



Community Health Worker Roles in Core Local Public Health Services

A Report by the Minnesota Community Health Worker Alliance

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Introduction

In 2014 the CDC and the State of Minnesota made a significant investment in Community Health Worker (CHW) strategies in local public health to reduce and prevent prediabetes and hypertension in four areas of Minnesota. This report documents the details and results of that investment. Known as the Community Wellness Grant (CWG), this project allowed local public health to invest in personnel, supervision, and build infrastructure to support CHWs. The results are impressive and show the potential and impact of CHWs far beyond diabetes and hypertension. The lessons learned and recommendations will help local public health departments long after the end of the grant. Most importantly, the report documents the critical roles of CHWs as an important component of local public health departments and their work to improve the health of all, including the importance of addressing the social determinants of health (SDH).

In the CWG projects, all CHWs found they could only address their clients' diabetes and hypertension issues after addressing the SDH such as safe housing, access to food and refrigeration, income, and employment. This is an important finding from the projects, particularly for those who struggle to connect CHWs as a solution to the management of specific diseases. Disease management is possible only after basic needs are met. Three of the projects sustained CHWs beyond the end of the grant. In the one community that did not, other organizations in the community sustained a CHW beyond the end of the grant.

Minnesota has made strategic investments in CHWs by passing legislation recognizing CHWs as providers and allowing health care reimbursement for CHW services. Minnesota created a standardized CHW certificate program used in the Minnesota State College System of community colleges, St Catherine's University, and Summit Academy which develops core CHW competencies. This curriculum has been purchased and is in use in 14 other states.

Minnesota also benefits from the leadership of the Minnesota Community Health Worker Alliance (MNCHWA) which serves as a leader, expert, catalyst, and convener in the CHW field. MNCHWA contracts with CHWs and content experts to provide technical assistance and other services across the state. It provides a CHW Leadership development program and an annual conference for CHWs and stakeholders.

As an effective public health workforce innovation, CHWs are a 21st century solution with potential for development in many other systems. Mental health, elder care, school districts, child care, youth development, hospitals, clinics, disease specific organizations, human/social services and others can benefit from integrating CHW strategies into their core services. CHW results help both the population served and the service providers. They are the bridge health care so desperately needs to be effective and cost-effective.

Anne Ganey

Anne Ganey, MPH, [Minnesota Community Health Worker Alliance](#)

Overview

Community Health Workers (CHW) are a growing, frontline public health workforce. Funding from the CDC gave Minnesota an opportunity to pilot CHWs in a variety of local public health efforts. This report reviews those efforts, results and lessons learned, with a focus on the integration of CHWs in core local public health roles.

Overview of 1422 Funding: Community Wellness Grants

Funding from the Centers for Disease Control was granted to the Minnesota Department of Health (MDH) in 2014. Known as 1422, State and Local Public Health Actions to Prevent Obesity, Diabetes, Heart Disease, and Stroke, this grant was called the Community Wellness Grant in Minnesota. The grant period was October 2014 through September 2018. The Community Wellness Grant (CWG) in Minnesota was part of a federally funded effort to reduce and prevent prediabetes and hypertension. The MDH awarded funding to CWG partners after assessing a variety of factors and partner capacity.

Four Community Wellness Grant (CWG) projects were awarded by MDH to disparate parts of the state. Each project was required to address environmental, health systems, community-clinical linkages, and lifestyle approaches to prevent and reduce prediabetes, diabetes, and hypertension. In all, there were 17 mutually reinforcing strategies to accomplish the goals of the CWG. This report focuses on Strategy 2.6: Engaging Community Health Workers as critical links. Due to the number, and interwoven nature of the strategies, it is difficult to pull out the specific investment made in CHWs. It was enough to hire personnel (CHWs) and develop needed infrastructure to support their work.

The Four Minnesota CWG Projects

Des Moines Valley/Nobles County is in rural, southwest Minnesota and includes the counties of Cottonwood, Jackson, and Nobles. It is an agricultural area of the state with a growing immigrant and refugee population employed primarily at a meat packing plant in Worthington, the largest city in the three counties.

Healthy Northland is in northeastern Minnesota. It covers almost one quarter of the land mass of Minnesota including the counties of Carlton, Cook, Lake, St. Louis, Aitkin, Itasca, and Koochiching. The area is mostly rural with much isolation and long winters. The population is largely white with several Indian reservations. Duluth is the largest city in the region.

The Minneapolis Health Department (MHD) serves the city of Minneapolis, one of the largest and most diverse cities in Minnesota. MHD chose to provide services in eight low-income public housing buildings.

PartnerSHIP 4 Health (PS4H) is located in northwest Minnesota. This is a rural, agricultural area with a growing immigrant population. Partners include Ottertail County Public Health, the New American Consortium, Lake Region HealthCare, Ringdahl EMS, F-M Ambulance and Perham Area EMS.

Strategy 2.6: Engaging Community Health Workers as Critical Links

This report looks specifically at work done under Strategy 2.6: To increase engagement of Community Health Workers (CHWs) to promote linkages between health systems and community resources for adults with prediabetes or at risk for type 2 diabetes, prehypertension, or hypertension.

CHWs are an emerging workforce, newer to most “mainstream” public health and health care settings but with deep roots in many communities. They are known by a variety of titles such as outreach worker, care guide, community health advisor, peer educator, promotora (Latino communities), and community health representative (American Indian communities). CHWs are recognized and endorsed by major health organizations such as the Centers for Disease Control and Prevention, the American Public Health Association, the Community Preventive Services Taskforce, the Health Resources and Services Administration, the Institute of Medicine, the Minnesota Department of Health and Twin Cities Medical Society.

CHWs play a key role in local public health functions and in this particular program, in addressing prediabetes, diabetes, and hypertension prevention and management by fostering improved provider-patient communications, healthy lifestyles, medication adherence, and appointment-keeping.

Additionally, CHWs address the social determinants of health, effectively reduce health disparities and diversify the health care workforce. Working on teams in a variety of settings—clinics, social service programs, oral health offices, schools, jails, and homeless shelters among many others, they are well-equipped to overcome gaps related to care and coverage due to language, literacy, cultural differences, lack of trust, poverty, geography, and other factors. Addressing these barriers in culturally-responsive ways makes public health and medical care more effective and leads to better outcomes.

CHWs understand individual, community, and cultural dynamics and navigate these complex relationships while helping their clients learn to manage a disease or create better health. Because they come from the community, they are trusted by the community. In Minnesota, CHWs attend community colleges to gain the Minnesota CHW Certificate, a credential approved by legislation which allows them to get a National Provider Identifier (NPI) and collect Medicaid and other health care reimbursement while working under an eligible organization and approved provider. (See Appendix B: Community Health Worker Coverage in Minnesota Health Care Programs)

Core Public Health Function & CHWs

[According to the CDC](#), there are three core functions of Local Public Health and 10 Essential Public Health Services. Taken together, these describe the activities that all communities should undertake through local public health departments.



Working closely with a supervisor such as a public health nurse, CHWs contribute to many of these core services within local public health departments. CHWs work in a bi-directional manner, communicating between provider and client and client and provider. Thus, CHWs can educate providers on cultural nuances affecting care and the living situations of clients while also teaching clients critical skills and knowledge about their health.

For specific examples of how CHWs filled core public health roles and their results, see Appendix G: Examples of CHW Work in Core Public Health Services, CWG Project Lens.

CHWs and Core Public Health Roles

Core Function	Public Health Service	CHW Role
Assessment	Monitor health status to identify community health problems	Implement individual and community assessments
	Diagnose and investigate health problems and health hazards in the community	Advocate for individuals and communities Participate in evaluation and research
	Evaluate effectiveness, accessibility, and quality of personal and population-based health services	Advocate for individuals and communities Participate in evaluation and research
Policy Development	Develop policies and plans that support individual and community health efforts	Advocate for individuals and communities Conduct outreach
	Enforce laws and regulations that protect health and ensure safety	Provide culturally appropriate health education and information
	Research new insights and innovative solutions to health problems	Provide culturally appropriate health education and information Participate in evaluation and research
Assurance	Link people to needed personal health services and assure the provision of health care when otherwise unavailable	Conduct outreach Provide direct services Care coordination, case management, and system navigation
	Assure a competent public health and personal health care workforce	Provide culturally appropriate health education and information
	Inform, educate, and empower people about health issues	Provide culturally appropriate health education and information Provide coaching and social support
	Mobilize community partnerships to identify and solve health problems.	Provide outreach Build individual and community capacity

Health Equity, Social Determinants of Health, & Cultural Understanding

As part of their core service work, local public health departments and their partners must consider how conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes.

These social determinants of health (SDOH), and actions to address the resulting health inequities, can be incorporated throughout all aspects of public health work. Through broader awareness of community and cultural issues and potential solutions, CHWs help key public health officials better incorporate consideration of community issues and the SDOH to transform and



strengthen their capacity and impact to advance health equity. In fact, this is one thing that sets CHWs apart from many other health providers. CHWs work holistically and addressing the SDOH as barriers to health is a critical part of their work. In the CWG projects, all CHWs found they could only address their clients' diabetes and hypertension issues after addressing the SDOH such as safe housing, access to food and refrigeration, income and employment.¹

Also important are the cultural dimensions of health and the impact of cultural beliefs and practices on health care and care plan compliance. CHWs understand the culture and can explain cultural nuances to providers. They also explain why care compliance is important and can help clients and providers work together to modify care plans to fit the culture. Examples of this include tailoring diabetic menus to include important cultural food items and holidays. Another example from the Des Moines Valley/Nobles

¹ [Ten Essential Public Health Services and How They Can Include Addressing Social Determinants of Health Inequities](#)

County project is the development of a numbers scale to assist a client with low literacy to record her blood glucose daily. Both of these cultural modifications improve compliance and health outcomes.

CHWs in the Community Wellness Grant Projects

All the CWG projects found that CHWs helped them understand and address the impact of the SDOH, local culture and health issues and improve health outcomes. There were four models of CHW adoption in the projects: CHWs embedded in a local public health department; CHWs embedded by a local public health department into public housing; CHWs co-located with a local public health department; and a regional public health collaborative with CHWs employed by and located in a variety of organizations, including local public health, across a large geographic area.

There were varying levels of funding put into Strategy 2.6, as the projects could choose where to invest their funds across 17 different strategies. The Des Moines Valley/Nobles County project and Minneapolis Health Department invested in CHWs from the beginning while PartnerSHIP 4 Health waited until the last year to invest in CHWs. Healthy Northland had one CHW at the start of the project and worked through a regional public health collaborative to invest in and expand CHWs in agencies across the region by sharing resources and braiding funding streams to support and sustain them. It had nine CHWs employed by the end of the project.

CHWs Embedded in Local Public Health

PartnerSHIP 4 Health

“(CHWs) have insight of community needs and impact. Particularly with the Latino community, they help us hear what the community needs. They help with community assessment.”

– Jodi Lien, Public Health Director
OtterTail County

PartnerSHIP 4 Health (PS4H) is located in northwest Minnesota. This is a very rural, agricultural area with a growing immigrant population. Large geographic distances separate small communities and health care facilities are concentrated in Fergus Falls. Smaller communities have volunteer emergency medical and fire services. About 21 percent of the population is over 65 and many are isolated, living alone. Although the immigrant population is growing, in 2016, five percent of the population were people of color; three percent Hispanic. Almost 10 percent of the population lives below the poverty level with another eight percent earning up to 149 percent of the poverty level. Twenty-three percent of residents make less than \$15,000 a year. The prevalence of diabetes is 10.3 percent.²

Partners include Ottertail County Public Health, the New American Consortium, Lake Region HealthCare, Ringdahl EMS, F-M Ambulance and Perham Area EMS. Due to the rural nature of the area and the number of isolated elders, PS4H originally focused on a community paramedic strategy.

CHW Strategy

PS4H developed and piloted a CHW position and then expanded to two CHWs working within the local public health department. In year four of the project, they began a process to create a CHW position. CHW Solutions, a consultant organization, assisted with creating the position and materials and a *CHW Solutions* staff CHW served as a pilot CHW. After seeing the results, PS4H recruited, onboarded, and hired two CHWs from the community. These two CHWs received their CHW certificates from Northwest Technical College. At the project end, one CHW was embedded in Ottertail County Public Health while the other relocated to another community.

² [Data USA: Otter Tail County](#)

The populations served by the PS4H CHWs during the CWG project were low income, particularly those at risk for diabetes or hypertension.

Challenges

PS4H was familiar with community paramedics (CP) but less so with CHWs. CPs work well in rural areas and the CP strategy was working for PS4H. As the CWG project matured, PS4H heard about CHW results from colleagues in the other projects and pursued this strategy as well. They quickly added CHWs and were pleased with the results.

Accomplishments

Ottertail County Public Health's CHWs work closely with WIC staff and clients. They visit with persons on various health promotion activities and offer prediabetes screening tools. Various outreach events are completed to educate the community on health behaviors. CHWs connect with persons at food shelves, libraries, WIC clinics, and county fairs and implement outreach for the Child and Teen Check-up program for identified non-English speaking families as well as generalized outreach. Recently, basic health education teaching has begun at the mental health crisis unit to review the basics of nutrition and physical activity. In addition, the county has built in one-to-one home visiting for CHW health education and capacity building.

Core Public Health Results of CHWs

Public Health Assessment: Monitor health status to identify community health problems.

Ottertail County Public Health Director Jody Lien is finding CHWs to be critical to the county's assessment role. "They have insight into community needs and impact," she says. "Particularly with the Latino community, they help us hear what the community needs. They help with community assessment."

Outreach and Screening

The CHW provides outreach at health promotion and other community events with screening for prediabetes. Unfortunately, it is too often not prediabetes but diabetes that is identified. The screening allows the county to connect people with diabetes to care.

WIC and Child and Teen Check-Ups

Ottertail County Public Health has high rates of childhood obesity, making culturally appropriate health education a critical component of Public Health's work with children. The CHW has integrated diabetes prevention education into WIC and Child and Teen Check-ups and clinics.

Other Outcomes

- Positive connections with staff on role and function and how to work with a CHW
- Positive staff feedback, including an understanding of the CHW's role and function and a willingness to engage the CHW
- Identification of CHW champion physicians in the community who advocate for the CHW role

- Reduced a communication barrier with the Latino community
- Community recognition of the CHW role
- The community is accessing the CHW for advocacy and health education needs
- Growth of the profession in the rural community from zero to two (Lake Region Health Center also added a CHW.)

CHWs Embedded in Public Housing

Minneapolis Health Department

The Minneapolis Health Department (MHD) serves the city of Minneapolis, one of the largest and most diverse cities in Minnesota.

CHW Strategy

MHD chose to start with a pilot project and eventually brought CHW services to eight low income public housing buildings. MHD-employed CHWs were embedded in public housing, an example of CHWs being placed within community organizations. The purpose was to build capacity in community agencies to integrate CHWs into programs. MHD built capacity by providing financial support, technical assistance to set up, run, and collect data on a CHW program, and help the organizations financially sustain CHW programs by accessing available reimbursement. They partnered with CHW Solutions and Volunteers of America (VOA) to do this.

VOA consists of 16 social service providers for 5,000 low income or public housing residents—people who are elderly, disabled, immigrants, or who live alone. These providers help residents connect to clinics and manage crises. VOA saw a need to address prevention and thought CHWs may be a way to do this.

CHW Solutions is a consulting organization which helped VOA create CHW programs and positions. A pilot program started in summer 2016. It was successful and was continued through the CWG project. At the end of the project, VOA is sustaining two CHWs to work in eight public housing buildings.

MHD and CHW Solutions worked through the process of setting up standing orders, standardized pathways, gaining approved CHW supervision for submitting reimbursement requests, and testing the reimbursement system. Pathways provide a service delivery model for programs to follow. As a funder, MHD used pathways to provide standardized metrics across programs. Pathways provide a defined end point which is helpful for billing. Billing was a lengthy process with much back and forth between the agencies and the MN Department of Human Services. If a reimbursement request was denied, CHW Solutions found out why. In this process they discovered and worked out kinks in the reimbursement system.

Challenges

- The CHW role was brand new for VOA.
- Reimbursement for CHW services is not high enough to cover costs.
- There is no traditional way to be referred to a CHW. The CHWs are often reaching people who don't have a provider. CHWs connect them to primary care providers.
- Many Pathways didn't work as hoped and modifications were developed.

Core Public Health Results of CHW Work Space

Assurance: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

CHWs became the mechanism to organize one-to-one support for residents who were not getting the health care and follow through they needed. CHWs connected (or reconnected) residents to providers. They helped schedule clinic visits, arranged transportation, sometimes attended visits, and helped with follow up. They also brought educational sessions to the buildings and supported and reinforced messages from providers. They arranged one-to-one meetings with community pharmacists. By employing CHWs in the public housing building, MHD fostered an approach that was both place-based (environment) and people-centered (individual). CHWs provide social support, navigation, and advocacy to high-risk residents to help them reach their health goals. Their activities include making referrals to clinical services and onsite classes, reinforcing health education messages, assessing the need for medication management support from community pharmacists, and providing group education. Using this approach, “CHWs made concrete differences in individual health outcomes, says Lara Pratt. “They built relationships with residents and connected them with services. This was not happening before. The residents report that they feel better. That’s what we want to see.”

Here is an illustration of how this works:

On September 30, a client wanted his blood pressure checked and found it was very high: 192/102. The CHW suggested he call an EMT but the client didn’t want to go to the ER. The CHW told him it wasn’t a good idea to do nothing with numbers this high. The client provided his doctor’s cell phone number. The CHW called the doctor and told him about the situation and was asked to bring the client in. At the clinic, the client’s B/P was still high and the doctor had to be somewhere else. The client was signed in with another doctor. The CHW stayed with the client through the entire visit. The doctor asked the CHW to monitor the client’s numbers for the coming few weeks and told the client to take his medicine in the morning to regulate his condition better. (He was taking it at night.) The doctor asked the CHW to check the client’s B/P an hour after he takes his meds and make an appointment for him if his numbers stay this high. The doctor gave the client a weekly medicine planner and the client used it. The client started taking his meds in morning. The CHW provided the client with hypertension education and monitored his blood pressure every Wednesday morning. The client’s BP numbers decreased week by week and by December 21 his numbers were 121/61 which is a hundred percent turnaround.

Outreach and Screening

The CHWs provide outreach and screening on site within the public housing buildings and at events for residents. CHWs conduct weekly blood pressure checks in some buildings to identify people with hypertension and help them to manage it. In one of these weekly checks, a CHW identified a resident with alarmingly high blood pressure. Because of the CHW’s intervention, the resident went to the clinic and participated in a medication management visit with a community pharmacist in the public housing building. The doctor discovered the client wasn’t taking one of her prescription medications. Upon his

recommendation, the client started taking it as prescribed. At the next weekly blood pressure check, the resident's blood pressure was back to normal.

Policy Development: Research for new insights and innovative solutions to health problems

MHD worked to show a *Proof of Concept*. With their CHW pilot program in 2016, they set out to demonstrate that CHWs provide useful services and that reimbursement for CHWs is attainable. They were successful at both.

MHD, VOA and CHW Solutions worked to create a standardized model for payments, leaving a structure, workflow, and process for an emerging profession in place at the end of the CWG project. This structure includes:

- a standing order built into the HER;
- billable progress note format;
- a system to share back to other providers in or outside the organization;
- [finding] a billing provider;
- [creating] a process for hiring and onboarding CHWs;
- [creating] CHW program materials;
- two CHWs working in five public housing buildings sustained beyond the project end.

Outcomes

- Two CHWs sustained to work in eight public housing buildings
- A standardized model for CHW care and reimbursement
- Residents report they feel better

CHWs Co-Located with Local Public Health: Des Moines Valley/Nobles County

Des Moines Valley

Des Moines Valley, made up of Cottonwood, Jackson, and Nobles Counties is fertile, agricultural land in southwest Minnesota. Much of the land is used for industrial farming, punctuated by small towns with largely aging populations and small prairie lakes. Worthington, the county seat of Nobles County is the largest city in the area with over 15,000 residents. It is home to the JBS Pork processing plant which attracts immigrants and refugees from many countries for the work. The Hispanic population makes up 40.6 percent of the overall population of Worthington.³

English Language Learners in the school district grew by 38 percent between 2009 and 2015 with over 36 languages spoken in schools. In 2016, 18 percent of residents had incomes below the poverty level, another 23 percent were below 200 percent of poverty. In other words, 45 percent of households earned less than \$50,000 a year.⁴

The prevalence of diabetes in Nobles County was 7.8 percent in 2013⁵. Hispanics are almost twice as likely as non-Hispanic whites to be diagnosed with diabetes by a physician. They have higher rates of end-stage renal disease, caused by diabetes, and are 40 percent more likely to die from diabetes as non-Hispanic whites.⁶

People with low income are 2.5 times more likely to report having diabetes than those with higher incomes (MDH, 2017).

Because of the concentration of poverty and the complexity of diverse ethnicities in the city of Worthington, need is concentrated there and the Des Moines Valley project focused most of their Strategy 2.6 work in the city, with strong and positive results.

Worthington is also home to Sanford Health, a hospital and clinic system. Sanford health coaches played a big role with the DMV CHWs.

CHW Strategy

Des Moines Valley hired three CHWs over the four-year project. One CHW was hired upon funding with a combination of grant funds and local public health funds and located in the local public health department. Two CHWs were hired in year three of the funding and housed within the CWG project, on

³ [Data USA: Worthington Health Risks](#)

⁴ [MN Compass City Profiles: Worthington](#)

⁵ [Data USA: Worthington Health Risks](#)

⁶ [U.S. Department of Health & Human Services, Office of Minority Health](#)

the third floor of the Nobles County Government Center. This allowed them to assist in the provision of County services also located in the building; public health, social services, financial assistance, child protection and employment services. The initial plan was to embed CHWs in public health. However, only one CHW was located within public health to help with local public health work and the other two CHWs remained separate from public health, located in the same building and able to bring people to public health as needed and often called to public health to assist with clients with diabetes or hypertension and/or multiple or complex issues or simply a language barrier.

CHWs did outreach and education in the community to promote their services. Most clients found them through word of mouth and shared community networks. As a result, many people began coming to the Government Center to find the CHWs and it was often through the CHWs that clients were connected to local public health and other County services. The CHWs also did much work with the health coaches at the Sanford hospital and clinic. A lively partnership between the health coaches and the CHWs evolved which made a great difference in the health coaches' understanding of patient situations, health care services provided, and health outcomes.

Challenges

- It is difficult to get an accurate census for Worthington because of a large population that doesn't participate.
- A considerable amount of time was spent educating local public health and other county staff, partners, and the community on CHWs as a new and emerging workforce; how they can be of assistance and the outcomes they achieve.
- Internal structure for a new position was not in place when the project started. Staff noted needs for the following items:
 - A clear CHW supervision strategy, materials, and orientation
 - A method to prioritize and a management strategy for requests for CHW assistance which came from individual clients and referrals from agencies
 - A way to document and retrieve reports showing CHW impact and outcomes
 - A method for billing for CHW services
 - A sustainability plan to keep CHW services available in the community post-CWG
- Less than half the clients served by CHWs have an eligible insurance to bill time to. Many residents (several thousands) can't maintain status.

Core Public Health Results of CHW Work Space

Assurance: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

- In Nobles County, the CHWs became a resource for local public health and other County services. They were often called to public health (travelling from the third floor to the first floor of the Government Center) to provide cultural and/or linguistic assistance. As the community began to self-refer to the CHWs, they became a source of referrals to local public health and other County

services, increasing access to populations in need. When individuals in need of service arrived at the CHW's door, they could easily walk them down to public health and connect them.

Assurance: Inform, educate, and empower people about health issues

- CHW outreach and screening related to hypertension, diabetes, and pre-diabetes
- Blood pressure and diabetes education outreach events in Spanish and other languages located in community sites such as churches and at the JBS plant.
- Provided basic information on what high blood pressure is, the consequences of uncontrolled blood pressure, how BP is checked, and a discussion of resources in the community that could support someone with high blood pressure identification, high blood pressure prevention, and blood pressure management.
- Connected participants to nutrition educators and cooking classes.
- Promoted Diabetes Prevention Program (DPP) classes and recruited clients to attend.
- Blood pressure and glucose screenings conducted with referral to CHW for follow up assistance.
- Individual work with clients with diabetes and/or hypertension
- Social determinants of health assessments
- Individualized and culturally specific education, coaching, skill building, and support for diabetes and hypertension management

Case Study: Improvement in Diabetes Management

A clinic-based health coach started working with a 62-year-old woman with diabetes in March 2016. The client shared a house with her granddaughter and worked at a local meat processing plant. To ensure on-the-job safety, she needed to be healthy and alert because she was working on the line with knives and was surrounded by others operating sharp instruments. She had insurance through her employer. The client's A1C level was 10.1 with an average blood glucose of 246. The health coach educated the client on diet, medications, and needed follow-up. During a follow-up visit in April, the client reported that she was occasionally testing blood glucose and taking medications as ordered. The client failed to come to a follow-up appointment. In September 2016 the client was not taking meds as directed or testing blood glucose. A1C was 9.0. The client came for an appointment in October and was still not testing blood glucose. The health coach lost track of the client when she discontinued coming to scheduled visits.

CHW Intervention, Results, and Cost Savings

In January 2017, the health coach involved a CHW who reached out to the client. Her A1C was 10.02. She refused home visits so the CHW visited by phone to help the client learn how to take medications and test blood glucose. The CHW attended medical visits with the client and spent time in the clinic lobby coaching her and showing her how to use her glucometer. The CHW learned that the client was resistant to needles and to testing her blood glucose. She also needed supplies, like testing strips, which the CHW secured for her. By April 2017, with 6.5 hours of CHW coaching in her own language, by phone and in person at medical visits, the client was testing her own blood glucose and taking medications as ordered. A1C was 6.6, a 65 percent reduction, and average blood glucose was 143, the lowest in the client record.

Cost Savings

- Overall health care costs for people with good blood glucose control (A1C <7) are 20 percent less than those with poor diabetes control (A1C <9). (CDC, 2012). People with diabetes incur \$13,700 in medical costs on average per year (ADA, 2017). Cost savings: \$13,700 X 20% = \$2,740. Program cost for 6.5 hours = \$247.55.
- CHW interventions yielded cost savings of \$2,740.00.
- Assessment: Diagnose and investigate health problems and health hazards in the community

Des Moines Valley/ Nobles County Case Studies

Case Study #1

A CHW Embedded in Local Public Health; Averting the Spread of Tuberculosis

The first CHW at Nobles County was hired in the first year of the project and embedded in local public health. He worked closely with the public health nursing supervisor on public health work, as a Hispanic liaison to the schools, and with the infant car seat education program. He played a large role in addressing active tuberculosis.

Situation

On November 18, 2016 a woman walked into the clinic for pre-employment screening. The doctor wanted a Mantoux test and chest x-ray. A diagnosis of active pulmonary tuberculosis was made and public health department was called. The client was told by the doctor and the public health nurse to stay at home to prevent the spread of the disease. Medications were not available locally, so the public health nurse had them overnighted during a holiday weekend. The client had no insurance to pay for the medication due to legal status.

CHW Intervention and Results

The CHW was engaged in the case and did the following:

- The CHW picked up the overnighted medications and took them to the client's home with the public health nursing supervisor, to instruct the client on using them and to ensure they were taken as prescribed.
- The CHW explained tuberculosis to the client in her own language and answered many questions in the course of a long home visit. The client said she didn't feel sick and didn't know why she should stay home. She kept going to work because she would lose her job if she stayed home. She didn't understand who the public health people were and why they were involved with her. She didn't understand why she had to go to Sioux Falls, an hour away, to see a pulmonologist and she didn't have a way to get there. She kept repeating that she didn't feel sick.
- The CHW went to the client's home twice a day to observe her taking her TB medications, ensuring they were taken correctly.
- The CHW transported the patient to Sioux Falls to see the pulmonologist.
- The CHW attended subsequent appointments with the patient at Worthington clinic and Sioux Falls.

- The CHW did bridge work: He brought necessary and important paperwork back and forth between clinic visits and local public health. Without him doing this, much of the paperwork would have been lost. The client would not have done this.
- Additional bridge work included the education the CHW provided the client: answering questions, explaining treatment, ensuring she understood what the doctor was telling her, explaining the importance of staying home to prevent the spread of the disease, etc.
- The CHW secured emergency funds for the client so she could miss work.
- The CHW completed an application so the patient was covered by Sanford Health Charity Care which saved the County the cost of her care.
- The CHW continued to monitor the patient to ensure she took all the medications as prescribed for the six-month course of care required and the case was resolved.

Cost Savings

Tuberculosis that is not resistant to first-line drugs requires at least six months of medication at a cost of \$17,000. Tuberculosis that is drug resistant can cost as much as \$134,000 per patient for treatment.⁷

By working with Sanford Charity Care, the CHW saved the county the \$17,000 cost of treatment. The cost of 300 hours of CHW time over the course of six months was \$11,421. By engaging the CHW in effectively treating the disease and preventing its spread, local public health saved the County thousands of dollars; perhaps hundreds of thousands of dollars due to the potential spread of disease and cost of medical care. Had a public health nurse done the daily supervision, the cost would have been \$13,455. Conservatively, the cost savings to the County were \$19,034.

Other Outcomes

- Served over 100 clients with complex needs providing one-to-one assistance with medication management, medical understanding and compliance, and the Social Determinants of Health such as literacy concerns, navigating health insurance and social service systems, housing, employment, and connection to resources.
- Created three case studies on cost savings making the business case for CHW services (See Appendix D: Value Proposition: Community Health Worker Services)
- As of September 2018, 94 billable claims were submitted for 23 different clients for a total reimbursement of \$4,464.
- CHWs are being sustained beyond the CWG project in the community at Southwestern Mental Health Center and Avera Clinic, a Federally Qualified Health Center. Although the CHW position was eliminated from Nobles County, community partners saw the value of CHWs enough to sustain them at their own expense.

⁷ [Star Tribune: TB Outbreak has Health Officials on Alert](#)

A Regional Public Health Collaborative: Healthy Northland

Healthy Northland is a public health collaborative in north central and northeast Minnesota. It covers one quarter of the land mass of Minnesota including the counties of Carlton, Cook, Lake, St. Louis, Aitkin, Itasca, and Koochiching. The area is mostly rural with much isolation and long, cold winters. Mining and tourism are major employers and there is tension between the two. The area is home to the Boundary Waters Canoe Area Wilderness, the north shore of Lake Superior, and many state parks and state and national forests.

The population is largely white with four Ojibwe Indian reservations and part of a fifth reservation. High levels of poverty affect the region. The largest city, Duluth, is a regional center for health care, government, education, and business. It is almost a frontier city in that it serves people going to and from large areas of open land and wilderness. Everyone passes through Duluth and when things go wrong, Duluth is the city to which people migrate. In Duluth, people of color make up 11 percent of the population.

About 21 percent of the population live in poverty and another eight percent live below 150 percent of poverty. Thirty-three percent of households are cost burdened and 55 percent of rental households are cost burdened. The median household income is \$45,950 but 40 percent of households make less than \$35,000 a year.⁸ There is a wide income gap in Duluth with one census tract earning an average of \$10,794 a year and another earning \$72,698 a year.⁹

Duluth has a very strong social services sector and many active charitable and community organizations. It has a long history of innovation and of organizations effectively working together to address the challenges of poverty and the SDOH. Healthy Northland is a great example of this type of partnership.

CHW Strategy

Healthy Northland made significant progress in increasing engagement of CHWs to promote linkages between health systems and community resources and in sustaining CHWs. This was done by working through the collaborative to grow the CHW field, embed CHWs in multiple organizations across the northland, provide regional networking to support CHWs and agencies which employ them, and continue to investigate the possibility of creating a CHW hub. The number of CHWs in the region grew from one at the start of the CWG project to nine by the end of the project. Healthy Northland provided regional networking and support to the CHWs and the organizations hiring them. Healthy Northland funded two out of nine to twelve CHWs and was instrumental in helping to braid together funding for the others through the partnership.

⁸ [MN Compass City Profiles: Duluth](#)

⁹ [Data USA: Duluth](#)

Challenges

- The sheer geographic distance covered by Healthy Northland is a challenge. A drive of four hours is not uncommon and two-hour drives are common place. Long, snowy winters complicate travel and add to the isolation of individuals and communities. Specialty care is located primarily in the city of Duluth, requiring people to travel to access health care services.
- Finding the right home for CHWs was difficult and Healthy Northland has had mixed results in retaining CHWs. The CHW at the Myers Wilkins School was steady during the project while several organizations have experienced turnover in part due to the mobility of the population the CHWs come from and/or the isolation of being the first or only CHW in an organization.
- Finding the right person for the CHW position.
- Learning about and from different cultures in a helpful way that had not happened before.
- Information sharing across distance.
- Financial sustainability for CHWs.

Core Public Health Results of Healthy Northland Work Space

Assurance: Mobilize community partnerships to identify and solve health problems

and

Policy Development: Research for new insights and innovative solutions to health problems.

Healthy Northland is a public health collaborative working through partnership and collaboration with community organizations to identify and solve problems and create innovative solutions. The partnership pools knowledge and expertise for the greater good. They are particularly good at sharing resources and braiding together funding streams as they come and go to sustain the mission and the work. They focus on a shared mission and vision of a healthy community with a growing CHW field and state and national connections.

Investigating a Hub Model

The Generations Health Care Initiative hosts a CHW learning and stakeholder group which is exploring the potential of creating a CHW Hub Model in Duluth, the largest city in the region. Generations staff also educate others in the region about CHWs and the Generations Health Care Initiatives foundation provides funding for the CHW located at Myers-Wilkins Elementary School through the Duluth Community School Collaborative. Both of these initiatives will be sustained.

Assurance: Assure a competent public health and personal health care workforce

Healthy Northland has increased the capacity of CHWs and the organizations which employ them through a regional networking strategy. Staff and partners have provided help to organizations to hire, train, and support CHWs. At the start of the project there were just two CHWs in the region. At the end of the project there is a cohort of nine to twelve CHWs being sustained across the region working in a variety of settings who are supported and connected by Healthy Northland through monthly networking calls and

face-to-face meetings. CHWs report that the networking meetings are extremely valuable, providing critical connections, relationships, support, and learning.

Healthy Northland has also provided funds for CHWs to get the MN CHW Certificate.

Healthy Northland has been influential in embedding CHWs in public health, integrated health partnerships, and community-based organizations

Healthy Northland increased the number of CHWs employed in the region from one to nine to twelve. (The number fluctuates according to funding.) At the end of the CWG project CHWs were embedded in the following organizations:

- Rural AIDS Action Network (RAAN)
- St Louis County Public Health, Maternal Child Health
- The Myer-Wilkins Community School Collaborative, a community-based collaborative strengthening families
- Ely Community Care Team, behavioral health (3)
- Community Action Duluth, poverty alleviation; social determinants of health, clients with chronic conditions such as prediabetes and hypertension
- Kiesler Wellness Center/Northland Counseling, behavioral health (2)
- Deer River Clinic

Other Outcomes

- Increased organizational collaborations
- Reduced emergency room visits
- Increased access to mental/behavioral health services
- Increase in number of people agencies are able to serve
- New referral sources
- Reduced barriers

CHW Lessons Learned and Themes Across Projects

All four CWG projects appreciated the opportunities the project provided. They all experienced success with CHWs and CHWs are being sustained in various manners beyond the end of project funding.

Overall lessons learned

- Projects hit the ground running and invented much of what is reflected in the Recommendations section.
- Projects shared successes and failures and learned from one another to prevent reinventing the wheel.
- Planning takes longer than anticipated.
- Partnerships are key (shared resources).

About the CHW position

- Hire the right person and have them get the CHW certificate.
- CHWs made a positive difference in clients' lives.
- CHWs made a positive difference in the organization and were appreciated by other members of the team.
- CHWs meet cultural/linguistic needs and reflect the community they serve.
- CHWs respond to the SDOH and meet basic needs first as a way to improve health and care plan compliance.
- CHWs made a positive difference in how the organization was perceived by the community.
- CHWs were effective in helping clients manage their diabetes and hypertension and, most importantly, feel better.
- CHWs were appreciated by community partners.
- CHWs are an Emerging Workforce: Learning how to recruit, hire, onboard, and support CHWs as the first in an organization was difficult (see Recommendations section).
- It would be helpful to set up much of the infrastructure for a CHW position before hiring.
- New position is an unknown. It takes a lot of education internally and externally.
- Pathways can be a helpful tool (they provide a framework).

Awareness of the CHW position

- There was a need to build awareness of the CHW role within the team, the organization, and with partners and in the community.

Sustaining the CHW positions

- Most of the projects sustained the CHWs. In the one community that did not, other organizations in the community sustained one CHW.
- Current reimbursement for CHW services is not enough to support the position.

Recommendations for Integrating CHWs into Local Public Health

Planning and readiness of the organization

- Understand the CHW role.
- Understand the nature of the position: out of office, home visits, relationship/trust building, community-based.
- Identify internal CHW champions.
- Educate staff on the CHW role and benefits to the team/organization.
- Prepare the team to adopt and integrate a new member.
- Prepare the team to get different and sometimes unexpected information from this team member about clients and community perceptions and realities.
- Get started on the CHW infrastructure needed (see below).

Hiring the right person may require organizational policy changes

- Someone from the community and/or very familiar with it.
- Recognized and trusted by the community.
- Knows the community, culture, language, and available resources.
- Passion and dedication for the job.
- Desire to make a positive difference.
- Likes working with people.
- Responsible; a problem solver.
- Ability to advocate for self and for others.
- CHW Certificate is a plus but hard to find at this point.

Recruiting

- Not just the usual places
- Through partners and clients
- Word of mouth
- Community outreach and fliers
- In different languages
- Ads in culturally specific media

Interviews

- Involve a CHW in the interview.
- Involve community members in the interview process.
- Bring candidates to the organization to see how they interact.
- Include prioritizing and problem-solving questions in the interview (Which challenge would you address first?).

Onboarding

- Pair new CHW with an experienced team member.
- Provide organizational-specific training.
- Shadow another CHW if possible.
- Close connection with supervisor with specific times set up for connections.
- Supervisor availability.
- Another staff member to accompany CHW on the first few home visits. For example, PS4H CHWs accompanied and learned from other home visiting staff in the agency.
- Intentional introduction and integration into the team.
- Introduction and connection to other staff.
- Equipment and connections: cell phone, laptop, email, connection to organizational technology, mobile hotspot.
- Introductions to partner organizations.

CHW Supervision

- Supervising CHWs requires time; mentoring, teaching, learning together.
- Familiarity with the CHW role.
- Willingness to advocate for the CHW and teach other team members about the role.
- Ability to mentor and train a new position.
- Trust between CHW and supervisor is important.
- Availability to the CHW as needed.
- Understand secondary trauma and burnout; many CHWs are at risk of this due to intense needs of population served.
- Flexibility; this is a different role. The importance of culture, community, and family must be part of it and it can look different. For example, building trust with a population may mean attending evening meetings and events, sharing a meal, or simply spending time talking with them.
- Understand the importance and fragility of trust. The supervisor must understand the trust CHWs build with the community and how quickly it can be harmed. For example, when one CHW agreed to attend an evening meeting, a county supervisor said it violated union rules and he could not attend meetings after work hours. This will not work for a CHW position because the community members usually need to meet in the evening. It harmed the trust he was building with the community and he likely attended the meeting on his own time.

CHW Infrastructure

- Supervisor familiar with the position and needs of CHW employee.
- Supervisor time; mentoring, teaching, learning together.
- Internal champions to support and promote the CHW role and inclusion.
- Safety plans for home visits/work in the community.
- Orientation plan for employee that works beyond the office/clinic walls.

- Equipment and connections: cell phone, laptop, email, connection to organizational technology.
- CHW back up- who can call their clients if they are sick? Who can fill in for them?
- Materials for CHW use: intake forms, organization approved health education materials, care plan forms, documentation, etc.
- Process for integration into team and connections to other staff members.
- Referral process and forms; accepting and making referrals.
- CHW position in organizational chart.
- Standardized CHW pathways, if appropriate.
- CHW access to and pathway in the EHR.
- In time, create lead CHW position and provide career opportunities.

CHW Sustainability Factors

- Positive working relationship with supervisor.
- Included and helped to feel like a valued member of the team.
- Full time work.
- Livable wages plus benefits.
- Flexibility
- Interaction with other CHWs, either within the organization or in another organization.
- Opportunities for advancement.

What Helped

All four projects noted the invaluable help of the following organizations:

- Minnesota Department of Health (MDH) staff working on the CWG projects, their accessibility, and expertise.
- The support and camaraderie of the staff involved in the four projects which grew to include monthly networking and shared learning phone conferences facilitated by MDH staff and the MN Community Health Worker Alliance.
- The support, consulting and resources of the Minnesota Community Health Worker Alliance. See Appendix E: Minnesota Community Health Worker Alliance Programs, 2018
- CHW Solutions, consulting, and materials created.

Summary

Community Health Workers play critical (and, as yet, underutilized roles) in providing the core public health functions of assessment, assurance, and policy development, as well as addressing the Social Determinants of Health, documented by the results of the Community Wellness Grant. The role of Community Health Workers in outreach, providing culturally appropriate health promotion and prevention services, improving health and cost savings, were key results of the projects. All projects found that CHWs first addressed the Social Determinants of Health—disease management cannot occur until these are addressed. Once these are addressed, improvements in care and health outcomes quickly follow.

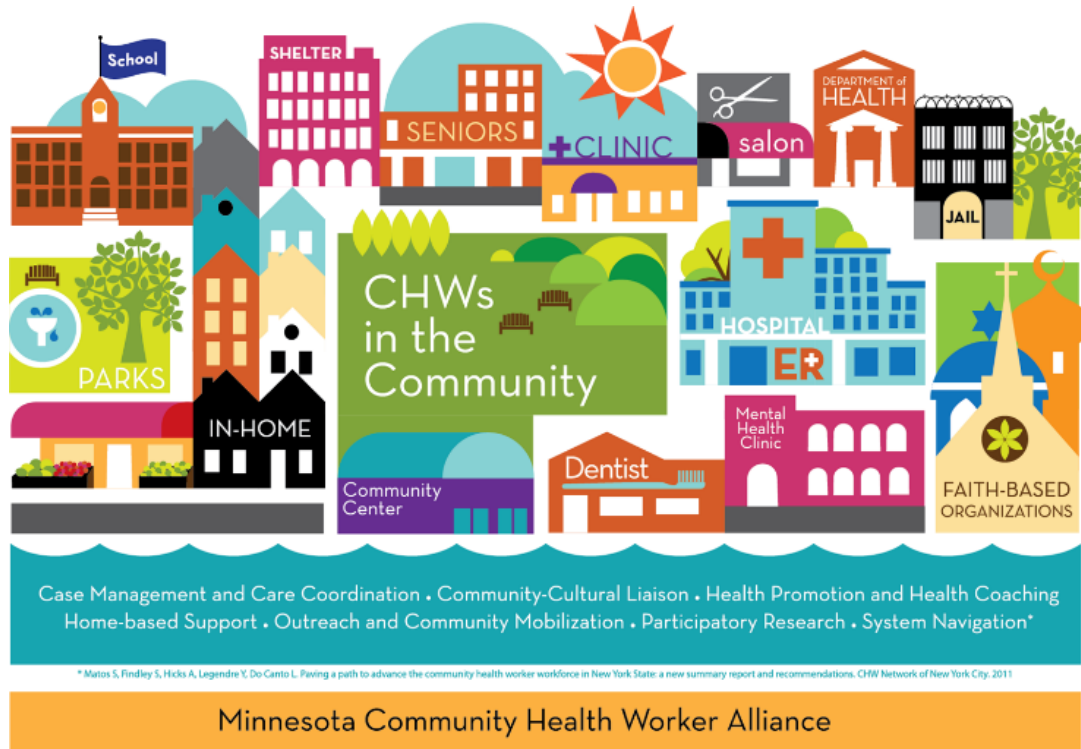
Community Health Workers function as a bi-directional cultural bridge between clients and providers and providers and clients. This liaison role is often identified as most critical for improving care and health outcomes and reducing disparities and costs. Adding Community Health Workers to the public health team has the potential to transform the field in many positive ways: Chief among them are improving cultural and systems knowledge in ways that make health promotion and health care more effective, pushing the practice of other providers up in their license, and lightening the burden on public health systems. Community Health Workers must be integrated into public health services to improve the health of individuals and communities, address the Social Determinants of Health, and accomplish the core goals of the public health system.

Please visit the [tools and resources](#) page on the [MNCHWA website](#) for access to an array of helpful tools and resources.

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About the Minnesota Community Health Worker Alliance



The Minnesota Community Health Worker Alliance is a nonprofit partnership that serves as a statewide leader, catalyst, convener, expert, and resource on achieving health equity and the Triple Aim (better care, better population health, and lower costs) through culturally appropriate, holistic CHW strategies focused on underserved populations.

The vision of the Alliance is equitable and optimal health outcomes for all communities. The mission is to build community and systems capacity for better health through the integration of community health worker strategies.

Learn more or sign up for the Alliance newsletter on [the MNCHWA website](#).

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End Notes

Our thanks to the CHWs and their Community Wellness Grant team at Des Moines Valley Health and Human Services and Nobles County (MN) Community Services Department for providing the client stories that are featured in the two case studies.

Case Study #1

Overall health care costs for people with good blood glucose control (A1C <7) are 20 percent less than those with poor diabetes control (A1C >9). (CDC, 2012) People with diabetes incur \$13,700 in medical costs on average per year (ADA, 2017). Cost Savings: $\$13,700 \times 20\% = \$2,740$. Program cost for 6.5 hours = \$247.55.

Case Study #2

- The average cost of an ED visit is \$1,423 (MEPS 2013). ED cost savings: $\$12,807 (\$1,423 \times 9)$.
- Average cost of medical hospitalization in 2012 was \$8,500 (AHRQ, 2014).

Hospitalization cost savings: $\$59,500 (\$8,500 \times 7)$. Program cost for 7 hours = \$266.49.

Appendix

Appendix A: CHWs: An Emerging Profession & Workforce Innovation

Appendix B: Community Health Worker Coverage in Minnesota Health Care Programs

Appendix C: The Community Health Worker Core Consensus (C3) Project: 2016 Recommendations on CHW Roles, Skills, and Qualities

Appendix D: Value Proposition: Community Health Worker Services

Minnesota Department of Health: Emerging Health Professions: Community Health Workers

Appendix E: Minnesota Community Health Worker Alliance Programs, 2018

Appendix F: Minnesota CHW Case Studies

Appendix G: Examples of CHW Work in Core Public Health Services, CWG Project Lens

Appendix A: CHWs: An Emerging Profession & Workforce Innovation

Community health workers in Minnesota and across the US serve diverse populations of all ages, in many different organizations. 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 payers:

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.

CHW Role and Scope of Practice

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 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 identifies key CHW roles and skills which have been endorsed and adopted by the Alliance and are part of Minnesota’s standardized CHW Certificate curriculum. See Appendix C: The Community Health Worker Core Consensus (C3) Project: 2016 Recommendations on CHW Roles, Skills, and Qualities.

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

Benefits of CHWs

CHWS ADD VALUE TO THE TEAM

As critical links between their communities and health care, CHWs reduce health disparities; boost health care quality, and cultural competence; and empower individuals and communities for better health. They do this by:

- Working within and beyond the office or clinic walls, conducting home visits, and connecting with clients in other community-based locations.
- Building client capacity for prevention and self-management.
- Addressing key social determinants of health; living conditions such as safe and affordable housing, and access to nutritious food which affect the client's health and ability to carry out the care plan.
- Serving as a liaison in building cultural understanding for both provider and the client.

The importance of the liaison role is often emphasized by new CHW employers. It transforms understanding of the client, improves care and compliance, and can change how services are provided.

CHWs Deliver Results

- They help their employers meet the Triple Aim: improved health, improved care, and reduced costs.
- They improve provider cultural competence and patient understanding of the health system.
- They reduce waste (e.g. no shows, workflow interruptions, lack of compliance).
- They address financial barriers to accessing health care services.
- They increase patient activation, satisfaction, and loyalty.
- They enable other health professionals on the team to work at the top of their licenses.

CHW Return on Investment

The return on investment from CHW strategies is an impressive three to one. Studies show that for every dollar invested in CHW strategies, three dollars are saved. Carl Rush, "CHWs: A National Perspective,"

Indiana CHW Coalition Community Symposium, 10/15/2012 In a Health Care Innovation Meta-Analysis of six innovative strategies, (health IT, behavioral health, healthcare home, telemedicine, workflow redesign, and CHWs) the only innovation that lowered costs was CHWs. Timothy Day, Health Care Innovation Awards Meta-Analysis and Evaluators Collaborative, Annual Report Year Three. Center for Medicare and Medicaid Services. February 2018. The evidence on CHWs is so convincing that at a national CHW Forum conducted by the CDC in May 2018, CDC staff said they had reviewed the evidence and were convinced that CHWs are effective. They encouraged the use of CHW strategies and infrastructure building to support CHW integration and expansion. (CDC CHW Forum, May 2018)

Appendix B: Community Health Worker Coverage in Minnesota Health Care Programs

Since July 1, 2008, the Minnesota Department of Human Services (DHS) has covered Community Health Worker (CHW) services under Minnesota Health Care Programs (MHCP) including Medical Assistance and MinnesotaCare. On an individual level, CHW services that are currently covered under MHCP consist of targeted, diagnosis-based health education designed for clients who may have challenges interacting with the medical system due to language or cultural barriers. On a system level, CHW services extend the reach of medical professionals into underserved communities by opening up a means for culturally appropriate, back-and-forth communication between practitioners and their patient panels.

Enrollment Guidelines

Contact health plans for specific credentialing requirements.

MHCP requires CHWs to enroll so they are represented on a claim as the provider who provided the services. During the enrollment process, Provider Enrollment will assign the CHW a Unique Minnesota Provider Identifier (UMPI) if the CHW does not have a National Provider Identifier (NPI).

CHWs interested in enrolling must submit the following signed and completed forms:

- [MHCP Provider Agreement \(DHS-4138\) \(PDF\)](#)
- [MHCP Enrollment Application \(DHS-4016\) \(PDF\)](#)
- [MHCP Applicant Assurance Statement \(DHS-5308\) \(PDF\)](#)

Attach a copy of the CHW certificate of completion issued by the Minnesota post-secondary school that offered the approved CHW curriculum developed by Minn State to the application form. Fax all signed and completed forms to MHCP at: 651-431-7462.

Currently-enrolled CHWs must inform DHS of their affiliation with dentists, ARPNs, certified PHNs or mental health professionals by completing and faxing a signed [Individual Practitioner MHCP Provider Information Change Form \(DHS-3535\) \(PDF\)](#).

MHCP Provider Enrollment will process the request within 30 days of receiving the signed and completed application, agreement, and applicant assurance statement and will screen the applicant. Provider Enrollment will send notification to the applicant to notify them of the outcome.

Enrolled CHWs are considered a “non-pay-to” provider but must be listed on the claim as the individual who rendered the CHW services. CHWs must provide an eligible MHCP-enrolled billing provider with their UMPI or NPI, so the eligible billing provider can submit claims for their services.

Eligible Billing Providers

The following provider types may bill for CHW services:

- Advance Practice Registered Nurse (APRN)

- Clinic
- Community Health Clinic
- Critical Access Hospital
- Dentist
- Family Planning Agency
- Federally Qualified Health Center (not outside the encounter rate)
- Hospital
- Indian Health Service (IHS) Facility
- Mental Health Professionals
- Physician
- Public Health Nurse Clinic
- Rural Health Clinic (not outside the encounter rate)
- Tribal Health Facility

Covered Services

DHS as well as health plans under contract for delivery of services to MCHP enrollees will cover diagnosis-related patient education services, including diabetes prevention and pediatric obesity treatment provided by a CHW, with the following criteria:

- MHCP requires general supervision by an MHCP-enrolled physician, APRN, certified public health nurse, dentist, mental health professional or non-enrolled registered nurse;
- A physician, APRN, dentist, certified public health nurse or mental health professional must order the patient education service(s) and must order that a CHW provides the service(s);
- The service involves teaching the patient how to self-manage his or her health or oral health effectively in conjunction with the health care team;
- The service is provided face-to-face with the recipient (individually or in a group) in an outpatient, home, clinic or other community setting;
- The content of the patient education plan or training program is consistent with established or recognized health or dental health care standards. Curriculum may be modified as necessary for the clinical needs, cultural norms, and health or dental literacy of the individual patients.

Billing Process

This process applies to DHS claims. Contact health plans for billing guidelines.

- Bill MHCP electronically using claim form 837P
- Use the National Provider Identifier (NPI) of the clinic, hospital, physician, APRN, public health nurse clinic, dentist or mental health professional as the “billing provider”
- Use one of the following procedure codes:
 - 98960 Self-management education & training, face to face, 1 patient
 - 98961 Self-management education & training, face-to-face, 2 - 4 patients
 - 98962 Self-management education & training, face-to-face, 5 - 8 patients

- 98962 (U9) Self-management education & training, face-to-face, 9+ patients
- Bill in 30-minute units and note that services are limited to 4 units per 24 hours and 24 units per calendar month per recipient
- Bill separate lines for each day that the service is provided
- Enter the appropriate diagnosis
- Enter the NPI or the Unique Minnesota Provider Identifier (UMPI) number of the CHW as “rendering provider.” If the billing provider is not the same as the ordering provider, the billing provider can only bill the number of units ordered by the ordering provider.

Documentation Requirements

Billing providers are required to document, along with other standard requirements, the following information for each CHW service ordered:

- An order for services signed by an MHCP-enrolled physician, dentist, APRN, certified public health nurse or mental health professional. The billing and ordering providers may be different. Standing orders are acceptable.
- Date of service, start and end time for the service, whether the service was delivered to an individual or group and if group, the number of patients present, summary of the session’s content, and the CHW’s signature and printed name.
- Patient education plan or training program used by the CHW
- Periodic assessment of the recipient’s progress and need for ongoing CHW services.

This information must be kept in each patient’s chart.

Current DHS Rates

Per 30-minute unit:

- CPT code 98960 1 client: \$19.92 (effective 1/1/2017)
- CPT code 98961 2-4 clients: \$9.70 (effective 1/1/2018)
- CPT code 98962 5-8 clients: \$6.89 (effective 1/1/2017)
- CPT code 98962 with the modifier U9 for groups greater than 8: \$4.07 (effective 8/4/2018)

CHWs may also provide fluoride varnish using the following codes:

- Medical code 99188: \$14.00
- Dental code D1206: \$14.00

Learn More

To network with CHW employers who are billing for CHW services or to share issues and recommendations, contact the MNCHW Alliance at info@mnchwalliance.org

For up-to-date information on DHS policy related to Community Health Workers, consult the [CHW section of the DHS Provider Manual](#).

For further information about requirements for enrolled DHS providers, see the [Provider Requirements section of the DHS manual](#).

November 2018

Appendix C: The Community Health Worker Core Consensus (C3) Project: 2016 Recommendations on CHW Roles, Skills, and Qualities

The Community Health Worker Core Consensus (C3) Project: 2016 Recommendations on CHW Roles, Skills, and Qualities

This document shares results of an assessment of Community Health Worker (CHW) standards and guidelines from states and select other sources throughout the US. These source data were contrasted against similar information identified two decades ago in the National Community Health Advisor Study (1994-1998).¹ Comparisons were made to the 1998 lists to generate the contemporary list of CHW roles and skills presented here. CHW qualities and attributes are not presented in this short report as the C3 Project has determined that these have remained constant over time and they are not in need of an update. The Project does, however, see attributes as critical to CHW practice. Most essential among these is "CHW's connection to the community served." The CHW roles and skills lists as presented here were refined by more than twenty US CHW Networks with an aim of assuring that they reflect CHW practice as defined by CHWs.

CHWs, also known as Promotores(as), Community Health Representatives®, and Peer Educators, among many names, work throughout the US to achieve health equity. CHWs increase understanding among other professionals about the effects of social determinants of health on patient's lives and their care, and also support individuals and communities in addressing those determinants.

CHWs are defined by the American Public Health Association CHW Section as follows:

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.

Within this definition, the reference to "[being] a trusted member of and/or [having] an unusually close understanding of the community served" is among the most noted and distinctive attributes of CHWs as a profession, valued by community organizations, employers, and community members alike. Along with that trust, CHWs possess a unique relationship and ability to communicate with those they serve, which increases their effectiveness and their value as members of interprofessional teams delivering patient- and community-centered care as well as in community development initiatives.

While the duties of an individual CHW position may not require all of the roles, skills, or qualities identified, we note that some CHWs may have additional important roles that fall outside of those recommended here. With that in mind, these recommended roles, skills, and qualities are intended to serve as a starting point to aid public and private entities working on developing CHW policies and administrative resources (e.g., standards and position descriptions) to support health and other initiatives carried out in accordance with local CHW and other leaders.



Contact c/o info@c3project.org Copyright: 2016

To join the C3 Project mailing list, go to c3mailing.chwsurvey.com

Please share any endorsement or adoption of roles and skills with the C3 Project team at: info@c3project.org.

	Role	Sub-Roles
1	Cultural Mediation among Individuals, Communities, and Health and Social Service Systems	<ul style="list-style-type: none"> a. Educating individuals and communities about how to use health and social service systems (including understanding how systems operate) b. Educating systems about community perspectives and cultural norms (including supporting implementation of Culturally and Linguistically Appropriate Services [CLAS] standards) c. Building health literacy and cross-cultural communication
2	Providing Culturally Appropriate Health Education and Information	<ul style="list-style-type: none"> a. Conducting health promotion and disease prevention education in a manner that matches linguistic and cultural needs of participants or community b. Providing necessary information to understand and prevent diseases and to help people manage health conditions (including chronic disease)
3	Care Coordination, Case Management, and System Navigation	<ul style="list-style-type: none"> a. Participating in care coordination and/or case management b. Making referrals and providing follow-up c. Facilitating transportation to services and helping to address other barriers to services d. Documenting and tracking individual and population level data e. Informing people and systems about community assets and challenges
4	Providing Coaching and Social Support	<ul style="list-style-type: none"> a. Providing individual support and coaching b. Motivating and encouraging people to obtain care and other services c. Supporting self-management of disease prevention and management of health conditions (including chronic disease) d. Planning and/or leading support groups
5	Advocating for Individuals and Communities	<ul style="list-style-type: none"> a. Advocating for the needs and perspectives of communities b. Connecting to resources and advocating for basic needs (e.g. food and housing) c. Conducting policy advocacy
6	Building Individual and Community Capacity	<ul style="list-style-type: none"> a. Building individual capacity b. Building community capacity c. Training and building individual capacity with CHW peers and among groups of CHWs
7	Providing Direct Service	<ul style="list-style-type: none"> a. Providing basic screening tests (e.g. heights & weights, blood pressure) b. Providing basic services (e.g. first aid, diabetic foot checks) c. Meeting basic needs (e.g., direct provision of food and other resources)
8	Implementing Individual and Community Assessments	<ul style="list-style-type: none"> a. Participating in design, implementation, and interpretation of individual-level assessments (e.g. home environmental assessment) b. Participating in design, implementation, and interpretation of community-level assessments (e.g. windshield survey of community assets and challenges, community asset mapping)
9	Conducting Outreach	<ul style="list-style-type: none"> a. Case-finding/recruitment of individuals, families, and community groups to services and systems b. Follow-up on health and social service encounters with individuals, families, and community groups c. Home visiting to provide education, assessment, and social support d. Presenting at local agencies and community events
10	Participating in Evaluation and Research	<ul style="list-style-type: none"> a. Engaging in evaluating CHW services and programs b. Identifying and engaging community members as research partners, including community consent processes c. Participating in evaluation and research: <ul style="list-style-type: none"> i) Identification of priority issues and evaluation/research questions ii) Development of evaluation/research design and methods iii) Data collection and interpretation iv) Sharing results and findings v) Engaging stakeholders to take action on findings

	Skill	Sub-skill
1	Communication Skills	<ul style="list-style-type: none"> a. Ability to use language confidently b. Ability to use language in ways that engage and motivate c. Ability to communicate using plain and clear language d. Ability to communicate with empathy e. Ability to listen actively f. Ability to prepare written communication including electronic communication (e.g., email, telecommunication device for the deaf) g. Ability to document work h. Ability to communicate with the community served (may not be fluent in language of all communities served)
2	Interpersonal and Relationship-Building Skills	<ul style="list-style-type: none"> a. Ability to provide coaching and social support b. Ability to conduct self-management coaching c. Ability to use interviewing techniques (e.g. motivational interviewing) d. Ability to work as a team member e. Ability to manage conflict f. Ability to practice cultural humility
3	Service Coordination and Navigation Skills	<ul style="list-style-type: none"> a. Ability to coordinate care (including identifying and accessing resources and overcoming barriers) b. Ability to make appropriate referrals c. Ability to facilitate development of an individual and/or group action plan and goal attainment d. Ability to coordinate CHW activities with clinical and other community services e. Ability to follow-up and track care and referral outcomes
4	Capacity Building Skills	<ul style="list-style-type: none"> a. Ability to help others identify goals and develop to their fullest potential b. Ability to work in ways that increase individual and community empowerment c. Ability to network, build community connections, and build coalitions d. Ability to teach self-advocacy skills e. Ability to conduct community organizing
5	Advocacy Skills	<ul style="list-style-type: none"> a. Ability to contribute to policy development b. Ability to advocate for policy change c. Ability to speak up for individuals and communities
6	Education and Facilitation Skills	<ul style="list-style-type: none"> a. Ability to use empowering and learner-centered teaching strategies b. Ability to use a range of appropriate and effective educational techniques c. Ability to facilitate group discussions and decision-making d. Ability to plan and conduct classes and presentations for a variety of groups e. Ability to seek out appropriate information and respond to questions about pertinent topics f. Ability to find and share requested information g. Ability to collaborate with other educators h. Ability to collect and use information from and with community members
7	Individual and Community Assessment Skills	<ul style="list-style-type: none"> a. Ability to participate in individual assessment through observation and active inquiry b. Ability to participate in community assessment through observation and active inquiry
8	Outreach Skills	<ul style="list-style-type: none"> a. Ability to conduct case-finding, recruitment and follow-up b. Ability to prepare and disseminate materials c. Ability to build and maintain a current resources inventory

	Skill	Sub-skill
9	Professional Skills and Conduct	<ul style="list-style-type: none"> a. Ability to set goals and to develop and follow a work plan b. Ability to balance priorities and to manage time c. Ability to apply critical thinking techniques and problem solving d. Ability to use pertinent technology e. Ability to pursue continuing education and life-long learning opportunities f. Ability to maximize personal safety while working in community and/or clinical settings g. Ability to observe ethical and legal standards (e.g. CHW Code of Ethics, Americans with Disabilities Act [ADA], Health Insurance Portability and Accountability Act [HIPAA]) h. Ability to identify situations calling for mandatory reporting and carry out mandatory reporting requirements i. Ability to participate in professional development of peer CHWs and in networking among CHW groups j. Ability to set boundaries and practice self-care
10	Evaluation and Research Skills	<ul style="list-style-type: none"> a. Ability to identify important concerns and conduct evaluation and research to better understand root causes b. Ability to apply the evidence-based practices of Community Based Participatory Research (CBPR) and Participatory Action Research (PAR) c. Ability to participate in evaluation and research processes including: <ul style="list-style-type: none"> i) Identifying priority issues and evaluation/research questions ii) Developing evaluation/research design and methods iii) Data collection and interpretation iv) Sharing results and findings v) Engaging stakeholders to take action on findings
11	Knowledge Base	<ul style="list-style-type: none"> a. Knowledge about social determinants of health and related disparities b. Knowledge about pertinent health issues c. Knowledge about healthy lifestyles and self-care d. Knowledge about mental/behavioral health issues and their connection to physical health e. Knowledge about health behavior theories f. Knowledge of basic public health principles g. Knowledge about the community served h. Knowledge about United States health and social service systems

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Photos

Photos in the Report are from the CDC Public Health Image Library (public domain) unless noted. CDC photos are available at: <http://phil.cdc.gov/phil/home.asp> and the Navajo Nation Community Health Representative Program.

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Appendix D: Value Proposition: Community Health Worker Services

Minnesota CHW Alliance, Feb 2018

CHW Role: Training, Trust, and Shared Life Experience

Community Health Workers (CHWs) are trusted, knowledgeable frontline health personnel who typically come from the communities they serve. As a result of their deep knowledge and understanding of their communities, CHWs are uniquely equipped to bridge barriers related to culture, race, language, literacy, socioeconomic status and other factors; expand access to coverage and care; and improve health outcomes. They apply their shared life experience and training in a variety of roles including patient education, outreach, advocacy, care coordination, coaching, and navigation. CHWs help clients prevent and effectively manage a wide range of health conditions including pre-diabetes, diabetes and hypertension. They work with underserved populations of all ages in rural, urban, and suburban communities across the United States.

Minnesota is the first state in the nation to offer statewide standardized CHW education through a network of post-secondary schools. Over 700 CHWs have completed the competency-based program that leads to a certificate recognized by payers including the Minnesota Department of Human Services and health plans.

CHWs Add Value to the Team

As critical links between their communities and the health care system, CHWs reduce health disparities; boost health care quality and cultural competence; and empower individuals and communities for better health. They do this by:

Working within and beyond the clinic and hospital walls, conducting home visits, and connecting with clients in other community-based locations.

- Building client capacity for prevention and self-management.
- Addressing key social determinants of health that busy clinicians may overlook in a routine encounter and typically lack the time and expertise to address. (Living conditions such as safe and affordable housing and access to nutritious food affect the client's health and ability to carry out the care plan.)
- Serving as a liaison in building cultural understanding for both provider and the client.

The importance of the liaison role is often emphasized by new CHW employers. It transforms understanding of the client, improves care and compliance, and can change how services are provided.

CHWs Deliver Results

- Helping their employers—providers, local public health, community-based organizations and other agencies—meet the Triple Aim: improved health, improved care, and reduced costs.
- Improving provider cultural competence and patient understanding of the health system.
- Reducing waste (e.g. no shows, workflow interruptions, lack of compliance).
- Addressing financial barriers to accessing health care services.
- Increasing patient activation, satisfaction, and loyalty.
- Enabling other health professionals on the team to work at the top of their licenses.

CHW Payment in Minnesota

Minnesota Health Care Programs (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 2007 state legislation and a state plan amendment approved by CMS. Visits may take place in the home, community, or provider setting. For services to qualify for payment, CHWs must hold a certificate, enroll with MHCP, and work under authorized clinical supervision provided by specific provider types. Coverage applies to MHCP beneficiaries enrolled in managed care plans and those receiving care from providers 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](#).

Across the state, Medicaid Accountable Care Organizations (ACOs), known as Integrated Health Partnerships (IHPs), have grown to 21 in number and now cover over 460,000 beneficiaries. CHW strategies are a good fit for IHPs 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. For more information, visit: [DHS IHP Overview](#).

“As an emerging workforce, CHWs show great promise toward reaching the Triple Aim. The Minnesota Department of Health Office of Rural Health and Primary Care is committed to supporting the integration of CHWs into the health workforce, in large part because the role is uniquely positioned to address social determinants of health for underserved populations. Where we see CHWs deployed, employers report a much more direct connection between the needs of communities they want to serve better and the goals of the organization.”

Will Wilson
Primary Care Financial & Technical Assistance Programs Supervisor
Minnesota Dept of Health (MDH)

Benefits to Clients, Providers, Payers, and Communities

- Net return of \$3 or better for every \$1 invested in CHW strategies (ASTHO webinar)
- CHWs increase the effectiveness of medical treatment and care.
- CHWs reduce costs related to preventable hospitalizations and unnecessary emergency department use.
- CHWs stabilize clients by addressing the social determinants of health.
- Health and social services professionals working with CHWs report that they greatly appreciate them and come to rely on their expertise on the team.
- Leading health authorities such as the Centers for Disease Control and Prevention and MDH support CHW strategies for effectively addressing costly health conditions such as hypertension and diabetes and for advancing health equity.

Tools and Assistance for CHW Integration

In Minnesota, there are tools, resources, best practices, technical assistance services, and learning communities to help health providers, local public health agencies, and community-based organizations effectively implement and support CHW programs.

[Minnesota Community Health Workers Alliance](#)

[Minnesota Department of Health: Emerging Health Professions: Community Health Workers](#)



Minnesota
**Community
Health Worker**
Alliance

Programs

Equitable and optimal health outcomes for all

The Alliance helps bridge clinical settings & diverse communities
to improve access, reduce costs, improve health outcomes & diversify the workforce



What We Do:

Education & Training

- ◆ Nationally recognized post-secondary standardized curriculum offered through seven schools (in-person or online options)
- ◆ Training programs for CHWs, employers
 - Creation of curriculum guide
 - Trauma awareness modules in the Native American, African American, and refugee communities
- ◆ Healthy Housing Project
- ◆ Education for clients, patients, consumers
 - Tooth Wisdom Project for seniors
- ◆ Annual state-wide conference
- ◆ Webinars offered throughout the year
- ◆ Technical assistance and consultation
- ◆ Program Evaluation

Field Building & Advancing CHWs as an Emerging Profession

- ◆ Monthly CHW Circle led by CHWs
- ◆ Supervisors Roundtable Calls
- ◆ CHW Leadership Development

Partnerships & Outreach

- ◆ Cancer Health Equity Network
- ◆ University of MN Pediatric Dental Home Project
- ◆ Many Faces of Community Health conference
- ◆ Rural CHW conference
- ◆ Monthly e-newsletter to 750 people
- ◆ Website library and resource center

Public Policy

- ◆ 2018-2019 focus: exploration on establishing state-wide registry and CHW certification process
- ◆ Advocate for sustainable funding solutions

www.mnchwalliance.org

A state-wide nonprofit organization

Appendix F: Minnesota CHW Case Studies

Case Study #1: Improvement in Diabetes Management

Background

According to the Minnesota Department of Health (MDH), the percent of Minnesota adults with diabetes has doubled since 1994 and the number is now at an all-time high. People with low income are 2.5 times more likely to report having diabetes than those with higher incomes (MDH, 2017). As many as 37 percent of Minnesota adults may have pre-diabetes (CDC, 2014). More than \$1 of every \$5 spent on health care in the US is to care for people with diabetes (MDH, 2017). CHWs play a key role in addressing our diabetes epidemic by fostering improved provider-patient communications, healthy lifestyles, medication adherence, and appointment-keeping.

Situation

A clinic-based health coach started working with a 62-year-old woman with diabetes in March, 2016. This client shared a house with her granddaughter and worked at a local meat processing plant. To ensure on-the-job safety, she needed to be healthy and alert because she was working on the line with knives and was surrounded by others operating sharp instruments. She had insurance through her employer. The client's A1C level was 10.1 with an average blood glucose of 246. The health coach educated the client on diet, medications, and needed follow-up. During a follow-up visit in April, the client reported that she was occasionally testing blood glucose and taking medications as ordered. The client failed to come to a follow-up appointment. In September 2016, the client was not taking meds as directed or testing blood glucose. Her A1C was 9.0. The client came for an appointment in October and was still not testing blood glucose. The health coach lost track of the client when she discontinued coming to scheduled visits.

CHW Intervention and Results

In January 2017, the health coach involved a CHW who reached out to the client. Her A1C was 10.02. She refused home visits so the CHW visited by phone to help the client learn how to take medications and test blood glucose. The CHW attended medical visits with the client and spent time in the clinic lobby coaching her and showing her how to use her glucometer. The CHW learned that the client was resistant to needles and to testing her blood glucose. She also needed supplies, such as testing strips, which the CHW secured for her. By April 2017, with 6.5 hours of CHW coaching in her own language, by phone and in person at medical visits, the client was testing her own blood glucose and taking medications as ordered. Her A1C was 6.6, a 65 percent reduction, and her average blood glucose was 143, the lowest in the client record. CHW interventions yielded cost savings of \$2,740.00.

“The US Community Preventive Services Task Force (CPSTF) recommends interventions that engage CHWs to help patients manage their diabetes. This finding is based on a systematic review that shows that patients who receive these interventions improve their glycemic and lipid control and reduce their healthcare use. Additionally, the available economic evidence suggests these interventions are cost-effective.”

–The Community Guide: [“Community Health Workers Help Patients Manage Diabetes”](#)

Case Study #2: Preventing Hospitalization Readmission and Emergency Department Use

Background

Studies of health care utilization outcomes have found CHW strategies to be effective in reducing emergency room use and hospital readmissions. For example, in a randomized controlled trial, the University of Pennsylvania patient-centered CHW model called IMPaCT improved post-hospital primary care access, discharge communication, patient activation, HCAHPS scores (adult inpatient satisfaction survey required by CMS for all U.S. hospitals), mental health, and recurrent readmissions for high-risk hospitalized patients with varied conditions (Kangovi et al., 2014).

Situation

A 36-year-old refugee mother of three young children who lived in subsidized housing struggled with lupus and related complications. She had access to some health insurance through her employer and was also covered under Medical Assistance. In 2016, she visited the hospital emergency department (ED) nine times and was hospitalized seven times.

CHW Intervention and Results

In January 2017, the clinic-based health coach referred the client to a CHW. The CHW learned the client was filling prescriptions but not taking her medications correctly. She was on Coumadin and had failed to show up for the required monitoring visits. She sought additional medication for symptom control at the ED and local rheumatology department. The health coach sent the medication list and instructions to the CHW who made home visits to better understand the client’s needs, explain the importance of her medications, and teach her how to take them as prescribed. The CHW also provided transportation for the client to specialty appointments in another community 65 miles away. The CHW assessed the client’s living situation and helped her find healthier housing for the family, get cash assistance, and obtain disability income because the client was unable to work. Altogether these efforts stabilized the client’s health and improved her living situation. As a result, she has been able to resume full-time employment. Since starting to work with the CHW, she has had no subsequent ED visits or hospitalizations. CHW services led to cost savings of \$72,000.

“The Twin Cities Medical Society supports the role of community health workers in the coordinated delivery of care in multiple health settings. Integration of community health workers as team members supports improved patient experience, improved health and reducing overall costs of health care services going forward. We encourage any applicable organizations to consider and implement CHW workforce strategies in their health care delivery systems.”

—TCMS Board Resolution, May 20, 2013

Appendix G: Examples of CHW Work in Core Public Health Services, CWG Project Lens

Public Health Service	CHW Role	Examples of CHW Work	CWG Project Work by CHWs	Outcomes
Monitor health status to identify community health problems.	Implement Individual and Community Assessments	<p>Outreach to specific hard to reach community groups and cultural communities and inclusion in health assessments.</p> <p>Identification of community/population specific health issues, strengths and barriers.</p>	<p>P4H- Home Visits, Health Fairs, WIC Clinics, Child and Teen Checkups, Community outreach and screening.</p> <p>MHD- Outreach and screening in public housing buildings.</p> <p>DMV/NC- Outreach and screening in the community.</p> <p>HN- CHWs located in a variety of settings. Outreach and screening at community events.</p>	<p>P4H- better understanding of health issues in the community.</p> <p>MHD- Public housing clients needing assistance with BP control identified and assisted.</p> <p>DMV/NC- Clients with uncontrolled diabetes and hypertension identified and referred for education and treatment.</p> <p>HN- Much work by CHWs addressing client SDOH related to health issues.</p>
Diagnose and investigate health problems and health hazards in the community.	Advocate for Individuals and Communities	<p>Conducted a home visit which determined mold was resulting in numerous emergency room visits for pediatric asthma attacks. The result was mold mitigation for an entire apartment building, effecting numerous families, removing the hazard and improving the health of this community. (Mankato Council of Churches Refugee Program with Nicollet County Public Health Nurse, 2017.)</p>	<p>P4H- Community Outreach and Screening</p> <p>MHD- Outreach and screening in public housing buildings. CHWs advocate with clients for treatment and medication management.</p> <p>DMN/NC- Monitored TB case. Prevented the spread of TB.</p> <p>HN- Home visits, clinic and LPH sites, school and mental health sites.</p>	<p>P4H- Residents screened who had diabetes referred for medical care.</p> <p>MHD- Residents screened who had hypertension received services on site and/or clinic visits were facilitated.</p> <p>DMV/NC-Client with TB contagion halted. Residents screened with diabetes or hypertension referred for treatment.</p> <p>HN- Ability to identify issues and respond collaboratively.</p>
Evaluate effectiveness, accessibility, and quality of personal and population-based health services.	Advocate for Individuals and Communities	<p>Advocated for changes in hours at local clinics to accommodate shift workers. (Rural FQHC and clinic)</p> <p>Facilitate culturally and linguistically appropriate focus groups with specific</p>	<p>DMV/NC- worked with Sanford Health Coaches to improve access, culturally appropriate services and care coordination for clients with diabetes and hypertension. Set up CHW pathway in Nightingale Notes</p>	<p>P4H- Better understanding of Hispanic health needs based on CHW work in community.</p>

	Participate in Evaluation and Research	populations to gain insight about effectiveness, accessibility and quality. Interpret surveys and other assessment tools with members of the population to gain needed input.	for documenting and evaluating CHWs services. HN- Investigating a Hub model for CHW expansion.	DMV/NC- Better diabetes and hypertension control in clients served. Cost savings documented. MHD- Brought or facilitated services to people in public housing who were not accessing them. HN- Better understanding of the impact of SDOH on population due to CHW work with community.
Develop policies and plans that support individual and community health efforts.	Advocate for Individuals and Communities Conduct Outreach	Conduct outreach and provide information and inclusion on community health efforts. Engage the community in the development of LPH plans. Provide community/culturally specific information into the planning and policy development process.	MHD- Proof of Concept: CHWs are effective and reimbursement can be attained. HN- Regional CHW Network and Investigating a Hub model for CHW expansion.	MHD- Proved the Proof of Concept: Standardized model for CHWs in Public Housing and for payments in place. HN- Regional CHW network with 9 CHWs in place and operating; continuing to investigate feasibility of Hub model for CHWs.
Enforce laws and regulations that protect health and ensure safety.	Provide Culturally Appropriate Health Education and Information	Act as a liaison to translate laws and regulations for the population and share information on cultural nuances affecting adherence to laws and regulations to enforcers.	DMV/NC- education to the immigrant population on vaccinations.	DMV/NC- An increase in the number of immigrants receiving vaccinations.
Research for new insights and innovative solutions to health problems.	Provide Culturally Appropriate Health Education and Information Participate in Evaluation and Research	Research and bring community/culturally specific knowledge and insights into solutions to health problems. Provide insight and educate providers on cultural nuances, strengths and barriers related to solutions. Sustaining CHWs	P4H- CHW feedback on local health issues MHD- new standardized model for CHWs in public Housing buildings. DMV/NC- CHW cost effectiveness study HN- Partnership- CHWs in various settings, school, public health, mental	P4H- One CHW position sustained at Ottertail PH beyond CWG funding. MHD- Standardized model for CHW care in public housing buildings. Standardized model for payments. Two CHWs sustained beyond project funding. DMV/NC- Documented significant cost savings from CHW services (see CHW

			health, clinics community action agency. Investigating a Hub Model for CHWs in the Northland	Value Proposition, 2018) One CHW sustained through community partners. HN- A variety of CHW models studied. At project end, nine CHWs sustained in various ways and organizations across the HN area.
Link people to needed personal health services and assure the provision of health care when otherwise unavailable.	Conduct Outreach Provide Direct Services Care Coordination, Case Management, and System Navigation	Conduct outreach to find and connect with hard to reach clients. Provide home visits to educate, empower and monitor progress on health issues. Assure access to services through care coordination and system navigation. WIC Clinics and Child and Teen CheckUps	P4H- Home Visits, Health Fairs, WIC Clinics and Child and Teen Checkups MHD- Bring services to residents in public housing buildings, care coordination. DMV/NC- Home Visits and care coordination. CHWs linked clients to services at the county and Sanford Health. CHWs accessible and called upon by WIC, Child/Teen CheckUp and PH Nursing. HN- CHWs housed in a variety of locations; home visits and onsite client support work, care coordination.	All projects linked people to needed health services and improved diabetes and hypertension care and compliance. HN- reduced ER visits; increased access to mental and behavioral health services, reduced access and other barriers to clients increased referral sources, increased client numbers.
Assure a competent public health and personal health care workforce.	Provide Culturally Appropriate Health Education and Information	Attain the MN CHW Certificate Act as a liaison: Work in a bi-directional manner, communicating between provider and client and client and provider on health issues, cultural nuances and the SDH. Increase the cultural competence of the health care workforce by providing community/culturally specific information and impacts of the SDH.	P4H- CHWs attained the CHW Certificate. CHWs regularly educate providers on cultural issues. MHD- CHWs have CHW Certificate DMV/Nobles – all CHWs got the CHW Certificate HN- CHWs getting the CHW Certificate.	Increase in understanding of the population and culturally competent care available in all areas. All projects CHWs had or were earning the CHW Certificate.
Inform, educate, and empower people about health issues.	Provide Culturally Appropriate Health	Conduct outreach to find and connect with hard to reach clients.	P4H- Home Visits, Health Fairs, WIC Clinics and Child and Teen Checkups.	P4H- CHW integrated into core public health services.

	<p>Education and Information</p> <p>Provide Coaching and Social Support</p> <p>Build Individual and Community Capacity</p>	<p>Provide home visits and/or groups to educate, empower and monitor progress on health issues.</p> <p>Plan or participate in health-related events and fairs to inform and educate the individuals and the community.</p>	<p>MHD- Bring services to residents in public housing buildings. Help clients understand and follow their care plan.</p> <p>DMV/NC- take services to people through home visits and worksites. Help clients understand and follow their care plan.</p> <p>HN- CHWs active in outreach, client direct services and community events.</p>	<p>MHD- Residents report that they feel better.</p> <p>DMVN Improved access to care and health outcomes. Example; clients with A1c >10 brought down to A1c <7.</p> <p>HN- Improved access to care and health outcomes. Reduced ED visits.</p>
<p>Mobilize community partnerships to identify and solve health problems.</p>	<p>Provide Outreach</p> <p>Build Individual and Community Capacity</p>	<p>Participate in community partnerships related to health and health equity.</p> <p>Provide outreach and inclusion to community members so the partnership reflects the community.</p> <p>Identify and provide coaching and support to empower new leaders from the community.</p>	<p>P4H- CHW participates in community efforts.</p> <p>DMV- CHWs started both a Hispanic and an African Task Force for Health.</p> <p>MHD- network of partner organizations CHWs can draw on and refer clients to.</p> <p>HN- works through a multidisciplinary community collaboration to promote and support CHWs and the agencies which employ them. Developed regional CHW network.</p>	<p>DMVN- engagement of the Hispanic and African communities (community members and leaders) on health issues. Fostered new and existing public health partnerships by offering CHW services to outside service organizations such as a family planning clinic, behavioral health center, clinic setting, and a local pharmacy.</p> <p>HN- Effective community collaborative in place to promote and support CHW employment and grow CHW field across northern MN, an increase in the number of collaborative members. Exploring hub model.</p> <p>Regional CHW Network in place and operational. Sustaining CHWs through collaboration and braiding funding streams and resources. Providing support to CHWs and employers through a regional CHW network and a multidisciplinary community collaborative.</p>

