Funding Community Health Workers:

Best Practices and the Way Forward

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ABSTRACT

Community health workers (CHWs), in their delivery of culturally competent care, play an integral role in promoting the health of communities. Many states have successfully utilized CHWs to reduce health disparities and promote health among low-income communities. Connecticut, in contrast, has a fragmented CHW workforce that is poorly understood and likely underutilized. Southwestern Area Health Education Center (SWAHEC), Inc. partnered with a student team at the Yale School of Public Health to identify initiatives and progress made by various states around the US related to funding mechanisms for CHW positions. Key informant interviews were conducted with representatives from Massachusetts, Vermont, Rhode Island, New York, California, and Texas to identify best practices and challenges faced when organizations and other agencies seek funds to pay CHWs. CHWs and those who work with CHWs are still facing poor recognition and lack of understanding, which contributes to difficulty in paying CHWs; as they are not a recognized professional workforce, it is challenging to identify funding sources for CHW positions. When funding for CHW positions is available, it is often in the form of short-term, soft money from sources such as grants. This theme appeared in the majority of interviews, suggesting that this remains a challenge in many, if not the majority, of states in the US. An important consequence for this type of funding is that positions for CHWs are often temporary and unstable, which affects their ability to work continuously within their communities. This is detrimental for both the CHWs and the communities they work in. Those working towards organizing CHWs in CT should ensure CHWs are the primary driving force behind CHW initiatives. In addition to educating health care professionals about the capacity of CHWs, establishment of formal training/certification programs may help facilitate the recognition and acceptance of CHWs as not only cost saving but integral to promoting the health of communities.

INTRODUCTION

Community health workers (CHWs) (also commonly known as promotoras/es, community health advisors, and lay health advocates) have played an integral role in the promotion of health in a number of communities.[1] As defined by the United States Department of Health And Human Services, CHWs are "lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve"[1]. Given their familiarity and status within the populations they usually serve, the role of CHWs as a community's liaison to healthcare access and health related resources can be critical to the population health of migrant or minority communities, where this knowledge may not be readily known or ascertainable.

Indeed, a number of studies have found migrant and minority communities to benefit from the presence of CHWs. Balcazar and colleagues (2005) conducted a study in which CHW programs were implemented in a number of predominantly Latino communities across the country. After CHWs had worked with members of these communities to promote a number of health-improving strategies, investigators found that community members improved heart health related behaviors. Additionally, Forster-Cox and colleagues (2007) analyzed the effects of CHWs in a U.S.-Mexico border town on promoting knowledge of health issues associated with pesticide use. Investigators found improved knowledge and behavior relating to safe pesticide use in the community after the intervention. In

addition to these studies, a literature review by Swider (2002) noted eleven studies finding at least partial evidence that CHWs increase access to health care. Further, this review found evidence that CHW interventions improved health status of communities in a number of studies.

Despite growing evidence supporting expansion of the use of CHWs, the role of CHWs has been limited by uncertainty and lack of standardization. Despite playing a role in communities for "almost as long as communities have existed…," (p.3)[1] CHWs have only recently begun to receive attention as a key strategy for promoting health in underserved or minority communities. Beginning in the 1960s, CHW programs were used in response to the problems faced by low-income communities, rather than in a preventative role they are more likely to take today.[1] However, CHW programs later began to receive state and federal funding, and are currently recognized as an important tool in strategies to help promote community health and combat health disparities in the country.[1]

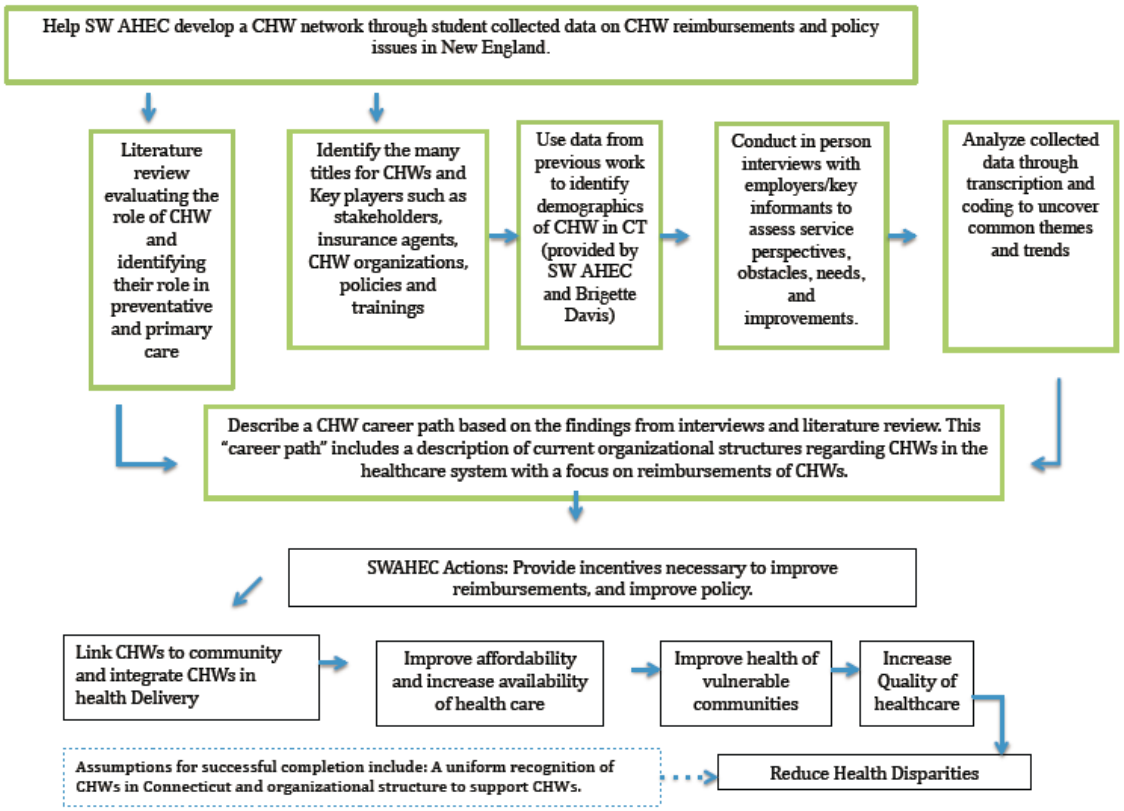
Currently, several states, including Texas and Ohio, have in place a credentialing system for CHWs; Texas also passed legislation requiring health and human services agencies to use CHWs "to the extent possible" in performing health outreach and education programs for recipients of medical assistance," while Ohio's awards a "certificate to practice" following completion of an approved training program.[1] Despite these developments, there is still no nationally standardized path for becoming a CHW, nor, given the wide range of duties and disparate training requirements of CHWs, is there a consensus as to where a CHW falls in terms of career advancement within the health professions. Without a universally recognized definition or role within the health care industry, effective recruitment and expansion of CHWs in the future may be limited.

Project Goals

Given the lack of standardization of the profession, this project is intended to contribute to the discussion and development of CHWs as an integral part of the Connecticut health services workforce, with an underlying goal of improving statewide health, particularly within disadvantaged and vulnerable communities. Currently, the status of CHWs in Connecticut is not clearly defined. Connecticut has no existing standardized CHW training program, nor a statewide occupational category that could be used by providers for insurance reimbursements. Instead, there exist a number of sub-categories or specialized CHWs (such as patient navigators) who are responsible for some of the functions traditionally associated with CHWs. The primary aim of the current project was to identify funding mechanisms used in various states to fund CHW positions and to understand sustainability of the workforce given these funding mechanisms.

To accomplish the objectives for this project, a number of key informants were interviewed to give their perspective on aspects of the CHW reimbursement process with which they are familiar. Practicing CHWs, identified preceptors of CHW training programs, employers utilizing CHWs, and individuals and organizers with experience with state or local policies utilizing CHWs were targeted for the key informant interviews; emphasis was placed upon finding key informants within Connecticut, but out of state individuals and organizers with CHW policy experience were contacted.

Figure 1. Program Theory



METHODS

Literature Review

A literature review was conducted to understand the role of CHWs nationwide with a focus on New England. The database search was employed using sources such as PubMed and governmental resources such as Health and Human Service. Our review looked for methodological and conceptual gaps, CHW associations, and key players in CHW organizations, taking into account the findings and weaknesses of published literature in the field. Methodological challenges faced with this database search stemmed from the dearth of information on CHWs, especially in the context of CT, a state with a relatively scattered CHW workforce.

Characteristics of CHWs in CT

The demographic characteristics of CHWs were obtained from a 2012 survey distributed by Southwestern AHEC, Inc. (SWAHEC). The surveys were distributed to 1) CHWs in various organizations around the state, and 2) health and human service employers. The CHW survey included sociodemographic questions such as race/ethnicity, gender, and wages. In addition, items were included to assess scope of practice of CHWs, met and unmet training needs, and challenges facing CHWs in CT. The employer survey included questions about funding mechanism in place for CHWs that they employ, as well as attitudes about the use of CHWs. The data from this survey was summarized by our team and included information about CHW characteristics, health care employer characteristics, and reimbursement distributions. As this was not the primary aim of the present study, the report for those surveys can be found in Appendix II.

Key Informant Interviews

An interview was developed to complement the descriptive work previously done by SWAHEC, and focused on the funding mechanisms currently used by other states to understand and assess economic sustainability of the CHW workforce (Appendix I).

Sampling and Recruitment

This study was approved by the IRB at Yale University. Key informants were chosen because of their work with and knowledge about CHWs. The focus was on key informants from the New England region. In the end, information was gathered from California, New York, Rhode Island, Connecticut, Massachusetts, and Vermont. Participants in our survey included practicing CHWs, identified preceptors of CHW training programs, employers utilizing CHWs, and individuals and organizers with experience with CHW associations. Phone interviews were conducted with all participants. Since we were interested in understanding the reimbursement of CHW we recruited experienced directors, academics, and CHWs. All participation was voluntary.

Design and Data Collection

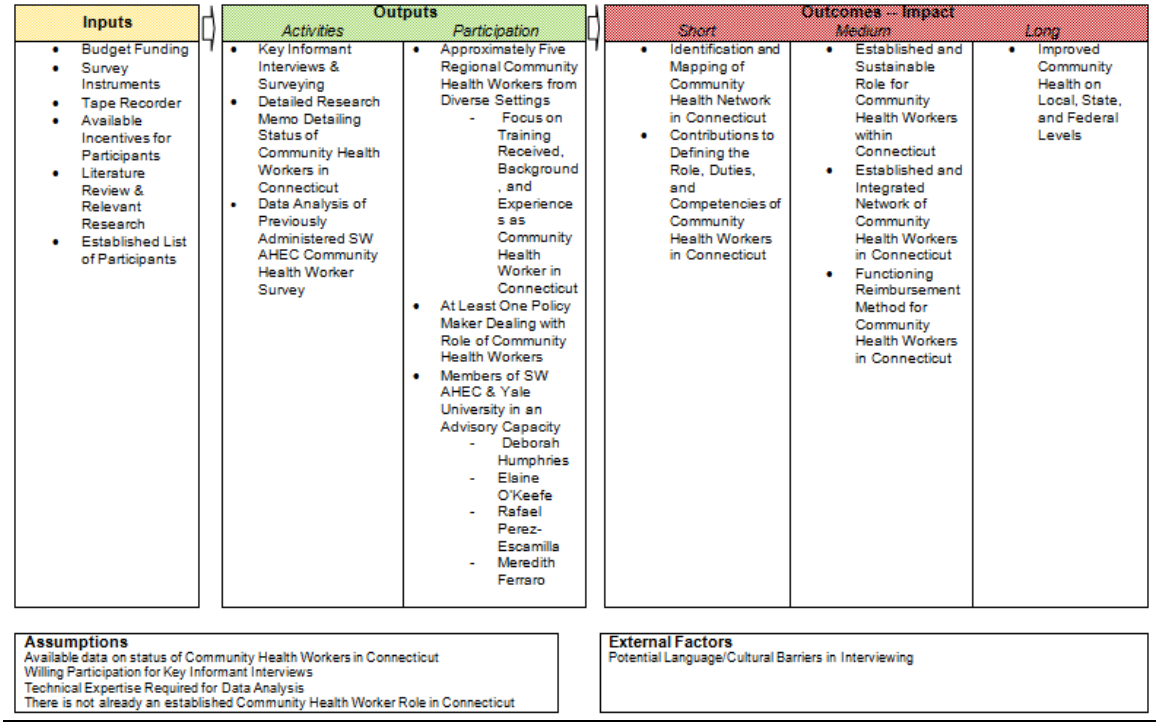
This study includes in-depth interviews with ten key informants in California, Rhode Island, Vermont, Massachusetts, Texas, and New York. Data collection occurred in April 2013. Five Master's candidates from the Yale School of Public health conducted the interviews. Interviews were conducted over the phone and participants were asked to give verbal informed consent. The participants were not given financial compensation but they were entered in a drawing to win a Kindle Paperwhite. Interviews lasted 40 to 60 minutes and were digitally recorded and transcribed to prepare for analysis.

Analytic Approach and Data Interpretation

Members from our team read through three transcripts to identify major themes common to the interviews. A coding tree was developed based on those three interviews by members of the group and was used to code the remaining interviews (Appendix III). Codes included definition of qualifications,

barriers, and funding mechanisms for reimbursement as well as sustainability of CHWs. Each transcript was coded by two members of the group. Qualitative analyses were conducted in Atlas.ti, and included generating a frequency report (Appendix II) for the number of times codes were used. In addition, quotes relevant to each theme were extracted and used to understand how the major themes related to reimbursement challenges for CHWs.

Figure 2. Logic Model



RESULTS

Participants

Ten key informants participated in this study. Participants were faculty focusing on community partners (including CHWs) in community based research, leaders in CHW associations, or leaders in CHW policy. Nine interviews were conducted.

Key Themes

Participants gave information about several broad themes relevant to financing and payment of CHWs and included: defining reimbursement, qualifications for reimbursement, barriers to reimbursement,

funding mechanisms for CHW reimbursement, job instability due to funding mechanism, movements to improve CHW reimbursement in the past and present, and cost-effectiveness of CHWs. Recommendations and best practices were also described by participants.

Defining Reimbursement

Participants were generally reluctant to use the term "reimbursement" when speaking on the topic of CHW compensation. Instead, participants saw the term as an antiquated frame of viewing CHWs, and even spoke of potential adverse political ramifications in using the term in policy discourse. According to one participant

> *"….that terminology [reimbursement] is not really applicable these days. The term reimbursement carries with it a lot of political baggage. If anybody in any state proposes making CHWs eligible for reimbursement, the state officials and certainly legislators are going to hear increased expenditures."*

Qualifications for Reimbursement

During the interviews, participants were asked to define qualifications for reimbursement or eligibility for other types of funding. Generally, participants highlighted both tangible and intangible skills, context-specific skills, and certification as qualifications for compensation.

Tangible Skills

Participants often emphasized a number of specific tangible skills as important for CHWs to be reimbursed or compensated. Tangible qualifications frequently mentioned included years of experience, clinical training, computer training, and bilingualism/biculturalism. One participant, in a quote reflective of a number taken in the interviews, stated

> *"[their payment] is determined based on their experiences, whether they are bilingual and bicultural. I think that adds something as well as if they have some sort of clinical background or special certification, whether they have some sort of computer literacy."*

Intangible Skills

Participants also described harder to quantify intangibles as important in determining a CHW's eligibility for reimbursement or other types of funding. Status within the community, a shared identity or background with the community served, and ability to develop connections and trust within the community were often viewed as key qualifications for a CHW to be employed and compensated. Indeed, the importance of intangible skills even over tangible qualifications is emphasized by one participant, who stated

> *"And we have another person who worked in the insurance company, and that is not the reason why we hired her, but boy, she is great a forming relationships and getting our name out there."*

Despite the importance of intangible qualities, participants also spoke of the difficulty of defining these qualities. One participant noted that

> *"…skills, alone, do not define or qualify someone to be a CHW. This is one of the biggest challenges for the field, because a big part of what makes the CHW effective are their relationships in the community, which in the past has been based on shared or common life experience with their community, and that is something that is really not something that is commonly considered within the standards for an occupation, and so that is a real fundamental issue. "*

Context-Specific Skills

In addition to tangible and intangible qualifications, participants also mentioned that skills specific to certain contexts may qualify CHWs for reimbursement or payment. One category where specific experience or skills would be useful for compensation is in chronic disease care, as one participant stated that

> *"For cancer, for a number of the really complicated chronic illnesses the patient navigator model seems to be one of the ones that is readily seen as a reimbursable service. You know, you are getting the patient to their services, you're getting the pharmacy prescriptions filled all of the mechanics of making sure they are getting the care the patient needs."*

Other specific contexts eligible for funding mentioned by participants were maternal and child health, as well as HIV/AIDS care:

> *"it used to be in the maternal and child health care and HIV/AIDs that there were funding categories that included funding for public health workers who essentially are CHWs."*

> *"I would say that the vast majority of stably funded employed CHWs, that I am aware of, are working in one or the other of those things, in MCH or HIV/AIDs."*

Certification & Training

While CHWs are often funded to do work in specific contexts, as mentioned above, participants emphasized the importance of certification and training programs to help CHWs remain eligible for different sources of funding. As one participants reported,

> *"Often CHWs are shifted to a different funding source and they do somewhat different work and this is why we advocate for core training, so that CHWs have that flexibility to learn some of the special health topics, but before they do that to get the core competencies that are required to do this work regardless of the disease topic or particular funding source, so the outreach, the communication, the advocacy, the*

capacity building, the cultural competency…."

Further, participants believed that certification & training to be important in establishing sustainable financing for CHWs:

> *"…we have recently established a certification program that teaches CHWs all the core competencies that we feel that they need. If they have taken this class or have some other way to demonstrate those competencies, then I would say that they should be reimbursable based on the fact that we know for certain that they are doing their job correctly."*

> *"[certification] is sort of like the 'be all end all' in my mind for what would qualify them for reimbursement, but we do look at other things. So let's say they take a training outside of our own training, but they have proof of what they learned and it is comparable, we would sort of branch all of that into their fee."*

Barriers to Reimbursement

Participants detailed a number of barriers CHWs face in qualification for reimbursement or receiving compensation for their work. In particular, confusion surrounding the role of CHWs, undervaluing of CHWs, complex funding sources, and clashing with other established health professions were cited as significant barriers to remuneration.

<u>Role Confusion</u>

Participants made clear that the confusion surrounding the role of CHWs has had an effect on their value within the health care system. As two participants note,

> *"…. the other thing is that as health care becomes more specialized, and more technical and more fragmented, CHWs really buck that trend. The rest of the health care environment has a hard time understanding the unique skillset that CHWs bring."*

> *"The folks in health care are used to measuring qualifications based on the extent of someone's clinical training, period. The fact that CHWs commonly have very, very limited clinical training, is not helpful to the understanding of the field by folks in healthcare. Particularly healthcare administrators either consider their personnel as either clinical or administrative, and the fact that the CHW is really neither one is very confusing to them."*

Indeed, this lack of understanding has been noted to place third party payers in a position where they are to decide whether to fund a profession with a role that has not been clearly defined. In speaking to this, one participant succinctly states that

> *"…payers for health services, including insurance companies, etc. really want to know what they are paying for…"*

In short, the confusion surrounding the role of CHWs was frequently cited as a barrier to CHWs receiving compensation for their work. However, despite the lack of confusion, participants with

direct experience with CHWs strongly testify to the value of the workforce. In discussing the role confusion of CHWs, one participant stated that

> *"We always had the vision that we were going to use CHWs. And just for some reason no one else in the state seems to have a good awareness of them. What I usually them is 'you better Google them because they are used all over the United States, all over the world, like what's the matter with you! How do you not know about CHWs?'"*

Undervaluing of CHWs

Frequently, participants discussed how they perceived CHWs to be significantly undervalued in the health care system, presenting a significant barrier to adequate compensation. As one participant mentions,

> *"It is very difficult to get folks to accept the idea that someone with very limited formal or higher education has the ability to do some of the sophisticated things that CHWs can really do."*

As discussed above, CHWs often possess intangible skills that are essential to performing their duties. However, an issue participants noted with the emphasis on intangible skills is devaluing their importance by members of the health care system. One participant notes that

> *"I myself am not an employer, but representing some employers that I have on my board and partnerships, I would say funding is a very difficult time because there is not a well-known standard definition or standard skill-set for CHWs they have a hard time proving the valuable nature of the work that they do outside of our state. And because our state budget is not exactly at our best right now, they are looking for funding elsewhere through private foundations and it is very difficult to explain to someone who is not familiar the benefits of CHWs."*

Similarly, another participant notes that the unique role CHWs often play can often be overlooked. According to one participant,

> *"I think that physicians see CHWs in very limited roles. I think they seem them as people who can interpret and translate but I do not think they seem them as equal members of the healthcare team. And there are situations where the chw knows more than the physician. But I think that physicians and nurses, and physical therapist, some of these mid-level professionals because most of these CHWs are women, the typical CHW we work with is a middle aged Latino woman not educated in the traditional sense, and I think physicians tend to discount them to a point. That is the truth, and that is how I see it. I think they see kind of a limited range, and I do not think that what they are capable of has really been tested. I think there is the possibility of using CHWs in all sorts of ways that has not been tried."*

Further, even when CHWs do receive compensation for their work, participants note that is often inadequate. In particular, one participant reported that

> *"Even though [the role of CHWs] is quite skilled work it is not always paid in very high levels."*

Complex Funding Sources

Participants noted that having to navigate complex funding sources is a barrier to compensating CHWs. As mentioned above, CHWs are rarely eligible for categorical reimbursement. Thus, CHWs are often left scrambling to find funding eligibility. To illustrate the complexity of the funding sources, one participant explains

> *"I guess the mechanisms is where you get into the deep weeds pretty quickly, because really, what we are talking about is embedding CHWs in the emerging payment structures that are now coming into play, like the patient-centered medical home, the accountable care organization, and I cant give you an answer to that question in a one-hour interview. Those things are beastly complicated to talk about, but I guess the point is that the payment mechanisms that we are talking about now are a form of risk sharing between the payer and provider."*

In discussing the obstacles CHWs and employers must undertake to receive funding for CHWs, one participant mentions that

> *"Definitely funding is a barrier. Funding is categorical whether it comes from the government or comes from private foundation. So that then becomes very difficult. Organizations have to continue to reinvent themselves to be innovative and exciting."*

Clashing With Established Professions

Adding to the barriers CHWs face to compensation is the clashing with other health professions that have roles overlapping with CHWs. As discussed earlier, CHWs workers have a relatively undefined role within the health care system; this uncertainty can lead to CHWs performing some functions of established professions, which, according to participants, are sometimes perceived by these professions as a threat to their role in the health professions. As two participants mentioned,

> *"And there is some suspicion, if not outright resistance-not by all, by any means, not all members of other professions, but some, enough to give them pause. I'm thinking about mainly nurses, social workers, and health educators who are not clear about how this will help or hinder them in their efforts to succeed as professionals. Some of them do look upon CHWs as an intrusion."*

> *"In some organizations more so than others because I feel in some situations, nurses and social workers can be a little threatened by CHWs because they view them as cheap labor that does the same thing that they do."*

Indeed, negative reactions from other professions were suggested by participants as limiting the impact of CHWs. In discussing this, one participant stated that

> *"I think that doctors would be quite happy working with CHWs, I think the nurses are the ones who aren't. I think to make a real change you have to bring the doctors and the nurses and the health educators in the circle. Everyone has to be on board that the CHW can make a great contribution that can really help everyone on the page. Nurses can deal with all the medical issues as well as some of the other things, but it is not*

necessarily a cost effective choice. I think in certain ways the medical model goes against the openness to seeing how CHWs can make a change."

Funding Mechanisms

Participants were asked to describe funding of CHWs, or how organizations pay their CHWs for work performed. Participants discussed short term funding (including temporary contracts and soft money positions), long term funding, funding provided by the government, and how the financing mechanisms for CHWs have evolved and changed over time.

Short Term Funding

All participants identified short-term funding as the primary mechanism for paying CHWs. This type of funding was described as temporary and unstable.

"Most of the funding has been in the form of project grants, and that is still the case for the most part, and it might be as short as a year, or even less, and often not for more than three years at a time. That has been the most common pattern."

Participants also discussed the implications of short-term funding in terms of sustainability, and described the effect of this type of funding on CHWs and their positions.

"Well here's the thing, they are usually, I shouldn't say usually, they are often not hired as temporary help, but there is only temporary funding. CHWs enter into employment under the premise that duringthe time the funding is in place, that something else will be found that is sustainable, and often it's not."

"Often the CHW have depended on grants and research projects to test things out. If the grants dry up, and grants have been drying up left and right, there's no more positions."

"I think we are still mostly funded by soft grants, soft money, grants. And that is one of the difficulties is that they have a certain period of time and after the period finishes, what happens with the CHWs?"

Long Term Funding and Government Funding

The participants who discussed long-term funding or financing for CHWs did so in the context of government funds supporting CHWs. While some government, longer term funding was mentioned, it was discussed much less frequently than shorter term, temporary funding mechanisms. State governmental agencies were identified as funders of CHWs.

"I also believe that even though they might not use the job title of CHW, other state agencies also fund services that are CHW services, so Department of Mental Health,

Department of Children and Families, you know, those sorts of things through a number of state agencies."

In addition, federal social insurance programs were mentioned as ways CHWs are financed. Medicaid was discussed by key informants from Massachusetts as a source of federal funds for services typically provided by CHWs. Important to note is that the CHW profession was mentioned as not reimbursable under Medicaid, but rather services typically associated with CHWs. Medicaid was discussed as a way to pay CHWs through a fee-for-service payment mechanism.

"There is funding available under certain MassHealth-our Medicaid program has certain services that can be performed by CHWs that are funded, such as tobacco cessation specialists-that service is supported through our Medicaid program, but I don't think any of those professions that you named are actually reimbursable per se in MA."

"…you can start to see Medicaid coming in to fund CHWs through the 11-15 wavier (federal wavier), which allows CHWs to be funded. So that is one of the ways which people have funded fee-for-service model, that's Minnesota's model for instance, directly funding CHWs. More typically the funding comes as part of a capitation like through Medicaid and it is up to the provider how they allocate them. The good news is when the CHW helps the team receive a level 3 certification; they get more of a reimbursement. Since the level 3 quality of care usually means having good care coordination and that is where CHWs come in, that's an increasingly thing that hospitals and private practices that use CHWs receive a lot Medicaid funding. They want to have this level 3 because it increases their payment. That's the Medicaid and capitation increase that is used to fund CHWs."

The Affordable Care Act and health reform were mentioned by several participants as an important part of potentially longer term funding provided by the federal government.

"The other thing that I just want to say is we've got some amazing opportunities with the implementation of the ACA, you know payment reform in Massachusetts."

"Pieces of the ACA talked about prevention, promoting healthier behaviors, etc. there are many CHW programs that are not based in healthcare settings so to speak would still be eligible for those grants, so I think the ACA really has a large focus on prevention and looking at doing things differently. I think that really open up the door for CHWs and CBOs."

"I think those of us who work in MA and across the region and across the country have some hopes that with health reform and the need to actually enroll and engage a whole new population in care, that there is going to-and also because CHWs are included in the ACA as a health profession-that we're really hoping that each of these little policy pieces lays the foundation for, again, more sustainable funding for the workforce."

Two participants who work with CHWs in Vermont identified a financing mechanism for CHWs that is unique among the state representatives interviewed. Insurance companies are required to pay into a fund (referred to below as PPP) that can be utilized to pay for community health services.

> *"What that means, is that if you are an insurance company doing business in this state you have to pay into PPP for medical homes, and you have to pay into helping fund the community health team. And actually we get a set amount of funds based on how many patients you have and all of that, there's a formula. And then you can decide within your community to decide how you will use those funds to help pay for your CHW team. We use it to partially fund the community connection program…[the funds come] from the insurance companies. So it includes commercial insurance, it includes Medicaid. And Vermont is one of the 8 states participating in the Medicaid pilot for advanced practice primary care. So Medicare also pays in to this pool of money for the community health team. So it Medicare and Medicaid and any commercial insurance who want to do business in the state of Vermont have to pay into it."*

Evolution of Funding for CHWs

While short-term, soft funding was identified as the most common way CHWs are paid for services, many participants acknowledged that the way organizations approach paying CHWs is changing. Health plans were identified as one example of groups paying CHWs via capitation and as part of a clinical care team.

> *"It is changing now to where, for example, third party payers, like health plans are willing to pay providers to employ CHWs as part of either a direct sort of contract expense, or as a legitimate expense as some part of a bundled payment or capitated payment plan. That is growing pretty rapidly."*

> *"Sometimes you'll have health insurance that funds their providers to have CHWs. Then another category would be like the patients in medical homes. These are cropping up where enlightened, and I think they are definitely enlightened, patient centered medical home … hire CHWs to be a part of their care coordination team. You have this model in Washington, you have this model in Oregon. Last year in the east coast we do have it. It is starting to catch on and primary care providers are starting to add CHWs to their team. Now these are all still through, sort of, private practices funding."*

Shifting attitudes about inclusion of CHWs was identified as one possible reason for finding novel or non-traditional ways to pay CHWs.

> *"That is changing and we are seeing hospitals, and to some extent health plans, who are saying 'We're not going to wait for somebody to pay us to hire them.' This is a fundamental shift."*

In addition, participants discussed the need to move away from fee-for-service reimbursement as a primary method of payment, and develop funding mechanisms to support CHWs in a way similar to other health care professionals integrated into clinical care teams.

> *"We are not advocates for the fee-for-service reimbursement. Fee for service is going*

away in all aspects of health care. I think to jump on that bandwagon right now is the wrong way to go because it is going to go away for all medical services and providers. So now is not the time to go there."

"The whole effort here for more sustainable funding is to move away from that kind of categorical, cyclical kind of funding to a more integrated approach to where CHWs will be considered to be an occupation, just like all the other members of a multidisciplinary care team, such as social workers, or dietician, or nurses or medical assistants."

Job Stability

Closely related to the funding mechanisms for CHWs is job stability. According to participants, CHW positions are often unstable and temporary, leaving some CHWs jobless. Others look for new jobs or get shifted into different positions where funding is available.

"Often the agency that a CHW is working for will try to renew the grant, or try to get another grant, or try to piece together another grant, so a number of things happen. Often CHWs get laid off. Often CHWs are shifted to a different funding source and they do somewhat different work."

"The services are here today and gone tomorrow."

Because of the instability of funds, CHWs may also leave positions to find more stable jobs.

"A lot of these positions carry no benefits, they are considered temporary hires, etc. so the stability is not good and there are a lot of folks who will jump from organization to organization. They will even leave a project early if they know that their own funding is going to run out in a year or less and there is a new project that they might get hired on."

According to participants, one of the key consequences of job instability faced by CHWs is related to the CHWs' positions within a community, and the trust each CHW builds with the people they work with. Ultimately, that trust is compromised and the health of vulnerable communities is compromised.

"So one of the fallouts from funding going away is that CHWs shift jobs, one is that they lose their jobs, and probably the worst one of all which happens is when CHWs that have built trust within their community get interrupted, those relationships that they have built are lost and are not that easy to rebuild. All that unstable funding really sabotages one of the unique things that CHWs are really able to do, which is to build trust within communities, which helps bring people in past the barriers to getting care."

Movement towards an understood, recognized, and valued workforce

While there were clearly identified barriers to the payment of CHWs for services, many participants noted progress made within states and nationwide in issues related to CHWs. This progress, which

was related to better definition, recognition, and valuing CHWs, is part of a complicated movement to enable the payment of CHWs for their services.

Better Role Definition and Understanding of CHWs

Historically, individuals and organizations involved in health care have not understood the role of CHWs, which was confirmed by several participants.

> *"It became very clear that CHWs felt that their work was often not understood, or recognized, or supported, or funded well."*

Improving understanding of CHWs within the health care system required, and to a large extent still requires, CHWs explaining their role and demonstrating their benefit to communities.

> *"You have to do your professional identity work. You have to be out there explaining to people what's unique about this workforce and you're building all the time sort of champions for the workforce within all the sectors."*

Participants from Vermont indicated success in this area.

> *"I would say in the very, very beginning, when we were a new breed but we quickly earned our place on the team. Now we are welcomed as part of the team, everyone knows that CHWs are a phone call away."*

Shifting Organizational and Institutional Recognition

While historically CHWs have not been recognized as a professional workforce, many participants discussed developments that indicate that CHWs are being recognized by some organizations and institutions. As mentioned in the previous section on government funding, the ACA specifically includes CHWs as health professionals. Participants expressed that this recognition is an important shift for the CHW workforce.

> *"There is a lot of … direct language that quotes CHWs as necessary to the health care team going forward and I know in RI and a lot of other states they are trying to prepare for the CHW workforce because … up until this point there hasn't been anything at a federal level that looks at CHWs as part of the healthcare team."*

In addition to the ACA, state agencies, such as the Department of Health in Rhode Island, have begun to include language about CHWs in public health programs.

> *"We have an instrumental goal in the way that CHW programs and positions are filtered into anything that comes out of our DOH [Department of Health]. Because of the fact that we have some people from the DOH on our advisory committee, they have been very vocal and great advocates, so every time they establish a new program or are putting funding out there for a new program, they make sure that CHWs are worded into the language and that has been a huge, huge help."*

Participant alluded to shifting attitudes about the value and importance of CHWs among organizations. In California, a large healthcare management organization was described as working towards more formal recognition of the workforce as a union.

> *"These organizations are recognizing that CHWs add significant value to their operation above and beyond the cost of employing them."*

> *"I think more organizations understand the value and I think that also has to do with the recognition, they find that this workforce is important."*

> *"There has been a movement, I know Kaiser the large HMO here, for example, has been moving aggressively to unionize the workforce."*

Valuing CHWs

Important to establishing sustainable models of financing and employing CHWs are not only understanding what they do, but also recognizing the value in what they do. According to participants, organizations and health care professionals are beginning to recognize the value of CHWs.

> *"I think you would hear from the doctors and nurses and other professionals, I've heard them say many times that they could not do their job without the CHW and without community connections. They really rely on them."*

> *"A similar thing that we are seeing emerge is that organizations may be very proud of having a CHW program."*

Integration and Collaboration

Participants emphasized that one important shift that has started to happen in some states is the integration of CHWs into teams composed of many different types of health care professionals. Implicit in this shift is collaboration between CHWs and health care professionals. It is likely that the integration and collaboration within the health care system arises from better recognition and understanding of CHWs and more valuing of the work of CHWs by other health care professionals.

> *"[There] is a shift from employing CHWs as part of a special program like an asthma prevention initiative, to being a part of a team, either on a public health/population basis, or as part of a clinical care provider team."*

> *"We work in a holistic model as part of our community health team where we work together with behavioral therapist and chronic disease management to totally make sure that people have what they need to increase their quality of life."*

> *CHWs [are] part of clinical care teams that are dealing with the management of chronic conditions in a primary care setting. So they are part of the team, rather than a separate program, you might say.*

> *"CHWs are the extended arm of the healthcare team that they are working with."*

Some reasons for this shift are the factors discussed previously; participants identified the ACA as a driving force behind better integration and collaboration.

> "*Now with the Affordable Care Act, I think people are also thinking about patient centered clinical models looking at how to integrate more CHWs and promotores into their clinical team within the clinical setting."*

Certification, Training, and Formal Education

An additional development in propelling the CHW workforce into a recognized and profession relates to training. Some participants identified training programs as important to building knowledge and enhancing capacity as a workforce. Note that one participant described training programs as less successful in one state (Rhode Island), which may suggest that CHW workforces in different regions or states may have different needs.

> *"I would say also something that has worked for other states but did not worked for us is that they established training processes first, then once people were involved in training and they were better able to better understand that there really is a workforce, that they are not isolated, that helps them (CHWs) to self-advocate for organizing, whereas in our state, we said you have to organize, so it can works both ways."*

> *"One of the other things that we do as an organization is to provide training for new promotores as well as a lot of advanced training on specific issues like advocacy leadership so we try not to replicate what already exists but really try to contribute to the current workforce with training that will enhance their current skills and knowledge base."*

Cost Effectiveness

Participants were asked whether their experience with CHWs showed that they played a role in providing cost effective services. The constant struggle to provide tangible evidence to answer this question was a common theme.

> *"I think we all know how difficult it is to prove a cost savings, cost-effectiveness when we are talking about prevention—because it is things that we prevented from happening."*

All participants were confident that CHWs would be part of a cost effective healthcare service model, although not necessarily in a stand-alone capacity. Respondents often cited the unique ability of CHWs to pull together parts of the current healthcare delivery model in a way that could provide substantial savings in the future.

> *"[Healthcare organizations] are going to be challenged to show how their organization is cost-effective at addressing those issues, so they are going to be looking at this not so much in terms of the micro-level cost-effectiveness of CHWs, but how they can help them achieve organizational goals, looking at something like the example of reducing readmission rates for hospitals. That's going to call for an interdisciplinary effort*

involving a bunch of different people, but there are some clear needs or opportunities for improving communication between providers and patients which the CHW can very efficiently help them achieve."

The multifaceted work of CHWs within communities was often reflected in the participants' responses to questions regarding cost effectiveness.

"The way we do it has a lot to do it navigation, has a lot to do with navigation system and also explaining the system how they work even talking about available resources. Those are always that someone in a clinic setting or someone in another setting doesn't have to take the time to explain. I think it's also explaining medications explaining how to prevent certain chronic illnesses for example, encouraging physical activity and community settings making sure people are healthier."

One participant, whose organization incorporates CHWs, described observing their cost effectiveness first hand:

"Our model happens to have the CHW and community connections as key members of our team. And we also get a lot more bang-for-the-buck that way."

The Way Forward

Each participant was asked to provide recommendations for the development of a sustainable CHW workforce in the state of Connecticut. Their responses most often highlighted a need for a synchronized, comprehensive change in the way that CHWs are recognized and valued by the healthcare sector and general public, in the way that CHWs are trained or certified, and the importance of CHW collaboration and leadership and in helping to realize these goals.

<u>Education and Outreach</u>

The results of the interviews clearly highlighted that most people don't understand who CHWs are, the ways they currently fit into our healthcare system, or what they are capable of bringing to the table in the future.

"What we are really trying to promote is the idea of CHWs as being the expert at understanding the life of the community, of the patient in a more holistic way, and trying to convince these other professions that there is a basis for this expertise in the life experience of the CHW that has value."

"I think this education is a crucial sort of, if not the first step, at least an early step, and trying to make something happen. And it is possible by getting testimonials from people within Connecticut—or potentially some people from neighboring states, particularly providers—to deliver specific testimonials about the value of CHWs that can make a huge difference."

Education and outreach were often seen as the foundation upon which to build a more stable stream of funding.

> *"As a new profession, they are going to have to do better in terms of advocacy and outreach. They are going to have to learn how to—I don't want to call it lobbying—of educating the state legislators and developing a nation wide presence. Like we have the National Public Health Association, CHWs should have a presence on the Hill where they can have well-paid, skilled lobbyists who will persuasively talk to Congress people about the needs to change some of the reimbursement and to recognize the contribution their profession can make."*

> *"…if you can show even in a small demonstration project that CHWs are very successful in, lets say, cancer screening or they are really successful in helping people access insurance programs or they are really successful as patient navigators—whatever it is, I think then you can make a better argument for sustainable lines of funding."*

Recognition and Acceptance

The participants spoke at length about the importance of recognizing the strengths and skills of CHWs and accepting their role as a member of the healthcare team. In many ways, the respondents described a challenge related to this theme, since so much of a CHW's skillset is comprised of intangible and context-specific skills.

> "*It's a hard thing to measure, soft, as it were, the contribution that CHWs make, but they clearly—all the research shows—that they really help improve health outcomes and so some of the challenge has been sort of bringing people together around a professional identity of CHWs, common research metrics to actually be making the case—the business case, resources for research and evaluation of programs, you know those are sort of the bigger picture challenges."*

Strong communication skills, cultural competency, and shared experience were some of the most important factors that contribute to the unique value of CHWs.

> *"That's going to call for an interdisciplinary effort involving a bunch of different people, but there are some clear needs or opportunities for improving communication between providers and patients which the CHW can very efficiently help them achieve."*

> *"What we are really trying to promote is the idea of CHWs as being the expert at understanding the life of the community, of the patient in a more holistic way, and trying to convince these other professions that there is a basis for this expertise in the life experience of the CHW that has value."*

Collaboration and Leadership

Collaboration was the most commonly cited recommendation for the development of a sustainable CHW workforce. The support, networking and advice CHWs can offer one another as they are incorporated into the larger healthcare system will be important in sustaining momentum.

> *"I think that folks need a place to kind of rally, come together, understand that they are all CHWs. That's how MACHWA started. We started because CHWs working in the field were saying that we needed a place for some networking, support, a place that we could gather to talk about the issues we are facing in the workforce. We were a network long before we grew into an association."*

> *"…that knowledge of being able to know folks and convene in a place—I mean I learned about it in a conference. It's certainly one of the best ways that we can help one another to help CHWs become more integrated into this work, and also ultimately have the health of our public in a better state, so I would say that is definitely one way. I think the other is to have a statewide network or association where you bring together promotores and CHWs where they talk about the issues that they face. That for us, as an organization, has been tremendously organizational and helpful, and a way to provide us a direction in terms of advocacy for this workforce."*

Beyond collaboration among CHWs, developing partnerships with policymakers, administrators, and other members of the healthcare delivery system will be essential.

> *"Yeah, it's a very interesting time now as this is unfolding, because I think a lot of people are really beginning to get it that the whole landscape is changing so drastically that this is the time to be connecting with people, and it's the time to be at the table, and it's the time to figure out which table to be at-that's what we're working on too."*

Strong leadership from within the CHW community is important not only for mentorship, but also for effective advocacy.

> *"Nothing stands by itself-it all needs to be attended to at the same time. You're building the workforce, you're strengthening the leadership capacity of the workforce, because if one of us goes to talk to a legislator it has some impact, but if a CHW goes to a legislator and tells them how they made a difference in that community that the legislator comes from, it makes a bigger impact."*

> *"I think that you need to identify CHW leaders. Somehow, convene your partners and hopefully get resources to convene partners so that CHWs can begin to come together to support figuring out what the state needs to move CHWs forward."*

> *"…just like any other profession, those in the profession really need to be the driving force."*

Training and Certification

Many respondents viewed a system of standardized training or certification as the missing link in formally connecting CHWs with the healthcare system. At the same time, such a formalized system risks alienating some of the most effective CHWs who are deeply embedded in communities and may not have the ability to fund or attend such a formalized program.

> *"Well, in the scientific and health community you have a lot of debates as to whether or not certification is a good idea for CHWs. Um, on some sides, it's definitely a good idea just because of the reimbursement component—it will open doors for reimbursement. On the other hand, it's unclear whether or not it will put additional burdens [on] CHWs and additional difficulties to CHWs. But in terms of reimbursement, I do think that would be important."*

> *"One of the benefits we hoped in becoming certified was that it may open up the door for some third party payment of some kind."*

> *"…as I said earlier, that years down the road, employers might prefer to hire certified CHWs. One of the reasons that it is not mandatory in our state—and at one point the legislature wanted to see mandatory training—the workforce rallied and said that's not what we want."*

The responses from participants indicated that there is no consensus yet in the community on the best way to initiate a training program. Questions remain in terms of where classes should be held, what the curriculum would contain—even how the skills taught would be assessed. There was a trend in support of a 'core competency' model of training that would provide a general overview of pertinent skills to those enrolled. Questions about specialized training remain, but maybe more importantly, there is concern that some of the skills that make CHWs so effective in their roles may not be able to be taught in classrooms at all.

> *"I would say that there is a need for a standard curriculum. The curriculum should be tied to education standards. As part of our research project we did a lot of looking what state training guidelines were. I think ideally, the training would be a community college credential. There are short tem training modules, but I would like to see community college credential. I would want to see a lot of attention put to the front side, not just classroom education."*

> *"Many of the places where people think about doing training are academic institutions, so finding the right place to do the training is very important. You have to take into account that it is an adult learning, that it is oriented towards the actual job. A work-study approach might be needed. The style of learning is very important. Then how do you know that somebody is able to do all that stuff? So you have to have some kind of standards you have to have some way of saying "This person is a CHW". And that is not as simple as it might sound, because academia says, " If they go to all the courses and they pass all the tests then they can do it." but what if it's not an academic training program? You really want to emphasize communication, you really want to emphasize if they can actually help someone navigate the*

system, do they know how to interact with somebody and help them steer and resolve any issues? You know all these things are something that does not lend itself to a multiple choice exam. Nor is it the people who you want to be CHWs who are good test takers. You have to have some way of saying "OK, they have the level of confidence that is needed". That is one of the most challenging aspects…"

Resources

As is the case around the country, scarce resources are a major threat to the development of a sustainable CHW model in the state of Connecticut. As mentioned previously, short-term and unstable sources of funding often counteract the progress CHWs are able to make in the communities they serve.

> *"So I would say in CT what you really need is to move towards having full time paid positions whether they be to the heath care system or whether they be through community organizations, whether it be through county health departments, but paid full time."*

Beyond monetary resources necessary to fund the work of CHWs, the participants described a lack of human and ideological resources vital for training and regulating this new workforce.

> *"And also what's needed is funding, not just to support CHW services, but to support training, to have a well-trained workforce. That's often lost in the shuffle because people ask 'How are we going to fund the services?' but you also need to fund the support for the workforce."*

> *"There is still a need beyond actual financing strategies that will support sustainable employment for CHWs for things like workforce development and occupational regulation if we are going to have standards for who is qualified to be a CHW, so there needs to be some resources behind developing a program to oversee that."*

Several respondents spoke of one resource, in particular, that is especially difficult to increase considering the unfamiliar nature of the CHW model at the present time: full-time employment.

> *"I would suggest arrangements for internships opportunities and that there should be jobs for people. It is sort of a difficult situation. You do not want to see people spend eighteen months in community college and then find out they cannot get a job."*

> *"I can think of a few agencies off the top of my head that hire just under full time hours, so let's say like 32.5 hours instead of 37 or 35 and that means that they don't have to pay the benefits. But often they are paid with benefits, but they are underpaid."*

DISCUSSION AND RECOMMENDATIONS

This paper has brought to the surface the challenges of reimbursement for CHWs in the United States. While doing so, this research has also highlighted additional challenges for CHWs such as training and understanding the many roles and names in which they operate. Recommendations and best practices were identified through speaking with key informants involved with the CHW workforce in several New England states, New York, Texas, and California. In highlighting the key challenges identified by this research, we hope that the information compiled in this report will guide and facilitate a dialogue about methods to promote the sustainable funding of CHWs, to highlight their unique skillset and role within their communities, and to create a network of empowerment for these individuals in the state of Connecticut. The following sections discuss several broad themes uncovered during interviews with key informants. We hope that community leaders in Connecticut, and elsewhere, can use this information to continue to define, shape, and empower the CHW workforce.

Key Challenges Faced by CHWs:

One central issue that Connecticut will need to address is the current structure of reimbursement and funding mechanisms for CHW services. Our research indicated that there was consensus among members of CHW advocacy and organizational groups that the term "reimbursement" is not appropriate for describing the way that CHWs are compensated in Connecticut. Our data revealed a shift in the language used to describe CHW compensation that views the term "reimbursement" as a loaded term in the sense that it has implications of structured compensation from third-party payers, and as a concept weighed down by political and economic ramifications. The word "reimbursement" is too easily associated with the idea of increased cost, and might contradict one of the most appealing characteristics of the CHW model: its ability to contain costs. It was the view of many participants that the word's use might hinder the evolution of a sustainable model for financing the work of CHWs.

In terms of CHW compensation, the majority of interviewees reported sources of funding to be short-term, which often leads to a disjointed work environment and significantly contributes to job instability for the CHW workforce. The "revolving door" phenomenon that often results as CHWs cycle through funding sources and move from project to project is detrimental to the relationships that they work so tirelessly to build within underserved and alienated communities.

Not only are funding sources typically unstable, but information gathered from these interviews also suggests that there is a considerable amount of confusion in the general public as a result of the diversity of titles and roles occupied by CHWs—which only further complicates matters of funding. The lack of knowledge of CHWs' skillsets and the importance of their work in their communities hinders the availability of employment for this population. Misunderstanding and undervaluing the roles of CHWs proved to be one of the largest barriers to funding. Additionally, our research revealed that balancing soft skills with formal education and training is a significant struggle for CHWs. The tension between valuing cultural competency, shared experience and community knowledge, versus more formal measurements of occupational preparation such as educational achievement and formal training, has also created barriers for the employment of CHWs in the current system.

Education and Training

Formal training and certification is limited among CHWs, and no universal set of training standards exists. Some participants felt that an established training program would be important as a means to insure adequate compensation of CHWs by providing a demonstrable set of skills and competencies. There was disagreement among the respondents regarding the most appropriate set of skills on which to focus. Some respondents favored a generalist training model that would provide basic navigation, access, and communication skills and would be applicable to a wide array of health issues, while others were in favor of a more specialized training model that would focus on specific diseases or types of disease, such as tobacco cessation, child and maternal health, and diabetes management. A common theme identified regarding the training/certification question was that hands-on field experience would be an essential component of a successful program.

There was also concern raised that the implementation of a formal program might alienate CHWs who are deeply embedded in the communities in which they live. This concern is particularly relevant for underserved immigrant communities with CHWs who may not have the financial resources or language skills required to access a formalized training program. If the development of a formal certification or training program were to become the defining factor in terms of identification of the CHW role and identity, states will be forced to address this barrier before implementation or else risk alienating one of the most important and dynamic sectors of the CHW workforce.

Collaboration and Integration into Clinical Care Teams

A common theme from interviews was that CHWs were often both seen as a threat to more established health professions (e.g. nurses), and devalued for their lack of standardized academic training. To address these occurrences, significant efforts must be made to fully integrate CHWs into healthcare provider models in clinical settings. These efforts can be focused on outreach and education to healthcare providers of the value of CHWs, and also consistent collaboration with healthcare providers to provide meaningful opportunities for CHWs within clinical care teams.

CHW Leadership and Empowerment

The importance of professional networks of CHWs and the capacity for CHWs to take leadership roles within these networks was a consistent theme in the interviews. Participants from states with a more established professional role for CHWs stressed the benefits that came from strong CHW networks in their states, including the opportunity to network, and to better advocate for a more integrated role of CHWs within the health care system. While strong efforts to create a professional network of CHWs are currently underway in Connecticut, they must be sustained to further elevate the role of CHWs in the state.

Limitations

Small sample size and limited generalizability were the primary limitations of the study. Though great effort was made to get a representative sample of key informants throughout the country, the sample size of participants was relatively small, and may not be completely representative of the

actual views of key figures within the CHW profession. This may be particularly true in Connecticut, where the status of the profession within the state made it difficult to locate individuals willing to participate in the study. Further, because of significant differences among states, the results and recommendations from participants in other states may not be fully generalizable to Connecticut, though great effort was made to interview as many participants as possible from the greater region in which Connecticut is located.

Conclusion

The insight offered and lessons learned from states with more defined roles for CHWs within the healthcare system should be considered in the development of the CHW profession in Connecticut. Education and outreach of the role and value of CHWs can help increase the recognition and acceptance of CHWs as an integral part of the healthcare system within the state. These efforts can be furthered by the creation of a strong professional network of CHWs, and the capacity building of CHWs to play key roles within these networks. Finally, an increased emphasis on certification and training of CHWs can maximize the impact CHWs in the community, and also help formally signal the value CHWs have consistently offered.

CHWs have consistently been shown to be a cost-effective strategy to improve the overall regional health, particularly in the most vulnerable of communities. Further recognizing, developing, and utilizing CHWs in Connecticut are important strategies to maximize positive health outcomes and reduce health disparities throughout the state, and should be pursued by key decision makers going forward.

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APPENDIX I – INTERVIEW QUESTIONS

This model is focused on the economic sustainability of the CHW workforce and the potential future role of CHWs in the health care system.

- What qualifies a CHW for reimbursement?
- How are CHWs reimbursed?
- What reimbursement mechanisms are in place?
    - Who pays the CHW?
- How are CHWs' fees determined?
    - Does the CHW have the power to manage their fee?
- Do you see CHWs playing a cost-effective role in the health care system?
- Is there state and/or federal money available to reimburse CHWs? How much?
    - Medicare
    - Medicaid

For other states:

- What barriers have you faced in terms of reimbursement of your CHW workforce?
- What guidance can you offer a state that is attempting to establish its own CHW workforce?

APPENDIX II – Frequency Codes

	PRIMARY DOCS									
CODES	1	2	3	4	7	8	9	10	11	Totals
1: Defining reimburs	0	0	0	2	0	1	0	0	0	3
2a: Tangible skills	0	2	1	1	0	0	1	1	1	7
2b: Intangible skill	3	0	4	2	0	0	1	1	1	12
2c: context-specific	2	2	0	2	0	1	3	2	6	18
2d: Defining qualifi	0	3	2	3	0	0	3	1	2	14
2e: Certification/tr	2	0	0	0	4	0	2	1	1	10
2f: Certification/tr	0	1	0	0	0	0	0	0	0	1
3a: Role confusion/l	5	4	4	5	1	2	1	4	4	30
3b: Undervaluing of	1	0	2	2	2	0	2	2	4	15
3c: Complexity of fu	0	0	0	1	1	2	3	0	3	10
3d: Threat to establ	0	0	1	1	1	0	0	0	1	4
3e: Cultural climate	1	0	1	1	1	1	2	0	3	10
3f: Certification/tr	0	1	0	0	0	0	0	1	1	3
4a: Evolution of fun	5	0	5	3	1	1	3	1	5	24
4b: Long-term	1	0	2	0	1	0	0	1	2	7
4c: Short term fundi	2	2	0	1	6	5	4	2	7	29
4d: Government	2	1	1	1	2	3	4	2	2	18
5a: Job instability	3	1	0	2	4	2	1	2	4	19
6a: Shifting institu	5	1	2	1	7	2	9	2	0	29
6b: Better role defi	3	0	1	0	0	2	3	0	2	11
6c: Beter integratio	1	0	5	5	3	1	4	1	0	20
6d: Valuing CHWs	2	0	2	2	1	1	1	0	0	9

6e: Collaboration	1	0	1	1	7	3	4	1	0	18
6f: Certification/tr	0	0	1	0	2	2	2	0	0	7
7: Cost effectivenes	1	2	4	4	2	2	1	1	2	19
8a: Education and ou	1	0	0	3	0	1	1	4	3	13
8b: Recognition and	7	0	0	3	2	2	0	3	3	20
8c: Collaboration	5	1	1	2	2	4	2	3	4	24
8d: Resources	4	1	0	1	2	0	2	1	0	11
8e: CHW leadership	2	0	0	0	2	3	1	1	3	12
8f: Certification/tr	0	2	2	0	1	4	0	2	2	13
8g: Stable funding	0	0	0	0	0	0	0	0	1	1
99: Good quote	8	0	5	6	0	5	2	2	3	31
Totals	67	24	47	55	55	50	62	42	70	472

APPENDIX III – Coding Structure

1. **Defining Reimbursement**

2. **Qualifications for Reimbursement**
    a. Tangible Skills
    b. Intangible Skills
    c. Context-specific Skills (general vs specialized)
    d. Defining qualifications
    e. Certification/training
3. **Barriers to Reimbursement**
    a. Role Confusion/Lack of Understanding
    b. Undervaluing of CHWs
    c. Complexity of Funding Streams (e.g. emerging payment structures coming into play)
    d. Threat to Established Profession
    e. Cultural Climate
    f. Certification/training
4. **Funding Mechanisms**
    a. Evolution of the Funding Streams
    b. Long-term
    c. Short term
    d. Government
5. **Sustainability**
    a. Job Instability

6. **CHW Workforce: Past to Present**
    a. Shifting Institutional Recognition/Organizational Recognition
    b. Better Role Definition/Demystifying the CHW Profession
    c. Better integration into healthcare system
    d. Valuing CHWs
    e. Collaboration
    f. Certification/training/formal education
7. **Cost Effectiveness**

8. **The Way Forward (reserved for recommendations)**
    a. Education & Outreach (who are CHWs, what do they do)
    b. Recognition and acceptance of the capacity of CHWs
    c. Collaboration
    d. Resources
    e. CHW Leadership
    f. Certification/Training