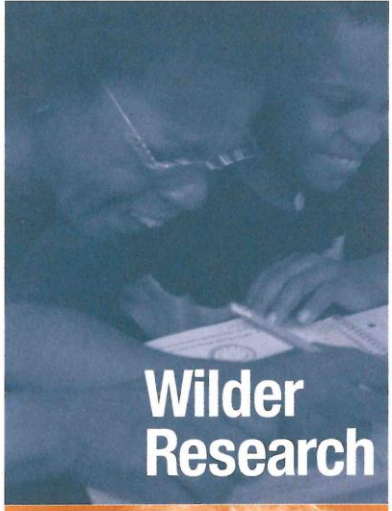

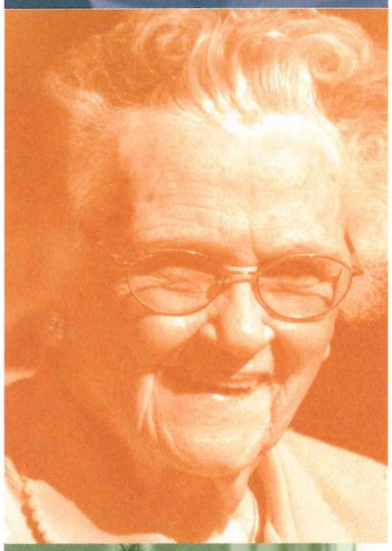

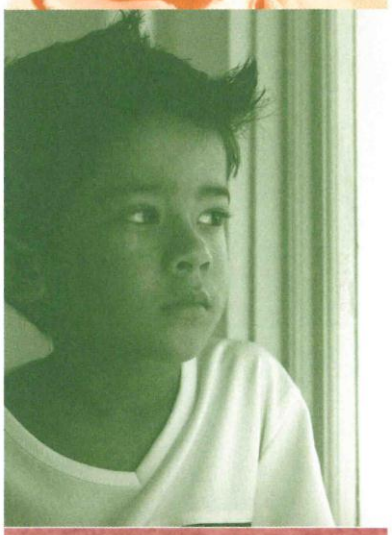

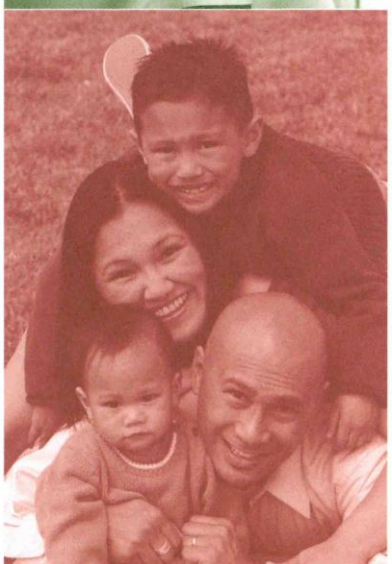

Community Health Workers in the Midwest: Understanding and developing the workforce

Findings from a Study of Community Health Workers' Role, Professional Development, and Cancer Information Needs Conducted for the American Cancer Society

JUNE 2012

Community Health Workers in the Midwest: Understanding and developing the workforce

Findings from a study of Community Health Workers about their work and cancer information needs conducted for the American Cancer Society

June 2012

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Acknowledgments

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Summary

Community Health Workers (CHWs) play a unique and valuable role in their communities, particularly in reducing health disparities by reaching underserved populations. To support efforts to build CHWs into a sustainable component of the health care system, the American Cancer Society - Midwest Division sought to increase understanding of and document the work of the CHW workforce specifically in the four states they serve – Iowa, Minnesota, South Dakota, and Wisconsin. They contracted with Wilder Research to assess CHW needs and to conduct a return on investment study.

Conducted between December 2011 and February 2012, the assessment included interviews with 23 key informants who employ or are recognized for their knowledge of CHWs, and a survey of 245 CHWs.

Characteristics of CHWs

Overall, the majority of CHW respondents were female (87%) – a trend consistent within each state; although South Dakota had a notably higher number of male CHWs (27%) than other states.

The race and ethnicity of CHWs varied across states. Wisconsin showed the greatest diversity, followed closely by Minnesota. On the other hand, CHWs in Iowa were either White (79%) or Black/African American (21%), and nearly all respondents from South Dakota were American Indian (98%). A sizeable portion of CHWs in Minnesota and Wisconsin were of Hispanic/Latino origin (30% and 26% respectively).

Forty-five percent of all CHWs surveyed reported fluency in a language other than English; Minnesota has the highest percent of bilingual CHWs (62%). The top three languages specified by those who are bilingual (n=111) include Spanish (44%), Lakota (17%) and Hmong (12%), however this also varied across states. Spanish- and Hmong-speaking CHWs resided predominantly in Minnesota and Wisconsin, while those speaking Lakota lived in South Dakota.

The role of CHWs

Both informants and survey respondents say that CHWs are involved in a variety of activities, and that their work is based largely on the needs of the communities they serve. Among the diverse roles that CHWs play, key informants report that **the most important and overarching role is fostering connections that bridge the gap between systems of health care and individuals.** This theme was supported by feedback from the Community

Health Workers: 80 percent identified "connecting people with medical services and programs" as a task they routinely performed, and over half also said their role included "assuring people get the coverage and services they need" (55%) and "providing care navigation" (52%). **A majority of key informants described the attribute that most often helps CHWs to be effective in this role as "a strong commitment to the communities they serve".**

However, it is also important to note that the research reveals a lack of clear understanding about who CHWs are and what the scope of their work includes. Informing audiences about their role will be crucial in expanding and integrating the CHW workforce to better serve the needs of various communities.

An assessment of the main areas in which CHWs tend to focus their work confirms that **their roles within the health care system are multi-dimensional** and include:

- **Creating more effective linkages between communities and the health care system.** Community outreach was ranked the number one primary task for CHWs in the survey overall.
- **Providing health education and information.** Education to both groups and individuals was included in the top five primary tasks for CHWs surveyed.
- **Assisting and advocating for underserved individuals to receive appropriate services.** Over half (52%) of CHWs surveyed are reaching homeless individuals, and 43 percent are connected with immigrants and rural residents as part of their scope of work.
- **Directly addressing basic health needs.** Forty percent of CHWs provide direct health services – in South Dakota, it is 86 percent.

Work Experience

Overall, CHWs have a great deal of work experience, are typically in paid positions, and report a diverse range of educational backgrounds. Training and career development in the CHW workforce varies widely within health care systems, states, and regions – there are no norms that are recognized nationally. The following characteristics apply to CHWs who participated in the survey. However, it should be noted that responses varied widely by state:

- CHWs generally have a great deal of work experience. Seventy percent of CHWs reported being active in their work for three years or more, including a quarter (25%) who had over 10 years of experience. This finding shows a dedicated workforce that is familiar with working in this field.

- **Individuals report a diverse range of educational backgrounds and training prior to becoming CHWs.** The vast majority of CHWs surveyed had at least some college experience (87%), if not a Bachelor's degree or higher (42%). Three in ten (31%) had a degree specific to nursing, social work, or health education. Education notwithstanding, 40 percent said they had received some formal training or education about community health work prior to working or volunteering as a CHW.

- **Most CHWs are in paid positions.** Eighty-six percent of CHWs were in paid positions at the time of the survey; however, about three in ten (29%) acknowledged that their positions were temporary, short-term, grant-funded, or they were unclear as to the permanency of the position going forward.

Training and career development

- **While beneficial, formal training may not be appropriate for all CHWs.** The majority consensus among key informants is that formal training and education is an important aspect of the CHW role; however, there are many factors to consider along the way. For example, some CHWs have very little formal education and placing them in a certificate program may not be beneficial. Also, training and certificate programs can be a financial burden on the CHW and his or her employer, and training must be tailored to the type of work that a CHW is doing and the needs of the community in which he/she will be working.

  On the other hand, many informants recognize the important role of certificate programs in creating a professional space for CHWs in the health care system.

- **The vast majority of CHWs were interested in receiving additional training concerning most cancers listed in the survey**. Although CHWs in South Dakota and Iowa mentioned prior training in a diverse range of cancer types, their interest in further training remained high.

Differences by state

CHWs in the four states within the Midwest Division have varying levels of training and education. This is likely a result of the different infrastructures available in each state to support CHW work. However, especially as the Patient Protection and Affordable Care Act (PPACA) takes effect, more consistency across states can help support more effective and efficient training programs for CHWs, career mobility (both geographically and upwards), and shared information between states on program successes.

- **The educational level of CHWs differs by state.** In South Dakota, nearly two-thirds of CHWs (65%) reported that their highest level of education includes vocational training or an Associate's degree, compared to four in ten who say the same in Minnesota (42%) and Wisconsin (39%). In Iowa, CHWs report higher levels of education with 95 percent having a Bachelor's degree or higher. In comparison, 52 percent of CHWs in Minnesota and Wisconsin reported the same.

- **The states differed in deployment of certified CHWs.** As a whole, nearly four in ten (38%) CHWs said they had completed a CHW certificate program. In looking at the specific states, however, the numbers fluctuate. Half of CHWs from Minnesota (50%) and South Dakota (47%) have completed a certificate program, compared to 25 percent of CHWs from Wisconsin, and none from Iowa.

- **Some states lack the infrastructure for training.** Key informant interviews noted that Iowa, South Dakota, and Wisconsin lack a well-developed infrastructure for training and educating CHWs through a certificate program.

Suggestions regarding overall training

Key informants in all four states suggested a need for a variety of training, including:

- **A mentor-mentee training model.** Informants suggested that the one-to-one support provided by this model would allow for new CHWs to learn from someone well-established in the field. It would also mitigate concerns surrounding CHWs who have less formal education.

- **Intensive weekend training sessions.** Conducting weekend-long trainings several times a year would relay significant amounts of information to CHWs in a format and setting that is less intimidating than a university setting.

- **A workshop series.** A formal (and free) workshop series could build upon one another and culminate in a certification.

Addressing cancer

One of the research questions posed by ACS - Midwest Division was, "To what extent and in what capacity are CHWs used to promote cancer and other chronic disease prevention and early detection?" Findings show that, while interest in cancer as a health issue is high, a smaller proportion of CHWs actually address cancer risk-reduction and screening in their work. Again, findings vary by state.

- Although 62 percent of all CHWs said "cancer" was a health issue they addressed in their work, when asked more specifically about educating the community on cancer risk-reduction and screening, only 24 percent said they "already did this."

- That being said, seven in ten (69%) CHWs were open to incorporating prevention strategies into their work.

- In Minnesota, all key informants reported that certification curricula include a module pertaining to cancer prevention and treatment.

- The focus on cancer prevention is driven by funding priorities and by what the CHWs have deemed as needs within a community. For example, in one community, the goal was for CHWs to educate community members on tobacco usage. As this work continued, CHWs began to note the need for education around cancer prevention, breast and colon cancer in particular, and incorporated this into their work.

- While key informants spoke very broadly about CHW cancer prevention work, most mentioned breast cancer early detection and/or breast health as an area where CHWs focus some of their efforts. This appears to support survey findings in which 67 percent of CHWs had received some training related to breast cancer.

- In Iowa and Wisconsin, informants described CHW outreach and education around breast health and colorectal cancer. One Iowa respondent explained that the CHWs he/she works with are beginning to ask more cancer screening questions when discussing health history with patients. In Wisconsin, respondents often mentioned the work being done by CHWs to teach women in the communities how to screen for breast cancer through self-exams.

Issues to consider

Overall, findings from the key informant interviews and surveys of Community Health Workers show strong support for the unique role that CHWs provide in their communities. Results also show that there are noteworthy differences among the four states regarding the primary tasks performed by CHWs, as well as training, education, and credentialing.

Several informants pointed out that the Affordable Care Act will result in 34 million people gaining health insurance, subsequently increasing the amount of health care services that are demanded throughout the nation and increasing opportunities for CHWs to serve their communities.

Given the complex and varying nature of the CHW workforce, we recommend keeping the following in mind when promoting the use of CHWs across the Midwest:

- **Educate health care providers about the roles and value of CHWs.** CHWs are often the bridge between the health care system and the communities they serve. However, findings suggest that the role of CHWs in the health care system lack integration and they are not fully understood by medical providers.

- **Address funding and reimbursement challenges with CHWs and their allies.** Currently, Minnesota is the only state of the four that has had success in creating policy that makes CHW services reimbursable. Nevertheless, even in Minnesota, reimbursement is limited to services provided to Medicaid patients.

- **Continue to evaluate and track outcomes related to CHW work.** Illustrating the roles and value of CHWs is vital to gaining sustainable funding and support for their work in the health care system. Most key informants reported a lack of capacity and funding for outcome evaluation of their CHW programming, which can demonstrate program effectiveness to community partners – some of whom may be willing to invest resources in program sustainability.

- **Consult with state and federal health policy experts knowledgeable about the Affordable Care Act** to identify the ways that CHWs can be incorporated and integrated into health care reform. Key informants expressed that future opportunities for CHWs will be highly dependent upon health care reform; therefore, now is a good time to explore ways in which CHWs can play a role in new systems, as well as in addressing the health care needs of various communities.

- **Develop state-to-state cancer prevention trainings.** Currently, cancer prevention efforts by CHWs are varied across and within states. Therefore, the creation of trainings that can be translated from state to state would be valuable. The top three requested training mechanisms include: printed educational materials, in-person training, and online training (e.g., e-learning or webinars).

- **Invest in further professional development to move the CHW field forward.** This may take the form of credentialing and certificate programs or other kinds of training and/or mentoring programs that support the continuing education of CHWs.

- **Implement certificate program in Wisconsin, South Dakota, and Iowa, using Minnesota's model as a guide.** These states show interest in implementing certificate programs. Consider working with stake-holders in these states to convene an alliance to move the possibility of certificate programming forward.

Introduction

CHWs play a unique and valuable role in their respective communities, particularly in reducing health disparities by reaching underserved populations. To support efforts to build CHWs into a sustainable component of the health care system, the American Cancer Society - Midwest Division sought to increase understanding of and document the work of the CHW workforce specifically in the four states they serve – Iowa, Minnesota, South Dakota, and Wisconsin. The ACS - Midwest Division contracted with Wilder Research to conduct an economic analysis and assessment of the CHW workforce.

Wilder Research designed a project comprised of three components: (1) a return on investment (ROI) framework; (2) key informant interviews with individuals who directly employ and/or work with CHWs and individuals who are involved in the training, organizing, and mobilizing of CHWs; and (3) a survey of CHWs in the four-state region consisting of an online survey and a paper self-administered questionnaire collecting information about CHWs background, education, training, employment, and scope of work. The findings reported here focus on the second and third components. Wilder Research's separate, companion report, entitled *Social Return on Investment in Community Health Workers in Cancer Outreach*, is available from the American Cancer Society - Midwest Division.

This report is presented in two sections: the first details results of the key informant interviews and the second describes the results of surveys with CHWs in Iowa, Minnesota, South Dakota, and Wisconsin. Both methods were employed to more clearly discern the scope of practice by CHWs in these states.

The project was guided by lessons learned from the *2007 Community Health Worker National Workforce Study*, prepared by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) Bureau of Health Professions. The American Cancer Society was interested in following up on these findings with specific research questions related to the work of CHWs in the four states served by the ACS - Midwest Division.

What is a Community Health Worker?

The term CHW can be defined in a variety of ways; however, this project was informed by the American Public Health Association definition of a CHW:

A Community Health Worker (CHW) 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. [1]

Community Health Workers often work in diverse, underserved communities to:

- Connect individuals to health care and social service resources
- Provide culturally appropriate and accessible health education and information, sometimes in languages other than English
- Ensure that individuals get the help they need, including referrals and follow-up services
- Advocate for individual and community needs

For the purposes of this study, "Community Health Worker" (CHW) is an umbrella term covering a variety of job titles and responsibilities, both paid and unpaid. CHWs may be known in different communities as:

- Lay health advisors
- Community health aides
- Outreach workers
- Promotores(as) de salud (Spanish translation: Health Promoters)
- Peer educators
- Patient navigators

[1] American Public Health Association. Community Health Workers. http://www.apha.org/membergroups/sections/aphasections/chw/

- Health coaches
- Community Health Representatives or CHRs

Community Health Representatives

CHWs who work with American Indian populations are known as Community Health Representatives (CHRs). CHRs most often do their work on tribal reservations. The CHR Program was implemented in 1968 to improve the health knowledge and practices of American Indian communities by promoting, supporting, and assisting the Indian Health Services (IHS) along with other American Indian organizations in delivering health care. The efforts of the CHR program staff have produced an American Indian and Alaska Native health service delivery system, which provides for follow-up and continued contact with the health care delivery system at the community level, thereby meeting the most basic needs of the American Indian and Alaska Native population.[2] Nearly all of the South Dakota respondents are Community Health Representatives.

Research questions

As part of this study, ACS identified several research questions to be explored.

Research questions for ACS work:

- How might the American Cancer Society effectively engage and support existing CHWs as a strategy to address cancer health disparities?
- How might the American Cancer Society effectively promote the utilization of CHWs in community health systems?

Study research questions:

- To what extent and in what capacity are CHWs utilized within the Midwest Division states to promote cancer and other chronic disease prevention and early detection?
- What are the compensation, training and professional development trends, and unmet needs of CHWs?
- What are the barriers experienced by employers who would benefit from integrating CHWs into their healthcare delivery team?
- What does the future hold for the CHW workforce?

[2] U.S. Department of Health and Human Services. http://www.ihs.gov/nonmedicalprograms/chr/index.cfm?module=goals

Section I: Results of interviews with key informants

This section summarizes key findings from a series of interviews with key stakeholders in Iowa, Minnesota, South Dakota, and Wisconsin with the goal of learning more about their work with CHWs and the impact that CHWs are having in their communities and various health care systems.

Study approach

Key informant interviews were conducted with individuals who are knowledgeable about CHWs (or persons in similar roles) in their state. They included staff from various agencies including: Federally Qualified Health Centers (FQHCs)/Community Health Centers (CHCs), state health departments, Indian Health Services (IHS), local healthcare agencies, and Community Health Worker training programs.

ACS staff were asked to identify five or six individuals in each of the four states who are most familiar with CHW use, deployment, and networks in their geographic regions. They were then asked to complete a form that outlined the name and contact information for each potential informant, their organization or agency, their title, and a brief explanation of why they thought the individual would be a good fit for the interview.

Wilder Research, in collaboration with ACS - Midwest Division staff, designed two versions of an interview guide – one to interview direct service providers (those who employ CHWs) and the other to facilitate conversation with CHW champions who did not directly employ CHWs. Based on the information provided by ACS staff, Wilder researchers categorized participants, and interviewers gave each informant the opportunity to confirm which category best fit his or her role.

Interviews were conducted by phone and lasted between 25 minutes and two hours; those lasting the greatest amount of time were often with informants who had been involved in CHW work for more than five years.

Response rates

Thirty-two key informants were identified and contacted for participation in this study; six from Iowa, five from South Dakota, eight from Wisconsin, and 13 from Minnesota. Because of the large number of contacts provided from Minnesota, Wilder Research worked with the Minnesota State Health Equity Director to prioritize who would be contacted.

None of the key informants contacted opted out of participating in the interview. One of the individuals was deemed ineligible because his or her work was with a broader group of health care providers, with less emphasis on CHWs. Another key informant was willing to participate, but was out of the country during the study period. Interviews were conducted between November 2011 and January 2012.

Overall, the response rate was 96 percent of those invited to participate and deemed eligible. Figure 1 shows the completion rate by state.

1. Key Informant interviews: Response rate by state and overall

State	Number of contacts provided	Number of individuals selected and eligible	Number of interviews conducted	Response rate
Minnesota	13	6	6	100%
Wisconsin	8	8	8	100%
Iowa	6	5	5	100%
South Dakota	5	5	4	80%
Total	**32**	**24**	**23**	**96%**

Characteristics of key informants

The 23 individuals interviewed have a wide range of involvement and perspectives in the CHW field and diverse backgrounds from which they approach their work. Informants included those with experience employing CHWs to conduct health education outreach across various communities and cultural groups, as well as those with years of experience acting as advocates to promote the role of community health work within public health and the broader health care system. Respondents had worked in their positions from two to 25 years.

The findings from the key informant interviews are detailed below and organized by key research questions that guide this work.

Question #1: To what extent and in what capacity are CHWs utilized within the Midwest Division states to promote cancer and other chronic disease prevention and early detection?

The work and role of a CHW can be conceptualized in myriad ways

Findings show that CHWs are involved in a variety of activities, and that their job descriptions and roles are based on the needs of the communities in which they are working, as well as dictated by the kind of funding that supports each program.

However, one overarching role for CHWs stands out: fostering connections that bridge the gap between systems of health care and individuals. Most key informants said one major attribute that helps CHWs to be effective in that role is a strong commitment to the communities they serve. A majority of the key informants expressed the idea that a CHW must come from the community, look like the community, and understand the community in order to effectively improve community health.

> The CHW is an important role. They must be a representative of the community they come from. They must look like the community. If they can't understand their community they won't be successful.
>
> The CHW connects a community to good health. They come from the community served, know the cultural practices of that community.
>
> Their main function is how well they know their people. They are representing the health of their community. The most important thing is that they [the CHW] know his/her people, and the people know them [the CHW].

The interviews also confirmed what has been documented by the HRSA study[3]– that community health work is vast and broad in scope. Regardless of state, informants all agree that health is a broad term within the CHW framework. Informants explained that CHW work is not always structured to fit in a medical setting. They added that CHWs are a relevant aspect of interventions on social conditions that impact health, such as housing and education. One informant explained:

> Health for a CHW is viewed very broadly – not just in a clinical/medical setting but it's the social determinants of health that the CHW is addressing: hunger, housing, and education. It is important that those without real knowledge of CHWs understand that the role can be vast yet still very important.

[3] U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Professions. (2007). *Community Health Worker National Workforce Study*. http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf

Another key informant explained that new health issues within communities are constantly emerging and that CHWs are in a perfect position to intervene. One example is educating communities and individuals about mental health.

> We are seeing new roles [for CHWs] in mental health. I think it's really important we continue to keep an eye out for areas where CHWs may not traditionally do their work but could still have an important impact. Then, over time, people will be used to the term "CHW" and the work they are capable of doing.

Key activities identified by informants

The most common activities of CHWs across the Midwest, as identified by the key informants, include:

- **Creating connections between community members and the health care system.** Key informants referred to CHWs as a vital "bridge" that connected communities to better health. Informants talked about the need to help community members feel more comfortable accessing the health care system. Informants mentioned women's health groups, health fairs, and word of mouth as ways that CHWs reach out to begin forming bonds with communities. One informant explained:

  > The majority of their [CHW] work should be out in the community. They don't spend much time in the clinics, maybe one day a week. Most of their time should be out in the community. Their work is intended as outreach and community-based service.

- **Educating medical and social service providers about community needs.** In addition to bridging care from the health care system to community members, CHWs also act as a bridge from community members to health care providers. One informant described them as "cultural brokers," explaining that:

  > CHWs are liaisons between health care systems and the community; they are cultural brokers who come from the community that is being served. They know the cultural practices of the group and educate the system and providers about the culture being served.

- **Providing health education and information.** CHWs place great emphasis on teaching basic concepts of health promotion and disease prevention. Informants explained that CHWs have been utilized effectively in delivering basic health messages in culturally appropriate ways. For example, Promotores(as) de Salud in one migrant farmworker project created culturally relevant messaging around breast health. Direct patient education is at the crux of CHW activities, and informants described a wide range of

activities aimed at educating individuals on issues, such as breast and other cancers, exercise, and nutrition.

- **Leading support groups**. In addition to health education, CHWs also provide discussion group sessions to provide direct support and encourage the use of a patient's immediate social network in following treatment regimens. In some communities, particularly Native American communities, CHWs sometimes conduct home visits with the goal of providing direct support to community members. CHRs on reservations also mentioned the Circle of Support model – a model that places CHWs as leaders of traditional support circles.

- **Basic screenings.** Conducting basic screenings is a core CHW activity. These screenings range from taking basic vital signs such as blood pressure, height, and weight to screening the home environment for possible health concerns.

- **Health insurance enrollment assistance.** While this was the primary role of CHWs in only one organization represented in our key informant sample, other key informants discussed the important role CHWs can play in assisting individuals with health insurance enrollment.

- **Patient Navigation**. Patient navigation is a process by which an individual – a patient navigator – guides patients with a health problem through and around barriers in the complex health care system. The types of patient navigation described in the key informant interviews varied greatly. In some cases, CHWs simply assisted individuals in explaining the services they needed and helped them to make the appropriate appointments with the necessary health care providers. Other CHWs played a more extensive role, mainly through coordinating the patient's care within the clinic or medical setting.

- **Care coordination.** Care coordination helps ensure that a patient's needs and preferences for care are understood, and that those needs and preferences are shared among providers, patients, and families as a patient moves from one healthcare setting to another. Care coordination is an important activity for some CHWs, particularly for those working in clinics using the Health Care Home model of care. The activities and responsibilities of CHWs in this setting include outreach to patients to explain Health Care Home, care planning and goal setting, identification of gaps in care, face-to-face team meeting with providers for case management, and monitoring transitions in care; for example, a patient recently discharged from the hospital who must be reconnected with primary care within 48 hours of discharge.

Other key CHW activities include assisting and advocating for underserved individuals to receive appropriate services, providing informal counseling, and building individual and community capacity in addressing health issues. One informant described CHWs as

constantly evolving and transforming based on the needs of communities and the health care system:

> CHWs must take advantage of opportunities available while remaining rooted in the community. They must play roles in many sectors not just traditional health care settings, but in aging and child and family services, to name a few. They [CHWs] are outreach workers, enrollment coordinators, peer educators, early childhood development. They can provide cultural wellness and serve as life coaches.

This list comprises the most common activities and/or ways that CHWs are utilized to improve health based on the information gained from the key informants. It is important, however, to note that every community is different and thus their needs will differ; as a result, CHWs perform their job duties based on those needs.

Populations served

Key informant interviews reflect CHWs' work with a variety of communities and populations to impact health and well-being. These groups range from racial and/or ethnically-based populations, such as African American, Hmong, Latino, Somali, and Native American, to geographic communities (rural versus inner city or urban). Other communities include the deaf/hearing impaired and migrant workers.

It is important to acknowledge that CHWs serve a far broader population than just the examples mentioned here, which simply reflect the responses of those in our study. Results from the survey [see the next section] with CHWs provide a more comprehensive list of who is being impacted by the work of CHWs in Iowa, Minnesota, South Dakota, and Wisconsin.

Health issues addressed

A wide variety of health issues, chronic diseases, and social issues are addressed by CHWs across the four states. Nearly all informants pointed out that the health issues addressed are often decided based on the type of funding that supports the work. For example, several informants mentioned receiving funding for CHWs to focus on breast cancer; others have received funding for CHWs to educate communities about tobacco use, diabetes prevention, and obesity.

The following is a list of other topics and/or health issues on which CHWs are working:

- Prevention and/or maintenance of chronic illness, such as diabetes, hypertension, cholesterol, and cardiovascular disease

- Social determinants of health, including but not limited to domestic violence, elder care, and injury prevention
- Mental and behavioral health needs, including substance abuse and its consequences (e.g. liver disease, renal failure, brain injury)
- Reproductive and sexual health, such as sexually transmitted infections (STI) education and HIV/AIDS

A focus on cancer prevention

Overall the focus on cancer prevention across the states in the ACS - Midwest Division varies. Informants reported that often times the decision to focus on a given disease is driven by funding sources. In other cases, the focus is derived from what CHWs have identified as deficits or needs within a community. For example, in one community the goal was for CHWs to educate community members on tobacco usage. As this work continued, CHWs began to note the need for education around cancer prevention, breast and colon cancer in particular, and began to incorporate this into their work.

In Minnesota, all informants reported that the certification curricula include a module pertaining to cancer prevention and treatment. Respondents were also quick to mention a variety of programs that are using CHWs in their work around cancer prevention, such as the SAGE program (a breast and cervical cancer screening program) and the American Indian Cancer Foundation. The Minnesota CHW Alliance has also sought out opportunities to work on cancer prevention. One Minnesota informant stated the following when asked about the role of CHWs in cancer prevention in the state:

> I have seen CHWs play a very respectable role in helping women with cancer optimize their treatment and prognosis…. There was an African American CHW and cancer survivor herself. I remember she would accompany women to appointments. Clinicians were clearly uncomfortable with her but over time it got to the point that clinicians accepted her and saw her as a resource. She had developed a strong reputation among clinic staff….The initial skepticism was gone.

In Iowa and Wisconsin, informants described CHW outreach and education around breast health and colorectal cancer. One Iowa respondent explained that the CHWs he/she works with are beginning to ask more cancer screening questions when discussing health history with patients. In Wisconsin, respondents often mentioned the work being done by CHWs to teach women in the communities how to screen for breast cancer through self- exams. Work has also been done by these CHWs to educate community members on recommended guidelines for cancer prevention, the myths around breast and cervical cancer, and the importance of following through with preventative clinic visits.

In South Dakota, key informants state that cancer has become a main priority. Respondents explained that they are seeing an increase in cancer diagnosis on the Indian reservations, and therefore they are using the ACS Circle of Life Program.

Question #2: What are CHW hiring, compensation, training and professional development trends, and unmet needs as articulated by stakeholders?

Key informants were asked a series of questions about hiring, compensation, training and education of CHWs. Responses to these questions provide an idea of the occupational landscape of CHWs. The findings from the survey with CHWs (see Section II) show education levels, compensation, and hiring practices as reported directly by CHWs.

Hiring

The key informant interviews show that the qualifications for CHWs vary widely. Some employers require a high school diploma as the minimum requirement, while others prefer (but do not require) a college degree – most were somewhere in between. Not only are there differences in hiring practices in Iowa, Minnesota, South Dakota, and Wisconsin but significant differences exist within states as well. The one commonality expressed by most informants is that employers hiring Community Health Workers look for individuals with strong knowledge of the community where they will be working. The level of education required for CHWs positions is dependent upon the type of position that will be filled. For example, one informant explained that the main role of CHWs in his/her organization is to assist community members with enrollment in public health insurance programs. The highly technical knowledge required for these tasks supports the hiring of CHWs with an undergraduate degree and some knowledge of the health care system. Others expressed that preferred qualities must include the following:

> We look for CHWs who have deep roots or shared life experiences in the communities they serve. They must share similar values, ethnic background and socio-economic status, as the people they will serve and they must speak the same language – linguistically and culturally.

Communication skills, combined with the ability to create interpersonal relationships and maintain confidentiality, were considered by most organizations as essential attributes for a job as a CHW. Organizational skills, such as the ability to set goals, develop action plans, and keep records, were highly regarded as well. Many of the respondents placed a high value on bilingual abilities, the ability to coordinate service referrals, and adeptness in promoting and advocating family and community wellness.

Compensation

There appears to be a wide range in compensation of CHWs both within and among states. Findings from key informants are reported by state given the important distinctions that exist:

Minnesota

In Minnesota, many informants reported that an entry-level salary for a full-time CHW is between $26,000 and $36,000 annually. Most informants also explained that, in many cases, CHWs earn an hourly wage and are not salaried. The hourly wages reported by informants in Minnesota ranges from $12 to $21 per hour. The higher end of the hourly range tends to be reserved for those who had worked in the position for five years or longer. Those who are salaried usually receive benefits. Some of the hourly employed CHWs in Minnesota also receive benefits – often this was based on whether the CHW was employed full-time or part-time. Many informants reported that community health work is part-time employment. The consensus in the state was that those CHWs working for community organizations are more likely to be paid less and have fewer opportunities to receive benefits while those working for the county or state have more opportunities for comprehensive benefit packages.

Wisconsin

In Wisconsin, informants reported hourly wages from $8 to $15 per hour. A majority of informants reported that CHWs work part-time; particularly those who are employed through a grant to provide community health work in a particular health area or related to a specific health issue.

South Dakota

In South Dakota**,** informants seemed to know little about the payment system for CHWs. Most guessed that the range was wide: starting at minimum wage and going up to $20 per hour. One informant suggested that the best paid CHWs are those that work on reservations who earn $12 to $16 per hour. Another informant attributed the lower pay on his reservation to the motivation of CHWs to do the work as a "calling." In this case, the main motivation to work was realizing that there is need in the community.

Iowa

In Iowa, informants reported that CHW salaries start at $30,000-$32,000, with some making as much as $36,000 annually. For those who are paid hourly, wages range from $8 to $15 per hour. Informants mentioned that these wages are dependent upon experience and education.

The CHW survey [see Section II] collected information directly from 245 CHWs about their wages.

Training, education, and credentialing

Findings from key informant interviews highlight that there are noteworthy differences among states regarding the training, education and credentialing of CHWs. Key informants described their current infrastructure for training and education, along with what they see as future needs and next steps for the training and education of the CHWs in their state.

Minnesota has a well-developed infrastructure for training and educating CHWs. The development of training and education for CHWs was on the radar of key stakeholders in Minnesota over ten years ago. As a result, work began in 2003 to create a Community Health Worker certificate program. This curriculum was developed by the Healthcare Education Industry Partnership, a project of the Minnesota State Colleges and Universities system, a coalition of rural and urban health care systems, Blue Cross and Blue Shield Foundation of Minnesota, The Robert Wood Johnson Foundation, and other groups. By 2005, the partnership had established an 11-credit Community Health Worker certificate program. In addition to being taught at five sites in Minnesota, the curriculum has also been sold to more than 30 organizations outside of Minnesota. One informant described the importance of Minnesota's CHW certification program as follows:

> The Minnesota CHW curricula carry credits and is based in higher education. This was intentional; to make sure it's not a dead end. CHWs can apply the credits they earn to a health occupations training if they want to move into a different health career. A lot of CHWs are the first in their family to enter into any sort of higher education. This opens the door to further advancement on part of CHW and his/her family.

Key informants in Minnesota see the value in the certification program and training, and several explained that employers value the fact that many of their CHWs have been through standardized training. One informant stated:

> For the CHW field to actually grow and become more fully integrated into the health and social services system, we need to have standardized training – it's an important building block in our state. When you look at CHWs as a bonafide career with its own professional identity – standardized training is vital.

While the certification program is valued by nearly all of the informants in Minnesota, it is clear that not all CHWs go through the certification program. To date, most organizations do not require that a CHW be certified. For those organizations that do require it, the employer may pay for the training after the individual has been hired. This is most often the case for CHWs working in the clinical setting. The reason for this is that in 2008, Minnesota legislation allowed Medicaid reimbursement for CHWs. For those who are certified and work

in these settings, their services can be submitted for reimbursement just as those of a physician, nurse, or other health care provider.

One informant described the certificate program as "…the liberal arts of the CHW role," meaning that it provides a relevant background that can be related to any CHW position. This informant continued by explaining that the certification program does not eliminate the need for on-the-job training. This sentiment was echoed by many of the other informants as well. One informant said:

> The certificate program is great; it provides a standard for level of training. Next, a CHW should receive on the job training specific to the role he or she will play in the organization. Finally, we must not forget the importance of ongoing and continuing education.

Informants explain that, thanks to the strong network of CHWs in Minnesota, particularly the Minnesota CHW Alliance and the CHW Peer Network (a network that brings together CHWs from a variety of settings), a number of organizations have been able to work together to create workshops, seminars, and other trainings on specific disease topics or social issues.

In Minnesota, informants were very vocal in explaining that the CHW certification is **not** a title or a degree. Opinions varied regarding whether a degree was a needed next step for credentialing. Some informants explained that if the purpose of a CHW is that they come from and represent a particular community (e.g. a marginalized or underserved community, a race- or ethnicity-based community, or a community with language barriers), requiring certification or creating a degree would likely limit who would have the resources to become a CHW. One informant explained:

> There is definitely no need for a [Community Health Worker] degree – the whole point is to be a community person, like Clara who lives next door. It's a para-professional job. The Certificate Program is a great help, but I don't want to see it as mandatory.

In Wisconsin, informants identify the need for a formal, flexible CHW certification program. A formal certificate program for CHWs does not currently exist in Wisconsin, but a majority of informants reported that the CHW community is moving towards the creation of a formal certification program. Informants had varied descriptions about what a certificate program might look like and the purpose it would serve. One informant explained:

> One of the things we pursue in Milwaukee is getting our training program certified – it will be portable, through a recognized certifying or licensing process – you have to do something to renew it on some sort of time line.

Another informant compared the proposed certification to Wisconsin's CNA state-required training and certification. Many agree that it is important that CHWs have some sort of documentation or credentials.

Other informants explained that there have been past efforts to create a certification program in Wisconsin. The main reason cited for its lack of success was that it was not flexible enough and was too formal – making it challenging to fit the varied needs of all CHWs. Along these lines, informants also explained that most CHWs do not have the time to take formal courses. When they are hired, they need to begin working right away. Another explained that:

> We find that having it provided through the technical colleges wasn't going to work here. It was too formal, too structured. We were more likely to have good partnerships with extension school programs.

Instead, these informants suggest that less structured trainings offered to CHWs periodically would be more useful. These trainings must be culturally relevant as well.

> If you are going to train CHWs, it is going to be in segments. It is going to be over a long period of time, like maybe once a month – You are going to have to work around the culture, if you are going to provide a training.

South Dakota does not currently have a certification program in place for CHWs but a variety of options are being considered. One informant explained that, through partnerships developed with local tribal colleges, work is being done to allow CHWs to earn a "community health certificate." This certificate includes skills on basic counseling, CPR, and pharmacology. Some informants expressed hesitation around this form of certification, explaining that it would not allow CHWs to bill for reimbursement for their services through Medicaid and/or Medicare. One informant recommended that an alternative would be that CHWs complete Certified Nursing Assistant (CNA) training. The reasoning for this was two-fold:

> I recommend they take CNA training, so they can work with those housebound and restricted to bed, and they can also be reimbursed if licensed as CNA, LPN, etc…If they become a licensed CNA, they can be reimbursed. We could also look at licensing CHRs as case managers, which would be reimbursable.

Preliminary discussions are underway regarding the creation of statewide CHW certification in Iowa. One informant explained that preliminary discussions have centered on the Certified Health Education Specialist (CHES) training. Another informant noted that the CHES training and certification process would be difficult for many CHWs to participate in, because an undergraduate degree is necessary to obtain this certification. Informants in Iowa described training programs that are taking place within particular organizations in an effort

to prepare CHWs. One organization has modeled their training programs after a Texas program targeting breast cancer.

The consensus in Iowa was that it is difficult to have a set curriculum for training CHWs when so much of the work varies depending on the type of project and its funding. One informant stated:

> Right now, my CHWs are working on breast cancer, so that is what they [CHWs] are trained in, so it's hard to have a set curricula. We have to go with whatever health issue we are being funded to intervene on.

Informants from Iowa more often expressed thoughts about not needing a certification program. One informant echoed this view, but saw the possible usefulness of certification:

> I think as long as each individual organization trains their CHWs formally and then also on the job it's ok. For example, the Promotora program uses an excellent training program developed by someone in Texas – it's very successful, we had a trainer come in the beginning and I've continued the training with their materials. As long as you have an effective training and formal training to begin with it's fine for individual organizations to do their own training. On the other hand, I do think it would be good to have a certification – that's what larger organizations will fund and makes us able to prove that our work is good…

The big picture

The majority consensus among key informants is that formal training and education is an important aspect of the CHW role, but there are many factors to consider. For example, it is important to remember that some CHWs have very little formal education and placing them immediately in a formal certification program may not be beneficial. Informants also stated that training must be tailored to the type of work that a CHW is doing, and the needs of the community in which he or she will be working.

On the other hand, many recognized the important role of certificate programs in creating a professional, and perhaps reimbursable, space for CHWs in the health care system.

With regard to training, education, and certification, key informants in all four states recommended implementing the following:

- **Mentor-mentee training model.** Informants suggested that the one-to-one support provided by this model would allow for new CHWs to learn from someone well-established in the field. It would also mitigate the concerns surrounding CHWs who have less formal education.

- **Intensive weekend training sessions.** Informants suggested that conducting weekend long trainings several times a year would be a useful way to relay significant amounts of information to CHWs in a format and setting that is less intimidating than a university setting.

- **Workshop series.** Informants also recommended a formal (and free) workshop series as an option for training. These workshops would build upon one another and culminate in a certification.

Formal career ladders

Thoughts on whether formal career ladders exist and/or should exist for CHWs were varied across the states and among informants within a given state. Overall, opinions can be split into three different groups:

- **Formal career ladders do exist for CHWs.** Informants who reported that formal career ladders exist for the CHW role in health, mostly supported the need for formal career ladders. They suggested the following mechanisms for formal advancement:

  - Nursing: A CHW might go on to become an LPN, CNA, or RN
  - Health care paraprofessionals: A CHW might move on to become a lab tech, pharmacy tech, or paramedic
  - Public health and social work: A CHW might go on to earn a degree in public health, community health education, or social work
  - CHW supervisor and/or Senior CHW: A CHW may choose to remain in his or her position and work towards becoming a supervisor or senior-level CHW

- **Formal career ladders do *not* exist for CHWs, but they should.** A majority of key informants, who responded that formal career ladders are non-existent for CHWs, suggested that the lack of credentials was the barrier. One informant stated:

> If CHWs earn credentials, it opens up a more formal career ladder and opportunities for them such as nursing, community education and social work.

Others, while supportive of creating a space for formal training of CHWs, suggested that states must be careful to not "over credentialize" CHWs because it takes away from the definition of a Community Health Worker.

> You have to be sensitive to how much regulation you do and what that does to them [CHWs] in the community.

- **Informal career ladders are a better fit for CHWs.** Other informants believe that formal career ladders are not necessary for the CHW workforce. Instead, these individuals suggest that informal career ladders are more appropriate given the education level of their CHWs. They also expressed the idea that more informal career ladders are important for maintaining the integrity of the CHW role. Examples of informal career ladders described were a "train the trainer" model, where more experienced CHWs use their expertise to train newer CHWs, or a model where CHWs earn more money by serving in a mentor role.

Question #3: What are the barriers, challenges, and successes experienced by employers who are working with CHWs?

Key informants from the four states have a variety of barriers, challenges, and obstacles to report when it comes to the goal of supporting the CHW workforce. While some of the challenges are particular to a given state and its current infrastructure and support of CHWs, others barriers are a result of the unique variety of roles that CHWs play within the health care system.

The following are the most salient barriers, challenges, and obstacles identified by key informants in all four states:

Funding and finances

Sustainable funding was the single most mentioned barrier and challenge to the work of CHWs. Funding and finances impact all aspects of the work that CHWs do and the organizations that employ them; and the tough economic climate was cited as a challenge for obtaining funding. A majority of the work that is carried out by CHWs across the four Midwestern states is funded through grants lasting from one to five years. Respondents continually explained that it is very difficult to sustain a program when the grants are short-term.

The ramifications of a lack of sustainable funding are significant and could cause challenges ranging from hiring to training to limitations in the provision of direct service. Inadequate funding makes it difficult for organizations to offer CHWs full-time work. This, in turn, makes it challenging to recruit and retain individuals for these positions. One informant summed up the funding challenge in this way:

> Right now the greatest challenge is in finding clear paths of employment outside of grants and studies.

While vital, grant funding is often limited in its focus, depending on the source. This requires CHWs to focus services in a single health area, and may mean that they have to ignore or

spend less time on other issues that may be occurring in the community. It also has implications for training and education. Often CHWs are hired and trained to respond to a particular grant topic. Once this funding is over, they may possess a skill set that allows them to work on only one particular health issue. Finally, informants expressed that they are seeing a decline in both the opportunities to apply for grants and the amount of money that is attached to them.

Pay stays lower, because of the volatility of funding. Informants expressed frustration with not being able to pay CHWs what they deserve and with the inability to guarantee full-time and long-term employment. They explained that this makes it difficult for CHWs to have a career.

CHW services are not reimbursable. Minnesota is the only state of the four that has recently had success in ensuring that the services of a CHW are reimbursable. Nevertheless, even in Minnesota, the parameters around reimbursement are limited to services provided to Medicaid patients. In Iowa, Wisconsin, and South Dakota, respondents agreed that reimbursement is a significant barrier for the work of CHWs. Informants agree that without an opportunity for a certification program, reimbursement will be difficult. In order to argue for reimbursement in other states, informants feel that some sort of "credentialing mechanism" must be in place.

Barriers related to education, training, and certification

Training and certification. The needs around training and certification vary between and among states, and many informants felt that the varying levels of education among CHWs make it difficult to identify and target training needs upon hiring.

In Minnesota, the certification curricula primarily focus on health promotion. The curricula does not include training particular to working in a clinical setting, and processes such as clinic flow and how to navigate Electronic Medical Records (EMR) are not covered. Minnesota informants also expressed frustration with the lack of opportunity for "testing out of" the certification program for those who have degrees in higher education in health-related fields.

In the remaining states where CHW certificate programs are not prevalent, informants report that organizations experience strain in having to take on the role of training their CHWs. This is often challenging due to limited funding and tight timelines.

Lack of integration into the health care system

Little awareness and knowledge about the role of CHWs in the health care system. Respondents explained that the CHW role is not well understood inter-professionally (e.g. among other medical professionals such as physicians, allied and occupational health, dental

students, etc.). Respondents felt that to be most effective, CHWs need to be better integrated into the everyday work of the clinic or health system. One respondent suggested that an awareness campaign is needed to educate health care providers about the role of CHWs. Another informant explained:

> For many providers in the clinical setting the CHW role is new, and clinicians immediately look for credibility and licensing to better understand the role that a CHW might play in their clinic.

When health care providers do not understand the role that CHWs can play in serving the health needs of their patient populations, they miss opportunities for integration of CHWs into health care settings. Or, CHWs end up playing the role of interpreters, which is not what they are meant to do.

> A lack of employers who understand how to use CHWs has resulted in positions, which would be well suited to CHWs, not being fulfilled in that way.
>
> I see a lot of work needing to be done for employers to really change their policies to have the health Promotores involved [as a member of the health care team]. I don't want to see them involved without protection. If the system doesn't change their policies, the health Promotores will be the victim of the system. In the hierarchical system, they will be the last in line. I don't want them to be lost in the system. They are too precious to be lost in the system. If the system can be flexible enough for the actual health Promotores, that would be very positive.

Additionally, several informants suggested that supervisors of CHWs need help to understand their roles and improve their supervisory skills:

Barriers expressed by those working with Promotoras de salud

In addition to the challenges and barriers mentioned above, the Promotores(as) de Salud programs experience their own unique set of challenges. One barrier often cited was that currently employed Promotores (as) are often monolingual Spanish speakers, making it difficult for them to be employed within English-speaking organizations. This challenge is directly linked to another often mentioned barrier for Promotores(as), which is the fact that, since the nature of the program is to recruit and hire individuals from within the community served, it is often the case that these individuals lack professional background and training as CHWs. Given the time and costs of training, compounded by the timelines and requirements of grants, organizations may hire community outsiders who already possess the specific skills and qualifications necessary to fulfill the role, despite their lack of social qualifications. Promotores(as) de salud programs may also struggle more with turnover than other CHW programs. This was a particular challenge for programs focusing on migrant worker populations. Again, due to the nature of the program and desire to hire CHWs from within the community,

those hired are often transient, making it difficult to invest in training when these individuals may not stay at the position for very long.

Measuring the success and benefits of using CHWs

An overarching theme of the interviews was that, while every informant believes that CHWs are a vital part of health care, it is difficult to enumerate and/or measure these benefits in a quantifiable way. Some informants stated that limited funding makes evaluation of CHW programs difficult. It is also difficult and costly to gather information on a comparison group of community members not served by CHWs. Finally, much of the work of CHWs is based on disease and illness prevention, which is difficult to measure.

While data is limited, key informants were asked to describe successes they had observed or measured related to the benefits and impact of CHWs. Examples include:

- **A Health Care Home model** reported that Health Care Home patients who have a CHW working with them to coordinate their care have higher rates of satisfaction with their care than those who do not receive support from a CHW. This model also focuses on quality indicators (asthma, diabetes, along with utilization and readmissions) to track the success of CHWs in their model of care. Thus far, they have been able to document a decrease in readmissions and utilization of the emergency room, which has translated into a cost savings for the system.

- **An increase in clinic visits** by community members who have received health education interventions from CHWs was described as an important success by many key informants. One individual explained that:

  > CHWs have been in the communities and earned peoples' trust and made them feel more comfortable and less afraid to be seen in a clinic.

One Wisconsin informant described the following anecdote to explain the success of CHWs in his/her community:

> We are getting people to come into screenings. We are finding more [cancers], earlier, so our registry is going up, but a lot of them are in remission. We have had a tremendous impact on getting people screened, diagnosed, and treated.

- **An electronic reporting system** within Indian Health Services (IHS) has allowed CHWs to report information on all services and activities in their daily work, broken down by the type of service (e.g. education on chronic disease, maternal/child health, etc). One informant described the measurable benefits of CHWs:

> What I see from their data is that they provide more one-on-one home contacts. Health education and case management are up there as well. Also monitoring patients and patient care. I can see those increases from the first years when I started here.

- **Tracking rates of diagnoses of diabetes.** Some CHW programs have specifically focused on tracking diabetes diagnoses. In 1995 an organization reported having diagnosed 200 people in the community with diabetes. As a result of CHW screenings over a 10-year period, diagnoses increased 500 percent. While higher rates of diagnoses are not ideal in terms of improving health, the informant explains that the increases in diagnoses are a direct result of CHWs educating the community about diabetes and creating access to screening. The subsequent success of CHWs in this organization is that the number of people that were diagnosed in 2011 has decreased significantly as a result of CHWs educating community members on how to prevent diabetes.

Question #4: What does the future hold for the CHW workforce?

Key informants described a long history of CHWs bridging the gap between cultural communities and health care. CHWs represent an important strategy for addressing disparities in health and health care experienced by underserved populations. Most informants agree that this is an exciting time for an exploration of the CHW workforce and how it can best fit within the health care system to serve the needs of various communities.

The Patient Protection and Affordable Care Act (PPACA), signed into law in March 2010, represents an important opportunity to explore new ways to integrate CHWs into the health care system. There was one overarching point made by several informants regarding CHWs and health care reform – that PPACA will result in 34 million people gaining health insurance, subsequently increasing the amount of health care services that are demanded throughout the nation.[4] This, combined with the aging Baby Boomer population, means that a significant increase in health services usage is inevitable. Informants suggest that CHWs can and should play an important role in mitigating the strain that will be placed on the health care system. One informant stated:

> There will be massive numbers of new people coming into the health care system due to health care reform. There are not enough health care providers to provide health care for all those new people. CHWs can play a role in providing basic care, educating on prevention and healthy lifestyles and helping people navigate the system, especially those new insured who are less familiar with it.

[4] Muhlestein, David. Will Health Reform's Newly Insured Overcrowd the Health Care System? Health Care. August 4, 2011. http://leavittpartnersblog.com/2011/08/will-health-reforms-newly-insured-overcrowd-the-health-care-system/

Another informant reports that, while, systematically, a great deal is "in flux" due to health care reform, he/she is confident that there will be many opportunities for CHWs to serve within the new system of care:

> The way care will be delivered, the incentive, the payment will all be retooled--more focus on measurement and outcome-- so how do you organize care in a way that is patient centered and going to deliver best outcomes for everyone. That may mean organizing in different ways for different communities to gain outcomes that are on par for everyone. The strategies align so well with increasing focus on triple aim[5]. We will be seeing primary care shortages and rise of mid-level professionals working at the top of their license and certificate. It's our hope that CHWs will become recognized members of teams and working with health professionals and more independently in the community.

While a lot remains unknown, it is clear from the interviews that health equity cannot be achieved without the work of CHWs. The important function that they play as a bridge between communities and the health care system is vital to the way they should and could be integrated into both health and social services in the future. One informant explained:

> There is definitely a place for the role. It [CHW work] aligns nicely with chronic disease management and public health. It is about outpatient care not acute care. As communities become diverse it will be vital – it is our reality.

Others reiterated that CHWs play a vital role within public health, particularly with respect to their focus on disease prevention:

> The health care system is broken, people are broken. I don't see that much health. I just see illness. We will need to focus on preventing illness-- that is what CHWs can do.

Sustainability

Many of the informants are thinking about, and offered ideas for, sustaining the CHW workforce.

- **Funding.** Informants frequently mentioned that funding and financial support for CHW work is a significant challenge. They also suggest that it is vital for sustainability of CHWs. Currently, most CHW programs receive support through federal or state grants (e.g., state public health departments) and foundations. Key informants expressed interest and need in exploring third-party reimbursement for CHW services. While Minnesota has been

[5] Institute for Healthcare Improvement (IHI) believes that new designs can and must be developed to simultaneously accomplish three critical objectives, or what we call the "Triple Aim": Improve the health of the population; Enhance the patient experience of care (including quality, access, and reliability); and Reduce, or at least control, the per capita cost of care. http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx

successful in obtaining reimbursement for CHW services provided for Medicaid services, informants expressed the need to push this model even further so that reimbursement is a possibility for care provided to populations outside of Medicaid.

- **Evaluation.** Several respondents said that rigorous program evaluation may enable the program to demonstrate the return on investment (ROI) for utilizing CHWs. Programs could use ROI information to demonstrate program effectiveness to community partners – some of whom may be willing to invest resources in program sustainability.

- **Development of a CHW cooperative and/or expansion of Minnesota CHW Alliance.** Informants expressed the importance of an alliance, cooperative, network or some other model that would allow for resource sharing, support, and information sharing.

Section II: Results of CHW survey

As mentioned, this study includes two primary methods for discerning the scope and spread of the CHW workforce in Iowa, Minnesota, South Dakota, and Wisconsin. Interviews with key informants, described in Section I, gathered in depth information from employers and champions. Section II describes the results of surveys completed directly by Community Health Workers in the four states.

Study approach

An online survey and a paper self-administered questionnaire (SAQ) were created to collect information directly from Community Health Workers about their education, training and current employment, and scope of work. The link (url) for the online survey was distributed in a variety of ways: emailed a direct link to CHWs who were identified by ACS staff, sent to listservs of which CHWs were members, and sent to participants of the key informant interviews who were able to forward it on to CHWs that they employ. The SAQ was mailed out to those who requested it, mostly employers of CHRs in South Dakota.

Before beginning the survey, respondents were provided with a definition of a CHW and asked if the description applied to their work or volunteer role. A positive response allowed them to move forward in completing the survey. Those who completed the survey were offered a ten-dollar gift card to Target or Walmart for their time. Surveys were completed in February 2012.

Response rate

Response rates can only be calculated for those who were sent a direct link to the survey. These respondents received two reminder emails. Of the 339 individuals who received a direct link, 134 completed the web survey for a response rate of 40 percent. However, this response rate does not include those who may have opened the survey or opted out because they were not CHWs.

We are not able to calculate the response rate for respondents who accessed the survey through an email link sent by others (including listservs).

2. CHW surveys: Response rate by state and overall

	Total email invitations delivered	Number who never responded	Number who opened/ clicked	Number who opted out	Number who completed from direct link	Number who completed through an invitation from a colleague (open-link)	Total completes
Minnesota	174	120	54	2	42	40	82
Wisconsin	134	73	63	0	58	19	77
Iowa	31	23	13	9	10	9	19
South Dakota	0	0	0	0	0	63**	63
No state specified	-	-	-	-	1	3	4
Total	339*	216	130	11	111	134	245

** An additional 7 email invitations were sent but bounced back as "undeliverable."*

These were not included as eligible cases in response rate calculations.

*** In South Dakota, several sites requested a paper version of the survey; 42 respondents completed a paper version that was sent back by mail to Wilder Research. These surveys were entered into the "open-link" invitation database.*

A total of 286 survey records were received by Wilder Research. In order to produce the highest quality findings, Wilder closely examined the records and found 41 of them inadequate to include in the analysis based on 1) eligibility and 2) data quality.

- Thirteen records were removed because the respondents did not meet eligibility requirements as presented in questions 1 and 2 of the survey, which were intended to "screen out" those who did not closely identify their work with that of a CHW. Eleven of these cases were from those who completed the survey via direct link, and another two records were those who completed the survey through the open link sent to CHW listservs.

- Twenty-eight records did not meet basic data quality standards, and had significant portions of missing data. Eighteen respondents completed the survey in less than five minutes, and chose to answer only the required questions.

A few things to note when interpreting the data

It is not known how well these 245 respondents represent the views of other CHWs in these four states. We know that there are many CHWs or persons in similar roles who did not participate in the study. This should be kept in mind when interpreting results.

Also, Iowa had the smallest number of CHWs who participated in the study (N=19). Again, we do not know the total number of possible respondents in Iowa or how well these 19

respondents represent the views of other CHWs in Iowa. Low numbers in Iowa may also indicate that the nature of the CHW workforce infrastructure is less developed in Iowa, so that it is more difficult to find CHWs to participate in the study.

Finally, the number of respondents who answered each question varies. This is reflected in the "N" sizes for each table. Some questions were required for all respondents, and some questions could be skipped. Items that had lower numbers of responses should be interpreted with caution.

Background of CHWs

Overall, the majority of CHW respondents were female (87%). South Dakota, however, had a notably higher number of male CHWs (27%) than other states.

3. Gender of Community Health Workers

	Minnesota (N=79)	Wisconsin (N=76)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=241)
Male	8%	8%	27%	16%	13%
Female	92%	92%	73%	84%	87%

Note(s): *[1] Four respondents did not provide their state of residence, but are included in totals.*

The race and ethnicity of Community Health Workers varied greatly across states. Wisconsin showed the greatest diversity among CHWs, followed closely by Minnesota. By contrast, CHWs in Iowa were either White (79%) or Black/African American (21%), and nearly all respondents from South Dakota were American Indian (98%). A sizeable proportion of CHWs in Minnesota and Wisconsin were of Hispanic or Latino origin (30% and 26% respectively).

4. Race/ethnicity of Community Health Workers

	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=245)
American Indian	5%	16%	98%	0%	33%
White	40%	31%	3%	79%	30%
Black/African American	15%	26%	0%	21%	15%
Asian	12%	9%	0%	0%	7%
African-born	9%	3%	0%	0%	4%
Other	16%	19%	2%	0%	12%
	Minnesota (N=77)	**Wisconsin (N=72)**	**South Dakota (N=59)**	**Iowa (N=18)**	**Total[2] (N=229)**
Hispanic/Latino(a) origin	30%	26%	3%	6%	20%
Mexican, Mexican American or Chicano	14%	10%	3%	6%	9%
Puerto Rican	5%	8%	0%	0%	4%
Other	10%	8%	0%	0%	6%

Note(s): *[1] Four respondents did not provide their state of residence, but are included in totals.*

[2] Three respondents did not provide their state of residence, but are included in totals.

Forty-five percent of all CHWs surveyed reported fluency in a language other than English; in Minnesota, over six in 10 (62%) CHWs were bilingual. The top three languages specified by bilingual CHWs (n=111) include Spanish (44%), Lakota (17%) and Hmong (12%), however this also varied across states. Spanish- and Hmong-speaking CHWs were predominantly residing in Minnesota and Wisconsin, while those speaking Lakota lived in South Dakota. "Other" languages spoken by CHWs included French, American Indian tribal languages, Arabic, Italian, and Jamaican.

5. Languages other than English spoken by Community Health Workers

	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=245)
Fluent in language other than English	62%	42%	40%	16%	45%
Spanish	33%	26%	0%	11%	20%
Lakota	0%	0%	30%	0%	8%
Hmong	6%	10%	0%	0%	5%
Amharic	2%	0%	0%	0%	1%
Oromo	2%	0%	0%	0%	1%
Somali	2%	0%	0%	0%	1%
Vietnamese	2%	0%	0%	0%	1%
Lao	1%	0%	0%	0%	0%
Swahili	1%	0%	0%	0%	0%
American Sign Language (ASL)	6%	1%	0%	0%	2%
Other	12%	3%	6%	5%	7%

Note(s): *Multiple responses allowed.*

[1] Four respondents did not provide their state of residence, but are included in totals.

The majority of CHWs surveyed had at least some college experience (87%), including vocational training or some college (31%), an Associate's degree (14%), or a four-year college degree or higher (42%). Levels of educational attainment varied within states: Over half of CHWs from Minnesota (52%) and Wisconsin (52%) earned a college or advanced degree, and nearly all CHWs from Iowa said the same (95%). CHWs from South Dakota were more varied in their educational backgrounds.

6. Education level of Community Health Workers

	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=245)
Some high school	0%	0%	6%	0%	2%
High school diploma or GED	5%	9%	22%	0%	10%
Vocational training or some college	30%	27%	43%	5%	31%
Associates/Two-year degree	12%	12%	22%	0%	14%
College Bachelor's degree	34%	38%	5%	58%	29%
Advanced degree (Masters or PhD)	18%	14%	0%	37%	13%

[1] Four respondents did not provide their state of residence, but are included in the totals

Community Health Workers were employed by or affiliated with a wide range of organizations. Over a third (36%) of CHWs were working with a nonprofit organization, 12 percent were working with city, state, or federally-funded public health organizations, 11 percent said they were working with a clinic operated by Indian Health Services (most of whom were from South Dakota) and 10 percent described their organization as a Community Health Center. Nearly one in five respondents (19%) specified a type of organization not included on the list below. CHWs from South Dakota explained they worked with tribal programs or health centers (though technically part of IHS they are largely independent with different programs and eligibility for services), and CHWs in other states said they were affiliated with an academic setting, such as a health center run by a university or a grant-funded research project.

7. Type of organization or agency affiliation

	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=245)
Nonprofit organization	54%	40%	10%	42%	36%
Public health organization (city, state, or federal)	12%	9%	6%	37%	12%
Indian Health Services (IHS) Clinic	1%	9%	32%	0%	11%
Community Health Center (CHC)	6%	16%	13%	0%	10%
Hospital	7%	10%	0%	10%	6%
Clinic (private health care system)	9%	4%	0%	0%	4%
Other	11%	12%	40%	11%	19%

Note(s): *Within state, percentages may not equal 100% due to rounding.*

[1] *Four respondents did not provide their state of residence, but are included in totals.*

Seventy percent of Community Health Workers reported being active in their work for three years or more, including a quarter (25%) who had over 10 years of experience. Wisconsin had the largest proportion of CHWs new to the profession (24% reported being in their role less than a year), while CHWs from South Dakota appeared to be the most seasoned, with 23 percent reporting over 20 years of experience.

8. Length of time as a Community Health Worker

	Minnesota (N=79)	Wisconsin (N=76)	South Dakota (N=61)	Iowa (N=19)	Total[1] (N=239)
Less than 1 year	6%	24%	7%	16%	13%
1-2 years	23%	16%	7%	16%	16%
3-5 years	23%	20%	25%	16%	21%
6-10 years	28%	24%	20%	26%	24%
11-20 years	16%	13%	20%	16%	16%
Over 20 years	4%	4%	23%	11%	9%

Note(s): *Within state, percentages may not equal 100% due to rounding.*

[1] Four respondents did not provide their state of residence, but are included in totals.

Question #1: To what extent and in what capacity are CHWs utilized within the Midwest Division states to promote cancer and other chronic disease prevention and early detection?

As seen in the previous section, the key informant interviews provided a broad context for understanding the work of CHWs in the Midwest region and how they promote cancer and chronic disease prevention. These findings indicate that there is a core set of activities that CHWs tend to carry out in their work. CHW survey respondents were asked about their key activities and roles as CHWs, the health issues they address, and the skills used to carry out their work.

Key areas of activities for CHWs

Community Health Workers were asked to select all of the tasks involved in their work and of those, which are their **primary** tasks. Just as was documented in the key informant interviews and the HRSA study of CHWs, it is clear from the survey findings that CHWs take on a variety of tasks and roles in serving their communities. Overall, 18 percent of CHWs reported "conduct community outreach" as their primary task, followed by "connect people with medical services and programs" (13%), and "provide health education to groups" (12%). These findings are similar to key informant findings that suggested **creating connections between community members and the health care system, educating medical and social service providers about community needs,** and **providing health education and information** are primary tasks of CHWs.

It is important to note that even the tasks that did not rank in the top five, or even top 10, primary tasks were still identified by CHWs as tasks they perform regularly. For example,

only 1 percent of CHWs overall reported "serve as a cultural link" as their primary task, but 58 percent included this as a task they perform. "Other tasks" (N=50) specified by CHWs were wide-ranging and included supervisory/training, home visits, obtaining medications or helping others enroll in programs for medications, office-related duties, collaboration with local clinics, and outreach activities.

The last line of Figure 9 shows how many CHWs select at least 10 of the tasks listed as part of their work: Over half (52%) of CHWs from South Dakota fell into this category, as well as about one in five CHWs in Minnesota and Iowa (24% and 21% respectively).

Wisconsin CHWs were the least likely to have selected at least 10 of the tasks. The fact that over a quarter (28%) of survey respondents overall said they perform at least 10 of these tasks as part of their role as a Community Health Worker further confirms the broad range of work this position encompasses.

The primary tasks reported by CHWs differed slightly for full- versus part-time positions. Paid, full-time CHWs were more likely to conduct health insurance enrollment, assure people get the coverage and services they need, provide direct health services, and educate individuals. Community outreach and care coordination were more strongly associated with paid part-time or volunteer positions.

9. Tasks performed by Community Health Workers

White columns= CHWs checked task as part of their work; Grey columns=CHW identified as " primary" task	**Minnesota (N=82)**		**Wisconsin (N=77)**		**South Dakota (N=63)**		**Iowa (N=19)**		**Total[1] (N=245)**	
	Task performed	Primary task	Task performed	Primary task	Task performed	Primary task	Task performed	Primary task	Task performed	Primary task
Conduct community outreach	80%	17%	78%	30%	71%	3%	100%	21%	79%	18%
Connect people with medical services and programs	84%	16%	73%	12%	87%	14%	58%	0%	80%	13%
Provide health education to groups	56%	11%	69%	16%	73%	0%	89%	42%	67%	12%
Provide health education to individuals (one-on-one)	77%	11%	70%	8%	90%	17%	68%	0%	78%	11%
Provide direct health services (e.g. take vital signs)	22%	4%	23%	6%	86%	19%	26%	0%	40%	9%
Provide care navigation and coordination	62%	15%	39%	4%	60%	2%	32%	11%	52%	7%
Assure that people get the coverage and services they need	52%	5%	36%	1%	84%	14%	47%	0%	55%	6%
Provide interpreter services	39%	5%	21%	3%	71%	0%	21%	5%	40%	3%
Transport people to appointments	13%	1%	17%	3%	90%	8%	16%	0%	36%	3%
Conduct health insurance enrollment	41%	6%	17%	3%	17%	0%	21%	5%	26%	3%
Connect people with non-medical services or programs	78%	0%	65%	0%	78%	3%	58%	0%	72%	1%
Serve as a cultural link	71%	0%	47%	3%	65%	0%	26%	0%	58%	1%
Education professionals about the needs of cultural communities	52%	2%	39%	1%	48%	0%	63%	0%	48%	1%
Other	16%	7%	19%	9%	24%	22%	32%	16%	20%	12%
At least 10 of these tasks selected	24%	-	12%	-	52%	-	21%	-	28%	-

Note(s): *White columns will not equal 100%; multiple responses selected.*

[1] *Four respondents did not provide their state of residence, but are included in totals.*

The top skills most commonly used by CHWs in their work include verbal communication (90%), teaching skills (74%), and written (71%) communication. Also notable is the high percentage of CHWs who report routinely using leadership skills (68%), which are an integral part of communicating with and between communities and health care systems. Survey respondents who indicated "other skills" (N=23) mentioned American Sign Language and other interpreter/communication skills, advocacy, and technical or administrative skills like case management/notes and computer skills.

10. Skills routinely used by Community Health Workers

Skills checked (ranked in order of overall frequency)	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=245)
Verbal communication	89%	92%	86%	100%	90%
Teaching	80%	73%	68%	84%	74%
Written communication	79%	70%	60%	84%	71%
Leadership	71%	77%	46%	95%	68%
Relationship building	80%	70%	46%	95%	68%
Organization	59%	77%	46%	79%	62%
Public speaking	60%	57%	37%	89%	54%
Bilingual	60%	35%	40%	16%	42%
Motivational speaking	44%	44%	22%	42%	38%
Other skills	9%	9%	13%	5%	9%

Note(s): *Columns will not equal 100%; multiple responses selected.*

[1] Four respondents did not provide their state of residence, but are included in totals.

Populations reached by Community Health Workers

In terms of race and ethnicity, the primary populations served by Community Health Workers aligned with those of the CHWs themselves, as seen earlier in Figure 4. For example, almost all CHWs in South Dakota reported themselves as American Indian, and, accordingly, the same CHWs said they are serving American Indians in their work. One notable difference from this trend is that CHWs in Minnesota are reaching African-born and Asian clients, though fewer described their own race as either category.

11. Race/ethnicity of primary populations reached by Community Health Workers

	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=245)
American Indian	15%	19%	100%	5%	38%
Black/African American	48%	47%	3%	32%	34%
Hispanic/Latino/a	55%	39%	3%	32%	34%
Non-Hispanic white	35%	27%	8%	74%	28%
African-born	32%	5%	0%	11%	13%
Asian	23%	12%	0%	5%	12%
Other	10%	5%	5%	5%	7%

Note(s): *Columns will not equal 100%; multiple responses selected.*

[1] Four respondents did not provide their state of residence, but are included in totals.

Community Health Workers also reported serving populations with specialized needs, most commonly uninsured individuals (74%), the homeless (52%), and those in rural settings (43%). Serving uninsured individuals was common in all states; however other special populations varied as seen in Figure 12. The top responses for those who selected "other" special populations (N=38) were elderly and youth, LGBT, transient populations (specifically, those who travel between reservations and other areas for health care), deaf/hearing impaired, and low income individuals.

12. Special populations reached by Community Health Workers

	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=245)
Uninsured	73%	81%	71%	63%	74%
Homeless	48%	43%	73%	47%	52%
Immigrants	76%	44%	3%	42%	43%
Rural populations	21%	22%	89%	68%	43%
Migrant	20%	9%	6%	26%	13%
Other	15%	14%	21%	11%	16%

Note(s): *Columns will not equal 100%; multiple responses selected.*

[1] Four respondents did not provide their state of residence, but are included in totals.

Health issues addressed

Key informant interviews illustrate that a wide variety of health issues, chronic diseases, and social issues are addressed by CHWs across the four states. In order to get a better sense of exactly which health issues in the Midwest region they are targeting, CHWs were asked to identify, from a list of 11 health issues, all of those they address in their work (Figure 13).

- CHWs address a wide array of health issues; about a quarter (23%) said they have addressed 10 or more.

- The top five health issues identified most often were women's health (64%), diabetes (64%), cancer (62%), nutrition (60%), and high blood pressure (58%).

These findings support the information reported by key informants, which suggests that prevention and/or maintenance of chronic illness (e.g. diabetes, hypertension, cholesterol, etc.); women's reproductive and sexual health; mental and behavioral health; and social determinants of health (e.g. domestic violence, injury prevention, etc.) are the main health issues addressed by CHWs.

Cancer ranks among the top three health issues addressed by CHWs in general, with over six in ten (62%) saying they deal with cancer in their work. Attention to cancer ranges by state; it is particularly high in South Dakota (76%), Wisconsin (71%), and Iowa (63%), and for Wisconsin CHWs it is the top health issue addressed. In Minnesota, cancer ranks towards the middle of the list, with 40 percent of CHWs saying they address it in their work. While Minnesota has less of a focus on cancer than the other three states, the large number of CHWs turning their attention to the disease indicates that support from ACS would be beneficial for the workforce.

Thirty-nine percent of CHWs specified other health issues they addressed, including: reproductive health or family planning, sexually transmitted infections and HIV/AIDS prevention, substance abuse and chemical dependency issues, pregnancy-related issues, immunizations, and diabetes prevention and screening. These are all on par with the health issues mentioned by key informants as well.

13. Health issues addressed by Community Health Workers

	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=245)
Women's health	63%	57%	79%	47%	64%
Diabetes	56%	52%	97%	37%	64%
Cancer	40%	71%	76%	63%	62%
Nutrition	59%	47%	82%	47%	60%
High blood pressure	45%	43%	97%	37%	58%
Cardiovascular/heart disease	40%	30%	81%	42%	48%
Physical activity	39%	40%	68%	42%	48%
Asthma	32%	33%	71%	26%	42%
Mental health	41%	23%	71%	32%	43%
Obesity	35%	29%	65%	42%	42%
Tobacco control	32%	29%	54%	47%	38%
Other health issues	34%	29%	57%	42%	39%
At least 10 of the issues described above	12%	8%	52%	26%	23%

Note(s): *Columns will not equal 100%; multiple responses selected.*

[1] *Four respondents did not provide their state of residence, but are included in totals.*

A focus on cancer prevention

Key informant interviews indicate that states are varied in their focus on cancer prevention. A majority of individuals interviewed felt that a focus on a certain type of cancer was dependent upon how the CHW work was being funded. In other cases, the focus is derived from what the CHWs have deemed as community needs.

The CHW survey did not ask a direct question about the types of cancer prevention work. Instead, participants were allowed to specify cancer types in the open-ended responses. Of the CHWs (N=151) who selected cancer as a health issue they address, many specified breast (27), cervical (11), prostate (9), colon/colorectal (12), lung (7), and brain (2) cancer. Multiple respondents identified more than one cancer that they addressed.

14. Percent in each state who are addressing cancer in their CHW work

	Percent
Iowa	63%
Minnesota	40%
South Dakota	76%
Wisconsin	71%

Question #2: What are the hiring, compensation, training and professional development trends and unmet needs as articulated by CHWs?

Titles, employers, and experience

When asked to identify one of three common titles used to describe the role of CHWs, about a third (29%) referred to themselves as a "Community Health Representative," including the majority of respondents from South Dakota. A quarter (25%) chose "Community Health Worker", and 5 percent described themselves as Promotora de Salud. The largest proportion of respondents, however, chose to write in a job title themselves (40%). The most common titles were "Health Educators," "Community Health Educator," "Community Outreach Coordinator," "Outreach Specialist," "Community Medical Assistant," or "Prevention Specialists." These findings support those from the 2007 U.S. Department of Health and Human Services, HRSA study *Community Health Worker National Workforce Study*, which explain that CHWs can hold myriad titles and descriptions, yet perform the same kinds of work in health care systems.

15. Current job titles

	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=245)
Community Health Representative	1%	18%	86%	0%	29%
Community Health Worker	45%	26%	3%	11%	25%
Promotora de Salud	5%	10%	0%	0%	5%
Something else/other	49%	46%	11%	89%	40%

Note(s): *Within state, percentages may not equal 100% due to rounding.*

[1] Four respondents did not provide their state of residence, but are included in totals.

Hours spent working as a CHW

Over two-thirds (67%) of survey respondents reported working or volunteering in their role as a Community Health Worker full-time (40 or more hours per week). CHWs in Wisconsin were more likely to be working less than 20 hours per week than CHWs in other states.

16. Average number of hours worked per week as a Community Health Worker

	Minnesota (N=77)	Wisconsin (N=73)	South Dakota (N=62)	Iowa (N=19)	Total[1] (N=235)
Less than 10 hours per week	9%	21%	3%	16%	12%
11-19	8%	10%	0%	5%	6%
20-29	16%	16%	2%	5%	11%
30-39	5%	7%	0%	0%	4%
40 hours	56%	37%	66%	58%	53%
More than 40 hours per week	6%	10%	29%	16%	14%

Note(s): *Within state, percentages may not equal 100% due to rounding.*

[1] Four respondents did not provide their state of residence, but are included in totals.

Employment status and compensation

Key informant interviews show that there is a wide range of employment status and compensation for CHWs, both within and among states in the Midwest region. Survey results indicate that 86 percent of CHWs participating in the study are currently in paid positions. Small variations across states emerged as well: CHWs in Wisconsin showed a slightly higher proportion of (unpaid) volunteers, while all of the CHWs in South Dakota (N=63) were in paid positions.

17. Paid versus volunteer positions by state

	Minnesota (N=79)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=243)
Paid	90%	71%	100%	89%	86%
Volunteer	10%	29%	0%	11%	14%

[1] Four respondents did not provide their state of residence, but are included in totals.

Combining the data presented in Figures 16 and 17, Wilder identified those who were currently working in (paid) full- versus part-time positions. As seen in Figure 18, the

majority of paid CHWs in Minnesota, South Dakota, and Iowa were working full-time. CHWs in Wisconsin, however, were more likely to be volunteers or be in paid part-time positions (56%).

18. Employment status of Community Health Workers

	Minnesota (N=77)	Wisconsin (N=74)	South Dakota (N=62)	Iowa (N=19)	Total[1] (N=236)
Paid full-time (40 hrs or more per week)	60%	45%	95%	74%	66%
Paid part-time (< 40 hrs per week)	30%	26%	5%	16%	20%
Unpaid volunteer	10%	30%	0%	11%	14%

Note(s): *Within state, percentages may not equal 100% due to rounding.*

[1] Four respondents did not provide their state of residence, but are included in totals.

Survey respondents were asked two questions related to the permanency of their work as Community Health Workers:

1. "Is your current position permanent or temporary?" and

2. "Does your position have long-term funding (more than 2 years)?"

The results, shown in Figure 19, indicate that seven out of ten (71%) CHWs said their positions were permanent; CHWs in South Dakota and Minnesota were most likely to report permanent positions. One in five CHWs (21%) acknowledged that their positions were temporary, supported by either short-term funding or grants. This finding was echoed by key informants who often expressed concern over lack of permanent funding and positions for CHWs. Fewer CHWs (8% overall) were unclear about the permanency of their positions. Not surprisingly, CHWs in paid, full-time positions were more likely to describe their positions as permanent (87%) than paid part-time positions or volunteers – a finding consistent across states.

Despite many reporting permanent positions in one question, only half (50%) said their positions also had long-term funding in the follow-up question, perhaps indicating a lack of clarity or confidence in their position lasting well into the future. This finding was also echoed by key informants who often expressed uncertainty around long-term funding sources for CHW positions.

19. Permanence of Community Health Worker positions

	Minnesota (N=81)	Wisconsin (N=77)	South Dakota (N=62)	Iowa (N=19)	Total[1] (N=243)
Permanent	67%	57%	98%	58%	71%
Temporary/short-term, or grant-funded	25%	30%	2%	32%	21%
Not sure right now	9%	13%	0%	11%	8%
	Minnesota (N=80)	**Wisconsin (N=77)**	**South Dakota (N=62)**	**Iowa (N=19)**	**Total[1] (N=242)**
Long-term funding	35%	44%	69%	63%	50%

[1] Four respondents did not provide their state of residence, but are included in totals.

20. Hourly salary of paid Community Health Workers

	Minnesota (N=81)	Wisconsin (N=77)	South Dakota (N=62)	Iowa (N=19)	Total[1] (N=243)
Less than $14/hour	16%	29%	77%	18%	39%
Between $14-17.99/hour	29%	25%	11%	6%	21%
$18 or more/hour	38%	19%	10%	65%	26%
Prefer not to answer	17%	27%	2%	12%	14%

[1] Three respondents did not provide their state of residence, but are paid community health workers and included in totals.

Figures 21 and 22 show the hourly salary reported by paid full- and part-time CHWs, respectively. There was some variability among states around compensation. This variability was also echoed in key informant interviews where informants reported compensation ranging from $8 to $21 an hour. CHWs in South Dakota were often paid less than $14 per hour, regardless of their paid status (full- or part-time). CHWs in Iowa reported the inverse, that is, they were more likely to make $18 per hour or more whether they were working full- or part-time. The salary distribution in Minnesota leaned toward higher pay (over $14 per hour), while Wisconsin CHWs were more likely to earn slightly less. Contrary to key informant findings, there was not a strong relationship between the number of years as a CHW and salary.

Overall, it seems the hourly salaries of part-time CHWs were more polarized than those in full-time positions; however, fewer part-time CHWs provided salary information so results should be interpreted with caution.

21. Hourly salaries of full-time[1] CHWs

	Minnesota (N=46)	Wisconsin (N=33)	South Dakota (N=59)	Iowa (N=14)	Total[2] (N=155)
Less than $14/hr	9%	24%	76%	21%	40%
$14-$17.99/hr	35%	33%	12%	7%	23%
$18 or more/hr	43%	18%	10%	57%	26%
Prefer not to answer	13%	24%	2%	14%	11%

Note(s): *Within state, percentages may not equal 100% due to rounding.*

[1]CHWs who reported being in a paid position and working 40 or more hours per week.

[2] Three respondents did not provide their state of residence, but are paid full-time CHWs and included in totals.

22. Hourly salaries of part-time[1] CHWs

	Minnesota (N=23)	Wisconsin (N=19)	South Dakota (N=3)	Iowa (N=3)	Total[2] (N=48)
Less than $14/hr	30%	37%	100%	0%	35%
$14-$17.99/hr	17%	11%	0%	0%	12%
$18 or more/hr	26%	21%	0%	100%	27%
Prefer not to answer	26%	32%	0%	0%	25%

Note(s): *Within state, percentages may not equal 100% due to rounding.*

[1] CHWs who reported being in a paid position and working less than 40 hours per week.

[2] Three respondents did not provide their state of residence, but are paid full-time CHWs and included in totals.

Education and Training

Key informant interviews found that there was variation among the states regarding education and training of CHWs. Findings from the survey support this. Forty percent of survey respondents began their role as a CHW with prior education or training specifically for Community Health Workers. CHWs from Minnesota were slightly more likely to have had this background (46%), which is not surprising given the CHW certification program that exists in Minnesota. Three in ten (31%) CHWs overall reported a degree in nursing, social work, or health education. After becoming a CHW, a large proportion of respondents (70%) received training (either on-the-job or voluntary) specific to their work. This trend was fairly consistent across states.

23. Training and formal education before and after working or volunteering in current role

	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=245)
College degree in nursing, social work, or health education	39%	29%	22%	32%	31%
Received formal CHW education or training BEFORE working/ volunteering in current role	46%	36%	37%	32%	40%
Received on-the-job training or volunteer training specific to current role AFTER started worked as a CHW	65%	73%	73%	74%	70%

[1] Four respondents did not provide their state of residence, but are included in totals.

Echoing the observations of key informants, those who had completed a college degree (any kind of Bachelor's degree) or formal training or education prior to assuming their role as a Community Health Worker were no more likely to be in paid, full-time positions than paid part-time employees. **Furthermore, there was no discernible trend in hourly salary when comparing CHWs with more credentials (such as a college degree or formal education/training) than other CHWs.**

Community Health Workers who reported on-the-job training after assuming their role were then asked about the types of training they received. Most commonly, they described this training as "continuing education" (90%), an initial orientation (53%), and/or mentoring (37%). Almost one in five (19%) said they completed a CHW certificate program as part of their professional development. Of those who described another type of training (16%), responses included Certified Nurses Aid programs, EMT and first responder training, first aid and CPR courses, conferences, and other peer training.

24. Type of on-the-job or voluntary training after working or volunteering in current role

	Minnesota (N=53)	Wisconsin (N=56)	South Dakota (N=46)	Iowa (N=14)	Total[1] (N=171)
Continuing education or training	93%	86%	87%	100%	90%
Initial orientation	48%	58%	40%	93%	53%
Mentoring	39%	40%	26%	50%	37%
CHW certificate program	21%	14%	26%	0%	19%
Other	14%	12%	23%	21%	16%

[1] Four respondents did not provide their state of residence, but are included in totals.

Certificate Programs

Just over one-third (38%) of Community Health Workers, overall, said they had completed a CHW certificate program. By state, half (50%) of CHWs from Minnesota, 47 percent from South Dakota, and 25 percent from Wisconsin said they had completed a certificate program. Key informant interviews found that Minnesota has a well-developed infrastructure for training and educating CHWs through a certificate program. Survey data are reflective of this finding in that Minnesota had the most survey respondents who reported completing a certificate program. No CHWs from Iowa reported completing a certificate program. Based on the results presented in Figure 25, it appears the majority of CHWs who completed a certificate program may have done so after assuming their role. CHWs from Minnesota and Wisconsin completed their programs in their respective states, but a higher proportion of certified CHWs in South Dakota had completed their program in another state.

25. Completed a CHW certificate program

	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=245)
Completed a CHW certificate program	50%	25%	47%	0%	38%
Issued by the same state of residence (n=89)	100%	95%	82%	NA	-

[1] Four respondents did not provide their state of residence, but are included in totals.

Community Health Workers who indicated having completed a certificate program were asked follow-up questions about the funding related to their program, and there were differences among states. In Minnesota, survey respondents with a CHW certificate had

paid for it using a variety of funding sources, including their own funds (27%), employer sponsorship (22%), and financial aid (22%). In contrast, certified CHWs in South Dakota were largely funded through their employers (86%). "Other" arrangements included state, county, or federal funding (such as state or county health departments or IHS) or unemployment benefits (such as their workforce development center).

26. Who paid for the certificate program?

	Minnesota (N=41)	Wisconsin (N=19)	South Dakota (N=27)	Iowa (N=0)	Total (N=91)
Employer	22%	42%	86%	NA	47%
Paid for it myself	27%	5%	0%	NA	14%
Financial aid from college	22%	5%	0%	NA	11%
Other	29%	42%	14%	NA	27%

Note(s): *Columns may not equal 100%; multiple responses selected.*

Although 39 percent of certified Community Health Workers were unable to report the cost of their program, over a quarter (29%) said the cost of the certificate program was at least $1,000. Fourteen percent of certified CHWs said their program was free.

27. Cost of CHW certificate program

	Minnesota (N=41)	Wisconsin (N=19)	South Dakota (N=29)	Iowa (N=0)	Total (N=93)
Certificate program was free	12%	30%	4%	NA	14%
$1,000 or less	10%	15%	30%	NA	17%
More than $1,000	44%	10%	22%	NA	29%
Don't know	34%	45%	44%	NA	39%

Note(s): *Columns may not equal 100%; multiple responses selected.*

Training related to cancer prevention

Although 62 percent of all Community Health Workers said "cancer" was a health issue they addressed in their work, when asked more specifically about educating the community on cancer risk-reduction and screening only 24 percent said they "already did this." That being said, over two-thirds (69%) of CHWs were open to incorporating these prevention strategies into their work. CHWs in Minnesota and South Dakota who completed a certificate were more likely to report already doing this work than non-certified CHWs.

28. Open to educating the community on cancer risk-reduction and screening

	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=245)
Yes	55%	49%	49%	26%	49%
Already do this	13%	30%	24%	47%	24%
Maybe	21%	14%	27%	21%	20%
No	11%	7%	0%	5%	6%

[1] Four respondents did not provide their state of residence, but are included in totals.

Nearly a quarter of CHWs have received no training on cancer prevention and early detection, a finding consistent across states. Of CHWs who had received training related to cancer prevention, this training most commonly focused on breast cancer (67%), followed by cervical cancer (46%), colorectal cancer (33%), and cancer disparities (30%), i.e. the over-representation of cancer in specific populations. Community Health Workers in South Dakota and Iowa seemed the most well-versed when it came to training on different types of cancers.

29a. Received training on cancer prevention or early detection

	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=61)	Iowa (N=19)	Total[1] (N=243)
No training received on cancer prevention/early detection	29%	17%	25%	26%	23%
Training received on at least one cancer prevention/ early detection topic	71%	83%	75%	74%	77%

[1] Four respondents did not provide their state of residence, but are included in totals.

29b. Training on cancer prevention or early detection by type of cancer

	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=245)
Breast cancer	60%	79%	66%	58%	67%
Cervical cancer	40%	42%	64%	21%	46%
Colorectal cancer	26%	18%	59%	37%	33%
Cancer disparities	26%	23%	39%	37%	30%
Lung cancer	16%	19%	54%	26%	28%
Other cancers	9%	6%	15%	5%	9%

[1] Four respondents did not provide their state of residence, but are included in totals.

Training on cancer risk reduction and prevention was funded by a variety of sources, but most frequently it was paid for by employers (52%). Interestingly, a quarter (25%) of CHWs from Iowa and 12 percent of CHWs from Minnesota had paid for this type of training themselves. Most of the time the training was reported as free or the cost was unknown.

30. Funding source and cost of cancer-related training received

Who paid for training related to cancer prevention or early detection?	Minnesota (N=42)	Wisconsin (N=39)	South Dakota (N=42)	Iowa (N=12)	Total[1] (N=139)
Paid for it myself	12%	5%	0%	25%	7%
My employer paid for it	49%	46%	59%	58%	52%
Don't know	16%	15%	24%	0%	18%
Other	23%	33%	175	17%	23%
How much did it cost?	**Minnesota (N=45)**	**Wisconsin (N=54)**	**South Dakota (N=43)**	**Iowa (N=14)**	**Total[1] (N=160)**
Free	53%	54%	37%	36%	46%
Under $500	13%	5%	2%	36%	10%
$501 or more	2%	2%	12%	14%	6%
Don't know	31%	39%	49%	14%	37%

[1] Four respondents did not provide their state of residence, but are included in totals.

Question #3: How much interest do current CHWs have in resources and learning opportunities around cancer prevention and cancer disparities?

The majority of CHWs were interested in receiving additional training concerning most cancers listed in the survey, as seen in Figure 31. Although CHWs in South Dakota and Iowa mentioned prior training in a diverse range of cancer types, their interest in further training remained high. The only type of cancer indicated among those who replied "other" was prostate cancer.

31. If offered free of charge by the American Cancer Society, would you be interested in training on prevention or early detection for any of the following...

Those answering "yes"	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=61)	Iowa (N=19)	Total[1] (N=243)
Cervical cancer	80%	78%	82%	42%	77%
Breast cancer	73%	75%	84%	47%	75%
Cancer disparities	76%	62%	89%	32%	71%
Colorectal cancer	73%	56%	82%	37%	67%
Lung cancer	63%	62%	52%	58%	60%
Prostate cancer (volunteered)	11%	5%	41%	5%	16%

Note(s): *[1] Four respondents did not provide their state of residence, but are included in totals.*

When asked about the best ways to deliver additional training, CHWs were most interested in printed educational or training materials (86%), in-person training (86%), or online or web-based training (81%). CHWs from Iowa overwhelmingly indicated that they would be interested in "online videos" (95%) as a resource or learning opportunity.

32. If offered free of charge by the American Cancer Society, would you be interested in the following resources and learning opportunities...

Those answering "yes" or "maybe"	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total[1] (N=245)
Printed educational or training materials	88%	88%	78%	95%	86%
In-person training	88%	84%	86%	79%	86%
Online or web-based training	80%	86%	71%	100%	81%
Workplace Lunch and Learns	77%	75%	73%	79%	76%
Online videos	72%	77%	62%	95%	72%
Electronic newsletter	76%	69%	56%	89%	69%
Phone-based training or conference calls	54%	55%	46%	79%	54%

[1] Four respondents did not provide their state of residence, but are included in totals.

CHWs were asked to describe the support they need in order to add cancer prevention and early detection messages into their work. Training/educational resources, information and resources, general training/education materials, and general information rose to the top as salient mechanisms of support. Wilder Research staff read the open-ended responses provided by 106 CHWs and grouped them into themes, as shown in Figure 33.

33. Support needed by CHWs to add cancer prevention and early detection messages into their work

What additional support would you need to add cancer prevention and early detection messages into your work? (Open-ended question grouped into themes; 106 participants responded)	N
Training/educational resources	33
Information and resources	32
General training/education materials	21
General information	19
Funding	10
Culturally specific	10
Specific training/education	8
Other*	7
Support from coworkers/supervisors	6
Culturally appropriate training/materials	4
Support groups for survivors	3
Training on prevention	3
Information for uninsured	2
Support from the broader community	1
Other specific information/resources	1
None/don't know	11

***Other responses include**: Help with marketing, Transportation, Time, Colonoscopy, more prostate checkups (N=2), getting people who smoke to our screenings for cancer.*

Selected open-ended responses include:

> I would need information and resources for services that will assist people in our community about early detection and cancer prevention. Methods such as eating habits, dealing with nutrition, the importance of exercising, and going to the doctor even when nothing is wrong.

> I would definitely like to be able to promote healthy diet and exercise in cancer prevention. I would love the American Cancer Society to support pamphlets about the role of too much sugar and healthy diet in cancer instead of screening techniques which are also linked to cancer. . . I'd also love to see pamphlets stating the role of a truly healthy diet and exercise instead of screening techniques where my clients can learn about true wellness. I would like to truly educate my clients about natural wellness to prevent cancer.
>
> Printed materials, websites, first-hand knowledge of any potential resources, screenings, or trainings offered in the community.
>
> Culturally appropriate printed materials, brochures, pictures, trainers
>
> I don't have a lot of experiences in the cancer prevention field and any resource that can enhance my knowledge and build my skills will be great.

These findings support a different survey question that asked whether CHWs felt it would be possible to educate the community on cancer risk and screening if it only took a few minutes. About three quarters of respondents were either already doing this (24%) or thought it was possible to incorporate it into their work (50%). Rates varied slightly by state with Minnesota having the smallest percentage of CHWs who said they were already doing this work (13%).

34. If it only took a few minutes, would it be possible for you to educate the community on cancer risk reduction and screening?

	Minnesota (N=82)	Wisconsin (N=77)	South Dakota (N=63)	Iowa (N=19)	Total (N=245)
Yes	55%	49%	49%	26%	50%
Maybe	21%	14%	27%	21%	20%
No	11%	7%	0%	5%	7%
I already do this	13%	30%	24%	47%	24%

Question #4: What do the CHWs see as the future of their profession?

While CHWs were not directly asked about their role in health care reform, they were asked how they see the role of CHWs evolving or changing in the next two or three years. Open-ended responses varied and were grouped into themes described in Figure 34. Most often mentioned by respondents were an increased role in advocacy/public policy, an overall increased demand for CHWs, and enhanced roles and opportunities and responsibilities.

As seen in the first section of the report, key informants agree that potential exploration of the CHW workforce and how the role can best fit into health care reform are important to investigate.

35. Changing role of CHWs

How do you see the role of Community Health Workers evolving or changing in the next 2 or 3 years? (Open-ended question grouped into themes; 153 participants responded)	N
Increased role in advocacy/public policy	24
Increased demand for Community Health Workers in general	24
Enhanced roles/increased opportunities and responsibilities	20
Further integration into the broader healthcare system	16
Need for increased/ongoing education/training of CHWs	14
Funding cuts/other sustainability challenges	11
Professionalization of the field (licensing, credentialing, degree requirements, etc.)	9
Ongoing education of the broader community	8
Increased focus on prevention efforts/education	8
Increased need for culturally specific services	5
Need to expand community outreach efforts	5
Other	9

* ***Other responses include****: Stability in earnings, more cost-effective, more supported/valued, more computer work.*

In an open-ended question, the CHWs identified several ways in which they could use more support as the nature of the work evolves; their responses are divided into four categories: education and training, awareness and recognition, funding, and wages and job availability.

The highest number of CHWs express the need for increased and ongoing education and training (n=52), followed by a desire for increased awareness and recognition of CHWs, especially by the medical community (n-34). Fewer CHWs mention monetary needs,

such as increased funding or support by the government (n=21) or increased pay for CHWs (n=15).

Several verbatim responses to this question are included below Figure 36.

36. Support needed by CHWs to move forward as a profession

What support do you think CHWs will need to move forward as a profession? (Open-ended question grouped into themes; 108 participants responded)	N
Education and training	
Need for increased/ongoing education/training of CHWs (general)	52
Certification/recognition of certification by Feds, State and other organizations	17
Need for increased training on chronic disease/cancer/health	6
Increased accessibility of training (affordable; evening)	4
Making CHW into a college degree/advanced training	3
Training regarding culturally-specific communities	2
Training related to technology	2
Training on public advocacy	1
Add CHW skills to other roles/professions (e.g. nurse, social worker, medical assistant) and increase salary	1
Awareness and recognition	
Increased awareness/recognition of CHWs especially by medical community	34
More care/communication/encouragement of CHWs	8
More prominent role in the community/outreach to community	8
Increased support by tribe	3
CHW champions/advocacy	1
Funding	
Increased funding/support by government	21
Increased government funding of basic needs of low income populations	4
Ability to bill insurance companies	2
Wages and job availability	
Increased salaries/pay for CHW	15
Employment placement/more job availability	7
Increased mileage reimbursement	2
Other	10
Unsure/don't know	3

** **Other responses include**: Cultural diversity, do not forget substance abuse prevention, evaluation, longer hours, supported by community, more volunteers, more resources*

Education. I just would like the education and support one needs to be effective to go out into my community and articulate the message/mission of [various organizations]. (Iowa respondent)

Continuing education and funding available. (Iowa respondent)

Make courses affordable and available to all CHWs and more open classes for folks that are working, having their own kids, and want to be professional on their job. (Minnesota respondent)

Accreditation acknowledged by various health sectors, more community resources and supports to bring CHWs to the forefront. (Minnesota respondent)

Advanced training for clinical practicum. (Minnesota respondent)

Recognition, training and better pay (Minnesota respondent)

State and National recognition of IHS and Tribal community college training (certified) (South Dakota respondent)

A more formalized title/program and more formal training/requirements, even if short in duration. There needs to be some standards for CHWs to begin to be recognized. (Wisconsin respondent)

They will need training in all phases, and available handouts, culturally-based, designed or having input by the population you will serve. As a full-fledged profession, some people will choose it as a profession, others will not go to school. Your main outreach with the most success will be from trained lay people in the community. I still think there needs to be those that will do it as a paid profession. The key is to get the folks that are culturally-based with their population. (Wisconsin respondent)

One suggestion would be to add these skills and responsibilities to existing and traditional role, such as nursing assistant, medical assistant, nurses or social workers, and increase pay based on the added responsibilities

CHWs will need to move forward as a profession. We need to respect what they believe first and provide health education and ask, what they like to know, and do? (Wisconsin respondent)

Funding and support from elected officials. (Iowa respondent)

Financial support from state and federal, as well as support for community needs (housing, therapy....) (Minnesota respondent)

Legislators, more grants to organizations that show a strong need for a CHW in the areas of underserved population. We would love to have money at our clinic specifically for a CHW, but a few employees do this as a dual role. (Wisconsin respondent)

The realization of the employers, stakeholders of the potential in the CHW and the money they save when they teach prevention. (Minnesota respondent)

Respect in the medical field. Ability to bill insurance companies. (Minnesota respondent)

Recognition for their services. Also I'd like to feel support from other providers that the services I provide are vitally important as theirs are, in that I am a cultural broker for my clients. Without a cultural broker and interpreter, the patient would not be able to understand what the doctor says in that appointment. (Minnesota respondent)

More recognition by others in the medical field because of the work we do. (South Dakota respondent)

Support from MD's/health care providers who have worked with CHW's and know their value. Leadership training and backing up CHW's (Wisconsin respondent)

We need to have a more prominent role in our schools, churches and neighborhoods. Once we gain ground we can build trust and provide a more direct services to the communities we served. We need educational support, training and for people to know better what is our role in the communities we serve. (Minnesota respondent)

A salary, to be identified as a profession, a great network of resources and partner organizations. (Iowa respondent)

I think CHWs will need to have an increase in pay or the position will remain a revolving door of new staff all the time. They need training to be effective, but without good pay there will NEVER be retention. (of course this also requires more education) (Iowa respondent)

Definitely outreach the community and providing education about early prevention methods and resources where they can seek help. (Wisconsin respondent)

More support from tribal council and public (South Dakota respondent).

Promotion. Promoting CHW will help. I believe that the community does not know we are out her as they do home health aides, CNA, MA'S. Organizations do not look at our position on professional level. To me it's looked upon as an entry-level position that a company can do with or do without. (Wisconsin respondent)

The support needed is getting organizations to see the need and cost savings associated with using CHW's in their practice. (Minnesota respondent)

Awareness of the need for communities of color such as American Indians and the need for CHWs to bridge the gap between healthcare providers and patients/clients to allow for better healthcare and experiences. (Minnesota respondent)

Issues to consider

Findings from interviews with key stakeholders and surveys of CHWs in the Midwest show that the role of a CHW is multi-dimensional and the profession differs widely by state and by agencies within each state.

Given the complex and varying nature of the CHW workforce, we recommend keeping the following information in mind when promoting the use of CHWs across the Midwest.

- **Educate health care providers about the roles and value of CHWs.** CHWs are often the bridge between the health care system and the communities they serve. However, findings suggest that the role of CHWs in the health care system lack integration and they are not fully understood by medical providers. In order to truly fulfill their role as a bridge between the community and the health care system, opportunities must be sought out to educate medical professionals about CHWs, their skills and their value to the health care system while exploring unique ways to fit their work and contributions into the health care system.

- **Address funding and reimbursement challenges with CHWs and their allies.** These issues, while challenging, are crucial to sustaining the CHW workforce. Currently, Minnesota is the only state of the four that has had success in ensuring that the services of CHWs are reimbursable. Nevertheless, even in Minnesota, the parameters around reimbursement are limited to services provided to Medicaid patients. In Iowa, Wisconsin, and South Dakota, respondents agreed that reimbursement is a significant barrier for the work of CHWs.

- **Continue to evaluate and track outcomes related to CHW work.** Illustrating the roles and value of CHWs is vital to gaining sustainable funding and support for their work in the health care system. Most key informants reported that there is little capacity and funding to conduct evaluation of the outcomes of their CHW programming. Tracking these outcomes can demonstrate program effectiveness to community partners – some of whom may be willing to invest resources in program sustainability.

- Consult with state and federal health policy experts, knowledgeable about the Affordable Care Act, to identify ways that CHWs can be incorporated and integrated into health care reform. Key informants expressed that future opportunities for CHWs will be highly dependent upon health care reform; therefore, now is a good time to explore and champion ways in which CHWs can play a role in new systems, as well as in addressing the health care needs of various communities. A key informant in Minnesota mentioned the Health Care Home model as an important mechanism for integrating

CHWs into the health care system. Others mentioned the patient navigator role as a potential opportunity to integrate CHWs into the system.

A policy expert will also be able to indicate if the Affordable Care Act has made provisions for training and education of a diverse health workforce and how these provisions might be used to support training efforts of CHWs.

- **Develop state-to-state cancer prevention trainings.** Currently, cancer prevention efforts by CHWs are varied across and within states. Therefore, the creation of trainings that can be translated from state to state would be valuable; these trainings could be comprehensive or geared toward a specific type of cancer. Survey results suggest that CHWs are particularly interested in breast, cervical, prostate, colon/ colorectal, and lung and esophageal cancer. The top three requested training mechanisms include: printed educational materials, in-person training, and online training (e.g. elearning or webinars).

  Most respondents said that the type of cancer prevention training they have received is a result of the funding and focus of the particular CHW project that employs them. Additionally, some CHWs end up targeting particular types of cancer based on what they are seeing as they are out in their communities doing their work. It is important to provide CHWs with the tools to address whichever cancers they encounter in their work in the community.

- **Invest in further professional development to move the CHW field forward.** This may take the form of credentialing and certificate programs or other kinds of training and/or mentoring programs that support the continuing education of CHWs.

  While certificate programs are important, they do not eliminate the need for other types of training such as on-the-job training and mentoring. A majority of CHWs, across all states received on-the-job training or volunteer training **after** starting their work as a CHW.

- **Implement certificate program in Wisconsin, South Dakota, and Iowa, using Minnesota as a model.** Minnesota has a well-established CHW certificate program in place, but the remaining states do not. Despite a lack of infrastructure in Wisconsin, South Dakota, and Iowa, these states show interest in implementing certificate programs. Consider working with stakeholders in these states to convene an alliance to move the possibility of certificate programming forward. Use Minnesota's experience as a model for how to achieve this goal. Wisconsin might consider leveraging resources and stakeholders from the Area Health Education Centers (AHEC) to do this work. Bringing in individuals from Minnesota instrumental in creating the program will not only help these states gain support and information in working towards this goal but

will also foster collaboration and relationship building among CHW stakeholders across the Midwest division.

It is also important to note that CHWs with a certificate are more likely to report already doing cancer prevention. This suggests that training is an integral part of addressing cancer prevention and disparities.