

Utilization of Community Health Workers In Emerging Care Coordination Models In California

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CONTENTS

Executive Summary
Introduction
CHW Definition and Scope of Work
CHW Evidence and Impact
CHW National Outlook
CHW California Outlook
Care Coordination State Policy Programs
Future Policy Considerations
Conclusion and Next Steps

This project was made possible with funding from the Blue Shield of California Foundation, Healthforce Center at UCSF has designed a two-phased project aimed at enhancing California's readiness to integrate Community Health Workers (CHWs) and Promotores in the health care delivery system. This research brief represents the culmination of the first phase of the project involving a synthesis of existing research on CHWs/Promotores, key informant interviews, and a policy scan of state-level initiatives that may influence the utilization of CHWs and Promotores.

Executive Summary

Community Health Workers (CHWs) and Promotores de Salud are playing an increasingly important role in community-based and clinical care settings. As healthcare reform addresses healthcare spending and enhanced coordinated care delivery to manage the crippling incidence of chronic disease, there is increased opportunity and need for holistic care team approaches that integrate clinical and community-facing roles. Further, addressing social determinants of health that impact vulnerable populations who are disproportionately affected by chronic disease necessitates care delivery models that are attuned to the specific sociocultural, socioeconomic, and linguistic needs of these targeted populations.

Standardized workforce data is limited in its capacity to demonstrate a clear supply and demand workforce model for CHWs and Promotores in California. While there is a standard occupational classification for CHWs yielding federal and state employment statistics, in practice there are dozens of different titles of paid and unpaid positions that fall under the umbrella of "CHW." Therefore, the employment data currently captures data for workers who are formerly classified under the given title and may not capture workers who are performing the *function* of community health work under other occupational titles.

However, current employment statistics on CHWs in California do show notable projected growth. Current state policy initiatives coupled with a shift across healthcare toward targeting social determinants of health, enhancing care coordination, and integrating social services and clinical care are further indicators of a broader opportunity and need for community health worker roles.

In California, the lack of a CHW certification body, defined scope of practice, standardized curriculum and training, and robust state reimbursement models/financing for CHW services have been recognized as barriers to fully implement effective workforce planning and optimize CHWs in practice.

There are targeted efforts currently underway at the public and private organizational levels to research and distill these

barriers as well as develop recommendations and priority actions to better utilize CHWs and Promotores in various care settings in California.

The renewal of the Medicaid 1115 waiver demonstration – Medi-Cal 2020 – has led to initiatives that individually and collectively incentivize care coordination and care management for high-need and high-utilizer populations. Additionally, the State Plan Amendment “Health Homes for Patients with Complex Needs” directly incentivizes the use of a defined CHW-role in the program design. While the Health Homes initiative is the only current program that explicitly names CHWs as part of the care design and payment reform effort, all initiatives reflect a potential need for CHW roles within the care delivery redesign and new payment methodologies that incentivize community engagement, outreach, and care management for program beneficiaries.

With these changes, we expect that CHWs and Promotores will be in a position to play an increasingly important role in these efforts with the appropriate workforce support in place.

Research to date has shown that effective workforce planning support in California could benefit from the following efforts:

- Increase the dissemination of evidence-based research demonstrating the return on investment (ROI) for integration of CHWs/Promotores into care teams in emerging statewide care coordination efforts.
- Identify case studies and best practices of successful integration models and partnerships between clinical and community CHW/Promotor workers within emerging state policy initiative care coordination pilot programs.
- Translate the functional demand for CHW/Promotor functions in evolving care delivery models into tangible jobs-to-be-filled.
- Enhance opportunities for CHW/Promotor workforce representatives to be prominently represented in statewide policy development, funding initiatives, and

healthcare payment reform efforts aimed at incentivizing care coordination and value-based payment models for the care of vulnerable populations.

- Identify sustainable funding models beyond isolated grant-based CHW/Promotor program support.
- Create enhanced, multi-faceted training and certification pathways to employment and professional development that supports all members of the workforce in order to enable professional growth into clinical settings while also preserving pathways for the vital community-based Promotor role.

Introduction

Community Health Workers (CHWs) and Promotores are playing an increasingly important role in the delivery of high quality and equitable health related services, particularly to vulnerable populations. CHWs/Promotores serve as a key linkage between community members and clinical services, serve as trusted individuals, and can advocate on behalf of communities regarding issues related to social determinants of health.

On a national level, several key legislative changes have led to a growing opportunity to enhance the utilization of frontline workers such as CHWs/Promotores to better coordinate services and supports for vulnerable communities to achieve the triple aim of better health, better care, and lower costs.

The Patient Protection and Affordable Care Act of 2010 includes provisions relevant to CHWs, with a promotion of grants “to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of CHWs” using evidence-based interventions to educate, guide, and provide outreach in community settings.^{1, 2}

Additionally, recent changes to Medicaid through the Medicaid Preventative Services rule allows for the potential reimbursement for preventative services for non-licensed providers, such as CHWs.³

As the healthcare system embarks on the process of transitioning from fee-for-service reimbursement and volume incentivized care to value-based care, new care delivery and payment models are being implemented across care delivery settings.

Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs) are designed to enhance care coordination and management for patient populations, enhance care transitions, and bridge care across clinical and community settings.

Several states - California, Minnesota, Vermont, and Washington - have developed Accountable Communities for Health (ACH) models aimed at establishing clinical and community partnership strategies that integrate care delivery system transformation with community-based social services to improve health outcomes, reduce costs, and impact behavioral, environmental and social determinants of health.⁴

Healthcare entities are taking on more financial risk and payment models are increasingly designed to incentivize outcomes and population health management through capitation, global, and bundled payment models. As such, care coordination across care teams is becoming an essential component of care delivery and payment reform, especially within efforts around chronic care prevention and management for high-cost populations.

With this evolution of health care and services in mind, the guiding objective for this project is to develop actionable insights into how CHWs and Promotores may be optimally utilized in emerging care coordination models in California.

This research brief represents the first phase of that effort and was guided by the following questions:

- What do data tell us about current supply and workforce dynamics of CHWs and Promotores in California?
- How will state policies impact future demand and opportunities to integrate CHWs and Promotores into team models?

- What workforce planning tools will optimally support the integration of the CHW/Promotor workforce into the current statewide efforts underway to expand clinical care coordination models in California in a way that preserves the community-centeredness of the role?

To gain insights into these research questions, we employed the following methods:

- Literature review of previous research and reports on CHWs and Promotores in California, along with a cursory review of state-based CHW research and policy outside of California.
- Policy scan of current state-level initiatives that may impact the demand for CHWs and Promotores in California.
- Key informant interviews with a targeted sample of entities working with CHWs and/or Promotores across various care settings.
- Participation in a convening of community-based organizations working to support and improve the CHW and Promotor workforce.

This research brief represents a stand-alone synthesis of findings and future policy considerations. It also provides the foundation for the next phase of work centered on case studies of select clinical care models across the state who are utilizing CHWs/Promotores in care coordination models, with specific emphasis on efforts that are integrating and expanding CHW models as part of the emerging care coordination state policy pilot programs currently underway.

CHW Definition and Scope of Work

As a workforce, CHWs represent a vital, yet complex, population of workers in California. A CHW is most commonly defined as:

“... A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between

health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.”⁵

While Promotores de Salud are often considered to be part of this CHW workforce, there are historical differences in the evolution of the role. The following definition was adapted from the APHA to be more inclusive and reflective of the full spectrum of community health work:

“Promotores de Salud/Community Health Workers (CHWs) are volunteer community members and paid frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. Promotores de Salud/Community Health Workers (CHWs) generally share the ethnicity, language, socioeconomic status, and life experiences of the community members they serve. These social attributes and trusting relationships enable CHWs to serve as a liaison, link, or intermediary between health and social services and the community to facilitate access to and enrollment in services and improve the quality and cultural competence of service. Promotores/CHWs can enhance provider-patient communication; preventive care; adherence to treatment, follow-up, and referral; disease self-management; and navigation of the healthcare system. Additionally, Promotores/CHWs build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino communities.”⁶

There are a wide variety of titles and functions that have been used under the umbrella “Community Health Worker” role, including but not limited to: case manager, community health educator, doula, enrollment specialist, family resource specialist, lay health advisor, patient navigator, peer support specialist, street outreach worker, health coach, family health advocate, health educator, outreach worker, peer health educator, Promotor de Salud, and system navigator.⁷

Historical Context

In order to understand the unique nature of this population of workers in the context of healthcare workforce planning, it is critical to understand that the role of the CHW/Promotor has developed primarily *within* underserved communities and primarily *within* community-based and social service organizations. While there is an increasing focus and interest on the ways in which CHWs and Promotores may be (or are currently) utilized in clinical care settings, their role and scope of work has developed largely within grassroots community organizational frameworks.

Therefore, while the use and function of Community Health Workers and Promotores is not new, the movement toward codification of the role and attention to this population of workers as a cohesive “workforce” is relatively recent.

The implications are two-fold:

First, CHWs’ and Promotores’ employment (or volunteer) status has historically been largely in community-based organizations. Their function often overlapped with healthcare settings directly or indirectly as CHWs and Promotores frequently operated as a conduit between community services and health services. However, until recently, CHWs and Promotores were not typically employed directly by traditional healthcare organizations.

Second, traditional healthcare entities (hospitals, clinics, health plans, etc.) are now seeking solutions to engage patients across clinical and community settings to promote healthy behaviors and prevent and manage chronic conditions. As these healthcare entities manage an increased volume of patients with severe chronic diseases who face socio-economic and socio-linguistic barriers, there is an increased focus on how to incorporate community-based CHW/Promotor roles into care coordination and care teams. The employment of CHWs/Promotores directly within traditional healthcare organizations has led to increased attention toward codification of the role with specific consideration to training, certification, and reimbursement within new payment models.

These historic and developing roles for CHWs do not represent two entirely separate models of CHWs/Promotores, but they do represent distinct employment models and potentially distinct models of workforce demand for CHWs/Promotores; this creates a need for more thorough and multi-faceted scope of practice, training/certification, and payment/reimbursement considerations.

As we consider how to optimally integrate and utilize CHWs/ Promotores into care coordination models, we recognize that workforce planning that aims to optimize “utilization” of CHWs/Promotores in traditional clinical care delivery settings will have distinct features from a strictly community-based CHW/Promotor role. However, these efforts will benefit from and should be rooted in collaboration or direct partnership with existing community-based employers of CHW roles and related CHW advocacy organizations.

CHW Evidence and Impact

There is growing evidence demonstrating the effectiveness of CHWs with regard to access, outcomes, and cost-effectiveness.

Studies continue to demonstrate the impact of CHWs on chronic illness reduction,⁸ improved medication adherence, increased patient engagement,⁹ community health improvement,¹⁰ and reductions in healthcare costs.^{11,12}

There is an organized effort underway to build a national consensus around CHW scope of practice, core skills, and core qualities to directly inform and support organizations providing CHW services and/or training. The most comprehensive output from this national effort can be found in the recently released report from the CHW Core Consensus (C3) Project, “Building National Consensus on CHW Core Roles, Skills, and Qualities”¹³ produced by a collaborative including the National AHEC (Area Health Education Centers) Organization, University of Texas – Houston Project on CHW Policy and Practice and affiliated leaders in CHW capacity building.

The consensus report outlines CHW roles, skills, scope of practice, competencies, and qualities; it is intended to provide guidelines, rather than national standards, that can inform state governments and other stakeholders working to develop workforce standards for CHWs. The C3 project maintains that a CHW-led state and/or national organization should be a key partner in any statewide standards development process.

Insights and recommendations from this national consensus effort outline the following as the core values that should guide CHW workforce development.

The report maintains that CHWs should:

- Share lived experience with the communities they serve.
- Be recognized as members of a unique profession with a unique scope of work.
- Be meaningfully involved in efforts to create policy for their field.
- Be recognized and rewarded for their experiential knowledge.
- Be trained and supported in a full range of roles to work across all levels of the socio-ecological model from the individual level to the family, community and policy levels.
- Participate in initial and on-going training that is informed by and based on popular education and adult learning, including relevant and practical content.
- Receive sufficient and appropriate supervision that supports their professional growth.
- Be compensated at a level commensurate with their skills, and as they gain experience, be involved as trainers for new CHWs.¹⁴

CHW National Outlook

As of 2012, only 16 states had any laws in effect with regard to establishing a CHW advisory body, CHW scope of practice, CHW certification or training process, standard

curriculum with core skills, state financing for CHW reimbursement/incentives for CHW services, or integration into team-based care.¹⁵

States vary considerably in their level of legislation and regulation of CHWs as a workforce. While the focus of this research is on California, we are including a brief summary of the following three states, selected because they have notable activity in certification, training, and organizations of CHWs: Minnesota, Massachusetts, and Texas.¹⁶

Minnesota

Minnesota enacted legislation in 2007 allowing CHWs with a certificate of standardized training or at least 5 years supervised experience with a clinician to be reimbursed by Medicaid. Billable services must be provided under medical supervision and the CHW must register as a Medicaid provider (but may not bill the State directly).

CHW training occurs within a statewide, standardized, and competency-based educational program within accredited post secondary schools, overseen by the MN State Colleges and Universities System. Programming includes classroom and field-based learning for individuals with a minimum of a high-school diploma or GED.

Massachusetts

In 2007, CHW legislation created a seat on the Public Health Council for a representative from the Massachusetts Association of Community Health Workers and a certification board in the Massachusetts Department of Public Health was established in 2010.

CHW positions are funded through grants, core operating funds, and other resources across government, foundation, nonprofit funding, and health plans. The state anticipates the shift toward global payments will further support CHW services. Medicaid supports isolated CHW services (e.g. high-risk pediatric asthma) and CHWs are incorporated into recent payment reform legislation.

CHW training is offered through community-based organizations, AHEC, local health departments

(Community Health Education Centers), and university schools of public health with training programs that focus on ten core competencies. CHW certification is available through the Board of Certification for Community Health Workers for both paid and volunteer workers who have completed 2000 hours of work experience, yet remains voluntary.

Texas

The majority of paid CHW positions are funded through grants or core budget funding. CHWs are involved in a small part of the over 1,300 projects as part of a recent Medicaid 1115 waiver and receive some reimbursement through the waiver projects. Medicaid/CHIP (Children's Health Insurance Program) contracting language was amended to include a definition of CHWs and includes CHWs as a potential part of administrative costs.

The Department of State Health Services (DSHS) established a statewide advisory committee in 2011 that provides recommendations for CHW training, funding, and employment.

Training is provided through community colleges, AHEC, Federally Qualified Health Centers (FQHCs), and CHW network and community organizations. DSHS operates the "Promotor(a) or Community Health Worker Training and Certification Program" for 2-year certification.

CHW California Outlook

California employs the largest number of CHWs/Promotores in the country (unadjusted relative to total population) and CHWs are notably organized and active within advocacy organizations such as Visión y Compromiso and the California Association of Community Health Workers (CACHW). However, there remain gaps in robust funding mechanisms, training, and professional pathways to support the large and diverse CHW/Promotor workforce and the settings they work within.

To address these issues on a statewide level, the California Health Workforce Alliance (CHWA) published a comprehensive statewide assessment report in 2013 identifying key factors impeding the engagement of CHWs as core members of primary care and prevention teams:

- A lack of stable funding streams and reimbursement mechanisms.
- Limited analytical capacity and access to external data sources.
- Limited knowledge of, and access to, evidence-based practices.¹⁷

CHWA followed up with three regional technical consultation meetings with dozens of clinical and administrative leaders across the state's safety net, culminating in the January 2015 report "Community Health Workers in California: Sharpening Our Focus on Strategies to Expand Engagement" with findings and recommended priority actions across four areas: Training, Organizational Capacity for Engagement, Data Capacity, and Resources.¹⁸

To build toward workforce planning for CHWs and Promotores in California, this research brief focuses in on three areas – CHW scope of work, training and certification, and financing and reimbursement – as it relates to the most recent 2016 statewide initiatives focused on enhanced care coordination efforts in California.

CHW Roles, Skills, and Scope of Practice Outlook

The variation and flexibility of the CHW/Promotor scope of work can be an asset in practice within many community-based settings, but presents challenges to efforts that are geared toward defining specific support, advocacy, and policy development for the workforce as a whole.

CHWs and Promotores, who are now or will be employed in clinical settings, require greater recognition among clinicians, a more defined scope of work, enhanced health-system capabilities (e.g. HIPAA compliance), and more robust clinical-community hiring and training partnerships to effectively integrate into care coordination efforts.

Training and Certification Outlook

At present, there is no standardized training model for CHWs/Promotores in California.

Traditional training data from sources such as the Integrated Postsecondary Education Data System (IPEDS), the Bureau of Labor Statistics (BLS), and the American Community Survey (ACS) are not able to yield comprehensive data on demand and supply due to the wide variability in the CHW role and the significant proportion of on-the-job training received by CHWs and Promotores.

According to a California Community College Curriculum Inventory, six community colleges offer certificate or degree programs.¹⁹ Some are currently on hiatus or revamping their programs based on future funding and employer demand.²⁰

San Francisco Community College (SFCC) is a leading training program that currently produces the largest number of Community Health Worker graduates of a certificate program across the state (123 in academic year 2013 – 2014).²¹ SFCC is currently revamping curriculum content that is utilized across California and other states.²²

Formalizing and standardizing the training and certification requirements for CHWs and Promotores remains controversial. While there is a desire by many to create a more defined professional pathway and enhanced training opportunities for the role, there is an equivalent desire to not exclude existing workers through mandatory certification or formal education requirements.

There is also a question concerning how to effectively standardize training or certification without a well-established pipeline of jobs that will be filled by CHWs/Promotores. In some ways, CHW training may be running ahead of capacity and demand. While research demonstrates a clear need for CHWs/Promotores based on the evidence of their impact on access, outcomes, and cost-effectiveness, the actual demand – in the form of established CHW positions to-be-filled – appears to be lagging.

Payment and Reimbursement Outlook

While studies continue to demonstrate impact of CHW utilization on health outcomes and cost, there remains a lack of robust reimbursement and financing mechanisms for CHW and Promotor models of care.

Some organizations have operationalized CHWs into yearly budgeting while others operate with some combination of stipends, grant funding, and/or non-paid workers (volunteers).²³

The majority of community-based organizations that currently hire and train CHWs and Promotores rely primarily on grant-based funding and private resources to sustain CHW programming, thereby creating a chasm between the *potential* opportunity that may be created by large-scale federal initiatives (discussed below) and organizations' immediate operational needs to sustain their models.

To implement new roles for CHWs in clinical care models, there is a need for value-based reimbursement models that clearly support the CHW and Promotor role as part of the care team.

Care Coordination State Policy Programs

There are several current and pending state initiatives in California where community health worker roles may be integrated within care improvement programs (See Table 1 for further detail).

The majority of initiatives are in the very beginning application and pilot stages; therefore, detailed analyses and outcomes are not currently available. However, a preliminary policy scan reveals potential opportunities for increased utilization of CHW-related roles within the following initiatives:

- PRIME (Public Hospital Redesign and Incentives in Medi-Cal)
- FQHC Payment Reform Pilot (APM)
- Whole Person Care Pilot
- Coordinated Care Initiative (renewed from 2013)
- Health Homes for Patients with Complex Needs

PRIME (Public Hospital Redesign and Incentives in Medi-Cal)

CHWs are not mandated, but CHW models are part of the literature on recommended approaches that designated PRIME entities (designated public hospital systems, district/municipal hospitals) can use as they develop their activities toward infrastructure improvement around high-cost populations focused on care management, care transitions, and behavioral health integration.

Some areas of focus for current PRIME pilots that may involve CHW roles include:

- Integration of Physical and Behavioral health
- Obesity Prevention and Healthier Foods Initiative
- Care Transitions: Integration of Post-Acute Care
- Complex Care Management for High-Risk Populations
- Transition to Integrated Care: Post Incarceration

FQHC Payment Reform Pilot (APM)

The FQHC Payment Reform Pilot will center on an alternative payment methodology (APM) that will incentivize a gradual transition from Prospective Payment Systems (PPS) to a Per-Member, Per-Month (PMPM) risk-based model. As FQHCs increasingly bear more risk and focus on population health management, the FQHC payment reform pilot drives an opportunity for care team roles (such as CHWs) that will enhance care coordination, care management, and care transitions for complex patient populations.

Whole Person Care Pilot

As a voluntary, county-based initiative targeting high-utilizers through increased coordination and access to clinical care, housing, and support services for the most vulnerable Medi-Cal beneficiaries, there is room to define how to integrate care coordination and use of CHW roles in the community coordination function under the Whole Person Care requirements.

Coordinated Care Initiative

To promote coordinated care for dual-eligibles (individuals qualifying for both Medicaid and Medicare benefits), a primary focus is on keeping beneficiaries in their home when medically appropriate. As such, in-home support

services and community health promotion are key components of care plans and an area where CHW roles are needed.

Health Homes for Patients with Complex Needs

The Health Home initiative was developed as a State Plan Amendment (SPA) to develop a network of providers that will integrate and coordinate primary, acute, and behavioral health services for the top 3-5% of the highest risk Medi-Cal beneficiaries.

There are six categories of required services that will be reimbursed:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care
- Patient and family support
- Referral to community and social support services
- Use of health information technology to link services, as feasible and appropriate

Community Health Workers are designated in the legislation as a “provider” type that is part of the care team providing the following services:

- Comprehensive Case Management
- Care Coordination
- Health Promotion

In the legislation, Community Health Workers are defined as a “paraprofessional or peer advocate.”

Functions of this role might include:

- Accompany members to office visits
- Arrange transportation
- Assist with linkage to social supports
- Distribute health promotion materials
- Call members to facilitate visits with care manager

These initiatives are squarely focused on clinical care delivery and health system payment reform. While there is a clear *potential* need for community health worker functions

in these initiatives aimed at incentivizing care coordination and care team redesign, there is not a direct mandate that creates an established demand pipeline for CHWs and Promotores.

Instead, these state policies present an opportunity and a need for greater coordination and partnerships between clinical services entities, community, advocacy, and training entities currently representing CHWs and Promotores.

California Accountable Communities for Health Initiative (CACHI)

The California Accountable Communities for Health Initiative (CACHI) is currently funded through The California Endowment, Blue Shield of California Foundation, Kaiser Permanente, Sierra Health Foundation, and administered through Community Partners. In July, 2016 CACHI awarded funding to six county-based healthcare delivery organizations from across the state to establish health system and community-based partnership models to achieve greater health equity targeting high-priority community issues including asthma, violence, obesity, and cardiovascular disease. These models hold further opportunities to leverage CHW/Promotor models of care in California as part of the ACH model of a more community-centered and prevention-oriented health system.

Future Policy Considerations

State-level policy initiatives, community-based organizational work, and clinical services models are collectively accelerating change around care coordination, care team models, and socio-culturally competent care. With these changes, we expect that CHWs and Promotores will be in a position to play an increasingly important role in these efforts with the appropriate workforce support in place.

To truly optimize the utilization of CHWs and Promotores into clinical care coordination roles, there needs to be an integrated supply and demand effort that jointly:

1. Defines a more precise and updated demand model within clinical care delivery settings as it pertains to

current efforts to enhance care coordination and value-based payment within safety net provider systems.

2. Develops a more robust supply model that acknowledges the unique, and sometimes underrepresented, CHW/Promotor workforce and provides supports for a multi-faceted scope of practice and training model that meets a defined demand across community and clinical settings.

Recommendations

Increase the dissemination of evidence-based research demonstrating the ROI for integration of CHW/Promotor into care teams in emerging statewide care coordination efforts.

- Target existing safety net hospitals and managed care plans involved in statewide care coordination and new payment models centered on managing complex chronic patients and integrating clinical and social services.

Identify case studies and best practices of successful integration models and partnerships between clinical and community CHW/Promotor workers within emerging state policy initiative care coordination pilot programs.

- Identify successful coordination efforts between provider systems and community partners to identify, train, and integrate CHWs/Promotores into clinical care coordination models.
- Capture best practices for defining the CHW/Promotor scope of practice, financing, and technical assistance needed to incorporate CHWs and Promotores into care coordination models.

Translate the need for CHW/Promotor functions in evolving care delivery models into tangible jobs-to-be-filled.

- If training is potentially running ahead of capacity, with defined jobs to-be-filled by CHWs/Promotors in clinical care settings lagging, identify resources for employers to help define and establish CHW jobs to-be-filled aligned with training pathways.

Enhance opportunities for CHW/Promotor workforce representatives to be prominently represented in statewide policy development, funding initiatives, and healthcare payment reform efforts aimed at incentivizing care

coordination and value-based payment models for the care of vulnerable populations.

- Identify and gain insights from CHW organizations and/or clinical/community partnerships that are participating in early stage pilot programs (e.g. PRIME, Health Homes).

Identify sustainable funding models beyond isolated grant-based CHW/Promotor program support.

- Build capacity for organizations to conduct robust evaluations and demonstrate measurable outcomes and ROI, which provides a major advantage in getting a “seat at the table” shaping policy, care delivery, and financing considerations for CHW/Promotores. Recent efforts include MHP Salud’s ROI Toolkit for Community Health Worker Programs.²⁴
- Enable enhanced opportunities for community-based organizations to network, build alliances, and identify potential partnerships with care delivery entities to build organizational capacity and potentially leverage larger-scale policy and financing opportunities.

Create enhanced and multi-faceted training and certification pathways to employment and professional development, preserving pathways for the vital role of undocumented members of the workforce.

- Incorporate current national efforts defining CHW roles, skills, and qualities into a statewide coalitional effort to provide a foundational scope of practice to guide education, training, and policy development.
- Identify community and clinical services pathways to employment around targeted social and clinical determinants of health, including:
 - Chronic disease management
 - Obesity prevention
 - Healthy behaviors/Health literacy
 - Nutrition access and education
 - Youth and adult alcohol and tobacco prevention/cessation
 - Patient navigation – health system, prevention and wellness resources

- Define tiered education and training needs for CHW/Promotor across employment settings to identify enhanced training requirements for CHW workers who work directly within clinical delivery systems:
 - Data collection
 - HIPAA compliance
 - EHR access and documentation
 - Communication with clinical care team

Conclusion and Next Steps

CHWs and Promotores are playing an increasingly prominent role in community-centered and clinical services models of care across California. Prominent CHW/Promotor advocacy efforts, state-level policy initiatives, and care delivery redesign efforts focused on care coordination, social determinants of health, and meeting the socio-cultural needs of target populations further elevates the role that CHWs and Promotores have played to date, and the potential impact this role may play in community and clinical settings in the future.

Building off of the insights presented above, Healthforce Center at UCSF will focus the next phase of this project on a deeper investigation of care delivery models utilizing CHWs and Promotores in varied clinical and community-based settings to provide an actionable framework for entities seeking to optimally utilize CHWs and Promotores in their care coordination efforts moving forward.

Appendix

TABLE 1: CA Department of Health Care Services (DHCS) Care Coordination and Management Initiatives²⁵

State Initiative	Program Description Summary	Potential CHW Opportunity
PRIME (Public Hospital Redesign & Incentives in Medi-Cal)	The Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Pool builds upon the Bridge to Reform Waiver's Delivery System Reform Incentive Payments (DSRIP) program to improve the quality and value of care provided by California's safety net hospitals and hospital systems. Participating PRIME entities will consist of two types of entities: Designated Public Hospital (DPH) systems and the District/Municipal Public Hospitals (DMPH).	Capitation drives demand for more integrated and coordinated care, enabling and encouraging use of CHWs. Integrating physical and behavioral health and management of complex care patients anticipated areas of focus for CHW integration.
FQHC Payment Reform Pilot (APM)	The payment reform methodology converts a health center site's current PPS rate to a per member, per month (PMPM) capitation payment that would be paid by their health plan(s) or IPA(s). CPCA anticipates the pilot will commence in 2017. The Capitation Payment Preparedness Program (CP3) is the readiness effort being developed to ensure demonstration sites are successful participants in the Alternative Payment Methodology (APM) pilot.	PMPM fee allows for more coordinated care, improved patient experience. Some sites using CHWs, expected to increase. "Non-traditional/Alternative encounters" will eventually be assigned a value as part of rate negotiations (but first need data to track clinic encounters).
Whole Person Pilot Program	The Whole Person Care (WPC) regional pilots focus on the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources.	Counties and community partners design pilot interventions targeting high-risk populations; can be creative how they integrate care coordination under WPC requirements. Assumption that CHWs will be used in some community coordination function.
Coordinated Care Initiatives	This coordinated care initiative aims to improve service delivery for all Medi-Cal beneficiaries, but particularly those who need coordination the most: the 1.1 million people eligible for both Medicare and Medi-Cal coverage ("dual eligible beneficiaries") and the 160,000 Medi-Cal-only beneficiaries who rely on long-term services and supports (LTSS). Combining the full continuum of services into a single benefit package, and delivering those services through an organized managed care delivery system will promote accountability, create efficiencies, and improve care coordination.	Program focus on keeping beneficiaries in the home. In-home support services and community health promotion are major components of care plans.
Health Homes For Patients with Complex Needs	For Section 2703 health home enrollment: 1. Individuals with two or more chronic conditions; 2. Individuals with one chronic condition and at risk for another; 3. Individuals with serious and persistent mental illness. HHP will target all three categories for health home eligibility with an emphasis on beneficiaries with high-costs, high-risks, and high utilization who can benefit from increased care coordination of physical health, behavioral health, community-based LTSS, palliative care, and social supports, resulting in reduced hospitalizations and emergency department (ED) visits, improved HHP beneficiary engagement and decreased costs	CHWs are eligible providers within team-based care for Health Home enrollees. Approved functions include: • Accompany members to office visits • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Call members to facilitate visits with care manager

References

¹ Patient Protection and Affordable Care Act, 42 USC § 18001 et seq.

² Patient Protection and Affordable Care Act , 42 U.S.C. 280g et seq.

³ Centers For Medicare And Medicaid Services, Update on Preventive Services Initiatives, Nov. 27, 2013, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf>.

⁴ Heider, T., Kniffin, T., & Rosenthal, J. (May 2016). State Levers to Advance Accountable Communities for Health. National Academy for State Health Policy. <http://nashp.org/wp-content/uploads/2016/05/ACH-Brief-with-Appendix.pdf>

⁵ American Public Health Association (APHA). <http://www.apha.org/membergroups/sections/aphasections/chw/>

⁶ Adapted from the American Public Health Association (2009). Community Health Workers National Workforce Study (HRSA) and the Patient Protection and Affordable Care Act (2010):

1. Community Health Workers Section, American Public Health Association. <http://www.apha.org/membergroups/sections/aphasections/chw>.
2. Community Health Workers National Workforce Study (HRSA). <http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf>
3. The Patient Protection and Affordable Care Act of 2010, PL. 111-148, sec 5101, 5102, 5313, 5403, and 3509.

⁷ Masters, B. (May 2015). Advancing Community Health Workers to Improve Health Outcomes and Reduce Costs: Recommendations for the California State Health Care Innovation Plan. Report to the California Health and Human Services Agency Secretary.

⁸ Allen JK, Dennison-Himmelfarb CR, Szanton SL. (2011). Community Outreach and Cardiovascular Health (COACH) trial: a randomized, controlled trial of nurse practitioner/community health worker cardiovascular disease risk reduction in urban community health centers. *Circulation: Cardiovascular Quality and Outcomes*. 595–602.

⁹ Heisler M, Spencer M, Forman J, Robinson C, Shultz C, Palmisano G, et al. (2009). Participants' assessments of the effects of a community health worker intervention on their diabetes self-management and interactions with healthcare providers. *American Journal of Preventative Medicine*; 37(6 Suppl 1):S270–9.

¹⁰ Centers for Disease Control and Prevention. (2011). Addressing Chronic Disease Through Community Health Workers: A Policy and Systems-Level Approach. Atlanta, GA: Center for Disease Control and Prevention; 2011

¹¹ Whitley E, Everhart R, Wright R. (2006). Measuring return on investment of outreach by community health workers. *Journal of Health Care for the Poor and Underserved*; 17(1 Suppl):6–15.

¹² Martinez J, Knickman JR. (2010). Community Health Workers: A Critical Link for Improving Health Outcomes and Promoting Cost-Effective Care in the Era of Health Reform. New York: New York State Health Foundation.

¹³ Rosenthal, E., Rush, C., Allen, C. (2016). Understanding Scope and Competencies: A Contemporary Look at the United States Community Health Worker Field. Progress Report of the Community Health Worker Core Consensus Project: Building National Consensus on CHW Core Roles, Skills, and Qualities. C3project.org.

¹⁴ Ibid

¹⁵ Centers for Disease Control and Prevention. (2013). State Law Fact Sheet: A Summary of State Community Health Worker Laws.

¹⁶ National Academy for State Health Policy. State Community Health Worker Models. <http://www.nashp.org/state-community-health-worker-models/>

¹⁷ Community Health Workforce Alliance (December 2013). Taking Innovation to Scale: Community Health Workers, Promotores, and the Triple Aim.

¹⁸ Community Health Workforce Alliance (January 2015). Community Health Workers in California: Sharpening Our Focus on Strategies to Expand Engagement.

¹⁹ California Community Colleges Chancellor's Office. <http://curriculum.cccco.edu/>

²⁰ Key Informant Interview – San Francisco City College.

²¹ Integrated Postsecondary Education Data System. National Center for Education Statistics. <http://nces.ed.gov/ipeds/>

²² Key Informant Interview – San Francisco City College.

²³ Masters, B. (May 2015). Advancing Community Health Workers to Improve Health Outcomes and Reduce Costs: Recommendations for the California State Health Care Innovation Plan. Report to the California Health and Human Services Agency Secretary.

²⁴ MHP Salud. (2016). ROI Toolkit: A Guide for Conducting A Return on Investment Analysis of Your Community Health Worker Program.

²⁵ DHCS State Initiatives Crosswalk (March 16,2016) and key informant interviews.