



COMMUNITY HEALTH WORKERS: INTEGRAL MEMBERS OF OREGON'S HEALTH WORKFORCE

A statewide needs assessment conducted by the Oregon Community Health Workers Association for the Oregon Health Authority Office of Equity and Inclusion

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¹ The title of our report intentionally echoes the title of a seminal 1995 article: Witmer, A., Seifer, S.D., Finocchio, L., Leslie, J., & O’Neil, E.H. (1995). Community health workers: Integral members of the health care work force. *American Journal of Public Health, 85*(8 Pt 1), 1055–1058. We have chosen to use this title to bear witness to the fact that CHWs are not a new workforce; rather, they have been integral to the health of communities around Oregon and around the country for decades. At last, CHWs are receiving the recognition they have long deserved.

Table of Contents

Executive Summary	3
Introduction	4
Background	5
Community Health Workers: A Brief Introduction	5
Community Health Worker Roles and Competencies	6
Community Health Workers in Oregon	6
Contributions to the CHW Evidence Base by Oregon-Based Researchers	8
Methodology	10
Overview	10
Assessment Questions	10
Data Collection	11
Data Analysis and Interpretation	14
Findings	14
THW Registry Data	14
CHW Survey	17
Employer Survey	23
Discussion Groups	29
Discussion	43
Summary of Findings	43
Cross-Cutting Findings	46
Limitations of the Study	47
Recommendations	49
CHW Roles and Scope of Practice	50
Training and Education	50
CHW Supervision	51
CHW Integration into the Health Care System	51
Funding and Payment Models	52
Professional Development	52
Evaluation of CHW Programs	53
Conclusion	53
References	54
Appendices	58

Executive Summary

Background

Community Health Workers (CHWs), trusted community members who work with communities to improve health through a variety of strategies, have been integral members of the health care workforce in many Oregon communities since the 1960s. In the context of health care reform, CHWs (also called promotores/as de salud and Community Health Representatives) have received increasing recognition for their unique ability to improve health and address health inequities. In June of 2017, the Oregon Community Health Workers Association (ORCHWA) received funding from the Oregon Health Authority (OHA) and Health Share of Oregon (HSO) to conduct a needs assessment of Oregon's CHW workforce.

Methodology

This statewide needs assessment used a developmental evaluation approach with a concurrent mixed methods design. It was guided by four overarching assessment questions:

- 1) What is the current composition of the CHW workforce in Oregon?
- 2) What is the current employment structure for the CHW workforce in Oregon?
- 3) What are the successes and challenges regarding four sets of issues?
- 4) What needs to be done to address problems and challenges?

The three primary data collection methods used to answer these questions were an online CHW survey (n=104), an online employer survey (n=25), and discussion groups with CHWs and allied workers around the state (n=240).

Selected Findings

Common findings across data sources indicate a need to:

- Increase representation of CHWs in all communities affected by inequities
- Provide education for all (especially supervisors) about CHW roles and scope
- Create a coordinated, statewide infrastructure for CHW training that is based on best practices and builds capacity around the state
- Provide clear guidance and billing codes in order to diversify funding beyond grants
- Spread the CHW paradigm, which is community-focused, non-hierarchical and appreciative of life experience, throughout the health system and dominant culture systems generally

Recommendations

A set of 31 recommendations are provided divided into the following seven categories:

- 1) CHW Roles and Scope of Practice
- 2) Training and Education
- 3) CHW Supervision
- 4) CHW Integration into the Health Care System
- 5) Funding and Payment Models
- 6) Professional Development
- 7) Evaluation of CHW Programs

Introduction

Community Health Workers, who are also commonly referred to as *promotores/as de salud* (health promoters) and Community Health Representatives, along with many other titles, are trusted community members who participate in training or *capacitation* (capacity building) so that they can promote health in their own communities.

In June of 2017, the Oregon Community Health Workers Association (ORCHWA) received funding from the Oregon Health Authority's Office of Equity and Inclusion (OEI) and Health Share of Oregon (HSO, one of Oregon's sixteen Coordinated Care Organizations) to conduct a needs assessment of Oregon's CHW workforce. This assessment builds on the findings of previous reports, including a 1994 *Directory of Community Health Worker Programs in Oregon* produced by the Oregon Public Health Association's CHW Sub-Committee, and various peer-reviewed articles and program reports about CHW practice in Oregon.

In this report, we begin by providing background on the CHW workforce in the US. The development of Oregon's CHW workforce is affected by developments at the national level; in turn, developments in Oregon have often influenced CHW workforce development around the nation. We next provide an overview of CHW roles and scope of practice; as our own report shows, a clear understanding of CHW roles and scope is essential to CHW integration. The introductory section also includes background on the CHW workforce in Oregon, including its history and current status. In addition, we review notable contributions to the CHW literature and describe efforts to identify common evaluation metrics led by Oregon-based researchers.

The second major section of our report provides details about the methodology we used to collect, analyze and interpret data about the CHW workforce in Oregon. In this section, we introduce our assessment questions and explain how we used a concurrent, mixed methods, emergent assessment design to answer these questions. We also introduce our primary data collection tools and methods.

The third section of the report consists of our findings, which are divided into four sub-sections: a portrait of certified CHWs as of Fall 2018, based on data publicly available through the Oregon Health Authority's Traditional Health Worker website and the American Community Survey; findings from the CHW survey; findings from the employer survey; and findings from group discussions conducted by ORCHWA with CHWs and others from around the state.

A Discussion section, which includes the limitations of our study, is followed by our recommendations for promoting the health and stability of the CHW workforce in Oregon. The Appendix includes all the tools we used to collect data, along with other resources on Oregon's CHW workforce. It is the fervent hope of the Oregon Community Health Workers Association that the findings of this report will serve to strengthen the CHW workforce around the state, allowing them to make an optimal contribution to improving health and reducing inequities.

Background

Community Health Workers: A Brief Introduction²

Community health workers (CHWs)—trusted community members who work with communities to improve health through a variety of strategies—are increasingly being acknowledged as integral members of the US health care workforce (American Association of Diabetes Educators, 2009; Brownstein et al., 2007; Calori et al., 2010; Gary et al., 2004; Institute of Medicine, 2010; Norris et al., 2006; Smedley et al., 2002; Viswanathan et al., 2009; Witmer et al., 1995). At once ancient and emerging, the CHW profession has its roots in natural helping systems that have existed in all human communities throughout history (Jackson & Parks, 1997). In the United States and many countries around the world, these systems became formalized in areas where large sectors of the population lacked health care and the conditions for good health (Wiggins & Borbón, 1998). As such, since their inception, CHW programs represent efforts to address and eliminate social and health inequities (Gonzalez Arizmendi & Ortiz, 2008).

Formal CHW programs in the United States have existed since the 1960s, when the Indian Health Service established its Community Health Representative Program and the Federal Migrant Act encouraged the hiring of outreach workers in programs serving migrant and seasonal farm workers (Wiggins & Borbón, 1998). Despite unstable funding and fluctuating policy support, the number of CHW programs in the United States has trended upwards from the late 1980s until today (Viswanathan et al., 2009). CHWs in the United States play a wide variety of roles, from connecting individuals to existing services, to sharing culturally appropriate health education, to organizing communities to identify and solve health problems (Wiggins & Borbón, 1998).

The body of peer-reviewed literature assessing outcomes of CHW programs is substantial and growing. CHW interventions have achieved a range of outcomes including improvements in perinatal and women’s health and chronic disease prevention and management, more favorable utilization of health services and reduced costs (Kieffer et al., 2013, 2014; Spencer et al., 2018). Increasingly, CHWs are gaining broader recognition for their contributions to addressing the social determinants of health, both by connecting individuals to housing, transportation, and other basic needs, and by organizing communities to address inequitable social conditions (Damio et al., 2017; Wiggins & Borbón, 1998).

Since 2010, as the result of decades of work by CHWs and their advocates, CHWs in the United States have moved from relative obscurity to center stage in U.S. health care reform. CHWs have figured prominently in both the Patient Protection and Affordable Care Act at the national level and in various state health care transformation bills (Rosenthal et al., 2010). Although

² Please note: This section draws almost verbatim on three peer-reviewed articles by the second author: Rosenthal, Wiggins, Ingram, Mayfield-Johnson & De Zapien, 2011; Wiggins, Hughes, Rodriguez, Potter & Rios-Campos, 2014; and Wiggins & Kaan, et al, 2013. Full citations are in the reference section.

generally welcomed as long overdue, the current situation is seen as a mixed blessing by some CHWs and their allies. Given the focus of health care reform on cost savings, the danger exists that CHWs will be socially constructed solely as case managers who work with individual “multi-problem” patients to decrease their use of medical services (Rosenthal, Wiggins, Ingram, Mayfield-Johnson, & De Zapien, 2011). Models from other parts of the world demonstrate how CHWs can be integrated into national health care systems without sacrificing their community-based knowledge or their ability to play multiple roles (Pinto, Wall, Yu, Penido, & Schmidt, 2012). In this historical moment, studies of the CHW workforce are particularly important, since thoughtful studies can help ensure that CHWs are supported to play a full range of roles, thus creating maximum benefit for their communities.

Community Health Worker Roles and Competencies

Key to understanding the actual and potential contribution of CHWs to health systems and communities is an understanding of their roles and competencies. As our report shows, a lack of understanding of CHW roles and competencies has produced a number of negative consequences. A variety of studies have attempted to identify core roles and competencies of CHWs, with competencies generally being conceptualized as a combination of innate qualities and learned skills. The first major effort was the 1998 National Community Health Advisor Study (NCHAS) (Rosenthal, Wiggins, Brownstein, & Johnson, 1998). Chapter Three of NCHAS identified seven core roles, eight skills clusters, and 18 qualities (Wiggins & Borbón, 1998). A 2007 study by the Health Resources and Services Administration largely reiterated the findings of the NCHA Study (HRSA). The 2015 CHW Core Consensus (C3) Report reaffirmed the existing seven roles and added three additional roles (Rosenthal, Rush & Allen, 2016). A variety of studies have pointed to the importance of supporting CHWs to play a wide range of roles (including roles as advocates and community organizers), and to the limitation of roles that can be associated with certain payment mechanisms (Ingram et al. 2012; Wiggins and Kaan, et al., 2013). The 2015 C3 list will be referred to throughout this report and is included as Appendix A.

Community Health Workers in Oregon

Oregon’s current efforts to further integrate CHWs into health services benefit from a long history of CHW programming, organizing, training and research in the state. CHW programs initiated in the 1960s in both urban and rural areas of Oregon were part of national initiatives such as the War on Poverty and the Indian Health Service’s Community Health Representative Program. These included the Community Health Representative Program initiated in 1967 at the Yellowhawk Tribal Health Center in Umatilla, Oregon. In 1988, staff at La Clínica del Cariño, a migrant and community health center in Hood River, received funding from the Bureau of Primary Health Care to start the El Niño Sano (The Healthy Child) Program, which became a hub for CHW activity that continues to this day (Carney et al., 2012; Volkmann & Castanares, 2011). Around the same time, staff in Oregon’s local health departments were responding to the HIV-AIDS epidemic by hiring CHWs based on their membership in communities most affected. With CHW programming growing in diverse communities around the state, in 1994 the first

statewide committee of CHWs was organized as part of the Oregon Public Health Association. In 2001, a CHW training center was founded as a partnership between the Multnomah County Health Department and multiple community-based organizations. Over 600 CHWs had participated in training provided by the Community Capacitation Center by the time the ACA was passed in 2010 (Wiggins, Kaan et al., 2013). These efforts were accompanied by work to increase awareness about and appreciation for CHWs among other health professionals, and Oregon CHWs and allies participated actively in national initiatives such as the 1994 National Community Health Advisor Act and the 1998 National Community Health Advisor Study. (For more information about the history of CHWs in Oregon, see Appendix B: Milestones in CHW/Promotor/a History with a Focus on Oregon.)

Building on this impressive history, in 2011, staff from the Office of Multicultural Health and Services (now the Office of Equity and Inclusion) at the Oregon Health Authority convened a Community Health Worker Policy Advisory Committee to advise the State on CHW policy development in the context of health care transformation at the State level. This group provided input on CHW provisions contained in House Bill 3650, which mandated the creation of coordinated care organizations (CCOs) and set the stage for health care transformation in Oregon. Passage of HB 3650 led to the formation, in September of 2011, of the Non-Traditional Health Worker Subcommittee (subsequently, the Traditional Health Worker Steering Committee), which was guided by staff at the Office of Equity and Inclusion. This group did work to differentiate CHWs from peer support/peer wellness specialists and patient navigators and, in January of 2012, produced a report with recommendations for competencies, and education and training requirements for these worker types. Rules for the approval of training programs and the certification of Traditional Health Workers (a category to which doulas were subsequently added) created by this group were finalized in 2013. With leadership from the Oregon Community Health Worker Association, in 2014 the Oregon Legislature passed House Bill 3407, which created the Traditional Health Worker Commission. The Commission has met continuously since that date to advise the Office of Equity and Inclusion in its policy-making efforts regarding THWs.

Concurrent with the creation of the CHW Policy Advisory Committee in 2011, a group that included representatives from the OHA, the Multnomah County Community Capacitation Center and the Northwest Regional Primary Care Association came together to offer a series of leadership development trainings for CHWs. They recognized that CHW policy was being made rapidly by the state, and while individual CHWs were participating, CHWs lacked an organized voice at policy making tables. The leadership development workshops were envisioned as a jumping off point for the creation of a statewide CHW association; this occurred in November of 2011, when a group of CHWs from multiple organizations came together at the Asian Family Center and formally organized the Oregon Community Health Workers Association (ORCHWA). The Association has grown steadily since that point, and now includes over 680 members from around the state. ORCHWA is guided by an all-CHW Board of Directors. Consistent with the reasons for its founding, ORCHWA's mission is to serve as a unified voice to empower and advocate for CHWs and their communities. Recently, Health Share of Oregon made a multi-year

contribution to support infrastructure-building at ORCHWA, primarily so that ORCHWA can expand its role as a contracting hub between health systems and culturally specific community-based organizations that employ CHWs.

Oregon has also long been a leader in CHW training. In 1990, CHWs from the El Niño Sano Program in Hood River were introduced to popular/people's education methodology. The following year, the program received funding from the Office of Minority Health that allowed them to expand to two additional sites, one at Salud Medical Center in Woodburn and the other at Valley Family Health Center in Nyssa. After participating in their own initial training series using popular/people's education, these CHWs became multipliers of knowledge and the methodology by planning and facilitating training series for their colleagues in the two other sites. This led, shortly thereafter, to these same CHWs leading training for other CHWs from around the state, supported by a Health Education and Training Center (HETC) grant to the Oregon Health & Science University. In the mid-1990s, cognizant of the movement toward regional CHW training centers that was occurring around the country, CHWs aligned with the CHW Sub-Committee of the Oregon Public Health Association began to contemplate the development of a similar regional training center for Oregon. This led, in 1999, to the founding of the CHW Capacitation Center (later, the Community Capacitation Center) at the Multnomah County Health Department. Over the next 18 years, staff at the CCC used a combination of content, methodology and values to create and conduct multiple training programs for CHWs around the state. Concurrently, other training programs for CHWs were developing around the state, including a clinically-focused training program at the Benton County Health Dept. Following passage of rules for approval of training programs in 2013, a number of community colleges and several quasi-governmental and community based organizations developed training programs for CHWs. Currently, the Oregon THW Commission lists six approved training programs for CHWs on its website.

Contributions to the CHW Evidence Base by Oregon-Based Researchers

Oregon CHWs and researchers have made substantial contributions to the development of a scientific evidence base regarding CHW interventions and outcomes. Demonstrated outcomes of CHW programs in Oregon have been impressive, as a representative sampling of studies demonstrates. Poder es Salud/Power for Health, a community-based participatory prevention research study funded by the Centers for Disease Control and Prevention (CDC), aimed to improve health and decrease disparities in the African American and Latinx communities in Multnomah County through the intervention of CHWs who used popular/people's education. Pre- and post-surveys with a random sample of members from participating communities revealed that the project was associated with statistically significant improvements in self-reported health status and decreases in depressive symptoms (Michael, Farquhar, Wiggins, & Green, 2008). Project CHWs expressed that their use of popular education contributed to increases in self-esteem, sense of personal potential, level of community involvement and participation, quantity and quality of leadership, and sense of community solidarity (Wiggins et al., 2008).

A study by Carney and colleagues (2011) which included long-time CHWs from the Columbia Gorge as co-authors found that a community garden intervention led by CHWs who used popular education was associated with statistically significant increases in vegetable intake by both adults and children, and with a decrease in the frequency of worry about running out of food from 31.2% to 3.1% ($P=.0006$). Analysis of qualitative data suggested benefits to participants in both physical and mental health as well as economic and family health.

An early evaluation study of the integration of CHWs into primary care teams in the Columbia Gorge concluded that “clinical community health workers have the potential to make a significant impact on clinical efficiency and effectiveness as ambulatory primary care clinics strive to transform into high-quality, patient-centered medical homes and become linchpins in accountable care organizations” (Volkman & Castañares, 2011). This first author on this study went on to apply learnings from the study in the development of an extensive, clinically-focused CHW program based at the Benton County Health Department in Corvallis, Oregon.

Researchers based in Oregon have also made substantial contributions to the literature about CHWs at the international level. Dr. Kenneth Maes of Oregon State University and his colleagues have conducted important research with CHWs in Africa, which has clear applications to the local scene. His work shows that public health policy makers in low-income countries and in various global organizations (WHO, donor foundations, and non-profits) think of CHWs as uniquely capable of filling massive labor gaps in health care systems around the world, at the same time that many CHWs face insecure employment and are paid at levels that keep them in poverty.

In an effort to increase the impact of research and evaluation about CHWs being conducted in Oregon, in 2014 the Oregon CHW Research Consortium was organized under the auspices of the School of Community Health at Portland State University. This group, which includes CHWs and researchers, developed a research agenda for CHWs in Oregon that is available upon request. With funding from the Cambia Foundation, the Research Consortium also organized a 2015 CHW Common Indicators Summit that brought together 16 CHWs and researchers from five states to identify a common set of process and outcome indicators for CHW practice. This effort, which builds on previous work conducted by the Michigan CHW Alliance, has continued and flourished. The CI Project, now led by Drs. Wiggins and Maes along with Dr. Edith Kieffer at the University of Michigan, includes more than 45 individuals located in more than ten states. An initial list of indicators has been developed and is being piloted in Connecticut, Oregon and Missouri. Currently, the group is seeking funding to create a stable infrastructure for the project based at ORCHWA. The short-term goal of the project is to identify and validate a core set of common process and outcomes indicators, and a larger set of recommended constructs, to systematically assess the impact of the CHW workforce, and the processes by which they achieve impact, across settings and disease and health promotion areas. The long-term goal is nationwide adoption of these indicators and development of a sustainable infrastructure to collect, aggregate, analyze, and report results of the indicators.

Methodology

Overview

This statewide needs assessment of the Community Health Worker workforce in Oregon as of 2018 used a developmental evaluation approach with a concurrent mixed methods design. Using a developmental evaluation approach means that, while evaluators begin with a particular idea about the questions they are seeking to answer and the strategies they will use to answer these questions, strategies – and even guiding questions – are open to change based on the changing situation and what is learned in the study (Patton, 1994). Similar approaches have been developed and recommended for activities like strategic planning (Kania, Cramer & Russell, 2014). Mixed methods evaluations use both quantitative data to understand *what happened or what changed*, and qualitative data to understand more about *how or why the change occurred*. Whereas in some studies qualitative and quantitative methods are used consecutively, in our study they were used concurrently, with the emerging results of one type of data constantly influencing the interpretation of the other type of data (Teddlie, Tashakkori & Johnson, 2008).

Assessment Questions

This study was guided by three sets of assessment questions. One set of questions came from the Oregon Office of Equity and Inclusion, as follows:

- 1) What is the demographic composition of the CHW workforce?
- 2) Does the composition of the workforce match the needs of Medicaid clients throughout the state? What are current gaps in the workforce?
- 3) What have been the successes, barriers and challenges regarding:
 - a. CHW training and professional development?
 - b. CHW hiring, retention, readiness and utilization?
 - c. Availability of culturally and linguistically specific THW services?
- 4) What needs to be done to address the issues identified in questions 2 and 3?

(Source: Exhibit 1, Program Description, n.d.)

A second set of assessment questions came from Health Share of Oregon:

- 1) How many community-based CHWs³ are currently active in Oregon?
- 2) Who is currently employing CHWs?
- 3) What existing payment models are being used to employ CHWs?
- 4) How are community-based CHWs being integrated into clinical care teams?
- 5) How do CHWs integrate into health systems (e.g. what roles do they play and how do they function on care teams)?
- 6) How are CHWs or an equivalent workforce utilized by Tribes across the state?

(Source: Health Share of Oregon Grant Agreement, Exhibit A: Statement of Work, n.d.)

³ In this context, “community based CHWs” means CHWs employed by community-based organizations or CBOs.

Finally, the Oregon Community Health Workers Association added additional questions that were of interest to ORCHWA, as the statewide professional association for CHWs:

- 1) What is the current status of CHW supervision in the state? What are strengths and how could supervision improve?
- 2) What types of training would contribute to CHWs' growth as health professionals? What changes, if any, need to be made to CHW training in terms of location, modality, timing, and/or cost?
- 3) What job duties do CHWs conduct?

For ease of reference, these three lists of questions have been combined into a single set of assessment questions:

Statewide Needs Assessment Questions:

- 1) What is the current composition of the CHW workforce in Oregon?
 - a. What is the demographic composition?
 - b. Does the current composition of the workforce match current needs?
 - i. Is the workforce sufficiently culturally and linguistically appropriate to meet the needs?
 - c. What is the size of the community based workforce?
- 2) What is the current employment structure for the CHW workforce in Oregon?
 - a. What organizations employ CHWs?
 - b. What payment mechanisms are being used to employ and/or obtain services of CHWs?
 - c. What are the job duties of CHWs around the state?
- 3) What are the successes, barriers and challenges regarding:
 - a. CHW training and professional development?
 - b. CHW hiring, retention, readiness and utilization?
 - i. How is the CHW workforce utilized by Tribes?
 - c. Integration onto teams (both clinical and otherwise)
 - d. Support and supervision
- 4) What needs to be done to address problems and challenges?

Data Collection

Data Collection Tools: Three primary data collection tools were used in this assessment. A qualitative discussion group guide composed of six open-ended questions and six demographic questions sought to answer questions 1.a. and 1.b., 2.c., and 3.a., 3.c., and 3.d. It was developed by staff at ORCHWA based on experience in the workforce development field. The overall intent was to learn about job satisfaction among CHWs by asking about supervision, professional development, and training. The second data collection tool was a 52-question survey designed for use by Traditional Health Workers by researchers at Portland State University, under contract to the Oregon Office of Equity and Inclusion. Questions were both

close- and open-ended and thus collected both quantitative and qualitative data. This survey primarily sought to answer questions 1.a., 1.b. and 1.c.; and 3.a. and 3.b. A third, 27-question survey composed of both close-and open-ended questions was designed and conducted by staff at the Center for Health Systems Effectiveness at the Oregon Health and Sciences University with community-based CHW employers. This survey primarily sought to answer questions 1.c., 2.a., 2.b., 2.c., 3.b., and 3.c. (The third survey was adapted from a survey designed for use with Coordinated Care Organizations. A similar tool was eventually used to guide interviews with staff from all 16 CCOs, inquiring about their experiences integrating CHWs. Results of the study in which that tool was used are forthcoming.)

A summary of assessment question with their respective data sources is provided in Table 1.

Table 1: Assessment Questions and Data Sources

Assessment Question	Data Source
1. What is the current composition of the CHW workforce in Oregon?	
a. What is the demographic composition?	THW Survey Discussion Groups
b. Does the current composition of the workforce match current needs? Is the workforce sufficiently culturally and linguistically appropriate to meet the needs?	THW Survey Discussion Groups
c. What is the size of the community based workforce?	THW Survey Employer Survey
2. What is the current employment structure for the CHW workforce in Oregon?	
a. What organizations employ CHWs?	Employer Survey
b. What payment mechanisms are being used to employ and/or obtain services of CHWs?	Employer Survey
c. What are the job duties of CHWs around the state?	Employer Survey Discussion Groups
3. What are the successes, barriers and challenges regarding:	
a. CHW training and development?	THW Survey Discussion Groups
b. CHW hiring, retention, readiness and utilization? i. How is the CHW workforce utilized by Tribes?	THW Survey Employer Survey Discussion Groups
c. Integration onto teams (both clinical and otherwise)	Employer Survey Discussion Groups
d. Support and supervision	Discussion Groups
4. What needs to be done to address problems and challenges?	N/A – Based on findings

Data Collection Processes

Discussion Group Guide: A total of 240 individuals responded to the Discussion Group Guide. Not all of these were CHWs; some identified with other worker types (e.g. doula, peer support specialist). Consistent with a developmental evaluation approach, the tool was used in a variety of ways in order to build and maintain trust and rapport and adapt to local situations. The most common way the tool was used was to guide semi-structured discussions with groups, similar to focus group methodology. ORCHWA's Workforce Development Director (the first author) facilitated a total of 13 groups in 11 locations around the state. Discussion groups, which were between 1 and 2 hours in length, were audio-recorded and transcribed by a professional transcriptionist. In addition, at a day-long THW Summit held in Lane County, 119 total participants engaged in self-facilitated small-group discussions using the guides, and recorded their answers both on the guide itself, as well as on flip chart paper. The flip chart pages were typed up for analysis. Finally, the Discussion Group Guide was transferred to Survey Monkey and made available to people who were unable to attend a face to face discussion. Seven responses were gathered in this way. Collection of data using the Discussion Group Guide occurred between January 1, 2018 and April 15, 2018.

Participants were invited to the discussion groups by a central point of contact for each group who already had a connection to ORCHWA. A \$10 Starbucks gift card was offered as an incentive to all participants except those who attended the THW Summit in Lane County. Before each group discussion, participants reviewed a document that provided background on the purpose of the discussion group and a description of what would occur, identified potential risks and benefits, and informed participants about their right to withdraw and receive further information. Participants were not required to sign the form; participation in the group constituted consent. (See Appendix C: Discussion Group Guidelines, and Appendix D: Discussion Group Guide, for more information.) While being open about potential risks, the facilitator strove to create an environment where participants felt free to voice their ideas and opinions.

THW Survey: After development by staff at PSU and OEI, the survey was translated into Spanish by staff at ORCHWA. It was transferred to Survey Monkey by ORCHWA staff and the link was disseminated by ORCHWA via email to a total of 13 groups around the state known to have strong connections to the CHW workforce. (See Appendix E: Further Information Regarding Data Collection.) In addition, it was disseminated via a distribution list of CHWs and CHW program staff developed over the course of 18 years by the Multnomah County Community Capacitation Center. The survey was completed by a total of 125 people of whom 104 were CHWs. (Since ORCHWA's purview for the statewide needs assessment included only CHWs, only CHW responses were used for analysis.) Survey responses were collected via the Survey Monkey link between February and April of 2018. (See Appendix F: CHW Survey.) Because there is no authoritative count of CHWs in Oregon, we cannot say what percentage of Oregon CHWs responded to the survey. Because we do not know how many people received the survey link, we also cannot calculate a response rate. Finally, we cannot say how many people started but did not complete the survey.

CBO Employer Survey: Community Based Organizations (CBOs) were invited to participate in the survey based on their inclusion on a list of CHW-employing organizations maintained by ORCHWA. Researchers from CHSE at OHSU contacted the CBOs and verified the appropriate contact information of a CHW supervisor at each organization. They sent invitations by e-mail to participate in the online survey via a survey link, along with the IRB-approved information sheet which explained the study and the participant’s rights. If participants did not respond to the first email, researchers followed up two more times via email. A total of 25 individuals responded to the survey. Forty-one individuals received the survey and 25 responded, for a response rate of 61%. (See Appendices G and H for more information about the survey.)

Data Analysis and Interpretation

Qualitative Data

Qualitative data, including transcripts from discussion groups and responses to open-ended questions on the two surveys, were transferred into Atlas.ti Version 8.2.3 (Scientific Software Development, 2018) for analysis. A coding scheme was developed by the original researcher (the third author). Quotations were sorted into codes and an initial write-up of results with interpretations was created. When the current researcher (the second author) arrived, she reviewed the codes and write-up. She did some recoding and created second level codes within each higher level code. While using some of the original interpretations and original write-up, she also added her own interpretations and wrote up the final version of the analysis.

Quantitative Data

Survey Monkey provides frequencies and percentages for responses to close-ended questions. Because questions on the survey were relatively straightforward, minimal additional analysis was needed, and mostly involved calculation of frequencies and percentages for free-response questions. We excluded results from other types of Traditional Health Workers and based conclusions on the sub-set of respondents who were Community Health Workers.

Findings

In this section, we first provide a portrait of certified CHWs based on data from the THW Registry, before going on to provide detailed findings based on each data collection method.

Traditional Health Worker Registry Data

In an effort to track certified CHWs (as well as other Traditional Health Workers) and make their names available to potential employers, the THW Registry was established in 2014. A new version of the Registry went live in 2017. While limited and ambiguous in some ways, data from the Registry can provide a portrait of the current deployment of certified CHWs around the state, and can begin to answer some of the questions guiding this assessment. As of the date these data were analyzed, there were a total of 570 certified CHWs in the Registry. Two types

of analyses are useful for answering Assessment Question 1.b., about whether the current composition of the workforce is appropriate to meet the needs of people around the state.

Table 2: Number of certified CHWs by County and ratio of CHWs to community members

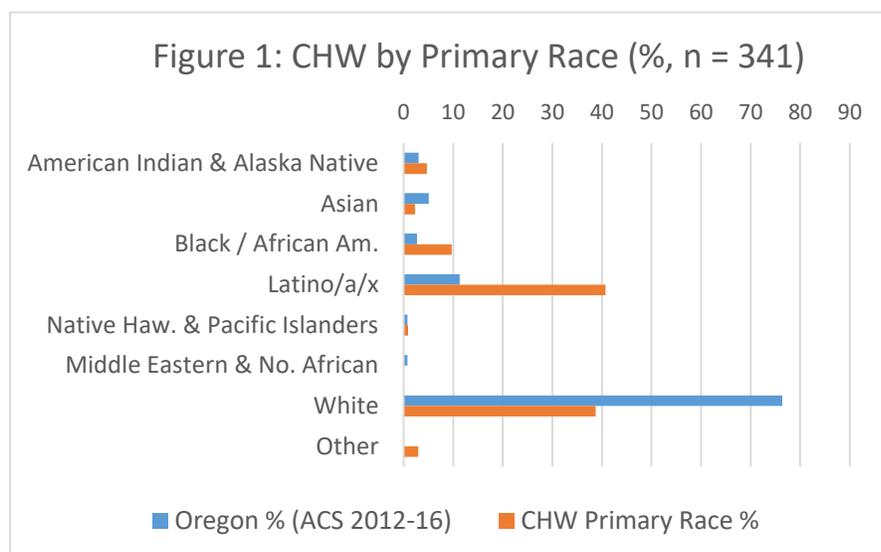
County	Cert CHWs	Population ¹		Extreme Poverty (<50% FPL)		Persons with Income <185% FPL	
	No.	No.	Ratio: 1 CHW:x pop	No.	Ratio: 1 CHW:x pop	No.	Ratio: 1 CHW:x pop
Baker	40	16,052	401	1,037	26	6,019	150
Benton	47	86,495	1840	9,738	207	29,618	630
Clackamas	142	389,438	2743	16,818	118	87,090	613
Clatsop	26	37,382	1438	1,667	64	12,937	498
Columbia	33	49,389	1497	3,123	95	14,857	450
Coos	39	62,775	1610	5,084	130	24,845	637
Crook	28	20,956	748	1,815	65	9,150	327
Curry	40	22,338	558	1,483	37	8,200	205
Deschutes	41	166,622	4064	10,198	249	51,740	1262
Douglas	33	107,194	3248	8,705	264	40,872	1239
Gilliam	29	1,883	65	116	4	650	22
Grant	28	7,276	260	453	16	2,722	97
Harney	34	7,229	213	501	15	3,065	90
Hood River	75	22,749	303	1,432	19	6,512	87
Jackson	84	208,363	2481	15,930	190	79,904	951
Jefferson	26	22,061	849	2,218	85	8,829	340
Josephine	63	83,409	1324	7,429	118	35,889	570
Klamath	31	65,972	2128	4,833	156	26,078	841
Lake	26	7,842	302	414	16	3,468	133
Lane	77	357,060	4637	34,840	452	135,016	1753
Lincoln	30	46,347	1545	2,667	89	16,831	561
Linn	48	118,971	2479	8,578	179	44,887	935
Malheur	46	30,551	664	2,486	54	12,550	273
Marion	65	323,259	4973	24,481	377	120,257	1850
Morrow	45	11,204	249	817	18	4,068	90
Multnomah	208	768,418	3694	62,644	301	253,993	1221
Polk	48	77,264	1610	6,029	126	25,344	528
Sherman	34	1,795	53	146	4	674	20
Tillamook	34	25,430	748	1,467	43	9,119	268
Umatilla	56	76,738	1370	5,229	93	26,839	479
Union	46	25,745	560	2,207	48	10,147	221
Wallowa	36	6,857	190	370	10	2,190	61
Wasco	54	25,492	472	1,805	33	9,210	171
Washington	164	556,210	3392	26,301	160	139,712	852
Wheeler	26	1,348	52	79	3	477	18
Yamhill	57	101,119	1774	7,404	130	32,445	569

Source: CHW figures: OHA 2018 as of 10/11/2018. Population Estimates: DHS 2017, using 2011-2015 American Community Survey data.

¹ Population estimates those living in group homes and other institutions.

Table 2 (above) provides the number of certified CHWs by county as of Fall 2018, and a ratio of CHWs to county residents in three categories, using 2017 American Community Survey data. Counties with notably low ratios of CHWs to persons in the county are highlighted. While these data are interesting, they must be interpreted with caution, since CHWs in the State’s registry are asked to identify **all the counties in which they are willing to work**. Therefore, while some CHWs only list the county where they live, others list every county in the state. Nonetheless, these data do seem to show that shortages of CHWs (as measured by a ratio of CHWs to population) exist in both urban and rural areas of the state, and are especially prominent in urban centers. However, other factors must also be taken into account in targeting resources for particular regions, including the distances CHWs in rural areas of the state must cross to reach their participants. (See Appendix I: Calculating CHW Shortages in Oregon.)

It is also possible to look at the race/ethnicity of CHWs with reference to various racial/ethnic



groups as a percent of total population. Figure 1 and Table 3 provide information on the distribution of primary race/ethnicity across the 570 CHWs included in the Registry when these data were extracted, as a percent of the total, and compares these data to the Oregon population as a whole. Here, it is important to note that, of the 570, a total of 196 did not select a primary

race/ethnicity; 29 declined to answer the question and 4 answered “unknown.” Nonetheless, the prominence of respondents choosing Latinx and White is notable.

Table 3: CHWs by Primary Race (%)

	Oregon		CHW	
	No.	%	No.	%
American Indian & Alaska Native	120144	3.0	16	4.7
Asian	201267	5.1	8	2.3
Black / African American	106540	2.7	33	9.7
Latino/a/x	449370	11.3	139	40.8
Native Hawaiian & Pacific Islander	29830	0.7	3	0.9
Middle Eastern & No. African	29918	0.8	0	0.0
White	3041616	76.4	132	38.7
Other	3582	0.1	10	2.9
Total	3982267	100	341	100

Notes. N=570; 196 did not select primary race, 29 declined, and 4 said unknown. ACS Figures (2012-16, statewide population estimates) used rarest group methodology to assign primary race. Primary race of CHW selected by CHW.

The data in these tables and figure were provided to us by the Office of Equity and Inclusion and are based on a question that asks respondents to identify a primary race/ethnicity. The data have been aggregated for comparison to categories in the American Community Survey. A table with disaggregated data is provided as Appendix J: Disaggregated Primary Race/Ethnicity of Certified CHWs. It is possible that one reason for the missing data is resistance to being asked to provide a *primary* race/ethnicity.

When reviewing the table and the figure, it is very important to remember that historically and currently, CHWs have served *communities most affected by inequities*. Looked at in this way, an apparent overrepresentation of CHWs from the Black/African American, Latinx, and AI/AN communities is revealed to be anything but that. An underrepresentation of CHWs in the Asian community warrants attention. Geospatial data as well as more nuanced data on ethnic, racial and multi-ethnic/racial identities among CHWs is necessary to make informed decisions about targeting resources to fill shortages of CHWs in Oregon’s various communities.

CHW Survey Findings

Participant Characteristics (n=104)

Respondents to the survey fielded by ORCHWA were able to choose any of the five THW worker types. A total of 104 chose “Community Health Worker”; this is the sample that was used for analysis. It should be noted, however, that further down in the survey a few respondents stated they were not currently working as CHWs and/or they were working primarily in administrative roles. Thus, respondents should be viewed as a non-random sample of those currently working as CHWs and those who have worked as CHWs in the past. Graphic displays for the results of selected questions in the survey are provided as Appendix K: Graphic Displays for Selected CHW Survey Responses.

A few characteristics of this sample are highly salient for putting into context the other findings from the survey. Notably, almost 70% of respondents reported making \$30,000 a year or more and 96% reported having at least some college. Less than 1% reported not having a college degree. These high levels of income and formal education do not mirror the historic demographics of CHWs, and should be kept front of mind when viewing other survey results.

Race/ethnicity categories chosen by respondents also speak to the selection bias inherent in the survey results. (It should be noted, in advance, that respondents could choose as many race/ethnicities as they desired.) At 46%, the percentage of Hispanic or Latinx respondents mirrors the percentage of Registry CHWs who chose Latinx as their primary race. However, almost 16% of survey respondents identified as American Indian/Alaska Native/Canadian Inuit, Metis or First Nations, whereas 4.7% identified as AI/AN in the sample taken from the THW Registry. Only 7.84% of survey respondents identified as African American, whereas 9.7% identified this way in the THW Registry. A larger percentage identified as Eastern European (13.73%) than identified as either African American or African, despite the fact that culturally specific certification trainings have been held in the latter two communities but not in the Eastern European community. While the survey results confirm that there is a diverse CHW

population in Oregon, more careful on-going data collection is needed to accurately assess the racial/composition of CHWs in Oregon.

The survey also provided data on linguistic diversity, disability status, and gender identity among Oregon's CHWs. Eighty-two percent of respondents preferred to use English outside of the home. Almost 10% preferred Spanish. Other languages mentioned included Somali and Arabic. Only 1% of respondents expressed a need for a spoken language interpreter when communicating with others. None expressed a need for a sign interpreter. One hundred percent of respondents expressed that they speak English well or very well. Only 1 respondent identified as Deaf or hard of hearing, while 3% (n=3) identified as vision impaired. About 4% of respondents identified as having difficulty concentrating, remembering, understanding, and/or making decisions, whereas 14% reported that a physical, emotional or mental condition limited their activities. In terms of gender identity, 78% identified as female, 19% as male, and 3% as genderqueer, gender nonconforming or non-binary. No other gender identities were named. A total of 77% of respondents reported they use she/her/hers pronouns, whereas 19.5 % use he/him/his, and 2% use they/them/theirs. Regarding sexual orientation, 80% identified as straight or heterosexual, 7% identified as bisexual, and 2% (each) identified as gay, lesbian or queer. A total of 4% declined to answer and 2% chose "other."

As to their rural/urban residence, a slight majority (52%) reported living in urban areas, vs. 37% in rural areas. Although there may be differences in how respondents characterize their location and how locations are characterized by state and national authorities, the percentage of rural respondents far outstrips the 16% of Oregonians who lived in rural areas as of 2017 (<https://www.ruralhealthinfo.org/states/oregon>). Twenty-five percent of respondents have been certified less than 1 year, whereas 54% have been certified between 1-5 years, and 6% between 6 and 10 years. Clearly a few respondents were not referring to Oregon State THW certification when they answered this question, since 3% stated they had been certified for 11 years or more, and the certification has only existed since 2014. A total of 12.5% were not certified.

Almost 70% of respondents reported they have not had difficulty finding work in their field. Reasons given (in open-ended responses) by those who had experienced difficulty included more people than jobs, employers now asking for bachelor's degrees/new educational requirements, "no jobs available for specific roles like community organizing, or working at community levels," low wages, under-valuing of the work, and lack of sustainable funding.

CHW Demographics vs. Community Needs

Assessment questions 1.a. concerned the degree to which the current composition of the workforce matches current needs across the state. A corollary question inquired whether the workforce is sufficiently culturally and linguistically diverse to meet the needs. As mentioned above, selection bias inherent in the survey means that it is impossible to answer this question directly by comparing the demographics of the workforce to state demographics. However, some questions included in the survey can help us begin to answer these assessment questions.

A sub-set of questions inquired whether CHW programs had a waiting list and whether they turned away clients. The majority of respondents (85%) reported not having a waiting list. While this response could be interpreted to mean that the supply of CHWs is at least partially meeting the demand, it could also be the result of community members not seeking services if they know in advance the services will not meet their needs (possibly because of linguistic or cultural differences.) A smaller but still sizable majority of respondents (74%) reported never turning away potential participants. When asked about reasons they turn away potential participants, CHWs commonly responded that they lack time or capacity, potential participants do not meet eligibility requirements, potential participants are not patients of the clinic, and/or potential participants have high need/high acuity.

Another set of questions asked about respondents' ability to provide culturally and linguistically specific services, and the barriers to and benefits of providing those services. A majority of respondents (71%) reported they were able to provide culturally and linguistically specific health services, while 16.5% said they could not and 13% said they did not know. Common barriers to being able to provide culturally and linguistically specific health services fell into four general categories. Category 1 included respondents who pointed to a lack of commitment from dominant culture systems to providing culturally and linguistically specific services. Sample responses from this group included: "Health system [doesn't] embrace the work," "Organization sometimes they just have the concept but they are [scared] when they find the reality," and "the organization does not support this approach, thus our staff are not trained to be culturally agile, or supported when we make individual efforts to do so." A second category of respondents pointed to deficiencies in themselves, such as "my age, and gender," "Not having the ability to become bilingual," "I do not speak the language of the people I work with so at times it is difficult to converse. I know a few words but not enough," and the response below:

I understand African American culture but I do not know allot about African culture, traditions, and norms. I have 2 clients that are from two different parts of Africa. They are in essence teaching me as I try to assist them.

A third, smaller category of respondents discussed what "culturally specific" might look like in their setting or community: "I work in rural eastern oregon (sic). The demographics I have experienced the most are low income, limited education, disabled. Cultural specific would look something like education about diet." The final category of respondents, perhaps not understanding the meaning of culturally and linguistically specific services, pointed to a lack of interpreters or translators.

Most respondents answered the question about successes in providing culturally and linguistically specific services in terms of the *advantages or positive outcomes* of these services, such as responsiveness, better and faster results, "people actually listen to me," and "making patients feel comfortable coming into the clinic." Other responses included: "Being able to help my families to access the services they need and support them in their own languages" and

“Having success in client becoming self-sufficient and exceeding their goals of having better health, self [esteem] and motivation to better eating habit choices.” Some respondents answered in terms of specific improved health outcomes associated with culturally and linguistically specific services: “Every patient i had in the tomando control class lost weight, improved bmi, or a1c.” Improvements in diabetes were also commonly mentioned.

Settings Where CHWs Work

Assessment Question 1.c. concerned the size of the community-based CHW workforce. Survey respondents were asked to identify how often they work in specified settings. Response options included: ALWAYS, FREQUENTLY, SOMETIMES, and NEVER. The most common settings where CHWs always worked were community-based organizations (CBOs) (53%) followed by clinics (36%) and family homes (24%). CHWs frequently worked in individual/family homes (33%) and other settings (31%). CHWs sometimes worked in hospitals (43%), and schools (40%). More information can be found in Table 3: Settings Where CHWs Work, below.

Table 3: Settings Where CHWs Work

	Always	Frequently	Sometimes	Never	Total
Community-based organization	53.19%	26.60%	14.89%	5.32%	94
	50	25	14	5	
Individual/family home	24.18%	32.97%	35.16%	7.69%	91
	22	30	7	7	
Government agency (e.g. county health dept.)	14.61%	21.35%	35.96%	28.09%	89
	13	19	32	25	
School	8.99%	16.85%	40.45%	33.71%	89
	8	15	36	30	
Clinic	36.36%	15.91%	21.59%	26.14%	88
	32	14	19	23	
Hospital	6.98%	17.44%	43.02%	32.56%	86
	6	15	37	28	
Other (please specify)	4.08%	30.61%	16.33%	48.98%	49
	2	15	8	24	

“Utilization” of CHWs

Assessment question 3.b. concerned successes, barriers and challenges regarding “utilization” of CHWs.⁴ Survey question 15 notably defined appropriate utilization for respondents as “you have done work that you are specifically trained to do.” Given this definition, 68% of respondents reported that their skills had been appropriately utilized. Future research and monitoring efforts should include a parallel question that defines appropriate utilization as “being able to use a full range of CHW roles and skills.” Such a question can get at whether

⁴ Please note that the phrase “utilization of CHWs” is objectionable to many CHWs, since it implies that they are cogs to be “utilized” within the health care and social service systems, rather than autonomous and self-directed professionals who bring unique strengths and skills to the workforce. However, because the word was used in the survey, it will also be used in this report. We recommend replacing the phrase “utilizing CHWs” with “integrating CHWs.”

CHWs are being supported to play a full range of roles, another aspect of appropriate utilization.

Survey question 16 asked respondents about work they have done as a CHW that falls outside of their skills or training. Qualitative responses fell into three categories. The first category included activities that historically or traditionally have been part of the CHW role and which are included in the C3 10 core roles, e.g. raising awareness about community needs, advocacy with systems, and care coordination. A second category of responses included tasks that would fall outside the 10 core CHW roles; some are complex clinical tasks like physical therapy, lymphatic massage, and mental health casework, while others are tasks that take time away from CHW roles and should usually be done by other staff, including transportation and translation. One respondent spoke for others about the necessity to educate their colleagues about appropriate and inappropriate CHW roles:

When I first started working I had to educate medical staff about the CHW scope of practice. I was asked to work on immigration paper work, be the first point of contact for patients that were manic or impaired due to being under the influence of mind altering substances, etc.

Some respondents appreciated the fact that they were able to do things others were not able to do, such as work across systems, and hoped that their way of working could be duplicated across the state. A third category of responses came from respondents whose primary role is not as a CHW (e.g. a Resident Services Coordinator in a housing community), but who are integrating CHW services into their role.⁵ A fourth category was composed of administrative tasks: project management, budgeting, grants management and reporting.

Training for CHWs

Assessment question 3.a. concerned successes, barriers and challenges regarding training for CHWs. A substantial majority (82.5%) of respondents felt their skills were sufficient to meet their job responsibilities. Three quarters of respondents reported having adequate training opportunities, while 19% said they did not. The two most often-mentioned barriers to skill development were lack of time and lack of funding. One respondent spoke for many, stating: “We are not allotted time or money for trainings, so the skills we do have are not increased, and skills we're lacking we are on our own to build.”

In terms of the kinds of skills CHWs felt they lacked, sample responses (each mentioned only once) included emerging health issues, financial management, clinical issues, Medicare, and pharmaceuticals. Several respondents mentioned a lack of training that was accessible and culturally relevant and responsive. One respondent also commented on needing skills to be able to challenge systems and speak firmly but clearly in order to be taken seriously in an inequitable and hierarchical system:

⁵ORCHWA recommends against this practice, since it does not preserve the integrity of the CHW profession.

The biggest barrier for me is not having the skills to challenge systems like the legal system, CPS, Doctors, and others with big titles. I am just now taking training to help improve my communication and diplomatic skills so that I can address them in a way that is graceful yet strong and firm. When I first started the judges, lawyers, CPS, and others did not take me seriously nor the work that I did. Some have come around, while others look down at the program or me as less or sub-par to the [dominant] cultures' programs and titles.

This CHW hopes that by improving communication skills, the CHW will be better able to gain credibility with dominant culture systems.

Table 4: Desired Training Opportunities

Topic	Number
Mental health	7
Grant writing	5
Diabetes/chronic disease education	4
Domestic violence	3
Motivational Interviewing	3
Landlord-tenant law	2
Self-care	2
Research and assessment skills	2

In answer to a related free-response question about what kinds of training opportunities would most help participants do their work, respondents mentioned the topics in Table 4 with the indicated frequency.

A final training-related question inquired about training opportunities that have been most helpful in developing job-related skills. Some respondents mentioned venues: CHW certification training, trainings facilitated by the Community Capacitation Center, conferences, monthly CHW community of practice meetings. Others mentioned topics. Four topics were mentioned far more often than any others: trauma-informed care (10), motivational interviewing (10), popular education (9), and communication (5). For a word map that is helpful in visualizing the results of this question, see Figure 2.

Figure 2: Word Map for Most Appreciated Trainings



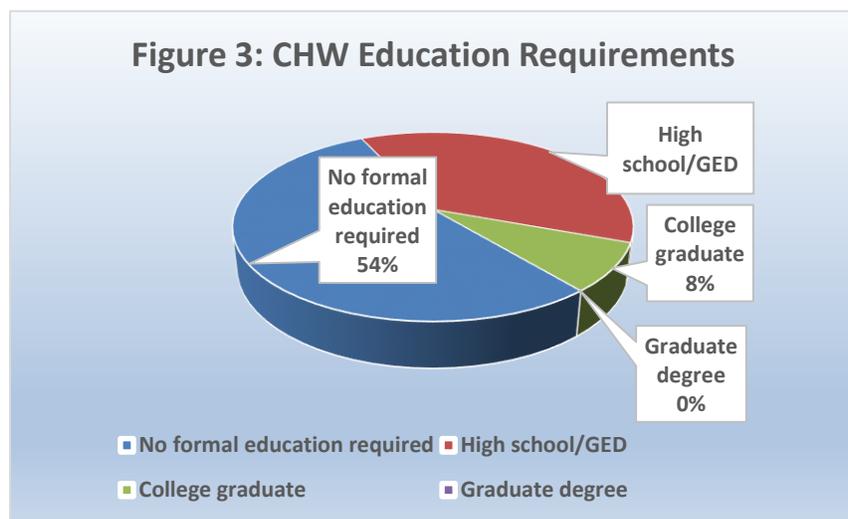
CBO Employer Survey Findings

Characteristics of CBO Respondents (n=25) and Community Health Workers

Twenty-five respondents from 23 organizations responded to the survey. Sixteen organizations responded for their entire organization, while nine described only their program or department.

Of the 25 respondents, 23 were able to state the number of CHWs who are employed in their program or organization. There were a total of 117 CHWs employed among 21 organizations that indicated the number of CHWs in their organization. The maximum number of CHWs listed for one organization was 18, and the minimum listed was one. The median number of CHWs who were employed by CBOs was four. Not all CHWs worked exclusively as CHWs, and some CBOs may define the CHW role differently.

Less than half (46%) of CBOs require OHA certification for their CHWs. Most (54%) do not require a certain level of formal education. Some (38%) require a High School/GED equivalent to work as a CHW. The highest level of education required is a College Graduate (8%) level, and none of the CBOs require a Graduate degree to work as a CHW.



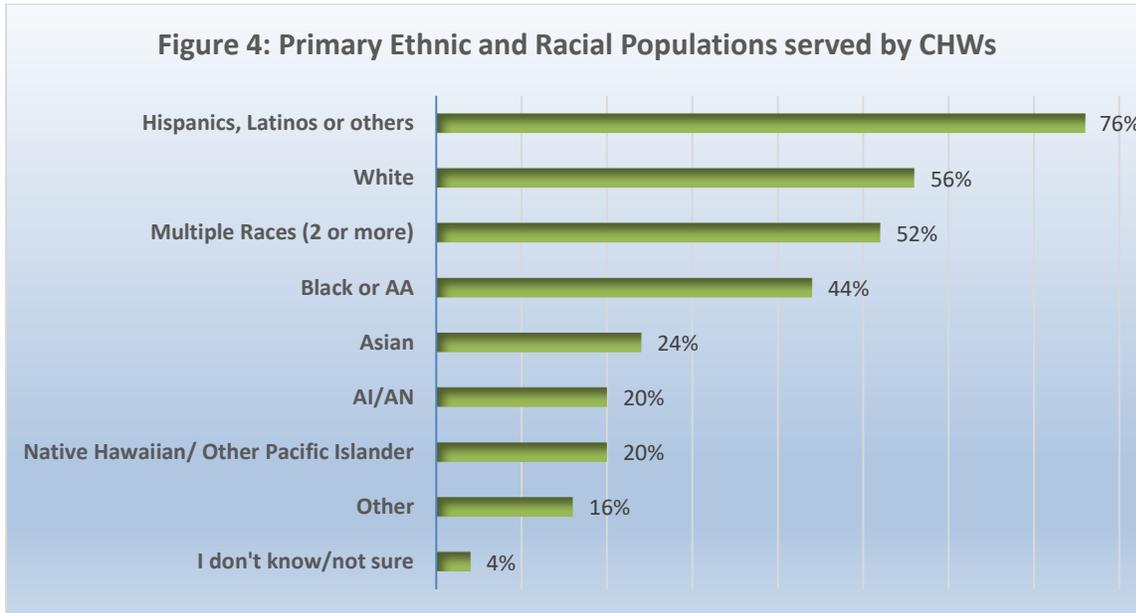
Most CHWs were paid on average about \$15-\$17.99 per hour (50%), followed by \$18-20.99 per hour (25%). The smallest percentage (4%) were either volunteers/unpaid, or paid \$12-\$14.99 per hour. A few (17%) stated that they did not know how much their CHWs were paid on average per hour.

CHW Demographics vs. Community Need

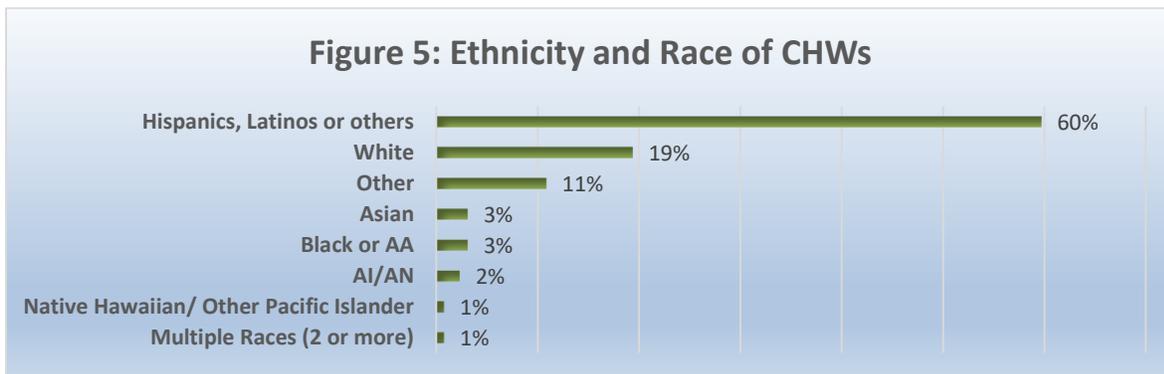
Twenty-four of the 25 respondents were able to list the ethnic and racial populations that their CHWs primarily serve. Just over three quarters (76%) of the organizations stated that their CHWs primarily serve Hispanics, Latinos, or others of Spanish origin⁶, followed by 56% White, 52% multiple races (2 or more) and 44% Black or African American. The least common ethnicities or races served were American Indian/Alaskan Native (AI/AN) and Native

⁶ Please note: This is how the race/ethnicity was categorized in the survey; thus, this is how it is reported.

Hawaiian/Other Pacific Islander (NH/OPI), both at 20%. Some also listed “Other” (16%) as one of the primary racial/ethnic groups served, and identified refugees, Russian, Arabic, and Somali populations in this category. Four percent indicated that they did not know or were not sure about the ethnicity and race of the populations that their CHWs serve.



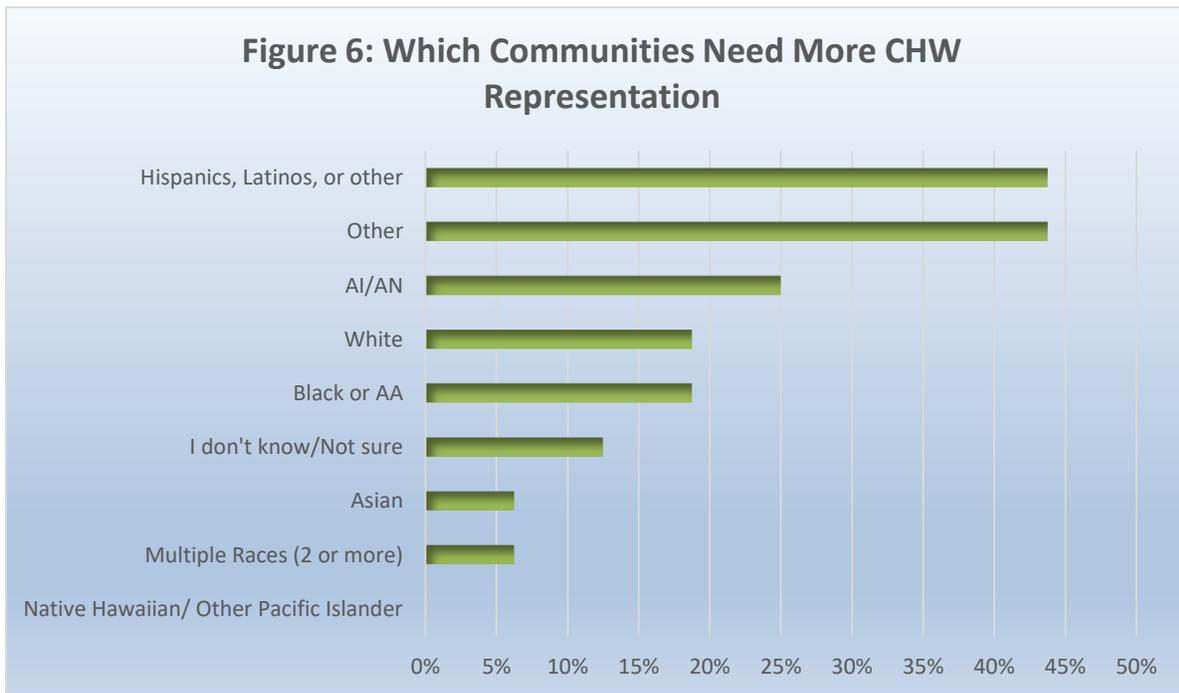
Most (80%) respondents were able to identify the number of CHWs within their organization who identify with the list of race/ethnicities provided. Sixty percent of CHWs were identified as Hispanics, Latinos or others of Spanish origin, and 19% were identified as White. Smaller percentages identified as Asian and Black (both 3%), AI/AN (2%), and NI/OPI and Multiple Races (both 1%).



When asked how CHWs represent the communities they serve, most listed: Shared Lived Experience (92%), Culturally-Specific Services (88%), and Multilingual Services (56%). Only 4% stated “none of the above.” Nineteen percent answered “Other.” It bears noting, here, that

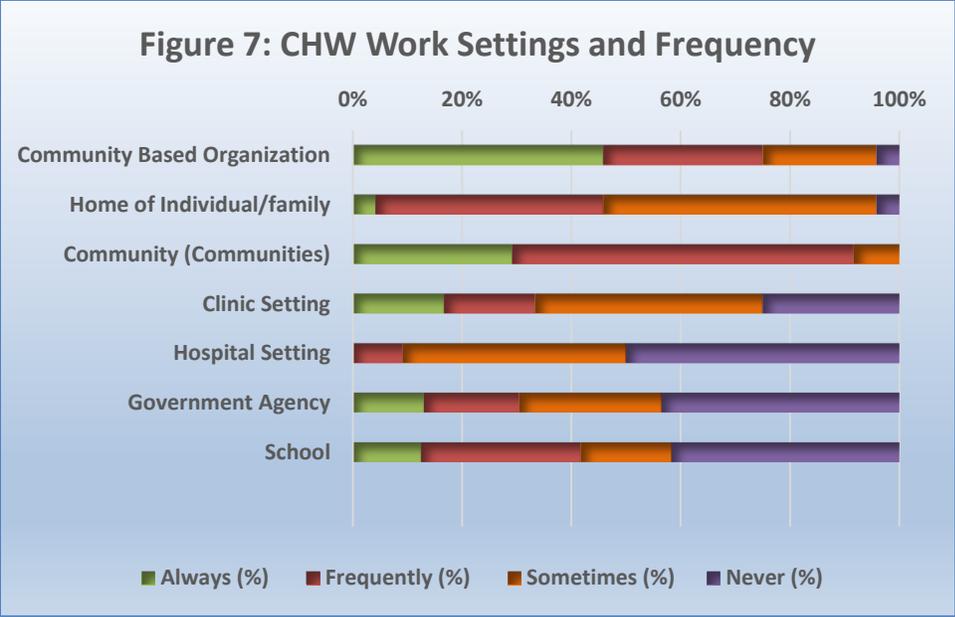
response options for this question were not logical, as they are not all ways that CHWs can represent the communities they serve; the question should have been worded differently to produce more actionable results.

Among those who responded to the question (n=16), nearly half of respondents (44%) stated that their Hispanic, Latino, or other Spanish origin members needed more CHW representation. This was followed by AI/AN (25%), and White and Black (both 19%). Also, 13% did not know which communities needed more CHW representation. None of the CBOs stated that they needed Native Hawaiian/Other Pacific Islander representation. Additional information can be found in Figure 6.



Settings Where CHWs Work

Respondents were then asked to identify how often their CHWs work in specified settings. Response options included: ALWAYS, FREQUENTLY, SOMETIMES, and NEVER. The most common settings where CHWs ALWAYS worked were CBOs (46%) followed by communities (29%) and clinics (17%). None of the CHWs ALWAYS worked in hospitals. CHWs FREQUENTLY worked in Communities (63%). CHWs SOMETIMES worked in homes of individuals/families (50%), and large percentages NEVER worked in hospital settings (41%) and schools (42%). More information is provided in Figure 7.



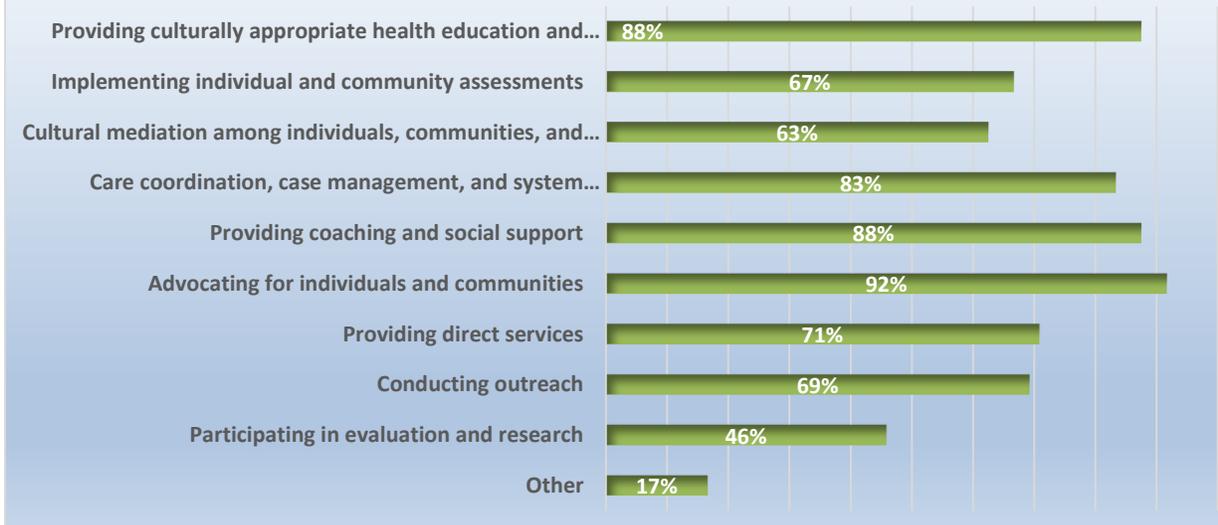
CHWs Addressing Health Inequities

Sixty-nine percent of respondents stated that their CHWs are engaged in initiatives to reduce health inequities. CBOs were asked to describe three health initiatives that their CHWs are involved in to reduce health disparities. They were told to rank these initiatives from highest to lowest priority. The most common initiatives were Outreach and Access to Services (30%) followed by Diet and Exercise (21%) which included health education and health coaching. The least frequent health initiative to eliminate disparities was Smoking Cessation and Oral Health Services (2%).

Roles of CHWs

All respondents indicated that they knew the roles of their CHWs. The most common roles for CHWs include: Advocating for Individuals and Communities (92%), followed by Providing Culturally Appropriate Health Education and Information and Providing Coaching and Social Support (both at 88%). One of the C3 roles (Building Individual and Community Capacity) was inadvertently left off the survey.) Seventeen percent stated “Other.” A breakdown of responses is provided in Figure 8.

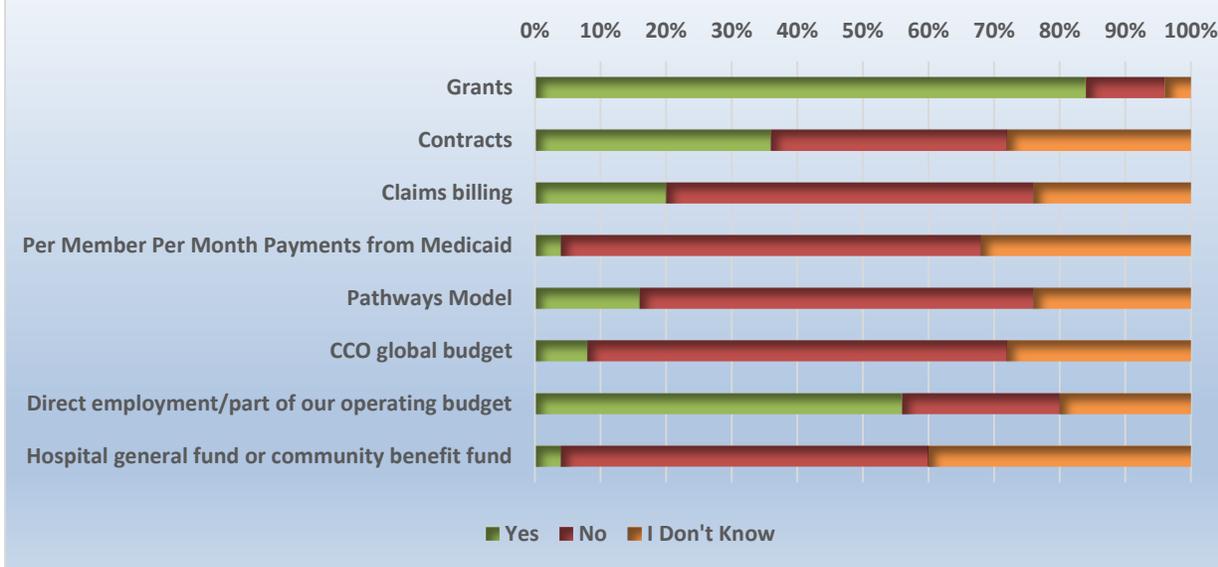
Figure 8: CHW Roles



Payment Mechanisms

Most organization pay for their CHWs with Grants (84%) followed by Direct Employment as Part of Their Operating Budget (56%). CHWs were least often paid with the CCO Global Budget (8%), Hospital General Funds or Community Benefit Funds (4%), or Per Member per Month Payments from Medicaid (4%). Of the 24 respondents only 3 stated “other”; responses can be found in Figure 9.

Figure 9: CHW Payment Mechanisms



Outcomes of CHW Interventions

CBO respondents were asked if they were tracking outcomes in CHW programs. The list of outcome indicators was derived from the CHW Common Indicators Project (Kieffer, Wiggins & Maes, 2018). The following categories were the most often selected (participants could choose more than one category): Increased Participant Access to Health and Social Services (79%), followed by Improvements in Participant Knowledge and Increased Participant Access to Basic Needs (both 63%). All participants were able to select one of the options provided on the survey. Only 13% responded “I don’t know.” A few (17%) stated “Other.” Over half of respondents (63%) stated that they plan to increase the number of CHWs within their organization in the next 12 months.

Discussion Group Findings (n=240)

A total of 240 individuals participated in one of 13 Discussion Groups held in 11 locations around the state. Almost half of these (119) participated in modified groups that took place at a THW Summit held in Lane County in January of 2018. Not all Discussion Group participants identified as Community Health Workers; some identified as supervisors and administrators, while others identified as other types of Traditional Health Workers. Therefore, the findings from the Discussion Groups should be understood as coming from a mixed group where CHWs predominated but where others were also present.

Based on our analysis of Discussion Group transcripts and notes, we identified six broad categories of findings: CHW role and job duties; training; professional development; support and supervision; CHW integration, both specifically onto team and into the health care system broadly speaking (two categories); and payment models and program evaluation (one category). Within each category, we identified barriers and challenges, and in some cases, successes and possible solutions. These findings respond to Assessment Questions 2.c. and 3.a., b., c., and d. We report those findings below.

CHW Roles and Job Duties

BARRIERS AND CHALLENGES

Despite at least 20 years of fairly intensive work to clarify and educate other health professionals about the core roles that CHWs play in communities and the health system, CHWs and supervisors who participated in our Discussion Groups still report that one of the major barriers CHWs face is lack of clarity about their roles, and the associated need to spend valuable educating others about their roles.

One reason identified for the lack of clarity about roles was inconsistent training: “Community health workers in general are sometimes an unknown classification for us ... In (our) county, this is a fairly new title/position with a lack of consistent trainings that have been available to our community.” Another reason identified was a problem that has plagued CHWs around the

world for many years: a multiplicity of titles. CHWs who participated in Discussion Groups had various titles including: home care worker, member service representative, case manager, personal support, community health representative, advocate and outreach worker. One worker commented that, because CHW job titles were so undefined, their job tasks included “everything.” Respondents commented that the variability in CHW roles made the work difficult for supervisors to understand and appreciate, especially if they had no CHW experience. Consequently, supervisors were not always prepared to orient new CHWs. Even more concerning for some participants was that the scope of responsibilities was not being tracked. CHWs pointed to a lack of understanding about CHW roles and responsibilities, job titles and education as reasons why they have to balance multiple employer expectations beyond the scope of community health worker duties.

Lack of clarity about the CHW role leads to a variety of other barriers, according to our respondents. A particularly acute challenge in the context of integration into health systems is CHWs being limited to a narrow scope of roles. Some respondents worried that they were asked to focus on a limited set of duties (e.g. system navigation or applying for insurance) that took time away from the full range of services they could be offering after forming relationships with participants. Also, concerns were expressed about the priority placed by the employer on some tasks that diverted time away from working with participants as expressed here: “It’s just like, well, you know, what’s part of our job? And we’re doing so many things, like also as part of the health department, that’s not really part of our job.”

Another participant shared a similar concern about the pressures that can result from being part of a multi-disciplinary team:

So it’s kind of like, well, we want to devote our time to our referrals, but then, we also have to do all this stuff, because we’re part of the ... team. And so, it’s just kind of like the lines and how much time do we have to dedicate to our referrals?

Although many of the job responsibilities shared by participants in the Discussion Groups (see Appendix L) are considered standard for CHWs, the list also includes many additional employer-specific expectations that result in balancing dilemmas for CHWs.

Even though awareness is growing about the influence of social conditions on health, this aspect of the CHW role is still difficult for some to understand. One participant reflected on the broad definition of health that is inherent in the CHW model:

That’s the thing about community health worker; that’s the title, but it’s not just health. Most of our community health workers in our community are actually in housing, so they are not even in healthcare. There’s, like, three of us that are in healthcare.

The lack of understanding about CHW roles resulted in one additional challenge. A recurring theme in the Discussion Groups was the constant responsibility (and associated stress) of CHWs to educate others about their role and scope. “When I first started working,” commented one participant, “I had to educate medical staff about the CHW scope of practice.” Sometimes

CHWs are mistaken for other health care workers: “I have to explain to the medical team about what I do each time I go in with a client. [I am] taken as an interpreter most of the time.” Often, CHWs find themselves educating their supervisors:

It’s not [that] our supervisors are bad, you know, but they don’t know what a community health worker is ... when the new wave of supervisors started in, I had to sit with the supervisor and explain to her what I did. She had no idea what I did.

The need to educate others sometimes even includes educating about the true meaning of health. “I feel like we’re constantly trying to educate the hospital system that health is more than just physical and mental health,” stated one Discussion Group participant.

SUCSESSES AND POSSIBLE SOLUTIONS

No specific successes were identified in this category.

One suggestion from a participant to address problems arising from non-standardization was to have the Oregon Health Authority formally recognize CHWs as a vocation and create an apprenticeship program: “[We] can be licensed and... recognized and everybody has one job description, instead of every little organization doing their thing.” Another participant mentioned doing presentations for health system partners about the CHW role: “I have done several presentations to the health care system to educate them [about] the roles of CHWs and the community I’m working with.”

While more will be said about this in the Recommendations Section of this report, it is important to note here that the Traditional Health Worker Commission Scope of Practice Subcommittee developed scopes of practice for all five THW worker types, which were subsequently approved by the THW Commission and are available on the THW website. The comments in this section of the report speak to the importance of continuing to disseminate key documents such as the CHW Core Consensus Report (Rosenthal, Rush & Allen, 2016), which identifies the ten core roles of CHWs, along with documents produced in Oregon such as the THW Scopes of Practice. Often, the true barrier is not an absolute lack of clarity about roles, but rather, a lack of clarity about the fact that the roles have, in fact, been defined.

Training and Education

BARRIERS AND CHALLENGES

The lack of a systematic approach to CHW training around the state was evident in the comments and reflections of our respondents. Barriers and challenges regarding training started with an absolute lack of training for some CHWs. In the words of one respondent:

And when we came on, we didn’t really have training. We had some, like, “here was how you do a home visit,” but no actual “here’s how to navigate resources. Here is how to you know talk to families.” We more likely took a community health worker

class, and that's how we learned how to do that. But [we] then just figured it out on our own.

Faced with a lack of training, this CHW and the CHW's colleagues were left to figure things out for themselves.

Another commonly-mentioned barrier was the combination of the cost of training, and the lack of organizational budgets to pay for training. This problem is particularly acute when workers must travel to attend training. According to respondents, some programs have limited budgets for continuing education, whereas other programs have built-in budgets for professional development. Differences from program to program, depending on the region and funding source, result in inconsistencies in what workers receive. One respondent commented on the combined impact of cost and distance on the availability of training:

Typically ... [I'm not able to attend trainings] because, like I said, with such a large staff, you know, sending people out of town is really expensive. And so it seems as though most trainings happen up in the Portland metro area. Even then, although better, it's expensive.

Respondents pointed to the importance of educating employers about the need for continuing education budget for CHWs for both professional development and to better serve participants.

As the quotation above suggests, there was a common perception among respondents that training is readily available in the Portland Metro area, but respondents in rural Oregon reported an inability to travel great distances to attend trainings, and they noted the difficulties of taking time off work. CHWs in rural areas of Oregon found far fewer opportunities for trainings than those who lived near urban areas and talked about feeling forgotten in terms of trainings. In the words of one respondent from a rural area:

I think if it's located within Jackson County, it's totally doable. But some things up in Eugene or even Rosenberg like, you know, we're probably not going to be given the whole day off to go to these trainings because, you know, it's going to take the whole day to go to the training, [and] come back. So if it's within Jackson County, it's fine, but if it's farther, if it's more of a statewide thing, then it's usually you don't get to do it.

Participants from rural areas expressed a clear desire for more training in their regions, given the barriers to traveling to obtain training.

Respondents also commented on a lack of information about available trainings, and confusion about what training might be most helpful. They expressed frustration over not being informed of potential training opportunities. Additional obstacles were tied to not knowing what was available and what skills would be needed to serve clients with diverse needs. According to one respondent, "It's tough to know what skills will be needed as I see different community members for different reasons with different complexities."

Other barriers to obtaining needed training included lack of time (conflicts between time dedicated to training and time dedicated to accomplishing work tasks), and employment status (with salaried workers generally having more access to training than hourly employees.) In terms of modality and venue, although some participants suggested on-line training options to improve access for training in rural areas, others considered this option undesirable because “online can be detached.” There was greater support for offering trainings in local settings with a focus on the local population being served.

In sum, availability of and access to training opportunities was dependent on a variety of factors: employment setting; proximity to urban areas; employment status; and integration of CHWs into the setting.

SUCSESSES AND POSSIBLE SOLUTIONS

Popular/people’s education was mentioned by respondents as an effective training methodology; this finding echoes the finding in the THW Survey (see the Word Cloud on p. 22) and is in line with identified best practices in CHW training (Wiggins, Kaan, et al., 2014).

A clear solution to some of the barriers mentioned was offering more training in locations throughout the state. As one respondent stated: “... if we could get more (trainings) around like Medford, Lakeview, if people wanted to come to Klamath that would be amazing because I think too often we are forgotten.” Identifying another best practice in CHW training, namely, adapting content to local needs, participants also suggested offering trainings that were specific to local areas: “(With) the population that we serve, I think that’s more what I come across is some of the trainings that are offered don’t necessary go across Oregon on a general enough (level) to actually work for a population.”

Participants provided an extensive list of desired training topics; see Appendix M for that list. In addition to health and skill topics, participants also expressed a desire for training on topics that would help them advance in their careers, specifically: certification, project management, facilitation and teaching skills, grant writing, data collection and analysis, policy development, advocacy (creating systemic change), and report writing. Finally, several participants expressed a desire to see defined career ladders for CHWs (both inside and outside the organizations where they worked) so that they would be able to see which paths were available and assess what type of professional development would help them progress along those paths.

Professional Development

BARRIERS AND CHALLENGES

The lack of clear career paths mentioned above was also a major barrier to professional advancement for our respondents. Many workers we spoke with did not have a clear vision of a career pathway as a Community Health Worker. Respondents had a clear understanding of their job duties and their roles within their organizations, but few people felt supported with a

career ladder which would help them develop professionally or take on increased responsibility. Even though workers would have liked more opportunities to advance, positions with greater responsibilities were not accessible and resulted in CHWs remaining in the same positions for 10 to 24 years. One respondent eloquently articulated the results of the lack of a career ladder:

There are no real steps for workers to take into more responsible jobs. We have workers that have been [CHWs] for 24, 20 and ten years ... Everyone does the same work and can expand a bit on doing some more medical-based work when they have their CNA. We would likely have more opportunity if we had levels to jobs.

This respondent feels that a tiered system could promote CHW career advancement; tiered systems will be discussed further below. Yet a barrier to the creation of tiered systems is the general instability of CHW programs, which results from the lack of dependable funding mechanisms. Many respondents indicated that high turnover rates (caused by the instability of grant funding) made tiered systems for professional development unlikely. Therefore, some workers believed that moving into different community-based programs with better reimbursement and stability could help their careers.

Another clear barrier to advancement was the need to obtain more formal education in order to move up. The CHW profession, unlike other professions, recognizes that the knowledge gained through life experience can be just as valuable as, and in some cases more valuable than, the knowledge gained through formal education. However, workers with a career history in community health work reported an inability to take on supervisory roles due to lack of formal education and felt undervalued by their organizations for their work experience. Many workers noted that promotional opportunities frequently require degrees for consideration.

A final barrier to professional development mentioned by many respondents was problems with the certification process. Workers reported experiencing extreme delays when renewing their existing certifications, and great difficulty navigating the processes of the THW Commission. This delay in processing also affected some employers. Respondents indicated that the Commission website isn't user-friendly; many workers reportedly had to contact the Commission directly for help. In communities of color in rural Oregon, program managers described several factors that made workers reluctant to continue with the process, such as: immigration issues, lack of documentation, and required criminal background checks.

SUCSESSES AND POSSIBLE SOLUTIONS

As mentioned above, one solution that appears to have worked well in some regions to promote CHW professional development is a tiered classification system for CHWs. Some programs have developed a tiered system of health workers in which established core values and job experience fosters upward mobility and increased pay. Participants from one organization described the three tiers of their model for CHWs as: 1) basic community health worker, 2) certified community health worker, and 3) lead community health worker. Advancement beyond the three tiers would require additional education and/or licensure.

Once again echoing the voices of CHWs going back to at least the 1990s, CHWs who participated in our discussion groups expressed a desire for options for professional advancement that are not dependent on obtaining degrees or further formal education.

Support and Supervision

BARRIERS AND CHALLENGES

Recalling the respondent quoted above who expressed an absolute lack of training options, some respondents identified the first barrier to effective supervision as an absolute lack of supervision. A great many participants said they did not have supervisors. “I’m not supervised ... as a community health worker,” stated one respondent. “We have no access to any community health worker supervision in this area.”

Even for those who do have supervisors, supervision is often spotty. Discussion group participants reported that their supervisory check-ins were frequently unscheduled, inconsistent and dependent on the availability of the supervisor.

So, with our supervisor, we don’t have, like, set dates that we meet with her. She kind of [says] whenever you can grab her in the clinic, she’ll, like, pull you and say let’s discuss this. But it’s literally, you have to go look for her. We don’t have anything set to meet with her, no. At least, not our clinic that I know about.

Another respondent described a similar experience of having to find the supervisor first in order to get support: “... whenever we’re in need of immediate supervision or a question, support, mainly support, I think is the big thing, it’s like you have to hunt them down.”

Some respondents did report having regular supervision sessions. However, the quality of supervision was a concern for participants who felt that they didn’t have enough time (or any time) with a supervisor to explore career paths or do goal setting for professional development. One respondent spoke to how discussions about professional development can get crowded out by other, more urgent topics:

...our supervisor we meet with weekly, which I definitely find beneficial, because it kind of helps us if we’re, like, stuck on something. But also, I feel like we’re just kind of touching the baseline, because she wants us to kind of do a lot ... and not really getting into depth... I mean, she wants us to, like, do other training stuff, but we don’t get to that point because we’re just so ... there’s so many other areas ...

Lack of supervision, lack of regular supervision, and lack of time for professional development during supervision were common threads running through the discussion groups. Workers cited changes in grant funding and programmatic changes as the most common reasons for lack of supervision.

A related problem, and again, one which has often been expressed by CHWs throughout the world and over time, are supervisors who don't understand the CHW role. Workers stated that they experienced lower levels of job satisfaction when their supervisors did not understand the CHW role and this was often the case when they were supervised by a non-community health worker. One participant articulated the connection between understanding the CHW role and understanding the role of CHW supervisor:

Our boss is not a community health worker, and I think it's kind of the same with not knowing the scope of practice ... it's kind of difficult because you know there's no real, scope of practice or ... she doesn't quite understand her job.

Lack of understanding on the part of supervisors about the CHW role and the settings in which CHWs work can lead to questions about their efficiency and effectiveness, as this respondent stated:

I just agree with what everyone has been saying about it'd be helpful to have a supervisor who knows the kind of work that we do so they understand why we do it. Because I think that's the hardest thing. It's like okay, well they've gone to the home visit but why did it take them three hours? You know. I mean I've gone. We've rode the bus with a patient downtown and it takes half a day you know and it could be a simple [thing] just to turn in an application but they might be from another city and ... don't speak English.

Similarly, when supervisors don't understand CHWs' scope of practice, they may not permit CHWs to attend community networking events, communities of practice or ongoing training. Many discussion group participants recognized that networking was necessary to supplement lack of training or to obtain resources to serve their respective communities, but expressed they were unable to participate in professional networking to build these connections.

A problem that is becoming more common as CHWs are integrated into health services are supervisors who do not understand the basic premises and values of public or community health. Another respondent identified this problem:

[My supervisor] doesn't do community work or any of that so there is always this constant, almost like having to re-convince her, like, this is why we need to be out in the community. It's a community health worker so, yeah. So supervision is definitely a challenge.

As more CHWs are integrated into health services, there is a danger of losing the "community" in "Community Health Worker." Additional barriers noted by respondents were supervisors who don't know the community and wide variation in supervision styles and accessibility, even within the same organization.

Respondents identified several unfortunate results of ineffective or inconsistent supervision. One result is isolation. One respondent described the situation this way:

But I think most people's experience is that they are pretty isolated. They are learning about things on the fly. How you access those [inaudible] is often trial and error and it doesn't help our clients because a lot of times [it's] the blind leading the blind sometimes ... So I think that having more trainings and maybe even having ... regional supervision available would be really helpful.

Common barriers to effective support and supervision for CHWs included lack of supervision, supervisors who don't understand the CHW role, and supervisors who don't understand community health.

SUCSESSES AND POSSIBLE SOLUTIONS

Not surprisingly, many of the successes and possible solutions identified by respondents were the inverse of the barriers and challenges mentioned. Workers expressed that they were most supported when their supervisor was either trained as a community health worker, or trained to supervise community health workers. Some CHWs said they had regularly scheduled weekly and/or monthly meetings where they could dependably receive feedback, support and resource updates. One respondent spoke about having a supervisor who was accessible even if scheduled supervision was not regular:

... as for like one on ones, we don't have a schedule, but it feels like if I ever need to, we can schedule one a week. So it's based on my need. If I feel like I need one, like weekly, or monthly, it's available. It just has to be within the week of when I initiate it.

Another success related to supervision was a good orientation and onboarding process. A supervisor/lead talked about an onboarding process for new CHWs at her organization that started with daily meetings, progressed to monthly meetings, and incorporated expectations, training and shadowing in addition to daily "huddles" (check-ins):

I work with our community health workers when they first get hired on. They are on 90-day probation, and then extended past that 90 days' probation, depending on the need. And what I've done is really try to address what the core competencies are that we've set up for our community health workers, train them not only in the field, but also with skills that they can apply with their patients. I check in with them quite frequently. They will be shadowing me with patients, and then they get to do their own patients and they have me there. Then, I do monthly check-in's, but because we are in the same office, I'm able to check in with them daily and then it goes monthly, and then at the 90-day mark. We can move it too if they need more assistance from me. But they know that I'm always here to help guide them. We do a lot of problem-solving together. We have morning huddles where we're able to address any concerns.

This quotation speaks clearly to the value of proximity, accessibility, a clear but flexible system, and effective on the job training.

Possible solutions obviously include more time for CHW supervision. Workers described their ideal supervisor as having time to focus on work-related issues, but also having time

to set goals and promote professional development. While not ideal, workers with a lack of supervisor support for professional development, goal setting, or job related issues sought out peer supports or other networking opportunities to fill the void left by a lack of direct supervision. As one respondent stated:

I get support from my peers and collaboration from the people that I know and that's about as good as it is. We have a medical clinic as part of our school district and we have [a] physician's assistant that works there so I can collaborate with her if there's an issue in my job that I have a difficult time solving on my own. But that's not supervision. That's again collaboration and networking.

In the absence of effective supervision, peer support can be crucial.

Historically, many of the most effective CHW programs have based supervision on the matrix model used in the field of social work. In this model, CHWs receive task supervision from an on-site supervisor, and clinical supervision from an appropriate clinician. In the ideal scenario, both task and clinical supervisor offer reflective and trauma-informed supervision. Respondents spoke to two versions of this model, one more intentional and one less intentional. In the more intentional model, a contract for reflective supervision helps to meet the needs of a program covering a broad service area:

We have a contract for ... reflective supervision, and I think that's due to [the fact that] our home visiting program serves eleven county service areas ... so we're all completely spread out within those eleven counties, which makes supervision kind of difficult.

In the less intentional model, other staff provide support when the supervisor is not physically available:

I think we also have it set up where [the supervisor has] also reached out to other staff to be there to provide support for us too. So she may not be available, but ... we have a behaviorist in our clinic and she has her meet with us once a month, and she sees patients, so she's kind of familiar with the work that we do with the patients. So she's also been available for support. So even though we don't have the [actual] supervisor, I feel that she could provide somebody ... for support if we were to need it.

Respondents described the ideal supervisor as supportive and possessing a deep understanding of the CHW role and scope of practice. The most appreciated supervisors had direct CHW experience. Participants wanted to have scheduled check-ins with their supervisors with enough time to cover urgent issues and updates on relevant resources, while also doing goal-setting and career planning (including discussing training opportunities). Supervisors should clearly articulate the role, duties, and expectations of the CHW while promoting integration of the CHW within the organization. Participants also expressed a preference for transparent and open communication and wanted supervisors to act as advocates for CHWs.

CHW Integration into Teams

Another category of responses dealt with CHW integration onto teams. CHW shared that their roles and integration were highly dependent on the setting. Processes to promote integration ranged from non-existent to an intentional process of on-boarding, one-on-one specialized training from team members and shadowing.

BARRIERS AND CHALLENGES

In clinical settings, a major barrier was separation from the medical team. Throughout the listening sessions, workers in clinical settings frequently reported a sense of separation from medical teams. While medical teams feel responsible for the comprehensive care of a patient, the community health workers reported receiving a single task/problem assigned at a time, which led to a general feeling of disconnection from both their teams and the patients.

Workers are located in a variety of settings and have functions that vary based on their positions. Some workers are based in office settings, and others in community based settings. Across all types of community health workers, they expressed a desire for better integration within their teams.

SUCSESSES AND POSSIBLE SOLUTIONS

Once again, respondents saw good onboarding and orientation as crucial to integration. One respondent provided this description of an intentional onboarding process:

In that first couple of months when the community health workers onboard ... the community health workers shadow the other team members ... they go the whole day with the CNA and see what that person does and they go the whole day with the nurse to see what that looks like and then the social worker as well. And included in that time, they do little mini educations. So, for example, the social worker might educate the community health worker on how to react if a client is suicidal, and they'll give that kind of specialty training.

A supervisor described how the supervisor orients new CHWs to the organizational culture:

... we talk a lot about culture, especially when I start training community health workers, I talk about culture, I (say) 'this is kind of what we expect and this is the support that you'll get' ... Making sure that we can keep that culture within the office ... so we can recognize everybody and make sure that everybody feels that our roles are valued.

Respondents also provided descriptions of well-functioning teams where CHWs were well-integrated:

We are very, very fortunate here where our team is very tight knit and trusting of each other ... since we're all in the same office ... I see the community health workers just going into the nurses' office and they chat right after an appointment or right before

an appointment. Or they'll say, 'hey, can you go with me on this home visit?' And same thing with the social workers and really same thing with the CNAs ... And then also as far as even telling the RN Case Manager like, 'hey I noticed that my patient is needing the support of the CNA to do chronic illness monitoring. Can you go ahead and add them on?' And so that's an add on. So the community health workers have a lot of say and support on what they are doing and just around the whole team."

This well-functioning team is characterized by frequent and open communication and obvious respect for the opinions and judgment of the CHWs.

CHW Integration within the Health Care System

Another category of responses dealt with CHW integration into the health care system more broadly. Participants in discussion groups identified several types of barriers to this integration, as well as promising successes and suggestions for solutions.

BARRIERS AND CHALLENGES

A key barrier – perhaps the key barrier – to broad integration of CHWs into the health care system is lack of respect for the CHW role. In the words of one respondent, “[I am] comfortable [interacting with the medical system] because I used to work in the medical system, but there's still not enough respect for the CHW's role.” This lack of respect and understanding can be expressed as irritation when CHWs contact other health care workers. Speaking about how the CHW is often met with irritation even when the CHW has the proper documentation, one respondent related this story:

Like since we work for Head Start we have a lot of releases for information so as long as we have that release of information [the relationship with the medical system is] usually good ... but ... we've had times where they just don't want to give us information. “Why isn't the client calling directly?” [they ask] even if we have a release of information. Sometimes I feel like they get a little annoyed but I mean that's part of our job as you know, because we have a release of information to kind of get that medical information from the doctor. But sometimes I do feel like they do get annoyed and like I've had MAs call us back, like, “why do you keep calling us?”

Several participants speculated that barriers they had experienced when interacting with the medical system were due to inherent differences in philosophy. That is, the hierarchical nature of the medical/health system would lead to conflicts with CHWs who were community/patient centered. Acting as advocates for marginalized communities and promoting self-advocacy and education would result in clashes as the hierarchy was perceived to be questioned. A discussion group participant spoke eloquently to the inherent conflict between the hierarchical medical system and the ethos of the CHW model, which this respondent had learned about in training:

... there's this model of a hierarchy in the medical field of doctors, nurses, CNAs, CMAs, or however that works. Whereas I feel like the training that I received it doesn't

represent that model. We work in a different [space]. Our training is not hierarchy; it's more how I see [a] patient-centered base and utilizing those resources ... I envision doing a home visit, doing a fall assessment. What's the wraparound services? Is this individual at high risk? Is there a referral going to the health coach or to the Tai Chi program for better balance? Is that loop being closed? And what does that look like? And how does that communicate? I think that's where we could improve in some of the training and organizational structure that we need to look at and how does that function in the system?

This respondent suggests that integrating CHW philosophy, as well as CHWs themselves, into the health care system could result in benefits for patients and communities.

SUCSESSES AND POSSIBLE SOLUTIONS

According to our respondents, factors associated with successful integration of CHWs into the health care system include working in teams, high quality and consistent supervision, proximity/access to other team members, sharing clients, clear job expectations, support of leadership, and creating patient care plans together. It is notable, but perhaps not surprising, how well this list of factors aligns with the research around CHW integration. Support from leadership has been mentioned in several studies as a crucial factor in promoting CHW integration (Rogers et al., 2018), as has proximity/access to other team members (Wennerstrom et al., date) and clarity about CHW roles (Payne et al., 2017).

Our respondents emphasized the importance of educating members of the health care team about the various roles within the team, along with inculcating respect for the different roles. One respondent suggested using team meetings for this education, while also providing a compelling description of the unique value CHWs bring to the medical system:

And in those [team] meetings would be a good time for education on what each other does. So I think that cross understanding of different roles and somehow at the same time teaching respect for each other. I don't know how to say it differently that ... we are really valuable in what we do and that we address different parts of this whole being that is their patient or our client or the member, and so yeah, it can seem often like, "Why are you here? You're unnecessary." When in fact we are addressing the social and emotional needs that are sometimes or often not addressed in a clinical medical [setting].

Concurring with recent research, our respondents provided a clear summary of barriers to CHW integration into the health care system, as well as suggestions for ameliorating those barriers and a compelling summary of why integration is so important.

Payment Models and Program Evaluation

Although the Discussion Group Guide (see Appendix D) did not include questions about payment models or program evaluation, this topic did arise in several groups, including one

group held in a tribal community. Main themes coming out of those discussions are reported below.

BARRIERS AND CHALLENGES

As our respondents confirmed, a significant barrier to paying for and appropriately valuing CHW activities is the fact that the State still has not established billing codes for CHW practice. One respondent pointed out the inconsistent policies that require CHWs in some areas to obtain provider numbers, but do not then use these numbers to reimburse for services:

And my fight is how can we get the state to embrace this? Right now the Medicaid, state Medicaid is not covering these services. They have us make sure that ya'll have your NPI, y'all have your Medicaid provider number but there's no way for us to get paid for their services because the state hasn't developed a process to accept claims ... You have your peer support. Your peer support folks the state has done that but not for this group of folks.

As this respondent emphasizes, whereas billing codes do exist (and have existed for some time) for Peer Support Specialists, this is not true for CHWs.

Respondents in tribal communities identified some particular barriers to making CHW services billable in their communities, as well as the critical importance of doing so. In the words of one administrator:

[All] of our community health folks and our tribal members here understand that sometimes they are going to talk and tell you guys [Community Health Representatives] a lot more about their health than they're going to divulge to a provider. And that is a critical need to ensure that their care is looked at. So there's got to be a way that the state can step up to the plate for tribes to get these services payable so we can sustain these community health workers.

Some background is helpful for understanding this comment. Currently, CHWs cannot bill Oregon Health Plan Open Card for their services. Only one CCO has a CHW fee-for-service billing policy and process. Even if more CCOs establish fee-for-service reimbursement for CHW services, tribal health centers may not benefit as much as other clinical settings because tribal members have the option of opting in to Open Card instead of being assigned a CCO.

As we have seen with other barriers, lack of ability to bill for CHW services creates further barriers, such as instability in CHW positions. As another respondent in a tribal community stated: "So even with the CHR [Community Health Representative] certification the services that I provide are not being payable. And being partially underneath a grant I'm very concerned about, after that grant is over, will I still have a position here?" Lack of stable funding for CHW programs results in stress for CHWs and impedes continuity of care for community members.

As will be discussed further below, CHW billing codes are not a panacea, and can produce their own series of unintended consequences. However, another negative result of not having CHW billing codes is the inability to track CHW services in claims data. Claims data is currently the primary source of quantitative information about the effectiveness of interventions, since it is possible, through statistical analysis, to study the association between these interventions and valued outcomes like reduced emergency room usage and reduced cost. One of our respondents clearly articulated the relationship between billing codes, claims data, the value accorded to CHW services, and CHW integration, in the quotation below:

So I feel like there's a large chunk of time where a lot of community health representatives were doing great things with patients, helping them lose weight, get physical, their labs were going down. But without that data in the systems to allow the medical providers to see that concrete medical evidence, it slowed down that integration piece of having the medical providers buy-in because if they would have known they would have saw the data and found more value in those services.

As this respondent states, if other health professionals can see clear, quantitative evidence of the effectiveness of CHW services, they are more likely to value CHWs and want to integrate them onto their teams. Having billing codes can contribute to this positive chain reaction.

SUCSESSES AND POSSIBLE SOLUTIONS

From our data, we identified several promising developments and possible solutions to the dilemma of lack of appropriate and workable payment models for CHW services. First among those was a desire among administrators to make the services payable, which indicates that the services are valued. One administrator who participated in a Discussion Group clearly articulated this value:

The goal really is to work with that medical team, be part of that medical team ... with the community health workers being part of that community connection to help our patients in our community. And my perspective is I'm frustrated and struggling with how can we get these wonderful services payable so that we can continue to provide this great service for our community members.

This administrator values CHW services and wants to be able to make them available to a wider range of community members.

Another positive development was the fact that one CCO (Eastern Oregon CCO) has developed a system to reimburse for CHW services. Respondents with access to this system lauded it and expressed their desire that it be extended to the entire state. An administrator from a tribal community described how the system works:

I don't see anything to do with a grant as far as billing. I'm totally billing ... Eastern Oregon CCO right now is the only one that we are able to bill for any of their [CHRs'] services but there's a very structured process to have in place before we're even able

to bill and that's where the coders come [in]. They have to make sure that it was in the provider's medical plan for that community health worker to do this task ... And if it's not in there then we can't bill for their service ... What we're kind of struggling with is how can we make sure that the state embraces us? This is just our coordinated care organization ... that follows any kind of a billing structure for this wonderful group.

A structured process developed by one CCO allows CHW programs in that region to bill for CHW services. This process could serve as a model in other regions. An additional success that bears mention is that, although its promise has not yet been realized, CHW certification in Oregon did at least set the stage for reimbursement of CHW services.

Discussion

Summary and Discussion of Findings

Summary of Registry Findings

Data extracted from the THW Registry reveal an unacceptably high ratio of community members to certified CHWs in both urban and rural areas around the state. An apparent over-representation of certified CHWs in some racial/ethnic communities must be understood in the context of the historic role of CHWs addressing persistent inequities in marginalized communities. An underrepresentation in other communities of color (notably the Asian community) needs to be addressed.

Summary of CHW Survey Findings

Findings from the CHW Survey need to be understood as coming from a sample that is not representative of CHWs generally in terms of level of formal education, income, and racial/ethnic composition. Taking that into account, a majority of respondents reported not having a waiting list and never turning away clients. A majority also reported being able to provide culturally and linguistically appropriate services; barriers included lack of commitment from dominant culture systems and characteristics of the workforce, i.e. a lack of CHWs who share the language and culture of those they serve. Respondents identified a variety of health related and other benefits associated with culturally specific services.

A majority of respondents felt their skills were being appropriately utilized; however, responses were contingent on the definition of appropriate utilization provided in the survey, and indicated a lack of clarity among the respondents about the CHW scope of practice. Three quarters of respondents reported having adequate training opportunities; most commonly mentioned barriers to training were lack of time and lack of funding. Particular topics, like mental health and grant writing, were mentioned as most needed, while others topics, including trauma, MI, and popular education, were mentioned as most appreciated.

Summary of CBO Employer Survey Findings

Twenty-five respondents representing 24 community-based organizations provided information about the 117 CHWs employed by their organizations. The number of CHWs employed ranged from 1 to 18, with an average being 4. Less than half require OHA certification and most do not require any formal education. Almost half of CHWs were paid between \$15.00 and \$17.99 per hour (\$31,200 - \$37,419/year); none were paid more than \$20.99 per hour. Not surprisingly, the proxy sample of CHWs employed in community based organizations created by employer responses to the survey has less formal education and lower pay than participants in the CHW survey, on average.

It is difficult to directly compare populations served to populations employed, since the question about populations served allowed respondent to choose all that applied, while the question about populations employed allowed for only one response choice. However, it is possible to see that all communities of color (with the possible exceptions of Latinx) are underrepresented among those employed. The relatively small percentages of respondents identifying a need for more multi-cultural representation among CHWs should be interpreted with care, since this could reflect the beliefs and experience of the respondents, rather than the beliefs and experience of the communities they serve.

As would be expected among a sample of CBO employers, the most common settings where CHWs always worked were the CBO and the community. The fact that 41% never work in hospitals indicates an opportunity for further collaboration between health systems and CBOs. Sixty-nine percent of CHWs in these CBOs were engaged in initiatives to reduce health inequities. The fact that 98% of CHWs at these organizations are involved in advocacy is encouraging, as is the fact that CHWs are playing a wide range of the C3 core roles.

It is discouraging but not surprising to see that grants are still the most common funding source for CHWs programs; on the other hand, it is encouraging the note that 56% of respondents stated that salaries for CHWs were part of their operating budget. The small percentage of organizations accessing hospital or community benefit funds, per member per month payments, and Medicaid indicate fertile ground for improvement. Substantial percentages of respondents (from 14% to 90%) were tracking the outcome indicators recommended by the CHW Common Indicators Project.

Summary of Discussion Group Findings

Participants in our Discussion Groups made important observations across a range of topics. Regarding CHW roles and scope, respondents stated that lack of clarity about roles led to CHWs being limited to a narrow range of roles and needing to take on tasks (including educating others about their roles) that diverted them from their primary roles.

Respondent identified a variety of problems with the current system for CHW training, most of which related to the lack of a comprehensive and well-planned training infrastructure throughout the state. Lack of time and variable access depending on employment status also

impede CHW training. Respondents recommended greater use of popular/people’s education methodology and provision of locally-focused training in local areas.

Barriers to effective CHW supervision ranged from an absolute lack of supervision, to lack of consistent and thorough supervision, to supervisors who don’t understand the CHW model or even, in some cases, a public or community health approach. Solutions mentioned included good orientation and onboarding and regular supervision provided by supervisors who understand the role, either because they have been CHWs themselves or because they have carefully studied the CHW model.

CHW integration into teams and into the health care system is currently impeded by separation of CHWs from the rest of the medical team, lack of access to the EHR, lack of respect for the CHW role, and paradigm conflict between the hierarchical, individually-focused medical system and the egalitarian, collectivist focus of the CHW profession. Possible solutions include focusing more attention on orientation and on-boarding, team functioning, and roles of all team members, including CHWs.

The lack of a set of CHW billing codes approved by the state contributes to the instability of CHW positions as well as the inability to include CHWs in studies that rely on claims data to assess the effectiveness of health care reform strategies. Positive developments include a desire among administrators to be able to bill for CHW services, and a possible model (with limitations) provided by a system for billing put in place by one Oregon CCO.

A Few Words About Payment Models

When assessing the relative importance of establishing billing codes for CHW services, it is important to identify and carefully consider the possible consequences of such an action, so that negative consequences can be avoided. Even if CHWs could bill for their services, CHW claims data would have major limitations. Because there are very few CPT and HCPCS billing codes which overlap with the CHW scope of practice, CHW claims data will provide an incomplete picture of the CHW scope of practice. In turn, claims data could distort CHWs’ true ability to improve health and address social determinants of health among participants.

There is also considerable debate within the CHW profession and among its proponents as to the risks and benefits of implementing billing for CHW services. Among CHWs themselves there is growing concern that billing will increase the pressure, already noted above, to limit CHWs to a narrow range of roles. Whether or not CHWs employed by CBOs (which often do not have the organizational infrastructure for medical billing) would benefit from the ability to bill is another concern among CHWs.

On the other hand, claims data is still the “language” often preferred by payers. Payers are key stakeholders in the health care system who could have considerable influence over decisions about whether or not to integrate CHWs and/or reimburse for CHW services in a particular

health system. Additionally, if CHWs can lay claim to reimbursable billing codes, this could further legitimize the profession and strengthen efforts to integrate CHWs into health systems.

Because CHWs add value to health care (consider CHWs' contributions to the six domains of *health care quality* as defined by the Institute of Medicine), a value-based payment structure specifically for CHW services could serve the profession well. Ideally this would be a tiered per-member-per-month (PMPM) payment triggered by a provider (or a variety of clinical staff such as LCSWs, RNs, etc.) entering social determinant of health diagnosis code(s) and a referral to a CHW. This PMPM would be used solely for CHW programs/employment or contracting.

It is not feasible or prudent to create new billing codes for CHWs solely so that they can better fit into the fee-for-service payment structure. Billing codes for CHWs should only be considered useful insofar as they can be extrapolated to inform the development of appropriate fee schedules for CHW services. These hypothetical CHW fee schedules should be taken into consideration when developing a value-based payment structure specifically for CHWs (i.e. determining the appropriate dollar amount for a PMPM payment dedicated to CHW employment, programs, or contracting).

Cross-Cutting Findings

Several themes stood out prominently across all data sources. The high ratio of community members to CHWs in both urban and rural communities and among multiple racial/ethnic groups indicates a need to continue to increase CHW representation in all communities affected by health inequities. We can substantiate need in the Asian community, but that does not mean this is the only community that is underrepresented among CHWs. Further data collection may allow us to substantiate need in other racial/ethnic communities, as well as in the LGBTQ2I community and the disability community, among others.

Education for all – including CHWs and supervisors -- about the CHW model, role and scope continues to be a high priority, especially as it promotes other desirable objectives such as CHW integration into the health system. Promotion of experienced CHWs into supervisory positions and better on-boarding and orientation will likely produce better functioning teams and better health outcomes.

A coordinated, statewide infrastructure for CHW training that implements best practices can do much to assuage the need for training that is both specific to and located in rural areas of the state. One best practice that came up time and again in our findings is popular/people's education. More training on mental health, trauma-informed care, motivational interviewing, communication, grant-writing and popular/people's education (as a topic) is also a high priority.

Our study identified a pressing need to continue to diversify funding mechanisms for CHW programs beyond grants. Clear guidance from the state, accompanied by specific CHW billing codes, can help achieve this goal. The fact that many CHWs based at CBOs never work at hospitals indicates a possible source of partnership and funding.

Finally, there is an on-going need to spread the CHW paradigm, which is non-hierarchical, community-focused and appreciative of life experience, throughout health systems and dominant culture systems generally. Doing so may further another important objective: increasing commitment to culturally and linguistically appropriate services among dominant culture institutions and systems.

Limitations of the Assessment

General Limitations

This assessment suffered from some general limitations, as well as limitations specific to each data collection method. In terms of general limitations, during the course of this assessment, ORCHWA was growing rapidly from a two-person organization to a team of ten. Staff transitions meant that the assessment started before the Workforce Development Director and the Data and Evaluation Manager were hired. As a result, changes that a researcher would have made to the tools were not made. A variety of standards that would have been followed by a researcher (such as careful collection of demographic data for the Discussion Group participants) were not followed. Further, once ORCHWA did obtain a Data and Evaluation Manager, that individual left within six months of being hired, meaning that the primary researcher responsible for most of the qualitative analysis was not the same researcher who completed and wrote up the results. All these transitions led to a lack of continuity and lack of attention to standards of scientific integrity.

CHW Survey Limitations

Regarding the CHW Survey, respondents shared anecdotally that the survey was too long and too personal. They also expressed fatigue with being asked to complete surveys generally. They recommended that surveys should be shorter, accompanied by incentives, and disseminated regularly so as to create a long-term picture. Additional limitations of the survey were that it was not readily available in languages besides English.

From the perspective of effective survey design, some of the survey questions were double-barreled and some were ambiguous, indicating faulty survey construction. Ambiguous questions resulted in ambiguous answers. It would have been helpful to define what was meant by “culturally and linguistically specific services,” both to raise awareness about the meaning of the concept and to obtain more actionable data. The survey suffered from a high level of selection bias, skewing the results toward CHWs with more formal education and higher salaries.

It bears noting, here, that to quantitatively answer the question about the demographic composition of the CHW workforce would demand a serious and on-going infrastructure investment that is far beyond the scope of this needs assessment. Using quantitative methods is certainly not the only way to answer this question, and perhaps not the best way to answer

this question, given the inherent limitations of a quantitative approach to a very complex social/ecological field. More appropriate approaches include asking CHWs and others to talk about their experiences and observations about unmet needs for more CHWs with particular identities, backgrounds, and community connections (through survey and open-ended questioning).

Employer Survey Limitations

According to staff at the Center for Health Systems Effectiveness, they did not reach out to every organization in Oregon that employed CHWs; they only reached out to the organizations that they were aware of, meaning that survey results cannot be generalized to all community-based CHW programs in Oregon. Newer organizations or those that are only recently integrating CHWs may be under-represented in this survey.

Discussion Group Limitations

As mentioned above, limitations of the Discussion Groups included the fact that demographic information was not collected, making it impossible to characterize Discussion Group participants, or to assess their degree of similarity or difference from participants in the CHW Survey and the sample of CHWs gathered by proxy in the Employer Survey. Some limitations that plagued the CHW survey (e.g. ambiguous wording, question order, etc.) also affected questions in the Discussion Group Guide.

Strengths of the assessment included careful attention to using the assessment to build and maintain relationships with CHWs and other Traditional Health Workers around the state; the partnership with the Center for Health Systems Effectiveness, which allowed this data to be collected and analyzed according to high standards; a developmental evaluation approach which allowed for changes in the methodology as the situation on the ground changed; and flexibility from the staff in the Office of Equity and Inclusion, who provided additional time for production of a high quality report.

Recommendations

Based on the findings outlined above, we have identified 32 recommendations divided into seven categories. If acted on, these recommendations will allow CHWs to make an optimum contribution to improving health and decreasing inequities around the state of Oregon, while also providing living wage jobs with opportunities for advancement in some of Oregon's most marginalized communities. Relevant citations from the CHW literature that provide substantiation for each recommendation are provided in parentheses after the recommendation.

CHW Roles and Scope of Practice

1. To address current confusion about roles, the State should disseminate widely respected, experience- and research-based statements about core roles and scope of practice of CHWs, including those contained in the 1998 National Community Health

Advisor Study, the 2009 American Public Health Association definition, the 2015 CHW Core Consensus Report, and the Scope of Practice for CHWs formulated and approved by the Oregon THW Commission.

2. The State should encourage (and in appropriate cases mandate) programs to use these respected formulations of CHW roles as the basis for position descriptions.
3. In order to preserve the integrity of the CHW model, achieve the promise of CHW programs and allow CHWs to have maximum impact on addressing the underlying social and structural causes of health inequities, the State should support CHWs to play a full range of roles, including roles as advocates and community organizers. (Damio et al., 2018; Islam et al., 2015; Johnson et al., 2012).

Training and Education

4. In response to the current piecemeal nature of CHW training around the state, the State and CCOs should support the development of a coordinated training system to equitably serve CHWs around the state. The system should build capacity in local communities and incorporate best practices in CHW training (e.g. popular/people's education, experienced CHWs as curriculum developers and facilitators, skill-based as well as content-focused training, and preparation to play a full range of roles). It should offer a combination of in-person and online modalities. The system should offer both cross-cultural and culturally-specific training opportunities, including training that is provided in and specific to the rural context, and that incorporates local knowledge and expertise.
5. The coordinated approach to training outlined above should also make room for a range of training providers (e.g. community-based providers, community-based organizations, community colleges, and universities) to bring their unique skills to the table, while discouraging duplication and competition.
6. The coordinated system outlined above should also place emphasis on identifying and training individuals with existing connections to communities most affected by inequities and ideally, those already serving those communities, with or without pay.
7. The coordinated training system should emphasize the importance of training individuals who possess the requisite qualities for CHWs, including community membership, as outlined in the Roles and Competencies Chapter of the 1998 National Community Health Advisor Study.
8. The THW Commission should actively support the development of advanced training options to promote CHWs professional development. In line with specialization opportunities offered by employers (see Recommendation 24 below), these options might include:
 - a. Early Childhood Specialist/Community Education Worker
 - b. Clinical Specialist
 - c. Specialists in Various Populations, e.g. people who have served in the military, people experiencing homelessness, elderly.
 - d. Community Organizing and Community Development
 - e. Violence Prevention

CHW Supervision

9. As part of the statewide system of training proposed in Recommendation 4 above, the State should make available high quality, accessible training for CHW supervisors. While it is important to provide training for non-CHWs who are currently acting as supervisors, the State should focus training opportunities on experienced CHWs who aspire to become supervisors.
10. CHW supervisor training should include a thorough orientation to the history, roles and competencies, and unique value of the CHW model, in order to assure that supervisors possess a deep understanding of the CHW model. In addition, supervisor training should help supervisors enhance their ability to communicate in a clear and transparent way, and advocate for CHWs on their team with other health professionals.
11. The State should disseminate clear guidelines about the nature and frequency of CHW supervision, assuring that it is reflective and trauma-informed. The State should encourage CHW programs, whenever possible, to offer both task and clinical supervision. Supervisory sessions should be long enough to accommodate both problem-solving around immediate issues, as well as goal-setting and professional development.
12. The State should educate program administrators and supervisors about the value and necessity for CHWs of participation in professional networking so that they will support CHWs to take advantage of opportunities provided.
13. While recognizing that this ratio will not be attainable in every workplace, the State should clearly communicate that, due to the challenging nature of CHW work and the high potential for re-traumatization, an ideal CHW to supervisor ratio is 5:1.

CHW Integration into the Health System

14. CCOs and health care systems should provide support for CHWs employed by community based organizations by contracting with employers for their services.
15. CHWs working in clinical settings should be recognized as full members of the clinical team and supported to play a full range of roles.
16. In order to facilitate effective integration, the State and CCOs should formulate and facilitate a variety of on-going opportunities to educate other health professionals about the history, roles and competencies, and unique contributions of CHWs (Payne et al., 2017). These educational sessions should also include education about the population-based, public health paradigm that guides CHW work (Rogers et al., 2018).
17. CCOs and health systems should provide CHWs involved in clinical settings with access to the medical record, allowing them to both read and contribute to care plans (Wennerstrom, et al., 2015).
18. The State should provide clear expectations and guidance about preparation of other staff for CHWs' arrival on teams, and orientation and on-boarding for CHW staff once they arrive on the team.

Funding and Payment Models

19. The State should provide clear guidance about a range of ways to pay for CHW services. This should include approval of a robust list of billing codes for CHWs, both to allow fee

for service billing when appropriate, and also to serve as a basis for calculating the value of CHW services within value-based models. The guidance should emphasize capitated and Alternative Payment Model (APM) options, as those most likely to support CHWs to play a wide range of roles (Damio et al., 2018; Islam et al., 2015).

20. The State should provide contracts and grants to community based organizations to support development of CHW programs that cannot be supported through health system reimbursement.
21. The State should encourage CHW programs to include funding for on-going CHW training and professional development, including costs of traveling to attend training and professional conferences.
22. The State should mandate an equitable level of compensation and benefits for CHWs in state-supported programs. Salaries should be commensurate with the complex, self-directed nature of CHW practice (not with the level of formal education required for the position.)

Professional Development

23. As one method of promoting CHWs' professional development, the State should encourage public institutions of higher education to work with community-based training providers to allow them to confer academic credit on trainees at reduced rates.
24. The State should encourage CHW programs to develop both internal and external career ladders that allow CHWs to achieve higher levels of pay and responsibility as they gain additional experience and expertise. Career ladders should offer options for specialization. Specialization options may include: Community Education Worker, supervision/leadership/administration, research/evaluation/performance improvement, clinical practice, training/capacitation, and community building/organizing.
25. While CHW advancement should not be dependent on obtaining formal education, CHW programs should support and encourage interested CHWs to obtain further formal education (for example, by offering flexible schedules and when possible, assistance with tuition and paid time off), as one way of increasing the diversity of the health professions workforce.
26. The State, CCOs and health care systems should partner with ORCHWA to support the development of regional CHW resource centers that could provide assistance with development of program and evaluation plans and position descriptions, recruitment and hiring, accessing appropriate training options for CHWs and supervisors, education about CHWs for other health professionals, etc.
27. The Office of Equity and Inclusion should continue to improve the CHW certification process, making the process smoother and more transparent and facilitating renewal. The Registry website should be adapted to be more user-friendly, for both CHWs and employers. Support should be provided to assist applicants to complete the background check process.

Evaluation of CHW Programs

28. The State should encourage CHW programs around the state to develop effective systems to measure the processes and outcomes of CHW practice, across all levels of

the socio-ecological model. These approaches should seek to measure the unique and specific contribution of CHWs to achieving positive health outcomes and increasing health equity (Islam et al., 2015).

29. In order to strengthen the science around CHW interventions and allow data aggregation at the state and national level, the State should encourage programs to consult the list of process and outcome indicators developed by the CHW Common Indicators Project and adapt this list for use in their programs.
30. The State should encourage CHW programs to use a community-based participatory approach to evaluation that is consistent with the principles of the CHW model and builds capacity in the marginalized communities where CHWs primarily work.
31. The State should mandate CCOs to emphasize quality over quantity in value-based payment systems, and to de-emphasize short-term, individually-focused incentive metrics in favor of longer-term, community-level metrics.

Conclusion

The Oregon Community Health Workers Association conducted a statewide needs assessment of the Community Health Worker workforce in Oregon using an emergent, mixed methods design and three primary data collection techniques. After analyzing the three data sets independently, we looked across all data sets to identify cross-cutting themes and a set of 31 resulting recommendations.

Following practice in other states like Michigan, it is our hope that this needs assessment will become a regular, annual or bi-annual occurrence. Collecting successive waves of data over time will allow Community Health Workers, their associations, the State, and Oregon communities to assess changes in the CHW workforce. Further, it will allow us to continue to improve conditions for this workforce, which is already essential to Oregon communities, and which has the potential to make an even greater contribution to improving health and reducing inequities. Emulating the commitment of CHWs themselves, we can take the long view and assure that future generations of Oregonians will live in a healthier, more equitable state.

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Appendices

Appendix A: Community Health Worker Core Consensus Project List of Ten Core Roles

Appendix B: Milestones in CHW/Promotor/a History with a Focus on Oregon

Appendix C: Discussion Group Guidelines

Appendix D: Discussion Group Guide

Appendix E: Further Information Regarding Data Collection

Appendix F: CHW Survey

Appendix G: CBO Employer Survey

Appendix H: Counties Served by Respondents to the Employer Survey

Appendix I: Calculating CHW Shortages in Oregon

Appendix J: Disaggregated Primary Racial/Ethnic Identities of Certified CHWs, 2018

Appendix K: Graphic Displays for Selected CHW Survey Results

Appendix L: Roles of CHWs in Tribal Communities

Appendix M: List of Desired Trainings