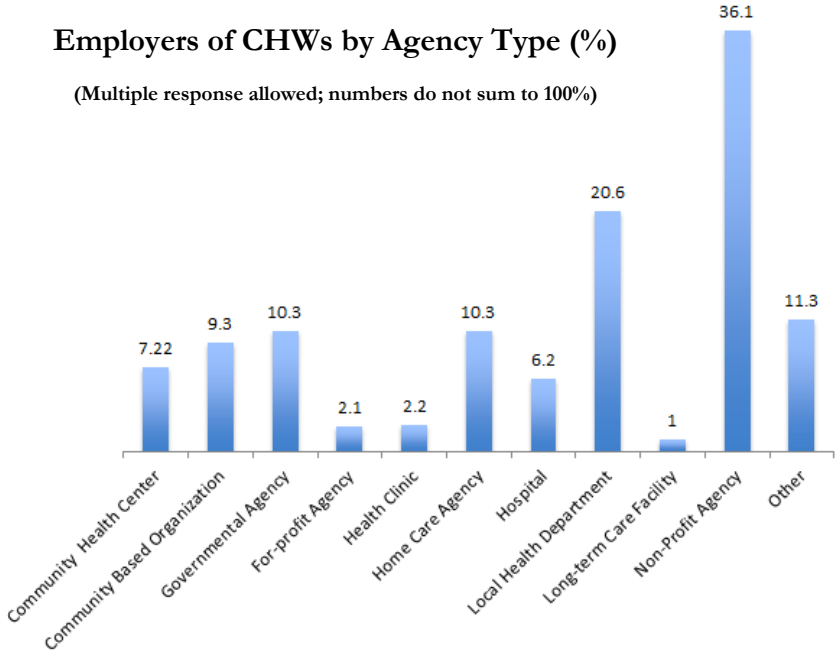
Employers: Overview

Who employs CHWs?

For the 97 respondents, non-profit employers represented the greatest number of survey respondents, with slightly more than one third of all responses coming from this sector. Combined with local health departments and governmental agencies, these three employer types accounted for nearly two-thirds of the survey respondents. The remaining respondents were comprised largely of community-based organizations, home care agencies, and hospitals.

Employers of CHWs by Agency Type (%)

(Multiple response allowed; numbers do not sum to 100%)

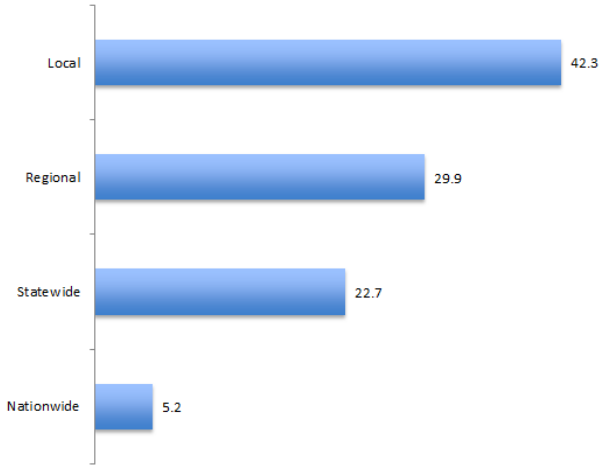


Where do health and human service providers work?

Connecticut health care employers (N=97) were heavily focused on local and regional areas of service delivery(75%). Only about 5% of CT health and human service employers surveyed work on a nationwide level.

Catchment area of CT CHW Employers (%)

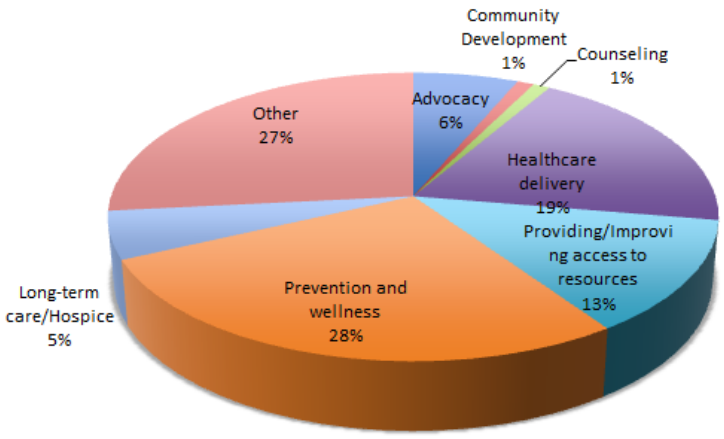
(multiple responses allowed; numbers do not sum to 100%)



Primary Purpose of Health and Human Services Employers

Health and human services employers (N=97) in CT focused the majority of their work on of preventative and wellness care (28%). Health care delivery and improving access to resources were the next largest services reported by surveyed employers (19% and 13%, respectively).

CT Health Care Employers Primary Purpose (%)

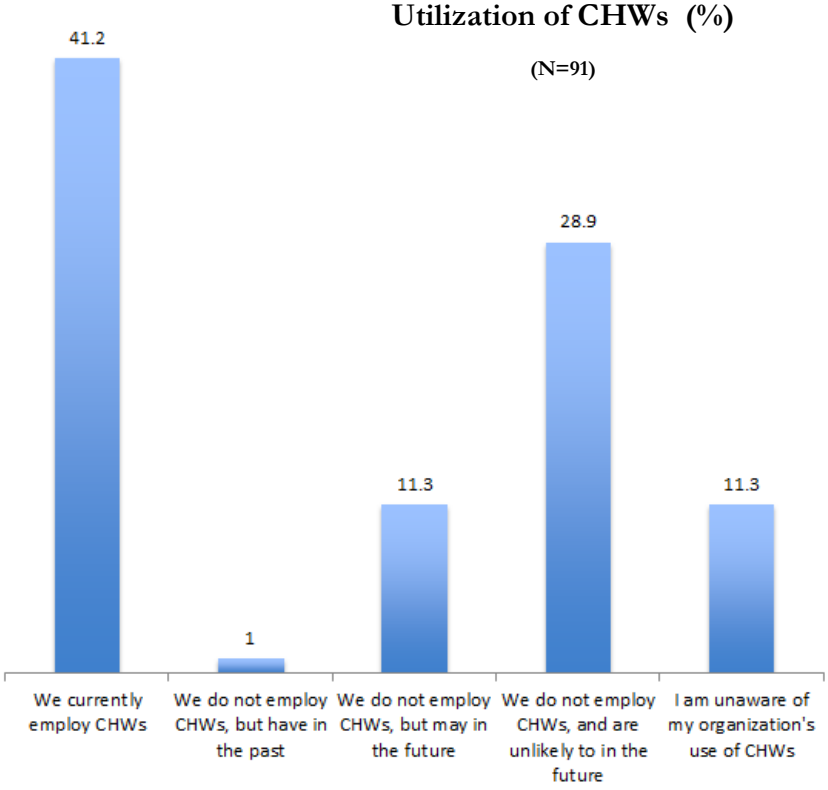


Employers: Utilization of CHWs

About 40% of employers surveyed indicated knowledge of employing CHWs in their workforce and about 40% did not. Nearly 12% of employers responded that they might consider hiring CHWs in the future. Another 12% were unaware if their organization employed CHWs. Whether or not the 40% of employers who indicated they did not employ CHWs *actually* do not employ CHWs is unclear, possibly due to role confusion and diversity of job titles of CHWs.

Utilization of CHWs (%)

(N=91)

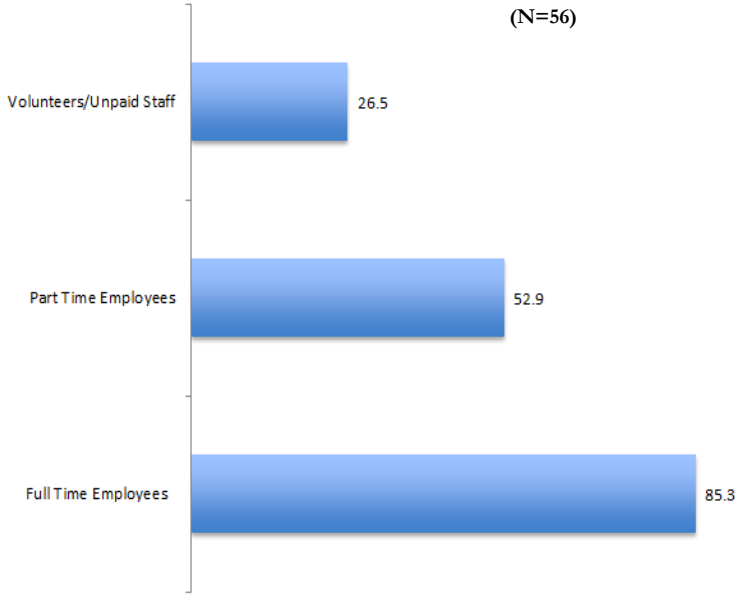


Employment Status

Fifty-six health care employers were aware of their organization's employment of CHWs. Of these employers, about 85% reported at least some CHWs as being employed full time. More than half of employers surveyed reported employing CHWs on a part-time basis. Almost 30% of the survey respondents utilized CHWs as volunteers.

Employment Status of CHWs (%)

(N=56)



Reimbursement of CHWs

Understanding funding streams and reimbursement mechanisms for CHWs affects sustainability of the workforce. In many states, Medicaid is one of the largest reimbursement mechanisms for CHWs. According to the National Conference of State Legislatures, individual states have recognized that CHWs are important within Medicaid programs because they are able to connect underserved populations with health resources. However, for successful integration of CHWs, individual states need established mechanisms to reimburse CHWs. Currently, these mechanism vary by state.

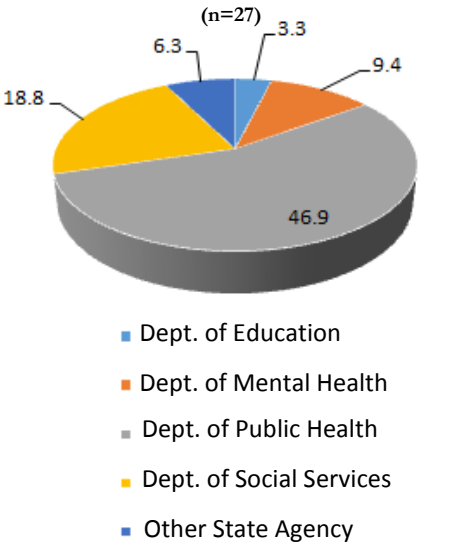
Reimbursement of CHWs in CT

Employers of CHWs in CT utilize a number of funding mechanisms. The graphs to the right show that CHWs were reimbursed from diverse sources, including local, private state, and federal agencies. CT's Department of Public Health represented the highest proportion of funding in the state, followed by the Department of Social Services. A large proportion of federal funding (37.5%) came from federal sources other than the Centers for Disease Control, Health Resource and Services Administration, the National Institutes of Health, and the US Department of Health. The largest source of funding from other agencies was "other agencies," which fall outside of local agencies, private foundations, non-profits, and other public funding.

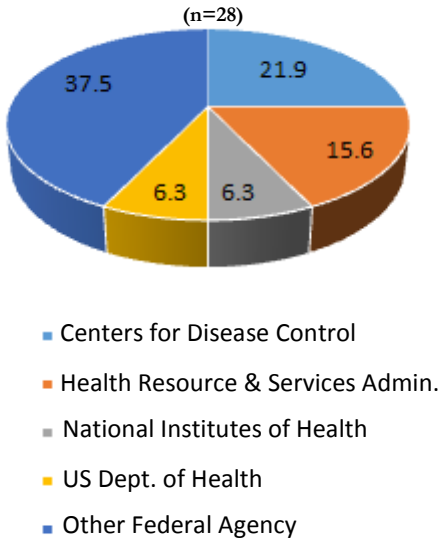
Some of the "other" agencies, companies, and organizations that were listed as sources of CHW financing include:

Aetna	Connecticut Health Foundation
CVS Caremark	General Operating Budget
Grants	Ryan White Funding
Taxes	Temporary Contracts
The Community Foundation for Greater New Haven	
The Susan G. Komen Foundaation for the Cure, CT	
Tribal Governments	Yale New Haven Hospital
Ryan White	

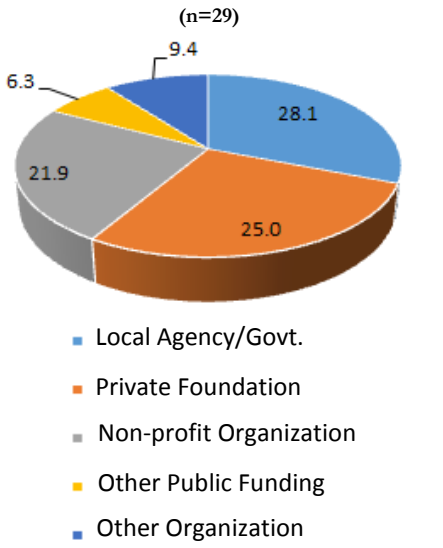
State Agency Funding (%)



Federal Agency Funding (%)



Other Agency Funding (%)



Reimbursement Cont'd

Cost-effectiveness

Historically, funding CHWs has posed challenges due to various factors, including roles that are not clearly defined, soft skills (such as interpersonal skills) that may be ill defined and not well understood by employers.

In their own words…

Most of the salaries are grant-supported. As important as they are, they are hard to justify without funding because their services are not reimbursable (at least at this time!)

-employer of CHWs

Professionals vs. para professionals have the potential to be more effective because they are able to deliver a higher degree of care in the community setting. Most funding sources do not share this position.

-employer of CHWs

I think that while they're very helpful, it's not cost effective because of course you're targeting a population with little or no income, therefore the more work we do with them, actually means the less money the organization takes in.

-employer of CHWs

Summary

Overview. Community health workers (also known as promotoras/es, community health advisors, and lay health advocates) have played an integral role in the promotion of health in a number of communities.[1] Given their connection and status within the communities and people they serve, the role of CHWs as a community's liaison to healthcare access and health related resources can be critical to the population health of migrant, minority, and other vulnerable communities, where this knowledge may not be readily known or ascertainable.[1]

Despite growing evidence supporting the expansion of the use of CHWs, the effective utilization of community health workers has been limited by uncertainty about who CHWs are and their scope of practice.[1,6] Consequently, CHWs have only recently begun to receive attention as a key strategy for promoting health in underserved communities.

CHW Characteristics. CHWs in CT are comparable to CHWs nationwide; they are predominantly middle-aged, minority women.[1] As the majority of CHWs who responded to the CHW survey target minority (African American and Hispanic) individuals, they are well-positioned to provide culturally competent care to the communities they serve. Similar to CHWs nation-wide, just over half of CT's CHWs have at least some college education. They work in various health areas and perform a wide array of activities, which is also consistent with CHWs across the country.[1]

The CHW survey confirmed that CHWs in CT are known by many job titles, which is a consistent problem identified by CHWs and those who work with CHWs. Ingram and colleagues noted that individuals serving in CHW roles described themselves variously as "outreach coordinators" and "community liaisons."[2] Similarly, Arvey & Fernandez[3] describe such workers as filling the role of "lay health advisors" and "*promotores*"—one of the most popular versions of the title in the Latino community.

The combined effect of the lack of a widely accepted and recognizable title to describe CHWs' roles, as well as the disease or special population-based specificity of many of these workers, has led to decades of relative anonymity. The first mention of such a role in the academic literature occurred in the 1950s.[1] Informal acceptance of the role as a part of the health care community began to take hold in the 1960s in attempts to combat health disparities and conduct other types of outreach work, but it was not until the turn of the 21st century that CHWs were officially acknowledged and identified as a component of a state-run health care system.[1] Most recently, the Affordable Care Act (ACA) recognizes CHWs as an integral liaison between communities and health care providers, and includes language about CHWs in the section Grants to Promote the Community Health Workforce (Section 5313).[4]

Summary Cont'd.

Training. One important outcome of the employer and CHW surveys was the desire for more training of CHWs. While most CHWs felt well-trained for their current job, most indicated that they would benefit from more training. Similarly, health and human service providers indicated interest in further training for CHWs, despite clear ideas of how to provide funds to support these activities. Some CHWs surveyed indicated a need for a standardized training program for CHWs in CT, and recognized Gateway Community College's contribution to the training needs of CHWs. In addition, continuing education opportunities may be beneficial.

Credentialing, which may be considered a more formal mechanism to provide training to CHWs while providing a record of their qualification to be a CHW, is one possible way to help CHWs meet their training needs. Currently, several states, including Texas and Ohio, have a credentialing system in place for CHWs, and Texas has also passed legislation requiring health and human services agencies to use CHWs as much as possible in performing health outreach and education programs.[1] Ohio awards a "certificate to practice" following completion of an approved training program.[1] Despite these developments, there is still no nationally standardized path for becoming a CHW, nor, given the wide range of duties and disparate training requirements of community health workers, is there a consensus as to where CHWs fall in terms of career advancement within the health professions.[1] Without a universally recognized definition or role within the health care industry, effective recruitment and expansion of CHWs in the future may be limited.

> The challenge with CHWs in the State of Connecticut is that they are not recognized and certified as career professionals. Support and lobbying needs to be done more at the state level in an effort to show the importance of this growing profession. With funding and certification there would be an allowance for higher salaries and mutual respect in the health field.
>
> -CHW

Financing of CHWs. As noted previously, the heterogeneity of job titles and job roles within the CHW workforce serves as an obstacle for their recognition as a professional workforce, which in turn seems to affect the payment of CHWs for the work that they do. Funding for CHW services in CT appears to come from various sources. Sustainable financing for CHW positions is a challenge faced by employers of CHWs nation-wide; a large portion of CHWs are paid through grants written to target specific diseases or conditions.[5] These grants provide short-term funded positions for CHWs that are not guaranteed to be renewed.[5] Consequently, CHWs may not have sustained, continuous employment, which not only affects CHWs but also the continuity of care in the communities they work.

Summary Cont'd.

Barriers. Unstable funding , lack of understanding of the benefit of CHWs, and low pay were identified as contributing factors to obstacles faced by CHWs. These factors affect job satisfaction and job security, and should be addressed to promote the sustainability of the CHW workforce in CT.

In addition, while many health care employers recognize the contributions of CHWs, many of the surveyed CHWs identified attitudes of employers that act as barriers to their professional development. Some do not feel a part of the organizations they work for, and others feel their skills are underappreciated. Others feel that formal CHW recognition by the state of CT would help give CHWs a professional, recognized identity.

In their own words...

Many CHWs who come into this career come with life, community, and educational experience that allows for them to work at times independently and also allows for them to bring their skills and experiences which should be respected and valued.

-CHW

The fact that we are looked upon as being low on the totem pole because we are not a profession is baffling to me because we have so much richness, experiences, commitment and compassion for the individuals we serve.

-CHW

As a CHW, I have experienced a lack of respect and support from agencies that have hired me for a specific project...I currently work in an organization where I am contracted and every day am made to feel that I am not a part of the organization...[and I] am made to feel as if my thoughts, contributions, and/or ideas are not valued.

-CHW

CHW Network. One encouraging finding from the CHW survey was that the majority of CHWs (85%) indicated interest in networking with other CHWs. In addition, 94.3% indicated support for the development of a CT CHW Network. Establishment of this network would likely benefit the workforce, and empower CHWs to mobilize and better establish themselves as an important, capable workforce that has tremendous capacity to improve the health of communities.

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