# Strengthening the Community Health Worker Workforce to Improve Maternal and Child Health in Nebraska: A State-Wide Assessment of Needs, Barriers, and Assets



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**EXECUTIVE SUMMARY**

Despite the scattered efforts in assessing the Community Health Worker (CHW) workforce needs, training, and sustainability by various agencies in Nebraska, so far no statewide assessment of the CHW workforce has been conducted in terms of perceived need for training, certification, barriers encountered in their work, and recommendations for policy and system changes that can facilitate and increase the effectiveness and impact of their work. The purpose of The Community Health Worker Statewide Assessment Study is to empower and engage Community Health Workers and stakeholders in Nebraska to share their perspectives on the steps our state can take in developing, supporting, and sustaining a professional CHW workforce, with a focus on maternal and child health.

To meet the aims of this study, we adopted an Exploratory Sequential Mixed Methods Approach in the data collection for this project, which was characterized by an initial qualitative phase of data collection and analysis, followed by a phase of quantitative data collection and analysis, with a final phase of integration of data from the two separate strands for comprehensive analysis. Our study was based on three phases of data collection. First, we conducted nine focus group discussions involving 65 CHWs across the state of Nebraska to collect in-depth qualitative data regarding the role of CHWs in their communities and within the healthcare system. Secondly, we conducted a statewide survey among 121 CHWs in Nebraska that assessed CHW demographics, training, services provided, and opinions on training and certification needs. Finally, we interviewed eight non-CHW key informants whose agencies employed or worked with CHWs in Nebraska to get their perspectives on CHW workforce development in their agencies and in Nebraska. The main intent of this study was to identify and uplift the voices of Nebraska CHWs.

Participating CHWs expressed pride in their work as well as unfavorable aspects of their job, such as systematic barriers, lack of time, and lack of funding. CHWs also faced difficulties within the healthcare system, such as lack of validation for their role. Over 40% of participating CHWs were providing a wide range of services to improve maternal and child health in their communities. Some of the primary identified training gaps included motivational interviewing, medical terminology, and maternal and child health topics. The most significant personal challenges that CHWs face in their work is lack of financial support and stress or burnout due to heavy workload. Over 80% of respondents in the survey supported establishing a statewide certification of CHWs in Nebraska to increase validation, standardize the profession, and create accountability. However, this issue was more divided amongst key informants representing different agencies employing CHWs. While proponents stated that the certification will create individual pride, provide core competencies, and validate the workforce, opponents listed barriers, such as lack of infrastructure in Nebraska, cost, time, and literacy levels, as prohibitive factors.

In light of these major findings from the study, it is recommended that the following steps should be taken to better train and support the CHW workforce to further promote community health and address health disparities in Nebraska:

1. There is a need to develop model CHW programs in Nebraska that clearly demonstrate the efficacy and impact of the work by CHWs in serving diverse populations and addressing health disparities. This is important due to the prevailing perceptions of CHWs that the value of their work has not been as positively appreciated by the health care system and the public as it should be.

2. It would be important for stakeholders including policy makers in Nebraska to have more extensive and rigorous debate on the need for establishing a statewide certification program for CHWs. While the overwhelming majority of CHWs in our statewide survey saw the need and benefits of establishing the program, this issue became very divided among non-CHW key informants representing different organizations employing or working with CHWs.

3. Our findings underscore the need to develop a clear and concise definition for CHWs that is disseminated throughout the state and clearly describe the scope of work for CHWs within the healthcare system. Currently in Nebraska, CHWs carry quite a few different job titles. This might create confusion when it comes to deciding who should receive which type of training or certification, and how CHW services should be integrated into health care delivery.

4. Currently the CHW workforce is predominantly female. There is a need for recruiting and training more male CHWs in case gender concordance might be needed to address gender specific health issues.

5. Many CHWs in Nebraska are currently providing a wide range of services to improve maternal and child health (MCH) in their communities. Stakeholder agencies can support and partner with trained CHWs to further promote MCH and to develop evidence-based strategies based on rigorous program evaluation.

6. In light of the revealed barriers confronted by CHWs in their work, there is a need of providing training opportunities that address the core competencies suggested for all CHWs that are not time, cost, language, or literacy level prohibitive.

7. It would help if all CHWs can be equipped with an updated community asset mapping (CAM) report to assist CHWs to more effectively connect community members who have diverse unmet health and social needs with related community resources.

8. Providing more stable employment and career advancement opportunities would be important for recruiting and retaining qualified CHWs. This is especially important given the observation that many CHWs in Nebraska work on a grant funded, temporary basis.

**ACKNOWLEDGEMENTS**

## INTRODUCTION

Community Health Workers (CHWs) are individuals from the community who have been trained to help their fellow community members to improve their access to health services and to promote community health. They play the role of intermediary between the community and the healthcare system and social services. This unique position allows CHWs to bridge the gap between underserved populations and health promotion resources and address health disparities across the state of Nebraska including disparities in maternal and child health, which has been a focus of the Nebraska Title V Maternal and Child Health (MCH) Program. With funding support from the Nebraska Title V MCH Program, findings from this first statewide assessment of CHW workforce in Nebraska are expected to help the Nebraska Title V Project and other stakeholders to better assess the status quo of the CHW workforce, especially for improving maternal and child health and reducing related disparities. The purpose of this study was to empower and engage CHWs in Nebraska to share their perspectives on the steps our state can take in developing, supporting, and sustaining a professional CHW workforce, with a focus on maternal and child health. Eight key informant (non-CHW) interviews provided additional perspectives. The results from this study will help to identify assets, barriers and unmet needs, and develop strategies that can further enhance the readiness, willingness, and capability of CHWs working in different regions in the state and serving diverse populations.

## BACKGROUND

CHWs play an important role in improving population health outcomes in clinical and community settings. CHWs provide family-centered support tailored to an individual or family's unique health needs. The concept of CHW has been used since 1960 and the definition varies from country to country and from state to state in the United States. In 2007, the Health Resources and Services Administration (HRSA) Community Health Worker National Workforce Study Report defined CHWs as "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" (HRSA, 2007). According to the definition by the American Public Health Association (APHA), CHWs are individuals who work in the public health sector and establish a relationship based on trust with their community allowing them to be the first point of contact connecting the community, health care, and social services (APHA, 2014). Furthermore, in 2014, The Nebraska CHW Coalition Steering Committee defined a CHW as a person who connects the community to different sectors of health and healthcare in order to assist individuals with positive health behavior changes (Nebraska CHW Education Work Group, 2014).

Community Health Workers can serve different roles that promote public health practices. They are primarily utilized in a clinical setting serving within a hospital.

CHWs generally fill non-clinical roles outside of the scope of traditional healthcare workers, often referred to as the 'health human resources' workforce (Torres et al., 2017).

Community Health Workers serve primarily as patient advocates and mediators between the physician and clients, helping them access health and social services (Perez & Martinez, 2008; O'Brien, Squires, Bixby, & Larson, 2009). Additionally, community Health Workers play different roles such as a member of the delivery care team, patient navigator, health educator, outreach coordinator, and organizer (O'Brien et al., 2009; Torres et al., 2017). In these unique roles, community health navigators can improve health outcomes for patients. CHWs can provide basic care for patients with a variety of acute and chronic conditions, such as obesity, diabetes, cardiovascular health, smoking cessation, cancer, reproductive health, asthma, and self-management.

Despite the limited amount of research that shows significant results of CHW interventions, there is evidence that supports the utilization of CHW interventions to improve patient outcomes. The majority of CHW research has been focused on their success in achieving patient health outcomes, especially in low-income and marginalized populations (Malcarney et al., 2017; Kim et al., 2016; Viswanathan et al., 2010). The most common and practical areas of CHW intervention include chronic disease management (Hunt, Grant, and Appel, 2011; Brownstein et al., 2007; Chang et al., 2010), enhancing disease prevention and promoting screening (Wennerstrom et al., 2016; Wells et al., 2011), improving healthy lifestyle ( reducing hospital readmittance, and enrolling in insurance (Coleman et al., 2006; Kangovi et al., 2015; Landers and Levinson, 2016;). Kangovi et al. (2015) described specific community health worker interventions that contributed to the reduction of readmission rates. The intervention consisted of creating a standardized model that would assist patients with care transition services. The finding showed that those who received the intervention were more likely to have high-quality follow-up communication, discharge communication, better self-reported mental health and less likely to be readmitted in the hospital (Kangovi et al., 2015). Another review of 18 community intervention sites found that the most beneficial attributes of CHWs are their knowledge of the community, communication skills, and personality (Hohl et al., 2016). Within Nebraska, CHWs specifically facilitate access to services, decrease health disparities, and improve the quality and cultural competence of service delivery (Nebraska CHW Education Work Group, 2014).

CHWs were also utilized to improve health outcomes in maternal and child health. In a study conducted by Rotheram-Borus et al. (2011), CHW interventions that consist of home-visits have shown to improve health outcomes for mothers that are at risk for HIV, alcohol dependency, and nutritional deficiencies. Twenty-four neighborhoods in Cape Town, Africa were randomly assigned the CHW intervention. The interventions consisted of a community health worker trained to deliver four antenatal and postnatal home visits to address HIV, alcohol usage, nutrition, depression, and health care with mothers. The intervention was effective in identifying at-risk mothers residing in the

selected neighborhoods (Rotheram-Borus et al., 2011). The success of the intervention was heavily reliant on the CHWs and their ability to address multiple health risks and challenges that were presented within their communities.

In recent decades, the CHW workforce in the U.S. has become more prevalent, with an estimated 54,000 CHWs officially employed in 2017 and thousands more informally working (Bureau of Labor Statistics, 2018). By 2020, the workforce will increase by 38% (Sellers et al., 2015). Since the enactment of the Affordable Care Act (ACA) in 2010 which allowed preventative services to be provided by non-licensed providers under the recommendation of a licensed provider, there have been more opportunities for CHWs and their services to become more integrated into the traditional care model (Malcarney et al., 2017). Typically, CHWs are funded through grants and Medicaid depending on the setting. A CHW's salary can vary depending on the type of work they are conducting and their organization (Nebraska Department of Health and Human Services, 2018).

Despite the large body of literature documenting the effectiveness of CHWs in promoting health and health equity among underserved communities and populations, there is still a lack of national standards on basic qualifications and competencies for CHWs (Kim et al., 2016). The lack of consistent findings in the literature regarding the selection and training of CHWs hinders the development of best practices necessary to develop a standardized role for a CHW (O'Brien et al., 2009). Depending on the state and organization, training and requirements for CHWs can vary. Many organizations require certification and field experience, while others are willing to provide training to CHWs that would be specific to the job duties they will be performing. According to the CDC (2019) "certification is not seen by the field as a prerequisite for CHW practice as the core CHW functions of relationship-and-trust building involve skills and traits that are not easily taught." Additionally, if CHWs are not supportive of statewide certification in a given state, it is not advised to implement a certification process (CDC, 2019). For CHWs, certification can improve their chances of employment and career stability (Malcarney et al.,2017). The U.S. does not have a national accreditation process for CHWs, with only 16 states requiring certifications or statewide training (Komaromy et al., 2018). Furthermore, there is a lack of shared core competencies, scope of work, training, and employment throughout the U.S. (Malcarney et al., 2017). Nebraska has two recognized and established training programs for CHWs. One, offered by DHHS, involves a schedule of one full-day in-person training, ten weeks of online coursework, followed by another full-day training and a practicum. The other training program, developed by the Behavioral Health Education Center of Nebraska in cooperation with community college partners, offers a year-long curriculum in the community college setting.

Thus far, there have been limited efforts to conduct a state-wide assessment of the CHW workforce regarding their perceived need for training, barriers encountered in their work, and recommendations for policy and system changes that can facilitate and increase the effectiveness and impact of their work (Kim et al., 2016; Toone and

Burton, 2016). Extant literature has documented many perceived barriers that Community Health Workers encounter in their work such as lack of role clarity, the absence of standardized procedures for CHWs, and limited opportunities to apply their services (Puett, Alderman, Sadler, and Coaters, 2015; O'Brien et al., 2009). In a study conducted by Puett et al. (2015), common barriers for CHWs were the inability to provide appropriate treatment referrals, which was due to a lack of resources and the observation that treatment referrals were not taken seriously by the treatment team and patients. CHWs felt that community resource constraints were a challenge in providing adequate care (Puett et al., 2015). CHWs also thought that they received inadequate supervision. CHWs reported lesser community recognition and intrinsic job satisfaction (Gopalan, Mohanty, & Das, 2012). Gopalan et al. (2013) discussed how excessive workload, frequent refresher training, and meetings took time away fromCHWs. CHW felt like they had limited autonomy at work to perform their social responsibilities beyond the specific guidelines (Gopalan et al., 2013). Other studies found that the current certification and training recommendations were based on insufficient evidence, with little input from CHWs (Komaromy et al., 2018; Allen et al., 2015; Findley et al., 2014; Ferguson et al., 2012).

In Nebraska, one recent study identified provider perceptions of CHWs and the integration of their services; however, very little information regarding the perceptions of CHWs in Nebraska has been identified (Chaidez, Palmer-Wackerly, and Trout, 2018). A study examining the integration of CHWs into professional interdisciplinary teams in Nebraska found that extensive work is still needed to integrate CHWs more successfully into the health system in Nebraska (Karsting, 2017). To better support this growing and crucial workforce in Nebraska, more research is needed on perceived barriers and training needs based on direct input from CHWs and other stakeholders before evidence-based policy and system changes can be formulated and implemented.

**APPROACH AND METHODS**

We adopted an Exploratory Sequential Mixed Methods Approach in the data collection for this project (Berman, 2017). This approach is characterized by an initial qualitative phase of data collection and analysis, followed by a phase of quantitative data collection and analysis, with a final phase of integration of data from the two separate strands for comprehensive analysis. The Community Health Worker Statewide Assessment Study was based on three components of data collection. First, we conducted a set of focus group discussions involving CHWs across Nebraska to collect in-depth qualitative data regarding the role of CHWs in their communities and within the healthcare system. Secondly, we conducted a statewide survey that assessed CHW demographics, training, services provided, and opinions on training and certification needs. Finally, we interviewed eight non-CHW stakeholders who employed or worked with Community Health Workers in Nebraska.

*Community Health Workers Focus Groups*

The research team developed a facilitator guide to outline how the Focus Group Discussion (FGD) would be held. Focus groups were held in 2019, with the first round being conducted in April and May 2019, and the second round in July 2019. Altogether, 10 focus groups were conducted at five health departments (Public Health Solution in Crete, South Heartland District in Hasting, Two Rivers in Holdrege/Kearney, Elkhorn Logan Valley Public Health Department and Douglas County Health Department) across Nebraska. Efforts were made to invite audiences who specifically self-identified as CHWs. Others, such as stakeholders, allies, employers, supervisors, etc., were discouraged from participating.  We held two separate sessions in each of the health departments, with each session covering different topics of discussion. The first session was focused on community health workers' perspectives on their role in the community and the second session was focused on the role of CHWs in the healthcare system. A trained facilitator led discussions in all these sessions. The facilitator read the consent form before the start of the FGD and a copy of the informed consent was given to participants. Participants were informed of audio-taping and photo-taking. All participants were over the age of 19 and could communicate in English. Basic demographic data were collected. For the FGD questions, please see Appendix A and B. Educational materials and networking opportunities were incorporated into the gatherings. Organizers recognized the reality that Community Health Workers are often not paid when away from their primary work assignment.  Individuals were offered a stipend for attendance if otherwise unpaid by an employer and, in cases where significant travel was involved, participants were compensated for mileage expenses.

*Community Health Workers Statewide Survey*

Based on qualitative feedback from CHWs who participated in the focus group discussions and a review of related literature, the research team drafted a survey

questionnaire and then updated the questionnaire with input from the Nebraska Community Health Worker Survey Committee. The questionnaire was pilot tested at a 2019 minority health conference before it was finalized and used in the Community Health Workers Statewide Survey. Data collection in the survey was primarily managed using REDCap (Research Electronic Data Capture) hosted at UNMC. REDCap is a secure, web-based application designed to support data capture for research studies.

REDCap at UNMC is supported by the Research IT Office funded by Vice Chancellor for Research (VCR). The published contents in this report are the sole responsibility of the authors and do not necessarily represent the official views of the VCR and NIH. In addition to the use of REDCap, a paper version of the survey was developed to accommodate individuals without easy access to the online survey. The survey started with an informed consent letter, a brief definition of Community Health Worker, and two screening questions to ensure eligibility. If the individual was not at least 19 years of age or self-identified as a CHW, the participant was prompted to exit the survey. If the eligibility requirements were met, the participant was then prompted to continue the survey and answer a total of 21 multiple-choice questions and one open-ended question (Appendix C). Participants were asked to provide an address at the end of the survey in order to receive a $20 gift card as compensation. This information was not linked to the survey responses.

A recruitment flyer with the eligibility requirements, information on the assessment with a direct link to the survey was emailed to identified organizations and individuals throughout Nebraska that work with or are familiar with CHWs. Eighty-seven community organizations, eight health systems, and all of the health departments were contacted to distribute the survey, including the UNMC Behavioral Health Education Center of Nebraska (BHECN) Community Health Worker Program and the DHHS Community Health Worker Health Navigation Program alumni listservs. Participants from the CHW gatherings were also contacted through email and asked to help spread the survey to other known CHWs. In September 2019, information regarding the study was released to the media to increase awareness and facilitate participant recruitment.

*Community Health Worker Key Informant Interviews*

The purpose of the key informant (non-CHW) interviews was to collect first-hand data from professional managers or leaders within agencies who have hired, worked with, or intend to work with CHWs. This would inform the study in the state of Nebraska on the system and employer perspectives on the CHW workforce to improve population health and to address health disparities.

A suggested list of key (non-CHW) informants was developed in August 2019 to include 20 individuals across the state of Nebraska. The initial plan was to interview 10 key informants from the Omaha and Lincoln area, and 10 from other areas across the state, in order to be representative of the Nebraska population. Invitations were sent via

email and phone calls. Potential participants were provided the consent form initially and sent the interview questions prior to the interview. The eight semi-structured interviews were conducted and recorded through Zoom and lasted approximately 40 minutes each. Key informants were compensated with a $50 gift card for participation. See Appendix D for interview questions.

**ETHICAL CONSIDERATIONS**

This study was approved by the Institutional Review Board of the University of Nebraska Medical Center (IRB # 900-18-EX). Data collection from eligible participants only started after we had obtained informed consent, and participants can choose to withdraw from the study or refuse to answer certain questions based on their personal judgements any time during the data collection process.

Only de-identified data were used in the final project report and related dissemination of project findings.

**ANALYSIS AND RESULTS**

**I. Community Health Worker Focus Groups**

**Participant Characteristics**

A total of 65 unduplicated CHWs participated in nine focus groups. Among the participants only three were male. Table 1 depicts the dates, location, and participants in the focus groups.

**Table 1: Focus Group dates, locations and participants**

| Health Department | Location | First Session – Date | First session – Participants | Second Session – Date | Second Session – Participants |
|---|---|---|---|---|---|
| South Heartland District Public Health Department | Hastings | April 9th | 15 | July 22nd | 13 |
| Elkhorn Logan Valley Public Health Department | Norfolk | April 23rd | 11 | July 27th | 10 |
| Two Rivers Public Health Department | Kearney | April 25th | 7 | July 30th | 12 |
| Public Health Solutions | Crete | April 30th | 6 | July 12th | 0 |
| Douglas County Health Department | Omaha | May 10th | 10 | July 26th | 7 |

Participants in the focus groups were predominantly part-time, paid employees based in a clinical or health care setting (Table 2). The majority received training prior to becoming a CHW or held some form of licensure.

**Table 2:** **Focus Group CHW employment descriptions**

|  | N | % |
| --- | --- | --- |
| **Work Setting (n=50)** | | |
| Clinical or health care organization | 17 | 34 |
| Community Organization | 11 | 22 |
| Not currently working as CHW | 10 | 20 |
| Other | 12 | 24 |
|  | | |
| **Work Status (n=48)** | | |
| Paid | 35 | 73 |
| Volunteer | 13 | 27 |
|  | | |
| **Work Hours (n =49)** | | |
| Full-time | 23 | 47 |
| Part-time or less | 26 | 53 |
|  | | |
| **CHW Training (n=50)** | | |
| Yes | 41 | 82 |
| No | 9 | 18 |
|  | | |
| **Licensure (n=49)** | | |
| Holds a license | 27 | 55 |
| Does not hold a license | 22 | 45 |

**Session One**

**Theme: Community Health Workers and the Community**

**Findings**

*Getting to Know Your Work*

When asked about their work, participants felt very proud to do their work and to help people with their health needs. Participants repeatedly recalled individual stories of helping one individual or family succeed, which made them extremely proud. The following are some testaments to their work:

*"…I'm kind of proud of the fact that I've been working at Head Start for almost six years. And while I've been there, several of the families that I started working with have become employees of Head Start."*

*"…One of the proudest moments is when you get a client and is improving on their health. You get to celebrate that with them and see them take charge of their health and get better."*

*"…I had an elderly client that I wanted to get screened for cancer… unfortunately the screen came back positive. But if I had not pushed for that screening, we never would have caught the cancer… It was treated and (he is or she is) now cancer free."*

*"…There are so many happy and proud moments…when you help to get it figured out, that is what makes it worth it."*

*"…sometimes, you have to listen underneath of what they're saying, because they can see an immediate need, but they may not see how to get there."*

The following are common themes that emerged regarding what CHWs were proud of in their work, liked about their work, disliked about their work, and barriers to their work overall.

Common examples of individuals being proud of their work:

- Developing programs
- Making a difference in someone's life
- Watching individuals grow
- Helping with Medicaid expansion
- Following a patient over time
- Having the trust of the community

Examples of aspects of their work CHWs liked:

- Seeing people change
- Flexibility and variability in job tasks
- Working with a variety of people
- Developing problem-solving skills

Common dislikes regarding CHW work:

- Systematic barriers
- Stress
- Lack of time
- Lack of community buy-in
- Underpaid
- Lack of male CHWs
- Long wait times for services
- Inability to help
- Amount of paperwork
- Feeling helpless
- Understaffed
- Large amount of responsibilities

Common barriers to their work emerged, such as:

- Language barriers
- Lack of knowledge of resources
- Lack of community buy-in
- Lack of time with clients
- Lack of training
- Working off hours to accommodate clients
- Lack of resources for referrals
- Performing tasks not in their job description
- Financial resources and funding allocations

Finally, CHWs discussed how these barriers affected community engagement and made their work more difficult overall. Examples of this sentiment are:

*"…Yeah, we can help you get housing. But it's going to be six to twelve months before we can get you an apartment." "Really? Why am I meeting with you?" I mean, in our area, where there are such long waitlists, or there's not resources… it's hard to keep people engaged when there's an immediate need and you don't have an immediate solution…"*

*"…One of the biggest obstacles is juggling my own family with my job and my personal life... Working a lot means I have to schedule clients in the evening which limits the amount of appointments I can make or spending time with my family."*

*"…Trying to explain to your peers how people learn and how people embrace this information is different than you is very difficult…"*

*" I mean, an ideal situation would be that everybody is aware of the different resources in a community and knowing that they can at least go to one location and ask for help and, even if they can't get the assistance there, that they can get information on where else they can go. But a lot of times, people don't know or are afraid to go."*

### Getting to Know Your Community

During the second portion of the session, CHWs were asked to discuss the communities they work in and the difficulties they face working in the communities. The following are major items discussed in this portion of the session.

Major health issues or barriers to health in the community:

- Insurance coverage
- Health Education
- Lack of health literacy
- Provider shortages
- Language barriers
- Medical Interpreters
- Cultural understanding
- Transportation
- Mental health services

Major maternal, child, and infant health issues in the community:

- Mental health (depression and anxiety)
- Lack of prenatal care
- Access and knowledge of contraception
- Poverty
- Child neglect
- Poverty and lack of financial support
- Lack of health insurance
- Lack of affordable childcare
- Unhealthy relationships and domestic violence

Some comments from this session include:

*"Regarding depression…I think I have noticed that more in a Hispanic culture, it's more taboos and not so much admitted to or talked about. It's kind of something you're not supposed to feel that way. So yeah, it's like, 'No. Something's wrong with you.'"*

*"Sometimes I feel like I'm kind of being intrusive even though it's something that I know is affecting the child, but I don't know how to approach it."*

*"I have noticed these moms that can't find work, can't find babysitters and are being isolated… I am seeing a decline in their mental health."*

*"Childcare is a major issue… they tend to work at night and work different shifts than the 8 to 5 world… they leave their children with older children or others… sometimes it's an issue…"*

*"The insurance did not speak Spanish, so they didn't understand, and they only covered certain items, so it didn't really help. They just pay but don't understand."*

*"What do I worry about? Women not being empowered to be themselves. So that's one of my worries."*

*"…it was very difficult to find healthcare. And so for example: families coming here where the mom was pregnant and not going to the hospital until the day that she was going to deliver, without having had any prenatal care. "*

**Session Two**

**Theme: Community Health Workers and the Health System**

**Findings**

In the second session, Community Health Workers (CHWs) were asked about their role in health systems, specifically their role on teams, use of documentation, and supervision. The following are the overarching themes that emerged.

**Team and Teamwork**

The CHWs agreed on three major points across all four focus group locations.

1. CHWs felt they needed to prove their usefulness before they were fully embraced by the health care team.

*"It's sort of like they don't get what we do at first. And then…they'll try it and it'll work for, like, a couple of patients. And they're like, Oh, this is great."*

*"When we first started in this position it was almost like a, a stigma with the doctors. And now, I think the doctors are way more accepting of it because they see what can be done. Um, they see what can be taken off of their plate what can be taken off their nurse's plate and given to us. And we can do just as good as job as they could."*

*"…so I had to get their buy-in as to why I'm there and my, uh-- I guess I had to show my value for being there. So once they started referring people to me, and they saw the results of actions that were taken, I started getting more referrals. And so they consider me more a part of the team because they could see that I did make a positive impact and in families' lives."*

2. In their roles within the larger system, CHWs felt that they were not seen as a professional.

*"…they may not see the community health worker as a professional."*

*"We are professionals. We are not, maybe, at the medical level that their healthcare provider is. But we are."*

3. Overall, CHWs felt they were the entry level for individuals to access the greater healthcare system.

*"I think a lot of it is independent, for my part, to start with, cause I meet with those patients independently in the clinic. And in order to be able to help them fully, I have to earn their trust… as you get their trust, you can build that circle for them."*

*"…We are there to advocate for the client. But we are also not only advocating; we are trying to, to close the gap in communication between the client and the provider."*

**Documentation**

When asked about documentation, CHWs felt they were able to access documentation from other providers and that other providers were able to access their information. The following were identified issues:

1. Various electronic documentation systems between organizations,
2. Repetitive documentation within one's own organization, and
3. Patients not having a medical home (i.e., finding documentation among several providers or no previous documentation available).

**Supervision**

CHWs overall expressed very positive working relationships with their supervisors. Supervision varied from traditional direct supervision to having remote supervisors (in other cities or at a different office). CHWs identified the following as the preferred characteristics of a great supervisor:

- Someone who knows the community
- Understands the required tasks
- Balances the numbers and the reality of the work
- Fosters creativity and self-direction
- Does not micromanage

*"…the service that you provide the clients that you're working with, that's not really tangible, and so having a supervisor who just doesn't get so wrapped up in numbers that they don't recognize the quality of service that you're providing to the clients you serve."*

**Potential for Advancement**

Potential for advancement varied among groups. The major factors seen as hindering advancement include:

- Current job is grant-funded and temporary
- The only promotion is when supervisor retires
- Requires a degree or other formal education
- Lack of compensation to stay or move up in the job

*"But then the struggle is then if you can work, there's limited advancement opportunities and, like, "Do I stay in this job where I get to do work that I am enjoying?" And it's tough, because, like, it is hard work, yet when you care about the work that you're doing, I mean, there is that stress and you have to balance it out. But then it's tough knowing, "I can do a manual labor job and make double or triple what I'm making."*

Individuals with opportunities to advance often have access to training, work in organizations that offer upward mobility based on experience, or in organizations that offer professional development funds.

*"But they started out-- most, most everybody that's in the top started out where we are or, or doing residential rehab, even, which is, is probably the, the lowest and kind of just moving up."*

**Training and Training Gaps**

CHWs were also asked to describe the training they received, preferences for training, and any training gap they identified in their work. The majority of CHWs agree that most of their training is from on-the-job, experiential work. Others stated they received orientation training in their job followed by other training as needed. Some CHWs are required to fulfill education hours per year, while others seek training to better their professional selves. On-the-job training includes internal training, and professional development training contracted through other organizations or online modules provided by other state health departments. Those who completed formal training completed the DHHS Community Health Worker Training or the UNMC Behavioral Health Education Center of Nebraska Community Health Worker training. Several participants had formal education through universities pertaining to their current employment or past employment.

Topics that were mentioned in previous trainings include:

- Chronic disease management
- Mental health (i.e., QPR training)
- Medical law and ethics
- Taking basic vital signs
- CPR
- Communication techniques

The following were identified as gaps in training:

- Motivational interviewing
- Cultural competency
- Insurance terminology
- How to communicate in certain situations
- Medical terminology
- Electronic documentation systems
- Maternal and Child health topics

*"…would be really helpful to just know a little bit more about the patients they see, to be more-- um, to have a little bit more knowledge on the behavioral aspect of it and how to approach a patient who breaks down crying and know what to do and why and how…"*

*"…I was only trained on what-- exactly what I needed to put into it."*

Possible solutions for these gaps are shadowing opportunities before the job begins, continuous training, in-person training sessions, mentoring, and a centralized resource database.
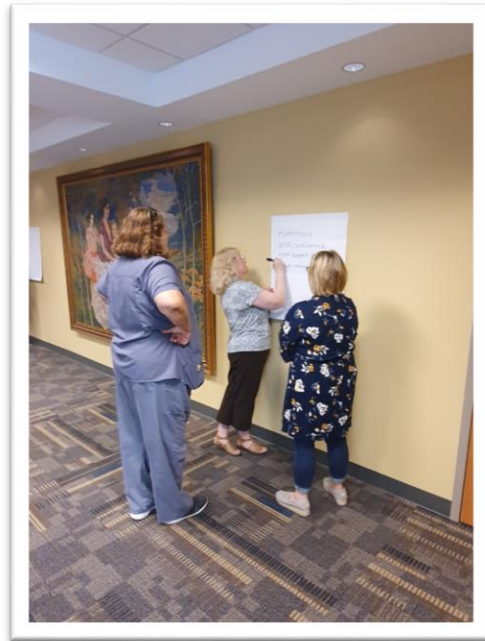
**Future Directions**

The following are possible future directions provided to facilitate more seamless integration of CHWs into the health system:

1. Education of community and providers of what a Community Health Worker does.

*"…Sometimes providers might not understand all the work and all the hard work that you have to put into getting the patient a resource, like, and just the supplies, food or transportation. They think it's easy. They think it's simple. But they really don't understand all the work that's put into it."*

*"They can come to you and tell you all the things which they don't tell their doctor, and you understand them. That's the key point of your role."*

2. Clearly define "Community Health Workers" as a profession and promote the scope of their abilities.

*"We're trying to figure out our boundaries and roles as with me and with the social worker because she can do everything I can do. Um, but I can't do everything she can do."*

*"I mean a doctor is a doctor, a nurse is a nurse. But a community health worker really varies in their function."*

Even within the CHW profession, some individuals expressed concerns with the definition and who actually qualifies as a CHW.

*"And I sense that they're – they're not actually – even though the work with members of the community, they're not community health workers of the norm as it not has been defined."*

Secondly, CHWs discussed to some extent the solutions to improving their status as a professional in the health system. While the overall consensus was that something needs to be done, there is not a clear agreed method to accomplish this. The most common suggestion was the education of healthcare providers and community, followed by certification within the CHW field. The following are insights for or against certification:

*"Certification is…basically acknowledging that you have some core competencies and that you are able-- like, that you have at least kind of a minimum-- like, this is the standard as far as, like, what you are capable and understand, and can then put forward. I mean, they don't necessarily cover everything, but I think-- I think it would make a difference."*

*"I don't even know how long it would be. I mean, there's just so many aspects to being a CHW that you just can't round them up into one, one or two days, so."*

*"I wish there was some kind of training on who's who and who does what, and that type of a thing."*

*"I don't know if-- well, when you're talking about clinicians, they always look at education. So it depends on your education level that you're walking in with. But if the community health worker had a, a certificate or some kind of a degree, so to speak-- to be certified in it, that might give it more credibility."*

**II. Community Health Worker Statewide Survey**

We conducted univariate analysis to understand the characteristics of participating CHWs in the statewide survey, their work and communities, previous training, and preferences for future training.

A total of 121 participants completed the survey, with 97 individuals completing the survey online and 24 completing a paper version of the survey. An additional 10 individuals began the survey but did not self-identify as a community health worker, which were excluded from analyses. The survey was completed in English.

**Participant characteristics**

Approximately 76% of the respondents resided within an urban county, as seen in Figure 1. Most of the respondents were females (Figure 2) in the 40-59 years age group (Figure 3), were married (Figure 4), and had obtained a college degree (Figure 5).

Figure 1: Home County of Survey Participants
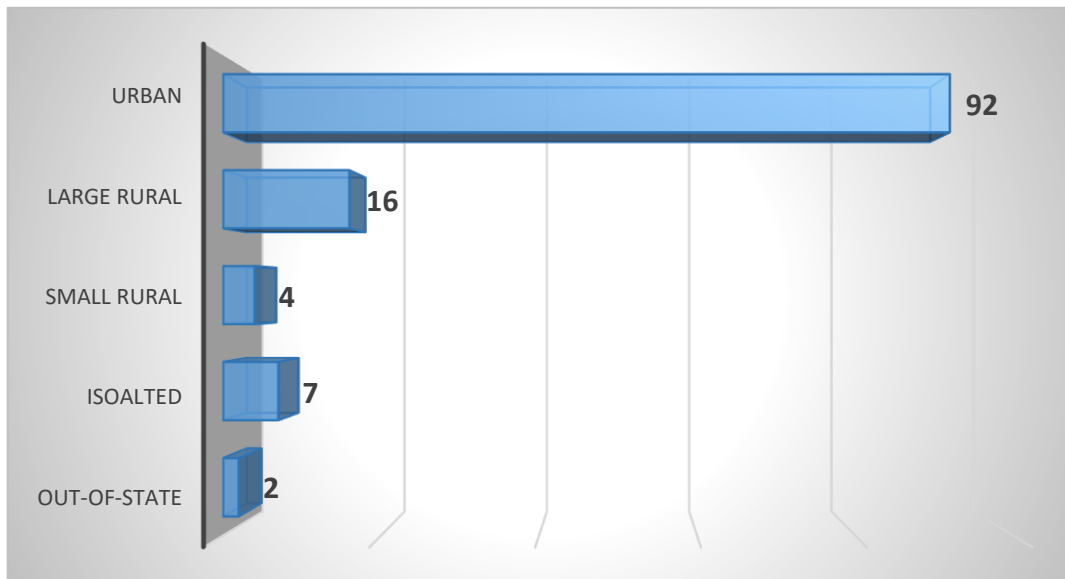
Figure 2: Gender of Survey Participants
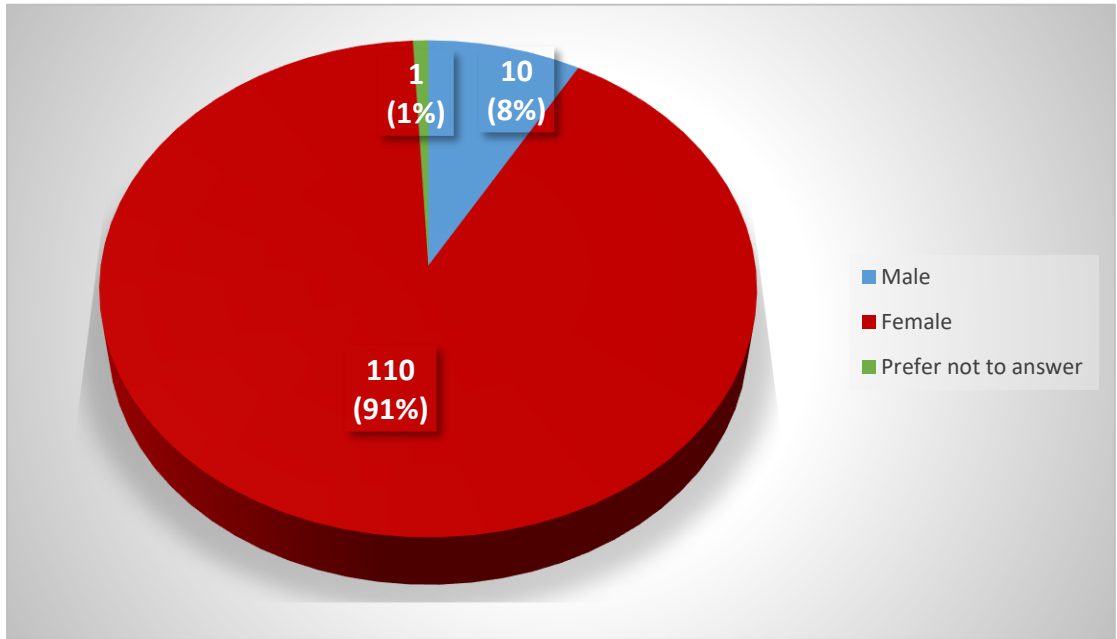


Figure 3: Age Groups of Survey Participants
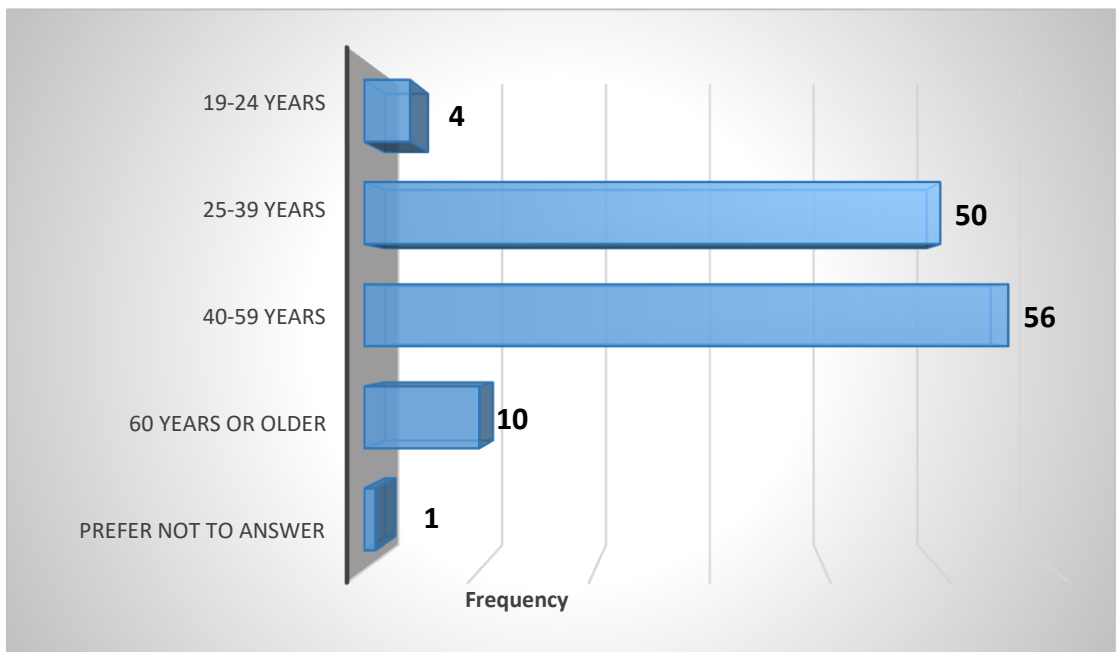
Figure 4: Marital Status of Survey Participants



| | |
|---|---|
| NEVER MARRIED/SINGLE | 28 |
| MARRIED | 72 |
| DIVORCED | 12 |
| LEGALLY SEPARATED | 0 |
| PARTNERED | 6 |
| WIDOWED/WIDOWER | 2 |
| PREFER NOT TO ANSWER | 1 |
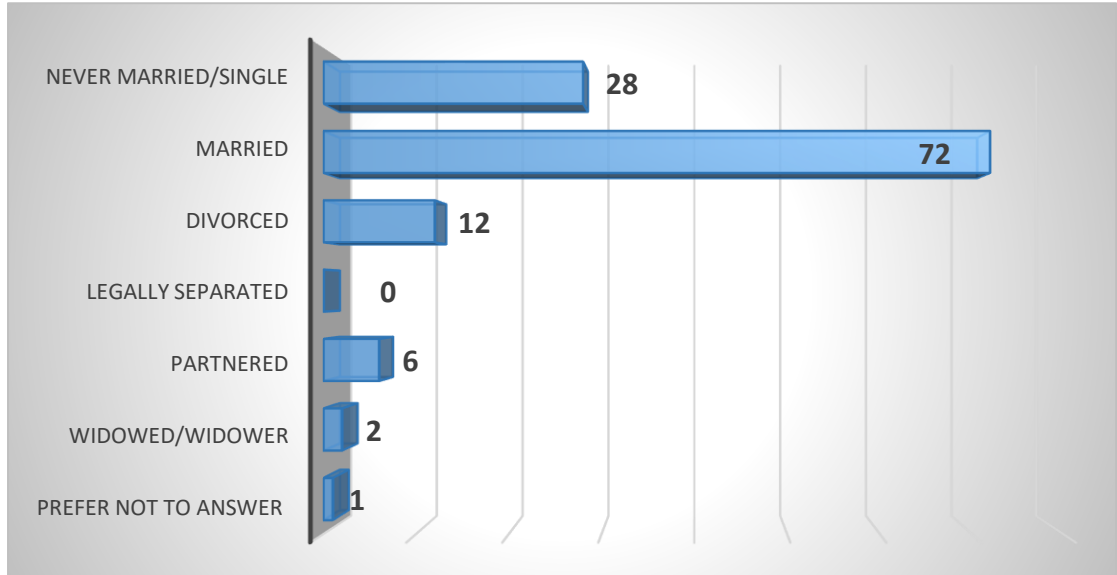
Figure 5: Educational Attainment of Survey Participants



| | |
|---|---|
| NEVER ATTENDED SCHOOL | 1 |
| GRADE 1-8 (ELEMENTARY) | 3 |
| GRADE 9-12 (SOME HIGH SCHOOL) | 14 |
| HIGH SCHOOL GRADUATE | 13 |
| 1-3 YEARS OF COLLEGE OR TECHNICAL SCHOOL | 19 |
| 4 OR MORE YEARS OF COLLEGE (GRADUATE) | 45 |
| MASTER'S DEGREE | 22 |
| PROFESSIONAL DEGREE (MD, JD, PHD, ETC.) | 2 |
| PREFER NOT TO ANSWER | 2 |
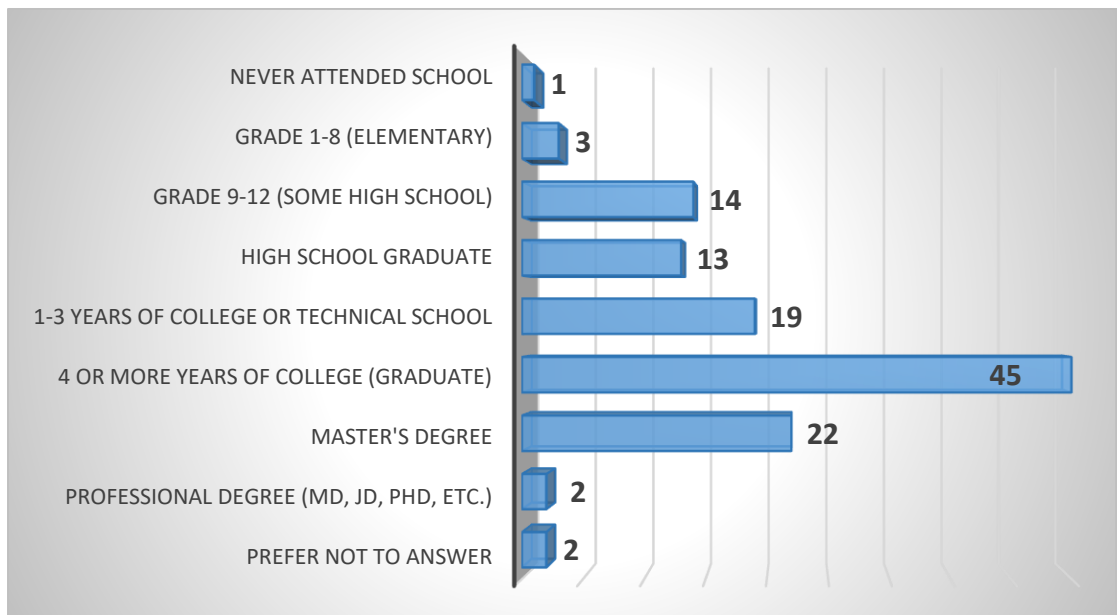
Among survey respondents, in terms of racial and ethnical background, over half of the respondents were non-Hispanic (Figure 6) and identified racially as Caucasian/White, followed by "Some other race" (Figure 7).

Figure 6: Ethnicity of Survey Participants
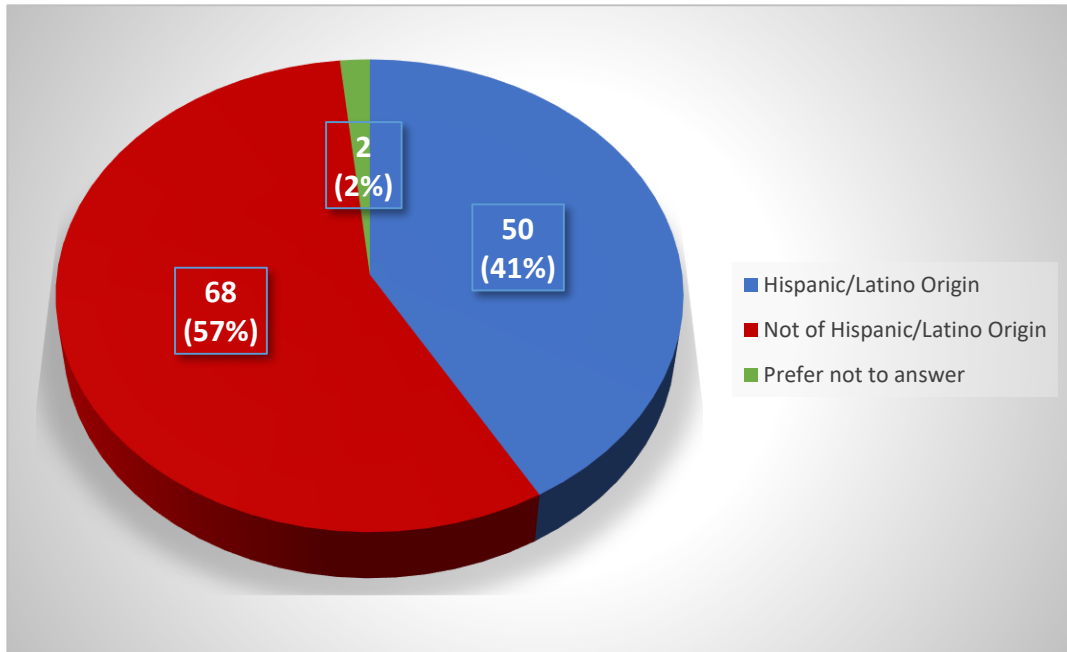


Figure 7: Race of Survey Participants
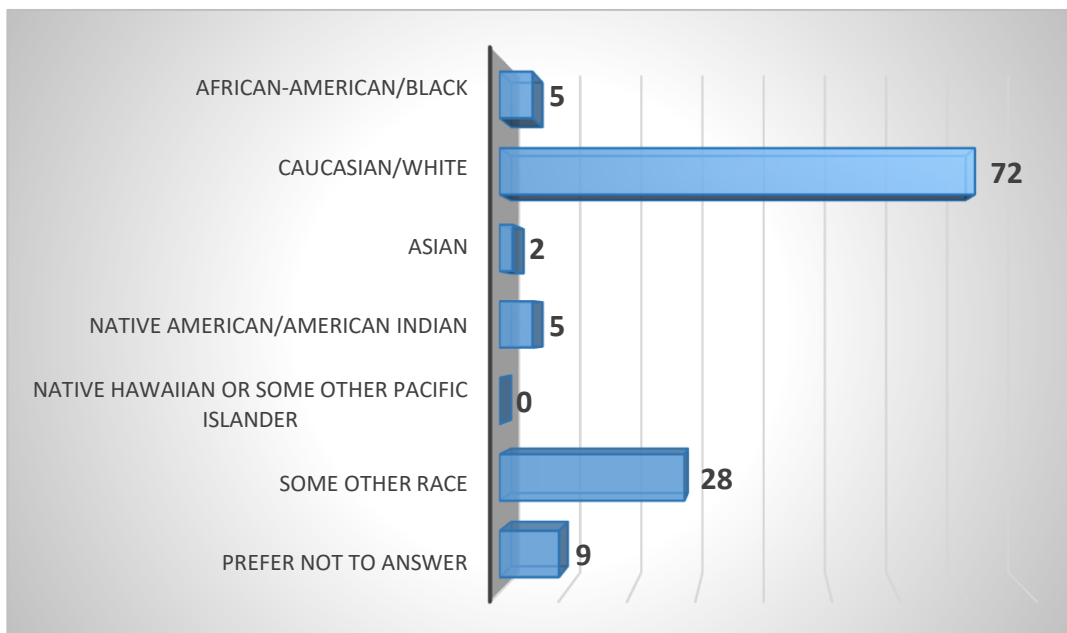
Among survey respondents, the English language was the primary language spoken at home followed by Spanish (Figure 8). Two individuals spoke more than two languages at home.

Figure 8: Primary Language Spoken at Home
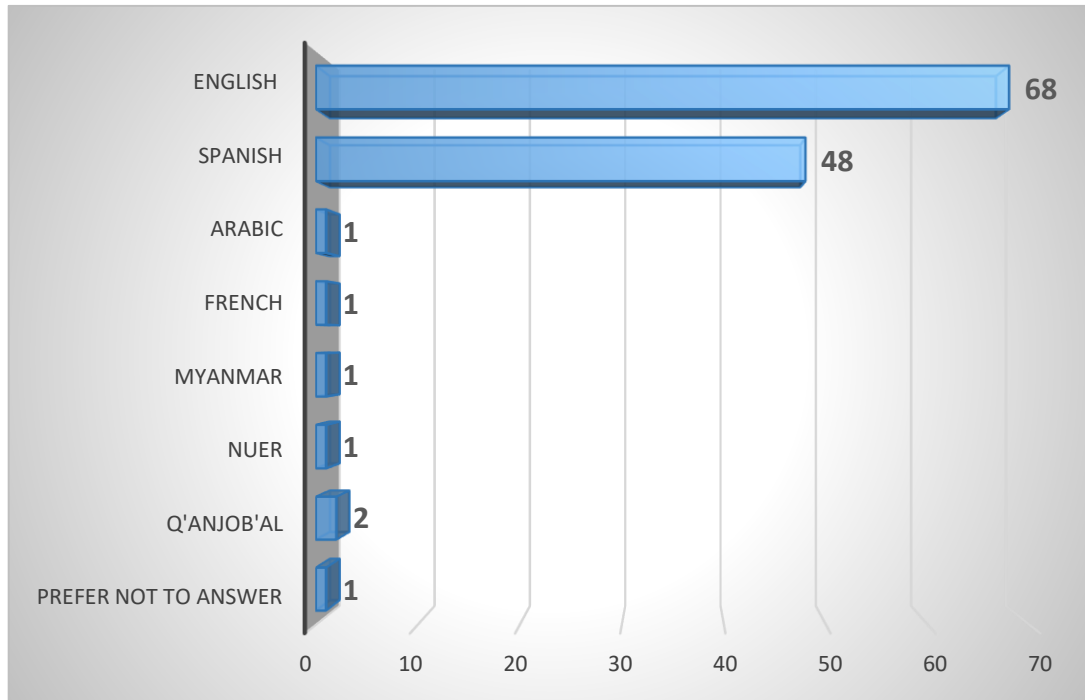


Of the 121 survey respondents, forty-three CHWs were born in a foreign country before residing in the United States (Figure 9). Individuals who were born in a foreign country have been in the United States for a mean of 22.7 years, ranging from 9 to 50 years. The majority of immigrant CHWs were from Mexico (n = 29) followed by Guatemala (n = 3).

Figure 9: Country of Birth
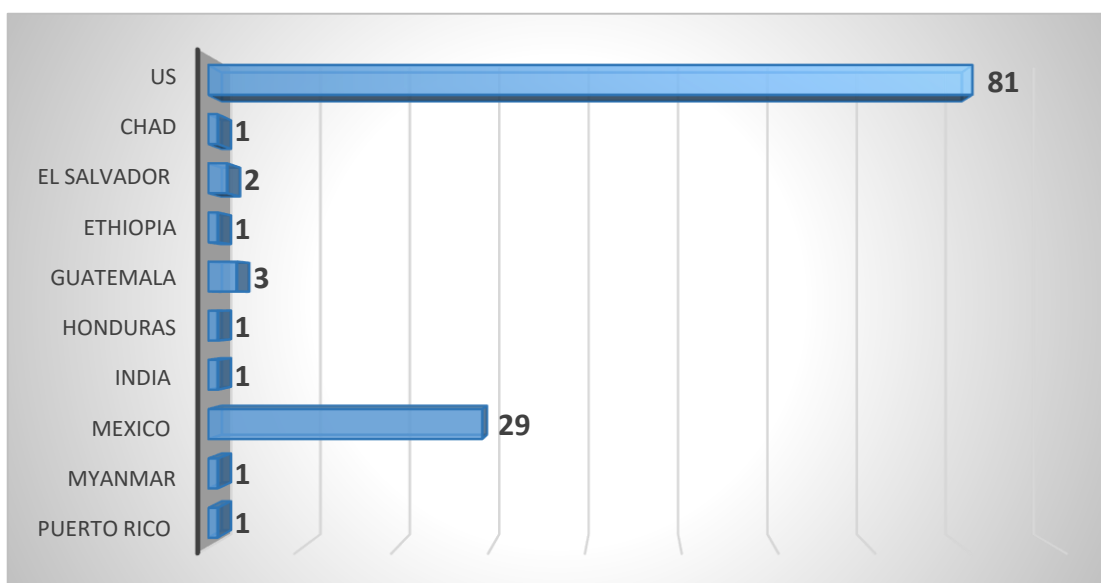
**Community Health Worker Job Title**

The survey respondents had a wide variety of job titles, employment descriptions, and organizational settings.

The majority of survey respondents did not identify their job title with the options provided in the survey. These included resource coordinators, resource navigators, health and wellness coordinators, outreach specialists, and support specialists. Of those who did identify their position with a provided term, "Promotora/Promotores de Salud" was the most common, followed by "Community Health Worker."

Figure 10: Job Title as Community Health Worker
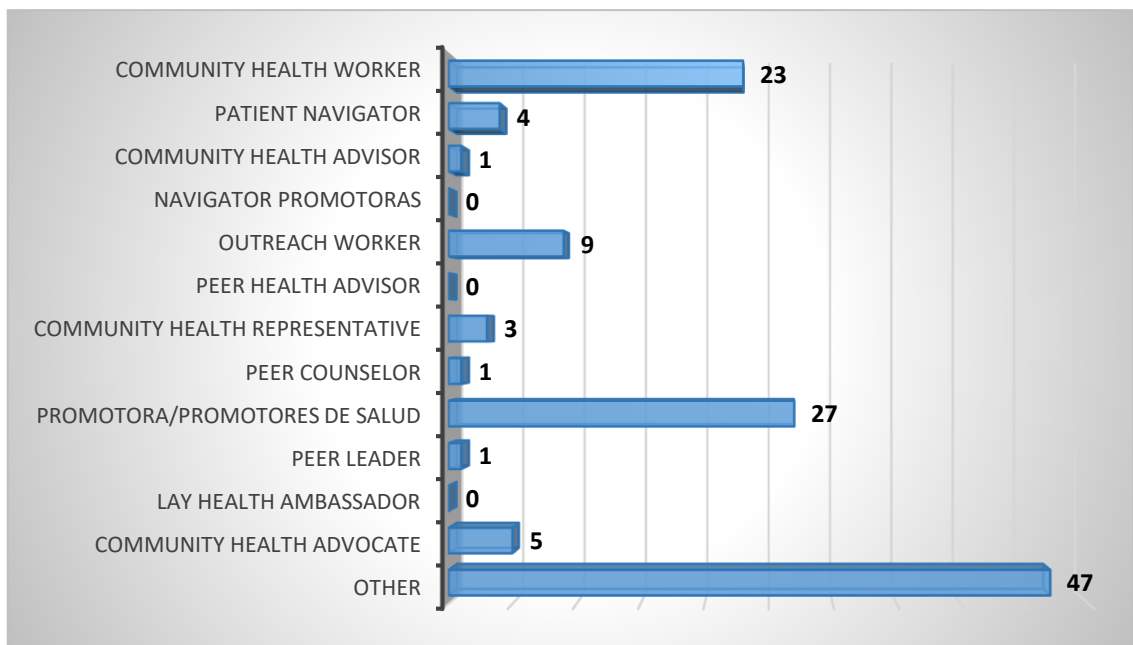


There were a variety of organizational settings in which survey respondents worked, with 35% employed in community-based organizations (Figure 11). There were not any respondents from the housing authority. Examples of employment organizations in the "Other" category include federal offices, non-profit breastfeeding centers, and no organizational affiliation.

Figure 11: Organizational Setting in which Community Health Workers are Employed
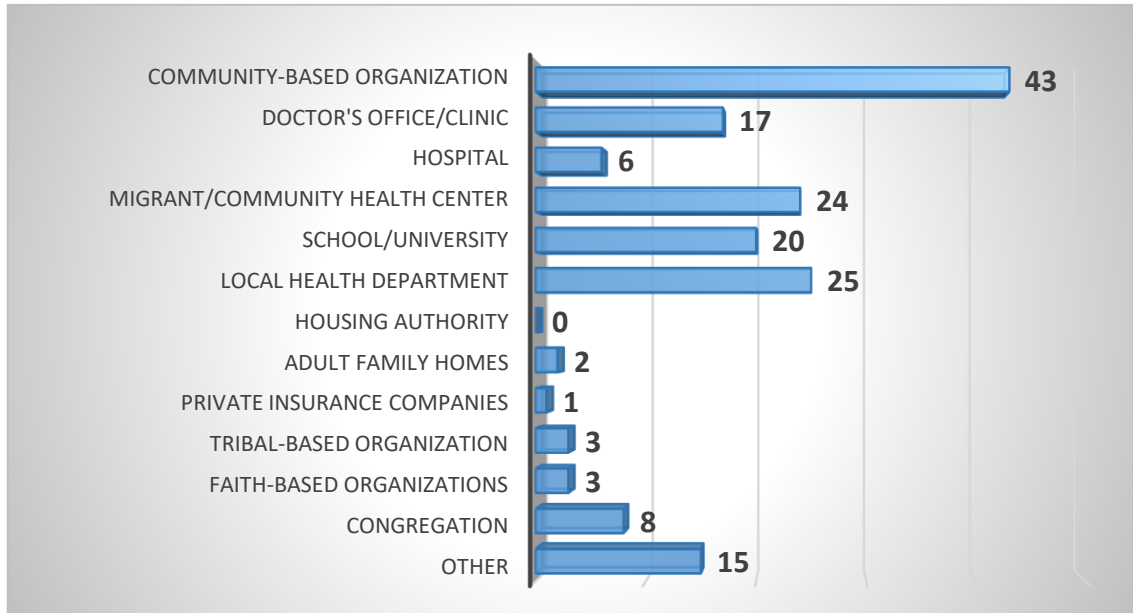


About two-thirds of the survey respondents reported full-time employment (Figure 12). The remainder were volunteers for the most part or part-time workers. One respondent was currently unemployed as a CHW and another was retired. Participants have been working as CHWs for a wide range of time, from 1 month to 40 years. The average time working as a CHW was 6.2 years.

Figure12: Employment Status as Community Health Worker
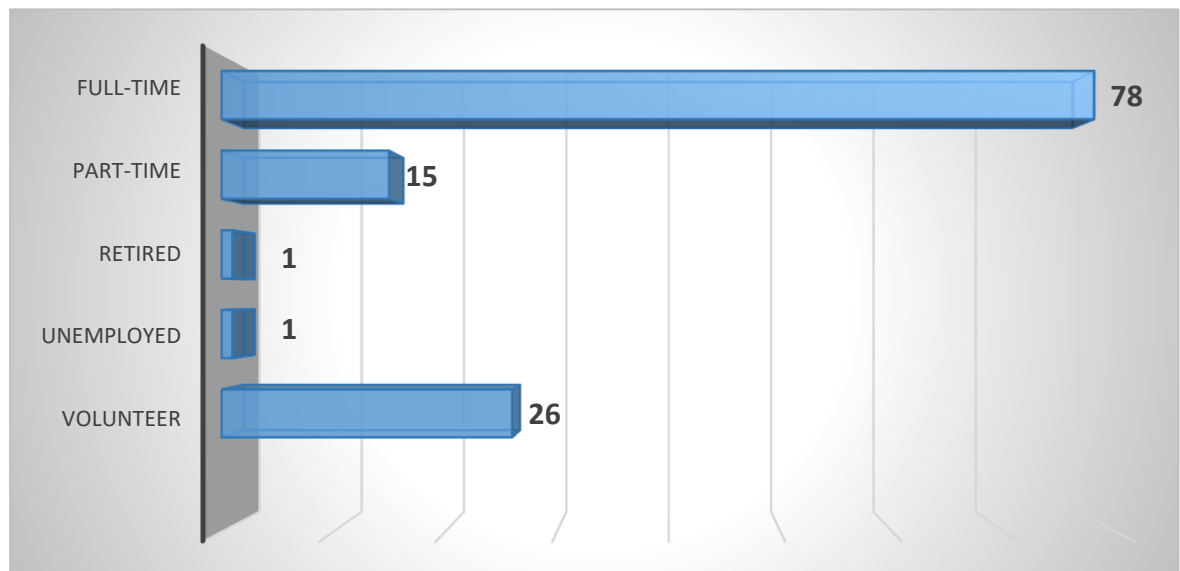
Survey respondents identified a wide range of tasks they are prepared to perform in their work (Figure 13). CHWs were mainly prepared to provide health education, attend community events, and connect patients to resources. "Other" tasks include applying for insurance, skill-building, accident prevention, and building social networks.

The largest focus areas of work identified through the survey were behavioral or mental health, chronic disease prevention, and obesity prevention (Figure 14). The least common focus of work was elder health and HIV or STDs. Other foci of services were disabilities, breastfeeding, cancer, and homelessness.

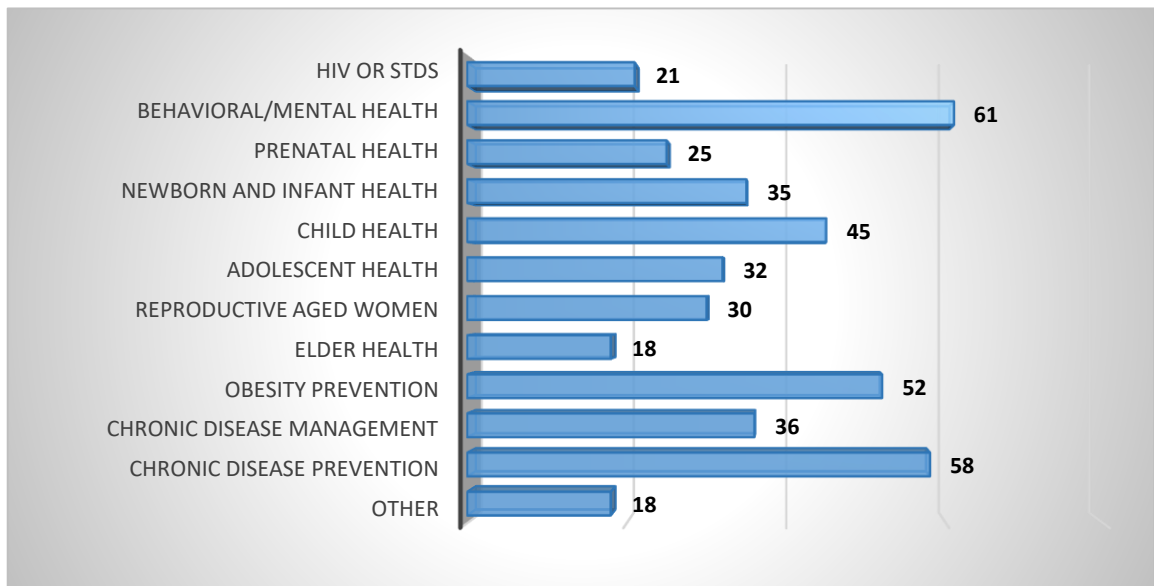Figure 13: Key Tasks Performed at Work
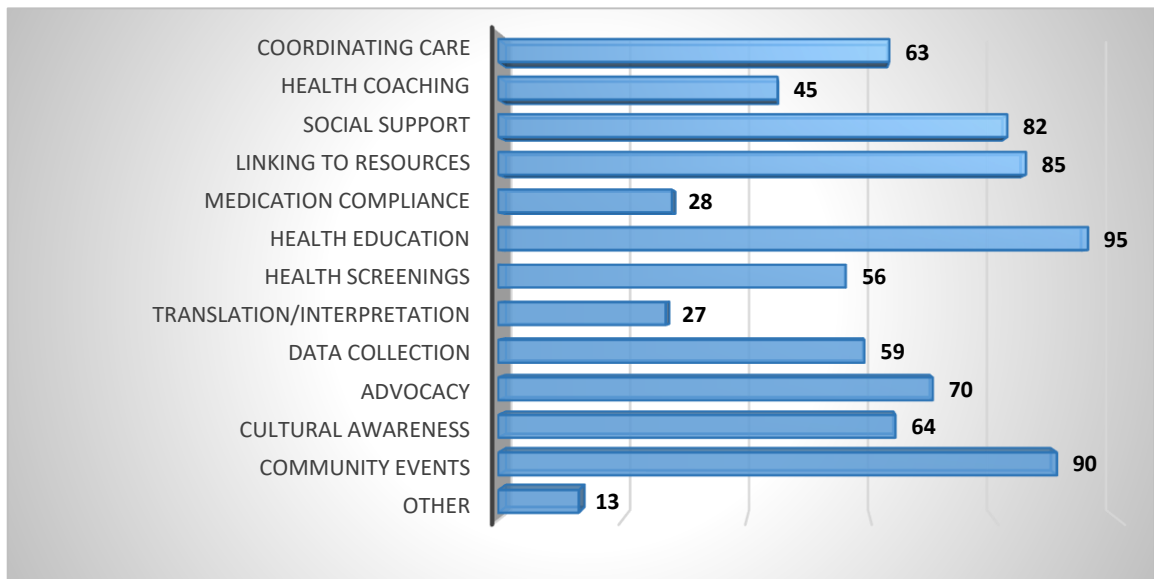


Figure 14: Major Focus Areas of Current Work

When asked about services provided to mothers, newborns, and infants, 50 CHWs in the survey indicated they currently provide these services (Figure 15). Of the 50 that stated they provided MCH services, mental health services, and home visitations were the most common (Figure 16). Other services included breastfeeding education and support, early intervention program referrals, injury prevention, and STI screenings.

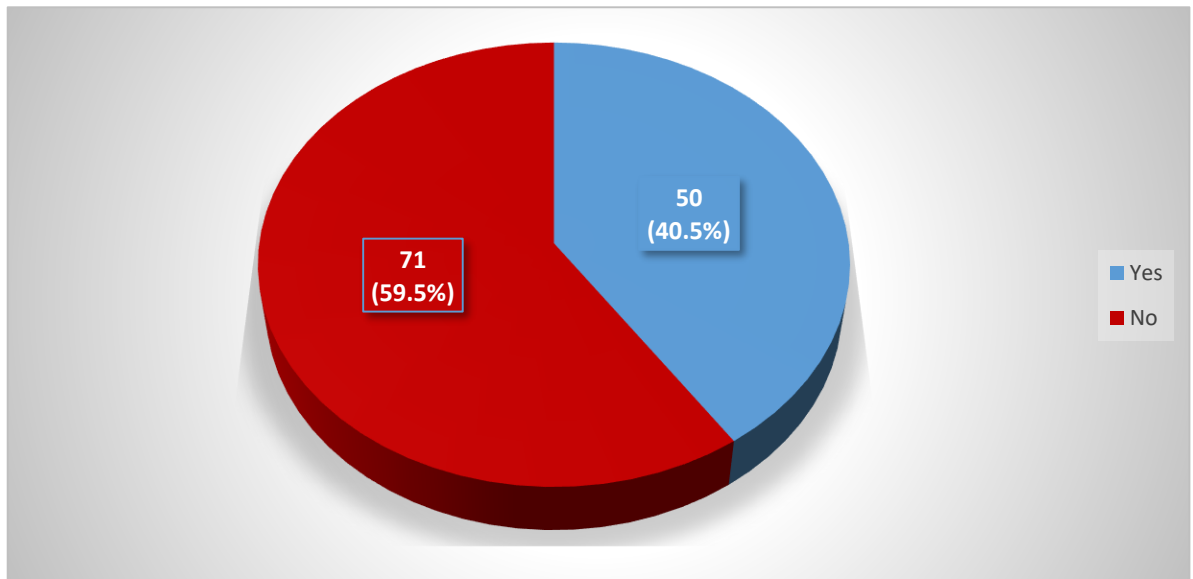Figure 15: Currently Providing Maternal, Newborn, and Child Health Services
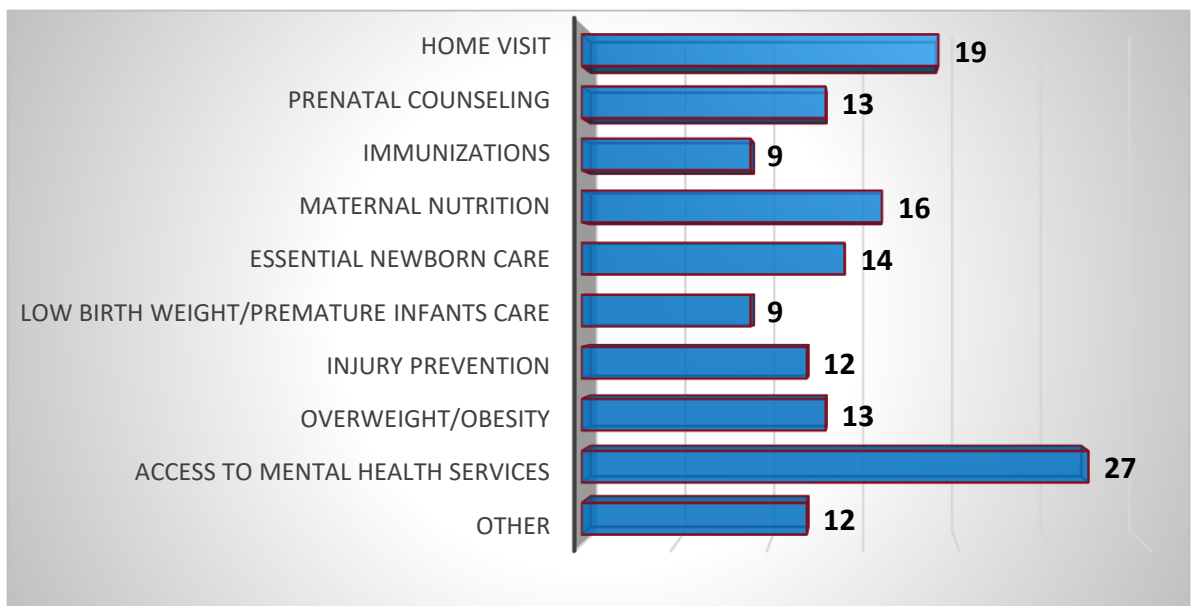


Figure 16: Specific Maternal, Newborn, and Infant Services Provided by CHWs

Other topics were explored, such as supervision and evaluation, major challenges in the work, and plans for the future. Survey respondents were asked about their supervision and evaluation within the workplace. Approximately 32% were supervised by administrative staff and 29% were supervised by another CHW (Figure 17). Other supervisors included specific project managers and one respondent stated there was no direct supervisor. Nearly 50% of the respondents were evaluated annually (Figure 18). One respondent stated they were unsure of when they were evaluated.
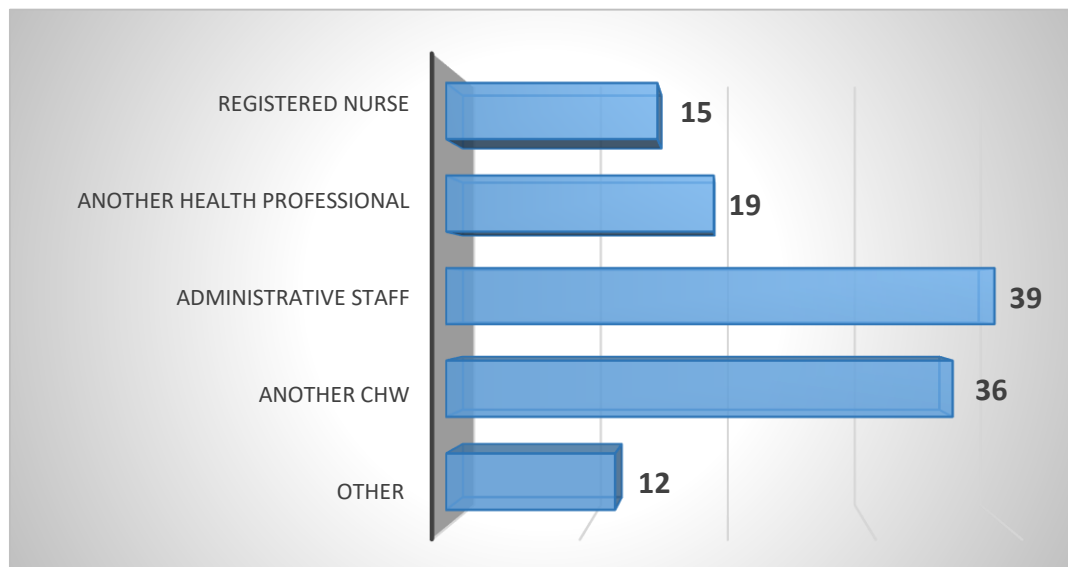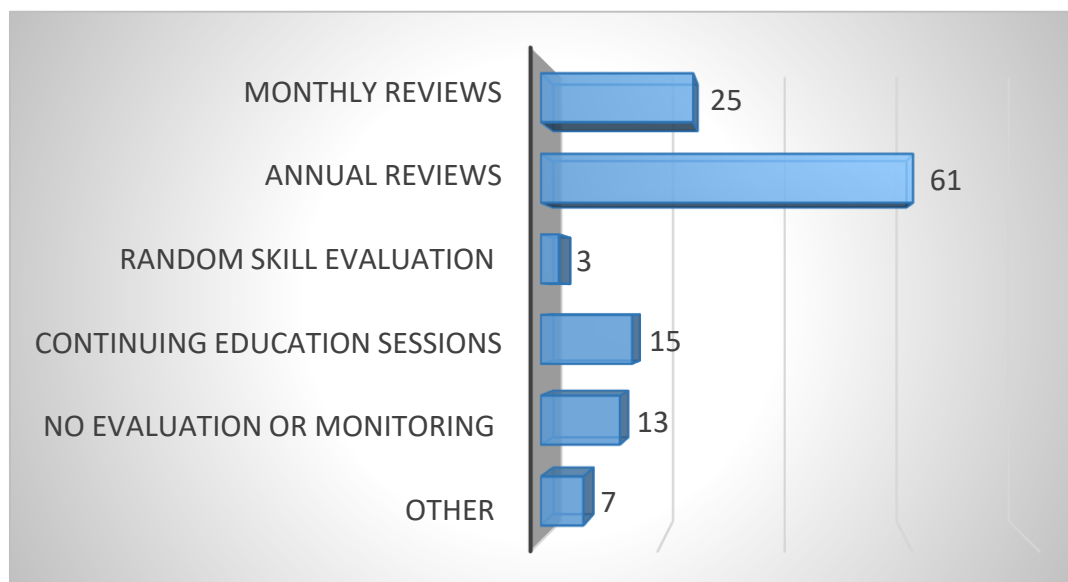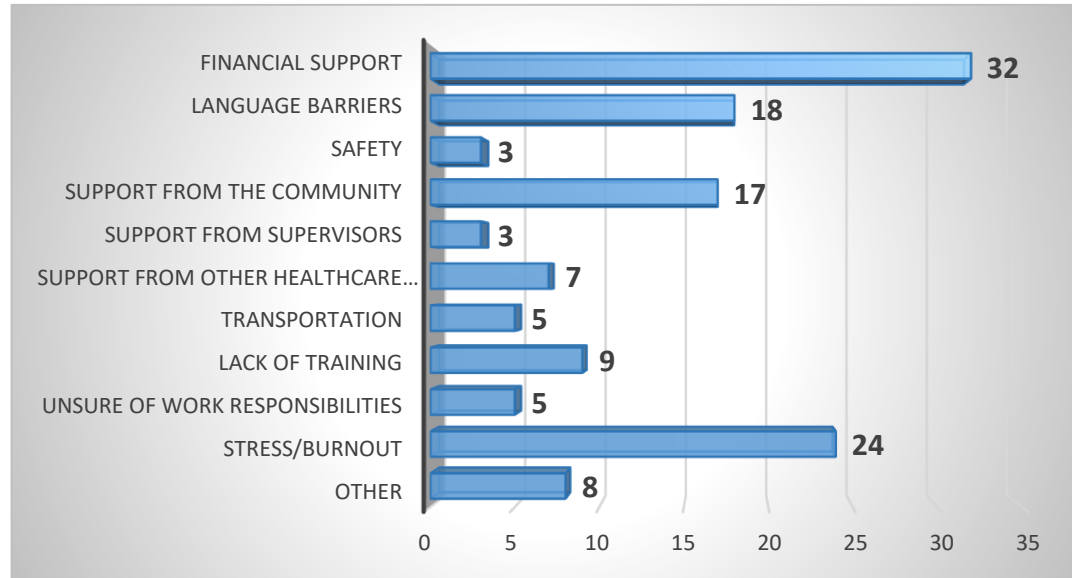
Figure 17: Supervisors of CHWs in the Survey



Figure 18: Monitoring and Evaluation of CHWs

The greatest personal challenge for CHWs in the survey was financial support, followed by stress or burn out (Figure 19). Other challenges were the lack of resources for referrals.

Figure 19: Greatest Personal Challenges for CHWs



Only 26% of survey respondents reported that they were aware of opportunities for professional development in their current position as a CHW (Figure 20). One respondent identified lack of potential for advancement as the biggest challenge they face in their work as a CHW. Over 80% of respondents were not planning on retiring in the near future (Figure 21).

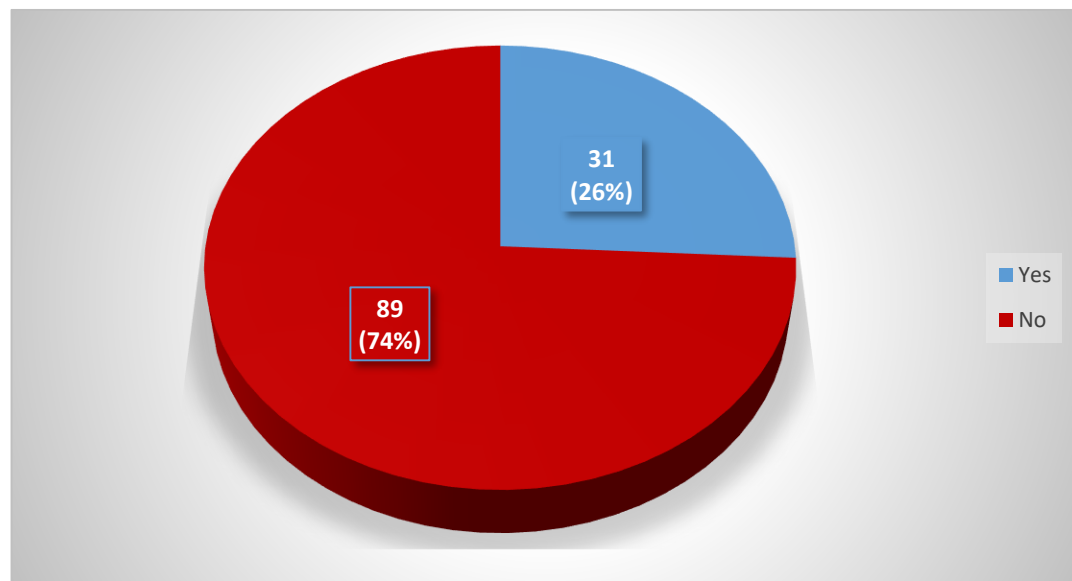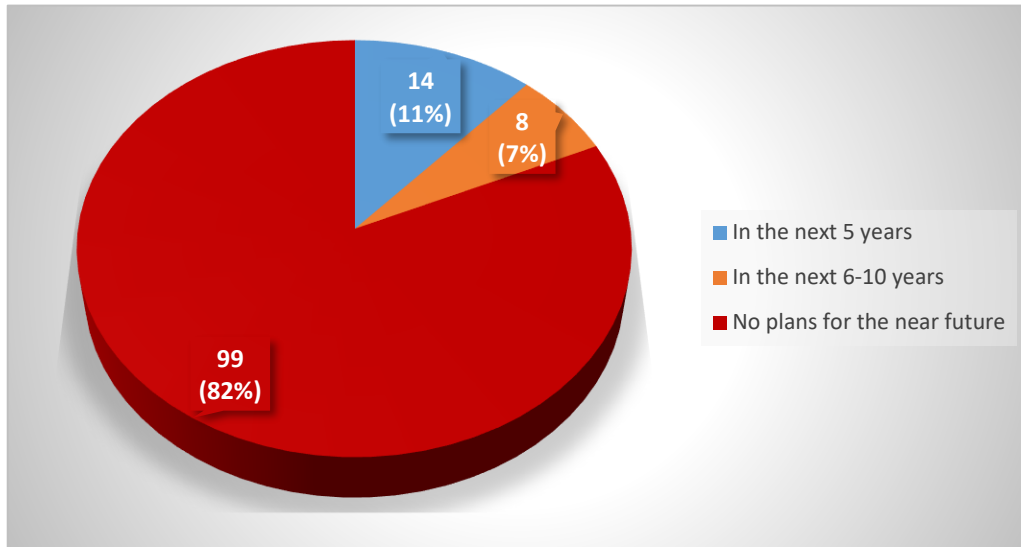Figure 20: Knowledge of Opportunity for Professional Advancement

Figure 21: Retirement Plans for the Future



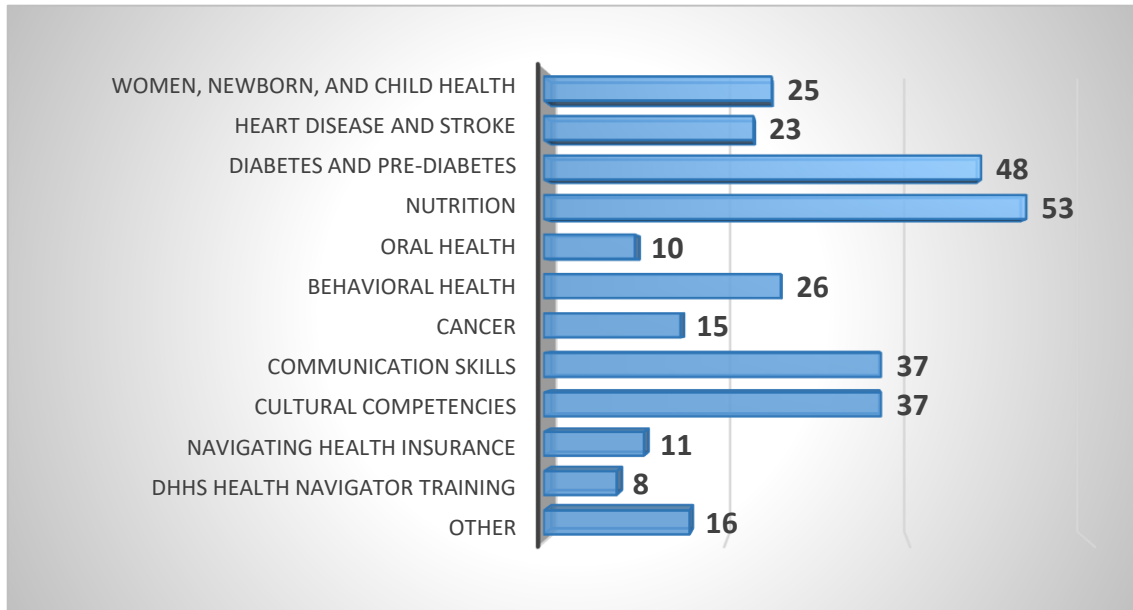**Community Health Worker Training**

Survey respondents were asked several questions regarding their training to become a CHW, the topics covered in the training, preferences regarding future training and opinions on a state-wide certification program. Nearly 60% of individuals received training prior to becoming a CHW (Figure 22). Out of these CHWs, eight or approximately 11% attended the DHHS Health Navigator training (Figure 23). Other sources of training include OneWorld Community Health Center, Methodist Hospital, BHECN, Boys Town, and various colleges and universities. Respondents received their training between 1991 and 2019, with the majority completing their training between 2014 and 2018.

Figure 22: Whether Received Training Prior to Becoming a Community Health Worker
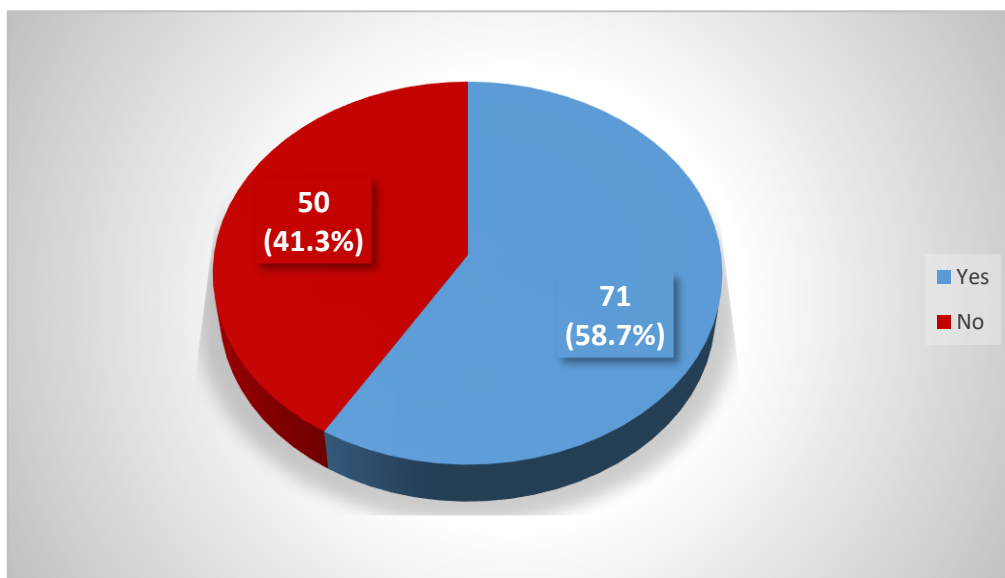
According to the survey responses, the most predominant topics covered during the training were nutrition, diabetes/pre-diabetes, communication skills, and cultural competencies (Figure 23). Other topics included sexual health, an overview of public health, and resources available to the community.

Figure 23: Topics Covered in Training Received by CHWs



Approximately 26% of survey respondents were aware of additional training, such as sexual and mental health training at OneWorld Community Health Center, BHCEN, DHHS Health Navigator Training, or training mentioned on the DHHS Health Navigator Alumni email list (Figure 24).

Figure 24: Knowledge of Training Opportunities among CHWs
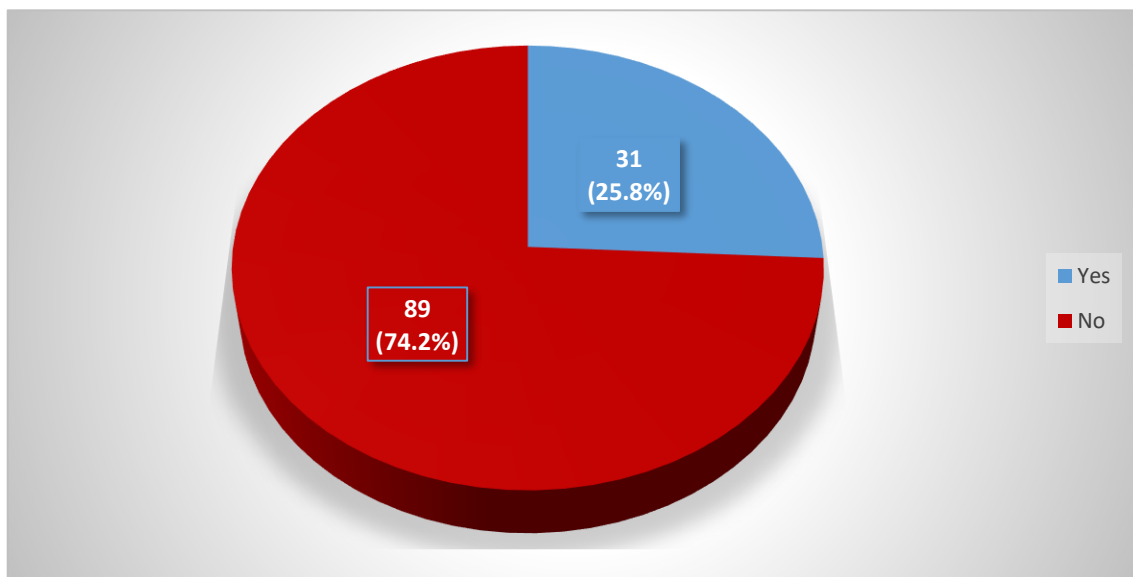
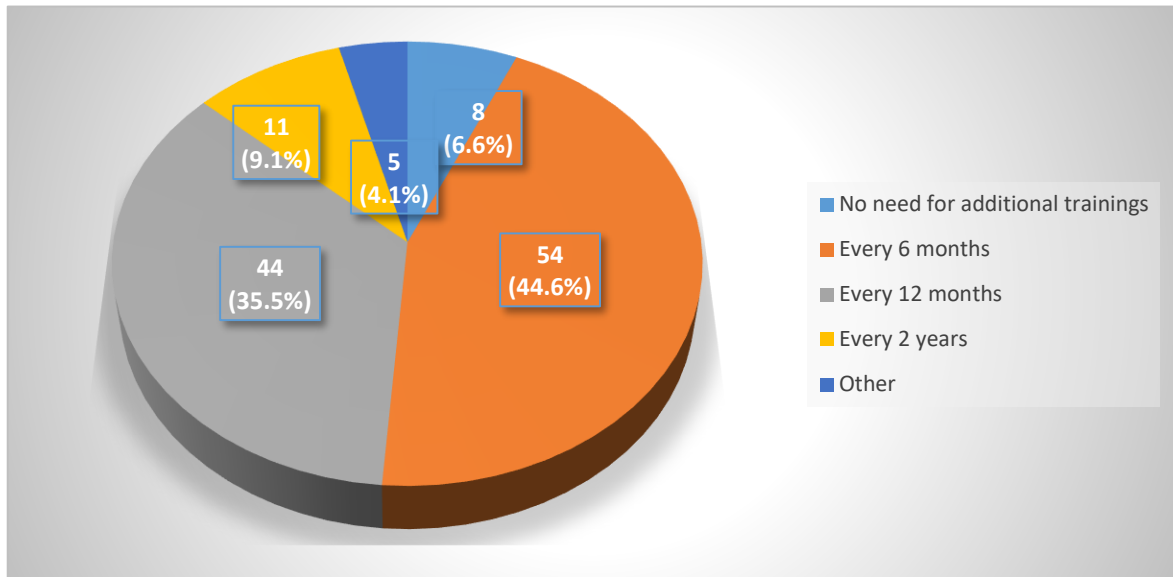Nearly 45% of survey respondents would prefer to be trained every six months, followed by 35.5% preferring every 12 months (Figure 25). Approximately 7% feel like there is not a need for any additional training. Other respondents felt there should be training as needed, without a specific time frame.

<u>Figure 25:</u> Training Preferences



Finally, survey respondents were asked their opinion regarding whether Nebraska should have a state-wide certification program for CHWs based on these two questions:

1) Do you think Nebraska should have a statewide certification program for community health workers as some other states do (e.g. Arizona, Florida, Indiana, Massachusetts, New Mexico, Ohio, Oregon, Rhode Island, and Texas)?  (Yes or No)

2) Why do you believe Nebraska should or should not have a certification program? (open-ended question)

The majority of Community Health Workers responded they agreed that a state-wide certification program would be beneficial (Figure 26). Over 80% of the respondents agreed that a state-wide certification program would be valuable to all CHWs. While the reasons for this point-of-view varied greatly, the most common themes that emerged were accountability, validation of their work, and standardization of knowledge (Table 3).  For instance, one CHW stated:

*"A statewide certification program would ensure that community health workers had an adequate amount of knowledge to help seek out health services for the people they support. It will also give community health workers the opportunity to talk to each other to gain resources, share experiences and give advice, and offer support to each other."*

Figure 26: Whether Nebraska Should Have a Statewide CHW Certification Program
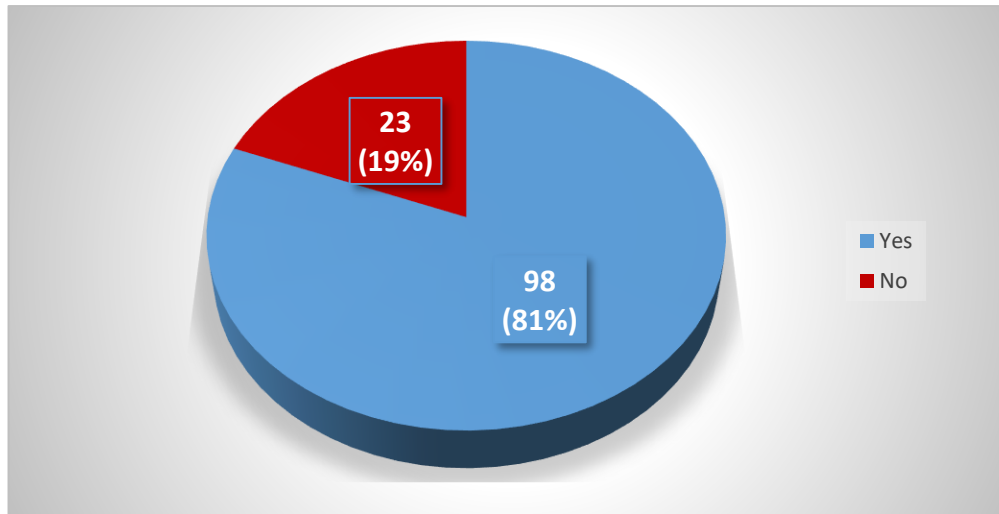


While the majority of CHWs stated a certification program would be beneficial, there were several concerns raised among the approximately 20% that said that there should not be a state-wide certification program. One major concern is that the nature of a CHW is that the knowledge is inherent with the individual's working experience in the community. For example, one individual wrote:

*"I feel that skills necessary to do Community Health Work are typically learned on the job and from experience out working with families in the community."*

Other reasons given against a certification program include additional training or job-specific certifications that are already in place. Others noted prohibitive barriers such as time off of work, transportation, and cost.

**Table 3: Major Themes on Certification of CHWs**

| Themes | Representative Quotes |
|---|---|
| Accountability | *Having a statewide certification program ensures that all CHW has the same basic training and therefore clients/patients can expect the same levels of care regardless of the area or county.* |
| | *Having ill trained or non-trained CHW presents dangers.* |
| | *It provides us a chance to hold ourselves accountable and achieve better standards for the people we serve.* |
| Validation | *There needs to be credibility for this profession so that it is respected.* |
| | *It would bring validation and professionalism to the role of CHWs.* |
| | *We make all other professions in the health field get licensed, why not us CHWs?* |
| | *It would provide more community awareness of what services can be provided. It can help with continuity of care. The individual would be seen more as a professional and valued by medical providers.* |
| | *A certification acknowledges that the role is authentic, professional, and valuable* |
| Standardized knowledge | *Everyone should have the most up-to-date training to ensure the best care for the community we serve.* |
| | *Certification can help to ensure appropriate training and skills that are universal throughout the state and communities.* |
| | *I think it would offer valuable initiative training that would add a level of comfort and confidence in having clear lines to follow and adding a benefit of showing available resources that can be utilized. I feel this would help the CHW be more apt and productive.* |

In order to assist with future recruitment of CHWs for research and other CHW-oriented events, survey respondents were asked where they heard about the survey. The major channels included referral from another CHW, local health department, or employer (Figure 27).

**Figure 27: Sources from Which CHWs Heard About the Survey**
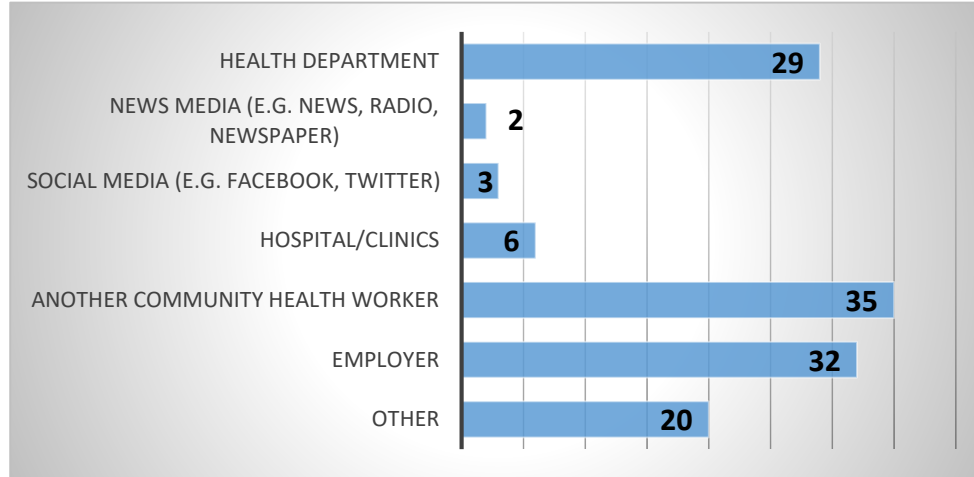


**III. Key Informant Interviews**

We also recruited and conducted semi-structured interviews with eight key informants in Nebraska that worked with CHWs. There were seven key informant interviews completed (with one interview having two key informants from the same organization) regarding the organizational perspective of CHWs. Of the 33 individuals contacted for interviews, seven agreed to participate, four did not believe they were qualified to speak on the topic, six showed initial interest but did not commit to an interview, and 16 did not respond.

Seven of the eight key informants were White and identified as non-Hispanic or Latino. All key informants were female. Seven of the key informants had a Master's degree and one had a professional degree. Approximately 50% were employed by a local health department, followed by a hospital system (Figure 28). The mean length of time employed by the organization was 8.71 years, with a range of 2 to 26 years. These organizations served several areas throughout Nebraska (Table 4).

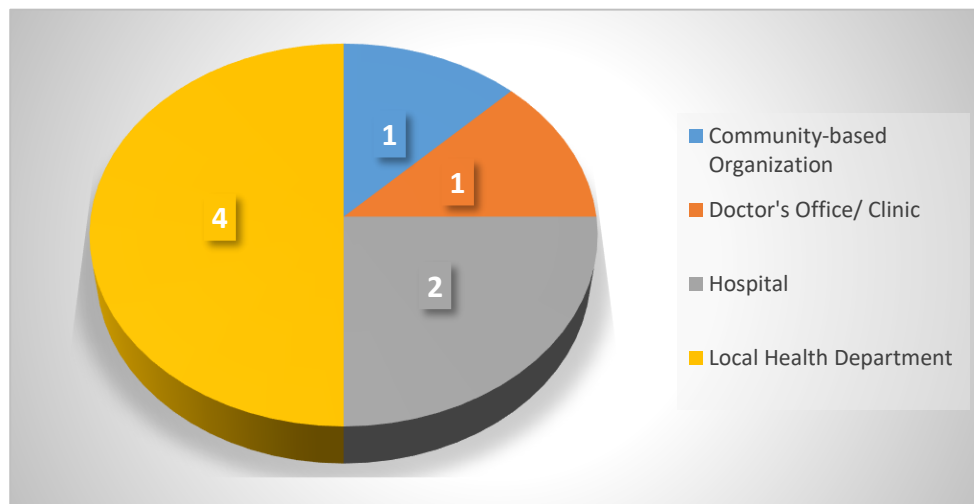Figure 28: Key Informant Interviewees by Organization Types

**Table 4: Key Informant Geographic Locations**

| Organization | Geographic Location |
|---|---|
| Community-Based Organization | Omaha, Lincoln, Norfolk, Kearney, and Scottsbluff |
| Hospital | Omaha, Kearney, Grand Island, Lincoln |
| Local Health Department | Omaha and Bellevue |
| Doctor's Office/Clinic | Omaha |

The following results are organized according to the transcribed answers of the key informants. Even with a modest number of informants, the responses were sufficient to allow for identifying common themes.

*Roles and Responsibilities of the Community Health Workers*

Key informants were asked to describe the roles and responsibilities of CHWs within their organizational setting. The description of the job responsibilities and tasks varied by organization type. A brief description has been provided in the table below (Table 5).

**Table 5: Key Informant Description of CHW Roles and responsibilities**

| Organization | Roles and Responsibilities |
|---|---|
| Community-Based Organization | Prevention specialist<br>case management |
| Hospital | Health education<br>Addressing social determinants of health |
| Local Health Department | Peer-to-Peer counseling<br>Health education<br>Linkage to care<br>Home visitations<br>Designing CHW training programs<br>Neighborhood educators |
| Doctor's Office/Clinic | Provide health education to individuals |

CHWs were employed full-time and part-time as dictated by funding sources. One organization utilized a large force of volunteer CHWs under the supervision of a full-time employed CHW. Funding sources also dictated the major focus of the work and the requirements of the position. Several CHW positions were temporary and short-term (less than eight weeks).

Several maternal, newborn, and infant services were identified by key informants in every organizational setting. The following is a brief list of some of these services.

- WIC
- Safe sleep program
- Sexual health and STI testing
- Home visitations
- Child healthcare
- Every Woman Matters Wellness Checks

- Lead testing
- Preconception health
- Head Start and early intervention
- "Count for Kicks" Program
- Infant Mortality
- Parents-of-Loss Counseling

CHWs do not necessarily work in all of these program types.

*Community Health Worker Supervision*

Supervision varied uniquely by organization; however, in general, CHWs were supervised directly with weekly or monthly meetings. The meetings provided CHWs one-on-one exchanges with the supervisor or were held as a group. Group meetings allowed for the incorporation of feedback of the larger team, provided time for additional training, and supported overall team morale. Supervisors ranged from senior CHWs, program managers, and clinical staff.

*Community Health Worker Training*

Every organization provided internal, on-the-job training for CHWs, which included orientation training, followed by job shadowing, and monitoring. Two organizations provided a more structured, formalized training while the other organizations had more informal orientation training. All seven of the organizations provide ongoing training as needed or at set intervals throughout the year. For example, one health department gathers all employees together four times a year for trainings.

Six key informants stated that a more formalized and structured ongoing training process is needed to help improve the performance of the CHWs. For example,

*"I think that would probably be one of the (organization's) biggest opportunities for growth. It's having a more robust, uh, informal like, not only an onboarding training but like a kind of skillset maintenance."*

*"I think we will be stronger if we start to implement some regular training."*

All key informants agreed that CHW training can be improved, and employers need to standardize the knowledge expected of CHWs.

*Supporting the CHW Workforce*

Key informants identified key areas to improve the support of CHWs and their work. The following are the common ideas presented in the key informant interviews:

- Compensation
- Sustainable funding sources
- Community support
- Team incorporation
- Centralized resource databank

- Insurance reimbursement
- Defining scope of work
- Provider support
- Training
- Networking events

At the state level, key informants agreed there need to be strategies to better integrate CHWs into the health care system as a whole. The most common solutions identified by key informants are training to develop a core competency set and clearly defining the role of a CHW in the healthcare system.

*"I think just what we're doing now is, is evaluating and exploring the system changes that might be necessary and looking at that training piece to be able to offer them more training and support."*

*"...so there was kind of a tension I think between medical assistance and community link advocates at some point, not necessarily a negative tension, just to pay attention to figure out who's doing what and how it's happening."*

According to key informants, these issues influence the recruitment of CHWs as well. CHW positions are largely grant-funded and therefore are usually unsustainable once the grant ends. This lack of permanency and explicit stipulations of a grant limit an organization's ability to recruit and retain CHWs. Other factors affecting recruitment are low compensation and a lack of full-time employment opportunities.

*State-wide Certification of CHWs*

As a potential solution to some of the revealed issues, we asked key informants about certification of CHWs. Three key informants were proponents of certification, three were against it, and two could see the benefits and negatives of a certification program.

Key informants speaking as proponents of certification of CHWs provided the following reasons:

- Develop common core competencies
- Provided accountability
- Acts as a pipeline to professional development

- Defines scope of the work
- Validates the workforce
- Encourages individual pride

*"I like the idea of, um, the certification because it does, um, provide some accountability for those people that are working as a community health worker and some continuity in what they're, they're learning and what they know."*

*"…The call to public health and the nuance skillset that it has, that goes into this kind of work… it's ever changing. That's like the one thing you can count on is like trends and advances and things like that. So it only makes sense to have, um, a certification process. A formalized road for education and ongoing education. So I would support that hands down."*

*"I would want to be careful that we make sure that we keep our perspective of community health workers really broad. And I've also said to entities as you hired my health workers, if they have that foundational training, then you can train them based on what you want them to do within your entity."*

Key informants speaking in opposition to CHW certification were concerned with the current infrastructure in place and barriers that may prevent people from gaining employment as a CHW. These barriers include:

- Transportation
- Time
- Literacy levels
- Language barriers
- Not wanting to return to school

- Cost
- Missing work
- Computer literacy
- Requirements for licensure
- Lack of employment opportunities

Another issue that arose was the ability to employ trained CHWs. Several key informants stated that there were not enough jobs or a sustainable model in place to support CHWs in Nebraska at this time. Without this infrastructure, there is no need for a certification program.

*"Why have a certification if you don't really have an established framework to, to sustain them, you know, what you kind of, if you're going to have an established framework to have to reimburse for them and um, you know, financially support the operation of them, then you probably want some sort of, um, standard in place."*

Finally, a key informant identified concern as to what core knowledge would be included in the certification. Many CHW responsibilities are job-related, and it may be challenging to develop a streamlined and effective training program to cover all CHWs.

*"When we think about certification, I think we've got to make sure we're not getting too far into the realm of, of maybe a specialty. Um, and just think really foundational. What would any community health worker get would need to be dependent on database but not dependent on the populations that may be serving."*

**STRENGTHS AND LIMITATIONS**

To our knowledge, this study represents the first statewide assessment of the CHW workforce in Nebraska based on comprehensive data collection from CHWs. The assessment purposefully incorporated both qualitative and quantitative data from different sources, which allows for triangulation between the data sources, thereby enhancing the depth and quality of the findings. One of the greatest strengths of this work was the effort to gather the voices and perspectives of CHWs in the state of Nebraska. This study is complemented by a limited set of non-CHW key informant interviews.

It should be noted that various limitations do exist, as explained blow.

**Focus Groups**

The focus group data described here represent only the perspectives of CHWs voluntarily participating and do not necessarily represent or provide a complete picture of community needs or perspectives on the CHW workforce. Therefore, these results cannot necessarily be generalized to all CHWs.

**Community Health Worker Statewide Survey**

Though the survey sample consisted of 121 individuals across Nebraska, the information provided by the survey respondents only represents their perspectives and may not entirely reflect or provide a complete picture of the CHW workforce across all areas of the state.

The information gathered relied on self-reports from respondents, which may be subject to recall biases, a limitation very common in cross-sectional surveys collecting self-report data. Additionally, the survey was only offered in English and may not include individuals who do not speak or read English proficiently.

**Key Informant Interviews**

The interview data described here represent only the perspectives of the eight non-CHW individuals interviewed and do not necessarily represent the official stance of their agencies. Given the large number of agencies employing community health workers in Nebraska, our findings based on interview with eight key informants do not capture all perspectives from various stakeholder agencies, which limits the generalized use of the findings.

Despite these limitations, the rich information collected in this study provides updated assessment of the current status quo of CHWs in Nebraska. The focus groups and survey combined provide a unique sample of the voices and perspectives of Nebraska CHWs. The identified barriers at the individual, organizational, and system levels can help policy makers and stakeholder agencies develop evidence-based strategies to more effectively train and support CHWs.

## RECOMMENDATIONS

In light of the major findings from this study, it is recommended that the following steps should be taken to better train and support Community Health Worker workforce to promote community health and address health disparities in Nebraska:

1.  There is a need to develop model CHW programs in Nebraska that clearly demonstrate the efficacy and impact of the work by CHWs in serving diverse populations and addressing health disparities. This is important due to the prevailing perceptions of CHWs that the value of their work has not been as positively appreciated by the health care system and the public as it should be.

2.  It would be important for stakeholders in Nebraska including policy makers to have more extensive and rigorous debate on the need for establishing a statewide certification program for CHWs. While the overwhelming majority of CHWs in the statewide survey saw the need and benefit of establishing the program, this issue became very divided among non-CHW key informants representing different organizations employing CHWs.

3.  Our findings underscore the need to develop a clear and concise definition for CHWs that is disseminated throughout the state and clearly describes the scope of work for CHWs within the healthcare system. Currently, in Nebraska, CHWs carry quite a few different job titles. This might create confusion when it comes to deciding who should receive which type of training or certification, and how CHW services should be integrated into health care delivery.

4.  Currently, the CHW workforce is predominantly female. There is a need for recruiting and training more male CHWs in case gender concordance might be needed to address gender-specific health issues.

5.  Many CHWs in Nebraska are currently providing a wide range of services to improve maternal and child health in their communities. Stakeholder agencies can support and partner with trained CHWs to further promote maternal and child health and evaluate program impacts.

6.  In light of the revealed barriers confronted by CHWs in their work, there is a need of providing training opportunities that address the core competencies suggested for all CHWs that are not time, cost, language, or literacy level prohibitive.

7.  It would help if all CHWs could be equipped with an updated community asset mapping report to assist CHWs to more effectively connect community members who have diverse unmet health and social needs with related community resources.

8.  Providing more stable employment and career advancement opportunities would be important for recruiting and retaining qualified CHWs. This is especially important given the observation that many CHWs in Nebraska work on a grant funded, temporary basis.

**CONCLUSIONS**

Community Health Workers represent a diverse emerging workforce prepared in a variety of ways to contribute to population health and equity.  Across focus groups and surveys, CHWs identified barriers to effective practice and professional development.  These include financial barriers, followed by burnout and heavy workloads. Addressing these barriers requires developing a sustainable model to hire, compensate, and retain CHWs, education of providers and community members on the role of CHWs and their services, more training opportunities for CHWs, more stable employment for CHWs including the opportunity for professional advancement, provision of community resource guides, and establishing a statewide certification of CHWs. Non-CHW key informants also helped identify ways organizations and employers can better support CHWs by acknowledging the value and importance of CHWs and by addressing barriers that have prevented CHWs from reaching their full professional development. This includes a lack of clear scope of practice, community and organizational support, training gaps, and inadequate work compensation. Organizations can better support CHWs by providing team environments, higher compensation, and clearly specified and reasonable job responsibilities and workload.

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**APPENDIX A – COMMUNITY HEALTH WORKERS FOCUS GROUP QUESTIONS (Session 1)**

1.  Please take two minutes to think about your experience working as a community health worker in your community. Is anyone happy to share what she/he is the proudest about her/his work?
2.  What do you like about your job as a Community Health Worker? What do you dislike about your job as a Community Health Worker?
3.  What are the key tasks you are prepared to perform as a Community Health Worker?
    a)  What is the setting you work in as a Community Health Worker?
    b)  What is a common term you use to describe your role as a Community Health Worker?
4.  What resources do you wish you had available when you try to promote health in your community?
    a)  Do you think poverty and language barriers are common obstacles that prevent people from getting and staying healthy?
    b)  What are the biggest challenges as a Community Health Worker?
5.  What do you need to do your best work?
    a)  What resources (money, people, other) do you need to do your work very well?
    b)  What are some changes that would help you do your job as community health worker better?
6.  Based on your experience and observation, what are the priority health issues of the populations you serve?
    a)  What are some important health problems in your community?
    b)  What are the health issues that are the focus of your work?
7.  Based on your observation, what are some of the most important health needs of women and children in your community?
    a)  What issues to you find with infant mortality? Access to health insurance? Health of women? STIs and sexual health?
    b)  What social, cultural, environmental factors influence women and their kids' health?
    c)  What is the predominant racial/ethnic background of the community you work in?/Are you prepared to work in that community?
    d)  What Maternal, Newborn, and Child health services do you personally provide?
8.  What can we do to better address the health needs of women and children?
9.  How difficult is it to address unmet health needs in your community?
    a)  What are some of the challenges to meet your community health needs?

**APPENDIX B – COMMUNITY HEALTH WORKERS FOCUS GROUP QUESTIONS (Session 2)**

1. In what way are you part of a team?
2. What are the advantages of having CHWs on teams?
3. What is your experience with electronic documentation tools or the use of the system?
4. To what extent do you help people navigate health insurance?
5. What are your relationships with other health professionals?
6. What would you like your relationships with other health professionals to be?
7. Do you have a supervisor? What makes a good supervisor for a Community Health Worker?
8. How is your work supervised?
9. How were you trained? What did you learn later that you wish was part of your training?
    a) How long was your training?
    b) What topics were covered in your training? Were you trained in the core competencies?
10. How should Community Health Workers be trained?
11. What would you like the future to be like for Community Health Workers in health care settings?
12. What are the key advantages of having CHWs on teams?

**APPENDIX C – COMMUNITY HEALTH WORKER STATEWIDE SURVEY**

### Introduction

A Community Health Worker (CHW) is an individual who:

- Serves as a bridge between public health, health care, behavioral health services, social services, and the community to assist individuals and communities in adopting healthy behaviors;
- Conducts outreach that promotes and improves individual and community health; and
- Facilitates access to services, decreases health disparities, and improves the quality and cultural competence of service delivery in Nebraska.

For this survey, Community Health Worker (CHW) is an umbrella term used to describe many different health positions. The following is a list of some titles used to describe CHWs:

- Community Health Worker
- Community Health Advisor
- Outreach Worker
- Community Health Representative
- Promotora/Promotores de Salud
- Peer Leader

- Patient Navigator
- Navigator Promotoras
- Peer Health Advisor
- Peer Counselor
- Lay Health Ambassador
- Community Health Advocate

Our purpose here is to conduct a statewide assessment of community health workers. Please do NOT take the survey if you are not a community health worker.

### Screening Questions:

1. Do you consider yourself a Community Health Worker based on the definition provided above?

    1 ☐ Yes (Please continue on to question 2)
    2 ☐ No (Please stop taking the survey now)

2. Are you 19 years or older?

    1 ☐ Yes (Please continue on to Section A)
    2 ☐ No (Please stop taking the survey now)

**Section A: Please tell us a little about yourself:**

1. What is your age group?

   1☐ 19-24 years      2☐ 25-39 years
   3☐ 40-59 years      4☐ 60 years or older
   5☐ Prefer not to answer

2. What is your gender?

   1☐ Male     2 ☐ Female
   3☐ Prefer not to answer

3. Are you of Hispanic or Latino origin?

   1☐ Yes   2☐ No
   3☐ Prefer not to answer

4. What is your race?

   1☐ African-American/Black      2☐ Caucasian/White
   3☐ Asian      4☐ Native American/American Indian
   5☐ Native Hawaiian or some other Pacific Islander
   6☐ Some Other Race (please specify):
   7☐ Prefer not to answer

5. What is your home zip code? (5 digits)

   |___|___|___|___|___|

6. What is your country of birth?

   1☐ Please specify:………………………………………………………………………
   2☐ Prefer not to answer

   6.a. If you were born in a foreign country, how many total years have you been living in the U.S.?   |___|___| Years    |___|___| months

7. Do you speak another language other than English at home?
   1☐ Yes, please specify:………………………………………………………………
   2☐ No (skip to 8)
   3☐ Prefer not to answer

8. What is your current marital status?
   1☐ Never Married/Single    2☐ Married    3☐ Divorced
   4☐ Legally Separated    5☐ Partnered    6☐ Widowed/Widower
   7☐ Prefer not to answer
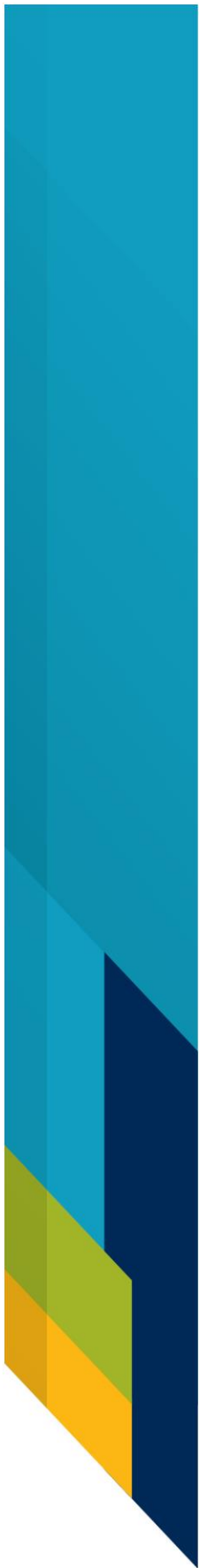
9. What is the highest grade or year of school you have completed?

1☐ Never attended school      2☐ Grade 1-8 (Elementary)
3☐ Grade 9-12 (Some High School)      4☐ High School Graduate
5☐ 1-3 years of college or technical school 6☐ 4 or more years of college (Graduate)
7☐ Master's degree      8☐ Professional degree (MD, JD, PhD, etc.)
9☐ Prefer not to answer

10. What is your current employment status as a community health worker?

1☐ Full-time      2☐ Part-time      3☐ Retired      4☐ Unemployed
5☐ Volunteer      7☐ Prefer not to answer

**Section B: Now we would like to know about your training and work**

1. What is your job title?
   1☐ Community Health Worker      2☐ Patient Navigator
   3☐ Community Health Advisor      4☐ Navigator Promotoras
   5☐ Outreach Worker      6☐ Peer Health Advisor
   7☐ Community Health Representative      8☐ Peer Counselor
   9☐ Promotora/Promotores de Salud      10☐ Lay Health Ambassador
   11☐ Peer Leader      12☐ Community Health Advocate
   13☐ Other (please specify): ………………………………………………………

2. How long have you been working as a community health worker?

   |___|___| years      |___|___| months

3. How many hours do you work or volunteer per week as a community health worker?
   1☐ Less than 10 hours      2☐ 10-30 hours
   3☐ 30 – 40 hours      4☐ More than 40 hours

4. How long have you worked at your current organization?

   |___|___| years      |___|___| months

5. What was your work experience before becoming a community health worker?
   1☐ Doctor
   2☐ Nurse
   3☐ Midwife
   4☐ Other health professional (e.g. social worker, CNA, medical assistant)
   5☐ Other (please specify): ………………………………………………………

6. Please describe the key tasks you are prepared to perform as a community health worker (Check all that apply).

1 ☐ Coordinating care      2 ☐ Health coaching
3 ☐ Social support      4 ☐ Linking to resources
5 ☐ Medication compliance      6 ☐ Health education
7 ☐ Health screenings      8 ☐ Translation/Interpretation
9 ☐ Data collection      10 ☐ Advocacy
11 ☐ Cultural awareness
12 ☐ Community events (e.g. health fairs or health classes)
13 ☐ Other (please specify):…………………………………………………………

7. Please list the health issues that are the focus of your work (Check all that apply).

1 ☐ HIV or STDs
2 ☐ Behavioral / Mental Health
3 ☐ Prenatal health
4 ☐ Newborn and Infant health
5 ☐ Child health
6 ☐ Adolescent health
7 ☐ Reproductive aged women (15-49 years)
8 ☐ Elder health
9 ☐ Obesity Prevention (Nutrition/Physical Activity)
10 ☐ Chronic Diseases (e.g. diabetes, high blood pressure, cancer) management
11 ☐ Chronic Diseases (e.g. diabetes, high blood pressure, cancer) prevention
12 ☐ Other (please specify): …………………………………………………………

8. Do you provide any services to improve Maternal, Newborn, and Child Health currently?

1 ☐ Yes, please specify (Check all that apply):

1 ☐ Home Visit      2 ☐ Prenatal Counseling
3 ☐ Immunizations      3 ☐ Maternal Nutrition (e.g. gestational diabetes)
5 ☐ Essential Newborn Care    6 ☐ Special Care for Low Birth Weight/Premature Infant
7 ☐ Injury prevention      8 ☐ Overweight/Obesity
9 ☐ Access to mental health services
10 ☐ Other (please specify):…………………………………………………………..

2 ☐ No

9. Did you receive any training before becoming a community health worker?

1 ☐ Yes (Please continue on to question 10a & 10b)

2 ☐ No (skip to 10)
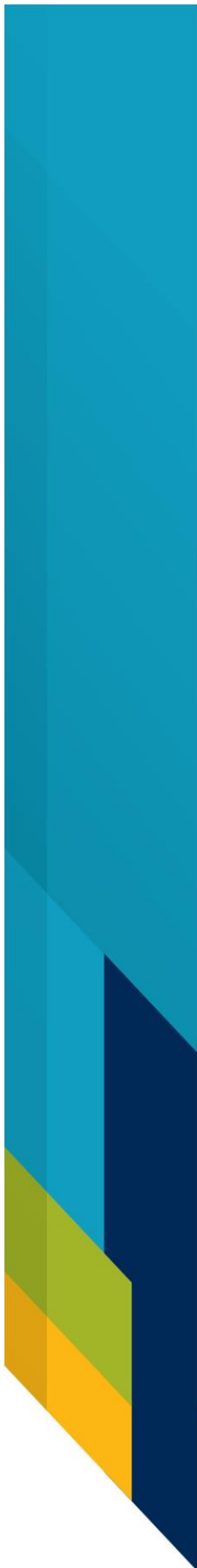
*9a. If yes, what was the year you were trained and how long was your training? Please provide the agency and training title if you can remember.*

Year _____

Duration (how many hours or days?) |___|___| days    |___|___| hours

Agency _____

Name of training_____

*9b. Topics covered during your training (select all that apply):*

1☐ Women, Newborn, and Child Health    2☐ Heart disease and stroke
3☐ Diabetes and Pre-diabetes    4☐ Nutrition
5☐ Oral health    6☐ Behavioral Health
7☐ Cancer    8☐ Communication skills
9☐ Cultural competencies    10☐ Navigating health insurance
11☐ DHHS health navigator training
12☐ Other (please specify): ………………………………………………

10. Are you aware of any current training opportunities for CHWs to reinforce initial training, learn new skills, or update their knowledge base?
1☐ Yes, please describe:………………………………………………………
2☐ No

11. While you are working as a CHW, how would you like to be trained?

1☐ Do not see the need for receiving any continuous training
2☐ Continuous training at least every 6 months for CHWs
3☐ Continuous training at least every 12 months for CHWs
4☐ Continuous training at least every 2 years for CHWs
5☐ Other (please specify)…………………………………………………

12. Please describe the community where you primarily work as a CHW.
*12a. What is the predominant ethnic background of the community you work in?*

1☐ Hispanic/Latino/Spanish
2☐ Non-Hispanic

*12b. What is the predominant racial background of the community you work in?*

1☐ African-American/Black    2☐ Caucasian/White
3☐ Asian/Pacific Islander    4☐ Native American/American Indian
5☐ Other (please specify): ………………………………

/

*12c. Please list the Nebraska counties that you practice as a CHW, and the hours per week you generally work in each county.*

Primary County:…………………………………………….... Hours per week:………
    *Primary County is the county you spend the majority of your time.

Secondary County:……………………………………………Hours per week:………

In the space below, list any other county that you work as a CHW and time distribution you spend in each of the counties.

        ………………………………………………………………………………………

13. What is the organizational setting where you work as a community health worker?
    1☐ Community-Based Organization         2☐ Doctor's Office/Clinic
    3☐ Hospital                             4☐ Migrant/Community Health Center
    6☐ School/University                    7☐ Local Health Department
    8☐ Housing Authority                    9☐ Adult Family Homes
    10☐ Private Insurance Companies
    11☐ Tribal-Based Organizations or Health Centers
    12☐ Faith-Based Organization (CHI Health, Lutheran Family Services, etc.)
    13☐ Congregation (church, mosque, place of worship, etc.)
    14☐ Other (Please Specify): ………………………………………………………

14. Do you have opportunities for promotion or professional advancement through the CHW program?
    1☐ Yes, please describe them: ………………………………………………………
    2☐ No

15. What is your biggest personal challenge when working as a CHW? **(Please select only one)**

    1☐ Financial support                2☐ Language barriers
    3☐ Safety                           4☐ Support from community
    5☐ Support from supervisors         6☐ Support from other healthcare professionals
    7☐ Transportation                   8☐ Lack of training
    9☐ Unsure of work responsibilities 10☐ Stress/ Burn out
    11☐ Other: …………………………………………………………………………

16. How is your work supervised?
    1☐ By Registered Nurses (RNs)
    2☐ By another health professional (i.e. Physician, Licensed practical nurse (LPN),
    Social Worker, dietician, etc.)
    3☐ By an Administrative Staff
    4☐ By another Community Health Worker
    5☐ Other (please specify): …………………………………………………………
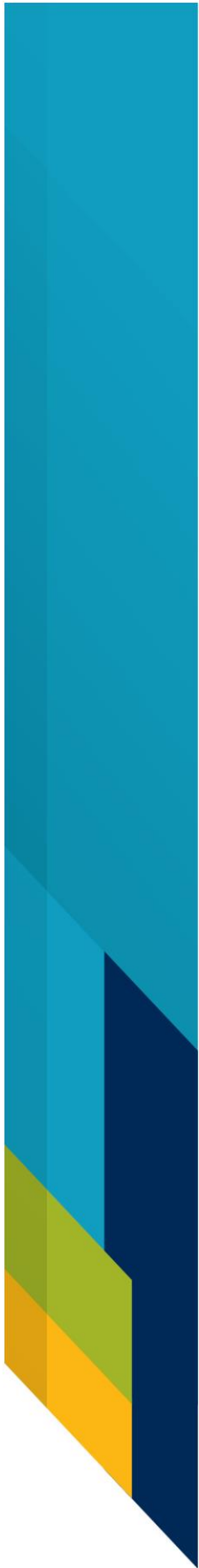
17. How is your performance monitored and evaluated?
   1☐ Monthly reviews
   2☐ Annual reviews
   3☐ Random skill evaluation
   4☐ Continuing education sessions
   5☐ No evaluation or monitoring
   6☐ Other (please specify): …………………………………………………………………

18. Do you expect to retire from your CHW position?
   1☐ In the next 5 years
   2☐ In the next 6-10 years
   3☐ Not planning to retire in the near future

19. How did you hear about this survey?
   1☐ Health Department
   2☐ News Media (e.g. news, radio, newspaper)
   3☐ Social Media (e.g. Facebook, Twitter)
   4☐ Hospital/Clinics
   5☐ Another Community Health Worker
   6☐ Employer (please specify): …………………………………………………………
   7☐ Other (please specify): …………………………………………………………………

20. Did you attend one of the Community Health Worker Gatherings recently hosted by selected health departments in Nebraska?

   1☐ Yes. Please specify (check all that apply):
      1☐ South Heartland District Public Health Department, Hastings, April 9th
      2☐ Elkhorn Logan Valley Public Health Department, Norfolk, April 23rd
      3☐ Two Rivers Public Health Department, Kearney, April 25th
      4☐ Public Health Solutions, Crete, April 30th
      5☐ Douglas County Health Department, Omaha, May 10th
      6☐ Public Health Solutions, Crete, July 12th
      7☐ Elkhorn Logan Valley Public Health Department, Norfolk, July 17th
      8☐ South Heartland District Public Health Department, Hastings, July 22nd
      9☐ Douglas County Health Department, Omaha, July 26th
      10☐ Two Rivers Public Health Department, Kearney, July 30th
   2☐ No

21. Do you think Nebraska should have a statewide certification program for community health workers as some other states do (e.g. Arizona, Florida, Indiana, Massachusetts, New Mexico, Ohio, Oregon, Rhode Island, and Texas)?

   1☐ Yes

   2☐ No

   21a. Why do you believe Nebraska should or should not have a certification program?
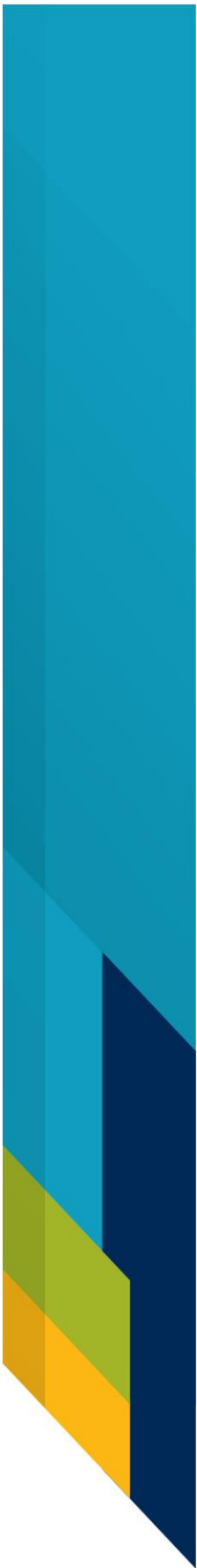
**APPENDIX D – COMMUNITY HEALTH WORKER KEY INFORMANTS INTERVIEW QUESTIONS**

Q1: Could you briefly describe the mission of your organization and the population you are serving?

Q2: Based on the mission of your organization, in what ways do you think Community Health Workers can help your organization accomplish its mission?

Q3: Are there Community Health Workers working in your organization now?

**(If yes to Q3)**
 Q3a. Could you describe their major responsibility and role in the organization?

Q3b. Do they provide any services to improve reproductive, women, newborn and infant health? Please specify.

Q3c. How is their work supervised and supported? Are they full-time employees?

Q3d. Have they received any job-related training since they started their position in your organization?

Q3e. How would you rate the performance of Community Health Workers in your organization, for example, excellent, very good, good, fair, or poor? Why?

Q3f. Did your organization encounter any issues when recruiting Community Health Workers?

Q3g. How supportive do you think your organization has been for Community Health Workers who work in your organization?

**(If no to Q3)**
Q3h. Do you know if your organization has been working with Community Health Workers in the past?

(If yes to Q3h) Could you briefly describe the working relation?

(if no to Q3h) Do you think your organization would be interested in working with Community Health Workers in the near future? Why?

Q4. Do you know if your organization has any plan of recruiting Community Health Workers in the next 5 years?

**(if yes to Q4).**
For Community Health Workers who would fit well with your organization, what are some of the most important qualifications you think they should have?

**(if no to Q4).**
Why?

Q5. To date 15 states in the U.S have developed certification programs for community health workers. Nebraska is not one of them. Do you think Nebraska should have its own certification program for Community Health Workers? Why?

Q6. Do you have any further comments related to Community Health Workers to share with us?