REPORT OF THE
JAMES MADISON UNIVERSITY

Interim Report on the Status, Impact, and Utilization of Community Health Workers

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 8

COMMONWEALTH OF VIRGINIA
RICHMOND
2005

JAMES MADISON UNIVERSITY

January 5, 2005

General Assembly Building
Division of Legislative Automated Systems
Attention: Angie Murphy
910 Capitol Square, Suite 660
Richmond, VA 23219

To the Honorable Mark R. Warner, Governor of Virginia and Members, Virginia General Assembly:

James Madison University, through its Virginia Center for Health Outreach is pleased to submit the following report studying the status, impact, and utilization of community health workers as directed by House Joint Resolution No. 195. The first-year report focuses on inventorying the number and roles of community health workers (CHWs) employed in Virginia and offers a standard designation for CHWs who are working under numerous titles. The study also identifies and reviews outcome studies and evaluations on the efficacy of community health workers.

The report speaks to the important, yet often unrecognized contributions that CHWs make in helping the most vulnerable members of our society access needed health and human services. It is this role where CHWs complement elements of the mission of James Madison University - to educate and enlighten citizens so that they may lead productive and meaningful lives. In addition, Virginia's CHWs share one of JMU's core values, that of service to others.

Making health and human services more efficient and accessible to all Virginians is indeed difficult. James Madison University stresses opportunities for interdisciplinary education and training for its students knowing that this builds creative approaches to address often complex challenges. CHWs, as members of health and human service delivery teams, offer a unique and valuable contribution to new models of service delivery.

On behalf of James Madison University and its Institute for Innovation in Health and Human Services, I would like to thank the members of the Study Resolution Committee who devoted their time and expertise in compiling this report. We look forward to completing the directives outlined in House Joint Resolution No. 195 during 2005.

Linwood H. Rose
President

LHR/pmr

Enclosure: HJR 195 Interim Report

MSC 7608
Alumnae Hall, Room 208
Office of Harrisonburg, VA 22807
THE PRESIDENT 540.568.6868 Phone
540.568.2338 Fax

Preface

House Joint Resolution 195 of the 2004 Virginia General Assembly directed James Madison University (JMU) to study the status, impact and utilization of community health workers in Virginia. Dr. Linwood H. Rose, President of JMU requested that the directives to be addressed by the study report be tasked to the Virginia Center for Health Outreach (VCHO) at JMU. The VCHO serves as a statewide forum for addressing CHW and CHW program issues across Virginia.

The Virginia Center for Health Outreach has brought together stakeholders to establish the Community Health Worker Study Resolution Committee *(Summaries of the six meetings held by the committee are located at http://www.vcho.cisat.jmu.edu/StudyRes.htm).* By consensus, the Committee decided to focus the first year of study activities on the following directives: (i) inventory the number and roles, of community health workers employed in the Commonwealth and explore a standard designation for such workers; and (ii) identify and review outcome studies and evaluations on the efficacy of community health workers.

CHW Study Resolution Committee 2004 Participants

Name	Title	Agency	Locality
Catherine Bodkin	State Program Consultant, Resource Mothers Program	Virginia Department of Health	Richmond
Maryellen Browne	President/CEO	Urban Resource Services, LLC	Virginia Beach
Jackie Bryant	Director	Healthy Families of VA	Charlottesville
Judith Cash, Co-Chair	President/CEO	CHIP of Virginia	Richmond
Karen Connelly	Director of Public Health Nursing	Virginia Department of Health	Richmond
Ruby Cox	State EFNEP/SCNEP Coordinator	Virginia Polytechnic Institute and State University	Blacksburg
Laura Darling	Director of Operations	CHIP of Virginia	Richmond
Ellen Dawson, PhD, ANP	Associate Professor of Nursing	College of Nursing and Health Science, George Mason University	Fairfax
Ruth Frierson	Region 6 Network Coordinator	Virginia Center for Health Outreach	Richmond
Julie Gochenour, Report Staff	Communications Director	Virginia Center for Health Outreach/James Madison University	Harrisonburg
Paul Hedrick	Policy Analyst	Department of Medical Assistance Services	Richmond
Kathy Heise	Director, BCCEDP	Virginia Department of Health	Richmond
Sandra Hopper, Report Staff	Operations Director	Virginia Center for Health Outreach/James Madison University	Harrisonburg
Jeffrey Lake	Deputy Commissioner	Virginia Department of Health	Richmond
Karen Lawson	Long Term Care	Department of Medical Assistance	Richmond

	Policy Analyst	Services	
Niloufar Nawab	Director of Language Services	Northern VA Area Health Education Center	Arlington
Jeff Nelson	Policy Analyst - Senior	Department of Medical Assistance Services	Richmond
Christopher Nye, Co-Chair and Report Staff	Director	Virginia Center for Health Outreach/James Madison University	Harrisonburg
Jessica O'Connell, Report Staff	Law Student	Georgetown University School of Law	Washington, DC
Lyzette Orr	Region 4 Network Coordinator	Virginia Center for Health Outreach	Arlington
Danetta Parrish	Region 5 Network Coordinator	Virginia Center for Health Outreach	Lynchburg
Lee Perkins	Nurse Manager	Virginia Department of Health	Winchester
Florene Price	Resource Mothers Program	Prince William Health District	Woodbridge
Johanna Schuchert	Executive Director	Prevent Child Abuse Virginia	Richmond
Jackie Scott, Report Staff	Director, Center for Sustainable Health Outreach	Georgetown University School of Law	Washington, DC
David Stasko	Human Services Program Consultant	Department of Social Services	Warrenton
Robert Stroube, MD	State Health Commissioner	Virginia Department of Health	Richmond
Rebecca Sturm-Clauser	Resource Mothers Program	Alliance for Families and Children	Lynchburg
Kate Watson, Report Staff	Law Student	Georgetown University School of Law	Washington, DC
Jane Wills	Executive Director	Rappahannock Area Health Education Center	Warsaw
Jane Zara, Report Staff	Law Student	Georgetown University School of Law	Washington, DC

James Madison University thanks the members of the Study Resolution Committee for their work on this interim report and their dedication to improving access to health and human services for all Virginians.

A special thank you is extended to the patrons of HJR 195, Delegate R. Steven Landes and Senator Janet D. Howell for their efforts to increase the effectiveness of Virginia's health and human service delivery systems.

Table of Contents

Executive Summary and Recommendation

BACKGROUND ON COMMUNITY HEALTH WORKERS

Introduction

Across the United States and Virginia, the community health worker (CHW) is emerging as a vital link between communities and health care providers. CHWs may work under a variety of titles but typically work almost exclusively in community settings. They serve as connectors between individuals and health and human service providers to promote health among groups that have traditionally lacked access to adequate health and human resources.

As community members, CHWs function effectively within a community's culture, language, and value system. The formation of the CHW-client relationship establishes trust between the CHW and the client. It is this trust that serves as a foundation for the successful dissemination of information and service delivery. As a trusted voice, CHWs are in a unique position to reach otherwise marginalized or vulnerable populations.

Characteristics of Virginia Community Health Workers and their Places of Employment

Community health workers are persons with varying degrees of training and education who provide a variety of services within health and human service delivery systems. A Centers for Disease Control study found that the *average* CHW receives forty hours or fewer of initial training, and 2-4 hours of in-service training per month.[1] This training is often focused on a specific topic or issue.[2]

CHWs work for a wide range of programs and reach a variety of populations. Such programs include those addressing infant and child health, family services, women's and reproductive health, nutrition, smoking prevention, HIV/AIDS, breast and cervical cancer early detection, elderly health and respite care, mental health, and substance abuse. Programs serve both males and females and the range of ethnic groups that comprise Virginia's population. Most programs are delivered through community-based agencies and local health departments, and are funded with federal and state monies. However, approximately one-third of programs are funded by local government agencies, non-profit organizations and private foundations.

Core Roles of Community Health Workers

The 1998 National Community Health Advisor (NCHA) Study provided descriptions of the core skills, roles, and major issues that confront CHWs throughout the U.S.[3] The NCHA Study identified seven core roles that characterize the work of CHWs in the United States.[4] These roles also accurately describe the work of Virginia CHWs. The core roles are:

1. Providing cultural mediation between communities and health and social service systems
2. Providing culturally appropriate health education and information
3. Assuring access to needed services
4. Providing informal counseling and social support
5. Advocating for individual and community needs
6. Providing direct services
7. Building individual and community capacity

Community Health Workers as Bridging Cultural and Linguistic Barriers to Health Care Services

Because they are often members of the communities they serve, CHWs engender trust with their clients. Using this trust, outreach and educational services provided by CHWs belonging to underserved and limited English proficient (LEP) communities have shown remarkable effectiveness in linking individuals with health and human service providers, insurance coverage and sources of continuous, appropriate health care.[5]

In its 2004 *Report of Acclimation of Virginia's Foreign Born Population*, the Joint Legislative Audit and Review Commission (JLARC) indicated that "by all accounts, the language barrier is the most common challenge faced by Virginia's foreign-born residents. Ethnic leaders reported that the language barrier not only causes difficulty in communicating, but may deter non-English speakers from seeking needed services or assistance."[6] The JLARC report also noted that in urban areas of Virginia, community-based organizations, and other non-profit or charitable entities are a vital resource to the foreign-born.[7] CHWs that are trained to provide interpretation in health care settings for limited English proficient (LEP) persons through the Northern Virginia Area Health Education Center are one example of CHW programs providing model services to LEP populations.

Community Health Workers as Connectors to Services

CHWs serve as connectors between services and the people who need them. In this role, CHWs make referrals to health and human services, serve as a motivator for

people to seek care and support, provide transportation to health and human service appointments and services, and often follow-up with individuals to ensure that they have received the care they sought or are following the course of care that has been prescribed for them.[8]

Working in communities where formal services are often not available, CHWs serve as a complement to services delivered by "formal" health and human service professionals (physicians, nurses, social workers, etc.) to provide more comprehensive and supportive care.

An example of the connector role of CHWs is the Comprehensive Health Investment Project (CHIP) of Virginia. CHIP, a non-profit organization with eleven regional sites across Virginia is an intensive home-visiting program that helps families establish and maintain relationships between a primary care clinician, the mother, and her baby. CHIP CHWs work in collaboration with a nurse or nurse practitioner and maintain regular (weekly or biweekly) contact with families over a period of months. CHIP clients have demonstrated a 20% improvement rate in immunizations, significant reductions in hospitalization stays and emergency room visits over two years of participation.[9]

CHWs as Providers of Informal Counseling and Social Support

Conditions of poverty, unemployment, discrimination, and isolation are characteristics of many communities where CHWs work. Clients of CHWs often describe themselves as having difficulty coping with day-to-day events.[10] There is a volume of literature that has demonstrated the importance of social support in preventing mental health problems and improving physical health outcomes.[11]

A report released in 2001 by the Surgeon General's Office Titled *Mental Health: Culture, Race and Ethnicity*, found that providers of mental health services often know little about the cultural values and backgrounds of patients they are treating or the traditions of healing and the meaning of illness within their cultures.[12] According to Dr. Satcher, "if people are going to feel comfortable discussing mental disorders, they have to be talking to someone they trust, and to someone who understands their culture and how things are expressed in their culture".[13]

Because of the trust established between CHWs and their clients, CHWs are there to offer their client's "*a shoulder to lean on*" when there is no one else.

Community Health Workers as Providers of Direct Services

In the various settings in which they work, CHWs provide a range of direct services. For many CHWs across the nation and in Virginia, this often means helping

clients and families meet basic needs. This includes helping persons secure food, clothing, transportation, adequate housing, and employment resources.

Similar to examples of school-teachers reaching into their own pockets to pay for needed supplies for school children, there are few CHWs who have not used their personal resources or time to assist their clients above and beyond their program's objectives. This happens despite what one Virginia CHW commented upon when she said that she was "one paycheck away from being in the same (poor) financial situation as my client".

Health care providers often do not know the environments that some of their patients live in and the struggles that they may have just to meet basic needs. In these situations, important medical information and treatment plans will often go unheeded and physical improvement will be minimal or not occur at all. This is often caused by the client's inability to follow a care protocol or regimen due to the immediacy of their economic, emotional and/or social situation.

In Virginia, programs such as CHIP, Healthy Families, Resource Mothers and AIDS Service Organizations are examples of CHW programs that must work to secure basic needs for their clients so that they are then able to address specific needs related to the goals and objectives of their programs.

Community Health Workers as Builders of Individual and Community Capacity

In many ways the previous six identified CHW roles contribute to the final core role of the CHW - building individual and community capacity.[14] To reduce gaps in community health, and strengthen public health systems, individual and community strengths and weaknesses need to be identified. Strengths need to be maximized while weaknesses are identified and minimized. Within local health and human service delivery systems, CHWs are often the ones working behind the scenes weaving together community resources to address their client's needs.

The practical experiences of CHWs provide essential contributions to public health and other health and human service activities that often prove to be models of care delivery or best practices. In this regard, CHWs provide invaluable services by acting as cultural liaisons between health and human service providers and the communities they serve.

INVENTORYING CHW PROGRAMS IN VIRGINIA: STATUS AND CHALLENGES

In its 1996 report titled *The Development of Community Health Advisor Programs Throughout the Commonwealth of Virginia*, the Institute for Community Health at Virginia

Tech estimated that there were as many as 4,000 Community Health Advisors (CHWs) working in Virginia.[15] The Virginia Center for Health Outreach database of CHW programs contains over 230 programs.

Challenges in Inventorying Programs

There are several factors that make gathering a complete list of CHW programs in Virginia very challenging. These factors include the following:

Number of Titles. The numbers of official titles used by programs in Virginia for work conducted under the core roles established by the NCHA Study are many and varied. The plethora of titles creates challenges for identifying an accurate number of CHWs.

Paid versus Volunteer CHWs. There are CHWs who work on a volunteer basis in Virginia. These CHWs may work in a variety of community settings. Volunteer CHWs are more likely to rotate in-and-out of work typical of CHWs. Their status and work as a CHW is more likely to not be documented than paid CHWs because they often operate without formal administrative structures.

Lack of Licensure or Certification. Health and human service professionals that must be licensed or certified to practice have accurate databases maintained by state agencies. For CHWs, the lack of formal licensure or certification means that there is no mandated central repository for CHW workforce information.

Funding. CHW funding comes from various sources, including federal, state and local agencies, and private sources such as foundations. This funding has time limits. The instability of funding sources often means that there is significant fluctuation in program staffing levels and their efficacy in meeting the program's mission.

Awareness and Integration. Often there is a lack of integration of CHWs into existing health and human service delivery systems and institutions. This occurs as a result of a lack of awareness of the role of CHWs and the employment of CHWs using a title other than "community health worker". Where integration does exist, the contributions of the CHW are often not well recognized.

DEVELOPING A STANDARD DESIGNATION FOR VIRGINIA CHWs

Background

The capacity of CHWs to improve access to health and human services, especially for Virginia's most vulnerable populations is great. Supporting this belief are

numerous groups, organizations, and programs across Virginia that recognize the value of CHWs and have worked to increase the visibility of the CHW role in health and human service delivery.

Despite these commitments, there is recognition that a barrier to maximizing the value of CHWs is that so many CHWs nationally and in Virginia work under a variety of titles. Many outreach workers in Virginia are unfamiliar with the title of "community health worker".

The limited understanding of the CHW role by other health and human service professionals can sometimes cause CHWs to be pushed beyond their training and, perhaps more significantly, at other times to be underutilized. This can, in part, be traced to the lack of a standard designation for persons performing one or more of the core roles of CHWs.

A Standard Designation for Virginia Community Health Workers

Based upon the work of the Study Resolution Committee, CHWs, and CHW program supervisors in Virginia, the following description of CHWs working across Virginia is offered:

A Community Health Worker applies his or her unique understanding of the experience, language and culture of the populations he or she serves to promote healthy living and to help people take greater control over their health and their lives. CHWs are trained to work in a variety of community settings, partnering in the delivery of health and human services to carry out one or more of the following roles:

- ***Providing culturally appropriate health education and information***
- ***Linking people to the services they need***
- ***Providing direct services*, including informal counseling & social support***
- ***Advocating for individual and community needs, including identification of gaps and existing strengths and actively building individual and community capacity***

*Direct services may include providing transportation, purchasing food on behalf of clients, other activities associated with basic needs, taking blood pressures, temperatures, monitoring blood sugar levels, measuring heights and weights, and teaching self-screening measures such as breast self-examinations. Direct services may also include instruction on constructive problem-solving, decision-making and planning.

***RECOMMENDATION*. In partnership with the Department of Human Resource Management, James Madison University and the Community Health Worker Study Resolution Committee should review the Direct Services Career Group Description to ensure that Community Health Workers are appropriately identified as a health care support occupation and defined in accordance with the Committee's findings.**

EVALUATING THE EFFICACY OF COMMUNITY HEALTH WORKERS

Background

In order to fully understand and communicate the value and impact that CHWs have on the population they serve and health and human service systems, many organizations conduct evaluations of their CHW programs. These evaluations are used to demonstrate various aspects of a given program, including its procedures, its strengths and weaknesses, its cost-effectiveness, and how it affects individuals and the community where services are delivered.

The information collected and analyzed in CHW program evaluations can serve many purposes. Often, evaluations serve as feedback regarding a specific program and assist administrators in determining whether or not programs should be continued, expanded, reduced, or discontinued.

Two types of evaluations are primarily used for CHWs and their programs - process evaluation and outcome evaluation.

- ***Process evaluations*** analyze how a given program operates and identifies aspects of that program that can be improved. Process evaluation considers what was done, when it was done, who did it, how often it was done, to whom it was done, and how well it was done.[16]

- ***Outcome evaluations*** determine both the short-term and long-term impact and value that a program has had. In the case of CHWs, they often consider the number of individuals enrolled in a given program, the health status of those individuals, and how those individuals have changed over the duration of the program.[17]

Both of these types of evaluations are useful in examining CHWs and CHW programs. Process evaluations are beneficial in providing an overall picture of a program's status and in examining internal strengths and weaknesses related to administration, techniques, personnel, and other aspects of a program. Outcome evaluations are beneficial in determining the external strengths and weaknesses of a program, primarily by analyzing the impact and value that a program brings to the community that it serves.

Following are several descriptions of evaluations utilized by selected Virginia programs that employ CHWs. Where available, outcome information is described.

The **AIDS/HIV Services Group** uses prevention educators to provide HIV/AIDS education and support services to nearly 8,000 individuals in central Virginia. In 2003,

these educators worked with individuals in Charlottesville, Waynesboro, and Staunton, and in Albemarle, Fluvanna, Nelson, Greene, Louisa and Buckingham counties. ASG received a substantial federal grant in 2002 which allowed it to expand its education outreach programs and hire additional CHWs to serve as educators. As ASG has expanded its education programs, it has evaluated its impact on HIV incidence as compared to statewide data using information gathered by the Virginia Department of Health. In Charlottesville, for example, the number of new cases of HIV dropped from twelve in 2001, to nine in 2002, and to three in 2003. This is ***a 67% decline in incidence***, ***compared to a statewide rate of 20%***.

The **Community Health Education Development (CHED) Program** targets rural counties in Virginia's Middle Peninsula to increase access to and use of existing health care services. This program was initially launched in three counties: Westmoreland, Caroline, and Essex. It was subsequently expanded to Northumberland, Lancaster, and Richmond counties. CHED performed an annual SWOT (strengths, weaknesses, opportunities, threats) analysis through both the developmental and implementation phases of the program and also gathered demographic information and data on community screening activities. The SWOT analysis covers program activities, outcomes, community benefits, and administrative aspects of the statewide CHED Program.

Comprehensive Health Investment Project (CHIP) of Virginia targets vulnerable children and their families with the goal of improving children's health and promoting wellness. This program supports a network of eleven community-based home visiting programs in the following localities and regions: Arlington, Greater Richmond, Greater Williamsburg, Norfolk, Chesapeake, Portsmouth, Petersburg, Jefferson Area, Roanoke Valley, New River Valley, and Southwest Virginia. CHIP offers four categories of services: screening, assessment, and planning; education and support; follow-up; and referral and outreach. Examples of CHIP outcome measures included:

- Increased employment rate among mothers (23% to 33%)
- Increased use of family planning methods increased from 54% to 68%
- Increased number of children enrolled in Medicaid and/or FAMIS Plus (70% to 81%)
- Decreased number of low birth weight baby (17.8% as compared to 7.0%) for women who enrolled in CHIP at least 4 months prior to giving birth

Expanded Foods & Nutrition Education Program (EFNEP) is a program that focuses on nutrition education and attempts to provide individuals with knowledge, skills, attitudes, and behaviors essential to a nutritionally sound diet. Virginia EFNEP operates in 26 counties and cities throughout the state, seven of which are urban and 19 are primarily rural. The program targets low-income families with young children and low-income youth. The program's economic efficiency over one year was calculated

through a cost-benefit ratio comparing the amount of money spent on the program to the potential savings from the program. The analysis determined that in 1996, the Virginia program resulted in benefits totaling $18,223,980 and costs totaling $1,713,081. The program had a benefit to cost ratio of $10.64 to $1.00, and an internal rate of return of 16.41%.

Healthy Families provides home visiting services to families in Virginia and has an overall goal of reducing risk factors for child abuse and neglect by positively impacting pregnancy outcomes, child health, parenting practices, and child development. Healthy Families (HF) collects outcome data from its clients using a standardized database and compares this data to statewide outcome goals and objectives. The 2004 Healthy Families Virginia Statewide Report focused on infant and child health outcomes and found that among program enrollees, 88% of babies were within the healthy birth weight range as opposed to the 77% statewide rate. Additionally, 85% of the children enrolled in programs received all of their scheduled immunizations while the Virginia average was only 64.8%. The child abuse and neglect rate among families enrolled in Healthy Families program is .97% (<1%) while the child abuse and neglect rate among families with characteristics similar to families enrolled in HF is 4.7%. Another outcome goal of HF programs is reducing subsequent births among enrolled teenage mothers. Approximately 94% of teenage mothers do not have additional births for at least two years after enrolling in the program.

Resource Mothers is a program directed at teenage parents focusing on enhanced birth outcomes, promotion of a stable home environment, and help establishing connections to existing support services within the community. Resource Mothers collects data regarding birth outcomes, subsequent pregnancies, and visits and support sessions within the program.

In 2004, teenage participants in Resource Mothers had a repeat pregnancy rate of 6.1%, significantly lower than the state average of 20%. The low birth weight rate among Resource Mothers participants was 9.03 (2004) per 1000 live births while the statewide rate was 10.6 (2002) per 1000 live births. The Resource Mothers report included information from 25 sites serving 87 localities throughout Virginia.

Challenges in Evaluating CHWs

Although each CHW program operates somewhat differently, there are general challenges to evaluating CHWs that would likely impact any program attempting to conduct an evaluation. These challenges stem from the following reasons:

Lack of funding. Many programs that employ CHWs lack sufficient funding to develop and implement an accurate evaluation program.

Lack of resources. Many programs that utilize the services of CHWs are limited in the amount of personnel that they can hire. Many programs do not have the capability to sufficiently train their employees to conduct and prepare evaluation reports.

Characteristics of the program and its services. Many of the services that CHWs provide to their clients are not quantifiable and the impact of these services is not easily measured or recorded. Additionally, CHWs offer many intangible benefits to their clients specifically through education and counseling.

Characteristics of the population served by the program. Individuals who receive services provided by CHWs are often a transient population and enter or leave programs due to changes in location, employment, financial status, or family status.

PROPOSED OVERVIEW OF YEAR TWO OF STUDY

James Madison University, in collaboration with the Study Resolution Committee, requests the opportunity to address the remaining directives outlined in HJR 195 in a report to be submitted to the Governor and the General Assembly no later than the first day of the 2006 Session of the Virginia General Assembly.

I. BACKGROUND ON COMMUNITY HEALTH WORKERS

Introduction

Across the United States and Virginia, the community health worker (CHW) is emerging as a vital link between communities and health care providers. CHWs are trained persons who educate and assist individuals and groups in gaining control over their health and their lives. They promote health by providing education about the prevention and management of disease, the reduction of injuries, and by helping community residents understand and access formal health and human service systems. CHWs work within health and human service delivery systems as a complement to other health and human service professionals. Paid and volunteer CHWs are found in a variety of settings including community clinics, not-for-profit and for-profit organizations, public health departments, churches and faith communities, and other community-based organizations. As community members, CHWs are in a unique position to function effectively with a community's culture, language, and value system. As a result, CHWs are able to reduce cultural, linguistic, social, and financial barriers to health care.

Legislators, policymakers, and health care systems are searching for feasible strategies to reduce soaring health care costs while maintaining access to quality health and human services. One promising strategy, supported by research and the experience of programs nationally and in the commonwealth, is the utilization of CHWs.[1]

Who Are Community Health Workers?

The concept of community members as active health advocates and healers is well known. All of the world's cultures have a lay health system that is comprised of natural health aides or community members whom others turn to for health advice or healing.[2] The United States' oldest and largest CHW program is the Community Health Representative Program established in 1968 to address the needs of Native American tribes.[3]

Community health workers, also known as community health advocates, lay health educators, resource mothers, home visitors, community health representatives, peer health promoters, community health outreach workers, and in Spanish, promotores de salud, are persons who work almost exclusively in community settings. They serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate health care.[4] This study report will discuss in greater detail what CHWs do and the roles that they perform within the nation's and Virginia's health and human service delivery systems.

Community health workers come from every ethnic group and vary in age from teenage peer educators to senior adults. CHWs often share a common experience with the clients they serve. This shared experience may be cultural, ethnic, economic, age, or one based on a shared health or other physical condition. The 1998 National Community Health Advisor (NCHA) Study found CHWs who were, among other backgrounds, a "displaced respiratory therapist, an immigrant nurse, a teenage mother, a migrant farm worker, a frustrated dental hygienist, a current janitor, a would-be social worker, and a sometimes homeless man".[5]

CHWs are commonly members of the same communities that they serve. It is the shared experience (or its perception) on the part of clients that the CHW understands their needs. The formation of the CHW-client relationship establishes trust between the CHW and the client. It is this trust that serves as a foundation for the successful dissemination of information and service delivery. As a trusted voice, CHWs reach otherwise marginalized or vulnerable populations.

Community health workers are persons with varying degrees of training and education who provide a variety of services within health and human service delivery systems. A Centers for Disease Control study found that the *average* CHW receives forty hours or fewer of initial training, and 2-4 hours of in-service training per month.[6] This training is often focused on a specific topic or issue.[7] Other CHWs require more extensive education and training as dictated by the programs that employ them. For example, Family Support Workers that provide home visiting under the Healthy Families Program must satisfactorily complete a series of education and training programs within six months of their hire. Additionally, there are ongoing educational requirements. There are over 200 Family Support Workers serving Virginia residents.

In 2002 the Virginia Center for Health Outreach at James Madison University conducted eight focus groups across Virginia in an effort to solicit direct input from CHWs. The Center used the information from the focus groups to guide its program development. The majority of CHWs identify themselves as natural helpers or caregivers and saw this as the reason behind their choosing the work that they do. The following statements evidence this self-identification:

- "I'm truly interested in helping people."
- "It inspires me to be able to help someone . . . it is my desire to be of help."
- "It is good to go into families . . . and help them see their strengths and help them build on that and watch them grow."
- "I have a lot of (parenting) experience that I can really share with these girls and they really seem to appreciate it."

These statements represent the caring CHWs have for the clients they serve and the connection that they feel with their clients. This connection enhances the trust that exists between the CHW and them.

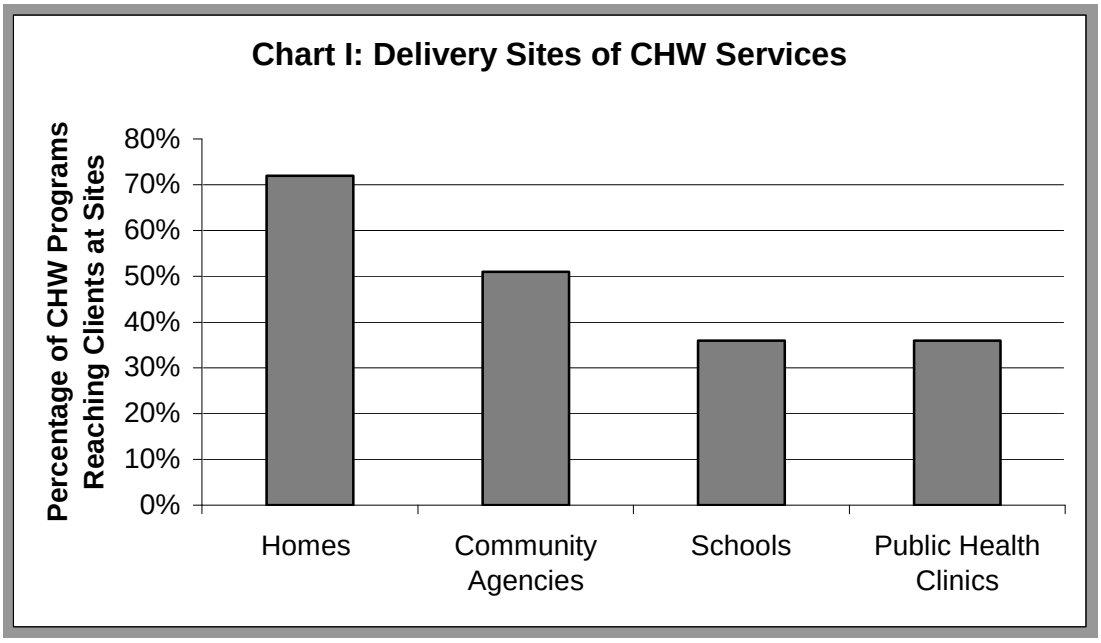
In conversations with CHWs, it is evident that CHWs worry about their clients' lack of resources. However, CHWs have personal concerns about low wages or salaries, tenuous program funding, and safe working conditions.

Characteristics of Virginia Community Health Workers and their Places of Employment

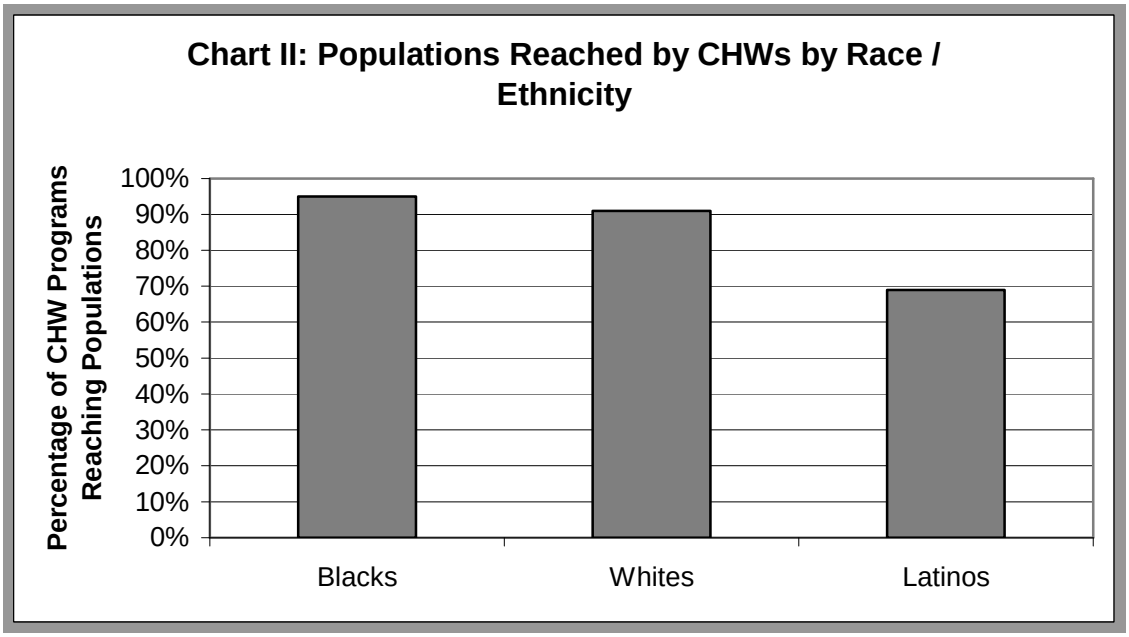
Utilizing data from a CHW program survey conducted by the Virginia Center for Health Outreach in 2002, a description of a composite CHW program in Virginia would find that CHWs…

…work in a community-based agency funded by either federal or state dollars. The CHW would work an average of 35 hours per week (combination of full and part-time employees) and would be paid a range of $6.50 to $10.50 an hour. The number of CHWs working in the program would be five and they would serve a multi-locality (cities and/or counties) area. A minimum of two of the CHWs would be members of their target population. The services they would provide would most likely be in the client's home or a community agency. The CHWs would serve 216 persons annually or an average of 43 clients. They would provide social support or informal counseling services, transportation, medical access counseling, community advocacy service, and information about risk identification.

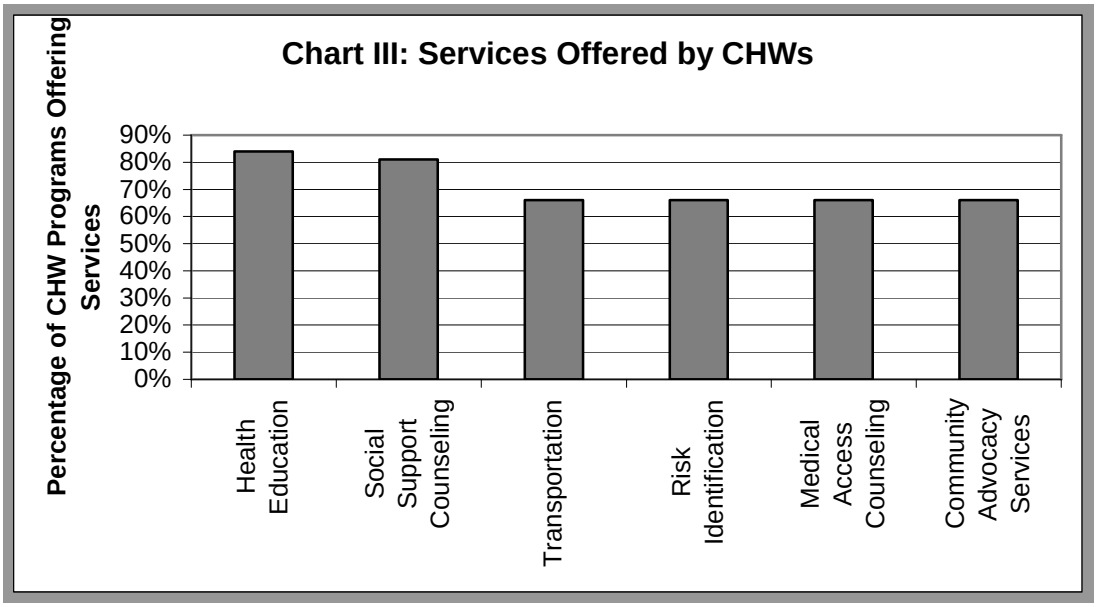
Charts 1-4 summarize information from the VCHO program survey, highlighting Virginia CHW program characteristics.



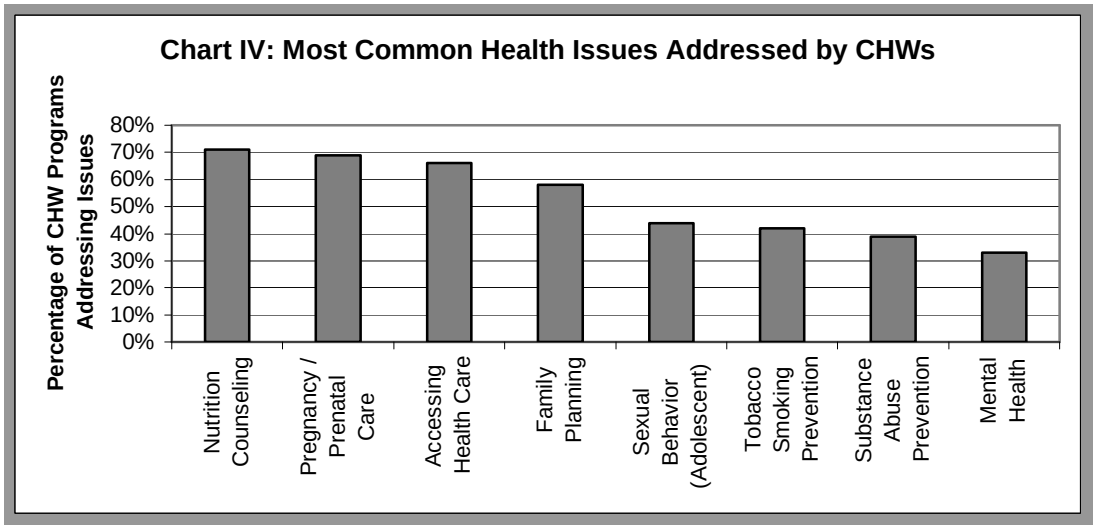
Most CHW programs are delivered in homes (72%), community agencies (51%), schools (36%), and public health clinics (36%).



Most sites reported serving Blacks (95%), Whites (91%), and Latinos (69%) more than any other racial/ethnic group.



Community heath workers most often provided their clients with health promotion or education (84%) and social support or counseling services (81%). About two-thirds of CHW program sites provide risk identification, transportation, medical access counseling, and community advocacy service.



The health problem addressed by one-third or more of sites include: nutrition counseling (71%), pregnancy/prenatal care (69%), how to access health care (66%), family planning (58%), sexual behavior among adolescents (44%), smoking prevention (42%), substance abuse (39%), and mental health problems (33%).

Additional information from the VCHO program survey included the following characteristics:

- Fifty-six (56) health worker titles were reported across 99 programs. Of these, the titles used most often included: Family Support Worker (18%), Resource Mother (10%), Outreach Worker (8%), and Family Resource Specialist (7%).

- Community-based agencies (48%) and local health departments (31%) are most often the type of agency that deliver community health programs utilizing CHWs.

- Programs are most often funded by state (66%) and federal (63%) monies. About one-third of the CHW programs are funded by local government agencies, non-profit organizations, and private foundations.

- Programs were as likely to serve both rural and urban areas (36%). Programs serving just rural areas were 35%. Twenty-nine percent (29%) serve just urban areas. Sites were also more likely to serve multi-county (48%) or town/city and surrounding vicinity (28%) areas.

- A majority of sites served both males and females ranging in age from 0 to 5 years and from 13 to 64 years old.

- Median number of people served in a 12-month timeframe at 83 sites was 216 people.

- Median numbers of health workers per site were 5.

- Forty-two percent (42%) of sites reported that fewer than *25* percent of their workers are members of the target population and 28% reported that 100% are members.

- The median numbers of hours worked per month by each worker were 150.

- Ninety-three (93) sites responding to the question of remuneration indicated that 87% provide compensation in the form of salary and 9% do not provide any compensation.

- Sites providing compensation and who responded to a specific amount of remuneration (N=71), indicated a median salary of approximately $10.50 per hour with the minimum reported salary being $6.50 per hour (*Note: for a sole wage earner with a family of four, $9.06 per hour, full-time, would place that family at 100% of the federal poverty level). The median salary is likely overstated due to the inclusion of*

some program supervisor salaries. Many CHWs working in public agencies are working part-time and hourly and are not offered benefits. Their compensation is closer to the minimum salary figure cited in the survey.

- Fifty-seven percent (57%) of sites reported that they supply other types of compensation, benefits, and incentives beyond or in addition to salary. Most often sites provided full-time state employee benefits (including health and life insurance, retirement, vacation pay, and personal and sick leave). Fewer sites supply continuing education and training or mileage/travel reimbursement.

- Eighty-three (83) sites reported that 40 hours was the median number of initial training hours their workers receive. Of the 70 sites that reported CHW inservice training hours per month, the median number of hours was four.

- A majority of sites reported that program coordinators (59%), nurses (52%), health educators (39%), community agency personnel (38%), and nutritionists (37%) helped train their workers.

- Seventy-seven (77) sites reported giving their workers recognition, pay increases (58%) and certificates (51%) as the types of recognition most often provided.

While the information above provides a description of Virginia CHW programs, additional national data found that over 50% of CHWs lacked health benefits and that an even larger percentage lacked retirement benefits. Despite the demanding nature of their work and the hostile conditions in which CHWs must sometimes work, half of the CHWs surveyed nationally had no basic sick leave or vacation benefits and job security was a major concern due to the frequent patchwork nature of funding for CHW programs.[8]

Core Roles of Community Health Workers

The 1998 National Community Health Advisor (NCHA) Study provided descriptions of the core skills, roles, and major issues that confront CHWs throughout the U.S.[9] The NCHA Study identified seven core roles that characterize the work of CHWs in the United States.[10] According to the study, the identification of common CHW roles is vital in assisting health care providers and others to better understand CHWs and the vital skills and abilities that they bring to the delivery of health and human services.[11] The study also recognized core competencies held by CHWs.[12] Figure 1. lists core roles and competencies of CHWs as identified in the NCHA Study.

Figure 1.

Core Roles of CHWs

1. Providing cultural mediation between communities and the health and social service systems
2. Providing culturally appropriate health education and information
3. Assuring access to needed services
4. Providing informal counseling and social support
5. Advocating for individual and community needs
6. Providing direct services
7. Building individual and community capacity

CHW Core Competencies

Communication Skills	Courage
Interpersonal Skills	Respect
Teaching Skills	Persistence
Service Coordination Skills	Desire to Help Community
Advocacy Skills	Resourcefulness
Empathy	Relationship with Community

Community Health Workers as Bridging Cultural and Linguistic Barriers to Health Care Services

CHWs help individuals overcome cultural and linguistic barriers to health care resources and information.[13] This role is significant when considering the growing diversity of Virginia's population. Virginia's geography and its population present special challenges for delivering health and human services. In its 2004 *Report of Acclimation of Virginia's Foreign Born Population*, the Joint Legislative Audit and Review Commission (JLARC) cited the following[14]:

> ***Between 1990 and 2000, the foreign-born population in Virginia increased 83 percent, from 311,809 to 570,279. The foreign-born population now accounts for eight percent of the State's total population. About two-thirds of Virginia's foreign-born reside in Northern Virginia. However, some localities in the Shenandoah Valley and southwest portions of the State have experienced the most rapid growth in their immigrant populations during the past decade.***

In addition, the JLARC report included the following table illustrating Virginia's ranking among all states for its foreign-born population.[15]

Figure 2. Virginia's Ranking Among States Based on Size of Foreign-Born Population in 2000	
Category	**Ranking***
Size of the foreign-born population	11th
Percent foreign-born in the total population	19th
Numeric change in the foreign-born population, 1990 to 2000	11th
Percent change in the foreign-born population, 1990 to 2000	25th
*Rankings include the 50 states and the District of Columbia. Source: Migration Policy Institute	

Although many factors affect health status, a lack of information as to available resources and especially culturally sensitive resources, diminish minorities' use of both preventive services and medical treatment.[16] Frequently, institutions and their representatives try to educate or persuade people based upon their own cultural models and not those of target populations. In addition, discriminatory treatment due to race, age, class and gender often prevent members of marginalized communities from gaining equitable access to adequate health care.[17] Many members of marginalized communities continue to distrust and feel intimidated by traditional health care providers. As a result, minorities will often avoid interaction with health care systems, even when doing so is detrimental to their health and well-being.[18]

Because they are often members of the communities they serve, CHWs engender trust with their clients. Using this trust, outreach and educational services provided by CHWs belonging to underserved and limited English proficient (LEP) communities have shown remarkable effectiveness in linking individuals with health and human service providers, insurance coverage and sources of continuous, appropriate health care.[19] As a result, short-term measurable improvements have included decreases in emergency room visits, length of hospital stays, and less medical complications in general. The use of CHWs can provide for greater availability of cost effective, culturally competent home and clinically-based services.[20] This promotes the timely use of medical services and better compliance with medical care provider's treatment instructions. In turn, CHWs often educate medical providers about existing cultural practices in their community.

In its 2004 report, JLARC cited programs that utilize trained medical interpreters (CHWs) as an imperative to providing high-quality interpretive services.[21] The JLARC report named the Northern Virginia Area Health Education Center's (AHEC) implementation of a particularly effective program in providing trained interpreters for clinical interpretation.[22] According to the report, the Northern Virginia AHEC's interpreters have successfully implemented a 40-hour course in health care

interpretation "that is widely considered a national standard for the training of health care interpreters."[23] This program has been successfully adopted by the Blue Ridge AHEC Program that serves the Shenandoah Valley - one of several geographic regions of Virginia mentioned in the JLARC report as having experienced significant growth in foreign-born populations.

In its 2000 review of the performance and management of the Virginia Department of Health, the JLARC noted that local service delivery has generally been good in organizing and delivering services in core programs of public health.[24] The report stressed, however, that problems still exist in ensuring long-term effectiveness in delivering tuberculosis prevention drug therapy to hard-to-reach populations. This includes foreign-born populations. The report suggested the ***increased use of outreach*** for better disease tracking and increasing immunization compliance, especially in major urban areas of Virginia.[25] Increased CHW funding would be a feasible approach to close these gaps in the delivery of health services.

Community Health Workers as Connectors to Services

CHWs serve as connectors between services and the people who need them. In this role, CHWs make referrals to health and human services, serve as a motivator for people to seek care and support, provide transportation to health and human service appointments and services, and often follow-up with individuals to ensure that they have received the care they sought or are following the course of care that has been prescribed for them.[26] In addition, depending upon their background, training and experience, CHWs can recognize symptoms that require care medical care.[27] Working in communities where formal services are often not available, CHWs serve as a complement to the clinical services delivered by "formal" health and human service professionals (physicians, nurses, social workers, etc.) to provide more comprehensive and supportive care.

One example of CHWs serving as health care connectors is *doulas*, health care workers who provide education and supportive care to women throughout the prenatal, childbirth and post-partum periods.[28] Pregnant women with such care have reduced length of labor, reduced use of pain medications and a reduced number of Caesarean deliveries.[29] Women under the care of CHWs or *doulas* during their pregnancy are more likely to be breast-feeding without problems at six weeks, have higher self-esteem, be less depressed and develop stronger attachments to their babies.[30] These attachments promote positive child development and serve as a foundation for effective parenting.

An example of a successful *doulas* program in Virginia is at Harrisonburg's Rockingham Memorial Hospital, which was established in collaboration with its Family

BirthPlace (obstetrical department). The *doulas* are recruited from the local Latino community and serve pregnant Latino women.

Another example of the connector role of CHWs is the Comprehensive Health Investment Project (CHIP) of Virginia. CHIP, a non-profit organization with eleven regional sites across Virginia, is an intensive home-visiting program that helps families establish and maintain relationships between a primary care clinician, the mother, and her baby. In the course of an interview for this report, a case manager from the Tidewater region described how she witnessed "new mothers taking an interest in their child's health and self-esteem" after participating in the program.

CHIP CHWs work in collaboration with a nurse or nurse practitioner and maintain regular (weekly or biweekly) contact with families over a period of months. CHIP clients have demonstrated a 20% improvement rate in immunizations, significant reductions in hospitalization stays, and emergency room visits over two years of participation.[31] In addition, babies born to pregnant women enrolled in CHIP have required fewer days of neonatal intensive care and have demonstrated other reduced costs for hospitalization.[32]

CHWs as Providers of Informal Counseling and Social Support

Conditions of poverty, unemployment, discrimination, and isolation in many communities often find CHWs working with clients who describe themselves as having difficulty coping with day-to-day events.[33] Stated previously, positive relationships are built upon trust. Because of the trust that CHWs establish with their clients, they are often in the best position to offer positive advice, support, and information. There is a volume of literature that has demonstrated the importance of social support in preventing mental health problems and improving physical health outcomes.[34] In essence, CHWs offer their client's "*a shoulder to lean on*" when there is no one else.

According to former U.S. Surgeon General David Satcher, members of minority groups tend to be overrepresented among those most vulnerable and in need of mental health treatment.[35] Satcher also noted that minorities often have less access to services, receive lower-quality care, and are less likely to seek help when they are in distress. A report released in 2001 by the Surgeon General's Office Titled *Mental Health: Culture, Race and Ethnicity,* found that providers of mental health services often know little about the cultural values and backgrounds of patients they are treating or the traditions of healing and the meaning of illness within their cultures.[36] According to Dr. Satcher ,"if people are going to feel comfortable discussing mental disorders, they have to be talking to someone they trust, and to someone who understands their culture and how things are expressed in their culture". [37]

The CHW as informal counselor and provider of social support is exemplified in many CHW activities and programs throughout Virginia. In addition to teaching parenting skills and providing a framework for positive child development, Family Support Workers with local Healthy Families Programs in Virginia have worked with young women, linking them to employment resources, convincing young mothers to stay in high school once they have delivered, and otherwise helping to empower their clients to work toward a positive future for their child and themselves.

The experiences of the winner of the VCHO's Outstanding CHW for 2003, Ms. Lois McNiel, a CHW with the Resource Mothers Program in the Lenowisco Health District, is a good example of social support provided by a CHW. Ms. McNiel was nominated by a primary care physician in the area. In making the nomination the physician wrote,

"I have been greatly impressed by Ms. McNiel's dedication to her work. We unfortunately, have a high teenage pregnancy rate in this area and several young girls have no resources available to them. The Resource Mothers are a wonderful resource for these girls, providing not only help with transportation, etc. but also the much-needed emotional support. In a similar case, Ms. McNiel has been helping a young mother with everything from transportation to counseling on the care of the baby. She was of tremendous help to this young girl throughout her pregnancy as well, and was the only 'family' present at the time of delivery."

In support of Ms. McNiel's nomination, a local principal wrote, "Lois McNiel goes the extra mile to assist our young mothers as well as those who are pregnant. She takes them under her angelic wings whenever others can't or won't. She takes them to appointments, shops for clothes to accommodate growing tummies, sits during labor and gives encouragement and wise advice. Lois visits night and day to check on 'her girls.' She has comforted many scared girls and brings experience, calm and common sense to an often-time terrifying experience."

Community Health Workers as Providers of Direct Services

In the various settings in which they work, CHWs provide a range of direct services. For many CHWs across the nation and in Virginia, this often means helping clients and families meet basic needs. This includes helping persons secure food, clothing, transportation, adequate housing, and employment resources. In this role, the NCHA Study quoted a New England CHW regarding the impact of helping clients meet basic needs. [38]

"In order for me to get to my job, I have to do that [meet basic needs] job first. If it's food, if it's heating, if you're hungry, I don't care what service I'm coming there to offer you, you can't hear me, because your mind and your belly is telling you something else. Now, if I can help you get food, then I can concentrate on what it is that needs to be done."

This same scenario has been voiced repeatedly by Virginia CHWs, especially those working with parents of newborns (Healthy Families, Resource Mothers, CHIP) and case managers (CHWs) working with HIV positive and AIDS clients. Similar to examples of school-teachers reaching into their own pockets to pay for needed supplies for school children, there are few CHWs who have not used their personal resources or time to assist their clients in some way. This happens despite what one Virginia CHW commented upon when she said that she was "one paycheck away from being in the same (poor) financial situation as my client".

Health care providers often do not know the environments that some of their patients live in and the struggles that they may have just to meet basic needs. In these situations, important medical information and treatment plans will often go unheeded (as represented in the quote above) and physical improvement will be minimal or not occur at all. This is often caused by the client's inability to follow a care protocol or regimen due to the immediacy of their economic, emotional and/or social situation.

Figure 3 (below) provides examples of direct services provided by select Virginia CHW programs.

Figure 3.
Examples of CHW Programs
Providing Direct Services in Virginia

CHWs with the Community Health Education Development Program (CHED) of the Rappahannock Area Health Education Center (Middle Peninsula and Northern Neck)

- Perform blood pressure measurements
- Measure blood glucose levels
- Provide informal counseling, health education information and referrals

CHWs with the Peer Advocates Coalition of Central Virginia

- Provide support and advocacy for persons newly diagnosed as HIV Positive
- Direct HIV positive persons not having their disease medically managed into care
- Assist individuals secure entitlement benefits
- Help clients navigate through often complex systems of HIV care
- Provide non-invasive HIV antibody testing for family members and significant others
- Provide pre and post-test counseling
- Provide medication adherence education and support group organization

CHWs with Project Connect, a partnership between the Virginia Health Care Foundation and the Virginia Department of Medical Assistance Services (DMAS). (51 Virginia localities)

- Identify and enroll eligible children in DMAS child health insurance programs (Family Access to Medical Insurance Security – FAMIS and FAMIS plus)

Community Health Workers as Builders of Individual and Community Capacity

In many ways the previous six identified CHW roles contribute to the final core role of the CHW - building individual and community capacity.[39] To reduce gaps in community health, and strengthen public health systems, individual and community strengths and weaknesses need to be identified. Strengths need to be maximized while weaknesses are identified and minimized. Within local health and human service delivery systems, CHWs are often the ones working behind the scenes weaving together community resources to address their clients' needs.

For example, school aged children often lack adequate primary care and fail to see physicians at recommended intervals to receive treatment for episodic and chronic health problems, or to get required immunizations in a timely manner. CHWs, in forming partnerships with other health and human service workers, help to reach out to these children's families, encouraging them to utilize needed health care services. The direct interactions of CHWs with their clients lead to more timely and accurate

diagnoses and treatment; this in turn improves health outcomes and reduces health care costs.

Similar to other public health practitioners, CHWs can be regarded as local health researchers seeking ways to improve health service delivery and care coordination for their communities.[40] The practical experiences of CHWs provide essential contributions to public health and other health and human service activities that often prove to be models of care delivery or best practices. In this regard, CHWs provide invaluable services by acting as cultural liaisons between the medical community and the communities they serve. The following are examples of how CHWs work within systems to improve care delivery.

- **Cultural compatibility and competence allow CHWs to bridge language and cultural gaps that can exist between community members and conventional health practitioners.**
- **CHWs translate technical terminology into lay language for community members and teach clients how to follow medication or other treatment regimens.**
- **CHWs introduce and help to establish collaborations between their clients and clinicians where the client becomes an active participant in their care.**
- **CHWs educate health care and social service providers about community needs, such as the need to change clinic hours, offer additional services, or offer insights into the effectiveness of certain practices.**

II. INVENTORYING CHW PROGRAMS IN VIRGINIA: STATUS AND CHALLENGES

In its 1996 report titled *The Development of Community Health Advisor Programs Throughout the Commonwealth of Virginia*, the Institute for Community Health at Virginia Tech estimated that there were as many as 4,000 Community Health Advisors (CHWs) working in Virginia.[41]

The Virginia Center for Health Outreach database of CHW programs contains over 230 programs. This includes multiple sites for some programs. The VCHO has divided Virginia into eight regions. Each region has its own coordinator. The coordinator is a CHW who resides or works in the region they represent. The coordinators' work on behalf of the VCHO is beyond the scope of their day-to-day CHW responsibilities. One task of each coordinator is to assist the VCHO in identifying CHW programs and details regarding their program. The VCHO maintains an online form for assisting programs in registering with the Center. Once identified, this information is entered into the VCHO database of CHW programs.

Challenges in Inventorying Programs

There are several factors that make gathering a complete list of CHW programs in Virginia very challenging. A number of these factors are cited elsewhere in this study report because they impact other issues affecting CHWs in Virginia.

Number of Titles. The numbers of official titles used by programs in Virginia for work conducted under the core roles established by the NCHA Study are many and varied. The plethora of titles creates challenges for identifying an accurate number of CHWs. For example, AIDS Service Organizations (ASOs – local non-profit agencies that provide services and support to persons living with HIV and AIDS) may have three distinct job titles and job descriptions for CHWs all working within a single agency. These include case managers, client advocates, and street outreach workers. In each case the CHW performs duties described by the NCHA Study.

Paid versus Volunteer CHWs. There are CHWs who work on a volunteer basis in Virginia. These CHWs may work in a variety of community or faith-based communities. They are natural helpers or caregivers who do not identify themselves as CHWs because they are unfamiliar with the term "community health worker" and its meaning. Volunteer CHWs are more likely to rotate in-and-out of work typical of CHWs. Their status and work as a CHW is more likely to not be documented than paid CHWs because they often operate without formal administrative structures. The lack of a formal administrative structure creates a challenge to identifying the program and the number of active CHWs working within them. In contrast, the presence of a formal

administrative structure typically means that the number of CHWs involved in the program, whether single or multi-site, may be collected from that administrative source. Word-of-mouth is often the most effective strategy for identifying these programs and documenting the work that is being performed with underserved or vulnerable populations.

Lack of Licensure or Certification. Health and human service professions that require licensure or certification to practice have accurate databases maintained by state agencies. For healthcare professionals in Virginia, this is the Department of Health Professions. The required or official collection of professional information helps the Commonwealth assess health professional workforce needs and contributes to health policy development. For CHWs, the lack of formal licensure or certification means that there is no mandated central repository for CHW workforce information. The Virginia Center for Health Outreach is working to fill this role on behalf of CHW programs in Virginia.

Funding. CHW funding comes from various sources including federal, state and local agencies, and private sources such as foundations. This funding has time limits. Most agencies with CHW programs must try to sustain themselves with a patchwork of funding. This results in heavy restrictions on the time-frames, scope and size of programs. Despite the importance of the work performed by CHWs in reaching vulnerable populations, the instability of funding sources often means that there is significant fluctuation in program staffing levels and their effectiveness in meeting the program's mission.

Awareness and Integration. Often there is a lack of integration of CHWs into existing health and human service delivery systems and institutions. This occurs as a result of a lack of awareness of the role of CHWs and the employment CHWs using a title other than community health worker. Where integration does exist, the contributions of the CHW are often not well publicized. For example, until a representative of the Department of Social Services (DSS) participated in the Study Resolution Committee it was not known that there are 2,287 Home-based Care Providers (HCP) or Agency Approved Providers (not referred to as CHWs) working across Virginia through local DSS offices. The HCPs provide transportation, home maintenance, and other activities of daily living.

III. DEVELOPING A STANDARD DESIGNATION FOR VIRGINIA CHWs

Background

In November 2002, the Virginia Center for Health Outreach held the first statewide CHW Conference in Charlottesville. The conference was attended by over 200 CHWs and CHW program supervisors. It was during this conference that after the first day's programming, an outreach worker who had been unfamiliar with the title "community health worker" was overheard proclaiming with pride in her voice that "I am a community health worker"! Perhaps for the first time, this CHW realized that her demanding work was valued by persons who were not her clients and that she indeed was the member of a recognized profession.

The capacity of CHWs to improve access to healthcare, especially for Virginia's most vulnerable populations is great. Supporting this belief are numerous groups, organizations, and programs across Virginia that recognize the value of CHWs and have worked to increase the visibility of the CHW role in health care delivery. This included work by a group of CHW program administrators and CHWs who helped to establish the Virginia Center for Health Outreach at James Madison University in 2001. Despite these commitments, there is recognition that a barrier to maximizing the value of CHWs is that so many CHWs nationally and in Virginia work under a variety of titles. Many outreach workers in Virginia are unfamiliar with the title of "community health worker".

The limited understanding of the CHW role by other health service professionals can sometimes cause CHWs to be pushed beyond their training and, perhaps more significantly, at other times to be underutilized. This can, in part, be traced to the lack of a standard designation for persons performing one or more of the core roles of CHWs.

A Standard Designation for Virginia Community Health Workers

Based upon the work of the Study Resolution Committee, CHWs and CHW program supervisors in Virginia, the following description of CHWs working across Virginia is offered:

A Community Health Worker applies his or her unique understanding of the experience, language and culture of the populations he or she serves to promote healthy living and to help people take greater control over their health and their lives. CHWs are trained to work in a variety of community settings, partnering in the delivery of health and human services to carry out one or more of the following roles:

- ***Providing culturally appropriate health education and information***
- ***Linking people to the services they need***
- ***Providing direct services*, including informal counseling & social support***
- ***Advocating for individual and community needs, including identification of gaps and existing strengths and actively building individual and community capacity***

*Direct services may include providing transportation, purchasing food on behalf of clients, other activities associated with basic needs, taking blood pressures, temperatures, monitoring blood sugar levels, measuring heights and weights, and teaching self-screening measures such as breast self-examinations. Direct services may also include instruction on constructive problem-solving, decision-making and planning.

Methodology for Determining a Standard Designation for Virginia Community Health Workers

The methodology for establishing a standard designation for CHWs was based upon the collection of descriptors of CHW work from other states, organizations and academic institutions (*See Appendix 2 for Chart*) and an inclusive analysis of the descriptors by the Committee, CHWs and CHW program supervisors.

Multiple states and public health organizations have undertaken efforts to develop a working definition of CHWs. Many of these definitions address who a CHW is, what motivates them, what services they offer, who their target populations are, how they reach their clients, what health topics they address, and how they fit into the greater health care delivery system. For instance, New Mexico's definition states that the "strength of CHW service lies in CHWs' cultural sensitivity and personal history with the community." This quality of CHWs resonated with Virginia CHWs. Many Virginia CHWs are members of the communities they serve and this lends itself to CHW qualities of cultural sensitivity and trust. Similarly, the Texas legislature agreed that a CHW is a "person who promotes health within the community in which the person resides." Ohio's CHW definition describes them as "[i]ndividuals who, as community representatives, advocate for individuals and groups in the community by assisting them in accessing community health and supportive resources." This trait was echoed throughout the country, including in Virginia. The majority of state CHW

initiatives emphasized the unique status of CHWs as liaisons and advocates who are trusted by both the community and by health care professionals. *(See Appendix 1 citations)*

The Committee selected a total of six definitions of CHWs that were considered appropriate representations of the diversity and breadth of CHW roles, functions, and populations served. The staff of the Virginia Center for Health Outreach made the six definitions available to its list of CHWs and CHW supervisors across Virginia. Respondents were asked to select the definition of a CHW that they felt most represented the roles and function that they provided. Approximately 150 responses ranking the six definitions were received. Two definitions were clearly ranked higher among the six that were selected.

The Committee then analyzed each of the two definitions that were ranked highest by the respondents. While there were similarities between the two definitions, there were also unique citations in each that the Committee did not wish to discard by merely adopting one or the other. The Committee then began discussing the merits of each definition, combining elements that were felt to be most inclusive of the roles and functions of CHWs while eliminating some elements that would ostensibly create distinctions thereby undermining the exercise of creating a standard description for CHWs.

Finally, the definition offered by the Study Resolution Committee was shared with the over 250 CHWs and CHW program supervisors who attended the third annual CHW Conference held November 16 and 17, 2004 in Richmond. Suggestions made at the conference were incorporated in the final description.

***RECOMMENDATION*. In partnership with the Department of Human Resource Management, James Madison University and the Community Health Worker Study Resolution Committee should review the Direct Services Career Group Description to ensure that Community Health Workers are appropriately identified as a health care support occupation and defined in accordance with the Committee's findings.**

IV. EVALUATING THE EFFICACY OF COMMUNITY HEALTH WORKERS

Background

In order to fully understand and communicate the value and impact that CHWs have on the population they serve and the health and human service delivery system, many organizations conduct evaluations of the CHW programs that provide services. These evaluations are used to demonstrate various aspects of a given program including its procedures, its strengths and weaknesses, its cost-effectiveness, and how it affects individuals and the community where services are delivered. Evaluations are typically performed by the periodic collection of information regarding the activities of CHWs and the social, financial, educational, and physical status of their clients. Most organizations conduct evaluations on an annual basis and are able to determine the impact that CHWs have had over the previous year and compare the recent results to those from the past.

The information collected and analyzed in CHW program evaluations can serve many purposes. Often, evaluations serve as feedback regarding a specific program and assist administrators in determining whether or not programs should be continued, expanded, reduced, or discontinued. Additionally, investors and other stakeholders frequently require that evaluations be conducted to provide a clear picture of how resources are being utilized and to determine whether or not programs utilizing CHWs are cost-effective. Finally, CHW programs can use evaluations as a tool for analyzing their impact on the community and making necessary changes to their individual strategies and techniques.

Two types of evaluations are primarily used for CHWs and their programs - process evaluation and outcome evaluation.

- ***Process evaluations*** analyze how a given program operates and identifies aspects of that program that can be improved. Process evaluation considers what was done, when it was done, who did it, how often it was done, to whom it was done, and how well it was done.[42]

- ***Outcome evaluations*** determine both the short-term and long-term impact and value that a program has had. In the case of CHWs, they often consider the number of individuals enrolled in a given program, the health status of those individuals, and how those individuals have changed over the duration of the program.[43]

Both of these types of evaluations are useful in examining CHWs and CHW programs. Process evaluations are beneficial in providing an overall picture of a program's status and in examining internal strengths and weaknesses related to administration, techniques, personnel, and other aspects of a program. The CHED Program, discussed below, uses a SWOT analysis, which is a process evaluation. Outcome evaluations are beneficial in determining the external strengths and weaknesses of a program, primarily by analyzing the impact and value that a program brings to the community that it serves.

Summary of Existing Evaluation Studies, Nationally and Virginia

Currently, both within Virginia and nationwide, existing health outreach programs conduct annual evaluations to determine the impact and value of their programs within the community. These evaluations are typically comprehensive in nature and analyze the entire program but also include specific information regarding CHWs and their duties and responsibilities. While programs highly value evaluation, many programs, however, cannot or do not perform evaluations due in part to any of the following reasons:

- lack of funding
- lack of resources
- characteristics of the program and its services; or
- characteristics of the population served by the program

Nationally. Many federal outreach programs have conducted nationwide program evaluations that include information about CHWs. In 1998 the NCHA Study, in part assessed CHW evaluation techniques and national trends. The study found that CHWs are aware of the benefits of program evaluations and that the information generated from evaluations is useful to CHWs in modifying their methods and techniques. Additionally, data collected through evaluations can be used to demonstrate to CHWs the value that their services add to the communities that they serve.[44]

For the purposes of this report, two national evaluations were studied. (*See Figure 4*)

Figure 4. Summary of Selected National Evaluation Studies

Program	Evaluation Title	Methodology	Evaluation Type
Early Head Start	Early Head Start Research and Evaluation Project June 2002	Outcome analysis	Outcome
Maternal Child and Health Bureau, DHHS	A Review of Home Visiting Programs	Outcome analysis	Outcome

The Early Head Start Program completed the *Early Head Start Research and Evaluation Project* in June 2002. Early Head Start was designed to enhance children's development and health, strengthen family and community partnerships, and support the staff that delivers services to low-income families. Low-income pregnant women and families with infants and toddlers are the target population for Early Head Start grantees. The program was evaluated by considering health, developmental, and behavioral outcomes. Outcome data was compared to control groups to determine the programs' impacts on child and family outcomes.

This project evaluated seventeen individual programs that represented a wide range of locations, ethnicities, and populations served. One of the program locations included in the study was the Early Head Start program in Alexandria, Virginia. Because the national evaluation project studied global impacts of Early Head Start by combining data from each of the individual programs, the Alexandria location is not specifically discussed in the report. However, its data was included in calculations of outcome measures regarding child cognitive development, child language development, child social-emotional development, parenting behavior, parent's physical and mental health, and family functioning.

The Maternal and Child Health Bureau within the U.S. Department of Health and Human Services (DHHS) conducted a nationwide review of home visiting programs. For purposes of this review, the term "home visiting programs" is used to describe programs nationwide that seek to improve child and parent outcomes by targeting high-risk pregnant women and families with special needs. Specifically, this review examined two types of home visiting programs, the Community Integrated Service System and the Maternal and Child Health Improvement Programs, and the methods through which these programs evaluate their efficacy. On the whole, these programs utilized outcome data related to their specific goals (e.g., cost-effectiveness of services, health status, immunization rates, infant mortality rates) to estimate the impact on the communities that they serve.

The national review included in its review of programs the Healthy Families program in Alexandria, Virginia. It discussed the program's target population (first time pregnant women at risk for child abuse and neglect), the role that CHWs (Family Support Workers) play, the scope of services, and the type of evaluations performed by the program. The statewide Healthy Families program evaluation is discussed in detail below; however, the Alexandria program tracks specific outcomes, including: demographics of enrollees, types of referrals, number of visits, immunization rates, and child development.

As a whole, most national evaluations including information about CHWs can be placed into one of two categories. The first category aims to describe the services that

CHWs provide and to propose changes that would improve the efficiency and efficacy of a given program. The second category utilizes health outcome data to determine the impact of a given program on its community. However, few studies include specific cost-benefit information that would be useful to a program's funding sources. Additionally, many programs lack resources to perform comprehensive evaluations by collecting and storing the necessary data; these programs are evaluated on a more general level. National CHW evaluations could benefit from additional resources to ensure accurate and useful evaluation results.[45]

Virginia. As discussed earlier in this study report, within Virginia, CHWs work for a wide range of programs and reach a variety of populations. Such programs include those addressing infant and child health, family services, women's and reproductive health, breast and cervical cancer early detection, nutrition, smoking prevention, HIV/AIDS, elderly health and respite care, mental health, and substance abuse. These programs serve both males and females and the range of ethnic groups and that comprise Virginia's population. Most programs are delivered through community-based agencies and local health departments, and are funded with federal and state monies. However, approximately one-third of programs are funded by local government agencies, non-profit organizations and private foundations. A majority of programs provide services in homes, communities, schools, and/or public health clinics. CHWs typically provide health promotion, health education, and informal counseling services. Within their programs, CHWs are known by more than fifty different titles, including Family Support Worker, Resource Mother, Outreach Worker, and Family Resource Specialist.[46]

For the purposes of this study report, seventeen organizations across Virginia were contacted to determine the availability of evaluations assessing CHWs. These organizations represented a wide range of locations within Virginia and target various populations. Of these organizations, seven were able to provide recent evaluation data (*See Figure 5*):

- AIDS/HIV Services Group (ASG)
- Community Health Education and Development Program (CHED)
- Comprehensive Health Investment Project (CHIP)
- Community Resilience Project
- Expanded Food and Nutrition Education Program (EFNEP)
- Healthy Families; and
- Resource Mothers.

The **AIDS/HIV Services Group** uses prevention educators to provide HIV/AIDS education and support services to nearly 8,000 individuals in central Virginia. In 2003, these educators worked with individuals in Charlottesville, Waynesboro, and Staunton, and in Albemarle, Fluvanna, Nelson, Greene, Louisa and Buckingham counties. ASG received a substantial federal grant in 2002 which allowed it to expand its education outreach programs and hire additional CHWs to serve as educators. Its education program specifically targets high-risk groups, including minorities, drug users, people under age 25, and gay and bisexual men. As ASG has expanded its education programs, it has evaluated its impact on HIV incidence as compared to statewide data using information gathered by the Virginia Department of Health. In Charlottesville, for example, the number of new cases of HIV dropped from twelve in 2001, to nine in 2002, and to three in 2003. This is ***a 67% decline in incidence, compared to a statewide rate of 20%***. The impact of this reduction is profound when considering the lifetime costs of treating HIV. According the Henry J. Kaiser Family Foundation, the annual costs of treating HIV, including combination antiretroviral medications and additional medical expenses related to care of opportunistic infections is approximately $18,000 to $25,000.[47] Applying this cost across the lifetime of six persons who do not contract HIV would represent a significant cost savings. This does not include costs of productivity lost to the disease and its related costs in the provision of non-medical support services.

The **CHED Program** targets rural counties in Virginia's Middle Peninsula to increase access to and use of existing health care services. This program was initially launched in three counties: Westmoreland, Caroline, and Essex. It was subsequently expanded to Northumberland, Lancaster, and Richmond counties. CHED performed an annual SWOT (strengths, weaknesses, opportunities, threats) analysis through both the developmental and implementation phases of the program, and also gathered data representing demographic information and community screening activities. The SWOT analysis covers program activities, outcomes, community benefits, and administrative aspects of the statewide CHED Program. This analysis was used to communicate recommendations regarding the program's funding, administration, target areas, target populations, and sustainability. Over CHED's three-year implementation phase, the SWOT analysis focused specifically on the program's ability to reach and screen individuals within its community. This analysis identified certain locations that had performed very well (Caroline and Westmoreland counties) and others that had difficulty during implementation (Northumberland, Lancaster, and Richmond counties).

In contrast, the CHED program focuses on a different public health initiative each year, and thus far has focused on screening individuals for high blood pressure and blood sugar levels. Its evaluation included data regarding the number of individuals screened, and their demographic information (age, ethnicity, type of insurance, county of residence). The CHED Program has performed approximately 13,200 health screenings in over 10 localities and 238 home visits since its

implementation. Over 97% of the screenings have been in the adult population with over 50% of the screenings being conducted among minority populations. Because it is a relatively new program, its evaluation focused on ways in which the program could be improved and expanded to other areas of the state and put less emphasis on specific outcome measures.

CHIP of Virginia targets vulnerable children and their families, with the goal of improving children's health and promoting wellness. This program supports a network of eleven community-based home visiting programs in the following localities and regions: Arlington, Greater Richmond, Greater Williamsburg, Norfolk, Chesapeake, Portsmouth, Petersburg, Jefferson Area, Roanoke Valley, New River Valley, and Southwest Virginia. CHIP offers four categories of services: screening, assessment, and planning; education and support; follow-up; and referral and outreach.

CHIP collects data from enrollees every twelve months and monitors changes over time in child health and family self-sufficiency outcomes. The report provides one year outcomes for the program's enrollees and emphasizes changes in child and family outcomes over time. For example, after one year, the employment rate among mothers increased from 23% to 33%, and the number of mothers with a family planning method increased from 54% to 68%. Additionally, the number of children enrolled in Medicaid and/or FAMIS Plus increased from 70% to 81%. Furthermore, pregnant women who enrolled in CHIP at least four months before giving birth were less likely to give birth prematurely (18.7% as compared to 8.3%) and to have a low birth weight baby (17.8% as compared to 7.0%).

The Community Resilience Project began in the aftermath of September 11 with the purpose of providing crisis counseling services to and promoting emotional healing and resilience among individuals affected by September 11 and other threatening situations. This project focused specifically on individuals in the Northern Virginia region. Program counselors provide outreach, individual counseling, referrals, education, and community counseling. To evaluate its impact, the Project conducted phone and mail interviews with adult counseling participants, community organizations that worked with the Project and individuals who staffed the Project. The evaluation includes comments and anecdotes from these conversations and data regarding certain questions that were asked of each interviewee.

Expanded Foods & Nutrition Education Program (EFNEP) is a program that focuses on nutrition education, and attempts to provide individuals with knowledge, skills, attitudes, and behaviors essential to a nutritionally sound diet. Virginia EFNEP operates in 26 counties and cities throughout the state, seven of which are urban and 19 are primarily rural. The program targets low-income families with young children and low-income youth and follows a nationally developed food and nutrition education curriculum called "Eating Right is Basic." EFNEP evaluated its impact using a cost-

benefit analysis in which the benefits included positive health outcomes, improved self-image, and improved quality of life Costs included personnel, equipment, travel, and training. The program's economic efficiency over one year was calculated through a cost-benefit ratio comparing the amount of money spent on the program to the potential savings from the program. The analysis determined that in 1996, the Virginia program resulted in benefits totaling $18,223,980 and costs totaling $1,713,081. Therefore, the program had a benefit to cost ratio of $10.64 to $1.00, and an internal rate of return of 16.41%.

Healthy Families provides home visiting services to families in Virginia and has an overall goal of reducing risk factors for child abuse and neglect by positively impacting pregnancy outcomes, child health, parenting practices, and child development. Healthy Families (HF) collects outcome data from its clients using a standardized database and compares this data to statewide outcome goals and objectives. The most recent evaluation report included information from 34 HF sites throughout Virginia. Twenty-five (25) of these sites use the database to collect and store data while eight sites use alternate evaluation methods.

The outcomes measured represent the following areas: child health, maternal health, child development, parenting and home environment, and child abuse and neglect. Because the program targets children and families, its evaluation includes child health outcome measures and specifically utilizes inputs related to these outcomes. For example, the Healthy Families Virginia Statewide Report focused on infant and child health outcomes, and found that, among program enrollees, 88% of babies were within the healthy birth weight range, as compared to the 77% statewide rate. Additionally, 85% of the children enrolled in programs received all of their scheduled immunizations, while the Virginia average was only 64.8%. The child abuse and neglect rate among families enrolled in Healthy Families program is .97% (<1%) while the child abuse and neglect rate among families with characteristics similar to families enrolled in HF is 4.7%. Another outcome goal of HF programs is reducing subsequent births among teenage mothers enrolled in programs. Approximately 94% of teenage mothers did not have additional births for at least two years after enrolling in the program.

Additionally, Healthy Families has developed four critical program elements: screening, assessment, enrollment, and engagement. The number of individuals reached by each of these elements is collected, analyzed, and compared to data from the previous year. For example, the state of Virginia has set annual goals or criteria for specific health outcomes, and Healthy Families aims to meet or surpass each state criterion. Virginia's criteria regarding child development include the goal to screen 90% of participating children semiannually for the first three years, and annually thereafter. In 2003, the rate of Healthy Families sites meeting or exceeding this criterion was 14% greater than in 2002 and 26% greater than in 2001.

Resource Mothers is a program directed at teenage parents focusing on enhanced birth outcomes, promotion of a stable home environment, and establishing connections to existing support services within the community. Resource Mothers collects data regarding birth outcomes, subsequent pregnancies, and visits and support sessions within the program. This data is compared to statewide averages each year in order to evaluate the direct impact of the program on Virginia residents. In 2004, teenage participants in Resource Mothers had a repeat pregnancy rate of 6.1%, significantly lower than the state average of 20%. The low birth weight rate among Resource Mothers participants was 9.03 (2004) per 1000 live births, while the statewide rate was 10.6 (2002) per 1000 live births. The Resource Mothers report included information from 25 sites serving 87 localities throughout Virginia. Of these sites, 19 are overseen by health district offices and seven by private contractors.

Figure 5. Summary of Existing Virginia Evaluation Studies

Program	Evaluation Title	Methodology	Evaluation Type
AIDS/HIV Services Group	2003-2004 fiscal year data	Outcome analysis	Outcome
CHED	CHED Program Evaluation 1998-2004	SWOT analysis	Process
CHIP	CHIP Program Evaluation – Summary and Outcomes 2004	Outcome analysis	Outcome
Community Resilience Project	Evaluation of the Community Resilience Project December 2003	Interviews to evaluate efficacy	Process
EFNEP	Cost Benefit Analysis of Nutrition Education Programs March 1999	Cost Benefit analysis	Outcome
Healthy Families	Healthy Families Virginia Statewide Evaluation Report 2000-2003	Outcome analysis utilizing PIMS	Outcome
Resource Mothers	Virginia Resource Mothers Program Annual Report 2003	Outcome analysis	Outcome

As a whole, these seven programs are indicative of the variety of methods that can be used to evaluate CHWs working in Virginia. The precise methodology used by a program in its evaluations is dependent on a number of factors. Within Virginia, each program's location, major goals, and client base is different. While all of the programs discussed above target low-income individuals, each program's evaluation reflects the unique aspects of that program and the diversity in the roles that CHWs play across the state.

The Challenge of Evaluating CHW Programs

Although each CHW program operates somewhat differently, there are general challenges to evaluating CHWs that would likely impact any program attempting to conduct an evaluation. These challenges stem from the following reasons:

- lack of funding
- lack of resources
- characteristics of the program and its services; or
- characteristics of the population served by the program

Lack of funding. Many programs that employ CHWs lack sufficient funding to develop and implement an accurate evaluation program. Numerous programs within Virginia that do not have formal evaluations still collect data from or about CHWs and their impact on the community. However, these programs are not able to analyze and store data in a manner that makes evaluations possible because they do not have the funding to afford the computer hardware or software technology that makes storage and retrieval efficient or they can not afford the technical assistance of evaluators.

Lack of resources. Many programs that utilize the services of CHWs are limited in the amount of personnel that they can hire. Individuals who are employed by the programs devote a majority of their time and energy to providing necessary services within the community and rarely have additional time to collect, analyze, and store data necessary to appropriately evaluate the program. Furthermore, many programs do not have the capability to sufficiently train their employees to conduct and prepare evaluation reports.

Characteristics of the program and its services. Many of the services that CHWs provide to their clients are not quantifiable and the impact of these services is not easily measured or recorded. Additionally, CHWs offer many intangible benefits to their clients, specifically through education and counseling. These benefits indirectly improve overall health outcomes but are not apparent as benefits themselves. For example, a CHW might help a mother obtain a GED or might assist in the enrollment of a child in the Virginia's child health insurance program (FAMIS). If these specific outcomes are not evaluated, the relationship between a child having health insurance and an improvement in that child's health would not necessarily be identified.

Furthermore, long-term health benefits might not be realized in an evaluation that measures outcomes every twelve months. For example, a CHW might work to introduce a family to the health care system by finding a primary care physician for a child and scheduling an introductory visit. In the long-term, this child will benefit from many additional services that he or she would not have received otherwise; however, over twelve months this impact might not be immediately evident in outcome data.

Finally, some programs might not have specific goals or access to baseline health data. Baseline health data establishes a foundation from which health outcomes can be evaluated. Very new programs or those programs that lack structure and organization often do not delineate program goals, target populations, or desired outcomes. In these programs, data cannot be collected because there is no guidance as to what type of information is necessary to evaluate the program. Additionally, very new programs, even those with defined goals, do not have data from prior years where outcomes can be compared. Some new programs will instead compare their outcomes to national or state-wide trends, but such a comparison does not depict CHWs' impact as precisely as does data over a longer period of time.

Characteristics of the population served by the program. Individuals who receive services provided by CHWs are often a transient population and enter or leave programs due to changes in location, employment, financial status, or family status. Evaluations require that information be collected over a significant period of time in order to determine the actual impact. It is very challenging to evaluate the impact of CHWs who routinely gain and lose clients, as the long-term benefits to these clients can not be analyzed.

VI. PROPOSED OVERVIEW OF YEAR TWO OF STUDY

James Madison University, in collaboration with the Study Resolution Committee, requests the opportunity to address the remaining directives outlined in HJR 195 in a report to be submitted to the Governor and the General Assembly no later than the first day of the 2006 Session of the Virginia General Assembly.

In conducting the second year of the study, the University shall (i) inventory the training of community health workers employed in the Commonwealth; (ii) determine ways to elevate the role of community health workers in the health care delivery system and to integrate more effectively such workers in public agencies; (iii) examine the potential use of community health workers as part of a best-practice quality measure for Medicaid and other contracted providers; (iv) explore the development of a statewide core curriculum that would be used for the training of publicly employed community health workers and be available for volunteer workers; and (v) recommend any other steps to maximize the value and utilization of community health workers.

FOOTNOTES

Executive Summary and Recommendations

1. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adult and Community Health. *Community Health Advisors/Workers, Selected Annotations and Programs in the United States, Volume III*, at xiv (1998).

2. S.A. Brown and C.L. Hanis, *A Community-Based, Culturally Sensitive Education & Group-Support Intervention for Mexican Americans with NIDDM: A Pilot Study of Efficacy*, 21(3) The Diabetes Educator 203 (May – June 1995).

3. University of Arizona, *The Final Report of the National Community Health Advisor Study*, 27-28 (1998).

4. *Id*. at 11-14.

5. Joint Legislative Audit & Review Commission. *Acclimation of Virginia's Foreign-Born Population: House Document No.9*, at 33 (2004).; *see also* L.R. Bone et al., *Emergency Department Detection & Follow-up of High Blood Pressure: Use & Effectiveness of Community Health Workers*,7(1) Am. J. Emer. Med. 16 (1989).; J.F.C. Fund et al., *Effect of a Cancer Screening Intervention Conducted by Lay Health Workers Among Inner-City Women*, 13(1) Am. J. Prev. Med. S51-57 (1997).; D.O. Fedder et al., *The Effectiveness of a Community Health Worker Outreach Program on Healthcare Utilization of West Baltimore City Medicaid Patients with Diabetes, With or Without Hypertension*, 13 Ethnicity & Disease 22 (Winter 2003).; D.L. Olds et al., *Long-Term Effects of Home Visitation on Maternal Life Course & Child Abuse and Neglect: Fifteen Year Follow-up of a Randomized Trial*, 278(8) J. Am. Med. Assoc. 637 (1997).

6. *Acclimation of Virginia's Foreign-Born Population*, *supra* note 5 at 33.

7. *Id*. at 16.

8. *The Final Report of the National Community Health Advisor Study*, *supra* note 3, at 27-28.

9. CHIP is a non-profit organization with eleven regional sites across Virginia; See *also* P.A. Boelens et al., *An Approach to Reducing Infant Mortality Rate Through the Utilization of Lay Home Visitors*, 37(10) J. Miss. State Med. Assoc. 379 (1999); H. Kitzman et al., *Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries, and Repeated Childbearing, A Randomized Controlled Trial*, 278(8) J. Am. Med. Assoc. 644 (1997); C. Barnes-Boyd et al., *Promoting Infant Health Through Home Visiting by a Nurse-Managed Community Worker Team*, 18(4) Public Health Nursing 225 (2001).; M. L. Poland et al., *Development of a Paraprofessional Home Visiting Program for Low-Income Mothers and Infants*, 7(4) Am. J. Prev. Med. 204 (1991).

10. *The Final Report of the National Community Health Advisor Study*, *supra* note 3, at 29.

11. *Id*.

12. Erica Goode, *Minorities are Lacking Mental Health Care, Study Says*, Kansas City.Com, Nov. 8, 2004, *at* http://kcstar.com/item/pages/printer.pat,local/3accecdb.826.html.

13. *Id*.

14. *The Final Report of the National Community Health Advisor Study*, *supra* note 3, at 32-34.

15. Virginia Center for Health Outreach at James Madison University, *Grant Application for Special Initiative Funding submitted to the Office of Rural Health Policy, Health Resources Services Administration, Department of Health and Human Services* 1 (2001).

16. *The Final Report of the National Community Health Advisor Study*, *supra* note 3, at 51-52.

17. *Id*.

II. BACKGROUND ON COMMUNITY HEALTH WORKERS

1. National Center for Primary Care, Morehouse School of Medicine. *Community Health Workers & Community Voices: Promoting Good Health at* 2 (2004) [hereinafter *Community Health Workers & Community Voices Promoting Good Health*].

2. The Center for the Health Professions, University of California, San Francisco, *Community Health Workers and Promotores in California* at 2 (2004).

3. *Id*.

4. A. Witmer et al., *Community Health Workers: Integral Members of the Health Care Work Force*, 85(8) *Am. J. Pub. Health* 1055 (1995).

5. University of Arizona, *The Final Report of the National Community Health Advisor Study* at 86 (1998) [hereinafter *Final Report of the National Community Health Advisor Study*].

6. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adult and Community Health, *Community Health Advisors/Workers, Selected Annotations and Programs in the United States, Volume III* at xiv (1998).

7. *Id*. at 243-244; S. A. Brown and C. L. Hanis, *A Community-Based, Culturally Sensitive Education & Group-Support Intervention for Mexican Americans with NIDDM: A Pilot Study of Efficacy*, 21(3) The Diabetes Educator 203 (May-June 1995).

8. *Final Report of the National Community Health Advisor Study*, at 79.

9. *Id, supra* note 5.

10. *Id*. at 11-14.

11. *Id*. at 11.

12. *Id*. at 15-17.

13. *The Final Report of The National Community Health Advisor Study*, *supra* note 5, at 25-26.

14. Joint Legislative Audit & Review Commission, *Acclimation of Virginia's Foreign-Born Population: House Document No.9*, at 33 (2004) [hereinafter *Acclimation of Virginia's Foreign-Born Population*].

15. *Id*. at 12.

16. The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, *How Race/Ethnicity, Immigration Status & Language Affect Health Insurance Coverage, Access to Care and Quality of Care Among the Low-Income Population* 5 (2003).

17. Institute of Medicine, *Unequal Treatment: Confronting Racial & Ethnic Disparities in Health Care.* (2002); *see also* R. Stein, *Panel Urges Health Care Coverage for All by 2010*, Washington Post, Jan. 15, 2004, at A2; M. A. Bobinski, *Inequities in Healthcare: Health Disparities and the Law: Wrongs in Search of a Right*, 29 Am. J. Law & Med. 363 (2003).

18. J. C. Gerber and D. L. Stewart, *Prevention and Control of Hypertension and Diabetes in an Underserved Population Through Community Outreach and Disease Management: A Plan of Action*, 9(3) J. Assoc. Acad. Minority Phys. 48 (1998).

19. *see Acclimation of Virginia's Foreign-Born Population*, *supra* note 13; *see also* L.R. Bone et al., *Emergency Department Detection & Follow-up of High Blood Pressure: Use & Effectiveness of Community Health Workers*, 7(1) Am. J. Emer. Med. 16 (1989).; J. F. C. Fund et al., *Effect of a Cancer Screening Intervention Conducted by Lay Health Workers Among Inner-City Women*, 13(1) Am. J. Prev. Med. S51-57 (1997).; D. O. Fedder et al., *The Effectiveness of a Community Health Worker Outreach Program on Healthcare Utilization of West Baltimore City Medicaid Patients with Diabetes, With or Without Hypertension*, 13 Ethnicity & Disease 22 (Winter 2003).; D. L. Olds et al., *Long-Term Effects of Home Visitation on Maternal Life Course & Child Abuse and Neglect: Fifteen Year Follow-up of a Randomized Trial*, 278(8) J. Am. Med. Assoc. 637 (1997).

20. *see* Gerber, *supra* note 17, at 48-52.

21. *see Acclimation of Virginia's Foreign-Born Population*, *supra* note 13, at 83.

22. *Id*.

23. *Id*.

24. Joint Legislative Audit and Review Commission, *Review of the Performance and Management of the Virginia Department of Health at* http://jlarc.state.va.us Summary/ Rpt244/ vdhstudy.htm 244.

25. *Id*. (Four out of ten people at high risk for tuberculosis do not complete medicines as prescribed; immunization rates are low in certain parts of VA, 30% of local health departments do not track immunization outcomes and 20% have no programs to contact un-immunized children.)

26. *Final Report of the National Community Health Advisor Study*, *supra* note 5, at 27-28.

27. *Id*.

28. *Community Health Workers & Community Voices Promoting Good Health*, *supra* note 1, at 12-13.

29. *Id*.

30. *Id*; *see also* D. L. Montgomery and P. L. Splett, Economic *Benefit of Breast-Feeding Infants Enrolled in WIC*, 4 J. Am. Dietetic Assoc. 379 (April 1997).

31. P.A. Boelens et al., *An Approach to Reducing Infant Mortality Rate Through the Utilization of Lay Home Visitors*, 37(10) J. Miss. State Med. Assoc. 379 (1999); H. Kitzman et al., *Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries, and Repeated Childbearing, A Randomized Controlled Trial*, 278(8) J. Am. Med. Assoc. 644 (1997); C. Barnes-Boyd et al., *Promoting Infant Health Through Home Visiting by a Nurse-Managed Community Worker Team*, 18(4) Public Health Nursing 225 (2001).; M. L. Poland et al., *Development of a Paraprofessional Home Visiting Program for Low-Income Mothers and Infants*, 7(4) Am. J. Prev. Med. 204 (1991).

32. *Id*.

33. *Final Report of the National Community Health Advisor Study*, *supra* note 5, at 29.

34. *Id*.

35. Erica Goode, *Minorities are Lacking Mental Health Care, Study Says*, Kansas City.Com, Nov. 8, 2004, *at* http://kcstar.com/item/pages/printer.pat,local/3accecdb.826.html.

36. *Id*.

37. *Id*.

38. *Final Report of the National Community Health Advisor Study*, *supra* note 5, at 32.

39. *Id*. at 32-34.

40. *Community Health Workers & Community Voices Promoting Good Health*, *supra* note 1, at 11.

III. INVENTORYING CHW PROGRAMS IN VIRGINIA: STATUS AND CHALLENGES

41. Virginia Center for Health Outreach at James Madison University, *Grant Application for Special Initiative Funding submitted to the Office of Rural Health Policy*, *Health Resources Services Administration*, *Department of Health and Human Services* at 1 (2001).

IV. EVALUATING THE EFFICACY OF COMMUNITY HEALTH WORKERS

42. *Final Report of the National Community Health Advisor Study*, *supra* note 5, at 51-52.

43. *Id*.

44. *Id*.

45. The Lewin Group, Inc., *Literature Review of Research Studies and Evaluations of Community Health Workers* (2001).

46. Virginia Center for Health Outreach at James Madison University, *Community Health Advisor/Worker Program Survey* at 3 (2002).

47. The Henry J. Kaiser Family Foundation, *Financing HIV/AIDS Care: A Quilt With Many Holes*, *HIV/AIDS Policy Issue Brief*; *at* http://www.kff.org/hivaids/1607-02.cfm (accessed Nov. 30, 2004).

APPENDIX 1.
AUTHORITY FOR THE STUDY

HOUSE JOINT RESOLUTION NO. 195

Requesting James Madison University to study the status, impact, and utilization of community health workers. Report.

Agreed to by the House of Delegates, February 17, 2004

Agreed to by the Senate, March 9, 2004

WHEREAS, community health workers are trained lay persons who, as trusted members of their communities, serve as health resource persons where they live and work, implementing culturally appropriate health education and outreach among groups that have traditionally lacked adequate health care; and

WHEREAS, community health care workers (known as home visitors, lay health outreach workers, peer health promoters, family support workers, and *promotoras*), help shape health care from the bottom up at the community level where needs exist and where real and lasting changes can occur; and

WHEREAS, community health workers, whether paid or volunteer, are an essential component of community wellness, promoting healthy practices and removing barriers to primary and preventive care; and

WHEREAS, Healthy Virginians 2010 calls for an increase in the quality of life, life expectancy, and the elimination of health disparities among different segments of the population; and

WHEREAS, 220 state, federal, local and private programs in the Commonwealth already use community health workers to address 21 of the 22 goals of Healthy Virginians 2010; and

WHEREAS, utilization of community health workers is an efficient and effective means of addressing the health and social service needs of people and communities and improves community health care by bridging socio-cultural barriers between vulnerable and underserved community members and health care systems; and

WHEREAS, the Commonwealth's communities are undergoing cultural change as new populations become residents; and

WHEREAS, providing culturally appropriate health care access, education, and information is necessary to ensure health as a right promised by the Constitution of Virginia, including "the enjoyment of life and liberty" and "pursuing and obtaining happiness and safety"; and

WHEREAS, community health workers constitute a viable, cost-effective support to health care in an era of decreasing federal and state funds and maximize state and federal resources if integrated into a public agency; and

WHEREAS, federal Medicaid regulations require appropriate outreach, enrollment, and translation/interpreter services, which means additional federal funding is available for the use of increased community health worker services; and

WHEREAS, the current state and federal Medicaid and health care crises will, without new resources, result in reduced availability of many services; and the utilization of culturally and linguistically appropriate care management through community health workers can serve as a best-practice quality measure in contract compliance; and

WHEREAS, the cost-benefit ratio of health care in today's economic climate favors the prevention and paraprofessional work of community health workers; and

WHEREAS, factors such as unstable funding, professional misperceptions of the role of community health workers, and the lack of standard community health worker identity, training, and documentation of impact contribute to the underutilization, attrition, and misunderstanding of community health workers, and increase program costs; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That James Madison University be requested to study the status, impact, and utilization of community health workers. The University shall seek participants from the Department of Medical Assistance Services, the Department of Social Services, the Child Health Investment Program, Healthy Families Virginia, the Expanded Food and Nutrition Education Program, the Smart Choices Nutrition Education Program, the Northern Virginia Area Health Education Center, George Mason University, and the Virginia Center for Health Outreach to assist in the conducting of this study.

In conducting its study, the University shall (i) inventory the number, roles, and training of all community health workers employed in the Commonwealth and explore a standard designation for such workers; (ii) identify and review outcome studies and evaluations on the efficacy of community health workers; (iii) determine ways to elevate the role of community health workers in the health care delivery system and to integrate more effectively such workers in public agencies; (iv) examine the potential use of community health workers as part of a best-practice quality measure for Medicaid and other contracted providers; (v) explore the development of a statewide core curriculum that would be used for the training of publicly employed community health workers and be available for volunteer workers; and (vi) recommend any other steps to maximize the value and utilization of community health workers.

All agencies of the Commonwealth shall provide assistance to the University for this study, upon request.

James Madison University shall complete its meetings for the first year by November 30, 2004, and for the second year by November 30, 2005, and the University shall submit to the Governor and the General Assembly an executive summary and report of its findings and recommendations for publication as a document for each year. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports no later than the first day of the next Regular Session of the General Assembly and shall be posted on the General Assembly's website.

APPENDIX 2
VARIOUS DEFINITIONS AND DESCRIPTIONS OF COMMUNITY HEALTH WORKERS

SOURCE	DEFINITION ROLES	MAIN TITLE USED	OTHER TITLES RECOGNIZED
Legislation			
Senate Joint Memorandum 076 CHA Program in New Mexico	A member of the community who works in community settings and serves as a connector between healthcare consumers and providers to promote health among groups that have traditionally lacked access to adequate care. The strength of CHW service lies in CHWs' cultural sensitivity and personal history with the community.	CHW	Community health advocate, promotoras, community health promoters, community advocates, outreach educators, doulas, peer health promoters, community health representatives.
CHW Act of 2002	Individuals who promote health or nutrition within the communities in which they reside by serving as a liaison between communities and health care agencies; providing guidance and social assistance to community residents; enhancing community residents' ability to effectively communicate with health care providers; providing culturally and linguistically appropriate health or nutrition education; advocating for individual and community health or nutrition needs; and providing referral and follow up services.	CHW	

Reports

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care	Witmer: Community members who work almost exclusively in community settings and who serve as connectors between healthcare consumers and providers to promote health among groups that have traditionally lacked access to adequate care. One of the greatest assets of lay health programs is that they build on the strengths of community ties to help improve outcomes for its citizens.	CHW, Lay Health Worker	Lay health advisors, neighborhood workers, indigenous health workers, health aide, consejera, promotora.
	Roles: Lay workers can facilitate community participation in the health system, serve as liaisons between patients and providers, educate providers about community needs and the culture of the community, provide patient education, assist in appointment attendance and adherence to medication regimens, and help to increase the use of preventive and primary care services.		
APHA Policy Statement 10/2001 http://www.chwnetwork.org/page15.html	Recognizes that there is no standard definition and this is a problem. Urges CHWs to develop a definition. "Due in part to their status as members of the community in which they work, CHWs effectively bridge sociocultural barriers between community members and the health care system."	CHW	Lay Health Advocate, Promotor(a), Outreach Educator, Community Health Representative, Peer Health Promoter, Community Health Outreach Worker
	Seven core roles: cultural mediation, provide culturally appropriate health education and information, assuring people get needed services, support and counseling, advocacy, provide basic services, and capacity building		

American Association of Diabetes Educators Position Statement http://www.aadenet.org/PublicAffairs/PositionStatements/Community%20Health%20Workers.pdf	Witmer: Community members who work almost exclusively in community settings and who serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate health care. DCHW: community members who work as bridges between their ethnic, cultural or geographic communities and health care providers to help their neighbors prevent diabetes and its complications through self-care management and social support, including community engagement.	Diabetes community health workers	Community health advocates, lay health educators, community health representatives, peer health promoters, community health outreach workers, promotores de salud.
CDC Division of Diabetes Translation http://www.cdc.gov/diabetes/projects/comm.htm	Witmer: See above Plus: One of the most important features of CHW programs is that they strengthen already existing community network ties. CHWs are uniquely qualified as connectors because they live in the communities in which they work, understand what is meaningful to those communities, communicate in the language of the people, and recognize and incorporate cultural buffers to help community members cope with stress and promote health outcomes.	CHWs and Promotores de salud	See above
Promoting Good Health http://www.communityvoices.org/Uploads/CHW_FINAL_00108_00042.pdf	Witmer: see above. CHWs are employed in diverse health care settings, including community-based organizations, insurance companies, hospitals, and health departments. They come from the same underserved neighborhoods and share the same cultural experiences as the people they serve, thus bridging the gap between health care agencies and local communities.	CHW	

	In US, CHWs are part of a growing field of social and human service assistants, that is, paraprofessionals who support health and social service providers by assisting individuals, families, and communities to access and receive health and social services. A CHW may have many different titles, but without a doubt s/he has a reputation in her/his community for being respectful, trustworthy, good at listening, responsive to the needs of others, and in control of her/his own life circumstances.		
Report on the Feasibility of Voluntary Training and Certification of Promotores(as) http://www.tdh.state.tx.us/ppdc/freport.pdf	Final Report of CHA Study: A person who, with or without compensation: provides cultural mediation between communities and health and human service system; informal counseling and social support; and culturally and linguistically appropriate health education; advocates for individual and community health needs; assures people get the health services they need; builds individual and community capacity; or provides referral and follow-up services. CHWs flourish in a variety of settings, including non-profit organizations, university programs, health clinics, local health departments, and faith congregations.	Promotor(a) and CHW	

Community-Campus Partnerships & Community Health Worker Initiatives (this is also on the CSHO website)	"An individual that is indigenous to his/her community and agrees to be a link between community members and the service delivery system." Service C., Salber E. (eds.): *Community Health Education: The Lay Health Advisor Approach*. Durham, NC, Duke University Health Care System, 1979.	Community Health Advisor	Lay Health Advisor Lay Health Worker
Developing a Research Agenda for Cultural Competence in Health Care: Community Health Workers http://www.diversityrx.org/HTML/RCPROJ_D.htm	*Community health workers (CHWs)* are typically members of a particular community whose task is to assist in improving the health of that community in cooperation with the health care system or public health agencies. The literature suggests that community health workers can work as agents of change by providing a variety of services including: outreach to underserved and hard to reach populations, health promotion/disease prevention educational instruction, patient tracking, needs assessment and the provision of follow-up services, patient advocacy and assistance, and in some instances limited health care services.	CHW	Community health advocate, neighborhood worker, indigenous health worker, lay health adviser/worker, consejera, promotora, outreach workers, liaison
WHO - Programme for the Control of Acute Respiratory Infections 1992. Teacher's Guide for a course for CHWs. http://www.who.int/child-adolescent-health/New_Publications/CHILD_HEALTH/Cough/teaguide.htm	CHWs usually are members of the community where they work, are selected by the communities, are answerable to the communities for their activities, are supported by the health system but not necessarily as part of its organization, and have a shorter training than professional workers. Characteristics: They spend most of their time in the community; they have comparatively little formal training in health care; they have some ability to read and write but generally not at a level where the training can be from written materials.	CHW	Village health worker, village aide, community health agent, community health guide, family welfare educator and barangay health worker

Report of the WHO/UNAIDS International Consensus Meeting on Technical and Operational Recommendations for Emergency Scaling-up of Antiretroviral Therapy in Resource-Limited Settings, 18.21 November 2003, Lusaka, Zambia	A trained health worker who lives within the community and works with other health and development workers as a team. This person often provides the first contact between an individual and the health system.	CHW	
	Types of community health workers vary between countries and communities, according to needs and available resources. In many societies, community health workers come from and are chosen by the communities where they work. Sometimes they work as volunteers; normally those who work part or full-time are rewarded, in cash or in kind by the community and the formal health services.		
Community Health Workers: Who they are and what they do. A report of The Community Health Worker Training Program http://www.communityhealthworks.org/chtdc_emerge1.html	Working mainly with underserved communities, these health workers serve in a variety of capacities, from functioning informally as volunteers, to having more formal roles as front line health care professionals. Also recognizes Witmer definition.	CHW	Community Health Worker (CHW), Lay Health Advisor (LHA), Community Health Representative (CHR) and Public Health Aide (PHA).
	There is not an agreed-upon set of skills for these health workers nor is there a clear definition of their role. Serving as "culture brokers" between their community and the health care system, they are indigenous to the community in which they work--ethnically, linguistically, socio-economically, and experientially. This "insider" orientation provides these workers with a unique understanding of the culture and strength of the community they serve. Because they are trusted they can serve as effective conduits of information, resources, services and advice on how to access those services. If respected as members of the health care team, these frontline workers can play an invaluable role in delivering culturally appropriate cost effective health care.		

Past Unity Presentation (National Conference for Community Health Workers)	An individual who demonstrates capacity to carry out the authorized program services; has resided for at least one year in the community in which the CHW program involved is to be operated; and is a member of a socioeconomic group to be served by the program.	Community Health Advisor	
	Responsibilities: Outreach services, public education/ health promotion and disease prevention, assistance in utilizing services, and other services determined by the Secretary of the Department of Health and Human Services.		

Government Agencies

Department of Health http://www.doh.gov.ph/cvhw/index.asp?cat_id=6&topic_id=2	A Community Health Worker is a Community Organizer-Educator-Health Care-Provider.	CHW	
	PRACTICE in organizing and mobilizing the community towards self - reliance. MAINTAIN regular contact with the community leaders and the health team. PROVIDE a linkage between the community and local agencies. ENCOURAGE the community to develop a health plan and to take their health and well-being. HELP the members of the community to understand and act on their own problems. KEEP the records of the work events happening in the community. DEVELOP appropriate knowledge and skills to promote local involvement. RESPECT the people's traditions and ideas, including their health habits and practices but remain firm in correcting unhealthy ones (traditions, habits and practices).		

Massachusetts Department of Public Health	A Community Health Worker (CHW) is a public health outreach professional who applies his or her unique understanding of the experience, language and/or culture of the populations he or she serves in order to carry out at least one of the following roles: bridging/culturally mediating between individuals, communities and health and human services, including actively building individual and community capacity; providing culturally appropriate health education and information; assuring that people get the services they need; providing direct services, including informal counseling and social support; and advocating for individual and community needs.	CHW	