

Building a Consensus on Community Health Workers' Scope of Practice: Lessons From New York

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Under the Affordable Care Act (Pub L No. 111-148), the landmark health care reform legislation signed into law by President Obama, millions of Americans will have access to quality, affordable health care. However, cultural, language, or other vulnerabilities can prevent millions of people from benefiting from this care. Community health workers (CHWs) are in a unique position to help. CHWs can break down barriers so that people can receive the health care services they need, and they can assist them in benefiting fully from those services.¹ A growing number of studies have shown that CHWs can help ensure equitable access to care, decrease health care costs, and improve outcomes, including self-management of chronic diseases such as asthma or diabetes.¹⁻¹³ The valuable role CHWs can play is clear, and many groups are now working to outline the details of their roles across a spectrum of conditions and communities.

In addition to the critical questions of how and for whom CHWs can most effectively provide these services, attention needs to be paid to ensuring that the CHW workforce is structured to respond to this demand. Surveys of the CHW workforce have concluded that although there may be as many as 120 000 CHWs in the United States today,¹⁴ there are no national standards defining what a CHW does as a member of the health care team or what criteria might be used to qualify CHWs for reimbursement through sustainable funding such as Medicaid. National organizations such as the American Association of Community Health Workers and the American Public Health Association (APHA) have been working to support the development of CHW workforce standards,¹⁵ and the Bureau of Labor Statistics has established a standard occupational code for CHWs.¹⁶ The APHA CHW Section's definition of a CHW is increasingly recognized as the nationally accepted definition:

Objectives. We evaluated efforts in New York to build a consensus between community health workers (CHWs) and employers on CHWs' scope of practice, training standards, and certification procedures.

Methods. We conducted multiple-choice surveys in 2008 and 2010 with 226 CHWs and 44 employers. We compared CHWs' and employers' recommendations regarding 28 scope of practice elements. The participatory ranking method was used to identify consensus scope of practice recommendations.

Results. There was consensus on 5 scope of practice elements: outreach and community organizing, case management and care coordination, home visits, health education and coaching, and system navigation. For each element, 3 to 4 essential skills were identified, giving a total of 27 skills. These included all skills recommended in national CHW studies, along with 3 unique to New York: computer skills, participatory research methods, and time management.

Conclusions. CHWs and employers in New York were in consensus on CHWs' scope of practice on virtually all of the detailed core competency skills. The CHW scope of practice recommendations of these groups can help other states refine their scope of practice elements. (*Am J Public Health*. Published online ahead of print August 16, 2012; e1–e7. doi:10.2105/AJPH.2011.300566)

Community Health Worker (CHWs) are front-line public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.¹⁵

Setting workforce standards begins with the establishment of a scope of practice, the roles and tasks performed by practitioners, along with the usual education and competencies required for that practice. In 1998 the National Community Health Advisor Study (NCHAS), a milestone review of CHW roles and activities, listed 7 basic roles, 8 core skills or competencies, and 7 additional qualities supporting accomplishment of these CHW roles¹⁷; however, these elements need to be reviewed and tailored as appropriate to ensure that they capture context-specific roles. Establishment of a scope of practice for credentialing is

a state responsibility, and 17 states are now in the process of establishing standards for CHWs.^{1,18,19}

As is the case with members of any other profession establishing standards for itself, CHWs should lead in identifying appropriate scope of practice roles, and this is the approach that has been adopted in New York.¹ In 2005, the Mailman School of Public Health and the CHW Network of NYC began an academic–community partnership to elicit CHWs' views on establishing practice and training standards. We learned that although CHWs felt they were recruited for qualities such as dedication to the community and trust, often employers valued a wholly different skill set that included informal counseling, teaching, and promotion of behavior change. CHWs saw themselves in terms of “who” they were in the community, whereas employers viewed them according to “what” they could do.²⁰ We concluded that if there is to be agreement on scope of practice, it is critical that each group, CHWs and their employers, agree on both the “who” and “what” questions.

To develop a consensus scope of practice, we set out to determine CHWs' perceptions of the most appropriate set of roles and skills for their profession, as well as potential employers' perceptions of those roles and skills. We used a community-based participatory research approach to simultaneously obtain input from CHWs and employers on these topics that could be used in achieving a consensus, and here we report on the recommendations derived from this multiyear process.

METHODS

The community-based participatory method used in this study involved the academic and CHW communities as equal partners in determining research questions, methods of data collection and analysis, and interpretation of findings.^{21,22} Columbia University's Mailman School of Public Health, our academic partner, had experience in developing community-based CHW programs, including specification of CHWs' roles, training, supervision, and feedback.

Our CHW community partner, the Community Health Worker Network of NYC (CHWN), is the city's only independent CHW professional association and currently has more than 350 members working in organizations encompassing a wide range of health concerns. CHWN is a nonprofit organization with a board of directors that also includes several key CHW stakeholders. Members pay no dues; annual conferences and training programs are supported by outside funders.

Building on the findings from our 2005 collaborative study regarding CHW roles,²⁰ we outlined what we needed to learn about these roles. CHWN convened a research committee that developed and then implemented survey tools aimed at obtaining the requisite data from CHWs and their employers. After considerable discussion about how to ask about possible roles, skills, and attributes, we decided to gather data on the qualities or attributes of CHWs via questions about background characteristics. We asked what unique qualities a CHW possesses and what aspects of CHWs' work are important for people in the community. All roles outlined in the NCHAS¹⁷ were included, but 2 were worded differently and expanded.

This process resulted in a grid of 25 specific skills including all interpersonal, communications, teaching, or organizational skills discussed in previous national or state listings of CHW skills, as well as any additional ones known to be used by CHWs in New York City. In the case of each skill, both CHWs and employers were surveyed as to whether it was a requirement for a CHW to be hired, whether training in the skill was provided by the organization, and whether the skill was recommended as part of the New York State CHW standards of practice. Additional questions covered sociodemographic characteristics, educational background and requirements, reimbursement and funding sources, and the health problem areas on which CHWs work.

In 2010, when our partnership expanded its investigation of CHW roles to develop scope of practice and related training and credentialing recommendations for the entire state,²³ we added questions in 3 skill areas (computer skills, supervision, and personal safety), increasing the number of skills assessed to 28; we also included questions on CHWs' background and training as well as on supervision and logistical and funding support. The revised 2010 questionnaires contained 22 questions for CHW employers and 45 for CHWs. Surveys were prepared only in English, given that the research committee decided that all CHW respondents would have the necessary language skills to complete the surveys in English. The revised questionnaires and the expansion of the investigation to the state level were approved as a modification to the original (2008) institutional review board protocol.

The surveys were implemented in 2 waves. In the first wave, which took place in 2008–2009, Survey Monkey was used to invite 305 members of CHWN with valid e-mail addresses to respond to the survey. Invitations were issued 3 times, and 103 CHWs responded with completed surveys. We prepared a list of 47 employers of CHWN members, and 21 employers responded to the Survey Monkey invitation.

The second wave of interviews was conducted in spring and fall 2010. The sampling frame for the second wave included employers and members of CHWN who had not yet responded to the original survey ($n = 230$), along with members of 2 emerging regional

CHW networks in Buffalo and Rochester, New York ($n = 65$). Responses to all 2010 CHW interviews (in the form of self-report, printed surveys) were solicited at the network's annual conference and 2 regional meetings (twice each). The CHW employer list was updated to include new CHW employers in the New York City metropolitan region as well as employers in the Buffalo and Rochester regions ($n = 12$ additional employers).

We received completed surveys from 123 CHWs and 23 employers during the second wave, resulting in an overall unduplicated sample of 226 CHWs (61% response rate) and 44 employers (75% response rate). CHWs' average age was 39 years; 78% were female, 42% were foreign born, 97% were working as CHWs at the time of the survey, and 40% were working full time. CHWs were involved in a wide range of health issues, with 50% to 22% currently or ever working on each of the following: wellness, nutrition, family planning, HIV/AIDS, domestic violence, maternal and child health, diabetes, substance abuse, mental health, smoking, hypertension, injury prevention, immunizations, and asthma. Most of the employers had fewer than 5 CHWs on staff, but 3 had 20 or more full-time CHWs. A majority of employers (68%) required that CHWs have a high school diploma or a general equivalency diploma.

After the data had been computerized and converted to Microsoft Excel (Microsoft Corp, Redmond, WA) spreadsheets, Stata version 11.0 (StataCorp LP, College Station, TX) was used to merge them into a CHW and employer database. Responses to questions asked only in 2010 were coded as missing for the 2008 respondents. All variables included in this study were dichotomous (coded as 0 or 1). The skills analysis excluded cases in which the respondent had not marked any responses in the skills grid (there were 39 such cases among CHWs and 4 among employers).

As a preliminary definition, consensus between CHWs and employers was defined as 50% of both groups recommending inclusion of a particular skill in the scope of practice. Attendees at a CHWN meeting reviewed the results and used the participatory ranking method to elucidate their views on discrepancies between the scope of practice rankings of CHWs and employers. Meeting participants

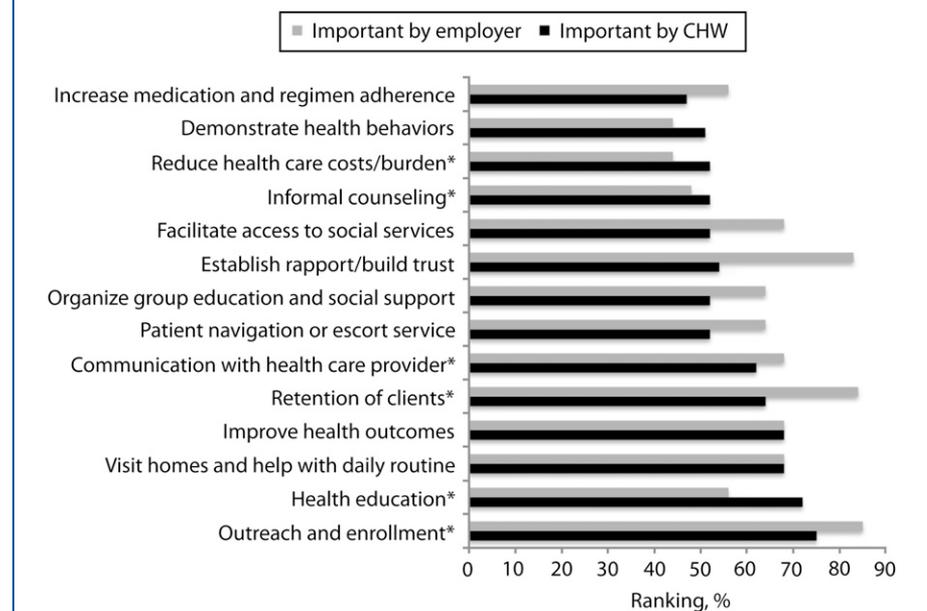
(n = 30) were asked to offer their opinion as to the relative importance of various skills, and they developed an overall ranking of skills according to their importance. On the basis of this discussion, we deemed that there was a consensus among CHWs and employers on a particular skill if the skill was recommended by 50% or more of CHWs and 50% or more of employers (either as a specific recommendation or as a skill for which training is provided). To allow for random response variation, we further specified the criterion for consensus as inclusion of 50% mark in the 95% confidence intervals for both CHWs' and employers' rankings.

RESULTS

More than half of the CHWs and employers surveyed in 2008 and 2010 agreed with the roles outlined in the NCHAS (5 basic roles in addition to one that combined 2 roles from the NCHAS review, providing referrals and providing direct services). The CHWs and employers most frequently mentioned as important advocating for individual and community needs (73% and 53%, respectively), providing a cultural bridge between communities and health professionals (67% and 53%), providing referral and follow-up services (63% and 88%), providing informal counseling and social support (62% and 56%), conducting outreach and mobilization (building community capacity; 61% and 88%), and providing culturally appropriate health education (59% and 82%).

CHWs' and employers' rankings of the contributions of CHWs shed additional light on the value they place on the insider perspective CHWs bring to their work (Figure 1). Contributions ranked most important by 50% or more of both CHWs and employers were outreach and enrollment, improving health outcomes, retention of clients, health education, establishment of rapport and trust, facilitating access to social services, organizing group education and social support, communication with health care providers, home visits, and provision of patient navigation services.

The additional questions asked in 2010 regarding CHWs' background showed that 78% of CHWs considered community residence important because it gave them valuable



Note. An asterisk indicates that an item was included in both the 2008 and 2010 surveys (CHWs, n = 221; employers, n = 40). Other items were included in 2010 only (CHWs, n = 119; employers, n = 21).

FIGURE 1—Rankings of community health workers (CHWs) and employers of the most important contributions of CHWs: New York, 2008–2010.

insider knowledge of the community. Residing in the community also conferred other valuable attributes: shared values and experiences with residents (cited by 59% of CHWs), an ability to communicate using examples from CHWs' own life (59%), and an ability to establish trust (56%). The ratings of employers were similar, with almost half (44%) preferring CHWs who live in the community and 80% preferring CHWs who share the same cultural or experiential background with residents.

Skills and Scope of Practice

CHWs' and employers' rankings of skills are shown in Table 1. Eighteen of the skills were recommended by at least 50% of CHWs, while 7 were recommended by 50% or more of the employers, with agreement on 6 of the 18 skills. By allowing for random variation in the responses and including a skill if the 50% mark is included in the 95% confidence interval, the CHWs recommended an additional 9 skills while the employers recommended an additional 7 skills, bringing their agreement up to 14 skills.

The participatory rankings at the CHWN meeting revealed a rationale for possible

differences between employer and CHW recommendations: whereas CHWs were considering detailed skills they needed on a day-to-day basis, they believed that employers considered only more general skills. The CHWN meeting participants suggested that the "day-to-day" skill requirements for employers would better be reflected in their suggestions regarding a skill for which they provide training. (col. 3, Table 1). Using this criterion, 50% or more of the employers provided training for 24 of the 28 skills. An additional 2 skills were recommended by the employers if we include those skills for which the 50% mark is included in the 95% confidence interval.

Using both criteria for employer recommendations, 50% or more of the employers matched 50% or more of the CHWs for 17 of the skills. If we allow for random variation in the response rate and include skill recommendations for which the 50% mark is included in the 95% confidence interval, both CHWs and employers recommended all but one of the skills (27 out of 28).

The final step in developing a CHW scope of practice involved framing roles according to

TABLE 1—CHWs' and Employers' Skill Set Recommendations for CHWs' Scope of Practice and Training: New York, 2008–2010

Skill Set	Recommended by CHWs (n = 184), % (95% CI)	Recommended by Employers n = 40), % (95% CI)	Employers Provided Training (n = 40), % (95% CI)
Interpersonal			
Ability to establish trust	55 (45, 63)	35 (20, 50)	50 (33, 66)
Bilingual	54 (45, 63)	25 (11, 39)	55 (39, 71)
Multicultural competency	55 (45, 64)	64 (36, 98)	57 (28, 87)
Provision of social support for clients	51 (42, 61)	68 (52, 83)	70 (55, 85)
Communication			
Advocacy (individual or community)	55 (45, 64)	65 (50, 80)	53 (36, 69)
Community organizing	55 (45, 64)	33 (02, 65)	83 (59, 99)
Outreach and enrollment	55 (46, 64)	23 (09, 36)	60 (44, 76)
Information sharing	49 (40, 58)	28 (13, 42)	68 (52, 83)
Listening	56 (47, 66)	23 (09, 36)	55 (39, 71)
Setting goals or making plans with clients	49 (39, 59)	63 (47, 78)	63 (47, 78)
Informal counseling	56 (47, 65)	55 (39, 71)	60 (44, 76)
Ability to lead group discussions or support groups	54 (45, 64)	30 (15, 45)	68 (52, 83)
Facilitating workshops and group activities	50 (40, 59)	25 (11, 39)	60 (44, 76)
Case management and referrals (including insurance)	56 (47, 65)	23 (09, 36)	53 (36, 69)
Medical interpretation	46 (37, 56)	15 (03, 27)	53 (36, 69)
Interacting with physicians/health care system	51 (42, 61)	35 (07, 64)	43 (13, 73)
Teaching			
Health education skills	64 (56, 73)	38 (22, 53)	70 (55, 85)
Role-playing and modeling health behaviors	53 (44, 63)	25 (11, 39)	50 (34, 66)
Adult learning techniques	46 (37, 56)	13 (02, 23)	60 (44, 76)
Chronic disease knowledge and management	47 (38, 57)	33 (17, 48)	63 (47, 78)
Home assessment and advice on daily routines	41 (31, 50)	36 (07, 64)	71 (44, 98)
Safety procedures at home visits ^a	43 (34, 53)	29 (02, 36)	79 (54, 99)
Organizational			
Computer skills (office, e-mail, Web) ^a	53 (44, 63)	50 (20, 80)	25 (11, 39)
Time management and scheduling	68 (60, 76)	53 (36, 69)	75 (61, 89)
Documentation and data collection	56 (46, 66)	35 (20, 50)	73 (58, 87)
Interacting with supervisors ^a	40 (30, 49)	10 (01, 20)	23 (09, 36)
Mentoring other CHWs	44 (35, 54)	45 (29, 61)	35 (20, 50)
Research (e.g., human subjects, consent)	41 (31, 50)	33 (17, 48)	65 (47, 78)

Note. CHW = community health worker; CI = confidence interval. With the exception of interacting with supervisors, all skills meet the consensus criteria.

^aIncluded only in 2010 (all other items were included in both 2008 and 2010).

the most appropriate supporting skills, with the relevant skills reported by both CHWs and employers as important being allocated to each role. During the participatory ranking discussion, CHWN meeting participants regrouped these skills into 5 major scope of practice roles (Box 1). Within their scope of practice, CHWs may perform 1 or more roles at the same time (e.g., home visiting and health education), and some skills assigned to a particular role may also be used in fulfilling other roles.

Training Standards and Credentialing

The 2010 survey polled CHWs and employers regarding their views on training standards and certification. Virtually all of the CHWs indicated their willingness to complete additional training if needed to attain the scope of practice standards. Most (80%) preferred to complete this training through their work (on the job or with sponsorship from their employer), with the balance willing to take courses at night or at community colleges. Almost three

fourths (71%) were willing to pay for training if they needed to do so. If there were a test required for certification, 81% reported they were very or somewhat likely to take the test.

Employers also supported standardized training. Employers reported currently using a patchwork of training strategies: 60% provided on-the-job training, 68% offered courses internally or made use of those offered outside the organization, and 56% offered short courses. Only 32% indicated

Consensus Between CHWs and Employers on CHWs' Scope of Practice and Related Skills: New York, 2008–2010

Scope of Practice Role	Related Skills
Outreach and community organizing	Strong interpersonal skills Multicultural competence and bilingual skills Advocacy skills Group facilitation Information exchange
Case management/care coordination	Informal counseling Goal setting and planning Time management
Home visiting	Safety procedures Environmental assessments Observation and listening
Health education/coaching	Health education Topic-specific health care knowledge Chronic disease management support Adult learning methods Modeling behavior change Participatory research methods
System navigation	Patient navigation Interpretation and translation Computer skills and ability to access information

Note. Roles and skills included here are based on the data presented in Figure 1 and Table 1, informed by the participatory ranking method results.

that they provided a comprehensive skills-based course. Responses in both 2008 and 2010 showed that the majority (93%) believed that a standardized training program would improve the effectiveness of CHWs at their organization. Most (80%) reported that they would have CHWs complete a training program if it were available. Almost all (92%) employers would hire more CHWs if they were available from a standardized training program. The constraining factor for employers was funding. CHW positions at these organizations are primarily funded by government grants (71%) and foundations (32%), with only 12% funded through insurance. Three fourths (76%) of employers would hire more CHWs if they could be reimbursed through Medicaid.

DISCUSSION

Informed by national perspectives on CHWs, our collaborative enterprise in New York is now revealing an emergent consensus between

CHWs and their employers on many of the key elements of CHWs' contributions and scope of practice. More than three fourths of CHWs and their employers in our study agreed that is essential for CHWs to be members of the community in which they work and to have shared life experiences with the people they serve. Their value to their community and employer is fundamentally linked to shared residence, identity, and experiences.¹² This underscores a key element of the CHW definition forming the basis of the Bureau of Labor Statistics' standard occupational code definition: shared ethnicity, language, socioeconomic status, and life experiences with the community members served.¹⁶

Thus, for CHWs there is a premium placed on permanence and staying within the same community and labor market. As a result, the New York CHW initiative is taking care to build strong regional CHW networks that help anchor the CHW workforce, providing stability for those who stay in the region and an

opportunity for CHWs moving into the region to quickly become "networked" so that they can function fully in the critical roles appreciated by programs and their clients.

As can be seen in Figure 1, there was remarkable consensus on the most important contributions of CHWs. More than half of CHWs and employers agreed that CHWs make valuable contributions to 10 outcomes, grouped into 5 major skill areas^{11,17}: engaging in outreach and enrolling and retaining patients; providing health education, group education, and social support; facilitating health promotion and adherence behaviors through home visits and providing assistance in navigating the health system; facilitating access to social services; and improving health outcomes.

There are some substantial differences within these assessments of important contributions, but of particular interest is the difference between CHWs and employers regarding the importance of reducing health care costs, with 52% of CHWs and only 44% of employers considering this important. Given the focus on reducing health costs in health reform and other CHW initiatives, this discrepancy merits further investigation.^{1,24–26} Differences between CHWs' and employers' rankings with respect to retention and establishment of rapport and trust may actually reflect the perspective of programs on the "bottom line" of retaining clients. Employers may hire CHWs because they can establish the trust needed to retain clients, whereas CHWs see trust as a quality that is instrumental in helping their clients achieve their own goals. Another interesting difference is that between CHWs' and employers' rankings of the importance of group versus individualized health education, with employers favoring group processes and CHWs favoring one-on-one educational opportunities such as those that arise during home visits.

Developing a consensus on CHWs' recommended scope of practice has been a progressive process. We initially sought to achieve a consensus among CHWs and employers concerning the major roles to be included in the scope of practice, which also encompassed the roles identified in the NCHAS.¹⁷ A consensus was reached by 50% or more of CHWs and employers on 14 of the 28 skills assessed. This was an area of concern for the

collaborative team, given that several of the skills rated highly by CHWs were not included in this consensus. Through the participatory ranking method, the CHWN meeting participants interpreted the ranking variance as stemming from different perspectives on scope of practice definitions. CHWs viewed the scope of practice as skills they needed for all aspects of their job, whereas employers included only general categories. A review of the skills for which employers provided training, namely the ones for which they held CHWs accountable, revealed that there was actually a consensus on 27 of 28 skills that CHWs would need to be completely prepared and that therefore should be included in their scope of practice.

As one CHWN member pointed out, the basic roles correspond to the major categories of reimbursable or billable services, whereas skills are trainable competencies that enable CHWs to fulfill these roles. From this perspective, we distilled the scope of practice recommendations into 5 basic roles: outreach and community organizing, case management and care coordination, home visits, health education and coaching, and system navigation. These roles are similar to those outlined in the Minnesota scope of practice²⁷ while being less oriented to health care cost reductions than, for example, in Massachusetts.²⁴

Limitations

Development of a consensus between CHWs and employers on CHWs' scope of practice has required repeated consultations with both groups. Obtaining survey responses from a statewide sample of CHWs was very challenging, given that our potential sample consisted of members of local CHW associations or those attending a meeting or event sponsored by these associations. Thus, our survey is not representative of CHWs not involved with these associations and probably excludes those who are unemployed or not currently working as CHWs. However, the broad representation of our CHWs in diverse health problem areas suggests that we have captured all of the basic work domains of CHWs in New York.

Although we had expected a limited response to our English-only surveys, this was less a limitation than we had anticipated. Almost half (42%) of the respondents were foreign born. Although we believe that our

61% response rate is acceptable for this type of sampling, we were more successful in obtaining responses from CHWs in the New York City metropolitan area (where we were able to contact CHWs more frequently) than in other parts of the state. With the recent establishment of a statewide CHW association, we will be able to identify any significant groups of CHWs that we may have missed in the 2 survey rounds completed thus far.

Conclusions

Through our collaborative approach, we have been able to nurture the development of a CHW-employer consensus on the appropriate scope of practice for CHWs in New York. When we compare the initial 2005 discussions with CHWs and employers concerning CHW roles with those taking place in 2010, an enormous increase is evident in terms of mutual understanding of the details needed to establish a system that is sustainable for both sides of the workforce, employee and employer.

In the next step of the process, we will use these scope of practice recommendations to develop a functional task analysis that will guide elaboration of detailed training standards to be used in New York for achieving these competencies. These standards will in turn serve as a basis for identifying standards for sustainable funding. We hope that our organization of scope of practice categories and nested skill groups will help other states in refining their own CHW scope of practice elements. ■

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Contributors

S.E. Findley and S. Matos established the academic-community partnership. S.E. Findley, S. Matos, A.L. Hicks, and D. Diaz led the conceptualization of the study. S. Matos, A.L. Hicks, and D. Diaz led the data collection. A. Campbell designed the database for both surveys, computerized all responses, and conducted the preliminary

analyses with S.E. Findley. S.E. Findley led the data analysis, working with A. Moore, A. Campbell, and D. Diaz to develop the bivariate analyses. The article was principally written by S.E. Findley, with contributions from S. Matos, A.L. Hicks, D. Diaz, and A. Campbell.

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Human Participant Protection

No protocol approval was needed for this study given that no identifiers were collected.

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