



The State of the Community Health Worker Field in Minnesota

A Report by the Minnesota Community Health Worker Alliance

December 2018

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Acronyms and Abbreviations Guide

ACA	Patient Protection and Affordable Care Act
ACO	Accountable Care Organization
Alliance	Minnesota Community Health Worker Alliance
C3	Community Health Worker Core Consensus Project
CDC	Centers for Disease Control (and Prevention)
CHW	Community Health Worker
CMMI	Centers for Medicare and Medicaid Innovation
CMS	Center for Medicare and Medicaid Services
CWG	Community Wellness Grant (Minnesota's CDC 1422 grant program)
DHS	Minnesota Department of Human Services (state Medicaid agency)
DSRIP	Delivery System Reform Incentive Payment Program
FQHC	Federally-Qualified Health Center
HR-US	HealthRise United States (Medtronic Foundation grant program)
IHP	Integrated Health Partnership (Medicaid ACO in Minnesota)
MA	Medical Assistance (Medicaid in Minnesota)
MDH	Minnesota Department of Health
MHCP	Minnesota Health Care Programs (MA and MinnesotaCare)
Minn State	Minnesota State University System
RCT	Randomized Controlled Trial
ROI	Return on Investment
SOP	Scope of Practice
SPA	State Plan Amendment

Introduction

“This is an ‘opportunity moment’ for community health worker programs.”

**– Jill Feldstein, MPA
Penn Center for CHWs**

The State of the Community Health Worker Field in Minnesota report provides a descriptive overview of the field within the broader context of national trends and developments. Commissioned by the Minnesota Department of Health (MDH), the report is prepared by the Minnesota Community Health Worker Alliance (the Alliance) as a resource for community health workers (CHWs), CHW employers and educators, policymakers, payors, and others interested in the progress, opportunities, challenges, and next stage work associated with the advancement of the CHW workforce and its benefits to Minnesota’s diverse communities. The report reflects the input from key informant interviews with state and national CHW experts from the CHW field, public health, education, and human services.

This report is organized around seven interrelated components that provide a comprehensive view of this emerging health profession with deep community roots:

- CHW Definition, Roles, and Competencies
- CHW Education and Training
- Models and Team-based Care (including recruitment, hiring, and supervision)
- Impact and Evidence
- Sustainability
- Occupational Regulation
- Leadership and Advocacy

While progress and next-stage work are identified in each of these key areas, critical cross-cutting needs are evident. Data on Minnesota’s CHW workforce and its impacts are needed as well as funding to build and organize the field for greater capacity and advocacy to achieve policy and sustainability improvements.

The following recommendations provide the framework for a field-wide strategic plan. With guidance by the Alliance, this road map will set priorities for action and serve to unify, coordinate, and accelerate field-building efforts. Coalition-building will be imperative to achieve some goals such as CHW certification. In other areas such as interprofessional relations, engaged individuals and organizations can step up to take on specific components with overall CHW leadership and voice.

We welcome your feedback on this report and your participation in the ongoing work of the Alliance. Please contact us at info@mnychwalliance.org to share or request information.

“The outlook for the CHW field in Minnesota is positive—and that’s critical to successfully tackling persistent yet preventable health inequities in our state. We have strong foundational education for CHWs. We’re making progress towards CHW sustainability. We’re launching exciting new work to build the CHW evidence base in our state and link it with national efforts. We’re exploring an inclusive CHW certification process to strengthen the field and fill in gaps. And importantly, we have a growing cadre of passionate CHW leaders who are eager to partner and shape the future of the field at the state and national level.”

**– LaTanya Black, CHW
Community Engagement Consultant
Minnesota CHW Alliance**

State of the Field Overview

Here is a summary of key points detailed in the subsequent sections of the report.

Field-building Component	Status	Next Steps
Awareness of CHW Roles & Skills	Growing awareness of role and impact among health care and public health providers	Build awareness of role, scope of practice and benefits among key audiences; promote interprofessional education and outreach through partnerships
Education & Training	Strong base with statewide standardized competency-based curriculum and new continuing education modules under development	Update core curriculum, develop priorities and guidelines for continuing ed; promote sharing of workforce development tools and CHW supervisor training & support
Models & Team-based Care	Growth in established programs and newer settings in metro and regional pockets; under-utilization of CHWs in key disparity areas	Broaden implementation of CHW strategies across state with focus on disparities (e.g. birth outcomes) and evidence-based models
Impact & Evidence	Shared learning through CHW Supervisor Roundtable and grant-supported projects such as the MDH Community Wellness Grant Project and HealthRise-US (HR-US) Initiative	Develop clearinghouse for MN CHW program evaluations and tools; launch MN Common Indicators Project
Sustainability	Increased numbers of CHWs enrolled in Minnesota Health Care Programs and more employers billing the Minnesota Department of Human Services and health plans for CHW services; no accountability for access to CHW services	Continue to improve MHCP payment and address network access while also seeking coverage under value-based financing models and other funding streams
Occupational Regulation	Exploration of CHW certification options by the Policy Committee of the MN CHW Alliance	Seek funding and expertise to design inclusive and responsive certification program including registry
Leadership & Advocacy	Growth in CHW leadership capacity	Continue CHW leadership development and create policy agenda with CHWs at table
Infrastructure & Funding	Growing ecosystem with undercapitalized infrastructure	Promote and grow regional organizing, statewide and national networking, and collaborative efforts with a common road map and diversified funding

Recommendations

The following recommendations form the framework for a strategic road map for use by CHWs, CHW employers, payors, funders, and other stakeholders to move the CHW field forward in Minnesota. Critical investments are needed to implement this road map.

Awareness-Building and Outreach

While state and national experts note significant improvements in awareness of the CHW workforce, they see important opportunities to build on progress to date to boost understanding of the role and its multiple benefits. CHW research, local impact data, and stories are critical to making the case for CHW integration and support.

Develop a broad communications plan with key messages geared to critical audiences including:

- health and social services professionals: reach out to leaders of professional associations and academic programs to promote stronger interprofessional education and collaboration for team-based care and policies that address health equity;
- provider systems and other potential CHW employers to introduce and expand effective CHW programs;
- payors: build understanding of the CHW role and stronger connections with decision-makers at DHS, health plans, IHPs, and unions;
- policymakers: with new faces in many elective offices and the executive branch in 2019, it will be essential to introduce the workforce and its effectiveness in addressing health equity and the Triple Aim;
- patients and the public: design and launch a public education campaign including outreach by CHW leaders to the cultural and ethnic media serving their communities.

Education

- Complete update of Minnesota's statewide standardized CHW curriculum.
- Build articulation agreements to strengthen the CHW educational ladder.
- Track and report key certificate program data.
- Identify and address CHW student recruitment and financial aid needs to close geographic and cultural gaps in the workforce.
- Partner to introduce the CHW certificate program to tribal Community Health Representatives and in northeastern Minnesota.
- Seek input on potential CHW continuing education guidelines as part of the exploratory CHW certification process.
- Develop priorities and resources for CHW continuing education.

Workforce Development Tools and Guidance

- Support CHW employer performance and CHW professional development including CHW supervisor training and design of CHW career ladders in clinics, public health, mental health and social services.

- Expand the Alliance’s role as a clearinghouse and center of excellence for CHW tools, best practices, guidelines, and materials to advance Minnesota’s CHW field.

Adopting CHW Models and Extending CHW Services

Work with state agencies, health providers, and community nonprofits to extend the implementation of CHW strategies to address key disparities in Minnesota including:

- infant mortality and low birth weight with priority on African American and American Indian communities where disparities are deepest;
- needs of low-income mothers and children through family home visiting programs;
- health and social needs of those leaving prison;
- uncontrolled childhood asthma among low-income families;
- housing-related threats to health among low-income families related to household lead, mold, radon, asbestos, pests, and other factors;
- prevention and treatment of sexually-transmitted infections and diseases including HIV;
- immediate and longer-term needs of homeless youth, adults, and families;
- recovery of those with substance use disorders including opioid addiction;
- upstream community initiatives as well as policy and systems change needed to address the social determinants of health including racism.

Impact and Evidence

- Invite CHW employers to share CHW program descriptions and evaluation outcomes to build a helpful database and collective resource for CHWs, their employers, prospective CHW employers, and payors that document the range and scope of CHW services, populations served and key results.
- Build participation in and support for the Minnesota Common CHW Indicators Project, an affiliate of the National Common Indicators Project, as a working group of the Alliance’s CHW Supervisor Roundtable.
- Promote CHW research and participation by Minnesota researchers in federal funding programs that build the CHW evidence base.

Sustainability

- Continue the momentum to improve and expand CHW payment under MHCP while also defining and pursuing CHW coverage options by the state’s growing network of IHPs as they take on greater risk and need to effectively measure and address the social determinants of health.
- Implement evidence-based models including Pathways Community HUB with its pay-for-performance approach to community care coordination by CHWs, starting small where there is the will, need, capacity, and investment on the part of several payors, CHW employers, and investors.
- Engage providers and payors on the integration and payment of CHWs under the Behavioral Health Home model and the Certified Community Behavioral Health Clinic model.
- Introduce CHWs into team-based family home visiting programs geared to high-risk pregnant and parenting women and their families.

- Include CHWs in the Minnesota Senior Health Options Program and waiver programs which offer case management and other services for low-income seniors and those with disabilities to help them live safely at home and prevent avoidable and costly nursing home and hospital admissions.
- Explore options for CHWs to join hospice/palliative care teams, Living at Home Block Nurse Programs, and dementia-friendly community initiatives to provide culturally-sensitive social support and related services to patients, families, and other caregivers.
- Investigate options for CHW coverage through health plan commercial accounts and union-sponsored health and welfare programs, especially in the hospitality, construction, and food processing industries that employ foreign-born workers.
- Learn from the Adult Rehabilitative Mental Health Services (ARMHS) billing success.
- Address barriers to CHW integration in FQHCs and Health Care Homes.
- Explore recognition of CHWs as essential providers.

Occupational Regulation

- Obtain support and expertise to create and implement an inclusive and responsive certification process leading to a well-designed and sustainable program that addresses Minnesota's needs and recognizes the unique identity of this workforce.

Leadership and Advocacy

- Continue the CHW Leadership Development Program.
- Develop mentorship program for new CHWs and for new CHW supervisors.
- Support development of policy agenda including certification and financing.
- Promote CHW participation on county and state advisory committees, councils, and government agency work groups.

Field-Building Infrastructure, Networking, and Collaboration

- Seek investments in next stage field-building work.
- Continue to support organizing and networking at the regional, statewide, and national levels to build capacity.
- Promote stronger government, provider, and workforce collaboration to achieve goals.

These recommendations reflect the Alliance's strategic directions and discussion from its 2016 and 2018 statewide conferences. They are also informed by interviewees for this project, the 3/15/2018 Medtronic Foundation-MDH colloquium organized for HR-US and CWG grantees, and the 11/14/2016 CHW Community Engagement event facilitated by DHS Health Care Administration Division with outreach by the Alliance.

CHW Definition, Roles, and Competencies

Scope of Practice and Professional Identity

“We are leaps and bounds ahead of where we were five years ago.”

– Durrell Fox, CHW
JSI, Atlanta

Community health workers in Minnesota and across the US serve diverse, underserved populations of all ages, in many different organizational settings, and under a wide variety of titles. Peer navigator, community educator, health advocate, outreach worker, and care guide are among the many titles used for the role. The following CHW definition, developed by the CHW Section of the [American Public Health Association](#), is now increasingly used by government agencies, funders, providers, and payors:

A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

Together, the roles and skills developed by the national CHW Core Consensus Project (“C3”) comprise the CHW scope of practice. Building on the seminal work of the 1998 Community Health Advisor Study published by the University of Arizona, C3 reaffirmed the original seven roles and added three additional competencies through a comprehensive and inclusive process that took place over the course of four years. Minnesota CHWs and stakeholders participated in the C3 process through a review group convened by the Minnesota CHW Alliance. The 2016 C3 report, [Understanding Scope and Competencies: A Contemporary Look at the CHW Field, A Progress Report on the CHW Core Consensus \(C3\) Project](#), identifies key CHW roles and skills which have been endorsed and adopted by the Alliance:

CHW Roles

1. Cultural mediation among individuals, communities, and health and social service systems
2. Providing culturally appropriate health education and information
3. Care coordination, case management, and system navigation
4. Providing coaching and social support
5. Advocating for individuals and communities
6. Building individual and community capacity
7. Providing direct service

8. Implementing individual and community assessments
9. Conducting outreach
10. Participating in evaluation and research

CHW Skills

1. Communication skills
2. Interpersonal and relationship-building skills
3. Service coordination and navigation skills
4. Capacity building skills
5. Advocacy skills
6. Education and facilitation skills
7. Individual and community assessment skills
8. Outreach skills
9. Professional skills and conduct
10. Evaluation and research skills
11. Knowledge base

Other important national developments that have impacted the CHW field in Minnesota and across the US include:

- Designation of a Standard Occupational Code for the CHW workforce by the US Department of Labor with advocacy by the CHW Section of the American Public Health Association and others (2010) CHW Occupational Employment Statistics
- Recognition of the CHW profession by the ACA (2010) About the ACA
- Centers for Disease Control and Prevention (CDC) funding under the multi-year 1305 and 1422 Chronic Disease Grant Programs (2013 and 2014) CDC's Funded State & Local Programs to Address Diabetes
- Recommendations by the US Preventive Services Task Force (2017) Community Health Workers
- American Diabetes Association Standards (2017 and 2018), Standards of Medical Care in Diabetes-2018, S10
- [Health Care Innovation Awards Meta-Analysis](#) which found CHW interventions to be the only one among six strategies funded by the federal Center for Medicare and Medicaid Innovation (CMMI) to reduce costs (2018)

Community Membership

As the field evolves, it is important to continue to support the authentic voice, unique nature, and professional identity of the CHW workforce. With greater recognition comes the threat of compromising the grassroots integrity of the field that certain educational, financing, and regulatory options can present, advises one national expert. What characterizes the CHW workforce is its trusted, culturally-responsive relationship with underserved communities based on CHWs' unique understanding, most often through shared demographics and/or life experience.

CHWs Possess the “Three C’s” of Community (ASTHO):

- **Connectedness:** CHWs know the community and move freely within it

- **Credibility:** CHWs are known and trusted as leaders and “natural helpers”
- **Commitment:** CHWs pursue their work out of a sincere commitment to the wellbeing of the community—because it is their community

CHWs apply their shared life experience with those they serve in their roles in home, community, and health and social services settings. Shared life experiences may be defined around language, culture, race, ethnicity, neighborhood/geography, class, ability, or other factors such as veteran status, immigrant background, justice-involvement, or specific health conditions such as HIV status or recovery from mental illness or addictions.

A Distinct Workforce

While CHWs have varied educational backgrounds ranging from high school diploma to graduate degrees, they are a distinct workforce. They do not typically hold an active U.S. license in another health discipline.¹ A CHW certificate is not generally an add-on credential for a practicing licensed health professional the way that a registered nurse or pharmacist might seek a diabetes educator certification or asthma educator certification as specialized training in the context of his or her own health discipline and professional scope of practice.

Across the occupational landscape, cross-training efforts that support the field are those that reflect the community membership or peer orientation at the core of the CHW role. These are typically frontline positions in which the recruits, like CHWs, come from the immigrant groups, recovery backgrounds, neighborhoods, and/or communities of color that they serve. For example, in Minnesota, peer recovery support specialists are being prepared for CHW roles.

What are the implications of CHW supervisors, clinicians, and health educators seeking CHW training in order to obtain credentials for reimbursement or professional development? A move in this direction creates scope-of-practice confusion, dilutes the unique professional identity of the workforce, and puts Minnesota out of step with the national CHW movement. “This would change the whole vibe of the CHW workforce,” according to CHW Durrell Fox who has been a leader in the field for several decades. Rather, CHW advocacy and support as strong allies and stakeholders within their own organizational and professional roles and fields is needed more than ever.

¹Foreign-trained health professionals who are not able to practice their profession in this country serve as CHWs as a way to help their communities and earn a living.

CHW Education and Training

Foundational Education, Continuing Education, and Worksite Professional Development

Standardizing the education and training students receive can be very helpful in defining the scope of practice for the profession, in clarifying regulatory requirements of the profession, and in establishing a niche in the health care marketplace.

[A Guide for Emerging Professions, MDH, p. 16](#)

CHW education is a major building block in the CHW field. It is key to quality assurance and payment. Minnesota is the first state in the US to develop a statewide, standardized CHW curriculum based in higher education. This nationally-recognized 14-credit model is currently offered as a CHW certificate program by seven Minnesota post-secondary schools in the Twin Cities metro area and in Greater Minnesota including:

- Minneapolis Community and Technical College
- Minnesota West Community and Technical College, Marshall
- Normandale Community College, Bloomington
- Northwest Technical College, Bemidji
- Rochester Community and Technical College
- St. Catherine University, St. Paul
- Summit Academy OIC, Minneapolis

The model also serves as the “chassis” for CHW education in Michigan and Montana and the curriculum has been adopted for use by the New Jersey Health Professions Consortium.

The curriculum and required internship provide foundational education on core competencies as well as health promotion and disease management topics needed by CHWs to work in a wide variety of health care, public health, oral health, behavioral health, education, and social services settings. To date, more than 650 individuals in Minnesota have graduated with a CHW certificate and work within their communities and the health care system or other settings. Those who complete the CHW certificate program are called “CHW certificate holders.” In Minnesota, diagnostic-related patient self-management and education services provided by CHW certificate holders working under clinical supervision are covered for payment under MHCP including Medical Assistance and MinnesotaCare.

The curriculum is praised by educators and employers alike for its breadth and flexibility. Within Minnesota, it is taught in person and online. It integrates numerous pedagogical approaches, from adult learning to popular education strategies that embrace social change. As a credit-bearing program, the curriculum also provides an educational pathway for CHWs to obtain an associate’s or bachelor’s degree or pursue other health careers. Some CHW certificate holders in Minnesota have returned to college to study nursing, social work, or public health. In this way, the field can help serve as a pipeline to grow and diversify the health care, public health, and social services workforce.

The curriculum was developed through an inclusive, multi-disciplinary process by the precursor group to the Alliance and was revised in 2010 from 11 to 14 credits based on feedback by CHW employers. It is copyrighted by Minnesota State and managed by the Alliance.

“Minnesota’s CHW curriculum model—developed by Minnesota State—is now offered in a growing network of post-secondary schools in Minnesota and across the US. By bringing together partners from the health field, higher education, and the community, a model program was created for an emerging health profession that provides an educational ladder for CHW students, often the first in their families to pursue post-secondary learning and career development. It reflects innovation, excellence, partnership, and commitment to growing and diversifying our health and social services workforce with a focus on health equity.”

**– Mary Rothchild, Ph.D.
Minnesota State System Office**

A Guide to the Minnesota CHW Curriculum is under development by the Alliance to familiarize CHW employers, providers, other health professions, policymakers, and interested others with its content, principles, and use. This resource will be particularly helpful to CHW supervisors as a baseline for reinforcing the curriculum content and creating on-the-job training that builds on its foundations.

The curriculum content is updated through the Alliance’s Education Committee which is comprised of CHW certificate holders and faculty from the schools that offer the CHW Certificate Program. Over the past five years, diabetes, hypertension, and mental health content has been systematically reviewed and updated with funding from MDH and the Robert Wood Johnson Foundation. With a grant from the Otto Bremer Foundation, the Alliance has developed a new module on trauma to prepare CHWs to address the profound health impacts of trauma and adverse childhood experiences (ACEs) on the individuals, families, and communities they serve. A strong focus of the module is on the opportunities for CHWs to promote healing in culturally-appropriate ways.

Access to CHW education has improved across Minnesota with the introduction of online formats for the standardized curriculum by Minnesota West, Northwest Technical College, and Rochester Community and Technical College. Tuition and financial aid policies vary across the schools that offer the CHW certificate program. Some employers pay for the program for their CHWs through the business education arm of local Minn State campuses, sometimes called “Customized Training.” Other CHW employers provide tuition reimbursement as an employee benefit. More employers are posting job descriptions that identify the certificate as a required or preferred qualification, recognizing the value of standardized, foundational CHW education.

Three Pillars of CHW Education

Along with foundational education, continuing education and on-the-job professional development comprise the three pillars of CHW education in Minnesota. While there are currently no requirements for continuing education, CHWs and their employers value ongoing learning so CHWs stay abreast of new knowledge, deepen their understanding of health conditions impacting their clients, and sharpen their skills for the purpose of better serving their clients and communities. The Alliance, MDH, Wellshare International's CHW Peer Network, CHW employers such as CHW Solutions, voluntary health associations, and other organizations offer a variety of free continuing education opportunities for CHWs either in-person or via webinar.

Exciting new CHW continuing education programs are under development. For example, the Minnesota Department of Human Services (DHS) has commissioned the Alliance to create a supplemental educational program for CHWs working with high-risk pregnant and parenting women, especially those with substance addiction. Minneapolis oral health provider Ready Set Smile is developing a series of educational modules for CHWs whose focus is oral health.

On-the-job orientation and ongoing professional development provide important employee guidelines and policies as well as essential job-specific information that are needed for CHW job performance, best practices, and career growth. Development of tools and resources by CHW programs can also help other team members understand the CHW role, competencies, referral guidelines, and work flow, leading to stronger teams and better outcomes. The CHW Supervisor Roundtable, an interest group of the Alliance for CHW managers, is a community of practice and ongoing forum for sharing workforce development challenges, successes, and resources.

Archived CHW webinars are available on the [Alliance website](#). Wellshare International provides free “lunch and learn” sessions four-six times per year on a variety of topics for an educational interest group it has organized—the Minnesota CHW Peer Network. Some of these videotaped sessions are available on the [Wellshare website](#).

Models and Team-Based Care

Infrastructure & Workforce Development Tools

For emerging professions, team-based models are a golden opportunity. Not only does team-based care create space for new roles in health care, but increasingly, health professionals are being trained to work with others and to maximize the unique skillset each profession brings.

[A Guide for Emerging Professions, MDH, p. 58](#)

An integral component of CHW field-building is support for the development, implementation, and evaluation of effective CHW models and team-based care. Keys to success are implementing infrastructure and tools to optimize CHW program performance. These include recruitment and hiring considerations; supervision and support; standardization such as documentation, work flows, and caseload; and clinical integration. Professional development and advancement opportunities as well as competitive salary and benefits are important to job satisfaction and retention. Strong execution strategies pay off in many ways. For example, the IMPaCT program at U Penn Center for CHWs has had a 1.7 percent turnover rate among its 30-member CHW team over the course of seven years. Well-designed programs lead to better outcomes, opportunity for expansion and replication, and stronger support.

Tools, guidelines, and networking are available at no charge from a variety of sources including the *MDH Guide for CHW Employers* developed by Wellshare International and the Alliance, a wealth of free downloadable resources on the Alliance website and on its two microsites (designed for mental health providers and asthma providers), and the ongoing work of the Alliance's CHW Supervisor Roundtable as a community of practice.

What are we learning about the uptake of CHW strategies by clinics that are new to the role? Based on qualitative research supported by a Clinical and Translational Sciences Institute grant, and in a first-ever study of health care home composition, investigators at the University of Minnesota and the Alliance identified the following set of factors in a [Health Care Home Issue Brief](#) that facilitated CHW employment in Minnesota Health Care Homes:

- presence of an internal champion;
- comprehensive view of patient population needs and diversity including psychosocial and cultural considerations, not exclusively a medical model;
- grant funding to support a CHW pilot and evaluation;
- Openness to workforce innovation on the part of clinic leadership and to the CHW model on the part of the health care home clinic supervisor.

It's important for members of the healthcare team to understand CHW roles and how CHW services support team performance and reach to improve access and outcomes. "What we found in piloting the CHW role is when the clinical team members see CHWs in action, then the role 'clicks' for them. They discover their value and learn that working together enables the team to better meet patient needs and bridge system gaps, especially where there are barriers related to culture, language and trust," says

Christine Bullerman, former coordinator of the Des Moines Valley Health and Human Services CWG Project serving Worthington, Minnesota and the surrounding region.

As reported by ASTHO, “It’s a theme in every state with community health workers,” says Rosalia Guerrero-Luera, program manager at the Texas Public Health Training Center’s CHW Training Program. “They aren’t there to take over your job, they’re there to help you do your job more efficiently. “They’re your eyes and ears.”

“We need a CHW champion with status in every organization and setting.”

**– Noelle Wiggins, EdD, MSPH
Oregon Community Health Worker Alliance**

CHW Models

There is a long tradition of CHWs as volunteer “natural helpers” across the US in rural areas such as Appalachia, inner city neighborhoods, and U.S/Mexico border communities. CHW programs were developed and funded as part of the 1960’s Great Society “War on Poverty.” Community health centers, migrant health programs, and mutual assistance associations have hired CHWs to address the needs of underserved clients. In Minnesota, health departments in Minneapolis and St. Paul were early adopters of CHW strategies with a focus on outreach and education to meet the health and social service needs of low-income families and refugees.

Over the last decade, the CHW field has produced, evaluated, and replicated evidence-based models that improve quality and health outcomes while reducing costs. The Minnesota CHW Alliance has hosted informational sessions for CHWs, supervisors, policymakers, payors, funders, and other interested stakeholders that feature the founders of the following models:

- [Individualized Management toward Patient-Centered Targets](#) (IMPACT) at the UPenn Center for CHWs provides tools, technical assistance, and research that have advanced the field.
- [Pathways Community HUB](#), piloted in Mansfield, OH and replicated in other OH communities, MI, WA, WI and other states uses a regional community care coordination approach and pay-for-performance financing from public and private payors.
- [Transitions Clinic Network](#) model, now active in 11 states and Puerto Rico, employs specially trained CHWs with a history of incarceration who help patients leaving prison make a successful transition to better health.

While there is interest in these models and adoption of some of their features or tools, none as yet have been fully implemented in Minnesota.

“Evidence-based models provide the pathway to sustainability.”

– Jill Feldstein, MPA
Penn Center for Community Health Workers

Reflecting health reform priorities, state government and foundation funding investments, and provider interest, many Minnesota CHW programs focus on adults with complex and costly health needs such as cancer, cardiovascular conditions, and diabetes. The CWG and HR-US projects are excellent examples of the application of CHW strategies to addressing pre-diabetes, diabetes and hypertension.

Drawing on their trust, cultural competence, and education, CHWs provide patient education and self-management services as well as advocacy, care coordination, navigational assistance, and social support. CHWs are employed by clinics, hospitals, public health agencies, and community-based organizations such as mutual assistance organizations, faith-based programs, and neighborhood centers. Newer employment sites include mental health agencies, oral health programs, public housing, and community action programs.

Gaps and Opportunities

Scale-up of successful CHW programs will extend their benefits in terms of quality, health, and cost savings. Based on studies of CHW effectiveness, using CHW models and team-based approaches to address persistent yet preventable health and social inequities in Minnesota will lead to measurable improvements and lower costs. There is strong empirical evidence for successful CHW strategies in the following areas but as yet CHWs in Minnesota are not widely integrated into care teams to address these conditions:

- infant mortality and low birth weight among African American and American Indian communities;
- needs of low-income mothers and children through family home visiting programs;
- uncontrolled childhood asthma among low-income families;
- housing-related threats to health among low-income families related to household lead, radon, asbestos, pests, mold, and other related factors;
- prevention and treatment of sexually-transmitted infections and diseases including HIV;
- homeless youth, families, and others who are unemployed, underemployed, or dealing with mental illness or addictions;
- chronic illnesses and behavioral health needs of those leaving prison.

“Part of what has made CHWs so effective is their ability to adapt to unique individual and community needs. It’s important for them to retain this flexibility as they are embraced by more sectors.”

– Noelle Wiggins, EdD, MSPH
Oregon Community Health Worker Alliance

Impact and Evidence

Dollars, Data, and Stories

“The CHW evidence is established, there is a growing body of published research on the effectiveness of CHWs.”

– Betsy Rodriguez, BSN, MSN
National CHW Expert

The CHW evidence base is growing and becoming more robust with stronger methods and study designs including randomized controlled trials (RCT) which are considered the “gold standard” in health services research. Searching Medline on the term “community health worker” yields over 1,000 studies published since 2010. Research is important to advance the field, improve CHW programs, and inform policies to address health equity, cultural competency, and the Triple Aim through CHW strategies.

Notable studies include:

- RCTs conducted by Shreya Kangovi, MD and co-investigators on the outcomes of the Individualized Patient Management toward Patient-Centered Targets (IMPACT) CHW model, most recently:
- [Effect of Community Health Worker Support on Clinical Outcomes of Low-Income Patients Across Primary Care Facilities: A Randomized Clinical Trial JAMA Internal Medicine, 2018](#)
- Results of the Pathways Community HUB model on African American low-birth weight conducted by Drs. Mark and Sarah Redding: Pathways Community Care Coordination in Low-Birth Weight Prevention ([Maternal and Child Health Journal, 2015](#))
- Rigorous evaluations of the CHW Asthma Program at Seattle-King County Health Department led by Jim Krieger, MD:
 - [Better Home Visits for Asthma, Lessons Learned from the Seattle-King County Asthma Program](#)
 - [American Journal of Preventive Medicine, 2011](#)

Minnesota-based organizations such as the Alliance and Mayo Clinic, Rochester have also contributed to the CHW research literature, including [Community Health Workers as an Extension of Care Coordination in Primary Care: A Community-Based Cosupervisory Model](#).

Systematic reviews of CHW evidence have been conducted by academic institutions and experts as well as private and public agencies including the Institute for Clinical and Economic Review and the U.S. Community Preventive Services Taskforce. Taskforce findings led to 2017 recommendations to engage CHWs in interventions to prevent cardiovascular disease and to manage diabetes.

Based on a review of CHW cost savings studies, national CHW expert Carl Rush reports that CHW return on investment (ROI) can be dramatic with a net 3:1 or better. [An evaluation of the CMMI Health Care](#)

[Innovation Awards](#) published in February 2018 reported, “Of six types of innovation components that we evaluated (i.e., used health IT, used community health workers, medical home intervention, focus on behavioral health, used telemedicine, workflow/process redesign intervention), only innovations using community health workers were found to lower total costs (by \$138 per beneficiary per quarter).”

While the burgeoning literature base is helpful and important for many reasons, Minnesota CHW employers and other CHW advocates find that published research findings are not always enough for making the CHW business case with local payors. Decisionmakers also want to know the results of local CHW programs.

“We need local CHW impact and evidence data to show payors the value of further investing in CHW services.”

**– Lara Pratt, MPH
Minneapolis Dept of Health**

While most CHW employers focus on delivery of patient services—not research, many conduct program evaluations that are used for continuous quality improvement, documentation of outcomes and cost savings, and program reporting and support. Gathering and reporting CHW program evaluation data along with CHW success stories is critical to advancing the field.

CHW employers such as Mayo Clinic, Hennepin Health, Ready Set Smile, and Wellshare as well as the CWG and HR-US grantees, measure CHW program performance on a number of variables that reflect their program models and goals. Sound program evaluation requires consistent documentation. Some CHW programs use documentation software such as the Omaha System and have been able to measure improved patient outcomes related to diabetes and hypertension. Documenting and reporting CHW impact on managing social risk is important. For programs that also look to CHWs for outreach and community input needed to assess gaps and needs, documentation systems must include community-level activities and results.

“We can measure what CHWs do but it can be hard to assign their unique value when they are working on the most difficult, time-consuming cases that no one else knows how to handle.”

**– Mary Rapps, MHA
Generations Health Care Initiatives**

Across the country, members of CHW alliances and associations face similar challenges and opportunities related to identifying key measures including those related to the social determinants of health, collecting data, and demonstrating impact. Without common indicators, it is not possible to

meaningfully aggregate CHW program outcomes at the state or national level or to understand how CHWs achieve these results.

In 2014, the Michigan CHW Alliance created the Common Indicators Project to fill this gap. This project has expanded and now comprises over 45 CHWs, researchers, and program staff from over 20 states.

The Common Indicators Project aims to fill an evaluation knowledge gap by creating a common set of evaluation indicators and measures to capture the contributions of community health workers (CHWs) to successful program outcomes and their added value to health care and human services systems. [MI CHW Alliance](#)

Building on discussions with national project organizers prior to the Alliance’s 2016 statewide conference and connections made by the CHW Supervisor Roundtable, the Alliance will invite interested CHWs, supervisors, and researchers to form a work group called the Minnesota Common Indicators Project which will serve as our state’s affiliate of the national effort.

“There’s a lot of momentum to drive with data and tell the story of CHW impact.”

**– Jody Lien, BSN, RN, PHN
Otter Tail County (MN) Public Health**

Sustainability

Political Will, Buy-in, and Payment

“Scaling and sustaining the work of CHWs in the US has been limited because of a lack of reimbursement for CHWs.”

**– Betsy Rodriguez, BSN, MSN
National CHW Expert**

Across the US, CHWs, employers, and allies are seeking sustainable financing for the full range of CHW services in order to start, maintain, and grow strong programs. Historically, CHW funding has been limited to unstable grant and contract support. In Minnesota and in other states, there is progress. Medicaid programs in Minnesota, Pennsylvania, and, most recently, Indiana pay for select CHW services. In other states, such as New Mexico, Medicaid waivers support CHW services such as care coordination for Medicaid managed-care organization enrollees. Newer value-based payment mechanisms implemented by states for support of Medicaid ACOs hold promise for CHW payment with greater flexibility.

Hospital community benefit programs are also a potential source of CHW funding. In Minnesota, the vast majority of funds are spent on state public program underpayments and charity care rather than on community health activities.

For more information see [Hospital Community Health Benefit Spending, 2013-2015: MDH Report to the State Legislature](#).

For updated information on the CHW payment landscape, see the maps available at the [National Academy of State Health Policy website](#).

Update on MHCP and CHW Coverage

Over ten years ago, prior to enactment of the ACA, the Alliance, then known as the Minnesota CHW Project at Minnesota State University, Mankato gained passage of a statute authorizing CHW patient education and care coordination payment under Medicaid. MHCP including Medical Assistance (Medicaid) and MinnesotaCare cover face-to-face CHW visits to individuals and/or groups for diagnostic-related patient education and self-management services, pursuant to the 2007 state legislation and the DHS state plan amendment (SPA) approved by the Centers for Medicare and Medicaid Services (CMS). CHW visits may take place in the home, community, or provider setting.

For services to qualify for payment, CHWs must hold an educational certificate from an accredited Minnesota post-secondary school that offers the standardized, competency-based CHW curriculum developed by Minn State and managed by the Alliance, enroll with MHCP, and work under authorized clinical supervision provided by specific provider types. Coverage applies to MHCP beneficiaries enrolled in health plans and those receiving care from providers paid by DHS on a fee-for-service basis. To learn

about CHW payment and coverage guidelines, including how to enroll, see the [Minnesota Dept of Human Services \(DHS\) Provider Manual](#). Minnesota's statewide standardized CHW education program was an important factor in gaining support for this coverage. In addition, the fiscal note attached to the bill showed that the coverage would be cost neutral.

For a variety of reasons, uptake of this funding stream (approximately \$40/hour with daily and monthly limits) by Medicaid-eligible CHW employers has been slow. CHW hiring by Medicaid-eligible providers, many new to this emerging health profession, has been gradual. CHW employers have found the CHW enrollment and billing experience to be cumbersome and complicated. Some CHW employers have opted to cover their CHWs as part of their operating budget due to positive ROI and the extensive time and expense of implementing billing procedures that cover only the patient self-management components of the broader CHW role. While payment for CHW care coordination was authorized by the Legislature, it was not included by DHS in Minnesota's SPA.

Systematic efforts made by CHW employers and advocates are leading to some progress. CHW enrollment in MHCP by their employers in order to be able to bill for patient education services has increased and there are now 124 active CHW enrollees.² These CHW employers serve patients in Beltrami, Dakota, Hennepin, Nobles, Olmsted, Ramsey, St. Louis, and Stearns Counties including the most populous and diverse of Minnesota's 87 counties.

Over the last several years, the Healthy Communities Financial Sustainability Work Group, convened by Greater Twin Cities United Way, has focused on tackling technical issues associated with Minnesota's current CHW reimbursement. By tracking their billing experience and sharing solutions, participants addressed common problems, built billing know-how, and developed a better understanding of the range of services covered under diagnostic-related patient education and self-management.

Related developments include:

- CHWs may now apply for and use the National Provider Identifier (NPI) on DHS claims which is a major breakthrough for some employers whose platforms do not accept the Unique Minnesota Provider Identifier (UMPI) that was originally required by DHS.
- A new billing code is now available from DHS for CHW patient education for groups that are larger than eight.
- DHS guidance on CHW client contact frequency and documentation has been favorably modified with input from dental CHW employers.

This CHW payment mechanism can provide a modest income stream for CHW employers that qualify as Medicaid providers, are able to bill for MHCP services, and successfully file claims. However, the current CHW benefit is limited and does not fully cover program costs. Further, these improvements are needed and additional or alternative financing solutions must be found. CHW employers report they must deploy their CHWs in patient education activities at 60-75 percent FTE in order to break even under the current rates and benefit scope. That is unrealistic in view of the range of CHW tasks that are needed to address patient needs. For example, key CHW roles such as outreach, care coordination, and helping patients find coverage and navigate the care system are not covered. Phone work and home visit travel time are not reimbursed which is challenging, particularly for rural CHW employers.

²Susan Kurysh, DHS, Dec 2018

Moreover, the current MHCP benefit does not extend to community-based CHW employers nor can it be tapped by federally-qualified health centers which operate under a different payment methodology. And while CHW diagnostic-related self-management services are a statewide MHCP benefit, at this time there are no contractual reporting or access requirements on the part of health plans and their provider networks to make them available within their networks. In the state of Michigan, to address access to CHW services, Michigan Medicaid developed and implemented a requirement that its managed care organization contractors provide at least one CHW per 20,000 members.

Value-Based Financing

Around the US and in Minnesota, there is growing interest in embedding CHWs into Medicaid redesign initiatives that address the social determinants of health and reward outcomes rather than volume. Value-based payment approaches are the future of health care financing and are recognized as an important priority for CHW sustainability.

“(In terms of CHW financing), I think about the statement by Katharine London (Principal at the University of Massachusetts Medical School’s Center for Health Law and Economics) that payment mechanisms already exist. It’s about using the payment mechanisms to support CHWs.”

**– Noelle Wiggins, EdD, MSPH
Oregon Community Health Worker Alliance**

CHW advocates and employers have been advised that CHW strategies are a good fit for Medicaid Accountable Care Organizations (ACOs), known as Integrated Health Partnerships (IHPs) in Minnesota, that are looking for new and better ways to meet quality targets (clinical, utilization, and health equity), control costs, and coordinate services across sectors under total cost of care shared risk. Across the state, there are now over 20 IHPs that cover over 460,000 beneficiaries. For more information, visit [DHS IHP Overview](#).

CHW employers and partners have questions about how to engage IHPs, what information is helpful to build the case for CHW integration and coverage, how to set up contracts, and whether IHPs, as health providers, are interested in supporting CHWs hired by community-based organizations. They wonder if IHPs will reinvest cost savings generated by CHWs into CHW programs.

“Sustainability is about more than stable financing; it’s about ongoing buy-in and support from diverse sectors and the political will to act on it.”

**– Gail Hirsch, MPH
Massachusetts Dept of Public Health**

Some states are including encouragement or requirements for CHW integration in their Medicaid innovation projects. Building an understanding of the CHW role and its value among state agency staff who are responsible for health care reform efforts is an important and long-term undertaking for CHW allies and advocates. The Alliance and some of its partners provided public comment to DHS on its guidelines for IHP 2.0 implementation in 2017. Emphasizing cultural competence and patient empowerment among IHP principles, articulating the value of emerging professions including CHWs as part of IHP-funded team-based approaches, including their effectiveness in addressing health literacy and social determinants of health, and encouraging use of proven CHW models such as Pathways Community HUB would help align IHP priorities and desired outcomes with CHW benefits. Notably, IHPs operated by Children’s Hospital, Essentia Health, Mayo Clinic, and North Memorial currently use CHW strategies.

For more information please see: [As Medicaid Costs Soar, States Try a New Approach.](#)

“All (CHW field-building) pieces impact sustainability.”

– Mary Rapps, MHA
Generations Health Care Initiatives

For more information

- [Billing and Contracting Clinic at the Alliance’s 2018 Statewide CHW Conference](#)
- [MDH-funded webinar for CWG grantees provided by CHW Solutions](#)
- [Best practices for CHW billing as part of the Healthy Communities Project supported by Medtronic](#)

Occupational Regulation

“In Minnesota, it is our biggest growth area. Building on the presentations and discussion at the Alliance’s 2018 statewide conference, we need to look at certification models developed by other states, delve into the research, and identify key expectations and information that will be helpful to creating our vision.”

– Mary Rapps, MHA
Generations Health Care Initiatives

As described in the *MDH Emerging Professions Guide to Professionalization*, regulation of health professions generally takes place at the state level. There are four levels or types of health professional regulation including: licensure, registration, certification, and permit. Licensure—the most complex form of occupational regulation—is not viewed as appropriate for the CHW profession. It is typically used by health occupations such as medicine, dentistry, and pharmacy where the practice presents the potential to harm the public and the practitioner operates independently, without supervision.

CHW Certification

Across the US, there is a trend toward voluntary certification of CHWs. In Minnesota, certification is applied to specific health occupations such as peer support specialists and emergency medical technicians.

Individual CHW certification programs typically include the following components:

- Authority and administrative home
- Certifying board or entity—composition, powers, operations
- Definition of a CHW
- Core competencies
- Scope of practice and practice standards
- Code of ethics
- Eligibility requirements
- Standards and protocols for assessing eligibility
- Continuing education requirements
- Procedures to apply, renew, revoke/expire, appeal, etc.

Certification also usually incorporates the establishment of a registry or roster.

According to [policy advice](#) from Geoffrey Wilkinson, MSW, and other CHW policy experts, the following key questions should be addressed in the CHW certification design process:

- Will the program certify individuals who work as CHWs?
 - Will the program be voluntary or mandatory?

- Will certification be required in order to use a title such as “Certified CHW?” OR
- Will certification be required for anyone doing the work of a CHW?
- Will the program also accredit or certify CHW training programs?
- Will the program certify instructors in CHW training programs?
- Will certification be carried out under state or private auspices?
- Is state recognition required for privately managed certification? State registry for privately-certified CHWs?

Certification of CHW programs operated by health providers and other organizations has been proposed as an alternative or complementary approach to individual CHW certification, similar to accreditation of health facilities and programs by the Joint Commission. Under CHW program certification, employers would be evaluated and certified on a set of key factors such as CHW hiring and supervision, work practices, and data analysis. This approach has not as yet been implemented in any states.

Across the US, states have pursued different models of individual CHW certification reflecting a variety of considerations including their own regulatory and political landscapes. Many states are in stages of exploration and development based on May 2018 data shared at the Alliance’s statewide conference:

- State-managed CHW Certification program: MA, NM, OH, OR, TX
- Private with State Health Dept cooperation: FL, RI
- Private without State Health Dept cooperation: IN
- Private under development: MI
- Authorizing law passed: IL, MD
- Exploring: AK, CO, KY, MN, MO, MT, NE, NV, OK, SC, VA, WA

CHW policy experts caution that it is important for CHWs and stakeholders to share any preconceptions about certification, define desired outcomes, and carefully design the program to reflect CHW voices and community membership at the core of the workforce.

Minnesota Outlook

While Minnesota has been a national leader in CHW education and financing, advocates and allies have chosen to monitor and learn from the successes and pitfalls of certification in other states rather than be in the forefront of CHW occupational regulation. Among the ingredients for a successful certification process are readiness, leadership, and consensus on the part of CHWs and key stakeholders. Financial resources and policy expertise are also needed to design and support an inclusive process.

There is now a body of experience across the US to be able to draw helpful lessons and identify best practices and effective models. With two cohorts of graduates of the Alliance’s CHW Leadership Development program, there is a growing cadre of CHW leaders in Minnesota who are well-equipped to play major roles in what is defined as a CHW-responsive process by national CHW experts.

Minnesota already has some of the major building blocks in place with respect to CHW certification considerations such as statewide standardized CHW education. Certification would organize and strengthen Minnesota’s existing field-building components as well as address important gaps. One of these gaps is a statewide CHW registry. This helpful tool is needed to identify members of the CHW workforce including their education, work experience, cultural strengths, and location; serve as a link between CHWs and potential employers; and provide a database for workforce analysis, projections and

needs assessments. Another gap is continuing education requirements to ensure that the CHW workforce remains up-to-date on best practices, skills and knowledge. Work is currently underway by the Alliance's Public Policy Committee to draft a report on guidelines, issues, opportunities, and options for designing a CHW certification program in Minnesota.

Leadership and Advocacy

Nothing about us without us.

– CHW Section, American Public Health Association

CHWs need to be at the table to guide the future of this profession. Allies and partners are also needed to build, measure, extend, and invest in this important work. As the voice of CHWs joined with allies from across the state, the Minnesota CHW Alliance strengthens and advances the CHW field to achieve equitable and optimal health outcomes for all communities. The Alliance plays a unique role as a statewide nonprofit leader for CHW education, integration, and policy change with over 15 years of field-building success. Formed in 2009 and incorporated in 2010, the Alliance evolved from the multi-disciplinary work group that created Minnesota’s model CHW curriculum and successfully passed CHW payment legislation. The Alliance is a 501(c)(3) governed by a diverse voluntary board that includes CHWs and representatives of stakeholder organizations.

Building CHW Leadership

CHW leadership development is key to successful CHW field-building including certification. Most CHWs work at the frontline and have little or no formal leadership training or experience. Yet many are natural leaders whose skills can be nurtured and grown. In order to strengthen the capacity of Minnesota CHWs to lead field-building efforts and speak for the profession, the Alliance designed and piloted the state’s first CHW leadership program in 2016 with funding from the George Family Foundation Catalyst Initiative. Building on the results of the pilot, the Alliance refined and offered this strengths-based program to a second cohort of CHWs in 2017-2018 with support from the Bigelow Foundation. To date, a total of 32 CHWs from the Twin Cities metro area and Greater Minnesota have completed the program.

Participants gather six times over three to four months to identify and grow their strengths; develop a supportive leadership learning network; meet and learn from local leaders in philanthropy, the media, and state government; and interact with a legislator and build advocacy skills. Through discussions with experts, they learn about the impact of trauma and how they can promote wellness and build resilience among their clients and communities. They also explore culture as a source of health and healing for themselves and those they serve.

Graduates have joined the Alliance board, drafted columns for the Alliance newsletter, facilitated breakouts at the Alliance’s statewide conferences, and successfully sought the Governor’s Proclamation of CHW Week in Minnesota. Several have represented the Alliance at national meetings and pursued career advancements. They will play lead roles in the CHW certification process in our state.

CHW Organizing Across the US

Among the exciting national developments in the CHW movement is the development of the National Association of Community Health Workers (NACHW). NACHW will be a formal membership organization

and will seek to engage local, state, and regional CHW membership organizations and their leaders in its membership, programming, and leadership structures. The Association's National Coordinating Council (NCC) is serving as its interim board. A soft launch took place in 2018 and the official introduction is scheduled for the April 14-17, 2019 national Unity Conference in Las Vegas.

Highlights from NCC's 2017 survey of state and regional CHW associations provide a picture of the organizational characteristics of the field:

- two-thirds of the 36 responding networks with known start dates were founded in the last 10 years;
- 40 percent are either incorporated and/or have 501(c)(3) status;
- over half of the responding networks have no paid staff;
- two-thirds raise funds to support their organization's activities;
- 27 organizations reported an annual budget and of those, half reported annual budgets of \$50,000 or less to support CHW/CHR/promoter operations;
- over half of those with annual budgets reported funding through foundation grants and/or corporate contributions or sponsorships;
- the most commonly reported activity by all networks was CHW professional development;
- almost two-thirds reported CHW representational and advocacy activities;
- almost all the responding networks indicated they would like more information on the effort to build a national CHW organization.

Infrastructure and Advocacy

Emerging health professions such as the CHW workforce need to create important infrastructure to provide policy and educational supports to build and grow their fields with the support of stakeholders and allies. This field-building activity typically happens at the state level and may require legislation. Often this essential formative work is carried out when CHW organizations are still in their infancy with small budgets and limited capacity.

Support by allies is critical to emerging health professions. For example, Minnesota's community paramedic workforce has benefited from the lobbying expertise of the Minnesota Ambulance Association. Similarly, the dental therapy/advanced dental therapy fields have received guidance and support from oral health leaders at the University of Minnesota and Minn State campuses.

As reported by ASTHO, state health agency leadership is crucial to strengthening the CHW workforce. State health officials and agency staff members play an important role in setting priorities, encouraging coordination and integration, bringing stakeholders to the table, and maintaining momentum to achieve the state's CHW workforce goals. For example, state CHW offices in Massachusetts and New Mexico have played a major role in CHW integration and certification activities. Recently, Mass Health, the Medicaid agency for the Commonwealth of Massachusetts, has elected to use federal DSRIP funds to support CHW supervisor training and expansion of CHW training capacity through a contract with the Commonwealth Corporation.

"Leadership from the state health official is really important."

– Gail Hirsch, MPH
Massachusetts Dept of Health

Under Minnesota’s Statewide Innovation Model grant from CMS, MDH spearheaded the Emerging Health Professions Initiative which funded six CHW pilot projects and supported the development of the CHW Tool Kit for Employers.

Advocacy and public policy initiatives utilize many different tools such as research and strategy; coalition-building and agenda-setting; training, organization, and mobilization of advocates and partners; public education and media campaigns; meetings with lawmakers, policymakers, and experts; and specialized expertise in communications, public affairs and legislative action.

Partnerships, pro bono expertise, state agency champions, and specialized funding such as the CDC’s new 1815 and 1817 grant programs that include a focus on CHW infrastructure and sustainability, are critical supports and investments that build CHW organizational capacity, create key policy scaffolding for the field, and accelerate progress. State health departments in Massachusetts, Oregon, Utah, and Wisconsin used a portion of their CDC 1305 and 1422 funds to strengthen their respective state’s CHW alliance. CDC 1815 and 1817 applicants that included CHW strategies in their proposals are making valuable capacity-building and policy investments to strengthen their state’s CHW workforce with funding that is often difficult to find and raise through private philanthropy.

“The future looks very promising with work that the Centers for Disease Control and Prevention is doing with states on CHW field-building with a focus on infrastructure and sustainability.”

– Gail Hirsch, MPH
Massachusetts Dept of Public Health

Advocacy work on the part of Minnesota’s CHW field is not new. Past efforts include CHW Day at the Capitol, testimony by CHWs and allies at public hearings, informational briefings on CHW models for DHS and MDH staff, outreach on behalf of DHS for CHW community engagement, and a series of meetings with DHS to improve current MHCP payment for CHW services. Going forward, strategic policy efforts are needed to advance the profession and its work that is integral to achieving health equity in Minnesota.

“We’re stronger working together.”

– Rachel Mahon Bosman, MPH
Minnesota Dept of Health

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Acknowledgments

Our thanks to the following experts from the CHW field, state and local public health, stakeholder organizations, and funding agencies for their valuable insights and generous time:

LaTanya Black, CHW, Community Engagement Consultant
Minnesota CHW Alliance

Rachel Mahon Bosman, MPH, Community Specialist
Health Promotion and Disease Prevention Division
Minnesota Department of Health

Christine Bullerman, Coordinator
Community Wellness Partners
Nobles County Health and Human Services

Jill Feldstein, MPA, Chief Operating Officer
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About the Minnesota Community Health Worker Alliance

Committed to equitable and optimal health outcomes for all communities, the Alliance serves as a catalyst, leader, convener, and resource to build community and systems' capacity for better health through the integration of CHW models.

As the voice of Minnesota CHWs joined with stakeholders across the state, Alliance priorities include:

- education and training for CHWs and those organizations that employ CHWs;
- advancing the field, including sustainability and CHW leadership development;
- continuing policy support in the areas of health access and equity, workforce diversity, and the Triple Aim through federal, state, local, and institutional policy change.

For more information, visit our [website](#). Our [tools and resources](#) page has an array of helpful tools and resources.

This resource was prepared in 2018 by the Minnesota Community Health Worker Alliance under a contract with the Minnesota Department of Health in support of the Community Wellness Grant with funding from the U.S. Centers for Disease Control and Prevention. Please use with attribution.