INVESTING IN COMMUNITY HEALTH WORKERS IS INVESTING IN UTAH REPORT 2021
In memory of Margarita Satini and the sacrifices of all community health workers across our state who do so much to protect and support our communities. The work of Margarita and all community health workers has made an enormous impact on all of Utah. We honor their legacy by continuing the work of a healthier and better state for everyone. This report is a celebration of all they give our state.
Photo credit from left to right, First row: Alliance Community Services Helmet Distribution, Pacific Islander Health Coalition Vaccine Clinic, Calvary Baptist Vaccine Clinic
Second row: Cache Refugee Immigrant Coalition, Calvary Baptist Vaccine Clinic, Alliance Community Services Vaccine Clinic
Third Row: Alliance Community Services Vaccine Clinic, Calvary Baptist Vaccine Clinic, Pacific Islander Health Coalition Vaccine Clinic
Fourth row: Best of Africa
This work could not have been possible without the support from:

Ixchel Rangel
Kevin Nguyen
Lisia Satini
Susi Feltch-Malohifo’ou
Tessa Acker
Yehemy Zavala Orozco
Association of Utah Community Health
Utah Community Health Worker Coalition
UPHA Community Health Worker Section
Utah Department of Health Office of Health Disparities
Utah Public Health Association,
Voices for Utah Children
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Key Terms

Advocacy: Can refer to peer-to-peer support in providing support and resources. Or the organized efforts to improve systems, policies, and structures in society.

Capacity Building: In this report, refers to the process of supporting and strengthening the skills and abilities of people and groups and communities to increase participation and empowerment in shared decision making.

Community: Any configuration of individuals, families, and groups who have common characteristics. In this report, communities may be grouped by age, geo-location, race, ethnicity, religion, socio-economic or health status.

Community Based Organization (CBO): In this report, will refer to local grassroots not-for-profit organizations working at local level and with connection to specific community(s) needs. In comparison, NGOs (non-governmental organizations) are typically large institutions and driven by a particular focus. (Example of an NGO would be United Way. Example of CBO would be Pacific Island Knowledge 2 Action Resources)

Health Care: Refers to medical services provided to individuals.

Health Disparities: Are preventable differences in health outcomes associated with economic, socio-cultural, environmental, and geographic disadvantage.

Health Equity: Is the state in which everyone has the opportunity to attain full health potential, and no one is disadvantaged from achieving this potential because of social positions of any other socially defined circumstances.

Medicaid: Is a federal health care program administered by states that serves many medically needy, disabled, low-income Americans. The federal and state government split the cost.

Public health: Is the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals. In this report, public health is also used to refer to public health agencies.

Social Determinants of Health (SDOH): Refer to the conditions in which people live, learn, work, play, worship, and age that affect a wide range of health and quality of life.

Unmet Social Needs: The human need for secure housing, safe transportation, healthy food, and economic stability. Note: Healthcare may refer to these as the social determinants; however, this report recognizes the need to distinguish between unmet social needs and the social determinants.

Acronyms

ACO: Accountable Care Organization
CHW: Community Health Worker
CBO: Community-Based Organization
UPHA: Utah Public Health Association
UCA: Utah Community Health Worker Association
UDOH: Utah Department of Health
LHD: Local Health Department
Utah’s History of Promotoras and Community Health Workers

Before diving into the formal policy report, we invite you to learn a brief annotated history of this workforce and their contributions to Utah. The origin story of Utah’s Promotoras and Community Health Workers (CHW/Ps) has been passed along through an oral historical accounting from many who helped ignite this workforce recorded by the authors of this report. This glimpse of the history shows the strength and ingenuity of these Utahns whose contributions have saved lives and increased community and belonging in Utah.

The American healthcare system is not known for its ease and accessibility. Even medical doctors share stories of confusion and frustration when faced with a child’s medical emergency. For those without health insurance, less formal education, or less access to the Internet, maintaining primary and preventive care can be impossible. Barriers are magnified for New Americans—immigrants and refugees—which is where the story of Utah’s promotora begins. In the 90’s, Utah’s Latin immigrant population began to rise and community leaders reported obstacles families were facing in health and security.

Numerous community-led initiatives were organized to coordinate resources and advocate for the needs of these new families. In the mid 1990’s, Sisters of the Holy Cross (now known as Holy Cross Ministries) created a promotora program, hiring bilingual and bicultural Utahns to build trust and connection and help serve unmet social and health needs of these families.

Quickly, the promotora and community health worker model was being adopted by other organizations and community leaders who had also noticed these gaps. In 1998, a group of Salt Lake promotoras created a grassroots organization, Comunidades Unidas, centered on strengthening immigrant communities. These organizations recruit and train trusted volunteers to be resource connectors and health promoters in the community.

In addition to resource connection and health education, pioneer CHW/Ps were asked to meet with hospitals, schools, and city government to bring health closer to residents. One solution was health fairs—bringing activities such as childhood immunizations and fire safety education directly to communities. As healthcare providers recognized they were struggling to reach Utah’s multicultural communities, CHW/Ps were asked to teach cultural competency in the 90’s and early 2000’s.

Promotoras and community health workers have been leaders in brokering cultural differences between the systems and communities. From teaching healthcare providers about Native Americans’ sacred religious and cultural traditions to advocating for trauma-informed approaches so refugees will feel safe. Calvary Baptist Church, Utah’s oldest Black Church, has a CHW program to promote health education and prevention services for their congregation.

[1] Promotora (or promotores) originates from Latin American countries, where lay community volunteers receive specialized training in health promotion and health education and work to promote health in the community without needing university education. As this workforce grew in Utah, the term community health workers may be used interchangeably with promotora.
A program partnering with Pacific Islander community health workers to improve maternal and infant health braids ancestral heritage with health education and has received national recognition. As organizations evaluate the reach of their programming, the services are utilized by urban and rural communities across Utah.

As this workforce continued to grow, several CHW/Ps recognized the need to collectively gather and provide more formal support to one another. In 2012, they organized an “interest group” through the Utah Public Health Association. Initially only a small number attended, but because of their persistence, over 100 CHW/Ps came from Weber, Utah, Summit and Salt Lake County to attend a 2015 conference.

As the CHW/Ps continued to formally organize and have a structured support system for each other, there has been increased support from the Utah health department, healthcare system leaders, Association of Utah Community Health, and elected officials. Through the pandemic, the CHWs organized weekly trainings with up to 200 CHW/Ps in attendance.

CHW/P programs can be found in faith-based organizations, over 20 community organizations, tribal communities, over a dozen clinics across rural and urban Utah, and a dozen local health departments. CHW/Ps were responsible for assisting tens of thousands with testing, quarantine, and vaccination efforts during the pandemic. Efforts continue to expand into serving people with disabilities, substance use addiction and mental health community, and domestic violence survivors.

In 2021, a formal professional association, Utah Community Health Worker Association, was created to serve the growing needs of this resilient and powerful workforce. The seeds planted in the 1990’s have grown statewide and across communities and have become essential to the future of public health and healthcare in Utah. Health is dependent on more than just medical or biological factors. The conditions of the communities we reside in; the level of our education and economic opportunity; the built environment of sidewalks, parks, and infrastructure; and the connectedness we feel to our neighbors are all foundational to our health. Their examples of hope, persistence, and selflessness have blessed countless lives.

Credit: Alliance Community Services, Vaccine Clinic
As the Covid-19 pandemic erupted in 2020, interest in an existing but underfunded community-centered workforce emerged. Federal and state policymakers, public health agencies, health system leaders, and social service providers increasingly recognized what neighborhood organizations and community clinics knew all along—community health workers are critical to improving health outcomes. The purpose of this policy report is to provide a brief snapshot of Utah’s health disparities; dive into the role of community health workers; and discuss opportunities for long-term sustainability of this workforce. We hope this policy report will provide policymakers, public health and healthcare leaders with an understanding of this unique workforce and how they fit into a vision of health equity in Utah.

Through the pandemic, case rates, death rates, hospitalization rates, and economic hardship have not been evenly distributed revealing inequalities in health outcomes across our state. Health disparities are unjust and preventable are not unique to the coronavirus. They exist in diabetes, cancer, infant mortality and many more health indicators. These gaps in health cannot be explained by biology or geographical boundaries. Instead, the causes are due to the conditions in communities that influence our health, otherwise known as the social determinants of health. Generating healthier outcomes will require policymakers and public health objectives to focus on addressing these social and environmental determinants of health.

Community health workers are frontline public health ambassadors and health educators, with a trusted and close understanding with the community being served. Health workers can assist community members in addressing unmet social needs, promoting health, and building the capacity of the community. Recommendations to support community health workers include partnering for health equity programming; formalizing certification; and development of a sustainable Medicaid payment model. Utah will benefit from these policies through improved health outcomes, increased empowerment in historically under-resourced communities, and a stronger health workforce.

This report is the result of a lengthy and highly collaborative process and reflects the local and national landscape for community health workers. The sum of this report was put together through a combination of CHW meetings and small group interviews, survey collection, and observations from public health practitioners. Moving toward health equity will not happen with one policy; however, collaborating with community health workers as co-equal partners will be an essential step forward.
Until the Covid-19 global pandemic, most Americans rarely thought about the strength and weaknesses within the public health infrastructure. While global infectious disease outbreaks are rare, the role of public health in the lives of Americans expands far beyond the coronavirus. Charles Edward A Winslow, one of the pioneers of public health defined public health as “the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals.”  

Public health interventions such as modernizing our sanitation and waste management systems, providing access to clean water, and immunizations are responsible for the most significant advancements to health in the 20th century. However, the 21st century lack of investment in public health spending has undermined prevention and weakened responses to health inequalities and new health threats. Prior to the pandemic, per-capita public health spending made up only 2-3% of all health expenditures, even though public health interventions are a far more cost-effective way to prevent disease and early death when compared to healthcare spending. Addressing the causes of sickness and poor health and providing an equal opportunity to healthy outcomes remains the focus of public health.

Utah Governor Spencer Cox’s One Utah Roadmap envisions “a state where residents are happy, safe, healthy, and successful. A place where we can grow old surrounded by the people we love and live peaceably in the most beautiful state in America. A place where we realize the good that comes from doing things together as ONE UTAH.”

For Utah to realize this vision, all Utahns must have equal opportunities for achieving their highest health potential, also known as health equity. Currently, economic, socio-cultural, environmental, and geographic disadvantages are responsible for population level differences in health outcomes. These differences, known as health disparities, are unjust and preventable and interfere with Utah reaching health equity.

Throughout the pandemic, health disparities manifested in infection, hospitalization, and death due to COVID-19. Within the Wasatch Front, odds of coronavirus infection were 2-3 times more likely in Rose Park and Glendale neighborhoods compared with Salt Lake’s Eastside neighborhoods. Statewide, Latino communities account for 14.2% of Utah’s population, but 40% of the state’s COVID-19 cases. American Indian and Alaskan Native communities in Utah experienced a case fatality rate three times higher than the state average.
While these data points received attention from media and elected officials through the pandemic, health disparities pre-date the pandemic and include dozens of health indicators. Diabetes is twice as prevalent amongst Utah Native Hawaiian and Pacific Islanders. Thirty percent of Black children and 31% of Latino children in Utah are living in poverty compared to 14.7% of children statewide. Asian infants born in Utah are more likely to have a low birth weight. 7

Disparities are not exclusive to race or ethnicity. People with disabilities were significantly more likely to report food insecurity than people without a disability (41.6%, 15.7%). Utah adults with disabilities are three times more likely than those without a disability to not access medical care due to cost. Utah adults with a disability have higher rates of smoking; report eating fewer fruits and vegetables; and getting less exercise than adults without a disability. 8

As public health research shows, zip code is a stronger predictor of health than genetic code, therefore looking at place-based health data warrant attention. 9 While there is less incidence of cancer in rural Utah, rural Utahns more often receive cancer diagnoses at a later stage than Utahns living in metro areas and have lesser survival rates than metro Utahns. 9 Women in Utah’s rural and frontier communities report low rates of accessing preventive and primary healthcare, i.e. women in frontier communities are least likely to get breast cancer screenings. 11

Women in rural and frontier communities have the highest rates of smoking across the state. 12 Economic opportunity is not equally distributed to rural Utah as it is the rest of the state, so rural Utahns face higher rates of poverty, lower rates of high school graduation, and higher rates of unemployment. 13, 14

These health disparities, whether between racial and ethnicity groups or between geographical regions, cannot be explained by natural biological differences. 5 It would be unhelpful to tell rural Utahns they must move to metro-urban Utah to secure healthier opportunities, nor should they need to.

Healthy opportunities ought to be extended to all Utahns, and this is done by addressing the actual causes of sickness and disease—the social, environmental, and behavioral determinants of health. 15

Securing healthier opportunities for all Utahns is not only the right thing to do; it is also more cost-effective. The visual below highlights how much the current system is failing this population group which often is facing both chronic health conditions and navigating social barriers in order to achieve wellness. 17
An estimated 1% of the US population accounts for nearly 23% of total healthcare expenditures and 5% of the population accounts for just over 50% of overall healthcare spending. Many of these patients have higher rates of hospital admissions and more frequent emergency department visits. These patients, though they interact within health and social service systems, do not achieve better outcomes. Economists estimate the cost of lower health with the cost of lower productivity has a national economic burden of at least $82 billion.

Over the last decade, health policy has adjusted incentives in healthcare where payment is less often attached to volume of services and more connected to outcomes of patients. This has forced healthcare stakeholders to recognize the social, environmental, and behavioral determinants of health. Addressing the unmet social needs, such as stable housing, for a diabetic individual is critical to accessing the food and insulin necessary to manage their diabetes. An asthmatic patient who lives in an apartment with poor indoor air quality, dust mites, and smoking neighbors will consistently frequent the emergency room until the causes of the attacks are controlled.

Addressing these unmet social needs requires trust, connection, and empathy to successfully connect these patients to appropriate resources. We plan to demonstrate how community health workers can assist community members in addressing unmet social needs, promoting health, and building the capacity of the community and how each of these play an essential role in building health equity. We will also demonstrate the need for formal recognition, empowerment, and financing of this workforce.
The American Public Health Association defines a community health worker as a “frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community being served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. In addition, a CHW builds individual and community capacity to improve health outcomes by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, the provision of social support and advocacy.”

Immigrants and refugees have historically had a stronger connection with community health workers, as the workforce originated and grew from these communities. Currently, community health workers interact most frequently with those experiencing low economic resources, multicultural communities, and others ignored by healthcare providers. Historically, the American healthcare system was not set up to generate healthy outcomes for all who participated. From the Tuskegee syphilis study to the segregation of hospitals and exclusion of minority populations from medical school to the modern-day opioid epidemic—trust in the healthcare system is influenced by lived experiences.
Community health workers are presently working in community-based organizations like Comunidades Unidas or Utah Pacific Islander Health Coalition; faith-based organizations like Holy Cross Ministries or Calvary Baptist; and federally qualified health centers like Urban Indian Health Center. Throughout Utah at the local health departments, Community health workers are working to assist with the COVID response and connecting individuals to resources. Healthcare providers such Intermountain Healthcare and the Association for Utah Community Health Centers have also employed community health workers as part of the Alliance for Social Determinants project. Within the University of Utah, they have been improving cultural competency for the medical school students.

The Multicultural Advisory Committee of the State of Utah's COVID-19 Response was formed to address disparities and increase equity during the pandemic. From the beginning, there were large disparities for communities of color as the case counts first began. As the vaccine rollout was being drafted, community health workers and other community leaders from the committee were able to share their concerns of the initial drafts and work on drafting a more inclusive proposal and have continued to be a part in leading vaccine clinics and dispelling misinformation in their communities.
To better address this gap, the Utah Department of Health has been exploring policies to better support CHW policies. Utah’s CHW workforce has been supported by both public health partners and other stakeholders in the community. The Utah Public Health Association (UPHA) has been the organizational home for a CHW-led support and education group, called the CHW Section. A newly organized collaboration, the Utah Community Health Worker Association (UCA), will provide more formalized professional development, on-site trainings for CHW employers, and better advocate for the workforce.

Currently, the CHW core skills training and certificate program is being administered by UDOH, though over time it is expected this will also move over to UCA.

While the core skills training provides a foundation for community health workers to learn, continuing education has been critical. The UPHA CHW Section has coordinated continuing education and support through the Covid-19 pandemic including over 25 trainings for resource support and pandemic messaging to keep communities informed. CHW Section leadership also facilitated advocacy trainings so that community health workers can best understand how to advocate for the needs of their communities during the pandemic.

The CHW core skills training was co-developed with the Utah Department of Health (UDOH) and community health workers in 2015 and includes the following CHW core skills:

- advocacy
- outreach
- capacity building
- individual and community assessment
- coordination and navigation
- interpersonal and relationship building
- education and facilitation, communication and professional conduct.

They are also expected to have knowledge about physical health, mental health, public health principles, and the social determinants of health. Currently, the CHW core skills training and certificate program is being administered by UDOH, though over time it is expected this will also move over to UCA.
Community health workers are a critical tool for health equity because their work is centered on the needs of the whole person and any barriers in their way to optimal health. The trusted connection places this workforce at a unique ability to improve the self-efficacy of those they serve. Community health workers are often impacted by many of the same social determinants as those they serve and can provide incredible insight for ways to move beyond a sickness system and to secure healthy opportunities for all Utahns. Obstacles facing this workforce include lack of resources to manage patients’ unmet social needs, under-representation in decision making, lack of formal recognition, and concerns for future funding and sustainability.

“I was working with a mother whose daughter just went to prison. She had to take care of the daughter’s children while she was in prison. I was able to help the woman connect with resources for the children and to provide the social support and friendship for her dealing with her daughter being in prison. I was present for all stages of the process, from when she was feeling afraid when she found out her daughter was going to prison, to when she started to feel supported after her daughter had gone to prison. I was able to help the entire family on a number of levels, not just the one woman.”
- Holy Cross Ministries

Credit: Utah Pacific Islander Health Coalition, Vaccine Clinic
**CHWs: Critical to Health Equity**

CHW Role in Addressing Social Determinants of Health at Individual and Community Level

*Building trust and understanding*

This positive experience within their communities further builds trust between not only Martin and Maria, but their community and the CHWs.

*Addressing social needs*

By helping to connect not only Martin but his community who has similar barriers to resources, Maria and the other CHWs were able to address a common issue faced by everyone who lived there.

*Community advocacy, capacity building, and solutions*

Maria and other local CHWs with support from their local health department, organize a farmers market to pop up in their community. Partnering with other organizations, their church, and school, they were also able to have resources onsite to help their community members with other potential barriers.

*Understanding of the community*

Maria recognizes similar underlying issues in their community. These include a lack of a grocery store that has fresh produce, not enough linguistically appropriate resources and many people not having health insurance.

*Connection and share experiences*

Martin gets connected with Maria, a CHW, through his provider. They both have shared similar experiences and share the same religion. This helps develop a trusting relationship.

*Recognition of unmet barriers and strengths*

Through their conversations, Maria identifies multiple barriers for adequate health for Martin's family. She also helps Martin identify strengths and support systems that he has.

*Connecting resources and individual support*

Maria establishes an individual plan with support and resources from Martin's church leaders, local food pantry, and local school nurse.
Moving Forward with Community Health Workers: Policy Recommendations

Recommendations to support community health workers include partnering for health equity programming; formalizing certification; and development of a sustainable Medicaid payment model. Details on each of the recommendations are organized below.

Partners for Health Equity

As the state and local governments invest in a vision towards greater health equity in Utah, partnerships with community health workers will be critical. As discussed above, being trusted members of communities, community health workers assist individuals with their unmet social needs during times of crisis. Secondly, they deliver health promotion and education in a culturally relevant and accessible way. Both services help community members navigate the health system, government programs, school systems, and maintain accurate information about healthy behavior. While this is one step in decreasing health disparities, the scope of practice for community health workers must go beyond exclusively resource connection and health education.

Securing equal opportunities for health, requires higher levels of community engagement. Advocacy is a core skill of community health workers. While assisting in social needs referrals of community members, community health workers go beyond that through advocating for systems to address the underlying causes of inequities.

Example: Instead of sole reliance on food pantries, a community explores the possibility of community gardening and investments into local farming as a more effective, sustainable, and healthy way to improve access to nutritious foods and combat diabetes. Local public health officials, community and faith leaders, partnering with CHWs, can help facilitate the dialogue and support community members in a shared decision-making model.

The buzz around the social determinants of health is not going to go away any time soon. Identifying and addressing these underlying causes of disease will require increased partnerships with community health workers. Recognizing that pilot programs to address health disparities may hit obstacles in implementation.

To ensure integrity of public and private funds, community health workers should be included in every step of the process, not as tokenized persons but as co-pilots. Their expertise should be considered when designing, passing, implementing, and evaluating programs to improve health outcomes. To reiterate, these are the people closest to the community. They are trusted influencers amongst the target population groups. They will ensure appropriate accountability.
When organizations, advocacy groups, and government agencies apply for grants or receive funding, money should be set aside for partnerships with community health workers. State and local health and social service agencies will benefit from identifying, recruiting, and compensating CHWs to sit on advisory committees, boards, and various stakeholder groups.

During the COVID-19 pandemic, community health workers have shown the expertise and knowledge they have about their communities needs and offered solutions to bring about necessary changes. Elevating the voices of community health workers in more decision-making groups will improve the impact of the programs and policies to reach more Utahns.

**Covid Community Partnership**

The Covid Community Partnership project was established as a pilot program to pay community-based organizations (CBOs) to mobilize their CHW workforce to work on pandemic related activities beginning in May of 2020. Successful outcomes have led to this program remaining a current project operating out of the Office of Health Disparities at the Utah Department of Health. Community health workers were tasked with providing education, prevention, testing, and access to resources for underserved and underrepresented communities across Utah. Through the contracts with the health department, community-based organizations were able to continue to pay and even hire more community health workers, expanding paid opportunities for this workforce during an economic recession. The CCP project even expanded into local health departments in the second phase and 12 LHDs have 40 CHWs on staff. At a macro-level, this program has allowed increased partnerships and new opportunities for reaching communities through culturally and geographically relevant methods.

This project has been most successful at reaching racial/ethnic minority communities for access to testing. Community health workers have been able to provide over 10,000 social needs assessments and identified the most common unmet social needs as housing, food, and utility assistance. Through resource connection, thousands of Utahns were able to secure needs through community health workers. This project is ongoing and the full analysis can be found on Office of Health Disparities website.  

A client and her family was connected with a CHW after testing positive for COVID-19. The family was low on food and did not have any friends or family available to pick up and deliver food to their home. Since the entire household was in quarantine, they were unsure how to get food while at home. On top of this, the family was struggling financially since they were unable to attend work. The CHW reached out to a few organizations that were working to provide groceries for COVID-19 patients, but unfortunately, none were accepting new applicants at the time. The CHW took it upon themselves to pick up and deliver groceries for the family to ensure they had enough food for the entire family during their quarantine.  
- Association for Utah Community Health
Certification

As noted in the sections above, there is not a formal recognition or credentialing process of community health workers in Utah. A state-by-state exploration shows most states are moving towards optional certification. Certification provides stakeholders, including the pioneers of the CHW workforce in Utah, with an assurance community health workers have certain competencies and can engage with their communities.

Previous efforts and conversations in Utah to certify community health workers have often stalled due to legitimate concerns that this would place unnecessary, unhelpful, and inequitable barriers to entering this workforce. To better understand these concerns a survey was administered to gather feedback about certification from the CHW workforce and other stakeholders including employers. Sixty seven percent of respondents supported a CHW certification policy.

Through open-ended responses, the survey was able to collect perceived benefits and concerns of certification. Perceived benefits of certification included the opportunity to develop a unified professional identity, greater funding opportunities, increased likelihood of becoming full-time employees, increased respect, and recognition.
Certification will also bring a greater differentiation between case managers and community health workers and create more safeguards to their communities and themselves. Perceived concerns reported were all centered on fears of exclusion—either due to cost, accessibility, immigration status, or those who have been doing the work for decades.

It would be harmful to the workforce and those they serve if this policy created more mistrust in marginalized communities. Reducing unnecessary barriers to certification is a priority for the policy to be fair and equitable. Suggestions, informed by the survey and by national recommendations, to consider in a certification policy are detailed below. The best policy decisions will occur when co-created with a diverse representation of community health workers.

**Certification Requirements:** In addition to completing the core skills training, a certification policy should include a significant number of “on the job” training hours or “community involvement” hours. When reflecting upon both the origins of community health workers, the impact is directly influenced by the trust and connection into the community this workforce has. Requiring on-the-job training or involvement in the community will ensure those strong connections and ensure the soft skills and interpersonal relationships are adequate.

Nearly two years ago, Martina’s six-year-old son Jose was kidnapped by his father during a court-authorized visit. Jose’s father first took him to Indiana and then fled with the boy to Mexico after Martina filed a police report. Martina did all she could to work with local police to rescue her son, but the police could not force Mexican authorities to detain her son’s kidnapper. Feeling there was nowhere else she could turn, Martina contacted Holy Cross Ministries during the fall of 2019. HCM’s case manager promptly communicated with the Mexican consulate in Salt Lake City, the U.S. consulate in Guadalajara, Mexico, the U.S. State Department and the FBI to initiate the process of locating Jose and uniting him with his mother. HCM’s case manager also did all she could to support Martina during this traumatic experience. She connected Martina with a trauma-informed therapist in HCM’s Counseling Program and a member of HCM’s legal immigration team, who helped Martina begin the application process for a U visa—a means for victims of crime to obtain legal status. Jose has now been found safe and he is now in custody with child protective services in Mexico. Martina is able to speak with Jose by phone twice a week. Although Jose’s legal case in Mexico is not yet resolved, Martina is very grateful her son is safe and that HCM will continue to assist her in this process until the family is reunited. *all names were changed to protect the privacy of the family*

- Holy Cross Ministries
Grandfathering: A grandfathering program recognizes and validates experience in the field as a credible pathway to being certified. Currently, the informal certificate of completion has a grandfathering component, and this can easily be transitioned upon the implementation of a certification policy.

Accessibility of Curriculum: The curriculum, application, and certification process should be inclusive and accessible for applicants in rural communities, individuals with disabilities, and residents whose primary language is not English. While hosting some virtual curriculum is one way to increase accessibility, there may be others who will learn best in person and this kind of flexibility will improve recruitment into this workforce. Hiring experienced community health workers to teach curriculum and continuing education is an effective way to build up new members of the workforce.

Application, Certification, and Registry: The application should not have undue barriers regarding citizenship status or education requirements. After exploring a variety of application and certification processes, this workgroup’s recommendation is to model the application process after Texas. Background checks will be completed by employers, therefore it’s unnecessary at this step. Some states have found community health workers who have been incarcerated do a better job relating and connecting to others who are navigating criminal and legal systems; therefore, it would be best to allow employers to make those decisions. Though certification will remain optional, the CHW professional association will maintain a workforce registry. UCA or UDOH would be ideal as the main certifying body, though there can be multiple certifying entities. Costs should remain low and subsidized by stakeholders such as healthcare partners, public health, and educational institutions.

A couple was referred to our CHW program by their doctor. This couple does not speak English and cannot read Spanish or English, making it difficult for them to communicate their needs with their doctor and others. The couple was running behind on housing payments as well as food supply. After conducting the intake, the CHW realized that the couple had a leaky roof which was contributing to chronic colds that they were suffering from. After a few months, the couple was approved for extensive home repairs. Not only were they able to fix the leak in their roof, but they are now able to fix other needed repairs throughout their home. The CHW expressed that this couple was very enjoyable to work with and this case was one of her biggest “wins” yet!
- Association for Utah Community Health
As programming is developed, employers should be involved and trained on the scope of practice for the CHW workforce. Additionally, employers will benefit from having enhanced and specialized continuing educational opportunities with specific skills training options beyond the basic certification process. This enhanced education prepares community health workers to perform the specific duties outlined by individual organizations. Each of these considerations and recommendations will reduce barriers and address concerns in the survey.

Certification is often a pre-requisite for Medicaid reimbursement. Some organizations with a long history in the community may choose to opt out of certification because they have their own processes set up. These organizations can make that choice, recognizing they have alternative funding streams beyond Medicaid. While optional, certification does provide a way for the workforce to maintain integrity of their work, ensure programs and services are delivered to community members in an effective manner, and set the foundation for Medicaid funding.

Texas: A Model for Successful Community Health Worker Certification

Upon surveying community health workers in Utah, concerns surfaced about whether a certification process would exclude non-citizen immigrants and refugees. Addressing this will be important to ensure that all communities, including immigrant communities, are represented, and served. Through exploring other state policies, Texas proved to be a strong example of how to effectively and equitably navigate this concern. Looking at the larger policy landscape, some concerns may not be entirely alleviated without comprehensive immigration reform but there are ways to successfully shape this policy without excluding immigrant communities. Texas developed and passed its certification policy and removed barriers based off citizenship status. In 2001, Senate Bill 1051 directed the Texas Department of Health to develop a training and certificate program for Community Health workers. Their implementation of this bill was informed by stakeholders including community health workers and their state public health agency to establish a minimal number of requirements while maintaining the integrity of the workforce. These requirements include being a Texas resident, be at least 16 years old, complete their training program, or have at least 1,000 cumulative hours of experience. By not requiring further proof of residency, more community health workers can obtain their certification without further fear and anxieties about immigration statuses affecting their work.

Moving forward, this consideration will be important for Utah’s policy to ensure our community health workers are reflective of all communities.
Fundamental to these shifts is moving away from fee-for-service models and more towards value-based purchasing. In Utah, the creation of the Medicaid Accountable Care model has forced attention to address total health of members by coordinating unmet social needs. Theoretically, Accountable Care Organizations (ACO) are taking on greater risk as they seek to fulfill the “Triple Aim” of “better health, improving patient experience, and lowering costs.” In Utah’s ACO model, the state Medicaid agency contracts with private health insurance companies. These health plans are given a monthly capitated amount per person enrolled in their plan and are required to manage the care for the enrolled members. Through this capitated spending, the healthcare system has recognized how challenging it is to manage care for these complex patients. This is one of the undercurrents of why health systems, health insurance plans, and hospitals have created programs seeking to connect the neediest Medicaid recipients to non-medical services influencing their health.

As mentioned in previous sections of this report, community health workers have proven effectiveness in resource connection and assisting individuals with unmet social needs. Understanding the incentives within the healthcare system illustrated above, it is obvious how community health workers can play a critical role in helping to decrease burdens of disease within the Medicaid community.
Beyond just the wraparound services, community health workers can advocate for system changes to create better conditions for Medicaid members. Other services within the scope of community health workers which also align with Medicaid members needs include diabetes prevention, care coordination, health literacy and education, and group classes for health promotion.\textsuperscript{34}

Because community health workers are unique in the way they interact with the traditional healthcare system, Medicaid funding specifics can have significant impacts on the services this workforce can deliver. Through the research, policy analysis, and qualitative interviews that informed this report, the most consistent concern is that this policy will overmedicalize community health workers and pull them away from the community. r states who do pursue Medicaid, the National Association of Community Health Workers recommends states use a value-based payment such as bundled payments.\textsuperscript{35}

A federal 1115 waiver will provide the most flexibility for Utah to design an innovative community health worker program that would generate the greatest impact, reduce unnecessary spending, and be professionally evaluated. While there are multiple ways Medicaid funding can be linked to community health workers, a new and innovative model deserves exploration with all stakeholders impacted.\textsuperscript{36} Assuming federal approval, Utah can provide CBOs with the option of doing this individually or opting into a network of service organizations.\textsuperscript{37} While this would allow them to continue in autonomy, it would also allow for greater collaboration and proper oversight. Reimbursement by Medicaid to a network of service organizations is an idea that has been piloted in several states across the country, but is still under evaluation.\textsuperscript{38}

Facilitating the formation of networks of service providers is appealing because it provides space for community health workers to maintain their competitive advantage – the ability to operate in the communities, neighborhoods, and churches with which they are most familiar. rmal organization within a network has the potential to decrease administrative burden, provide the state a less risky way to fund CBOs, and decrease the likelihood of bad actors committing Medicaid fraud. However, complications could arise if a policy is rushed through or if key stakeholders are left out. Facilitating this conversation with the goal to maintain the trust of the Medicaid beneficiaries, negotiate equitable contracts, and monitor power balances between healthcare stakeholders and community-based organizations should be done with a recognition of the potential pros and cons.
Investing in Community Health Workers is Investing in a Stronger Utah

Investing in community health workers yield a variety of positive outcomes. Recent evaluation from Utah’s Covid Community Partnerships (CCP) provides some clear metrics of success.

Community Health Workers organized and funded through the CCP project in collaboration with the Wellness Bus were more successful at reaching racial and ethnic minority communities compared to all tests conducted statewide. In a group of approximately 17,000 Utahns who were assessed for unmet social needs by the CCP CHWs, 8,123 individuals reported unmet social needs to a CHW and 7,064 were referred to at least one resource to meet their unmet social need. The Covid Community Partnership had a reach of approximately 3 million from the community-based organizations, AUCH community clinics, and local health departments who were asked to organize social media campaigns and other mass communication distribution. While disparities show up across the health and economic impacts of COVID-19, when community health workers were more involved in the state response, the disparities gap began to shrink.

Additionally, through task forces and input sessions, community health workers were able to advocate for culturally appropriate food while dealing with food insecurity of those impacted by Covid-19. Community health workers helped shape many of the effective vaccination strategies.

Beyond the pandemic, other states who have partnered with Medicaid members have been able to report the following metrics:

- Detroit, Seattle, and St. Louis showed that CHWs providing home visits to families have children with asthma resulted in fewer unscheduled or urgent care visits.

- In rural Arkansas one CHW program for the elderly and adults with physical disabilities reduced state Medicaid costs by $3.5 million, a return on investment of 300%.

- A health center in New Mexico that used CHWs to provide intense individualized support for complex patients who had very high healthcare needs saw even greater saving with four dollars saved for every dollar invested.

- In Boston a CHW program decreased hospitalizations and emergency department visits by including home visits focused primarily on black and Hispanic children with asthma.

- In Philadelphia Promotoras hosted educational workshops which led to significant increase in cervical cancer screening among Hispanic women.

Beyond individual health, power in community health workers lies in empowerment and increased engagement of the community at large.
Conclusion

Health disparities and unequal opportunities for healthy outcomes undermines the foundation of our beautiful state. It is in the best interest of all of us, as Utahns, to strive for a state that reaches the vision Governor Cox and Lieutenant Governor Henderson have laid out. Utah should truly be a place “where residents are happy, safe, healthy, and successful. A place where we can grow old surrounded by the people we love and live peaceably in the most beautiful state in America. A place where we realize the good that comes from doing things together as ONE UTAH.” Though community health workers are a new workforce to many, they have been around strengthening the fabric of Utah for decades. As trusted messengers in their communities, their role in promoting health, addressing unmet social needs, and building the capacity of the community is critical.

These policy recommendations were crafted with input and collaboration from leaders in the CHW workforce and with the purpose of asking policymakers to take decisive action to sustain the progress made through the pandemic. Empowerment and investment in community health workers is an investment in Utah. While it is not feasible to implement these recommendations within the first year, this report should guide efforts for this workforce in the next 1-3 years. However, this report is not a replacement of partnering with leaders in the CHW workforce to move forward. Creating sustainability to this workforce will provide stability for veteran community health workers, far too many whom work for no or very low wages. Investments in CHW sustainability will provide more workforce opportunities for community members to secure a decent and valuable job that is not dependent on college degree. As referenced throughout the report, this workforce has originated from geographic regions and racial/ethnic minority communities which have been underinvested in and often have less economic opportunities. These policies collectively create some unique workforce development strategies by valuing lived experience, connectedness, and trust within communities.
References

[11] Rural areas are classified as having a population of 6-99 people / sq. mile, make up 40% of the land area in the state of Utah and contain 21% of the population. Frontier areas have < 6 people/ sq. mile and cover 55% of the state but only contain 3.5% of the total population.
[14] https://www.ruralhealthinfo.org/states/utah
[21] See oral history of Promotoras and Community Health Workers in Utah featured at the beginning of this report.
[22] https://www.cdc.gov/tuskegee/timeline.htm
[25] The survey was organized by the Finance and Advocacy Workgroup Chairs from the CHW Coalition, a coalition of both CHWs and stakeholders organized under the Utah Department of Health. The survey was distributed in both Spanish and English from October 2020- January 2021 winter. 82 responses were received, of those responses and 65% of respondents identified as CHWs or promotoras.
[26] https://www.astho.org/Community-Health-Workers/CHW-Certification-Financing/
[27] See highlighted box for more details
[31] https://www.astho.org/Community-Health-Workers/Q-and-A/
[33] https://www.chcs.org/resource/aco-resource-center/