DEPARTMENT OF HEALTH

Community Health Worker Initiatives in Minnesota

AN ENVIRONMENTAL SCAN OF THE CHW FIELD

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Community Health Worker Initiatives in Minnesota: An environmental scan of the CHW Field

Minnesota Department of Health
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Executive Summary

Background

In 2023, the Minnesota State legislature enacted statute (Sec. 144.1462 MN Statutes) for the Minnesota Department of Health (MDH) to support collaboration and coordination between state and community partners to develop, refine, and expand the community health workers (CHW) profession in Minnesota; equip community health workers to address health needs; and to improve health outcomes. One component of the legislation is for MDH to design, conduct and evaluate CHW initiatives using measures such as workforce capacity, reach of services, and return on investment as well as descriptive measures of existing CHW models as they compare with the national CHW landscape.

The purpose of this environmental scan is to understand the current structure and impact of existing CHW models in Minnesota and nationally and barriers and facilitators to expand the impact of the Community Health Worker workforce in Minnesota.

Method and scope

The scope for this scan includes looking at the state and national levels to assess and understand types of CHW implementation and payment models, roles and functions, settings, measurements, and available outcomes data. Information learned about Minnesota will inform the development of a sustainable plan for CHW infrastructure in the state that will support the needs of diverse and under-resourced communities.

Data gathering consisted of existing data from state agencies and community partners, key informant interviews, literature review, national policy groups, Minnesota Community Health Worker Alliance Supervisors Roundtable and Education Committee, as well as attending state and national stakeholder conferences. Informational interviews were conducted across the state with **105 stakeholders in 11 organizational settings**. Future data collection will include employer surveys, CHW surveys and focus groups and ongoing monitoring of existing data sources.

Current implementation models and measurement in Minnesota

Based on the information obtained and available for this environmental scan, approximately **54% of Minnesota counties have CHW initiatives** at some level of implementation or scale in a variety of employer settings. There is a wide variety of job titles, settings, roles, and functions of CHWs in Minnesota. The defining feature of a CHW is the **Scope of Practice** in Minnesota which is aligned with the American Public Health Association (APHA) and the National Council on Core Consensus Standards.

Currently there are **1,631 certificate holders in Minnesota.** As of 2024, it is estimated that **there are 880 CHWs active in the workforce.** 209 CHWs are currently enrolled with MN DHS to bill for reimbursement from MN Medicaid. As of 2023, only **37 enrolled CHWs have billed claims** in the past two years (less than 5% of the active workforce). CHWs also provide disease specific work. This may be in clinics, community-based organizations, and voluntary/disease specific organizations such as the American Lung Association, American Cancer Society or Epilepsy Foundation.

Implementation models vary by setting both clinical and community based. Clinically based models focus on health care system navigation, care coordination, patient education, and addressing social determinants of health. Examples of currently existing models in Minnesota include:

- IMpaCT
- MDH Health Care Homes
- DHS Behavioral Health Home Services
- Transitions Clinic Network
- Resource navigation and patient education in oral health settings (Community Health Workers and Oral Health: Improving Access to Care Across the Lifespan in Minnesota).

Community based models focus on community resource navigation and overcoming barriers to health outcomes, outreach, and connection to care, as well as health education. Examples of currently existing models in Minnesota include the Pathways Community HUB, a variety of other Community Hub Models, Childhood Resource Navigation Hubs, Third Party Payors/Managed Care Organizations (general outreach and navigation), school-based family engagement navigation, Local Public Health family home visiting and Tribal Nations Community Health Representatives.

Program level demonstration of CHW impact on quality, health outcomes and experiences are not readily available with consistency statewide. Identifying and building data collection systems is needed to track how CHWs, by model, facilitate access to services and improve the quality and cultural competence of service delivery, improve access to care, health outcomes, and reduce disparities through cultural, language, and community specific navigation, education, advocacy, linkage to services, lower health care costs, improve quality, and patient satisfaction.

Workforce preparation and retention

CHWs do their work successfully through building **relationships, community connections and sharing cultures of lived experience** with patients. These established components can be complemented by structured implementation of the MN CHW Alliance Scope of Practice. Defined roles and functions can be implemented in a variety of ways including evidence-based implementation models as well as community centered promising practices. Obtaining a CHW certificate provides a consistently trained workforce that can enroll to bill for medical reimbursement of CHW services.

CHW employers would benefit from technical assistance on **organizational readiness, retention practices and reimbursement**. There is an opportunity to work with internal staff on increasing alignment between CHWs documentation of services, quality improvement efforts and electronic health records. Increased alignment with documentation systems and data dashboards supports ongoing quality improvement monitoring and reimbursement. Dashboards can be tools for advocacy with organizational leadership for systems improvement impacting health equity and demonstrating the value of the CHW workforce. CHW Employer Peer Groups, in tandem with technical assistance, could address complex topics including:

- Building peer support regional teams of employers across settings to increase local capacity (via group technical assistance from MN CHW Alliance).
- Collective applications for grant funding.
- Identification of funding opportunities consistently for all settings.
- Use of effective data sharing language that allows for impact measures.
- Support and encourage materials for county board/hospital board presentations.

Sustainability

To support the advancement of the field and move more effectively and efficiently toward improved patient experiences and health outcomes, stable payment structures are needed across organizations. The recommendations from the scan include:

- Support implementation of evidence-based model implementation.
- Support organizational documentation of how CHWs spend time within the Scope of Practice and reimbursement.
- Identify and share where CHWs document patient experience and CHW activity that is accessible and make available in a dashboard.
- Identify and share evidence and experiences in Minnesota where CHW activity has shown an impact on patient health outcomes.
- A statewide measurement system in Minnesota to support baseline understanding as well as progress towards CHW workforce development, including qualitative information directly from CHWs themselves.
- Increase awareness of supports and funding CHWs need to be effective.

Next steps

The work of the MDH CHW Initiatives and Community Engagement unit will focus on collaboration and communication with the Minnesota Community Health Worker Alliance, partners, and stakeholders to build a sustainable, evidence based CHW workforce model to effectively address health challenges in diverse and under-resourced communities across Minnesota. This includes the development of a sustainability plan that will include identified steps for CHW workforce and outcomes measurement, training and career development, financing and sustainability, and support of evidence-based and best fitting models in Minnesota. Additional employer and CHW data collection will inform an updated Environmental Scan to be available in 2025.

Introduction

According to the American Public Health Association, Community Health Workers (CHWs) are trained frontline public health professionals that come from the communities that they serve and serve as a liaison and link between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Evidence shows that Community Health Workers impact patient health and health care system access (Impact of Community Health Workers on Access to Care for Rural Populations in the United States: A Systematic Review).

CHWs can:

- Improve health outcomes (chronic disease control, mental health, healthy behaviors, health disparities).
- Reduce health care costs (emergency room use, hospitalizations, health care spending) with a 3:1 return on investment.
- Advance health equity (provide cultural, linguistic and community specific services, address social determinants of health, advocate for individual and community needs).
- Improve satisfaction and quality for patients' experiences (improve patients perceived quality of care and positively impact provider satisfaction).

The health care system needs support to improve outcomes for underserved populations, while reducing costs. CHWs are a health equity workforce that is growing steadily. Many employers, both large and small, in the health care, public health, non-profits, schools and social service areas are employing CHWs with increasing frequency and looking for support to fund these positions. These factors, along with increasing costs for basic needs across the country, are providing an opportunity for unprecedented growth in the field and improved health outcomes for the most marginalized in both urban and rural communities in Minnesota.

Background

The MDH CHW Initiatives and Community Engagement unit collaborates between state and community partners to support training, financing and evaluation and measurement of the CHW workforce. Integral to the work is the Minnesota Community Health Worker Alliance (MN CHW Alliance), a professional advocacy and capacity building organization for the CHW Profession. In 2023, the Minnesota State legislature enacted statute (Sec. 144.1462 MN Statutes) to expand and strengthen the CHW workforce through a grant to MNCHWA for CHW infrastructure and capacity building and for the Minnesota Department of Health (MDH) to design, conduct and evaluate CHW initiatives. The evaluation component includes using measures such as workforce capacity, reach of services, and return on investment as well as descriptive measures of the existing CHW models as they compare with the national CHW landscape (Minnesota Office of the Revisor of Statutes, 2023). The purpose of this environmental scan is to understand the current structure and impact of existing CHW models in Minnesota and nationally and barriers and facilitators to expand the impact of the Community Health Worker workforce in Minnesota.

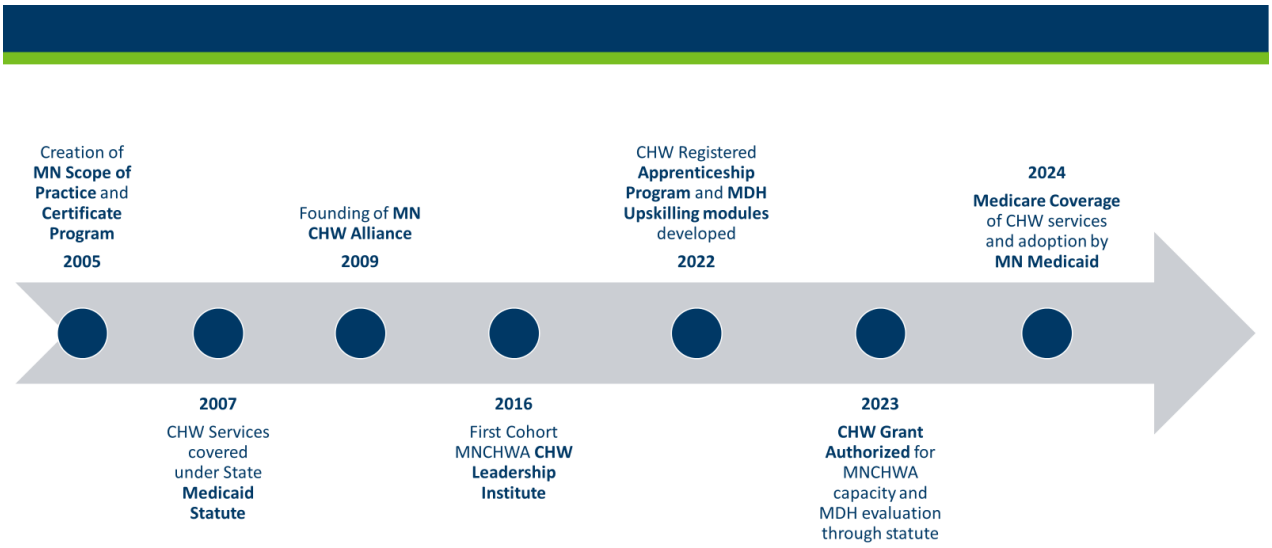
Based on interviews across the state with 105 stakeholders in 11 organizational settings, the Minnesota Department of Health (MDH) has summarized the feedback on what support is needed to expand the impact of the Community Health Worker (CHW) workforce in Minnesota. Based on the information obtained for the scan at this time, approximately 54% of Minnesota counties have CHW initiatives at some level of implementation or scale across various settings. This scan builds from previous work that describes the CHW field well and demonstrates its impact on health equity. Previous scans and toolkits have been created for Minnesota and nationally in:

- 2015 Experiences of Community Health Worker Employers in Minnesota
- 2016 Community Health Worker Toolkit 2016 – guide for employers
- 2018 The State of the Community Health Worker Field in Minnesota – Minnesota Community Health Worker Alliance
- 2023 Staffing Local Health Departments in Minnesota—Needs, Priorities, and Concerns
- 2024 State Community Health Worker Policies: Minnesota - NASHP
- 2024 50-state scan of Medicaid payment for community health workers

CHW infrastructure in Minnesota

Minnesota has **a robust infrastructure** in place to support the CHW profession, including a statewide CHW-led association, invested stakeholders, an identified scope of practice, strong academic CHW certificate training program, a registered apprenticeship program and upskilling trainings, and medical billing and reimbursement. See the timeline below for the progression of the CHW field in Minnesota from 2005 to 2024.

Timeline of CHW Infrastructure in Minnesota 2005-2024



- 2005: Creation of Minnesota Scope of Practice and Certificate Program
- 2007: CHW Services covered under State Medicaid Statute

- 2009: Founding of MN CHW Alliance
- 2016: First Cohort of MH CHW Alliance Leadership Institute
- 2022: CHW Registered Apprenticeship Program and MDH Upskilling modules developed
- 2023: CHW Grant authorized for MN CHW Alliance capacity and MDH evaluation through statute
- 2024: Medicaid coverage of CHW services and adoption by MN Medicaid

Invested stakeholders

The Minnesota Community Health Worker Alliance (MN CHW Alliance) is a statewide non-profit whose mission is to build community and systems capacity for better health through the integration of CHW strategies. MN CHW Alliance serves as a convener, catalyst, expert, and resource to advance and integrate community health worker strategies. Current resources offered through MN CHW Alliance include:

- Technical assistance (growing in 2024)
- CHW Learning Circles – CHW Peer Support
- CHW Supervisor Roundtable – Supervisor Peer Support
- CHW Education Committee - Educational Institutions
- Legislative Action Committee
- CHW Student Support – HRSA CHWTP grant scholarship and apprenticeship trainees
- CHW Regional Leadership Institutes (regional focus new in 2025)
- CHW Advisory Committee (new in 2025)

The statewide reach of CHWs is indicative of a growing level of stakeholder awareness and investment in this professional role. CHW employers include local public health, health care systems, managed care organizations, Federally Qualified Health Centers (FQHCs), community-based organizations, schools, and emergency services/law enforcement.

Many Minnesota state agencies partner to support the work of the CHW field including, the MDH Community Health Worker Initiatives and Community Engagement unit (established in 2024), which works with MN CHW Alliance and partners to build a sustainable, evidence based CHW workforce model to effectively address health challenges in diverse and under-resourced communities across Minnesota. Key strategies include training and workforce development, infrastructure and sustainability planning, and evaluation and measurement. MDH is working across state agencies on workforce measurement, training, financing, and workforce development strategies including with the Department of Human Services (DHS) (coverage of services), Department of Labor and Industry (DLI) (apprenticeship training), Department of Employment and Economic Development (DEED) (workforce growth), and the Office of Higher Education (OHE) (CHW certificate data).

Statewide scope of practice

There is a wide variety of roles and functions for CHWs in Minnesota and nationally. The roles and functions generally align with the MN CHW Alliance Scope of Practice as well as the CHW Roles, Skills and Competencies outlined by the National Council on the CHW Core Consensus Standards. Services provided most often are system navigation, peer support, community resource connection (including paperwork support) and health education. This scope is applied widely across at least 11 settings and 15 titles in Minnesota.

Academic CHW Certificate training program and upskilling trainings

Current CHW workforce information is pieced together from several data sets, but the most salient measure may be the number of CHWs who have completed a certificate program through one of the higher education programs in the state. This measure is central to the CHW landscape as the certificate is required for an employer to bill for reimbursable services through Medicaid (Minnesota DHS) and Medicare (Center for Medicare and Medicaid Services). Over the past decade, 10 CHW certificate programs were active at one point. Currently six programs are active (all available virtually, two with in-person options). The reported number of CHWs that hold a certificate is 1,631, with all six active programs reporting and four formerly active program reporting as of Nov. 1, 2024. This number is inclusive of the current 2024 years completions (not yet available through OHE).

Medical billing and reimbursement

Since 2007, Minnesota has been a leader in the nation in establishing policy and a medical billing and reimbursement system for CHW services. Minnesota was the first state to include CHW services as a fee-for-service (FFS) payment in the state Medicaid benefit through a State Plan Amendment (SPA). This resulted in Minnesota Health Care Programs (MHCP) coverage of diagnostic-specific health education services provided face-to-face to individuals and groups by CHW certificate holders. This includes both fee-for-service as well as enrollees of managed care plans. For CHW services to qualify for coverage, CHWs must have completed the CHW Certificate Program, be enrolled with DHS as a provider, and provide services under an order and general supervision of authorized MHCP enrolled provider types such as physicians, advance practice nurses, dentists, certified public health nurses working in a unit of government, and mental health professionals.

As of 2024, MHCP expanded CHW service coverage to include new Health Related Social Needs (HRSN) services performed by CHWs. Services are intended to address unmet social determinant of health (SDOH) needs that affect the diagnosis and treatment of the patient's medical problems. New MHCP covered CHW services include Community Health Integration (CHI) which includes assessment and planning, system navigation, facilitating access to resources, care coordination, health education, self-advocacy, social & emotional support, health coaching or motivation to reach care plan goals.

As a result of this expansion of coverage for Medicare defined codes, the covered CHW services in Minnesota are more closely aligned with the Minnesota CHW Scope of Practice.

Intended results and outcomes of CHW work in Minnesota

The CHW workforce can reduce health disparities and improve health outcomes in Minnesota. Evidence shows that CHWs do this by facilitating access to services and improving the quality and cultural competence of service delivery. Integrating CHWs into the public health and health care delivery systems increases access to care (Community Health Worker Integration with and Effectiveness in Health Care and Public Health in the United States) by supplying appropriate workforce resources to historically underserved and underinsured communities (Knowles M. C., 2023). Evidence shows CHWs improve access to care, health outcomes, and reduce disparities through cultural, language, and community specific navigation, education, advocacy, and linkage to services (Community Health Workers: Evidence of Their Effectiveness). CHWs also lower health care costs and improve quality and satisfaction, including through fewer ER visits and hospitalizations. A recent study (Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment) found a $2.47 return on investment for every Medicaid dollar spent on CHW interventions.

> "CHWs not only provide education to the community, but give education to providers on cultural, system barriers and lived experiences of patients."
>
> -CHW Supervisor

Method and Scope of Environmental Scan

It was important early on to identify the scope for this scan within the timeline necessary for MN CHW Alliance and MDH grant funded activities. The scope for this phase of the scan includes looking at the state and national levels to assess and understand types of CHW implementation and payment models, roles and functions, settings, measurement, and available outcomes data. Information learned about Minnesota will inform the development of a sustainable plan for CHW infrastructure in the state that supports the varied needs of the many diverse communities.

Data gathering consisted of existing data from state agencies and community partners, key informant interviews (105), literature review, attending national policy group meetings, Minnesota Community Health Worker Alliance Supervisors Roundtable and Education Committee, as well as attending state and national stakeholder conferences.

Existing Minnesota data

Existing data was used from state government agencies and community partner sources. The Minnesota DHS provided data about the number of providers registered with DHS to be able to bill for reimbursement of CHW services. This data was available by provider zip code. The Minnesota DEED provided Labor Estimates of currently working CHWs. This data was available by economic development region. The Minnesota OHE provided data about CHW certificate program enrollment and completion. This data was available by the county in which the CHW certificate holder shared for an address at the time of enrollment. The MN CHW Alliance Registry currently had limited data available for CHWs or CHW employers. The MN CHW

Alliance and MDH had data available on expansion of trained CHWs through the HRSA Community Health Worker Training Program grant.

Key informant interviews

105 key formant interviews were held between July 1, 2024 – Nov. 25, 2024. Each was an average of 30 minutes long and the majority were held virtually through Microsoft Teams. The outreach was meant to cover a variety of stakeholders and settings statewide, with a keen focus on diversity of geography and cultural communities. Key informants included the following:

- 14 CHWs
- 27 Local Public Health staff
- 9 hospital systems staff
- 18 community-based organizations staff or providers
- 2 Tribal Nations staff
- 2 Managed Care Organizations staff
- 1 school elementary principal
- 5 educators from higher education programs

The conversation focused on learning from these prompts:

- Where are CHWs working? In what roles and settings?
- How are CHWs doing their work?
- How do we know the impact?
- How are employers funding these positions?

Included in this list of stakeholders was representatives from statewide organizations such as Minnesota state agencies, higher education and public health institutions, research foundations, state chapters of health societies/associations, as well as staff from nationally recognized CHW implementation models such as CHW Pathways, IMPaCT, and Transitions Clinic Network.

In addition, MDH evaluation staff attended the Minnesota Rural CHW Conference in Worthington, Minnesota (July 17-18, 2024), National CHW Association Unity Conference (Aug. 22, 2024) and a biweekly national CHW policy group during this time. Locally, MDH evaluation staff attended the MN CHW Alliance Supervisor Roundtable, the CHW Education Committee and the Legislative Action Committee. To further explore gaps identified in this scan, secondary questions and expanded CHW initiatives measurement will be included in the next iteration of this scan, expected in 2025.

Summary of the Community Health Worker Field

CHW training

Certificate curriculum, apprenticeship, upskilling, and leadership development are all components of CHW training programs in Minnesota. Identifying funding to support these initiatives is an ongoing effort, as well as removing and reducing barriers to employers and CHWs for participation in training.

Certificate program

Minnesota was the **first state to implement an academic credit based CHW training curriculum in the nation**. The 16 credit CHW Certificate program is offered at six colleges and universities in Minnesota and is accessible for living and working individuals across the state in **online and hybrid formats**. The CHW Certificate is required for Medicaid and Medicare billing. Current workforce development efforts funded by the Health Resource Services Administration (HRSA) through the CHW Training Program (CHWTP) have additionally created an apprenticeship program, free online continuing education modules (referred to as upskilling), and professional development opportunities for CHWs and have resulted in more training for CHWs beyond the foundational core competencies offered in the CHW Certificate program. Strategies are needed to continue to make the current CHW Certificate program accessible to diverse communities across the state, as well as to develop additional specialty training and career development pathways to increase the CHW workforce.

The six higher education programs currently offering the CHW certificate program are Normandale Community College (Bloomington), St. Catherine's University (St. Paul), Saint Mary's University (Minneapolis/Winona), Rochester Community and Technical College (Rochester), Northwest Community and Technical College (Bemidji), and Minnesota West Community and Technical College (Worthington). Mankato State is a new program in the early stages of development.

According to the data reported to the Minnesota Office of Higher Education by the 10 CHW certificate programs that have ever offered the program, there are 1,371 CHWs who have obtained a certificate from a Minnesota higher education program in the past two decades. An estimated 260 more CHW certificates are expected to be completed by the end of the current academic year, making the total 1,631.

All programs have virtual courses offered (both synchronously and/or asynchronously), while a small number have in-person options. Saint Marys' has two CHW programs: an English language program and a Spanish language program. The Spanish-language CHW program is a unique offering, designed for Catholic Sisters who come from Spanish-speaking countries to serve in Spanish-speaking parishes throughout the US. Rochester Community Technical College offers CHW certificates to employer cohorts on an on-demand basis out of their Business and Workforce Education program. CHW instructors notice successful program completion depending on whether competing home life/work priorities outweigh program requirements and the online format. Program retention efforts are going on in many programs. One staff member from a higher education program indicated that they ended the program in 2019 due

to “insufficient entry-level job openings, insufficient wages that did not approach family-sustaining income, and a lack of strong or clear career laddering for our graduates.”

In recent years MDH has taken steps to increase statewide access to appropriate and effective CHW services in partnership with MN CHW Alliance through the HRSA CHWTP grant funding (2022) and state legislative funding (2023) to expand and strengthen the CHW workforce across Minnesota. From the fall of 2023 to the fall of 2024, an additional 185 trainees received scholarships through the HRSA CHWTP and were enrolled in the CHW certificate program at one of the five participating schools. Other HRSA grant funding opportunities also support additional CHW workforce development efforts across the state including St. Catherine University’s CHW Certificate Program and Sanford Bemidji’s community health hub.

Minnesota CHW Certificate Holders 2005-2024

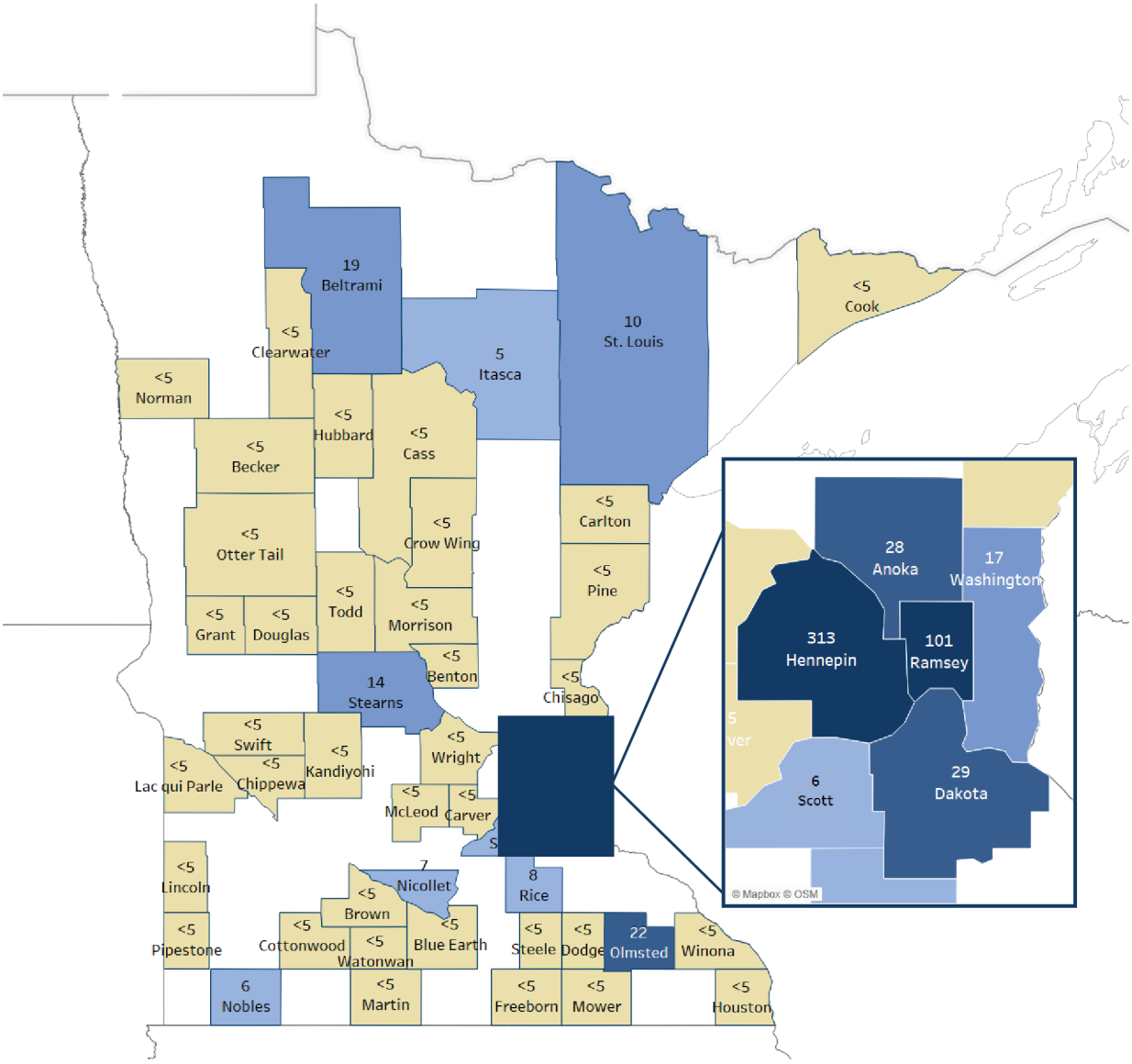


Image description: Minnesota map by county showing highest locations of CHW certificate completions are majority in the Metro Area and a few select counties in Greater Minnesota. 36

counties have less than five certificate holders, while those with the most are Hennepin (313), Ramsey (101), Dakota (29), Anoka (28), (Olmsted (22) Beltrami (19), Stearns (14), St. Louis (10). North and southwestern parts of the state have the fewest.

HRSA CHW Training Program

The HRSA CHW Training Program (CHWTP) grant aims to increase access to care and prevention services, strengthen the public health workforce, and achieve health equity in populations disproportionately impacted by poor health outcomes. MDH partners with the MN CHW Alliance, academic institutions, and employers to provide scholarships for individuals to complete the Minnesota CHW certificate program, engage employers in apprenticeship and provide stipends for CHW apprentices, develop upskilling trainings for CHWs, and enhance CHW certificate curriculum and materials for language and cultural communities.

As of December 2024, there are currently 185 scholarship recipients for the CHW Certificate program, three apprentices, and 52 CHWs enrolled in upskilling CHW training modules. There are currently four registered apprenticeship sites and eight organizations in the process of becoming registered apprenticeship sites. Of the enrolled trainees, 60 trainees have completed the CHW Certificate Program, three trainees have completed apprenticeship, and 35 have completed the upskilling training modules. Due to the length of the training programs and timing of enrollment, we anticipate being able to report a higher percentage of completions by Spring 2025.

One of goals of the HRSA CHW Training Program is to increase the trained CHW workforce from Black, Indigenous, and People of Color (BIPOC) and/or limited English proficiency (LEP) backgrounds and in geographic areas of the state with a high Social Vulnerability Index (SVI). The program objectives are to increase the number and diversity of CHWs in Minnesota; improve the capabilities and increase the skills of current CHWs; increase and improve the on-the-job training available for CHWs through field placement and the creation of a registered apprenticeship program; and improve health equity through strategic CHW recruitment from within communities experiencing health disparities and increasing employment opportunities for CHWs serving communities experiencing health disparities.

A combined summary of HRSA CHWTP trainees from Fall 2023-Fall 2024, indicates that **60%** of trainees have reported to be members of BIPOC communities. The counties with the largest number of trainees include Hennepin County with 25% of trainees, Beltrami County (17%), Ramsey County (9%), and Stearns County (6%). All these counties have a high or medium-high SVI. There is broad geographic distribution of trainees across the state including in most counties with high or medium- high SVI. However, there are still geographical areas from the Northeast, Northwest, Southwest and West Central regions of the state with high SVI that have a lower percentage of scholarship trainees where there is opportunity for additional trainee recruitment. For a national comparison, Centers for Disease Control has an interactive map Social Vulnerability Index (SVI).

MDH HRSA CHWTP Trainees (Counts) by SVI Area (Shaded) 2023-2024

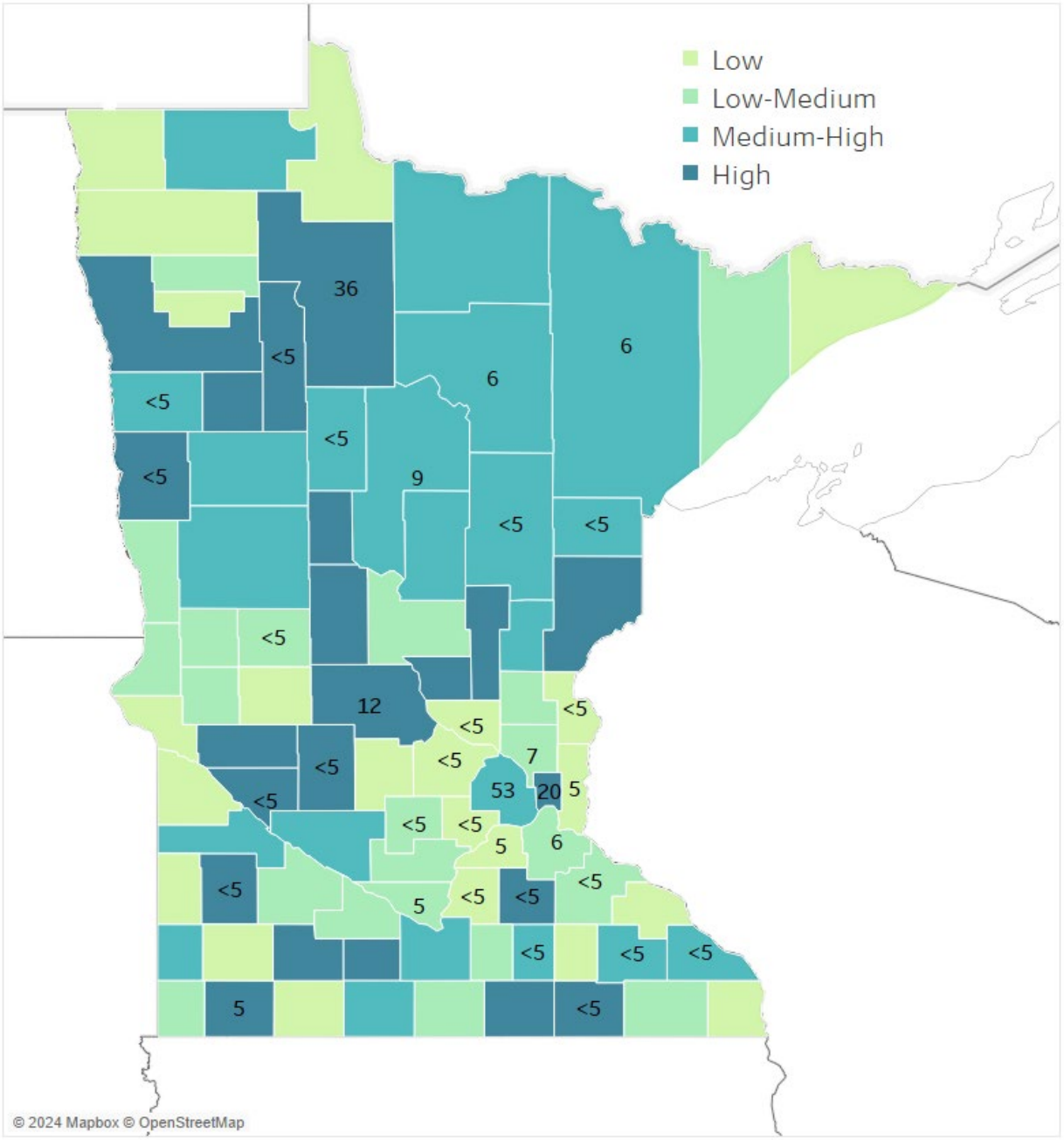


Image description: Minnesota map by county showing highest locations of high social vulnerability index (SVI) and the counts of HRSA funded CHW certificate program scholarships recipients. The Metro Area and the northern half of the state, as well as half of the counties in central and southeastern Minnesota have medium to high SVI. The count of HRSA scholarships was the highest in the metro, Beltrami and Stearns counties. All those counties have medium to high SVI.

The Registered Apprenticeship Program (RAP) component of the HRSA CHWTP, is a partnership with the Minnesota Department of Labor and Industry (DLI) to implement a Registered Apprenticeship Program as a career pathway where employers can develop and prepare their

future workforce, and individuals can obtain paid work experience combined with on-the-job learning and related classroom instruction. CHW apprentices acquire valuable experience and career training, growth, and advancement in the CHW profession.

Common barriers to implementing an apprenticeship model include existing supervisor/administrative staff capacity, both time and funding, general awareness of the training model, and the steps and potential funding to support the employer or the CHW in the process. Finally, some employers or supervisors don't see the need or benefit to the agency or clients. Support from HRSA and DLI grant funding has added capacity at the MN CHW Alliance to promote apprenticeships for CHWs, provide stipends to CHW apprentices, and support interested parties in overcoming barriers to having this training support piece added to the CHW experience.

> "A consistent challenge to having apprenticeship is the startup costs [for the CHW] before they become billable."
>
> -Community-based organization

Through the upskilling component of the HRSA CHWTP, four online CHW training modules on health promotion and chronic disease prevention topics have been developed and are currently available for free in the MDH learning center for CHWs working in the community to continue upskilling. Topics include asthma, diabetes, heart health, and stroke. Additional modules in development include oral health, dementia, hypertension and the CHW role in local public health. The modules have been well received by community CHW leaders, one CHW leader identifying these as an *"excellent role for MDH in moving the profession forward."*

CHW workforce in Minnesota

The Department of Employment and Economic Development occupational estimates there are 880 CHWs currently working in the state as of the first quarter of 2024. The seven-county metro area had the highest estimate of employed CHWs (520), followed by Southeast (79), Arrowhead (60), Central (50), South Central (30), Headwaters (30), Southwest, North Central, West Central (20 each). Compared to other states, Minnesota is not in the top five for highest employment level or highest concentration of jobs and location quotients in Community Health Workers. It is difficult to estimate how many CHWs without certificates are currently working in the field. These findings suggest it will be helpful to build out more systemic measurement to track the growth and persistence in the field, through the MN CHW Alliance CHW Registry or other methods such as the registry utilized by the Minnesota Doula program.

The links below provide more detailed data on wages and geography as well as info on methodology.

- Occupational Employment Statistics (DEED)
- Occupational Employment and Wage Statistics (OEWS)

CHW Labor Estimates by Economic Development Region

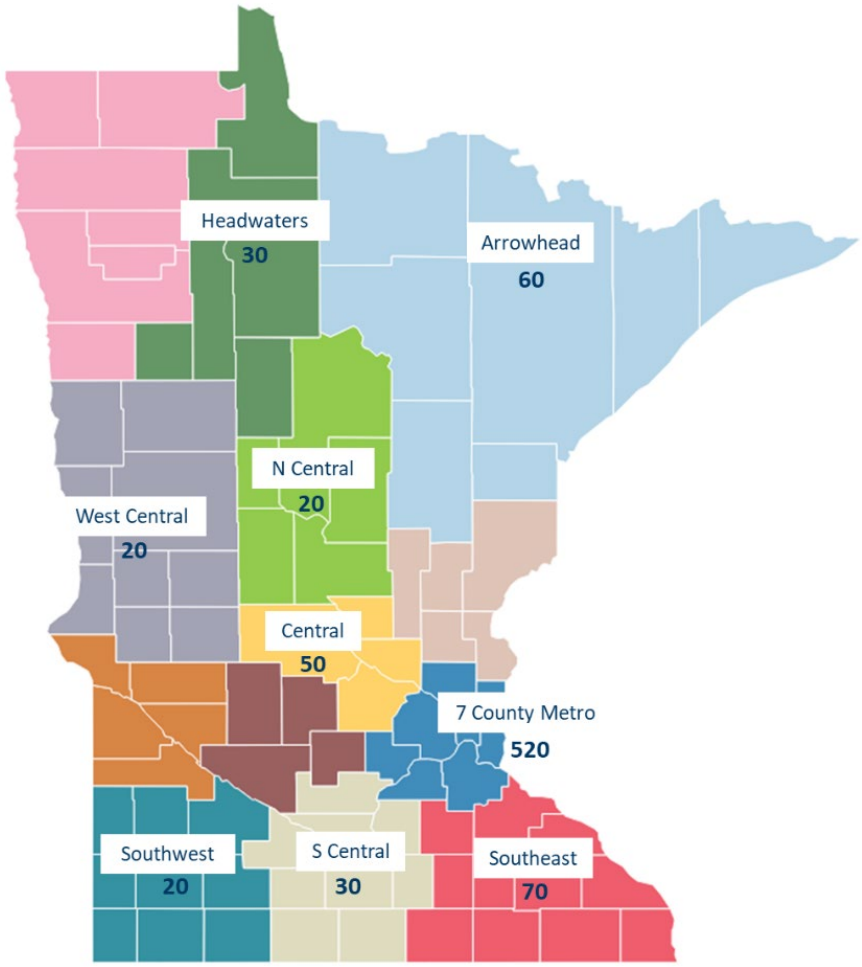


Image description: In the First Quarter of 2024 there were 880 total CHWs working in MN statewide. The Seven County Metro had the highest estimate of employed CHWs (520), followed by Southeast (79), Arrowhead (60), Central (50), South Central (30), Headwaters (30), Southwest, North Central, West Central (20 each).

In Minnesota, CHW services are provided across a variety of settings and under many titles. These settings include community organizations, health departments, managed care plans, mental-health centers, long-term care facilities and health systems. Although there is a US Bureau of Labor Statistics industry profile for the role, CHWs are employed under many job titles. Some of the job titles include Community Health Workers, Lead CHW, Senior CHW, Community Health Representative, Promotora, Community Connectors, Network Navigators, Patient Navigator, Community Advocate, Patient Advocate, Care Guide, “Other” Navigator, Community Health Resource Specialist, Certified Medical Assistant, Certified Peer Support Specialist, CHW Team Lead/Supervisor, Case Aid, and Community Outreach Coordinator. It is not common to include Health Educators or those working alongside community members on mental health or substance use recovery, for example Peer Recovery Navigator, Peer Recovery Support Specialist, or Certified Peer Specialists. These are often recognized by their own

occupational class and training. Standardization of job titles for CHW and CHW-like positions would allow for better measurement of the workforce.

Settings for CHW work

As of the compiling of this report and the data available, **47 counties out of 87 have some form of CHW services** taking place at some level of implementation or scale in a **variety of employer settings.** Areas of the state that have **less activity** include **southwestern and western Minnesota**. All seven counties in the metro area have CHW presence through local public health, health care organizations, or community-based organizations, however the settings vary. Local public health in the metro area is engaged at various levels with CHWs through community partners countywide.

> "We have ongoing conversations about CHWs and how they could possibly be incorporated into our department however we feel the work is getting done with our current positions and do not necessarily see how a CHW position brings added value compared the amount of work it would take to develop a CHW program from scratch. If we were to explore the use of CHWs there is limited to no funding to do this along with barriers we would face outside of our department related to requesting new positions. We have considered sending staff to obtain a certificate but have anecdotally heard the reimbursement is minimal from our metro partners."
>
> -County public health staff member

In locations with larger populations, there is more of a presence of CHW work through health care organizations, community-based organizations, and non-profits. **In Greater Minnesota there are pockets of activity and areas with extremely limited or no activity** (Southwestern areas near the state border, western Minnesota near state border, north central Minnesota). In rural locations, health care organizations and MCOs have coverage, with small numbers of CHWs covering large population areas of rural communities with limited resources and health care access. Other organizations provide services across the state as a hub organization that provides evidence-based health programs led by CHWs.

CHW initiatives are **showing up across MDH programs and grants** in the form of Home Visiting Promising Practices and Statewide Health Improvement Partnership (SHIP) initiatives in local public health, Healthcare Homes in primary care clinics, in Rural Health Centers and Critical Access Hospitals through the Office of Rural Health and Primary Care, Minnesota Interagency Council on Homelessness, and in the Health Promotion and Chronic Disease Division areas of Arthritis, Asthma, Cancer Control and Prevention, Cardiovascular Health, Diabetes and Chronic Kidney Disease, Healthy Aging, Injury and Violence Prevention, and Oral Health. Other MDH initiatives support CHW-adjacent programs, that engage community-based organizations and navigators such as the Health Equity Covid Community Connectors and peer support workers through substance-use disorder work.

CHW scope of practice: roles and functions

CHWs play a **variety of roles and functions** in the many settings where they work. One of the main roles is navigation of systems and resources, including insurance and medical paperwork, access to medical appointments, and health resources. Health education is a role that often includes the topics of vaccines, car seats, diabetes prevention and cardiovascular health. Another impactful function is navigating community support options to address social determinants of health, including paperwork, transportation, and patient advocacy. CHWs assist patients with detailed health care system navigation, which starts with empathetic listening to both the patient and the service provider and continues to become advocacy at clinic or social service agencies. Finally, an essential function is the advocacy for systems change to both the CHW employer organization and across community resource systems (medical, social service, public health). CHWs often help meet the needs of clients and community members, at times completing tasks that do not require CHW training or experience to fill gaps that could be completed by other staff (e.g. interpreting, completing paperwork).

> "I do it all-car seats, DHS paperwork and next thing I know I am looking at a furnace.
>
> -CHW in rural southern Minnesota

CHW and CHW Ally groups across the country have defined the Scope of Practice, roles, and functions of a CHW. The American Public Health Association has created a CHW definition. The National Council on CHW Core Consensus Standards primary aims are to expand cohesion in the field and to contribute to the visibility and greater understanding of the full potential of Community Health Workers (CHWs) to improve health, community development, and access to systems of care. The National Council on CHW Core Consensus Standard's primary aims are to put forth a single set of CHW roles and competencies (qualities and skills), which are the national standards determined, developed, led, and informed by the CHW workforce.

MN CHW Alliance describes the development and purpose of the CHW Scope of Practice on the MN CHW Alliance website. There are five distinct roles of the CHW scope of work that differentiates their role in the health care and social service settings: bridging gaps, navigating services, advocating for people or system improvement, providing direct services, and building capacity. The CHW Scope of Practice (adapted from the MN CHW Alliance) is below:

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

1. Enhance care quality by aiding communication between provider and patient to clarify cultural practices
2. Educate community members about how to use the health care and social service systems
3. Education the health and social service systems about community needs and perspectives
4. Establish better communication processes.

Role 2: Navigate health and human service system

1. Increase access to primary care through culturally competent outreach and enrollment strategies
2. Make referrals and coordinator services
3. Reach people the knowledge and skills needed to obtain care
4. Facilitate continuity of care by providing follow-up
5. Enroll clients into programs such as health insurance and public assistance
6. Link clients to and inform them of available community resources.

Role 3. Advocate for individual and community needs

1. Articulate and advocate needs of community and individuals to others
2. Be a spokesperson for clients when they are unable to speak for themselves
3. Involve participants in self and community advocacy
4. Map communities to help locate and support needed services.

Role 4. Provide direct services

1. Promote wellness by providing culturally appropriate health information to clients and providers
2. Educate clients on disease prevention
3. Assist clients in self-management of chronic illnesses and medication adherence
4. Provide individual social and health care support
5. Organize and/or facilitate support groups
6. Refer and link to preventive services through health screenings and health care information
7. Conduct health related screenings

Role 5. Build individual and community capacity

1. Build individual capacity to achieve wellness
2. Build community capacity by addressing social determinants of health
3. Identify individual and community needs
4. Mentor other CHWs – capacity building
5. Seek professional development (continuing education)

Implementation models used in Minnesota

While the most studied implementation models are in health care and clinical settings, community-based program models are widely used in various settings in the state as well, as described by the Rural Health Information Hub.

In local public health settings, CHWs often join a public health nurse in the family home visiting model. The IMPact model was launched by one health system in 2024 across nine clinical locations. The evidence based PCHI CHW Pathways community model has traction in southern MN. Implementation models vary, but the core roles and functions are described well in the literature, including MHP Salud, a national Latino CHW Support Organization.

A small number of community-based organizations have seen success contracting with health care clinics or managed care organizations providing CHW services such as health education, outreach and engagement of specific populations, connection to and appropriate utilization of health care services, navigation to community resources and addressing barriers to social determinants of health.

The Table 2 and 3 below is a brief description and examples of CHW implementation models by setting in Minnesota.

Table 2: Clinic Based/Clinical Implementation Models

Model	Description	Example Site
IMPaCT Care	An evidence-based model implemented in clinic and hospital settings to support patients in achieving personal goals leading to improved outcomes. CHWs drive system engagement and navigate clinical appointments. Organizations participate in model for a fee which includes a 10-day training, all materials for startup, ongoing training, and supervisor support. Evidence suggests interventions that address socioeconomic determinants of health have impact on patients and a positive return on investment (Kangovi, 2020).	One hospital system in Greater Minnesota began implementation of this model in April 2024 and is in the first six months of implementation at nine clinic locations (one CHW per clinic for a total of nine CHWs).
Health Care Home	A primary care clinic or clinician can obtain certification by the Minnesota Department of Health to implement a Patient and Family Centered Medical Home model to coordinate care among the primary care team, specialists, and community partners to ensure patient centered, whole person care and improve total health and well-being. The levels of progression of certification encourage organizations to address health equity, social determinants of health and clinical-community linkages. The Health Care Homes program encourages integration of CHWs as parts of	25% of HCH in Minnesota have CHWs on their teams according to the three-year certification/ recertification as of September 2024. One metro hospital system has 25 CHWs working in clinics through pods (nurse, social worker, CHW) primarily using telephone outreach with patients interested in the CHW support. Partnership with the quality improvement team has allowed them to show value and impact through outcome metrics and cost

Model	Description	Example Site
	its approach to team-based care, but it doesn't include requirements around the CHW interventions, CHW qualifications or training.	reductions. To date they are not billing for services but are interested.
Behavioral Health Home	"Behavioral health home" services refer to a model of care focused on integration of primary care, mental health services, and social services and supports for adults diagnosed with mental illness or children diagnosed with emotional disturbance. The behavioral health home (BHH) services model of care utilizes a multidisciplinary team to deliver person-centered services designed to support a person in coordinating care and services while reaching his or her health and wellness goals. The BHH model has specific requirements for care team members in statute, which include CHWs as Behavioral Health Home Specialist and Qualified Health Home specialists.	One non-profit in the metro area is a Minnesota BHH and has three CHWs on staff with certificates that partner with three social workers.
Transitions Clinic Network	The Transitions Clinic Network (TCN) model is an evidenced-based program that improves the health and reentry outcomes for people returning from incarceration. Each Transitions Clinic Program works with specially trained CHWs with a history of incarceration. The Transitions Clinic Network provides technical assistance and training to community clinics across the country.	In Minnesota, one hospital has a TCN clinic that focuses on identifying individuals in the county jail with a history of Opioid use disorder and connecting them with CHWs to use the clinic.
Oral Health	Oral Health CHW intervention models are in dental clinic, school, and home visiting settings in Minnesota. CHWs are shown to increase knowledge of oral health best practices, and activities like brushing and flossing among patients. These services are especially needed in dental care professional shortage areas. Several states, including Minnesota, are exploring ways to	There is a community-based organization that provides on-site dental treatment and health education to children from underrepresented communities through schools and children's programs.

Model	Description	Example Site
	bring education, care coordination, and enhanced access to oral health services by incorporating CHWs into care delivery (Community Health Workers and Oral Health: Improving Access to Care Across the Lifespan in Minnesota).	

Table 3: Community Based Implementation Models

Model	Description	Example Site
Pathways Community HUB	The CHW Pathways Hub model (CommunityHubManual.pdf (ahrq.gov) is an evidence-based, organized, pay-for-performance network of CHW services designed to improve health outcomes by addressing social determinants of health through implementation of Pathways. Pathways are standardized tools utilized by CHWs to identify, track, and address specific risk factors. Each pathway is closed when a measurable outcome is achieved which is tied to payment. A pathways Hub backbone manages billing and referrals for all the community care agencies where the CHWs are directly employed. The HUB model is a financially accountable care model with funding by managed care plans (including Medicaid), health departments, and philanthropic funders. Organizations can implement the pathways model concept independently or become certified by the Pathways Community Hub Institute (PCHI) to become either a Pathways Community Care Agency or a PCHI hub (Pathways Community HUB Institute).	A CHW Pathways Community Hub in southeastern Minnesota is established in partnership with a health care system foundation, health system, and a network of community-based organizations. They have established contracts with Managed Care Organizations as a part of braided funding mechanisms to finance the hub with partners.
Other Community Hub Models	Other community hub models consist of creating a community-based care coordination network that identifies individuals with modifiable risk factors – medical, social, behavioral – and connects them to services, tracks outcomes and contracts with payers that directly tie	One community-based organization provides backbone support to a network of community-based organizations and health systems that makes evidence-based health promotion programs facilitated

Model	Description	Example Site
	payment back to those outcomes. Different types of hubs include Umbrella Hub, Community Care Hub, Early Childhood Hub, and Community Resource Centers. The structure in common across hub types is a backbone support, collective impact, financing, and resource alignment across community organizations, clinics, and social services agencies. Hub models can improve efficiencies for community members. Hubs may employ CHWs or other staff the support community-based coordination, navigation functions, and education.	by CHWs available to people throughout Minnesota.
Childhood Hubs	Backbone staff and organizations convene and connect multiple community resources together for navigators to support families to access specific social, health and educational needs (Community Resource Centers: Minnesota Department of Human Services.	Community-based organizations have navigators to provide early childhood screening connection and follow-up, child care applications and financial assistance and navigation and connection to local organizations and resources including but not limited to food access, housing, transportation, health care or mental health service.
Third Party Payors/Managed Care Organizations	MCOs can integrate CHWs as part of population or care management teams. CHWs employed by the health plan often conduct outreach telephonically or at community events. CBOs also contract with MCOs to provide CHW services to MCO members to provide outreach and connection to health and social services.	One insurance company has three CHWs on staff to provide outreach to members across 12 counties. The positions are embedded within the communities they serve and have experience connecting people with health and social services. Their role at the MCO is to make sure members' health and social needs are met, allowing them to achieve the best possible outcomes.
School-Based Family	CHW models in schools include integrating CHWs into educational settings to support	A community-organization integrates a CHW in elementary and high schools in a large

Model	Description	Example Site
Engagement Navigators	students and family access to health and community services.	population center in MN to provide navigation services.
Family Home Visiting	Family home visiting is a voluntary, home-based service ideally delivered prenatally through the early years of a child's life. It provides social, emotional, health-related and parenting support and information to families and links them to appropriate resources.	Many local public health departments are using this model when they send a home visiting nurse with a CHW visiting together to a home or community location. The CHWs provide navigation services, often bridging language and cultural barriers.
Tribal Nations Community Health Representative	Tribal nations across MN and nationally have Community Health Representative (CHR) programs deeply rooted in the tribal culture and community. CHRs are frontline public health workers who improve access to health care in American Indian/Alaska Native communities and build community capacity. Some CHRs in Minnesota are trained as CHWs through the CHW Certificate Program. Other CHRs complete tribal specific training such as through the Indian Health Service.	One tribal health organization is deploying CHRs to work with individuals experiencing homeless to address social needs and provide health education.

Financing, billing, and sustainability

Financing new CHW positions and sustaining CHW positions is cited as an ongoing barrier for widespread implementation of CHW programs. CHW programs and services in Minnesota are supported through a variety of funding mechanisms including medical billing and reimbursement, grants, and operational funding. Many organizations utilize braided funding methods to finance CHW positions. Payment and funding mechanisms varied by setting, but fall generally into these areas: organizational funding, contracts with MCOs, community or state grants, property taxes (county) and DHS Medicaid services claims reimbursement. There are examples of county corrections or public health using county funds to support positions as well. Braided funding appears to be thought of as the goal for maximum sustainability.

Financing and billing

Minnesota was the first state in the nation to include CHW services as a Medicaid fee-for-service (FFS) benefit. Since 2007, Minnesota Medicaid has reimbursed for diagnosis-based Health Education services provided by CHWs that have completed the CHW Certificate Program. Reimbursement codes have recently been expanded through both Medicaid and

Medicare to include a broader scope of CHW services to address Health Related Social Needs (HRSN). However, less than 15% of CHWs in Minnesota have ever been enrolled with DHS to bill for services out of those CHWs that have completed the CHW certificate program. According to MN DHS claims data, which includes both Fee for Service and Managed Care Claims, for the period from Jan. 1, 2021, to Dec. 31, 2023:

- 37 CHWs rendered services out of 209 CHWs enrolled with DHS to bill for services. Of the 37, six CHWs rendered services under more than one billing provider.
- A total of 24 billing providers submitted claims for CHWs. The provider types include billing entities for physician services, community health clinic, consolidated provider organization, hospital, Indian health facility provider, physician, and public health nursing organization.

As of December 2024, no CHW service claims were submitted to DHS for the newly covered services to address HRSN (Community Health Integration codes G0019, G0022).

Table 4: CHW Services Claims Summary – Jan. 1, 2021, to Dec. 31, 2023

Claims by Service Code	Number
Number of claims submitted by service code 98960 - Self-management education & training, face-to-face, 1 patient	2,252
Number of claims submitted by service code 98961 - Self-management education & training, face-to-face, 2-4 patients	896
Number of claims submitted by service code 98962 - Self-management education & training, face-to-face, 5-8 patients	1,319
Total	4,467

The map below describes the geographic distribution of health care provider organizations enrolled with DHS to bill for CHW services between Jan. 1, 2021, and Dec. 31, 2023, by regions of Minnesota Association of County Social Services Administrators. Most of the organizations that bill for services are in the Twin Cities metro area. No organizations are enrolled to bill along the western border of the state.

Provider Organizations Enrolled to Bill for CHW Services by Region 2024

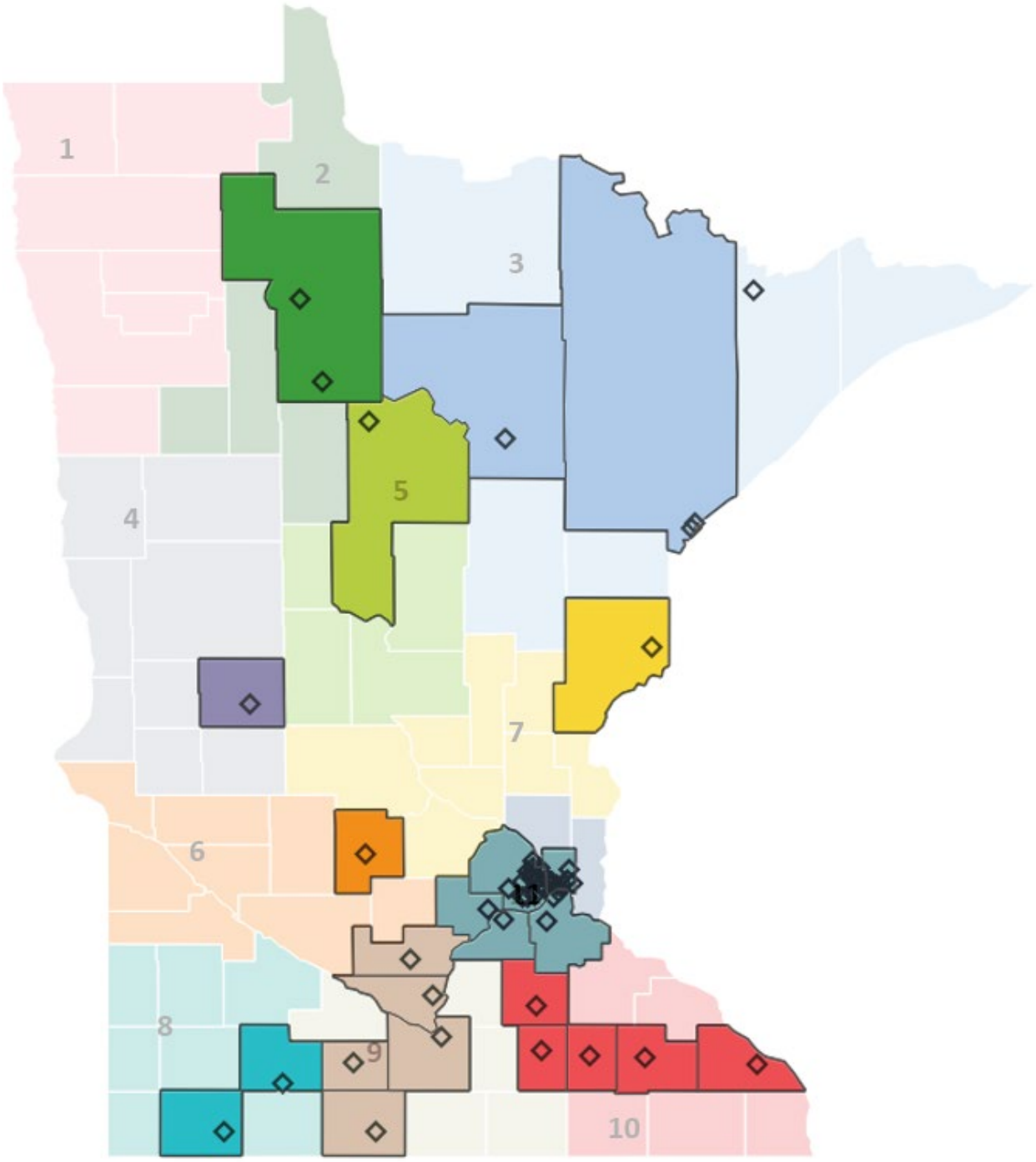


Image Description: Count of provider organizations enrolled to bill for CHW services with DHS 2024 Minnesota Association of County Social Services Administrators (by MACSSA Region). Most of the providers billing are in the metro area. No providers are enrolled to bill along the western border of the state.

Table 5: Count of Providers (Organizations) Enrolled to Bill for CHW Services with DHS by Minnesota Association of County Social Services Administrators (MACSSA) Region from Jan. 1, 2021 to Dec. 31, 2023

MACSSA Region	Number of Providers
Region 1	0
Region 2	9
Region 3	6
Region 4	<5
Region 5	5
Region 6	<5
Region 7	<5
Region 8	<5
Region 9	13
Region 10	7
Region 11	159

Key informants in Minnesota report low provider uptake in CHW services billing is due to **low reimbursement rates, visit based billing limitations, and limited scope of CHW services covered**. Additionally, Federally Qualified Health Centers (FQHCs) are unable to access reimbursement outside of bundled payment rates and some Community Based Organizations (CBOs) lack mechanisms for Medicaid reimbursement without contracting with a medical provider or health care organization to meet ordering and general supervision requirements.

Many key informants commented that more support is needed to implement billing systems for CHW services. Confusion about billing mechanisms and what is covered has been a major barrier. There is varied view of how much time and effort should be put into billing with the rates as they currently are. Themes emerged quickly from key informants about hesitancy, frustration, and the back-and-forth nature of submitted claims to DHS for billable CHW services due to claim errors and denials. Two key issues were lack of awareness of previous and updated billing codes (including the details and limitations of each) and support for learning the process of submitting.

> "If the billing is not accepted the first time, the cost of the billing staff to figure it out already is not worth the time to bill."
>
> -CHW supervisor at a community-based organization

Integrated health partnerships

There are other health care financing options for CHW services within the state, including value-based care models such as Integrated Health Partnerships (IHPs). IHP is Minnesota's Medicaid Accountable Care Organization model to improve care delivery and lower the cost of

care through innovative delivery models. Minnesota DHS contracts with health care delivery systems to provide innovative high-quality, efficient care to Minnesota's Medicaid population. The model includes an option for shared risk and shared savings. IHP participants also receive a population-based payment for care coordination and are required to design an intervention to address specific health care disparities observed in the IHP's population.

For more information, see Health Equity Interventions Summary for Minnesota Integrated Health Partnerships. The IHP team at DHS updated this document in July 2023 that outlines not only the specific organizations contracting with DHS under the model, but it goes into deep detail as to how each organization is implementing the model and many include CHWs in their interventions.

Nationally, the issue of sustainable funding is being studied and discussed. The Association of State and Territorial Health Officials and the Center for Health Care Strategies recently released a brief (Opportunities for Public Health Agencies to Advance Sustainable Financing of Community Health Worker Programs) outlining ways states can support the CHW workforce through policy implementation, capacity building for braided or blended funding models and CHW training and certification to align with financing opportunities. A national environmental scan of Medicaid reimbursement approaches allows idea sharing and state by state comparison.

"Billing is not enough to make this position work."

-Staff member at community-based organization

Sustainability

Retention

Multiple studies have identified barriers that lead to poor CHW retention. Barriers identified include short term funding, CHW led services being excluded from quality metrics, low wages, and persistent job insecurity. On the other hand, there are also concerns that standardization risks the over-professionalization of CHW roles, which could degrade the cultural ties and trust between CHWs and patients. The literature describes retention concerns and possible solutions in the following:

- American Journal of Public Health: Retention of Community Health Workers in the Public Health Workforce: Public Health Workforce Interests and Needs Survey, 2017 and 2021
- Health Affairs: Advancing Community Health Worker Models In Health System Reforms: Policy Recommendations From The RADx-UP Initiative

Retention was cited by key informants in Minnesota as a barrier to successful CHW program implementation. Themes that came up regularly included low salary levels, availability of fulltime work, supervision, and ongoing support to navigate both internal organization and colleague dynamics. Reflective practice was named in multiple locations as a positive supervisory tool to support CHWs and debrief work and client experiences. Turnover continues to be a theme in this professional role. Several key informants highlighted the cultural differences or racial bias of workplaces as negative retention factors leading to turnover in CHW

positions. Some organizations experienced turnover related to professional development and training of CHWs that then moved on to other health and social services careers.

> We found a good person and then after two years they go back to school to get a LADC or social work degree. This story happens over and over.
>
> - Local county public health supervisor

Career pathways

Developing Sustainable Community Health Worker Career Paths tells the story of professional growth options within the field. Many community health workers want to advance professionally as community health workers rather than become social workers or nurses. Highlighted in the HRSA Community Health Worker Career Pathways are ways that CHWs can move through a career pathway allowing for increased retention in these essential positions.

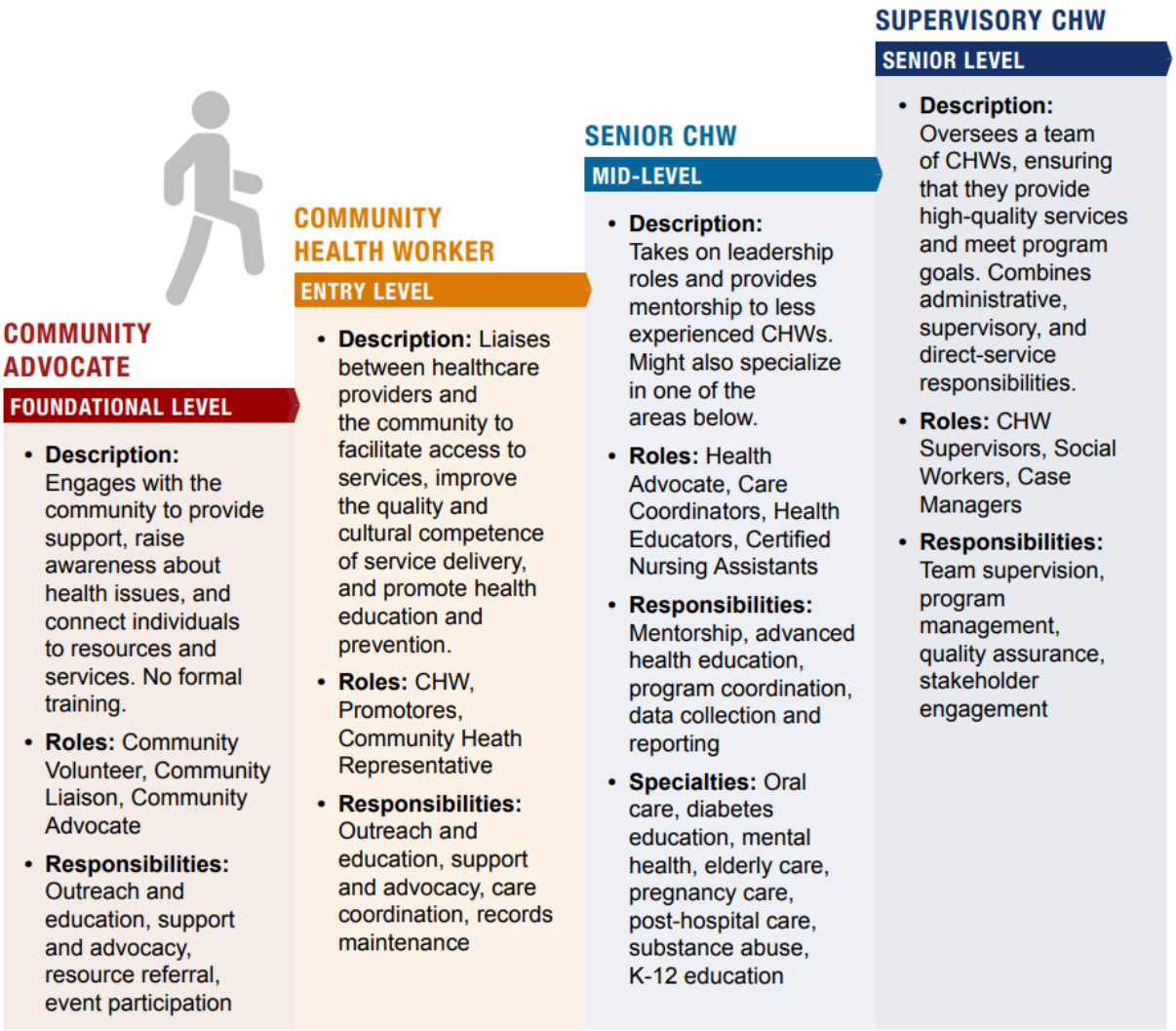


Image Description: potential career growth pathway shown with titles beginning with Community Advocate (foundational level), moving to Community Health Worker (entry level),

moving to Senior Community Health Worker(mid-level) and ending with Supervisory Community Health Worker (senior level) (HRSA Community Health Worker Career Pathways).

Minnesota does not have a specific career pathways program for CHWs, however, the CHW Certificate Program was created with the opportunity to articulate with other health and human services professions such as nursing and social services. The MN CHW Alliance also has a CHW Leadership Institute, which is designed to provide leadership and career development training and opportunities for CHWs.

One county in Minnesota has developed its own CHW career pathways program. It was designed to support the public health infrastructure decline, address the racial disparities that exist in accessing health care and provide low wage earners in the county with an opportunity for professional growth and development. The program provides college preparatory coaching and mentoring, tuition reimbursement, technology equipment, book stipends, laboratory fees and incidental expenses for transportation and/or childcare, and other related academic costs. A wage supplement is also provided to allow participants to enroll in the academic program fulltime while working a reduced schedule. Participants on the community health worker pathway receive a community health worker certificate and are eligible to become a certificate holding community health worker. Graduates can work in health education roles in Public Health or Social Services with the potential to earn $21-$45 an hour.

Environmental Scan Findings: Barriers and Facilitators

Feedback summarized below is based on national literature review and informed by 105 interviews with Minnesota employers and CHWs (former and presently working in the community). Themes described are gathered into barriers, facilitators, and tools.

Barriers to CHW program development, employment, and sustainability

Organizational readiness, training, supervision, retention, and funding are themes that emerged regularly through key informant interviews. Retention came up regularly in interviews and literature review. Themes included low salary levels, availability of fulltime work, supervision, and ongoing support to navigate internal organization colleague dynamics. Intentional preparation ahead of hiring a CHW has been shown to improve the experience and retention of the role. Many tools nationally and locally are available to support staff familiarity with and preparation for integration of the CHW role.

Documentation is consistently noted as a challenge for CHW workflows as well as for capturing information needed for program evaluation and billing. Logistically, case notes are most often tracked in an electronic data base (ex. PH Docs, Salesforce, Electronic Health Record, EPIC). When aligned well, this can ease the burden of billing on the financial or administrative staff. Family home visiting has a lot of documentation that can be a barrier to time with the patient. The Pathways Model has been noted as documentation heavy and difficult to flex with cultural nuances of patients.

Common barriers to implementing an apprenticeship on the job training model included existing supervisor or administrative staff capacity, both time and funding, general awareness

of the training model, the steps and potential funding to support the employer or the CHW in the process. One Behavioral Health Home administrator found that asking one of the professions to do an apprenticeship in the workplace where they were already working was not equitable when, in their view, other professions in the same organization were not being asked to do this.

Funding and sustainable financing is an ongoing barrier that has impacts on retention due to stabilization of positions over years and level of FTE for those positions, wages and supervisor time and capacity. Another barrier is limited capacity and experience of employers to confidently explore braided funding opportunities independently or with regional or community partners. Finally, some organizations don't see the value proposition in developing or formalizing the CHW role within their organization given the challenges with funding and sustainability.

> A huge barrier on billing is knowing the rates, the process, the frequency. How do you ACTUALLY bill?
> -CHW supervisor

Facilitators and components of successful CHW employment success

Preparing the organization for the success of the CHW position ahead of hiring was regularly noted as a facilitator to ease of entry and integration to the team. Internal advocacy tools to increase awareness of the role and the value are important for retention and sustainable braided funding. Connection to and integration with colleagues was identified across settings as a successful strategy. Structure often included regular weekly meeting with supervisors and bimonthly or monthly meetings with peer CHWs. Reflective practice was highlighted in multiple locations as a positive supervisory tool to support the CHW and debrief work experiences. For those CHW who have not completed a certificate, paid time to do CHW certificate homework at work and supervisor support of the work and program made a difference.

Continuing education or upskilling opportunities offered consistently, via Impact, Pathways or MDH Upskilling modules are also valued by employers. Building employment levels to allow for professional growth in the field also contributes to sustainability. A common situation reported by employers was CHWs actively pursuing alternative higher education degrees, eventually leaving the field to move into those roles (social work, nursing, public health). This can be viewed as both a success as well as a challenge.

Recommendations to Support Employer Capacity for Successful Employment of CHW Workforce

Based on learnings from the scan, key themes include a need for technical assistance for financing for CHW programs, regional and partnership supports needed for successful CHW programs, and implementation and measurement of CHW models.

Workforce preparation and retention

Technical assistance needs: organizational readiness and financing

The infrastructure for a CHW employer is going to be integral to a successful CHW program. Four tools or system builds that rose up to the top of the list and are described below include: organizational readiness tools, documentations systems, data dashboards, and billing workflows and systems. Additional information from national groups, like the Association of State and Territorial Health Officials, provide a full range of tools and policy preparation for an organization.

Organizational readiness tools

Creating a matrix of CHW Employer Readiness for the organization to use as a self-assessment tool (i.e. 1= not at all ready to hire CHW, 5= prepared to fully support and fund CHW) could be beneficial to preparing employers for successful implementation of CHW services. Recommended topics for technical assistance by MN CHW Alliance include review of policies, preparing onboarding schedules, training plan for CHWs on implementation models (i.e. Pathways (Hub or Care Agency), Impact, Healthcare Homes). To be prepared for a successful CHW employment experience, regular connection with MN CHW Alliance technical assistance staff to do the pre-work ahead of meetings is recommended. Examples from national sources include the following: Tools for Recruiting and Retaining CHWs in Public Health Agencies .

> One thing that is missing is the vital role that CHWs can play in informing their organization of how to better serve populations that the CHW shares cultural congruence with. CHWs are a bridge and the traffic flows both ways on the bridge (if organizations are open to this).
>
> -CHW ally

Documentation systems

Sustainability begins with aligning tracked activity to billing requirements. Time tracking by patient encounter type, activity, or group work by the CHW, in the EHR for example, can ease the burden of administrative staff navigating the complex billing requirements. Billing staff will be able to segment and bill more efficiently and reduce paid time to do that. Effective documentation also supports data collection and metrics reporting. Logistically, case notes are most often tracked in an electronic data base (ex. PH Docs, Salesforce, Electronic Health Record, EPIC). When done well, this can ease the burden of billing on the organizational staff and increase the financial sustainability of CHW programs through paid claims.

Data dashboards

Support for developing an internal data dashboard on program and process metrics is essential. One hospital system has created an internal CHW data dashboard, through EPIC, that provides structured feedback and data reporting options for administrators about patient encounters by month and disaggregated demographics. The existence of the dashboard helps build awareness

of the role and its impact internally for an organization. It can create connection and ease the billing process for CHW and the finance staff.

Billing workflows and systems

Billing Medicaid and MCOs for CHW Education has continuously been cited as a barrier for organizations. In January 2024, Medicare introduced a new set of CHW covered services called Community Health Integration (CHI), which is now also covered by MHCP. This creates new opportunities as well as challenges for CHW organizations to implement workflows and systems to bill for CHW services. Technical assistance is needed for developing CHW workflows and documentation for billable services as well as organizational systems for contacting and billing payors.

The National Association of Community Health Workers (NACHW) implemented a Community Health Worker (CHW) survey in 2021. Results included opportunities for action described by the author including: *"CHW payers and funders must eliminate short-term grants and restricted reimbursement for CHW roles."*

Regional or setting specific collaboration

Utilizing existing regional teams of employers or supervisors across settings can increase local capacity and sustainability of CHW workforce. Peer groups, along with technical assistance, can address complex topics including billing, support and make room for subgroups (by type of setting) for problem solving, collective applications for grant funding and identify and push out funding opportunities consistently to all settings.

Additionally, encouragement and support for effective MOU or contract language that allows for data sharing would lead to impact measurement. To support both the organizational readiness and improve the CHW program implementation, peer support between administrators could focus on areas that impact the ongoing success of the CHW program (e.g. MOU or contract language, data sharing agreements, braided funding methods, reimbursement billing, program advocacy and prioritization in the great health context). Along with technical assistance, peers could also support and encourage material development and plans for local county or hospital board presentations, talking points about the CHW field to decision makers and funding requests needed.

Sustainability of CHW professional role

CHWs do their work successfully through building relationships, community connections and sharing culture and lived experience with patients. These established components can be complemented by structured implementation of the CHW Scope of Practice. Defined roles and functions can be implemented in a variety of ways and evidence-based implementation models. The recommendations include financial sustainability through reimbursement and braided funding streams and growth of the professional role across settings.

Growth of the profession

To support the advancement of the field and move more effectively and efficiently toward improved patient experiences and health outcomes, evidence-based model implementation supports are needed (peer support, regional support, or group TA from MN CHW Alliance) for defined models (both clinical and population-based models listed above). The infrastructure of the model would support organizational documentation of how CHWs spend time within the Scope of Practice and provide much needed role definition internally. Clear guidance and support should be offered on CHW documentation of patient experience and system successes and gaps in a form that is CHW, and dashboard connected. Organizational policies are recommended for safety, travel, and offsite work to accommodate the variety of CHW activities to serve the patient specific needs.

Alongside internal structures, there are recommended tools that increase awareness of supports CHWs need to be effective. Several of these include:

- Community specific resource lists, updated based on CHW feedback.
- Peer support by region internal or external to the organization (peer support and supervisor connection on a regular basis).
- Warm introductions to area resource providers as part of onboarding protocols for employers of CHW.
- Medical provider/director education about CHW role as part of organizational readiness.
- Apprenticeship steps including a rubric (best practice) and funding.

Supervisors and administrators could identify and share evidence and experiences in the community where CHW activity has shown an impact on patient health outcomes. It is recommended to include qualitative information directly from CHWs themselves. According to the author of this Frontiers in Public Health 2023 article, “the importance of retaining skilled and experienced CHWs and educating other health professions about CHWs' critical roles will result in decreased attrition professional growth, and improved program quality.”

Financial sustainability

The National Association of Community Health Workers (NACHW) provided a 2023 report Sustainable financing of Community Health Worker employment: Key options for states to consider outlining the funding options at this time in the United States. These may vary by state, however, give a good summary of potential financing includes:

- Federal government: public health, block grants, HRSA 330 funding
- State and local government funds
- Health Care Provider Funds: Internal Financing
- Blended or braided funding: multiple sources
- State Medicaid policy actions: Waivers and SPAs
- Medicaid MCO contracts

In Minnesota, based on the key informant interviews, the following themes were identified as most relevant for building financial sustainability across settings:

- Policy for reimbursement rate increases.
- Billing reimbursement training, peer support and community partner feedback on system improvement.
- Peer support for identifying and braiding funding sources.
- Promotion of the CHW field and advocacy for healthy equity as a funded priority in practice.
- Provide for potential funding needs.

Several of these recommendations could be operationalized with existing funding sources like the statewide HRSA CHW Training Program grant, the MN CHW Alliance CHW grant, or funds designated for demonstration projects. Current funding needs include:

- Funding for salary and benefits of CHW positions
- MN CHW Alliance staff time for preparation and TA
- Apprenticeship stipends - for CHW and/or employer
- Stipend for organizational readiness participation
- Stipends for regional peer support team leads.

Components of successful CHW program implementation in Minnesota

Building from previous scans and reports on the landscape of the CHW workforce in Minnesota and on other toolkits developed nationally (Community Health Worker program standard: A roadmap for the Commonwealth of Virginia), the grid below outlines the needs identified for successful CHW program implementation and the activities and tools needed to support successful CHW employment and CHW experience.

Tables 6-14 show components of successful CHW program implementation in Minnesota.

Table 6: Organizational Readiness

Activity in Minnesota	Tool (Organization)
Employer has connected to MN CHW Alliance for technical assistance about strategic/structural preparation	Organizational Readiness Check List Staff preparation checklist (see national resource tool kits) Policies for home visiting, travel, offsite work settings Documentation of CHW roles and workflows, caseloads, funding, and sustainability planning
Determination of CHW implementation model/CHW roles and development of CHW standard work, documentation, workflows	CHW readiness checklist CHW and CHW supervisor job description Clinical and social work team familiarity with role
Development of business case, financing model, documentation, and measurement	EHR set up for CHW data tracking

Activity in Minnesota	Tool (Organization)
Internal team communication about role to colleagues and partner agencies/clinics (prepare for system improvement advocacy feedback)	Communication tools for internal awareness of role and scope

Table 7: Recruitment and hiring diverse staff from communities served.

Activity in Minnesota	Tool (Organization)
Clearly define and decide scope of role to be hired in alignment with C3 and MN Scope of Practice	MN CHW Alliance Technical Assistance
Draft job description, interview questions, and selection criteria	Sample job descriptions, market rates for CHW pay scales, sample interview questions (MN CHW Alliance) The National Association of County and City Health Officials CHW Toolkit 2024
Notification to existing CHW certificate holders of job posting by MN CHW Alliance	MN CHW Alliance Registry

Table 8: Employer sponsored orientation and training.

Activity in Minnesota	Tool (Organization)
Develop and implement orientation and training on CHW role, functions, integration, and standard work	Orientation and training plans and curriculums Documentation to be able to bill easily, safety, data protection, best practices, outreach to whom about what? (role and standard work)
Implement apprenticeship program	Technical assistance, training content/suggestions (MN CHW Alliance)
Stipend for apprentice or funding for employers to sponsor apprenticeship	HRSA, state or federal funding for apprenticeship programs

Table 9: Organizational support for CHW Certificate program completion within 18 months of hire, if not already obtained *(Increased CHW with certificate to be able to bill DHS for services)*

Activity in Minnesota	Tool (Organization)
Employer as internship site for CHW certificate requirement	Supervisor Roundtable (MN CHW Alliance)
Financial Aid	Employer tuition assistance programs, HRSA CHW scholarship, Promise Grant, Dual Pipeline Funding
Paid work time for homework	Funding at organization
Supervisor support of course content and/or student support from MN CHW Alliance	Staff time at organization

Table 10: Support for CHW and supervisor (hire, train, supervise and retain)

Activity in Minnesota	Tool (Organization)
CHW referred to join peer support groups such as CHW Circle	CHW Learning Circles (MN CHW Alliance)
Supervisor referred to join peer support groups such as Supervisor Roundtable	Supervisor Roundtable (MN CHW Alliance) or regional leadership work (MN CHW Alliance)
Regular 1:1 meetings and supervision support	Frequency of connection with CHW recommended topics to include holding roles within team, boundaries personal and professional, scope of practice, reflective practice, complex case review and caseload review.
CHW integrated into interdisciplinary team meetings, huddles, case reviews.	MN CHW Alliance technical assistance
Internal advocacy for CHW roles and integration in local organization	Communication tools for internal awareness of role and scope – include output or process measures periodically to help show colleagues impact of role (MN CHW Alliance)
Regular monitoring of standard work and metrics for CHW workflows, continual process improvement	Monitor and report individual, process, and program outcomes (dashboards, reports, etc.)
Opportunities for CHW engagement with the community and advocacy and an individual and systems level	MN CHW Alliance Learning Circles or Legislative Action Committee

Table 11: Organizational financing and sustainability (program evaluation, financing, ROI, bill, braid funds, outcomes)

Activity in Minnesota	Tool (Organization)
Oversight of financing, model implementation, documentation, and measurement	Tools, templates, workflows, and standard work
Program Measurement and Evaluation- local organization level	Process and output
Organizational process and staff to support CHW to apply for NPI number or UMPI number, DHS enrollment	Templates and tools such as standing orders, DHS Billing videos/webinars
Organizational process and staff resources to bill for CHW services	NPI #, UMPI number and DHS enrollment instructions to do this

Table 12: Long term professional development and connection to the field

Activity in Minnesota	Tool (Organization)
Continuing education and specialty trainings	MN CHW Alliance CHW Circle and Training Hub, CHW Leadership Institute, Annual Statewide Conferences, MDH Upskilling Modules, NACHW, APHA/MPHA, Organizational professional development
Shared decision making with CHW	CHW and Employers
Career advancement tracks for CHWs	CHW and Employers

Table 13: Advocacy (salaried, skilled, supervised and supplied)

Activity in Minnesota	Tool (Organization)
Competitive and livable wages for CHW positions	Legislative Advocacy Committee- MN CHW Alliance
Revenue streams and operational funding in place to sustain and expand CHW services.	MN CHW Alliance via Supervisor Roundtable
System/process for education of physicians, practices, and health system leadership about CHW profession, roles, efficacy, clinical integration models, and financing.	MN CHW Alliance via Supervisor Roundtable

Activity in Minnesota	Tool (Organization)
Renegotiating MCO contracts for higher payment rates for CHW services	MN CHW Alliance via Supervisor Roundtable
CHWs included in policy and advocacy platform	MN CHW Alliance via Legislative Action Committee
Clarifying and reducing administrative barriers of existing MHCP guidelines	MDH, DHS, MN CHW Alliance

Table 14: Evaluation

Activity in Minnesota	Tool (Organization)
Impact/outcome data	MDH to lead analysis - Statewide CHW Common Indicators
Workforce and training metrics	MDH and MN CHW Alliance
Cost and ROI	Hospital utilization, ED utilization, disaggregated by location, patient race/ethnicity, impact on health conditions MN CHW Alliance demonstration project findings
Value and Success Stories	MDH and MN CHW Alliance

Next Steps for the MDH Community Worker Initiative

The next steps for MDH CHWI are to partner with the MN CHW Alliance to connect with CHWs and key stakeholders across the state to build a sustainable plan for supporting the CHW workforce and measurement of the impact of CHWs on health outcomes. MNCHWA will also be conducting demonstration projects in 2025 to further understand and document CHW implementation models in the state and the impact and value of CHWs.

MN CHW Alliance demonstration projects

This scan has helped inform demonstration projects to be conducted by the Minnesota Community Health Worker Alliance funded through an MDH grant agreement. The goal of the demonstration projects is to understand and document the value of CHWs in Minnesota in a variety of settings to include at least one health care organization, one local public health agency, and one community-based organization. MN CHW Alliance will provide technical assistance to grant organizations on organizational readiness, hiring, CHW program development and CHW integration into the team; and evaluate pilot grants for outcomes, results and lessons learned to report to MDH and key stakeholders. The results will inform the development of a sustainable plan for CHW infrastructure that supports the varied needs of diverse communities in Minnesota.

Continued measurement and sustainable plan

MDH will continue to gather information on state and national models to inform the creation of the statewide sustainability plan for CHW infrastructure as well as a statewide measurement

system for CHW impact and outcomes. This effort will include ongoing measurement in partnership with employers, CHWs, MN CHW Alliance and MCOs. MDH will continue to explore future evaluation efforts to learn about health disparities in health outcomes for Minnesotans and the growth and sustainability of this professional role.

Environmental scan updates

The next phase of the Minnesota CHW landscape environmental scan will be available in 2025. It will include a focus on organizations serving individuals experiencing homelessness and veterans and a clear picture of structure of employment and partnership with Managed Care Organizations, health care organizations, tribal health organizations, and community-based organizations. CHWI will partner with the MDH Office of American Indian Health to learn more about Tribal Nations Community Health Representatives. The scan will also continue to explore the state and national landscape for financing and sustainability.

Sustainable plan development

The development of a multi-year state sustainable plan will include a partnership between the MN CHW Alliance and MDH to convene CHWs and key stakeholders across the state to develop a sustainable plan for CHW infrastructure that supports the diverse needs of communities and aligns with the most appropriate CHW model. The sustainable plan will be a roadmap of action steps to get to a sustainable CHW infrastructure. Stakeholders will be encouraged to participate in a variety of ways, including through workgroups focusing on aspects such as: workforce development and training, payor/policy/ financing, CHW advocacy, awareness and advisory (CHW focus/CHW led), billing and reimbursement, contracts and data use agreements, data, and measurement, etc. A team of stakeholders will draft the Statewide Sustainability plan and give input on the layout and content of final deliverable.

Measurement

Key to moving the profession forward will be identifying and monitoring a variety of indicators that are relevant to CHW initiatives in Minnesota. Meaningful measurements that are identified for a sustainable plan could include CHW certificate program data, labor estimates and DHS claims data regarding provider, geography of participating employers and individuals served by CHWs. Using the Common Indicators, which provides ability to compare with other states, employer and CHW surveys would a beneficial data source over time. To ensure data is collected across settings, partnerships established with Minnesota Association of Community Health Centers, Minnesota Hospital Association, Local Public Health Association, Healthcare Homes, and CHWs will be conducted through focus groups or a survey.

Future directions for evaluation

The development of evaluation measures will continue as more data and information become available through measurement and storytelling in the community. Some sources of information already identified included the MN CHW Alliance Demonstration Projects data and community partner feedback, an employer survey through the Minnesota Hospital Association and CHW evaluation surveys from the MDH Upskilling online trainings. Future directions could

include a more robust CHW Employer Survey (in alignment with CHW Common Indicators) and the development of an Organizational Readiness Matrix delineating the successful components of CHW Program Implementation. More information will be collected through an updated MN CHW Alliance Registry. Many organizations have process evaluation information and qualitative stories across staff and patient populations. Identifying partnerships to share in analysis of health outcome data, documented system improvements across multiple settings and collective measures will facilitate the ability to describe this important work in the community and the health care system.

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