

**Consultants’ Report to the**

**Arizona Community Health Worker Workforce Coalition**

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Note: this report was prepared by the authors as individual contractors to the University of Arizona, and as such does not represent an official work product of the University of Texas

1. **Overview of the Arizona Community Health Worker Workforce Coalition**

**Initiation Progress and Related History**

**The Legacy of Community Health Workers in Arizona—A Starting Point**

As Arizona begins a new initiative to sustain the Community Health Worker (CHW) workforce during the era of Affordable Care Act (ACA), the state is building on a long history of leadership in the CHW field, giving it important assets for developing successful strategies to expand CHW employment and sustainability.

Among those assets, the state is home to many innovative and successful rural and urban programs including CHWs serving tribal communities, border communities and inner city urban neighborhoods. The State-supported Health Start program is among the oldest in the nation, with ongoing public support. Tribally-based Community Health Representatives (CHRs) also have a strong presence in the state and are part of the nation’s longest standing program of publically support for CHWs.

Arizona is also noted for its early development of several CHW networks, including the state-level Arizona Community Health Outreach Worker Association (AzCHOW) and the national *Red de Promotores,* based in Yuma. CHRs have participated in regional networks as well as the former National Association of CHRs; the leader of that network was based in southern Arizona. Though both these latter groups are now less prominent at a national level, they have played an important role in helping to give visibility to the field at the regional, national and even bi-national levels. This strong history of CHW leadership is a tradition the state can build on to assure self-determination in the CHW workforce.

In addition to Arizona’s early work in CHW services and networking, Arizona also has produced significant CHW research from evaluation of CHW services such as Border Health Si and to national policy focused surveys and studies examining the state of the field.

**Organizing meetings of the Coalition – Spring 2013 Coalition**

In 2013, it is encouraging to see Arizona once again pushing forward on the CHW front with the formation of the Arizona CHW Workforce Coalition. In the Coalition, many new and existing CHW stakeholders from across the state have successfully come together to examine options for sustaining the CHW workforce. Support from Arizona Department of Health Services’ Bureau of Tobacco and Chronic Disease funding for this work appears to represent a turning point in renewing active state support. Reflecting this is the announcement at the May 23 Coalition meeting that ADHS officials have applied for funds to support a position in the Department focused on CHWs. The State also appears to have recognized the importance of CHW leadership in developing and sustaining CHWs, an important starting point for the work ahead for the Coalition.

This Coalition, under the coordination of long-time leaders in field at the Mel and Enid Zuckerman College of Public Health (MEZCOPH), can build on the history described above and harness emerging stakeholders with a newer interest on CHWs. The Coalition’s successes in bringing together representatives of the public sector in education, community and economic development, and health services and promotion, has set the table for strong and fruitful actions. The strong mix of public sector members gives the Coalition a needed base of support, expanding this membership, especially to engage the private sector, is one the greater challenges facing the Coalition (See discussion of Stakeholder Diversity below for further discussion).

**The Spring 2013 two statewide meetings of the Coalition** have each accomplished important goals. In the first meeting in Tucson on March 8, 17 Coalition participants developed a strong base of common knowledge about the many areas that need to be addressed in order to develop sustainability among CHWs.[[1]](#footnote-1) The key areas of policy identified by outside consultant team (Rush and Rosenthal) include:

* Occupational Regulation: occupational definition and skills standards
* Workforce Development: CHW-led employer/funder supported education and capacity building
* Sustainable Financing: supporting a full spectrum of CHW roles and settings from ongoing sources of funding
* Evaluation and Research: Core metrics and common agenda

The March 8 meeting included an initial assessment of the Coalition’s internal strengths and weaknesses, and external opportunities and threats (a “SWOT analysis”). Among the strengths identified were the group’s historical base, which has produced longstanding relationships within the state as well as an extensive base of data from past and current initiatives. Weaknesses included limited resources for support of CHW networks, limited inclusiveness and cohesiveness among those disparate networks, uncertainty about how to assimilate clinical roles for CHWs, and a historical insular or “in-group” image which could be discouraging other stakeholders from participation. Opportunities included health care reform, potential employer champions, transborder resources, partnerships with other states and adoption of CHWs by additional agencies. Potential external threats included employer resistance due to weak understanding of the definition of CHWs, pitfalls of acting out of urgency, potential for exclusion of some subgroups of CHWs, threats to the CHW identity from growth of clinical roles, and currently weak connections to tribal governments.

The March 6 group also identified the need for contemporary data about CHWs in the state and a workforce survey was proposed, which the Mel and Enid Zuckerman College successfully implemented in preparation for the next meeting.[[2]](#footnote-2)

From the focus of the first meeting the Coalition began to identify desired outcomes and first steps for collective action. Areas identified at the first meeting set the stage for four Work Groups established in a second meeting held on May 23 in Phoenix, with more than twice the number of participants. A report on the Survey at the May 2013 meeting allowed the Coalition to examine the current status of CHWs in the state and identify areas in need of further attention. Among the notable early findings of the Survey are xxxxxxxx

The topics of the four Work Groups formed for the first stages of action planning are similar to the four identified by our consultant team:

1. Occupational Definition and Awareness
2. Workforce Development (education etc)
3. Sustainable Financing
4. Data and Credibility

The Work Groups held a brief organizing session at the end of the May 23 meeting, in which they brainstormed initial priority goals, discussed potential for an early “win” to build momentum, and considered additional stakeholders (individuals and groups) who could be helpful to their work. Notes from the Work Groups appear below.

1. **Analysis of Arizona CHW Workforce Coalition Current Activities and Work Groups**

**a. Work Group on Occupational Definition and Awareness**

This Work Group had six participants one of whom identified as a CHW and/or as a liaison to AzCHOW.

**Work Group Goals /Focus:** To identify a state-wide definition for CHWs in Arizona and increase awareness.

**Work Group-Identified Action Plan**

The Work Group defined a number of strategic directions. They demonstrated a high level of energy and momentum for concrete action when they reported to the group on their proposed actions. We note there seemed to be some hesitation and potential cross-purpose efforts when the discussion began regarding a Coalition focus on the idea of a border-wide unique CHW definition.

The Work Group agreed that the Coalition should undertake the following action steps and even took action on the first few steps. The steps they identified (note: some combined, language shifted) include:

1. Evaluate if the APHA CHW definition is a good fit for Arizona in order to suggest changes.
2. Work with local CHWs (Lourdes/AzCHOW) to identify other key roles that may better suit CHWs in Arizona

1. Present to AzCHOW Board for a vote and then present at AzCHOW conference
2. Put forward a CHW definition Resolution to be developed by AzPHA

**Consultant comments about CHW definitions**

We have learned from experience in policy campaigns in Texas, Massachusetts and other states that defining the parameters of a field to policy and health finance professionals means determining a core of knowledge and skills that any worker claiming to be a CHW must have mastered, as well as arriving at a common understanding of a scope of practice and related parameters for this occupation. CHWs have not yet reached the point of shared understanding that is held in other professions such as nursing.

Key to understanding this workforce is the recognition and validation of a distinct form of *expertise* in CHWs. Clinicians and administrators looking at health-related occupations tend to rely on the extent of clinical training to define and classify the occupation. While some exposure to clinical content is important, the CHWs contribution needs to be viewed in the context of a distinctive scope of practice and a distinct set of core competencies that are not clinical in nature.

The current status of consensus on CHW definition and awareness of CHWs in Arizona is likely to follow the patterns found in other parts of the US where agreement on a definition and related core roles and qualities is elusive and awareness is lacking among health professionals and the public alike. The May 2013 Arizona CHW-Employer survey results suggest that CHWs and employers have similar views on roles and skill requirements. Still, there were several areas they saw differently including CHW roles in screening, research, and interactions with other members of the health care team.

Awareness of CHWs was not formally addressed in the Arizona survey and typically is not the focus of studies of CHWs. Given that, data from El Paso provide some insights on the state of awareness. In an NIH-funded CHW study, a randomized telephone survey of homes in two small area communities where CHWs/Promotores serve revealed that only 20 percent of community residents had ever heard of a CHW. Awareness levels are also typically low among health care professionals. Again Texas data may shed some light where awareness of CHWs ranked as a barrier to integration of CHWs among health employers throughout the state.

**Consultant recommendations for Definition and Awareness Work Group**

Given initial observations on Arizona’s situation, the focus of the Occupational Definition and Awareness Work Group appears to be on target. The early action steps they proposed are also on target and can lead to success in this area. However, we have observed that work in this area can become drawn out and discouraging, so we suggest that efforts be made to safeguard this Work Groups interest and energy.

Specific recommendations include:

1. Consider ways to engage a range of stakeholder in the definition confirmation process. Stakeholders should include CHWs from varied settings and cultures, other health professionals, and employers and administrators (see discussion on stakeholders in the General Recommendations section of this report).
2. Consider the value of a process to gain Border state endorsement of the APHA definition of CHWs to help build momentum for national and bi-national opportunities for promoting CHWs.
3. Do not delay planning for “CHW Identity Campaign” activities to reach health care provider and payers, as resources permit, the public. Other Coalition activities will be much more difficult without some initial efforts to increase awareness.
4. Undertake a rigorous Scope of Practice definition process with broad participation from Coalition members and others.
5. Consider taking a position on the Patient Navigation function as a part of the definition process, due to the growing use of this term.

**Special Considerations for Confirming a CHW definition and Related Role/Scope Explorations:**

The Work Group specifically reviewed the APHA CHW definition and recommendedreplacing that definition’s phrase “unusually close” to an “in-depth understanding of his/her communities served.” Upstream feedback from a statewide definition confirmation process, especially examining the APHA definition, will also contribute to a critical ongoing examination of assumptions among APHA CHW Section leaders. Such feedback might be even more meaningful if it stems from a border-wide definition confirmation and refinement process.

**CHW Scope of Practice**

Unfortunately, the definition of a scope of practice for CHWs has lagged behind other developments in the field. To date only New York[[3]](#footnote-3) and Minnesota[[4]](#footnote-4) have attempted to promulgate scopes of practice, and both would probably be considered “limited ” compared to similar definitions for other professions. It could be argued that clear communication with providers, payers and other health professions cannot be achieved in the long run without a CHW scope of practice. The New York policy initiative applied a rigorous “functional job analysis” technique which produced a richly detailed picture of what CHWs actually (or potentially) do (available on request if further investigation is pursued). An early attempt at definition in the San Francisco Bay Area in the 1990s found clear distinctions in roles and skill sets between what they termed the “Clinical CHW” and the “Community Health Outreach Worker.”

**CHWs and Patient Navigators (PNs)**

We recommend that Arizona deal early and directly with the ongoing confusion of definitions between CHW and PNs. The term PN has received greater attention recently, due in part to the Patient Navigator Act (2005) and its reauthorization in the Affordable Care Act (2009). PNs are most often associated with cancer diagnosis and treatment, but they have proven to be effective in other chronic conditions.

As discussed in the March 8 meeting:

* PNs are assigned to specific patients; CHWs are often not, depending on their role
* PN duties are a subset of potential CHW duties
* PNs may have another occupational background (RN, MSW); this is a legitimate program design choice but it should be made explicit
* A nurse navigator can also find other employment as a nurse, as a CHW should be able to take CHW positions other than that of a PN

**b. Work Group on Workforce Development (education etc)**

This group had the largest number of participants of the four Workgroups on May 23, with twelve participants including one who identified as a liaison to AzCHOW and/or as a CHW

The Work Group discussed a range of needed activities, but focused its initial energy on reaching some common standards for CHW core competencies curricula across the state as an “early win.” This was described as a “Consolidated Core Competency Curriculum.”

Other priorities discussed included:

1. Assessing the need for a CHW Workforce
2. Market assessment for CHWs: i.e., who is hiring CHWs? Who should hire them?
3. Market development: e.g., educating health agencies / “users of CHWs employees”
4. Educating CHWs themselves: e.g., training / CORE Curriculum / different options for certification programs
5. Educating stakeholders on the benefits of CHWs / outcomes / impact of CHWs

Details of early activity on this first point are summarized below,

**Strategy/Actions Needed**

1. Circulate and review existing curriculum T.O.Cs: SARA(?), PLL, Jump Start, Direct Caregivers, HIS (CHR), AZCHOW review, CSP (?) and Lily Mar’s work
2. Involve stakeholders in curriculum development: \*CHWs

\*Health Plans

\*Health Agencies

1. Draft content for stakeholder input

**CHW Leadership Strategy to Support FIRST WIN (CHW capacity building etc)**

Review AzCHOW results from their 2012 Conference and the Coalition’s recent Survey, to assure incorporation in a Consolidated Curriculum.

FIRST WIN Resources Needed from the Coalition, other sources: curricula (circulated / shared) and time to participate in review of proposals

**Stakeholders to be Added for FIRST WIN and/or to Work Group Coalition:**

Lily Mar

**Consultant recommendations for the Workforce Development Work Group:**

1. This work group may need to divide into two subgroups, since the collection of workforce and employer demand data will be time consuming and resource-intensive in itself. Data from employers can and should include their views on skill requirements, which should inform curriculum standards.
2. This Work Group will also need to negotiate boundaries on collection of workforce data with the Data and Credibility WG. They should be prepared for the challenges of identifying current and potential employers for such studies, since experience nationally has shown this to be a labor-intensive process, which is inextricably related to awareness of CHWs among organizations which have not employed them.
3. The Work Group will also need to coordinate closely with the Occupational Definition and Awareness (OD&A) Work Group, since the Core Competencies adopted by the Coalition must support the Coalition’s definition and Scope of Practice for CHWs, which will be brought forward by the OD&A Work Group. An awareness campaign for Arizona will also facilitate the collection of workforce data as noted above.
4. Basic vs. full qualification (levels): opinions vary widely, nationally and (in all likelihood) within Arizona on the extent of basic education programs for CHWs. Curricula vary from 20-30 hours of instruction to over 200, so training providers clearly differ in their views on this point. Historically it has also been a matter of “what the market will bear” in terms of both the cost of initial training and employers’ willingness to let CHWs spend “non-productive” time in training. An argument can be made that pre-hire preparation required for new hires does not need to equip them to be “fully qualified” as CHWs, i.e., that some core skills can be developed through on-the-job and in-service learning.
5. The Work Group may need to contend with a pattern noted nationally that developers and owners of CHW curricula are not often willing to share actual curriculum materials, even to offer them for sale.
6. We have found nationally that state and federal workforce development agencies are often enthusiastic partners in these efforts, and they may have access to employers through other channels as well as access to training funds. We suggest the Work Group consider the federally approved apprenticeship model for CHWs in this context.

**c. Work Group on Sustainable Financing**

This group had ten participants of whom one identified as a CHW and as a liaison to AzCHOW. In plenary session on May 23, the Coalition participants discussed a presentation by Carl Rush on sustainable financing, in which Carl presented a schematic for viewing financing options for CHWs in three broad pathways: (a) under the current system of health care financing, mainly through health plans and internal financing of CHW positions within an organization’s core budget; (b) as part of ongoing population-based primary prevention and community development efforts; and (c) within emerging patient-centered care structures such as the patient-centered medical home, which accept accountability for health outcomes and not simply delivering units of service. A discussion of this framework is attached as Appendix B.

**Work Group Goals/Focus:**

* Where should the coalition focus its sustainability efforts.

(Example: NAZCARE is integrated care agency, blended with CHWs/CHRs cost as for peer support specialist which are billable.)

* ACA and structures it is predicting, such as ACO. How is it incorporated into that model?

**Work Group –Identified Action Plan**

The Work Group defined a number of strategic directions but did not complete details of an Action Plan. There was concern expressed that healthcare organizations would gravitate towards the least expensive option in any decision about staffing. The Work Group agreed that the Coalition should:

1. Find at least one “champion” in each key stakeholder category: FQHC / Hospital / Health Plan / Behavior Health / System Administrators
2. Look at ACOs statewide - some examples:

(TMC / El Rio / MCHC) + Phoenix model

Phoenix Children’s

JC Lincoln Scottsdale Health Care

Banner

1. Contact organizations pursuing the Health Insurance Exchange Navigator Role: good timing, CMS is receptive to CHWs

Relates well to CHW skill set / job description

Both CMS (general market) and HRSA (FQHC) funding available

Look at related occupations and relationships to CHWs (Roberta for several titles)

1. Move quickly to consensus on Job description and rate.
2. Look at potential role of CBOs as employers of CHWs - their capacity is under-utilized
3. Get Molina CHW job description HMS/UNM (Care coordinator)
4. Find Managed Care Organization examples
5. Pursue ongoing State funding for this effort

**Consultant Recommendations on Sustainable Financing**

1. The Work Group should gather data on examples of each strategy within and outside of Arizona.
2. The Work Group should identify as many stakeholders as possible who are already committed to integration of CHWs into ongoing operations, and engage them in the Coalition.
3. The Coalition should focus early attention on potential “wins” within existing health care structures, such as Medicaid (AHCCCS) MCOs using examples of promising models from other states.
4. The Work Group should egage key players currently developing PCMHs and ACOs in Arizona in a task force to learn about the potential of CHWs.
5. After gauging interest among stakeholders in the various potential financing models, the Work Group should focus the Coalition’s energy on one or two strategies considered most promising.

**d. Work Group on Data & Credibility**

This group included seven participants of which almost 50 % (3) were linked to AzCHOW and/or were CHWs.

**Work Group Goals/Focus: (registry)**

1. Comprehensive list of CHWs/ Promotores(as) in each county with specific goal towards health.
2. In order to combine list, 1st defining the definition across the board and knowing all the “names” of CHWs.
3. List of duties within each CHW
4. Cost benefits of CHW to organization
5. Meta-analysis of cost of management

**Work Group-Identified Action Plan DO NOT WORK ON THIS\_\_NEED TO ADD HERE**

The Work Group also defined a number of strategic directions. They demonstrated high energy and leadership when they reported these to the group. Of all the groups, this is the one that identified a formal Future Meeting plan for July 1, 2013. Assuming this is a newly scheduled meeting this action suggests important momentum that should be harnessed.

The Work Group identified that the Coalition should undertake the following action steps through creating a:

* 1. Comprehensive list / registering all CHWs as best as possible ideally with an on-line data base
	2. Cost benefits of CHW to organization meta-analysis emphasizing cost and management
	3. CHW Leadership Strategy to support CHW capacity building and other efforts as needed

The CHW field is truly at a tipping point including the CHW research agenda and innovation and potential for improvement through collective research efforts are significant. Efforts proposed in this report can help to move the integration of CHW services into clinical practice setting to improve patient outcomes across a spectrum of public health.

**Considering consensus on CHW data and credibility**

As identified by the Work Group as a focus area, work in the area of cost benefit research appears to be in demand. Ongoing success in this is a valuable asset for work on any other area identified by the Coalition.

XXX MORE

**About CHW Data**

We have learned from experience in …

**Additional Work Group Steps for Developing and Promoting-** CHW Data and Credibility

1. Develop core key measures
2. Pool data
3. List of varied CHW roles—duties for varied “jobs DOES THIS Go Here?
4. Develop core key measures
5. Pool data
6. List of varied CHW roles—duties for varied “jobs DOES THIS Go Here?

END

1. **General Observations and Recommendations**

The Coalition is presented with a unique opportunity in time. A number of influences are converging including the challenges of healthcare reform, the refocusing of programs such as CDCs chronic disease funding, the availability of data and program examples from other states, interest from CMS, and a general sense in healthcare and public health that persistent challenges require new approaches.

The Coalition’s work to date reflects a growing capacity among state players to take action that should ultimately impact CHW growth and sustainability in the state. The level of support from state-level public sector representatives is valuable and should continue to be developed and maintained.

**Coalition Development:**

1. The Coalition should establish a Steering Committee of Work Group representatives and formalize Coalition leadership. The Steering Committee should take steps to hold all Work Groups accountable for engagement of CHW leadership in their work. This should not be a symbolic gesture or limited to individual CHWs’ involvement, but should effectively represent CHW voices statewide (see point d. below).
2. The State, UA and others should support Work Groups with staff and communications support to the extent possible.
3. The four Work Groups established are on target, but they most deal with overlap of responsibilities and work products: as noted in the March 8 meeting, “everything is connected to everything else!” However, notably absent from the Work Groups’ priorities is development of a viable statewide CHW Network or Federation. The Coalition should use its new momentum as a means to consolidate, nurture, and support CHW leadership and participation in a unified network or association as a voice for CHWs, bridging regional and cultural differences within the state. This may evolve as one statewide membership organization or some form of federation model convening leadership from various CHW groups in state, such as AzCHOW, the Phoenix area CHW group, CHRs etc This topic was discussed but not included in the action planning in the May 23rd meeting.

**Observations and recommendations regarding stakeholder participation**

The initial group of Coalition participants is broadly representative and includes individuals who are very committed, but we recommend a methodical review of potential representation, emphasizing trade and professional associations as well as individuals and companies, nonprofits and state government agencies.

**Who is missing from the picture?**

The Coalition, to its credit, includes a number of local and state health administrators and researchers. The involvement of several community colleges offering CHW curriculum is also valuable. Not-for-profit Community Based Organizations (CBOs) are also well represented on the Coalition. Not as well represented are health care providers, from all sectors (public, CBOs, private), health care payers and the private sector overall. Additionally, tribal representation has been limited.

Also, perhaps most importantly, as noted above , involvement of CHW leaders is key, especially those organized into an existing network, is limited. To this end, AZCHOW is clearly present and it is important to stay vigilant about integrating their AZCHOW’s voice and other CHW leaders. Active plans for this would be an investment in developing long term support for CHWs.

Recommendations for specific organizations to include to expand the success and reach of the coalition include:

1. Professional associations, mainly nursing, medical and the Arizona chapter of the National Association of Social Workers
2. District and State level leaders in education, including individuals from low-income communities and targeted schools/districts; Head Start
3. Health care providers, mainly via their trade associations, but including individual opinion leaders and “champions” who have embraced CHW roles in their companies or organizations: hospitals, hospice, home health, FQHCs, private medical practices
4. Health Plans / Insurers including their state association
5. Housing officials and community action agencies

Restated here for clarity are specific observations and recommendations presented earlier for the four Work Groups:

**Consultant recommendations for Definition and Awareness Work Group**

Given initial observations on Arizona’s situation, the focus of the Occupational Definition and Awareness Work Group appears to be on target. The early action steps they proposed are also on target and can lead to success in this area. However, we have observed that work in this area can become drawn out and discouraging, so we suggest that efforts be made to safeguard this Work Groups interest and energy.

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**Consultant Recommendations for the Sustainable Financing Work Group**

1. The Work Group should gather data on examples of each strategy within and outside of Arizona.
2. The Work Group should identify as many stakeholders as possible who are already committed to integration of CHWs into ongoing operations, and engage them in the Coalition.
3. The Coalition should focus early attention on potential “wins” within existing health care structures, such as Medicaid (AHCCCS) MCOs using examples of promising models from other states.
4. The Work Group should egage key players currently developing PCMHs and ACOs in Arizona in a task force to learn about the potential of CHWs.
5. After gauging interest among stakeholders in the various potential financing models, the Work Group should focus the Coalition’s energy on one or two strategies considered most promising.

**Consultant Recommendations for the Data and Credibility Work Group**

Public Health Worker Core Competencies Compared to CHW Core Competencies

Appendix A

**8 Core Competencies of a Public Health Worker**

<http://www.phf.org/resourcestools/Documents/Core_Competencies_for_Public_Health_Professionals_2010May.pdf> ( p 3)

1. Analytic/Assessment Skills
2. Policy Development/Program Planning Skills
3. Communication Skills
4. Cultural Competency Skills

1. Community Dimensions of Practice Skills
2. Public Health Sciences Skills
3. Financial Planning and Management Skills
4. Leadership and Systems Thinking Skills

**7 Core Competencies of a Community Health Worker**

<http://crh.arizona.edu/sites/crh.arizona.edu/files/pdf/publications/CAHsummaryALL.pdf>

1. Bridging cultural mediation between communities and the health care system
2. Providing culturally appropriate and accessible health education and information often by using popular education methods
3. Assuring that people get the services they need
4. Providing informal counseling and social support
5. Advocating for individuals and communities within the health and social service systems
6. Providing direct services (such as basic first aid) and administering health screening tests
7. Building individual and community capacity

**Appendix B. A Framework for Understanding Options for Sustainable and Financing of CHW Employment**

**Background**

The current predominant structure of funding for CHW services, through short-term grants and contracts, is likely to persist for some. However, this pattern is not sustainable or desirable in the long run for several reasons:

it favors narrowly defined CHW roles

it does not encourage integration of CHWs into the ongoing operations of the employing organizations

it does not incentivize employers to invest in workforce development and continuing education

it encourages a proliferation of job titles and narrowly focused job training

it creates an unstable and unpredictable job market for CHWs

it undermines long-term relationships with the community served

The consideration of possible sustainable funding patterns can easily become very complex, but we can begin by considering two basic domains of CHW activity: in healthcare delivery and in population-based public health or community development. Each of these domains of activity as a distinct pattern of ongoing financing of services. Given the recent developments in healthcare reform, however, now appears to be a promising third pathway. The emerging hybrid structures such as the patient centered medical home are part of an attempt to shift from funding of units of service to payment for outcomes and/or quality. This means that these new structures are accountable for the overall health of the covered patient population as well as for the delivery of care.

**A Framework: Three Basic Pathways**

The table below represents some key features of each of these pathways, and which are represented as columns in the table. This table is intended as a starting point for discussion, since the full elaboration the workings of the various models would, as implied earlier, rapidly become quite complex. The rows in the table represent important examples of, or distinctions between, features of each pathway.

At the bottom of the table, the reader is reminded that any given payer, notably the State or a health plan, may choose several options for structuring employment of CHWs, either employing them directly, funding positions within healthcare provider organizations through contracts or add-ons such as care coordination fees, through separate contracts with community-based organizations, or promoting the engagement of CHWs as independent contractors, either individually or through co-ops.

**A. Conventional health care financing**

Some of the promising models of CHW employment in healthcare include CHW roles in redirecting emergency department users to more appropriate sources of care, care coordination for high cost utilizes of care ("hot-spotters"), improving birth outcomes through early intervention and prenatal coaching, supporting chronic disease self-management in a primary care setting, improving care transitions (notably reducing rates of hospital readmissions), and supporting the retention of individuals and home and community-based long-term care settings. Specific examples of each of these models have been identified, where they have been found to improve outcomes, quality of care, access to care, and/or cost control. These models call for the application of a wide range of potential CHW roles as shown in the table.

A growing number of healthcare leaders are recognizing the value of these models, and there are a range of potential payment mechanisms to support them as shown in row 3 of the table. Minnesota has pioneered in this area, authorizing fee-for-service payment under Medicaid state plan amendment for CHWs providing services under a procedure code for patient self-management education. More attention, however, is being focused on influencing practices of managed care organizations under Medicaid and Medicare, since MCOs have considerable flexibility in the use of funds received in the form of capitation payments. However, most of the MCO expenditures for CHWs have been classified as administrative expenditures and both the MCOs and the state are operating under an administrative expenditures under Medicaid. Federally-qualified health centers (FQHC's) have the latitude to include the costs of CHWs in the calculation of their perspective per-visit payments as "enabling services," but an expansion of this practice will involve fairly complex negotiations between the FQHCs and the state and/or HRSA.

One important mechanism for financing CHW positions is receiving increasing attention recently, namely that of "internal financing," or the integration of CHW positions into the organization’s core budget. Many kinds of organizations, including providers and payers, may be persuaded that CHWs have enough impact on core operations and outcomes, including financial sustainability, to justify budgeting for them without a dedicated source of payment. Examples have been noted of hospitals, MCOs, and community health centers adopting this practice. The driving principle in many of these examples has been documentation of a financial return on investment from an employment of the CHWs. Molina Health Care, an MCO with Medicaid contracts in 10 states, has demonstrated return on investment from care coordination with high utilizers in New Mexico, and is implementing this model in all of the states where it is doing business.

**B. Population/community and-based public health**

Population-based prevention has been challenged historically by inadequate funding and the difficulty of linking prevention investments to improvements in health outcomes and cost savings. There has been increasing interest in recent years in the social determinants of health, asset-based community development (ABCD) and health literacy. Physicians in particular have expressed their frustration at recognizing the influence of social determinants on their patients health status, while having limited capacity to influence those aspects of the patient's lives.

Amid growing concern about the rise of chronic conditions such as diabetes and cardiovascular disease, there is increasing pressure for ongoing activities to address the root causes of these conditions in nutrition, physical activity and rates of obesity. It is possible that a consensus will arise and public policy about the need for ongoing investment in primary prevention related initiatives in policy around the built environment show potential for engaging CHWs and issues around housing and economic opportunity. These initiatives will call upon CHW's to play greater roles in community advocacy and organizing, and they may also open opportunities for ongoing funding related to community development and housing. Advocates wish to pursue models such as block grant funding to local health departments, or an ongoing endowed prevention trust fund as established in Massachusetts under their 2006 health care reform legislation.

Several states have been willing to experiment with CHW approaches to community organizing for health improvement, including Delaware and Texas. In the case of Texas, a recent statewide Medicaid 1115 waiver has supported a number of local projects involving CHWs, including one in San Antonio which will place 10 CHW's in one neighborhood for this purpose.

**C. Patient-centered care systems (emerging hybrid structures)**

Healthcare reform in the near term future is focusing great deal of attention on patient centered care systems, as a means of shifting from payment for units of service to payment for outcomes. The most widespread of these models is the patient-centered medical home (PCMH). We have summarized below provisions of the NCQA accreditation standards, used in many states, which have particular relevance to the contribution of CHWs to the success of the PCMH:

**Area 1: Enhance Access and Continuity**

* Element F: culturally and linguistically appropriate services (CLAS)
* Element G: the practice team - CHWs can add depth of understanding of the patient/family situation

**Area 2: Managing the Patient Population**

* Element A: patient information; assuring the team has a complete picture, and patient/family are being candid
* Element C: patient assessment
* Element D: population management; emphasizes prevention
* Patient-Centered Medical Homes

**Area 3: Managing care**

* Element A: patient reminders
* Element C: care management (care plan and follow-up)
* Element D: medication management (reconciling and recording)

**Area 4: Self-care support and community resources**

* Element A: self-care support
* Element B: referrals to community resources

**Area 5: Tracking and coordinating care**

* Element A: lab test follow-up
* Element B: referral follow-up
* Element C: coordination and care transition

The roles of CHWs may differ somewhat between the PCMH and the accountable care organization (ACO), since the ACO accepts financial responsibility for The entire cost of care for the covered population, including hospitalization. However both the PCMH and the ACO have the financial flexibility to include CHWs as part of the care team; the payer may also choose to provide supplemental payments for certain patients of populations with complex needs or greater medical risk, and CHW roles in some cases might be focused on those populations.

**Sustainable Financing of CHW Activities: Three Broad Pathways**

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|  | **Basic pathways** |
|  | **A****Conventional health care** |  | **B****Population/community-based public health** |  | **C****Patient-centered care systems (emerging hybrid structures)** |
| **1****Promising program models** | Emergency room diversion“Hot-spotters” (high cost users)Prenatal/perinatal coachingPrimary care based chronic disease managementCare transitionsHome/community-based long-term care |  | Specific condition-focused initiativesCommunity development approach (social determinants) |  | Patient Centered Medical HomesAccountable Care OrganizationsHealth Homes |
| **2****Specific CHW roles in these models** | Care coordinationSelf-management support for chronic conditionsReferral and assistance with non-medical needs and barriersMedication management supportPatient/family advocacySupport and extension of health educationPatient navigation |  | Basic outreach and educationCommunity advocacy/organizing |  | Combination of health care and population-based (as at left) |
| **3****Payment mechanisms for these models** | Fee for serviceManaged care organizations: admin/service dollars; dualsMedicaid 1115 waiversInternal financingProspective payment (FQHCs) |  | Medicaid waiversBlock grantsPrevention trust fund (Mass. model)Pooled funds from third-party healthcare payers |  | Bundled/global/prospective paymentSupplemental capitation payment for specific services |

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| **4****Options for third-party payers** | CHWs directly employed by payerHealth care provider contracts/add-ons to hire CHWsCBO contracts to employ CHWsCHWs as independent contractors |

1. A summary of the March 8 meeting results, prepared by Dr. Samantha Sabo, have been provided to the Coalition. [↑](#footnote-ref-1)
2. This summary of preliminary Survey findings, also prepared by Dr. Sabo, has been provided to the Coalition. [↑](#footnote-ref-2)
3. <http://www.chwnetwork.org/_clientFiles/nycchw/_media/chw_initiative2011report.pdf> (pp. 6-9) [↑](#footnote-ref-3)
4. http://mnchwalliance.org/scope.asp [↑](#footnote-ref-4)