THE LOUISIANA COMMUNITY HEALTH WORKER WORKFORCE STUDY COMMITTEE REPORT

Final Report
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EXECUTIVE SUMMARY

Community health workers (CHWs) are frontline public health professionals who are trusted members of and/or have an unusually close understanding of the communities they serve. Through a variety of activities such as health education, outreach, and connecting underserved populations to resources, CHWs improve health outcomes, reduce hospitalizations and emergency department use, decrease health care costs, and enhance quality of care. Moreover, CHWs address the social determinants that influence health, such as housing, food, and education by connecting people to community resources. They can also help improve the community conditions that can lead to poor health.

CHWs are currently underutilized in Louisiana. In 2019, the Louisiana Legislature created the Louisiana Community Health Worker Workforce Study Committee (Committee) to provide the Louisiana Department of Health with recommendations on how best to support and expand this workforce.

The Committee examined major CHW policy issues, including options for training CHWs and financing their positions. In addition to reviewing best practices and examining peer-reviewed literature, the Committee collected data about Louisiana CHW and employer perspectives on workforce development issues through a survey and in-depth interviews. Sixty-five CHWs and 37 employers participated in the survey. Additionally, 21 CHWs and 15 employers completed an interview.

Based on this work, the Committee recommends the following:

1. Members of the Louisiana CHW Workforce Study Committee, along with other stakeholders, should continue to collaborate as a CHW Workgroup. At least half of the Workgroup members should be CHWs. The Workgroup should advise on ongoing CHW workforce policy issues and support implementation of the recommendations listed below.
2. The State of Louisiana should adopt and use the American Public Health Association CHW definition for all State CHW policies and programs.
3. The State of Louisiana should adopt the CHW Core Consensus (C3) Project as a guideline for developing CHW programs and ensure that Louisiana CHWs have the capacity and support to carry out the full range of CHW roles.
4. The CHW Workgroup should provide technical assistance to CHW-led professional groups. These groups can support the workforce by convening CHWs and offering training.
5. The CHW Workgroup should create a process to evaluate and recognize standardized CHW core competency training programs. Certifying CHWs is not recommended at this time.
6. The CHW Workgroup should create a voluntary, online CHW registry in partnership with CHW professional groups.
7. The CHW Workgroup should collaborate to develop a broad, statewide educational campaign about CHW roles and program implementation models for health care providers, community-based organizations, public health practitioners, and the general public.
8. The CHW Workgroup should provide technical assistance to organizations that currently employ CHWs or plan to hire CHWs. This support should include sharing best practices in CHW program development and implementation, as well as data collection strategies.
9. All State CHW programs should use common, standardized measures to track CHW programs and outcomes.
10. The CHW Workgroup should collaborate with Louisiana Medicaid to create a CHW benefit to be financed on a per member per month basis.

INTRODUCTION

Louisiana has high rates of chronic disease, maternal mortality, and sexually transmitted infections.[1-3] Over 14% of Louisiana adults had diabetes in 2019, compared to a national prevalence of 10.4%,[1] and Louisiana ranked 4th in the country for adults with hypertension, at 39% of the population.[2] The rate of maternal mortality between 2011 and 2016 was 12.4 deaths per 100,000 live births, with Black women four times more likely to experience pregnancy-related death than their White counterparts.[3]

Health outcomes across the state also vary significantly based on location. On average, people living in South Louisiana enjoy better health than those in the northern half of the state.[4] Social and economic factors like education, transportation, and housing weigh heavily into Louisiana's disparate health outcomes, as do health behaviors such as tobacco use.[4]

Community health workers (CHWs) can contribute to addressing these issues. CHW is an umbrella term that covers a wide variety of job titles, including community health representative, outreach worker, *promotor*, and community health navigator, among others. According to the American Public Health Association:

> Community health workers (CHWs) are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.[5]

CHWs work in a wide variety of settings such as Federally Qualified Health Centers, community-based organizations, health departments, and universities. They are recognized for their ability to reduce hospitilizations,[6] decrease health care costs,[7-9] and enhance quality of care.[10] CHWs are also effective in helping people prevent and manage chronic diseases, such as cardiovascular disease and type 2 diabetes.[10] Research has shown that CHWs can improve use of preventive and primary care among individuals with a chronic disease.[11] Moreover, CHWs address the social determinants of health (e.g. housing, food security, transportation, education, and other factors) by connecting individuals and families to community resources,[10] and by improving community conditions that affect health.[12]

CHWs have been serving their communities in the U.S. since the 1950s.[13] Since then, the workforce has evolved organically, with little standardization of programs or workforce policy. In 1998, the National Community Health Advisor Study[14] was the first systematic effort to document CHW activities nationwide. Roughly a decade later, the Community Health Worker National Workforce Study further illustrated the scope of CHW programs throughout the U.S.[13]

Throughout the past decade, there has been increasing focus on expanding and supporting the CHW workforce across the country. For example, the Community Health Worker Core Consensus (C3) Project, which included representation from Louisiana, engaged CHWs and experts nationwide to define CHWs' core roles and skills.[15] CHWs and other stakeholders also recently established the National Association of Community Health Workers to represent members of the workforce.[16]

Although these national efforts have been important, the majority of policies related to the CHW workforce are made at the state level. One major question that states often struggle to answer is how to pay CHWs, as these positions are generally financed by short-term grants,[17,18] rather than sustainable sources of funding. In some cases, Medicaid has supported CHW positions and achieved health care

cost-savings.[19] For example, in New Mexico, CHWs paid on a per member per month (PMPM) basis for the services they offer to Medicaid managed care members have achieved a 4:1 return on investment.[20] Recently, another study showed that CHWs helped high-risk patients improve chronic health conditions, resulting in cost savings for Medicaid.[21]

Generally, for a CHW to be paid through Medicaid, a state must adopt a CHW definition and specify what experience or training a CHW must have. As of 2020, sixteen states have implemented or are in the process of creating programs to certify CHWs, with the hope that formalizing the workforce will create new mechanisms for funding CHWs.[22] However, there has been little research on how such credentialing may affect the CHW workforce.

Over the last several decades, Louisiana's CHW workforce has developed informally through a wide variety of programs led by the Louisiana Office of Public Health, community-based organizations, Federally Qualified Health Centers, hospitals, neighborhood groups, and universities. They have addressed a variety of health conditions including asthma, obesity, HIV, lead poisoning prevention, diabetes, and maternal and child health.

In 2010, a group of CHWs and CHW supporters established the Louisiana Community Health Outreach Network (LACHON) to serve as a professional association for CHWs. In 2011, LACHON collaborated with a university-based researcher to develop the only CHW-informed core competency training program in Louisiana, which has been used to train approximately 150 people across the state. LACHON provides educational opportunities for CHWs and hosts monthly membership meetings for CHWs to share resources. Since 2013, LACHON has also held an annual conference for CHWs.

In 2019, a Legislative Resolution established the Louisiana Community Health Worker Workforce Study Committee (Committee) to examine the state's current CHW workforce and provide the Louisiana Department of Health with policy recommendations on how best to support and expand the CHW workforce. In keeping with nationally established best practices,[23] the Committee was required to be at least 50% CHWs. It was co-led by an experienced CHW who directs LACHON and a researcher who has studied and collaborated with CHWs for a dozen years.

The charge of this Committee was to provide recommendations on the following:

- The CHW definition to be used in Louisiana
- Skills, roles, and competencies for Louisiana CHWs
- How to develop CHW training infrastructure in Louisiana
- Enhancing Louisiana employer readiness for hiring CHWs
- Tracking CHW employment in Louisiana
- Sustainable methods of financing CHWs in Louisiana
- Whether certification is necessary or desirable in Louisiana

We, the members of this Committee, met at total of six times between July 2019 and February 2020. Two subcommittees (CHW Training and CHW Financing) met two to three times each. We also collaborated to conduct a formal study of CHWs and their employers. Below, we describe in detail our methods, results, and recommendations.

METHODS

DATABASE DEVELOPMENT

We began our study by creating a database of CHWs and CHW employers throughout the state. We started with an existing list of CHW employers (e.g. non-profit organizations, Federally Qualified Health Centers, social service agencies, etc.) that LACHON had previously assembled. To this list we added the names of individual CHWs, CHW programs, and employers that Committee members knew, as well as names of individuals and programs that other community partners shared with us. We also reviewed community resource lists, conducted web-based searches, and made announcements at community meetings to identify additional possible CHWs, programs, and employers. We placed phone calls to agencies to verify contact information of all CHWs and employers. These CHWs and their employers also shared information about other CHW programs with which they were familiar. We then added these individuals and agencies to the database and contacted them to verify CHW employment.

DATA COLLECTION

During a Committee meeting, we reviewed and agreed upon a list of topics about which we wanted to gather CHW and CHW employers' input. The group agreed that demographics (e.g. age, education, and region of employment), CHW activities and roles, desire for training, knowledge about CHW credentialing, ideas for expanding the workforce, and financing issues should be explored. All of these topics were aligned with the charge of the Committee.

We collected data about CHW and employer perspectives in two ways: a survey and in-depth interviews. Survey questions were based on a survey tool used for a similar workforce study in another state. We developed a semi-structured interview guide that covered the above-mentioned topics in greater detail. Members of the Committee reviewed questions and provided suggestions for improvement before we began the study.

We announced the launch of the study at LACHON's 7th annual conference in September 2019, which had roughly 70 CHWs and employers in attendance. Participants who were interested in completing a survey during the conference had the option to do so on paper or on a tablet. After the conference, we sent via email an online link to the CHW and employer survey to conference participants, people on an existing LACHON email distribution list, as well as to all people in the database. We sent multiple reminders and encouraged people to forward the survey links to other CHWs and employers. We also offered the opportunity for CHWs to fill out a paper-based survey at LACHON monthly meetings in October, November, and December 2019. We completed survey data collection in December 2019.

To gather in-depth perspectives on our areas of interest, we reached out to a subset of CHWs and employers to invite them to participate in an interview. We contacted potential participants by phone or email, depending on the availability of contact information. We aimed to interview CHWs and employers who worked in all regions of Louisiana and in a variety of settings. Interviews were conducted in person or by phone between October and December 2019. An experienced CHW interviewed CHWs and an experienced CHW program administrator interviewed employers. We audio-recorded all interviews and a professional service transcribed all recordings verbatim.

DATA ANALYSIS

Data from the survey were mostly quantitative. We used a SPSS software (version 26) to tabulate responses to questions and summarize findings. In some cases, participants did not answer all questions. We report the number (n) of responses for each question.

To interpret the information gathered from the interviews, we used applied thematic analysis techniques, in which text is organized into smaller chunks, or quotations, to identify common themes

across interviewees. The two interviewers collaborated to develop a list of codes to help categorize quotations and used a software program, Atlas.ti (Version 8.4.4), to assign codes to all quotations. We then examined the quotations assigned to each code to help identify key themes. We present key quotations that illustrate these themes in the results section below.

LIMITATIONS

It is important to acknowledge that this study has limitations. Although we tried to identify CHWs and employers throughout Louisiana, it is likely that we did not locate all of them. The perspectives of CHWs and employers who were not identified or chose not to participate in the study could vary from those who opted to participate. CHWs with lower levels of education or limited computer literacy skills may have been less likely to respond, and their perspectives may also be different from participants' views. In spite of these limitations, this study provides new insight into an important workforce in Louisiana.

RESULTS

DEMOGRAPHICS OF SURVEY AND INTERVIEW PARTICIPANTS

Table 1: Survey Participant Demographics

Variable	Community Health Workers (n= 65) n (%)	Employers (n= 37) n (%)
Age, years, range	23-70	26-63
Age, years, mean ± SD	42.6 ± 13.0	45.0 ± 9.5
Sex*		
Female	44 (67.7%)	27 (73.0%)
Male	9 (13.8%)	5 (13.5%)
Genderqueer	1 (1.5%)	-
Non-binary	1 (1.5%)	-
Transgender Female	1 (1.5%)	-
Transgender Male	1 (1.5%)	-
Transmasculine	1 (1.5%)	-
Unknown**	7 (10.8%)	5 (13.5%)
Race***		
African American/Black	35 (53.8%)	15 (40.5%)
White	14 (21.5%)	12 (32.4%)
Native American/American Indian	6 (9.2%)	-
Asian/Pacific Islander	2 (3.1%)	3 (8.1%)
Other	4 (6.2%)	-
Prefer not to answer	3 (4.6%)	2 (5.4%)
Unknown**	7 (10.8%)	6 (16.2%)
Ethnicity		
Non-Hispanic	51 (78.5%)	31 (83.8%)
Hispanic or Latino	7 (10.8%)	1 (2.7%)
Unknown**	7 (10.8%)	5 (13.5%)
Education		
Graduate/Professional degree	14 (21.5%)	22 (59.5%)
Bachelor's degree	20 (30.8%)	6 (16.2%)
Some college or 2-year degree	17 (26.2%)	4 (10.8%)
High school or GED	4 (6.2%)	-
Less than high school	2 (3.1%)	-
Unknown**	8 (12.3%)	5 (13.5%)

* Participants were asked to report their sex and were given the option to write in their answer. Five (7.7%), wrote in their gender as listed in the table.
**Participant(s) did not provide an answer to this question.
***Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).

Table 2: CHW Survey Participant Employment

Variable	Community Health Workers (n=65) n (%)
Type of Organization	
Federally Qualified Health Center	26 (40.0%)
Community Based Organization	19 (29.2%)
Health Department	7 (10.8%)
Managed Care Organization	5 (7.7%)
Hospital	1 (1.5%)
Parish Health Unit	1 (1.5%)
University	1 (1.5%)
Other	1 (1.5%)
Unknown*	4 (6.2%)
Employment Status	
Full time	57 (87.7%)
Part time	6 (9.2%)
Unknown*	2 (3.1%)
Hours per week, mean ± SD	36.1 ± 9.9
Years of experience, range	0-37
Years of experience, mean ± SD	5.7± 7.7
Location**	
Region 1	43 (66.2%)
Region 2	10 (15.4%)
Region 3	5 (7.7%)
Region 4	6 (9.2%)
Region 5	3 (4.6%)
Region 6	-
Region 7	4 (6.2%)
Region 8	1 (1.5%)
Region 9	7 (10.8%)
Unknown*	2 (3.1%)

*Participant(s) did not provide an answer to this question.

**Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).

Table 3: CHW Survey Participants' Most Commonly Reported Titles

Title Reported	n=65 n (%)
Community Health Worker	14 (21.5%)
Coordinator	11 (16.9%)
Community Health Navigator	9 (13.8%)
Outreach Specialist/Director	3 (4.6%)
Care Manager	3 (4.6%)
Patient Navigator	3 (4.6%)
Certified Application Counselor	2 (3.1%)
Community Health Educator	2 (3.1%)
Community Health Services Representative	2 (3.1%)
Navigator	2 (3.1%)
Peer Prevention Specialist	2 (3.1%)
Prevention Navigator	2 (3.1%)
Other	9 (13.8%)
Unknown*	1 (1.5%)

*Participant(s) did not provide an answer to this question.

Table 4: Interview Participant Demographics

Variable	Community Health Workers n=21 n (%)	Employers n=15 n (%)
Age, years, range	**24-74**	**26-63**
Age, years, mean ± SD	44.4 ± 14.7	44.0 ± 10.3
Gender		
Female	17 (81.0%)	13 (86.7%)
Male	4 (19.0%)	2 (13.3%)
Race*		
African American/Black	17 (81.0%)	8 (53.3%)
White	4 (19.0%)	5 (33.3%)
Native American/American Indian	2 (9.5%)	-
Asian/Pacific Islander	1 (4.8%)	2 (13.3%)
Other	-	1 (6.7%)
Ethnicity		
Non-Hispanic	19 (90.5%)	14 (93.3%)
Hispanic or Latino	2 (9.5%)	1 (6.7%)
Education		
Graduate/Professional degree	5 (23.8%)	12 (80.0%)
Bachelor's degree	7 (33.3%)	2 (13.3%)
Some college or 2-year degree	9 (42.9%)	1 (6.7%)
High school or GED	-	-
Less than high school	-	-

*Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).

Table 5: Interview Participant Employment

Variable	Community Health Workers n=21 n (%)	Employers n=15 n (%)
Type of Organization		
Community Based Organization	7 (33.3%)	2 (13.3%)
Federally Qualified Health Center	5 (23.8%)	3 (20.0%)
Health Department	5 (23.8%)	1 (6.7%)
Managed Care Organization	1 (4.8%)	3 (20.0%)
Parish Health Unit	1 (4.8%)	1 (6.7%)
University	1 (4.8%)	2 (13.3%)
Other	1 (4.8%)	3 (20.0%)
Employment Status		
Full time	20 (95.2%)	14 (93.3%)
Part time	1 (4.8%)	-
Volunteer	-	1 (6.7%)
Hours per week, mean ± SD	39.2 ± 1.8	40.3 ± 8.1
Years at current organization, range	.3-10	.5-19.8
Years at current organization, mean ± SD	3.4 ± 3.1	7.1 ± 6.7
Location*		
Region 1	13 (61.9%)	7 (46.7%)
Region 2	5 (23.8%)	3 (20.0%)
Region 3	3 (14.3%)	-
Region 4	4 (19.0%)	2 (13.3%)
Region 5	2 (9.5%)	-
Region 6	2 (9.5%)	1 (6.7%)
Region 7	2 (9.5%)	1 (6.7%)
Region 8	2 (9.5%)	1 (6.7%)
Region 9	2 (9.5%)	-

*Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).

CHW ROLES AND ACTIVITIES

CHW roles and activities vary based on the type of agency in which they are employed, the health or social issues that the they address, and the communities they serve. In 1998, the Community Health Advisor Study first began to articulate the full range of roles in which CHWs can engage.[14] Since then, researchers and workforce advocates have reasoned that clearer definitions of CHWs' roles and skills could enhance program and policy development, increase appreciation of the CHW role among other health professionals, and facilitate CHWs' integration into health care delivery teams.[24]

In 2016, the CHW Core Consensus (C3) Project conducted national research to document CHW roles and skills.[15] A CHW from Louisiana was one of two CHWs selected from throughout the nation to help lead the project. The following core roles were found to be consistent nationwide:

- Cultural mediation among individuals, communities, and health and social service systems
- Providing culturally appropriate health education and information
- Care coordination, case management, and system navigation
- Providing coaching and social support
- Advocating for individuals and communities
- Building individual and community capacity
- Providing direct service
- Implementing individual and community assessments
- Conducting outreach
- Participating in evaluation and research[15]

National recommendations advise that states seeking to develop their CHW workforce should begin by exploring the roles that CHWs in that state currently fill.[25]

CHW ROLES AND ACTIVITIES IN LOUISIANA

Based on our survey findings, CHW roles in Louisiana are generally consistent with those identified by national research. CHW survey participants reported that their roles included individual or community outreach and education, care coordination, conducting outreach, and participating in community development actions, among other activities.

Table 6: CHW Roles and Activities

Roles	n=65 n (%)
Individual or community outreach and education	52 (80.0%)
Care coordination	41 (63.1%)
Conducting outreach	40 (61.5%)
Participating in community coalitions or community development activities	36 (55.4%)
Medical appointments (e.g., scheduling, maintaining, etc.)	35 (53.8%)
Communicating between providers and patients/families	33 (50.8%)
Individual or community needs assessment	31 (47.7%)
Case management	30 (46.2%)
Teaching health literacy	29 (44.6%)
Promoting healthy lifestyles (e.g. nutrition, exercise, etc.)	28 (43.1%)
Informal support/counseling	21 (32.3%)
Motivational interviewing	21 (32.3%)
Helping patients with medication/treatment adherence	18 (27.7%)
Support groups (e.g. organizing, leading)	14 (21.5%)
Assisting with transitions of care (e.g. post hospital discharge)	13 (20.0%)
Chronic disease self-management	10 (15.4%)
Unknown*	1 (1.5%)

Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).
*Participant(s) did not provide an answer to this question.

We also found that Louisiana CHWs connect clients and patients to a variety of services including health insurance enrollment, education assistance/resources, food assistance, and transportation.

Table 7: Resources to which CHWs Refer Clients

Resources	n=65 n (%)
Health insurance enrollment	44 (67.7%)
Education assistance/resources	40 (61.5%)
Food security	37 (56.9%)
Transportation	34 (52.3%)
Housing	32 (49.2%)
Employment	30 (46.2%)
Translation/interpretation	27 (41.5%)
Violence prevention (e.g. shelter)	25 (38.5%)
Child care	19 (29.2%)
Income assistance	19 (29.2%)
Legal services	15 (23.1%)
Other non-medical service	12 (18.5%)
Fuel assistance	7 (10.8%)
Unknown*	1 (1.5%)

Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).
*Participant(s) did not provide an answer to this question.

We asked CHWs about the populations they serve. They most frequently reported working with people who do not have insurance, people experiencing homelessness, and individuals without a primary care provider.

Table 8: Populations CHWs Serve

Populations	n=65 n (%)
Uninsured individuals	41 (63.1%)
Homeless individuals	34 (52.3%)
Individuals without a primary care provider	33 (50.8%)
Individuals with substance use disorders (e.g. opioid use disorder)	29 (44.6%)
Seniors (ages 65 and up)	28 (43.1%)
Pregnant women and infants	27 (41.5%)
Individuals with a history of incarceration	25 (38.5%)
Sexual or gender minorities (i.e. LGBTQ people)	24 (36.9%)
Children/adolescents	23 (35.4%)
History of frequent hospitalization	22 (33.8%)
Individuals with physical disabilities	20 (30.8%)
Foreign nationals/immigrants/refugees	18 (27.7%)
Isolated rural residents	16 (24.6%)
History of frequent emergency department use	14 (21.5%)
Farm workers	5 (7.7%)
Unknown*	1 (1.5%)

Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).
*Participant(s) did not provide an answer to this question.

CHWs often focus primarily on one or more health conditions. CHWs surveyed reported that they most commonly address the following health issues: Mental health, HIV/AIDS, diabetes, and substance use.

Table 9: Health Issues CHWs Address

Issues	n=65 n (%)
Mental/behavioral health	28 (43.1%)
HIV/AIDS	27 (41.5%)
Diabetes	27 (41.5%)
Substance use	26 (40.0%)
Hypertension	22 (33.8%)
Heart disease	20 (30.8%)
Obesity	17 (26.2%)
Tobacco cessation	17 (26.2%)
Asthma	15 (23.1%)
Cancer	15 (23.1%)
Maternal and infant health	15 (23.1%)
Oral health	9 (13.8%)
Other health issues/chronic diseases	9 (13.8%)
Unknown*	2 (3.1%)

Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).
*Participant(s) did not provide an answer to this question.

In interviews, CHWs primarily described their roles in terms of providing resources and serving the community. Interviewees specifically discussed how CHWs interact with and are members of the communities they serve. CHWs also served as community liaisons and advocates. Employers often mentioned health education, screening, patient navigation, and community outreach as primary CHW activities.

Table 10: CHW and Employer Descriptions of Common CHW Roles and Activities

Theme	Quotation
Provide resources for clients	*"My role as a community health navigator is to engrain our organization into the community as being a known resource for... people in need of any type of assistance with health or overall wellbeing. We do assist those that are in need with things such as finding housing… or food resources, food distribution centers, food benefits, anything, as well as, their homes with utility assistance programs..."* – CHW *"…my role is to contact these individuals and try and help navigate and link them back into care and link them with any type of community resources that they are in need of. If that means mental health treatment, substance abuse treatment, any type of housing, anything of that nature that will make them have an easy transition as to living with HIV."* – CHW
Advocate for communities	*"I feel like, me personally, I'm an advocate for people in the community…I am an advocate for the people, my parish."* – CHW *"I advocate for what is important to the clients that I work for. And I do training. I advocate for improving of their health. I give them resources and I promote their health."* – CHW
Community outreach	*"…we do HIV education, STI education, tobacco treatment, diabetes and weight management. I mean, a lot of community outreach…our job really is to serve clients at [organization]…but we saw the need to do more community outreach around PrEP, around just, you know, people knowing about the clinic. A lot of people don't know what [organization] is. So we've done a lot of community work over the past year as well."* – Employer *"…[CHWs] do outreach in communities that are vulnerable and making sure that those community individuals or families are connected to what resources that they need."* – Employer

Positive aspects of the CHW profession

CHW interview respondents reported many positive aspects of their jobs, particularly being able to connect clients to resources, contributing to positive changes in a client's health, interacting with fellow community members, and providing social support. Feeling like they "made a difference" in a client's life was also a positive aspect of being a CHW, along with employer understanding of their role, and having a supportive supervisor. Among employer interview respondents, the most valuable aspect of the CHW profession included CHWs' ability to engender trust and connect with hard-to-reach populations.

Table 11: CHW and Employer Perceptions of Positive Aspects of the CHW Profession

Theme	Quotation
CHWs promote positive health outcomes	*"I made an appointment for her, and she went to the hospital…they did all the tests, and they…found out that she had cancer, cervical cancer, and she got surgery, and guess what, she's doing great. She's doing fine."* – CHW *"My job is to improve the relationships between people with [health condition] and the health care industry, to actually eventually improve the health outcomes for people who suffer from this kind of condition…so we can help improve their overall quality of life."* – CHW
CHWs connect clients to resources	*"The fact that we work in the communities that are in need. We're actually able to provide resources."* – CHW *"What I like most about my current job is being able to network on and pick up different resources that will better benefit the client."* – CHW
CHWs reach communities and build trust	*"I think it's helped bridge the gap in the community. I feel like we've been able to strengthen community partnerships by having CHWs."* – Employer *"…just the ability to get in community spaces that are part of their circles of influence. And having the ability to communicate in a way that it's representative of the communities that we're working with."* – Employer

Challenging Aspects of the CHW Profession

The CHW workforce nationally struggles with turnover, in part due to low pay.[26] The majority of CHW survey respondents earned less than $40,000 annually, which is below the median income in Louisiana. Approximately 30% disagreed or somewhat disagreed with the statement "I am fairly compensated for my work," with roughly another third reporting that they agreed somewhat.

Table 12: CHW Annual Income

Income	n=65 n (%)
Less than $10k/year	7 (10.8%)
$10k to < $20k/year	4 (6.2%)
$20k to < $30 k/year	15 (23.1%)
$30k to <$40k/year	19 (29.2%)
$40k to less than $50k	12 (18.5%)
$50k a year or more	7 (10.8%)
Unknown*	1 (1.5%)

*Participant(s) did not provide an answer to this question.

Of the CHWs surveyed, approximately one third held an additional job outside of the CHW field, with 59.1% of those respondents reporting they worked the second job to supplement their income as a CHW.

Table 13: Reasons CHWs Work in Other Non-CHW Positions

Reasons	n=22 n (%)
I work at another job to supplement my income as a CHW	13 (59.1%)
Community health work is not my primary occupation	7 (31.8%)
My work as a CHW is volunteer work	3 (13.6%)
Other	3 (13.6%)

Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).

CHW survey respondents reported varied access to resources to support their work. Those who participated in interviews expressed frustration with a lack of basic operating supplies (e.g. telephone, computer, office space, etc.).

Table 14: Resources Available to CHWs

Resources	n=65 n (%)
Computer	57 (87.7%)
Access to copy/fax/scanner	56 (86.2%)
Shared office space	42 (64.6%)
Reimbursement for mileage	42 (64.6%)
Cell phone (including reimbursement for use of personal phone)	38 (58.5%)
Private office space	28 (43.1%)
Tablet	16 (24.6%)
Unknown*	2 (3.1%)

Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).
*Participant(s) did not provide an answer to this question.

The CHWs interviewed described several challenges they experience in their jobs. Their main concern was a lack of available of services or resources (e.g. housing, transportation, utility assistance, etc.) to which to refer clients, and related disappointment when they were unable assist clients with needs. Another challenge they mentioned was the inability to reach clients who lack up-to-date contact information. They also felt frustrated when clients did not follow through with referrals. Additionally, CHWs described frustration with a lack of support for CHW programs by health care providers. They also reported challenges with caseloads being too high, emotional burden, and low pay due to short-term grant funding.

Table 15: Common Challenges CHWs Experience

Theme	Quotation
Lack of resources for clients	*"Some people, they're looking for shelter, they're looking for food, they're looking for utility assistance…Sometimes that's a big challenge for us to try to find them just somewhere to go even for the night. It's hard."* – CHW *"I really don't have a lot of power to expand the resources that I have…it frustrates me in seeing that more often than not within my daily job. One mom came to one of our events…She needed housing. She was homeless and with her baby…It frustrated me that I couldn't help her in the capacity that she needed me to help her. I run into that a lot."* – CHW
Inability to reach clients	*"This one case. Poor lady...in her late 70s. She doesn't have a cell phone. She doesn't know how to use a computer. So, my way of contacting her is via mail…There's physically no other way to get in contact with her, because the address listed, she said she's not there all the time…She doesn't have like a permanent place. So just recently I sent her another letter and I haven't heard anything back. So that's probably the hardest thing to deal with it, is to know that someone needs and then you can't reach them to check in on them, make sure everything's okay."* – CHW *"The population a lot of times that we're dealing with, connecting back to them is hard. Their phones may be disconnected or changed in a matter of a couple of days. And so, being able to get back to them is not always as easy and since we're not in the doctor's office and we're not seeing them on a regular basis in that setting, sometimes we may not be able to get back in touch with them."* – CHW
Clients not following through on referrals	*"The biggest challenges I guess would be when you have patients who you can tell them something, you could try to help them as much as you can, and they just don't do what you tell them. And they don't do what the provider tells them. I guess that will be our biggest issue. They don't follow through."* – CHW
Case load is too high	*"Right now, I just feel like...by my caseload being so heavy, I don't have time to just spend a lot of time on each individual person."* – CHW
Emotional burden	*"One more challenge is when you see a nine-year-old or an eight-year-old that got shot by a street bullet. It's like, it's a mental challenge. It'll make your day go from seeing the sunshine to seeing thunder and lightning."* – CHW *"I would like to add that being a community health worker is rewarding because you get to connect with the community, but it's also a challenge because you also see the need of the community, and you realize the lack of resources that are available for the need of these families, and you try to take on those issues. You try to save people when you can't."* – CHW
Low pay	*"For some reason or another, CHWs are not recognized money-wise. They're not getting paid for half of what they do."* – CHW

Career opportunities for CHWs

Over 75% of CHWs surveyed completely or somewhat agreed that they were utilized to their full potential in their current position, and about three fifths indicated that there may be opportunities for promotion within their organizations. When asked about possibilities for career advancement for CHWs who may desire to move into other positions, the majority of CHW and employer interviewees reported CHWs could advance to become CHW team leaders or supervisors. Both groups also saw administrative

positions, state or public health positions, and management roles as options for CHWs seeking to advance. There was agreement that CHWs seeking to enter a different role could move into case management, social work, or counseling.

CHW PROGRAM ADMINISTRATION

CHWs work in a wide variety of settings, including community-based organizations, health departments, churches, schools, and health care systems. Given the variety of workplaces, CHW program models also vary widely. We sought to explore how CHW programs are carried out in Louisiana.

HIRING CHWS

Regardless of where they work, one of the most important qualifications that a CHW can have is that they must be trusted by the community they serve. When employers were surveyed about preferred qualifications of CHW applicants, they most frequently identified prior experience with the population to be served, knowledge of community services and resources, and having a valid driver's license for work-related travel.

Table 16: Employer-Reported Preferred CHW Qualifications

Qualifications	n=37 n (%)
Prior experience with the population served	32 (86.5%)
Knowledge of community services or resources	30 (81.1%)
Shared background with the population served	24 (64.9%)
Valid driver's license for work-related travel	24 (64.9%)
Own car for work-related travel	19 (51.4%)
Social services background	16 (43.2%)
Bilingual or multi-lingual	15 (40.5%)
Prior experience as a CHW	15 (40.5%)
Health care background	10 (27.0%)
Unknown*	3 (8.1%)

Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).
*Participant(s) did not provide an answer to this question.

Employers identified a handful of strategies for ensuring that CHWs are trusted by their communities. First, prior knowledge of CHW candidates, primarily from community-based activities, was helpful to employers. They often looked for connections to other community-based organizations, volunteer experience, past job experience, references, and in one case, a customer service background. Additionally, employers reported using the interview process to evaluate interpersonal and communication skills, and in one instance, used role playing. Employers also asked about a candidate's life experience that would help the applicant relate to clients. A common job announcement strategy was to post flyers advertising the position in community-based organizations rather than advertising online.

Table 17: Employer Strategies for Hiring Effective CHWs

Theme	Quotation
Hire someone you know	*"She takes a lead in her church…I have actually been to her church and seen her get up and talk and engage with her congregation. I had a unique opportunity to kind of have known her and seen her in her setting. When this position came open, I called her and said, 'I think I might have something that will work for you. What do you think about it?'"* – Employer
Screen for interpersonal skills	*"I tell candidates when I'm interviewing them, what I say is 'I'm not the wizard. If you have a heart for helping people, I can teach you [organizations]'s spiel, [organization]'s process, but you have to want to help people.' In the Wizard of Oz, he could give you heart. I can't give you heart. But if you have that, we can teach you what we need to be done."* – Employer
Recruit through word of mouth	*"Honestly, all of the people that have been recommended...I haven't hired anyone who hasn't been recommended by somebody I trust."* – Employer
Look for candidates with similar life experience to clients	*"The community health worker that was [working with people living with HIV] was also a woman who was living with HIV, and that was something that was important to us."* – Employer

CHW PROGRAM STRUCTURE

Employers most frequently reported that their CHW programs were developed within the last ten years, and a few employers interviewed said they have been employing CHWs for 15 years or longer.

Table 18: Employer-Reported Length of CHW Program

Length	n=37 n (%)
Less than one year	4 (10.8%)
1-2 years	5 (13.5%)
3-5 years	8 (21.6%)
6-10 years	11 (29.7%)
More than 10 years	6 (16.2%)
Unsure	3 (8.1%)

Employers reported that funding for CHW programs came from private grants, state programs, administrative funds, federal cooperative agreements, parish millages, and federal grants.

Table 19: Employer-Reported CHW Position Funding Sources

Source	n=37 n (%)
Core operating funds	15 (40.5%)
Grant funding – Federal	11 (29.7%)
Grant funding – State	6 (16.2%)
Grant funding – Private	9 (24.3%)
Other	2 (5.4%)
Not sure	2 (5.4%)
Unknown*	2 (5.4%)

Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).
*Participant(s) did not provide an answer to this question.

CHW survey respondents reported a wide variety of team members with whom they interact regularly, with over half working with other CHWs, a program manager or front desk staff.

Table 20: CHWs' Organizational Team Members

Team Members	n=65 n (%)
Other CHWs	37 (56.9%)
Program manager/Director	36 (55.4%)
Front desk staff	34 (52.3%)
Case manager	28 (43.1%)
Primary care provider	21 (32.3%)
Registered nurse	20 (30.8%)
Behavioral health care provider	19 (29.2%)
Social worker	15 (23.1%)
Medical assistant	14 (21.5%)
Dietitian/nutritionist	13 (20.0%)
Other	2 (3.1%)
Unknown*	1 (1.5%)

Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).
*Participant(s) did not provide an answer to this question.

When asked about their perspectives on team collaboration, almost two-thirds of CHWs surveyed reported that they felt well-integrated into the teams at their organization, and over four fifths agreed completely that they were valued by their fellow team members.

Table 21: CHW Perspectives on Team Collaboration

Survey Statement	Agree completely	Agree somewhat	Disagree somewhat	Disagree completely
I am well-integrated into the team at my organization *(n=63)*	40 (63.5%)	19 (30.2%)	2 (3.2%)	2 (3.2%)
I am a valued member of the teams I work with *(n=59)*	48 (81.4%)	9 (15.3%)	2 (3.4%)	-

Among employers that reported using electronic health records (EHRs) in clinical settings, 75% allowed CHWs to access the EHR and 73.3% allowed CHWs to document their activities in a patient's chart.

Table 22: Employer-Reported Electronic Health Record Use by CHWs

Survey Statement	Yes	No
Organization utilizes electronic health records (*n=36)*	16 (44.4%)	20 (55.6%)
CHWs have access to electronic health records (*n=16)*	12 (75.0%)	4 (25.0%)
CHWs record activities in electronic health record (*n=15)*	11 (73.3%)	4 (26.7%)

Employer interviewees working in clinical settings reported that warm handoffs between care providers and CHWs (i.e. the provider personally introduces the patient to the CHW) were common. Interactions between CHWs and providers relied heavily on EHR access, as the teams utilized the electronic system to send messages between members of the care team.

Employer survey respondents largely reported that regular meetings and written reports were the primary methods they used to track CHW activities and progress.

Table 23: Employer Tracking of CHW Activities

Activity	n=37 n (%)
CHW has regular meetings with supervisor	26 (70.3%)
CHW creates written narrative reports	24 (64.9%)
Quantitative reports	15 (40.5%)
Electronic health records	3 (8.1%)
Other	2 (5.4%)
Unknown*	3 (8.1%)

Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).
*Participant(s) did not provide an answer to this question.

Employers interviewed were asked about the types of supervision and interactions CHWs have in their organizations, particularly within health care teams. In general, employers met either individually or in teams on a regular (weekly, biweekly, monthly) basis to discuss cases and resource needs. These team meetings allowed for CHWs to share knowledge and resources with each other and connect with each other for support. One employer talked about "the magic that everyone brings to the team" being shared in these meetings, particularly by CHWs who have a unique perspective on client concerns. Multiple employers mentioned utilizing text messaging and group chats for issues requiring immediate attention, and those working in health care settings talked about the importance of CHWs using EHRs.

Table 24: Employer Descriptions of CHW-Team Interactions

Theme	Quotation
Regular meetings	*"We have weekly staff meetings that last about two hours. The first hour is more formal…we're going over any changes in policies and procedures or any updates...Then the second hour is much more informal. We kind of talk about good cases, bad cases. Sometimes we're doing like the postmortems on…[a] complex case."* – Employer
CHWs share knowledge and resources	*"Everyone has different levels of experience and education on the team, but everyone brings something magical to the team…so when they do have something that's, I guess more unique and more difficult, they bring it to the entire team and everyone chimes in with resources of who they know."* – Employer
CHWs offer unique perspectives	*"Because sometimes it may go against the norm…because you have not experienced that problem. But they [CHW] can tell you what worked for them and we try to engage people where they are, not where we're most comfortable."* – Employer
CHWs use EHR	*"That would be pivotal for them to do their job, so in terms of what could be different, I think all community health workers should have access to EMRs…They're expected to look at the records of the person before they go make their face-to-face visit so they can be able to speak knowledgeably, but also comfortably with the person."* – Employer

Employers discussed challenges to supervising CHWs and how these issues can be addressed. They reported concerns about caseloads, helping CHWs to remain motivated despite stress, and a lack of standardization of skills. One employer believed CHWs might require more professional development and oversight than other employees, and others noted the importance of helping CHWs address job-related emotional burden.

Table 25: Employer Strategies for Supervising CHWs

Theme	Quotation
Offer professional development	*"We prioritized different things than we would normally prioritize when hiring [CHWs]. So, when you prioritize other things, sometimes you don't get the usual things that come with a new employee. So professional development was a big thing."* – Employer
Address emotional burden	*"It's hard…to do a brain dump and go to the next case and not think about that person you just left. …so, we have to find ways to let them offload their emotional and mental stress. So, we try to engage them. We give them poems for inspiration. We have little sounding board meetings where they're free to speak their minds and say the things that are working, not working, just as a mental health refresher."* – Employer

CHW PROGRAM CHALLENGES

Employer interviewees were asked to identify challenges and needs of their CHW program. They reported a lack of respect for CHWs from those who are unfamiliar with the profession and a resistance from some staff to have CHWs on the team because CHWs do not have a formal certification. One employer reported a lack of buy-in from frontline clinical staff, whereas they felt mid-level and executive leaders were very supportive of CHWs.

Employers reported that they need more CHWs to meet the needs of their programs and to reduce strain on current CHWs. Employers also discussed the need for CHWs to reach people through methods other than telephone calls because of frequent phone number changes among clients. There was a concern that funders' program requirements are often inflexible and keep CHWs in the office, rather than in community settings.

Employers reported a lack of understanding about how best to supervise CHWs in their organizations, as well as concerns over a lack of standardization of skills among CHWs. They also discussed a need for additional CHW program funding opportunities. Other challenges reported included the logistics associated with conducting community-based health screenings and follow-up, limited office space, and EHR access.

Table 26: Employer-Reported Challenges of CHW Programs

Theme	Quotation
Clinical staff do not understand CHW role	*"I would want to change the level of respect for what they do, even though they're not providers or clinicians. What they do is just as valuable and just as important."* – Employer *"…we got buy-in from mid-level and senior staff at the hospital very early on. They really sing our praises quite frequently. Getting those frontline nurses, case managers, other personnel to buy into the concept and actually do the referrals. That's been our biggest challenge that it's taken us a while to get over."* – Employer
Need for more CHWs	*"I need more team members."* – Employer *"To have more community health workers, because five throughout the state is a challenge. Five to cover the whole state is a challenge."* – Employer *"We need more manpower, because, as you know, Louisiana has a lot of rural remote areas. So, we can't hire anyone for all 64 parishes, but someone in all 64 parishes need us."* – Employer
Inability to reach clients	*"A lot of our [clients'] phone numbers are no longer in service, are not operational. They're out of minutes. It's various reasons why we can't find some of our members. But they need us…"* – Employer
Lack of education about CHW supervision	*"I think initially one of the challenges…for us to figure out what's her role and like how's it going to look and like logistical challenges. Like hey, where is she going to have an office space, for example? Where is she going to conduct this interview? How does she fit in, in terms of like the HIPAA rules and how do we get her access to the EHR?"* – Employer *"I think that some sort of training...because sometimes I question about whether I am, did I structure this right? Or whether I am giving them the foundation to succeed?"* – Employer
Lack of standardized training and skills	*"…standardization of knowledge and skills because they come in different, for lack of a better phrase, shapes and sizes in terms of their knowledge and their background and what they can offer. So, one community health worker might be very different from the next, and you could see one in one organization might not translate to the same skills and knowledge in another organization or in a different state."* – Employer
Lack of funding for CHWs	*"I think as an organization we do support the concept of [CHWs], it's just seeking grant funding for it has been the biggest challenge. We're constantly having to seek resources."* – Employer *"I mentioned the challenge of funding. That's the biggest challenge right there."* – Employer *"Yeah, I was really sad that we had to end our program because of lack of funding. They [CHWs] wanted to continue. That was very, very hard to do."* – Employer

Strategies for expanding the CHW workforce in Louisiana

Although it is difficult to quantify the precise number of CHWs in Louisiana (and nationally) due to frequent turnover and differing job titles,[26] our research indicates that the workforce in Louisiana is likely made up of just a few hundred people. This could be because sustainable funding for many CHW positions does not exist and policies to support the workforce in Louisiana have not yet been developed. Interview and survey respondents were asked to identify ways to increase the number of CHWs in Louisiana and how to provide support for existing CHWs to ensure that they remain in the workforce.

Supporting CHWs

Benefits are often an important component of job satisfaction. Among CHWs surveyed, approximately half had access to retirement plans and disability or life insurance. Paid time off and access to health/dental insurance were the most commonly reported benefits.

Table 27: Benefits CHWs Receive from Employer

Benefits	n=65 n (%)
Paid time off (vacation, sick time, personal time, etc.)	48 (73.8%)
Health/dental insurance	47 (72.3%)
Mileage/parking reimbursement or other transportation benefits	45 (69.2%)
Disability or life insurance	33 (50.8%)
Pension or retirement plan	33 (50.8%)
Wage/salary increase	27 (41.5%)
Paid leave for training/education	26 (40.0%)
Tuition assistance	15 (23.1%)
Unpaid leave for training/education	9 (13.8%)
Paid parental leave	8 (12.3%)
Child care	2 (3.1%)
None of the above	3 (4.6%)
Other	1 (1.5%)
Unknown*	1 (1.5%)

Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).
*Participants did not provide an answer to this question.

CHWs and employers interviewed believed that CHWs should have access to a full organizational benefit package (e.g. educational stipends, retirement, health insurance, etc.), fair compensation, and basic operating supplies. CHWs expressed a need for more resources for their clients. CHW interview respondents also felt that training and continuing education would support the workforce. Employers felt that additional training opportunities and continuing education, as a way to increase skills and make CHWs feel valued, could be a key form of support. Furthermore, employers recognized the importance of CHWs identifying as members of a larger workforce. They believed this could be achieved by supporting conference attendance, mentoring, and allowing CHWs to participate in organizations in which they connect with one another.

Table 28: Strategies to Support CHWs

Theme	Quotation
Provide benefits	*"Like I said, pay, benefits, across the board as a whole."* – CHW *"One of the things is that what we've done with our community health workers is that we pay them, and I don't want to call it a humane wage, is that they make between $40,000 and $45,000 a year. That's starting off. They get benefits. They get retirement. And they are treated as professionals. They have offices, they have cell phones, computers, and things like that. We need to treat them like the professionals that they are. Like we would treat anybody else that's working for, let's say, our agency."* – Employer
Provide fair compensation	*"I understand that there is a value of working with people that are passionate about what they are doing. They still need to pay their house and get their needs…That has to go hand and hand with, if you value them, you pay them."* – Employer
Create client resources	*"It's just that we need more effort put into resources for people that they actually need, grounded in things that are helping the overall health of people."* – CHW *"Definitely create more resources for it. So, if the state wants more CHW's, then create more funding for their job…create more resources that will help with their jobs, like as I mentioned transportation or access to food…"* – CHW
Provide training and continuing education for CHWs	*"I think with just the training itself, and knowing that they have someone supporting them, they're trying to get them at a better place."* – CHW *"I'm not sure if that's already happening or if it's even possible, but to have trainings and continuing education, maybe provided through our state's community health worker association maybe. But just for them to know that there's a place to go to access education, access information."* – Employer
Help CHWs identify as members of the workforce	*"I sat in at a couple meetings and we were, they were just brainstorming and saying what a CHW did, so I was like "Oh, okay. I'm a CHW." So everyone in the room wound up being a CHW. So there's letting them they are part of a larger group."* – Employer
Support CHW conferences or coalitions	*"I definitely would like a community health worker conference where we can dialogue with other community health workers and learn from each other…We can exchange information, because I don't think we would learn that from other people. We can definitely learn that from other community health workers who are actually doing the job that we're doing."* – CHW *"…a network of community health workers…an actual meeting place or…an email thread or something with all the community health workers in the city, I feel like it could be really beneficial for all of us to share resources."* – CHW *"I think we can have more of a coalition where there's meetups for people that are known CHWs and we're coming together, whether it's monthly or quarterly, and just share information with one another because this is new. I know it's new to me and the CHWs in our area. So if we can meet other CHWs that's been doing this or new as well, and we can all learn from one another."* – Employer

Creating new CHW positions

Over two thirds of employers surveyed cited lack of funding as a barrier to hiring new CHWs.

Table 29: Employer-Reported Barriers to Hiring CHWs

Barriers	n=37 n (%)
Lack of funding	21 (56.8%)
Do not need (additional) CHWs	5 (13.5%)
Inability to bill insurers for CHW services	4 (10.8%)
Lack of certification of CHWs	4 (10.8%)
Lack of training for CHWs	3 (8.1%)
Lack of clarity about their value	1 (2.7%)
Lack of clarity on how to integrate them with other teams	1 (2.7%)
Unknown*	7 (18.9%)

Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).
*Participants did not provide an answer to this question.

When asked how best to increase the number of CHWs in Louisiana, CHWs and employers interviewed agreed on the need to educate the general public, health care providers, administrators, and organizational leaders about the CHW workforce. Employers reported that increased awareness might motivate people to seek CHW positions. CHWs also identified the need for increased pay and access to training as key to increasing the number of CHWs. Both groups identified funding as critical to expanding the workforce, with employers feeling that sustainable financing would make it more of a career choice, rather than a short-term position based on grant requirements. Employer interviewees also reported the need to generate evidence about CHW effectiveness.

Table 30: Strategies to Increase the CHW Workforce

Theme	Quotation
Provide education about CHWs	*"More talk about it. A lot of people don't know what community health workers are. So basically, having a platform, speaking about community health workers, going into different organizations letting them know the benefits of community health workers."* – CHW *"We have to figure out a way to make individuals understand how they can incorporate CHWs into their organizations…It just takes education, basically, and making people understand how this model works."* – CHW *"I think there needs to be an understanding of what this community health worker role is and who is part of it."* – Employer *"I think just in general, educating the public about that this type of job and these people are out there and they can be a resource to you. So, I think really just educating everybody, but I think, particularly, the health care community. I think they sometimes view non-medical, non-clinical staff with a little bit of suspicion or as being different."* – Employer
Increase CHW pay	*"Finding more funds. Everything revolves around money. You can't have people if you don't pay them. It's just not going to work."* – CHW *"Better pay…I think the basic thing would be the pay."* – CHW
Provide CHW training	*"I just truly believe that the state should implement something that will allow CHW training across the board."* – CHW
Provide sustainable funding	*"A challenge is that it's not funded. It's very hard for sustainability, because you know it's a need and you see it working and you see that people have really stressful realities. And then you're able to work with them on that, but then the company may be bleeding trying to keep it, you know…I guess people that hold the money, they don't get it."* – Employer *"I think every community clinic would employ community health workers if there was money for it."* – Employer
Generate evidence	*"If there are more kind of studies that confirm the benefit of having community health workers as a good start."* – Employer

TRAINING

Historically, CHW training often focused on preparing CHWs to work on programs focused on a particular health topic (e.g. HIV, diabetes, hypertension, asthma, etc.). These courses have frequently been offered as one-time events. In recent years, there has been a move toward training CHWs in core competencies that are necessary to be successful, regardless of the health or social issue(s) that a CHW addresses in their position.

Best practices in CHW professional development include in-person, non-didactic instruction using adult education principles that draw on participants' life experience. A variety of organizations provide training including community-based organizations, community colleges or universities.[27] Several states now offer standardized training programs that award a certificate of completion. The most common skills these programs aim to develop align with the competencies identified by the CHW Core Consensus (C3) Project including:

- Communication skills
- Interpersonal and relationship-building skills
- Service coordination and navigation
- Capacity building
- Advocacy
- Education and facilitation
- Individual and community assessments
- Outreach
- Professional skills and conduct
- Evaluation and research
- Knowledge base[15]

Louisiana has not adopted a standardized training program. Some CHWs working in Louisiana today have been trained on the job, through community-based organizations or programs located in other states. The Louisiana Community Health Worker Institute (currently based at LSU Health Sciences Center—New Orleans) and LACHON have collaborated to offer core competency training to roughly 150 people.

CHW TRAINING EXPERIENCE

Among CHWs surveyed, roughly half had completed core competency training, and over 40% had received training in each community advocacy, patient navigation, and leadership.

Table 31: CHW General Training Experience

Training	n=65 n (%)
CHW core competency training	32 (49.2%)
Community advocacy	28 (43.1%)
Patient navigation	27 (41.5%)
Leadership	26 (40.0%)
Motivational interviewing	22 (33.8%)
Peer support	20 (30.8%)
Chronic disease self-management	17 (26.2%)
Other CHW-specific training	8 (12.3%)
Medical interpreting training	6 (9.2%)
Languages other than English, including sign language	3 (4.6%)
Unknown*	1 (1.5%)

Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).
*Participants did not provide an answer to this question.

In terms of health conditions, CHWs surveyed had most commonly been trained on HIV/AIDS, diabetes, mental/behavioral health, and substance use.

Table 32: CHW Experience with Training in Health Topics

Topic	n=65 n (%)
HIV/AIDS	29 (44.6%)
Diabetes	25 (38.5%)
Mental/behavioral health	24 (36.9%)
Substance use	22 (33.8%)
Sexual health	21 (32.3%)
Hypertension	18 (27.7%)
Heart disease	15 (23.1%)
Tobacco cessation	14 (21.5%)
Cancer	13 (20.0%)
Asthma	12 (18.5%)
Obesity	12 (18.5%)
Maternal and infant health	9 (13.8%)
Falls prevention	7 (10.8%)
Oral health	6 (9.2%)
Other health issue/chronic disease	4 (6.2%)
Unknown*	5 (7.7%)

Participants had the option to check more than one answer. Percentages may not total to 100% and total number of responses may be greater than the number of respondents (n).
*Participants did not provide an answer to this question.

When asked to describe prior experiences with training, CHW and employer interview participants all indicated some level of training for CHWs, and most of the training was done in-house at the hiring organization. The majority of courses were also completed in-person, though some were both in-person and online. About one third of CHW interview respondents had received training from the Louisiana Community Health Worker Institute over the past five years. CHWs and employer interviewees mentioned the Louisiana Office of Public Health, Louisiana Breast and Cervical Health Program, the Coastal Resource and Resiliency Center, LACHON, the Sickle Cell Foundation, the University of South Alabama, Boston University, and the University of Phoenix as other training providers.

Training content for Louisiana CHWs

CHWs surveyed indicated their level of interest in being trained in a variety of topics. Over 80% of respondents were very interested in leadership, CHW core competencies, and community advocacy.

Table 33: CHW Interest in Training Topics

Topic	Very interested	Somewhat interested	Not at all interested
CHW core competencies (n=54)	45 (83.3%)	7 (13.0%)	2 (3.7%)
Leadership (n=51)	45 (88.2%)	5 (9.8%)	1 (2.0%)
Community advocacy (n=53)	44 (83.0%)	7 (13.2%)	2 (3.8%)
Sexual health (n=50)	39 (78.0%)	11 (22.0%)	-
HIV/AIDS (n=55)	38 (69.1%)	16 (29.1%)	1 (1.8%)
Languages/sign language (n=53)	39 (73.6%)	9 (17.0%)	5 (9.4%)
Patient navigation (n=53)	39 (73.6%)	11 (20.8%)	3 (5.7%)
Peer support (n=50)	39 (78.0%)	9 (18.0%)	2 (4.0%)
Maternal and infant health (n=49)	38 (77.6%)	9 (18.4%)	2 (4.1%)
Mental/behavioral health (n=51)	36 (70.6%)	14 (27.5%)	1 (2.0%)
Cancer (n=50)	35 (70.0%)	11 (22.0%)	4 (8.0%)
Diabetes (n=50)	35 (70.0%)	12 (24.0%)	3 (6.0%)
Hypertension (n=50)	35 (70.0%)	11 (22.0%)	4 (8.0%)
Motivational interviewing (n=50)	35 (70.0%)	13 (26.0%)	2 (4.0%)
Heart disease (n=50)	34 (68.0%)	13 (26.0%)	3 (6.0%)
Substance use (n=47)	32 (68.1%)	13 (27.7%)	2 (4.3%)
Chronic self-disease management (n=49)	31 (63.3%)	16 (32.7%)	2 (4.1%)
Obesity (n=50)	30 (60.0%)	15 (30.0%)	5 (10.0%)
Medical interpreting (n=49)	25 (51.0%)	18 (36.7%)	6 (12.2%)
Tobacco cessation (n=46)	20 (43.5%)	16 (34.8%)	10 (21.7%)
Oral health (n=45)	16 (35.6%)	22 (48.9%)	7 (15.6%)
Asthma (n=43)	15 (34.9%)	18 (41.9%)	10 (23.3%)
Fall prevention (n=42)	14 (33.3%)	17 (40.5%)	11 (26.2%)

When asked to identify ideal content for CHW training in Louisiana, employer and CHW interview respondents reported many core competencies, including communication skills, community education, outreach, establishing boundaries with clients, and service coordination. Both interview groups emphasized a need for training on the health care system, types of health care providers, and medical terminology. An employer interviewee previously attended a cultural humility training with their CHW, and given the positive experience, stated that their organization was making it mandatory for all new employees. Additional specialty topics mentioned included mental health first aid and chronic disease. Finally, both CHW and employer interviewees expressed a need for training on how to better explain or define the CHW role to others.

Table 34: CHW and Employer Suggestions for CHW Training Topics in Louisiana

Theme	Quotation
Core competencies	*"Confidential[ity], privacy, engagement, advocating, because those are the main things. Keeping patients' information confidential. Keeping their privacy. Being able to engage in the client and be able to be their advocate for that client."* – CHW *"Building trust and relationships with the community. Even partners of the community, like the clinics that we go to, how to go about doing that, how to navigate referrals and from community-based clinics, community members, and participants using just a range of outreach methods for engagement purposes. And also understanding organizational policies and procedures and making sure that outreach is conducted within those guidelines."* – CHW *"Training would have to be background as far as the demographics, cultural training, confidentiality training, again communication…"* – Employer
Cultural humility	*"It should cover that cultural part…I don't think everybody understands that there are cultural differences…and meeting them where they are as far as addressing the social determinants of health."* – CHW
Health care system	*"…more training as far as [the]health care field. I talk to the nurses and the providers on a regular basis, and then I always ask questions. So maybe more training in the health care field."* – CHW *"…information about the health care system, like what's a primary care doctor, what's a specialist, how can members or patients navigate going to the pharmacy, getting their medications, making appointments, accessing resources that help with addressing social determinants of health."* – Employer

Perceived benefits of standardized training

When asked about perceived benefits of standardized CHW training, CHW interviewees said that it could provide skill sets to enhance their work. Additionally, CHWs interviewed felt that training would allow them a better understanding of the roles they can fill. Other responses from CHWs included the potential for networking opportunities, increased pay, and increased cultural competency.

Both CHWs and employers interviewed reported a belief that training would lend credibility to the role, provide education to stakeholders, and create standardization across the profession. Employer interviewees thought standardized training would be particularly helpful for CHWs working in health care settings. Other employer interview responses focused on employability of trained CHWs, increased number of CHWs trained and ready for hire, and the opportunity for CHWs to learn how to advocate for themselves.

Table 35: CHW and Employer Perceived Benefits of CHW Standardized Training

Theme	Quotation
Credibility for profession	*"Because I think it will help people understand that it's more than just a job. It would help them understand, especially if you have those type of courses in that training where you'll be able to interact better with the patient."* – CHW *"Some benefits of a standardized training is… they are more inclined to take the work seriously."* – CHW
Increased pay	*"I think that it would definitely help with pay increase."* – CHW
Professional development	*"Really just getting away and being able to learn something and come back and being able to use it. They gave us all the information that we learned so it was very helpful to bring that back and be able to keep studying it and keep using it."* – CHW *"We don't know everything because when we sleep things are changing. So it's always good to have continued training."* – CHW
Standardization of CHW role	*"I actually do think the training would be beneficial just because a lot of the information, no matter what area they're working in or the people that they serve, I think it would be beneficial just to have some type of standardized training."* – CHW *"We have standardization across the board...We know that if you're working with a community health worker that, first, the community health worker has this knowledge or skill set, but also that we know that our clients are getting a certain standard of care across the board."* – Employer *"Then you know everyone is learning the same thing. There's a lot of confidence in that. So there's not all of these different trainings. It's just this is the training, everyone takes it, and you know if you are hiring…then you have more confidence in what they're going to do, because it's just a standard."* – Employer

Concerns about standardized training

CHW and employer interviewees identified potential costs associated with standardized training as their main concern. CHWs expressed that implementing a standardized training program could be difficult. Employer and CHW interviewees were concerned that national standards do not exist, a standardized training would be too rigid to fit individual organizations' needs, and that CHWs might not feel comfortable in formal educational settings or with taking exams. Lack of clarity about whether experienced CHWs would be required to complete standardized training was a concern from both interview groups. Time away from work or not being compensated during training was also a perceived issue.

Table 36: CHW and Employer Concerns about Standardized Training

Theme	Quotation
Costs	*"That's my major thing is the cost, you know, the cost for individuals that may want to become a CHW and find out that it has to be a test. Some individuals, like I say, may not be able to afford to pay for the fee."* – CHW *"Maybe cost. So yeah, definitely if it was a smaller organization…investing a lot of money into training might not be something that's feasible for an organization."* – Employer
Training could be too rigid	*"I think different people have different strengths, so sometimes if you try to standardize something too much it takes away from that personal touch that people can have, you know, or pull from their own personal strengths in the position."* – CHW *"I think the goal is to have CHWs not be disease specific, like it's anything you need. So, if someone were to get standardized training, you would have to make sure that they were knowledgeable on most chronic conditions, which may be a challenge."* – Employer
Formal training creates barriers	*"It can be a barrier to certain communities that might not necessarily have access to formal education, for example. So I'm imagining if there's a community that does not have many people who have gone through the formal educational process who might have folks who are interested in becoming community health workers but don't necessarily know how to navigate going to school or going through training or taking exams, then that creates a barrier."* – Employer
Experienced CHWs do not need training	*"I am concerned about people who've been doing this a long time and then if there's a training that's standardized that they have to do, then is this a pass, fail? Or is this a completion, incomplete? Because I think about like my older people, or the idea of community health workers is that they do have different educational backgrounds. And so, what if someone is a beautiful CHW but they don't have the best test-taking skills, you know? And then they can't pass this. Then what?"* – Employer *"If it was made mandatory for an actual CHW position…maybe some of the older generation may not want to go through that, and well I'm already a CHW, why do I have to take this standardized test or why do I have to go through this training? I've been doing this for 35, 40 years. Why do I need to do it?"* – CHW
Time away from work	*"The biggest challenge will be trying to find the time and the money."* – CHW *"I think some of the challenges would be one, is just the time. I think that a lot of people who are doing this kind of work are oftentimes...may not have that amount of time or be able to take time off of work unless you're getting paid to do a training or something."* – Employer

Training Administration

When asked who should develop and conduct a potential standardized training, CHWs and employers interviewed supported a collaborative approach, particularly one that included CHWs or a CHW professional organization, such as LACHON, and other stakeholders. Other interview responses included state and public health entities, universities, faith-based organizations, non-profit or community-based organizations, managed care organizations, health care systems, and community colleges.

When asked who should be responsible for paying any fees associated with a standardized training program, most CHW and employer interviewees answered that employers should be responsible. A small number of interview respondents in each group felt that the state should be responsible, and two respondents offered that a federal grant to pay for training might be helpful for smaller organizations.

Table 37: CHW and Employer Perspectives on Training Administration

Theme	Quotation
Collaborative group should administer training	*"I think you need to look at stakeholders from around the state who have been CHWs, and maybe individuals who have been supervisors of CHWs in the past, and you maybe start a work group that can create how that should look."* – CHW *"It would have to be an eclectic mix of agencies, because I couldn't see one agency alone being able to put together something that'd work for the entire state…You know just a really large mix of people as well as other CHWs, just because they've worked in the field. They understand what's going on."* – CHW *"No, I think a collaboration would be your best approach, because everyone may have a different idea but everyone has something different to contribute as well. So if you could create a melting pot where you take ideas from various organizations and you put them together, you come out with something galvanized, something that's all-inclusive and whole...You want it to be a partnership, not a competition."* – Employer
Responsibility for fees	*"Not the CHW. They can't afford it! No, you have to find a way to pay. Somebody's going to have to find a way to pay for it. Maybe you have to find a host organization or find some money to pay for it, but definitely not the CHW. A lot of times when we're working in this industry, you can't afford it. I'm just being honest."* – CHW *"The state. I know sometimes it can be funded by the organization, but like I said that some organizations can't afford to do and it can become a problem." – CHW* *"I would assume it would be the agency…We've always just kind of done it when it came to training."* – Employer

CERTIFICATION

In recent years, there has been increased interest in certifying CHWs. The Association of State and Territorial Health Officials (ASTHO) describes certification as a "potential mechanism to help assure stakeholders that CHWs are proficient in certain crucial capabilities."[18] Generally, obtaining a certification requires completing a standardized training program, and it may require an exam and continuing education. Some sort of governing body must oversee the certification process. ASTHO makes the important distinction that licensure is reserved for people who perform clinical duties that pose a significant risk of harm to the public. Licensure is therefore not necessary for CHWs because they do not conduct clinical work.[18]

As of 2020, 16 states have implemented or are in the process of implementing some sort of voluntary certification for CHWs.[22] However, there is little research on how such certification may affect the workforce. In the absence of effectiveness data, the CDC recently undertook efforts to understand the process of developing and implementing certification.[25] Findings included the need to engage stakeholders in the CHW workforce to assess knowledge of and desire for certification.[25]

Nationally, there is tremendous inconsistency in stakeholders' understanding of certification.[28] There is often confusion about the difference between educational certificates (e.g. certificates of completion from training programs) and certification.

KNOWLEDGE ABOUT CERTIFICATION

In keeping with national trends, CHWs and employers in Louisiana demonstrated a lack of knowledge about certification and confusion between standardized training and certification. The majority of interview respondents, both CHW and employers, were only vaguely familiar with certification. There was a perception among interviewees that standardized training leads to certification and then reimbursement for CHW services, either from Medicaid or Ryan White funding, which is inaccurate.

PERCEIVED BENEFITS OF CERTIFICATION

CHW survey participants largely endorsed several possible benefits of certification including the opportunity to learn new skills, improving work, and gaining credibility.

Table 38: CHW Perceptions of Certification Benefits

Survey Statement	Agree completely	Agree somewhat	Disagree somewhat	Disagree completely
Providing me with the opportunity to learn new skills (n= 56)	46 (82.1%)	8 (14.3%)	2 (3.6%)	-
Clearly defining my role as a CHW (n= 56)	44 (78.6%)	7 (12.5%)	3 (5.4%)	2 (3.6%)
Improving my job opportunities (n= 55)	44 (80.0%)	9 (16.4%)	1 (1.8%)	1 (1.8%)
Improving the work I do as a CHW (n= 55)	42 (76.4%)	11 (20.0%)	1 (1.8%)	1 (1.8%)
Increasing the respect I receive from other professionals (n= 56)	38 (67.9%)	11 (19.6%)	7 (12.5%)	-
Increasing my employer's confidence in my abilities (n= 56)	38 (67.9%)	13 (23.2%)	3 (5.4%)	2 (3.6%)
Increasing my self-confidence as a CHW (n= 55)	37 (67.3%)	12 (21.8%)	3 (5.5%)	3 (5.5%)

Employers generally agreed that certification would help CHWs learn new skills and gain respect from colleagues. They also agreed that CHW certification could increase sustainable funding and expand CHW roles.

Table 39: Employer Perceptions of Certification Benefits

Survey Statement	Agree completely	Agree somewhat	Disagree somewhat	Disagree completely
Helping CHWs learn new skills (n=33)	27 (81.8%)	5 (15.2%)	-	1 (3.0%)
Improving CHWs' work performance (n=33)	25 (75.8%)	5 (15.2%)	2 (6.1%)	1 (3.0%)
Expanding the CHW workforce (n=33)	24 (72.7%)	5 (15.2%)	3 (9.1%)	1 (3.0%)
Increasing the respect CHWs receive from other professionals (n=33)	24 (72.7%)	5 (15.2%)	2 (6.1%)	2 (6.1%)
Helping obtain more stable funding for CHWs (n=33)	23 (69.7%)	6 (18.2%)	3 (9.1%)	1 (3.0%)
Better integrating CHWs with other team members (n=33)	23 (69.7%)	5 (15.2%)	4 (12.1%)	1 (3.0%)
Expanding CHWs' responsibilities (n=32)	22 (68.8%)	5 (15.6%)	4 (12.5%)	1 (3.1%)

Among CHWs and employers interviewed, many of the perceived benefits of certification aligned with the survey data. Interviewees focused on the standardization of skills, improved job performance, sustainability, health system and stakeholder interest in working with and supporting CHWs, credibility among stakeholders, and opportunities for professional development. There were also interview respondents who felt that certification might lead to increased hiring, an increase in the size of the workforce, and therefore an increase in compensation.

Table 40: CHW and Employer Perceived Benefits of Certification

Theme	Quotation
Improved job performance	*"…it would also make them especially more certified in their position, so they're able to help people even more and more efficiently. So, they might get different kind of training or more hands-on training to learn better how to help people and definitely they can make connections within other communities and other community health workers."* – CHW *"I think the benefit of a training, is the training itself. I think once they go out and get the training they need, and they are qualified, or the re certifications that they need, that shows they are qualified to do their job, and do what is expected of them to do, to get the community where they want it to be."* – CHW
Increase CHWs' credibility	*"I think it'll give us more prestige within the structure of health care."* – CHW *"As soon as you have a certification program, people automatically see a little bit more value in something."* – Employer *"It seems like in Louisiana, it's a young field compared to…the field in some other states...If there was a program or a certification in Louisiana that was offered and recognized, I think that would give more credibility to the position and the role."* – Employer
Access to continuing education	*"I have heard of the training and certification in, I don't know one or two other places...I personally would like that because those continuing education courses over time, you'll get to know new advances or things that may have changed, new laws, new rules, new methods."* – CHW *"I think I support it because that means they're getting continuing education on basically staying up to date on trends and changes."* – CHW
Increase CHW pay	*"Because if you get certified, your pay would increase."* – CHW *"If you get the certification, supposedly you get the pay with the certification."* – CHW *"Once you're certified, then that says I've gone through a process to achieve a certain level and I've passed a standardized test, so now I am certified and I'm compensated as such."* – Employer
Increase CHW employment	*"It shouldn't have to be that way, but I guess when there's a certification or when there's a certificate or some sort of official-ness behind it, people tend to buy into things a little bit more. So it might increase buy in, and people may hire CHWs more."* – Employer
Sustainable funding	*"…to have some sort of certification where it could be a billable service under Medicaid, private insurance companies, Ryan White."* – Employer *"The only thing that I could see a benefit of it is…how can we bill Medicaid for it? Where we can also be sustainable?"* – Employer

Concerns about certification

CHWs agreed with several negative statements regarding certification. They most commonly agreed that they would not be able to afford costs associated with such a process, and roughly two thirds had some concern about non-CHWs creating requirements for CHW certification.

Table 41: CHW Concerns about Certification

Survey Statement	Agree completely	Agree somewhat	Disagree somewhat	Disagree completely
I would not have the resources to pay for it (n= 57)	24 (42.1%)	15 (26.3%)	8 (14.0%)	10 (17.5%)
I do not want people who are not CHWs to create requirements for CHW certification (n= 55)	24 (43.6%)	12 (21.8%)	7 (12.7%)	12 (21.8%)
I already have the skills I need to do my job based on my experience (n= 57)	18 (31.6%)	18 (31.6%)	13 (22.8%)	8 (14.0%)
It could change how the communities I serve see me (n= 57)	16 (28.1%)	17 (29.8%)	7 (12.3%)	17 (29.8%)
My employer would not pay for it (n= 55)	13 (23.6%)	15 (27.3%)	12 (21.8%)	15 (27.3%)
It would not make a difference in the work I do (n= 56)	13 (23.2%)	10 (17.9%)	16 (28.6%)	17 (30.4%)
The people I serve do not believe I need a certification (n= 57)	12 (21.1%)	15 (26.3%)	14 (24.6%)	16 (28.1%)

Roughly three quarters of employers surveyed agreed at least somewhat that certification could change community perception of CHWs and that CHWs would not have funds to complete certification.

Table 42: Employer Concerns about Certification

Survey Statement	Agree completely	Agree somewhat	Disagree somewhat	Disagree completely
It could change the way community members perceive CHWs (n= 31)	13 (41.9%)	10 (32.3%)	5 (16.1%)	3 (9.7%)
CHWs would not have the resources to pay to become certified (n= 31)	10 (32.3%)	13 (41.9%)	7 (22.6%)	1 (3.2%)
It may create tension between certified and uncertified CHWs (n= 32)	7 (21.9%)	9 (28.1%)	12 (37.5%)	4 (12.5%)
There may be too many requirements for CHWs to become certified (n= 30)	6 (20.0%)	6 (20.0%)	15 (50.0%)	3 (10.0%)
It would cost us money to pay for CHWs to become certified (n= 30)	6 (20.0%)	10 (33.3%)	11 (36.7%)	3 (10.0%)
Certified CHWs could require higher salaries (n= 32)	5 (15.6%)	15 (46.9%)	10 (31.3%)	2 (6.3%)
CHWs already have the skills they need to do their job based on their experience (n= 31)	4 (12.9%)	13 (41.9%)	10 (32.3%)	4 (12.9%)

Similarly, employers and CHWs interviewed were concerned about being responsible for additional costs associated with certification, though the majority of CHWs interviewed felt that the employer should cover such fees. Two employers interviewed believed that CHWs should pay for certification costs.

Outside of cost, CHWs interviewed were concerned about the potential time certification could take away from their jobs, and they expressed that they did not want to take an exam. Employers interviewed were also concerned about time away from work and that CHWs with limited formal education would not be comfortable in academic settings. Some employers perceived that experienced CHWs were already effective without being certified and that they may be unable to complete certification requirements. People who were more familiar with certification expressed concern over the bureaucratic process that would be required to administer certification and the possibility of non-CHWs regulating the workforce.

Table 43: CHW and Employer Concerns about Certification

Theme	Quotation
Costs	*"If they have to pay the cost, again, I can't say this enough, CHWs do not make a lot. If that cost is something that they have to fork out themselves, sorry, probably will be a problem for them."* – CHW *"I think that probably that would leave out a huge number of people that could be CHWs just because of bureaucratic and administrative challenges, especially if there's any money that affiliated with it also, like paying these fees. And I think we would end up losing well-qualified people if we needed to do that."* – Employer
Prohibitive exam requirements	*"They may not have the ability to pass a certification, but that doesn't mean they can't do the job."* – CHW *"Sometimes we consider lived experience or connection to the community over high school diploma or college degree. And it could or could not be something that they're comfortable with. So if that person hasn't been in an academic setting for a very long time, or there's something that they're just not into, but they're good at their job, it may be a deterrent."* – Employer
Bureaucratic hurdles	*"[CHWs] are overworked a lot of the times. Certification could be one more thing that they have to do that would certify them and more so if you're thinking about people who have been doing this work for a long time. Do I really need this?"* – Employer *"I think just starting some kind of new certification, that means more bureaucracy. So, just navigating that system of getting certification, maintaining that certification."* – Employer
Non-CHWs regulating the workforce	*"We have gatekeepers that know their community better than anybody. Who would come up with a certification training? [People] who've never done outreach, who've never engaged the community? And then they're the ones that's putting on this standard or what it should look like. And then never stepped foot in any community at all."* – Employer *"I don't want that certification because basically it's going to be, the people that's going to be putting this certification together are going to be white people who are researchers who don't know anything about the vulnerable populations. People who don't know about communities that are being served, you know, who are trying to tell gatekeepers what they need to be doing, and you're not doing this right, and that's something that I would challenge."* – Employer

When asked about any additional potential barriers to a CHW becoming certified, CHWs and employers interviewed felt background checks would be problematic for CHWs who had been justice-involved. CHWs and employers were also concerned about the amount of time away from work that certification could require, while others mentioned multiple barriers. One CHW interviewee mentioned that certification materials (e.g. training and exams) would need to be available in languages other than English.

Table 44: Potential Barriers to CHWs Obtaining Certification

Theme	Quotation
Background checks	*"There are people who are coming home from prison that can work a community and know what they're doing once they get some training. Will they be able to do certification? Will they be able to go to classes?"* – CHW *"Well, like you say sometime you have community health educators are those that are part of the community, so criminal backgrounds or records may be a hindrance because some of those people may actually be your best community health workers. They've done something early on in their life and now they're a little older or wiser...I give them the opportunity to get on the right path."* – Employer
Time away from work	*"I think time is always a big one."* – CHW *"Travel. Logistics. If there is a supervisor or an agency that doesn't see the value in allowing the person to take time to do that during work hours, that would be a challenge."* – Employer
Multiple barriers	*"What about those people who's been doing this forever? And now that we're at this point and now we're saying you need to be certified and the certification costs this and it means this, and you have to take this test and you have to apply for this. That would create the same reality for people we're trying to help right now. It's obstacles. Just to be employed. Now we've created, as a CHW network, a barrier to employment."* – Employer

RECOMMENDATIONS

RECOMMENDATION 1: CONTINUE STATE-RECOGNIZED MULTI-STAKEHOLDER CHW WORKGROUP

Members of the Louisiana CHW Workforce Study Committee, along with other interested stakeholders, should continue to collaborate as a CHW Workgroup. At least half of the Workgroup members should be CHWs. This Workgroup should continue to advise the Louisiana Department of Health and other relevant Louisiana stakeholders about ongoing CHW workforce policy issues and support implementation of the recommendations listed below.

RECOMMENDATION 2: ADOPT THE AMERICAN PUBLIC HEALTH ASSOCIATION'S CHW DEFINITION

The State of Louisiana should adopt and use the American Public Health Association's definition of CHWs in all CHW policies and programs. It is the most widely used definition nationally, and it represents the full range of Louisiana CHWs' roles identified in our study.

RECOMMENDATION 3: ADOPT CHW CORE CONSENSUS PROJECT ROLES, SKILLS, AND COMPETENCIES

The State of Louisiana should adopt the Community Health Worker Core Consensus (C3) Project as a guideline for developing CHW training and CHW programs so that Louisiana CHWs have the capacity and support to carry out the full range of their roles. The C3 roles, skills, and competencies are consistent with the work of Louisiana CHWs, and have been endorsed by the Louisiana Community Health Outreach Network.

RECOMMENDATION 4: PROVIDE TECHNICAL ASSISTANCE TO CHW PROFESSIONAL GROUPS

The CHW Workgroup should provide technical assistance to CHW-led professional groups, as needed. Such organizations can support the workforce by convening CHWs to share resources and best practices, and by offering training and continuing education. CHW-led organizations may benefit from outside support with strategic planning or program administration.

RECOMMENDATION 5: SUPPORT CHW CORE COMPETENCY TRAINING IN LIEU OF CERTIFICATION

The CHW Workgroup should create a process to evaluate and recognize standardized CHW core competency training programs in Louisiana based on CHW and employer desire to ensure that CHWs receive sufficient training and support. Given that many of the perceived benefits of CHW certification can be achieved through standardized training and CHW and employer concerns about certification, implementing a CHW certification process in Louisiana is not recommended at this time.

RECOMMENDATION 6: CREATE AN ONLINE CHW REGISTRY

The CHW Workgroup should create a voluntary, online CHW registry in partnership with CHW professional groups. A registry would allow for ongoing assessment of CHW workforce activities, distribution of CHWs throughout the state, and need for workforce support.

RECOMMENDATION 7: PROVIDE EDUCATION ABOUT CHWS

The CHW Workgroup should collaborate to develop a broad, statewide educational campaign about CHW roles and program implementation models. Target audiences should include health care providers, community-based organization staff, public health practitioners, and the general public. Such education could help overcome confusion about CHWs and support creation of new CHW positions.

RECOMMENDATION 8: PROVIDE TECHNICAL ASSISTANCE FOR CHW EMPLOYERS

The CHW Workgroup should provide technical assistance to organizations that currently employ CHWs or plan to hire CHWs. This support should include sharing best practices in CHW program development and implementation, as well as data collection strategies.

Recommendation 9: Use common data indicators

All State of Louisiana CHW programs should use common, standardized measures to track CHW activities and outcomes. Programs currently use different indicators to assess outcomes, creating difficulties in tracking effectiveness across programs.

Recommendation 10: Implement a Medicaid CHW benefit

The CHW Workgroup should collaborate with Louisiana Medicaid to create a CHW benefit. This benefit should be financed on a per member per month basis, as opposed to a fee for service reimbursement model, which has experienced limited uptake in other states.

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