

**COMMUNITY HEALTH WORKERS EVIDENCE-BASED MODELS TOOLBOX**

**HRSA OFFICE OF RURAL HEALTH POLICY**

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## **Introduction**

The U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Office of Rural Health Policy (ORHP) coordinates activities related to rural health care within HHS. ORHP has department-wide responsibility for analyzing the possible effects of policy decisions on 62 million residents of rural communities. ORHP was created by Section 711 of the Social Security Act to advise the Secretary of Health and Human Services on health issues within rural communities, including the effects of Medicare and Medicaid on rural citizens' access to care, the viability of rural hospitals, and the availability of physicians and other health professionals. ORHP administers grant programs designed to build health care capacity at both the local and State levels.

Currently there are many challenges to identifying promising practice models and evidence-based models in rural communities. As such, ORHP recognized the need to develop these for specific issue areas ORHP grantees focus on. ORHP selected Community Health Workers (CHW) as the first topic area due to Agency priorities and the important role CHW's play in rural communities in providing needed health care. The intent was to conduct extensive literature reviews on CHW models that have been proven to work and then share those strategies with rural communities so that they do not have to reinvent the wheel.

## **Module 1: Introduction to Community Health Workers**

### ***1. Who are Community Health Workers (CHWs)?***

“Community health workers (CHWs) are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, Promotoras, outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening.” (HRSA Community Health Workers National Workforce Study, 2007).

While CHWs are members of the health care work force, national databases have traditionally not included a specific occupation code to report CHWs. For this reason, there is no official estimate of the number of CHWs in the United States. However, the CHW National Employer Inventory (CHW/NEI) assessed the personal and professional characteristics of CHWs by contacting organizations that employ CHWs. Summary findings on CHW demographics are published in HRSA's Community Health Workers

National Workforce Study, available online at:  
<http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf>.

In 2009, the Department of Labor Bureau of Labor Statistics created a distinct occupation code for CHWs. The definition of the CHW occupational code is:

*Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs. Excludes "Health Educators" (21-1091).*

## **2. What are the roles of CHWs?**

CHWs' roles in the community varies and depends on the sector in which they work (social services, health care), the services they provide to patients/clients (advocacy, outreach, education, clinical services), and the skills and competencies required for the position (communication, cultural competence, training, professional experiences, education). CHWs' activities are tailored to meet the unique needs of their communities. Generally, their roles include:

- Creating more effective linkages between vulnerable populations and the health care system;
- Managing care and care transitions for vulnerable populations;
- Ensuring cultural competence among health care professionals serving vulnerable populations;
- Providing culturally appropriate health education on topics related to chronic disease prevention, physical activity and nutrition, and cultural competence;
- Advocating for underserved individuals to receive appropriate services;
- Providing informal counseling; and
- Building community capacity to address health issues.

## **3. What are the advantages of including CHWs in your rural program?**

CHWs are valuable for community programs that aim to improve health in rural populations. Frequently, CHWs are members of the communities that they serve, and are adept at building community capacity and ensuring the delivery of culturally competent services. They develop trusting, one-on-one relationships with consumers/clients and providers. Since rural communities are typically highly connected, CHWs may have a greater opportunity to develop relationships with consumers, liaise between providers and consumers, and garner support from organizations that also serve the community. By contributing to the delivery of primary and preventive care, CHWs may facilitate improvements in health status and quality of life in rural communities.

## **Module 2: CHW Program Models**

### ***1. Are there different models of CHW programs?***

CHW programs are designed to improve access to care, increase knowledge, prevent disease, and improve select health outcomes for populations. CHW programs are carefully tailored to meet the unique needs of the community. CHWs can serve as a Promotora de Salud or lay health worker, a member of the care delivery team, a care coordinator or manager, health educator, outreach and enrollment agent, and a community organizer or capacity builder. The CHW program models are not mutually exclusive; some CHW programs will fall into more than one of these categories. The models and relevant implantation considerations are discussed below.

#### ***Promotora de Salud/Lay Health Worker Model***

Description of Model: In the promotora/lay health worker model, CHWs are members of the target population that share many of the same social, cultural and economic characteristics. As trusted members of their community, promotoras provide culturally appropriate services and serve as a patient advocate, educator, mentor, outreach worker, and translator. They are often the bridge between the diverse populations they serve and the health care system. The promotora model has been applied in the United States and Latin America to reach Hispanic communities in particular. It has been used widely in rural communities to improve the health of migrant and seasonal farm workers and their families. Additionally, in rural border communities, promotoras often conduct environmental health and home assessments and deliver education about environmental health hazards.

Implementation Considerations: This model is most effective when the promotoras are members of the target population – not just individuals who speak the same language or share some of the same characteristics. Even in cases where promotoras are members of the target population, they may encounter barriers to providing services. A common barrier in border communities includes distrust of the program. Additionally, many promotora programs serve rural and frontier communities, where transportation is limited and travel to the target population is difficult.

#### ***Member of Care Delivery Team Model***

Description of Model: In this model, CHWs render direct health services in collaboration with a medical professional. They may measure blood pressure and pulse and provide first aid care, medication counseling, and health screenings, among other basic services. In programs with a more holistic approach or a medical home model CHWs may work alongside a team comprised of a physician, nurse or allied health worker, or assistant to deliver health education or basic screening services while the provider conducts a medical exam. This model is often used when CHWs work with providers in a mobile clinic setting.

Implementation Considerations: While CHWs may render limited direct health services, serving in this capacity raises questions about the consequences of mistakes or negligence. In some States, including Virginia, there is a “Good Samaritan” statute or other law that addresses civil liability issues for CHWs. For example, people voluntarily performing certain types of care in good faith are immune from civil liability for acts or omissions resulting from that care. However, if a volunteer or paid CHW is negligent, the community health organization or employer may be liable.

While CHW programs recognize these liability issues, few have formal policies in place. Programs should explore whether their State has relevant laws in order to understand the broader context of their activities. Programs should also assess their liabilities (e.g., do CHWs drive their own vehicles to appointments and/or transport patients in their vehicles? Is the employer responsible for a CHW who is injured on the job? Does the employer’s liability change if the CHW is a paid versus volunteer employee?). Organizations that hire CHWs may consider acquiring malpractice insurance. Programs should educate CHWs about their scope of practice and responsibilities.

### ***Care Coordinator/ Manager Model***

Description of Model: As a care coordinator or care manager, CHWs help individuals with complex health conditions to navigate the health care system. They liaise between the target population and a variety of health, human, and social services organizations. They may support individuals by providing information on health and community resources, coordinating transportation, and making appointments and delivering appointment reminders. Additionally, CHWs may work with patients to develop a care management plan and use other tools to track their progress over time (e.g., food and exercise logs). For example, in one rural CHW program, CHWs served as a care transition coach for rural elders that were discharged from home health services.

Implementation Considerations: In this model, the CHW provides case management to individuals who have chronic conditions and/or individuals who need help navigating the health care system. The CHW may encounter questions or situations that require help from trained health care professionals. Programs may pair CHWs with a medical professional whom they can call with questions. CHWs must understand the procedures associated with an emergency (e.g., nearest hospital, who to call, their scope of practice, and responsibilities). This model necessitates that the CHWs have a strong understanding of the health care system and resources available in their community. CHWs that serve as a care coordinator or care manager often receive disease-specific education and training.

### ***Health Educator Model***

Description of Model: In this model, CHWs deliver health education to the target population related to disease prevention, screenings, and healthy behaviors. CHWs may teach educational programs in the community about chronic disease prevention, nutrition, physical activity, and stress management, and also provide health screenings.

Additionally, in rural communities, or *colonias*, along the U.S.-Mexico border where families live in close proximity to agricultural fields, CHWs often provide training on pesticide safety and environmental hazards.

Implementation Considerations: CHWs often attend cultural competency trainings to deliver culturally appropriate health education. CHW programs serving populations in border communities must ensure that their CHWs deliver culturally appropriate health education and nutrition information. CHWs that are delivering health education in an outreach situation (e.g., home visiting) will also need additional training to ensure that they understand the scope of their work and the steps to take in case of an emergency.

### ***Outreach and Enrollment Agent Model***

Description of Model: The outreach and enrollment agent model is similar to the health educator model with additional outreach and enrollment responsibilities. In this model, CHWs conduct intensive home visits to deliver psychosocial support, promote maternal and child health, conduct environmental health and home assessments, offer one-on-one advice, and make referrals. They also help individuals to enroll in government programs. CHWs that serve in an outreach capacity typically receive specialized training.

Implementation Considerations: As an outreach and enrollment agent, CHWs may visit hard-to-reach populations in their homes. Programs may consider acquiring liability insurance prior to employing CHWs in this model given that travel and home visits may be required. Additionally, programs should counsel their CHWs to be aware of their surroundings during their travels. For example, most programs counsel their CHWs to discontinue an appointment if they feel uneasy during a home visit.

CHWs in outreach and enrollment models often require additional education about eligibility requirements for State and Federal programs. If CHWs are serving a non-English speaking population, it is helpful if they are bilingual so that they can communicate with agencies or providers during the enrollment process.

### ***Community Organizer and Capacity Builder Model***

Description of Model: As community organizers and capacity builders, CHWs promote community action and garner support and resources from community organizations to implement new activities. CHWs may also motivate their communities to seek specific policy and social changes. They build relationships with public health organizations, grassroots organizations, health care providers, faith-based groups, universities, government agencies, and other organizations to develop a more coordinated approach to serving their target population. CHWs may also participate on the larger program Steering Committee to network, increase their knowledge about the program, and strengthen their professional skills. In this model, a CHW may be employed by a health care provider, community organization or other entity.

Implementation Considerations: In this model, CHWs must have extensive knowledge of the health care system and the different organizations in their community that provide social and support services to their target population. The CHWs must feel comfortable articulating their ideas in front of a large group and networking with other community stakeholders.

***2. How have CHW programs served rural, frontier, and tribal communities?***

CHW programs are often designed to serve populations in rural, frontier, and tribal communities. In rural communities, CHWs often support populations in their transition from home health services and in the prevention and/or management of chronic conditions.

For example, community health advisors have worked to reduce cardiovascular risk among rural African-American women. This project employed a health educator model, where the community health advisors conducted community-wide educational classes on nutrition, physical activity, and smoking cessation.

In addition, CHWs work with tribally managed or Indian Health Service programs in hundreds of American Indian and Alaska Native nations. CHWs implement diabetes-focused programs for American Indian and Alaska Native populations. CHW programs also conduct outreach to rural migrant and seasonal farm workers and border communities.

***3. How can you adapt CHW programs to meet the unique needs of your community?***

CHW programs typically incorporate characteristics from more than one of the CHW models (e.g., promotora, member of care delivery team, care coordinator/manager, health educator, outreach and enrollment agent, and community organizer/capacity builder) to develop a program that effectively meets the needs of the target population.

Communities should conduct a comprehensive community health needs assessment to identify community health priorities. From there community agencies should convene to determine potential roles and functions that CHWs may serve to address these needs, and models upon which CHW programs may be designed.

## **Module 3: Training Approaches for CHWs**

***1. Is there a standard curriculum for training CHWs?***

There is no standardized training curriculum for CHWs. Many States have training programs at academic institutions and direct services agencies, though the content, focus and organization of these programs vary. One of the challenges in developing a standardized curriculum for CHWs is that each community's needs are different; thus, trainings differ from program to program.

CHWs often participate in an on-the-job training program to develop competencies directly related to their activities. Trainings are administered either formally by the coordinator of the CHW program or informally through mentoring (from an experienced CHW or health care provider). Additionally, some CHWs pursue formal training at an educational institution.

Many rural CHW programs have created their own educational and training curricula from existing resources and best practices. Curricula may include training on accessing health care and social services systems; translating, interpreting, and facilitating client-provider communications; gathering information for medical providers; delivering services as part of a medical home team; educating social services providers on community/population needs; teaching the concepts of disease prevention and health promotion to lay populations; managing chronic conditions; home visiting; understanding community prejudices; and other topics.

### ***2. What types of training materials are available for CHW programs?***

Many programs have developed resources for on-the-job training. These programs have adapted existing materials from the Centers for Disease Control and Prevention, other Federal and State agencies, and academic institutions to create their own training materials and curricula to ensure that the CHWs learn the skills necessary to serve the target population. Common components of CHW training materials focus on cultural competence, patient intake and assessment, protocol delivery, screening recommendations, risk factors, insurance eligibility and enrollment, communication skills, health promotion, and disease prevention and management. Some States require training on the legal and ethical dimensions of CHW activities.

The Community Health Worker National Education Collaborative offers a variety of CHW educational resources, curricula, and promising practices. Other training resources and publications are available from Community Health Works. Partnerships between college systems, communities, and employers are often involved in the development of the CHW training curricula.

### ***3. Does our State have a CHW certification program?***

Health and human services agencies in some States require CHWs to have State-level certification – meaning that they must pass an approved training program and have acquired specific skills and competencies. Credentialing and certification programs are often administered by the local health department or another agency at the State level. A number of educational institutions offer courses, certificates, or degrees in the CHW field.

Texas was the first State to explore the utilization of CHWs and develop legislation to govern their activities in 1999. Texas requires CHW programs in health and human services agencies to hire State-certified CHWs when possible. In 2003, Ohio developed

its first CHW certification program; as of May 2010, three accredited CHW certification programs are available. Other States such as Indiana and Alaska have certification programs that authorize CHWs to conduct specific activities, such as home visits and clinical service delivery, respectively. Alaska's certification programs date back to the 1950s. While they do not require certification, North Carolina and Nevada have implemented State-level standards for training CHWs and provide training at the State level. Arizona, Southern California, Massachusetts, and Virginia have developed curriculum and CHW programs at community colleges and the States may be moving towards certification. Other States that have non-State-mandated certification programs and/or are exploring certification and utilization of CHWs include Kentucky, New Mexico, Minnesota, and Hawaii.

#### ***4. How have programs trained CHWs?***

Many programs provide on-the-job training so that CHWs can develop competencies directly related to their activities. Trainings are administered either formally by the coordinator of the CHW program or informally through mentoring (from an experienced CHW or health care provider). Additionally, some CHWs pursue formal training at an educational institution. Skills trainings can range from a few hours of informal education to formalized training courses that last one or more days. Trainings may include active learning techniques involving role playing, skits, brainstorming sessions, problem-solving games, and small group discussions.

Rural and tribal communities have conducted intensive train-the-trainer educational sessions for volunteer farm workers and community members that wanted to become CHWs; many urban CHW programs have also conducted similar trainings. In some cases, trainings are led by a provider such as a physician's assistant or nurse, or a health professions student. In other programs, the CHWs trainings are led by an experienced manager or program coordinator. CHWs also attend State-level trainings on emerging issues that affect the target population (e.g., new criteria for Medicaid enrollment).

## **Module 4: Implementation of CHW Programs**

### ***1. What resources will you need to implement a CHW program?***

The resources required for a CHW program depend on the goals of the program and the program models selected, the scope of the program's activities, and the needs in the community. During the program implementation phase, successful implementers of CHW programs have been able to identify existing resources from other organizations and tailor them to address the particular needs of their communities.

Additionally, many existing CHW programs have established relationships with other community organizations and consider these relationships to be important to their success. Community partners may serve as potential funders for CHW programs and provide guidance about the program. Potential partners include public health organizations, universities, health and dental plans, foundations, government

organizations, community service organizations, volunteer groups, multicultural alliances and associations, local hospitals, and State and local health departments.

## ***2. What do you need to consider before recruiting and hiring CHWs?***

Before recruiting CHWs, programs should decide whether they will pay their CHWs and how (via salary or stipend) and whether they will hire the CHWs as employees of the organization (full or part-time) or recruit the CHWs as volunteers. Existing programs emphasize the importance of hiring CHWs who are involved with and are knowledgeable about the communities they serve. Depending on the scope of the program, an organization may recruit volunteers and pay them a stipend to conduct outreach activities, or hire a health professional that is certified as a CHW to deliver screening services. Generally, the scope of the program and the needs of the community affect the recruitment strategy. CHW programs typically identify individuals with some formal education and specific skills and qualities that will benefit their program. Approaches and venues for recruiting CHWs include:

- Radio programming
- Church meetings
- Community meetings
- Local recreational centers
- Local schools (e.g., parent-teacher organizations)
- Social events (e.g., dances, fairs, and sporting events)
- Other community groups
- Newspapers
- Worksite fliers
- Community fliers
- Face-to-face recruitment
- Word of mouth
- Referrals from current CHWs
- Internal recruitment from within the organization

When recruiting CHWs, organizations should be clear about the job expectations, time commitments, and compensation provided (if any). Communicating the expectations of the position is especially important for those CHWs serving as volunteers. Additionally, programs should assess whether access to transportation will be a barrier for CHWs who must travel to attend training activities or conduct outreach activities in the community.

## ***3. How are CHWs compensated?***

CHW programs may receive funding from Federal, State, or local agencies, foundations, community organizations, and other funders. These funds may be used for program management, employee salaries and benefits, program materials, facilities, transportation, and other resources. CHWs who receive financial compensation for their services are often paid through a grant.

Volunteer CHWs may be compensated for their participation through incentives (e.g., gift certificates) or reimbursement for travel. Some current implementers of CHW programs require that CHWs maintain an independent tracking log to record information such as the number of outreach visits and mileage per visit. The information in the tracking log is then used to determine the appropriate incentive or reimbursement.

Other programs may provide greater compensation to CHWs for their work, paying them on an hourly basis or as a full-time employee with benefits. Programs typically base CHW salaries on local wages for similar workers.

#### ***4. What are the unique challenges of implementing CHW programs?***

Implementation of CHW programs in rural areas can present unique challenges. The primary barrier for CHWs and the populations they serve is limited access to transportation. Since the target population may not have access to transportation, CHWs are required to travel to rural communities to provide services or conduct outreach. At times, populations may be located in remote areas, where roads are not safe or impassable due to inclement weather. Some programs provide CHWs with resources when they travel in areas where access to technology (e.g., cell phone service and Internet connectivity) is limited. Current implementers of CHW programs have emphasized the importance of providing CHWs with resources such as weather survival kits or wireless Internet access cards; however, if program funds are limited, such resources may not be available.

Occasionally, cultural barriers present a challenge in CHW programs. Implementers may need to adapt outreach and education materials, such as information packets, to ensure that all program materials and information are culturally appropriate. During the hiring process it is important to ensure that CHWs have an understanding and cultural awareness of the communities they serve.

CHW programs may encounter difficulties with referring their patients to providers and coordinating services with outside providers and agencies. Agreements with current organizational partners in the community and identifying opportunities to work with new organizations will help to extend the reach of the CHW program. [Additional information on implementation considerations in this care setting is available in Module 2: [click here.](#)]

Finally, implementers of CHW programs have acknowledged challenges related to institutionalizing CHWs into the health care system.

## **Module 5: Planning for Sustainability**

### ***1. How do you plan for the sustainability of your CHW program?***

Three critical issues are linked to the sustainability of CHW programs: evaluation, program financing, and credentialing. CHW programs that have incorporated an

evaluation component into their activities will be able to convey the impact of their programs. A 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 which may be willing to invest resources in program sustainability. To date, few rural CHW programs have had ample resources to calculate the ROI for their programs. [Additional information on evaluation is available in Module 6: [click here.](#)]

CHW programs should also identify financial models for sustaining their activities post-funding. Currently, most CHW programs receive support through Federal or State grants (e.g., State public health department) and foundations. Another potential financial model is third-party reimbursement for CHW services. Several rural communities have explored third-party reimbursement for CHW health education services through Medicaid. Some States have expressed concern that third party reimbursement would necessitate rigorous credentialing of CHWs. Credentialing is a controversial topic as opponents suggest that widespread credentialing would limit the scope of CHWs' activities and reduce their flexibility to be able to respond to the needs of their communities.

Health reform may offer new opportunities for sustaining CHW programs. The Patient Protection and Affordable Care Act recognizes CHWs as members of the health care workforce and allows Congress to allocate funding to establish a Federal grant program to support the use of CHWs in medically underserved areas. Grants would be available to health departments, clinics, hospitals, Federally qualified health centers and other private organizations for programs using CHWs.

## ***2. What is a sustainability plan, and why do you need one?***

A sustainability plan is used to document the program's sustainability actions and strategies. Strategies might include identifying fiscal sustainability models, securing resources from community partners, and/or changing the size or scope of the CHW program to reflect the available resources. The sustainability plan provides information about the timeline for each sustainability activity.

In addition to the sustainability plan, CHW programs should create a continuity plan that describes how the program is conducted and lists important resources and information. The continuity plan will ensure that important processes and knowledge are documented and preserved in case of staff transitions.

## ***3. What types of community resources are available for planning for sustainability?***

When planning for sustainability, many rural CHW programs have worked to create strategic alliances between community organizations and public and private agencies. Some have implemented a Board of Directors or Strategic Advisory Council to guide their program. Creating a sense of ownership for the CHW program among the various stakeholders in the community has helped them to identify new opportunities to sustain

their activities. Community organizations may offer key resources such as facilities for CHW trainings, financial resources, transportation and other services. Securing memoranda of understanding from these organizations and agencies may help to specify the roles of each organization once the initial program funding expires.

Some rural CHW programs have worked to develop strong partnerships in the business community, in particular (e.g., including local business leaders on their Board of Directors). Buy-in from the business community has helped some communities to increase awareness of their program's benefits; these partners and others may be able to identify new funding sources or fund parts of the program.

#### ***4. Which foundations and other organizations have funded CHW programs and research?***

A variety of foundations and organizations have funded CHW research. As of 2010, the California HealthCare Foundation was building a Statewide network of CHWs that facilitates the exchange information about outreach and service delivery strategies, local and Statewide issues, and lessons learned and best practices. Through this initiative, six regional collaboratives are charged with developing regional action plans. In 2009, the Aetna Foundation awarded community health grants for philanthropic initiatives that focused on delivering health education and/or increasing access to health care using Promotoras. In 1998, the Annie E. Casey Foundation and the University of Arizona funded the National Community Health Advisor Study which reached 400 CHWs across the country to identify core roles and competencies.

On the Federal side, in 2010, the Centers for Medicare and Medicaid Services' Hispanic Health Services Research Grant Program funded research on Hispanic Medicare, Medicaid, and SCHIP health disparities. This program also supported promotora activities in the past. The National Institutes of Health, National Heart, Lung, and Blood Institute, and the Centers for Disease Control and Prevention funded a 2008 study exploring the use of a community health advisor to reduce cardiovascular risk among rural African-American women.

Additionally, the Centers for Disease Control and Prevention has been involved in a variety of CHW projects that focus on diabetes health promotion, including a promotoras project, diabetes education for CHWs in the Indian Health Service, and diabetes prevention and control programs involving CHWs in rural and urban communities.

Kaiser Permanente has also funded CHW program initiatives. In the northern California area, Kaiser Permanente's Fresno-Community Benefits Program conducts a community needs assessment every 3 years to identify priority health issues for vulnerable populations. They have funded promotora activities in the past. In southern California, Kaiser Permanente San Diego conducted a pilot where CHWs helped to expand and improve care to frail elders with dementia.

## **Module 6: Measuring and Evaluating the Impact of CHW Programs**

### ***1. How do you evaluate the impact of your CHW Program?***

CHW programs may lack the funding, time, or expertise to conduct a methodologically rigorous program evaluation. Despite these challenges, most CHW programs are collecting some type of qualitative and/or quantitative data that can be used for evaluation purposes. Even with limited data, it may be possible to evaluate the effectiveness of certain processes and activities, the achievement of program objectives, the potential for program sustainability, and the impact of the CHW program on outcomes such as health care access and quality. To date, few evaluations have focused on the cost-effectiveness of CHW programs.

CHW programs may hire an external evaluator or assign an internal staff member to serve as an evaluator. Given that many organizations lack evaluation staff or funds to hire them, CHWs may be assigned to collect program evaluation data or administer surveys. This can present a challenge as CHWs may not necessarily have the appropriate skills to collect program data or conduct evaluation activities.

In developing an evaluation plan, evaluators of CHW programs emphasize the importance of employing simple data collection techniques and utilizing existing surveys and data tracking mechanisms. Programs often use existing individual encounter forms, group education session documentation, clinic reports, and case management reports to collect program data. If a CHW program focuses on clinical service delivery, it may be important to record and track patient information pre- and post-intervention. Data may also be collected on the effectiveness of CHW outreach or the quality of a health education session. Evaluations may also solicit feedback from community representatives, program stakeholders, and health care providers.

Given the diversity of CHW programs, there is not a one-size-fits-all evaluation approach. There are many resources available to help guide the development of an evaluation plan for your CHW program.

### ***2. What types of metrics are commonly used in evaluations of CHW programs?***

The specific goals of the CHW program should be considered when determining the metrics for program evaluation. Existing CHW programs collect data on patient demographics, program processes, consumer behaviors, and other outcomes. Metrics used by existing CHW programs include:

- Demographic information of participants
  - Gender
  - Age
  - Language
  - Health status (e.g., diabetes, arthritis, etc)

- Access to health care with specific source
- Access/type of health insurance
- Access to health care in other countries (e.g., for migrant workers)
- Physical activity and nutrition information
- Process measures
  - Number of consumers who receive education
  - Number of CHW program activities consumers engage in
  - Number of CHWs involved in community activities
  - Number of referrals made by CHWs
  - Number of education programs facilitated by CHWs
  - Number of people screened
- Consumer behaviors
  - Reasons consumers use the CHW services
  - How patient learned of CHW services
  - Presence/ types of compliance and self-management issues
- Outcomes of CWH interventions
  - Health outcomes (e.g., blood glucose level, blood pressure, etc.)
  - Health care utilization
  - Consumer satisfaction
  - Improvements in knowledge about or awareness of health issues
  - Cost savings (e.g., fewer emergency department visits)

## **Module 7: Dissemination of CHW Resources and Promising Practices**

### ***1. How can you disseminate your CHW promising practices to other communities?***

Disseminating best practices benefits the CHW community, including new implementers of CHW programs, organizations with existing CHW programs that are looking to refine or expand their activities, and health care providers who are interested in contracting with CHWs. Some current implementers of CHW programs have focused on disseminating knowledge and sharing information on issues related to the implementation, sustainability and evaluation of CHW programs. They have identified the following methods for dissemination of program materials and findings:

- Local and regional networks of community organizations and other partners
- Participation at conferences
- Other community outreach activities

## Module 8: Rural CHW Program Clearinghouse

### 1. *What are some examples of rural CHW programs?*

The HRSA Office of Rural Health Policy funded rural communities to implement CHW programs as part of the 330A Outreach Authority program. This program focuses on reducing health care disparities and expanding health care services in rural areas. Examples of current 330A Outreach Authority grantees that developed a CHW program in a rural community are provided below. [Additional information on CHW program models is available in Module 2: [click here.](#)]

**Applicant name:** Ben Archer Health Center

**Project title:** Health Without Borders

**Grant period:** 5/1/2009 – 4/20/2012

**Contact name:** Mary Alice Garay, Executive Director

**Location:** Hatch, New Mexico

**Program Overview:** The overall goal of the program is to reduce health disparities related to chronic diseases through health education for management and prevention, improved access to care, and better integration of CHWs into the health care system. CHWs provide outreach, health awareness, and education among border residents, and migrant and immigrant sub-population groups in the targeted service area.

**CHW Model(s):** Promotora; health educator; outreach and enrollment agent

**Applicant name:** Migrant Health Center, Western Region, Inc.

**Project title:** Health Education for Farmworkers in Puerto Rico

**Grant period:** 5/1/2009 – 4/30/2012

**Contact name:** Mr. Reynaldo Serrano, Executive Director

**Location:** Mayaguez, Puerto Rico

**Program Overview:** The goals of this program are to: 1) increase knowledge in the farm worker population for the prevention of HIV/AIDS and domestic violence; 2) increase knowledge in the farm worker population for the prevention of diabetes; and 3) work toward program sustainability and ownership among the various stakeholders to reach additional farm workers post-grant. Volunteer farm workers conduct educational sessions with other farm workers at health fair and community events. Community outreach workers travel with clinic providers to deliver health education services to farm workers in rural areas.

**CHW Model(s):** Promotora; health educator; outreach and enrollment agent; member of care delivery team

**Applicant name:** Migrant Health Promotion

**Project title:** Futuros Saludables (Health Futures)

**Grant period:** 5/1/2009 – 4/30/2012

**Contact name:** Dr. Gayle A. Lawn-Day, PhD, Executive Director

**Location:** Weslaco, Texas

**Program Overview:** This program improves access to primary and mental health services, as well as nutrition and physical fitness education, for uninsured and medically disenfranchised Latino residents of rural Hidalgo County, Texas. Promotoras and Community Health Aides work to increase participants' access to health care services and knowledge about available health services and health education topics. The Promotoras organize and lead small group presentations and provide information about nutrition and healthy cooking, exercise, stress management, gang violence, domestic violence, substance abuse, depression and anxiety, and child neglect and abuse. The Community Health Aides go door-to-door in the colonias and talk with families about health concerns and provide information and referrals.

**CHW Model(s):** Promotora; health educator; outreach and enrollment agent

**Applicant name:** Delta Health Alliance

**Project title:** The Delta Community Health Worker Program

**Grant period:** 5/1/2010 - 4/30/2011

**Contact name:** Karen C Fox, PhD, President and Chief Executive Officer

**Location:** Stoneville, Mississippi

**Program Overview:** This program utilizes CHWs to improve health outcomes for community health center patients who have been diagnosed with diabetes, cardiovascular disease, or hypertension. CHWs coordinate available resources for patients, including follow-up and referral processes; arrange for transportation assistance; enroll patients in benefits programs; provide health education to patients, groups, and families; ensure patients receive appropriate medical care and have a medical home; assist families in developing necessary skills and resources to improve health status, family functioning, self-sufficiency; and work with local pharmacists to improve medication management and compliance.

**CHW Model(s):** Health educator; outreach and enrollment agent; care coordinator/manager

**Applicant name:** Clemson University

**Project title:** Health Coaches for Hypertension Control

**Grant period:** 5/1/2010 – 4/30/2011

**Contact name:** Cheryl J. Dye, PhD, Program Director

**Location:** Clemson, South Carolina

**Program Overview:** The main focus of the program in rural Oconee County is to train Health Coaches to provide services (e.g., health education, telephone counseling, and support groups) to patients who were referred by a family physician practice. Health coaches conduct group classes on hypertension control and other issues, guide patients in developing individualized action plans for self-management, and provide telephone counseling for patients.

**CHW Model(s):** Health educator; care coordinator/manager

**Applicant name:** Family Health Centers

**Project title:** Rural Health Care Services Outreach Grant Program

**Grant period:** 5/1/2010 – 4/30/2011

**Contact name:** Heather Findlay

**Location:** Okanogan, Washington

**Program Overview:** The goal is to provide high quality comprehensive health services and culturally and linguistically appropriate health information to migrant and seasonal farmworkers and their families in Okanogan County through the implementation of a Promotora program. Promotoras provide education, information and referrals to migrant and seasonal farmworkers in farms, orchards, and other areas in which they work and live.

**CHW Model(s):** Promotora; health educator; outreach and enrollment agent

**Applicant name:** Kodiak Island Health Care Foundation (Kodiak CHC)

**Project title:** N/A

**Grant period:** 9/3/2009 – 4/30/2012

**Contact name:** Ms. Brenda S. Friend, Executive Director

**Location:** Kodiak, Alaska

**Program Overview:** The Kodiak Community Health Center (KCHC) is increasing access to health care for underserved populations on Kodiak Island. The target population includes seniors, homeless, workers, and residents of Cannery Row (fisherman, fish and seafood processing employees, warehouse workers, and small businesses) and the surrounding area of Boat Harbor. KCHC recruited, interviewed, hired, and oriented outreach registered nurses (RNs) to conduct outreach and provide health education services. Outreach RNs must speak Tagalog. Along with a medical team, the outreach RNs can also provide some direct health services.

**CHW Model(s):** Outreach and enrollment agent; health educator; member of care delivery team