SENATE JOINT MEMORIAL 076
REPORT ON THE DEVELOPMENT OF A COMMUNITY HEALTH ADVOCACY PROGRAM IN NEW MEXICO

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NEW MEXICO
DEPARTMENT OF
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"It is the policy of the state of New Mexico to promote optimal health; to prevent disease, disability and premature death; to improve the quality of life; and to assure that basic health services are available, accessible, acceptable and culturally appropriate, regardless of financial status. This policy shall be realized through the following organized efforts:

- ***education, motivation and support of the individual in healthy behavior***
- ***protection and improvement of the physical and social environments***
- ***promotion of health services for early diagnosis and prevention of disease and disability***
- ***provisions of basic treatment services needed by all New Mexicans"***

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I. Executive Summary

During the Forty Sixth Legislature, First Session 2003, the New Mexico Legislature adopted Senate Joint Memorial 076. The Memorial requested that the New Mexico Department of Health (NMDOH) "lead a study on the development of a Community Health Advocacy Program in New Mexico, including the program's methods, structure, financing and implementation, that utilizes various categories of community health advocates."

As defined in SJM 076, Community Health Advocates include "community health workers, promotoras, community health promoters, community advocates, outreach educators, doulas, peer health promoters and community health representatives." The term Community Health Worker (CHW) has been used throughout this report. It is intended to encompass all of the job titles listed in the memorial.

This report provides a comprehensive analysis of the contribution of Community Health Workers (CHWs) to the health and stability of New Mexico communities and the potential for development of additional CHW programs in New Mexico. Included in this report are inventories of existing service-delivery programs and sites and the supply and distribution of CHWs, as well as an assessment of the potential for CHWs to reduce health-professional shortages.

The data, analysis, and findings of this report show that access to CHWs for many New Mexicans has the potential to improve public health outcomes, increase access to care, and reduce costs for health services. Thus, this report includes recommendations for initiatives needed to provide for the sustainability of CHWs and ways that a statewide CHW program may contribute to the economic and workforce development of New Mexico through public-private partnerships.

The following list is a summary of the taskforce's major recommendations. A full list of taskforce recommendations is provided in Section V of this report.

I. Administration

A. Establish a Community Health Workers (CHW) Advisory Committee.
B. Establish and fund a program in the NMDOH to coordinate and facilitate development of the CHW program statewide.

II. Methods and Structures

A. Recognize CHWs as generalists and specialists, depending on their training and field of work.
B. Develop a certification process so that certification can be offered.
C. Create a salary schedule and compensation plan based on regional parity and parity for practicing CHWs.

D. Educate medical professionals on utilization of CHWs for health promotion and disease prevention and management.

III. Financing/Economic Development

A. Increase and/or modify Rural Primary Health Care Act (RPHCA) funds to specifically provide funds for CHW services and incentives for recruitment and retention of CHWs.
B. Leverage existing dollars from federal, state, Tribal, and Indian Health Service programs for training and employment of CHWs.
C. Investigate reimbursement for CHWs under Senate Bill 743 which requires third-party insurers to offer tobacco use and smoking cessation counseling services to their insured members.
D. Establish a critical shortage area designation for CHWs providing care to the underserved.
E. Develop criteria, designation, and expanded financial incentives for public/private partnerships that use CHWs to promote healthier communities.
F. Use the Senior Employment Older Workers Program to provide subsidized job placement for adults age 50 and older wishing to serve as CHWs.
G. Require organizations and facilities receiving state funds for clinic operations and services to, where feasible and appropriate, establish partnerships with private and/or other health providers for CHW services.
H. Include CHW services in private health insurance plans through the State Insurance Commission.

IV. Medicaid Best Practices

A. Determine ways to maximize Medicaid funds through use of CHWs.
B. Authorize the State Medicaid Program to develop, direct, and implement contractual modifications to current Medicaid Managed Care Contracts to assure a payment mechanism for support of the CHWs.

V. Training/Curriculum/ Career Ladder

A. Create standards for core curricula based on core competencies established in this study.
B. Develop a core training program with additional components on specialty areas of health.
C. Enhance funding to NM community colleges, technical schools and universities to establish programs to promote a career ladder for CHWs.
D. Use the Senior Employment Older Workers Program to provide training for adults age 50 and older who wish to serve as CHWs.

VI. Evaluation and Effectiveness

A. Create a statewide evaluation system and database for collecting and analyzing information about CHW programs and their effectiveness.

II. Introduction

During the Forty Sixth Legislature, First Session 2003, the New Mexico Legislature adopted Senate Joint Memorial 076. The memorial can be found in **Appendix A**. SJM 076 was sponsored by Senators Linda Lopez, Sue Wilson Beffort, Dede Feldman, and Mary Kay Papen. The Memorial requested that the New Mexico Department of Health (NMDOH) "lead a study on the development of a Community Health Advocacy Program in New Mexico, including the program's methods, structure, financing and implementation, that utilizes various categories of community health advocates." The New Mexico Departments of Children, Youth and Families, Human Services, Education, Economic Development, Aging and Long Term Care, and Labor (NMCYFD, NMHSD, SDE, DED, NMALTCD, and NMDOL) were also tasked with participating in the study.

The community health advocate is a "a member of the community who works in community settings and serves as a connector between healthcare consumers and providers to promote health among groups that have traditionally lacked access to adequate care." The strength of CHW services lies in CHWs' cultural sensitivity and personal history with the community. As defined in SJM 076, Community Health Advocates include "community health workers, promotoras, community health promoters, community advocates, outreach educators, doulas, peer health promoters and community health representatives."

However, one important finding of this report is that "Community Health Worker," not "Community Health Advocate," is the nationally-recognized term for community-based health promoters. Thus, in accordance with the recommendation of study participants and to assure consistency, the term Community Health Worker (CHW) has been used throughout this report. It is intended to encompass all of the job titles listed in the memorial. The term used in New Mexico communities is often specific to the community served.

III. Study Methods

A multi-disciplinary taskforce was formed to provide technical assistance, consultation, and feedback on the data from the perspective of CHWs and community stakeholders. Taskforce participants included representatives from the following public and private sectors: state governmental agencies identified in the memorial, professional associations, community health clinics, post-secondary education, managed-care organizations, local hospitals, tribal Community Health Representative (CHR) programs, the Indian Health Service, and CHWs themselves. The complete list of taskforce participants can be found in Appendix B.

Participation in the taskforce deliberations continued to grow as additional stakeholders were identified over the course of the last six months. Even as the report was being drafted, focus groups continued to be held. It is envisioned that the work of the taskforce will continue until the end of the year.

At an organizational meeting on May 30, 2003, core members of the taskforce created a work plan that included data collection, analysis, and presentation. Workgroups were established to research and make recommendations about the following topics:

- Methods, structures, and implementation of various categories of CHWs
- Financing, including tax incentives
- Use of CHWs as part of best-practice quality measures for Medicaid
- Curriculum
- Career ladder, certification, licensure, and degrees
- Evaluation and effectiveness
- Participants in the Memorial study

The full taskforce met three subsequent times, on July 14, August 3, and September 11, 2003; all meetings took place in the Albuquerque area. A temporary workgroup for the development of survey tools and data collection was assigned at the July 1 meeting. Workgroups used conference calls to accomplish interim goals between full meetings of the taskforce. Each workgroup developed recommendations, which were presented at the September 11, 2003 meeting of the taskforce. At that meeting, results, conclusions, and recommendations were presented and agreed upon by the group.

The work plan designed by the SJM 076 Taskforce was divided into three phases:

A. Phase 1: Survey Design/Focus Group Format/Assessment Design

Two surveys tools and a format for conducting focus groups were designed by a workgroup of the SJM 76 Taskforce. The overall research goal was to better understand issues affecting CHWs in New Mexico. The surveys were conducted with support of the Kellogg Community Voices New Mexico at the University of New Mexico Health Sciences Center for Community Partnerships (CCP) and the Border Health Office (BHO) of the NMDOH. The focus groups and questionnaire completion were conducted with

support of the CCP, BHO, tribal CHR programs, and agencies that employ or have an interest in CHWs.

Survey Tool 1: *Community Health Advocates Survey/Assessment* (See Appendix C) This survey was adapted from a survey developed by the CCP in 1998. It was designed to gather information from organizations that do or could potentially employ CHWs. Surveys responses were collected by telephone interviews, in-person interviews, fax, and postal mail. It was used to gather information about the number of CHWs working in the state, their geographic distribution, populations served, funding sources for programs that use CHWs, training availability, and employer expectations of CHWs.

Survey Tool 1 was designed to answer the following questions:

- What are the characteristics and factors that strongly relate to rural CHW preference?
- What factors correlate with the provision of services to New Mexico residents?
- What are the variances in demographic characteristics and experience among New Mexican CHWs?

Survey Tool 2: *Community Health Advocate Questionnaire* (See Appendix D). A second survey tool was designed for distribution to CHWs currently working in New Mexico. Survey responses were collected during focus groups, regularly-scheduled meetings of CHW organizations, and by postal mail and fax. The CHW Questionnaire was divided into four sections: demographic characteristics, employer practices, self-evaluation, and training practices and needs.

Survey Tool 2 was designed to answer the following questions:

- What are the demographic characteristics of CHWs in New Mexico, including age, gender, ethnicity, education level, and geographic location?
- What are standard practices of organizations that use CHWs, including wages, benefits, supervision, job duties, and hiring practices?
- How do CHWs evaluate their skills using as criteria the eight core skills and knowledge identified in the 1998 National Community Health Workers Study? CHWs were asked to rate themselves on a scale of one to ten, with one being "not at all confident" and ten being "extremely confident" in these skill and knowledge areas.
- How are New Mexico's CHWs trained? How do they describe and evaluate their initial and continuing training, including number of hours, topics, and how well their training has prepared them for their work?
- What additional training needs do CHWs have?
- What other areas of knowledge or skills would be beneficial to their work as CHWs?

Focus Groups (See Appendix F): A standardized method of conducting focus groups was developed by the taskforce. Because of time constraints, focus groups were conducted simultaneously in different areas of the state by several skilled facilitators. The survey

tools workgroup developed a written script, which was provided to all facilitators. Spanish/English translation was provided during focus groups when necessary.

During each focus group, the facilitator explained the purpose for collecting information for the SJM 076 study. If they had not yet done so, participants were then asked to fill out the CHW questionnaires in addition to participating in the focus group. This increased the return rate of questionnaires and provided a basis for launching focus group discussion. After the questionnaires were completed, the facilitator led a discussion by asking as many of the following questions as time allowed:

1. If funding were not a problem, would you be interested in pursuing a college degree?
2. Do you think that a CHW training program should require going to college?
3. In what sort of setting should CHW training take place?
4. If you were asked to design a curriculum for CHWs, what essential elements would you include?

B. Phase 2: Data Collection and Analysis

This phase involved:

- distribution of Survey Tool 1, Community Health Advocates Survey/Assessment and collection of responses;
- distribution of Survey Tool 2, Community Health Advocates Questionnaire and collection of responses;
- development of a database to quantitatively analyze the responses to Survey Tools 1 and 2;
- the use of focus groups to collect and analyze qualitative information about CHWs work, initial training, and current training needs;
- a literature search, collection of reports for background information, and an environmental scan;
- the identification, collection, and analysis of data on funded programs,
- an inventory and assessment of supply and distribution of CHWs; and
- an assessment of the training and curriculum availability for workforce development.

Workgroups from the SJM 076 Taskforce, including representatives from NMDOH, CYFD, HSD, DOL and SDE, conducted research on the use of CHWs throughout the U.S., including national patterns, characteristics and supply of CHWs, and federal and state initiatives to address CHW services and Medicaid programs, as well as tribal CHR initiatives and the Indian Health Services. Compilation and analysis of state-level data included Medicaid participation, geographic distribution, population served, public and private financial resources and existing resources for educational and training programs. Additionally, the SJM 076 Taskforce requested information on existing CHW services funded by tribal governments and the Indian Health Service Facilities.

Survey Tool 1 was used to collect data about CHW services, including the absence of CHWs, at 41 community health center sites, 31 Indian Health Service sites, and 60

community service organizations. To assess the resource capacity and operational factors affecting CHW care delivery in the indigent care CHW network,

Approximately 220 CHWs participated in 19 focus groups held in communities statewide. These communities were: Hatch, Las Cruces (two focus groups), Deming, Sunland Park, Anthony, Silver City, Truth or Consequences, Mimbres, Albuquerque (five focus groups), Farmington, Santa Fe (two focus groups), Espanola, and Laguna Pueblo. Communities were chosen to represent geographic diversity, urban and rural areas, and areas of high concentration of underserved and populations at high risk for disease.

The additional analysis of the survey included extensive cross-tabulations of the provider database from Survey Tools 1 and 2.

C. Phase 3: Formulation of Recommendations

Data, analysis and findings resulting from the work done in Phases I and 2 were presented. Members of the taskforce provided valuable input and information, and presented additional data. The taskforce delineated a comprehensive list of issues and options, which were distilled into the Recommendations and Potential Strategies matrix found in Section III. Recommendations were presented to the Departments of Health, Children, Youth and Families, Human Services, Education and Labor on September 29, 2003.

IV. Study Results

The literature review and experience of taskforce participants provided an international, national, and statewide context for understanding the work and efficacy of CHWs. In New Mexico, the rest of the United States, and worldwide, CHWs are working to promote community health and well-being. The international and national emergence of CHWs as community specialists has broad implications for the continued development of CHW programs in New Mexico.

A. The Role of CHWs Worldwide

A CHW is "a member of the community who works in community settings and serves as a connector between healthcare consumers and providers to promote health among groups that have traditionally lacked access to adequate care" (A. Witmer, et al). CHWs are called by a variety of names including Community Health Workers, Promotores, Community Health Representatives, Doulas, Peer Breastfeeding Counselors, Auxiliaries, Barefoot Doctors, Health Agents, Health Promoters, Family Welfare Educator, Peer Educators, Health Volunteers, Village Health Workers, and Community Health Aides.

This multiplicity of names correlates with the multiple roles that CHWs play in their communities. According to the International Medical Volunteers Association, (IMVA), CHWs "can perform preventive medical services, monitor the community's health, identify patients at risk, act as liaisons between the community and the health system, interpret the social climate…and they are often the only practical means of providing longevity and breadth to the health programs." IMVA observes that CHWs around the world currently provide, among other services, first aid, surgery assistance, operating room technician and equipment sterilization, treatment of minor illnesses, medication dispensation, pre- and postnatal guidance, delivery of babies, environmental health education and surveillance, school health, referrals, collection of vital statistics and home visits.

The positive impact of CHWs on community members' physical and mental health can extend to their communities' economic status. Improved community and individual health status have often been major determinants in the successful economic development of countries around the globe, and CHWs are often identified as the mechanism for improvements in health status.

Internationally, CHWs have successfully maximized limited health resources and improved health outcomes:

- In Ethiopia, disease surveillance, environmental health, immunization, nutrition and injury prevention services in addition to primary care supported by CHWs shore up a fragile public health program in rural geographically isolated provinces.
- In South America, most notably Brazil and Peru, Community Health Workers have over the past two decades dramatically increased care access, immunization status, prenatal care and postnatal outcomes. Working in partnership with licensed members of community health teams, Community Health Workers have specific

block assignments. They are responsible for the integration of health care into the homes of their fellow community members. The Trujillo Project, located in the Moche District of Trujillo is lead by the National University of Trujillo and is based on the theme of family surveillance.

- Formed as a partnership between the district public health departments, the schools of medicine and nursing, community leaders and the Kellogg Foundation, the Proyecto Uni project has significantly impacted birth outcomes, reduced the morbidity rates and reduced the impact of environmental related diseases. The project monitors the health status of each family within the neighborhood and develops individual and family care plans that are carried out in the community. In addition, the status of the community's health is posted in each clinic on a large map, depicting house by house the ongoing health status of its members. (W.K. Kellogg Foundation Community Voices: Health Care for the Underserved "Community Health Workers" Unpublished Paper).
- A John Hopkins study noted the effectiveness of CHWs in the management and reduction of tuberculosis as a major factor in reducing the disease in Bangladesh.

B. CHWs in the United States

Significant differences exist between the US model of health care and those of other countries that use CHWs in the delivery of care. The US model is driven by specialty technology and compounded by multiple factors: the complexity of financing, a highly organized and developed professional licensing and credentialing process, an active litigation and loss concern environment, the presence of overarching public health programs, the lack of access to care due to coverage gaps, and the increasing demand for behavioral health services within the population.

Unlike many undeveloped nations, the U.S. has been successful in the elimination of environmentally- and vaccine-preventable diseases. As a result, CHWs' evolving role in the U.S. has been in three occupational areas: as facilitators of health- and social-service access through outreach; health education and promotion; and more recently, care and disease management. CHWs in the U.S. provide outreach, health promotion and disease prevention, educational instruction, patient tracking, patient advocacy and assistance, and in some instances, health-care services. They work in health-care clinics, hospitals, community-based organizations, tribal health programs, local public health offices, WIC clinics, schools, and many other settings.

Nationwide, many social- and health-services organizations use CHWs as volunteers and paid personnel. Competencies and/or requirements for positions include: basic skills training; interview techniques; home visitation; orientation to community resources; possession of a driver's license, referral and follow-up for care and services; and in the case of translation, bilingual competencies. Agencies in New Mexico and elsewhere use CHWs as eligibility workers and enrollment specialists for Medicaid.

The authors of "Community Health Workers and Community Voices," a study funded by the W.K. Kellogg Foundation, point out that the participation of CHW's in outreach and

enrollment efforts has proven to be a more effective strategy for reaching underserved populations than traditional media-based strategies. CHWs act as "information brokers in the community," providing referrals, translating health information so that it is understood in laymen's terms, and offering support to people who are uncomfortable with a sometimes imposing health-care system. CHWs also play critical roles in educating community members about policy as well as collecting information that can be used to inform policy and reform health systems (Marguerite Ro, et. al).

Under the title Community Health Representative (CHR), CHWs have been working in Native American communities throughout the U.S. since 1968. The CHR plays a significant role in the health care of Native American communities across the U.S. In addition to the education and outreach services they provide, many CHR's are licensed Emergency Medical Technicians and certified First Responders.

Several nonprofit organizations represent CHWs on a national level. These include the National Community Health Workers Association (NCHWA) and the Lay Health Workers National Network/*Red Nacional De Promotors de Salud.* Doulas are represented and supported by the Doulas of North America (DONA), the Childbirth Education Foundation, and Lamaze, International.

1. CHWs Effectively Help People Overcome Barriers to Health Care

Increasingly, language, socio-economic, ethnic/cultural characteristics and health-professional shortages are being identified as contributing factors to poor health outcomes for many of the nation's minorities. Lower income is also associated with decreased utilization of health services among adults. Among the elderly, homebound seniors and the rural elderly, including Native American elders on reservations, face serious barriers to accessing care. The decreased utilization among adults is often related to the lack of disposable income, lack of a provider relationship, barriers associated with infrastructure issues, such as hours of clinic operation, existing debt to local clinics and resulting utilization of urgent or emergent system for primary health-care concerns. Children in low-income, uninsured families are less likely to use health-care and oral-health services. Populations that face linguistic and literacy barriers are also less likely to benefit from services received and more likely to have less follow through and more difficulty in successful treatment outcomes. Additional barriers include lack of transportation, child care services and knowledge of the often complex system.

Available literature on the efficacy of CHWs suggests they can work as "agents of change" by providing a variety of services to underserved people. Examples include:

- A recent study by the CDC's Division of Diabetes Translation suggests that CHWs are uniquely qualified as "connectors" between MCOs, government organizations and patients. Language, cultural identity and traditional health practices were also identified as barriers that CHWs help to overcome. CHWs provide valuable feedback to health-care providers regarding the community's health needs and the cultural relevancy of identified interventions. The CDC

researchers conclude that because of their unique position, skills, and expanded knowledge base, CHWs can feasibly reduce health-care and personal cost and improve health outcomes. However, the researchers observed that three elements are necessary for CHWs programs to be effective: recognition of the roles, skills, and contributions of CHWs; support for programs, including stable funding, technical assistance, and evaluation; and continuing education.

- A study conducted by the Pew Health Professions Commission evaluated the use of CHWs in the U.S. and concluded that CHWs can make substantial contributions to health-care access and improve health status in hard-to-reach populations. The study reports that CHWs fill an important access gap in the delivery system by "demystifying" system barriers and providing motivation for positive health behaviors.

- A comprehensive study of literature sponsored by the U.S. Department of Health and Human Services (USHHS) Office of Minority Health and the Agency for Healthcare Research and Quality concludes few studies exist that empirically measure the impact of CHWs. However, their findings suggest CHWs were effective in increasing health-related knowledge and self-care practices through health education and instruction. CHWs were also credited with higher rates of health-promotion course completion for community members. CHWs in the USHHS study facilitated behavioral change in the target population by providing encouragement and support and serving as role models. Increases in screening rates were attributed directly to their use in several studies. CHWs were effective in decreasing high-risk behaviors in the target population. They enhanced case management, tracking, and monitoring of patients, resulting in better follow-up for medical care. CHWs were highly valued by administrators, program staff and clients. The USHHS researchers caution that there are methodological concerns about the data used in the literature review. Foremost, there is no standard training required of CHWs, and agencies use CHWs in different ways. Quantitative evaluation of the effectiveness of CHWs programs is difficult because the populations CHWs serve are hard to reach and are highly mobile.

- According to Doulas of North America (DONA), 11 studies have shown that birth doulas – women "trained and experienced in childbirth who [provide] continuous physical, emotional, and informational support to a woman during labor, birth and the immediate postpartum period" – positively affect birth outcomes for the mother and infant. When doulas were involved, birth outcomes showed shorter labors, fewer complications, fewer Cesarean sections, and less need for forceps, vacuum extraction, oxytocin, pain medications, and epidurals. Mothers reported greater satisfaction with the birth experience, more positive assessments of their babies, and less post-partum depression. Infants experienced shorter hospital stays, fewer admissions to special-care nurseries, and breastfed more easily. Overall cost savings to the health-care system were significant.

2. Cost Effectiveness of CHWs

CHW work is most cost effective when the priority health needs of the community served are emphasized, adequate training and resources, including supervision and technical competencies, are available, and the access, acceptability and participation of community beneficiaries are improved. Lower fixed and variable costs of field versus fixed clinical services can further lower the cost of services by a CHW program. The resulting impact on health delivery and health outcomes is seen in a selection of a more efficacious intervention, an improved quality of care with greater coverage, and reduction of disparities. The resulting lower average costs, while long term in the making, also improve individual and population health outcomes.

- A Community Health Outreach Program sponsored by the University of Maryland at Baltimore offers a striking example of cost reduction. The program achieved a 27% reduction in Medicaid costs over the past three years, an average savings of $11,000 per patient.

- CHWs in the Pew study cited above also decreased the cost of care through their work in disease prevention and health promotion, specifically by increasing child immunization rates, decreasing incidence of hypertension, educating clients about smoking cessation, and providing pre- and post-natal education resulting in decreased infant mortality.

3. Training of CHWs

A need for a standardized core training curriculum for CHWs was almost universally recommended in the literature reviewed. CHWs worked in different fields of expertise, which ranged from education in specific health problems such as asthma, diabetes, and hypertension, to pre- and postnatal care, to behavioral health, to Medicaid enrollment. Despite the diverse roles that CHWs play in their communities, several studies have identified core skills and knowledge competencies that CHWs must possess to be effective in their service to communities. In addition, the potential for identifying a sustainable funding source will undoubtedly be influenced by the addition of a validated and quantifiable curriculum and levels of competencies on the part of the individual CHW.

More recently the CHW has been viewed by primary care and, to a lesser degree, specialty providers such as those in behavioral health, as potential contributors to the successful care management of the most difficult cases in communities. For example, researchers at Johns Hopkins noted the effectiveness of CHWs in the successful treatment and follow up of tuberculosis patients. The Hopkins' study is one of several that shows the level of competency and training of the CHW directly correlates to the successful outcomes of the services provided. This level of competency, when coupled with the community competencies, dramatically increases the effectiveness of CHWs.

Several training models exist in the U.S. Notable models include:

- The San Francisco Community College has developed a CHW Curriculum at or near the Associate's level. The program requires a high school diploma or a GED and tuition.

- The University of Arizona Area Health Education Center Program developed its Community Health Advising curriculum in 2001. The 16-credit basic certificate program is a competency-based curriculum that includes six hours of field work. The program requires a high school diploma.

- Northwest Vista College in San Antonio, Texas offers two tracks – a 26-credit hour certificate and a 65-66- credit Associate of Applied Science degree program. The program is designed to prepared graduates "to become members of the health-care system by working with nurses and public health professionals." A high-school diploma or GED is required for admission.

- The Native American CHR program provides a model for training that combines a recognition of core competencies with the flexibility of training to meet specific community needs. Training for CHRs is provided by the Indian Health Service in cooperation with the Tribes. All CHRs are offered the opportunity to take the "Community Health Representative Basic" course, a three-week curriculum that "is designed to 'introduce' the students to a broad base of health-related topics." After graduating from the basic course, most CHRs receive additional training and gain additional competencies. The additional training focuses on the area or health issue the CHR is asked to address, such as diabetes, nutrition, prenatal education, smoking cessation, asthma, or emergency medical response.

- Three certification programs for doulas exist in the United States. DONA offers a nationwide certification program for doulas. The program requires 16 classroom hours and attendance at three births. The Lamaze Foundation also offers a certification program, The most extensive certification program is offered by the Childbirth Enhancement Foundation, Inc. The curriculum requires 24 classroom hours, approximately 160 contact hours, includes a self-directed study program, and requires that the doula-in-training attend at least 10 births. There is also a continuing education requirement.

C. CHWs at Work in New Mexico

New Mexico's CHWs serve urban and rural communities; they work with Hispanic, Native American, Anglo, and other ethnic populations; and they provide services ranging from Medicaid enrollment to health education to translation to client advocacy. An estimated 500 CHWs work in New Mexico. Nearly 150 serve in the southern or border areas and about 150 serve on tribal lands.

The identification of New Mexico CHWs and the entities they work for is an ongoing task. Because of the diversity of duties performed by CHWs, their wide geographic

distribution, multiple job titles, and the instability of many of the organizations they work for, it was extremely difficult to find information about organizations that employ or use volunteer CHWs. Volunteer CHWs were especially difficult to identify and interview during this study. Of 150 organizations identified as having the potential to work with CHWs, 56 reported using lay health workers to supplement or provide programs and services. The remaining 94 entities did not employ or work with CHWs, did not respond to the survey, or phone numbers were disconnected and no new contact information was available. Organizations identified were health clinics, hospitals, local public health departments, tribal health programs, and community-based organizations with an emphasis on social or health services.

In "New Mexico Community Health Worker Program Evaluation," a study published in 1998 and funded by the Robert Wood Johnson and the Henry Kaiser Foundations, Kristine Trollestrup, Ph.D., M.P.H., notes in her conclusions: "[CHWs] work in a variety of settings and serve a diverse clientele. The participating [CHW] programs were located in both rural and urban settings. They ranged from independent programs to programs which were part of a medical clinic or a local health department. [CHWs] also served clients of all ages."

Other conclusions reached in Trollestrup's study of CHWs in New Mexico were:

- "CHWs provide a variety of services and assistance to their clients…. Activities of the CHW may be tied to funding sources such as the state breast and cervical cancer prevention programs and the diabetes program. However, many CHWs also provide general assistance with transportation, completing forms and seeking out social and medical services.
- CHWs' self efficacy is very high. CHWs have a very high self-efficacy score or a strong positive belief that they can perform well…their overall self-efficacy score was similar to nursing students'.
- Clients are very satisfied with their CHWs. Almost all would recommend the CHW to someone else.
- CHWs have a positive effect on their clients' knowledge, behavior and health outcomes. Clients report being very comfortable with skills for maintaining good health, (prenatal, women's health and diabetes)… CHWs also increased access to and use of prenatal care. Diabetic clients participating in a promotora program also experienced a significant decrease in hemoglobin A1c levels. The social support provided… by the CHW may play an important role in these positive outcomes."

Tollestrup's conclusions are reinforced by the experiences of SJM 076 Taskforce participants, the primary data collected during the study, and the work of other researchers. Other research studies of CHW programs in New Mexico found CHWs to be effective at reaching out to New Mexico residents and reducing health-care disparities

in the state. Studies suggest that CHWs have a positive affect on the health of people with issues such as diabetes and who need prenatal care. There is documentation of better birth outcomes in women who were served by CHWs. Longitudinal cost savings have also been demonstrated. CHWs are thought of highly by clients, health-care providers, and others with whom they interface.

CHW's can play a major role in overcoming mistrust in the health and social services systems. They are distinguished because of their role as trusted sources of information. They operate in formal and informal networks of individuals and have the ability to discuss health issues that some may find personal.

1. CHW Programs in New Mexico

New Mexico CHW programs offer examples of innovative program design and resourceful use of CHWs. Some of the CHW programs in New Mexico are described below. Many others exist, and a comprehensive Resource Directory of all CHW program in New Mexico would be a benefit of a statewide CHW program.

- Gila Regional Medical Center's (GRMC) First-Born Program uses CHWs to provide home visits to families with first babies. The program has received recognition as an Innovative and Exemplary Substance Abuse Prevention Program from the federal Substance Abuse and Mental Health Administration (SAMHSA). CHWs who work for the GRMC First-Born Program assist first-time mothers with their needs during phases from prenatal through early childhood, including education, nutrition, STD prevention, nursing, early childhood health, and education.

- Border Vision Fronteriza (BVF) II uses CHWs to conduct community outreach and education and enroll pregnant women and children in Medicaid and the State Children's Health Insurance Program (SCHIP). The program received a 2003 Border Models of Excellence Award. In early 2003, the New Mexico Legislative Reform Committee adopted the BVF model to be replicated statewide to increase the enrollment of children and pregnant women into state Medicaid/CHIP programs. Results of the BVF II project were presented in June 2003 at the Institute for Women's Policy Research Conference in Washington, D.C.

- The Southern Area Health Education Center's Environmental Health Education and Home Safety Project uses CHWs to educate residents of Dona Ana County in the areas of pesticide safety, handling of hazardous household products, food safety, fire safety and emergency planning. The program received a 2003 Border Models of Excellence Award.

- Community Health Representatives (CHRs) are Tribal employees and have been employed by and working in Tribal communities since 1968. They serve as both generalists and specialists, depending on the needs of the Tribes. CHR responsibilities are in the areas of environmental health, maternal and child

health, health education and promotion, diabetes, vision care, oral health and others. CHRs indicate that an important role is in reducing isolation among tribal elders. Many CHRs become Emergency Medical Technicians (EMTs) because of the need for emergency services in Tribal communities. Tribal CHR programs are operated under federal contracts and with federal funds.

- The CHR program in Laguna Pueblo provides a wide range of services including an elder project that targets isolation faced by many elders in the community. CHRs assist elders with referrals, health education, and keeping physician appointments, identify those who need handicap-accessibility in their homes, and organize "field trips" for elders who would otherwise be left alone.

- La Familia Medical Center (LFMC) in Santa Fe has used the CHW model since 1994. The model developed and used by the LFMC seeks to overcome cultural barriers preventing access to health care for the underserved. LFMC CHWs are drawn from the clinic's patient population. Because they are managing their own chronic illnesses, they have an in-depth and personal knowledge on which they base the methods of self-management that they share with their patients. LFMC providers say the CHWs provide an invaluable service to the patients and are an essential member of the health-care team.

- The Healthy Families First/Primeros Pasos program, operated out of the Santa Fe Health Office of the DOH Public Health Division, provides parenting support from the prenatal period through the child's third year of life. The program's mission is to promote and enhance the healthy development of children and families in Santa Fe County. The program uses licensed personnel along with promotoras. Voluntary home visits, beginning during the prenatal period and continued as needed through a child's third year of life (intensive home visiting), can produce improved birth outcomes, increased parenting skills, prevention of child abuse and neglect, promotion of healthy child development, improved school readiness, reduction of developmental delays, increased immunization rates, and utilization of preventive health services The program, which began in 1992, employs three CHWs and serves an average of 68 clients at any one time. Three-quarters (77 percent) of clients are pregnant teenagers. CHWs completed 1004 home visits and received 246 referrals in 2002. CHWs in the program are currently going through a credentialing process through National Healthy Families America, Inc.

- The Doula Program at Saint Vincent Hospital in Santa Fe was established in 1999. Funded by the Frost Foundation, the program supplies Doula services to people who can and cannot afford the service. Those that can afford pay $498.00 The Doula is paid $400.00 and the rest is put into a "kitty" to keep the grant functioning. As of 2002, the program had grossed $100,000 and expanded its services. The program is staffed by an Administrative Assistant, Lactation Consultant, and Childbirth Educators. The program has nine certified Doulas and 21 interns. Doulas are certified through the Childbirth Enhancement Foundation.

Doula Services consists of three prenatal visits, the birth, and at least two postpartum visits. The Doula Program is currently meeting the needs of one-half of birthing women at St. Vincent Hospital.

- Support, Empowerment, Advocacy, and Doulas (SEAD) is a community-based program that provides bilingual doula care to limited-English-speaking pregnant women in the Southeast Heights neighborhood of Albuquerque, New Mexico. The mission of SEAD is to increase access to quality health care among limited-English-speaking pregnant and parenting Vietnamese and Hispanic women (including teens), and their children. SEAD was established in 1999 in response to needs expressed by these women for quality medical interpreting, culturally competent health information and emotional support during pregnancy, labor and delivery. Doulas in SEAD are bilingual and bicultural community women who have been trained as both doulas and medical interpreters. Through their connection with the community and a strong partnership with local health clinics and the University of New Mexico Hospital, SEAD doulas bridge the cultural and linguistic gulf between the health-care system and the people most in need of services. The doulas advocate for clients and assist with infant care, breastfeeding and family planning issues in a culturally appropriate manner. SEAD's four doulas, all of whom are employed part-time, served 114 clients between June of 2001 and September 2003.

- The Doula Program at Presbyterian Hospital in Albuquerque provides doula support to women of all income levels on a sliding-scale basis. Doulas in the program are certified through DONA. They offer pre- and post-natal support to pregnant women and their partners, infant massage classes, and other services. Doulas rotate taking call to provide 24 hour/7-day a week coverage for clients during labors and birth.

- A program in Anthony trains youth CHWs to assist other youth in substance-abuse prevention, pregnancy prevention, the prevention of HIV/AIDs and other sexually transmitted infections, and general health and well-being issues.

- Seven CHW programs are currently funded through the County Maternal and Child Health Plan Act (Chaves, Dona Ana, McKinley, Santa Fe, Sierra, Socorro, and Torrance counties). These programs address locally-identified needs and coordinate services on the individual and community level. CHWs in the programs work across agencies to improve access to care, provide information and referral, link with providers, and assist clients to navigate complex systems of eligibility and services. They utilize intimate knowledge of local resources, relationships with the communities they serve, and established credibility with providers to effectively problem solve barriers to care. Because they are funded to address priorities in each county's MCH Plan, their efforts are cost effective and provide critical safety-net services.

- Coordinated Systems of Care, New Mexico, Inc., (CSC) is the sustainable extension of the Central New Mexico Healthy Communities Access Program (HCAP) grant collaborative. The mission of CSC "is to improve health outcomes among high risk populations in New Mexico by addressing interrelated medical and social determinants of health." CSC expands the capacity of the HCAP safety net medical providers to include behavioral and social-service case management and referral. The target population are people with complex medical, behavioral and social service needs, which often causes them to fall through the cracks of the traditional provider system. Clients typically surface in high-cost encounters, such as emergency room visits and in-patient hospitalizations. CSC uses an intensive, community-based case management model that features an integrated primary care and behavioral/social service linkage supported by a promotora. A case manager/promotora team work with each client conducting assessments, developing care plans and accessing resources to increase health and well-being. Promotoras receive training in a competency based curriculum and supervision/mentoring by experienced case managers.

- The Parents as Teachers program in Las Cruces employs licensed personnel along with lay health workers to provide one home visit each month for parenting education to Las Cruces High School parents of children from birth to three years of age.

- The New Mexico Department of Health Women, Infants and Children (WIC) Program began piloting the use of peer counselors to support WIC clients to breastfeed in 1992. WIC Breastfeeding Peer Counselors are former or current WIC mothers who have had a successful experience with breastfeeding their baby. They go through an eight-hour training program and are paid a stipend to help motivate and support other WIC mothers during their pregnancy and early postpartum period to breastfeed. Breastfeeding peer counselors help other women through monthly telephone calls, as well as visits to the mother's home, clinic and hospital where she delivers. Since this pilot program began in 1992, the WIC Breastfeeding Peer Counselor Program has continued to operate in six WIC clinics.

- La Clinica del Pueblo de Rio Arriba, a primary health center located in Tierra Amarilla, NM, was established in 1969 by a group of area families in response to the lack of medical services in the area. La Clinica del Pueblo provides quality, yet affordable, health care in a culturally-sensitive manner. La Clinica del Pueblo's Community Outreach Program uses two promotoras to serve more than 70 diabetic clients. The promotoras work with diabetics in make changes necessary in order to control their diabetes and lead healthier lifestyles. The promotoras teach healthy diets and exercise and the importance of self-care and communicating with a primary care provider. La Clinica del Pueblo de Rio Arriba serves all community members but focuses on the uninsured and underinsured. Home visits are made to those who are elderly or homebound for

any reason. The clinic has been providing this service since 1995 and also offers screenings and education to the communities it serves.

- Recently, the Robert Wood Johnson Foundation awarded a research grant to the UNM Family and Community Medicine Department for the utilization of CHW'S in the management of care for adults with chronic depression.

- The "57 Black Pearls of Health Network" is a program proposed through the Office of African-American Affairs Health Network. The program plan centers on the use of "pearls," which are defined as advocates in the area of health for persons of African descent in their community. "Pearls" are envisioned as vital links between health-care and social-services systems. A Pearl is a person who "provides a familiar face to your community while providing valuable information and/or just being there when a family needs support."

In addition, three organizations of CHWs exist in New Mexico. These are:

- The New Mexico Community Health Workers Association (NMCHWA) achieved federal tax-exempt status in 2003. The NMCHWA began as a Robert Wood Johnson Foundation "Opening Doors" project. The goal of the project was to create a self-sustaining organization of CHWs in New Mexico. The mission of the NMCHWA is "to bring community health workers together into a cohesive body that promotes outreach, education, and support for the CHW model, each other as well as their respective communities. Additionally, the association provides networking opportunities, information exchange and training for community health workers." The NMCHWA has been used as a model for the development of CHW associations in other states.

- The Promotora Committee of the Border Health Council is an organization of CHWs. Its mission is "to give recognition to promotores/as or CHWs as highly-trained, educated, and valued partners in the health-care system within the community."

- The New Mexico/Southern Colorado (NMSC) Community Health Representative (CHR) Association represents more than 90 CHRs from 22 tribal programs in New Mexico and Southern Colorado. Founded in 1974 by a group of CHRs who were concerned about the lack of communication and training among tribal CHR programs, the NMSC CHRA coordinates CHR-specific training to improve and enhance skills and knowledge levels of CHRs. The organization's primary purposes are to: foster better communication and information among tribal health programs, provide technical support and best-practice information with peer programs, advocate for CHRs through collaboration with similar entities, and lobby for the needs of CHRs on the state, tribal and national levels. The NMSC CHRA has fostered its goals and objectives through collaboration with Indian Health Services, the U.S. Department of Health and Human Services, and other organizations.

2. Characteristics of CHWs in New Mexico

It is difficult to draw a general profile of "the" CHW in New Mexico, as the effectiveness of CHWs lies in the ways they reflect the diverse needs of New Mexico's communities. In other words, there is no "average" New Mexico CHW. The approximately 220 CHWs surveyed and/or interviewed for this report spoke highly of their accomplishments, showed confidence in their abilities, and were eager to learn additional skills. Their major motivation in choosing their careers was to help their communities. They said they desire recognition for what they do, safety measures like cell phones during home visits, an increase in pay, benefits including health insurance, and additional training opportunities.

Demographic data collected through Survey Tool 2 illustrate the diversity of CHWs in New Mexico. A sampling of this data is graphically summarized in Appendix G**.** Of 146 CHWs who responded to the question, 126 (86 percent) were women and 20 (14 percent) were men. Out of 141 respondents who answered the question about ethnicity, 108 (78 percent) were Hispanic (seven of whom identified themselves as "Mexican" or "Mexican-American"), 17 Caucasian, 13 Native American, 2 African-American, and 1 was Asian-American. Respondents ranged in age from 13 to 64; the average age was 40. Twenty-eight percent have a high school diploma or GED; 12 percent have less than a GED; 33 percent have attended some college; 15 percent have Associate's Degrees, and 13 percent have Bachelor's Degrees.

1. Employment Profile of New Mexico CHWs

In New Mexico, CHW's work for many types of employers, including community based organizations, tribal health programs, primary care clinics, social service organizations, insurance companies, hospitals, and health departments. They come from the same underserved neighborhoods and share the same culture as the people they work with, so they are better able to bridge the gap between health-care agencies and local communities.

CHWs work throughout the state of New Mexico, with the highest concentrations in the south and on tribal lands. Their wages range from $5.05/hour to $16.00/hour, with an average wage of $7.50. Generally, CHWs on the high end of the pay scale have been working for several years and have supervisory duties. More than half (55 percent) said that their employers had required them to have a high school diploma or GED upon hire; the ability to speak and write English was also required for 55 percent of them. Most CHWs who participated in the study work full- or part-time. Of study respondents, 128 (88 percent) were paid and 18 (12 percent) were volunteers. However, these results may be skewed because volunteer CHWs were more difficult to reach through surveys and focus groups.

More than half (53 percent) of New Mexico's CHWs either have no health insurance or rely on public health insurance themselves. CHWs who work for clinics or hospitals are

more likely to receive additional benefits such as health insurance and sick leave; many of those who work for community-based-organizations have no benefits.

Commonly, CHWs in New Mexico are multi-trained and multi-tasked in the communities they serve, providing services under categorical funded grants and responding to community needs beyond the boundaries of their funding source. Their job titles include promotora, doula, community health specialist, community health representative, peer breastfeeding counselor, and nutrition educator. Promotore/a is the title most commonly used throughout the state. A significant number of doulas work in the state, both as employees of hospitals and in private practice. CHWs who work on tribal lands are CHRs.

The job functions of CHWs in New Mexico vary widely but fall into the general categories of CHWs working elsewhere in the U.S. They provide education about health issues, disease management, translation, referrals, and more. Almost all of them make home visits.

D. Issues Facing CHWs in New Mexico

Despite the many successes of New Mexico's CHW programs, many challenges remain to the development of a stable, sustainable, statewide CHW program. The following issues were identified by workgroups of the SJM 076 Taskforce.

1. Administrative

Clinics in New Mexico, including primary care community health centers funded from both state and federal funds, NMDOH-funded community and institutional sites, and other non-profit clinics, often rely on part-time volunteers or, if grant or other funds are available, full-time CHWs to accomplish their mission of providing health care to underserved populations.

In many counties, these clinics serve residents who must travel long distances to receive care. Less populated areas of the state may not be able to support full-time providers, but innovative community options or strategies for mobile or part-time approaches are being discussed, a majority of which require local outreach follow up and interpretive services.

Other New Mexico departments also operate field offices that utilize or could utilize the interpreter services, outreach, eligibility, and case management services provided by CHWs to enhance the outcomes of their services.

2. Methods and Structure

CHW models take a novel approaches to health care by attending to the family as a whole, including their health needs and barriers to services. As a result, CHWs and the provider community they work with often need support in understanding one another's role and how to relate to one another and the individuals they serve. One challenge is to

ensure that the role of CHW is acknowledged and validated in the system of service for the communities in which they work.

CHW models must possess a great flexibility that allows for adaptation to any community. The services offered will differ by community according to the needs of each community. Each package of health-care and social-services measures must be tailored to the needs of the specific community.

The system of care and other providers are more productive and efficient when CHWs are engaged in providing basic health information and services that are not otherwise available to people in underserved communities. The inclusion of one or more CHWs in the treatment team is rapidly becoming the preferred method to integrate these crucial workers into health-care systems. Many successful programs have recognized that CHWs are the real "eyes, heart, hands and feet of health care for the community."

3. Financing/Economic Development

The need for a continuous and stable funding source of CHW programs was identified as problematic and a barrier to effective CHW outreach by those participating in the in focus groups and the SJM 076 Task Force. Funding for CHW programs has historically been erratic, more often grant-based and, in most cases, reliant on the capacity of the sponsoring agency to seek and sustain funding for CHW activities. While the value of the CHW as part of the treatment team has been documented as critical, there are few examples of sustained funding sources.

CHWs have been employed for several years in various Community Health Centers in New Mexico, and in some, career opportunities continue to develop. There are additional examples of CHWs obtaining advanced degrees and moving into licensed health and social service careers. For many CHWs, however, there is no ongoing sustainable opportunity for training, employment and career advancement. If sustainable funding were available, employment of people in local communities as CHWs would provide a source of increased economic development in those communities.

Tribal CHR programs are operated under federal contracts and with federal funds. These funds have sustained the programs to a degree over the years. However, funding for CHR programs has never been adequate, and Indian Health Service funding has not increased to meet the many demands of an increasing Native American population with many health disparities.

CHR programs exist only on tribal lands, most of which are extremely rural in nature. However, many Native Americans currently live in urban areas, and Native Americans continue to relocate to urban areas as a result of federal policies, most notably Welfare-to-Work. It is often impossible for recipients of Temporary Aid to Needy Families (TANF) to remain on tribal lands, where jobs are scarce, and simultaneously fulfill the work requirements imposed on them by the Personal Work Opportunity and Reconciliation Act of 1995. In New Mexico, more than 40 percent of Native Americans

now reside in urban areas, and most are in need of health-care and other services. As a result, the CHR programs are challenged to provide the level of service necessary.

The employment prospects for CHWs are excellent. One study followed up with trained CHWs and the organizations that employed them approximately one year after their certification. Upon completion of the course, 100% of the newly certified CHWs found employment.

According to a survey conducted by the United States Department of Labor, for the year 2000 there were more than 271,000 paid positions for health and social assistants in the US. The USDOL survey predicted that with the aging of America, increased demands for long-term care and management of chronic diseases will push the demand for this segment of the labor market to 76% growth by 2010. Increases in the number of paid positions will increase the potential for the unemployed, under-employed and underserved within communities to participate in the expanded job market with appropriate and contemporary training.

The added economic development good news is that New Mexicans can decrease their need for costly health care services if prevention and education initiatives are started at an early age. Chronic disease linked to personal health behaviors can lead to absence from school and work, failure to thrive, and can create long term economic and social impact within communities.

New Mexico state health policy stipulates that health services should be available, accessible, and culturally appropriate for all New Mexicans. However, significant data capture the overall health-professional shortages in New Mexico. For example, the Health Resources Services Administration (HRSA) lists 30 of New Mexico's 33 Counties as Health Professional Shortages Areas. Studies by the Health Policy Commission have demonstrated the continued shortage of health-care access for the rural areas of the state. In addition, recent data from the HRSA State Health Workforce Profiles, December 2000, suggest that health-professional shortages are a major problem in the regional border states. SJM 076 references that CHWs are generally accepted as an essential component of a continuum of health care services that optimize the health and well being of individuals. The adequacy of preventive and early intervention services have been demonstrated to impact health status and demands on the health care system.

4. Medicaid Best Practices

The Medicaid program has been the recent focus of numerous proposals for case management, outreach and increasing enrollment of eligible populations for services, disease management, and provision of culturally-competent services. New Mexico's Medicaid population is one of the areas where CHWs can influence the positive outcome of the health-care encounter and potentially, as has been the case in Baltimore, reduce the overall cost of care.

The SJM 076 Medicaid Subcommittee explored the various proposals and waivers developed by other states in light of New Mexico's needs. The subcommittee also reviewed "Medicaid System Redesign Ideas and Possibilities, A Draft Discussion Paper" by the New Mexico Human Services Department. The report proposes the use of "promotoras" to provide outreach, health education and other services to improve access to care. This report also proposes that NMHSD consult with NMDOH to learn whether any similar program utilizing the skills of promotoras currently exists, and to evaluate how best to develop a pilot project that helps to reduce costs. At least two examples exist:

- The use of CHWs to support or deliver case management services was explored by the Sangre de Cristo Community Access Program in Northern New Mexico. Four areas of care were targeted: cardiovascular health, hypertension, diabetes and substance abuse.
- In the Central New Mexico Community Access Program, CHWs are being trained to offer a variety of services to the area's more complex and potentially costly patients. The development of a pilot project that will use Medicaid support for case management is under discussion with the managed care organizations.

The need to reduce expenditures and enhance access to care presents a major policy issue for the state Medicaid program. Medicaid has traditionally supported limited prevention and intervention services including those of the Early Periodic Screening, Diagnostic and Treatment initiatives for children and family planning and breast and cervical cancer services for women. Clinical services provided under the program are reimbursable only to licensed and credentialed health professionals approved under the state plan. Escalating costs of clinical and long term care services are now threatening the programs and services "covered" under the State Plan. The very type of services that may potentially reduce or moderate the increases in the programs costs may not be reimbursable under the current program protocols or sustainable under the current or projected budget. Certification of CHWs and their acceptance as valuable members of the health-care team may increase opportunities for reimbursement of their services.

Another approach to the Medicaid utilization problem may be to reduce barriers to appropriate care access. Some reasons for not accessing care in a timely or appropriate manner may lie with attitudes, challenges and the health awareness of the Medicaid patients themselves. In the rush of care giving, where productivity of the provider is based on Relative Value Units (RVU), translation of instructions accompanying prescriptions and the understanding of the diagnostic determination is often incomplete or incorrectly understood by the patient. This failure to comprehend can lead to poor treatment outcomes, non-compliance on the part of the patient or in some cases a worsening of the health condition. CHWs who are trained and can offer a culturally relevant and clinically correct translation can greatly increase the return on investment of the Medicaid dollar. These are the very barriers that CHWs can assist in reducing.

Some Medicaid mandates were addressed by the directives of Texas HB 1184 "to evaluate the feasibility of seeking a federal waiver so that CHW services may be included as a reimbursable service provided under the Medicaid program." The Texas committee

found that each state has a degree of latitude to fashion a program to meet the unique needs of its communities. The committee recommended that the state of apply for a waiver under Section 1915 and 1115 under Title XIX of the Social Security Act of 1965. The two categories in which services of CHWs can be considered under waiver provisions are program waivers, which provide exemptions from sections relating to managed care and home and community based waivers (section 1915); and research and demonstration waivers, which authorize the deployment of experimental or pilot programs that would otherwise conflict with the federal Medicaid statute (section 1115)."

The Texas committee suggests that potential areas for CHW reimbursement are included in existing Medicaid guidelines as Home Health Aides and the EPSDT screenings. Reimbursement under Medicaid would provide CHWs with a paid position and increase the likelihood of a health insurance package as part of their employment benefits.

An additional concern in New Mexico is the high percentage of the population, primarily adults, who are uninsured. Many CHWs do not have health-care coverage themselves. A table depicting the distribution of the Medicaid and the uninsured by county can be founding Appendix E. It is clear that the state has comparable county level problems in populations in need of services and the high number of Medicaid and uninsured. Health-professional shortage issues compound the problem.

5. Training

Each New Mexico program surveyed and each focus group sponsored by SJM 076 emphasized the importance of training to the overall performance outcomes and self-assurance of the practicing CHW. Currently each organization is responsible for and attempts to provide training in core competencies and continuing education for general and specialized areas of work.

A standardized, statewide, accessible training curriculum was noted as one of the major needs by almost all study participants. However, in a minority report, the Rio Arriba Family Care Network (RAFCN) stated that they felt the development of a statewide training curriculum would be detrimental. They argue that the strength of CHW services lies in each CHW's cultural sensitivity and personal history with the community, and that a standardized training curriculum would institutionalize the role of the CHWs in a way that would fundamentally alter their role. RAFCN objected vehemently to "any hint that training would be influenced by universities."

Five major curricula are currently being used in New Mexico. Each curriculum has its strengths and drawbacks:

- The *Reaching Out* curriculum was developed by the New Mexico Area Health Education Center and the New Mexico Prenatal Care Network in 1993. The 40-hour general curriculum provides an overview of the work of CHWs including sections on communication and finding community resources. It is a competency-based curriculum that includes appropriate methodologies such as hands-on

practice, role-plays and an overall emphasis on experiential learning. However, the curriculum is limited in scope to pre- and postnatal care, sexually transmitted infections, and early childhood health. This curriculum was offered by the University of New Mexico and continues to be offered by La Clinica de la Familia in Anthony, which has adapted it to their needs. No standardized update of the curriculum is available; however, updating of the curriculum is currently underway supported by the Border Health Office.

- Santa Fe Community College, through La Famillia Medical Center, offers an overall CHW certification program that focuses on communication, life skills, diabetes, hypertension, depression, and other health problems. The focus is on training CHWs to become part of a health-care team; CHWs are understood to be "specialists in community." Program participants have the option of completing a two-year associate's degree. However, the program is not offered on an on-going basis.

- The "Community Health Representative Basic" course for CHRs is provided by the Indian Health Service in cooperation with the Tribes. In addition to this basic curriculum, specialty training is offered, depending on the needs of the tribal community.

- The University of New Mexico offers a CHR specialist curriculum at its Gallup campus. The focus of the program is on diabetes; it requires 1.5 years to complete and leads to a two-year science degree. Although the program has been successful, it is only open to CHRs and Gallup has no dormitory accommodations. Program developers plan to offer it online in the near future.

- The University of New Mexico, Community Voices and La Colmena Inc. offers a Community Health Advocates Curriculum based on the competencies of the National Community Health Advisor Study (University of Arizona, 1998) and San Francisco State University Standards of Practice manual for Community Health Workers. The curriculum requires 180 classroom hours and a simultaneous internship, which is integral to the educational program. Thirty-three hours of field practice with a preceptor are required. Classroom methodologies used are: small group discussions/case discussions, lectures, seminars, and workshops. The internship component includes on-the-job training with preceptors from health, social and behavioral-services agencies. Students enter the program as a cohort or group, attending all their classes together. Learning is approached as a mastery of skills in a real-life situation and not a regurgitation of facts. Evaluation is competency-based, and a tutor or instructor is the primary link between courses and field work. Students must have eight weeks of work experience credit as a paid or volunteer health worker during their program of study.

The issue of core competencies for CHWs remains a question across the U.S. In 1998 researchers at the University of Arizona developed the "National Community Health

Advisor Study." The study, which was funded by the Annie E. Casey Foundation, created the groundwork for CHW research and program development in the U.S. The University of Arizona researchers identified eight core skills and knowledge areas for CHWs. These skills were:

▪ Communication Skills o Listening o Use language confidently and appropriately o Ability to read and write well enough to document activities	▪ Capacity-Building Skills o "Empowerment"—Ability to identify problems and resources to help clients solve problems themselves o Leadership o Ability to strategize o Ability to motivate
▪ Interpersonal Skills o Counseling o Relationship-building o Ability to work as a team member o Ability to work appropriately with diverse groups of people	▪ Advocacy Skills o Ability to speak up for individuals or communities and withstand intimidation o Ability to use language appropriately o Ability to overcome barriers
▪ Knowledge Base o Broad knowledge about the community o Knowledge about specific health issues o Knowledge of health and social services systems o Ability to find information	▪ Teaching Skills o Ability to share information one-on-one o Ability to master information, plan and lead classes, and collect and use information from community people
▪ Service Coordination Skills o Ability to identify and access resources o Ability to network and build coalitions o Ability to provide follow-up	▪ Organizational Skills o Ability to set goals and plan o Ability to juggle priorities and manage time

To better understand the training needs of CHWs in New Mexico, CHWs who participated in the SJM 076 study were asked to rate their confidence in the areas identified in the 1998 study. Almost all CHWs rated their competencies at eight or above on a ten-point scale, with one being "not at all confident" and 10 being "extremely confident." They felt least confident in their knowledge base (especially relating to specific health issues), service coordination skills, and organizational skills.

When asked to identify which skills they considered essential to a core curriculum for CHWs in New Mexico, participants identified 13 skills and three knowledge areas. They also identified several specialty areas in which they work (see **Appendix F**). The CHWs in the SJM 076 study generally agreed with the competencies listed in the National Community Health Advisor study but requested training in additional skills, most notably computer literacy, safety, and stress management, which they considered essential to their work as CHWs.

During focus-group discussions, almost all CHWs said that they would be interested in pursuing a college degree if obstacles including funding, transportation, and childcare were removed. However, they strongly felt that CHW training, even if standardized, needs to be local, flexible, and accessible. Almost all participants said they did not think a CHW curriculum should be a college-based learning experience. Many participants expressed concern that a college-based CHW curriculum would not meet their needs, would be expensive, and would dissuade the type of person who makes the "best" CHW from pursuing the training. This person was described as a "housewife," often with limited English skills, but one who worked in her community (volunteering for church groups, other non-profits, and hospitals) to promote change before becoming a CHW. This qualitative description, however, contrasted with the survey results, which showed that most CHWs who participated in this study (60 percent) had attended at least some college, often as a result of their employment as CHWs.

Two groups of doulas who participated in focus groups said that they had already undergone a rigorous training and certification program, which they considered essential to their success. Both groups were certified through national organizations of doulas. Doulas at St. Vincent's Hospital in Santa Fe emphasized the rigor and extensive requirements of the Childbirth Education Foundation certification program. Most of the St. Vincent's doulas held additional degrees, including Doctor of Oriental Medicine as well as traditional Bachelor's and Master's degrees from accredited universities. Doulas at Presbyterian Hospital in Albuquerque, who were certified through DONA, concurred that their standardized training, although less intensive, was essential.

CHWs emphasized the need for bilingual (usually English/Spanish) training that includes written materials. CHWs said their training had prepared them "pretty well" for their jobs, but most said that they learned more from previous experience or on-the-job training, especially with mentors, than from classroom training. They asked for a competency-based evaluation process that included mentorship and on-the-job training.

CHWs also offered suggestions ways their initial training could have been improved. Most commonly cited were interviewing skills, communication skills, and safety. Almost all respondents said they would be interested in receiving more training, with computer literacy, leadership, English as a Second Language, employee rights, and public relations/media being the specific areas identified.

All CHWs who responded to the survey said they had been hired then trained; training was paid for by their employers. Employers consistently reported a need for more training opportunities and more funding for training.

6. Certification

The question of certification was discussed at length by members of the SJM 076 Taskforce, CHWs, and CHW program directors. Several people expressed grave reservations about the potential problems that could arise if mandatory or voluntary certification requirements were imposed on CHWs. These included the potential loss of

CHWs who might feel that the training and certification process was too difficult, concerns about cultural appropriateness of the certification process, and changing the emphasis of work from members of the community to a career-ladder model.

At the same time, the potential benefits of certification were reviewed. Certification could increase chances for third-party funding from agencies for training and employment of CHWS, the potential for Medicaid reimbursement, and recognition of CHWs as highly-trained and skilled extenders of the health-care system.

All participants agreed that certification should be offered rather than required. They also agreed if any sort of certification expectations are ever adopted for CHWs in New Mexico, those CHWs currently working in the state should be grandfathered in through a streamlined, expedited process. Doulas have national certification and would want that certification to be the accepted certification for doulas in the CHW program in New Mexico.

7. Evaluation and Effectiveness

In 1995, Michael D. Barnes, Ph.D., CHES wrote in his recommendations for the development of a CHW education and training program in New Mexico: "It was my impression from a few CHW program directors that they would welcome assistance in developing an evaluation design and evaluation tools, but that it would have to be specific to their own program and needs. I believe this is possible, but that a set of consistent tracking items could be built in across the state."

The lack of evaluation tools remains a problem for CHW programs in New Mexico. Although CHWs are widely used in hard-to-reach populations, further work is needed to measure their true effectiveness. Problems in evaluating CHW programs include a lack of standardized measures, reliance on self-report data, and a poorly defined intervention. There is a dearth of CHW process and outcome evaluation evidence in the literature. Process evaluation (i.e. number of home visits, etc.) is more common than outcomes evaluation (what happens after the CHW provides care).

However, three studies in New Mexico show effectiveness of CHWs in particular areas:

- La Familia Medical Center (LFMC) in Santa Fe has used the Community Health Worker model since 1994. Over that period, clinical outcomes attributed to use of this model have drawn national and international attention from organizations including the Centers for Disease Control, the Bureau of Primary Health Care, Dartmouth Medical School, a Russian Women's Clinic and a Ugandan Health Clinic. The use of promotoras has increased first trimester entry into health care over 20% from 1994 to 2001 and those increases have been sustained over the years. With utilization of CHWs as doulas, LFMC's cesarean delivery rate has exceeded the Health People 2010 goal. Other successes attributed to promotoras include increasing the prevalence of breastfeeding from 35% to 50% at 6 months, increasing immunization rates, and improving disease management for diabetics.

Before the Promotores program, less than 10% of patients monitored their own blood sugar levels; presently 90% of patients served are self-monitoring at La Familia. After visiting LFMC's promotora program, Dr. Paul Uhlig, a cardiovascular surgeon at Dartmouth Medical School stated, "I came away with an even greater certainty that the heart of what we do as caregivers takes place in the magic of respectful relationships. What I saw was a determination to treat every person with dignity and respect, and a belief that all things are possible. Out of that comes a process of self-care that probably has no limits."

- Presbyterian Healthcare Services in Albuquerque employs a CHW (promotora) at its Rio Bravo office; this CHW focuses on disease management for diabetic patients. Research was conducted to determine if patients who had a year of promotora intervention (telephone support, assistance with bureaucratic hurdles, home visits, Spanish language), score more than 20% improvement on a "Diabetes Service Compliance Score Card" when compared to their service use in the baseline year. Of particular interest was an improvement in hemoglobin A1c levels found through blood tests, a key tool in blood sugar management. The Diabetes Compliance Score rose 40% when compared to baseline, exceeding the program goal of a 20% improvement. The evidence suggested important strides were made, including increasing patient compliance to routine diabetes services and a reduction in hemoglobin A1c readings.

- The New Mexico Department of Health Women, Infants and Children (WIC) Program began piloting the use of peer counselors to support WIC clients to breastfeed in 1992. A 1994 study of this pilot project demonstrated that WIC mothers using a peer counselor are nearly three times as likely to initiate breastfeeding as WIC mothers who do not use a peer counselor. A subsequent study in 2002 of WIC breastfeeding data shows that the peer counselor clinic sites average a 68 percent breastfeeding initiation rate compared to a 64 percent statewide breastfeeding initiation rate. Consistently over the past ten years, the WIC peer counselor program has proved that it increases the incidence of breastfeeding and thus, WIC's funding source, USDA, has given this type of breastfeeding initiative priority over other breastfeeding initiatives.

According to the National Community Health Advisor Study, some of the challenges to effective evaluation are lack of resources for evaluation training and implementation, lack of methods and opportunity to measure long-term effects, and time away from clients. These barriers can be overcome by ensuring that goals and objectives are clear and measurable, allowing time for evaluation training, developing methods that measure costs and savings associated with delivering CHWs services, and involving the CHWs in all aspects of the program, including evaluation.

E. Legislative and Policy Initiatives Affecting CHWs

1. Federal Legislation and Policy

a) Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 provides for certain rights and assures meaningful access to services for persons with limited English proficiency. Executive Order 13166, signed in 2000 by then-President Clinton, and further guidance from the Office of Justice clarifies the implementation of the provisions of Title VI.

The DHHS defines meaningful access "as language assistance that results in accurate, effective communications between provider and client, at no cost to the client. Typically, effective programs are presumed to have four elements: an evaluation of the language needs of the population being served, a written policy on language access, staff training and monitoring."

The Office of Management and Budget in a cost-benefit analysis of the guidance effect on the health-care environment "suggested a host of advantages to providing language assistance, among them better communication between patients with limited English proficiency and English speaking providers; greater patient satisfaction; more confidentiality and truer "informed consent" in medical procedures; fewer misdiagnoses and medical errors; cost savings through fewer emergency room visits; less staff time in dealing with non-English speaking patients; and fewer eligibility and payment errors."

However, implementing such services is costly. Hourly rates for the services have ranged from $25-60.00 for staff interpreters and language banks to $130.00 and up for telephone language lines. To offset the costs of direct or contract services, states can draw down federal match under Medicaid and Title XXI in two ways. The services can be billed for as part of the medical services cost, thus raising the base rate, or states may bill for it as an administrative cost at a Medicaid match rate of 50-50 or for Title XXI at a capped rate of 10 percent. At least five states, Hawaii, Maine, Minnesota, Utah and Washington are receiving the funds and implementing the program.

This is an area of potential support for the CHW programs that address the financial, personal and public health outcomes of communities, offers cost effectiveness for the health care dollar, and promotes economic development for local interpreters.

b) National Hispanic Health Act

Senator Jeff Bingaman, among others in Congress, has developed a proposed National Hispanic Health Act (NHHA). The NHHA contains specific programmatic health services for Hispanic populations, fiscal resources in the form of federal funds,

partnerships with higher education in health-professional education and recruitment, and prevention roles in the delivery of health care for at-risk populations utilizing CHWs. Combining numerous legislative initiatives, the omnibus bill focuses on issues and populations that New Mexico CHWs currently address. The bill offers innovative proposals to address many of the problems facing New Mexico and other border states while expanding programs and services that could be performed by CHWs. If enacted, the legislation would offer yet another opportunity to link the CHW with resources and address major health disparities in the communities they serve.

c) Indian Health Care Improvement Act

The Indian Health Care Improvement Act (PL94-437) authorizes funding and provision of health-care services to Native Americans. Most of the funding and services are geared to Native Americans residing on tribal lands; CHR programs serve only residents of these areas. However, as Native Americans continue to migrate to urban areas, the need for CHR programs moves with them. Changes to this legislation need to address the need for health services and provide additional funding for these services, including CHR programs, in urban areas with a significant number of Native American residents.

d) Homeland Security

Legislation on initiatives that are the focus of homeland security and anti-terrorism point to another potential role for CHWs. CHWs could play an important role increasing the effectiveness of the response to security concerns and offer an ongoing community presence for dealing with emergency preparedness, disease surveillance, and follow-up. For members of the uninsured in a community, the CHW may be the first or the only contact for health-care concerns or referrals to agencies such as FEMA. The CHW can serve as the first responder in underserved communities, interpret critical information during a natural or human-created emergency, and clearly translate to community members their role in the process of emergency preparedness and response.

2. State Legislation and Policy

As CHWs have entered the gap between the underserved and health- and social-services systems in the U.S., several states have introduced legislative efforts to provide standardization of CHW training and certification requirements while maintaining the flexibility and integration into the community that is the hallmark of CHW best-practices models. The major issues addressed have been certification, standardization of curricula, establishment of core competencies, and funding.

Both Texas and Oregon adopted voluntary certification and training of CHWs. The Texas State Legislature enacted House Bill 1984 (HB 1984) to study the "Feasibility of Voluntary Training and Certification of Promotoras or Community Health Workers." A Program Development Committee was formed of CHWs, members of the general public, representatives from university systems, and state governmental agencies.

The committee states that non-standardized training of CHWs can easily lead to a disconnect between agencies and results in an uncertainty as to what basic competencies potential employers can expect. The report goes on to state that, "Implementation of standard curriculum guidelines, which instill portable skills, would ensure a common stock of knowledge and guarantee certain basic skills."

The committee also recommended that local, regional and statewide leadership opportunities for CHWs be coordinated to share best practices. This leadership committee would help form the model for deployment of CHWs and the implementation of their role in Medicaid. The Texas Department of Health (TDH) was tasked to play a large role in the development of the leadership, in the organization of training curriculum, and in the testing and certification of CHWs.

Although the process serves to standardize knowledge and skills and increase the quality of service provided by CHWs, problems have occurred with recruitment, placement, access to training, and implementation. Texas adopted a grandfather clause for CHWs currently working in the state; however, one experienced CHW interviewed said she had waited for one and one-half years for her certificate and still had not received it. Many potential CHWs do not have access to the community colleges where training is provided. Written course materials and exams have not yet been translated into Spanish or other languages. Funding is extremely limited.

"We lost a lot of good promotoras," says Sylvia Sapien, BSW, Program Director for *La Clinica de Familia* in Anthony. "The grandfathering process became disciplinary and cumbersome. Only two promotoras have been grandfathered in as of yet."

"It seems like the system is not really in place yet," agrees Martha Castro, BSW, Border Vision Fronteriza director for El Paso. "Certification provides recognition and allows promotoras to charge for their services. In that sense it has been positive. But there are negatives. Certification will exclude the promotoras who are good but who do not have a high school diploma or do not speak and write English well. It's a good thing for those who can take advantage of training, but those are few. The system is not as yet in place to really provide for a secure training for promotoras. Are most of them outside the system now? Yes. "

In 2001 the Oregon State Senate reviewed Senate Bill 791, which proposed a voluntary certification of CHWs, created a State Board of Community Health Workers in the licensing office, and authorized payment for services of CHWs by medical assistance programs. The Oregon Legislative Assembly web site did not list SB 791 as 'major' legislation; therefore, the status of the legislation is unknown and a full version of the legislation is not available.

V. Conclusions

Development of a CHW program in New Mexico has the potential to reduce health disparities, bolster economic and workforce development, reduce health-care costs, and create healthier, safer communities. New Mexico now has the opportunity to continue its leadership in the innovative use of CHWs to reduce health disparities. However, the development of a CHW program in New Mexico must be undertaken only with full awareness that the success of CHWs depends on their "culturally rich perspective in addressing the needs of their community," as observed by the Rio Arriba Family Care Network, Inc.

The results of this study suggest that CHWs are useful in promoting health education and providing culturally-appropriate health promotion and supportive services, and that use of CHWs may result in significant longitudinal cost savings. However, CHWs are underutilized, partly because of a lack of empirical evidence about CHW effectiveness. Because CHWs work with a highly mobile, hard-to-reach population, follow up and outcomes are difficult to measure. Better documentation based on quality indicators could help to alleviate this problem.

Because CHWs are "community specialists" who are members of the communities in which they work, they can effectively serve hard-to-reach populations. Their personal networks and their knowledge of local cultures, languages, needs, assets, and barriers to service enhance their effectiveness. As one group of researchers summarized their results, "enhanced utilization of CHWs can reduce health disparities."

The SJM 076 Taskforce drew the following conclusions:

- CHWs serve as liaisons between individuals and health-care providers, public health professionals, and social-services providers. In New Mexico, the gap between health-care providers and need is large and growing. Creation of a sustainable, well-trained corps of CHWs could help to fill this gap.

- The efforts of existing CHWs and the development of additional opportunities would benefit from overall state level support and coordination. At least two state agencies, the NMDOH and the NMHSD, have demonstrated the use of CHWs in implementing state initiatives at the local level.

- Several studies show that in New Mexico, CHWs effectively and efficiently assist hard-to-reach populations to gain access to health-care and social services, provide health education, disease prevention and management, medical interpretation and translation, and reduction of health disparities.

- CHW programs are attractive because of the potential cost-savings that may occur due to the appropriate use of health-care resources and the reduction of uncompensated care. Cost savings have been demonstrated and the potential for additional, especially longitudinal, cost savings is great.

- Evaluation of CHW programs is vital to justify their effectiveness. Although studies are promising, more empirical data need to be collected. Problems in evaluating CHW programs include the lack of standardized measures, reliance on self-reported data, and inadequately-defined interventions.

- CHWs play an important role in the system of services for their communities. However, the lack of established core competencies, scope of practice, and standardized training presents obstacles to the recognition of CHWs in New Mexico.

- CHWs need high-quality, competency-based training that is not academic in nature. Instructors are better accepted when they are talking from experience and with full knowledge of the CHWs' work and the communities they serve.

- CHWs serve a low-income, preponderantly non-English speaking population.

- Certification is a potential win-win opportunity for both agencies and CHWs. For agencies that are facing compliance issues, CHWs with certification and competencies can assist those organizations to be responsive to corrective action plans for special populations, including people with limited English proficiency. For CHWs and the programs that employ them, certification offers career opportunities and greater likelihood for third-party reimbursement, including Medicaid.

- Certification poses challenges for both agencies and CHWs. If certification and training standards are enacted without funding, and without awareness of the cultural contexts of CHWs' work, the net result will be to decrease the number of CHWs working in the state and reduce access to care for the population. Among the lessons learned in Texas are the need to have the system fully operational before imposing certification requirements and ensuring that adequate funding is provided to carry out the mandates.

- CHWs reach underserved populations more effectively than high-cost media campaigns or high-tech interventions and can help improve quality of health care while reducing costs.

- The effectiveness of new initiatives in homeland security and emergency preparedness, including risk communication, can be greatly enhanced if trained and supported CHWs are employed in their respective communities throughout the state.

- CHWs provide translation and demonstration of complicated concepts and activities.

- Through use of CHWs, the importance of epidemiological surveillance and the follow-up on reportable disease can be underscored and supported on the ground in communities most at risk and currently with less access to health care.

- CHWs assist providers by educating them about the cultural norms of their communities, allowing providers to better relate to their clients and to deliver appropriate treatment. This function is especially relevant for disseminating health information such as when and how to find a health care provider, standards for preventive care, or information regarding health crises (e.g. outbreaks or epidemics).

- CHWs follow up with patients concerning the correct use of their medications. They can help patients manage their chronic diseases (e.g. diabetes, asthma, hypertension), thereby reducing additional health visits or care.

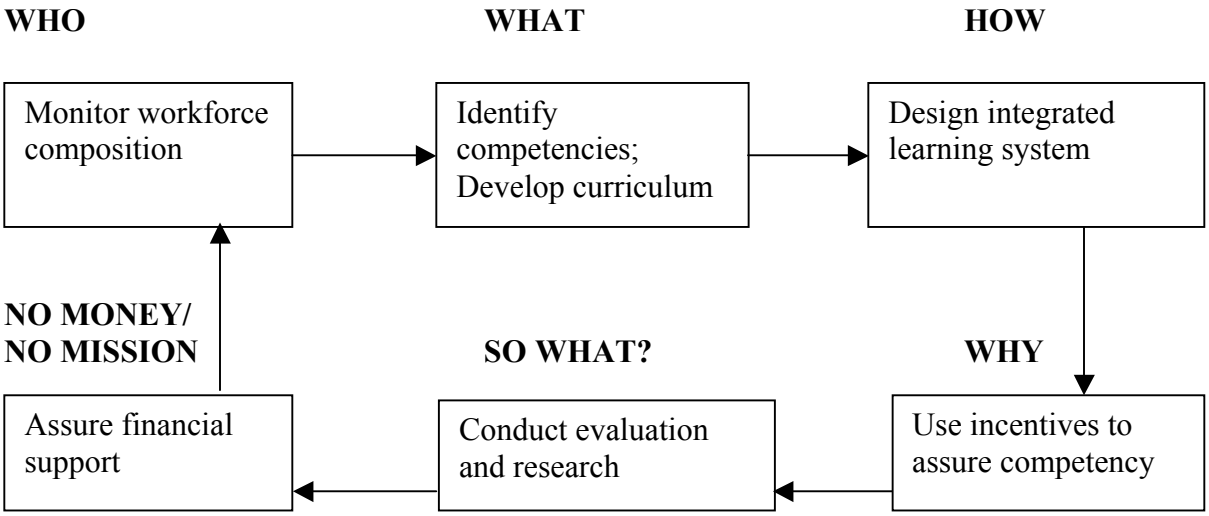
- If trained and supported, CHWs can build vital relationships between providers, administrators, and the community itself. Improving access to care, especially in a time when resources are tight, requires that efforts be efficient, coordinated, and, when possible, collaborative. Besides linking communities to health systems, they also link health systems and providers to community stakeholders such as churches, local businesses, and other health and social agencies.

VI. Recommendations

The SJM 076 Taskforce met on September 11, 2003 to finalize recommendations of the work groups. The Taskforce recommends that statewide CHW program be developed. The following recommendations include initiatives needed to provide for the sustainability of CHWs and ways that a statewide CHW program may contribute to the economic and workforce development of New Mexico through public-private partnerships.

The overall strategy for the development of a CHW program in New Mexico recommended by the SJM 076 Taskforce follows the U.S. Centers for Disease Control projected model for workforce development:

COMMUNITY HEALTH WORKER WORKFORCE DEVELOPMENT MODEL



A number of taskforce participants expressed concern about the potential for mandatory certification, licensure and regulation of CHWs. *It is the full consensus of the participants that any New Mexico CHW model developed must assure that any legislation/state planning be inclusive of CHW input.* It must also contain significant options for CHWs to choose the paths of their careers. The cultural and ethnic diversity of the state must be considered in the development of the CHW program. Furthermore, the unique needs of communities and Tribal sovereignty must be respected.

Although CHRs are tribal-based, urban populations of Native Americans would also benefit from similar services adapted to the urban environment. It was strongly suggested that such a service be created for urban Native Americans, particularly for the Albuquerque area's estimated 35,000 Native Americans. However, because funds for CHR programs have never been adequate, funds should not be diverted from the current

CHR program. Any urban CHR service should be funded separately from tribal CHR programs.

The SJM 076 Task Force strongly recommends that the NMHSD and the various departments providing services to the Medicaid-eligible populations of the state carefully review the successes of the various state and national models of CHW services, provide opportunities for development and implementation of pilot programs, and evaluate the programs and services for system-wide implementation.

There are a number of approaches to sustaining the valuable work that CHWs perform. The range and scope of the services needed by the communities in the state will undoubtedly accommodate CHWs' choice to promote the health of their community with advocacy and tradition-based care, as well as the trained, certified provider of health-care management and disease prevention.

The following matrix delineates recommendations and potential strategies. In recognition of the unique needs of communities and the sovereignty of Tribes, many of these recommendations need to be seen as recommendations, not as requirements or mandates.

RECOMMENDATION	**POTENTIAL STRATEGIES**
I. Administration	
A. Establish a Community Health Workers (CHW) Advisory Committee with support from the Department of Health (DOH), the Human Services Department (HSD), and other state agencies.	▪ Include CHWs, health-care providers, community-based organizations, Tribes, Indian Health Service, State agencies, and other stakeholders.
B. Establish and fund, through Legislative appropration, a program in the NMDOH to provide centralized, statewide technical support and centralized coordination and policy development.	▪ Develop and coordinate a CHW program, including: ▪ Facilitate networking ▪ Explore and expand options/ resources for funding and training ▪ Manage certification ▪ Develop and manage standardization of training ▪ Market benefit of CHW work; use a web-based Resource Directory ▪ Manage statewide evaluation. ▪ Facilitate the work of the recommended Advisory Committee. ▪ Consult with agencies, public and private stakeholders, CHWs, CHW organizations, Tribes, Indian Health Service, and other interested entities and individuals. ▪ Identify and recognize CHW roles/

	unique responsibilities, demographics, populations served. ▪ Work with Small Business Administration and other state and local economic development resources for loans and technical assistance. ▪ Explore the establishment of an incentive program. ▪ Ensure grants and contracts include funding for training and evaluation based on public health outcome criteria.
II. Methods and Structures	
A. Recognize CHWs as generalists and specialists, depending on their training and field of work.	
B. Develop a certification process so that certification can be offered.	▪ Develop the process in multiple phases with adequate time, funding, and technical support. ▪ Involve CHWs in the development of the certification process. ▪ C. Develop a streamlined and expedited process for grandfathering of currently-working CHWs
C. Create a salary schedule and compensation plan based on regional parity and parity for practicing CHWs.	▪ Set standards for salary schedules including benefits. ▪ Build a career ladder model.
D. Educate medical professionals on utilization of CHWs for health promotion and disease-prevention and management.	
III. Financing/Economic Development	
A. Increase and/or modify Rural Primary Health Care Act (RPHCA) funds to specifically provide funds for CHW services and provide incentives for recruitment and retention of CHWs.	
B. Leverage existing dollars from federal, state, Tribal, and Indian Health Service programs for training and employment of CHWs.	Investigate funding from programs including: ▪ The Workforce Investment Act of 1996; ▪ The Personal Work Opportunity and Responsibility Act of 1995; ▪ On-the-Job training funds from the NM Economic Development Department; ▪ Titles 19 and 21 Medicaid funds to

	support services for people with limited English proficiency; ▪ The Environmental Protection Agency; ▪ Centers for Disease Control; ▪ Homeland security and emergency preparedness; ▪ NM Health Service Corps; and ▪ State Council Fund contractors.
D. Investigate reimbursement for CHWs under Senate Bill 743, which requires third-party insurers to offer tobacco use and smoking cessation counseling services to their insured members.	▪ Utilize CHWs as tobacco-use and smoking-cessation counselors in communities unable to access such services locally.
E. Establish a critical shortage area designation for CHWs providing care to the underserved including rural, indigent, special needs populations, and Medicaid recipients.	
F. Develop criteria, designation, and expanded financial incentives, such as gross receipts tax exemptions, other tax incentives, low interest loans, and Foundation Grant funds for public/private partnerships that use CHWs to promote healthier communities.	▪ Investigate programs including in-home care for the elderly and disabled, medical translation and interpreter services, doulas (birth attendants) for pregnant women, outreach and education programs for disease management.
G. Use the Senior Employment Older Workers Program to provide subsidized job placement for adults age 50 and older wishing to serve as CHWs.	▪ Expand health promotion activities and outreach efforts at Senior Centers statewide through the use of CHWs.
H. Require organizations and facilities receiving state funds for clinic operations and services to establish, where feasible and appropriate, partnerships with private and/or other health-care providers for CHW services.	▪ Recognize the need for competency requirements for those contractors licensed by outside entities (i.e. JCAHO, NCQA, etc.) and covered by liability carriers.
I. Include CHW services in private health insurance plans.	▪ Ask the State Insurance Commission to assure the inclusion of CHWs. ▪ Provide parity in payment schedules. ▪ Provide options for patient education and other clinically-related prevention programs as " core benefits," ▪ Assure standard reimbursement rates across provider agencies (including IHS and Tribal Agencies).
IV. Medicaid Best Practices	
A. Determine ways to maximize Medicaid	▪ Investigate the possibility of applying

funds through use of CHWs.	for Medicaid waivers under Section 1915 and 1115 under Title XIX of the Social Security Act of 1965. ▪ Apply for Funds from the Center for Health Care Strategies, Inc. for the Medicaid Managed Care Programs' Best Practices Grants for improvement in systems of care and in access to quality care.
B. Allow HSD to authorize the State Medicaid Program to develop, direct, and implement contractual modifications to current Medicaid Managed Care Contracts to assure a payment mechanism for support of the CHWs.	▪ Develop and implement a CHW program for medical translation and interpreter services, health education, outreach and care support services for underserved and rural populations in New Mexico. Acting agencies should be HSD and DOH, in consultation with New Mexico Primary Care Association (NMPCA), New Mexico Hospital and Health Systems Association (NMHHSA), MCOs, and Early Start/Head Start. ▪ Investigate other potential areas for CHW reimbursement under existing Medicaid guidelines such as current Home and Community-based Waivers (Health Aides) and the EPSDT screenings.
V. Training/Curriculum/ Career Ladder	
A. Create standards for core curricula based on core competencies discussed by CHWs in this study.	▪ Develop a competency-based curriculum that provides a general set of skills identified in this study. ▪ Supplement the general certification curriculum with curricula in specialty areas of knowledge that CHWs wish to pursue. ▪ Include both theory and practice.
B. Develop a core training program with additional components on specialty areas of health, with monthly in-service presentations of local community resources.	▪ Ensure that training is available locally, in both English and the language of the community to be served. Translate both audio and written materials. ▪ CHWs should have input into and/or deliver the training. ▪ Train CHWs as instructors. ▪ Train mentors to guide new CHWs through on-the-job training internship.

	▪ Use multi-media and distance-learning technologies, including video conferencing, e-learning, videos, and interactive CD-ROMs, to deliver training. ▪ Ensure that training is affordable and accessible to all community members. ▪ Ensure that training is culturally appropriate and language-relevant with flexibility for childcare and family needs. ▪ Use non-traditional students' learning techniques in non-intimidating settings with the flexibility of time and alternate learning systems. ▪ Adapt training curriculum for local community implementation.
C. Enhance funding to NM community colleges, technical schools and universities to establish programs, including welfare-to-work for support of individuals in rural and underserved communities, to promote a career ladder for CHWs.	▪ Investigate funding from the CDC for health-care workforce development.
D. Use the Senior Employment Older Workers Program to provide training for adults age 50 and older wishing to serve as CHWs.	
VI. Evaluation and Effectiveness	
A. Create a statewide evaluation system and database for collecting and analyzing information about CHW programs, including cost/benefits, improved health status, and their overall effectiveness.	▪ Seek CHWs' participation in the development of the evaluation system. ▪ Adequately fund the evaluation system and database. ▪ Include focus groups, written surveys, online evaluation, and a 1-800 telephone number for survey purposes. ▪ Simplify evaluation tools. ▪ Include process and outcome data. ▪ Use data gathered through these methods to affect policy and programming.

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Appendices

Appendix A: Senate Joint Memorial 076

A JOINT MEMORIAL

REQUESTING THE DEPARTMENT OF HEALTH TO LEAD A STUDY TO DEVELOP A COMMUNITY HEALTH ADVOCACY PROGRAM IN NEW MEXICO.

SJM 76 Page 1

WHEREAS, New Mexico ranks at the bottom or near the bottom of many national health statistics; and

WHEREAS, New Mexico is experiencing a continuing and critical shortage of health care providers, particularly in rural and inner-city areas; and

WHEREAS, New Mexico has a tradition of strong communities, volunteerism and community services and places

a high value on the depth and richness of its multicultural heritage; and

WHEREAS, community health advocates, such as community health workers, promotoras, community health promoters, community advocates, outreach educators, doulas, peer health promoters and community health representatives, both nationally and in New Mexico, serve as a successful and effective means of addressing the health and social needs of people and communities; and

WHEREAS, community health advocates serve as an extension of professional health care providers and bridge cultural differences by offering culturally and linguistically appropriate care to underserved communities; and

WHEREAS, federal medicaid regulation requires appropriate outreach, enrollment and translation services, which means additional federal funding is available for the use of increased community health advocate services; and

WHEREAS, the current state and national medicaid and health care crises will, without new resources, result in reduced availability of services, and utilization of culturally and linguistically appropriate care management through community health advocates can serve as a best-practice quality measure in contract compliance; and

WHEREAS, the hundreds of community health advocates, many currently serving with little or no pay, are a ripe opportunity for economic and community development through the provision of recognition and steady fiscal support of their

valuable services; and

WHEREAS, New Mexico has an opportunity to create an innovative model to address the state's pressing health needs, increase access to care, promote economic development and ensure healthier communities;

NOW, THEREFORE, BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO that the department of health be requested to lead a study on the development of a community health advocacy program in New Mexico, including the program's methods, structure, financing and implementation, that utilizes various categories of community health advocates; and

BE IT FURTHER RESOLVED that legislative recommendations be developed to address economic opportunities for communities, reimbursement by the department of health for community health advocate services, the potential of tax incentives as encouragement for employment of community health advocates by private health care providers and the identification of matching grant opportunities for outreach and training; and

BE IT FURTHER RESOLVED that the study examine the potential for use of community health promoters as part of a best-practice quality measure for medicaid and other contracted providers; and

BE IT FURTHER RESOLVED that the department of health be requested to develop an innovative curriculum based on existing models that include service delivery, economic development and other aspects of a community health advocacy program in New Mexico; and

BE IT FURTHER RESOLVED that the human services department, the department of economic development, the department of labor, the state department of public education, the children, youth and families department, the state agency on aging and appropriate organizations representing the interests of community health advocates or utilizing the services of community health advocates participate in the study; and

BE IT FURTHER RESOLVED that the department of health report its legislative

recommendations to the interim legislative health and human services committee at its October 2003 meeting; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the department of health, the human services department, the economic development department, the labor department, the state department of public education, the children, youth and families department, the state agency on aging and appropriate organizations representing the interests of community health advocates as community health workers, promotoras and others.

Appendix B: Taskforce Attendees

SJM 76 TASK FORCE LIST COMMITTEE CONTACT INFORMATION revised 10/24/03					
First	**Last**	**Address**	**E-mail**	**Phone#**	**Fax#**
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		NM DOH			
		PO Box81675			
		ABQ, NM 87502			
Lynne	Anker-Unnever	Aging and LTC Department	Lynne.anker-Unnever@state.nm.us	255-0971	255-5602
		(State Agency on Aging)		Ext. 102	
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		ABQ, NM 87110			
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		Belen, NM 87002			
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		ABQ, NM 87113			
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		PO Box 838	gathplac@cia_g.com		
		Thoreau, NM 87323			
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		Education Program			
		MSC 10 5550			
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		Santa Fe, NM 87502			
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		and Education Program			
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		Suite 5650			
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		Medical Assistance Division			
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		455 St. Michaels Dr.			
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		625 Silver SW			
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		PO Box 2357			
		Window Rock, AZ 86515			

Appendix C: Survey Tool 1

COMMUNITY HEALTH ADVOCATES
SURVEY/ASSESSMENT

1. Name of Organization		
2. Project Name		
3. Contact		
4. Address		
5. Telephone		
6. Email		
7. Does your organization employ Community Health Advocates CHAs (i.e. CHWs, Promotoras, CHRs, Doulas, etc.)	___Yes If Yes, Employed ___Full Time	___No ___Part Time
8. Major source of program income	___State/Federal	___Other
9. My organization or agency has voluntary CHAs (i.e. CHWs, Promotoras, CHRs, Doulas, etc.)	___Yes	___No
10. What programs or services are offered?		
11. What population is served?		
12. There is a home visiting component	___Yes If yes, please describe	___No
13. Number of CHAs (i.e. CHWs, Promotoras, CHRs, Doulas, etc.) your organization works with per year.	___1-3 ___6-8	___4-6 ___9 or more
14. Does your organization train CHAs (i.e. CHWs, Promotoras, CHRs, Doulas, etc.)?	___Yes If yes, describe	___No
15. Are Community Health Advocates in your organization formally trained? (i.e. CHWs, Promotoras, CHRs, Doulas, etc.)?	___Yes If yes, please describe	___No
16. Who provides training to Community Health Advocates in your organization?	___CHW/Promotora/CHR ___Social Worker ___Nurse	

	___Physician ___Other (describe)	
17. Does your organization have a database of CHAs (i.e. CHWs, Promotoras, CHRs, Doulas, etc.)?	___Yes	___No
18. Does your organization have a database of **trainers** for CHAs (i.e. CHWs, Promotoras, CHRs, Doulas, etc.)?	___Yes	___No
19. Does your organization need training for CHAs (i.e. CHWs, Promotoras, CHRs, Doulas, etc.)?	___Yes	___No
20. Does your organization have a budget to support training of CHAs (i.e. CHWs, Promotoras, CHRs, Doulas, etc.)?	___Yes	___No
21. What are the ten most valuable skills for CHAs (i.e. CHWs, Promotoras, CHRs, Doulas, etc.)? Please rank in order of importance and add any additional skills that you feel are important.	__Multi-cultural competence __Community outreach __Communication/conflict resolution __Self-management __Bilingual/bicultural __Patient Education and Counseling __Interviewing/intake __Reporting and documentation __Appropriate training __Knowledge of entitlements and referrals __Other __Other	

21. What are the issues you feel need to be addressed by this Memorial Study that will help Community Health Advocates programs successfully improve the health of people in New Mexico?

_____
_____
_____
_____
_____

22. If you know of any any other organizations that use Community Health Advocates (i.e. CHWs, Promotoras, CHRs, Doulas, etc.), please list them so we may contact them for additional information:

THANK YOU FOR YOUR VALUABLE INPUT.

Appendix D: Survey Tool 2

Community Health Advocates Questionnaire

Date: _____

Location: _____

Employer: _____

Work Phone _____

Work E-mail _____

Thank you for taking the time to complete this questionnaire, which is part of a statewide study of community health advocates community health workers, promotoras, community health representatives, doulas, and other lay health workers.

Here's why it is important for you to take part in this study. During its 2003 session, the New Mexico Legislature passed Senate Joint Memorial 76, which requests that the New Mexico Department of Health lead a study to develop a community health advocacy program in New Mexico.

The Department of Health developed a statewide taskforce to conduct the study. The taskforce is composed of people from around the state, including community health advocates, program directors, nurses, and more. But even the most diverse taskforce can't develop a program without your input. The goal is not to tell you what to do, but to give you a voice in developing a community health advocate program for New Mexico. So, to ensure that the study includes input from as many community health advocates as possible, the taskforce developed the questionnaire I've just distributed, and it is conducting meetings like this one around the state.

When you have completed the questionnaire, please return it by mail or fax to:

Regina Petroni-Mennin, PhD
UNM Community & Outreach Dept.
Cancer Research & Treatment Center Ste. B78
900 Camino de Salud N.E.
Albuquerque, NM 87131-5636
FAX 505-272-4780

Thank you!

Job Title: (e.g. promotora, community health worker, community health worker, community health advocate) _____

What is the geographic area in which you work? _____

_____

Would you be willing to be contacted for a follow-up interview or attend another focus group meeting?

Yes Maybe No

Gender: Female Male

Age: _____

Ethnicity: _____

Formal Education Level:
- _ Less than high school/GED
- _ High school/GED
- _ Some college
- _ Associates Degree
- _ Bachelor's Degree

Section I: Employer Practices

1. Did your employer require that you had a high school diploma or GED before you received training?

Yes No

2. Did your employer require you to speak and write English to hire you?

Yes No

3. Are you paid or volunteer? _____

4. If you are paid, how are you paid?
- _ Hourly: How much per hour? _____
- _ Weekly salary: How much per week? _____
- _ Biweekly salary: How much per pay period? _____
- _ By assessment? How much per assessment? _____

5. Do you have health insurance?
   _ Yes – private (through your employer)
   _ Yes – public
   _ No

6. Do you receive other benefits?
   _ Sick leave
   _ Annual leave
   _ Family leave
   _ 401K
   _ Other retirement plan
   _ Other benefits _____

7. Are you supervised?
   Yes No
8. If yes, by whom are you supervised?
   _ Health educator
   _ Program Director
   _ Social Worker
   _ Coordinator
   _ Community Health Worker/Promotora
   _ Nurse (R.N. or L.P.N.)
   _ Nurse Practitioner or Physician's Assistant
   _ Physician
   _ Other _____

9. Using a scale of one to ten, where one means "unacceptable" and ten means "excellent," please rate the quality of supervision you receive on a scale of one to ten,."

Support	1	2	3	4	5	6	7	8	9	10
Guidance	1	2	3	4	5	6	7	8	9	10
Knowledge	1	2	3	4	5	6	7	8	9	10
Direction	1	2	3	4	5	6	7	8	9	10

Section II: What You Do

1. What does the word "promotora" (or community health advocate, community health representative, doula, or whatever job title you have) mean to you? How would you define promotoras/community health workers and the roles they play in their communities?

2. Which of the following are problems in your community?
   - _ Lack of or low-paying jobs
   - _ Crime
   - _ Lack of access to health care and other services
   - _ Lack of transportation
   - _ Lack of recreation
   - _ Limited educational opportunities
   - _ Other _____
   - _ Other_____

3. As a promotora, how do you help to address these problems in your communities?
   - _ Serve on committees and/or boards
   - _ Educate community members about available resources
   - _ Work with community leaders (e.g. elected officials)
   - _ Provide information to media outlets (e.g. newspapers, radio and television stations)
   - _ Other _____
   - _ Other _____

4. What other roles do you think promotoras could play in your community?

Section III: Self-Evaluation

Eight core skills and knowledge competencies for promotoras were defined in the 1998 National Community Health Advisor Study. They are listed below. Using a scale of one to ten, with one being "not at all confident" and ten being "extremely confident," please rate yourself in each of the areas:

	(1-10)
Communication skills ▪ Listening ▪ Use language confidently and appropriately ▪ Ability to read and write well enough to document activities	
Interpersonal skills ▪ Counseling ▪ Relationship-building ▪ Ability to work as a team member ▪ Ability to work appropriately with diverse groups of people	
Knowledge Base ▪ Broad knowledge about the community ▪ Knowledge about specific health issues ▪ Knowledge of health and social service systems ▪ Ability to find information	
Service Coordination Skills ▪ Ability to identify and access resources ▪ Ability to network and build coalitions ▪ Ability to provide follow-up	
Capacity-building skills ▪ Empowerment: Ability to identify problems and resources to help clients solve problems themselves ▪ Leadership ▪ Ability to strategize ▪ Ability to motivate	
Advocacy Skills ▪ Ability to speak up for individuals or communities and withstand intimidation ▪ Ability to use language appropriately ▪ Ability to overcome barriers	
Teaching Skills ▪ Ability to share information one-on-one ▪ Ability to master information, plan and lead classes, and collect and use information from people in the community.	
Organizational Skills ▪ Ability to set goals and plan ▪ Ability to juggle priorities and manage time	

Section IV: Training

1. What organization provided your initial training? _____

2. How was your initial training paid for?
   _____

3. Did you receive any training before you were hired?_____

4. Who provided your initial training?
   - _ Promotora
   - _ Nurse
   - _ Nurse practitioner
   - _ M.D.
   - _ Other _____

5. What form did your initial training take? (Please check all that apply)
   - _ Classroom lectures
   - _ Hands-on practice scenarios in a classroom or other location
   - _ Written materials (Please identify) _____
   - _ Videos
   - _ Audio-tapes
   - _ Interactive media (internet, CD-ROM, etc.)
   - _ Field work or on-the-job training
   - _ Other (Please describe) _____

6. Was training offered in your native language?

   Yes No

7. How many contact hours were required for you to complete your initial training?

8. How long (in weeks, months, or years) did it take you to complete your initial training?

9. Did your initial training cover all of the skills and knowledge areas defined by the National Community Health Advisor Study (page 5)?

   Yes No

10. How well do you feel that the promotora training you received prepared you for the day-to-day work you do?

    Very well Pretty well Not too well Not at all well

11. In what specific areas do you feel your training could have better prepared you for your work?

12. Would you be interested in receiving more training? In which specific areas would you like to receive more training?

13. Have you continued to receive training as a promotora? What additional training have you received since your initial training?

14. Do you think that any of the following skills and/or knowledge areas should be added to the core curriculum for CHWs? (Please check all that apply)

    _ Computer literacy
    _ Library research
    _ Internet research
    _ Public relations/media
    _ Leadership (serving on committees, boards, etc.)
    _ English as a Second Language (ESL)
    _ Health Insurance Portability and Accountability Act (HIPAA)
    _ Your rights as an employee
    _ Other _____

Appendix E: Percentages of Medicaid, Medicare, and Uninsured for New Mexico by County in Comparison to the U.S. (Urban and Rural)

	Pop for Whom Poverty status Is Determined (Census Data 2000)	Ratio of Income in 1999 to Poverty Level; <200% Poverty (Census Data 2000)	Medicaid Enrollees Dec 2000 (NMHSD)	Calculated Uninsured by County (Total NM Pop < 200% FPL Minus Medicaid Enrollees)	Calculated Percentage of Pop Uninsured
United States Total	281,475,000	84,974,000	41,000,000	43,974,000	15.62%
New Mexico Total	1,783,907	737,693	323,897	413,796	23.20%
Bernalillo County	547,422	180,194	77,998	102,196	18.67%
Catron County	3,513	1,812	389	1,423	40.51%
CHW'sves County	60,087	28,903	15,011	13,892	23.12%
Cibola County	24,414	13,268	5,365	7,903	32.37%
Colfax County	13,759	5,422	2,421	3,001	21.81%
Curry County	43,858	20,779	9,142	11,637	26.53%
De Baca County	2,162	985	394	591	27.34%
Dona Ana County	169,559	87,626	40,363	47,263	27.87%
Eddy County	50,908	21,889	10,224	11,665	22.91%
Grant County	30,365	13,785	6,087	7,698	25.35%
Guadalupe County	4,167	2,083	1,153	930	22.32%
Harding County	810	327	76	251	30.99%
Hidalgo County	5,838	3,163	1,250	1,913	32.77%
Lea County	53,682	25,584	11,134	14,450	26.92%
Lincoln County	19,169	7,114	3,000	4,114	21.46%
Los Alamos County	18,255	1,175	314	861	4.72%
Luna County	24,741	15,602	5,978	9,624	38.90%
McKinley County	73,947	46,820	22,535	24,285	32.84%
Mora County	5,146	2,789	1,214	1,575	30.61%
Otero County	60,893	27,703	7,830	19,873	32.64%
Quay County	9,941	5,028	2,169	2,859	28.76%
Rio Arriba County	40,877	19,080	9,416	9,664	23.64%
Roosevelt County	17,267	8,662	4,194	4,468	25.88%
Sandoval County	89,422	26,562	13,358	13,204	14.77%
San Juan County	112,410	51,883	19,367	32,516	28.93%
San Miguel County	29,125	15,021	7,234	7,787	26.74%
Santa Fe County	126,999	39,040	13,424	25,616	20.17%
Sierra County	12,957	6,204	2,445	3,759	29.01%
Socorro County	17,490	9,650	4,237	5,413	30.95%
Taos County	29,760	13,687	6,641	7,046	23.68%
Torrance County	16,318	7,480	4,853	2,627	16.10%
Union County	4,154	1,711	691	1,020	24.55%
Valencia County	64,492	26,662	13,496	13,166	20.41%
Unknown			494		

Data Analysis and Formatting: UNM Center for Community Partnerships 8/12/03, Daniel Derksen, MD
Data Set: Census 2000 Summary File 3 (SF 3) - Sample Data
NM Medicaid Enrollment Dec 2000 from: http://www.state.nm.us/hsd/mad/Reports.htm

Appendix F: Skills and Knowledge Areas

Essential Skills and Knowledge Areas for CHWs in SJM 076 Study

Essential Skills	
Communication	▪ Oral ▪ Written ▪ English as a Second Language (ESL) ▪ Culturally-appropriate language ▪ Bilingual ▪ Cultural sensitivity
Basic Computer Literacy	▪ Internet research ▪ E-mail ▪ Word processing ▪ Desktop publishing ▪ Spreadsheets
Leadership skills	▪ Serving on committees/boards ▪ Event organizing ▪ Group facilitation ▪ Public speaking ▪ Teaching skills
Presentation skills	▪ Preparing a presentation ▪ Hands-on demonstrations ▪ Culturally appropriate client education ▪ Both groups and individuals
Safety	▪ Prevention of and protection from communicable diseases ▪ Scene safety ▪ Self-defense ▪ Recognition of dangers
Service-coordination skills	▪ Resource-finding ▪ Referrals ▪ Networking
Outreach skills	▪ Media literacy ▪ Reaching school systems/agencies ▪ Working with volunteers ▪ Reaching community members ▪ Interpersonal skills
Interviewing	▪ Interacting with substance abusers ▪ Age-appropriate ▪ Mediation/conflict resolution
Stress Management	▪ Health and well-being of CHWs ▪ Avoiding “burnout”
Reporting and Documentation	▪ Confidentiality ▪ Accuracy ▪ Health Insurance Portability and Accountability Act (HIPPA)
Administrative/Organizational Skills	▪ Ability to set priorities ▪ Time management ▪ Planning and goal setting

Essential Knowledge Areas for CHWs in SJM 076 Study

Essential Knowledge Areas	
Basic Health Issues	▪ Nutrition ▪ Exercise ▪ Diabetes ▪ Cardiac ▪ Hypertension ▪ Asthma ▪ Pre/postnatal ▪ Early childhood ▪ Sexually Transmitted Diseases ▪ Emergencies
Employee Rights	▪ Scope of Practice ▪ Supervisory limitations
Health and Social Services	▪ Agencies within community ▪ Network with providers ▪ Familiarity with community

Areas of Specialization for CHWs in SJM 076 Study

Specialty Areas	
Physical Health	▪ Diabetes Education ▪ Hypertension control ▪ Cardiac health ▪ Women's health ▪ Breastfeeding ▪ Asthma ▪ Oral health
Behavioral Health	▪ Smoking cessation ▪ Substance-abuse prevention/response ▪ Depression
Service Coordination	▪ Eligibility specialists ▪ Medicaid enrollment ▪ SCHIP enrollment ▪ Medical Assistance Program
Emergency Response	▪ Cardiopulmonary Resuscitation ▪ First Responder ▪ Emergency Medical Technician, Basic ▪ Emergency Medical Technician, Intermediate ▪ Emergency Medical Technician, Paramedic ▪ Emergency Preparedness ▪ Post-emergency service coordination

Appendix G: Graphical Representations of Study Results

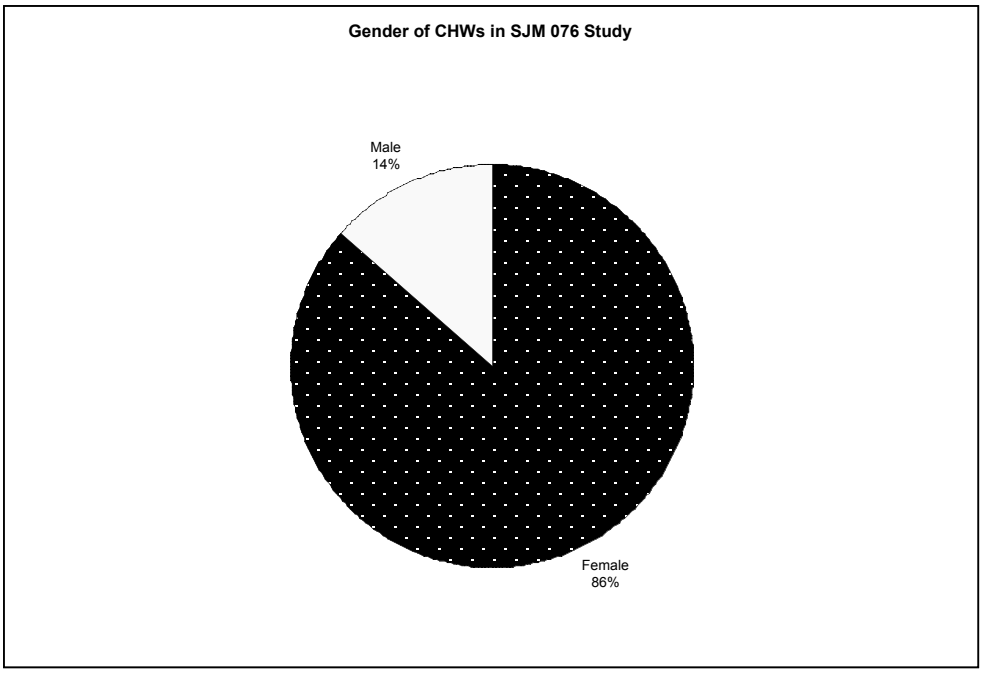

Figure 1: Gender

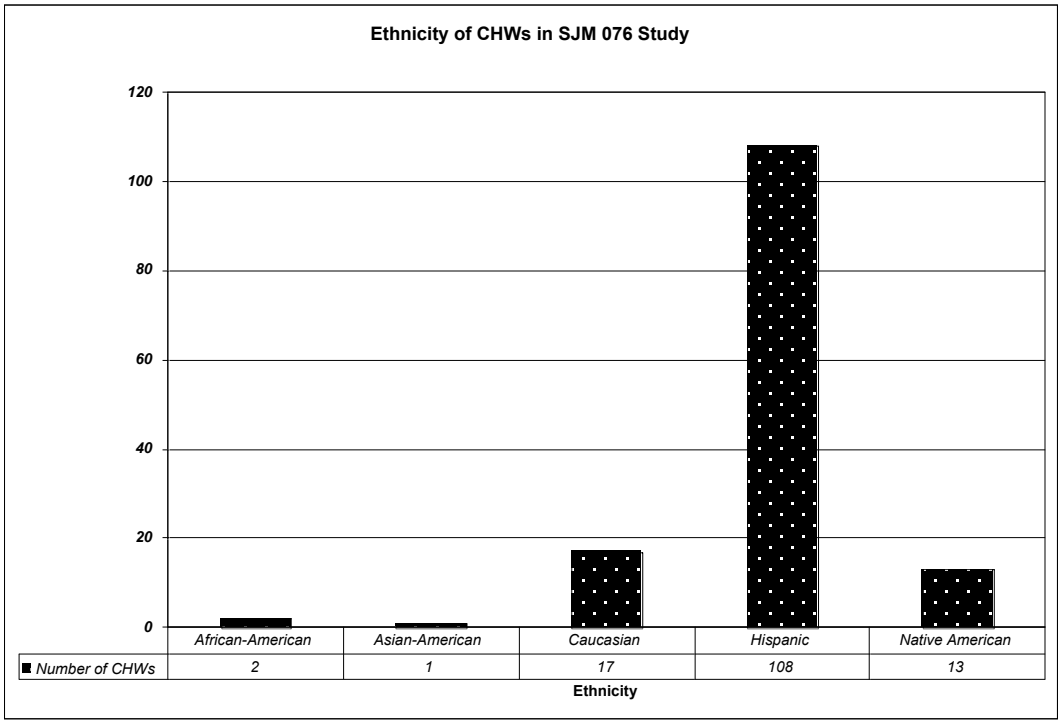

Figure 2: Ethnicity

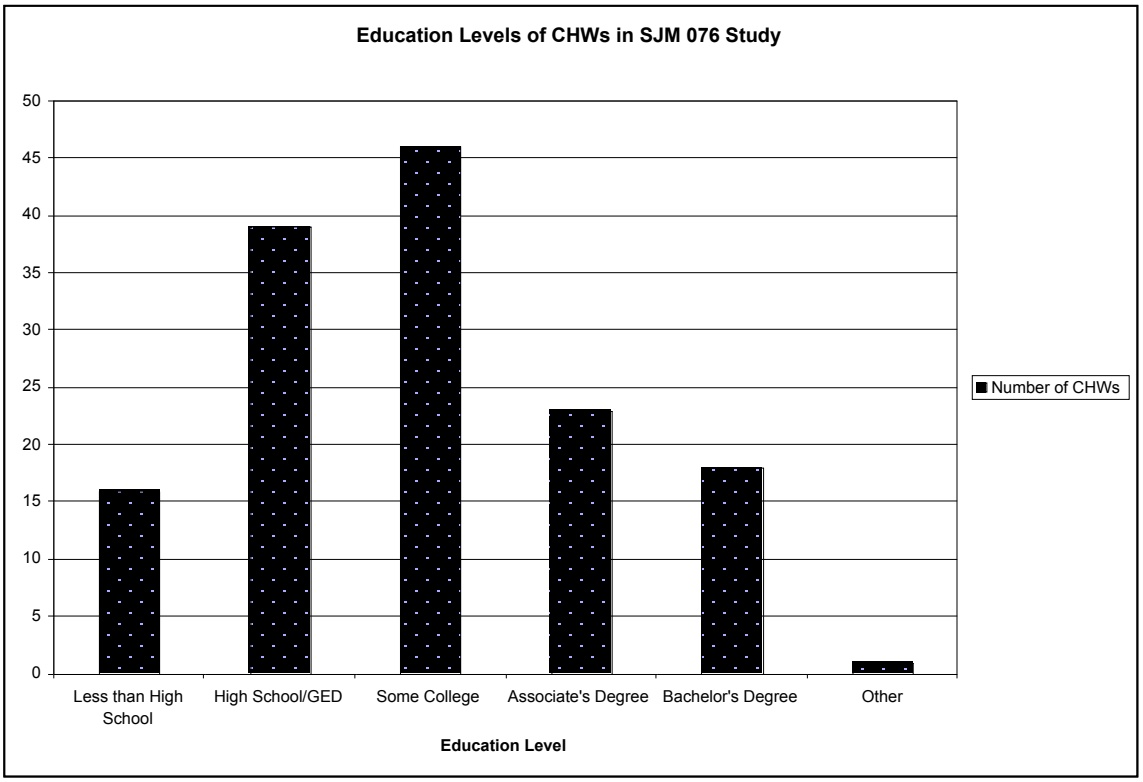

Figure 3: Education Levels

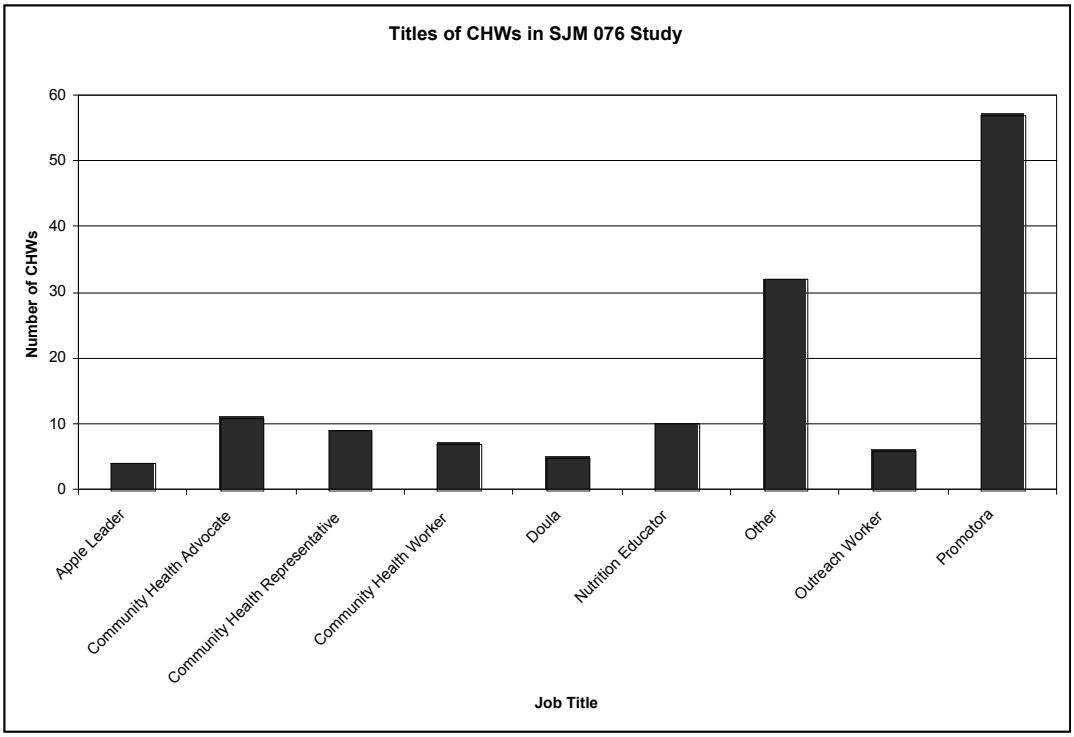

Figure 4: Job Titles

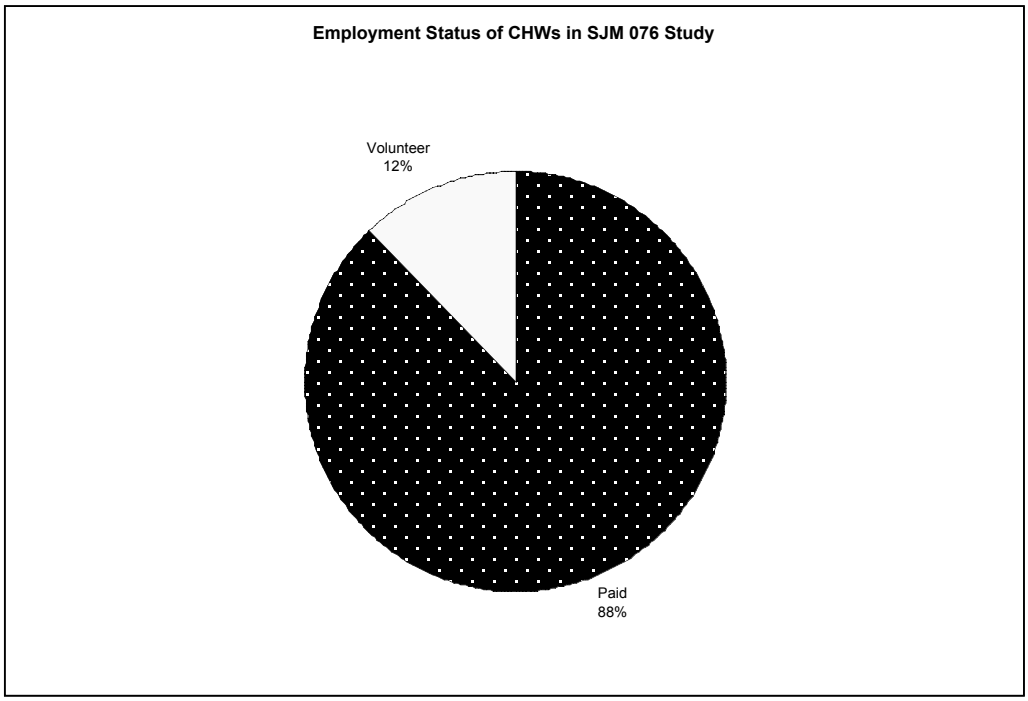

Figure 5: Employment Status

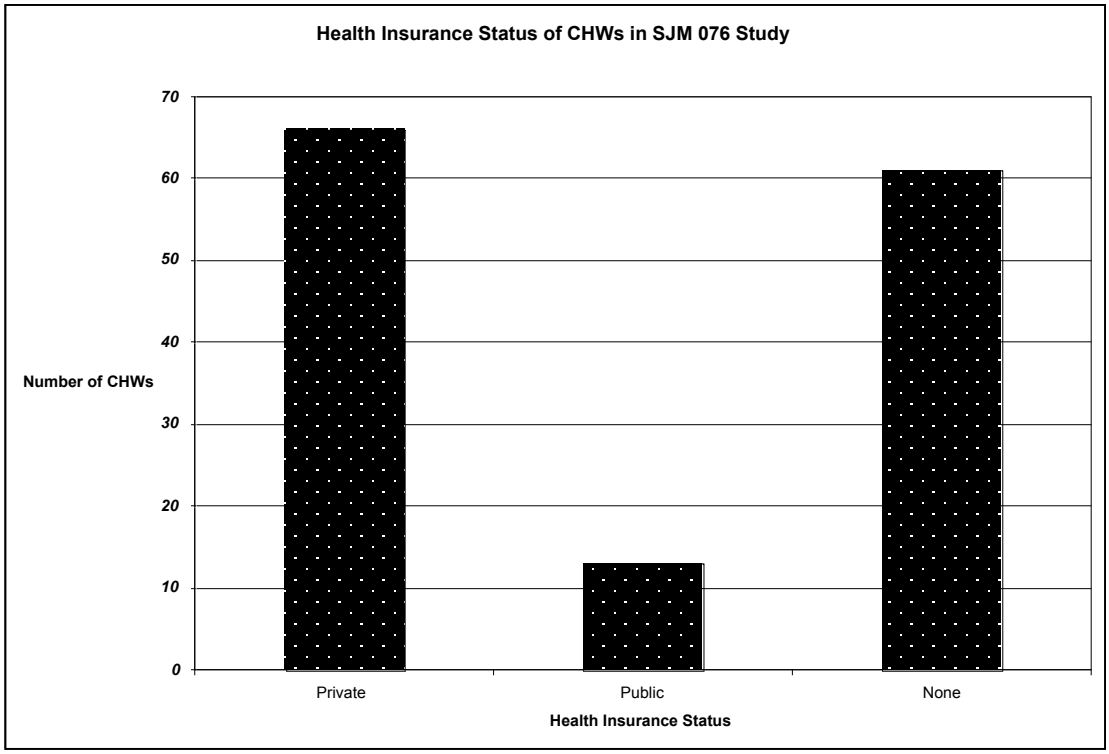

Figure 6: Health Insurance Status

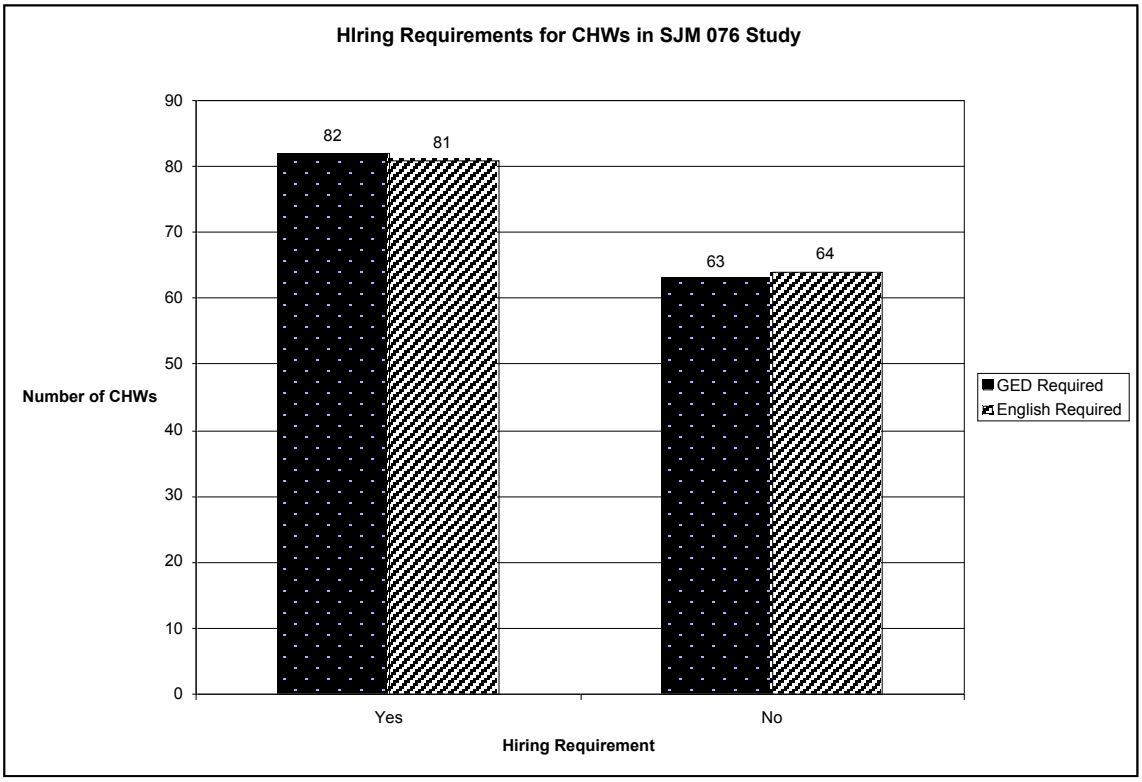

Figure 7: Hiring Requirements