The Role of Evaluation in Developing and Sustaining Community Health Worker Coalitions: The Example of the Michigan Community…

Article *in* The Journal of ambulatory care management · September 2015

DOI: 10.1097/JAC.0000000000000113

9 authors, including:

Justin List
University of Michigan
29 PUBLICATIONS **148** CITATIONS
SEE PROFILE

Lee Anne Roman
Michigan State University
39 PUBLICATIONS **441** CITATIONS
SEE PROFILE

J Ambulatory Care Manage
Vol. 38, No. 4, pp. 284–296

The Role of Evaluation in Developing and Sustaining Community Health Worker Coalitions

The Example of the Michigan Community Health Worker Alliance

Edith C. Kieffer, PhD, MPH; Nicholas Yankey, MPH, MSW; Katherine Mitchell, LMSW; Caitlin G. Allen, MPH; Mary R. Janevic, PhD, MPH; Claireta Thomas, BS; Justin List, MD, MAR, MSc; Gloria Palmisano, MA; Lee Anne Roman, PhD, MSN

Abstract: Community health workers (CHWs) have demonstrated effectiveness in improving health outcomes and addressing health inequities. Statewide CHW coalitions are supporting expansion of the CHW workforce and influencing health policy. Evaluations can play a key role in sustaining coalitions. This article discusses how evaluation has informed the development, processes, and initiatives of the Michigan Community Health Worker Alliance. We highlight the Michigan Community Health Worker Alliance's internal process evaluation, a statewide survey of CHW programs, and other evaluation activities to illustrate how CHW coalitions can use participatory evaluation to develop and reinforce coalition strengths and accomplish mutual goals.
Key words: *Centers for Disease Control Evaluation Framework, coalitions, community-based participatory research, community health workers, evaluation, health inequities*

COMMUNITY HEALTH WORKERS (CHWs) have demonstrated effectiveness in meeting the needs of underserved populations, improving health outcomes, and addressing health inequities (Balcazar et al., 2011). However, lack of understanding of the unique expertise of CHWs, together with a critical need for standardized

Author Affiliations: *School of Social Work, University of Michigan, Ann Arbor (Dr Kieffer and Ms Mitchell); Center for Clinical Management Research, VA Ann Arbor Health Care System, Ann Arbor, Michigan (Mr Yankey); Behavioral Science & Health Education, Rollins School of Public Health, Emory University, Atlanta, Georgia (Ms Allen); University of Michigan School of Public Health, Ann Arbor (Dr Janevic); Community Health and Social Services Center, Inc, Detroit, Michigan (Mss Thomas and Palmisano); Robert Wood Johnson/VA Clinical Scholars Program, and Department of Internal Medicine, University of Michigan, Ann Arbor (Dr List); Department of Internal Medicine, University of Michigan, Ann Arbor (Dr List); and Department of Obstetrics, Gynecology, and Reproductive Biology, College of Human Medicine, Michigan State University, East Lansing (Dr Roman).*

All authors are also affiliated with the Michigan Community Health Worker Alliance (MiCHWA).

None of the authors have any conflicts of interest, including financial, consultant, institutional, and other relationships that might lead to bias or a conflict of interest.

Supplemental digital content is available for this article. Direct URL citation appears in the printed text and is provided in the HTML and PDF versions of this article on the journal's Web site (www.ambulatorycaremanagement.com).

Correspondence: *Edith C. Kieffer, PhD, MPH, University of Michigan School of Social Work, 1080 S. University Avenue, Ann Arbor, MI 48109-1106 (ekieffer@umich.edu)*

DOI: 10.1097/JAC.0000000000000113

workforce development and sustainable financing mechanisms, limits the integration of CHWs into new systems of care (Balcazar et al., 2011). Statewide CHW coalitions are addressing these concerns by focusing on expansion of the CHW workforce and influencing health policy (Rosenthal et al., 2010).

Coalitions are organizations of diverse groups that can build awareness, exchange information and strategies, mobilize resources, and coordinate responses to complex issues (Butterfoss & Francisco, 2004). Coalitions are a participatory means to engage a broad group of diverse stakeholders to address health disparities, often using community-based participatory research (CBPR) approaches to guide activities (Duran et al., 2013). Nevertheless, keeping stakeholders engaged in coalition work is challenging, especially if they are unsure that their efforts are achieving results (Butterfoss & Francisco, 2004). Evaluations can play a key role in sustaining coalitions by documenting goal accomplishment and impacts on health, health care, and policy (Butterfoss & Francisco, 2004).

This article aims to illustrate ways that CHW coalitions can use participatory evaluation to develop and reinforce coalition strengths and accomplish mutual goals. We discuss how evaluation has informed the development, processes, and initiatives of the Michigan Community Health Worker Alliance (MiCHWA). We highlight how MiCHWA evaluates its functioning as a coalition through process evaluation and how MiCHWA supports evaluation of CHW programs in Michigan, using the example of its statewide CHW Program Survey. We also briefly describe how MiCHWA's CHW Network used national CHW evaluation results to help build its size, strength, and identity and how MiCHWA is contributing to national efforts to measure the contributions of CHWs across multiple programs.

BACKGROUND AND OVERVIEW OF MiCHWA

The State of Michigan does not recognize CHWs as a state-regulated profession. Nonetheless, CHWs have been addressing health disparities in Michigan for decades, especially in maternal and child health programs and a variety of grant-supported initiatives. Years of inability to sustain successful CHW programs and employment, following the end of grant support, led a group of people from community, academic, and health care organizations to convene a statewide meeting of stakeholders in August 2011. Immediately following the meeting, an expanded group of planners founded MiCHWA, a statewide coalition that unites CHWs, CHW programs, and stakeholders from community, regional, and state organizations in Michigan. MiCHWA is an informal organization, with no legislative base or official connection to state government, although state government employees participate in MiCHWA. Its first meeting was held on September 22, 2011, by conference call, and working groups (WG) began to form. Its first official Steering Committee (SC) meeting was an in-person meeting on December 16, 2011, in Lansing, Michigan's state capital. The University of Michigan School of Social Work has hosted MiCHWA from its inception. The Nokomis Foundation, which supported the founding stakeholder meeting, provided funding for MiCHWA's first several years of operation. Its current funding derives from multiple grants and some donations.

MiCHWA's mission is to promote and sustain the integration of CHWs into Michigan's health and human service systems through coordinated changes in policy and workforce development. MiCHWA currently has 31 organizational partners, a 23-member SC, 4 WGs, an evaluation board, management team (a 4-member team composed of a CHW, an academic SC member, a community-based CHW program manager and MiCHWA's director), and hundreds of active participants. A full-time director conducts day-to-day activities, supported by the management team and graduate student interns. MiCHWA's SC members serve according to membership guidelines (http://www.michwa.org/about/steering-committee). MiCHWA, itself, does not have formal membership. People freely participate in MiCHWA WGs and activities and interact with its several communication

Table 1. MiCHWA Working Groups

CHW Network
Goal: Grow and strengthen a vibrant network of diverse CHWs and CHW supporters throughout Michigan
Key activities: The working group unites CHWs statewide, strengthening leadership, peer support, and resource sharing. Accomplishments include social gatherings, a CHWs-only mailing list, growing membership, and reach to urban and rural areas.
Education and Workforce
Goal: Strengthen and support CHW workforce development and education in Michigan
Key activities: The working group reviews and makes recommendations related to CHW curriculum, certification, and scope of practice. Accomplishments include MiCHWA's 2012 Employer Survey and recommendations for CHW core competencies and certification processes. An ad hoc group of working group members and employers developed MiCHWA's core competency-based curriculum in 2014 and launched 3 curriculum pilot training courses in 2015.
Policy and Finance
Goal: Identify and develop sustainable policies and financing mechanisms for CHWs in Michigan
Key activities: The working group identifies and discusses policy and finance models and evidence and tracks Michigan's policy and finance environment. Accomplishments include MiCHWA's 2013 policy brief supporting CHW certification and reimbursement and review of CHW financing and payment models.
Communications
Goal: Develop and sustain effective communications mechanisms for MiCHWA and CHWs in Michigan
Key activities: The working group promotes CHWs through a Web site, Facebook page, and Twitter account. Accomplishments include MiCHWA's Web site, development and maintenance of MiCHWA's branding standards, creation of 2 CHW promotional videos, and recognition of August 2014 and August 2015 by Michigan's governor as Community Health Worker Appreciation Month.

Abbreviations: CHW, community health worker; MiCHWA, Michigan Community Health Worker Alliance.

channels, for example, newsletter, Facebook page, Twitter account. MiCHWA's actions are driven by yearly goals, objectives, and activities developed by each WG (Table 1). Each WG has 2 leaders, at least one of whom should be a CHW. Four CHWs currently co-lead 3 of the WGs (http://www.michwa.org/working-groups). WG co-leaders serve on the MiCHWA SC, which meets monthly by telephone or in person. WGs meet monthly by telephone. E-mail and telephone communication links MiCHWA members between meetings.

MiCHWA's SC used a participatory process (Israel et al., 2008) to adapt its 7 guiding principles (http://www.michwa.org/about/governance) from those of the Detroit Community Academic Urban Research Center (http://www.detroiturc.org/about-cbpr/cbpr-principles.html).

CBPR principles underlie MiCHWA's operating philosophy, support partner engagement and its consensus-based decision-making process, and shape its participatory evaluation approach (Sprigett & Wallerstein, 2008). MiCHWA's first guiding principle states: "CHWs provide active leadership at all levels of MiCHWA." CHWs actively influence the activities and decisions made by MiCHWA's committees. As SC members and WG co-leaders and participants, they contribute to planning and developing MiCHWA objectives, activities, materials, and recommendations. The SC aims for a minimum of one-third of its members to be CHWs. Decision making by consensus

amplifies the relative power of CHWs beyond their numbers within MiCHWA.

MiCHWA'S EVALUATION ACTIVITIES

MiCHWA's Evaluation Advisory Board

From its inception, MiCHWA's SC recognized the critical role of evaluation in developing and maintaining its structure and activities, building and strengthening its partnerships, measuring outcome achievement, acquiring and maintaining funding, and achieving CHW sustainability. The SC established the MiCHWA Evaluation Advisory Board (EAB), which includes CHW, community, health and social service, and academic organization partners. Its activities are supported by graduate student evaluators. The EAB plans and conducts process, context, and outcome evaluations of MiCHWA and its activities. As MiCHWA and its scope of activities have grown and developed, the EAB now supports evaluation of several CHW activities in Michigan and assists MiCHWA's SC and WGs in using the results of evaluations conducted by others to inform their activities.

MiCHWA's evaluation model

The Figure depicts MiCHWA's coalition evaluation model. In accordance with constructs from Community Coalition Action Theory (Butterfoss & Kegler, 2009), MiCHWA's coalition inputs (e.g., membership, staffing, structures, and processes) are marshaled to implement activities to achieve expected coalition outcomes. MiCHWA's evaluation activities are informed by the Centers for Disease Control and Prevention's (1999) Framework for Program Evaluation in Public Health. The EAB uses this framework's cyclical evaluation process to document and improve MiCHWA's actions. For example, coalition inputs including the Education and Workforce WG, staff, and partner activities, helped develop CHW core competencies and launch

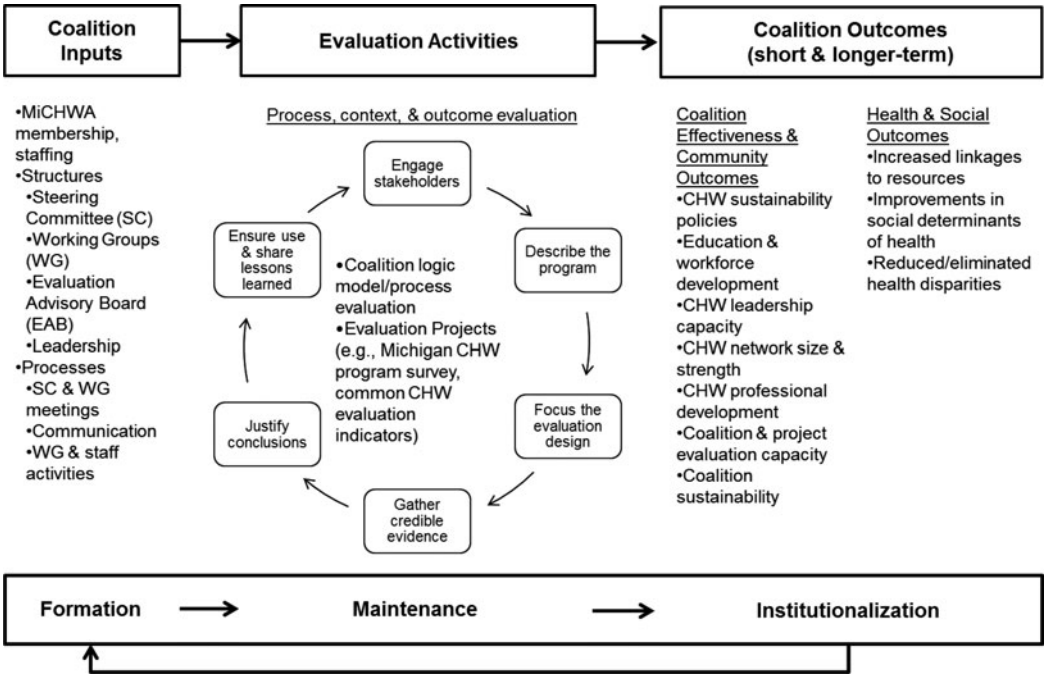

Figure. MiCHWA coalition evaluation model, adapted from Butterfoss and Kegler, 2009, and Centers for Disease Control and Prevention, 1999. MiCHWA indicates Michigan Community Health Worker Alliance; CHW, community health worker.

CHW training. The EAB helped evaluate CHW training and conduct a 2014 CHW Program Survey. Together, these actions contribute to short-term education, workforce development, and sustainability outcomes necessary to achieve longer-term improvements in social determinants of health and reduced health disparities. At its base, the model shows MiCHWA moving through coalition formation to institutionalization stages, during which its effectiveness as a coalition increases along with improved community, health, and social outcomes (Butterfoss & Kegler, 2009). Importantly, coalition processes are not linear. The coalition may loop back to earlier stages as evaluation results, new initiatives, and internal or external challenges arise.

How MiCHWA evaluates its functioning as a coalition through process evaluation

Coalitions and partnerships can be evaluated on adherence to CBPR principles to reach an effective collaborative process and achieve their goals (Duran et al., 2013). Numerous methods for assessing a partnership's intermediate and long-term outcomes, including surveys and in-depth interviews, can be developed and implemented using a partnership's participatory principles (Israel et al., 2013). MiCHWA's process evaluation methods are organized by the 6 steps of the Centers for Disease Control and Prevention (1999) framework.

Steps 1 and 2: Engaging stakeholders and describing the program

At its first formal SC meeting, SC members developed MiCHWA's mission and began developing its governance structure and operating principles. At subsequent meetings, members representing each WG began drafting goals and related objectives and activities that were approved by the SC in subsequent meetings. At the suggestion of a community-based SC member, the SC asked the management team to develop a logic model for MiCHWA planning and evaluation. The MiCHWA management team worked with the University of Michigan School of Social Work Curtis Center Program Evaluation Group director and graduate student evaluator to draft the logic model, based on earlier work by the SC and WGs. The SC edited the draft before approving the final logic model. The logic model displays the following: (1) the individual and system conditions surrounding the organization (including mission, need statement, funding, and staffing); (2) MiCHWA's components (governance structure, WGs, EAB); (3) planned activities (corresponding with MiCHWA's objectives) and outputs for each component; and (4) short- and long-term outcomes. The EAB updates MiCHWA's logic model annually, incorporating new yearly objectives and activities developed by WGs and approved by the SC. The 2014 version is located in Supplemental Digital Content, Figure (available at: http://links.lww.com/JACM/A50).

Step 3: Focusing the evaluation design

The EAB and the graduate student evaluator developed MiCHWA's first-year evaluation plan, which is updated annually. Process, context, and outcome evaluation questions were developed to guide evaluation activities. Data collection focused on 6 areas: (1) recruitment, engagement, and coverage of key stakeholders; (2) factors that facilitated MiCHWA's establishment; (3) barriers and facilitators to MiCHWA's maintenance and growth; (4) partnership formation process; (5) process by, and degree to which, MiCHWA accomplished its yearly goals and objectives; and (6) process by, and degree to which, MiCHWA met its short-term, intermediate and long-term outcome expectations.

Step 4: Gathering credible evidence

MiCHWA uses multiple data sources to provide a comprehensive response to the evaluation questions. Two key sources will be highlighted here: an annual survey of SC members and qualitative in-depth interviews conducted in 2012 with SC members. The survey was adapted from an instrument for evaluating dimensions of group dynamics within CBPR partnerships (Schulz et al., 2003). Survey items assessed (1) SC members' general satisfaction with the organization,

its processes, and activities; (2) inclusion of key stakeholders in the SC; (3) challenges, accomplishments, and capacity of the SC; (4) SC members' perceptions of organizational factors related to MiCHWA's maintenance and growth; (5) level of trust in the partnership; and (6) impact of the SC on coalition outcomes. With minor changes, survey items have remained largely consistent over the 3 years it has been administered. The qualitative interviews helped the EAB more richly document the story of MiCHWA's formation and accomplishments.

Steps 5 and 6: Justifying conclusions, ensuring use, and sharing lessons learned

Each year, evaluation reports are developed and distributed to the MiCHWA EAB and SC for interpretation, monitoring, and program improvement. After SC discussion and approval, the annual logic model, evaluation plan, and end-of-year evaluation reports are disseminated on MiCHWA's Web site.

Examples of MiCHWA's process evaluation results

Examples of MiCHWA's process evaluation results over 3 years are reported in Table 2. Full annual evaluation reports are available at http://www.michwa.org/about/evaluation.

Evaluation participation

Each year, more than 75% of SC members completed the survey. More than a quarter of respondents were current or former CHWs. Participation in the 2012 SC member interviews spanned the entire range of MiCHWA stakeholders.

General satisfaction and trust

SC members have consistently reported moderate to high levels of satisfaction with SC activities and progress. The vast majority of SC members have reported a sense of ownership in what the SC does. During 3 years, the proportion of SC members agreeing that they have adequate knowledge of MiCHWA resources and resource allocation steadily increased. SC members reported moderate to high levels of trust among SC members each year. A majority of SC members agreed or strongly agreed with the statement, "SC members trust one another," although agree or strongly agree responses decreased somewhat from year 1 to year 3. Each year, all or most members reported that their opinion is listened to by other SC members.

Impact of SC participation on members

Each year, SC members reported moderate to high increases in knowledge of the role, impact, and challenges faced by CHWs because of their involvement with MiCHWA. Nearly all respondents reported moderate to high increases in knowledge of statewide and national CHW advocacy efforts. SC participation also increased members' knowledge of other member organizations and of general community organizations and resources in Michigan.

SC accomplishments and challenges

SC members identified development of statewide partnerships and the MiCHWA committee infrastructure, governance policies, and goals and objectives as the major SC accomplishments in its first year. In the 2012 qualitative follow-up interviews, SC members identified factors that facilitated these accomplishments, including diverse and committed stakeholders with a clear purpose and mission; being inclusive of CHW contributions; establishing participatory operating principles, consensus-building processes, and openness to suggestions; ability to make connections; core funding and support for infrastructure and the full-time coordinator; and consistent, organized meetings.

The survey also identified barriers to the maintenance and growth of MiCHWA and achieving some of its goals. These have included Michigan's political climate that is inhospitable to new regulations and certifying boards, inadequate CHW representation, and lack of SC member time. Follow-up interviews with SC members in 2012 helped explain some of the barriers to adequate CHW representation. A member said: "How are [CHWs] going to do this if they don't get released . . . time"? Another member said,

> ". . . It's quite difficult to sit at a client's home on Monday, but you know, Wednesday you sort of deal

Table 2. Steering Committee Survey Results, 2012-2014

	% Agree or Strongly Agree		
	2012 (n = 18)	**2013 (n = 18)**	**2014 (n = 18)**
Satisfaction			
I am satisfied with the activities of the Steering Committee during the past year	100	94.5	94.4
I am satisfied with the progress of the Steering Committee during the past year	88.9	77.8	88.9
I have a sense of ownership in what the Steering Committee does	88.9	83.3	83.3
I have adequate knowledge of the MiCHWA resources and resource allocation process	66.6	77.8	88.3
Trust			
Steering Committee members trust one another	100	94.1	83.3
My opinion is listened to by other Steering Committee members	100	100	94.4
Knowledge of CHWs and community organizations			
My involvement with MiCHWA has increased my knowledge of the *role* of CHWs	75.0	88.2	94.4
My involvement with MiCHWA has increased my knowledge of the *impact* of CHWs	83.3	94.1	94.4
My involvement with MiCHWA has increased my knowledge of the *challenges faced by* CHWs	66.7	88.2	88.9
My involvement with MiCHWA has increased my knowledge of efforts being conducted to advocate for CHWs in Michigan	83.4	100	100
My involvement with MiCHWA has increased my knowledge of national efforts being conducted to advocate for CHWs	83.4	100	100
Participation in the Steering Committee has increased my knowledge of other member organizations	66.7	100	77.8
Since my involvement with MiCHWA, I am more familiar with general community organizations and other resources in Michigan	58.3	88.2	100

Abbreviations: CHW, community health worker; MiCHWA, Michigan Community Health Worker Alliance.

with the policy and infrastructure roles of your job. Other professions don't struggle with that. If you're a nurse, the world knows you're a nurse. You don't have to moonlight convincing the world that they need you . . . ."

The SC used survey and interview results to document successes. They also used results to develop activities aimed at addressing challenges. For example, barriers in the policy environment were addressed by forming

relationships and partnerships with key policy stakeholders statewide and developing the MiCHWA policy brief. Identified gaps in CHW training, and awareness of the roles of CHWs, were addressed by identifying and agreeing upon CHW core competencies and curriculum and developing communication and outreach materials. The 2013 survey documented specific efforts to increase CHW participation in WGs. The 2014 survey documented successful community-building efforts within the CHW Network, CHW appreciation month, development of CHW education opportunities, growth in Annual Meeting attendance and participation, and recognition of MiCHWA as a primary organization supporting CHWs in Michigan.

How MiCHWA supports evaluation of CHW programs in Michigan: CHW Program Survey 2014

In a second example of supporting coalition activities through evaluation, MiCHWA collaborated with the Michigan Department of Community Health to conduct a survey of CHW employers and managers. The survey's purpose was to gain a better understanding of the type of work CHWs are doing in Michigan, who their employers are, the nature of the programs they work in, the data programs routinely collect, funding mechanisms, barriers to sustainability, and training needs.

Survey development and distribution

The survey instrument was developed by the EAB following comprehensive review of existing survey tools and review by CHW program and evaluation experts who provided feedback about the survey content, flow, and usability. The final 66-item survey included open- and close-ended items. The survey was transferred to a Web-based survey tool. A link to the survey was e-mailed to 158 program representatives (representing 88 organizations) on MiCHWA's mailing list and to health-related organization membership lists statewide. MiCHWA promoted the survey on its Web site, on social media, and in its newsletter. Because of the open distribution process, we could not calculate a response rate or the proportion of existing CHW programs reached.

Survey results

A comprehensive report of survey results was provided to the Michigan Department of Community Health and is available on MiCHWA's Web site (http://www.michwa.org/about/evaluation/program-survey). Examples of findings in several key domains are offered in the following text.

Agencies employing CHWs

Survey respondents represented 37 programs from major population centers and rural regions, throughout Michigan. The majority of agencies (62%) self-identified as community-based service providers and employed an average of 9.7 CHWs (range, 1-40). About half of CHW programs were supported by federal agency grants, with funding periods of 6 months to 5 years. The most frequently reported barrier (87%) to CHW sustainability was funding uncertainty.

Focus of CHW work and reasons for employing CHWs

Health issues addressed by more than half of Michigan CHW programs included diabetes (65%), nutrition (55%), obesity (55%), heart disease (52%), and physical activity (52%). CHW roles reported in at least half of CHW programs responding to the survey included health promotion and coaching (81%), systems navigation (75%), case management and care coordination (63%), outreach and community mobilization (63%), home-based support (59%), and serving as a community/cultural liaison (50%). CHWs addressed social determinants of health by connecting clients to resources (97%) and assisting with food security (55%), housing (59%), employment (45%), and education (45%). Major themes in an open-ended question about the rationale for employing CHWs included the following: CHWs' ability to engage and establish trust due to shared experiences and their ability to be "cultural brokers"; cost-effectiveness relative to clinical staff; their effectiveness in engaging clients and

improving outcomes; and funding requirements. Table 3 provides illustrative quotations from open-ended responses.

CHW training and compensation

Most surveyed programs required CHWs to have a high school diploma/GED (59%) but no prior health-related experience (77%). Program-specific and competency-based training was made available to CHWs by 97% and 82% of programs, respectively. While 80% of programs did not require continuing education for CHWs, 91% provided ongoing training and 66% offered professional development opportunities. Hourly CHW wages ranged from $10 to $28; $12/h was the most frequently reported rate. Annual salaries ranged from $25 000 to $58 000. More than 80% of responding agencies offer benefits to CHW employees that include sick and personal leave, health insurance, mileage reimbursement, and vacation accrual.

Next steps

The MiCHWA EAB and SC reviewed survey results to identify implications and recommendations for action by its WGs. MiCHWA and the Michigan Department of Community Health will collaborate to re-administer the survey in 2016 to assess CHW program sustainability and identify CHW and program growth trends.

How MiCHWA's CHW Network used national CHW evaluation results to help build its size, strength, and identity

The CHW Network is MiCHWA's CHW-led and CHW-focused WG (http://www.michwa.org/working-groups/mi-chwnetwork). It supports CHWs statewide by promoting awareness by CHWs and others of CHW professional identity, roles, and contributions, sharing information about resources, training and job opportunities, and holding continuing education and social events. In early 2014, MiCHWA distributed the National Community Health Worker Advocacy Survey (NCHWAS) (Sabo et al., 2015) to CHW Network members, MiCHWA's CHW employers, and other networks. In late 2014, the Arizona Prevention Research Center released preliminary NCHWAS state-level reports to states with substantial participation. In Michigan, 102 CHWs responded. MiCHWA's CHW Network reviewed Michigan's results to identify ways to increase CHW Network participation and address needs. For example, CHW Network leaders noticed that more than half of respondents indicated they were not members of a CHW professional association or group. Some CHWs may not view themselves as professionals or MiCHWA's CHW Network as a professional association or group. MiCHWA's CHW Network does not require

Table 3. CHW Program Rationale for Employing CHWs, MiCHWA Program Survey 2014

"Many CHWs share similar life experiences, backgrounds, and characteristics of clients being served . . . they are able to connect with clients on a level that other health care providers are quite often not able. CHWs have been equipped with the training and knowledge necessary to provide clients with the education and skillset to help manage their disease(s)."
"Trusted by the community, therefore, more effective and able to engage people in an authentic way; (2) Sustainability—more likely to stay in their jobs and have a personal investment; (3) Capacity building (related to above as well)—desire to build the capacity of the community by investing in community members' skills and employment."
"We felt that CHWs would be the best way in which to address barriers, connect patients with resources, and foster a trusting relationship. We also felt that employing CHWs, in the long run, would be a more cost-effective method for conducting the aforementioned activities, as opposed to utilizing a nurse or case manager."
" . . . CHWs serve as cultural brokers and bring a unique personal and professional expertise that complements the expertise of our other case management team members (RNs and SWs)."

Abbreviations: CHW, community health worker; RN, registered nurse; SW, social worker.

dues or signatures for membership. Some CHWs have noted confusion about who counts as a member.

To increase member identification, the CHW Network identified outreach and building awareness of the CHW Network as 2015 priorities. The CHW Network created a statewide CHW-only mailing list for CHWs to distribute resources and discuss questions and issues. The CHW Network also began sharing photographs of CHWs and coworkers addressing specific health and social issues each month. Members expect that increased participation in the CHW Network will strengthen the CHW voice when decisions are made concerning the profession and the work that CHWs do. A stronger CHW Network will raise CHW professional awareness and identity so that they can advocate for CHWs with the same passion that they use to advocate for the people they serve.

How MiCWHA is contributing to national efforts to measure the contributions of CHWs across multiple programs: Common Indicators Project

Many studies of CHW program outcomes describe CHW activities but inadequately measure how they address the social determinants of health and other nonclinical indicators of CHW impact or how these indicators are linked to outcomes. This gap limits our ability to demonstrate the unique contributions or "added value" of CHWs to policy makers, payers, and health and human service leaders who ultimately hold the keys to CHW sustainability. CHW advocates have called for development of a common set of evaluation measures that will facilitate comparison across studies and for pooled analyses to strengthen the overall economic case and to provide consistent performance measurement tools for health systems to use in evaluating CHWs (Agency for Healthcare Research and Quality, 2009; Gutierrez Kapheim & Campbell, 2014; Rosenthal et al., 1998).

MiCHWA's Common Indicators Project aims to identify a common set of process evaluation measures that can be used by CHW programs to explain their successful outcomes. The EAB is collecting information from the following sources: (1) CHW evaluation literature review to identify commonly used process evaluation indications; (2) key informant interviews with national and state CHW evaluation experts; (3) focus groups with CHWs in 3 Michigan regions; and (4) an online CHW evaluation-focused survey of Michigan CHW program administrators. The EAB will present an analysis of all results to the MiCHWA SC to generate consensus recommendations for a Common Indicators evaluation data set.

CONCLUSIONS

Across the United States, there are a growing number of statewide coalitions supporting the CHW profession and promoting CHW program sustainability within communities and an evolving US health care system (Rosenthal et al., 2010). Evaluation is a critical component of coalition efforts (Butterfoss & Francisco, 2004). From its inception, MiCHWA has used the lens of participatory evaluation to reflect on, learn from, and build upon our experiences to inform our work, guided by our logic model and measurable goals and objectives. Our process evaluation demonstrated our ability to engage diverse, previously isolated stakeholders throughout Michigan on the common mission of achieving CHW sustainability. Participation improved members' connections with each other and policy makers and increased members' awareness of organizations, resources, and the roles and accomplishments of CHWs statewide. MiCHWA's process evaluation helped us improve our processes and implement activities needed to achieve our mission.

The MiCHWA Program Survey, combined with Michigan's NCHWAS data, forms a comprehensive picture of the CHW field in Michigan, including the most pressing needs perceived by CHWs and CHW program managers. The descriptive profile of CHWs and CHW programs from Michigan's 2014 survey is broadly consistent with national reports (Arizona Prevention Research Center, 2014; Ingram et al., 2012; US Department of Health and Human Services,

2007) and state/regional surveys (California Health Worker Alliance, 2013; Hardeman & Gerrard, 2012; Michigan Community Health Worker Alliance, 2012). Such findings can mobilize action for standardization of training and policy change. Our Common Indicators Project has the potential to foster standardized measurement of the unique CHW contributions to successful program outcomes, thereby strengthening evaluations that build the case for sustainable financing of CHW programs.

Challenges, strengths, and opportunities

Three issues pose challenges for use of evaluation by CHW coalitions: time, expertise, and money. Evaluation, including design, measurement tools, and reporting, needs to be a priority to inform decision making and sustain coalition activity. This was initially a challenge for MiCHWA, as its SC and WGs undertook many tasks simultaneously. While the SC made time for reflection during its initial year, this has not always been prioritized as the scope and complexity of our activities have grown but the size of our staff has not. Evaluation activities that are not used or valued may be a signal to scale back or identify a clearer purpose. For example, the finding that SC member trust has decreased over time suggests that adequate time in coalition meetings needs to be spent reviewing evaluation results and using results to address concerns and guide decisions. Because of resource constraints, we have not repeated qualitative interviews despite their usefulness during our formative year. These interviews can provide a rich opportunity for understanding survey findings and exploring solutions to problems (Israel et al., 2013). As with most partnerships, our qualitative interviews and SC member surveys have been conducted with a small number of people. This is not uncommon for partnership evaluations (Israel et al., 2013; Lantz et al., 2001). A strength is that we compared aggregate data during 3 consecutive years to assess changes in the group over time (Israel et al., 2013).

Evaluation requires extraordinary staff and volunteer commitment. Dedicated volunteers rely on their employing organizations to allow time for coalition activities. Recruiting and retaining CHW participation in MiCHWA have been challenging due to conflicting job responsibilities and job loss. Only one CHW is on the EAB. Despite these barriers, MiCHWA's experience emphasizes the crucial importance of working with employers to develop strategies that support CHW participation and leadership development.

Interest and expertise in data-related activities may be low in many coalitions, even when members know the value of evaluation. Perceptions by coalition members, including CHWs, that evaluation requires quantitative skills may be a barrier. However, in MiCHWA, CHWs make crucial contributions to the relevance and usefulness of MiCHWA's evaluation both by identifying important themes in evaluation results and discussing implications during SC and WG meetings and by participating on the EAB. MiCHWA has also supported CHWs attendance at the annual meeting of the American Public Health Association and encouraged participation in sessions highlighting CHW program evaluation. CHWs participating in the Common Indicators focus groups actively discussed CHW roles in data collection and evaluation efforts. Commitment to building capacity of CHW and other community coalition members to participate in evaluation should be central to evaluation activities.

MiCHWA has also leveraged the expertise and resources of its academic partners to help the EAB conduct evaluation activities by recruiting and training graduate students in participatory evaluation, supported by work-study funds. Other CHW coalitions may benefit from similar community-academic partnerships. In doing so, it is important for CHW coalitions to ensure that CHW members remain central to guiding evaluation aims, helping develop its models and methods and interpreting results, through participation in groups such as MiCHWA's EAB and SC. The growing expertise in participatory evaluation of our members and staff has led to the inclusion of evaluation services in its grant applications as a sustainability strategy. This has increased funded support for MiCHWA operations and ensured that evaluation is an integral

component of its own work and other organizations' CHW projects. Recently, MiCHWA received funding to provide evaluation services for organizations conducting CHW training and integrating CHWs into health care teams.

The processes, strategies, and lessons of MiCHWA's participatory experience can provide guidance for efforts by other CHW coalitions. The growth of evaluation capacity in CHW coalitions can strengthen national efforts to advocate for policies that promote the CHW profession and sustain CHW programs that promote community health and work toward elimination of health inequities.

REFERENCES

Agency for Healthcare Research and Quality. (2009). *Outcomes of community health worker interventions* (Evidence Report/Technology Assessment No. 181). Rockville, MD: Author.

Arizona Prevention Research Center. (2014). *2014 National Community Health Worker Advocacy Survey reports*. Retrieved from http://azprc.arizona.edu/nchwas-2014

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

Butterfoss, F. D., & Francisco, V. T. (2004). Evaluating community partnerships and coalitions with practitioners in mind. *Health Promotion Practice, 5*(2), 108–114.

Butterfoss, F. D., & Kegler, M. C. (2009). The community coalition action theory. In: R. J., DiClemente, R., Crosby, & M., Kegler (Eds.), *Emerging theories in health promotion practice and research* (2nd ed., pp. 237–276). San Francisco, CA: Jossey-Bass.

California Health Worker Alliance. (2013). *Taking innovation to scale: Community health workers, promotores, and the Triple Aim*. Needham: MA: Barnett.

Centers for Disease Control and Prevention. (1999). Framework for program evaluation in public health. *MMWR Morbidity and Mortal Weekly Report*, *48*, RR-11.

Duran, B., Wallerstein, N., Avila, M., Belone, L., Minkler, M., & Foley, K. (2013). Developing and maintaining partnerships with communities. In: B., Israel, E., Eng, A., Schulz, & E., Parker (Eds.), *Methods for community-based participatory research for health* (2nd ed., pp. 44–68). San Francisco, CA: Jossey-Bass.

Gutierrez Kapheim, M., & Campbell, J. (2014). *Best practice guidelines for implementing and evaluating community health worker programs in health care settings*. Chicago, IL: Sinai Urban Health Institute.

Hardeman, R., & Gerrard, M. D. (2012). *Community health workers in the Midwest: Understanding and developing the workforce*. Saint Paul, MN: Wilder Research.

Israel, B. A., Lantz, P. M., McGranahan, R., Guzman, J. R., Lichtenstein, R., & Rowe, Z. (2013). Documentation and evaluation of CBPR partnerships. In: B.A., Israel, E., Eng, A. J., Schulz, & E. A., Parker (Eds., pp. 386–387), *Methods for community-based participatory research for health* (2nd ed.). San Francisco, CA: Jossey-Bass.

Israel, B. A., Schulz, A. J., Parker, E. A., Becker, A. B., Allen, A. J., & Guzman, J. R. (2008). Critical issues in developing and following CBPR principles. In: M., Minkler, & N., Wallerstein (Eds.), *Community-based participatory research in health* (2nd ed., pp. 47–66). San Francisco, CA: Jossey-Bass.

Lantz, P. M., Viruell-Fuentes, E., & Israel, B. A. (2001). Can communities and academia work together on public health research? Evaluation results from a community-based participatory research partnership in Detroit. *Journal of Urban Health*, *78*(3), 495–507.

Michigan Community Health Worker Alliance. (2012, October 10). *MiCHWA Employer Survey 2012: Final report*. Retrieved from http://www.michwa.org/wp-content/uploads/MiCHWA-2012-End-of-Year-Report-FINAL.pdf

Rosenthal, E. L., Brownstein, J. N., Rush, C. H., Hirsch, G. R., Willaert, A. M., Scott, J. R., . . . Fox, D. J. (2010). Community health workers: Part of the solution. *Health Affairs*, *29*(7), 1338–1342.

Rosenthal, E. L., Wiggins, N., Brownstein, J. N., Johnson, S., Borbon, I. A., & Rael, R. (1998). *A summary of the National Community Health Advisor Study: Weaving the future*. Retrieved from http://www.chw-nec.org/pdf/CAHsummaryALL.pdf

Sabo, S., Wennerstrom, A., Phillips, D., Haywood, C., Redondo, F., Bell, M., & Ingram, M. (2015). Community health worker professional advocacy: Voices of action from the 2014 National Community Health Worker Advocacy Survey. *Journal of Ambulatory Care Management*, *38*(3), 225–235.

Schulz, A. J., Israel, B. A., & Lantz, P. M. (2003). Instrument for evaluating dimensions of group dynamics within community-based participatory research partnerships. *Evaluation and Program Planning, 26*, 249–262.

Sprigett, J., & Wallerstein, N. (2008). Issues in participatory evaluation. In M. Minkler & N. Wallerstein (Eds.), *Community-based participatory research for health from process to outcomes* (2nd ed., pp. 200–213). San Francisco, CA: Jossey-Bass.

US Department of Health and Human Services. (2007). *Community Health Worker National Workforce Study*. Washington, DC: Health Resources and Services Administration, Bureau of Health Professions.