Community Health Workers: Recommendations for Bridging Healthcare Gaps in Rural America

This policy paper reviews select research findings on Community Health Worker (CHW) integration relevant to policymakers, considers challenges, and presents recommendations to incorporate the CHW model in rural communities to improve health outcomes, reduce health disparities and enhance quality of life for rural Americans.

Main Findings:

◊ CHWs serve as an evidence based practice to improve health outcomes and population health—especially for vulnerable, at-risk populations.

◊ Rural communities face numerous healthcare challenges, including: hospital closures, lack of access to healthcare services, healthcare professional shortages and lack of culturally appropriate services.

◊ CHWs help bridge healthcare gaps and challenges facing rural communities.

◊ Rural health decision and policymakers should consider the following in terms of integrating CHWs into rural healthcare: workforce development; occupational regulation; and sustainable funding.

Introduction: Who are Community Health Workers?

The American Public Health Association adopted the following definition of a Community Health Worker (CHW):

> *"A Community Health Worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."*[1]

CHWs are known by various names across the United States and the world, including: Community Health Advisor, Community Health Advocate, Community Health Representative (CHR), Health Coach, Lay Health Advocate, Lay Health Worker, Outreach Educator, Outreach Worker, Patient Navigator, Promotor(a) (peer health promoter), Peer Counselor, and Peer Leader, to name a few titles. For the purposes of this report, the paper uses the term CHW.

CHWs have the unique opportunity and ability to facilitate culturally appropriate care and services to help bridge the gap between rural Americans and the healthcare field. Rural Americans face a unique combination of factors that create disparities in healthcare. Economic factors, cultural and social differences, educational shortcomings, lack of recognition by legislators, and the isolation of living in remote areas impede rural Americans' abilities to lead normal, healthy lives.[2] In addition, rural hospital closures and medical workforce shortages in rural healthcare delivery pose a serious threat to the health of rural communities in the U.S. This policy brief calls attention to the incorporation of Community Health Workers (CHWs) as an avenue to address the medical workforce shortages in rural communities and to improve the health of rural Americans. The brief serves to provide information and evidence to the National Rural Health Association members and other policymakers to advocate on behalf of the incorporation of CHWs in rural communities as a strategy to improve population health.

Community Health Workers help address the healthcare gaps and serve as a means of improving health outcomes for underserved populations living in rural communities while reducing costs. In the 1960s, the inability of the modern Western medical model of trained physicians to serve the needs of rural and poor populations throughout the developing world became progressively more apparent. Given the obvious need for new approaches, the Barefoot Doctor concept gained attention around the world as a type of alternative health worker (such as auxiliaries and paramedics) without university-type training who complements more highly trained staff such as doctors and nurses.[3] Barefoot Doctors are farmers who received minimal basic medical and paramedical training and worked in rural villages in the People's Republic of China. Their purpose remained to bring healthcare to rural areas where urban-trained doctors would not settle.[4] During this period, the Barefoot Doctor approach served as a guiding concept for early CHW programs in numerous countries including Honduras, India, Indonesia, Tanzania, and

Venezuela; in addition, tribal communities in the U.S. began using this model in the 1960s with Community Health Representatives (CHRs).[5]

Training of Community Health Workers

Training for CHWs varies widely, including formal educational programs and on the job training.[6] Training commonly focuses on standard skills and competencies rather than achieving specific education levels.[7] Several states—Colorado, Indiana, Nebraska, Nevada, New York, Ohio, South Carolina, Texas and Washington—have training programs, some of which are connected to state certification established by state agencies.[7,8] In 2014-15, The Community Health Worker (CHW) Core Consensus (C3) Project, funded by the Amgen Foundation, the Sanofi Corporation, CHW Apprenticeship Project, and Wisconsin Department of Health Services, compiled results from a national CHW curriculum crosswalk and consensus building effort in the first year project report that offers recommendations for national consideration related to CHW core roles (scope of practice), core skills, and core qualities (skills and qualities are collectively defined as competencies).[9] The intention of the proposed roles, skills, and qualities remains to inform the range of CHW practice. The C3 recommended roles include: cultural mediation; culturally appropriate health education and information; care coordination, case management, and system navigation; coaching and social support; advocacy; capacity building; direct services; assessments; outreach; and evaluation and research.[9] The C3 recommended skills include: communication; interpersonal and relationship-building skills; service coordination and navigation; advocacy; education and facilitation; outreach; professional skills and conduct; evaluation and research; and knowledge base.[9] A few key CHW qualities, characteristics and attributes include: connection to the community (shared culture, background, socioeconomic status, language, etc.); strong; courageous; friendly; outgoing; sociable; patient; open-minded; motivated; empathetic; dedicated; respectful; honest; responsible; compassionate; persistent; creative, and resourceful.[10,11]

CHWs serve as key players in the healthcare team. Settings employing CHWs include primary care practices, hospitals, public health departments, community based organizations, and patients' homes.[8] CHWs facilitate improved care for rural patients by conducting follow-up visits in the comfort of their home for purposes of health promotion and/or research to name a few. In addition, CHWs help patients navigate the healthcare system, help identify and address access to healthcare barriers, and help provide continuity of care.

Incorporation of CHWs within the healthcare team reduces healthcare costs. The social and financial return on investment varies depending on the disease. A recent study conducted by Wilder Research in 2012 called *Social return on investment: Community Health Workers in Cancer Outreach*, showed the benefits generated by CHWs offset the investment made.[12] In the study, a CHW had the potential to generate $862,440 in benefits per year, and each person served by CHWs generates $12,509 per year in net present valued benefits.[12] Fifty-four percent of the benefits resulted from increased efficiency in the use of healthcare services, and 46 percent of benefits accrued in value of years of life not lost.[12] Several states have experienced a return on investment when adding CHWs to the healthcare team. In East Texas, two separate hospital systems reported success in employing CHWs working with Emergency Department patients. The reported savings resulted in a return on investment ranging from 3:1 to more than 15:1.[13]

Moreover, a self-insured manufacturer in Georgia and a labor union in Atlantic City reported their return on investment as high as 4.8:1 by employing CHWs to coordinate care and help manage the employees with the highest health costs in their systems.[13] The Children's Hospital of Boston Community Asthma Initiative found a reduction of 65% in ED visits and an 81% reduction in hospitalizations when utilizing CHWs. In this case, the state legislators then introduced an amendment to the Medicaid budget to establish a bundled payment for the management of high-risk pediatric asthma patients, including home visits by CHWs.[13]

In short, given the history of incorporating CHWs; their abilities, roles, skills, and characteristics; and their cost effectiveness, rural communities and rural health policymakers have an opportunity to advocate for the incorporation of CHWs—particularly in light of mounting rural healthcare challenges such as hospital closures and healthcare workforce shortages.

Rural Healthcare Workforce Shortages

The U.S. faces a maldistribution of healthcare providers; health professionals largely concentrate in urban locations in much of the nation. As of August 2014, non-metropolitan areas accounted for 60% of Primary Medical Health Professional Shortage Areas according to the Health Resources and Services Administration (HRSA) Data Warehouse.[14] Such maldistribution leaves rural populations at risk for limited access to care and subsequently, poorer health outcomes. Rural populations are increasingly aging and face significant health disparities.[15] Older parents living in rural areas characterized by chronic youth out-migration are less likely to live near to their adult children than older metro parents. Consequently, formal and informal services provided by adult children may be scarce, and rural communities face a growing need to compensate for this shortfall.[16] With the shortage of healthcare providers in rural America, there is a great need for additional primary care support.

While CHWs do not typically serve in clinical roles, CHWs serve as intermediaries to link clinical services to community based services and organizations. CHWs can help support the healthcare workforce in rural areas by increasing the community's health knowledge and self-sufficiency through outreach, community education, informal counseling, social support and advocacy.[17] Through these roles CHWs extend care beyond the clinical walls and between doctor visits, reducing gaps in access. Home visits and health education discussions serve as interventions designed to prevent chronic disease. The reduction of chronic disease in turn allows the current healthcare workforce to have more clinical availability—ultimately improving healthcare access to the community. As part of an integrated primary care team, CHWs inform healthcare providers of the community members' health concerns and the cultural relevancy of interventions by helping the providers build cultural competency and to strengthen communication skills.[18] This feedback mechanism improves efficiency in the community healthcare delivery system. Because of CHWs' roles in improving healthcare access and outcomes, strengthening healthcare teams, and enhancing quality of life for people in poor, underserved, and diverse communities, the estimated number of CHWs in the U.S. rose from 10,000 in 1998 to 120,000 in 2010.[19] Moreover, CHWs can create a health career pathway entry point for those typically underrepresented in the healthcare industry, leading to the potential increase of healthcare providers.[20]

With the increase of CHW numbers, national interest in how CHWs support the local healthcare workforce continues to grow. The federal government, private insurers, employers, researchers and community advocates have all considered the CHW role as one potential solution to the projected physician and nursing shortage and racial and ethnic disparities in health outcomes.[21] The Patient Protection and Affordable Care Act (ACA) has recognized CHWs as important members of the healthcare workforce who can help to build capacity in primary care.[22] The ACA also authorized the Centers for Disease Control and Prevention (CDC) to issue grants nationally to organizations utilizing CHWs to promote positive health behaviors and outcomes for medically underserved populations in the following ways:[22]

1) "To educate, guide, and provide outreach in a community setting regarding health problems prevalent in medically underserved communities, particularly racial and ethnic minority populations;
2) To educate and provide guidance regarding effective strategies to promote positive health behaviors and discourage risky health behaviors;
3) To educate and provide outreach regarding enrollment in health insurance including the Children's Health Insurance Program under title XXI of the Social Security Act, Medicare under title XVIII of such Act and Medicaid under title XIX of such Act;
4) To identify, educate, refer, and enroll underserved populations to appropriate healthcare agencies and community-based programs and organizations in order to increase access to quality healthcare services and to eliminate duplicative care; or
5) To educate, guide, and provide home visitation services regarding maternal health and prenatal care."

Several state programs have received funding to build the CHW workforce.[7] CHW roles vary from state to state, as does the training to become a CHW. Although CHWs are a newer, formalized addition to the healthcare workforce, there are models demonstrating how CHWs address healthcare workforce gaps.

Examples of CHWs Bridging Healthcare Workforce Gaps

The literature demonstrates the utility and impact of CHWs in a variety of rural healthcare settings, as described by in Table 1. The role that CHWs play in healthcare services includes all key roles of a CHW, including: advocacy, access, education, and care support. In some cases, such as in Medicaid managed care support in New Mexico, [23] the success of the CHW program has led to the spread of the program throughout the state, including rural and frontier areas. This model documented a significant reduction in both numbers of claims and payments after the CHW intervention. CHWs can play an important role in the transition to value and care support in rural settings with work in the community to support chronic disease management,[19,23-24] insurance enrollment[19] and prevention.[25,26] For example, a CHW program in Massachusetts helped over 200,000 uninsured people enroll in health insurance programs, while increasing access to primary care and improving quality and cost-effectiveness of care.[19] CHWs integrated into the care team at a clinic, critical access hospital or emergency department can assist with care coordination, increased access and healthcare navigation leading to reduced hospitalizations and reduced 30-day hospital readmissions.[27-30] A project in Montana via a Federal Office of

Rural Health Policy (FORHP) Frontier Community Health Care Network Coordination Grant with eleven critical access hospital pilot sites used a care transitions coordinator and CHWs in a network. The pilot sites saw a decline in hospitalizations and 30-day readmissions.[30] One of many CHW efforts in Kentucky focused on assisting emergency department patients with non-life-threatening situations to find an appropriate medical home.[30] Furthermore, CHWs can assist with overall reduction of cost in the long term care setting.[31] In Arkansas, a three-county rural demonstration in the Mississippi Delta region is focusing on Medicaid-eligible elderly and younger adults with physical disabilities with potentially unmet long term care needs. This program has produced an estimated savings of $3.5 million in Medicaid expenditures.[31] Within the home health role, CHWs can improve access to needed medications and medical equipment and increase chronic disease screenings—all leading to a valuable return on investment for dedicated funding sources, including state government.[32] Because access to specialty care in rural areas is limited, CHWs can also partake in telehealth services to receive trainings, consults or co-manage complex medical cases with specialists as part of a care team.[32] In New Mexico, CHWs are used to support both education and care support. Telehealth is used in Project ECHO to connect front-line primary clinical teams, including CHWs, with specialist care teams for training and co-management of patients in need of complex care support. Project ECHO work has been found to reduce racial and ethnic disparities in treatment outcomes to minority communities.[32]

Table 1 summarizes the use of CHWs across various state settings according to the literature. Setting and host organization examples of CHWs utilization include but are not limited to: clinics, communities (e.g., chronic disease management, insurance enrollment, prevention), hospitals (e.g., critical access hospitals, urban hospitals, emergency departments), faith-based organizations/churches, home health, long term care, oral health, public health (e.g., health departments, community health centers), schools, telehealth, tribal communities, universities and work places (e.g., farms).

Table 1: Literature Review of CHW Programs and Projects in Rural Areas

Setting	Key Role	State	Outcomes and Key Findings
Clinic	Advocacy, Access, Education, Care Support	Oregon[27]	Oregon law regarding community care organizations (CCOs) calls for use of "non-traditional health workers" (e.g., CHWs). Includes working with clinical health navigator and Registered Nurse Care Coordinator.
Community – Chronic Disease Management	Education	Texas [24]	Increased children's asthma knowledge, asthma self-management and metered dose inhaler technique in rural area via lay health educator-delivered classes.
	Advocacy, Access, Education, Care Support	Mississippi[19]	Project in the Mississippi Delta region by state employees addressing community-clinical linkages. Formalized commitments with clinical sites. Use online web portal to collect qualitative and quantitative information for evaluation.

	Advocacy, Access, Education, Care Support	New Mexico[23]	Working with Medicaid Models of Care (MOCs) with federally qualified health centers (FQHCs). Significant reduction in both numbers of claims and payments after the CHW intervention. Model success expanded to rural and frontier areas.
Community – Insurance Enrollment	Advocacy, Access, Education, Care Support	Massachusetts[19]	Helped 200,000+ uninsured people enroll in health insurance programs. Increased access to primary care and improved quality & cost-effectiveness of care.
Community – Prevention	Advocacy, Access, Education, Care Support	Washington[25]	Community activities increased mammography use at follow-up in regular users & among other users.
	Education	North Carolina[26]	Valuable role of lay health promoters in delivering occupation health information to immigrant Latino workers.
Critical Access Hospital (CAH)	Advocacy, Access, Education, Care Support	Montana[29] 11 pilot sites[28]	Federal Office of Rural Health Policy (FORHP) Frontier Community Health Care Network Coordination Grant with 11 critical access hospital pilot sites with care transitions coordinator & CHWs in a network. Decline in hospitalizations and 30-day readmissions.
Emergency Department	Access	Kentucky[30]	Assist patients with non-life-threatening situations to find medical homes.
Faith-based organizations / churches	Education, cancer screening	North Carolina[33]	CHWs provided prevention information & referrals to colorectal cancer screenings; results not conclusive (suboptimal reach & diffusion).
	Education, breast cancer screening	Colorado[34]	*Promotoras* (CHWs) in four Catholic churches delivered breast-health education messages personally. Women exposed to the Promotora intervention had a significantly higher increase in biennial mammograms.
Home Health	Access, Education, Care Support	Kentucky[30]	Family healthcare advisors accessed >$24.1 million in medications at no cost. Return on investment (ROI) to state of 1:15-20. Improved cancer screening rates.
Long Term Care (LTC)	Advocacy, Access, Education, Care Support	Arkansas[31]	3-county rural demonstration in Mississippi Delta region focusing on Medicaid-eligible elderly & younger adults with physical disabilities with potentially unmet LTC needs. Growth of Medicaid spending in participant group lowered by 23.8% producing total. Estimated savings of $3.5 million in Medicaid expenditures.

Oral Health	Education, Care support	Oklahoma, tribal areas (Montana)[35]	Pilot project to test CHWs in oral health education/prevention (conducted in Tribal areas, rural settings, and urban areas).
	Education	New York[36]	CHWs taught residents how to use the My Smile Buddy smart phone app in rural & urban settings.
Public Health Settings	Access, Education	Texas[37]	Su Vida, Su Salud/Your Life, Your Health, a community program to increase participation in breast and cervical cancer screening, conducted at local health departments, utilized positive role models featured in the media and CHWs for positive social reinforcement (included urban and rural counties).
Schools	Education, Prevention	Texas[38]	School-based intervention targeting childhood obesity prevention through multiple strategies, including CHWs.
Telehealth	Education, Care Support	New Mexico[32]	Use of Project ECHO to connect front-line primary clinical teams, including CHWs, with specialist care teams for training and co-management of patients in need of complex care support. Project ECHO found to reduce racial and ethnic disparities in treatment outcomes to minority communities.
Tribal	Education	New Mexico[39]	Community Health Representative (CHR) led community-oriented educational intervention helped inform standards of practice for the management of diabetes, engaged diabetic populations in their own care, & reduced health disparities for the underserved Zuni population.
	Access	North Dakota[40]	Utilized CHRs/patient navigators to improve health outcomes for cancer patients. Study found patient navigation as a critical component in addressing cancer disparities in tribal communities.
Work place (farms)	Education	Illinois[41]	CHWs effectively trained farm workers in eye health and safety, improving the use of personal protective equipment and knowledge.

Policy Implications

Analysis of Current Relevant National and State Policies

CHW Funding Sources

- Grants
- Foundations
- Health Departments and Other Providers
- Medicaid
- Community Based Organizations

Occupational Regulation

Occupational regulation refers to the certification, licensing or other regulations/credentials for community for CHWs that falls under state legislatures.[23] Some states have set regulations for CHW standards/competencies, trainings, and credentialing processes. Credentialing requirements might include: required training, skills, competencies, standard scope of practice (outlining CHWs practice abilities and limitations).[7] An important purpose of credentialing remains to serve as a reimbursement basis for CHW services. Massachusetts, New Mexico, Ohio, Oregon, and Texas currently have regulations establishing CHW certification; Illinois, Rhode Island and Maryland passed legislation setting up work groups/task forces charged with determining requirements.[8] Additionally, other states are investigating or working towards establishing certification processes through state agencies or other non-legislative directives (e.g., Michigan).[8] Some CHW networks, associations, and organizations believe creating uniform occupational regulations or requirements will restrict a field traditionally community driven, with minimal entry barriers—concerned that regulation may prevent some from becoming CHWs.[42]

Workforce Development

Like credentialing, policymakers are contemplating the training, education and other needs to effectively develop the CHW workforce in their respective states. CHW training differs greatly; as mentioned previously, training may include formal educational institutions or job-based learning.[6] Several states have training programs; some are connected to certification or credentialing established by state agencies.[8]

Policies Impacting CHW Workforce

- State-level standards for education or training focusing on skills and competencies.[8]
- Development of training programs in health departments, state agencies, non-profit organizations, educational institutions, CHW associations and other entities.[8]
- Development/requiring specific training (e.g., disease-specific, population specific) necessary for certain jobs.[18]
- Utilization of clinicians, experienced CHWs, supervisors or instructors to train CHWs.[6]
- Training for CHWs and other healthcare providers to integrate CHWs into medical care teams.[17]
- Resource allocation for CHW workforce

Sustainable Funding

Traditionally, grants and CHW volunteer programs served as the primary funding sources for CHW programs. Reimbursement for CHW services continues to serve as a major issue facing the CHW workforce.[43] The 2014 Medicaid rule expanded reimbursement of preventive services, allowing for the potential reimbursement for CHW services through state Medicaid programs.[44] State Medicaid programs may reimburse community-based preventive services recommended by a physician or other licensed provider—allowing service delivery by practitioners

other than physicians (e.g., CHWs). However, states must submit a state plan amendment and define CHW and services rendered by CHWs for CHW reimbursement.[45,46] Few states funded CHWs through Medicaid prior to 2014. Minnesota became the first state to reimburse for CHW services under Medicaid in 2007; legislation outlined requirements for certification or experience, CHW supervision and services covered.[47] Medicaid programs that include managed care or capitated rates have more flexibility to fund CHWs through care teams. New Mexico utilized a Medicaid demonstration waiver to require managed care organizations to include CHWs in the care coordination team.[48] Also, Michigan appropriated about $70 million under a State Innovation Model (SIM) grant from the Centers for Medicare & Medicaid Services (CMS) for its Blueprint for Health model, which establishes Accountable Systems of Care (ASC) to foster more incorporation of CHWs into healthcare teams.[49] Another source of potential CHW funding is through state-initiated waiver programs (e.g., Section 1115 of the Social Security Act).[50] Some states also utilize CHW funding through the "Delivery System Reform Incentive Payment" (DSRIP) initiatives, which allows states to promote payment and system redesign to achieve population health goals.[50]

Analysis of Current NRHA Relevant Policy Positions

Currently, the National Rural Health Association (NRHA) has several policy positions that align and support the inclusion of CHWs into rural community healthcare. For the purposes of this paper, the following outlines a few of the most key and relevant NRHA policies that support CHW practice in rural areas.

1) Support the training of future healthcare workers and continued education and training for healthcare professionals.[51]

- Rural America continues to face healthcare shortages. NRHA supports the training of future health workers as well as the supporting the need for continuing education and training. This policy position should consider and include the recruitment of CHWs as well as supporting the ongoing education and training of current CHWs in rural areas.

2) Scope of practice changes and practicing at the top of one's scope of practice.[51]

- In light of healthcare shortages in rural areas, healthcare workers often do not have the opportunity to practice at the top of their abilities. For example, registered nurses (RNs) often engage in patient education, enrollment and eligibility services, and other activities that do not always allow them to perform at the top of their scope of practice in providing direct medical care services. CHWs have training and qualities that uniquely qualify them to provide some of the services other professionals currently provide in light of no one else to fill those gaps.

3) Reimbursement and payment policy reform.[51]

- NRHA currently supports and advocates for rural healthcare reimbursement and payment policy reform. There are some unique opportunities for funding CHW

programs—such as through Waiver programs or directly through CMS plans. NRHA should support reimbursement and payment policy reform to include CHW programs in rural areas.

4) Incentivizing/developing new models of care and transforming existing models of care.[52]

- ❖ NRHA actively engages in advocating, researching, and developing new models of care as well as reforming current models. Given the ability of CHWs to positively impact the care and health outcomes in rural communities given their unique roles, characteristics and skill set, NRHA and rural health policymakers should include models of care that actively engage CHWs as part of medical care teams.

5) Develop and support culturally and linguistically competent healthcare and social service programs.[53]

- ❖ NRHA actively supports and engages in activities and initiatives that advocate for health equity among all rural residents. CHWs traditionally share the same background, language, socioeconomic status, and values of the community they themselves are part of. Given those shared values and characteristics, CHWs have the unique opportunity and ability to provide culturally appropriate care and services and help bridge the gap between rural residents and the healthcare field.

Analysis of Relevant Studies Supporting the Utilization of CHWs in Rural Communities

As mentioned previously, numerous studies conducted in rural and urban settings support the utilization of CHWs in rural areas. Table 2 summarizes state and national policies supporting the evidence-based practice of CHWs in urban and rural settings.

Table 2: Literature Review National & State CHW Policies

State	Scope of Practice	Training Requirements
National[54]	5 prevailing models of care to engage CHWs: 1. *Member of care delivery team*: CHW works in direct coordination with providers. 2. *Navigator*: assisting clients with navigation through complex health/social service systems & dealing with various providers. 3. *Screening & health education*: teaching client self-care & disease screening methods & taking patient vital signs. 4. *Outreach-enrolling-informing agent*: links clients to applicable services.	According to a national CHW survey, about 50% of CHW employers had some educational or training requirement for CHWs: - A Bachelor's degree was a prerequisite in 32% of organizations - 68% required post-hire training through continuing education via classroom instruction (32%), mentoring (47%), and on-site technical assistance (43%) with durations of training ranging from 9-100 hours. - Employer-based training often focused on generic CHW skills and competencies as well as cultural awareness; whereas specific training

	5. *Organizer*: Advocacy, self-directed change & community development.	was made to understand medical & social services, home visiting/navigation, providing health education/counseling, as well as first aid & CPR.
Alaska[55]	<u>Certified community health aide must demonstrate/maintain proficiencies in</u>: 1. Identifying/understanding problem-specific complaints for adults & children (e.g., acute care for eye, ear, respiratory, digestive, or dermal issues). 2. Various CHW roles villages. 3. Medical ethics.	1. Pre-session or equivalent prior to admission to Session I training course. 2. Emergency Medical Technician (EMT) or Emergency Trauma Technician (ETT) training course approved by State of Alaska. 3. Session I training course provided by a Community Health Aides and Practitioners (CHA/P) Training Center. 4. Approved field work after session I (minimum of 20 patient encounters; post session learning needs (PSLN) identifying learning needs in performing essential skills; post session practice checklist identifying skills to be taught).
Florida[56,57]	1. Bridge cultures between communities & health/social service system. Improve patient education & follow-up. Advocate for individual & community needs. 2. Fill gaps in service delivery. 3. Help to reduce emergency department visits & re-hospitalizations. 4. Provide culturally appropriate health education & information. 5. Assure people receive needed services to build individual & community capacity.	Does not have any laws defining a CHW or current actions to move toward statewide CHW certification.

	6. Provide access to clinical & community services. 7. Provide information & social support to members of the community.	
Massachusetts[58]	1. Client advocacy. 2. Health education. 3. Outreach & health system. 4. Navigation.	Required certification by Board of Certification of the Department of Public Health in order to list oneself as a "certified CHW." Currently developing policies to inform certification.
Minnesota[58]	1. Provide culturally appropriate health education, information, & outreach in community-based settings. 2. Bridge/culturally mediation between individuals, communities, & health & human services. 3. Assure people access needed coverage & services. 4. Provide direct services (informal counseling, social support, care coordination, & health screenings). 5. Advocate for individual & community needs.	Statewide volunteer CHW competency-based curriculum program based in post-secondary educational institutions. The training is not mandatory; however, in order to receive Medicaid reimbursement for authorized CHW services, all CHW employees of an organization must hold certifications.
New Mexico[59,60]	1. Informal & motivational counseling & education. 2. Interventions to maximize social supports. 3. Care coordination. 4. Facilitation of access to healthcare & social services. 5. Health screenings.	"Certification is seen as a necessary step to add CHWs as providers of preventative services to the Medicaid State plan". Totally voluntary according to the New Mexico Department of Health.
New York[11]	1. Outreach and community mobilization. 2. Community/cultural liaison. 3. Case management & care coordination 4. Home-based support. 5. Health promotion & health coaching. 6. System navigation. 7. Participatory research.	Multiple methods of CHW training (school/work based, etc.). No single state-wide curriculum. No current state certification.
Ohio[56]	1. Assist members of the community by assessing community health & supportive resources through	Required certification in order to legally be allowed to perform tasks delegated by a nurse or higher authority.

	home visits & referrals. 2. Provide education, role modeling & referrals. (chapter 26 of Ohio Administrative Code 02-02-2010 OAC 4723-26-04)	
Oregon[56,61]	<u>According to Oregon law, a CHW must:</u> 1. Have experience in public health. 2. To the extent practicable, share the ethnicity, language, SES, & life experiences with community served. 3. Assist community members to improve their health & increase their capacity to achieve/sustain their own wellness. 4. Provide health education/information that is culturally appropriate to the individuals being served. 5. Assist community residents in getting needed care. 6. May provide peer counseling & guidance on health behaviors. 7. May provide direct services (first aid or blood pressure screenings).	To qualify for reimbursement by Medicaid (Oregon Health Plan), non-traditional health workers must be certified by the Oregon Health Authority via successful completion of an approved training program & enrolled in the state's central registry.
Rhode Island[56]	<u>Rhode Island state law says responsibilities of CHWs should include (not limited) to:</u> 1. Link communities with services for legal challenges to unsafe housing conditions. 2. Advocate/outreach with state/local agencies to ensure clients receive appropriate services/benefits. 3. Advocate for individuals/families within the healthcare system. 4. Connect individuals/families with appropriate services/advocacy 5. Assist agencies to promote culturally competent care, effective language access policies & practices. 6. Disseminate best practices to state agencies.	Does not require any licensing or certification, but maintains credentialed CHW training programs.

	7. Train healthcare providers to help patients/families access appropriate services, including social, legal & educational services.	
Texas[56]	Liaison between healthcare providers & patients through activities that may include (not limited) to: 1. Assist in case conferences. 2. Provide patient education. 3. Make referrals to health & social services. 4. Conduct needs assessments. 5. Distribute surveys to identify barriers to healthcare delivery. 6. Make home visits. 7. Providing bilingual language services.	Certification required to hold a CHW position. Legislation not actively enforced. Certification is through a 160-contact hour approved training course or through 1,000 verified hours of experience as a CHW.
Washington[62]	1. Make sure people get access to needed health/social services via service coordination, referral & follow-up. 2. Provide informal counseling, coaching or social support to people. 3. Provide culturally appropriate health education information. 4. Provide basic services & screening tests 5. Provide a cultural link between organizations & communities. 6. Advocate for the needs & perspectives of the community members served. 7. Help community members increase their health knowledge & be self-sufficient.	Voluntary free training & certification for CHWs to increase their skills. No current state certification.

Recommended Actions

In light of the evidence base supporting the effectiveness of CHWs to improve access to care and health outcomes, rural health policymakers should consider the following actions to support and advocate for the integration of the CHW model in rural communities.

1. **Support and advocate for the employment of CHWs** in rural hospitals, critical access hospitals, rural health clinics, federally qualified health centers, private practices, social service entities, non-profit organizations, faith-based organizations, schools, academic institutions, and other community based organizations.

2. **Support, participate, and advocate** for the establishment of a national scope of practice for CHWs.

3. **Advocate and research reimbursement and funding mechanisms** to support the CHW model in rural areas, allowing metric reimbursement such Quality Payment Programs (QPP) to then be tied to allowed benefits.

4. **Support and advocate for policies that allocate resources** for CHW workforce development, including training.

5. **Promote the provision of incentives** (e.g., financial) for agencies that hire CHWs (e.g., rural county health departments, state departments of rural health) in rural settings.

6. **Support and advocate for comprehensive evaluation** of CHW programs—including cost saving, client outcomes, and CHW scope of practice.

7. **Support the establishment of a national rural health clearinghouse** for innovation-based practice models, toolkits, and other shared technical resources for CHW models in rural areas.

8. **Support the creation of a repository of CHW training programs** across the U.S.—particularly those programs that provide training in remote, rural areas.

9. **Support and investigate CHW certification and/or credentialing** and its potential impact on rural CHWs and communities.

Conclusion

CHWs have the unique ability and opportunity to improve the health of rural residents who face particular disparities and challenges due to their geographic location. CHWs can help address the numerous challenges facing rural healthcare, such as lack of access: hospital closures, shortage of healthcare providers, lack of culturally appropriate services, and other challenges unique to rural America. CHWs and rural health policymakers and stakeholders should consider partnering across the U.S. to promote the inclusion of CHWs as sustainable members of healthcare teams in rural areas and as bridges between healthcare systems and rural communities.

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