

**REPORT OF THE  
JAMES MADISON UNIVERSITY**

**Final Report on the Status,  
Impact, and Utilization of  
Community Health Workers**

**TO THE GOVERNOR AND  
THE GENERAL ASSEMBLY OF VIRGINIA**



**HOUSE DOCUMENT NO. 9**

**COMMONWEALTH OF VIRGINIA  
RICHMOND  
2006**



January 6, 2006

General Assembly Building  
Division of Legislated Automated Systems  
Attention: Angie Murphy  
910 Capital Square, Suite 660  
Richmond, VA 23219

To the Honorable Mark R. Warner, Governor of Virginia and Members, Virginia General Assembly:

James Madison University, through its Virginia Center for Health Outreach is pleased to submit the final report studying the status, impact, and utilization of community health workers (CHWs) as directed by House Joint Resolution No. 195. The final report focuses on ways to elevate the role of community health workers in the health care delivery system; integrate more effectively such workers in public agencies; examine the potential use of community health workers as part of a best-practice quality measure for Medicaid and other contracted providers; explore the development of a statewide core curriculum for the training of publicly employed community health workers as well as be available for volunteer workers; and to recommend any other steps to maximize the value and utilization of community health worker.

The final report offers seven recommendations that build upon the successful completion of the recommendation from the interim report - in collaboration with the Virginia Department of Human Resource Management; "community health worker" has now been added to the Direct Service Career Grouping within the Occupational Family of Health and Human Services. This addition provides a resource to describe the work of CHWs across multiple audiences and sectors.

The challenge of eliminating barriers to health and human services and reducing health disparities among vulnerable population groups is a tremendous challenge. Virginia's CHWs have and continue to make valuable contributions in the delivery of health and human services. To successfully meet this challenge and to make our health care delivery system more efficient will require that all health and human service professionals work together and draw upon the unique skills and knowledge that each possess.

JMU and the Virginia Center for Health Outreach are eager to work with public and private agencies to advance the work of CHWs through these recommendations and other activities that will help shape an increasingly responsive and effective health and human services workforce for the commonwealth.

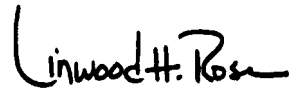
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The Honorable Mark Warner and Members, Virginia General Assembly  
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On behalf of James Madison University and the Institute for Innovation in Health and Human Services, I would like to thank those members of the Study Resolution Committee who devoted their time and expertise in 2004 and 2005 in compiling the interim and final reports.

Sincerely,

A handwritten signature in black ink that reads "Linwood H. Rose". The signature is written in a cursive style with a large initial "L".

Linwood H. Rose  
President

LHR/vcho

Enclosure: HJR 195 Final Report

## Preface

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House Joint Resolution 195 of the 2004 Virginia General Assembly directed James Madison University (JMU) to study the status, impact and utilization of community health workers in Virginia. Dr. Linwood H. Rose, President of JMU requested that the directives to be addressed by the study report be tasked to the Virginia Center for Health Outreach (VCHO) at JMU. The VCHO serves as a statewide forum for addressing CHW and CHW program issues across Virginia.

The Virginia Center for Health Outreach has brought together stakeholders to establish the Community Health Worker Study Resolution Committee (*Summaries of the meetings held by the committee are located at <http://www.vcho.cisat.jmu.edu/StudyRes.htm>*). By consensus, the Committee decided to prepare an interim study report that focused on the following directives: (i) inventory the number and roles, of community health workers employed in the Commonwealth and explore a standard designation for such workers; and (ii) identify and review outcome studies and evaluations on the efficacy of community health workers. The final study report focuses on (iii) determining ways to elevate the role of community health workers in the health care delivery system and to integrate more effectively such workers in public agencies; (iv) examine the potential use of community health workers as part of a best-practice quality measure for Medicaid and other contracted providers; (v) explore the development of a statewide core curriculum that would be used for the training of publicly employed community health workers and be available for volunteer workers; and (vi) recommend any other steps to maximize the value and utilization of community health workers.

### CHW Study Resolution Committee 2004-2005 Participants

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James Madison University thanks the members of the Study Resolution Committee for their work on the interim and final reports and their dedication to improving access to health and human services for all Virginians.

A special thank you is extended to the patrons of HJR 195, Delegate R. Steven Landes and Senator Janet D. Howell; for their efforts to increase the effectiveness of Virginia's health and human service delivery systems.

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## Executive Summary and Recommendations

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### SUMMARY OF CURRENT TRAINING OF COMMUNITY HEALTH WORKERS

Community health workers in Virginia and nationally receive training through various methods. Nationally, the most common type of training is “on-the-job.” There are three major trends in implementing CHW training and certification. These trends are:

1. on-the-job training or a practicum to improve program capacity and enhance standards
2. community college – based training providing academic credit through formal education
3. state level certification that legitimizes the work of CHWs and enhances reimbursement opportunities for CHW provided services<sup>1</sup>

### TOWARD DEVELOPMENT OF A STATEWIDE CORE CURRICULUM FOR CHWS

Standard training in combination with self-defined core tasks and activities are cited as important steps toward professionalization<sup>2</sup>. Many CHWs are concerned at their lack of recognition among policy makers and health care professionals. CHWs, CHW supervisors, and CHW program directors recognize that the potential for CHWs to improve the effectiveness and sustain programs includes the adoption of skill standards for CHWs<sup>3</sup>. The adoption of skill standards is viewed as necessary to achieve a label of “provider” of a defined set of services<sup>4</sup>. Attaining the label of “provider” is necessary to recognition, integration of CHWs into health professional teams, and third-party reimbursement for CHWs.

The increasing recognition of the important role CHWs can play in the delivery of health and human services has led to increased demand for CHWs. In order for CHWs to gain wider acceptance throughout the health services sector, the often-times significant gaps in CHW preparation have to be addressed<sup>5</sup>. Workshops, lectures, and non-credit continuing education opportunities exist beyond basic education and training. However, core, standardized programs provide CHWs with greater opportunities to develop the contextual framework in which they perform their work compared to “piecemeal” workshops and similar opportunities<sup>6</sup>.

Virginia CHWs were asked to rank core competencies identified by the National Community Health Worker Study according to their perceived importance. The core competencies by order of CHW ranking included verbal communication, client advocacy skills, service coordination skills, outreach skills, teaching skills, understanding poverty, informal counseling skills, organization skills, written



communication, how to work as a team, conflict resolution skills, documentation skills, self-care skills, and leadership skills. Many respondents commented about the difficulty of ranking the knowledge, skills, and abilities (KSAs) as they considered all of them important.

### Sample of Core Knowledge, Skills, and Abilities Education Offered by Virginia CHW Programs

Utilizing the knowledge, skills, and abilities listed by Virginia CHWs, CHW programs were asked to identify how much training time was devoted by the program to providing each knowledge, skill, and ability. It was difficult to assess the amount of core training being provided by Virginia CHW programs. While offering education and training to CHWs, CHW programs provide a combination of core knowledge, skills, and abilities within current training. “Teasing-out” core competencies from these trainings was difficult for program respondents.

### **Formalizing Core Knowledge, Skills, and Abilities for CHWs**

The core skills required of CHWs have evolved around programs that early on recognized the importance of core skills for CHWs. The identification of core CHW skills gained momentum through research produced through the 1998 National Community Health Advisor Study (NCHAS). The study articulated core roles of the CHW and skills necessary to complete these roles. The NCHAS was an important vehicle in communicating research about CHWs to a national audience. The NCHAS recommended that CHW program staff use the core skills identified in the study when recruiting and hiring CHWs.

The seven CHW core *roles* as described by the NCHAS included:

1. Bridge cultural mediation between communities and health and social service system
2. Provide culturally appropriate health education
3. Assure people get the services they need
4. Provide informal counseling and social support
5. Advocate for individual and community needs
6. Provide direct service.
7. Build individual and community capacity

The NCHAS suggests that the core roles of CHWs (listed above) be used along with community strengths and needs assessment when developing CHW programs. The study also recommends that these core roles be used to explain CHW work to those outside of the field. This recommendation is critical to integrating CHWs into health care teams so that these teams are able to access vulnerable populations.

## **EDUCATION AND TRAINING OF CHWs: BEYOND A CORE CURRICULUM**

CHW training and education can be categorized in many ways. For this study, formal education and training beyond a core curriculum is being characterized as non-academic continuing education for programs that offer academic credit. Programs that offer academic credit may also include a CHW's core curriculum and offer additional education and training that build upon the CHW's core education.

### **Non-Academic Credit Continuing Education**

As described earlier, the majority of CHW training occurs on-the-job. Continuing education is decentralized, and is most often provided by CHW programs. A 2002 program survey completed by the Virginia Center for Health Outreach found that 70 CHW program sites reported a median of four hours of monthly inservice or continuing education hours.

The amount of continuing education received by CHWs is often dependent upon program resources. As program resources diminish, continuing education budgets (travel, fees, lodging) are reduced or eliminated.

### **Academic Credit Training Programs**

Historically, many CHW programs have worked with community colleges to establish academic credit for CHW training<sup>7</sup>. According to the NCHAS, partnerships between CHW programs and community colleges have gone through periods of demand when there were large numbers of CHWs seeking credit. These programs dissolved as either demand or resources, whether personal or program, became increasingly limited<sup>8</sup>.

The sustainability of current programs, expansion of existing programs, and development of new academic credit programs for CHWs will depend upon a number of factors. Many of these factors are interdependent. These factors include:

- Recognition of CHWs as important members of the health and human services workforce by policy makers and other health and human service professionals
- Integration of CHWs into interdisciplinary health professional teams
- Available CHW career advancement opportunities where there is dependency upon academic credit programs
- Adoption of formal core knowledge, skills and abilities across CHW programs
- Partnerships between CHW programs and community colleges and other institutions of higher learning
- Reimbursement for CHW-provided services

## MAXIMIZING THE ROLE OF COMMUNITY HEALTH WORKERS

Eliminating health disparities among racial, cultural, and economically disadvantaged populations has remained a priority of the U.S. Department of Health and Human Services since it was first expressed in the document *Healthy People 2000* and reaffirmed in *Healthy People 2010*<sup>9</sup>. CHWs are considered to be important members of the healthcare workforce in reducing barriers to health and human services among vulnerable populations.

The integration of CHWs as members of health care teams within the context of roles where research has shown CHWs to be particularly effective is a promising strategy for improving health outcomes and efficiencies within health and human service delivery systems.

## FINANCING OF CHWs

Most funding for CHW programs is derived from state, federal, and local sources. Some programs receive private funding from foundations and private community agencies such as United Ways. Funding is often time-limited and may be targeted to specific issues or population groups<sup>10</sup>.

A stable source of funding offers CHW programs the opportunity to maximize the promise of CHWs and establish strategies of integrating CHWs into health and human service teams. One element of a long-term solution to the unpredictability of CHW program funding is for states to recognize the unique and important role CHWs play in accessing hard to reach population groups. This includes fully utilizing outreach and education dollars that are available through Medicaid and State Children's Health Insurance Plans (SCHIP).

Medicaid offers CHWs several options for funding in addition to SCHIP initiatives. Through the Medicaid waiver system, CHWs may be able to utilize Medicaid funding avenues<sup>11</sup>. Application for Medicaid waivers is accomplished through collaborative work between CHW program and CHW advocates and state Medicaid offices<sup>12</sup>. Another Medicaid funding option is the Administrative Claiming program. Administrative Claiming takes advantage of a provision in Federal law permitting states to claim federal financial participation for administrative expenses state's incur in operating their Medicaid programs.

## RECOMMENDATIONS

**RECOMMENDATION 1:** Virginia's Community Health Worker programs, in collaboration with the Virginia Center for Health Outreach at James Madison University should adopt core knowledge, skills, and abilities (KSAs) and the elements within each that are essential to development of a curriculum that supports the understanding and practice of each KSA.

**RECOMMENDATION 2:** Upon the adoption of core knowledge, skills, and abilities, Virginia's Community Health Worker programs should recognize an individual CHW's achievement of each KSA, regardless of the CHW program providing the KSA.

**RECOMMENDATION 3:** In collaboration with and the cooperation of Virginia's Community Health Worker programs, the Virginia Center for Health Outreach should develop the necessary data collection system to register the attainment of core knowledge, skills and abilities of individual Virginia CHWs.

**RECOMMENDATION 4:** The Virginia Center for Health Outreach, in collaboration with Virginia's Community College System and other institutions of higher learning, should explore and develop ways to provide CHWs with educational opportunities that offer academic credit and identify career pathways.

**RECOMMENDATION 5:** Health professions training programs should identify opportunities within existing curricula to educate students and practicing professionals regarding the role of CHWs in an efficient and effective health and human service delivery system.

**RECOMMENDATION 6:** The Commonwealth of Virginia, in collaboration with public and private agencies, should seek opportunities to support demonstration projects that integrate community health workers within existing health and human service delivery systems that care for vulnerable populations.

**RECOMMENDATION 7:** In collaboration with the Virginia Department of Medical Assistance Services, the Virginia Center for Health Outreach and CHW programs should examine opportunities for additional Medicaid reimbursement that utilize CHWs.

## I. SUMMARY OF CURRENT TRAINING OF COMMUNITY HEALTH WORKERS

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Community health workers in Virginia and nationally receive training through various methods. The National Community Health Advisor Study (NCHAS) found that 83% of CHW respondents to its survey received formal on-the-job training<sup>1</sup>. Second to formal on-the-job training was experience while performing the job (79%) with only 21% of the respondents indicating school-based experience<sup>2</sup>.

In a study conducted for The Office of Rural Health Policy, Health Resources and Services Administration of the U.S. Department of Health and Human Services, one-third of the country's states currently have some form of state-sponsored training programs for CHWs<sup>3</sup>. The study, conducted by the Southwest Rural Health Research Center (SWRHRC), identified three major trends related to implementing CHW training and certification. These trends are<sup>4</sup>:

1. community college - based training providing academic credit through formal education
2. on-the-job training or a practicum to improve program capacity and enhance standards
3. state level certification that legitimizes the work of CHWs and enhances reimbursement opportunities for CHW provided services

### Examples of Basic CHW Training in Other States

A collaboration of three Connecticut agencies found results similar to the NCHAS findings. The collaboration identified 226 health and human service organizations state-wide employing a total of 993 outreach workers. The CHWs were employed in a variety of public health service activities<sup>5</sup>. The most common type of training received by the Connecticut CHWs was on-the-job training (85%).

**“Issues of uneven skill development and education, lack of acceptance by other health professionals, and lack of agreed-on standards of practice are synergistic problems undermining their (CHW) efficacy and use. If we are to meet labor demand for CHWs, education must develop toward standardized competencies and assessment tools that at the same time retain the heart of CHWs’ effectiveness – their roots in and knowledge of their communities.”**

Love, et. al.

The Massachusetts Department of Public Health published a report titled, *Community Health Workers – Essential to Improving Health in Massachusetts*. The report found that 71.6% of CHWs receiving training were provided their training through their

employing agency<sup>6</sup>. The report issued seven action steps including development of a set of core competencies and guidelines for CHWs.

### Basic CHW Training and Continuing Education in Virginia

Basic and continuing education is a necessity for CHWs. A 2001 survey of Virginia CHWs conducted by the Virginia Center for Health Outreach at James Madison University mirrored findings of the NCHAS and the Connecticut and Massachusetts studies. Virginia CHWs reported that basic training length and the type of training provided varied between and within programs. CHWs also indicated that the quality of continuing education was equally varied. The following statements from CHWs represent the differences that exist in training and continuing education.

**Eighty-three (83) Virginia CHW program sites responding to a 2001 survey indicated a median of 40 hours of initial training with 70 sites indicating additional continuing education of four hours (median) per month.**

Virginia Center for Health Outreach

*"I had ten weeks of training and it was about 21 different (syllabi)."*

*"We had a week of initial training and ongoing training about twice a month."*

*"We have forty hours of training."*

*"I just shadowed the staff that was already there for about a month or two."*

In addition to compiling data on CHW training, the NCHAS asked CHWs their opinion regarding the development of training standards for CHWs. An overwhelming number – 77%, indicated their support for training standards. Additionally, 71% of respondents supported the development of state or national certification for CHWs<sup>7</sup>.

According to the U.S. Department of Labor, Bureau of Labor Statistics, workers who fall into the classification of social and human service assistants (this classification includes the title of community support worker and community health outreach worker among others) with no more than a high school education are likely to receive extensive on-the-job training to work in direct-care services<sup>8</sup>. Nationally, this worker classification was anticipated to "grow much faster than average"; a phrase that means the occupation is expected to increase 36 percent or more for the period 2002 – 2012.

Many CHWs are concerned at the lack of recognition among policy makers and health care professionals. CHWs, CHW supervisors, and CHW program directors recognize that the potential for CHWs to improve the effectiveness and sustain programs includes the adoption of skill standards for CHWs<sup>9</sup>. The adoption of skill

standards is viewed as necessary to achieve a label of "provider" of a defined set of services. Attaining the label of "provider" is necessary to recognition, integration of CHWs into health professional teams, and third-party reimbursement for CHWs.

In the Southwest Rural Health Research Center (SWRHRC) Study, an analysis of 17 CHW programs found that certification and training programs were evolving. Earlier training was most often initiated by local or regional efforts<sup>10</sup>. The evolution of CHW training is characterized through formalization of earlier, less systematic training activities of CHWs. Ongoing efforts of CHWs, CHW organizations and their allies have spurred formalization efforts. The development of the Virginia Center for Health Outreach at James Madison University in 2001 is an example of formalization of grassroots efforts to promote CHWs and issues pertaining to CHWs. Table 1 below summarizes rationale for CHW training and certification.

**Table 1**  
**Why Training and Certification?**<sup>11</sup>

**Governmental/Health Care System Perspective**

1. Access to and more strategic use of outreach workforce
2. Systematic training and systemic recognition
3. Broader health care access and affordability
4. Access to financial resources for reimbursing CHWs
5. Quality of care assurance

**Community Perspective**

1. Access to new health care resources
2. New access to service points
3. Recognition and acceptance of the CHWs – ease and comfort

**CHW Perspective**

1. Career Advancement
2. Validate significance of CHWs' work/greater recognition
3. Greater community capacity building
4. Personal satisfaction and growth
5. Greater opportunities for receiving reimbursement/payment

## II. TOWARD DEVELOPMENT OF A STATEWIDE CORE CURRICULUM FOR CHWs

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Standard training in combination with self-defined core tasks and activities are cited as important steps toward professionalization<sup>12</sup>. Standard training and recognition of core roles and skills of health and human service workers are important to understanding roles, expectations and establishing identity within programs and the broader health and human services workforce. The core roles of CHWs are well documented and described. There is an increasing volume of research that describes numerous skills and abilities that comprise or support these roles. The increasing recognition of the important role CHWs can play in the delivery of health and human services has led to increased demand for CHWs<sup>13</sup>. To gain wider acceptance throughout the health services sector, the often-times significant gaps in CHW preparation have to be addressed<sup>14</sup>.

The CHW core roles as described by the NCHAS include the following:

1. Bridge cultural mediation between communities and health and social service system
2. Provide culturally appropriate health education
3. Assure people get the services they need
4. Provide informal counseling and social support
5. Advocate for individual and community needs
6. Provide direct service.
7. Build individual and community capacity

For many community health workers, not only in Virginia but across the country, training occurs most frequently on-the-job without common standards or curricula. The training is most often designed by the program employing the CHW and responds to the specific program missions. Workshops, lectures, and non-credit continuing education opportunities exist beyond basic education and training. However, core, standardized programs provide CHWs with greater opportunities to develop the contextual framework in which they perform their work compared to “piecemeal” workshops and similar opportunities<sup>15</sup>.

Oversight and standardization of training, curricula, and certification are the responsibilities of organizations and regulatory groups for many health and human service professionals including physicians, nurses, social workers, physical and occupational therapists and many others. In addition, education and training programs such as schools of medicine and nursing also have certification and accrediting bodies.



### Survey of Knowledge, Skills, and Abilities among Virginia CHWs and CHW Supervisors

The knowledge, skills, and abilities (KSAs) ranked by Virginia CHWs and CHW supervisors were selected from recommended competencies contained in the NCHAS. In addition to the NCHAS, these core skills and knowledge have been documented in CHW research findings. These elements were presented to Virginia CHWs and CHW supervisors by the Virginia Center for Health Outreach to be ranked according to what the respondents believed were most essential to being a successful CHW. One KSA, “understanding what it is like to live in poverty”, was suggested by the CHW Study Resolution Committee and added to the list.

<b>Knowledge, Skill, Ability</b>	<b>CHW Ranking (N=148)</b>	<b>CHW Supervisor Ranking (N=90)</b>
Verbal Communication	1	1
Advocacy Skills	2	2
Coordinate Services for Clients	3	3
Outreach Skills	4	7
Teaching Skills	5	4
Understanding of Poverty	6	5
Counseling Skills (informal)	7	9
Organization Skills	8	6
Written Communication	9	13
How to work as a team	10	8
Conflict Resolution Skills	11	10
Documentation Skills	12	11
Self-Care Skills	13	12
Leadership Skills	14	14

These KSAs have typically not been presented to Virginia CHWs as single competencies but have been incorporated in other skill building activities. Many respondents commented about the difficulty of ranking the KSAs as they considered all of them important.

### Sample of Core Knowledge, Skills, and Abilities Education Offered by Virginia CHW Programs

As part of this study, the Virginia Center for Health Outreach at JMU designed an online survey to determine how much group or classroom education and training

was being provided by Virginia CHW programs around the same list of KSAs the CHW and CHW supervisors were asked to rank. The programs below participated in the program KSA survey and represent a **significant** number of Virginia CHWs.

1. Comprehensive Health Investment Project (CHIP) of Virginia and the following affiliates:
  - Chesapeake, Greater Williamsburg, and Northern Virginia
2. Community Health Interpreter Service/Blue Ridge Area Health Education Center
3. Expanded Food Nutrition Education Program & Food Stamp Nutrition Education
4. Healthy Families Virginia
5. Resource Mothers Program
6. Virginia Breast and Cervical Cancer Early Detection Program

Limitations of the reported information include: (1) the number of programs indicating that they had to “tease-out” time devoted to the KSAs listed from other topic areas, i.e., the KSAs were provided through other topics and, (2) four programs, located in different regions of the state, represented the Comprehensive Health Investment Project (CHIP) program model.

Knowledge, Skill, Ability	0 Hours	1-3 Hours	4-6 Hours	6-10 Hours	More than 10 Hours
<b>Verbal Communication</b>	4	4	1		
<b>Advocacy Skills</b>	5	3	1		
<b>Coordinate Services for Clients</b>	8	1			
<b>Outreach Skills</b>	4	3	1		1
<b>Teaching Skills</b>	5	2	1		1
<b>Understanding of Poverty</b>	5	2	2		
<b>Counseling Skills (informal)</b>	7	1			1
<b>Organization Skills</b>					
<b>Written Communication</b>	6	2	1		
<b>How to work as a team</b>	6	2	1		
<b>Conflict Resolution Skills</b>	7	1	1		
<b>Documentation Skills</b>	3	3	2		1
<b>Self-Care Skills</b>	5	2			2
<b>Leadership Skills</b>	9				

## **Formalizing Core Knowledge, Skills, and Abilities for CHWs**

The core skills required of CHWs have evolved around programs that historically recognized the importance of core skills for CHWs. This has gained momentum through research produced through the 1998 NCHAS. The study articulated core skills of CHWs and communicated findings to a national audience. The NCHAS recommended that CHW program staff use the core skills identified in the study when recruiting and hiring CHWs<sup>16</sup>.

One of the earliest programs (1995) to recognize the need for core skills education for CHWs was San Francisco State University and the City College of San Francisco. Together they formed Community Health Works and have been a leader in the development of a core curriculum for CHWs.

### Community Health Works of San Francisco CHW Generalist Core Curriculum

Community Health Works of San Francisco, a partnership of the Department of Health Education at San Francisco State University and the Health Science Department at City College of San Francisco developed the first college-credit certificate for CHWs in the United States<sup>17</sup>.

The required core program includes four complementary elements. Research prior to implementation of the certificate program identifies five process competencies that, regardless of topic area, include skills that applied to most CHWs<sup>18</sup>. A second element of the curriculum includes instruction in leadership and work place competencies. The third element includes instruction in health promotion and disease prevention content areas with the goal that the CHW provide advice and appropriate referral information to clients. The final element addresses general system and policy issues that act as determinants of health.

I. PROCESS COMPETENCIES	
1. Client Intake and Interviewing Beginning the Interview Discussing Protocol & Procedures Communication Skills Identifying & Prioritizing Needs	2. Client Orientation to Agency 3. Care Coordination Referrals & Information Follow-up and tracking 4. Health Advising one-on-one 5. Outreach
II. LEADERSHIP/WORK CULTURE COMPETENCIES	
<ul style="list-style-type: none"> <li>▪ Time Management</li> <li>    Keeping a Calendar</li> <li>    Organizational Skills</li> </ul>	<ul style="list-style-type: none"> <li>▪ Resume/Cover Letter Writing</li> <li>▪ Stress Management</li> <li>▪ Team Skills</li> </ul>
III. TOPICS: INTRODUCTORY KNOWLEDGE AND REFERRAL INFORMATION	
<ul style="list-style-type: none"> <li>▪ Maternal and Child Health</li> <li>▪ STD/HIV</li> <li>▪ Tuberculosis</li> <li>▪ Drug/Alcohol Harm Reduction</li> <li>▪ Family Planning</li> </ul>	<ul style="list-style-type: none"> <li>▪ Mental Health</li> <li>▪ Domestic Violence</li> <li>▪ Nutrition</li> <li>▪ Homelessness</li> <li>▪ Tobacco</li> </ul>
IV. "BIG PICTURE" SYSTEM KNOWLEDGE AND ATTITUDES	
<ul style="list-style-type: none"> <li>▪ Social and Economic Determinants of Health</li> <li>▪ Primary Care</li> <li>▪ Influence of Poverty, Racism, Gender and Sexuality</li> </ul>	<ul style="list-style-type: none"> <li>▪ Managed Care</li> <li>▪ Welfare Policy</li> <li>▪ Immigration Policy</li> <li>▪ Community Advocacy and Organizing</li> </ul>

### The Minnesota Community Health Worker Project

The Minnesota Community Health Worker Project (2004), a statewide initiative of public and private groups that works to improve healthcare quality and access for vulnerable populations recognizes that CHWs are essential to this effort. According to the Project, over 90% of employers of CHWs in Minnesota indicated a need for standardized training for CHWs<sup>20</sup>.

A closer look at the Minnesota curriculum includes the following core studies<sup>21</sup>:

*Advocacy and Outreach* (3 credits; 48 hours of internship) - The course focuses on the CHWs personal safety, self-care, and personal wellness and on the promotion of health and disease prevention for clients.

*Organization and Resources: Community and Personal Strategies* (2 credits; 48 hours of internship) - The course examines the CHWs knowledge of the community

and the ability to prioritize and organize work with an emphasis on the use and critical analysis of resources and on problem solving.

*Community Health Worker's Role in Teaching and Capacity Building (2 credits)* – The course targets the CHW's role in teaching and increasing the capacity of the community and of the client to access the health care system. The CHW learns about methods for developing and implementing client-based plans.

*The Community Health Worker: Legal and Ethical Responsibilities (1 credit)* – The course looks at legal and ethical dimensions of the CHW's role. The course also examines CHW boundaries, agency policies, confidentiality, liability, mandatory reporting and the impact of cultural issues and their impact on legal and ethical responsibilities.

*The Community Health Worker: Coordination, Documentation and Reporting (1 credit)* - The course focuses on the importance and ability of the CHW to gather, document and report on client visits and other activities. Emphasis is placed on appropriate, accurate and clear documentation with consideration of legal and agency requirements.

*Communication Skills and Cultural Competence (2 credits)* – The course provides the content and skills in communication to assist CHWs in effectively interacting with a variety of clients, their families and a range of healthcare providers. CHWs learn about communicating verbally and nonverbally, learning, listening and interviewing skills.

Cost of the courses is \$123.53 per credit hour for students attending the urban-based Minnesota Community and Technical College and \$107.75 per credit hour at the rural-based South Central Technical College<sup>22</sup>.

The NCHAS suggests that the core roles of CHWs be used along with community strengths and needs assessment when developing CHW programs and that these core roles be used to explain the work of CHWs to those outside of the field<sup>23</sup>. This last recommendation is critical to integrating CHWs into health care teams that are able to access the vulnerable populations.

## RECOMMENDATIONS

**RECOMMENDATION 1: Virginia's Community Health Worker programs, in collaboration with the Virginia Center for Health Outreach at James Madison University should adopt core knowledge, skills, and abilities (KSAs) and the elements within each that are essential to development of a curriculum that supports the understanding and practice of each KSA.**

**RECOMMENDATION 2: Upon the adoption of core knowledge, skills, and abilities, Virginia's Community Health Worker programs should recognize an individual CHW's achievement of each KSA, regardless of the CHW program providing the KSA.**

**RECOMMENDATION 3: In collaboration with and the cooperation of Virginia's community health worker programs, the Virginia Center for Health Outreach should develop the necessary data collection system to register the attainment of core knowledge, skills and abilities of individual Virginia CHWs.**

### **III. EDUCATION AND TRAINING OF CHWs: BEYOND A CORE CURRICULUM**

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"When you're an outreach worker, where do you go from there?" You have all this experience and you can't go further." *A Virginia CHW*

#### **Non-Academic Credit Continuing Education**

Continuing education, as defined in the Ohio Administrative Code governing certification of community health workers means "a planned learning activity that builds upon a community health worker's pre-certification education program and enables a community health worker to acquire or improve skills, knowledge or behavior that promotes professional or technical development or the enhancement of career goals and is approved by the board" (Nursing)<sup>24</sup>.

As described earlier, the majority of CHW training occurs on-the-job. The NCHAS found that on-site training is valued by many agencies<sup>25</sup>. Continuing education is decentralized, and is most often provided by CHW programs. A 2002 program survey completed by the Virginia Center for Health Outreach found that 70 CHW program sites reported a median of four hours of monthly inservice or continuing education hours. Program coordinators (59%) were most often cited as the providers of training. Nurses (52%) and health educators (39%) were also frequently cited as providers of training. The amount of continuing education received by CHWs is dependent upon program resources. As program resources diminish, continuing education budgets (travel, fees, lodging) are reduced or eliminated.

With on-site training, CHW programs are able to utilize local health and human service providers as trainers. These relationships also can lead to important partnerships where services are coordinated and information shared. This could also

support the introduction of CHWs to other health and human service providers where the role of the CHW is included in a cross or interdisciplinary approach to service provision.

### **Academic Credit Training Programs and Certification**

In Virginia, there is not certification of CHWs and there is currently no formal movement within the state that seeks certification of CHWs. However, there are elements inherent in certification that is valuable to maximizing the role of CHWs within the health and human service workforce. Principle among these is training and continuing education.

Historically, many CHW programs have worked with community colleges to establish academic credit for CHW training<sup>26</sup>. According to the NCHAS, partnerships between CHW programs and community colleges have gone through periods of demand when there were large numbers of CHWs seeking credit. These programs dissolved as either demand or resources, whether personal or program, faded<sup>27</sup>. One Virginia program typified this example.

#### CHIP of Virginia and Virginia Western Community College - An Early Start

From 1993-1997 the Child Health Investment Project (CHIP) of Virginia and Virginia Western Community College (VWCC) piloted what may be the first academic credit program targeted to community health workers. CHIP recognized the need for a basic level of knowledge and a desire to support ongoing training of its CHWs as well as parents enrolled in the program. In collaboration with VWCC, a career studies certificate in child and family support services was developed. Approval for the certificate was awarded and community colleges located in regions where other CHIP programs operated were invited to consider offering the courses.

The certificate program was designed to support the knowledge, skills, and abilities for positions providing child and family support, regardless of whether someone was a CHIP employee or an enrolled parent. The program focused on children from birth to age eight and their families. The pilot program offered at VWCC was an option in the Early Childhood Development Program. CHIP of Virginia offered scholarship support to CHIP staff and parents enrolled in the CHIP program. To receive the certificate, the following courses were to be successfully completed.

1. Human Relations
2. Child Health and Nutrition
3. Child Psychology
4. Community Resources and Services
5. A coordinated 16 week internship in Human Services or Child Care

According to CHIP staff, CHWs with CHIP who had never attended college used the course as a “stepping-stone” to furthering their education. The course was not used as a requirement for employment with CHIP nor was it used as core training. However, CHIP recognized the internship requirement of the course as being particularly important in order to gain directed experiential learning in a collaborative environment.

The scholarships were made available through a federal Family Resource and Support grant. Once the federal funding was no longer available, financial barriers caused barriers to program enrollment and the pilot program lapsed.

The Center for Sustainable Health Outreach at The University of Southern Mississippi, an initiative dedicated to CHW training and education, has compiled a summary of examples of college and university programs providing credit, certificate and degree-granting programs for the generalist community health worker. Several of these programs are summarized below.

#### Sinclair Community College, Dayton, Ohio

High school graduates and those with a GED are eligible for admission into this four-hour credit program. Individuals enrolled in the program are trained to link persons with community resources, communicate community needs to providers, and promote community involvement in disease prevention and health promotion<sup>28</sup>. Training includes a classroom component as well as community-based experiences. Community and agency groups serve a dual purpose in the program, acting as instructors and educators to the trainees as well as to their own group or agency, which they educate about the community health workers<sup>29</sup>. Trainees must pass three application tests as well as a comprehensive final test and evaluation of their work in the community.

#### Santa Rosa Junior College; Santa Rosa, California

The college offers a 20.5 credit program that provides training for those persons wishing to enter the community health worker field and for those community health workers who wish to further their skills. The program is designed so that it may be completed in two semesters, with part-time students able to complete the program in two semesters and two summer sessions<sup>30</sup>. Credits earned in the certificate program may be applied toward an associate degree in a variety of majors, and there is also a career ladder for students who wish to earn a bachelor's degree in health science or health education or a master's degree in public health<sup>31</sup>.



### Mission College; Santa Clara, California

The program is offered as either a Community Health Worker certificate (30 credit hours) or an associate of science degree (60 credit hours) in community health work<sup>32</sup>. Students are trained to become liaisons between consumers and providers of health care services. Roles for which the student is prepared include communicating health information to encourage proper utilization of services, instruction in preventive health, and utilizing expertise to link consumers with appropriate care<sup>33</sup>. The primary focus of the program is to further train those persons who are already employed in health care settings in order to enhance performance in their current position or to create opportunities for career mobility<sup>34</sup>.

### Community-Voices Miami (CVM)

CVM is a W.K. Kellogg Foundation funded initiative that seeks to improve access to health care services for underserved and vulnerable populations of Miami and Dade County, Florida. CVM has partnered with the United Way of Miami-Dade to develop the Community Health Workers Project. The goal of the project is to integrate CHW practice and training with existing primary and preventive healthcare services and community resources and ultimately develop a professional career track for CHWs<sup>35</sup>. With the support of Miami-Dade College, local funders, and project participants, CVM will pilot a CHW curriculum in three sites in the Miami-Dade County region<sup>36</sup>. Upon successful completion of the curriculum, Miami-Dade College will provide students with certification. The project is viewed as a step toward CHW credentialing and broader implementation of the model.

The sustainability of current programs, expansion of existing programs, and development of new academic credit programs for CHWs will depend upon a number of factors. Many of these factors are interdependent. These factors include:

- Recognition of CHWs as important members of the health and human workforce by policy makers and other health and human service professionals
- Integration of CHWs into interdisciplinary health professional teams
- CHWs seeking career advancement opportunities where there is dependency upon academic credit programs
- Adoption of formal core knowledge, skills and abilities across CHW programs
- Partnerships between CHW programs and community colleges and other institutions of higher learning
- Reimbursement for CHW provided services

## RECOMMENDATION

**RECOMMENDATION 4: The Virginia Center for Health Outreach, in collaboration with Virginia’s Community College System and other institutions of higher learning, should explore and develop ways to provide CHWs with educational opportunities that offer academic credit and identify career pathways.**

## IV. MAXIMIZING THE ROLE OF COMMUNITY HEALTH WORKERS

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Eliminating health disparities among racial, cultural, and economically disadvantaged populations has remained a priority of the U.S. Department of Health and Human Services since it was first expressed in the document *Healthy People 2000* and reaffirmed in *Healthy People 2010*<sup>37</sup>. CHWs are considered to be important members of the healthcare workforce in reducing barriers to health and human services among vulnerable populations.

The integration of CHWs as members of health care teams, within the context of roles where research has shown CHWs to be particularly effective, is a promising strategy for improving health outcomes and efficiencies within health and human service delivery systems.

The programs highlighted below are examples of how CHWs have been integrated into various organizations or have addressed specific population groups or health conditions. Common to each example is the illustration of the seven core roles of CHWs identified by the NCHAS.

**“The widespread incorporation of CHWs into the health delivery system offers unparalleled opportunities to improve the delivery of preventive and primary care to America’s diverse communities.”**

Pew Health Professions  
Commission 1994

### CHWs and Integration in Health Services Sites

#### CHWs and managed care organizations

The utilization of CHWs in managed care organizations can incorporate the spectrum of roles most closely identified with CHWs. This includes increasing elements of cultural competence and health literacy within managed care organizations (MCO). In particular, vulnerable populations including low income persons and the

elderly often lack an understanding of care directives. The CHW is able to effectively bridge the gap between the client and the often confusing structural elements of the delivery system. This confusion extends to clinical instructions. For example, a Virginia CHW recalled a client that had been prescribed a medication for her asthmatic child dispensed through an inhaler. The prescribing physician assumed the child's mother would know how to properly administer the drug. The CHW discovered that the mother was spraying the inhaler in the air, similar to how one would use a can of air freshener. There are numerous examples that can be cited by CHWs where clients have inappropriately used medications or misunderstood treatment directives because they did not understand.

There is much documentation regarding the assistance CHWs provide persons in navigating health and human service delivery systems. Since 1971 Kaiser Permanente in Hawaii has employed CHWs to increase Medicaid enrollees access to preventive services. Kaiser utilized CHWs as single-points-of-contact from whom their members could obtain information, advice in understanding how to use Kaiser's facilities and link members to services not provided by Kaiser such as housing, social services, legal services, etc.<sup>38</sup> For CHWs employed by Kaiser, a significant percentage of their time was devoted to recruitment, enrollment and orientation of eligible AFDC (Aid to Families with Dependent Children). Within Kaiser's services, the CHWs' role evolved to managing high-risk members who were pregnant, asthmatic or diabetic. Kaiser found that 10% of its Medicaid enrollees had complex social, psychological and medical problems that consumed a great deal of outreach team's time<sup>39</sup>. These teams included CHWs. Kaiser's evaluation of the CHWs found the following:

- Physician and nurse leaders, though initially skeptical, expressed the wish that all members (not just Medicaid enrollees) could have outreach workers (CHWs)<sup>40</sup>
- Over most of the 20 year review, the capitated amount charged by Kaiser for Medicaid enrollees was 15-20% below fee-for-service Medicaid charges. This percentage has narrowed in recent years<sup>41</sup>
- Medicaid enrollees used more preventive services such as immunizations than commercial group members, made more visits to nurse practitioners than other members, and less visits to specialists. The average utilization of ambulatory care was almost identical to the utilization pattern of commercial members<sup>42</sup>

#### CHWs and federally supported health centers

In 1998, the Bureau of Primary Health Care, Health Resources and Services Administration of the U.S. Department of Health and Human Services conducted a study of CHWs working in seven federally supported centers providing health care for medically underserved populations.

The study concluded that successful health centers with experienced staff often cannot meet all patients' needs<sup>43</sup>. However, these centers, using CHWs to support and/or expand existing projects, enables health centers to satisfy more of their patients' needs. Using CHWs to implement new programs can also be positive. For example, CHWs can help to orient community members to managed care, particularly in states that are mandating enrollment in managed care for Medicaid and other state beneficiaries. Programs found that when CHW activities were integrated with the center's clinical operations, patient needs were less likely to "slip through the cracks"<sup>44</sup>.

### CHWs and Inappropriate Use of Emergency Rooms

Inappropriate use of emergency rooms is increasing across the nation. This is caused in part by the growth of foreign-born populations who are not familiar with the delivery of health care services in this country, the growth of the uninsured and Medicaid populations that are having difficulty accessing community-based primary care services. It is conventional wisdom that in the United States, if someone does not know where to turn for health care, or does not have the financial resources to access care, he/she seeks care through hospital emergency departments.

The value of CHWs as navigators, cultural liaisons, and trusted voices within vulnerable populations has significant potential to reduce inappropriate use of hospital emergency departments. The effectiveness of CHWs in working with persons impacted by chronic diseases such as diabetes, asthma, hypertension, and HIV/AIDS helps direct persons to appropriate community sources of care in addition to helping people access information that helps them to more efficiently manage their health. The National Center for Primary Care at the Morehouse School of Medicine issued a report in 2003 that recommended that CHWs be placed in emergency departments in order to assist patients to understand the process of emergency department care; enroll in available health insurance programs; identify and initiate relationships with community-based primary care resources; and to access and utilize follow-up care and medications that would reduce the likelihood of a repeat visit for the same condition<sup>45</sup>.

### **CHWs and Chronic Disease Management**

#### CHWs and reducing asthma morbidity among urban children

Use of community health workers to obtain health, social, and environmental information from African-American inner-city children with asthma was one component of a larger intervention study designed to reduce morbidity in African-American children with asthma. A subset of 140 school-aged children with asthma was recruited and enrolled in a program to receive home visits by CHWs for the purposes of

obtaining medical information and teaching basic asthma education to the families<sup>46</sup>. Data obtained by the CHWs revealed low inhaled steroid use, high beta 2 agonist use, frequent emergency-room visits, decreased primary-care visits, and increased allergen and irritant exposure<sup>47</sup>. Appropriately recruited and trained CHWs are effective in obtaining useful medical information from inner-city families with children with asthma and providing basic asthma education in the home<sup>48</sup>.

### CHW - Academic Health Center partnership to address hypertension

Johns Hopkins University physicians, nurses and public health workers joined with the East Baltimore Heart, Body and Soul Program. This 15-year intervention involved multiple strategies implemented in an inner-city African American community and targeted screening and detection of high blood pressure. This involved peer outreach in churches and CHWs stationed in emergency rooms<sup>49</sup>. The program also involved continuing education of CHWs, the use of media messages and recruiting area food markets and fast-food restaurants to promote healthy lifestyles<sup>50</sup>.

In the initial five-year phase of the project, the rate of control of hypertension in the intervention group doubled from 38% to 79% with a 35% decrease in hospitalizations and a 65% decrease in mortality from uncontrolled hypertension<sup>51</sup>. In the second eight-year phase, control of hypertension among men rose from a baseline of 12% to 40%<sup>52</sup>.

## **CHWs and Reaching Vulnerable Populations**

### The Kentucky Homeplace Project

Kentucky Homeplace was established in 1994 by the Kentucky General Assembly. The program was originally developed by the University of Kentucky Center of Excellence in Rural Health as a demonstration project receiving funding from the Commonwealth of Kentucky<sup>53</sup>. The program hired residents from the affected communities and trained them to be Family Healthcare Advisors (FHCAs). The FHCAs then provide a variety of health and social services to people living in their communities<sup>54</sup>.

The initial group of FHCAs focused on assisting their clients in a variety of ways; beginning with a home visit. During the home visit, the FHCA would assess the family's health care needs and help them decide how best to address these needs<sup>55</sup>. The FHCA would encourage their clients to have regular medical checkups and seek preventive care, thereby reducing the use of more expensive emergency care. As a member of the community, it was believed that the message would be better received

from the FHCA than from an “outsider”. Clients would also be linked to reduced price and free medical services and drugs whenever possible.

In the July - September 2005 quarter, the project assisted clients in accessing \$10.2 million dollars of free medications with a mean value of \$297.21 per prescription<sup>56</sup>. Over 7,700 clients received services from the project during the quarter with a mean cost per client of \$68.20 and a mean cost per service of \$4.00 per client (based upon an average of 17 services per client)<sup>57</sup>.

### CHWs and in-home care for older adults

The majority of older Americans and those with disabilities wish to remain independent and seek care options where they can receive needed assistance in their homes. According to a report by the American Association of Retired Persons (AARP), the United States has no organized *system* for providing the basic personal care that would allow older persons and the disabled to remain in their homes longer<sup>58</sup>. Many Virginia programs including Area Agencies on Aging, Department of Medical Assistance Services, Departments of Social Services, either provide services or provide financial support for persons providing activities associated with Activities of Daily Living (ADL) such as bathing, meal preparation, etc. The AARP report recognizes that as people age, assistance with daily activities such as dressing, bathing, and preparing meals, activities that are often provided informally by family members, is needed more frequently than medical care<sup>59</sup>. Ostensibly, the aging of the U.S. population impacted the U.S. Department of Labor projection that social and human service assistants will “grow much faster than average” for the period 2002 - 2012.

Medicare beneficiaries with three or more chronic health conditions such as heart disease, diabetes, and asthma, account for almost 90 percent of total spending while beneficiaries with no chronic conditions account for less than one percent<sup>60</sup>. The provision of care at home or in assisted-living facilities instead of nursing homes support greater independence for older persons as well as provide better value<sup>61</sup>. Research has indicated that a care model that promotes patient self-management, practice teams that include non-physician personnel, and decision support based on evidence-based practice guidelines and clinical information systems is effective in managing chronic conditions<sup>62</sup>. Beyond providing personal care services to older adults, CHWs, integrated into multidisciplinary health care teams, can support in-home compliance with prescribed treatment regimens that help older adults live more independently, longer. This offers the older adult a greater quality of life and cost-savings in the delivery of health care services.

## CHWs and Improving the Quality of Health and Human Services

### CHWs and Cultural Competence

**“...the issues of health care utilization, health risk reduction, and strength of therapeutic alliance are suggested as the primary concerns or domains for examining best practices of CHWs providing culturally competent care.”**

Nemchek and Sabatier

As the diversity of many communities in Virginia increases, the issue of cultural competence in the delivery of health and human services is frequently discussed. Cultural competence includes the following attributes; cultural awareness, cultural knowledge, cultural understanding, cultural sensitivity, and cultural skill<sup>63</sup>. A core role of CHWs is providing cultural mediation between communities and health and human service delivery systems. The trust that CHWs establish with their clients enable the collection of information that is often inaccessible to other health and social service providers<sup>64</sup>. When this information is shared with health and human service personnel, more accurate diagnoses and treatment plans are possible.

The National Center for Cultural Competence has identified several reasons why cultural competence is important for health and human service practitioners. The first reason is the age, race, and ethnic diversity changes taking place in the country<sup>65</sup>. The second is that eliminating health status disparities among racial and ethnic populations calls for cultural competence among health and human service professionals<sup>66</sup>. The third reason for cultural competence is improving outcomes of health and human services<sup>67</sup>.

### CHWs and Health Literacy

Health literacy is the ability of an individual to access, understand, and use health-related information and services to make appropriate health decisions<sup>68</sup>. Today, patients are asked to assume more responsibility for self-care within an increasingly complex health care system<sup>69</sup>. U.S. Surgeon General Richard Carmona, citing a study of English-speaking patients in a public hospital, said that one-third of the patients were unable to read basic health materials. In addition, 26% of the patients could not read their appointment slips and 42% did not understand the labels on the prescription bottle<sup>70</sup>. According to Carmona, most patients hide confusion from their physicians because they are too ashamed and intimidated to ask for help. This is confirmed by the

**“Low health literacy costs the health care industry \$73 billion a year in misdirected or misunderstood health care services. More than 90 million Americans cannot adequately understand basic health information.”**

Richard H. Carmona, M.D.  
United States Surgeon  
General

Blue Ridge Area Health Education Center at James Madison University. The Blue Ridge AHEC coordinates an interpreter program for limited English proficient persons in Harrisonburg and Rockingham County. The coordinator for the program notes that interpreters are frequently asked to clarify health professional statements after the appointment despite that every word is interpreted for the benefit of the patient and the health care professional. Health literacy is critical in accessing services, understanding prescriptions, treatment directions, and the promotion of healthy behaviors and primary prevention. Carmona has called for the utilization of CHWs to improve health literacy and suggests that for health literacy to improve that there needs to be increased collaboration among all sectors of the health care industry, including policy makers.

### CHWs: Establishing Trust while Improving Quality of Maternity Care

The research article *Providing health care to low-income women: a matter of trust* explored health care experiences that influence patient trust among low-income women in the United States with respect to health care professionals and lay health workers (CHWs). The study method included focus group discussions with 33 prenatal and postpartum women aged 18-45 years<sup>71</sup>. According to study results, factors related to greater trust specific to patient-provider relationships included (1) continuity of the patient-provider relationship, (2) effective communication, (3) demonstration of caring and perceived competence<sup>72</sup>. Not surprisingly, women with less trust in their physicians reported an unwillingness to follow their advice<sup>73</sup>. Most of the women reported having more trusting relationships with CHWs and nurses than with physicians<sup>74</sup>. Speculation suggests that CHWs and nurses spent more time the women and this impacts feelings of trust. It must be pointed out, in fairness to physicians, that pressures of health care financing within an increasingly complex health care system does not support physicians spending greater amounts of time with patients.

## RECOMMENDATIONS

**RECOMMENDATION 5: Health professions training programs should identify opportunities within existing curricula to educate students and practicing professionals regarding the role of CHWs in an efficient and effective health and human service delivery system.**

**RECOMMENDATION 6: The Commonwealth of Virginia, in collaboration with public and private agencies, should seek opportunities to support demonstration projects that integrate community health workers within existing health and human service delivery systems that care for vulnerable populations.**



## V. FINANCING OF CHWs

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Most funding for CHW programs is derived from state, federal, and local sources. Some programs receive private funding from foundations and private community agencies such as United Ways. Funding is often time-limited and may be targeted to specific issues or population groups<sup>75</sup>. Many CHW program budgets are comprised of funding from all of the sources named above. Program leaders are often in constant search of funding sources. A patchwork of funding with limited time frames or funding applicability creates cycles of unpredictability and undermines program continuity.

CHW research has emphasized that for CHW services to be eligible for reimbursement, a number of factors have to be considered. One of these is that there is a common definition of the role of CHWs. Officials with the Virginia Department of Medical Assistance Services have supported this statement by emphasizing that developing an overarching definition of the scope of services provided by CHWs is important to seeking reimbursement for services. The interim report recommended the adoption of the title of “community health worker” within Virginia’s job classification system. In collaboration with the Virginia Department of Human Resource Management, “community health worker” has now been added to the Direct Service Career Grouping within the Occupational Family of Health and Human Services. This addition provides community health workers in Virginia a resource to describe the work of CHWs across multiple audiences. Also important in moving toward Medicaid reimbursement for CHWs is the development of training standards for CHWs.

A stable source of funding offers CHW programs the opportunity to maximize the promise of CHWs and establish strategies of integrating CHWs into health and human service teams. One element of a long-term solution to the unpredictability of CHW program funding is to fully utilize outreach and education dollars that are available through Medicaid and State Children’s Health Insurance Plans (SCHIP). The Department of Medical Assistance Services in partnership with the Virginia Health Care Foundation (VHCF) has been successful in increasing enrollment in Virginia’s SCHIP called FAMIS (Family Access to Medical Insurance Security). Outreach workers and CHWs have played a key role in the increase in enrollment. This funding is time-limited with the hope that programs are able to absorb the CHW positions without VHCF funding.

The Department of Medical Assistance Services (DMAS) has been reimbursing for services delivered by those who are considered CHWs. These include Resource Mothers, home health and personal care coverage programs. DMAS offers waiver services to allow for community-based long-term care services to person who would

otherwise require nursing home care or other forms of institutional care. Typically, these persons require care over long periods of time. CHWs have had an important role in the delivery of these services. Through the Medicaid waiver system, CHWs may be able to utilize Medicaid funding avenues<sup>76</sup>. Another Medicaid funding option is the Administrative Claiming program. Administrative Claiming takes advantage of a provision in Federal law permitting states to claim federal financial participation for administrative expenses states incur in operating their Medicaid programs. Such expenses may include costs of intake, assessment, service planning, arranging Medicaid services for recipients, and overseeing service delivery--many of the activities typically performed by case managers<sup>77</sup>.

### **Barriers to Maximizing CHW Integration**

There are several issues confronting CHWs and CHW programs that represent barriers to the integration and maximization of CHWs within health and human service delivery systems. First is a general lack of standardized core education and training discussed earlier in this report. Second is a lack of recognition of community health workers as a component of the health and human service workforce. Unlike other professions, such as medicine, nursing, and allied health professions, CHWs lack formal associations and other advocacy organizations. Third is the lack of research focusing on CHW process and outcome evaluation<sup>78</sup>.

The acknowledgement of a lack of evaluation studies compared with numerous published articles and calls for increased utilization of CHWs are not contradictory. A sign purported to have hung in the office of Albert Einstein at Princeton University read "Not everything that counts can be counted and not everything that can be counted counts". However, the environment in which health care systems operate places emphasis on evidence-based practice and increasing accountability of health care systems and providers<sup>79</sup>. Although each CHW program may operate somewhat differently, there are general challenges to evaluating CHWs that would likely impact any program attempting to conduct an evaluation. These challenges stem from the following reasons:

- lack of funding
- lack of resources
- characteristics of the program and its services; or
- characteristics of the population served by the program (i.e. highly mobile)

In addition, much of the work performed by CHWs occurs outside formal institutions that have the capacity, if not the requirement to produce outcome reports; for example, hospitals and managed care organizations.

## RECOMMENDATION

**RECOMMENDATION 7: In collaboration with the Virginia Department of Medical Assistance Services, the Virginia Center for Health Outreach and CHW programs should examine opportunities for additional Medicaid reimbursement that utilize CHWs.**

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## VI. CONCLUSION

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Introducing the reader to *Community Health Workers and Community Voices: Promoting Good Health* (2003), Dr. Henrie Treadwell eloquently implored the use of CHWs to create a more responsive and effective health care workforce for the United States.

Reaching out into homes and into the community to promote healing and wellness as an integral part of practice is as old as health care. But this practice is threatened.

Prevention was a hallmark of health providers' work many years ago. And assessing the local context, as it contributed to health, was considered as *sine qua non* in prescribing intervention and treatment. Community health workers used to conduct outreach, back when physicians made house calls, and public health nurses delivered services and conducted routine surveillance and prevention activities. These activities were compromised when some felt that it would be more efficient to deliver care somewhere other than in homes and in communities. Some may have considered it too dangerous for frontline workers to go into neighborhoods, or that greater quality could be assured if everyone came to a central facility. Or perhaps it is simply that the profession became "professionalized" and it was no longer "modern" to go out to where the people lived.

The reasons for withdrawal from the community are unclear. What is clear is that the health care system, if measured by the ultimate benchmark of equity, or no disparities, is an extremely poor performer particularly when one considers the fiscally intense resourcing of facilities and of the current first tier providers. Far too many of America's poor and underserved cannot access the clinic or provider office to obtain the basic health and associated services that they need to remain well. For many, the barrier to care is often the difficulty in finding someone who will take the time to talk and direct them to the various services and resources they need. No one has ever proven that going and reaching out was or is an ineffective or non-cost-accountable way of maintaining the health of people and of communities as a whole.

Reversing the tide to bring back what was valuable - what worked in past models of service and outreach - is challenging. We seem to have become a nation that requires unparalleled sophistry about cost-effectiveness of health outreach workers yet, other health care costs rise exponentially. At the same time, we know intuitively and factually that our health systems save money when people access care for prevention versus costly care as a result of preventable emergencies or chronic conditions. A more user friendly conduit that gets people into care is needed.

The story of a community health worker (a.k.a., promotora, doula, lay health advisor, outreach worker, frontline worker, etc.) of reaching and improving the health of individuals seems simplistic, yet is not simply related. The story is one of special people willing to see and able to understand how health is diminished or improved by social place, educational achievements, economic opportunities, quality of housing, among other factors. Community health workers are able to weave together an agenda to help change individual circumstance while insuring access to appropriate health care services. Too many individuals don't receive assistance and are unable to find their way to appropriate and effective health care as the walls around the systems appear to be too high for many to scale.

One wonders what we were thinking when services were withdrawn from the field and placed within walls. Evidence continues to mount showing that some groups within this country consistently experience disparate access and treatment and unequal outcomes. Many health systems and agencies are working to remove the barriers of the intellectual, cultural, and physical walls by putting into place individuals who can bridge the gap between institutions and those individuals or communities who need care. Bridging the gap is only the most basic element of what community health workers provide when assisting the poor, underserved, and disconnected in search of healing.

The art of communicating, of reaching, of touching individuals effectively in order to heal is perhaps the most promising hope that we have of eliminating health disparities while we mend a broken health care system headed toward financial meltdown. Yet, using the cadre of community health workers that we know works so effectively in bringing people into care and in reducing costs seems not to have gained priority national attention. This document (Community Health Workers and Community Voices: Promoting Good Health) seeks to tell the comprehensive story of the community health worker, the work of outreach, preparation for this work, and options for financing. We also hope that this document will move many to action: to the use of community health workers, and to the work of educating policy makers about the integral role that these

frontline workers can and must play in making our health system whole and fiscally stable.<sup>80</sup>

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## FOOTNOTES

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## **APPENDIX 1. AUTHORITY FOR THE STUDY**

### HOUSE JOINT RESOLUTION NO. 195

*Requesting James Madison University to study the status, impact, and utilization of community health workers. Report.*

Agreed to by the House of Delegates, February 17, 2004

Agreed to by the Senate, March 9, 2004

**WHEREAS**, community health workers are trained lay persons who, as trusted members of their communities, serve as health resource persons where they live and work, implementing culturally appropriate health education and outreach among groups that have traditionally lacked adequate health care; and

**WHEREAS**, community health care workers (known as home visitors, lay health outreach workers, peer health promoters, family support workers, and *promotoras*), help shape health care from the bottom up at the community level where needs exist and where real and lasting changes can occur; and

**WHEREAS**, community health workers, whether paid or volunteer, are an essential component of community wellness, promoting healthy practices and removing barriers to primary and preventive care; and

**WHEREAS**, Healthy Virginians 2010 calls for an increase in the quality of life, life expectancy, and the elimination of health disparities among different segments of the population; and

**WHEREAS**, 220 state, federal, local and private programs in the Commonwealth already use community health workers to address 21 of the 22 goals of Healthy Virginians 2010; and

**WHEREAS**, utilization of community health workers is an efficient and effective means of addressing the health and social service needs of people and communities and improves community health care by bridging socio-cultural barriers between vulnerable and underserved community members and health care systems; and

**WHEREAS**, the Commonwealth's communities are undergoing cultural change as new populations become residents; and

**WHEREAS**, providing culturally appropriate health care access, education, and information is necessary to ensure health as a right promised by the Constitution of Virginia, including "the enjoyment of life and liberty" and "pursuing and obtaining happiness and safety"; and

*WHEREAS*, community health workers constitute a viable, cost-effective support to health care in an era of decreasing federal and state funds and maximize state and federal resources if integrated into a public agency; and

*WHEREAS*, federal Medicaid regulations require appropriate outreach, enrollment, and translation/interpreter services, which means additional federal funding is available for the use of increased community health worker services; and

*WHEREAS*, the current state and federal Medicaid and health care crises will, without new resources, result in reduced availability of many services; and the utilization of culturally and linguistically appropriate care management through community health workers can serve as a best-practice quality measure in contract compliance; and

*WHEREAS*, the cost-benefit ratio of health care in today's economic climate favors the prevention and paraprofessional work of community health workers; and

*WHEREAS*, factors such as unstable funding, professional misperceptions of the role of community health workers, and the lack of standard community health worker identity, training, and documentation of impact contribute to the underutilization, attrition, and misunderstanding of community health workers, and increase program costs; now, therefore, be it

*RESOLVED* by the House of Delegates, the Senate concurring, That James Madison University be requested to study the status, impact, and utilization of community health workers. The University shall seek participants from the Department of Medical Assistance Services, the Department of Social Services, the Child Health Investment Program, Healthy Families Virginia, the Expanded Food and Nutrition Education Program, the Smart Choices Nutrition Education Program, the Northern Virginia Area Health Education Center, George Mason University, and the Virginia Center for Health Outreach to assist in the conducting of this study.

In conducting its study, the University shall (i) inventory the number, roles, and training of all community health workers employed in the Commonwealth and explore a standard designation for such workers; (ii) identify and review outcome studies and evaluations on the efficacy of community health workers; (iii) determine ways to elevate the role of community health workers in the health care delivery system and to integrate more effectively such workers in public agencies; (iv) examine the potential use of community health workers as part of a best-practice quality measure for Medicaid and other contracted providers; (v) explore the development of a statewide core curriculum that would be used for the training of publicly employed community health workers and be available for volunteer workers; and (vi) recommend any other steps to maximize the value and utilization of community health workers.

All agencies of the Commonwealth shall provide assistance to the University for this study, upon request.

James Madison University shall complete its meetings for the first year by November 30, 2004, and for the second year by November 30, 2005, and the University shall submit to the Governor and the General Assembly an executive summary and report of its findings and recommendations for publication as a document for each year. The executive summaries and reports shall be submitted as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports no later than the first day of the next Regular Session of the General Assembly and shall be posted on the General Assembly's website.