Minnesota Community Health Worker Roadmap: *Charting a Sustainable Future for the CHW Workforce in Minnesota*

Executive Summary

Community Health Workers (CHWs) play an invaluable role in Minnesota's health and social service landscape. Recognizing this, Minnesota embarked on a journey to strengthen and sustain the CHW workforce which supports the varied needs of all communities across Minnesota. This roadmap outlines a strategic plan and corresponding logic model and measurement plan to integrate and sustain CHWs more fully into the state's health infrastructure. The Minnesota Community Health Worker Alliance (MNCHWA) in partnership with the Minnesota Department of Health (MDH) engaged stakeholders in a community-based planning process informed by previous foundational work, an environmental scan and community experience and knowledge.

The goal of the roadmap is *to develop, refine, and expand the CHW profession in Minnesota; equip CHWs to address health needs; and to improve health outcomes*. The plan has nine objectives and 35 strategies. Objectives cover the following areas:

- CHW voice and leadership;
- Growing awareness of CHWs and the benefits of CHW services;
- Increasing the number, diversity, service types and geographic locations of CHWs;
- CHW training, development and advancement opportunities.
- CHW integration into evidence-based models and care teams;
- A measurement/evaluation system;
- Funding models.

This roadmap is meant to be used by all CHW stakeholders in Minnesota. MDH and MNCHWA can support and develop the field. The role of stakeholders is to utilize the strategies in the road map to guide and expand CHW programs and services across Minnesota. Employers, health care, social service and community-based organizations are particularly critical to expanding CHW services. This roadmap and MNCHWA resources and consulting services are available to assist.

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Prepared by: Minnesota Community Health Worker Alliance (MNCHWA), Minnesota Department of Health (MDH), Community Health Worker Initiative, Stakeholders and Partners; **June 30, 2025**
This work was funded by the Minnesota Department of Health Community Health Worker Grant, made available through the Minnesota Legislature.

LINKS

CHW Roadmap: https://mnchwalliance.org/wp-content/uploads/2025/07/Minnesota-Community-Health-Worker-Roadmap-7.01.25.pdf

Logic Model
https://www.health.mn.gov/communities/commhealthworkers/docs/logicmodel2025.pdf

Measurement Plan: https://mnchwalliance.org/wp-content/uploads/2025/07/Measurement-Plan-and-Appendix-Final.pdf

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Date: June 2025

Introduction and Purpose

Community Health Workers (CHWs) are pivotal in bridging communities and health systems, addressing health disparities, reducing health care costs, and promoting health equity. Recognizing their invaluable role, Minnesota has embarked on a journey to strengthen and sustain the CHW workforce that supports the varied needs of diverse and under-resourced communities across Minnesota. This roadmap outlines a strategic plan to integrate and sustain CHWs more fully into the state's health infrastructure and corresponds to a CHW Logic Model and Measurement Plan which outlines the goals, strategies, activities and expected outcomes.

Defining Community Health Workers

According to the American Public Health Association (APHA):

“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.”

Minnesota Community Health Worker Scope of Practice

Bridge the gap between communities and health/social service systems:

As members of the local community, community health workers are well positioned to facilitate communication between provider and patient to clarify cultural practices, educate community members about appropriate use of the health care and social service systems, and educate the health and social service systems about community needs and perspectives.

Help patients navigate health and human services systems:

Community health worker roles include promoting access to primary care through culturally competent outreach and enrollment strategies, making referrals and coordinating services, educating patients on the knowledge and skills needed to obtain care, providing follow-up services to facilitate continuity of care, enhancing access to coverage by assisting clients in enrolling in public assistance and other programs for which they qualify, and linking clients to and informing them of available community resources.

Advocate for individual and community needs:

Community health worker roles include engaging communities and individuals in advocating for themselves, articulating and advocating on behalf of the needs of the community and individuals (especially those unable to speak for themselves), and understanding the resources and support available in local communities.

Provide direct services:

Community health workers provide direct services to patients and providers, including providing culturally appropriate information on health, wellness, and disease prevention and management; assisting clients in self-management of chronic illnesses and medication adherence; organizing and/or facilitating support groups; providing referrals and linkages to preventive services (e.g., screenings); and conducting health-related screenings.

Build individual and community capacity:

Community health workers work to identify individual and community needs. They help build the capacity of individuals for wellness. They help build the capacity of communities by addressing the social determinants of health. They also mentor other community health workers to build their capacity. They promote their own professional development through continuing education and peer support.

Organizational Missions

Minnesota Community Health Worker Alliance (MNCHWA)

The Minnesota Community Health Worker Alliance is a statewide nonprofit organization dedicated to improving the health of all Minnesotans.

The Mission is to build community and systems capacity for better health through the integration of community health worker (CHW) strategies.
The Vision is equitable and optimal health outcomes for all communities.
MNCHWA serves as a convener, catalyst, expert, and resource to advance and integrate better health through community health worker (CHW) strategies. CHW approaches are an integral part of the solution to the challenges facing our communities, health care, public health, and social services systems. MNCHWA builds awareness, promotes education, partners to integrate and expand access to CHW models, shares research, and takes action for greater impact. provide information, networking, training, consulting, and technical assistance services.

Minnesota Department of Health (MDH) CHW Initiatives

The Minnesota Department of Health (MDH) is committed to strengthening and expanding the CHW workforce in Minnesota with the goal of reducing health disparities and improving health outcomes in Minnesota.

MDH CHW Initiatives supports collaboration and coordination between state and community partners to: develop, refine, and expand the community health worker profession in Minnesota; equip community health workers to address health needs and conditions that impact community health and wellbeing; and improve health outcomes.

Community Health Worker Infrastructure in Minnesota

The CHW infrastructure in Minnesota includes The MDH CHW Initiative, The Minnesota Community Health Worker Alliance (MNCHWA), and a variety of stakeholders and partners. The MDH CHW Initiative provides leadership in the state in CHW awareness, policy and infrastructure to strengthen the CHW workforce; data collection and evaluation to inform best practices for the best fitting CHW models in MN; promotes integration of CHWs into public health initiatives across the state and within the MDH; and provides CHWs access to no-cost learning modules on health promotion and chronic disease topics in their online Learning Center.

MNCHWA has worked to establish:

- a CHW Scope of Practice,
- a 16 credit CHW Certificate Training Program offered in partnership with the MinnState College and University System at community colleges,
- The CHW Certificate as the recognized credential,
- Reimbursement for CHW services,
- a CHW Leadership Institute,
- a monthly CHW Learning Circle,
- A quarterly CHW Supervisor Roundtable,
- Various training and conference opportunities
- A CHW Registry.

Environmental Scan: Minnesota's CHW Landscape

An environmental scan conducted in late 2024 revealed:

- **CHW Certificate Holders:** 1,631 (64% from Greater Minnesota)
- **Employed CHWs:** Approximately 880
- **CHW Employers:** 77 employers billing Medicaid; 209 CHWs enrolled with DHS
- **Geographic Coverage:** CHWs active in 54% of Minnesota counties
- **Settings:** CHWs embedded across 11 sectors, including healthcare, public health, and community organizations
- **Key Barriers:** Low salaries, lack of full-time positions, inconsistent supervision, and documentation challenges
- **Facilitators:** Organizational readiness, employer champions, reflective supervision, and CHW leadership development

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Workgroup Formation and Discussions

To develop this roadmap, four workgroups were established, each focusing on a strategic area:

1. Training & Workforce Development

2. Evidence-Based Models and CHW Services
3. Sustainable Funding and Policy
4. Data and Evaluation

Each workgroup was comprised of CHWs, employers, educators, payers, policymakers, and other stakeholders. Through a series of meetings and discussions, they identified challenges, opportunities, and recommendations for strengthening the CHW workforce in Minnesota.

Guiding Principles and Values

The workgroups identified the following core principles to guide the roadmap:

- **Equity:** Ensuring fair access to resources and opportunities for all communities.
- **Inclusion:** Valuing diverse perspectives and experiences in decision-making processes.
- **Collaboration:** Fostering partnerships across sectors to achieve common goals.
- **Sustainability:** Building long-term systems and structures to support the CHW workforce.
- **Empowerment:** Promoting CHW leadership and professional growth.

OBJECTIVES, JUSTIFICATION, STRATEGIES AND ACTIVITIES

Goal: By 2028, develop, refine, and expand the CHW profession in Minnesota; equip CHWs to address health needs; and to improve health outcomes.

The following objectives, strategies and activities were identified, reviewed and approved by stakeholders through the Sustainable Plan workgroups and planning process. They are also reflected in the CHW Logic Model.

Objective One: By June 2028, advance the CHW profession and workforce with direct input and voice of CHW themselves.

Justification: *Ensures CHW voices and experience are reflected in leading the field.*

Strategy 1: CHWs have voice in any structural changes (changes to scope, certificate, continuing education, data, research on CHWs in Minnesota, etc. (*Nothing about us without us.*)

Activities:

- Create avenues for CHWs to co-design trainings and programs they are a part of, following the principle of "Nothing About Us Without Us."
- CHW research training course. (U of MN, U of Michigan)

Strategy 2: Develop CHW led work group or professional organization to advance the field.

Activities:

- CHWs are at the table and involved in field building - CHW Circle, Leadership Institute, work groups, etc.
- Develop local CHW Coalitions by geography: Support CHW groups to facilitate networking, resource sharing, and joint problem-solving.

Strategy 3: Support emerging CHW leaders in the CHW profession (includes professional development and leadership programs.)

Activities:

- Continue and expand access to the Alliance's CHW Leadership Institute.
- Identify professional and leadership development opportunities for CHWs.
- Embed leadership skills into all levels of training, including conflict resolution, advocacy, public speaking and peer mentoring.
- Provide professional development opportunities to CHWs- community and professionally based leadership positions, conferences and training.
- Ensure CHW voice and leadership in development of profession such as certification – "Nothing about us, without us"

Strategy 4: Raise awareness with community and state agency stakeholders.

Activities:

- CHW leaders are integrated into community and state agencies.

Objective 2: By June 2028, expand community awareness of CHWs and results

Justification: *Builds awareness and integration of CHW services and results***.**

Strategy 5: Statewide Public Education Campaign

Activities:

- Public Awareness Campaign: Use media (billboards, social media, local TV/radio) to raise awareness of the CHW role and results. Consider a "CHW Month" with community events.
- Build public awareness campaign of CHW role; Tailored messaging for legislature, CHW employers/potential employers, community leaders throughout the state, and peer agencies (ex. state agency staff who are responsible for health care reform efforts).
- Highlight ROI in Advocacy: Capture cost savings (e.g., 3:1 ROI) and translate them into advocacy materials for funders and policymakers.
- Conduct cost study to present correlation between positive health outcomes (including reduced disparities) and higher reimbursement for CHW services.
- Develop a one-stop-shop website for the profession with resources including training materials for CHWs, employers, academic and professional institutions, legislature etc.

Strategy 6: Train the Trainer for CHW Advocacy

Activities:

- Train-the-Trainer for CHW Advocacy: Empower CHWs and allies to tell their stories and advocate for sustainable roles in their own words.

Objective 3: By June 2028, increase the number of rural and diverse students completing the CHW certificate program from baseline of 142 rural students (52%) and 68 students from diverse communities (55%) to 80% combined students from rural or diverse communities.

***Justification**: CHWs from these areas are often best positioned to serve their communities. Local access to training reduces geographic and financial barriers.*

Strategy 7: Raise awareness with employers about CHW roles (or CHW-like roles), the CHW certificate program and scholarship options, program models available.

Activities:

- Create videos and other materials.

- Conduct outreach in rural locations.
- Tabling/presenting at conferences.

Strategy 8: Seek out funding sources to pay for CHW certificate completion (focus on rural and diverse cultures), continue HRSA funded scholarship program through 2025.

Activities:

- Continue student support at MNCHWA, recruiting cultural groups and rural locations.
- Foster diversity in recruitment by reducing financial and logistical barriers to CHW certificate.

Strategy 9: Higher Education partners sustain and grow certificate program sites (especially in rural and underserved areas).

Activities:

- Pipeline programs, recruitment efforts for staff and students and internships, increase offerings to Tribal Nations or other schools.
- Increase availability and access to the CHW Certificate program.
- Explore alternative methods to gain the certificate without compromising the education and training CHWs receive.
- Create Targeted Pipelines: Partner with rural schools, community colleges, and immigrant/refugee-serving organizations to train culturally and linguistically diverse CHWs.

Objective 4: By June 2028, increase the number of CHW (certificate holders or not) in the workforce from 880 (DEED estimate) by 10% (968).

Justification: *Anchors CHWs in institutional structures, creating job security and legitimacy. Tiered career pathways improve retention and offer professional growth opportunities, making CHW roles more sustainable and appealing. CHW integration enhances care coordination, trust and improved health outcomes.*

Strategy 10: Outreach to expand diversity and location of employers hiring CHWs.

Activities

- Engage in presentations and share videos and case studies about diverse locations and models.
- Provide organizational readiness and program development consulting and technical assistance services.

Strategy 11: Raise awareness with employers about CHW retention, wages, support, value add, inclusion with colleagues in other professions.

Activities

- Provide consulting/tech assistance for retention practices, value add information, professional development, appropriate compensation, etc.

Strategy 12: Organization readiness and technical assistance for employers

Activities

- Provide job title/class templates.
- Offer consulting/technical assistance to set up job class/pay scale, scope of work, program design, etc.
- Encourage MNCHWA organizational readiness assessment and employer readiness training.

Strategy 13: Support supervisors of CHWs.

Activities

- Offer supervisor training.
- Provide time for CHW supervision, huddles and problem solving.
- Continue to provide the CHW Supervisor Roundtables, reflective practice.
- Provide technical assistance and support to CHW supervisors.

Strategy 14: Increase utilization of apprenticeship and on the job training/mentorship for new CHWs (certificate holder/or in process, new apprentices.)

Activities

- Increase the number of Registered Apprenticeship Sites.
- Utilize the Alliance's umbrella CHW apprenticeship for on-the-job training and mentorship.
- Strengthen the state's CHW apprenticeship program that enables those with lived experience to receive stipends and or livable wages while they attend school and work.

Strategy 15: Develop tiered career pathways for CHWs, including specialty roles and training opportunities.

Activities

- Create tiered CHW roles (e.g., CHW1, CHW2, CHW3) that support pay equity based on years of experience, leadership roles, specialized training, etc., CHW as supervisors of CHW programs (creating tiered roles internal to organizations, MNCHWA can provide consulting/ assistance).
- Promote Career Pathways: Develop clear CHW career ladders that include advancement into supervisory or specialized roles (e.g., chronic disease management, behavioral health). Specialization is tied to pay increases or role shifts.
- Incentivize clearer CHW job titles to track employment accurately through funding and grant preferences to employers hiring for CHW positions.

Objective 5: By June 2028, increase the number of unique CHWs (certificate holders or not) from 37 at baseline to 50 annually that complete trainings (MDH training online for baseline) beyond core curriculum.

Justification: *Continuous learning and connection enhances CHW effectiveness and strengthens the workforce. Tiered career pathways improve retention and offer professional growth opportunities, making CHW roles more sustainable and appealing. These competencies ensure CHWs can deliver inclusive, respectful and effective care.*

Strategy 16: Centralize system to find/complete trainings (clearinghouse.)

Activities

- MNCHWA Platform and registry provide awareness, and information on CHW trainings.

Strategy 17: Develop ongoing CHW training opportunities and specialty training for all CHW in the state (employed or not, certificate holder or not.)

Activities

- MDH continue and expand online CHW training modules on public health, chronic disease, and health promotion topics (certificate not required).
- Explore creating an infrastructure for Continuing Education credits
- MNCHWA trainings offered through registry.
- Create avenues for CHWs to co-design trainings and programs they are a part of, following the principle of "Nothing About Us Without Us."
- Build collaborative training programs for CHWs interested in further training or specializing in healthcare areas (e.g. behavioral health, cancer, geriatric, SUD) impacted by workforce shortages.
- Standardize Medical Terminology Support: Offer ongoing training for CHWs in medical language, dialect variations.
- CHW research training course (U of MN, U of Michigan).

Strategy 18: Integrate cultural competency and health equity into trainings opportunities

Activities

- Develop Cultural Competency Modules: Include training for CHWs and employers in culturally responsive care, especially for emerging immigrant communities (e.g., Sudanese, Afghan).

Objective 6: By June 2028, increase the number of employers that are supporting the use of evidence based models (baseline of 37) by 20% and documenting promising practice models.

Justification: *Proven models can guide effective CHW program design and demonstrate return on investment. CHW integration enhances care coordination, trust and improved health outcomes.*

Strategy 19: Create technical assistance to get started by model type. Could include cohorts in MN to build out models, document promising practices, for measuring / ensuring fidelity.

Activities

- National resources related to models.

- Funding for efforts to implement models, organizational/employer readiness via MNCHWA.
- Data support for measurement in one location.
- Demonstration projects.
- Tools: Tool kits / templates, facilitated cohort, problem solving teams/MNCHWA community of practice for those using same models.

Strategy 20: Implement and evaluate evidence-based and community-driven CHW models across health care, public health, and community organizations to meet the varied needs of communities across Minnesota

Activities

- Implement and expand the use of evidence-based models such as Pathways Community Hubs, IMPACT, and team-based care models.
- Document and Share Community-Driven Models: Collect and publish success stories from programs that focus on whole-person care, cross-sector referrals, and cultural bridging. (CHW led research could be lifted up here.)
- Create Tools: One pagers, case studies, conference presentations.

Strategy 21: Promote CHW integration into healthcare teams and community-based organizations.

Activities

- Launch Organizational Readiness tools and Stakeholder Orientation to support optimal job alignment and integration on teams and educate organizations on appropriate CHW roles to prevent misutilization (e.g., transporters vs. trusted health advisors).
- Promote Interdisciplinary Team Integration: Provide guidance and training to supervisors and clinical teams on CHW roles to foster respect and reduce professional role conflict (e.g., with social workers, nurses).
- Structure CHW schedules and documentation to recognize CHW Contributions: Advocate for provider schedules to include CHW visit time, and develop EHR-compatible templates and training that reflects relationship-building needs that reflects relational and holistic work.

Strategy 22: Document and disseminate best practices and success stories.

Activities

- **Publish a compendium** of CHW best practices (CHW research inclusion….)

- **Host** annual CHW model innovation summit.

Objective 7: By June 2028, establish a functional measurement system for annual indicators of CHW infrastructure in MN.

Justification: *Enables better workforce planning, communication and impact tracking. Informs policy and practice and builds momentum for system-wide change. Provides data to justify funding and expand evidence-based practices. Keeps decision makers informed with current trends and needs.*

Strategy 23: Build data communication tools (registry, landing page (website) and dashboards).

Activities

- Finalize CHW Platform landing page location, invest in IT needed to support dashboard function, determine personnel needed to maintain.
- Establish CHW research workgroups (expansion of the CHW role to include research and evaluation).
- Build up a robust CHW Registry platform that increases statewide connectivity for CHWs and Allied CHW professionals.
- Strengthen the Statewide CHW Registry- Use the registry to track employment, cultural/language data, billing success, and geographic distribution of CHWs.

Strategy 24: Build relationships with data partners (include Data Use agreements if necessary.)

Activities

- Build relationships with data partners.
- Create and/or share template data use agreements.
- Engage CHWs in measurement and evaluation.

Strategy 25: Establish metrics to evaluate CHW impact on health outcomes.

Activities

- Develop a comprehensive evaluation plan with standardized metrics and frameworks.
- Strengthen data infrastructure for monitoring and evaluating CHW programs.
- Conduct regular surveys and studies to inform policy and practice.

- Create an ongoing data collection system on CHW distribution, services, and community needs.

Strategy 26: Promote CHW-led research and evaluation initiatives.

Activities

- Engage CHWs and communities in creating and interpreting evaluation metrics.

Objective 8: By June 2028, increase the number of employers billing for CHW time to MA and Medicare for reimbursement by 15% from 37 (baseline in 2024) to 42 in 2028.

Justification: *Enables long-term funding mechanisms tied to service delivery. Enhances CHW sustainability. Supports transparency and consistency across providers.*

Strategy 27: Raise awareness with decision makers

Activities

- Relationship building: one on one meetings.
- Advocacy
- Reports of barriers in billing process.

Strategy 28: Create consulting/technical assistance to get started

Activities

- Provide training, consulting and technical assistance on how to set up for billing and bill.
- Provide tools, documents and other online tools
- Create a billing learning community to learn, share information, identify barriers and support one another.
- Facilitate peer learning opportunities where employers/organizations can learn from organizations in other states or within Minnesota that have successfully built billing partnerships.

Strategy 29**:** Increase the CHW reimbursement rate

Activities:

- Continue legislative and other advocacy to create alignment between DHS, policy makers and payors on the rate.
- Set minimum reimbursement standards at $60 per unit or $120 per hour for CHW services to ensure a livable wage and job retention.

Strategy 30: Advocate for full implementation of reimbursement for a broad range of CHW services.

Activities

- Tie Services to Medicaid Core Benefits: Explicitly link CHW services to Medicaid-covered care coordination and disease management to secure prioritization in funding models.
- Expand billable services by advocating for policy changes that reflect the full scope of CHW contributions (e.g., outreach, health education, resource navigation) under Medicaid and new billing codes (e.g., G0019, G0022). Care coordination and outreach can be reimbursed.
- Remove Initiating Provider Visit Requirement: Advocate for policy changes at the federal and state levels to eliminate the requirement for a physician visit before CHWs can bill Medicare/Medicaid services.
- Support Medicaid enrollment for CBOs or establish umbrella organizations to bill on behalf of smaller CBOs.
- Maximize Medicaid and MCO Reimbursement: Align CHW services with reimbursable Medicaid benefits and incentivize MCOs to contract directly with CBOs.
- Explore CHW Certificate Internship Billing: Create a mechanism for reimbursement of services delivered by CHWs providing eligible billing services during their required internship.
- Encourage Ecosystem-Based Models: Promote models that braid funding (e.g., grants + billing) and adapt to local context (e.g., rural vs. urban needs).

Strategy 31: Establish/streamline use of standardized billing, including use of codes and reimbursement rates.

Activities

- Simplify Billing Infrastructure: Support technical assistance and reduce administrative complexity—particularly for small, rural, and low-volume organizations—through centralized billing support or shared service models.

- Streamline Payment Timelines: Work with DHS and payers to reduce claim return rates and expedite reimbursements, minimizing cash flow gaps for community-based organizations.
- Designate CHW billing champions within payer and provider systems to co-develop streamlined billing pathways.
- Provide training and technical assistance to employers on billing and reimbursement processes, gaining NPIs for CHWs, CHW role and scope of practice, and organizational readiness.
- Promote the development of community care hubs (CCHs) that can centralize billing, data collection, and reporting infrastructure. Provide funding for hub development.
- Host cross-sector training sessions to align interpretation of CHW billing codes, improve implementation consistency, and reduce errors in claim submission
- Provide grant funding and technical assistance for CBOs to train staff in CHW program development, billing, data collection, and healthcare navigation.
- Formalize Stakeholder Feedback: Establish a workgroup and/or Interagency Council (including CHWs) to track implementation barriers with new billing codes and regularly report findings to DHS and legislative stakeholders.
- Create CHW Liaison role within DHS for CHW billing and policy support and leverage MDH's supportive role to advocate for DHS engagement with CHW programs

Objective 9: By June 2028, increase the number of actionable ways to pay for positions from grants and billing to a wider set of options

***Justification**: Provides stability during early program development and scaling. Enhances CHW program sustainability.*

Strategy 32: Raise awareness of CHW impact and outcomes and braided funding.

Activities

- Include CHW benefits in public awareness campaign and conference presentations and tabling.
- Include "how to" on braided funding in CHW Supervisor Roundtable, consulting/technical assistance to employers and conference presentations.
- Create a CHW research work group on impact and outcomes measurement.

Strategy 33: Identify other funding sources (mechanisms- bill payors outside of Medicaid (via invoices/contract with payors))

Activities

- Create a workgroup to research funding mechanisms nationally and in Minnesota with CHWs involved
- Develop Rural CHW Placement Incentives**:** Implement incentive programs (e.g., stipends, housing support, mileage reimbursement) to recruit and retain CHWs in rural and underserved areas.

Strategy 34: Secure funding for CHW positions through state, private, and federal grants.

Activities

- Use grants for Infrastructure Development: Apply public health and other state/national funding and philanthropic grants to build administrative and programmatic capacity.
- Pilot Pay-for-Performance Initiatives: Launch demonstration projects that tie private or public investments to CHW-related health outcomes.

Strategy 35: Develop policies that support CHW integration and sustainability into organizational budgets, county, state funding.

Activities

- Coordinate with County and State Resources: Integrate CHW funding with local levies, state innovation grants, and DHS pilots to expand reach and sustainability.
- Engage Policymakers: Advocate for policy changes that support flexible, value-based payment models for CHW services.
- Advance Legislative Advocacy: Promote legislation that enhances CHW funding, recognizes CHW contributions to high-need populations, and addresses systemic billing and workforce barriers.
- Improve Communication and Relationships with State Agencies – MDH, DHS, DEED, DOL, etc.
- Create Model Contracts: Develop standard templates that define roles, metrics, payment rates (e.g., $120/hour), and data sharing protocols between CBOs and payers.
- Align CHW funding with value-based payment models, tying reimbursement to outcomes such as improved chronic disease management or reduced ER use.
- Implement Shared-Risk Agreements: Use shared-gain/loss models to align incentives between CBOs and health systems while mitigating financial risks.

Conclusion

This roadmap represents a collective effort to recognize, support, measure and sustain the vital work of Community Health Workers in Minnesota. By implementing these strategic recommendations and adhering to our guiding principles, we aim to build a more equitable and effective health system for all Minnesotans.

Who Should Use This Road Map?

This roadmap is meant to be used by all CHW stakeholders. MDH and MNCHWA can support and develop the field. It is stakeholders who must implement many of the strategies identified through the planning process and in the road map.

The role of MDH is to strengthen and expand the CHW workforce in Minnesota through collaboration and coordination between state and community partners.

The role of the Minnesota CHW Alliance is to serve as a clearinghouse, catalyst, expert, resource, educator, service provider and field builder to advance and integrate community health worker strategies across Minnesota. MNCHWA is the first contact point when starting CHW services and programs.

The role of stakeholders is to utilize the strategies in the road map to guide and expand CHW programs and services across Minnesota. Employers are particularly critical to expanding CHW services. This roadmap and MNCHWA resources and consulting services are available to assist.

How to Use this Road Map

Stakeholders may use this roadmap to guide their CHW and health improvement work. It can be a primary planning tool, driving strategies and data collection. It can be helpful in engaging CHWs and communities, creating grant applications and evaluation plans, designing CHW programs and data collection systems, expanding CHW training and education, finding and implementing the right CHW model, gaining payment for CHW services, and more. Most importantly, wide use of the road map will contribute to the development and expansion of CHW services across Minnesota and the resulting improvement in individual and community health.

Acknowledgments

We extend our deepest gratitude to the CHWs, partners, stakeholders, organizations, and community members who contributed their time, expertise, and passion to the

development of this roadmap. Your commitment to health and community well-being is the foundation of this work.

Together, we are building a healthier Minnesota.

Note: This roadmap is a living document and will be updated regularly to reflect progress, new insights, and evolving community needs.

This work was funded by the Minnesota Department of Health Community Health Worker Grant, made available through the Minnesota Legislature.

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Appendix A: Stakeholders and Partners Contributing to this Road Map

Workgroup Leads

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Evan Curtain, Wellshare International
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Kali Dahmus – CUHCC, Education Program Manager
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Rebecca Hansen, Park Nicollet/Health Partners
Kecia Hayslett, Excellence Health Career Center
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Carrie Harris, CHW, Volunteers of America
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Sadie Herbst, Duluth School Community Collaborative
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Appendix B: CHW Common Indicators

CHW Common Indicators

1. CHWs[1] will be involved in data collection for many of these indicators. This is true, for example, of indicators that are included in pre-post surveys/assessments with participants.
2. Whenever possible, we recommend that indicators be operationalized in existing data collection and/or case management tools, to reduce the burden on CHWs and data management staff.
3. We have developed quantitative indicators because they are easiest to implement in a consistent and reliable way. We recommend that these indicators be used along with qualitative methods that are specific to the culture/community and setting.
4. When we recommend an indicator be collected on a CHW Encounter Form, that can occur either on paper or via an online case management database like RedCap, CareScope, ETO, SMART Sheets, etc.
5. Assessing CHWs' contributions to improving population health (e.g., with community-level indicators) is crucial. However, it is beyond the scope of most CHW programs to do that on their own; for this reason, among others, we do not include community-level indicators. We do, however, include a participant general health indicator (Indicator #6, below).
6. For collecting initial assessment data, some CHW programs use Intake Forms, some use a pre-assessment, and some use both. Any of the participant outcome indicators that we recommend for inclusion in a pre-assessment could also be included in an Intake Form, as long as that same indicator is repeated at regular intervals to assess change
7. We acknowledge the importance of health care utilization and cost measures; however, not all CHW programs have access to utilization and/or cost data. One of the criteria for the CHW Common Indicators was potential for use in ALL CHW programs, regardless of setting, community, or geographic location.
8. Statements that proceed each indicator are explanations of that indicator. These introductions are not intended to be used in data collection tools.
9. The CHW Center for Research and Evaluation is constantly making changes and improvements to these indicators. Before using the Indicators, we strongly recommend you contact us by using the form on our website, to ensure you are using the most updated version of each indicator in the recommended way.
10. The CHW Common Indicators do not represent a complete set of all the questions that need to be asked in a statewide CHW survey, nor do they represent all the questions or indicators necessary for measuring participant outcomes. They are intended as *core set of measures* that can be used in all settings. Particular workplaces, programs, statewide associations, state and local health departments, etc., will need to supplement these indicators with others suited to their unique circumstances.

NOTE: The indicator grid below includes the construct, its definition, a rationale for measuring that construct in programs that employ CHWs, and how to operationalize the construct. To learn how to measure the construct, click on the hyperlink embedded in the name of the construct. This will take you to a place lower down in the document where the measurement approach is explained.

CHW Center for Research and Evaluation: CHW Common Indicators Grid (version 03.28.2025)
(References available upon request.)

Construct	Definition	Rationale for Measuring	How to Operationalize
#1 CHWs' level of compensation, benefits, and promotion (PROCESS)	The salary paid to CHWs in relation to their FTE and local cost of living, in addition to the presence or absence of various benefits, as well as opportunities for promotion	*(1) Justice*: Insufficient payment is exploitative and unfair. (2) *Effectiveness/performance*: Sufficient compensation allows CHWs to dedicate their full time and attention to community health work because it provides for all their material needs. (3) *Addressing poverty and lack of good jobs within communities*: Sufficient compensation for CHWs can facilitate a pathway out of poverty over the long-term. Living wage CHW jobs provide job development in communities.	**Method 1: CHW surveys** **Method 2: CHW employer surveys**
#2 CHW enactment of the	How often individual CHWs or a group of CHWs within a program,	Collecting these data is critical to evaluating the unique contributions of CHWs and the outcomes they achieve. Research suggests that CHWs are better able to contribute to improving	**CHW Encounter Forms** or other forms used to track CHW

10 core roles (PROCESS)	organization, state, or region enact each of the 10 core roles defined by the National C3 Council (formerly, the C3 Project).	health and decreasing health inequities when they are supported to play a full range of roles. In addition, clarity about CHW roles can foster CHW integration into teams and will also allow training to be geared to meet CHWs' needs, and/or to emphasize the necessity of playing a full range of roles.	interactions with individuals and groups.
#3 CHW-facilitated referrals (PROCESS)	Completed referrals facilitated by the CHW, through which the participant successfully receives attention, care, and/or resources from a clinic, other healthcare or social service agency or public service.	Making and facilitating referrals for community members to needed and appropriate health or social services is directly connected to at least 7 of the 10 core roles of a CHW as defined by the Natl. C3 Council. This key component of CHW work is currently being measured at the individual programmatic level, and although there are various models and survey questions used within the domestic and international setting, there is no other recommended standard instrument that can be used to generate national data sets for this activity.	**CHW Encounter Forms** or other forms used to track CHW interactions with individuals and groups (paper or digital).
#4 CHW involvement in decision-and policy-	The extent to which a CHW can be involved in policy making both within their own	Policy making is one of the three core functions of public health. CHWs' ability to address the social determinants of health and eliminate health inequities depends on their ability to create and influence health-promoting	**CHW surveys**

making (PROCESS)	organization and in the larger community on work time and/or as part of their volunteer commitment.	policy, both within and outside their employing agency. Being able to influence policy depends on knowing who to work with, being trusted by other policy actors, and being supported to engage in policy making on work time.	
#5 CHW integration into teams (for example, health care teams) (PROCESS)	The extent to which CHWs are members of a collaborative and communicative team with other providers (i.e. nurses, doctors, social workers, health educators, pharmacists, etc.) within a clinic, school, social service agency, etc.	Well-functioning, transdisciplinary teams have been recognized by the Institute of Medicine as key to the safety and quality of care across multiple settings. Integration of CHWs into transdisciplinary healthcare and social service teams is widely recognized as key to the effectiveness, cultural appropriateness, and quality of care. Despite wide recognition of its importance, integration of CHWs into care teams and its impact on team functioning are rarely measured. Also, while care teams may include CHWs, this does not mean CHWs are meaningfully integrated as full participants in those teams.	**CHW surveys**
#6 Participant self-reported physical, mental,	The self-reported assessment of perceived physical, mental and emotional	An indicator of self-reported health is important for monitoring and assessing the perceived general and functional health and quality of life of individuals and populations. It is widely used in the U.S. and worldwide, relatively easy to	**Participant surveys**

and emotional health (OUTCOME)	health and quality of life.	measure, and generally correlates well with clinically measured health status, use of health services and health care costs. Self-reported health incorporates the voices of individuals and provides a more holistic view of overall health.	
#7 Participant health care and social needs (OUTCOME)	Health care and social needs currently experienced by the participant.	A key proven outcome of CHW action is more secure access among participants (and their households) to primary care and various social services that may be needed (e.g., food banks, housing support, legal support, etc.). More secure access to primary health care and social services, in turn, is crucial to the wellbeing of marginalized households and communities.	**Participant surveys or assessments**
#8 Participant social support (OUTCOME)	The level of support (i.e., assistance/help) that participants perceive from others to deal with regular and emergent life challenges, including economic, social, health, and emotional challenges.	The presence of social support has been associated with faster recovery from illness, responsiveness to treatment in stress-related illnesses, fewer pregnancy complications, decreased levels of depression, greater life satisfaction, and better well-being. Lack of support is strongly associated with increased morbidity and mortality. CHWs provide social support both directly, by accompanying community members, and indirectly, by linking them to existing groups and starting new ones.	**Participant surveys**

#9 Participant empowerment (OUTCOME)	A composite measure assessing both actual and perceived empowerment. Includes 10 domains: self-efficacy, sense of community, perceived control at the community level, decision-making ability, education/knowledge/skills, critical consciousness, optimism, inner peace, communication, and resources.	Empowerment is recognized by the World Health Organization and health agencies around the world as a core concept in health promotion and integral to the achievement of social equity. Empowerment independently predicts self-reported health status and depression, and is in the pathway to improved health, making it a good intermediate measure of health status. Increasing empowerment is seen as a critical CHW function; it has also been hypothesized that CHWs are unique among other health and social service professionals in their ability to support participants to increase their empowerment.	**Participant surveys**
#10 Policy and system change: program/ employer level (OUTCOME)	Policies and system changes at the *employer level* that address CHW workforce development and sustainability (e.g., training, payment, etc.).	The CHW workforce is best respected and stabilized through policies that support their sustainability, including a recognized definition and scope of practice/roles, core-competency-based training, voluntary certification mechanisms, appropriate supervision, and payment mechanisms that support sustained employment, e.g., general funds and sufficient and holistic forms of reimbursement. CHW employers and programs can institute these policies at the CHW employer/program level.	**CHW program/employer surveys**
#11	Policies and system changes at the *state level* that address	State governments can also facilitate policy and systems changes that support CHW programs, employers and the CHW	**Systematic review of a state government's**

Policy and system change: state level (OUTCOME)	CHW workforce development and sustainability (e.g., training, payment, etc.).	workforce. These changes include, for example, a recognized definition and scope of practice/roles, core-competency-based training, voluntary certification mechanisms, appropriate supervision, and payment mechanisms that support sustained employment, e.g., general funds and sufficient and holistic forms of reimbursement.	**policies and practices**
#12 Supportive and reflective CHW supervision (PROCESS)	Quantity and quality of supervision provided to CHWs within a given organization or program.	The quantity and quality of supervision for CHWs is broadly recognized by various stakeholders, including CHWs themselves, as crucial factors affecting the ability of CHWs to grow as professionals, experience job satisfaction, and effectively promote health in their communities. CHWs and other experts thus recommend that institutions invest in supervision programs involving careful supervisor training.	**Surveys of CHWs *and* CHW supervisors**