



Supporting Community Health Workers to Enhance Effectiveness of Behavioral Health-Primary Care Integration

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Executive Summary

Background

In 2018, Northwest Regional Primary Care Association (NWRPCA) received a planning grant from the RCHN Community Health Foundation to identify key principles, current best practices, and workforce development requirements to support the involvement of Community Health Workers/Promotores/as (CHW/Ps) in behavioral health-primary care (BH-PC) integration at Community/Migrant Health Centers (C/MHCs).

Methodology

Methods included a literature review, focus groups, a survey, an advisory group, and informal conversations with colleagues around the country. Quantitative data was analyzed to produce frequencies and percentages for the group as a whole and for selected sub-groups. Qualitative data was analyzed using standard qualitative analysis techniques (i.e. a close reading of the notes and listening to audio recordings followed by the identification of key themes and sub-themes).

Findings

Awareness of and appreciation for CHW/Ps in primary care

- There is a wide range of perspectives and models regarding CHW/Ps in primary care and behavioral health.
- There is general agreement that CHW/Ps have much to offer a stressed mental health system which often lacks cultural competence.
- Primary care and behavioral health providers need to develop a better understanding of the well-established scope of roles of CHW/Ps.
- There is lack of clarity about the value, impact and outcomes of CHW/P interventions.
- Lack of awareness about how CHW/Ps can complement other providers can lead to resistance to their integration.
- CHW/Ps are much more aware of what they bring to integration of BH-PC than are administrators and other providers.

CHW/P contributions to behavioral health

- CHW/P interventions have been associated with reduced stress and depressive symptoms.
- The relationship with the CHW/P is a key factor in promoting improvements in mental health and emotional wellness.
- CHW/Ps can enhance behavioral health services in C/MHCs through their holistic perspective, their strong relationship-building skills, and their understanding of the barriers inherent in the system.
- CHW/Ps increase access by creating bridges among communities and behavioral health services.
- CHW/Ps possess a highly developed understanding of the collective, holistic, culturally specific nature of mental health and emotional wellness.

- Addressing social determinants of health is at the core of CHW/P practice.
- Many of the activities in which CHWs already engage promote emotional wellness.
- CHW/Ps provide emotional support organically, in the midst of other activities.
- When adequately supported, CHW/Ps are uniquely positioned to promote emotional wellness and improve mental health.
- CHW/Ps tend to view behavioral health services as “very integrated,” likely because they facilitate integration on a daily basis.

Pressing issues and barriers

- CHW/Ps face a variety of barriers when they attempt to connect community members to behavioral health services.
- Even when CHW/Ps accompany community members to services, they often face racism, classism and other forms of discrimination.
- Existing training curricula lack focus on behavioral health.

Improving CHW/P contributions to behavioral health

- Allocating physical space to CHW/Ps promotes their integration.
- A variety of supports centering around pay, recognition, opportunities for advancement, and supportive and trauma-informed supervision are essential for the success and retention of CHW/Ps.
- In order to benefit fully from the presence of CHW/Ps, systems must engage them as trainers and leaders.

Recommendations

Based on the findings in this report, taking the following steps can help to assure that CHW/Ps can make an optimal contribution to the integration of behavioral health services in C/MHCs:

- Provide ongoing education to all members of the primary care and behavioral health team about the well-established scope of roles of CHW/Ps, their value and impact in primary care and behavioral health settings, and how they can complement the work of other providers.
- To enhance their effectiveness, improve recruitment, training and supervision of CHW/Ps in C/MCHs.
- Recruit CHW/Ps as supervisors for other CHW/Ps, and provide training for supervisors about the CHW/P model and reflective and trauma-informed supervision.
- Allocate physical space to CHW/Ps in clinics to communicate value and increase visibility and accessibility.
- Create opportunities for CHW/Ps to educate other providers about a range of topics related to community wellness and behavioral health.
- Provide training and professional development opportunities for CHW/Ps, particularly in areas of mental health (e.g., mental health first aid, motivational interviewing).
- Advocate for funding models, including reimbursement for CHW services, that recognize CHW/Ps as essential members of the primary care team.

Introduction

More and more, community and migrant health centers (C/MHCs) are seeing the positive health benefits of integrating behavioral health care into their patients' primary care. As C/MHCs work to develop models of team-based care to provide integrated behavioral health services, attention is turning to the roles that Community Health Workers/Promotores/as (CHW/Ps)¹ can play in the promotion of emotional wellness and the provision of mental health services to the community.

In 2018, Northwest Regional Primary Care Association (NWRPCA) received a planning grant from the RCHN Community Health Foundation to identify key principles, current best practices, and workforce development requirements to support the involvement of CHW/Ps in behavioral health-primary care (BH-PC) integration at C/MHCs. The overarching goal of the project was to enhance the effectiveness of BH-PC integration by recognizing and strengthening the role of CHW/Ps. The primary outcome of this initial grant is this report intended for dissemination to C/MHCs as a resource to inform and enhance the role of CHW/Ps as part of BH-PC integrated services.

Key questions guiding this project were as follows:

1. What roles do CHW/Ps play in the C/MHC setting?
2. How well is behavioral health integrated into primary care in C/MHCs?
3. What are current practices, challenges, and opportunities regarding engagement of CHW/Ps in integrated BH-PC settings?
4. What is the work that CHW/Ps do related to behavioral health?
5. Why are bridges to mental health services needed in C/MHCs?
6. How can CHW/Ps be leveraged as a crucial workforce to enhance the effectiveness of integrated BH-PC services?
7. What training do CHW/Ps need to work effectively in integrated settings?
8. To what extent does current CHW/P training incorporate topics related to mental health as well as aspects of BH-PC integrated services?

Background

Who are Community Health Workers/Promotores/as de Salud (CHW/Ps)?

Community Health Workers/Promotores/as de Salud (CHW/Ps) are trusted community members who improve health and reduce health inequities through a variety of strategies. Throughout history, CHW/Ps have improved the health of communities by providing social

¹ In the mid-1990s, health professionals from around the country who went by a variety of titles but shared a common orientation and community membership chose “Community Health Worker” as the umbrella title for their profession. At the same time, they agreed that, in their own communities, they would continue to use the title that held the most cultural and historical relevance. In the Latinx community, this title is “Promotor/a de Salud.” In the Native/American Indian community, the title is Community Health Representative. In this report, we will use the initials “CHW/Ps” to be inclusive of all these professionals, except when specific sources have used another title.

support, culturally centered health education, cultural mediation, direct service, advocacy for individuals and communities and community organization (Rosenthal et al., 2018). In primary care and other clinical settings, CHW/Ps have frequently conducted care coordination, outreach, assessment, and shared prevention services, referrals, and follow-up. Further, CHW/Ps are recognized as effective community organizers (Farquhar et al., 2008), which enables them to work upstream to address the social determinants of health.

Based on their orientation as community members, CHW/Ps naturally understand their community's health from a holistic or organic perspective rather than a purely physical, clinical perspective. Crucially, they help communities understand the broader societal context that affects the health of individuals and the community. The work of a CHW/P is the work of building mutually beneficial relationships with other community members based on empathy, love and compassion. This love for the community is what motivates CHW/Ps to listen, empathize and do what they can to help others. Empathy and love arise naturally and without pity, enabling CHW/Ps to support community residents' own empowerment and ability to take steps to create change in their lives (Vision y Compromiso, 2020).²

According to a 2018 article by the Association of American Medical Colleges, CHW/Ps are front-line public health workers trained to address a host of obstacles to healthy lives.

What's more, they possess something that doctors don't always have: a deep understanding of local issues and resources. CHWs often speak a patient's language, both literally and metaphorically. And they've increasingly become a key part of some patients' health care team. CHWs might exercise with patients, monitor their blood pressure, go with them to doctor's appointments, or visit when they're lonely. Throughout, they help address a vast array of social determinants of health, from food insecurity to lack of health insurance.

A variety of studies that have emerged over the last 10 years have suggested that CHW/Ps can contribute to the achievement of a variety of important goals in clinical settings, when they are well-chosen and well-supported and when their role is clearly understood by everyone on the health care team (Israel et al., 2015; Kangovi et al., 2015; Katigbak et al., 2015).

Integrated Behavioral Health and Community/Migrant Health Centers (C/MHCs)

In recent years, as both opioid misuse and suicide have reached epidemic levels in the U.S., the need for integrated BH-PC has become increasingly apparent. It is a top priority for several state and federal agencies within health and human services departments.

² Various sections of this report are drawn, with permission, from content provided by Vision y Compromiso (<http://visionycompromiso.org/>). Citations to "Vision y Compromiso 2020" refer to the content provided and included in this report.

According to the National Alliance on Mental Illness (2020), 20% of adults in the U.S. experience mental illness each year, and half of all care for common mental health or psychiatric disorders happens in primary care settings (SAMHSA-HRSA Center for Integrated Health Solutions). Nationally, C/MHCs have seen significant increases in the number of both mental health and substance use disorder (SUD) patients served. According to the Uniform Data System of the Health Resources and Services Administration, during the three-year period from 2017-2019 the number of mental health patients increased by 26% and the number of Substance Use Disorder (SUD) patients increased by 93%, making mental and emotional wellness a pressing issue in C/MHCs (HRSA, 2020). At the same time, C/MHCs have increasingly sought models for being able to more effectively integrate behavioral health into primary care. While a single model or solution doesn't exist, for the purposes of this report and project, NWRPCA referred to the "Standard Framework for Levels of Integrated Healthcare" which identifies six levels of integration within three main categories: coordinated care, co-located care, and integrated care (SAMHSA-HRSA Center for Integrated Health Solutions).

C/MHC patients are living with depression, anxiety, questions about gender identities, isolation, lack of social support, trauma, fear related to being arrested, deported, and/or separated from family, homelessness, food insecurity, substance abuse, lack of culturally relevant resources, language barriers, chronic disease and other chronic barriers. All are issues that may not come up in a routine, time-constrained clinic visit, but all directly affect a patient's health and well-being, and can destabilize a patient's future access to health care.

Prevalence data from most studies of mental and emotional wellness find that people with a diagnosed mental health condition represent only a fraction of diagnosable cases (Mental Health America, 2020). Those who meet the criteria for one or more mental health conditions are just the tip of the mental health iceberg. These data represent individuals who have been seen at least enough times to diagnose their condition. However, there are many more individuals "below the surface" who are simply struggling with the pressures of everyday life, who do not meet the classification of a disorder, and who simply need support to overcome the less acute conditions of emotional distress. These individuals could benefit from learning to identify and more effectively manage the causes of their distress; unfortunately, they are not easily identified nor diagnosed, and local community services to support them are almost nonexistent (Vision y Compromiso, 2020).

CHW/Ps and Behavioral Health Integration

Until recently, the work of CHW/Ps has gone largely unnoticed and unappreciated by the health care system generally and the behavioral health system in particular.³ However, CHW/Ps have always promoted emotional wellness and addressed mental health problems as part of their work.

³ A partial exception to this rule are peer support specialists, who support patients with mental illness and/or SUD based on their own personal experience of these conditions. While peers and CHW/Ps share the characteristic of community membership, they are distinct in other ways.

Useful models and precedents for CHW/Ps integration in behavioral health in C/MHCs also exist. In the late 1980s, physicians at La Clínica del Cariño (LCDC, now One Community Health), a C/MHC in Hood River, Oregon, began to notice a preponderance of Latina immigrants coming in with vague, non-specific complaints, which the providers loosely labeled “depression visits.” Fortunately, LCDC had established a CHW/P program in 1988; the seven female CHW/Ps in that program were also well aware of the problem of isolated and depressed women within their community.

Responding to this need in their community, the CHW/Ps began to organize “cooking classes.” These classes brought together Latina women and their children from remote farmworker camps. While the children were cared for, the CHW/Ps facilitated interactive classes about topics ranging from depression to domestic violence. They then moved to the kitchen, where the women prepared familiar dishes using healthy ingredients. The classes ended with chatting and socializing over the meal the women had cooked, where they were joined by the children (Hayes et al., 1994; Wiggins & Castañares, 1993).

The pilot project was formalized and extended in 1991, when LCDC received a grant for a program that specifically focused on promoting emotional wellness and ameliorating mental health problems among Latinx farmworking women and teens. In 1992, staff from MHP Salud (then called the Midwest Migrant Health Information Office) in Saline, Michigan, visited the program at LCDC in preparation for developing their own emotional wellness promotion program, which is now well-developed (MHP Salud, 2020).

The CHW/P has an advantage over most mental health providers in understanding the emotional and mental health of the community. Understanding a person’s context takes time. CHW/Ps interact frequently, often daily, with their friends and neighbors, which allows them to develop a deeper, more realistic understanding of how residents are affected by and cope with daily stressors. They understand that most “mental health” issues in the community are not called “mental health” issues but referred to as “worries,” “stress,” “nerves,” or simply “things I’m dealing with.” They are dealt with in culturally familiar ways by talking things out with a trusted individual, spending time with a social support network, participating in community events, and building community with neighbors (Vision y Compromiso, 2020).

CHW/Ps have a unique ability to listen to the community. They understand the social and cultural factors that affect a person’s emotional well-being. With additional training, CHW/Ps can support residents to understand and manage the many factors that affect their emotional wellness. CHW/Ps who work in mental health clinics can benefit from participating in training on topics that include resiliency, motivational interviewing, stress management, nutrition and physical activity, social determinants of health, mental health first aid and how to create social support networks, among others (Vision y Compromiso, 2020).

The insights they gain as they develop a deeper understanding of the community's needs regarding emotional wellness can help increase understanding of how clinic staff can best approach their community's overall mental and emotional health needs from a more holistic perspective. CHW/Ps become powerful advocates for improved services and play a vital role in increasing community participation in organized advocacy activities to address the root causes impacting the mental health and well-being of the entire community (Vision y Compromiso, 2020).

Methods

Methods used to answer key questions in this study included a literature review, a survey, focus groups, an advisory group, and informal conversations with colleagues around the country. Quantitative data collected via the survey was analyzed to produce frequencies and percentages for the group as a whole and for selected sub-groups. Qualitative data collected via the focus groups, advisory group, and informal conversations was analyzed using standard qualitative analysis techniques (i.e. a close reading of the notes and listening to audio recordings followed by the identification of key themes and sub-themes).

Literature Review

The purpose of the literature review was to explore what is currently known about CHW/Ps (and to a limited degree, peer support specialists), their roles in integrating behavioral health into primary care, and what makes them successful. The review was expanded to include roles of CHW/Ps and/or peers in primary care generally, and CHW/P models, focusing on those in the Latinx community.

A preliminary query was conducted in PubMed, ResearchGate, and the Springer database. Criteria for article selection included material in biomedical, behavioral health, and public health academic journals, and was limited to studies conducted in the United States. Search terms used were *Community Health Workers, Promotoras, Lay Health Advisor, Peer Advisor, Peer Support Staff, Peer Delivered, Community Interventionist, Care Coordinator, Peer-to-Peer Worker, Mental Health Services, Mental Health, Behavioral Health, Chemical Dependency, Crisis Counseling, Stress Management, Integration, Primary Care, Community Health Center, and Neighborhood Health Center.*

A secondary search for grey literature from governmental and non-governmental sources was conducted using Google and Google Scholar. Sources included committee reports, policy papers, and organizational training resources. Search terms included: *barriers in using CHW/Ps, peer advocates and capacity to deliver services; roles in mental health service delivery for peer advocates; roles and functions of promotores in behavioral health; roles and functions of CHW/Ps; capacity of CHW/Ps in delivering mental health interventions; and promotores in mental health service delivery.*

In sum, the searches indicate that literature is emerging that emphasizes the role of CHW/Ps in providing mental health services within primary care settings. Most of the literature is recent, which may indicate that literature on this topic can be expected to increase. A total of twenty sources were identified that dealt with CHW/Ps *and/or* peer support specialists *and/or* primary care *and/or* behavioral health. Only 12 of 20 dealt with CHW/Ps' and/or peers' role in behavioral health and only nine of these focused on CHW/Ps (rather than peers). However, these nine include two systematic reviews, indicating there is additional literature that can be included in future searches. An annotated bibliography of articles included in the literature review is provided as Appendix A. Articles that did not meet the criteria for the review were organized into a suggested reading list (see Appendix B).

Focus Groups

A total of four focus groups were conducted, two with a variety of C/MHC staff and two with CHW/Ps exclusively.

In October 2019, two focus groups with C/MHC staff were facilitated by two faculty members from the University of Washington Latino Center for Health. A total of 16 participants responded to an invitation to join a focus group that would examine the roles that CHW/Ps play related to physical and behavioral health. These focus groups were held on consecutive days during NWRPCA's Fall Primary Care Conference held in Seattle, WA. Along with one CHW/P, participants included clinicians, administrators, behavioral health providers, and quality improvement staff and represented a variety of states including Alaska, Montana, Oregon and Washington.

The focus group guide, which was developed in collaboration with NWRPCA staff, is included as Appendix C. Questions inquired about roles of CHW/Ps, types of services CHW/Ps provide, how CHW/Ps support behavioral health in the community and at C/MHCs, the integration CHW/Ps in the provision of services, and the training and supervision of CHW/Ps. Based on audio recordings and notes taken during the focus groups, researchers provided a summary of themes to NWRPCA staff.

A second set of focus groups were conducted by NWRPCA staff and consultants with CHW/Ps. One focus group took place at the Annual Conference of the Oregon CHW Association in Medford, OR, in August of 2019. Dinner was served and the focus group drew 18 participants. The second focus group was conducted in Skagit, WA, in September 2019, drawing 8 participants. A different focus group guide which used popular education techniques was used. Popular education, also referred to as "people's education," creates settings in which people most affected by inequities can share what they know, learn from others in their community, and use their knowledge to create a more just and equitable society. Popular education and the CHW/P model grew out of many of the same historical roots and share key principles, such as ideas that people most affected by inequity are the experts about their own lives, and that experiential knowledge is just as important as academic knowledge.

After an introduction, the setting of group agreements, a *dinámica* and the signing of a consent form, facilitators inquired about participants' experiences serving community members with mental health issues, the types of support they provide, the ways in which CHW/Ps promote emotional wellness, the support they have and the support they need, and the training they have and the training they need.

Detailed notes were taken during the two latter focus groups. Based on these notes, themes were later identified, and data was summarized into categories.

Survey

A 14-question survey was created by staff at NWRPCA and fielded using Survey Monkey between June 27 and July 26, 2019. Links to the survey with a request to participate were sent via NWRPCA's distribution list; recipients were also requested to share the survey with their colleagues. Analysis of survey results was conducted by faculty at the University of Washington Latino Center for Health. The survey tool is provided as Appendix D.

Advisory Group and Informal Conversations

An advisory group composed of staff (primarily CHW/Ps and program managers) from community health centers, primary care associations, and local and national community-based organizations met monthly from February through December of 2019. The makeup of the group was somewhat fluid, with about 20 different individuals participating at some point in the process, and five to six individuals participating consistently. Group members helped develop the survey tool, provided insight into the focus group structure and methodology, shared their own individual and organizational perspectives about CHW/Ps and behavioral health integration, and in general served as a sounding board for NWRPCA staff, who shared ideas and updates about the direction of the project. In addition, NWRPCA staff reached out to approximately 10 individuals over the course of the project to gain their input via informal conversations.

Findings

Below, results of each data collection activity are provided separately, followed by a summary of the findings.

Literature Review

One notable finding from the literature review was the wide range of perspectives of the authors. These ranged from extremely top-down (indicated by the use of phrases like "instructing the promotores" and "received the intervention") to grassroots and empowerment-oriented. Program models were similarly varied, ranging from clinically oriented models that were based on minimal knowledge of the CHW/P model, to community-based models that sought to address underlying disparities in power and resources. There was general agreement that CHW/Ps and peers have much to offer a stressed and often culturally incompetent mental health system, especially in marginalized communities where culturally appropriate services are especially scarce.

Many studies indicated the need for a clearer understanding among primary care and behavioral health providers of the well-established scope of practice of CHW/Ps (Wiggins & Borbon, 1998; Rosenthal et al., 2018), and for improved recruitment, training and supervision strategies. (For suggestions, see Brown et al., 2019). One article (Early et al., 2016) identified the need for training programs that center the language, culture and reading level of the CHW/Ps. Study authors uniformly agreed that more study is needed to understand and optimize the role of CHW/Ps in behavioral health.

Notable studies included a 2018 systematic review by Barnett and colleagues of behavioral health interventions involving CHW/Ps in low- and middle-countries (LMICs), as well as high-income countries. It found that most articles meeting inclusion criteria had been published since 2010, and that CHW/Ps in LMICs have a more involved role in providing psychosocial interventions than CHW/Ps based in the U.S. The primary rationale cited for employing CHW/Ps was to fill gaps caused by shortages of degreed mental health workers. Authors also express hope that employing CHW/Ps would destigmatize and demystify behavioral health.

One study by Daniels and colleagues (2017) suggests that people with different mental health needs might be best served by different kinds of CHW/Ps. Peer Support Specialists, who have historically worked with people with experience of substance use and/or severe and persistent mental illness, seem to be especially suited for working with specific behavioral health concerns or complex illnesses, according to this study. This contrasts with CHW/Ps, who may be more suited to promoting emotional wellness through generalized activities. It is also possible that, with training and experience, CHW/Ps can provide both general and specific supports to patients working to realize their mental health.

CHW/Ps have also been shown to be able to facilitate effective behavioral health programs when trained to do so. An article by Sternberg and colleagues (2019) indicates that not only is it possible to train CHW/Ps to provide stress management programs but these programs have successfully decreased depressive symptoms and stress. The key takeaway here is that with proper support, CHW/Ps can provide a valuable skillset to meet community mental health needs. One additional study (Tran et al., 2014) documented reduced stress and depressive symptoms associated with a promotora-led intervention.

A qualitative study by Perales et al. (2018) reinforced the idea that the value of CHW/Ps goes beyond supporting patients' interactions with services. This study provides evidence that the professionalism and rapport from CHW/Ps promotes positive relationships and lifestyle behavior changes. In this study, the only participants who reported consistently poor scores for anxiety, depression, or both, were also those who reported neutral or negative experiences with the CHW/Ps, emphasizing the importance of the CHW/P-participant relationship.

Survey

Complete survey results are presented in Appendix E. A total of 209 individuals from 11 states responded to the survey. The greatest number of respondents were from Oregon (36.8%) and Washington (23.4%). The largest percentage of respondents (47%) worked in C/MHCs. The most common role identified by respondents was CHW/P (47%), followed by Management/Administration (23%). The vast majority of respondents either were CHW/Ps themselves or worked with CHW/Ps. Respondents identified multiple titles used for and by CHW/Ps in their organizations, but the fact that more than half (53.1%) use “Community Health Worker” reflects that the field is coalescing around that title. Other common titles include Promotor/a de Salud and Outreach and Enrollment Specialist, both at 22.5%.

In terms of the kinds of behavioral health activities in which CHW/Ps are engaged, the most common are those related to addressing social determinants of health (59.3%), those oriented toward improving wellness and healthy living (58.9%), outreach (57.4%), one on one interactions (56.9%), and facilitating classes and trainings (55%). (This question allowed respondents to choose all that apply, so percentages do not add up to 100.)

Overall, most survey participants (43%) expressed that behavioral health was very integrated in their organization. This was also true when looking at just those working at C/MHCs (49%). Comparing across roles, those in management and provider roles were more likely to say that their organization was “somewhat integrated,” (43.6% and 45.5%, respectively) while CHW/Ps were more likely to say that their organization was “very integrated” (45.3%).

Qualitative responses to an invitation to elaborate on the question about level of integration revealed that sites that are very integrated appear to have case managers and counselors who participate in clinic team huddles and preplan visits for clients depending on their needs. At one site that noted being “very integrated,” behavioral health providers are members of the patient’s care team and analyze patient data to determine which patients should be seen by a behavioral health provider. Barriers to integration identified by respondents include varying levels of miscommunication, lack of support, and lack of time for behavioral health and medical providers to coordinate their work. Respondents at a location that is “somewhat integrated” report that CHW/Ps frequently consult on cases but are typically driven by present needs or reactive to presenting issues.

According to survey respondents, there is a great deal of consistency between the types of behavioral health-related trainings in which CHW/Ps currently participate (Q10), and those that CHW/Ps need to enhance behavioral health services (Q11). In both cases, the top four responses were Mental Health First Aid, Working with Patient/Client, CHW/Promotor, and Trauma/PTSD.

Majorities of CHW/Ps, managers and providers answered “yes” to the question about whether CHW/Ps can play a larger role in enhancing behavioral health in their organizations (Q12); the percentage of providers who responded “yes” was smallest at 51.6%. Qualitative responses to the “please elaborate” prompt fell into three general

categories related to infrastructure needed to make this happen, concrete roles CHW/Ps can play, and training needed by CHW/Ps and other members of the primary care team.

Focus Groups

Focus group conducted by the University of Washington Latino Center for Health

Titles and Roles.

Echoing findings in the literature review, participants shared that multiple titles continue to be used for CHW/Ps. Despite the plurality of titles used, participants held similar understandings regarding the qualities of CHW/Ps. Several participants identified the community embeddedness of the work of CHW/Ps and the importance of their trusted relationship with the community. Others stated that CHW/Ps play the role of a hub, a connector and a liaison for services.

Focus group participants shared that the roles of CHW/Ps are not uniformly understood across providers and team members in primary care and behavioral health settings. “There still appears to be some nebulosity around roles and titles; that may be more of a provider, than a community concern,” one participant stated. According to another, “some [CHW/Ps’] roles are not fully understood by clinicians and providers in the clinic.”

Participants also reported lack of clarity about the impact of CHW/Ps. “Not enough people understand how CHWs can make a difference,” stated one participant. While a few affirmed the value of CHW/Ps as providing a “huge return on investment with using follow-up care” and provide significant cost savings to the organization, others reported that it remains “hard to quantify the effectiveness of CHW/Ps.”

Behavioral Health Integration.

Integrating behavioral health and primary care services is a dominant paradigm in the health field, yet challenges persist. As one CHW/P lamented, “Providers still have the impression that behavioral health is for mental health or addiction issues only, so behavioral health workers are not fully utilized.” Participants revealed that while many entities are in the process of working towards integration of behavioral health services, success varies by location and across levels.

CHWs’ Role in Integration

The literature review reveals that the role of CHW/Ps in the behavioral health context and their contributions to integrated care are less studied and less understood. A key finding from the focus groups is that administrators and providers were less aware of the role and capacity of CHW/Ps in the integration of services than are CHW/Ps. Also, a general perspective among focus group participants is that CHW/Ps are more engaged in the context of physical health compared to mental health services.

Several participants acknowledged the lack of inclusion of CHW/Ps on teams, limiting their voice and contributions. “[No CHW/Ps] have direct connection to our Integrated Behavioral Health Program,” one participant stated.

One respondent expressed that “CHW/Ps are effective in helping” behavioral health integration. Another respondent indicated that CHW/Ps are helpful for screening patients in primary care. Such screening is informative for the primary care physician but also can expedite referral of patients to behavioral health when warranted. On the other hand, one participant noted that behavioral health providers at times resist the integration of CHW/Ps.

Noteworthy is the experience within one organization where CHW/Ps are fully integrated on one service but in another service, they are not integrated at all. A contributing factor to this dynamic is the provision of designated physical space in the organization. CHW/Ps who had such space were viewed as integral members of the team and were valued by other team members. This was not the case for CHW/Ps who lacked physical workspace. The allotment of space to CHW/Ps in the clinic or the same building appears to contribute to their integration within teams.

Training.

Congruent with findings from the literature review, findings from the focus groups affirmed the need to provide more specialized training in order to maximize the effectiveness of CHW/Ps, particularly within communities that often go underserved. One participant remarked, “We want to train CHW/Ps to participate and work with RNs.” (It is hoped training will also be provided to the RNs.) Several participants acknowledged that in Washington State, requirements for training of CHW/Ps are lax. Another noted that a tension exists regarding the desire for more training. “Tension exists with training/standardization [because of] fear [among CHW/Ps] that professionalism will diminish the potency of interaction and veer away from a peer-to-peer working model.” Indeed, several focus group participants revealed that a major strength of CHW/Ps is their person-to-person relationship with patients, compared to practitioners’ clinician-to-patient relationship.

Among CHW/P focus group participants, training ranged from none to 80 hours and one participant acknowledged, “we have a difficult time getting people to go through training.” One participant expressed that, “standardized training may not fully meet the full needs of the community.” This comment foreshadows comments made in the CHW/P focus groups about the need for training that is based in popular education and that reinforces the unique skills and perspectives of CHW/Ps.

Barriers.

Respondents revealed several significant barriers concerning the role and integration of CHW/Ps, namely, 1) lack of coordination of work responsibilities of CHW/Ps across behavioral health and health care settings, 2) limited funding to train and pay CHW/Ps, 3) inability to bill for services rendered by CHW/Ps, and 4) lack of physical space in clinic sites when CHW/Ps are embedded on teams.

According to participants, the lack of ability to bill for CHW/P services limits the expansion of their services, which is deemed to be useful and needed. Participants pointed out that lack of space can signal that the CHW/P is not seen as integral to the care team and can result in the CHW/P voice not being included in decision-making to inform culturally responsive care.

Focus groups conducted by NWRPCA

Mental and Emotional Health Issues in the Latinx Community.

Focus group participants identified a variety of pressing mental health concerns and risk factors among the Latinx community members they serve. These issues include anxiety, depression, generational issues between elders and youth, gender identity and sexual orientation issues among youth, isolation, chronic stress (caused by immigration issues among other causes), homelessness, substance abuse and self-medication, stigma around mental health issues, and lack of culturally centered mental health care and services. Notably, these issues are virtually unchanged from those identified in an earlier study of mental health issues among Latina migrant and seasonal farmworkers served by a C/MHC (Wiggins & Castanares, 1993).

Roles of CHW/Ps in Promoting Emotional Wellness.

Participants in the focus groups spoke eloquently and passionately about the important work of CHW/Ps in promoting emotional wellness and ameliorating mental health problems in their communities. CHW/Ps' contribution is based on a highly developed understanding of the collective, holistic, culturally specific nature of mental and emotional wellness. In the words of a participant in the Medford focus group, "That's what we do as CHW/Ps; we do the collective work instead of the individual work. We bring people together and that's mental health work." A participant in the Skagit focus group summed it up this way: "*Porque la salud de ellos es la salud de nosotros. Es la salud pública, salud preventiva.*" (Because their health is our health. It's public health, it's preventive health.) Emphasizing the importance of social support in mental wellness, another Medford participant succinctly stated, "We promote bonding. We combat isolation. We do the collective work."

Because of their understanding of the nature of health, CHW/Ps know that many activities in which they normally engage promote mental and emotional wellness:

Charlas [talks or classes], outreach, home visits, healthy cooking classes, bailoterapia [dance therapy], migrant camp visits, homeless patient support, maternity support services, travel and transportation are all behavioral health activities. These activities sometimes facilitate the first touch with a patient. The activities and work that [CHW/Ps] do involve meeting patients where they are at, which may include going to their work, directly to their home, going to their community, speaking their language.
(Medford Focus Group, 2019)

They further articulate that they provide emotional support organically, in the midst of doing other work, like filling out applications:

Sometimes people come in for a simple thing like filling out an application with me. From there we get to talking while I'm doing the application. They start to share more things with me, they relate, they share stories [and] concerns. They come in with all of this stress due to the application and other things that are going on ... They've shared with me they've gone to speak with providers and they weren't able to connect; perhaps it was because they weren't Latinos ... Then they share with me that they feel better ... I assure them that their paperwork is done, [that] what they shared is safe and that we did what we needed to do. (Medford Focus Group Participant, 2019)

CHW/Ps relate that their culturally appropriate activities help to counteract the individualism so prominent in dominant culture in the U.S. A participant in the Medford focus group shared that "Our work [as CHW/Ps] is related to emotional/behavioral health [in] that in this country/culture it's a very individualistic society [where] everyone does their own thing ..."

Focus group participants repeatedly emphasized the importance of building relationships, and how this allows them to create access by building bridges between community members and behavioral health services:

[CHW/Ps] listen, they take time to build relationships and trust with patients, they have a culturally tuned ear to listen to the nuances of what people need. [CHW/Ps] promote relationships and bonding with [CHW/Ps], with the health center, with other resources and providers, by doing so addressing issues of access to health care [and] access to resources. In order for patients to get the services they need, they need to feel comfortable connecting to the spaces where these resources can be provided; this is part of the critical bridging CHW/Ps do. (Medford Focus Group Participant, 2019)

Summing up the absolutely essential role of cultural bridging, a Skagit focus group participant stated, "*Sin puente cultural no se conectan con estas comunidades.*" (Without cultural bridges, you cannot connect to these communities.)

CHW/Ps are well aware of their ability to comfort and support community members, and use that knowledge as evidence that they are effectively improving behavioral health:

I tell [families] that my job is to connect families with the resources that they need, but in reality, we do much more than that. Today [while I was] at the conference, a client called me in crisis. I was able to support her, I reassured her, I told her I was here far away, but I talked and listened. By the time I needed to hang up to go to a workshop, I was able to hear that she was calmer. I assured her that I would see her when I get back. ... I think that shows that I'm doing this work and I'm doing it right.
(Medford Focus Group Participant, 2019)

A final comment from a participant in the Medford focus group clearly identifies the nature of CHW/Ps' behavioral health work, and concludes that CHW/Ps are uniquely suited to doing this work:

The work that [CHW/Ps] lead is the culturally relevant, culturally accessible interpretation of non-clinical behavioral health work that is critical to supporting patients' mental health and emotional well-being. CHW/Ps are critically equipped to do this work. (Medford Focus Group, 2019)

Integration into Behavioral Health.

Participants in the focus group expressed confidence that CHW/Ps can make a unique contribution to behavioral health given the right conditions:

CHW/Ps are positioned to do ... behavioral health interventions ... at a better level with better outcomes than any social worker or psychologist; it's just getting the right understanding of how the western system works and the community to better integrate the two. (Medford Focus Group Participant, 2019)

However, they also mentioned a number of barriers and challenges related to behavioral health interventions. The first was resistance among community members to engaging in behavioral health services because of the taboo nature of mental health. A second was lack of capacity within the system. In the words of one participant, "We convince them to [go for an appointment] and then once they go, the demand it's too high; it's one to six months out. They end up not going and it gets worse." If community members actually go for an appointment, the kinds of questions they are asked can increase resistance, making them feel vulnerable and increasing their sense of powerlessness. In the case of teen-parent conflicts, community members fear that genuine answers may trigger involvement with child protective services. All these barriers are heightened if the therapist is not culturally congruent or at least culturally responsive. "It's frustrating when I have worked hard to convince someone to go to a therapist, doctor, counselor, and then they go and they don't have a good experience," stated one focus group participant.

Participants also stressed that for referrals to be effective, they need to go with the community member to the service, partly to assure that community members are treated with respect and dignity, even though this doesn't always work. "Sometimes even when I go with them," stated one participant, "we still experience racism, classism; we are still invisible." In addition, the fact that CHW/Ps are often out of the clinic making these connections can cause frustration on the part of team members, who want CHW/Ps to be at their desks when they need them. CHW/Ps must negotiate a complicated set of dynamics in order to improve community wellness.

Support Received and Support Needed.

CHW/Ps in the focus groups mentioned a variety of kinds of support that help them to feel valued and be effective. These include regular supervision sessions, an open-door policy on the part of supervisors, job descriptions that prioritize experience over formal education, supervisors who really understand the work they do, and perhaps most crucially, supervisors who have been CHW/Ps themselves. Just like the community members they serve, CHW/Ps need to feel valued and have people who will listen when they need to talk. In one clinic where the supervisor was a CHW/P, this sense of value is expressed through an annual picnic:

For example, we have an annual “retreat” after our Migrant Health Clinics. We all get in the van, we go to the park, we play guitar and music on the drive, we all get together we make a *carne asada* (barbecue). We feel the season lift from us. [Supervisors] understand the work is hard and we get to celebrate. This is something we look forward to every year.

When supervisors have not been CHW/Ps or do not know enough about the work CHW/Ps do, then CHW/Ps must take on the additional job of educating their supervisors. In the words of one participant, “I have worked at the same organization for (x) years and I have gone through 5-6 supervisors and every time I see a new supervisor, I have to start all over again.” Particular barriers were mentioned with supervisors who are clinicians. Also, respondents stressed that having supervisors go to trainings about their role is often not enough; they suggested that supervisors accompany them when they are doing the work in order to understand it better.

When asked what they need, participants in the focus groups mentioned better pay; opportunities for advancement that are not dependent on, but do include opportunities to get more formal education; recognition that their work can lead to vicarious trauma and support to deal with this; and having CHW/Ps as leads in the PCMH model. They also need cultural humility on the part of providers: “Western culture is so clinical; we need culturally relevant, culturally humble support from providers.” Finally, repeating a theme that has been heard from CHW/Ps for many years, participants mentioned that other providers can see them as a threat, perceiving (usually incorrectly) that they may be replaced by CHW/Ps.

Training received and training needed.

When asked about the training they have received, participants mentioned the 90-hour certification training provided through the Oregon CHW Association; trainings about trauma-informed care and dealing with burnout, grief and loss; suicide prevention; popular education; motivational interviewing; and a variety of other topics. Participants wanted more training about the Public Charge rule and immigration generally; domestic and family violence; vicarious trauma; popular education; and LGBTQ2I issues. Notably, they also want to develop their leadership through opportunities to co-facilitate and lead meetings. And finally, participants recognize that they are not the only ones who need training. In the words of one participant: “People in power need training from us. Take off your badge, listen!”

Summary of Findings

Awareness of and appreciation for CHW/Ps in primary care

- There is a wide range of perspectives and models regarding CHW/Ps in primary care and behavioral health.
- There is general agreement that CHW/Ps have much to offer a stressed mental health system which often lacks cultural competence.
- Primary care and behavioral health providers need to develop a better understanding of the well-established scope of roles of CHW/Ps.
- There is lack of clarity about the value, impact and outcomes of CHW/P interventions.
- Lack of awareness about how CHW/Ps can complement other providers can lead to resistance to their integration.
- CHW/Ps are much more aware of what they bring to integration of BH-PC than are administrators and other providers.

CHW/P contributions to behavioral health

- CHW/P interventions have been associated with reduced stress and depressive symptoms.
- The relationship with the CHW/P is a key factor in promoting improvements in mental health and emotional wellness.
- CHW/Ps can enhance behavioral health services in C/MHCs through their holistic perspective, their strong relationship-building skills, and their understanding of the barriers inherent in the system.
- CHW/Ps increase access by creating bridges among communities and behavioral health services.
- CHW/Ps possess a highly developed understanding of the collective, holistic, culturally specific nature of mental health and emotional wellness.
- Addressing social determinants of health is at the core of CHW/P practice.
- Many of the activities in which CHWs already engage promote emotional wellness.
- CHW/Ps provide emotional support organically, in the midst of other activities.
- When adequately supported, CHW/Ps are uniquely positioned to promote emotional wellness and improve mental health.
- CHW/Ps tend to view behavioral health services as “very integrated,” likely because they facilitate integration on a daily basis.

Pressing issues and barriers

- CHW/Ps face a variety of barriers when they attempt to connect community members to behavioral health services.
- Even when CHW/Ps accompany community members to services, they often face racism, classism and other forms of discrimination.
- Existing training curricula lack focus on behavioral health.

Improving CHW/P contributions to behavioral health

- Allocating physical space to CHW/Ps promotes their integration.
- A variety of supports centering around pay, recognition, opportunities for advancement, and supportive and trauma-informed supervision are essential for the success and retention of CHW/Ps.
- In order to benefit fully from the presence of CHW/Ps, systems must engage them as trainers and leaders.

Discussion

The lack of documentation of CHW/Ps' role in behavioral health contrasts with what we found in our own research and outreach to partners: that **CHW/Ps are uniquely prepared to facilitate effective behavioral health interventions because of their connection to the community**. CHW/Ps tend to be enmeshed in their communities and have intimate knowledge of the social determinants which affect community members' mental and physical health (Vision y Compromiso, 2020). They tend to be familiar with resources for addressing these social determinants in ways that clinicians may not be.

Focus group participants reported that CHW/Ps “always work with social determinants of health...offering time, support, [and] openness to families for connection to mental health supportive services.” In doing so, CHW/Ps “diminish mistrust of health care entities and reduce stigma within communities, both of which serve as potent barriers for communities of color and marginalized population to access and utilize health care services.” CHW/Ps are clearly key to **promoting wellness and getting resources to communities**.

This suggests that amplifying the role of CHW/Ps in behavioral health work is one way to **combat burnout among clinicians**. Burnout occurs when clinicians do not feel able to address the social determinants of their patients' health, like housing instability, violence in the community, or insufficient nutrition. CHW/Ps can also be effective at **filling the gap for behavioral health workforce shortages**. In Alaska, Behavioral Health Aids are trained and employed by tribal health organizations. Their unique training and location suit them to provide valuable mental health support where physicians cannot go. This is reflected in our review of the literature, which shows that there is an uptick in CHW/Ps facilitating psycho-social interventions for behavioral health conditions.

Additionally, our study reveals that the term “mental health” has a negative connotation for many communities who associate it with being “crazy.” This acts as a barrier to care for those in need of services but also limits community understanding of effective behavioral health interventions. CHW/Ps provide context that promotes the priority of emotional wellbeing, reframing the question as not one of lack of mental health but of promoting well-being.

In the words of Vision y Compromiso (2020), “people in the community express that what they need to manage their own emotional wellness and lessen the need for intensive mental health services is a trusted individual to talk to, who is non-judgmental, has an empathic ear, can help the person identify their own solutions and understand the resources in the community that can help them have a healthier emotional lifestyle.”

CHW/Ps do face difficulties when trying to provide care to their communities. Most notably, CHW/Ps have to straddle the **divide between marginalized communities and medical institutions**. That work often sees them vying for the trust of their communities. This concern is reflected in a 2019 commentary by Garfield and Kangovi:

[CHW/Ps] increasingly are transitioning from their grassroots, community-based origins to become integrated members of health care teams. The marriage of community health and formal health care is powerful, but it’s also tricky. If CHW/Ps lose their identity and become medicalized, their effectiveness in the community is lessened. Health care leaders must grapple with a fundamental question: How do we integrate a grassroots workforce into health care without totally coopting it?”

A unique barrier for CHW/Ps is the system they are asked to promote among the community. The further this system is from community understanding and agreement, the harder the CHW/P must work to promote it. In a bid for professional recognition, CHW/Ps can run the risk of seeming too much like members of a medical system and not enough like members of the community. ***CHW/Ps must strike a delicate balance between being health professionals and representatives of the community.***

Another barrier CHW/Ps face is the lack of awareness of their roles, and lack of high-quality supervision and training across medical establishments. Though an integral part of many care teams and care models, **CHW/Ps’ well-established set of roles has not been consistently implemented** in those models. This means that CHW/Ps are not always supported to play a wide range of roles across the health care system. Different health care communities have different definitions of CHW/Ps, different conceptions about what they do, and different ways of measuring their success and effectiveness. CHW/Ps have to be mindful that the medical communities they work within frequently do not know the value they bring to the care team and the best ways to employ their skills for the patients’ benefit. Efforts like the CHW Common Indicators Project are seeking to address this gap, by collaboratively identifying common process and outcome indicators for CHW practice (Wiggins et al., in press).

CHW/P involvement in mental health services is so powerful precisely because of the intimate relationship between the CHW/P and the patient seeking services. CHW/P involvement can be crucial to patients’ positive outcomes and self-reported outlook. The lack of awareness of the CHW/Ps’ scope of practice has the potential to negatively impact patient care as well. This usually comes in the form of CHW/Ps having difficulty communicating in their care teams.

A 2018 study by Slantz et al. suggests that CHW/Ps bring more to their teams than they might be getting credit for. Clearly communicating their roles to the care team could positively impact not just the CHW workforce but the care team's orientation to the patient receiving services. Clearly spelling out CHW scope and impact would likely help not just the CHW profession but patient outcomes as well.

Recommendations

Based on the findings in this report, taking the following steps can help to assure that CHW/Ps can make an optimal contribution to the integration of behavioral health services in C/MHCs:

1. Provide ongoing education to all members of the primary care and behavioral health team about the well-established scope of roles of CHW/Ps, their value and impact in primary care and behavioral health settings, and how they can complement the work of other providers.
2. To enhance their effectiveness, improve recruitment, training and supervision of CHW/Ps in C/MHCs.
3. Recruit CHW/Ps as supervisors for other CHW/Ps, and provide training about the CHW/P model and reflective and trauma-informed supervision.
4. Allocate physical space to CHW/Ps in clinics to communicate value and increase visibility and accessibility.
5. Create opportunities for CHW/Ps to educate other providers about a range of topics related to community wellness and behavioral health.
6. Provide training and professional development opportunities for CHW/Ps, particularly in areas of mental health (e.g. mental health first aid, motivational interviewing).
7. Advocate for funding models, including reimbursement for CHW services, that recognize CHW/Ps as essential members of the primary care team.

Next Steps

Having completed this pilot project, NWRPCA will now seek to cement its support for CHW/Ps and the integration of CHW/Ps into C/MHCs via the development of a Community Health Worker Institute. Through this Institute, NWRPCA will leverage state, regional, and national partnerships to accomplish three goals: 1) provide capacity building, leadership and professional development training for CHW/Ps to enhance their capacity to work in integrated settings; 2) provide resources, training, and technical assistance that helps CHCs establish scopes of practice for CHW/Ps that fit the needs of their local communities and supports integration of CHW/Ps into clinical and community-based teams; and 3) support policy development to finance and sustain CHW services.



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