Draft: Equitable Health Care Task Force Meeting Summary

Meeting information

- June 26, 2024, 1:00-4:00 p.m.
- Meeting Format: WebEx
- MDH LiveStreamChannel

Members in attendance

Sara Bolnick, ElijahJuan (Eli) Dotts, Mary Engels, Marc Gorelick, Bukata Hayes, Joy Marsh, Maria Medina, Laurelle Myhra, Cybill Oragwu, Miamon Queeglay, Nneka Sederstrom, Megan Chao Smith, Erin Westfall, Yeng M. Yang

Key meeting outcomes

- Workgroups began to organize these problem statements in terms of feasibility and impact of potential solutions to those problems, while ensuring alignment with the vision statements of each workgroup.
- Barriers to achieving an equitable health care system were fleshed out as numerous

Key actions moving forward

- Workgroups will meet to complete the problem identification and categorization (with technical and facilitation support from DeYoung Consulting and MDH).
- MDH will review the outcomes of each workgroup discussion to draft a proposal for engagement of outside subject matter experts and the public. Additionally, MDH will outline the approach for conducting an environmental scan of promising practices and policies with a research team at the University of Minnesota.

Summary of meeting content and discussion highlights

Meeting objectives

The following objective was shared:

- Identify and clarify the problems the task force wants to solve for that align with their vision of an equitable health care system in Minnesota.

Welcome and grounding

Task force members were welcomed and the agenda was reviewed.

MDH Update

MDH provided an update on where the task force is in the overall process: workgroups have developed visions and workplans, while MDH and DeYoung Consulting have analyzed the content of those workplans and discussions so far to get a sense of cross-cutting issues, information and engagement needs, and gaps, and to identify areas in need of clarification. The planning team, in its analysis, felt more clarity was needed on the health care equity problems that the task force wanted to solve. Thus, MDH created an initial set of problem statements based on all insight gathered so far. These problem statements serve as a foundational tool to identify the information needed to develop effective solutions.

MDH plans to use the results of the discussions during this meeting to firm up our plans for engagement with subject matter experts and the public, and the approach to the environmental scan of promising practices and policies in other states with a research team at the University of Minnesota.

Additionally, in response to requests for more support, MDH staff will begin to participate more in workgroup discussions. Their roles will encompass providing support, engaging with workgroup members, and facilitating discussions with subject matter experts. They will share valuable information and perspective to ensure that each workgroup has the necessary resources and guidance to achieve their goals effectively.

Vision and Definition of Health Care Equity

A separate meeting with two task force members was held previously to revise the vision and definition of health care equity based on the task force's feedback on the initially drafted statements. The revised statements were presented to the task force members, who rated their support. The revised statements were supported by all or nearly all task force members present. The term "self defined optimal health" was particularly called out as strong, although there was a question about how to measure self-defined health goals. There was also a question about what is meant by "health care system," and it was shared that this term should refer to every aspect of the health care system and every touch point that a patient might have so it encompasses delivery, payers, etc. There was a desire to clearly communicate this. The task force was invited to email or call with any pending major concerns.

Problem Identification

MDH shared a compilation of problem statements that were lifted from task force workplans and discussion notes thus far. The problem statements were organized by the four health care focus areas: workforce, financing, access and quality, and delivery. Because discussions about access and quality have overlapped with discussions about delivery, those problem statements

were combined. Task force members were asked to review during the meeting and elaborate by adding more statements to their own workgroup's area.

Problem Categorization

The task force split into their workgroups in breakout rooms to discuss the four priority areas. They were charged with organizing the many problem statements into four quadrants based on two axes: feasibility and impact. The axes represent high and low feasibility, and high and low impact, allowing the workgroups to prioritize the issues.

Below are the problem statements that each workgroup perceived as potentially presenting the most feasible and most impactful solutions.

Health Care Finance

Members of this group are Bukata Hayes, Taj Mustapha, and Cybill Oragwu.

- Miscommunication in healthcare financing, who charges or pays who, and for what. Patients assuming providers determine cost, overinflated pricing by7 facilities, payers paying less than agreed rates, etc. Cost of care is a mystery for patients. Don't know what our of pocket costs will be.
- Reimbursement is different based on type of coverage and health insurance carrier
- Low reimbursement rates for mental health care
- Low reimbursement rate for preventative and primary health care when compared to sick care, procedures and surgeries
- lack of recognition of pay for preventative care vs sick care in reimbursement and clinician pay.
- Payment models don't support whole-person care
- Reimbursement doesn't support interventions that address social determinants of health
- Payors don't work fast enough to update benefits, reimbursement etc. It takes multiple years 2-3 to make coverage changes.
- insurances can change coverage mid-year
- Instability in healthcare coverage tied to employment, poor continuity of care
- Payors aren't incentivized to provide adequate and appropriate coverage to reimburse and sustain what needs to be done to address patient health
- No consensus on where the source of funds needed to bridge gaps in care to achieve health equity
- Paying for service instead of paying for outcomes
- Not uniformed coverage for community health workers
- private equity ownership impacting cost and delivery of care

- CMS coverage and reimbursement isn't enough, it needs to be updated
- Small health systems struggle to be sustainable
- Financing rewards treatment vs prevention

Health Care Workforce

Members of this group are Mary Engels, Joy Marsh, Maria Medina, and Vayong Moua.

- Barriers to the cocreation of workforce equity strategies include the lack of Employee Resource Groups (ERGs) and ERG input
- Lack of standardized Diversity, Equity, Inclusion, and Belonging (DEIB) training and access to training resources and training requirements.
- Barriers to mentoring and leadership development exposure for emerging leaders from underrepresented groups.
- Employees from underrepresented groups don't feel sense of belonging in workplace
- Health care workforce lacks understanding of health care inequities
- Healthcare pipeline efforts often times just focus on recruitment, not retention and inclusion
- Small and public funded clinics (FQHCs) can't offer competitive wages
- Health Professional accreditation, licensing policies a barrier for students who are low-income
- Lack of accountability to drive workforce equity outcomes
- We aren't creative in assessing/defining who is a member of the equity team (ie taxi drivers, landlords, etc.)
- Primary care is losing out to specialty care and hospital medicine due to incongruent compensation structure.
- No requirements for Board and Sr. Level positions to reflect community demographics.
- Lack of new types of positions that would address equity (e.g., cultural navigators, advocates, etc.)
- There aren't professional standards for language service providers in health care
- Challenges in systems/staff turnover, to recruit and retain staff which increases work loads and demands
- Cost and time a barrier to education for diverse and low income students
- minoritized communities need financial assistance to pursue careers in healthcare; big barrier to entry
- Clear connection and support from Pre-k to Graduate school

Health Care Delivery and Access & Quality

Members of this group are Marc Gorelick, Laurelle Myhra, Miamon Queeglay, Sonny Wasilowski, Erin Westfall, Tyler Winkelman, Elizete Diaz, ElijahJuan Dotts, Nneka Sederstrom, Megan Chao Smith, Patrick Simon S. Soria, and Yeng M. Yang

Note that the following list is partial; the group did not have time to organize all problem statements that were identified.

- Public health and clinical data are not integrated
- Patients experience language barriers
- Transportation barriers to accessing services
- Lack of data to identify and address health inequities
- Performance metrics don't adequately address equity and outcomes
- Lots of interactions among these issues - implementing one solution isn't going to have the same impact as doing many of them together
- Evidence shows that by itself DEIB Training has modest impact, needs to come with other systemic changes/ cultural transformation , too
- Patients don’t experience culturally inclusive and responsive care
- Barriers to providing culturally congruent care include the lack of required DEIB foundational training for all
- Inadequate capacity for mental health care
- Lack of broadband internet in rural communities with which to receive care
- Lack of technology access and broadband internet generally (not focused on rural areas)

Public comments

No public comments were received in this period.

Closing and action items

No public comments had been received to present in this meeting.

A brief feedback poll was provided to the task force. Seven individuals responded. Their responses are summarized here:

- Respondents mostly strongly agreed that the meeting was effective. Average rating was 3.7 (on a scale of 1-4, with 4 being “strongly agree” that the meeting was effective).
- Respondents mostly agreed that the task force is fairly on track toward developing thoughtful recommendations by June 2025. Average rating was 3.4 (on a scale of 1-4 with 4 being “strongly agree” that the task force is on track).

The task force was thanked and reminded of the next meeting on August 21, 2024, which will be an in-person meeting with the option to join virtually. Workgroups are charged with meeting before the full task force meeting in August, to complete the problem identification and categorization, and information and engagement activities in Mural with facilitation support from DeYoung and MDH.

- Workforce: July 8
- Access and Quality / Delivery: July 12
- Financing: July 15

Contact to follow up

With questions or comments about Equitable Healthcare Task Force, please reach out to the Health Policy Division at health.equitablehealthcare@state.mn.us.

Meeting summary note

All task force members' comments are represented, identities are intersectional, and discussions reflect barriers and solutions that affect many communities at once.

Public comment

One member of the public submitted comments to *health@equitablehealthcare@state.mn.us* between the June and August task force meetings.

So currently there is an effort to rebrand acupuncture and much of Chinese medicine. I was wondering is there an opportunity to discuss this?

The acupuncture needle is one of the oldest medical devices for the management of pain. Acupuncture and Chinese medicine have been in practice in the US since the 1700's. There was a reintroduction to acupuncture and Chinese medicine in the 1970's. During that time the acupuncture needle was declared experimental even though it had been in use in cultural communities. Because the FDA declared its investigation they blocked the importation of the acupuncture needle for a while. Because now the needle was declared a medical device it was declared the practice of medicine and only medical doctors were allowed to use the acupuncture needles. In the country there were efforts to jail practitioners of acupuncture. Licensing laws were tried starting in the 1970's. In Minnesota it took over 20 years for the practice of acupuncture to be established. Still in some states the practice of acupuncture is not allowed or is sort of underground because of the licensing.

Rebranding of acupuncture started about 10 years ago. The American Physical Therapy Association, in order to get around licensing laws, started using acupuncture needles claiming they are not doing acupuncture but dry needling even though they are not using hypodermic needles with medication as they say Janet Travell researched. The problem is Janet Travell's work is from acupuncture. She was quoted in newspapers noting that her technique was similar to acupuncture but using a hypodermic needle. The physical therapists are claiming that they invented something new with an acupuncture needle. That as acupuncturists we do not know anatomy and physiology and we do not stick needles in muscles. This is not true. There are many variations of acupuncture techniques from different cultures. Acupuncture can be delivered at the surface, in the muscle, all the way to the bone and into large joints in the treatment of pain. There are other techniques that are more systematic. That is why there are different lengths and gauges of needles. There are techniques in which we leave the needle in for seconds and then there are techniques where we leave them in for several minutes. There are documents to show from the 1970's that trigger point needling in the muscle was acupuncture but the Physical Therapists are claiming they have invented a new use for the acupuncture needle.

Chinese medicine also includes some non needling techniques like cupping and gua sha. The physical therapy profession and other professions are claiming again they have invented something new which they have not. They make claims about these techniques when provided by acupuncturists that are not true and they are rebranding even those claiming to come up with a new technique.

I have tons of historical documents. If you want a presentation I could provide one. I could provide you with documents but I do not want to overwhelm you.

There are many more historical documents but here are some links to a few of them.

Please speak out about the rebranding and the false narratives about acupuncture and Chinese medicine.

Chinese Doctor advertising in the 1700's.
https://www.newspapers.com/article/lancaster-intelligencer-chinese-dr-j-h/140727048/

1897 acupuncture needles showing different lengths. There are many more lengths and types of needles. Smithsonian Institute
https://collections.si.edu/search/detail/edanmdm:nmah_722556?q=Acupuncture+&record=20&hlterm=Acupuncture%2B

1916 Hawaii Attorney General opinion on acupuncture and moxibustion page 248-250
https://books.google.com/books?id=q0wwAQAAMAAJ&newbks=1&newbks_redir=0&printsec=frontcover&pg=PA248&hl=en&source=gb_mobile_entity#v=onepage&q&f=false

1947 multiple articles about Janet Travell's work
https://www.newspapers.com/article/freeport-journal-standard-chinese-have-l/104062437/

https://www.newspapers.com/article/springfield-leader-and-press-chinese-wer/104148351/

1947 acupuncture practice in Japanese internment camps in US.
https://www.jstor.org/stable/community.31046561

1970's article about acupuncture style delivered to president Kennedy. Shows Janet Travell's interest in Chinese medicine.
https://www.newspapers.com/article/morning-pioneer-dry-needling-is-acupunct/112991940/

1970's Eric Tao arrested for practicing medicine
https://www.starnewsonline.com/story/news/2007/09/16/eric-tao-colo-acupuncturist-dies-at-81/30321958007/

1972 Minnesota Medicine states acupuncture practice of medicine
https://www.newspapers.com/article/star-tribune-acupuncture-the-practice-of/54322227/

1972 Dr Bonica interview on MPR on acupuncture
https://archive.mpr.org/stories/1972/10/06/dr-john-bonica-discusses-use-acupuncture

New York shuts down acupuncture clinic
https://books.google.com/books/about/Pittsburgh_Post_Gazette.html?id=N-ANAAAAIBAJ

FDA details acupuncture needles
https://books.google.com/books/about/Report_of_the_Federal_Security_Agency_Fo.html?id=eixzUIdByJYC

Acupuncture needle patent 1973
https://patents.google.com/patent/US3856019A/en

1973 NIH conference on acupuncture page 33 shows trigger point needling is acupuncture.
https://www.google.com/books/edition/Proceedings_NIH_Acupuncture_Research_Con/JJpp7ciKjaoC?hl=en

1973 AMA against weekend courses on acupuncture
https://www.newspapers.com/article/the-memphis-press-scimitar/106471187/
Dr. Walter Judd calls on all licensing boards to stop acupuncture practice. "Dr. Judd said his council has received a number of complaints about physicians receiving "quickie" three-or four day "training"sessions and then opening clinics that treat dozens of patients daily."
"No doctor should offer acupuncture unless he has been thoroughly trained and knows what he's doing."
"I don't know how much training a doctor needs, but three or four days isn't it" Dr. Judd said."

1975 Anatomical comparison between acupuncture and nerve block study.

> Matsumoto T, Lyu BS. Anatomical comparison between acupuncture and nerve block. Am Surg. 1975 Jan;41(1):11-6. PMID: 803045.
> "Although there are numerous acupuncture points, it is our purpose to point out the similarity in the location of some of these and the location of anatomic sites commonly used for local and regional anesthesia. We believe that acupuncture can be used in conjunction with local anesthesia, nerve-block, or alone, in the control of pain arising from pathologic states."

Minnesota Attorney General opinion on acupuncture
https://drive.google.com/file/d/1jkT67DCasYUSct0cZRTAWGVHXSnHr1Qm/view?usp=drivesdk

1979 Acupuncture black market of needles due to FDA blocking the importation of needles
https://www.newspapers.com/article/the-san-francisco-examiner-acupuncture/121501324/

1980 state of acupuncture in Minnesota. Interview with Edith Davis founder of one of the schools of acupuncture in Minnesota. MPR.
https://archive.mpr.org/stories/1980/12/01/acupuncture

1980 MPR interview the discussion on acupuncture, cupping and guasha or coining. Sometimes there was accusations of child abuse in immigrants use.
https://archive.mpr.org/stories/1980/12/23/southeast-asian-immigrant-folk-medicine

https://pubmed.ncbi.nlm.nih.gov/8988581/
Skin scraping, cupping, and moxibustion that may mimic physical abuse

K M Look et al. J Forensic Sci. 1997 Jan

https://jamanetwork.com/journals/jamapediatrics/article-abstract/512346

September 1985
The Mistaken Diagnosis of Child Abuse A Form of Medical Abuse?
Robert H. Kirschner, MD; Robert J. Stein, MD
Author Affiliations
Am J Dis Child. 1985;139(9):873-875. doi:10.1001/archpedi.1985.02140110027022

1980 "Medicare coverage statement: Acupuncture is the selection and manipulation of specific acupuncture points through the insertion of needles or "needling," or other "non-needling" techniques focused on these points. The NCD for Acupuncture (30.3), issued in May 1980, states that Medicare reimbursement for acupuncture, as an anesthetic or as an analgesic, or for other therapeutic purposes, may not be made. Accordingly, acupuncture was not considered reasonable and necessary within the meaning of section 1862(a)(1) of the Social Security Act (the Act)."

1981 Dr Kai Hunt practice acupuncture in Alexandria
https://collection.mndigital.org/catalog/dcs:291#?c=&m=&s=&cv=

Hunt, Dr. Kai. *Interview with Dr. Kai Hunt, Douglas County, Minnesota*. 1981-02-25. Douglas County Historical Society, collection.mndigital.org/catalog/dcs:291 Accessed 29 Aug. 2023.

1985
The Maintenance of Professional Authority: Acupuncture and the American Physician

This paper examines the response of the medical profession to a situation in which its cultural authority was potentially challenged: the sudden, large-scale importation of acupuncture into the United States in the early 1970s. I describe how the medical profession coped with a therapeutic modality that could not be explained by the biomedical model. Various tactics were used to limit the practice of acupuncture to physicians, thereby mitigating the threat of the growing popularity of lay practitioners. Once it was securely under the control of the medical profession, the practice of acupuncture was severely restricted, and an effective but enigmatic modality was removed from the medical regimen.

https://www.jstor.org/stable/800772

1993 FDA review of acupuncture practice.
You will find historical references
You will see reference to acupuncture needles being used for seconds and minutes. This was written without much feedback from the acupuncture community.
https://downloads.regulations.gov/FDA-1993-P-0434-0014/content.pdf

1993 All the documents to request that acupuncture to no longer be investigational to FDA by William Nelson
https://www.regulations.gov/docket/FDA-1993-P-0434/document

1996 FDA reclassifies acupuncture needle

https://www.washingtonpost.com/archive/politics/1996/03/30/fda-removes-bar-to-coverage-of-acupuncture-by-insurance/5cbfaed1-074b-4ffd-9fc3-91bdd8f93e17/

> “Until now, however, acupuncture needles have been classified as Class III medical devices, meaning their safety and usefulness was so uncertain that they could only be used in approved research projects. Because of that "experimental" status, many insurance companies -- as well as Medicare and Medicaid -- have refused to cover acupuncture.
>
> Although FDA officials are aware that most acupuncture treatments in this country are not part of any formal experimental protocol, they have for years turned a blind eye to such infractions. But in December 1994, a team of lawyers and acupuncturists formally asked the FDA to approve the needles for the treatment of five conditions: pain, nausea and vomiting, substance abuse, asthma and other respiratory conditions, and stroke and paralysis.
>
> Scores of scientific studies were submitted with the application to bolster claims that acupuncture was a safe and effective treatment for those ailments.
>
> "We reviewed their petition and said there is some suggestion that acupuncture works for these specific claims but it doesn't reach the level of proof we generally require," said Bruce Burlington, director of the FDA's center for devices and radiological health. "But we did conclude that a substantial number of states regulate acupuncture as a healing art, and within the context of acupuncture as a healing art we can ask, do these needles break, do they cause infections, and do they work as a tool for the art of acupuncture?"
>
> In the end, Burlington said, the agency decided that acupuncturists themselves -- not the needles they use -- should be the main focus of regulatory efforts. "We don't ask, Does gall bladder surgery work?' " he said. "We ask, Can a knife make an incision?' So it didn't require us to establish that acupuncture works, but that needles work in acupuncture."

2007 American Society of Anesthesiologists says the Chinese were first use of anesthesia was a heart transplant. Obviously in order to do a heart transplant you need to know how it works.
https://www.woodlibrarymuseum.org/wp-content/uploads/newsletters/NL_2007.PDF

2012 Prior to this journal articles in NIH and Medline were limited to those they allowed as science. After this date more articles were made available for research. Many languages for research were never translated to be included in research. Currently English is the predominant language for research which excludes all other languages. Many research articles do not offer linguistically inclusive policies.

Academic publishing requires linguistically inclusive policies
https://royalsocietypublishing.org/doi/10.1098/rspb.2023.2840

This is important because part of the strategy to rebrand acupuncture was to use research articles that excludes people and cultures that use acupuncture that were never translated or included prior to 2012.

https://www.nih.gov/sites/default/files/about-nih/nih-director/testimonies/nih-policies-procedures-promoting-scientific-integrity-2012.pdf

Scientific integrity does not involve plagiarizing someone's work or culture's tools claiming a new use when there isn't.

The continued misinforming of the public is wrong.

Please say something about the rebranding of acupuncture and many of the non needling techniques.

Community Health Worker Training Program

ADVANCING THE COMMUNITY HEALTH WORKER WORKFORCE IN MINNESOTA

Community Health Worker Training Program grant overview

In September 2022, the Minnesota Department of Health (MDH) received a three-year grant from the Health Resources and Services Administration to strengthen and diversify the community health worker (CHW) workforce. The grant aims to increase access to care and prevention services, strengthen the public health workforce, and achieve health equity in underserved populations.

The Community Health Worker Training Program grant provides scholarships for students pursuing a CHW certificate at an accredited institution and stipends for CHWs participating in registered apprenticeship programs. The grant will increase training opportunities for new and existing CHWs and make training curriculum and materials available in multiple languages.

Who are community health workers?

Per the American Public Health Association, a CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community 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.

A CHW also builds 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.

Why community health workers?

- CHWs are effective in improving conditions to support health, reducing health disparities, and preventing chronic health conditions, injury, violence, and substance use disorders.
- CHWs increase access to preventive health care and social services, reduce avoidable health care expenses, help service providers provide quality and culturally appropriate care, and address the social conditions that impact health.
- A sustainable, diverse, evidence-based CHW workforce model will facilitate improved health outcomes and health equity for communities that experience disproportionately poorer health outcomes.

Community Health Worker Training Program initiatives

MDH partners with the Minnesota Community Health Worker Alliance, academic institutions, and employers to:

CHW Certificate program scholarships

- Recruit individuals from underserved communities to complete CHW Certificate program
- Provide scholarships to trainees to complete the CHW Certificate program and to address barriers (transportation, childcare, Wi-Fi, supplies) - up to $3,750 for 90 students per year

Apprenticeships and field experiences

Increase employment opportunities and improve on-the-job training for CHWs through:

- Partnerships with organizations to develop employer paid registered apprenticeships
- Stipends to apprentices: $7,500 for 35 apprentices per year
- Increase partnerships with organizations to host CHW field experiences or internships

Training and materials for CHWs

- Advance knowledge of new and existing CHWs through free trainings and a training directory
- Make CHW curriculum and materials available in multiple languages

How to get started

Certificate program and scholarships

1. Trainee applies to CHW Certificate program school of their choice. Visit the Minnesota Community Health Worker Alliance Education webpage (https://mnchwalliance.org/education/) for more information.
2. Trainee completes scholarship application on Minnesota Community Health Worker Alliance website at https://mnchwalliance.org/chw-certificate-scholarship/.
3. Scholarship recipients participate in meetings and provide data as requested.

Apprenticeships

1. Employer registers for apprenticeship through Minnesota Department of Labor and Industry (DLI).
2. Apprentice applies for apprenticeship through employer.
3. Employer hires apprentice and provides training and data as requested by DLI and the Training Program.
4. Apprentice applies for stipend through Minnesota Community Health Worker Alliance, participates in meetings and provides data as requested for the CHWTP.

Contact us

MDH HRSA CHWTP Grant: Kristen Godfrey Walters | Kristen.Godfrey.Walters@state.mn.us

Minnesota Community Health Worker Alliance: Rachel Stoll | rachel@mnchwalliance.org

Community Health Worker

Follow Your Heart to a Caring Career

Find your fit in health care employment that makes a real difference in the lives of others

Community Health Workers (CHWs) are trusted, knowledgeable frontline health personnel who typically come from the communities they serve and have a shared life experience. CHWs serve as a liaison between health/social services and the community to facilitate access to services and improve health outcomes and the quality and cultural sensitivity of service delivery. CHWs empower individuals and communities for better health through a range of activities such as system navigation, education, connection to resources, informal counseling, social support and advocacy.

This position might be right for you if you enjoy working with individuals to increase health knowledge, self-sufficiency, and access to care and resources.

JOB OUTLOOK

CHWs are an emerging workforce, newer to most "mainstream" public health and health care settings–but with deep roots in many communities. Nationally, employment of community health workers is projected to grow 14 percent from 2022 to 2032, much faster than the average for all occupations.

OTHER JOB TITLES FOR POSITIONS THAT DO SIMILAR WORK:

Community Health Representative (American Indian communities), Promotora de Salud (Latine communities), Outreach Worker, Care Guide, Community Health Advisor, Healthcare/Patient Navigator, peer educator, health educator, insurance navigator, program coordinator, and more.

EDUCATION

A high school diploma or GED is typically required for someone working as a CHW. Experience living in and/or sharing the culture and language of the community served is often a preferred job qualification. Employers also provide on-the-job training and Registered Apprenticeship Opportunities. Some employers may require completion of the 16 credit, academic CHW Certificate program offered by accredited post-secondary colleges and universities in Minnesota. Look at the job description and ask the employer about what is needed during your job interview.

Tuition assistance may be available through an academic institution or through the MN CHW Training Program grant: CHW Certificate Scholarship (mnchwalliance.org).

LICENSING INFORMATION

No health care-related licensing is required. Some positions may require a driver's license. Ask your employer about what is needed during your job interview.

CERTIFICATION INFORMATION

No health care-related certification is required. Some organizations may require that you complete the academic CHW Certificate Program and register your certificate with MN DHS. Ask the employer about what is needed during your job interview.

BACKGROUND STUDY

People who want to work as a CHW in certain settings such as health care must complete and pass a comprehensive criminal background check as required by state law.

LANGUAGE SKILLS

People who are bilingual in English and languages other than English are encouraged in this occupation. Some employers may require that you take a language skills test. Ask the employer during your job interview about what is needed and how your language skills can be used to help others.

COMMUNITY HEALTH WORKER

CAREER GROWTH

There are opportunities for career growth after a person gains experience as a CHW. Sometimes employers pay for training for workers to become certified in higher levels of health care such as Social Work or Nursing and earn more money. Ask the employer during your job interview about opportunities for career growth. Some CHWs may also obtain other credentials such as a Certified Nursing Assistant, Medical Assistant, Doula, and others.

WAGES

Hourly rates may vary based on education, experience, geographic area, and job duties. The mean CHW hourly wage in MN is approximately $22.70/ hour based on 2023 data from the US Bureau of Labor Statistics. The hourly pay can range from $15- $35 per hour.

DAILY WORK ACTIVITIES

CHWs work in a variety of sectors including health care, public health, communities, schools, and more. In healthcare, CHWs work in hospitals and clinics, home visiting, and public health and community organizations. Daily work activities in different settings may vary and include:

- Meet with individuals and families in the home, health care setting or community to provide culturally and linguistically appropriate health information, resources, and system navigation.
- Serve as an advocate and liaison between the client and the medical team (e.g. doctors, nurses, and social workers) to understand and meet health and social needs.
- Assist clients in and teach skills to access health, dental and social services by assisting to schedule appointments, medical transportation, and interpreter services.
- In some settings, CHWs may assist with clinic rooming and front desk processes or conduct health related screenings (e.g. height, weight, blood pressure, diabetes risk test, etc.).
- Work with clients to understand and breakdown barriers to taking medications as prescribed, assist with access to prescriptions (e.g. refills, financial support programs).
- Work with clients to set health goals, develop and follow-up on care plans.
- Screen clients for health and social needs (e.g. housing, food, financial, employment, school, etc.) and link them to social and community resources.
- Provide basic needs (e.g. direct provision of food, household supplies, delivery of medications, etc.).
- Assist clients with completing paperwork and applications for programs such as health insurance and public assistance.
- Assist clients with reading mail, billing questions, and arranging payment plans.
- Teach people how to use technology and phones for accessing virtual care and services.
- Assist with care transitions and facilitate continuity of care by providing follow-up between health care visits, which may include home visits.
- Articulate and advocate needs of community and individuals to others and teach client self-advocacy skills.
- Promote wellness by providing culturally appropriate health information to clients and providers.
- Deliver health promotion and chronic disease management education (1:1 and group activities)
- Assist clients in self-management of chronic illnesses, including medication adherence, healthy eating, physical activity, and other health promotion activities.
- Provide dental education and support services (e.g. fluoride varnish)
- Organize and/or facilitate support groups.
- Provide coaching and social support, such as nutrition training, recovery services for mental health and substance use disorders, and chronic disease management and prevention.

HOW TO FIND WORK AS A COMMUNITY HEALTH WORKER

- Talk to someone at a CareerForce location near you:
  - Visit CareerForceMN.com/locations
  - Call 651-259-7500
- Go to the MN CHW Alliance website: Home (mnchwalliance.org)

CareerForceMN.com/CaringCareer

651-259-7500 – language interpretation services available

CareerForce™

Minnesota's Career Resource

Minnesota Community Health Worker Alliance

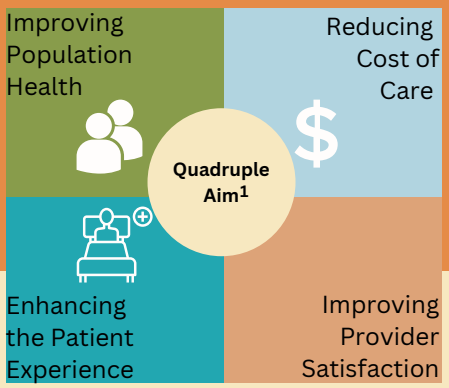
What is a Community Health Worker (CHW)?

Community health workers (CHWs) are a health equity workforce. CHWs come from the communities they serve, sharing identities, geography, and experiences. This commonality uniquely qualifies CHWs to relate with and provide support to people in their community. By addressing barriers to care that occur within different language, cultural, and socioeconomic identities, CHWs improve health outcomes and advancing health equity.

CREDENTIALS:

- Competency-based certificate with field experience
- Knowledge of community, culture, and systems

HEALTH EQUITY WORKFORCE



CHWs are trusted, knowledgeable frontline health personnel who come from the communities they serve who:

- Bridge cultural and linguistic barriers
- Address social drivers of health (SDOH)
- Expand access and quality of coverage and care
- Increase cultural competence and affordability
- Improve health outcomes and health equity

PROVEN COST SAVINGS:

CHW strategies save money while improving care which helps individuals return to health, their family, community, and jobs. CHWs:

- help clients access care and increase use of primary and preventive care [2,3]
- generate net cost savings through decreased use of urgent care, emergency care, hospitalizations, hospital readmissions, inpatient, and outpatient behavioral health care[4]
- have a return on investment of $3 for every $1 invested [5]

IMPROVED HEALTH:

CHWs provide culturally competent care increasing trust in the healthcare system. Improved health outcomes saves the healthcare system money. Improved outcomes include but not limited to:

- asthma [6,7]
- diabetes [8]
- cardiovascular disease[8]
- COVID-19 prevention and mitigation[9]
- increased cancer screenings [10]

Mission Statement: Build community and systems capacity for better health through the integration of CHW
Vision Statement: Equitable and optimal health outcomes for all communities.

https://mnchwalliance.org

REFERENCES:

1. Strategies for Quality Care website. https://www.strategiesforqualitycare.com/quadruple-aim. Accessed November 22, 2022.
2. Attipoe-Dorcoo, S., et al., *Engaging Community Health Workers to Increase Cancer Screening: A Community Guide Systematic Economic Review.* American Journal of Preventive Medicine, 2021. 60(4): p. e189-e197.
3. Kangovi, S., et al., *Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment*. Health Affairs, 2020. 39(2): p. 207-213.
4. Rodriguez, N.M., et al., *Indiana community health workers: challenges and opportunities for workforce development*. BMC Health Services Research, 2022. 22(1): p. 117.
5. Rush, C.H., *Return on investment from employment of community health workers*. J Ambul Care Manage, 2012. 35(2): p. 133-7.
6. Coutinho, M.T., et al., *Community Health Workers' Role in Supporting Pediatric Asthma Management: A Review*. Clin Pract Pediatr Psychol, 2020. 8(2): p. 195-210.
7. Shreeve, K., et al., *Community Health Workers in Home Visits and Asthma Outcomes. Pediatrics*, 2021. 147(4).
8. Jacob, V., et al., *Economics of Community Health Workers for Chronic Disease: Findings From Community Guide Systematic Reviews.* American Journal of Preventive Medicine, 2019. 56(3): p. e95-e106.
9. Grier-McEachin, J., *Sidebar: Community Health Worker Prevention Services: COVID-19 and Beyond*. North Carolina Medical Journal, 2021. 82(5): p. 353-355.
10. The Community Guide website. https://www.thecommunityguide.org/pages/tffrs-cancer-screening-interventions-engaging-community-health-workers-cervical-cancer.html. Accessed November 22, 2022.