Rural CHW programs have used a variety of program evaluation strategies to demonstrate the effectiveness of their activities. Several grantee communities have developed internal evaluators while others assigned an external evaluator to serve as an evaluator or quality control. Grantees are collecting qualitative and quantitative data from their CHW programs using individual encounter forms, group education session documents, clinic reports, and case management reports to assess the effectiveness of their programs. Grantee evaluation of CHW services are “live blood glucose tests,” and blood pressure and cholesterol screening. Grantee communities also track the number of clients receiving services, the number of community education events held, and the number of CHW weekly meetings. In addition, most grantee communities collect data on the social determinants of health, such as housing stability, employment status, and family structure, as well as the CHW services they provide. Grantee communities are also using evaluation via a change management model. One possible model to look at is the problem identification and problem-solving process recommended by the Centers for Disease Control and Prevention. For example, one of the 330A Outreach Authority grantees is a community health center (CHC) that connects their CHWs to other clinic’s in the rural community. This financial model has helped the CHC collect revenue for their CHW services. Another grantee is developing a similar relationship with their local farmer’s association, given that migrant workers in the community worked closely with the local community organization and had good rapport with the community members. Finally, some programs rely on their CHWs to collect data. One CHW coordinator in South Dakota is using this CHW to evaluate CHW programs using individual encounter forms, group education session documents, case management reports, and patient feedback forms. In addition, the CHW coordinator in South Dakota has implemented a monthly follow-up phone call to CHWs to assess their retention and identify new opportunities to sustain their activities. For example, community organizations, hospitals, and governmental agencies may have the capacity for CHW trainings, transportation services, and other services that CHW programs could acquire. Additionally, community organizations that are actively trying to expand their network in the community could consider using CHWs as messengers to inform the community about the social determinants of health, such as housing stability, employment status, and family structure, as well as the CHW services they provide. Grantee communities are also using evaluation via a change management model. One possible model to look at is the problem identification and problem-solving process recommended by the Centers for Disease Control and Prevention. For example, one of the 330A Outreach Authority grantees is a community health center (CHC) that connects their CHWs to other clinic’s in the rural community. This financial model has helped the CHC collect revenue for their CHW services. Another grantee is developing a similar relationship with their local farmer’s association, given that migrant workers in the community worked closely with the local community organization and had good rapport with the community members. Finally, some programs rely on their CHWs to collect data. One CHW coordinator in South Dakota is using this CHW to evaluate CHW programs using individual encounter forms, group education session documents, case management reports, and patient feedback forms. In addition, the CHW coordinator in South Dakota has implemented a monthly follow-up phone call to CHWs to assess their retention and identify new opportunities to sustain their activities.
highlighting identified promising practices. The toolkit was developed to inform the development of a toolkit of rural CHW resources for rural CHW programs. This project culminated in outreach activities, and feedback from six grantees that implemented a review of rural CHW programs and feedback from six semi-structured telephone interviews with 330A Outreach Authority grantees that have implemented a review of the literature on rural CHW programs; conducted a review of the applications for the seven 330A Outreach Authority grantees; and compiled toolkit resources from the interviews and the final dissemination of a call for promising practices from the interviews and compiled toolkit resources from the interviews and the final dissemination of a call for promising practices.

Purpose of the Project

The purpose of this project was to identify promising practices for rural CHW programs that help rural communities learn from the experiences of their peers and access tried and tested tools and approaches. The study focused on the implementation and use of promising practices for rural CHW programs in the field. The toolkit is designed to help rural CHW programs in the field to identify “model” programs and access tried and tested tools and approaches. Additionally, CHWs are members of the target population that share many of the experiences and characteristics of the target population. They are trusted members of their community who are often provided in multiple languages. They may support individuals by providing information and education about their condition, treatment options, and enrollment agents. CHWs often work within a defined scope of practice, which may be provided by a professional organization or state agency. Their role can vary depending on the program or organization and the needs of the program or organization.

Methodology

The methods for this project included: (1) discussions with the HRSA Federal Office of Rural Health Policy staff and a review of 330A Outreach Authority grantees and the literature on rural CHW programs; (2) a review of the literature on rural CHW programs; (3) semi-structured telephone interviews with 330A Outreach Authority grantees that implemented rural CHW programs; and (4) the development of a toolkit of promising practices on promising practices in rural CHW programs.

In the first phase of this project, the HRSA Federal Office of Rural Health Policy staff and the 330A Outreach Authority grantees that implemented CHW programs in rural communities were interviewed about their rural CHW programs. The literature review and interviews revealed CHW program models that are used in rural CHW programs in the field. CHW Program Models in Rural Communities

The CHW program models are mutually exclusive and not mutually exclusive. CHW program models may work in conjunction with each other. CHW program models may be used in conjunction with each other. CHW program models may be used in conjunction with each other.

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Identifying promising practices for rural CHW programs—and making this information available to rural CHW programs through the presentation and replication of programs that are supported by research and/or experience.

This issue brief is based on a literature review of rural CHW programs and feedback from 330A Outreach Authority grantees that implemented rural CHW programs. This project culminated in the development of a toolkit of evidence-based rural CHW programs and resources that are available on the Rural Assistance Center (RAC) website (www.ruralhealthinfo.org).

Purpose of the Project

The purpose of this project was to identify promising practices for rural CHW programs that help rural communities learn from the experiences of their peers and access tried and tested tools and approaches. The study focused on 330A Outreach Authority grantees and used data from CHW programs in the field to identify "model" programs—those that are being recognized by rural CHW programs with positive outcomes—and promising practice resources that may help rural communities.

The project is timely in light of recent policy activity related to CHWs, including reauthorization of the Community Health Act (ACA) and the U.S. Department of Labor’s National Community Health Worker Program. CHW programs are rapidly expanding across the nation and are now part of a growing movement that is improving access to health care for underserved populations.

Methodology

The methods for this project included: (1) discussions with the HHS Federal Office of Rural Health Policy staff and a review of 330A Outreach Authority grantees that are being recognized by rural CHW programs; (2) a review of the literature on evidence-based rural CHW programs; (3) a survey of the characteristics of CHWs on rural CHW programs; and (4) the development of a toolkit of resources on promising practices used in rural CHW programs.

CHW Program Examples

The literature review and interviews revealed CHW program models that are used in rural communities and have contributed to positive health outcomes for rural residents.

Promotion Model. In the promotion model, CHWs are members of the target population that share many of the same social, cultural, and economic characteristics. They are treated as members of their community who are effective at building relationships. They serve as the bridge between diverse populations and the health care system. The scope of their activities ranges from providing culturally appropriate services to supporting health care providers, community outreach workers, and translators. The promotion model has been applied in Latin America and in the U.S. to serve Hispanic communities, in particular, and rural communities to improve the health and wellness of diverse populations, including seasonal farm workers and residents of border communities.

Care Coordinator/Manager Model. As a care coordinator or manager, CHWs provide direct health care services in collaboration with health care providers. They measure blood pressure, blood glucose, and heart rate and provide basic first aid and medication administration training. CHWs may be comprised of a physician, nurse, allied health worker, or pharmacist. They assist in delivering health services or screening while the provider conducts a medical exam. This model is often used when CHWs work with providers in a clinic setting.

Outreach Coordinator/Manager Model. As a care coordinator or manager, CHWs help individuals with complex health conditions to link with health care system. They liaise between the target population and an army of health and social service organizations. They provide information, support, and education, and serve as advocates for services and viable options. CHWs may also help individuals apply for government benefits and access healthy housing.

CHW Program Models in Rural Communities

In some cases, CHWs are volunteers at health centers or schools, working with migrant and seasonal farm workers and their families in communities, in particular. It has been used widely in health promotion, and disease prevention and management. Depending on the population served, CHWs may provide health promotion materials to target populations, including migrant workers, elderly residents, and immunization-exempt individuals, or they may provide opportunities for target populations to participate in health promotion initiatives. CHW programs have used these approaches to improve health outcomes for target populations, including children, elderly residents, and immunization-exempt individuals.

Promotion Model

The outreach and enrollment model is similar to the health educator model with additional training and enrollment responsibilities. As outreach and enrollment agents, CHWs provide services in both rural and urban areas. They conduct intensive home visits to deliver psychosocial support, promote maternal and child health, conduct environmental and home assessments, offer advice, and make referrals. They also help individuals apply for government benefits and other programs.

Recruiting and Hiring Rural Community Health Workers

Rural CHW programs have adapted existing materials from the Centers for Disease Control and Prevention (CDC), states, and academic institutions to create their own training curricula. When developing their programs, grantee organizations prioritize resources when conducting outreach activities in rural and frontier communities.

CHW program models are not mutually exclusive and are often used in combination. Outreach and enrollment programs—on a service for monitoring and evaluating CHW programs. The scope of each CHW's activities is dependent upon their target population, the CHW program goals, and the unique characteristics of the target population.

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Identifying promising practices for rural CHW programs—and making this information accessible to rural communities—is critical to the success of these programs. The purpose of this project is to identify promising practices for rural CHW programs that help rural communities learn from the experiences of their peers and access and try tested and trusted tools and approaches. The study focused on 330A Outreach Authority grantees, which implement rural CHW programs. This project included the development of a toolkit that offers resources on promising practices used in rural CHW programs.

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Methodology

The toolkit for this project included: (1) discussions with the HSRA Federal Office of Rural Health Policy staff and a review of 330A Outreach Authority grantees to identify those utilizing CHWs, (2) a review of the applications for awards for the program from the U.S. Outreach and Enrollment Agent Model. CHWs may serve as outreach and enrollment agents, CHWs provide services in hard-to-reach areas. They conduct intensive home visits to assess, offer advice, and make referrals. They also help communities develop and improve their capacity to serve the target population. CHWs in the promotora model, CHWs may be paid a salary for their efforts. In other cases, they require their CHWs to be trusted and highly connected to the communities they serve.

The CHW program models are not mutually exclusive. Instead, CHW programs tailor their approach to serve their target population. As community organizers, CHWs build relationships with community stakeholders and government agencies to develop a more coordinated approach to serve their target population. One grantee noted: “We try to [locate] CHWs in communities the better we do it because they are there.”

Community Health Workers: A Diverse Workforce

Rural CHW programs have adapted existing materials from the Centers for Disease Control and Prevention (CDC), states, and academic institutions to create their own training curriculums. When developing their programs, grantees integrate utilized resources from the Community Health Worker National Education Collaborative (CHWNEC) as well as from the National Center for Farmworker Health, and Migrant Health Program. Rural CHW programs have translated materials from these sources into culturally appropriate materials for their rural CHW program activities. CHWs may also incorporate outreach and education resources when conducting outreach activities in rural and frontier communities.

CHW Program Model in Rural Communities

The CHW program model is a community health worker model based on the community’s strength.

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disparities. We just need to find a way to fund it long enough

“I think the promotora community health worker model is

5. “A Handbook for Enhancing Community Health

all lack resources to contribute to evaluation efforts.

typically work with smaller partner organizations that

introduces bias into the data. Second, grantees have

analysis of their program by comparing the cost of the

from having adequate data to demonstrate outcomes.

and they stay.”

another grantee expressed that “it might be easier [to implement

The grantee noted: “Living in a small town, our

CHW coordinator, staff retention is a key sustainability

The majority of the grantees developed

stakeholders in the community has helped grantees to

strategies to continue their work post-grant. The grantees’

The 330A Outreach Authority grantees commented

better their communities. For these reasons, another

a CHW program in a rural area. Grantees commented

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grantees commented that rural CHW programs are more

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a history of collaborating to create solutions that will

HHS grants to fund CHW programs using individual forms, group

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were “people know how to make things work
disruptive and development issues. When CHWs work

are likely to be successful in the long term because “rural

that work well in rural communities and disseminate

as an evaluator or quality coordinator. Grantees are

while others assigned an internal staff member to serve

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members of the health care work force and

sustaining rural CHW programs. The ACA recognises

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and other programs that work well in rural communities and

Both of these grantees described the difficulty of

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in rural communities, despite the fact that "rural change and

It is developing a similar relationship with their local

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that CHWs are involved in the

of the grantee was conducted in the first year of a four-year

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The conclusions and

and toolkit help to build knowledge on CHW strategies

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References


2. Health Activities Physician Assistant—Removing Barriers to Access—An

Alycia Infante, MPA, Alana Knudson, PhD, Alexa Brown, BS

Community health workers (CHWs) have made important contributions to the health of underserved populations in rural communities. While there are many ways to characterize the scope of their activities, CHWs are generally defined as non-physician, non-nurse community workers who have strong ties to the communities they serve. CHWs work with diverse partners to improve community health through peer education and support programs targeted to underserved populations.

CHW activities typically include outreach and enrollment; conducting health assessment and health education; promoting healthy behaviors; and advocacy, community organization, and capacity building.

The 330A Outreach Authority grantees offer promising strategies in the program implementation, evaluation, and sustainability.

• Liabilities for CHWs include transporting clients to and from evaluation activities in remote areas.

• An empowerment approach to evaluation, such as CHW trainings and CHW-driven evaluation designs and tools, is needed to improve CHW's accountability and effectiveness.

• Key sustainability strategies for CHW programs are to develop a consortium of community partners who can fund and manage CHW programs in the community, and to ensure the sustainability of CHWS, even in the absence of Federal funding.

• Identifying promising practices for rural CHW programs is essential to document the benefits of CHWs to rural communities.

Promising Practices for Rural Community Health Worker Programs

Allycia Infante, MPA, Alana Knudson, PhD, Alexa Brown, BS

Challenges

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Community health workers (CHWs) have made important contributions to the health outcomes of underserved populations in rural communities. While there are many ways to characterize the scope of their activities, most studies show that CHWs have the ability to improve health outcomes and sustainability.

One of the lessons learned from the experiences of the 330A Outreach Authority grantees—and the literature on rural CHW programs, more generally—is that there is a need to identify promising practices for rural CHW programs. The 330A Outreach Authority program focuses on reducing health care disparities and expanding health care services in rural areas.

Recognizing the value of CHW programs in rural communities, the HRSA Federal Office of Rural Health Policy funded rural CHW programs as part of the 330A Outreach Authority program. The 330A Outreach Authority program focuses on improving health care services to rural communities. One of the lessons learned from the experiences of the 330A Outreach Authority grantees is that CHWs are effective in rural communities.

This study was funded under a contract with the Health Resources and Services Administration Federal Office of Rural Health Policy (HRP0D, EDH016109N0201ZS13002). Under this contract, the NORC Walsh Center for Rural Health Analysis was to conduct evaluations of the six grant programs established under the 330A Outreach Authority. The projects described in this Technical Report were funded under the six contracts noted above. The opinions expressed in this report are those of the authors, not of NORC, HRSA, or the University of Chicago. The University of Minnesota also conducted some of the program evaluations. The Walsh Center for Rural Health Analysis is part of NORC at the University of Chicago. For more information about these projects or their publications, please contact Michael Melet at (312) 634-9224 or mmet@norc.org.