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Urban and Rural Differences in Community Health Worker Workforce in Nebraska

Prepared by:

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University of Nebraska Medical Center

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BREAKTHROUGHS FOR LIFE.

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EXECUTIVE SUMMARY

Community Health Workers (CHW) play a significant role in promoting health and health equity in many communities. Our previous report, *Strengthening the Community Health Worker Workforce to Improve Maternal and Child Health in Nebraska: A Statewide Assessment of Needs, Barriers, and Assets* (Su et al., 2020), provided an updated assessment of CHW characteristics and perspectives across the entire state of Nebraska. Considering the diverse health needs and differential access to health services between the rural and urban areas in Nebraska, the current report furthers our previous analysis by exploring and highlighting the differences between CHW working in urban and rural communities across Nebraska.

This report was based on secondary analysis of data from the previous study, which utilized an Exploratory Sequential Mixed Methods Approach to collecting the data in three phases: 1) a qualitative phase consisting of nine focus group discussions with 65 CHWs from across Nebraska; 2) a quantitative survey focusing on demographics, training, provided services, and opinions on training and certification services among 121 CHWs in Nebraska; and 3) interviews with eight key informants who worked for agencies which employed or worked with CHWs in Nebraska.

A significant theme identified throughout the survey results and focus groups was language barriers. The two most common languages spoken by both urban and rural CHWs are English and Spanish; Arabic, Burmese, Nuer, Q'anjob'al are also spoken by a small subsection of rural CHW. Rural counties have the highest rates of limited-English-proficiency (LEP) residents across the state. Of the ten counties with the highest rates of LEP residents, six are rural and have resident LEP rates ranging from 6.8% in Dodge County to 29.9% in Colfax County (Anthone et al. 2021). A strong focus should be placed on increasing language services, including translation and interpretation services.

The following similarities and differences between urban and rural locations were identified through our CHW workforce assessment:

- Review of CHW service locations indicates a disproportionate lower presence in rural communities based on state population distribution. While 35% of the population in Nebraska resides in rural areas, only 22.3% of surveyed CHW work in rural locations (RHIHub 2019).

- The majority of CHW in urban and rural areas are non-Hispanic/Latino, primarily English-speaking White women, pointing to a need for diversifying the CHW workforce in light of the increasingly diverse population in Nebraska.

- Less than 50% of CHW in urban and rural areas provide services to children or mothers. No CHW surveyed provides special care for low birth weight and premature infants in rural areas. Other maternal and child health services of benefit to the community when provided by CHW include pre-pregnancy health education, immunization promotion, and home visiting for families with infants.

- Differences exist in health issues of focus. Obesity prevention and chronic disease management were less represented in rural areas, while behavioral/mental health and elder health were less represented in urban areas. Few CHW are involved in HIV/STD prevention in both urban and rural locations.

- Differences between urban and rural CHW also were identified in key tasks performed. CHW in urban areas were less likely to perform key tasks including linking to resources, health coaching, translation/interpretation, data collection, and advocacy. Health screening was the only key task not strongly represented in rural areas.

- Training (including previous and continued) differed among rural and urban CHW. The most common training topic among urban CHW was nutrition while the most common for rural CHW were nutrition and cultural competencies. CHW across the state desire continuing education opportunities at least every six months to a year.

- A vast majority of all CHW would like to see statewide certification for CHW offered.

- Urban and rural CHW identified similar barriers to success, including inadequate financial support, inadequate support from their community, and stress/burnout. Urban CHW also identified language barriers as an additional barrier to success.

In light of these major findings, a number of recommendations are made to better train and support the CHW workforce, in order to promote community health and to address health disparities between urban and rural areas in Nebraska:

1) Increase the number of CHW in underserved rural communities. Focus specifically on the 16 rural counties in Nebraska with no hospitals, federally qualified health centers (FQHC), or community clinics.

2) Recruit and train CHW who reflect the racial and ethnic makeup of the communities they serve.

3) Increase the availability of translation and interpretation services for common LEP language groups.

4) Increase training in maternal and child health for CHW in rural and urban areas. Maternal priorities include improving access to prenatal care and reducing prematurity. Child health priorities include injury prevention and improving mental healthcare access.

5) Address differences between urban and rural areas in Nebraska by increasing rural CHW with expertise on obesity prevention and HIV/STDs, and urban CHW with expertise in chronic disease management, elder health, and behavioral/mental health.

6) Standardize training of CHW across Nebraska. Increase CHW knowledge and expertise in women's health, mental health, parenting education, reproductive health, nutrition, and cultural competencies.

7) Institute a statewide CHW Certification program.

8) Propose and support studies on sustaining financial support for CHW and the places they are employed to help address the 25% of CHWs who identified financial support and a livable wage as their most pressing personal challenge.

9) Include CHW in continuing education and programmatic efforts to address health disparities throughout the state of Nebraska.

ACKNOWLEDGEMENTS

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INTRODUCTION

In January 2020, the Nebraska Department of Health and Human Services (NE DHHS), in partnership with the University of Nebraska Medical Center, College of Public Health, Centers for Reducing Health Disparities (COPH CRHD), released a comprehensive assessment of the Community Health Workers (CHW) workforce throughout the state of Nebraska. This assessment included focus group discussions with CHW, in-depth interviews with organizations that employed CHW, and an online survey to collect data from CHW in Nebraska (Su et al., 2020). The assessment provided qualitative and quantitative information regarding CHW roles, both within their communities and the greater healthcare system, as well as data outlining CHW demographics, training, provided services, and opinions on the training and certification of CHW.

Out of the 93 counties in Nebraska, 50 counties are rural and over a third of the state population reside in rural areas. Shortage of healthcare resources and long driving distance from healthcare facilities constitute unique challenges for many rural Nebraskans. Understanding the urban-rural differences in CHW workforce development thus becomes important for consideration when initiating and sustaining targeted program efforts to address health disparities across different regions in Nebraska. This current report utilizes the previous report data and provides information on the differences in CHW workforce and perspectives between urban and rural communities in Nebraska.

BACKGROUND

Community Health Workers (CHW) provide multiple services including culturally appropriate education, health and social services referrals, assistance in navigating the healthcare system, coordination of care, advocacy, chronic illness/disease management, and translation/interpretation (RHIhub, 2019). CHW facilitate access to health services for underserved populations by assisting them to navigate complex healthcare and social service systems, which in turn reduces healthcare costs and improves overall health (Lopez 2015).

CHW provide a unique service by delivering geographically, linguistically, and culturally appropriate services to communities that are often hard to reach by the traditional healthcare system in most states. In Nebraska, CHW assist in identifying and addressing healthcare disparities in unique communities across the state. In Nebraska, approximately 85% of the state's land mass is identified as rural, with over 35% of the state population living in these geographically isolated regions (RHIhub, 2019). Rural counties reported the highest levels of poverty, oldest ages of citizens, highest rates of uninsured or underinsured, and a higher prevalence of chronic diseases. According to a previous NE DHHS report, there is also a considerable shortage of healthcare professionals and lower rates of routine healthcare visits and screenings (Nebraska Rural Health Advisory Committee, 2020).

Individuals living in rural areas experience higher rates of health disparities for a multitude of reasons, including exposure to occupational risks, substandard housing, lack of access or proximity to providers, clinics, and hospitals, lower socioeconomic status, and social/geographical isolation (Trout Chaidez and Palmer-Wackerly, 2020; Healthy People 2020; RHIhub, 2019). Living in a rural area has such a significant impact on health that *Healthy People 2020* included it as one of their 14 top health disparities (Healthy People 2020). A community health worker is defined as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served" (APHA, 2014). They typically live in the same community in which they work, are well-versed in the community, culture, and language(s), and, especially in rural areas, help people overcome structural barriers in accessing healthcare (Logan and Castaneda, 2020; Lopez, 2015; Trout, Chaidez, and Palmer-Wackerly, 2020). This is especially crucial for immigrant and marginalized populations where individuals experience significant health disparities due to persistent and transgenerational vulnerabilities, structural barriers, and lack of access to technology and transportation (Logan and Castaneda, 2020).

Nebraska is currently experiencing a surge in minority population increase, with three rural counties with minority populations accounting for over 50% of the population within the county – Thurston, Colfax, and Dakota Counties (Nebraska Rural Health Advisory Committee, 2020). Between 2000 and 2010, 80% of Nebraska's counties experienced an increase in minority populations while simultaneously seeing a sharp decline in the non-Hispanic White population. In fact, eleven rural Nebraskan counties experienced a 100% net minority population growth over this time (Hall, Dakota, Platte, Dodge, Saline, Colfax, Scotts Bluff, Adams, Otoe, Dawes, and Cheyenne) (Drozd, 2017).

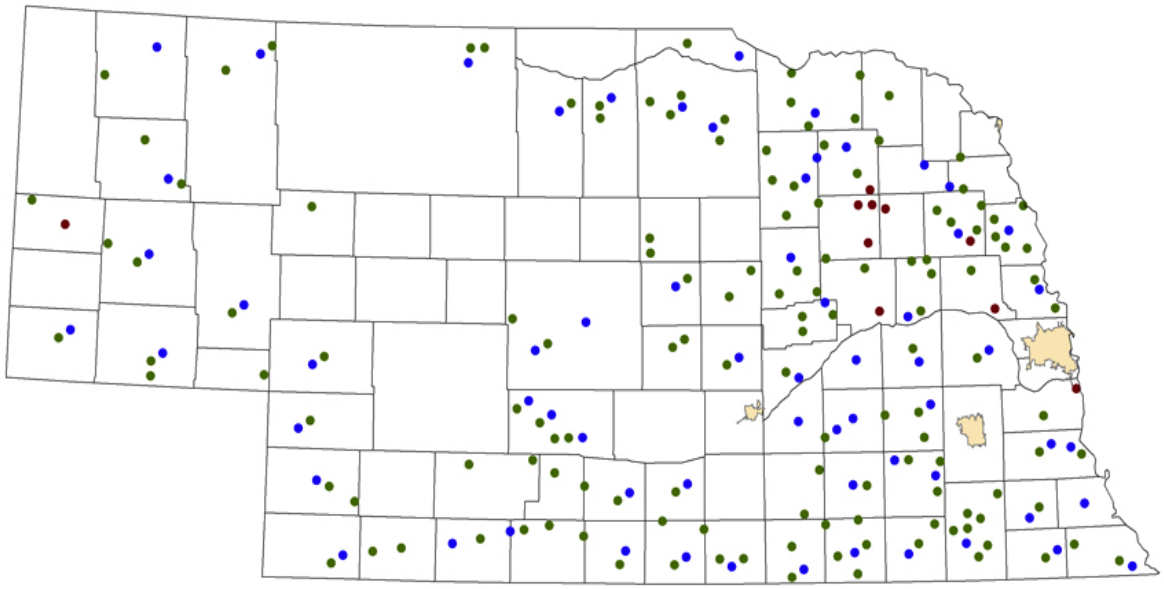
The Limited English Proficient (LEP) population in Nebraska has grown substantially since 2008, with 11.22% of Nebraskans speaking a language other than English (Anthone et al., 2021). The top 10 non-English languages spoken in Nebraska are Spanish, Vietnamese, Arabic, Chinese, German, French, Amharic/Somali/Afro-Asiatic, Nepali/Marathi/Indic, Swahili/other African, and Hindi (Anthone et al., 2021).

These demographic trends in Nebraska point to the need of developing and diversifying a CHW workforce equipped to effectively engage and serve Nebraska's increasingly diverse state population. Addressing persistent unmet health needs in underserved communities, many of which have concentrations of minority, low-income residents, requires professional services from well-trained CHW working as part of interdisciplinary teams with the expertise for promoting community health through culturally and linguistically responsive programs.

A recent study conducted by the University of Nebraska at Omaha Center for Public Affairs Research indicated that of 93 counties, five are considered 'core metropolitan' (having or tied to a city of over 50,000 residents), seven are outlying metropolitan (commuter towns to a large metro), 9 are micropolitan core (containing a non-metropolitan city between 10,000 – 49,999 residents). Also, 22 are rural with an urban cluster (non-metropolitan with a city of 2,500 – 9,999 residents), and 50 are 100% rural (largest city/town has less than 2,499 residents) (Schafer 2018). Almost 35% of Nebraskans are estimated to live in rural areas, and as of 2019, the estimated poverty rate in rural areas was 10.9%, with an estimated 7.9% of the population uninsured (RHIHub, 2021; USDA Economic Research Service, 2021; Kaiser 2019a, Kaiser 2019b). Across the entire state, lack of healthcare coverage is trending downwards among all racial and ethnic groups except White/Non-Hispanic (Kaiser Family Foundation).

The figure below from the Rural Health Information Hub (RHIhub) provides a snapshot of healthcare facilities across rural Nebraska. A total of 16 Nebraska counties do not have any healthcare facilities indicating a high need for supplementary healthcare supported by CHWs.

Selected Rural Healthcare Facilities in Nebraska



RHIhub Rural Health Information Hub

Source(s): data.HRSA.gov, U.S. Department of Health and Human Services, January 2021

APPROACH AND METHODS

The approach and methods in this report are the same as those outlined in the *Strengthening the Community Health Worker Workforce to Improve Maternal and Child Health in Nebraska: A Statewide Assessment of Needs, Barriers, and Assets (*Su et al., 2020*),* in which a 3-phase Exploratory Sequential Mixed Methods Analysis was utilized (Berman, 2017). This consisted of an initial phase of qualitative data collection, a quantitative data collection phase, and a final phase of data integration. Qualitative data collection consisted of a series of focus group discussions with Community Health Workers across Nebraska and interviews with eight stakeholders who work with or employed CHW. The quantitative data was collected via a statewide survey looking at demographics, training, provided services, and opinions on training and certification. Participants in the qualitative data gathering were 19 years of age and older and could communicate in English. Survey eligibility parameters include 19 years of age and older, self-identified as a Community Healthcare Worker, and worked in Nebraska.

Community Health Workers Focus Groups

Nine Focus Group Discussions (FGDs) were designed and implemented throughout the state of Nebraska in five pre-determined public health districts including Public Health Solutions in Crete, South Heartland Public Health Department in Hastings, Two Rivers Public Health Department in Holdrege/Kearney, Elkhorn Logan Valley Public Health Department, and Douglas County Health Department in Omaha. FGDs were divided into two rounds of three hours at each location. The first round of FGD in April-May 2019 was framed around the role of CHW in community; the second round in July 2019 around the role of CHW in clinical services.

A trained facilitator led discussions in all these sessions following a predeveloped facilitator guide to ensure consistency across FGDs. Eligible participants were all over the age of 19 years, self-identified as a CHW, and worked in Nebraska. A more detailed explanation of FGDs can be found in the original report, *Strengthening the Community Health Worker Workforce to Improve Maternal and Child Health in Nebraska: A Statewide Assessment of Needs, Barriers, and Assets (*Su et al., 2020*).* For the FGD questions, please see Appendix A and B. Educational materials and networking opportunities were incorporated into the gatherings. Individuals were compensated with a $60 gift card for their participation in each focus group, if not otherwise compensated for participation by an employer.

Community Health Workers Statewide Survey

Based on qualitative feedback from CHW who participated in the focus group discussions and a review of related literature, the research team drafted a survey questionnaire and updated the questionnaire with input from the Nebraska Community Health Worker Committee. The questionnaire was further 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 REDCap, we developed a paper version of the survey 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 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 identify organizations and individuals throughout Nebraska working with or familiar with CHW. Eighty-seven community organizations, eight health systems, and all 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 CHW. 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 interviews was to collect first-hand data from individuals in agencies that have hired, worked with, or intend to work with community health workers. This was to inform perspectives on how employers view the community health worker workforce, including effectiveness and economic considerations.

A suggested list of key informants was developed in August 2019 to include 20 individuals across Nebraska. The initial plan was to interview 10 key informants from the Omaha and Lincoln area, and 10 from other areas across the state to represent 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 semi-structured interviews were conducted and recorded through Zoom and lasted approximately 40 minutes. Key informants were compensated with a $50 gift card for participation. See Appendix D for interview questions.

ETHICAL CONSIDERATIONS

Full ethical considerations for this study can be found in *Strengthening the Community Health Worker Workforce to Improve Maternal and Child Health in Nebraska (*Su et al., 2020). The study was approved by the Institutional Review Board at the University of Nebraska Medical Center (IRB #900-18-EX). Data collection from eligible participants only started after we had obtained informed consent. Participants could choose to withdraw from the study or refuse to answer specific questions based on their judgments at any time during the survey, focus groups, or interview.

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

ANALYSIS AND RESULTS

Univariate analyses were conducted to identify characteristics of participating urban and rural CHW, looking specifically at training, focus areas, maternal and child health offerings, and feelings regarding future training and statewide certification. The previous CHW Workforce Assessment identified five levels of rural to urban. For this report, the categories were condensed to urban and rural, with urban representing individuals in Omaha and Lincoln metro areas (including those who live in Council Bluffs, IA but work in a Nebraska community) and rural representing the remainder of the respondents (Su et al. 2020).

As described in the previous report, 121 total surveys were completed; ninety-seven were completed online and 24 were done on paper. The survey was in English. According to the Bureau of Labor Statistics (BLS, 2020), an estimated 380 formal CHW are employed within Nebraska. In addition, individuals without a formal CHW title position may account for another 200 to 300 CHW within the state. With this estimated population of CHW in Nebraska, the surveys reached approximately 20% to 32% of Nebraskan CHWs.

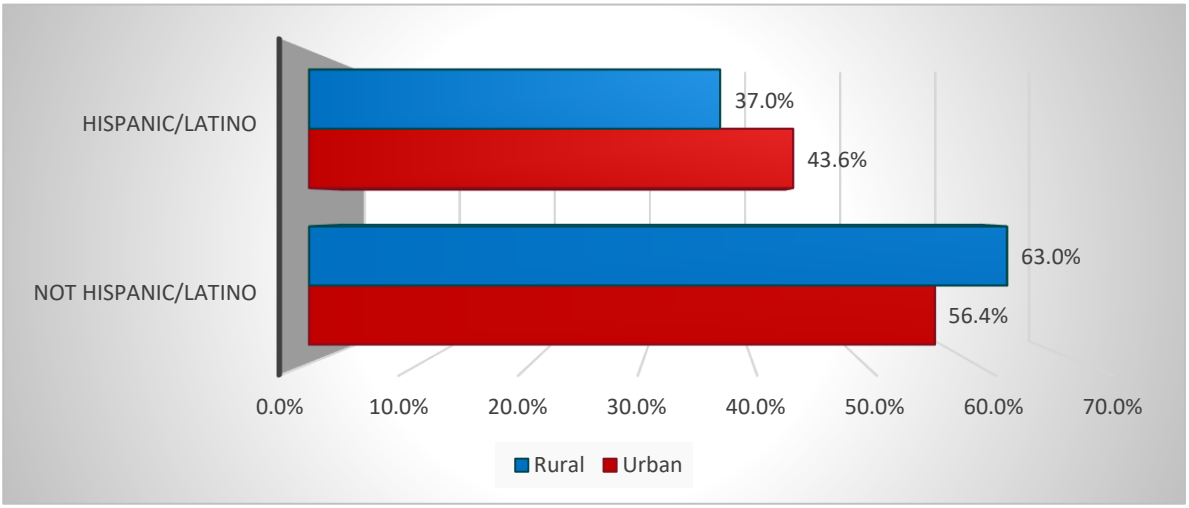
Participant Characteristics

Approximately 78% of the CHW participants in the survey work in urban locations, as seen in Table 1. Most of the urban respondents are women (91.5%), in the age groups 25-39 (45.7%) and 40-59 (43.6%), married (56.4%), and college graduate (37.2%). Rural respondents share similar overall characteristics except for age: rural CHW trended older, with most between 40 and 59 (55.6%).

Minor differences in education levels exist, with urban CHW having higher rates of Masters or professional degrees education (21.2% urban v. 14.8% rural). However, a major difference to be noted is regarding employment status. Over 25% of urban CHW participating reported working on volunteer status, while no rural CHW reported working as volunteers. In contrast, a higher proportion of full-time CHW work in rural areas as compared to urban (77.8% v. 60.6%).

Table 1. Demographic Breakdown, Urban v. Rural Locations (n=121)					
	Urban		Rural		Total
	n	%	n	%	n
Location	94	77.7%	26	22.3%	120
Age					
19-24	4	4.3%	0	0.0%	4
25-39	43	45.7%	7	25.9%	50
40-59	41	43.6%	15	55.6%	56
60+	5	5.3%	5	18.5%	10
Prefer not to Answer	1	1.1%	0	0.0%	1
Gender					
Male	7	7.4%	3	11.1%	10
Female	85	91.5%	25	88.9%	110
Ethnicity					
Hispanic/Latino	42	45.2%	8	29.6%	50
Not Hispanic/Latino	50	53.8%	19	66.7%	68
Prefer not to Answer	1	1.1%	1	3.7%	2
Race					
White/Caucasian	50	53.2%	22	81.5%	72
Not White/Caucasian	37	39.4%	3	11.1%	40
Prefer not to Answer	7	7.4%	2	7.4%	9
Marital Status					
Never Married/Single	26	27.7%	2	7.4%	28
Married	52	56.4%	19	70.4%	71
Other (Divorced, Separated, Widow(ed), Prefer Not to Answer)	15	16.0%	6	22.2%	21
Education					
Never Attended School	1	1.1%	0	0.0%	1
Grade 1-8	3	3.2%	0	0.0%	3
Grade 9-12	13	13.8%	1	3.7%	14
HS Graduate	8	8.5%	5	18.5%	13
1-3 Years of College or Technical School	12	12.8%	7	25.9%	19
4+ Years of College	34	37.2%	10	37.0%	34
Master's Degree	18	19.1%	4	14.8%	22
Professional Degree (PhD, MD, JD)	2	2.1%	0	0.0%	2
Prefer not to Answer	2	2.1%	0	0.0%	2
Employment					
Full-Time	56	60.6%	21	77.8%	78
Part-Time	11	11.7%	4	14.8%	15
Retired/Unemployed	1	1.1	1	3.7	2
Volunteer	25	26.6	1	3.7	26
Statewide Certification					
Yes	77	81.9%	21	77.8%	98
No	17	18.1%	6	22.2%	23

Figure 1: Predominant Ethnicity of Community Served



In both rural and urban locations, the predominant ethnicity is Not Hispanic/Latino (Figure 1). CHW ethnicity in our study is similar, with the majority of CHW identifying their ethnicity as Not Hispanic/Latino (Figure 2). In Nebraska, the Hispanic/Latino community makes up 11.4% of the Nebraska population (US Census, 2019). The percentage of Hispanic/Latino CHW in both rural and urban settings in our study exceed that of the general population.

Figure 2: Predominant Ethnicity of Survey Participants

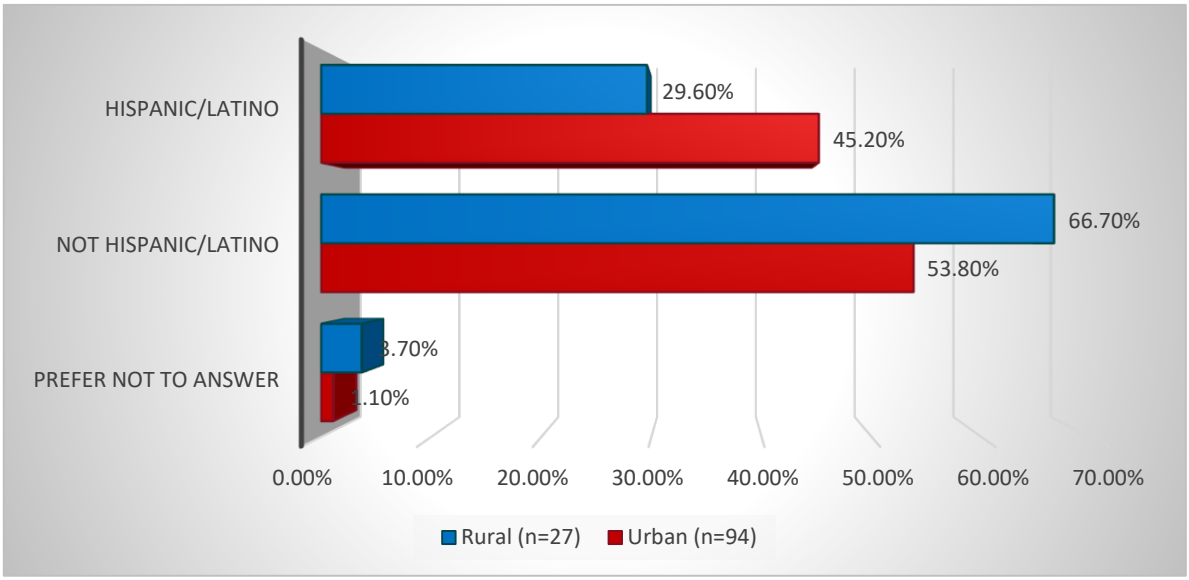
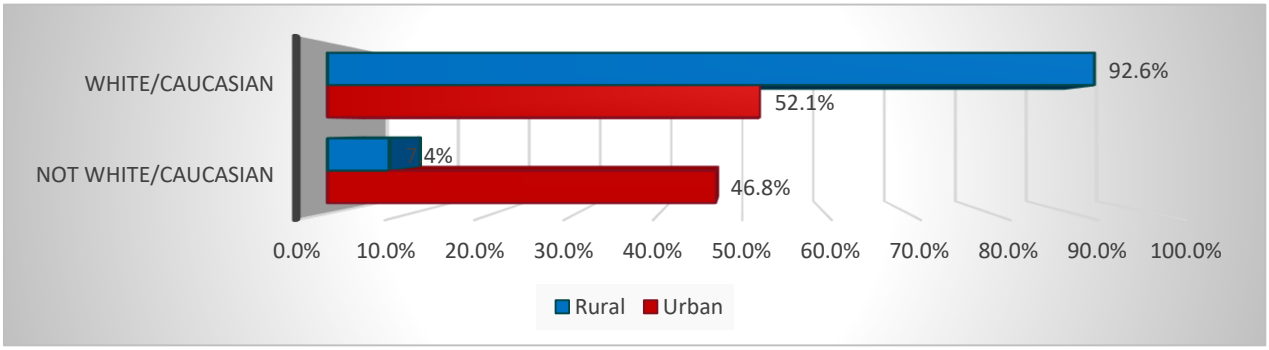


Figure 3: Racial Breakdown of Communities Served



Nebraska communities are mostly White/Caucasian in both urban and rural areas (Figure 3). In rural communities there is a greater gap between the White/Caucasion majority and the non-White minority. Among CHW in our study, a similar distribution appeared (Figure 4).

Figure 4: Racial Breakdown of Survey Participants

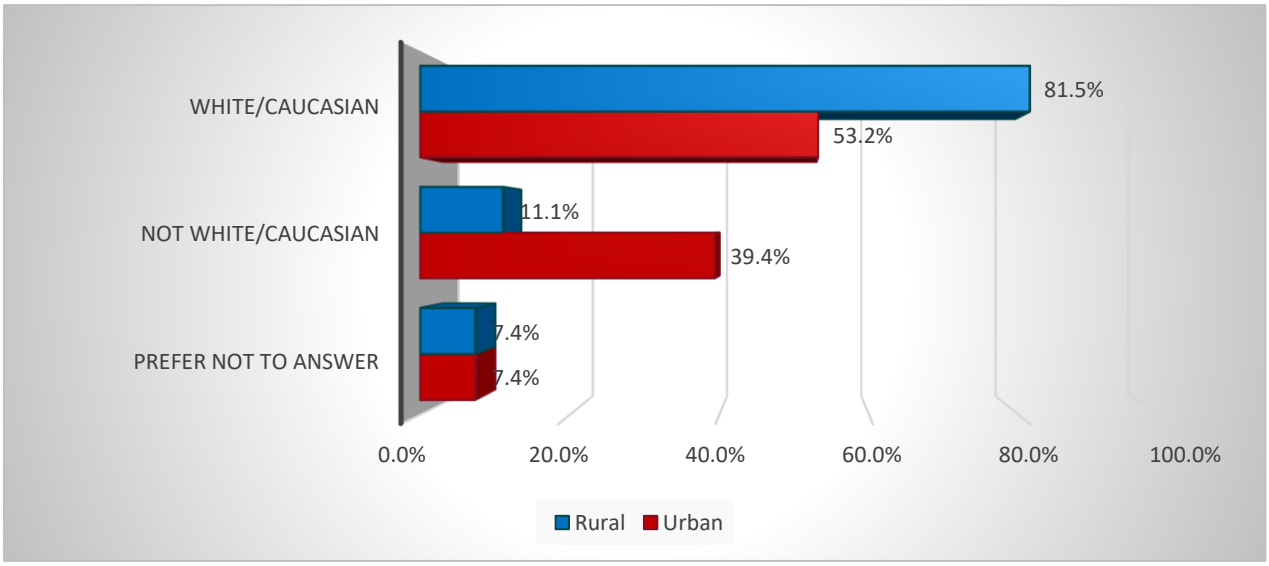
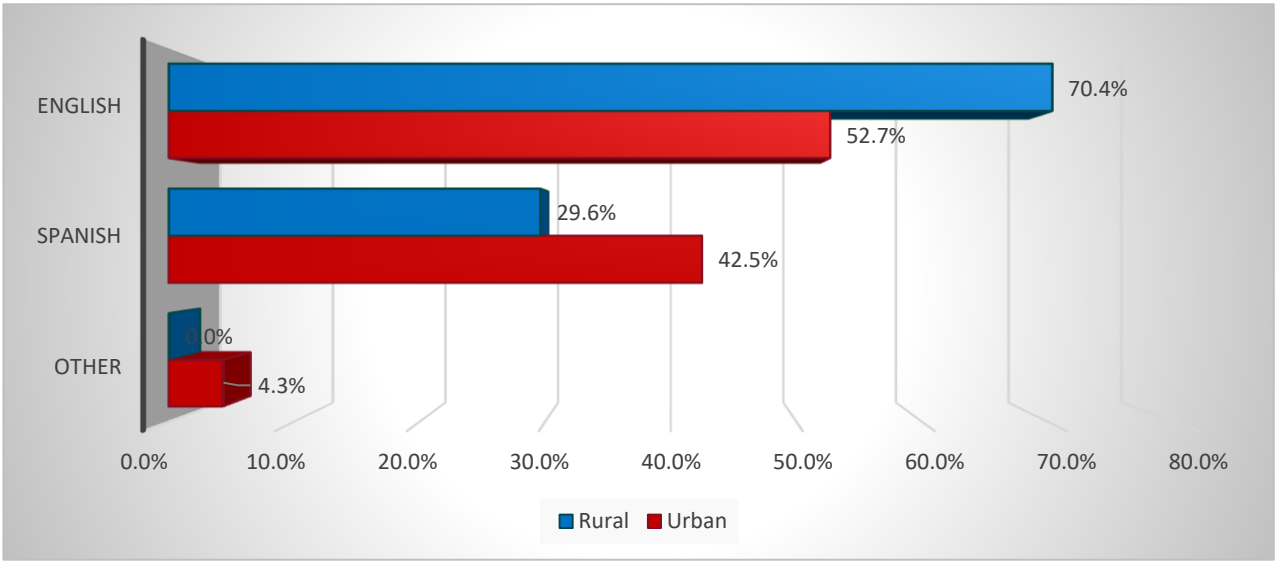


Figure 5: Primary Language Spoken at Home

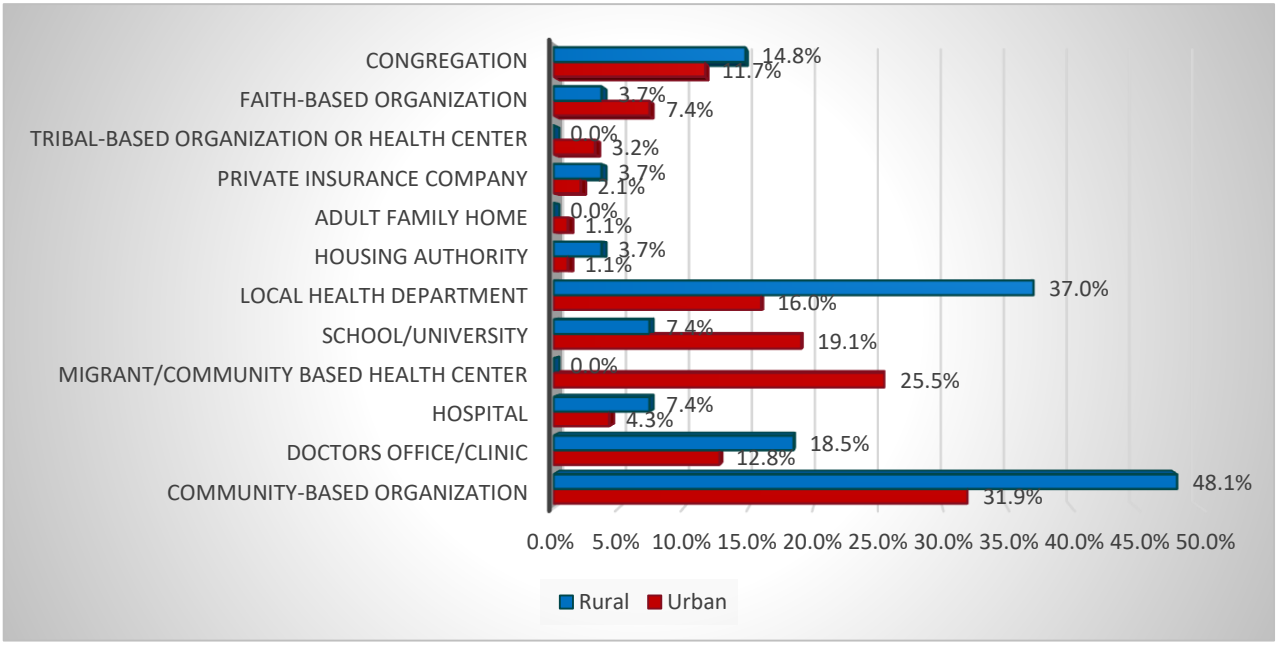


In both urban and rural areas, the primary language spoken at home by survey participants was English (Figure 5). Spanish was the second most common, with other listed languages including Arabic, Burmese, and Q'anjob'al, a Mayan language spoken in Guatemala and parts of Mexico (University of Illinois, 2020).

Community Health Worker Employment Information

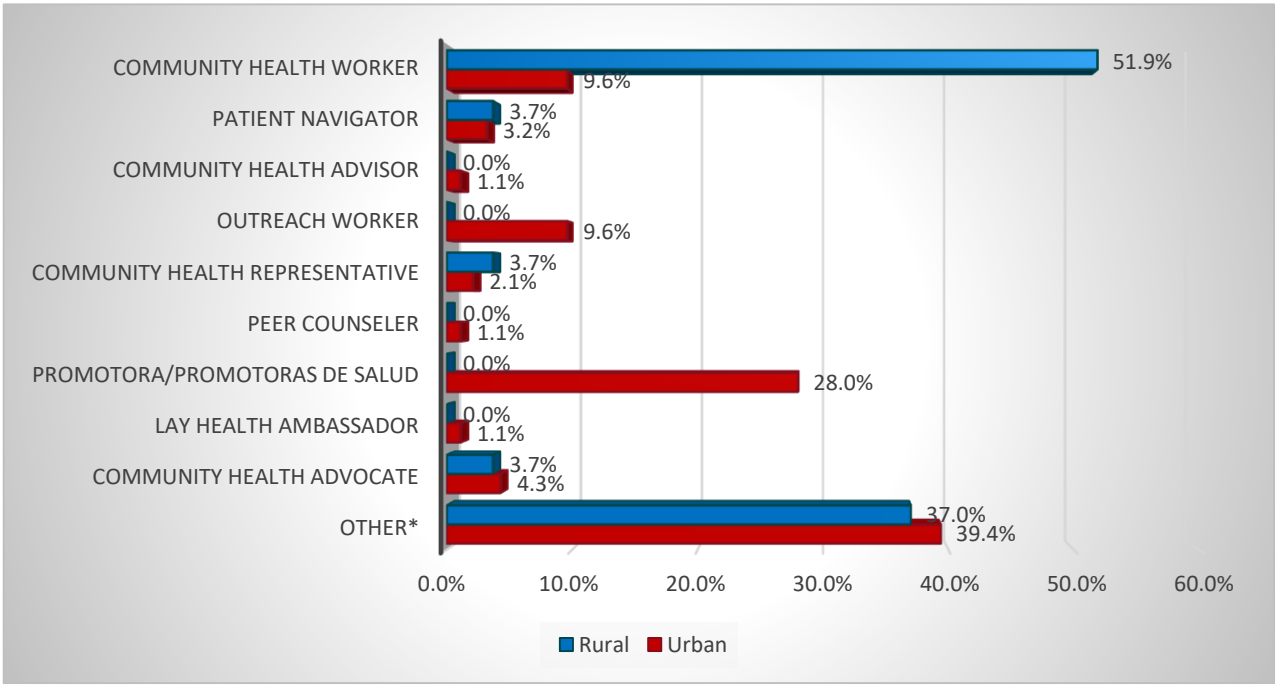
CHW are employed in various locations with numerous job titles, employment descriptions, and tasks and responsibilities. For example, most urban survey CHW participants worked for a community-based organization or a migrant/community-based health center, while most rural CHW were employed with community-based organizations or local health departments (Figure 6).

Figure 6: Employment Organization or Practice Setting



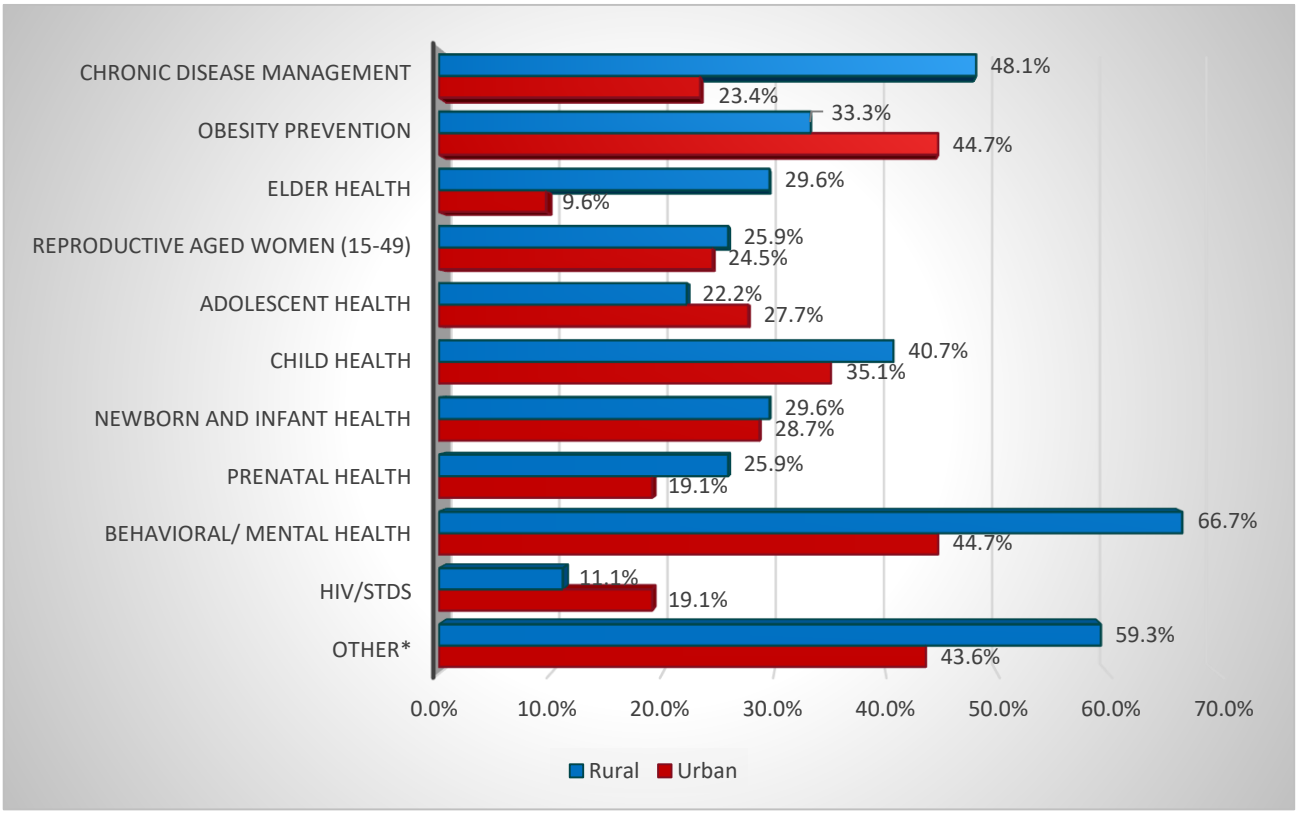
Job titles were as diverse as the CHW population (Figure 7). The majority (51.9%) of rural participants identified Community Health Worker as their job title; however, 37% of rural and 39.4% of urban (a majority) identified 'other' and provided nearly 30 alternative job titles.

Figure 7: Job Title as Community Health Worker



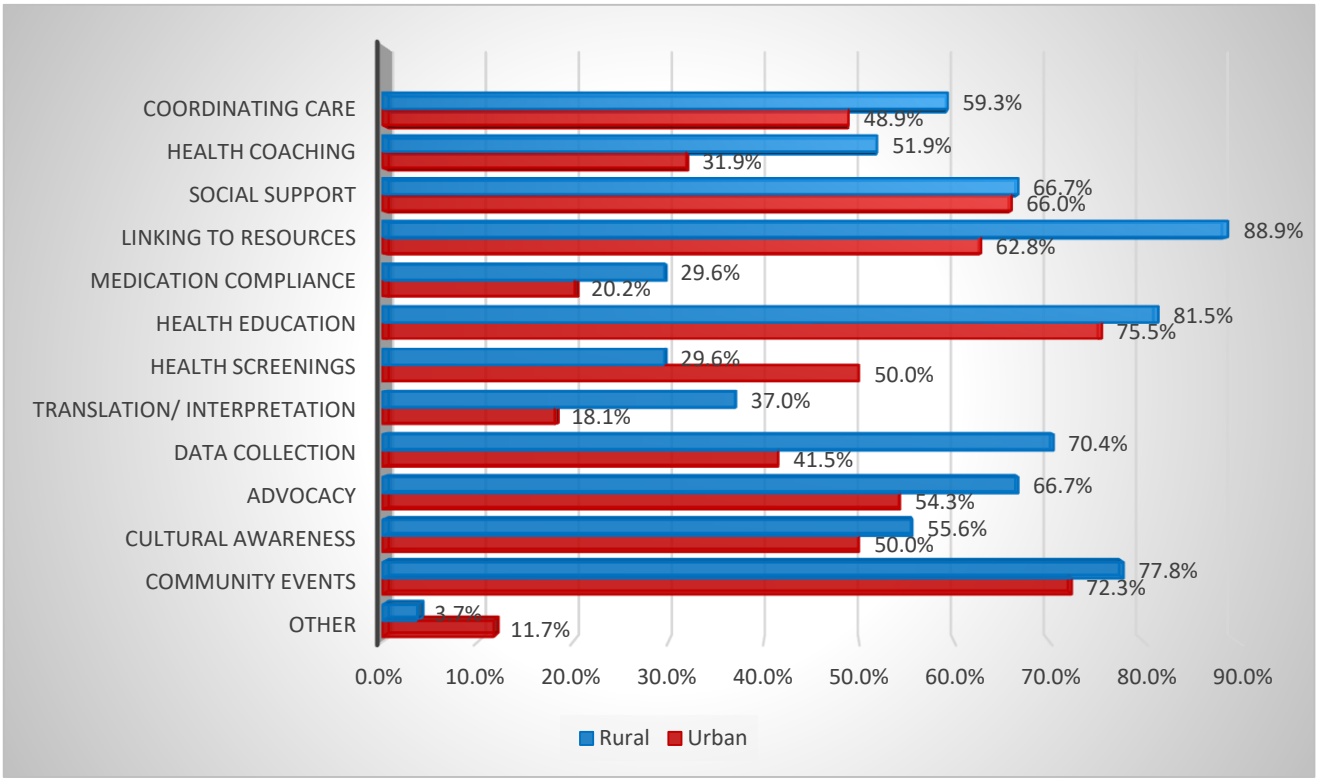
*Breastfeeding Educator, Case Manager, Community Health Manager, Community Outreach Specialist, Community Support Worker, Director, Family Consultant, Health and Wellness Coordinator, Health Technician, In-Home Family Consultant, Mental Health Facilitator, MHI Coordinator, Office Manager, Order Picker, Outreach Manager, Parent Resource Coordinator/Navigator, Prevention & Support Services Supervisor, Prevention & Outreach Specialist, Public Health Nurse, Residential Rehabilitation Specialist, School Health Office, Sexual Health Educator, Social Work Supervisor, Special Populations Manager, Substance Abuse Prevention Coordinator, Translator, Wellness & Health Advocate

Figure 8: Focus Health Issues Reported by CHW



Survey respondents identified many health issues they focus on in their day-to-day work (Figure 8). Behavioral/mental health and child health were two areas that both rural and urban CHW identified as a primary areas of focus. Obesity prevention and chronic disease management also were focus health issues for urban and rural CHW. Urban versus rural differences exist. Looking at chronic disease management, 48.1% of rural CHW focus on chronic disease management compared to 23.4% of urban CHW. Differences can be seen in elder care (29.6% rural and 9.6% urban), behavioral/mental health (66.7% rural and 44.7% urban) and obesity prevention (44.7% rural and 33.3% urban). Less than 20% of CHW in both urban and rural locations focus on HIV/STDs. Urban locations have higher percentages of CHW focused on issues of obesity prevention, adolescent health, and HIV/STD. CHW in rural locations focus on chronic disease management, elder health, reproduction, child health, newborn and infant health, prenatal health, behavioral and mental health, and other. There are only three areas (Obesity Prevention, Adolescent Health, and HIV/STD) urban CHW focus on to a greater extent; all other focus areas receive greater attention from CHW in rural locations.

Figure 9: Key Tasks Performed by CHW



In the survey, CHW reported performing varying tasks as shown in Figure 9. Health Education was the most common task performed by CHW in urban locations, while Linking to Resources was the most performed task identified by rural CHW. A common task for both groups was participating in Community Events, while Social Support (urban) and Health Education (rural) rounded out the top three most commonly performed tasks for both groups of CHW.

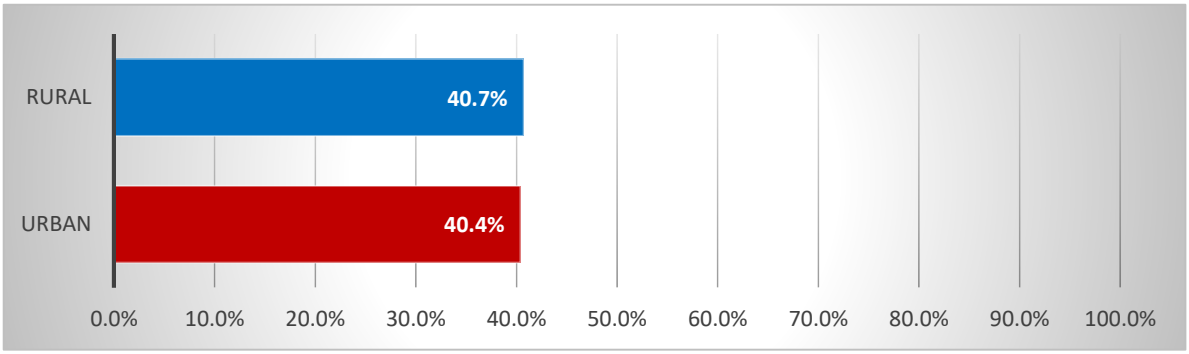
FGD participants had similar reports of focus areas of their work, primarily described as focusing on institutional barriers to receiving healthcare services. For example, both urban and rural participants reported health insurance access, interpretation services, transportation, mental health access, prenatal care, and availability of dental services as the top areas that CHW focused on in their work. In urban areas, CHW also focused on food insecurity, health literacy issues, and health education, while rural CHW focused on finding services provided at convenient times and addressing concerns of documentation status in the local communities.

All CHW agreed that lack of knowledge of the healthcare system, provider shortages, mental health issues, chronic diseases (especially cancer, obesity, and diabetes), and domestic violence are key issues affecting local communities.

Maternal and Child Healthcare

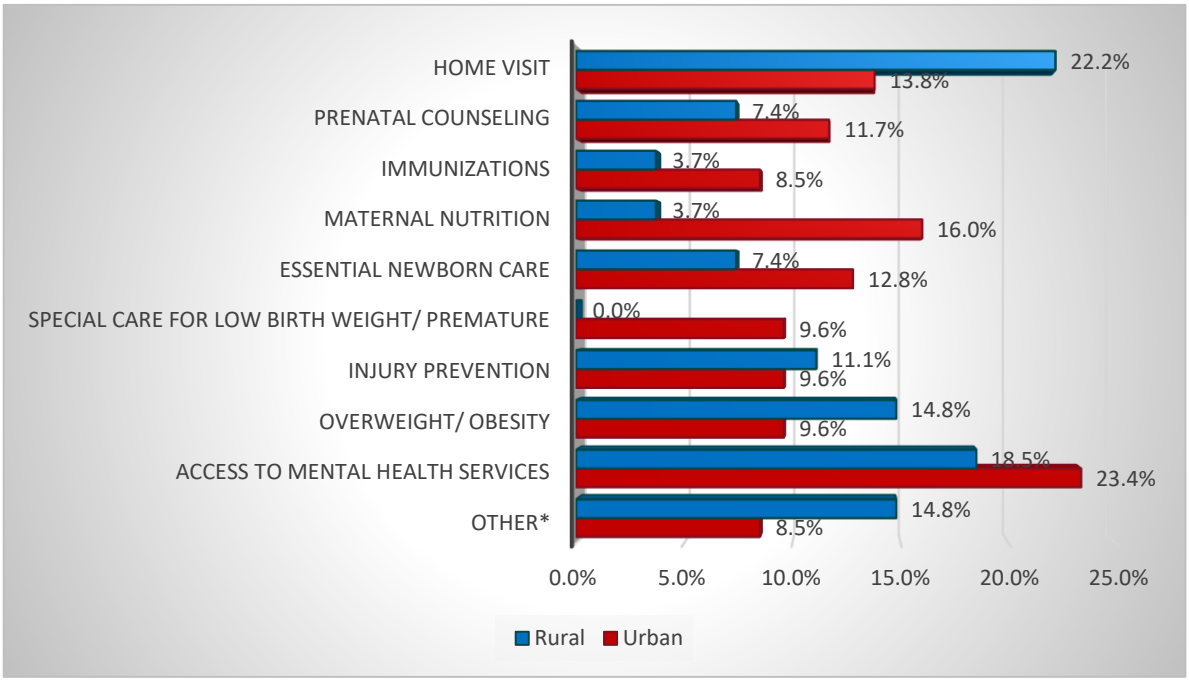
Looking specifically at maternal and child health (MCH) issues, we found a similarity between CHW in urban and rural locations, offering MCH related services. Over 40% of urban and rural CHW are involved in provision of MCH services (Figure 10).

Figure 10: Percentage of CHW offering Maternal and Child Health



Of those CHW who provide MCH services, the types of services vary widely. In urban areas, the top three provided services are Access to Mental Health Services, Maternal Nutrition, and Prenatal Counseling. In rural areas, CHW provide Home Visits, Access to Mental Health Services, and Overweight/Obesity Counseling (Figure 11).

Figure 11: Maternal and Child Healthcare Services Offered



Among focus group discussion participants, the majority of CHW stated they performed some MCH services in their daily work. Those who provided such services stated that Mental Health Services (especially depression, anxiety, and postpartum depression), lack of health insurance, contraceptive education, and healthcare costs were major aspects of their MCH work. Urban CHW identified major issues as adolescent mental health and sobriety in pregnancy, while rural CHWs faced issues such as overcrowding in the home, maternal isolation, childcare issues, childhood neglect, suicide, and unhealthy relationships and domestic abuse. Overall, there was a lack of formal services and resources provided in rural areas to assist with these issues, leading to CHW bearing the burden of addressing most of these issues.

Comments from CHW regarding maternal and child health issues:

"…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."

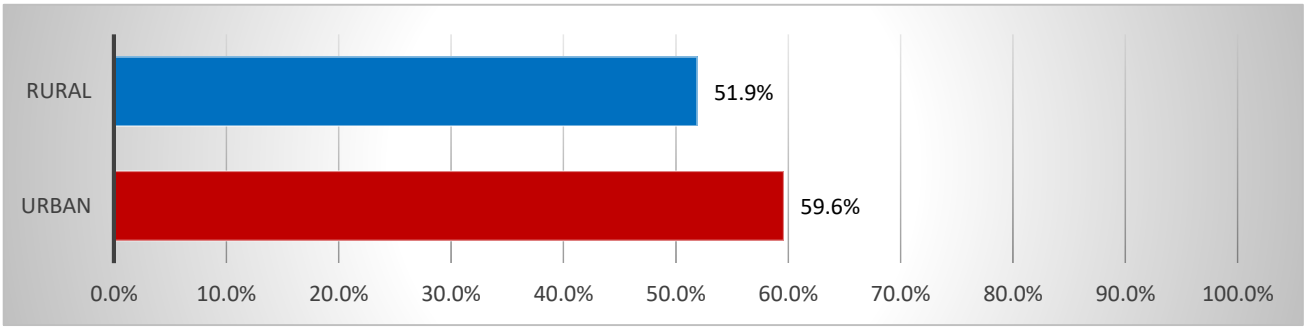
"I have noticed these moms that can't find work, can't find babysitters and are being isolated… I am seeing a decline in their mental health."

"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…"

Community Health Worker Training and Certification

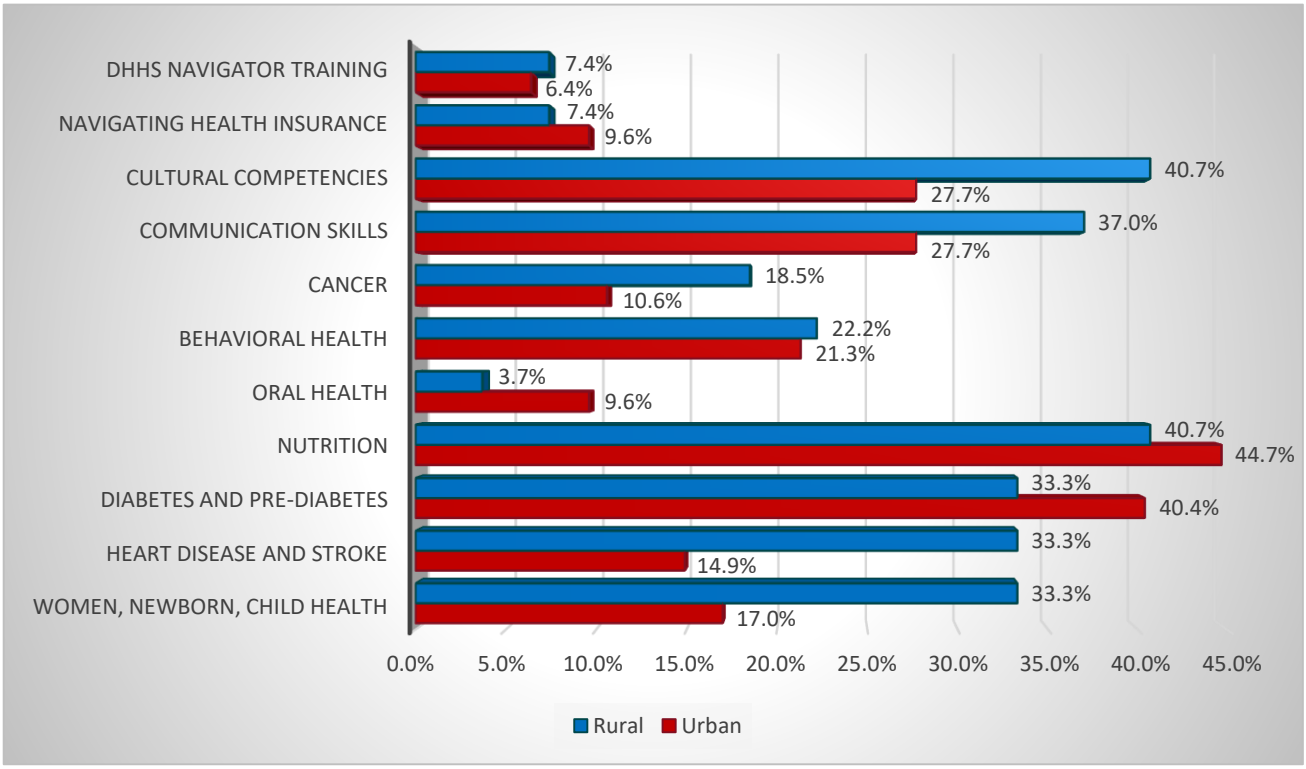
In both rural and urban communities, over 50% of all CHW received training prior to starting their current position (Figure 12).

Figure 12: Percentage of CHW who received training prior becoming a CHW



Topics covered during training differ based on CHW location. More rural workers received training in cultural competencies, communication skills, and nutrition, while more urban workers received training in nutrition and diabetes/pre-diabetes (Figure 13). More than twice as many rural compared to urban CHW received training in heart disease/stroke and women, newborn, and child health.

Figure 13: Topics Covered During CHW Training



Focus group discussion (FDG) participants indicated that sources of training included the following:

- Formal work training
- Work orientation
- CNA
- On-the-job training
- DHHS CHW training
- Medical assistant
- Training modules
- Previous life experience
- On-boarding from other employees

FDG participants also identified the following as major gaps in their training, indicating a need for an increased focus on these specific topics:

- Cultural competency
- Discussion of difficult topics
- Consistent core competencies
- Medical Assistant programs

FDG participants from rural areas indicated that they received the majority of their training on the job:

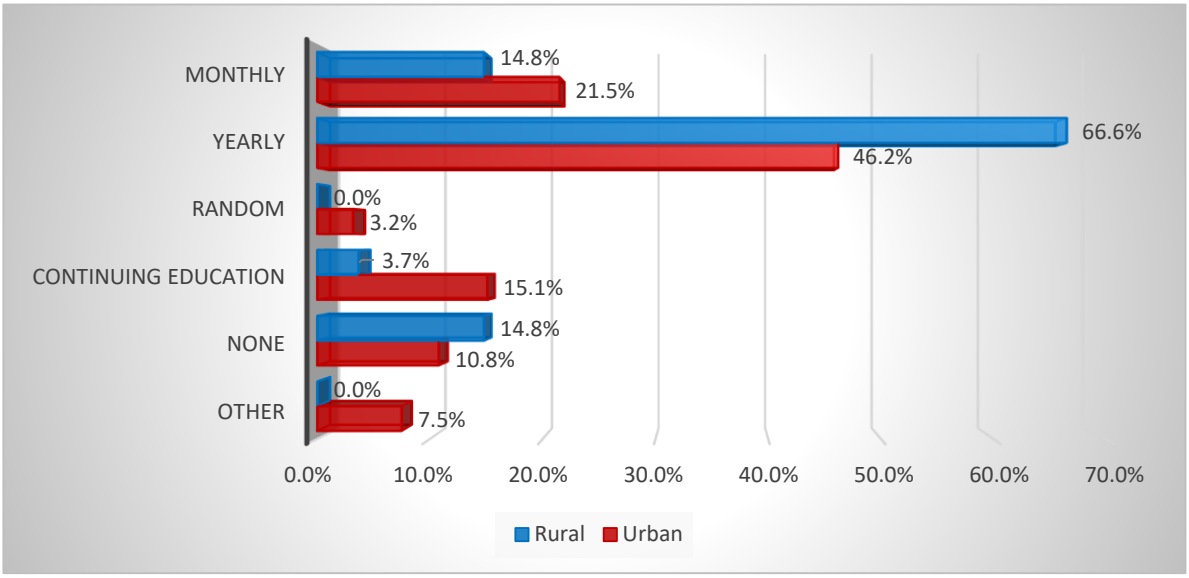
"They kind of gave us a broad overview of what we might be doing. But definitely learning on the job what you are doing is most basic."

Key informant interviews with individuals representing agencies or organizations that employ or work with Community Health Workers also discussed the important of training opportunities and understanding core competencies for CHWs:

"… it's 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."

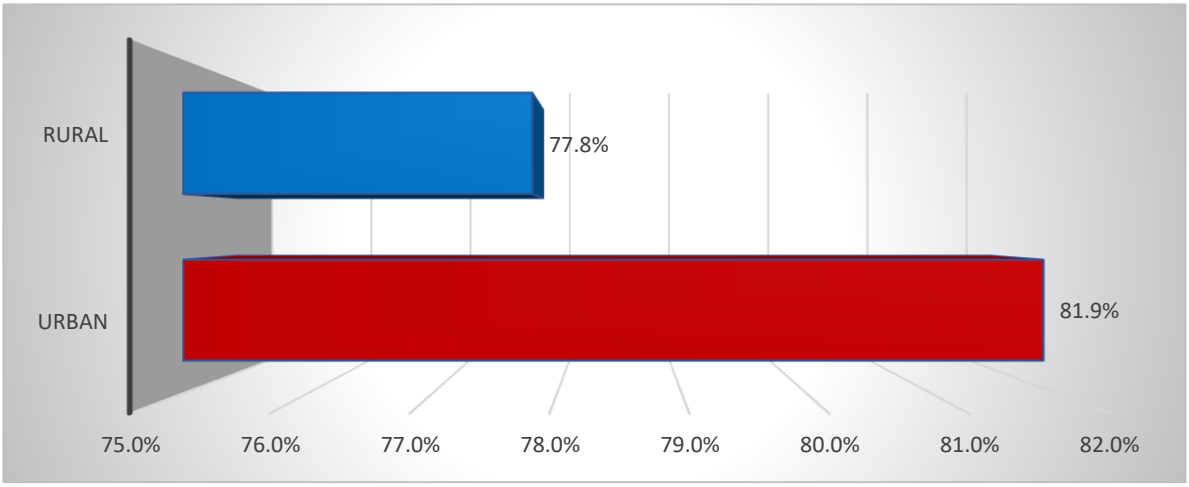
CHW in urban and rural settings were similar in desired training intervals. A majority of both indicated continuing education at least every six or twelve months as the most desirable interval (Figure 14).

Figure 14: Community Health Worker Desired Training Intervals



A majority of both urban and rural Community Health Workers are in favor of a statewide CHW certification, indicating that adoption and implementation of statewide standards would be accepted across the field (Figure 15).

Figure 15: Community Health Workers in Favor of Statewide Certification



Challenges Facing Community Health Workers

Work conducted by Community Health Workers is not without its challenges. Focus group discussion (FDG) participants identified several areas that they dislike about their work:

- Systematic barriers
- Lack of community buy-in
- Long wait times for services
- Large number of responsibilities
- Stress
- Low wages
- Inability to help
- Feeling helpless
- Lack of time
- Gender disparities
- Amount of paperwork
- Understaffed

FDG participants also identified multiple barriers to effective work:

- Language barriers
- Lack of community buy-in
- Inability to help
- Lack of resource knowledge
- Lack of client-facing time
- Lack of referral resources
- Lack of training
- Off-hour work
- Performing tasks outside of their job description
- Inadequate financial resources and funding allocations

"…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 then 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."

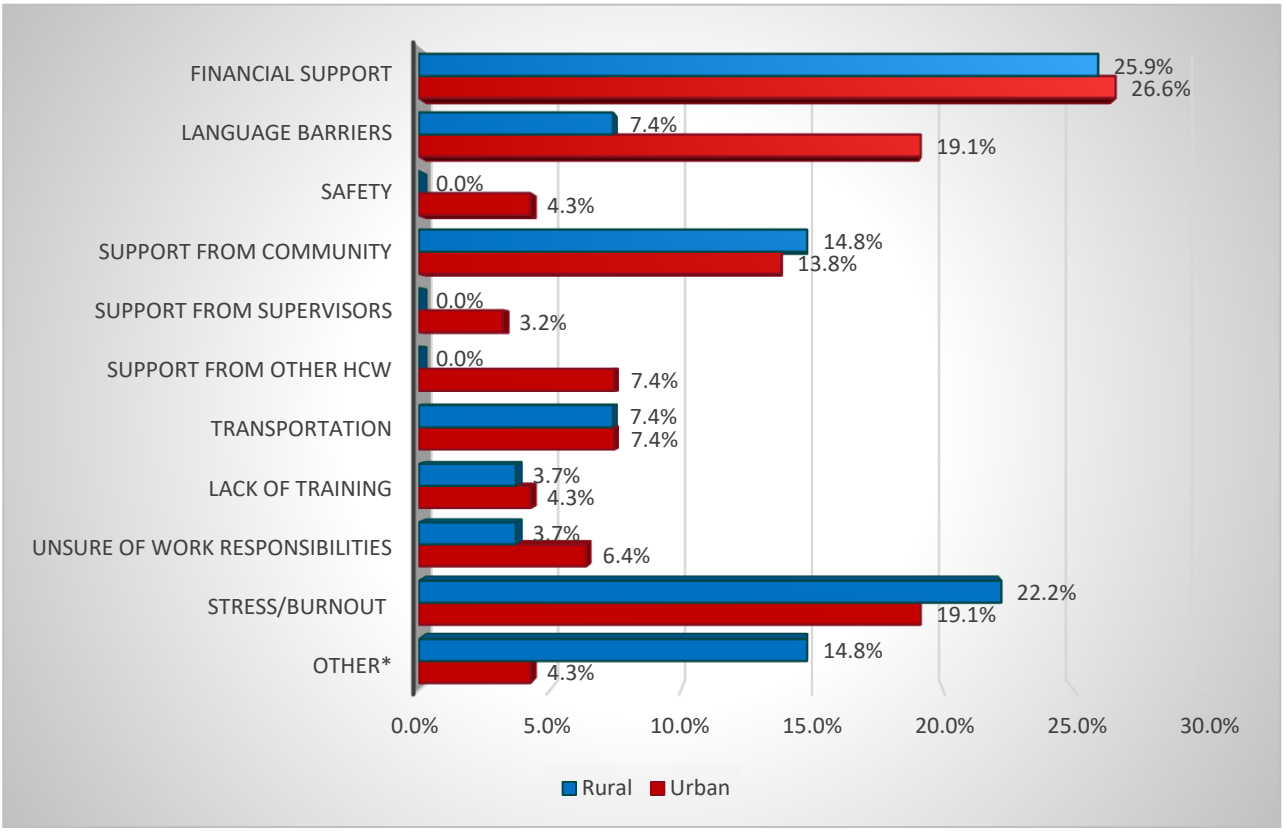
Key informant interviews also touched on challenges for the CHW workforce, specifically regarding the need for education of the community and medical providers of what a Community Health Worker's job entails:

"Gosh, I don't even know. I mean, at the beginning, that when we first started in this position it was almost like a, a stigma with the doctors."

"…to feel that we are respected in our clinics, in our settings, that there is the value of what we bring is recognized and that we are a contributing part of that team."

Challenges and barriers identified by FDG participants were substantiated by findings from survey participants (Figure 16). Rural and urban survey participants identified relatively similar challenges. The greatest differences between urban and rural CHW were in Language Barriers (19.1% urban v. 7.4% rural) and Other (14.8% rural v. 4.3% urban). Participants were given the opportunity to provide free-form responses in the Other category, which included working with Licensed Clinical Social Workers (LCSW) and establishing roles, tribal member involvement, more time from work, lack of support from the medical community, lack of potential, lack of time for volunteering, finding participants, and lack of mental healthcare for uninsured.

Figure 16: Barriers to CHW Success



Other*: Working with LCSW and establishing roles, tribal member involvement, more time from work, lack of support from medical community, lack of potential, lack of time for volunteering, finding participants, lack of mental healthcare for uninsured.

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 and their employers. 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. However, it should be noted that various limitations do exist, as explained below.

Focus Group Discussions (FGD)

The focus group data described here represent only the perspectives of the individuals interviewed 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 areas of Nebraska.

Community Health Worker Statewide Survey

Though the survey sample consisted of 123 individuals across Nebraska, the information provided by these 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 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 individuals interviewed and do not necessarily represent the official stance of their agencies. Moreover, key informants were not themselves CHW. Given the large number of agencies employing community health workers in Nebraska, our findings based on interviews with eight key informants may not capture all perspectives from various stakeholder agencies. Therefore, caution should be used in generalizing findings from this study to the whole state.

Despite these limitations, the rich information collected in this study provides a unique assessment of the current status quo of CHW in Nebraska. 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 CHW.

RECOMMENDATIONS

Communities throughout Nebraska are developing local plans for addressing local health issues. For example, all local health departments either have or are in the process of developing five-year community health improvement plans (CHIPs). In addition, the Patient Protection and Affordable Care Act authorized all nonprofit hospitals to develop a community health needs assessment (CHNA) and an implementation plan. It is our position that CHW can greatly facilitate the formation and implementation of CHIPs by making sure that community voices and perspectives are well represented and heeded. In light of the documented differences in the CHW workforce between urban and rural areas in Nebraska, we propose the following recommendations:

1) Increase the number of CHW in underserved rural communities in Nebraska, focusing specifically on the 16 rural counties that have no hospitals, Federally Qualified Health Centers (FQHC), or community clinics.

2) Promote recruitment and training of CHW that reflect the racial and ethnic makeup of the communities they serve.

3) Increase the availability of translation and interpretation services for common LEP language groups.

4) Increase training in maternal and child health for CHW in both rural and urban areas, focusing especially on priorities of improving access to prenatal care and preventing premature births and infant mortality, access to mental health services for children, and injury prevention.

5) Reduce health disparities between urban and rural areas in Nebraska by increasing rural CHW with expertise on obesity prevention and HIV/STDs, and urban CHW with expertise on chronic disease management, elder health, and behavioral/mental health.

6) Standardize training of CHW across the entire state with a focus on increasing CHW knowledge and expertise in mental health, maternal health, nutrition, and cultural and linguistic competencies.

7) Institute a statewide CHW certification program.

8) Propose and support studies on sustaining financial support for CHW and the places they are employed to help address the 25% of CHWs who identified financial support and a living wage as their most pressing personal challenge.

9) Include CHW in future professional development efforts that are targeted to addressing health disparities in rural areas throughout the state of Nebraska.

REFERENCES

American Public Health Association. (2014). Support for community health workers to increase health access and to reduce health inequities. https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/14/19/support-for-community-health-workers-to-increase-health-access-and-to-reduce-health-inequities.

American Public Health Association. (2021). *Community health workers*. https://www.apha.org/apha-communities/member-sections/community-health-workers

Anthone, G.J., Vincent, C., Medinger, S.A., & Rodriguez, J. (2021). Nebraska language and limited English proficiency report card 2021. Department of Health & Human Services, Division of Public Health, Office of Health Disparities and Health Equity. https://dhhs.ne.gov/Reports/Language%20and%20LEP%20Population%20Report%20Card2021.pdf

Drozd, D. (2017). Comparing Nebraska Population Change by Race and Ethnicity. *NExUS: Making the Connection*. Omaha, NE: University of Nebraska at Omaha Center for Public Affairs Research. https://digitalcommons.unomaha.edu/cgi/viewcontent.cgi?article=1388&context=cparpublications

Kaiser Family Foundation. *(n.d.).* Uninsured rates for the nonelderly by race/ethnicity. https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-raceethnicity/?activeTab=graph&currentTimeframe=0&startTimeframe=11&selectedRows=%7B%22states%22:%7B%22nebraska%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Kaiser Family Foundation (2019a). Nebraska: Disparities. https://www.kff.org/state-category/disparities/?state=NE

Logan, R.I. & Castaneda, H. (2020). Addressing health disparities in the rural United States: Advocacy as caregiving among community health workers and promotores de salud. *International Journal of Environmental Research and Public Health. 17*(9223). Doi: 10.3390/ijerph17249223

Lopez, P. (2015). Development of Nebraska's community health worker workforce. *Public Health Association of Nebraska.* https://publichealthne.org/resources/Documents/CHW%20Policy%20Paper%20Final%204-7-15.pdf

Robb, J. & Cordes, H. Nebraska's population grew 7.4% during the last decade, moving state up to 37th largest in rankings. *Omaha World Herald.* April 26, 2021. https://omaha.com/news/state-and-regional/nebraskas-population-grew-7-4-during-past-decade-moving-state-up-to-37th-largest-in/article_68b8f634-a698-11eb-a61a-efafd6eb806b.html

Rosenthal, E. L. (1998). *A summary of the National Community Health Advisor Study*. Baltimore, MD: Annie E. Casey Foundation.

Rural Health Information Hub. (n.d.). *Rural data explorer.*
Rural Health Information Hub. (2019, April 22) *Rural health disparities*. https://www.ruralhealthinfo.org/topics/rural-health-disparities

Rural Health Information Hub. (2019, November 14) *Community health workers in rural settings*. https://www.ruralhealthinfo.org/topics/community-health-workers
Rural Health Information Hub. (2021, January 13). *Nebraska*. https://www.ruralhealthinfo.org/states/nebraska#:~:text=Nebraska%20covers%2076%2C872%20square%20miles,Lincoln%2C%20Omaha%2C%20and%20Bellevue.

Schafer, J. (2018). *Nebraska's Increasing Urbanization*. Unomaha.edu. https://www.unomaha.edu/college-of-public-affairs-and-community-service/center-for-public-affairs-research/documents/nebraskas-increasing-urbanization.pdf

Su, D., Toure D., Ern, J., Vinton, V., Ouattara, B., and Crum, A. (2020) "Strengthening the Community Health Worker Workforce to Improve Maternal and Child Health in Nebraska: A Statewide Assessment of Needs, Barriers, and Assets." Nebraska Department of Health and Human Services, Division of Public Health. https://dhhs.ne.gov/MCAH/CHW-Workforce-Assessment-Report.pdf

Trout, K.E., Chaidez, V., & Palmer-Wackerly, A.L. (2020). Rural-urban differences in roles and support for community health workers in the Midwest. *Family and Community Health 43*(2), 141-149. Doi: 10.1097/FCH.0000000000000255.

United States Department of Agriculture Economic Research Service. (2021, February 24). *State Fact Sheets: Nebraska*. https://data.ers.usda.gov/reports.aspx?StateFIPS=31&StateName=Nebraska&ID=17854

University of Illinois, Department of Anthropology and Department of Linguistics. (2020). *Illinois language resource initiative: Q'anjob'al*. http://faculty.las.illinois.edu/rshosted/Qanjobal.html

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 healthcare settings?
12. What are the key advantages of having CHWs on teams?

APPENDIX C – COMMUNITY HEALTH WORKER KEY INFORMANTS INTERVIEW QUESTIONS

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?