Community Health Workers

Discussion Paper

Consumer Health Foundation
Natalie Erb
MPH Fellow
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INTRODUCTION

The Community Health Worker (CHW) field is gaining attention as a solution to many of the challenges presented by the rapidly changing demographics, health system, and epidemiological profile of the United States. A range of CHW programs exist across the country, each unique in its particular role in the community, funding structure, and training requirements. This report presents an overview of the CHW field. It describes national trends, local programs, and a variety of successful models to inform a conversation about ways improve the effectiveness and sustainability of CHW programs in the Washington, D.C. region.

DEFINITION

The American Public Health Association defines a Community Health Worker (CHW) as:

> 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 (About Community Health Workers).

Although various stakeholders (community-based organizations, researchers, certification programs, etc.) often develop a unique definition of their community health workers, the following aspects are universal:

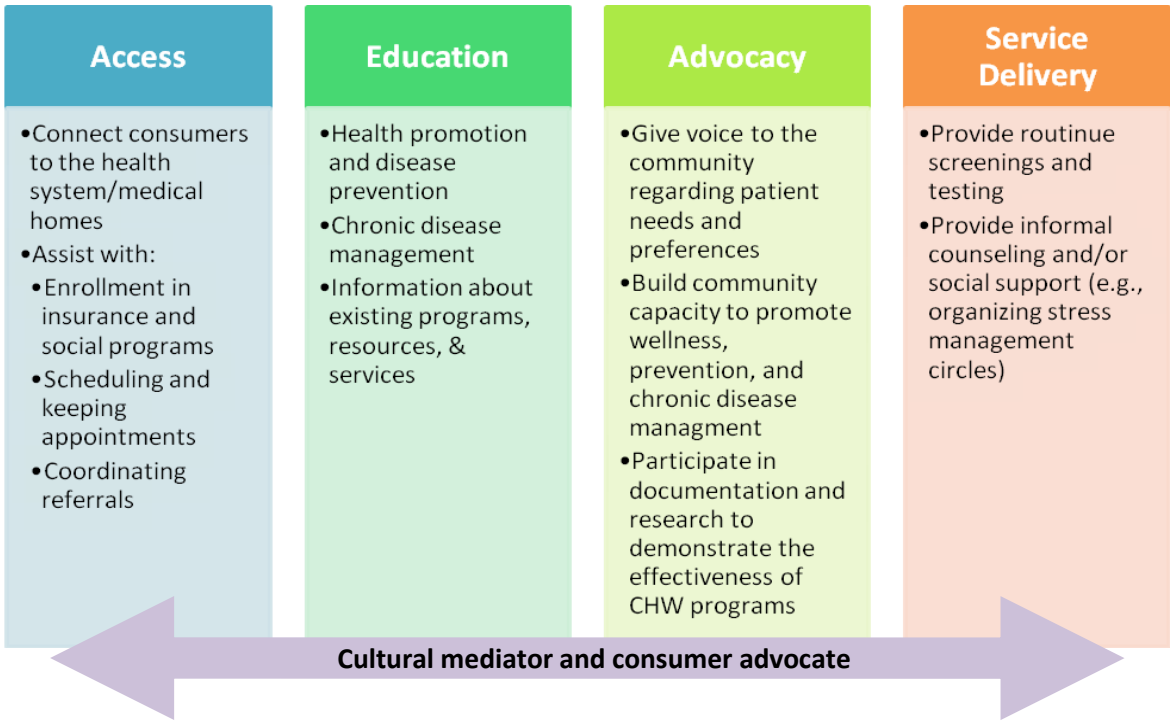
- CHWs have strong ties (e.g., language, culture, residence) to the communities they serve;
- CHWs act as intermediaries between communities and systems (most often the health system but also other social services);
- Activities range from patient education to advocacy efforts, always with the intent of empowering individuals to improve individual and community health.

Notably, in 2010 the Department of Labor's Standard Occupational Classification included a unique occupational classification for a Community Health Worker (SOC 21-1094). This is a crucial step in moving toward sustainable reimbursement models.

ROLES

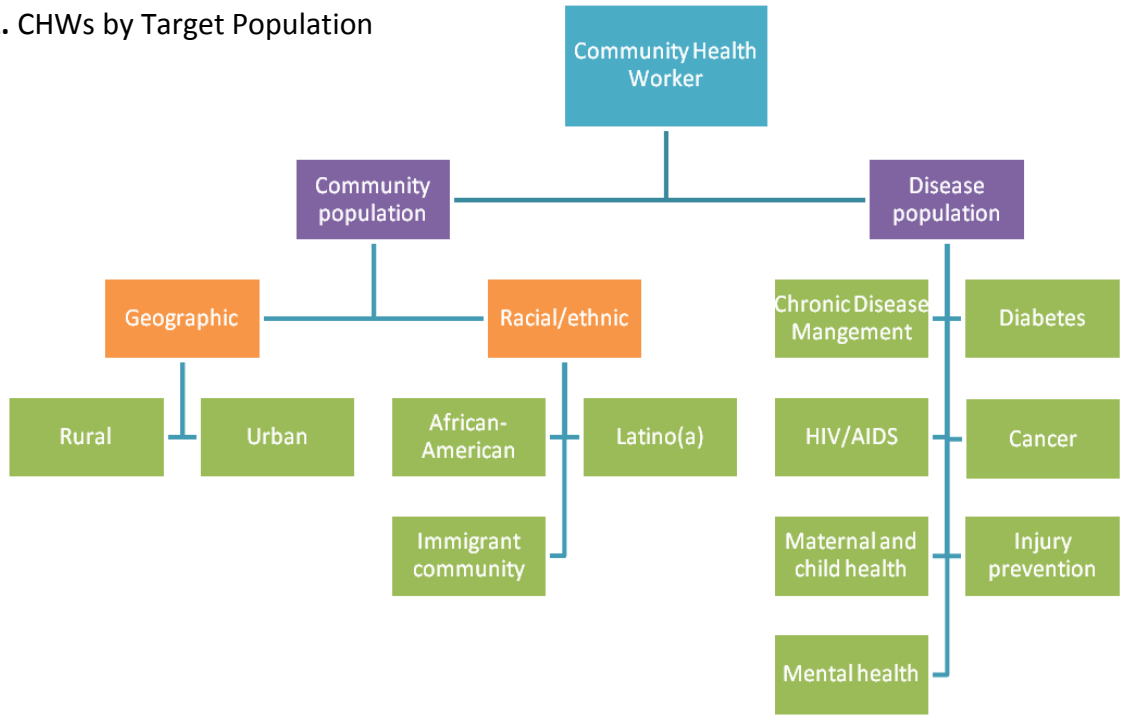
CHWs have four main roles: promoting access, providing education, advocacy, and service delivery. Table 1 categorizes CHW activities by role. Most CHWs perform activities across multiple roles. Regardless of the specific activities they perform, CHWs are always consumer advocates and cultural mediators.

Table 1. CHW Roles and Activities



Another way to define CHW roles is by target population. CHWs work primarily in underserved, vulnerable communities that may be defined racially or ethnically, geographically, or by disease. CHW work is crucial in the elimination of health disparities and the promotion of health equity. Below are the most common target populations of CHW programs.

Table 2. CHWs by Target Population



Above all else, CHWs are reactive to community needs. Their roles and responsibilities are developed in response to a particular challenge faced by a community. Some examples include:

- A state health department discovers that women of color are receiving breast and cervical cancer screenings at lower rates than white women. The health department hires CHWs to conduct educational outreach, assist women in scheduling and keeping appointments, and following up with patients after their office visits in an effort to eliminate this disparity.

- A hospital recognizes that many children are repeatedly visiting the emergency room for asthma attacks. The hospital hires CHWs to visit the homes of these children to help families address conditions that may be aggravating the child's asthma (e.g., mold, rodents) and develop a plan to manage the asthma successfully.

- A community-based organization notices language and cultural barriers that prevent the local immigrant community from accessing health care. They may hire CHWs to act as cultural intermediaries and translators and to help individuals access care.

LOCAL PROGRAMS

A variety of CHW programs exist in the D.C. area. These programs engage a range of populations and perform a number of the roles listed above. Although the differences in programs may be most obvious, vis à vis their population focus, a closer examination reveals that many of these organizations are performing similar activities and have similar goals.

CASA de Maryland – CASA de Maryland is a community organization with a vision for strong, economically, and ethnically diverse communities in which all people – especially women, low-income people, and workers – can participate and fully benefit, regardless of their immigration status. CASA facilitates *Salud es Vida*, a program to address public health and primary care needs in the community. The program includes health education and improved access to screening and treatment services for HIV, cancer, and tobacco use prevention. CASA also provides a bilingual telephone health line to inform community members of available services and to help them navigate the system and provide medical interpreting services for limited English speakers.
Training. The program utilizes a peer training model to prepare their community health promoters.

District of Columbia Primary Care Association (DCPCA) – DCPCA is a nonprofit health action and advocacy organization working to ensure that all residents of Washington, D.C. have the ability and opportunity to lead healthier lives. Funded by the Department of Health and GWWDC, DCPCA has developed a pilot program in partnership with UDC-CC to train community health workers. Following this pilot, the Capital Health Careers program funded scholarships to train additional CHWs at UDC-CC. In addition to establishing this training program, DCPCA has received a grant from GWWDC to establish and convene the CHW Professional Network. This network will provide an opportunity for CHWs to

support each other professionally, establish their own voice as advocates for sustainable employment and initiate an opportunity for CHWs to build their own organization.

Training. The training includes two 12 week sessions followed by a 45 hour practicum. Scholarships are available through the Capital Health Careers Program. The Core Competencies of the CCDC program are:

- Increase access to primary and preventive care;
- Increase participation in screening for chronic diseases and conditions;
- Teach strategies and behaviors for wellness and prevention;
- Provide culturally competent care;
- Explain available health coverage programs and facilitate enrollment;
- Facilitate appointment-keeping;
- Increase compliance with prescribed regimens.

La Clínica del Pueblo (LCDP) – La Clínica del Pueblo is a federally qualified health center that serves the Latino and immigrant populations of the Washington, D.C. metro area. LCDP hires and trains community health workers through their *promotores de salud* program. *Promotores* assist in the assessment of health needs within the community and develop strategies grounded in public health and community mobilization to address these needs at the individual, family, group, community, or structural level. *Promotores* are central to La Clínica's community education and health fairs as well as their HIV prevention programs. *Promotores* host different *charlas*, or educational "chats," on a variety of topics, ranging from cancer to healthy eating, at health fairs and other La Clínica events. LCDP's HIV/AIDS programs also rely heavily on *promotores. Promotores* trained in HIV prevention conduct street outreach and visit Latino establishments to disseminate HIV prevention messages.

Training. LCDP's *promotores* participate in topic-based trainings facilitated by La Clínica to develop skills and knowledge necessary to work as CHWs.

McClendon Center – The McClendon Center is a D.C.-based community mental health rehabilitation services program. The McClendon Center employs a part-time Wellness Navigator to assist clients in identifying health care needs (other than mental health needs), such as dental and nutritional care, and will help clients access care and track their progress. Ideally, the Wellness Navigator role will be filled by a mental health consumer.

Montgomery County Department of Health and Human Services – The Montgomery County Department of Health and Human Services supports a number of CHW programs through its Minority Health Initiatives. The African American Health Program offers mini-grants to community-based organizations to conduct outreach. The Asian American Health Initiative includes a Patient Navigators Program through which trained Asian American medical interpreters offer translation services at community clinic sites and through a telephone hotline. Additionally, the Health Promoters Program "Vias de la Salud" provides training and empowerment of Latino health promoters using strategies of health promotion and healthy lifestyle behaviors. Health promoters work to access to care and to advocate for policies that impact and benefit the community.

Positive Pathways – The Washington AIDS Partnership and the Institute for Public Health Innovation created the Positive Pathways community health worker program to serve HIV-positive women and their partners. The program utilizes a philosophy of "meeting people where they're at" to identify and (re)engage people living with HIV/AIDS (PLWH/A), build peer-based trust and knowledge, provide personalized assistance to navigate systems, support PLWH/A throughout early parts of care, and assist with access to other resources. The program has trained and supported 12 CHWs who work at safety net primary care providers, the safety net hospitals, primary care providers specializing in HIV/AIDS care, and grassroots community-based organizations. The program also utilizes a range of outreach partners and venues including the D.C. Jail, substance abuse treatment organizations, syringe exchanges, homeless service organizations, food pantries, reproductive health organizations, domestic violence organizations, churches, re-entry programs, and public housing and housing providers.

MOVING THE REGION FORWARD

To improve the sustainability and workforce conditions of the CHW field, advocacy should address both education and financing options for CHW programs. The existence of local programs and the forthcoming implementation of the Affordable Care Act (ACA) present a unique opportunity to develop the field. The following sections – Education, Financing, ACA Opportunities, Organizing and Networking, and Models – present the opportunities available and examples of successful models across the country. Discussion for a regional plan should be informed by an understanding of community needs, existing programs, and successful models elsewhere.

It is also important to understand and acknowledge how the history of CHW programs may contribute to some resistance to professionalization. The CHW field is characterized by a number of tensions, shown in Table 3. As we develop a regional strategy to move forward, these are important to keep in mind.

Table 3. The CHW Tensions

Community members	⟷	Health care system/team member
Lay person	⟷	Credentialed/Professional individual
On the job, tailored training	⟷	Standardized training
Ill-positioned for Randomized Controlled Trial (RCT) studies	⟷	Will stand up to RCT evaluation
Broad, encompassing approach & roles	⟷	Tailored, specific roles
Independent	⟷	Integrated/interdependent
Direct, out-of-pocket payment model	⟷	Services reimbursable
Volunteer	⟷	Paid

* Table adopted from Dower, Knox, Lindler, & O'Neil, 2006.

EDUCATION

Certification and training requirements for CHWs vary widely across the nation. Dower, Knox, Lindler, & O'Neil identify the three major options for CHW training and certification:

1. Community college-based training

2. On-the-job training
3. Certification at the state level

There is no national consensus on whether or not CHWs should be certified, but there has been a recent trend toward increasing the number of education and certification programs. Increasing training and education requirements will increase access to new funding sources and will help develop a career ladder for CHWs. Training programs should reflect the needs of the trainees and build not only a knowledge base about health and community issues, but also crucial skill sets such as: communication skills, service coordination skills, capacity building skills, teaching skills, organizational skills, advocacy skills, and interpersonal skills (Wiggings & Borbón, 1998).

Table 4. CHW Education Strategies

Strategy	Benefits	Challenges
Community college training	• Academic credit and formal education increases career advancement opportunities • Easier transition to other careers that require more education (e.g., nursing, social work)	• Language barriers • High school diploma/GED requirements • Lack of programs in the region • Cost
On-the-job training	• Improves the capacity of CHWs within their particular focus • Enhances standards of practice • Presents fewer barriers (e.g. language, GED)	• Lack of transferability across jobs • Less standardized • More difficult to arrange for reimbursement
State-level certification	• Recognizes and legitimizes the work of CHWs • Opens up potential reimbursement opportunities for CHW services • Will accelerate the integration of CHWs into care coordination teams	• Language/education barriers • Difficult to get the state to adopt this strategy • Certifications may not be valid across state-lines. This is particularly difficult for an area such the D.C. region in which workers are often crossing state lines.

FINANCING

One of the most pressing challenges in the CHW field is the lack of adequate financing structures. In most states CHWs are not eligible for reimbursement by Medicaid and/or other public or private

insurance programs. It is estimated that more than two-thirds of CHWs are paid (Rosenthal 2010), but wages and benefits vary widely by state, program, and funding source. Many CHW programs are funded through temporary funding sources, such as grants, so lack of continuity and job (in)security are common challenges. Dower, Knox, Lindler, & O'Neil identify four categories of funding options:

- Foundation/Government Agency
- Medicaid
- Government General funds
- Private organization

The most common funding structure is reliance on short-term, categorical grants and contracts from foundations and government agencies. The benefits and challenges of each funding option are listed in Table 5.

Table 5. CHW Funding Strategies

Source	Benefits	Challenges	Examples
Charitable foundations and government agencies (grants or contracts)	• Most common • Well-known option • Evaluations required	• Short-term • Categorical	• Latino Health Access - Santa Ana, CA
Medicaid (Reimbursement; §1115 Waiver; Managed Care Contract)	• Relative stability	• Very rare so few models exist • Time-consuming to establish • Cost data required • Opposition from competing providers	• Heath Plus – New York City (MCO that employs 35 CHWs) • Alaska State Division of Medical Assistance (tribal organizations eligible for reimbursement)
Federal, state, or local government general fund	• Relative stability • Data collection	• Time-consuming to establish • Political barriers to establishment	• Fort Worth Department of Public Health, Outreach Division, TX • San Francisco Department of Public Health
Private organizations (e.g., hospitals,	• Decisions to establish	• Stability tied to business success	• APS Healthcare Inc. • Christus Spohn Health

managed care organizations, insurance companies, and employers)	programs can be made quickly • Cost and quality data collection conducted • Potential stability	• Threat of losing the change agent/social justice lens • Populations CHWs serve have often been ignored by these groups	System, Corpus Christi, TX

To increase access to training programs and sustainable funding models, CHWs must successfully define their work in the context of the value it brings to communities and to the health care system. Many roles are not unique to CHWs; they are activities that are performed by a number of other professions. To expand the field, CHWs must be able to explain how their model offers additional value. For example, why is it more effective to have community health workers conducting nutrition education outreach than for an insurance company to send informational brochures? Why is it more effective to have CHWs partnering with HIV/AIDS patients to improve care than for the patient to meet with a nurse at a clinic? A clear demonstration of value will allow groups to take advantage of more sustainable funding streams, particularly some of the programs that will be offered through the Affordable Care Act.

AFFORDABLE CARE ACT OPPORTUNITIES

The continued implementation of the Affordable Care Act creates a favorable climate for the expansion of CHW programs. The Act creates a number of programs and grants that may fund CHW programs and also creates incentives for prevention and population health management. As payment models shift – from a fee-for-service model to bundled payments and capitation - hospitals, clinics, and insurers will be held accountable for their patient's health outcomes before, during, and after medical visits. These groups may develop greater interest in CHW programs and seek to engage CHWs in working with underserved populations.

Some specific components of the Affordable Care Act provide opportunities for the CHW field:

- Health homes and care management services for Medicaid participants;
- Incentives for prevention of chronic diseases in Medicaid;
- Incentives for employer-sponsored prevention and wellness programs;
- Incentives to reduce readmission rates;
- Health insurance exchanges (navigator role);
- Creation of Accountable Care Organizations.

Additionally, the ACA offers grant programs that will support CHW utilization:

- Grants to Promote the Community Health Workforce – Sec. 5313 – to promote positive health behaviors and outcomes in medically underserved areas though the use of CHWs

- Community-Based Collaborative Care Networks – Sec. 10333 – to support community-based collaborative care networks that serve low-income individuals

ORGANIZING AND NETWORK BUILDING

To successfully advocate for increased education and funding opportunities, CHWs will need to develop a strong regional network and leadership structure. As mentioned above, one of DCPCA's major goals is the creation of a CHW Professional Network. Such a network will strengthen organizing and advocacy efforts and will help engage stakeholders to create opportunities for CHW employment.

MODELS

Many successful CHW programs may serve as useful models for the D.C. region. The following examples are from a 2006 report, "Advancing Community Health Worker Practice on Utilization: The Focus on Financing," that also includes a number of additional case studies and information on funding models.

Case Study: Minnesota Health Worker Alliance

One of the best examples of a comprehensive, sustainable CHW program is the Minnesota Community Health Worker Alliance. The Minnesota CHW Alliance developed a MN CHW Certificate Program curriculum that is now used at four community colleges. They maintain an education committee that updates the curriculum and works to expand the program to other schools. Additionally, the program maintains a workforce committee to "promote the role of CHWs, communicate with community members about the role of CHWs, share best practices, provide training, and identify additional funding sources to help pay for CHWs." In addition to the establishment of training programs and professional support networks, in 2007 the Minnesota Health Care Programs (MHCP), a division of the Minnesota Department of Human Services, received federal approval to reimburse services provided by community health workers enrolled as fee-for-service MHCP providers. The curriculum and the steps required to bill for CHW services, as well as additional information about the program, can be found at www.mnchwalliance.org.

Case Study: San Francisco Department of Public Health

The San Francisco Department of Public Health (DPH) employs community health workers and has created a career ladder for CHWs with positions ranging from Health Worker (HW) I to IV. In fiscal year 2005 – 06, approximately 34 FTE Health Worker II and 6 FTE Health Worker III positions were approved. While some positions are generalists, others are specific to a condition such as asthma. See table below for summary information. Over the years, several individuals from community organizations, the Health Commission, the Board of Supervisors and CHW education and training programs played roles in negotiating the budget to include these positions.

Health Worker Level	Training/Experience	Essential Duties	Annual salary
I	Completion of 9th grade + 1 year community health experience	• Go through intensive training • Register patients • May interpret • Makes appointments; visits patients	$36,000-$43,900
II	Completion of high school + 1 year experience as HWI or equivalent	• Advises patients re services • Liaison between professional staff & community • Assists with data collection • May interpret and transport	$40,500-$49,100
III	Completion of high school + 2 years experience as HWII or equivalent	• Supervises lower level HWs • Interviews, screens patients • Assists in treatment planning • May conduct activity groups	$44,200-$53,700
IV	Completion of high school + 2 years experience as HWIII or equivalent	• Supervises & trains lower level HWs • May supervise program or project component • Meets with community representatives • Interviews, screens patients • Provides social counseling activities	$51,700-$62,800

Case Study: Latino Health Access

Location: Santa Ana, California
Population served: Latinos in Orange County, primarily medically uninsured
Website: www.latinohealthaccess.org

Latino Health Access is a non-profit organization committed to "improving the quality of life and health of uninsured, under-served people through quality preventive services and educational programs, emphasizing full participation in decisions affecting health." In all nineteen programs currently active at Latino Health Access, promotores educate and support community members in all types of health issues. The programs offered range from general health promotion, to chronic disease management, to creating an environment friendly to positive health choices. The promotores themselves, 32 in all, are trained and supported through Latino Health Access, and a reputation for successful programs has led to partnerships with government agencies, academic centers, health maintenance organizations and community organizations.

Funding: Latino Health Access sustains its programs by piecing together a combination of grants, private contracts, and private donations. As its grant-funded demonstration programs (both governmentally and privately funded) are shown to be successful, the goal is to develop them into fee-for-service programs in contract with local institutions and health care organizations. Latino Health Access has had some success with this model, and has recently contracted to provide a version of its highly successful diabetes management program with Kaiser Permanente. Fundraising activities have also brought in corporate donors that support particular programs or aspects of a group of programs. Latino Health Access anticipates they will still be writing grants and exploring fee-for-service opportunities over the next several years. A few years ago, Latino Health Access experienced a budget crisis after losing several large grants. As a result, all staff members, including promotores, were required to reduce their hours. Not wanting to be faced with the same situation again, the organization refocused its efforts to develop a diversified funding base and to cross-train its promotores so they have multiple competencies, intending to establish itself as a reliable service provider and employer in the community. Even as it sees greater opportunities for community involvement, Latino Health Access has chosen to only seek grants that allow it to utilize its existing workforce and that fund programs capable of being continued in some form, perhaps funded by non-grant sources, after the initial grant period ends. In fact, America Bracho, the Executive Director of Latino Health Access believes that, "As an organization we need to move toward fee-for-service opportunities." Latino Health Access intends to grow carefully using diversified funding sources so that new programs can be supported and thrive.

Case Study: Health Plus

Location: Brooklyn, New York
Population served: Public health insurance recipients in all 5 boroughs of New York City
Website: www.healthplus-ny.org
Health Plus, with 280,000 members, is one of the largest managed care organizations in New York City providing care to Medicaid and Child Health Plus recipients and participants in New York state's affordable health insurance program. It employs approximately 35 CHWs, known as community health education associates. Thirty of these deliver targeted outreach to their enrollees. The rest provide general community education services. Some of the services provided by the community health education associates are health risk assessments, case management referrals, appointment scheduling, targeted clinical interventions, follow-up with users of emergency departments, prenatal and well-child visit facilitation, and in-home visits. In addition, they provide health information programs to the community through partnerships with churches and other community-based organizations. The associates are hired (requirements include a high school diploma and preferably community representation) and trained in-house by Health Plus.

Funding: All of the health plans offered by Health Plus are government-funded. For the Medicaid program, a capitated rate comes from the state for each enrollee in their plan. As long as a prescribed set of regulations are followed, this money can be spent however the plan chooses. The executive team at Health Plus has chosen to employ community health education associates to meet and exceed state Medicaid requirements and demonstrated a commitment to this workforce by expanding the program from a staff of two in 1998 to the current level of 35 associates. To this point the community health education associates have not been threatened with a loss of funding. However, Margie Bowen, the Director of Health Education and Community Outreach, sensing the need to demonstrate quantifiable benefits to bolster these workers' value in the organization, is moving Health Plus toward better tracking of the outcomes associated with the community health education associates' work.

Case Study: Fort Worth Department of Public Health, Outreach Division

Location: Fort Worth, Texas
Population served: Residents of the city of Fort Worth, Texas
Website: www.fortworthgov.org/health/OR

The Fort Worth Department of Public Health's Outreach Division has six neighborhood-based Outreach Teams. Each team has three members: one nurse or social worker team leader and two community health workers. The Outreach Teams work in collaboration with the local police, and respond to the immediate needs of individuals and the community in real-time. Outreach Team offices are located in local police stations, and police responding to calls will refer non-urgent health or social issues to the Outreach Teams. Team referrals may come from police, fire or code compliance departments or from the community at large. The teams are available to anyone in the city of Fort Worth, regardless of income. However, most of their work is focused on low-income, underserved clients. In addition to responding to referrals, community health workers also deliver health education programs in their assigned areas of the city.

Funding: Salaries for twelve community health workers have been in the personnel budget for the Department of Public Health since 1997. At that time the public health program changed from a jointly run program between Tarrant County and the city of Fort Worth into separate Departments of Public Health for each. The county maintained control of health clinics, while Fort Worth's focus shifted to neighborhood based care. As part of the departmental restructuring, Assistant City Manager Libby Watson sold the idea of neighborhood outreach teams to the City Council, and a permanent place in the budget was made for community health workers. In the aftermath of Hurricanes Katrina and Rita in Fall of 2005, neighborhood outreach teams were a vital link between disaster refugees in Fort Worth and city services. City employed community health workers helped provide much needed services, such as obtaining prescriptions from pharmacies for the victims. "Our response to the hurricanes was a feather in our cap," notes Barbara Murph, Manager of the Fort Worth Public Health Department's Outreach Division. With increased visibility for its work, the Outreach Division hopes to gain support for the expansion of the CHW program to include more targeted outreach focusing on health disparities and to meet the needs of a growing community. However, because new positions must be added to the city's budget to expand the program, the Outreach Division must once again engage the political process and convince the city's political leaders that public health services at the community level should be a priority.

Case Study: Christus Spohn Health System

Location: Corpus Christi, TX
Population served: Residents of Corpus Christi, primarily medically indigent individuals
Website: www.christusspohn.org

Christus Spohn Health System is a non-profit, faith-based health care system with several locations throughout South Texas. The community health worker program started at the Christus Spohn Hospital Corpus Christi-Memorial and has since expanded to include three family health centers. Currently, Christus Spohn employs seven community health workers in Corpus Christi. At the hospital, two community health workers are available in the emergency department and two serve the inpatient floors. Their roles include helping eligible patients sign up for the county's indigent care program,

attending to patient comfort needs by offering blankets and reading material, and linking patients to family health centers for follow-up care. Additionally, at each of three Christus Spohn family health centers one community health worker is available for health education home visits and to connect recently discharged patients to the clinic. In addition to their location-specific duties, each of the seven community health workers works to connect ten patients, who are identified as having accessed emergency care multiple times for non-urgent needs during the past 90 days, to appropriate primary care services.

Funding: The Christus Spohn Health System employs all of its community health workers on a fulltime basis and their salaries are included as part of the operating expenses for the system. The Memorial Hospital campus holds a 30-year contract with Nueces County to administer the county's indigent program for a flat fee of $24 million per year. However, this provision only covers about 50% of the actual operating costs for the program. Seeing that a high number of costly emergency department visits occurred during hours when the hospital's affiliated primary care clinics are open, a team from the hospital convened to explore the issue. They found that barriers to appropriate care for many patients could be linked to language needs, apprehension in addressing all of their concerns with a physician, registered nurse, or social worker, and a lack of simple health care system navigation tools. Relying on research indicating the promising work of CHWs elsewhere in the US, Christus Spohn chose to pilot its community health worker program in 2004. With success from both a patient satisfaction and budgetary standpoint, support from hospital leaders led to the inclusion of community health workers in the budget in subsequent years.

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