2022 Vermont Community Health Worker Surveys

Vermont Department of Health

January 2023

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COMMUNITY HEALTH WORKERS OF VERMONT

VERMONT DEPARTMENT OF HEALTH

Contents

Introduction

Background

Community Health Worker (CHW) is an overarching term used to describe people who provide services to members of the community with a goal of helping them improve their health. There are many different job titles associated with the term CHW in Vermont, such as Lay Health Worker, Care Coordinator, Community Resource Coordinator, Navigator or SASH Coordinator, and Peer Recovery Specialists. CHWs often work through a local agency, organization or health care system and share ethnicity, language, socioeconomic status, values, and life experiences with the community members they serve.

In 2018, the Vermont Department of Health (VDH) was awarded a five-year Centers for Disease Control and Prevention (CDC) cooperative agreement to focus on strategies and partnerships to help prevent and manage heart disease and diabetes in Vermont. Research has shown that CHWs are effective in improving outcomes, increasing client engagement, and reducing costs.[1] Due to this growing evidence, the grant included strategies to support the development of a statewide CHW infrastructure.

To promote statewide understanding, support, recognition, and value of CHWs in Vermont, the Vermont CHW Steering Committee was formed. The committee includes a diverse group of representatives from across the state including the VDH, Blueprint for Health, SASH (Support and Services at Home), the University of Vermont Health Network Home Health & Hospice, Community Colleges of Vermont, Northeastern Vermont Regional Hospital, OneCare Vermont, Northern Counties Health Care, Southern Vermont Area Health Education Center, and the University of Vermont Extension - Bridges to Health Program.

One of the Steering Committee's first key activities was to develop the Vermont-specific CHW definition, which was formally adopted in June 2019. An inclusive process was used to write the definition. The team reviewed national definition guidance and coordinated with CHWs across the state, using Vermont CHW voices and experiences to inform the definition. Concurrently, an initial environmental scan was conducted to address the lack of data available to understand the landscape of CHWs across Vermont. Building on the results of the initial landscape assessment, the Steering Committee collaborated with evaluators to develop and implement the Vermont CHW Survey. This survey has been conducted annually since 2020 to further characterize the

[1] Kangovi, S., Mitra, N., Grande, D., Long, J. A., & Asch, D. A. (2020). Evidence-based community health worker program addresses unmet social needs and generates positive return on investment. *Health Affairs*, *39*(2), 207–213. https://doi.org/10.1377/hlthaff.2019.00981.

landscape of CHWs working across the state, inform efforts to support the workforce and assess progress towards infrastructure goals.

Methods

VDH sponsored the 2022 Vermont CHW Survey and contracted with Professional Data Analysts (PDA) to develop and complete the assessment. PDA and VDH developed the survey collaboratively with input from Steering Committee members. The 2022 survey built on the first two iterations of the Vermont CHW Survey fielded in 2020 and 2021 (healthvermont.gov/systems/health-professionals/community-health-workers). Select revisions and additions were made to the survey to address current needs. Survey items were adapted from other statewide CHW surveys as well as the National CHW Common Indicator Project.[2]

The 2022 survey was open from May 16 to June 16, 2022. It was distributed through a variety of channels including listservs and newsletters with outreach conducted by VDH, liaisons from the Steering Committee and partner organizations. The survey included questions for both CHWs and CHW employers and/or supervisors. The first question on the survey served as a screener question that sent respondents to either the question set for CHWs or CHW employers.

Data cleaning was conducted to produce a final dataset and frequencies for all quantitative questions were calculated. Qualitative data from open-ended questions was inductively coded and grouped into high-level themes. This report contains results from an analysis of respondent data from 83 CHWs and 33 CHW employers who are included in the analysis.

The Vermont Community Health Worker survey is in part, supported though the DP18-1815 Vermont Department of Health grant from the Centers for Disease Control and Prevention, Improving the Health of Vermonters through Prevention and Management of Diabetes and Heart Disease and Stroke.

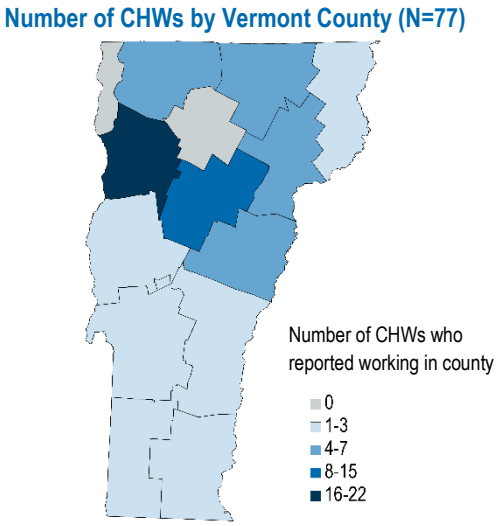
[2] National CHW Common Indicators Project: https://www.nwrpca.org/page/CHWCommonIndicators.

Workforce

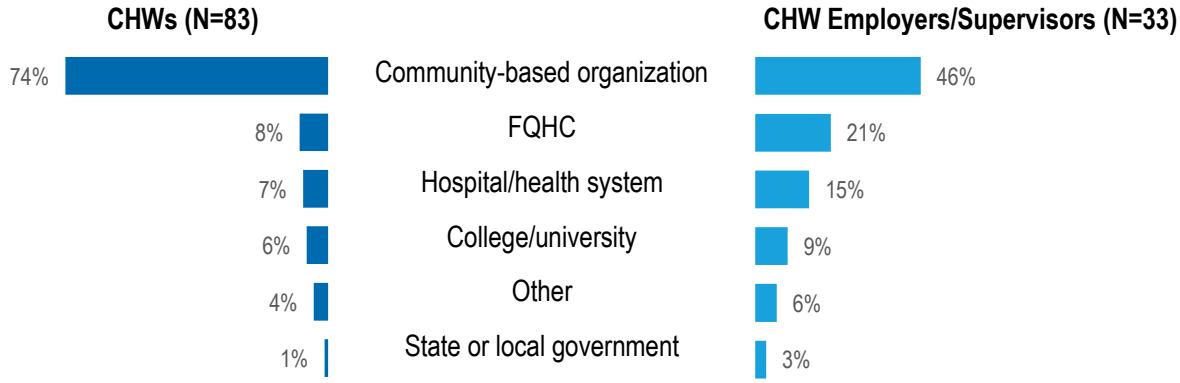
This section describes the workforce of Vermont CHWs and employers that responded to the 2022 survey.

Employment

CHW survey respondents work for organizations with service sites located in 12 of Vermont's 14 counties. More than half of the CHWs who provided information about where their organization is located work within the Burlington-South Burlington-Barre combined statistical area (Chittenden County N=22, Franklin County N=6, Washington County N=15). Respondents to the CHW employer/supervisor survey work at service sites in 10 of the 14 counties: Addison, Bennington, Caledonia, Chittenden, Franklin, Lamoille, Orange, Orleans, Rutland, and Windsor.



The majority of CHW respondents work in community-based organizations (74%); 15% work in clinical settings (8% Federally Qualified Health Centers (FQHCs) and 7% hospitals/health systems). Many of the respondents to the CHW employer/supervisor survey also work in community-based and health care organizations; however, more than one third work in clinical settings (21% FQHCs and 15% hospitals/health systems).



One in five respondents (19%) had been employed as a CHW for less than one year. One third (33%) have been working as a CHW for one to three years, 37% for four to 10 years, and 11% for 11 years or more.

Most CHWs who responded to the survey are employed full-time (69%). Almost one in five CHWs (18%) reported being employed in a different role with some duties similar to CHWs.

Employers were asked a series of questions about the CHW workforce at their organization. A majority (88%) of employers who responded to the survey directly supervise at least one CHW, with a median being three. Half (50%) of CHW employer respondents have never been CHWs, while 28% consider themselves to have previously been CHWs and 22% consider themselves current CHWs.

About half of employers (52%) reported that their organization has employed CHWs for more than 10 years.

Years organization has employed CHWs (N=31)	
Less than 3 years	19%
4-6 years	19%
7-10 years	10%
More than 10 years	52%

Most (77%) employers reported that their organization employs full-time CHWs, about half (52%) employ part-time CHWs, and 6% employ per diem CHWs. The number of paid CHWs employed by an organization varied, with a median value of four CHWs. No employers reported that their organizations employ unpaid volunteer CHWs. When asked if their organization tracks and reports the CHW workforce under the US Department of Labor Bureau of Labor Statistics Standard Occupational Classification (#211094), 79% were unsure.

Job Titles

CHWs can go by many titles that fall under the CHW umbrella. CHWs responding to the survey reported more than 20 different job titles with the three most frequent titles being SASH Coordinator, CHW, and Service Coordinator. Almost 1 in 5 (18%) CHWs selected "Other" for their title.

Employers reported more than 25 different titles for the CHWs that they employ/supervise. The three most common titles employers reported were similar to those reported by CHWs: SASH Coordinator (25%), CHW (41%), and Service Coordinator (16%).

Job titles reported by CHWs (N=83)	
SASH Coordinator	29%
CHW	16%
Service Coordinator	14%
Community Resource Coordinator	7%
Prevention Specialist	4%
Recovery Coach	4%
Community Health Program Coordinator	2%
Cultural Broker	1%
Family Support Worker	1%
Health Educator	1%
Outreach Specialist	1%
Public Health Aide	1%
Other[1]	18%

[1]Other titles included: certified health coach, clinical care coordinator, Doula/Doula case manager/ childbirth educator/ perinatal professional, mental health case manager, IDD services eligibility/access coordinator, program coordinator and recovery coach, program manager, refugees women's coach/community support, resource coordinator and substance use counselor

CHW Definition

Almost all (95%) CHWs agree that the Vermont CHW definition describes the work they do at their practice or organization. Among employers, 72% reported that their organization has a written definition of a CHW; a majority (86%) of those with a definition noted that the definition is similar to, or based on, the Vermont CHW definition.

Vermont CHW Definition: A CHW is a frontline public health professional who is a **trusted member** of or has a close understanding of the community being served. A CHW uses a **person-centered approach** to build **trusting relationships** that enable the CHW to serve as a **liaison** between health and social services and the community to facilitate access to services and improve the quality and cultural and linguistic competence of service delivery. In addition, a CHW increases self-sufficiency, wellbeing and **positive health outcomes** through a range of activities such as outreach, community education, supportive guidance, self-management, coaching and the provision of social support and advocacy.

Education Requirements and Hiring Priorities

In terms of the minimum levels of education or training required for CHWs, six out of ten CHW employers reported that their organization requires a high school diploma or GED.

Employers selected the attributes they prioritize when hiring CHWs. Knowledge of community services/resources, a valid driver's license for work related travel, and prior experience with the population served were more common priorities than a shared background with the population served (58%) or prior experience as a CHW (39%). See Appendix A, Table A.1 for additional information.

Hiring priorities for CHWs (Top 3, N=31)

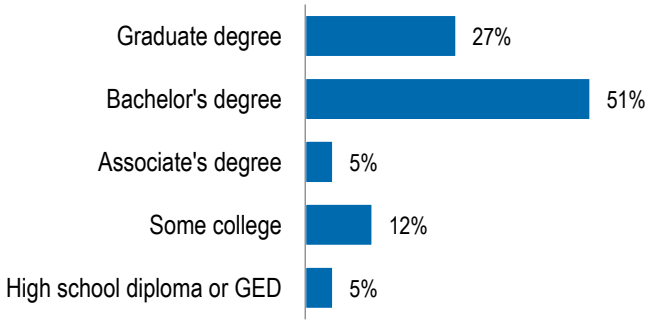
- Knowledge of community services or resources (77%)
- Valid driver's license for work-related travel (77%)
- Prior experience with the population served (74%)

CHW Demographics

Most CHWs identify as female (86%) and white (83%). In terms of age, approximately one quarter (26%) are younger than 35 years, one half (51%) between 35 and 54 years, and one quarter (23%) are 55 years and older.

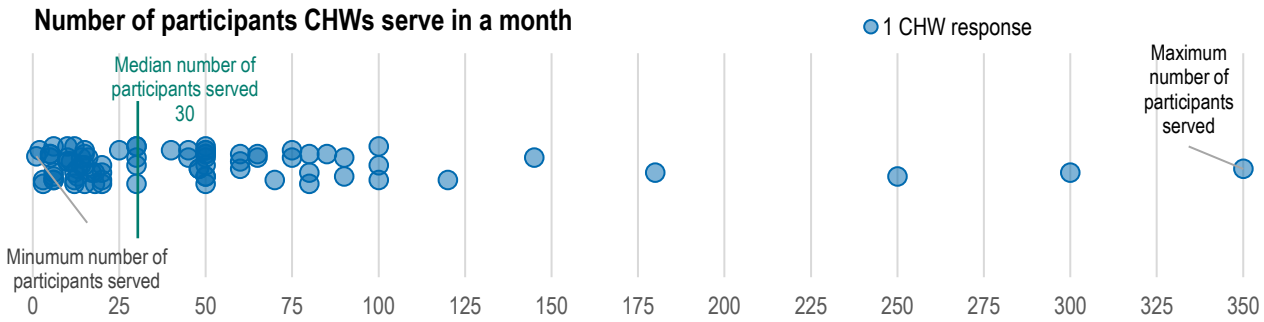
A majority (78%) of CHWs report having a bachelor's or graduate degree. In addition, 30% reported being a licensed or certified health professional or having completed a formal CHW training program (16% of respondents were unsure if they were a licensed/ certified health professional or had completed a formal CHW training program). The most common types of training or certifications were a formal CHW training program (N=7), a Licensed Nursing Assistant (LNA, N=4), clinical social worker or other mental health professional (N=4), and Licensed Alcohol and Drug Counselor or Certified Alcohol and Drug Counselor (LADC or CADC, N=3). Other trainings and certifications reported include Certified Recovery Coach (N=3).

Highest Level of Education Completed by CHWs (N=78)



Participants and Populations Served

CHWs serve between one and 350 participants on average in any given month, with a median of 30 participants. The variation in number of participants served may reflect differences in the size of the population served as well as differences in how CHWs estimated the number of participants (e.g., individuals versus encounters) and/or the types of encounters included.



Respondents were also asked a series of questions describing the participants they work with primarily. For the purposes of this survey, "participant" refers to the individuals CHWs provide services to; some CHWs use the terms clients or patients. CHWs most commonly reported working with individuals with low incomes (54%), individuals living with a disability (53%), and older adults 65+ (48%). When asked if their work as a CHW was focused on specific areas of health or chronic disease, the most common responses were disabilities (39%), mental/ behavioral health (39%), diabetes (36%), and hypertension (36%). One in five CHWs (18%) indicated that their work is not primarily focused on specific areas of health or chronic diseases. See Appendix A (Tables A.2 and A.3) for additional information.

Populations CHWs Work With (Top 3, N=83)	
Individuals with low-income	54%
Individuals living with a disability (i.e., intellectual, physical, sensory, mental)	53%
Older adults (ages 65 and up)	48%

Primary Areas of Health or Chronic Diseases (Top 4, N=82)	
Disabilities (i.e., intellectual, physical, sensory and/or mental)	37%
Mental/behavioral health, including suicide prevention	37%
Diabetes	34%
Hypertension	34%

CHWs were also asked if they work with any specific race/ethnicity groups. One in five (20%) reported they do not work with any specific race/ethnicity groups. Most CHWs who work with a specific group reported working primarily with white participants (67%), Black or African American participants (11%), and/or Hispanic or Latino participants (10%).

When asked how they personally relate to the people they serve, CHWs most commonly reported living in the same community as the participants they serve (82%).

How CHWs personally relate to the people they serve (N=78)[1]	
Same community	82%
Same spoken language	74%
Same race/ethnicity or cultural background	53%
Same identity or lived experience	33%
Same health conditions	31%

[1]Other responses included: low income/rural, I practice person centered motivational interviewing and try to meet them where they are, depends on who I am speaking with

CHW Activities

The Steering Committee developed a scope of practice using the roles and competencies from other states[3] and the Community Health Worker Core Consensus (C3) Project as a guide[4]. The scope of practice was included in the 2022 Vermont CHW Survey to assess its alignment with the practice of CHWs across the state. All CHW respondents selected at least one scope of practice activity, with most (75%) selecting five or more of the 11 activities, suggesting the activities CHWs are performing align with the State's scope of practice. The activities CHWs most commonly mentioned performing include bridging the gap between individuals, communities and the health and social services systems (86%), participating in care coordination and system navigation (80%), and advocating for individuals and communities (80%).

Vermont Scope of Practice Activities	CHWs report conducting this activity (N=83)	Employers report CHWs perform this activity (N=27)	Employers report activity is included in job descriptions or CHW scope of work (N=27)
Bridge the gap between individuals, communities and the health and social services systems	86%	93%	63%
Participate in care coordination and system navigation	80%	85%	59%
Advocate for individuals and communities	80%	85%	52%
Provide health coaching and social support	67%	89%	63%
Conduct outreach	61%	81%	70%
Help build individual and community capacity	54%	70%	48%
Conduct case management	49%	85%	67%
Provide direct service	48%	67%	59%
Provide culturally and linguistically appropriate health education and information	45%	78%	41%
Conduct individual and community assessments	45%	63%	52%
Participate in evaluation and research	22%	48%	33%

There were some differences between how employers reported the activities CHWs perform and those identified in the CHW scope of work and/or job descriptions at their organizations. Similar

[3] Massachusetts, Minnesota, Ohio, Arizona, Maryland, Indiana, Oregon, Kentucky and Texas

[4] CHW Core Consensus Project: https://www.c3project.org/

to CHWs, employers commonly reported that CHWs at their organizations bridge the gap (93%), participate in care coordination and system navigation (85%), and advocate for individuals and communities (85%). However, most employers also reported that CHWs provide health coaching and social support (89%) and conduct case management (85%). When asked to identify which activities are included in the job descriptions or scopes of work for CHWs at their organization, bridging the gap (63%) again emerged as a top activity but outreach (70%), conducting case management (67%), and providing health coaching and social support (63%) were the other activities most reported. Variations in CHW and employer responses could be due to differences in organizational makeup across participants in the CHW and employer surveys (e.g., more employers were from clinical organizations). Alternatively, there could also be differences in the language/terminology CHWs and employers use for activities or in perspectives on roles.

Resources and Referrals

Referral to Services

As noted above, CHWs commonly bridge the gap between individuals, communities, and the health and social services systems which includes connecting participants to a variety of services and resources. CHWs reported referring participants to many services, most commonly food security resources (85%), transportation (79%), mental/behavioral health services (74%), and financial assistance for health care services (68%). See Appendix A, Table A.4 for additional information.

Services that most CHWs refer participants to (Top 4, N=81)

Food security resources (e.g., food pantry, 3SquaresVT, SNAP)	85%
Transportation	79%
Mental/behavioral health services	74%
Financial assistance for health care services (sliding fee scale, free clinics, YouFirst, etc.)	68%

My Healthy Vermont

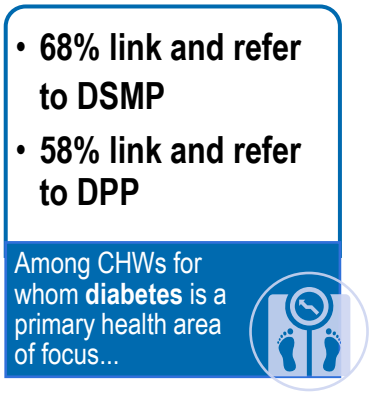
CHWs reported limited awareness (29% to 51%) of the free resources available through My Healthy Vermont's (myhealthyvt.org) suite of chronic disease prevention and control workshops. Awareness was highest for the tobacco cessation workshops and lowest for hypertension control workshops.

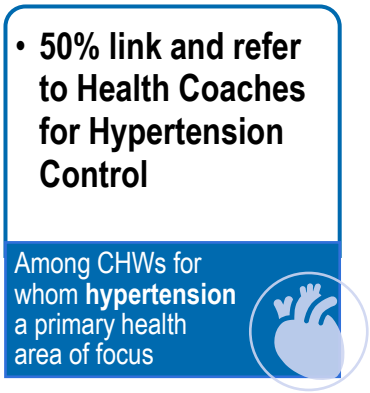
38% of CHWs were not familiar with any of the listed My Healthy Vermont workshops

Similar percentages of CHW respondents reported they link or refer participants to My Healthy Vermont workshops (29% to 54%). In fact, the majority of CHWs who are familiar with a given workshop also refer participants to that program (79% to 93%, data not shown). However, between 24% and 36% of CHWs described each workshop as not applicable to their work activities (see Appendix A, Table A.5), indicating that there are opportunities to increase CHWs' awareness and understanding of My Healthy Vermont workshops and their benefits.

My Healthy Vermont Workshops	CHWs are familiar with this resource	CHWs link or refer participants to this resource
Tobacco Cessation (Fresh Start)	51%	54%
Diabetes Self-Management Program (DSMP)	46%	43%
Diabetes Prevention Program (DPP)	35%	39%
Chronic Disease Self-Management Program (CDSMP)	35%	36%
Health Coaches for Hypertension Control	29%	29%

As noted above, diabetes and hypertension were two health conditions commonly selected by CHWs as a focus of their work. Among those who identified diabetes as a primary area of health for their work, more than two thirds link and refer participants to diabetes management workshops (DSMP) and more than one half link and refer to diabetes prevention workshops (DPP). Similarly, among those who identified hypertension as a primary area for their work, one half link or refer participants to Health Coaches for Hypertension Control workshops.





When asked if there were any other chronic disease management community resources to which CHWs link or refer participants, respondents mentioned:

- Mental health resources (NAMI Vermont, WRAP Emotional Support workshop)

- Other chronic disease prevention and management resources (Little Rivers Health Care's chronic care management program, chronic pain self-management, Stay Healthy learning series, Vermont Chronic Care Initiative, physical activity opportunities like Bone Builders and Tai Chi)
- Other primary care resources (primary care physicians, dental health services, eye care services, mammogram services, HIV treatment programs)
- Other related resources (local food banks, transportation services, housing, and employment services)
- Other tobacco cessation resources (i.e., 802Quits; My Life, My Quit; Truth Campaign; cessation programming for youth)
- Services for older Vermonters (Stay Steady falls prevention program)
- Services for Vermonters needing in-home care (Home Health, Choices for Care, VNA)
- Substance use treatment and recovery resources (VT Helplink, BAART, SMART Recovery)

Workplace Experience

This section describes the workplace experience, challenges, and benefits of CHWs in Vermont.

Experience at Organization

When asked about their experience at their organization, both CHWs and employers agree that organizations value the work CHWs do. However, fewer CHWs reported feeling respected, understood or well-utilized than employers reported. About half of CHWs felt that they were utilized to their full potential compared to two thirds of employers reporting CHWs were used to their full potential. Notably, almost three quarters (73%) of employers felt that the providers CHWs work with understand the role and work of CHWs while about only one half of CHWs (33%) agreed with this statement. In addition, nearly two thirds of employers (63%) felt that CHWs are paid fairly for their work while only one third of CHWs (33%) felt the same.

Experience at organization	% of CHWs who agree (N=78)	% of Employers who agree (N=27)
My organization values the work that CHWs do	88%	96%
The other healthcare, social service and/or education providers CHWs work with respect CHWs and the work they do with program participants	71%	85%
CHWs are well integrated into the clinical care team and/or organization/community teams	59%	63%
The other healthcare, social service and/or education providers CHWs work with understand the role and work of CHWs	51%	73%
CHWs are utilized to their full potential	50%	67%
CHWs are paid fairly for their work	33%	63%

CHW Supervision

When asked to consider their primary supervisor, the majority of CHWs reported feeling appreciated (88%), encouraged to grow professionally (84%), and that their supervisor understands the strengths and needs of communities they serve (86%).

Employers/supervisors most commonly reported providing supervision through informal feedback and guidance (85%), although many also reported providing performance-based reviews (74%) and on-the-job coaching (70%). About half of CHW employers identified that they would benefit from CHW supervisory training related to integrating CHWs more effectively into

the organization/care team (52%) and assessing performance in the field (52%). This indicates that there are opportunities to standardize training and supervisory methods for CHW employers.

What type of supervision employers provide (N=27)[1]		What type of supervisory training would benefit employer (N=25)[1]	
Informal feedback and guidance	85%	Integrating CHWs more effectively into the organization/care team	52%
Performance-based reviews	74%	Assessing performance in the field	52%
On-the-job coaching of CHW duties	70%	Mentoring/coaching CHWs in the community	44%
		Understanding an overview of the health system	32%

[1]Other responses included: formal supervision weekly, one-on-one supervision, regular one-on-one meetings to evaluate growth and training needs as well as strengths and passions, review of database entries and random case reviews

[1]Other responses included: networking among peers, creating boundaries, training on how to connect with specific populations (i.e., seasonal workers), boundaries in service

Integration

CHWs were asked a number of questions to learn about how they are integrated into clinical/organizational care teams. Overall, 76% of CHWs report having access to participant records through their own account in their employers' main participant tracking form/system (e.g., participant files, print health records, Electronic Health Record (EHR)); 4% can access the system through another provider or staff member's account; and 20% do not have access to participant records. The percent of CHWs with access to participant records through their own account differs among CHWs working in clinical settings (92%) and non-clinical settings (72%).

More than eight out of 10 CHWs (84%) report working directly with members of a clinical care or organizational team (i.e., nurses, social workers, primary care providers, mental/ behavioral health providers). This number is slightly higher among CHWs in clinical settings (92%) compared to those in non-clinical settings (83%).

Among CHWs who work directly with members of the care team, the most common responsibilities include participating in regular meetings (78%), documenting participant encounters in the participant tracking system (64%), and participating in case/participant reviews (60%).

76% of CHWs have access to participant records through their own account in their employers' main system

84% of CHWs work directly with members of a clinical care or organizational team

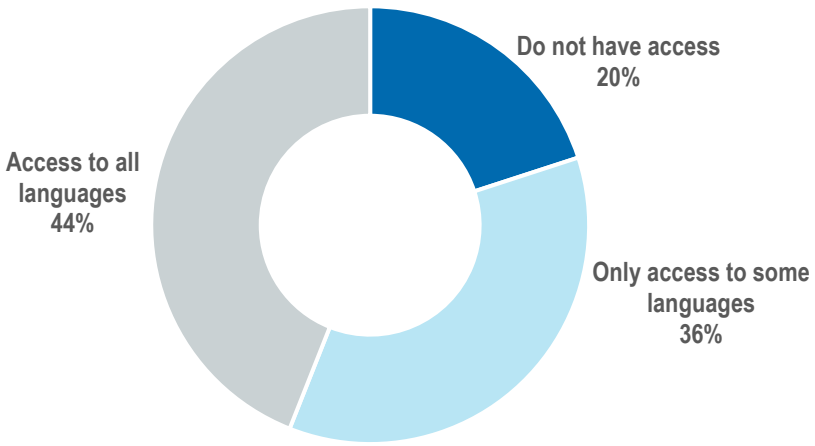
Responsibilities as a member of a clinical care/organizational team (N=67)	
Participate in regular meetings	78%
Document participant encounters in the same participant tracking system as other members of the care team	64%
Participate in case/participant reviews	60%
Help develop care plans	55%
Help implement care plans	54%
Receive participant referrals or assignment for education or other support	52%
Participate in/conduct participant assessment	51%
Provide medical interpreting services	15%
Other (included: provide technical assistance/problem solving)	1%

Two thirds of CHWs (65%) reported that their organization invites them to engage in the design, development, implementation and/or monitoring of programs and services that impact the communities they serve; 14% reported their organization did not invite them to engage in these activities, and 21% were unsure. Conversely, fewer than one third of CHWs (29%) are members of one or more groups/organizations that make (i.e., develop and/or enact) policy for their community, city, county, state or tribe as part of their job; 59% of CHWs reported they were not members of such groups and 13% were unsure.

Interpreter Services

Overall, 78% of CHWs reported needing interpreter services (data not shown). Among those that need services, 20% do not have access to interpreter services when needed to communicate with a participant and 36% could only access interpreter services for some language needs.

Access to interpreter services among CHWs who need them



Challenges and Resources Lacking

When asked to select the top three challenges they experience as CHWs, respondents most commonly reported a lack of resources to meet participant needs (59%), poor pay and/or benefits (54%), and a lack of stable funding (39%). See Appendix A, Table A.6 for additional information. Among those who reported a lack of resources to meet participant needs:[5]

72% reported a lack of community resources that participants can be referred to

66% reported a lack of funds (short-term and/or long-term)

62% reported a lack of clinical resources that participants can be referred to

55% reported a lack of time/capacity

When asked for other comments about the profession, CHWs discussed how rewarding and enjoyable they find their work, despite the many challenges of the job. However, CHWs also reported feeling insufficiently compensated and hampered by structural and financial barriers to helping patients.

I really enjoy my role as a [CHW] in Vermont. I think it's an incredibly important position especially working with populations that are the most disadvantaged and disproportionately disadvantaged. - CHW

A very challenging time, underpaid, under-appreciated by suffering families and community members, unsustainable profession. On the positive side, those who work in the field tend to have great capacity for compassion, are hard workers and value service to others over financial and emotional well-being (this, however, can be problematic, as the rate of burnout is incredibly high). - CHW

I help a lot with getting patients connected to the community and providing them with resources for food, utilities, unemployment, clothing, healthcare, insurance, transportation, fuel assistance and assisting them with various applications. Sometimes I do struggle with finding those resources or knowing if I'm providing everything out there that's possible, or if I just have limited knowledge of what is available to patients. - CHW

[5] Other resources lacking mentioned by CHW respondents included: "no direct service staff, even if people meet clinical eligibility, staff to provide services, community activities, finding staff is challenging (especially since the pandemic), staff to provide essential services.

Employers identified a number of barriers that prevented their organization from hiring additional CHWs, with two thirds (67%) of employers identifying a lack of funding. In addition, more than half of employers (56%) selected lack of qualified applicants and more than a third (37%) selected an inability to bill insurers for CHW services. Few employers identified a lack of clarity about the value, roles, and qualifications of CHWs as barriers.

Barriers to hiring additional CHWs (N=27)	
Lack of funding	67%
Lack of qualified applicants	56%
Inability to bill insurers for CHW services	37%
Lack of clarity on their scope of work	11%
Lack of training for CHWs	11%
Lack of clarity on which qualifications to look for	7%
Lack of clarity on how to integrate them	7%
Other[1]	7%
Lack of clarity about their value	4%
Not applicable	4%

[1]Other responses included: rate of pay, everybody has different language around these roles

Benefits to Employing CHWs

CHW employers reported several benefits of CHWs, with all (100%) noting improved health outcomes for patients and most (89%) reporting improved access to care.

Benefits that CHWs bring to organizations (N=27)	
Improved health outcomes for participants	100%
Improved access to care	89%
Reduced healthcare costs for participants	67%
Increased success reaching hard-to-reach target populations	67%
Improved health for minority and underserved populations	67%
Reduced healthcare costs for organizations	56%
Increased medication and treatment regimen adherence for participants	56%

When asked how their organization tracks or analyzes the impact(s) of CHWs, employers mentioned:

- tracking utilization/encounter data (e.g., numbers enrolled, encounters, types of assistance provided, RBA (risks, benefits, and alternatives)

- measuring patient outcomes (e.g., quality measures, rehospitalization, emergency room visits, care plans implemented, participant progress, health outcomes)
- using patient and employee surveys to assess satisfaction and gather feedback
- using cost data such as return on investment, reduction in uncompensated care

Reflections

When asked for other thoughts on CHWs at their organization, many employers noted the value of CHWs' work to participants, communities, and health care systems. They also cited challenges like low funding from legislators, inability to bill for CHW time and high rates of burnout (particularly in light of the COVID-19 pandemic response) that made hiring and maintaining CHW staff difficult. Another employer expressed frustration over the lack of bi-directional information sharing between healthcare and community-based entities, which makes it a challenge to measure the impact of CHW efforts.

Employer respondents view CHWs as integral to patient or client care and note that many CHWs are highly dedicated to their work. One employer noted that the CHWs they employ have been very dedicated to their work and regularly seek out opportunities to build their skills. Another noted that CHW roles often serve as steppingstones to further education and opportunities in health care (e.g., nursing).

As has been documented previously, CHWs go by many different titles and there is sometimes confusion around what constitutes the work of a CHW. For example, one employer perceived CHWs as having a Master of Public Health degree and a focus on broader population health, not individual patient health. However, they provided additional information which suggests they are already doing CHW-like work, but just don't recognize it as such (e.g., addressing social determinants of health-related needs).

CHW's do valuable work and help improve the quality of life of the people they support. – CHW employer

…they are an integral part of the health care system – CHW employer

The CHW role often provides a steppingstone to further education and training in the medical fields. Many CHW over the years have pursued nursing degrees. – CHW employer

They are hard-working team members who are often under-appreciated by outside care providers. – CHW employer

We are lucky to work [with] some very committed CHWs who are eager to assist our target population. They never miss an opportunity for skills building and education to further prepare themselves to help support our most vulnerable clients. – CHW employer

CHW Infrastructure

CHW Funding and Sustainable Funding Mechanisms

Employers identified sources of funding for CHWs at their organizations. One third of employers reported a single funding source while the remaining two thirds reported multiple funding sources. State and other grant funds are among the most reported funding mechanisms, suggesting that many CHWs are being funded at least in part by grant funds, which are not considered to be a source of sustainable funding. The survey defined sustainable funding as systems of budgeting that do not depend on applying for program or project grants or contracts. Sustainable funding can come through ongoing revenue streams that fund CHW services or through incorporating CHWs into the overall program budget. Overall, 70% of employers selected at least one sustainable funding mechanism.

Employer-reported Funding Sources for CHWs (N=30*)	
Other grant funds	50%
Community Health Team / Blueprint for Health / OneCare VT**	43%
State of Vermont grant (e.g., Health Disparities, You First, Heart Disease & Diabetes)	37%
Organizational operating budget**	30%
Clinical operating budget (FQHC, hospital or clinic)**	23%
Medicare**	20%
Medicaid**	10%
Private insurance	10%
HRSA funding	10%
Direct contract with another organization that employs CHWs	3%
Volunteer	3%

*Excludes one employer who answered unsure and did not select any funding sources.
**Sustainable funding mechanism

Open-ended responses about other sustainable funding mechanisms that organizations have pursued in the last year yielded a mix of responses that included both grant funding and sustainable mechanisms. Responses representing sustainable funding mechanisms include:

- "2021 OneCare VT Care Coordination payment model"
- "Care management"
- "Fee for service model"
- "Incorporating into clinical budget"

- "Medicare"
- "[C]ontractual revenue through the FQHC….You truly need a mix of the grants and contracts to make this work."

CHW Skills and Training

The top three areas in which CHWs have received training were knowledge of legal and ethical standards (76%), communication skills (75%), and interpersonal and relationship-building skills (68%). CHW employers reported that their organizations have provided training in several areas, including legal and ethical standards (85%), service coordination and navigation (78%), and education and facilitation/coaching skills (70%).

CHWs and employers had similar responses when asked about the areas of training needs for CHWs. The three skills most commonly identified for training needs were: use of public health concepts and approaches, capacity building skills, and cultural and linguistic competency. Cultural and linguistic competency was the most common area for employers with almost two thirds (63%) identifying this area as a training need compared to 39% of CHWs. See Appendix A, Table A.7 for additional information.

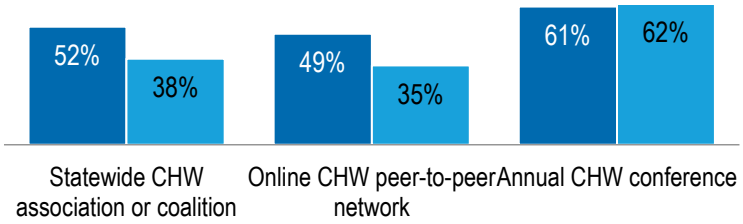
Areas of Training Needs	CHWs would like more training	Employers report that CHWs need more training
Use of public health concepts and approaches	45%	59%
Capacity building skills	43%	44%
Cultural and linguistic competency	39%	63%
Advocacy skills	38%	41%
Evaluation and research skills	38%	33%
Education and facilitation/coaching skills	34%	37%
Individual and community assessment skills	34%	30%
Outreach skills	31%	30%
Service coordination and navigation skills	28%	22%
Interpersonal and relationship-building skills	26%	37%
Knowledge of legal and ethical standards (i.e., HIPAA)	25%	26%
Communication skills	23%	37%

CHW Network Engagement

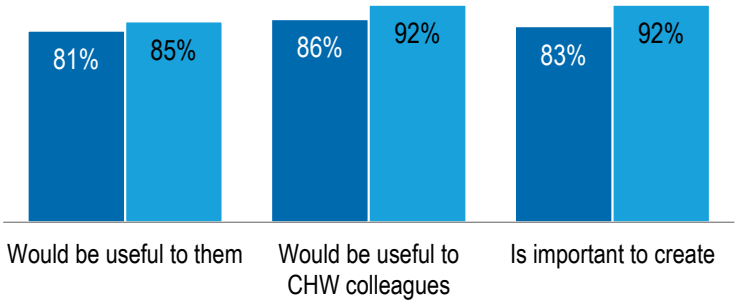
Both CHWs and employers were asked about their interest in engaging in a statewide association, online CHW peer-to-peer network, and an annual CHW conference. Overall, 75% of CHWs and 73% of employers are interested in at least one activity (data not shown), with 33% of CHWs and 27% of employers interested in all three types of opportunities (data not shown).

More than 60% of CHWs and employers are interested in participating in an annual CHW conference. Survey respondents were also asked their opinion about the value of a Vermont CHW network. Most CHWs and employers agree that a Vermont (VT) network is important to create and would be useful to themselves and to CHW colleagues.

CHW and Employer interest in engagement activities



CHWs and Employers agree a VT CHW network...



COVID-19

Fifty-three CHWs and 18 CHW employers consented to answering additional questions about impacts of the COVID-19 pandemic.

CHW Participation in COVID-19 Duties

Overall, 58% of CHWs started working as a CHW with their current employer before the start of the pandemic (prior to March 2020) and 42% started work as a CHW during the pandemic. Most CHWs reported conducting COVID-19-related activities. More specifically, in the past year, the majority of CHWs reported conducting COVID-19-related education and outreach (75%) and over half reported scheduling COVID-19 testing and vaccine appointments (59% each).

COVID-19-Related Activities (N=53)	
Education and outreach to participants/community members regarding COVID-19	75%
Schedule testing appointments	59%
Schedule vaccine appointments	59%
COVID-19 symptom monitoring and supporting home-based care for participants with COVID-19	47%
Host vaccine sites/clinics	45%
Host testing sites/clinics	30%
Other[1]	13%
None of the above	11%

[1]Other responses included: coaching/working with other agencies to support clients, community outreach for substance support, contact tracing, coordinating with other service providers and advocating for care, education and support specific to COVID-19 pandemic and illness during perinatal time, in-home PCR testing for homebound participants, test kit distribution, isolation support (food, PPE deliveries)

Suggestions for a More Equitable Community Response

About 40% of CHW survey respondents that consented to answer COVID-19 questions suggested additional strategies for a more equitable community response to COVID-19. Several CHWs suggested that outreach and education continue to include a variety of virtual and in-person modes, from telehealth visits to mobile health services, to in-home visits, with the caveat that internet access is not always available to everyone for visits or to sign up for testing or vaccine appointments. Additional efforts may be needed to ensure certain populations (e.g., elderly, homebound) have transportation to receive care, vaccines, or testing and that interpretation services are available for patients. A few CHWs also mentioned challenges with trying to combat misinformation about COVID-19. It was suggested that building relationships with affected communities is key to combatting misinformation, even if it does take additional

time and resources. Relatedly, another CHW mentioned the importance of involving underserved community members in decision-making processes. One CHW suggested that CHWs might need more education and peer support resources to prevent CHW burnout and turnover.

Impacts on Populations Served by CHWs

The majority of CHWs reported that during COVID-19 populations they served struggled with social isolation. COVID-19 also led to challenges accessing food, transportation, and stable housing, as well as physical and mental health services for the populations they serve.

COVID-19 Impact - Populations Served More Likely to….(N=53)	
Have problems with social isolation	91%
Need free/low-cost food	85%
Need mental health services	81%
Have problems with transportation	81%
Have problems with accessing health care services	77%
Experience housing instability	72%
Need substance use services	42%
Be unemployed	40%
Other[1]	6%

[1]Other responses included: limited childcare access, issues getting tested for COVID-19 and issues with employment and not wanting the vaccine, dental

Impacts on CHWs

Employers (N=18) offered their thoughts about challenges faced by CHWs during COVID-19. Some of the biggest challenges reported by employers were trying to manage constantly changing duties and protocols related to COVID-19. Not being able to meet face-to-face with patients was deemed a large barrier, especially as patients were dealing with greater mental health challenges and social isolation as well as struggling with basic food, housing, and transportation needs. CHW burnout and turnover was noted as a challenge as well as the shift to virtual care (hard for some CHWs and some patients). Organizationally, remote and hybrid work also led to more disconnection between care team members.

Employers of CHWs were also asked about opportunities that COVID-19 presented. One of the most cited opportunities was the availability of additional funding to hire and train CHWs. CHWs could also help meet more patient needs (in-person or virtual). The introduction of virtual work environments helped build the technology skills of staff and virtual visits/telehealth appointments eliminated barriers to care for some patients. Staff have also developed new skills

navigating through a variety of pandemic-related challenges and some organizations evolved or expanded their service models. One employer noted that it helped them understand their role during a pandemic (e.g., serving as testing and/or vaccination sites). Another employer mentioned now having enhanced their community partnerships as a result of COVID-19.

Conclusions

Considerations

This survey is the third annual Vermont CHW Survey and offers valuable information about the landscape of the CHW workforce in Vermont. The following factors should be considered when interpreting the results:

- Results are based on the information provided by the CHWs and employers who responded to the survey and may not reflect the entire CHW workforce and CHW employers/supervisors in the state.
- The survey was administered online which may have been a barrier to participating for those with limited internet access. In addition, the survey was only available in English which may have hindered participation for CHWs with limited English language fluency.
- While extensive efforts were made to reach and limit analyses to CHWs and their employers/supervisors, it is possible that some respondents who do not serve in those roles completed the survey and were included in the analysis.
- The employer survey was designed to capture perspectives of both employers and supervisors. Therefore, some organizations have multiple respondents who completed the survey and are represented multiple times in employer results.

Main takeaways and recommendations

- Most CHW respondents were white, female and had a high level of education compared to the high school degree minimum education required by employers. In addition, most CHWs relate to the people they serve through living in the same community and sharing the same spoken language. Half or fewer share the same race/ethnicity or cultural background and about one third share identity/lived experience or the same health conditions.
    - **Recommendation**: While CHWs relate to and represent the participants they serve in many ways, the CHW workforce would benefit from additional racial and ethnic diversity so that patients/community members that identify as Black, Indigenous, and People of Color have opportunities to interact with CHWs with more similar racial identities.
- CHWs create a demonstrable impact on the participants and organizations they work with. Many employers reported multiple funding sources to support CHWs and 70% of employers selected at least one sustainable funding mechanism. However, state and other grant funds are among the most reported funding mechanisms, which are not

considered to be a source of sustainable funding. In addition, about two thirds of employers reported a lack of funds as a barrier to hiring more CHWs.

- **Recommendation**: Buy-in and support from key stakeholders, including CHWs and decision makers across community and clinical organizations, are key to developing a successful and sustainable CHW infrastructure. Conversations about sustainable funding for clinical and non-clinical organizations have been ongoing throughout the CDC cooperative agreement and are a current focus of state-level efforts. Continued discussion and education around sustainable funding mechanisms and involving a variety of stakeholders including payers is crucial to advancing CHW efforts in Vermont.

- Almost two out of five CHWs are not familiar with any of the My Healthy Vermont workshops. While most CHWs who are familiar with a given workshop also refer participants to that program, between one quarter to one third of CHWs reported that specific workshops were not applicable to their work activities. Even among CHWs whose work includes a focus on diabetes and hypertension, between one half and one third do not link or refer to workshops for the management or prevention of those conditions.
  - **Recommendation**: These findings indicate that there are opportunities to increase CHWs' awareness and understanding of the specific workshops available through My Healthy Vermont and their benefits. Increased familiarity with workshops can lead to an increase in referrals, so that more Vermonters can benefit from these free resources.

- Both CHWs and employers identified use of public health concepts and approaches, capacity building skills, and cultural and linguistic competency as areas of training needs for CHWs. In addition, CHW employers identified that they would benefit from CHW supervisory training related to integrating CHWs more effectively into the organization/care team and assessing performance in the field.
  - **Recommendation**: These responses can help inform state-level workforce training efforts.

- Employer and supervisor respondent perspectives differ from CHWs in certain key ways (e.g., fair compensation for CHWs, roles and responsibilities).
  - **Recommendation**: Future data collection efforts that utilize qualitative methods (i.e., interviews or focus groups) are recommended to augment survey findings by providing additional context and detail. In addition, developing and maintaining a registry of organizations who employ CHWs would facilitate future iterations of the CHW survey and support Vermont CHW network and engagement efforts.

Appendix A – Additional data tables

Table A.1: Hiring priorities (Which of the following does your organization look for when hiring a CHW?) (N=31 CHW employers/supervisors)	N	Percent
Knowledge of community services or resources	24	77%
Valid driver's license for work-related travel	24	77%
Prior experience with the population served	23	74%
Own car for work-related travel	20	65%
Social services background	19	61%
Shared background with the population served	18	58%
Health care background	16	52%
Prior experience as a CHW	12	39%
Bilingual or multi-lingual	7	23%
Other[1]	2	6%

[1]Other responses included: parent of a child with a disability or special health care need, this is like a wish list as we only have so much we can pay, so while we would love all these things, what do we absolutely need

Table A.2: Priority Populations (Which of the following populations do you primarily work with as a CHW?) (N=81 CHWs)	N	Percent
Low-income individuals	44	54%
Individuals living with a disability (i.e., intellectual, physical, sensory and/or mental)	43	53%
Older adults (ages 65 and up)	39	48%
Individuals living with a mental health disorder/mental illness	32	40%
Rural residents	27	33%
Individuals with substance use disorder or in recovery	25	31%
Individuals with a history of frequent hospitalization	25	31%
Uninsured individuals	18	22%
Individuals experiencing homelessness	17	21%
Children/adolescents	14	17%
Individuals without a primary care provider	14	17%
Pregnant or postpartum women and infants	10	12%
LGBTQ individuals	9	11%
Farm workers	8	10%
Individuals who are incarcerated or transitioning from incarceration	7	9%
Foreign nationals/immigrants/refugees	5	6%
Not applicable - I do not work primarily with any specific populations	2	2%

Table A.3: Health Conditions (Is your work as a CHW primarily related to any of the following areas of health or chronic diseases?) (N=82 CHWs)	N	Percent
Disabilities (i.e., intellectual, physical, sensory and/or mental)	30	37%
Mental/behavioral health, including suicide prevention	30	37%
Diabetes	28	34%
Hypertension	28	34%
Substance use	21	26%
Heart disease	20	24%
Falls prevention	19	23%
Obesity	18	22%
Cholesterol management	16	20%
Dementia/Alzheimer's	15	18%
COVID-19	14	17%
Tobacco cessation	13	16%
Oral health	11	13%
Asthma	10	12%
Cancer	10	12%
Maternal and infant health	9	11%
Reproductive/sexual health	9	11%
Other[1]	9	11%
HIV/AIDS	4	5%
None of the above	14	17%

[1]Other responses included; mostly youths/unsure of health conditions, all of the above/pediatrics, healthy cooking, COPD, variety of issues, all of the above, older adults, preventative care, family re-unification

Table A.4: Services CHWs connect participants to (Which of the following services do you connect participants to?) (N=81 CHWs)	N	Percent
Food security resources (e.g., food pantry, 3SquaresVT, SNAP)	69	85%
Transportation	64	79%
Mental/behavioral health services	60	74%
Financial assistance for health care services (sliding fee scale, free clinics, YouFirst, etc.)	55	68%
Case management	51	63%
Housing	51	63%
Fuel/utility assistance	49	60%
Long-term services and supports (e.g., home care, adult day programs)	47	58%
Education assistance/resources	45	56%
Health insurance enrollment	45	56%
Payment assistance for medication	41	51%
Legal services	34	42%
Income assistance	32	40%
Violence prevention (e.g., shelter)	31	38%
Translation/interpretation	30	37%
Employment	27	33%
Child care or pre-school	21	26%
Re-entry programs	10	12%
Other[1]	4	5%
None of the above	2	2%

[1]Other responses included: postpartum support services, Vermont Economic Services, housekeeping, social/exercise programs

Table A.5: MyHeathVT Workshop Referral (Below is a list of community resources for chronic disease management. For each resource, please indicate whether you link or refer participants to the program.)	Yes, I link or refer participants to this program	No, I do not link or refer participants to this program	Not applicable to my work activities
Diabetes Prevention Program (DPP) (N=77)	39%	26%	35%
Diabetes Self-Management Program (DSMP) (N=77)	43%	23%	34%
Chronic Disease Self-Management Program (CDSMP) (N=75)	36%	28%	36%
Tobacco Cessation (Fresh Start) (N=76)	54%	22%	24%
Health Coaches for Hypertension Control (N=73)	29%	37%	34%

Table A.6: Top Challenges for CHWs (What are the biggest challenges that you experience as a CHW? (please choose your top three)) (N=79 CHWs)	N	%
Lack of resources to meet participant needs	47	59%
Poor pay and/or benefits	43	54%
Lack of stable funding	31	39%
Lack of care coordination/service integration	17	22%
Lack of training opportunities or resources	10	13%
Duplication of services	9	11%
Lack of acceptance from other health care workers	9	11%
Lack of standard definition of who CHWs are	6	8%
Lack of understanding about CHW contributions to the community	6	8%
Hostility/competition from other health care workers	5	6%
Lack of understanding of scope of practice	4	5%
Personal safety	4	5%
Other[1]	3	4%
None of the above	2	3%
Accessing participant information	0	0%

[1]Other responses included: participant mental health barriers, too much work, lack of staffing

Table A.7: Training Areas	CHWs (N=80)		Employers (N=27)	
	Received training	Would like more training	Organization provided access to training	CHWs need training
Communication skills	75%	23%	67%	37%
Interpersonal and relationship-building skills	68%	26%	67%	37%
Service coordination and navigation skills	66%	28%	78%	22%
Capacity building skills	39%	43%	30%	44%
Advocacy skills	60%	38%	44%	41%
Education and facilitation/coaching skills	65%	34%	70%	37%
Individual and community assessment skills	56%	34%	63%	30%
Outreach skills	63%	31%	67%	30%
Knowledge of legal and ethical standards (i.e., HIPAA)	76%	25%	85%	26%
Evaluation and research skills	45%	38%	33%	33%
Use of public health concepts and approaches	46%	45%	41%	59%
Cultural and linguistic competency	55%	39%	52%	63%