Attachment 1: Phase I Report

Assessment of the Community Health Worker (CHW) Workforce in PA

Initial Progress Report – Phase I

April 12, 2013

The initial focus of the "CHW Assessment" project was successful completion of the Phase 1 literature review, as specified in the Work Statement. The purpose of this review was to help shape the design of the environmental scan of the CHW workforce in PA by identifying: (a) potential data elements, data collection instruments, and methodologies (including survey frame construction and implementation strategies); (b) operational definitions of CHWs; and (c) existing CHW structural models. The sections that follow include a summary of key literature review findings and recommendations regarding the design of the Alliance's environmental scan instruments and protocols. Given that the Department of Health (DOH) and Alliance partners on this project have agreed to use a recent CHW assessment conducted by the University of Utah's Center for Public Policy and Administration as the prototype for our environmental scan, a modified version of the Utah survey is included as an appendix.

A. Literature Review Methodology

Inclusion criteria for the literature review included articles that: focused on CHWs in the US, European countries, and Mexico and were published between 2006-2013 (inclusive). The PubMed and EBSCO MegaFILE databases were used to locate relevant articles in peer-reviewed journals. The search terms *environmental scan*, *case manager*, *community health worker*, lay *community health worker*, *lay health worker*, *lay health advisor, peer counselor, peer educator, promotora*, and *patient navigator* were used to identify relevant articles. In addition, bibliographies of relevant articles were searched to identify articles that did not appear in our initial searches.

B. Literature Review Findings

Literature review findings have been divided into the following three categories: environmental scan methodologies, CHW definitions, and CHW structural models.

Environmental Scan Methodologies:

A search for national-level and state-level CHW assessments and environmental scans was conducted, resulting in review of 3 national assessments and 14 state-level (or multi-state level) assessments.

National level assessments included the following:

- *The National Community Health Advisor Study (1997)*
- *Community Health Workers and Community Voices: Promoting Good Health (2003)*
- *Community Health Worker National Workforce Study (2003)*

The *National Community Health Advisor Study (1997)* is widely referenced as the premier study of CHW across the nation. Their analysis addressed four key areas: (1) core roles and competencies of CHW, (2) evaluation of the impact of CHW programs, (3) strengthening the CHW field and establishing its place in the health care delivery setting, and (4) CHW adaptations to the changing health care environment. Findings from this research remain core to comprehensive assessments of CHW programs. This study identified seven core roles played by

CHW. These seven core roles are often used in assessing the type of work performed by CHW and include the following:

- bridging cultural mediation between communities and the health and social service system
- providing culturally appropriate health education and information
- assuring people get the services they need
- providing informal counseling and social support
- advocating for individual and community needs
- providing direct service
- building individual and community capacity

This national study highlighted additional key findings. While CHWs can influence a wide range of health issues, there are numerous obstacles to rigorous, multi-site evaluations of these programs. This study provides a four-part framework for guiding CHW programs in their evaluation efforts. This framework includes the following four recommendations: make evaluation essential, promote a CHW research agenda, develop evaluation guidelines and tools, and recognize CHWs as partners in program evaluation. Secondly, it is important to develop strategies that promote CHW career paths. These include improving the recognition of qualities and skills required of CHWs, developing clear program and agency standards, and strengthening CHW networks to enhance the development of the CHW field. Finally, CHW programs were strongest within the nonprofit and public health fields. However, CHWs were emerging as key players within managed care programs through the roles they played in linking managed care and communities through outreach, patient education about managed care systems and health issues, and providing follow-up services. This national level report found that CHWs had significant benefit to community residents as well as those who finance health care.

The *Community Health Workers and Community Voices: Promoting Good Health (2003)* report is a Community Voices Publication of the National Center for Primary Care at Morehouse School of Medicine. The report documents how CHWs address problems of health disparities, poor access to care, and the rising cost of health care. This report identifies obstacles to sustainability of CHW programs that include lack of stable funding, the need for training and certification, and the need to institutionalize and integrate CHW programs into existing health systems. One part of the financing solution is states' use of outreach and education dollars made available under Medicaid (including Medicaid waiver systems) and the State Children's Health Insurance Plan. Medicaid Managed Care Organizations can also either be encouraged or mandated to support CHWs in the conduct of community-based outreach and education. CHW workforce recommendations include standardizing CHW training and certification based on core roles and competencies required in the position. Furthermore, it is important to ensure that hiring policies for CHWs are appropriate for the skills and knowledge that they bring and do not present unnecessary barriers. There is also an opportunity to link CHW employment to job training programs and to establish CHWs as one step in a health /medical career ladder. This report also advocates for the integration of CHWs into the health care delivery system. CHW programs are common in various segments of health care, such as diabetes, asthma, maternal and child health, HIV/AIDS, cardiovascular disease. Poor visibility and understanding of CHW programs has led to an underutilization of CHWs in the health care system. However, in

designing effective health care systems, it is critically important to factor in community needs to better understand the integral function and value of CHWs in health care systems.

The *Community Health Worker National Workforce Study (2007)* provided key information related to identification of specific CHW activities that included culturally appropriate health promotion and health education, assistance in accessing medical and non-medical services and programs, translation/interpretation services, counseling, mentoring, social support, and transportation services. This study identified six key functional areas for CHW activity that match those identified in the National Community Health Advisor Study conducted in 1997. Study findings classified CHW programs into five prevailing models of care. These include: (1) member of care delivery team, (2) navigator, (3) screening and health education provider, (4) outreach-enrolling-informing agent, and (5) organizer.

State-level assessments and CHW reports included:

- *Report on Community Health Worker Programs (2012)* – a review of seven state programs for the development of an infrastructure for training and certifying CHWs in the state of North Dakota
- *Southern California Promotores (Community Health Workers) Needs Assessment, San Diego and Imperial Counties, 2010-2011- "South CA"*
- *Four U.S. Border States' Community Health Worker Training Needs Assessment (2011)- California, Arizona, New Mexico, Texas ("Border States")*
- *Community Health Workers in Utah – An Assessment of the Role of CHWs in Utah and the National Health Care System (2012)*
- *Community Health Workers in Rhode Island (2009)*
- *Texas Community Health Worker Study (2012)*
- *Paving a Path to Advance the Community Health Worker Workforce in New York State (2011)*
- *Indiana Community Health Worker Workforce Assessment (2012)*
- *Community Health Workers – Policy Recommendations to the State of Illinois (2012)*
- *The Alaska Community Health Aide Program: An Integrative Literature Review and Visions for Future Research (2003)*
- *Community Health Workers in Massachusetts: Improving Health Care and Public Health (2009)*
- *Minnesota Community Health Worker Employer Survey (2002)*
- *Final Report on the Status, Impact, and Utilization of Community Health Workers (2006) - Virginia*
- *Michigan Department of Community Health, Community Health Care Worker Survey (2011)*

These fourteen state level assessments and environmental scans provided great insight into the practice, scope, work, and environment of CHWs across the nation. Following the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA) of 2010, many states undertook projects either to review CHW programs that currently existed in their state or to assess projects in other states as a basis for creating their own CHW infrastructure. Three states, however, conducted reviews and/or scans of CHW projects long before passage of the PPACA and HCERA: Alaska, Massachusetts, and Minnesota.

Alaska is the sole state where Community Health Aides (CHA) are used to provide non-physician primary care in extremely remote, frontier communities. While overseen by physicians, CHAs provide clinical primary care, unlike most CHWs in other programs across the nation. These indigenous CHA receive extensive training, beginning with credentialing and ending with certification under their state certification board. This certification is required to be eligible for reimbursement under the state Medicaid program. *The Alaska Community Health Aide Program: An Integrative Literature Review and Visions for Future Research (2003)* is a comprehensive analysis of CHAs, including training, oversight, reimbursement, and outcomes. It also introduces their new Dental Health Aide program, which will provide dental services in remote, frontier communities similar to the primary care provided by CHAs. Due to the extensive clinical nature of CHAs, this study was excluded from our analysis. The *Community Health Workers in Massachusetts (2008)* is a widely referenced report for its state-initiated, policy-focused analysis of using CHWs to reduce barriers to insurance and primary care, reducing inappropriate utilization of health care services and care related to chronic disease, and in developing a stronger CHW workforce that insures high standards, cultural competency, and quality of service. This study's methodology included focus groups with CHWs as well as a CHW employer survey. Four primary CHW strategies were identified: client advocacy, health education, outreach, and health system navigation. Both employers and CHWs cited these four strategies as essential components of their work. While a state-mandated certification was not in place at the time of the study, CHWs, employers, funders, and payers all agreed that a standardized CHW certification was critical to the advancement and professionalization of the workforce. Presently, the state of Massachusetts requires a Certificate of Competency to practice as a certified CHW, issued by the Board of Certification of Community Health Workers. The state of Minnesota is often cited as the gold standard in the field of community health work. The Blue Cross and Blue Shield of Minnesota Foundation launched the "Growing Up Healthy in Minnesota" initiative in 2001 to address the challenges and cultural barriers faced by persons of different cultures, races, and ethnicities when interacting with the health care system. This was followed by a statewide survey (2002) of health and human service organizations to learn more about the use, training, and employment of CHWs and medical interpreters. The primary goal of this investigation was to learn about CHW and medical interpreter roles within health-related organizations rather than to measure the prevalence of CHWs and interpreters. As such, the sampling frame included health and human service organizations in counties having a minority population of 5% or greater, an Indian reservation, or an organization serving bicultural/bilingual clients. The survey instrument had a greater focus on CHW employment than on interpreter employment and included multiple choice and open-ended questions related to the employment, training, functions, effectiveness, and future needs of CHWs. In 2007, Minnesota received Federal approval for CHW reimbursement under a Medicaid State Plan Amendment and, in 2008, Federal approval for CHW expansion to provider types supervised by Certified Public Health Nurses and Dentists. For Medicaid reimbursable services, CHWs are trained health educators who work with Minnesota Health Care Programs (MHCP) recipients who may have difficulty understanding providers due to cultural or language barriers. CHW Medicaid services are defined as "a diagnosis-related, medical intervention, not a social service."

The *Indiana Community Health Worker Workforce Assessment Surveys (2012)* methodology included two survey links – one for CHWs and one for CHW employers and Payers. Surveys were available in hard copy and on-line. Survey invitations were distributed to more than 400

persons identified by the Indiana CHW Coalition and was accompanied by a letter from the Indiana Commissioner of Health. All recipients were encouraged to widely share the link, creating a snowball sampling effect. On-line surveys were live for three weeks with invitations repeated weekly via email and postal mail during the three-week period. This methodology had highly successful return rates: nearly 80% of CHWs were eligible and qualified for the survey and 89% of CHW employers/potential employers qualified. No "payers" responded to the survey. The top five core roles of CHW in Indiana were (1) health education and promotion, (2) assuring access to care, (3) counseling and support, (4) cultural mediation, and (5) community advocacy. Most CHWs and employers of CHWs in Indiana report that CHWs work on specific health issues – diabetes, nutrition, tobacco control, mental health, and high blood pressure. CHWs and employers identified what they felt were the most pressing needs of those served by CHWs. These included health information, disease management, social support, transportation, and employment. While most CHWs delivered their services on a one-to-one basis, other formats included telephone, community meetings/forums, group classes, and texting.

Community Health Workers in Utah (2012) is a comprehensive assessment of CHWs in both the nation and the state. Following the PPACA in 2010, the Utah Department of Health's Heart Disease and Stroke Prevention Program initiated an assessment of the role of CHWs in Utah. This included an extensive literature review, a nationwide survey, and a Utah-specific survey on current practices and impacts of programs that utilize CHWs. The literature review informed the creation of the national survey instrument, and the national assessment was conducted to form the context for their state assessment. Methodology for their national assessment included a guided interview with leaders of state level CHW associations (typically the executive director). Where no state level association existed, organizations were identified through state referrals or internet searches. One state representative completed an on-line version so that she could view the topics to be covered in the survey. Ten states were included in the national survey because of their active CHW programs, one of which was chosen because of its close proximity to Utah and its similar demographic composition and political environment. Their national assessment included questions on the titles of CHWs, target populations, financing, certification and training, state legislation, and recommendations for the state of Utah.

Utah's state assessment was based on data gathered through the literature review and the national assessment and used to build a base knowledge of CHWs in Utah – mimicking DOH requirements for the environmental scan of Pennsylvania. Methodology for this assessment included an on-line survey link forwarded to 200 individuals or organizations. It was also forwarded to others using a snowball sample where it was sent to a known target population with requests to forward it to others as appropriate. Eighty-eight responses were collected with a rough response rate of 44%. Their snowball sampling approach limited calculation of accurate response rates. This survey consisted of 22 multiple choice and open-ended questions and took less than 15 minutes to complete. Input was solicited in the following areas:

- type of organizations engaging CHWs and if they were paid or volunteer
- populations targeted and in what areas of the state
- CHW roles and functions
- funding for services
- requirements for educational level and type of training received
- types of policy or systems changes required to make sustainability of CHWs easier

Community Health Workers in Rhode Island (2009) is a state level assessment of the CHW workforce and a prediction of the demand for CHWs in the present and future. More than 70% of the Rhode Island CHW workforce is employed in Nursing & Residential Care Facilities and Ambulatory Health Services. Nearly 20% are employed or volunteering at one third of the state's hospitals. For those organizations having full-time CHWs, 51% required Bachelor's Degrees and 8% required Advanced Degrees. The top five functions of CHWs in Rhode Island included: (1) assist people in receiving care they need, (2) assist people in accessing appropriate health education and information, (3) provision of direct services such as blood pressure screening, (4) provision of informal counseling and guidance on behaviors, and (5) promoting healthy living through education. The *Report on Community Health Worker Programs (2012)* is a study of CHW programs in seven states for use by the North Dakota Department of Health to inform potential development of a CHW infrastructure in the state. Ten core CHW programmatic questions were asked of representatives in Minnesota, Massachusetts, New Mexico, New York, Colorado, Washington, and Wisconsin. Questions centered around the existence of CHW, the setting in which they worked, state policies for reimbursement, state level CHW organizations or alliances, state level education, training, and/or certification programs, and if a current CHW curriculum existed. Michigan's *Community Health Care Worker Survey (2011)* included responses from 54 CHWs. It provided a profile of Michigan's CHW workforce, their experience as a CHW, job security, barriers to effective work, internal relationships, and training. Most Michigan CHWs do most of their work in client homes. Three-quarters most often have contact with other CHWs and about 39% have contact with clinical staff (e.g., physicians, nurses). Racial and ethnic minorities are the most targeted population, including African-American, Mexican, and Arab-American/Middle Eastern clients with the prime age group under age 30. The five highest-ranking activities performed by CHWs in Michigan include: (1) health education and information, (2) collaboration with other agencies, (3) office work that included scheduling client follow-up appointments, (4) referrals, and (5) helping clients enroll in health plans.

A number of the above referenced state reviews were excluded from our investigation of environmental scan methodologies. Five state reviews and scans (Border States, Southern CA, Virginia, Illinois, and New York) focused on CHW core competencies, training, CHW perceived needs, certification, and performance standards and measures. The *Paving the Path to Advance the CHW Workforce in New York State (2011)* is a policy brief written by the New York State Community Health Worker Initiative. This initiative was formed to advance the CHW workforce by establishing statewide recommendations for CHW Scope of Practice, Training and Credentialing, and Financing. The *Texas Community Health Worker Study (2012)* resulted in seven recommendations to the Texas legislature. These recommendations included CHW education, professional development, and recognition as well as investigation of sustainable funding through Medicaid, Medicaid Managed Care contracts, and the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver. This study also explored efforts to incorporate CHWs into Patient Centered Medical Homes and related care management structures.

CHW Definitions:

Through our extensive literature review, numerous definitions of "community health workers" were identified. The National Community Health Advisor study used the following definition:

> "Community health workers are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, "promotores(as)", outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening." (1997)

The most common definition of community health worker is that adopted by the American Public Health Association (APHA) in their 2009 policy statement – *Support for Community Health Workers to Increase Health Access and to Reduce Health Inequities.* This definition is 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 CHW 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 CHW 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."

Several variations of these two primary definitions were identified:

Texas: "A CHW provides cultural mediation between members of a community and health and social services, with or without compensation. To serve in this capacity, a CHW: (a) is a trusted member of the community and has a close understanding of the ethnicity, language, socio-economic status, and life experiences of the community served; (b) helps people gain access to needed services; and (c) increases health knowledge and self-sufficiency of the community through activities such as outreach, patient navigation and follow-up, community health education and information, informal counseling, social support, advocacy, and participation in clinical research."

Ohio: "Community Health Workers are individuals who, as community representatives, advocate for individuals and groups in the community by assisting them in accessing community health and supportive resources through the provision of education, role modeling, outreach, home visits and referral services."

Rhode Island: "CHW are trusted members of or have a close understanding of the community they serve. This enables these workers to minimize social and cultural barriers between

community, health and social service institutions. They often act as a bridge to complement and enhance the work performed by many other health and social service professionals."

Utah (used an abbreviated version of the APHA definition): "CHWs are defined by the American Public Health Association as frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served."

Massachusetts: The Massachusetts Dept. of Public Health defines CHWs as "public health workers who apply their unique understanding of the experience, language, and/or culture of the populations they serve in order to carry out one or more of the following roles: (a) providing culturally appropriate health education, information, and outreach in community-based settings, such as homes, schools, clinics, shelters, local businesses, and community settings; (b) bridging/culturally mediating between individuals, communities, and health and human services, including actively building individual and community capacity; (c) assuring that people access the services they need; (d) providing direct services, such as informal counseling, social support, care coordination, and health screenings; (e) advocating for individual and community needs; and (f) additional roles as may be identified by the board that may emerge in the development of community health worker practice."

CHW Structural Models:

The *Community Health Worker National Workforce Study (2007)* identified five prevailing models of care engaging CHWs. These include: (1) member of care delivery team, (2) navigator, (3) screening and health education provider, (4) outreach-enrolling-informing agent, and (5) organizer. In the 'member of care delivery team' model, the CHW was most often subordinate to a clinical lead provider such as a physician, nurse, or social worker. CHW tasks were specific and delegated by the lead clinical provider. The 'navigator' role placed a greater emphasis on the CHW's ability for helping individuals negotiate complex health and social service systems. This model required the CHW to have a high degree of knowledge about the health care system but not necessarily a high degree of clinical knowledge. In this particular model, the CHW's major contribution was that of improving access and educating consumers on the timely use of primary care. The 'screening and health education provider' model was relatively common and often included in categorically funded initiatives (e.g., specific chronic diseases such as asthma and diabetes). In this model, CHWs taught self-care methods, administered basic screening instruments and took vital signs. There were concerns about the quality of services, however, which prompted for close evaluation of the CHW's training and close supervision of their services. Outreach Worker was a common job title for the 'outreach-enrolling-informing agent' where CHWs identified people who were eligible for benefits and/or services. They encouraged the client to apply for help or to go to a provider location for care. The 'organizer' model often involved volunteer CHWs who became involved in a community over a specific health issue, promoting self-directed change and community development.

The Massachusetts study (2009) identified four main strategies for CHW functions. These include client advocacy, health education, outreach, and health system navigation. In addition to

the seven core roles identified in the National Community Health Advisor Survey, the literature review identifies the following broad functions of CHWs:

- client advocacy
- health education
- outreach
- health care system navigation
- care coordination
- translation/interpretation
- insurance enrollment
- support for medication adherence
- health screening
- chronic disease self-management
- emergency preparedness

Key to the work of CHW is the manner in which they *differ* from other health care workers. CHWs relate to community members as a peer and have expertise based on shared cultural or life experiences with the clients they serve. CHWs are trusted members of the community because of their personal understanding of the community in which they work. CHW often provide services in the client's home though they are sometimes provided in a number of community-based settings (such as churches, community meetings, etc.). In most CHW programs, the CHWs do not hold clinical licenses though a number of states mandate certification through an approved CHW program.

The literature review identified numerous types of organizations utilizing CHWs. These include educational institutions, ambulatory health services, hospitals, nursing and residential facilities, health plans or insurers, community based organizations (including social assistance programs, public housing authorities, immigrant and refugee assistance programs, faith based organizations), health providers (including community health centers, public outpatient health clinics, private medical providers, health departments, inpatient health facilities), mental health agencies, charitable organizations, and advocacy organizations. Additionally, numerous names are used by those providing community health work. These include: community health worker, community health representatives, lay health advisor, peer health promoter, lay health advocate, promotora/promotora de salud, peer support specialists, patient navigator, and a number of titles relating to 'outreach' – including outreach worker, outreach educator/specialist, and street outreach worker.

C. Recommendations for the Assessment of the CHW Workforce in PA

1. Utilize the APHA definition of CHW, as identified in their 2009 policy brief
2. Include all titles/names for CHWs as identified in the preceding paragraph
3. The *Community Health Workers in Utah – An Assessment of the Role of CHWs in Utah and the National Health Care System (2012)* will be used as the initial base for survey development
4. Minor modifications/additions based on assessments from the Minnesota and Indiana surveys
5. Scan frame to be developed by the Alliance of PA Councils, using their statewide network of providers, HealthyWoman Program Regional Managers, WiseWoman program partners

6. Phone verification to be conducted on all organizations identified in the initial scan frame
7. survey mode must be both on-line and in paper format
8. three to four weeks is adequate time frame for survey go-live period
9. non-responders will be contacted by phone and email on weekly basis til close of survey
10. utilize snowball sampling methods to increase potential number of respondents

Our proposed methodology for the PA environmental scan can be found on pages 11-13. An enhanced 'brief summary' bibliography for the national and state scan reports can be found on pages 14-19.

Please note that the draft survey instrument is a separate document and attached to this report.

Community Health Worker Environmental Scan – Methodology

As per on-going discussions with the PA Department of Health (DOH), the purpose of this environmental scan is to obtain information on the current Community Health Worker workforce in PA. There are three primary objectives:

1. Identify organizations in PA that currently utilize some type of CHW in their organization
2. Collect detailed information on these programs
3. Utilize information gathered through an extensive literature review, the scan of CHW programs in the State, and other available data (e.g., Census data, various chronic disease rates, etc.) to identify existing CHW resources, gaps in service provision, and make recommendations to the DOH.

Survey Instrument:

An extensive literature review identified several tested survey instruments. With input from DOH, the assessment tool used in the Community Health Workers in Utah – An Assessment of the Role of CHWs in Utah and the National Health Care System (2012) was identified as a base instrument for use in the environmental scan of PA. We will add additional questions to this baseline survey based on findings from the literature review and in consultation with the DOH. These may include adding items such as obesity, nutrition, tobacco (to address risk factors for disease) under the CHW function section. While the Utah survey has been tested and used by a number of other state organizations conducting CHW scans, we will pilot test the final draft of the instrument for ease in completing, understandability, and to obtain feedback on its content. We expect to pilot the survey instrument the week of April 22-26, 2013. Any necessary revisions will be made April 29-30, 2013.

Survey Mode:

The survey mode will by both mail and on-line. The mailed survey instrument will be created using Remark software which generates "bubble" surveys that can be easily scanned and summarized. Data in the Remark software can be exported to Excel and imported into a statistical analysis package, such as SPSS. This will reduce the potential for data entry errors. The on-line survey will be created using Survey Monkey.

Survey Elements:

a. The types of organizations that engage CHWs in their programs
b. How CHWs are paid (or if they are volunteers)
c. Do the CHWs work with a specific population (e.g., African-Americans, Hispanics, etc.)
d. Do the CHWs focus on a specific problem or condition (e.g., maternal & child health, CVD, cancer, diabetes, etc.) Do CHWs address risk factors for disease? (e.g., smoking, obesity, etc.)
e. Do the CHWs target specific geographical areas
f. Function or role served by CHWs
g. How CHW services are funded
h. Training/education levels required
i. Input on policy or system changes to make it easier to sustain CHWs

The survey instrument will consist of both close-ended (multiple choice) and open-ended questions. Open-ended questions will focus on policy and systems change for CHW in PA.

Scan Frame:
We will utilize the extensive network of the four partners of the Alliance of Pennsylvania Councils to identify organizations that use community health workers. For purposes of the scan, 'community health worker' includes, but is not limited to, community health workers, promotora, peer advocate, peer support specialist, lay health advisor, patient navigator, community health representative, lay health advocate, peer health promoter. Representatives from the four family planning councils in PA have identified a preliminary list of contacts for the environmental scan. Contacts for the scan were identified by HealthyWoman Project Regional Program Managers, field office managers, and via the literature review (e.g., "peer specialists" working in behavioral health programs in PA). For this phase, the scan will focus on identifying employers throughout the Commonwealth who utilize the services of community health workers and obtaining details on their projects. The initial list included 75 unduplicated organizations. However, an additional 53 organizations have been identified as of 4/10/2013. Alliance partners are continuing to compile names of contacts for the scan frame and will continue to do so until April 19.

All organizations identified on the final scan frame will be contacted by phone to verify they have this type of worker within their organization. During the phone verification, if the organization utilizes some type of CHW within their organization, the caller will tell them about the environmental scan being conducted, the importance of it to the State, and inform them of when the survey will be received. We will also collect the name of the person to whom the survey should be directed, and verification of their address and e-mail.

The proposed timeline and activities for conducting the environmental scan are identified below.

PROPOSED TIMELINE:

April 8, 2013	Alliance partners receive script for use in contacting potential survey recipients
April 12, 2013	Submit to DOH: Literature Review, Preliminary Review of State Models, Initial Summary of Financing and Payment Models, Methodology for Environmental Scan, Draft Survey Instrument [AH, FPC]
April 19, 2013	Survey Stage I: List of potential organizations to receive survey complete and submitted to Linda Snyder, Adagio Health [AH, FPC, FHC-CP, MFHS representatives]
April 22-26, 2013	Survey Stage II: Phone verification that organizations on contact sheet actually have CHW/patient navigators/etc. working in their organization. (a uniform script has been provided to all project partners) [FHC-CP, MFHS]
April 22-26, 2013	Survey Stage III: Validation of survey instrument. [AH, FPC]
April 29-30, 2013	Survey Stage IV: Revisions to survey instrument as needed. [AH]

May 1-3, 2013	Survey Stage V: Survey instruments mailed/on-line survey links emailed. Survey goes live. [AH]
May 20-21, 2013	Survey Stage VI: Wave 2 mailing/emailing of survey to non-responders [AH]
May 21-24, 2013	Survey Stage VII: Phone contact with non-responders to encourage completion of survey. [FHC-CP, MFHS]
June 4, 2013	SURVEY CLOSES
May 6-June 4, 2013	On-going review and validation of survey data. [AH, FPC]

Bibliography & Literature Review Summary – National CHW Assessments

Rosenthal, E. Lee. National Community Health Advisor Study. A Policy Research Project of the University of Arizona, 1997.

The National Community Health Advisor Study (1997) is widely referenced as the premier study of CHW across the nation. Their analysis addressed four key areas: (1) core roles and competencies of CHW, (2) evaluation of the impact of CHW programs, (3) strengthening the CHW field and establishing its place in the health care delivery setting, and (4) CHW adaptations to the changing health care environment. Findings from this research remain core to comprehensive assessments of CHW programs. This study identified seven core roles played by CHW that continue to be used in assessing the type of work performed by CHW. These roles include bridging cultural mediation between communities and the health and social service system, providing culturally appropriate health education and information, assuring people get the services they need, providing informal counseling and social support, advocating for individual and community needs, providing direct service, and building individual and community capacity.

Ro, Marguerite J., et al. Community Health Workers and Community Voices: Promoting Good Health. A Community Voices Publication. National Center for Primary Care, Morehouse School of Medicine, 2003.

The report documents how CHWs address problems of health disparities, poor access to care, and the rising cost of health care. This study identified seven core roles played by CHW. These seven core roles are often used in assessing the type of work performed by CHW and include the following: bridging cultural mediation between communities and the health and social service system, providing culturally appropriate health education and information, assuring people get the services they need, providing informal counseling and social support, advocating for individual and community needs, providing direct service, and building individual and community capacity. It concludes with seven policy recommendations: (1) establishing public funding streams to support CHWs (e.g., Medicaid, SCHIP), (2) encouraging states to support the use of CHWs through their Medicaid managed care contracts, (3) including CHWs as part of health care teams that coordinate care for special populations and vulnerable populations, (4) involving CHWs in planning efforts to reform health systems, (5) support/finance/develop training and certification programs for CHWs, (6) supporting research efforts that evaluate CHW programs, and (7), supporting demonstration programs that examine the role and utilization of CHWs in improving access to care.

Community Health Worker National Workforce Study. U.S. Department of Health and Human Services, Health Resources and Services Administration, 2007.

This is a report on a comprehensive national study of the CHW workforce and the factors that affected its utilization and development. Verified CHW employers in all 50 states were part of the assessment as well as in-depth interviews of employers and CHWs in four states. Through this study, specific CHW activities included culturally appropriate

health promotion and health education, assistance in accessing medical and non-medical services and programs, translation/interpretation services, counseling, mentoring, social support, and transportation services. This study identified six key functional areas for CHW activity that match those identified in the National Community Health Advisor Study conducted in 1997. Study findings classified CHW programs into five prevailing models of care. These include: (1) member of care delivery team, (2) navigator, (3) screening and health education provider, (4) outreach-enrolling-informing agent, and (5) organizer. Consistent with other assessments and the literature, funding was considered a major barrier to the development of the CHW workforce, including short-term funding and reliance on multiple funding sources.

Bibliography & Literature Review Summary – State CHW Assessments

Matos, Sergio, et al. Paving a Path to Advance the Community Health Worker Workforce in New York State: A New Summary Report and Recommendations, October 2011.

A project of the New York State CHW Initiative to advance the CHW workforce by establishing statewide recommendations for the employment, training, certification, and financing of CHW programs. Committee made recommendations on CHW Scope of Practice, CHW Training and Credentialing, and CHW Financing.

Community Health Workers in Rhode Island. Rhode Island Department of Labor and Training, September 2009.

This brief is an assessment of the size of the Rhode Island CHW workforce, including salary information and prediction of the demand for CHW in the present and the future.

Community Health Workers, Policy Recommendations to the State of Illinois. Mid-America Regional Public Health Leadership Institute, Technical Assistance Project, December 2012.

This policy brief developed recommendations to the State of Illinois on the following: (1) A standard definition of a community health worker, (2) A model for statewide certification, (3) Foundation for developing CHW curriculum, and (4) criteria to develop statewide performance standards and measures. Authors also researched CHW policy models in other states: Alaska, California, Indiana, Massachusetts, Michigan, Minnesota, New York, and Texas.

The Alaska Community Health Aide Program: An Integrative Literature Review and Visions for Future Research. Alaska Center for Rural Health and the Health Resources and Services Administration, August 2003.
Comprehensive review of the Community Health Aide program in Alaska. Included program history, training, funding, and health outcomes. Provided a brief overview of a new program focusing on dental health.

Community Health Workers in Massachusetts: Improving Health Care and Public Health. A report of the Massachusetts Department of Public Health Community Health Worker Advisory Council, December 2009.

This report is a comprehensive assessment of the Massachusetts community health worker workforce, including an overview of CHW programs in the state. The report makes recommendations for a sustainable CHW program in Massachusetts in four areas: (1) conduct a statewide CHW identity campaign, (2) strengthen workforce development, (3) expand financing mechanisms, (4) establish an infrastructure to ensure implementation of recommendations. Massachusetts is widely quoted in CHW

assessments as it had included CHWs in its health care reform law of 2006 and pays for CHWs under Medicaid administrative match.

Michigan Department of Community Health, Community Health Care Worker Survey. Glengariff Group, Inc., October 2011.

Assessment of community health workers in Michigan conducted via telephone interviews. Summary information on CHW demographics, experience, job security, where they do their job, who they serve, services provided, barriers to effective service, internal relationships, and training.

Hang, Kaying and Joan Cleary. Critical Links: Study Findings and Forum Highlights on the Use of Community Health Workers and Interpreters in Minnesota. The Foundation - Blue Cross Blue Shield of Minnesota, May 2003.

Findings from an employer survey of community health workers and interpreters in Minnesota, highlighting six key findings. Also provided profiles of three community health worker projects: Woman to Woman Program (cancer screening and treatment, Laotian, African-American, Latina women), PathFinder Program (navigating the health care system, Hispanic clients), and Neighborhood House (HIV and STDs, Latinas). Minnesota is also widely recognized as a premier state in CHW initiatives with their passing of legislation for Medicaid reimbursement of CHW conducting patient education and care coordination services.

Crum, Robert. "Promoting Community Health Workers to Reduce Health Disparities in Minnesota." Robert Wood Johnson Foundation, December 2012.

This report summarizes the Minnesota Community Health Worker Alliance's creation of a statewide standardized training and their development of a sustainable funding stream to support CHW services in Minnesota. This report also provides key lessons learned from the funded project.

Final Report on the Status, Impact, and Utilization of Community Health Workers. House Document No.9, Report of the James Madison University, 2006.

Mandated by Virginia House Joint Resolution No. 195, this report focuses on ways to elevate the role of community health workers in the health care delivery system, more effective means of integrating these workers in public agencies, an examination of the use of CHWs as a best-practice quality measure for Medicaid and other contracted providers, exploration of the development of a statewide core curriculum for the training of CHWs (paid and volunteer), and recommendations for maximizing the value and utilization of CHWs.

Ritchie, Dannie, M.D., M.P.H. Community Health Workers: Building a Diverse Workforce to Decrease Health Disparities. The Transcultural Community Health Initiative, May 2004.

Report on the Rhode Island Foundation Roundtable Series for Community Health Worker curriculum development and sustainability. This roundtable had two objectives: development of a strategic plan for the creation of a core curriculum for CHW training programs and the creation of action steps to facilitate placement of CHW program graduates in paid positions.

Texas Community Health Worker Study – Report to the Texas Legislature. Department of State Health Services and the Health and Human Services Commission, December 2012.

This report is in response to the legislative charge in Texas H.B. 2610 (48.102, Texas Health and Safety Code) which charged the state of Texas to undertake a study of the desirability and feasibility of employing promotores and/or community health workers in Texas and to explore methods of funding and reimbursement.

2012 Annual Report, Promotor(a) or Community Health Worker (CHW) Training and Certification Advisory Committee. Texas Department of State Health Services, CHW Publication No. 24-14024.

This is an excellent summary of the work of a well-established CHW Advisory Committee formed at the state level. It provides details on their goals, objectives, activities, and outcomes of their work.

McCormick, Sara, et al. Community Health Workers in Utah: An Assessment of the Role of CHWs in Utah and the National Health Care System. Center for Public Policy & Administration, The University of Utah, 2012.

This is an excellent overview of community health workers. An extensive literature review was conducted as well as a national assessment (10 states) and a Utah state assessment of employers of CHWs. The state survey consisted of 23 questions on the type of organization, specifics of how CHWs were engaged (paid/volunteer, wages, number of CHWs working and hours, benefits, etc.), CHW roles/functions, type of clients and any specific diseases they target, educational requirements, training, how CHWs are paid, specific geographic areas, and some open-ended questions on systems/policy changes. Assessed Impact on Health Outcomes; Economic Impact; Training and Integration into Current Health Care Infrastructure. This survey has been used in other statewide assessments of CHW programs.

Eng, Howard J. Four U.S. Border States' Community Health Worker Training Needs Assessment. The Southwest Border Rural Health Research Center, 2011.

A cross-sectional study design was used to examine the four U.S. Border States community health worker training needs. This study utilized a literature review to identify CHW roles and current training models in the border region, identification of

CHW employers in the four Border States, and collection of data from CHW employers on training needs. The three greatest training needs were language skills, computer training, and advocacy.

Southern California Promotores (Community Health Workers) Needs Assessment, San Diego and Imperial Counties, 2010-2011. California Department of Public Health, Office of Binational Border Health, 2011.

The goal of this study was to understand and determine existing barriers and challenges employers may perceive and/or experience when utilizing promotores or CHW. Questionnaires were administered to both employers of CHW as well as promotores. Results showed that promotores need to be trained in a variety of core competencies as well as having knowledge about the specific health issues addressed by their organization. Major challenges identified included promotora reliability due to lack of funds for salaries, transportation, childcare, and incentives.

Dickson, Lynette and Rachel Yahna. Report on Community Health Worker Programs. The University of North Dakota, School of Medicine and Health Sciences, 2012.
The North Dakota Coordinated Chronic Disease Prevention Program designated funds to develop an infrastructure for training and certifying CHWs. Ten core programmatic questions were asked in their review of seven states: Minnesota, Massachusetts, New Mexico, New York, Colorado, Washington, and Wisconsin. Questions focused on CHW programs in the state, title used by the CHW, settings in which they work, if their CHW programs were assessed, state policy related to reimbursement for CHW programs, state-level interest groups leading CHW efforts, formal certification and training curricula.

Indiana Community Health Worker Workforce Assessment Surveys. Community Resources, LLC under supervision of the Indiana Department of State Health Services, 2012.

This study assessed CHWs, Employers of CHWs and Payers across the state of Indiana. Data was collected on the CHW environment (organization type, race of CHW, urban/rural status, wages, relationship to community served, factors influencing their decision to become a CHW, training and capacity building, core roles and skills, health issues addressed by CHWs, most pressing needs of those served, how/where services are delivered and new areas for expansion of CHW initiatives.