Experiences of Community Health Worker Employers in Minnesota

A review of CHW utilization, lessons learned, and future outlook from select organizations employing CHWs in Minnesota

N O V E M B E R   2 0 1 5

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Introduction

Community Health Workers (CHWs) are important health professionals who provide a broad range of health-related services reaching underserved populations in their respective communities. The work of CHWs can reduce health disparities and ensure culturally appropriate care. In order to support continued efforts to promote the value of CHWs in the community, the Minnesota Department of Health contracted with the Minnesota Community Health Worker Alliance and Wilder Research to identify experiences of organizations that employ CHW certificate holders. These organizations shared a wide range of experiences related to their utilization of CHWs including: history of implementing CHWs, CHW roles within the organization, populations served, funding of CHW work, challenges and benefits of CHWs, and outcomes of CHWs.

Methodology

Wilder Research staff conducted 11 key informant interviews with organizations that employ certified CHWs, using 10 open-ended questions. The Minnesota Community Health Worker Alliance and the Minnesota Department of Health provided a list of potential respondents. Organizations interviewed in Greater Minnesota included: Essentia Health, CentraCare, and Mayo Clinic. Organizations interviewed in the Twin Cities metro area included: Hennepin County Medical Center (HCMC), HealthEast Care System, Minnesota Visiting Nurses Association (MVNA), South Side Community Health Services, St. Paul-Ramsey Health Department, Health Empowerment Resource (HER) Center, NorthPoint Health and Wellness, and Neighborhood HealthSource.

Limitations

These interviews were conducted with CHW supervisors from select CHW employers from across the state. These key informant responses are not intended to represent the opinions and perspectives of the entire organization or every CHW employer in the state. Instead, these responses are intended to dive deeper into the experiences of CHW supervisors and employers. This information can then be used to plan for continued expansion of the CHW workforce.

Executive summary

In Minnesota CHWs work in a variety of settings: in the community and in clinical settings, in the Twin Cities metro area and in Greater Minnesota, and within smaller organizations and large health systems. The type of work CHWs do remains consistent, even though it is carried out in different ways. CHWs are most commonly responsible for building rapport with clients, connecting clients to resources to address social determinants of health, providing follow-up support, providing education, and building relationships with other providers.

Benefits of CHW services are found at the patient, staff, and organizational level. The main benefits identified include:

- Services are more culturally appropriate as CHWs are more often culturally representative of those they serve.

- Comprehensive, patient-centered care leads to better patient experience and outcomes for both medical and non-medical needs.

- Staff can work more efficiently, focusing on the tasks they are trained for.

- Better relationships are establish between the organizations that employ CHWs and the communities they serve.

- Organizations have greater capacity to be more connected to other health and social service providers in their communities.

Challenges CHW employers identified related to:

- Limited financing mechanisms and financing sustainability for CHW services.

- Finding and hiring CHWs with adequate education and experience.

- Defining the role of CHWs and effectively integrating them into the care team.

- Demonstrating outcomes of CHW services, especially when there are considerable non-medical needs or the patient has complex needs.

Funding is a challenge for most organizations, so it is also an area CHW supervisors are looking to diversify.

■ Most organizations currently rely on funding sources that can be difficult to maintain in the long term, including grants (private or government) and internal organizational funds.

■ Few organizations currently bill for CHW services, but most organizations hope to do so in the future.

■ Low reimbursement rates are a concern for many CHW employers.

■ A shift toward value-based care, rather than fee-for-service, is a system-wide goal.

There are a number of key lessons learned that should be considered by organizations looking to integrate CHWs into care teams for the first time including:

■ Clearly identify community and organizational needs, then define the role of CHWs to determine how they will meet those needs and fit into existing care teams.

■ Seek support and knowledge from other organizations that have previously begun using CHW services and ensure your organization has a CHW champion to support CHWs and their work.

Overall CHW supervisors are very invested in the work their CHWs provide and they believe the use of CHWs both within their organizations and across health systems will continue to increase in the future.

Background

What is a Community Health Worker?

The term Community Health Worker (CHW) can describe a very diverse group of individuals who provide health and outreach services to their communities, and may or may not have formal CHW education. The American Public Health Association defines CHWs as follows:

> *A community health worker 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.*

Community Health Workers in Minnesota

In 2000, the Health Resources and Services Administration (HRSA) estimated that the number of paid Community Health Workers (CHWs) in Minnesota was between 1,200 and 1,500, with an average estimate of 1,400. HRSA also estimated another 500 CHWs worked in Minnesota as unpaid volunteers (Health Resources and Services Administration, 2007). The Bureau of Labor Statistics most recently estimated the number of CHWs in Minnesota to be approximately 710, which was an increase from their estimate of 640 in 2012 (Bureau of Labor Statistics, 2014).[1] While we cannot definitely identify why the two estimates are so disparate, it is likely a result of varying definitions of what roles are included under the CHW umbrella term.

Based upon previous estimates of the number of CHWs in the state of Minnesota and the proportion of certificate program enrollees versus completers (1,361:454), Wilder Research estimates that there are approximately 1,100 to 1,200 CHWs in Minnesota, with approximately 430 to 470 CHWs having completed a CHW certificate program. We believe these are conservative estimates (Wilder Research, 2015).

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[1]   The Bureau of Labor Statistics began reporting on Community Health Workers separately from other Community and Social Service Specialists in 2012.

Results of key informant interviews

Characteristics of CHW supervisors, employers, and clients served

The 11 CHW supervisors interviewed varied in their personal experiences and history with CHWs, as did the organizations they work for. All respondents were part of organizations with significant CHW employment experience. While respondents were in CHW supervisory roles, their positions included titles related to public health nursing, clinical outcomes, outreach, Health Care Homes, care coordination, community engagement, and quality. All respondents reported having similar responsibilities including hiring and training CHWs, general management of CHWs, and coordinating and planning of programs. Additionally, two respondents indicated they provide medical services to patients in addition to their supervisory responsibilities. Supervisors' years of experience at the organizations they are currently employed ranged from less than one year to more than 25 years.

- Three worked at their current organization two years or less.

- Four worked at their current organization three to five years.

- Four worked at their current organization six or more years.

The respondents' organizations ranged geographically and organizationally.

- **Twin Cities metro vs. Greater Minnesota**: Seventy-three percent of respondents were employed by organization in the metro, while 27% were in Greater Minnesota.

- **Types of organizations**: Five respondents were from Integrated Health Systems, three from Community Health Centers, one from county public health, one from a community-based clinic, and one from a home visiting and home care organization.

- **Single clinic/site vs. System of clinics/sites:** Forty-five percent of respondents were employed by an organization that had multiple sites, while 55% were at an organization that was a singular location.

- **CHWs employed:** The number of CHWs employed at each organization ranged from as few as one CHW to as many as 26. The median number of CHWs employed by the organizations is five.

All respondents indicated all or nearly all the clients they serve are on Medicare, Medicaid, or are uninsured and are low-income. Most organizations primarily serve clients who are

African American, Spanish-speaking, Karen, or Hmong. Organizations that serve rural areas with less racial and ethnic diversity indicated they serve those in their communities with the highest needs and fewest resources.

How CHWs are utilized by employers

The way in which these organizations utilize CHWs is as diverse as the definition of CHW itself. CHWs are most likely to work in the community, in a medical setting (clinic), or they may split their time between the two. The organizations represented in these interviews utilized their CHWs in a variety of settings as described in Figure 1. Those organizations that split their CHW work between the community and clinic typically had specific CHWs assigned to each area.

1. Where the majority of CHW work occurs

	Number of CHW employers
In the community	4
In the medical setting (clinic)	3
Split between the community and clinic	4

Although CHWs work in a variety of locations, their responsibilities are generally the same regardless of where they work.

- **Building rapport with clients**: Because CHWs are typically from the same cultural communities as the people they serve, respondents believe they are better able to develop relationships, build trust, and bridge the gap between patients and the health system.

- **Connecting clients to resources to address social determinants of health**: All respondents felt CHWs are key to addressing the social determinants of health that often hinder health improvements that can be realized with medical care. CHWs regularly connect clients with transportation, food shelves, employment, housing, health insurance, and social service needs.

CHWs bring an amazing glue to the care team between the patient and clinical professionals. CHWs break down barriers other team members don't have time to address, like insurance, like understanding how to make appointments, coordinating transportation, and checking in to see how you're doing on the goals you've wanted to achieve in your life.

- **Providing follow-up support**: Regardless of whether CHWs initially connect with people in a health care facility or in the community, all respondents indicated CHWs

follow-up with clients in person and/or over the phone to ensure continuity of care and service.

- **Educating**: In the community, CHWs provide education by providing educational materials and giving presentations via health fairs, street outreach, and social media. In the health care setting CHWs often meet with patients to provide education immediately after clinical staff. In this way, CHWs are able to spend additional time with patients.

- **Building relationships with other providers**: Because a large part of a CHW's role is to educate about and connect clients to the resources they need to improve their health, CHWs are also expected to develop relationships with medical and non-medical service providers.

Whether in the clinic or community, all respondents indicated that their CHWs provide services related to the following health areas: diabetes, cardiovascular health, general health and well-being, tobacco use, weight management and nutrition, women's health, and self-management of chronic conditions.

The biggest variation in CHW responsibilities is related to the type of health care services they provide. While some organizations had deployed CHWs in the community providing educational and community outreach services, some organizations also utilized CHWs in clinics to provide basic medical services (e.g. taking blood pressure, drawing blood) as part of the medical care team.

Implementation and financing of CHWs

Respondent organizations had been employing CHWs for as few as one year to as many as nine years, with an average of four years.[2] Each organization initially started using CHWs because they identified people in their community with needs that were not being met with a traditional approach to health care. All clinical respondents felt they needed to address these non-medical needs to improve the overall health outcomes of their patients. Organizations wanted to have CHWs that were representative of the diverse communities they were serving.

Looking beyond the goal of better addressing the health of those in their community, respondents reported a number of ways in which their organization began to actually use or move towards the use of CHWs, including:

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[2]   Two respondents were unable to provide information on how long their organization had been employing CHWs.

- Internal or external advocacy by a CHW champion, such as a physician leader, a Chief Operations Officer, and a partner organization (five respondents).

- Being part of a focused initiative (five respondents).

- Years of non-CHWs doing similar work, which then gradually transitioned into those roles being CHWs (two respondents).

- Having an organization founded on the use of CHWs (one respondent).

- Street outreach providing informal health education (one respondent).

Current funding

Key in the implementation of CHWs is an organization's ability to fund the work that they are doing. As an emerging profession, there is not yet a standard way in which the work of CHWs is supported financially: key informants interviewed mentioned a variety of approaches.

Respondents' CHW positions have been, or are currently, funded in the following ways:

- **Private grants for specific initiatives (seven respondents)**: The most commonly mentioned grants included those from United Way, Blue Cross and Blue Shield of Minnesota Foundation, and Medtronic. Other grants mentioned were provided by MNSure, Volunteers of America (VOA), and Susan G. Komen.

- **Bill for services (four respondents)**: Of those organizations billing for services, three indicated they are billing for care coordination as part of Health Care Homes and two had billing contracts with larger insurers.

- **Operations budget or other internal funding (three respondents)**

- **Federal or state government grants (two respondents)**

- **Other (three respondents):** Other ways CHWs work is supported is through tax levies (government CHW employers), Prepaid Medical Assistance Program managed care plans, and event sponsorship.

Future funding

A number of ideas were presented as to how organizations would like to change the funding of their CHW services in the future, both in the short and long term.

- **Bill for services**: Four respondents wanted to either start billing for services or wanted to bill for more services in the future.

- **Grants**: One respondent wanted to begin pursuing grants as a way to supplement the amount they are currently reimbursed for services.

- **Utilize cost-savings in value-based care:** Three respondents discussed how they would like to operate in a value-based care setting, rather than fee-for-service, so they could fund CHW services with the savings from their work.

While most respondents were either currently billing for services or were hoping to bill for services, several respondents acknowledged that as organizations it was perceived that the cost of setting up the ability to bill for services was not worth the amount of money they would be reimbursed. Another respondent indicated her organization was not planning to bill, because they felt it would constrain their ability to provide services based on need rather than service type. Conversely, several respondents indicated that although grant funding allowed them to implement CHW services, the topic-specific nature of the grants (e.g. diabetes-focused, obesity-focused) still put constraints on the comprehensive work they wanted and needed to do.

Benefits of CHWs and their work

CHW supervisors reported many benefits to the work CHWs do not only when it comes to patient experience and health outcomes, but also at the organizational level. Overall, the benefits of CHW work and drivers behind the integration of CHWs in care teams are related to CHW's ability to address social determinants of health and "bridging the gap" between clinical providers and the people that they serve.

Culturally appropriate services

All interview respondents reported that the biggest benefit of using CHWs was their ability to build meaningful, trusting relationships with their patients. CHWs are able to communicate with patients in a way that reduces misunderstandings due to cultural differences, and also can convey complex health information in a way that can be understood by all. This impacts both the patients' understanding of their participation in their care, but it also ensures other staff are relaying information in a clear way. In total, this helps to improve health equity for all.

> *We had a Karen patient and her blood sugars were all over the place, but she kept saying, "I'm taking my meds, only eating a piece of bread, I'm watching my carbs." An English-speaking Caucasian RN and doctor kept beating their heads against the wall trying to figure out why in the world this patient, who seems very responsible and compliant, had these outcomes, these labs that keep going up and down. Then the care guide [who had come through a refugee camp] turned to the patient and said, "do you put the white dipping sauce on your bread?" And [the patient] said "of course,"that's how you eat bread here." In refugee camps [people are] given sweetened condensed milk with bread because it's packed full of calories and puts meat on your bones. That completely changed why one piece of bread fluxed her blood sugar so much because sweetened condensed milk is packed with sugar. They talked to her about that and limiting it over time and she has had great blood sugar control since then. – CHW Supervisor*

Comprehensive, patient-centered care

As discussed by many respondents, the individuals served by CHWs often have some of the greatest needs, while also having the fewest resources. These individuals typically need medical services, in addition to assistance and services from several other providers. Other benefits of CHWs is that they have time with patients to explain diagnoses and self-care, do in-home follow-up, advocate for the patient with clinical staff, and connect them to a variety of non-medical resources that address unmet needs related to housing, transportation, food, insurance, and prescriptions. In total, the work by CHWs ensures patients more comprehensive and continuous care than they would have received without services from a CHW. This is yet another way CHWs connect patients with the care they need.

Also by having a better understanding of their medical and non-medical needs and the resources available to address them, individuals that work with CHWs are empowered to manage their own care and have more knowledge about accessing and navigating the health care system.

> *I had an individual who had a couple of chronic big conditions, was just so non-compliant, and was homeless. She was living in a tool shed in December in [northern Minnesota]. Even though she needed an appointment, the last thing I wanted to talk about was an appointment. Instead we talked about housing, food, and trust. Then after that, because she had pretty significant mental illness we got her on some medications to manage anxiety, and spread out appointments so it wasn't like all these things at once. I was also able to work with her insurance to get her transportation. - CHW*

Using staff more efficiently

Beyond the benefits to the patients, the use of CHWs within organizations and on care teams benefits clinical staff in terms of improving workload and boosting morale. While most clinical staff see the importance of spending an extended amount of time with

patients or discussing with them how to address non-medical issues, these staff are not best suited to this work. By utilizing CHWs, the workload is reduced for clinical staff, most often nurses, and clinical staff are "working to the top of the licensure" which means the organization overall is getting the highest productivity out of their workforce.

Secondly, overall staff morale is reported as being improved when CHWs are on care teams because they have the capacity to address the underlying causes or influencers of health issues that may prevent medical intervention from yielding positive changes. Also by connecting with patients on a more personal, one-on-one level, CHWs can encourage patients to make behavioral changes that clinical staff cannot.

> *CHWs enable staff to work to the top of their licensure or certification. At our organization, CHWs haven't had set schedules or requirements to meet with patients on a 15 minute or set schedule like other providers. They're able to spend more time with patients on all the details that can sometimes fall through the cracks.*
>
> *Nurses are trained to do skilled nursing, but they find the navigating social services overwhelming and exhausting– this burden can be lifted because of CHWs. Fear of not being able to do it all, and having another person on the team helps us to cover it all.*
>
> *A [clinical] provider had been talking with a 50 year-old patient weighing about 350 lbs. for years about losing weight, but she had never really been engaged or willing to make changes. The provider was growing in frustration, so he asked her to work with a care guide. The care guide had a history of struggles and challenges with weight loss herself, so they talked about that and the fear of failing on that journey. The care guide worked with her for a month and at the end of that month, the patient decided to go through a bariatrics program and start a really good weight loss regimen. The cardiologist and endocrinologist were thrilled because that was one of their recommendations as well.*
>
> *-CHW Supervisors*

Connect the organization to the community

Several respondents who supervise CHWs working in the community felt CHWs are able to make the organization part of the community, rather than being external to the community. During outreach in the community, CHWs are the face of the organization and make the organization and its services more well-known and accessible.

Another benefit is that CHWs build relationships with other service providers in the community where they are located. CHWs need to be well-informed about all resources patients may need to utilize. It is also helpful for them to have relationships with providers in the community, because there are then more opportunities to share knowledge and collaborate, and more potential to share resources.

Outcomes of CHW work

For those CHW employers reporting they collect information on the outcomes of CHW work (six respondents), the most common measures discussed related to:

- Emergency room utilization rates
- Hospital readmission rates
- Appointment 'no show' rates
- A1C levels
- Blood pressure
- Body mass index and weight
- Cost savings

Additionally, all respondents indicated they collect 'process' information related to the delivery of their CHW services. Examples included the number of people CHWs served or contacted, number of presentations given, number of materials distributed, and counts of various screenings provided including body mass index, blood pressure, blood glucose, cholesterol, and sexual health.

Several respondents indicated that they also collect more anecdotal information about the outcomes of CHW work. They felt anecdotal information is better able to capture the complex nature of CHW work and the non-medical outcomes that are currently more challenging to collect.

All respondents were willing to share the data (outcome and process) they collect on CHW work, although most did not have data readily available and at least one would be unable to share this information due to organizational policies. One respondent did have outcome data available, but because their CHWs are employed as part of a larger initiative, the outcomes cannot be directly attributed to CHWs.

Opportunities for improvement

Across the board, CHW supervisors interviewed felt CHWs were very important to the work their organizations do. Nevertheless, there are several areas of potential improvement that could be made to make the use of CHWs easier and more sustainable.

Financing

The biggest challenge to employing CHWs identified by 9 of 11 CHW supervisors is the current way in which CHW work is funded.

There is an overall lack of diversity in funding streams that can support the work of CHWs. While grant funding is most common, respondents reported feeling that the work of their CHWs was too directed by the objectives and focus areas of the grants, rather than the true needs of their communities. Also because grants are time-limited and some are short-term (two years or less), there was additional stress related to the continuous cycle of identifying and securing new grants. Grants were viewed as a funding source that is very hard to sustain.

While many saw billing for CHW services as the future of their funding, respondents also acknowledged that billing for CHW services is inflexible and that reimbursement rates for CHW services were too low. Several CHW supervisors reported that low reimbursement rates were preventing them from implementing the mechanisms needed to bill for CHW services.

Several respondents perceived lack of funding as their only barrier to hiring more CHWs, even though a need for them was identified.

Adequate education and hiring

Another area with an opportunity for improvement is the hiring of qualified CHWs, which was identified as a challenge by five respondents.

CHWs come out of certificate programs with knowledge of working with the community, but extensive training had to be provided to CHWs once hired to increase their knowledge of working on a clinical team and within a clinical setting.

Organizations also experienced challenges in being able to find enough CHW candidates to hire, mostly as a result of the rural locations of their organizations. Similarly, another organization found it challenging maintain a CHW workforce that is representative of the patient population, as large changes have occurred in the demographics of the populations they served. While the organization may have an adequate number of Spanish-speaking CHWs, more recent increases in the Hmong population means they have a Greater need for Hmong CHWs.

Finally, the ability to hire and keep experienced CHWs has also been a challenge, which related directly back to the challenges in funding. Experienced CHWs may go on to pursue additional education, while others may take other types of jobs that pay more.

Defining role and integrating into care team

As an emerging health profession, it is not surprising that four respondents indicated one of their biggest challenges has been defining the role of CHWs, including what the scope of their work should be and how they fit into a care team. While interview respondents generally identified similar objectives for CHWs including connecting patients with resources, providing education, and building rapport with patients, the way these objectives are operationalized and actually carried out can be difficult to define.

Additionally, it can be difficult for clinical staff on a care team to understand how to best utilize the skills and knowledge of CHWs. Respondents indicated this is a result of clinical staff being unfamiliar with CHWs. This can also occur when the organization does not clearly identify the business need and or service gap for CHWs before bringing them into the organization. Without adequate integration of CHWs onto care teams, CHWs may end up frustrated with their role and clinical staff may not see the value of CHWs.

Demonstrating outcomes

While all CHW supervisors felt the benefits of CHWs are significant, seven of the twelve respondents indicated that they found it difficult to quantify these benefits in a way that clearly demonstrates the value of the services needed for buy-in from non-clinical management staff.

Nearly all respondents found anecdotal evidence best demonstrated the value of CHW services, because many CHW benefits come from identifying and addressing non-medical needs. Quantitative outcome data on CHWs is often limited or may be difficult to attribute directly to the work of CHWs. This is especially true given the complexity of patient needs and CHW interventions.

Lessons learned and future outlook

Even though respondents had varying levels of experience and the organizations they worked for varied, CHW supervisors all provided similar thoughts around the most important lessons they learned through the years of integrating and employing CHWs.

- **Identify community and organizational needs**. Employers should assess both internal and external needs and determine how CHWs could meet those needs.

- **Clearly define the role of CHWs**. While the role of CHWs may change over time, employers should ensure that there are guidelines and expectations for the work of

CHWs. This will help identify the role they will play on a care team and reduce the potential for staff confusion and frustration for both CHWs and clinical staff.

- **Reach out to organizations that have been through the process**. Employers should identify organizations that have similar models to those they are interested in implementing, and discuss with them how they went about initiating and maintaining CHW services.

- **Identify a CHW champion**. Because there is no standard CHW role and many organizations are using CHWs for the first time, it is important to have a non-CHW staff person supporting their work and helping to define their role.

- **Start small**. After identifying organizational and community needs and determining how CHWs can meet them, organizations should hire a manageable number of CHWs, have them work within the role previously identified, then evaluate what changes need to be made to address the identified needs.

Despite challenges in providing CHW services, all CHW supervisors remained extremely positive about the future of CHW work. All believed that the use of CHWs will expand both for their own organization and within the health system overall. Respondents felt that the use of CHWs will only enhance the health care system, because they can address some of the shortcomings of traditional health care delivery. This includes addressing social determinants of health, increasing community members' knowledge of and access to health care, promoting equality in health care delivery, and bridging the gap in time and resource investment for each patient. CHWs are able to achieve this as a result of the trust and relationships they build with communities, their role in care coordination, and the fact that they share the same cultural background as those they serve.

Additional CHW success stories

"We're seeing patients from very remote areas of Africa in places where they'd never even seen a clock and have no idea of sense of time. Somalis have a word that refers to time, but it means sometime before sunset. When we say 2:00, that's a foreign concept that takes some time to get used. What happens if [Somali patients] are not able to be here within a reasonable amount of time for an appointment? We understand it's a process and we need to be sensitive to the amount of change our Somali population is going through, especially related to trauma, and behavioral health. That's one of the things we're looking at – how do we engage with the community to make is safer to talk about post-traumatic stress or anxiety or depression"

"For Somali women, if they had a C-section that ended their ability to have children in the future, they have a strong bias against others getting C-sections. We reeducate that community so they know that's not necessarily the case. A number of really challenging medical, ethical situations have come up where people have refused to have C-sections at the peril of their babies – those situations highlight the need to make sure we're doing better on both sides. Both understanding why they're afraid, but also helping them understand their options."

"An older Latino man stopped taking depression medication and told CHW that it was inhibiting his sexual performance. He has a perfectly sound reason for what he's doing, but it's also something we can't really fix. The CHW told provider "he's not simply refusing" so maybe she can work with him to find something else. So we worked on getting him a mental health provider to address the issue in a different way. Nurses don't always have the time to dig-in and clients may not tell them even if they did, so it helps to have someone there who can."

"We work with a 16 year-old recent male Karen refugee who has severe disabilities, but somehow got put into the mainstream school system. His parents really didn't understand how to advocate for him or even understand they had an option to advocate for him not being a fit at that school. He hated the school and was really regressing – he kept missing school, parents got letters about being taken to court for truancy. Eventually between the Ramsey County case worker, the Karen CHW, parents, and provider, we figured out a way of getting him into a special school, and now he's excelling. All his well-child checks are coming back much more strong and he's not shutting down as much. His provider reported that he's the most healthy he's been in a long time."

– CHW Supervisors

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