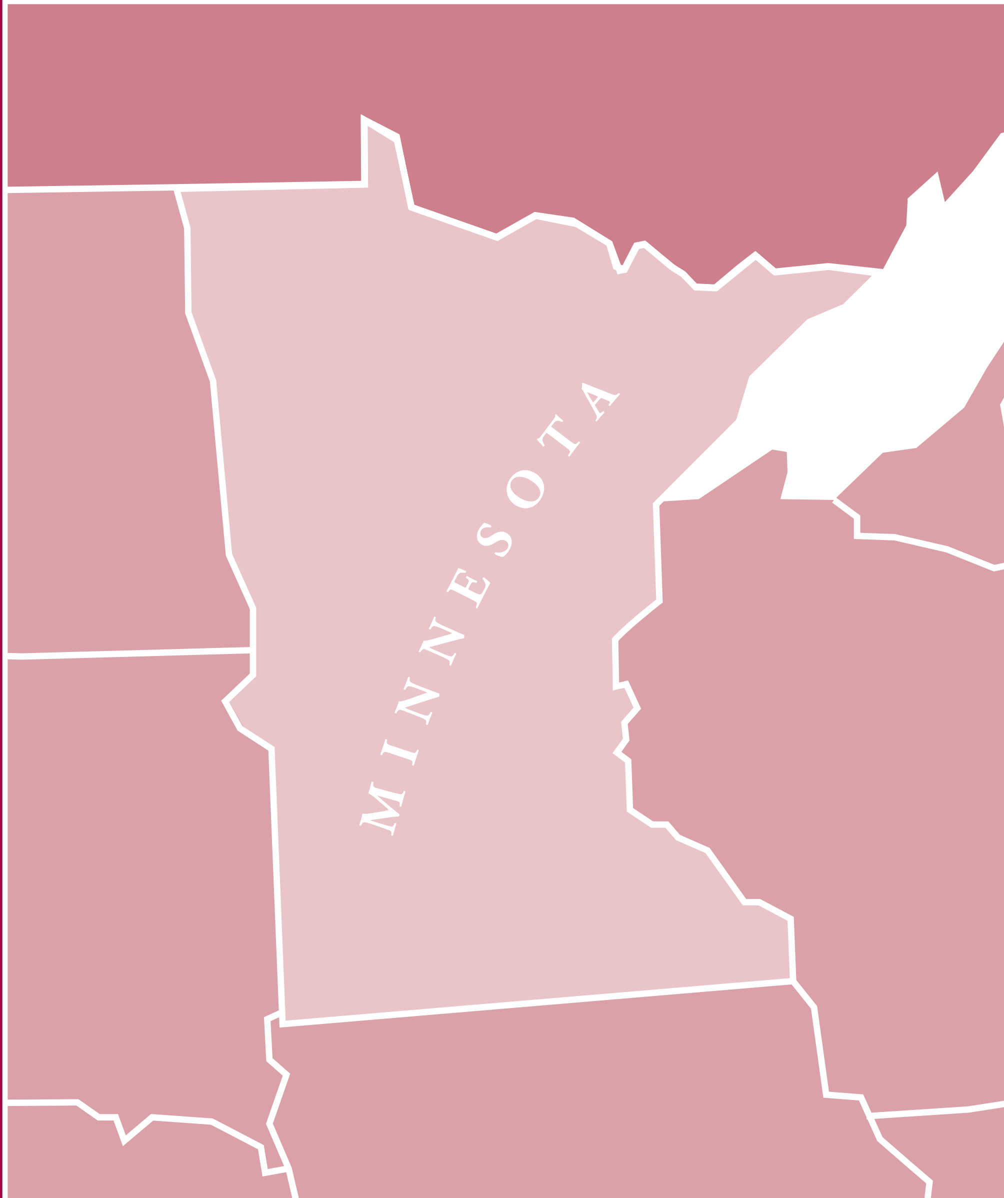
Funding CHW Programs and Services in Minnesota: *Looking to the Future*

Supplement to
Advancing Community Health Worker Practice and Utilization: The Focus on Financing



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Commissioned by the
Blue Cross and Blue Shield of Minnesota Foundation

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Acknowledgements

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The views expressed in this document are those of the authors and do not necessarily reflect the views of the National Fund for Medical Education, the UCSF Center for the Health Professions, or the Blue Cross and Blue Shield of Minnesota Foundation.

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Preface

By almost any measure, the US health care system is one of the most costly social systems in the world. In part this is a by-product of where the system is focused: in expensive sub-specialty care in tertiary care institutions. While this approach to care delivery provides much of what is attractive about the system, it also creates the under investment in community based and public health strategies.

But many of the challenges confronting health care today are simply beyond the grasp of the expensive highly specialized system. Concerns such as cultural competence, disparity of health outcomes, excessive costs, lack of prevention, and inadequate primary care cannot be addressed by the array of high tech resources. Rather, the system needs to redirect some of its efforts to more community based and public health orientated strategies.

The community health worker (CHW) represents just such a resource. Over the past three decades these essential providers have emerged to respond to real problems faced by the public—often the very public which has not been fairly served by the mainstream system.

Over these three decades the CHW has become a trusted partner of communities and individuals in need. Without asking permission, seeking professional certification, or billing for every service these workers have provided basic health education, rudimentary primary care, referral to the mainstream system, interpretation of what this system means and, perhaps most importantly, hope to many of those American who are the most vulnerable and least well served by the current way health care is configured.

To enlarge the role of the community health care will require action on the part of health systems, health professionals, public policy makers and the consuming public. However, perhaps the greatest changes need to be advanced by the CHWs themselves. To expand this role will require that significant changes be made in how they are organized, structured and financed. The development of the final shape of these considerations should come from the leadership of the CHW community. It should of course be informed by all stakeholders.

The study that follows contains a set of considerations about the future structure of the work which CHWs provide. The analysis and recommendations are meant as a place for the beginning of discussions related to this future.

Edward H. O'Neil, MPA, PhD, FAAN
Director, UCSF Center for the Health Professions

Executive Summary

Minnesota is often ranked as the healthiest state in America. However, for many Minnesotans, high quality health care and high health status are still elusive. In particular, several racial and ethnic minority groups in Minnesota experience higher rates of disease and premature death than white groups.

Several steps have been taken in Minnesota to advance the use of Community Health Workers as part of the effort to address health disparities and to improve health care for Minnesotans generally.

- Community Health Workers have been employed in many settings throughout Minnesota to help connect members of underserved communities with the health care system and to help reduce health disparities.
- Minnesota's Eliminating Health Disparities Initiative has provided grants to many organizations that employ CHWs.
- The Minnesota Healthcare Education-Industry Partnership's Community Health Worker Project has been established to work on education, employment, reimbursement and financing issues.
- A standardized education curriculum has been developed for community health workers in Minnesota. This curriculum has been implemented at six sites, including community colleges in the Minnesota State Colleges and Universities (MNSCU) system and a private vocational school.
- Several studies have been conducted in Minnesota regarding the Community Health Worker workforce.

Current funding of CHW positions in Minnesota

- Mirroring the national scene, most CHW programs in Minnesota are funded by grants and contracts from charitable foundations and government agencies.
- Some CHW positions, or portions of some positions, are funded by governmental general funds
- Third-party reimbursement has been reported to be funding source for some CHW positions but such arrangements could not be confirmed.
- Many CHW programs and positions are funded by multiple, diversified sources.

Five Issue Areas

In *Advancing Community Health Worker Practice and Utilization: The Focus on Financing,*[1] five issue areas were identified as worthy of attention to sustain the role and employment of CHWs. The questions in these areas have not been yet been fully answered by the CHW community nationally and will likely be issues to resolve for funding arrangements, regulation and workforce evolution generally. An exploration of where Minnesota lies on each of these issues is presented below.

Role in Health Care: The State of Minnesota has not formally or legislatively defined the Community Health Worker. The Health Education Industry Partnership's Community Health Worker Project has developed a working definition and role of the Minnesota community health worker. Although the definition has not been made final — the group has agreed to revisit the definition — it is a step in the right direction. Should the legislature or any third-party payer choose to use the group's definition, several issues still need to be addressed.

Fair payment: Data has been collected on salaries and benefits for some CHWs in Minnesota indicating that compensation varies depending on several factors, including type of organization, job specialization, employment qualifications, the number of CHWs employed in the organization and whether funding is short-term or long-term. Reimbursement formulas for third-party arrangements to pay for CHW services have not been developed.

Preparation: Minnesota is relatively well-positioned on the issue of CHW preparation. After years of collaborative work, a standard CHW curriculum has been developed and implemented at several community colleges and a technical college in Minnesota. This effort provides CHWs, potential employers and potential third-party payors with standards regarding the education and training of CHWs.

Supervision: Information collected from CHW employers indicates that a cultural disconnect between CHWs and their supervisors can present itself. Some discussion of supervisor training has occurred but standards for qualifications and competencies of CHW supervisors have not been developed.

Evaluation: Several studies have been conducted and published that focus on the Minnesota CHW workforce. However, there is limited outcomes- or cost-effectiveness research that has been conducted of Minnesota CHW programs. There are no peer-reviewed publications on outcomes- or cost-effectiveness of CHW programs or interventions in Minnesota settings. While CHW advocates in Minnesota can and should look to out-of-state research for transferable findings, more systematic data collection and analysis of local CHW programs — particularly of those employing

CHWs with a common education through the state's CHW curriculum — could both improve services and improve the likelihood of securing third-party payment or reimbursement.

Conclusion: Future funding of CHW positions in Minnesota

In many ways, Minnesota is very well positioned to expand its use of community health workers and to secure CHW funding that is more sustainable than short-term and categorical grants. In particular, statewide efforts to implement a standardized curriculum and to explore policy development related to CHW employment have prepared the way for policy makers and health leaders to more fully integrate CHW services into the healthcare system. Several concluding observations are offered here to further that goal.

As various agencies and organizations in Minnesota identify specific needs among their enrollee, patient, employee, client or constituent populations, they might find that CHW interventions might best meet those needs. Making the right *match between the need and the possible intervention* is key.

It is quite possible that *partnerships* might be a cost-effective way to best use CHWs. For example, an employer and a health plan might collaborate to hire a CHW to conduct independent yet interrelated tasks for a common population of individuals.

Given the work that has already been done statewide on standardized education and establishing the HEIP MNCHW Policy Council, Minnesota's *Medicaid program* as well as other third-party public or private health care insurers have substantial resources upon which to rely as they explore the possible benefits CHWs could bring to their enrollees.

For CHW programs already in existence, one of the key components of sustainable financing, at least for the short term, will be *diversified funding*. A combination of funding sources drawn from public and private grants, revenues for CHW activities and possibly reimbursement for services will provide the most stable fiscal position.

Introduction

Minnesota context

The state of Minnesota is generally considered an exceptionally healthy state. In the annual surveys United Health Foundation has conducted since 1990, Minnesota has been rated the healthiest US state ten out of sixteen times and has never been rated lower than number two. To do well, states must be successful on a wide range of factors that include health insurance coverage, heart disease rates, total and infant mortality rates, the rate of motor vehicle deaths, high school graduation rates, childhood poverty, and public health spending.[2]

However, for many Minnesotans, optimal health is elusive. In particular, the Minnesota Department of Health has documented sobering statistics on the disparities between Whites and other racial and ethnic populations in the state.[3]

American Indians in Minnesota

- In their first year of life, Minnesota's American Indian babies die at a rate more than two times higher than the White rate. Rate of inadequate or no prenatal care among American Indian women is almost six times higher than the White rate.
- Injury and violence disproportionately affect American Indians more than any other racial/ethnic group in Minnesota. American Indian males ages 18 and 19 have suicide rates six times higher than in any other age or population group. The overall injury-related mortality rate was nearly three times higher among American Indians than that of Whites.

Latinos in Minnesota

- Minnesota Latinos were the group most likely to be uninsured as compared to all other racial groups.
- The HIV infection rate for Latinos in Minnesota is seven times higher than the rate among Whites.
- In Minnesota, Latinos are almost twice as likely to die from diabetes as Whites. They are also twice as likely to experience serious complications such as eye disease.

African Americans in Minnesota

- Minnesota's African American infant mortality rates have been two to three times higher than the White rate for 20 years.
- Among African American youth aged 15–24, firearm injury mortality rates are eight times greater than for all male 15–24 year olds in Minnesota, and 15 times greater than the rates of all ages, races and genders combined. Compared to Whites in Minnesota, African American males in this age group are 25 times more likely to die as a result of firearms.
- The breast cancer mortality rate is 50 percent higher in African American women than in White non-Hispanic women, even though the incidence rates are similar.

Asian Americans in Minnesota

- Asians experience fewer deaths related to diabetes than all other groups but the diabetes death rate among Asian Americans in Minnesota is increasing at a greater rate than among any other racial or ethnic group.
- Asian American women have significantly higher incidence and mortality rates of cervical cancer than White non-Hispanic women.

CHWs in Minnesota

As in many parts of the US, Minnesota's health care providers are challenged by these disparities and by demographic and immigration trends that bring new needs to the system. The root causes of some of Minnesotans' health disparities are unknown and many approaches might be taken to mitigate or eliminate them. One possible solution that has been explored by various organizations in MN has been to employ community health workers. For years, CHWs have been demonstrating an ability to bridge the gap between the health care system and community members — particularly those from underserved and immigrant populations — in need of health care and other human services.

Minnesota, like most states, does not have a definitive count of the number of CHW programs or CHWs working in the state. However, based on survey research and other sources, it is clear that a significant number exist. The Healthcare Education-Industry Partnership's Community Health Worker Project currently lists about 60 organizations in Minnesota that employ community health workers.[4] In its Minnesota Community Health Worker Directory, the Minnesota International Health Volunteers lists contact information for almost 50 agencies — many with multiple delivery sites — that employ CHWs.[5] A 2005 CHW workforce report identified 35 employers and 176 CHW positions in the Twin Cities Metro area alone.[6]

Eliminating Health Disparities Initiative and CHWs

Under Minnesota's Eliminating Health Disparities Initiative (EHDI), which aims to improve the health status of the state's populations of color and American Indians, the state allocates a total of $9.5 million in competitive grants per biennium to local programs and projects statewide.[7] Although the utilization of CHWs is not required to obtain an EHDI grant, out of approximately 50 programs that are in receipt of EHDI grants, an estimated 20 rely on community health workers to staff the programs.[8] The Initiative has two main goals: 1) by 2010, decrease by 50% the disparities in infant mortality rates and adult and child immunization rates for American Indians and populations of color in Minnesota compared with the rates for whites; and 2) close the gap in health disparities of American Indians and populations of color as compared with the rates for whites in five priority health areas. Grantees focus on one or more of the following health priority areas: infant mortality; immunizations; breast and cervical cancer; cardiovascular disease; diabetes; HIV/AIDS or sexually transmitted diseases; injury and violence; and healthy youth development as a strategy for reducing out-of-wedlock teen births, which are linked to poor birth outcomes.[9]

The Healthcare Education-Industry Partnership Community Health Worker Project

The Healthcare Education-Industry Partnership (HEIP), an affiliate of the Minnesota State Colleges and Universities (MnSCU) system, works as a collaboration among higher education, the healthcare industry, professional and trade associations and state agencies to address critical healthcare workforce issues in Minnesota.[10] One of HEIP's programs is the Minnesota Community Health Worker Project (MNCHW).

> The Minnesota Community Health Worker Project is a statewide coalition of public higher education, rural and urban health care systems and major players working together to reduce cultural and linguistic barriers to health care improve quality and cost effectiveness of care, and to increase the number of health care workers who come from diverse backgrounds.[11]

The vision of the Minnesota Community Health Worker Project, which lists 21 organizations and agencies among its Funding and Community Partners,[12] is to create:

- A process to standardize the profession for CHWs
- A standardized process for educating CHWs in Minnesota
- A process for incorporating CHWs into the healthcare workforce by working with health plans and payers to create a sustainable employment market[13]

The MNCHW program has established a Policy Council, with statewide representation, that meets regularly to address issues such as the education, certification, evaluation and reimbursement and financing for CHW services.

In part as a response to a 2003 study finding that most of the surveyed Minnesota organizations employing CHWs saw a need for standardized CHW training,[14] the MNCHW program has developed a standardized education curriculum for community health workers in Minnesota. The eleven-credit curriculum, developed by the CHW Project Advisory Committee in partnership with Dr. Sue Roe of the University of Arizona, consists of six courses and an internship. Upon completion, individuals are awarded a certificate. This curriculum is being offered at six sites, including five MnSCU community colleges and a private trade/vocational school. As of June 2006, 126 students have graduated from programs using the HEIP CHW curriculum.

Minnesota's interest in the CHW workforce as a valuable sector of the health care system is also evidenced by a June, 2006, meeting held in Eagan to discuss opportunities for future funding streams for CHW positions. This meeting was part of the national research and policy project sponsored by the Blue Cross and Blue Shield of Minnesota Foundation that would produce *Advancing Community Health Worker Practice and Utilization: The Focus Financing*[15] and the report at hand on funding CHW services in Minnesota. Building on the current research, the work of the Minnesota Community Health Worker Policy Council, and national work on financing of CHW positions, a group of Minnesota health care leaders convened to hear in-state as well as national perspectives on CHW financial challenges and possible future directions. A summary of the meeting can be found in Appendix A.

Selected Publications on Minnesota's Community Health Workers

Several studies have been conducted in Minnesota that explore, among other things, employment and funding of CHW programs and positions. This research, together with some qualitative publications, provides considerable information on employment settings and arrangements for CHWs working in Minnesota.

- Hang K, Cleary J. *Critical Links: Study Findings and Forum Highlights on the Use of Community Health Workers and Interpreters in Minnesota*. Eagan, MN: Blue Cross and Blue Shield of Minnesota Foundation, 2003.
- Healthcare Education Industry Partnership. *2005 Community Health Worker Work Force Analysis: Summary of Findings for Minneapolis and St. Paul*. Eagan, MN: Minnesota CHW Project. 2005.
- *Critical learning: Bicultural Community Health Workers' views on prospective training opportunities*. Eagan, MN: Blue Cross and Blue Shield of Minnesota Foundation, 2004.
- Leinberger-Jabari, A., Werner, L. *Voices of the Community: A Profile of Minnesota's Community Health Workers*. Minnesota International Health Volunteers, 2005

Current funding of CHW positions in Minnesota

Funding for Minnesota CHW programs and positions appears to mirror the national scene. Most programs are funded by grants and many programs rely on diversified, or combination funding sources.

The Blue Cross and Blue Shield of Minnesota's 2003 report, *Critical Links: Study Findings and Forum Highlights on the Use of Community Health Workers and Interpreters in Minnesota*, found that 84% of the 156 participating organizations used government grant funds for CHW positions and 44% relied on foundation grants. Participant panelists noted that, while common, foundation and government grants are considered unstable and inadequate in large part because of their categorical, short-term nature.[16] More than 75% of CHWs in the Minneapolis-St.Paul metropolitan area reported that government grants are sources of funding for CHW positions at their organizations.[17]

Examples

- Approximately 20 of the recipients of grants under Minnesota's Eliminating Health Disparities Initiative employ CHWs. Some of these programs were already in place and the EHDI grants permitted expansion; others were started with the EHDI grants.[18]
- Minnesota International Health Volunteers employs CHWs to serve as liaisons between health providers and the communities they wish to serve. After many years of international experience, MIHV has expanded its services to provide assistance to immigrants in Minnesota. According to its 2005 Annual Report, government grants account for 41% of MIHV's revenue and foundation and corporate grants account for 29%.[19]

Some CHW positions in Minnesota are funded, at least in part, by governmental general funds.

Example

- In 2005, Hennepin County reported employing over 60 CHWs. At the time, the county was seen as the largest single employer of CHWs in the Minneapolis-St. Paul area and possibly the state.[20] If anything, the number of CHW positions employed by Hennepin County has increased. While portions of CHW salaries are funded by general, county tax revenues, they are also all subsidized to some degree by programmatic funds from other sources.[21]

A third source of CHW funding might be through insurance reimbursement. In one statewide Minnesota study, 42% of organizations employing CHWs reported Medicare, Medical Assistance or insurance reimbursement as funding sources for their CHW positions.[22] In a study that focused solely on CHW positions in the Minneapolis-St. Paul metropolitan area, 15% of employers reported that third-party reimbursement was a funding source for CHWs.[23] More research is needed on this topic as the authors were unable to identify or confirm any public or private insurance programs in Minnesota that recognize CHW services as reimbursable. It may be that the definitions of CHWs used in these studies captured other workers, such as bachelor's prepared case workers or certificated doulas, in its pool of "CHWs".

Finally, organizational operating budgets are also funding sources for CHW positions. Seventy-two percent of the Minnesota CHW employers surveyed in 2002 reported "Funding within the organization" as a funding source for CHWs.[24] Thirty-one percent of the organizations participating in the Minneapolis-St. Paul area CHW study reported that CHW positions were internally funded within the organization.[25]

Five Issue Areas

In *Advancing Community Health Worker Practice and Utilization: The Focus on Financing*,[26] five issue areas were identified as worthy of attention should the expanded employment of CHWs, and payment and reimbursement for their services, be pursued. An exploration of where Minnesota lies on each of these issues is presented below.

Issue #1: Role in Health Care

What role does the CHW play? What are the clear and defined responsibilities and competencies? Nationally, CHW programs with sustainable funding have generally identified a specific healthcare need that was not being met in a particular population and clearly articulated the role CHWs play in meeting that need.

The Situation in Minnesota

The State of Minnesota has not formally or legislatively defined the Community Health Worker. The Health Education Industry Partnership's Community Health Worker Project, through its statewide Policy Council has developed a working definition and role of the Minnesota community health worker (see Appendix B). Although the definition has not been made final — the group has agreed to revisit it — it is a step in the right direction. Should the legislature or any third-party payer choose to use the group's definition, a few issues still need to be addressed. One question will be whether individuals who have been practicing for some period of time as CHWs but who have not completed an approved CHW training curriculum will be considered "Community Health Workers" eligible for employment, payment, reimbursement or other recognition. Also needing attention will be how CHWs are similar to and different from other health and social work professions.

Issue #2: Fair Payment

How should CHWs be compensated for their services? What reimbursement templates and formulas best reflect the value of CHW services in a format that can be understood and adopted by potential payers? Will reimbursement be via capitation or fee-for-service? If fee-for-service, what will be the reimbursable unit of service, cost per unit, and dose or frequency of unit?

The Situation in Minnesota

A 2005 study found that CHWs in the Minneapolis-St. Paul area earned a median minimum salary of $12.25 and a median maximum salary of $18.60 per hour. However, CHWs were reportedly compensated “inconsistently”. Compensation varied depending on several factors, including type of organization, job specialization, employment qualifications, the number of CHWs employed in the organization and whether funding was short-term or long-term. Eighty percent of CHWs reportedly were offered benefits.[27] As far as is known to the authors, insurance reimbursement formulas have yet to be developed for CHW services in Minnesota.

Issue #3: Preparation

What competencies are required of CHWs? What roles do standardized education, internships, on-the-job training and certification play in providing and assuring CHW competence?

The Situation in Minnesota

Minnesota is relatively well-positioned on the issue of CHW preparation. After years of collaborative work, a standard CHW curriculum has been developed and implemented at several community colleges throughout Minnesota.[28] This effort provides CHWs, potential employers and potential third-party payors with standards regarding the education and training of CHWs. At present, the CHW educational program, with its associated certificate awarded upon completion, is an optional pathway to employment. Still to be determined will be whether certification will be required of CHWs employed in Minnesota in the future and whether the CHWs who have been working for some period of time can be “grandfathered” into any such requirement without needing to complete the course.

Issue #4: Supervision

What is the appropriate level and type of supervision for CHWs? What qualifications and competencies should be required of the supervisor?

The Situation in Minnesota

In its 2003 *Critical Links* report, the Blue Cross and Blue Shield of Minnesota Foundation noted that, in organizations where CHWs are employed, “supervisor-employee dynamics can be challenging because of differences in cultural values and employees’ work experiences. For example, employers of CHWs… confronted different culturally based perspectives related to work ethics.”[29] Minutes of the meetings of the Healthcare Education-Industry Partnership CHW Project Policy Council indicate interest in developing a CHW supervisor training program at some point.[30] At this point, there are no standards for the qualifications or competencies of CHW supervisors in Minnesota.

Issue #5: Evaluation

What does the research say about the outcomes- and cost-effectiveness of CHW programs and services? Is there any evidence of positive impact on access to care, quality of care or return on financial investment?

The Situation in Minnesota

Several studies have been conducted and published that focus on the Minnesota CHW workforce. These reports provide a rich source of information about CHW employment, including where CHWs are working, how they are compensated and what sources fund their programs. One qualitative survey reported that most CHW employers queried in Minnesota rated their CHWs as effective in helping the organizations provide service to bicultural and bilingual community members; some respondents also commented on the cost-effectiveness of CHWs assisting clients in seeking preventive care and early screening.[31] However, there is limited rigorous outcomes- or cost-effectiveness research that has been conducted of Minnesota CHW programs. As far as the authors are aware, there are no peer-reviewed publications on the impact of CHW programs or interventions on health care access, cost or quality in Minnesota settings. While CHW advocates in Minnesota can and should look to out-of-state research for transferable findings, more systematic data collection and analysis of local CHW programs could both improve care and improve the likelihood of securing third-party payment or reimbursement for CHW services.

Some of these goals might be accomplished through the work of the Evaluation/Research Committee of the of the Healthcare Education-Industry Partnership Community Health Worker Project's Policy Council. The committee has developed a Minnesota CHW Project Evaluation Plan that will track the impacts CHWs are making in the state.[32] In addition, Minnesota's Eliminating Health Disparities Initiative legislation attempts to address the limited research in this area by trying to improve data collection and analysis for positive goals.[33] With growing numbers of CHWs earning certificates in Minnesota, a strong base is developing for research purposes. This pool of potential study participants will have a common education that will permit researchers to develop meaningful studies looking at the impact of these workers on issues of cost-effectiveness and quality of care.

Conclusion:

Future funding of CHW positions in Minnesota

In many ways, Minnesota is very well positioned to expand its use of community health workers and to secure CHW funding that is more sustainable than short-term and categorical grants. In particular, statewide efforts to implement a standardized curriculum and to explore policy development related to CHW employment have prepared the way for policy makers and health leaders to more fully integrate CHW services into the healthcare system. Several concluding observations are offered here to further that goal.

Multiple health care needs challenge Minnesota. As various agencies and organizations in Minnesota identify specific needs among their enrollee, patient, employee, client or constituent populations, they might find that CHW interventions might best meet those needs. Making the right *match between the need and the possible intervention* is key. For example, some needs that could be considered to be addressed by a strong CHW program include: addressing disparities in infant mortality; brokering cultural issues; and improving access to and appropriate utilization of care.

It is quite possible that *partnerships* might be a cost-effective way to best use CHWs. Entities that find CHWs to be a promising fit to meeting needs include the state Medicaid office, public and private hospitals, private sector business employers, government agency offices and departments, health plans and community clinics. Some of these organizations share common pools of people. For example, a business might have employees who could benefit from having their health care options explained to them by a bicultural CHW; these same employees might be enrolled in a health plan that is seeking to improve the way those individuals access the health care system. Both the employer and the health plan might collaborate to hire a CHW to conduct separate but interrelated tasks for this same population of individuals.

Given the work that has already been done statewide on standardized education and establishing the HEIP MNCHW Policy Council, Minnesota's *Medicaid program* as well as other third-party public or private health care insurers have substantial resources upon which to rely as they explore the possible benefits CHWs could bring to their enrollees.

For CHW programs already in existence, one of the key components of sustainable financing, at least for the short term, will be *diversified funding*. A combination of funding sources drawn from public and private grants, revenues for CHW activities and possibly reimbursement for services will provide the most stable fiscal position.

Appendix A

Proceedings of the June 19, 2006, Meeting:
Options for Advancing and Sustaining the Community Health Worker Role in Minnesota

On June 19, 2006, a group of representatives from community health worker organizations, government agencies and health plans in Minnesota convened to discuss existing and potential financing strategies for supporting the work of community health workers in their state. Designed to be the first of many discussions on this topic, participants offered their impressions of the preliminary findings presented by the National Fund for Medical Education/UCSF Center for the Health Professions' research team. In articulating specific examples of the financing models outlined, meeting participants developed a stronger understanding of the status of community health workers in Minnesota and the opportunities for expanding the involvement and capacity of such individuals in the Minnesota healthcare infrastructure.

Meeting participants included four individuals with ties to academic, provider and community-based organizations working directly with community health workers, one representative from the Minnesota Department of Human Services, five representatives from the health plan sector (three of whom were from Blue Cross and Blue Shield of Minnesota), two representatives from the Blue Cross and Blue Shield of Minnesota Foundation (this project's funder), the facilitator, who has a background in public health in Minnesota, and three members of the National Fund for Medical Education (NFME)/UCSF Center for the Health Professions research team. A representative from the Minnesota Department of Health was unable to attend.

Held at the Blue Cross and Blue Shield of Minnesota campus in Eagan, Minnesota, the day's events consisted of participant introductions, declarations of purpose, presentations on community health worker financing, education, and organization, an interactive visioning session, and, in conclusion, articulation of next steps to be taken by participants.

The day's proceedings began as Daniel Johnson, the Executive Director of the Blue Cross and Blue Shield of Minnesota Foundation, welcomed the participants and offered opening remarks on the commitment of the Foundation to consider the social determinants of health in its projects and its goal of being a leader in making Minnesota the healthi-

est state in the country. Joan Cleary, the Associate Director at the Foundation, then described how the work of the NFME/UCSF Center for the Health Professions research team tied into the Foundation's goals and existing work.

Next, the NFME/UCSF Center for the Health Professions research team presented its findings on the various means by which community health workers are funded and potential methods for financing their work in the future. This publication's companion national report, entitled *Advancing Community Health Worker Practice and Utilization: The Focus on Financing* provides a thorough description of the research and findings presented at the meeting in Eagan, Minnesota.

Following the presentation on financing, participants heard Anne Willaert, Director of Project Design and Development for the Healthcare Education Industry Partnership describe the role HEIP has played in standardizing the education of community health workers in Minnesota through its Community Health Worker Project and Policy Council. Further description of HEIP and its role in advancing the role of the community health worker is available elsewhere in this publication. Diana DuBois, Executive Director of Minnesota International Health Volunteers (MIHV), also offered insight into the status of a growing association of community health workers, the MN CHW Peer Network, formed and hosted by MIHV, in providing a forum for networking and professional advancement.

The richest insights were revealed as participants discussed the overall role of CHWs in the healthcare system and how each of the financing models identified by the NFME/UCSF Center for the Health Professions research group might apply to the healthcare environment in Minnesota.

In discussing how CHWs currently and potentially fit into the healthcare landscape in Minnesota, several themes emerged. Participants questioned the need to decide who should fund CHWs until specific organizational or agency needs are identified and it is determined whether or not CHWs might meet those needs. Defining such needs was stated to be a collaborative effort between communities, employers, and health plans. Areas where CHWs might be an appropriate fit include situations where cultural competence is a priority, in rural areas that have less access to healthcare providers than in urban areas, and where CHWs can fill gaps created by a shortage of other healthcare providers. Whether CHWs should be seen as a community resource available to many or a resource targeted to a specific client-base was not resolved.

Health plan representatives noted that while CHWs may play many roles, it is important to identify specific services that these workers will perform, as this is the way the current health system is set up. Payment must be linked to specific services provided. Other less quantifiable roles for CHWs will not be compensated directly, though governments and foundations may have the means to support compensation for such roles.

As grants from foundations and government agencies account for 65–90% of the funding for CHWs in the Minneapolis/St.Paul Metro area, and is not generally considered a sustainable source of funding, little discussion about this payment model arose.

Issues surrounding payment of CHWs via public insurance included the onerous process of getting approval for a new service provider for state-administered federal insurance programs and determining whether the Minnesota Department of Human Services has the existing authority to pay directly for the services of non-traditional providers such as CHWs with Medicaid funds. Certification and/or training were also emphasized as necessary steps to ensure that government funds are paid out only to qualified individuals.

Possible opportunities for private insurance providers to include CHW services as part of their plans were also discussed. Private insurers, serving as a link between employers and health care providers, might open up avenues for influence that perhaps are not available to or utilized by smaller, less well-funded community based organizations. If utilizing CHWs to provide outreach, education, or simple health services can be shown to temper the rising costs of health care for employers, then employers may choose employee plans that incorporate CHW services. Private insurers may be able to fund such demonstration projects. Developing incentive plans for physicians or clinics which are based on pay-for-performance may also lead them to incorporate CHWs as part of their client offerings if attention provided by CHWs leads to improved health outcomes. Systematic approaches to care management may necessarily require the contributions of multiple types of health providers to achieve the best outcomes. In general, health plan representatives preferred that legislative action not be pursued as a first step to coverage of CHW services. CHW services can be "sold" to employers if demonstration projects showed their value.

A few local governments within Minnesota were identified as employing CHWs directly, though little discussion arose concerning this form of CHW financing.

Discussions surrounding private sector employment of CHWs also focused on the need to show the value of the CHW and in identifying specific needs that can be met by services provided by CHWs.

Prior to adjourning the meeting each participant was asked to identify the next steps she was going to take based on the information presented and discussed. These "next steps" included initiating outside conversations with other participants, prioritizing the information received, working to further understand some of the issues presented, moving forward on public insurance fact-finding, collaborating on a cost-benefit analysis, speaking with health plan clients about CHWs, working towards Minnesota-specific clinical evaluation outcomes, and making a business case for CHWs.

Appendix B

Definition and Role of the Minnesota Community Health Worker[34]
Health Education Industry Partnership Community Health Worker Project
2006

Community Health Workers (CHWs) are members of the community they serve. They build relationships and trust at the grassroots level and bridge the gap between individuals, families and communities with health and social services. CHWs are paraprofessionals who have graduated from an approved CHW training curriculum*, they work in clinical and community facilities to provide health and social service linkages. CHWs teach community members and providers the knowledge and skills needed to understand, give and receive appropriate care and service options for all Minnesotans.

Core Roles of Community Health Workers

Role 1: Bridge the gap between communities and the health and social service systems

- a. Educate community members about how to use the health care and social service systems
- b. Educate the health and social service systems about community needs and perspectives
- c. Gather information
- d. Communicate with identified populations
- e. Improve quality of care by aiding communication between provider and patient to clarify cultural practices

Role 2: Promote wellness by providing culturally appropriate health information to clients and providers. For example:

- a. Health promotion and disease prevention
- b. Assist clients in managing their chronic illnesses

Role 3: Assist in navigating the health and human services system

- a. Connect with people needing services
- b. Make referrals and coordinate services
- c. Teach people the knowledge and skills needed to obtain care
- d. Facilitate continuity of care by providing follow-up
- e. Manage paperwork (e.g., help with application for public assistance)

Role 4: Advocate for Individual and Community Needs

a. Articulate and represent needs of community and individuals to others
b. Be a spokesperson for clients when they are unable to speak for themselves
c. Involve participants in self and community advocacy

Role 5: Provide Direct Services

a. Link to community resources to meet basic needs
b. Provide individual social and health care support
c. Organize and/or facilitate support groups
d. Refer and link to preventive services through health screenings and healthcare information

Role 6: Build Individual and Community Capacity

a. Build individual capacity to achieve wellness
b. Build community capacity by addressing social determinants of health
c. Identify individual and community needs
d. Mentor other CHWs – capacity building
e. Seek professional development (continuing education)

* Recognizing that until recently there was no formal training curriculum for CHWs. This definition looks toward the future using the new curriculum that will facilitate employment, provide opportunities for advancement — academically and professionally — and foster reimbursement for CHW activities.

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