Report to the
California Health and Human Services Agency Secretary, Diana S. Dooley

Advancing Community Health Workers to Improve Health Outcomes and Reduce Costs
Recommendations for the California State Health Care Innovation Plan

from
The California State Healthcare Innovation Plan
Workforce Work Group

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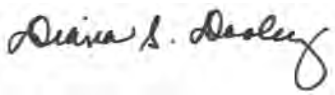
- Letter from the Secretary -

I am pleased to release this report on Advancing Community Health Workers (CHWs). This report was developed by a public-private sector Work Group under our State Health Care Innovation Plan design process, which was funded by a federal grant from the Center for Medicare and Medicaid Innovation. Expanding opportunities for CHWs was identified as a key strategy in the Innovation Plan's Workforce building block that relates to all three of our *Let's Get Healthy California* pathway goals: *Redesigning Health Care; Creating Healthy Communities; and, Lowering the Cost of Care.*

California has a great running start on promoting CHWs as a key component of the health workforce; various health care organizations are experimenting with including them as part of their health care teams. Members of our Work Group represented leading organizations that educate, hire, and train CHWs; in addition, CHWs themselves were represented on the Work Group. I deeply appreciate their work, as well as the input of CHWs from the field who participated in our regional forums. I am grateful to co-chairs Kevin Barnett with the California Workforce Alliance, and Lupe Alonzo-Diaz with our Office of Statewide Planning and Development, who superbly led this effort within a tight timeframe. Additional thanks go to Blue Shield of California Foundation, which provided critical support for this Work Group.

This report includes many excellent suggestions for how CHWs can be meaningfully incorporated into our four key Innovation Plan initiatives—Accountable Communities for Health, Health Homes for Patients with Complex Needs, Maternity Care, and Palliative Care—to improve health outcomes for California's diverse populations. As the Work Group noted at the end of the report, there are several complex issues that we hope to continue to research and discuss going forward. I am optimistic that we have the commitment and expertise to meet this challenge and enhance and expand CHWs' role in our health delivery system.



Diana S. Dooley
Secretary
California Health and Human Services Agency

This report and the Work Group's efforts were made possible with the generous support from Blue Shield of California Foundation.

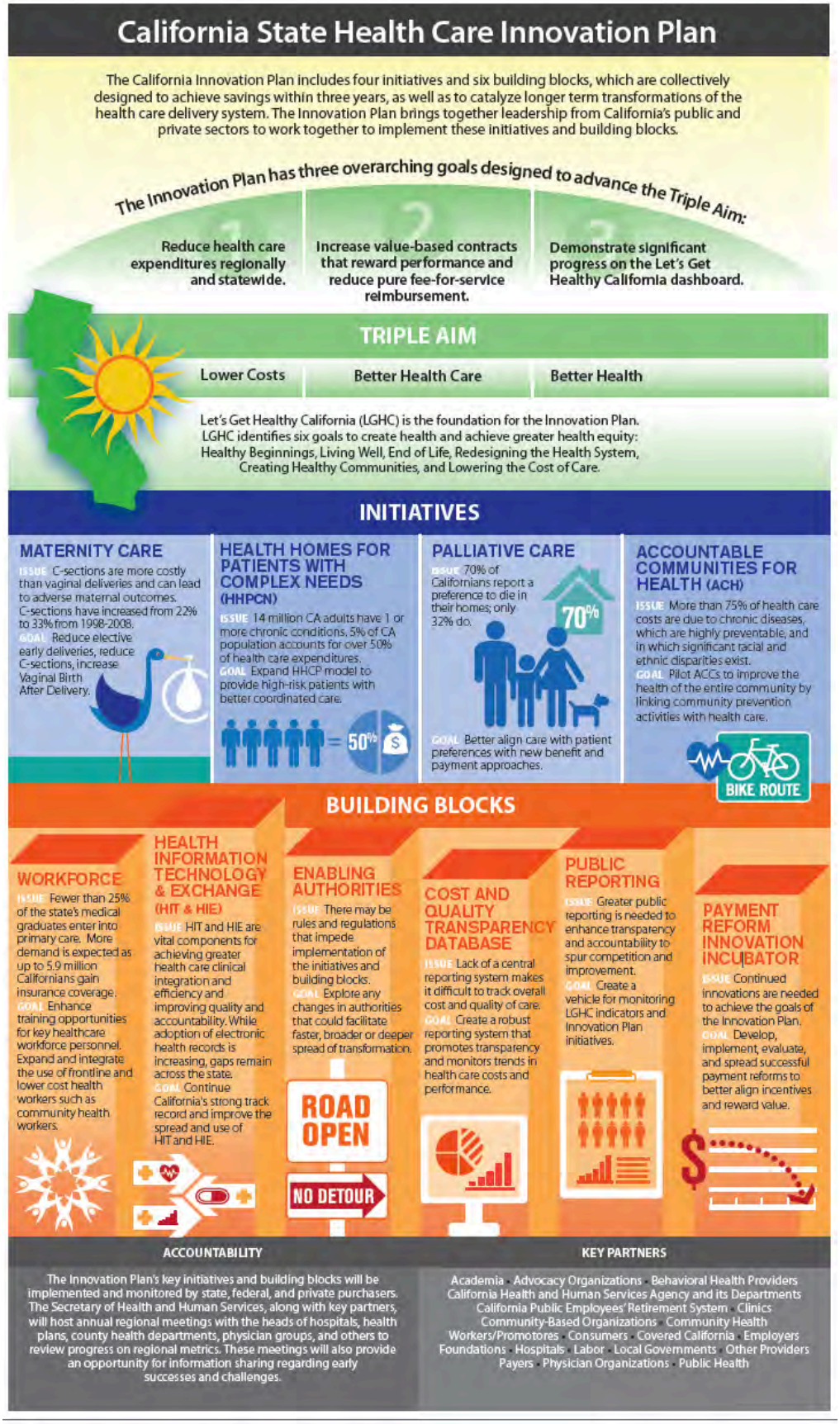
The final report was prepared by Barbara Masters, who also served as the facilitator of the Work Group.

California State Health Care Innovation Plan
Workforce Work Group: Community Health Workers
Draft Report

I. Introduction

In 2012, Governor Jerry Brown issued Executive Order B-19-12, establishing the Let's Get Healthy California (LGHC) Task Force, a group of more than 40 health and health care leaders in the state, to engage in a process to "*envision what California will look like in ten years if we commit to becoming the healthiest state in the nation."* Under the leadership of the Secretary of the California Health and Human Services Agency (CHHS Agency), the Task Force produced a framework for assessing Californians' health across the lifespan, focused on healthy beginnings, living well, and end-of-life. (http://www.chhs.ca.gov/Documents/___Let%27s%20Get%20Healthy%20California%20Task%20Force%20Final%20Report.pdf.) The framework also identified three pathways that most profoundly shape the health and health care landscape — redesigning the health care delivery system, creating healthy communities and neighborhoods, and lowering the cost of care—and made clear that eliminating health disparities is critical to achieving each of the state's goals.

In 2013, California received a Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) Design Grant and developed a plan, using the LGHC report as a foundation, for implementing significant health system and payment reforms. This plan, the State Health Care Innovation Plan (Innovation Plan, http://www.chhs.ca.gov/pages/pritab.aspx) was prepared with support from key health and health care leaders in the state, and outlines a vision where *"California is home to high quality, efficient, seamless health systems throughout the state, which improve health outcomes for all Californians."* The Plan is guided by the Triple Aim and outlines transformation strategies that reward value and innovation, improve quality of care, promote care coordination, create transparency, reduce disparities, and foster competition. The Plan includes four core initiatives and six building blocks to achieve these strategies.


California State Health Care Innovation Plan
The California Innovation Plan includes four initiatives and six building blocks, which are collectively designed to achieve savings within three years, as well as to catalyze longer term transformations of the health care delivery system. The Innovation Plan brings together leadership from California's public and private sectors to work together to implement these initiatives and building blocks.
The Innovation Plan has three overarching goals designed to advance the Triple Aim:
1 Reduce health care expenditures regionally and statewide.
2 Increase value-based contracts that reward performance and reduce pure fee-for-service reimbursement.
3 Demonstrate significant progress on the Let's Get Healthy California dashboard.
TRIPLE AIM
Lower Costs
Better Health Care
Better Health
Let's Get Healthy California (LGHC) is the foundation for the Innovation Plan. LGHC identifies six goals to create health and achieve greater health equity: Healthy Beginnings, Living Well, End of Life, Redesigning the Health System, Creating Healthy Communities, and Lowering the Cost of Care.
INITIATIVES
MATERNITY CARE
ISSUE C-sections are more costly than vaginal deliveries and can lead to adverse maternal outcomes. C-sections have increased from 22% to 33% from 1998-2008.
GOAL Reduce elective early deliveries, reduce C-sections, increase Vaginal Birth After Delivery.
HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS (HHPCN)
ISSUE 14 million CA adults have 1 or more chronic conditions. 5% of CA population accounts for over 50% of health care expenditures.
GOAL Expand HHCP model to provide high-risk patients with better coordinated care.
= 50%
PALLIATIVE CARE
ISSUE 70% of Californians report a preference to die in their homes; only 32% do.
70%
GOAL Better align care with patient preferences with new benefit and payment approaches.
ACCOUNTABLE COMMUNITIES FOR HEALTH (ACH)
ISSUE More than 75% of health care costs are due to chronic diseases, which are highly preventable, and in which significant racial and ethnic disparities exist.
GOAL Pilot ACCs to improve the health of the entire community by linking community prevention activities with health care.
BIKE ROUTE
BUILDING BLOCKS
WORKFORCE
ISSUE Fewer than 25% of the state's medical graduates enter into primary care. More demand is expected as up to 5.9 million Californians gain insurance coverage.
GOAL Enhance training opportunities for key healthcare workforce personnel. Expand and integrate the use of frontline and lower cost health workers such as community health workers.
HEALTH INFORMATION TECHNOLOGY & EXCHANGE (HIT & HIE)
ISSUE HIT and HIE are vital components for achieving greater health care clinical integration and efficiency and improving quality and accountability. While adoption of electronic health records is increasing, gaps remain across the state.
GOAL Continue California's strong track record and improve the spread and use of HIT and HIE.
ENABLING AUTHORITIES
ISSUE There may be rules and regulations that impede implementation of the initiatives and building blocks.
GOAL Explore any changes in authorities that could facilitate faster, broader or deeper spread of transformation.
ROAD OPEN
NO DETOUR
COST AND QUALITY TRANSPARENCY DATABASE
ISSUE Lack of a central reporting system makes it difficult to track overall cost and quality of care.
GOAL Create a robust reporting system that promotes transparency and monitors trends in health care costs and performance.
PUBLIC REPORTING
ISSUE Greater public reporting is needed to enhance transparency and accountability to spur competition and improvement.
GOAL Create a vehicle for monitoring LGHC indicators and Innovation Plan initiatives.
PAYMENT REFORM INNOVATION INCUBATOR
ISSUE Continued innovations are needed to achieve the goals of the Innovation Plan.
GOAL Develop, implement, evaluate, and spread successful payment reforms to better align incentives and reward value.
ACCOUNTABILITY
The Innovation Plan's key initiatives and building blocks will be implemented and monitored by state, federal, and private purchasers. The Secretary of Health and Human Services, along with key partners, will host annual regional meetings with the heads of hospitals, health plans, county health departments, physician groups, and others to review progress on regional metrics. These meetings will also provide an opportunity for information sharing regarding early successes and challenges.
KEY PARTNERS
Academia · Advocacy Organizations · Behavioral Health Providers · California Health and Human Services Agency and its Departments · California Public Employees' Retirement System · Clinics · Community-Based Organizations · Community Health Workers/Promotores · Consumers · Covered California · Employers · Foundations · Hospitals · Labor · Local Governments · Other Providers · Payers · Physician Organizations · Public Health

The four initiatives are: maternity care, health homes for patients with complex needs, palliative care, and accountable communities for health. These initiatives focus on different aspects of the health care system that experience particularly high costs—uncoordinated care for people with complex chronic conditions, maternity care, and end-of-life care. The fourth initiative is a pilot program, which would test a new population health model that seeks to link health care systems with community resources to address a chronic condition on a community-wide basis and which maintains a focus on prevention.

Through the greater use of team-based care and care coordination (including linking with community and social services), implementation of best practices, incorporation of lower-cost health providers where appropriate, and respecting patient preferences for care options, these initiatives will lower costs while improving health outcomes.

One of the Innovation Plan's building blocks is workforce, out of recognition that successful transformation of the health care delivery system depends on ensuring adequate capacity, training, and cultural engagement of a wide range of health care professionals. In particular, employing Community Health Workers (CHWs) and other frontline workers within the various initiatives was identified as a critical strategy. To inform the development of the Innovation Plan early on, a state of the field report was commissioned, "Leveraging Community Health Workers within California's State Innovation Model: Background, Options and Considerations." The report provides background information on CHWs, describes possible approaches for incorporating them into primary care and community-based practice models, identifies evidence of beneficial outcomes associated with using CHWs, and describes possible financing mechanisms. The report can be found at:
http://www.chhs.ca.gov/Documents/Issue%20Brief%20on%20Leveraging%20Community%20Health%20Workers%20Under%20California%27s%20State%20Innovation%20Model%20(SIM)%20Initiative.pdf

Formation and Charge of the Work Group

In order to further inform the Innovation Plan, the state formed a Workforce Work Group, co-led by Lupe Alonzo-Diaz, M.P.Aff., Deputy Director of the Office of Statewide Health Planning and Development (OSHPD) and Kevin Barnett, Dr.P.H., M.C.P., co-director of the California Health Workforce Alliance. The Work Group was comprised of representatives from community clinics, health plans, hospitals, public health, academia, education and training, philanthropy, and CHW organizations, as well as from various state departments (see Appendix for the roster).

The Work Group was charged with reviewing key issues and options for how CHWs can best be utilized, supported, and expanded across the state as part of each of the Innovation Plan's four initiatives described above. In addition, given its six-month time frame and the complexity of issues likely to be raised, the Work Group also was charged with identifying issues for later consideration by the state.

To be clear, the Work Group had a very specific focus, and it's important to recognize that a significant number of CHWs perform a variety of roles in communities and organizations—both inside and outside of the health care system—that are not associated with the Innovation Plan initiatives that were the focus here. Therefore, Work Group members urge that policymakers and providers be mindful to not create "unintended consequences" with regard to the broader CHW/Promotor field, as they move forward in addressing the needs of this effort.

An initial in-person meeting of the Work Group was held on March 28, 2014. Monthly two-hour calls were held every month thereafter, except for July, during which the Work Group held two forums with working CHWs in order to directly obtain their perspectives and input. The Work Group came together for a final in-person meeting on November 7, 2014.

The Work Group began its deliberations with a discussion of the definition of a CHW. Subsequent meetings were structured to draw from the extensive knowledge of the various Work Group members to better understand the landscape in California today and to identify challenges and needs going forward. Topics included:

- Potential roles and functions of CHWs within the Innovation Plan Initiatives
- Employment settings and mechanisms of employing and deploying CHWs
- Funding and financing
- Core competencies
- Training

A list of meeting dates and topics can be found in Appendix 2, and notes from the meetings can be found at (http://www.chhs.ca.gov/pages/pritab.aspx). This report summarizes and synthesizes the discussions held by the Work Group and proposes a set of next steps for the both the state and other stakeholder organizations to consider; it also references innovative approaches and models, where appropriate, being implemented from around the country. Because Work Group members played different roles and came from various perspectives and organizations, consensus was not reached on all issues. Rather the report attempts to capture the nature of the discussion and the different opinions expressed.

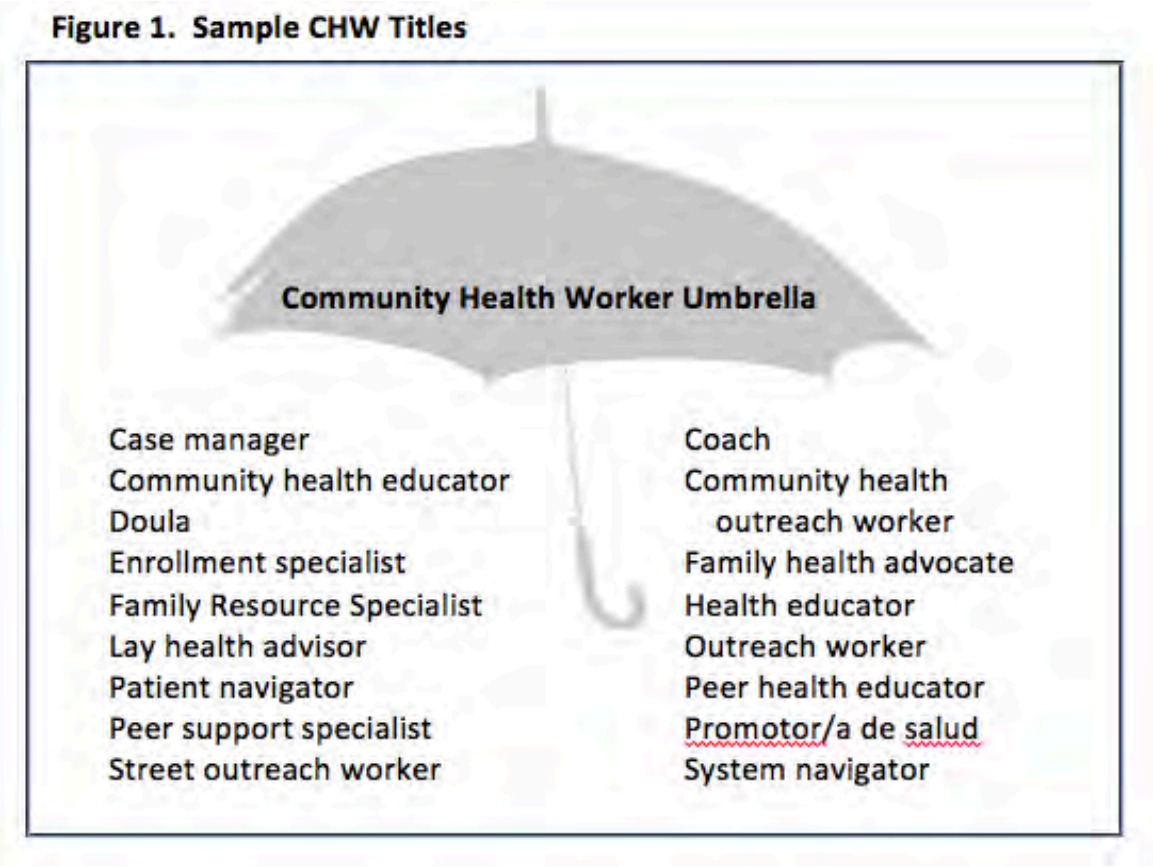
On December 16, 2014, Secretary Dooley was informed by the Center for Medicare and Medicaid Innovation that California would be receiving a modest State Innovation Model grant, which would enable the state to move forward with many of the key elements of the proposed Innovation Plan. The state is committed to advancing the concepts, developed in consultation with stakeholders, that were included in the Innovation Plan.

This report can serve as a foundation for a variety of efforts to advance the scale and spread of CHWs in California, including the state's effort to implement section 2703 of the Affordable Care Act regarding Health Homes for Patients with Complex Needs and the proposed section 1115 Medi-Cal Waiver, both of which are currently under consideration. That said, it's important to note that the findings and recommendations reflect the deliberations of the Work Group, which operated under the parameters set forth by the Innovation Plan and its proposed four initiatives.

II. Definition of Community Health Worker

There are dozens of job titles that encompass different aspects of what CHWs do.[1,2] One Work Group member reported that she had collected 160 titles of CHW-type positions. The wide variety in titles is the result, in part, of a lack of standardization of the field, positions being created through grant funding, and differing needs of the organizations. Figure 1 shows a sampling of titles that fall under the umbrella of a Community Health Worker.

Figure 1. Sample CHW Titles



Moreover, different government agencies and organizations have developed different definitions of CHWs. For example, the federal Health Resources and Services Administration and the Centers for Disease Control, both within the Department of Health and Human Services use their own definitions. The Work Group reviewed the range of

[1] See, for example, Davis, A. "Leveraging Community Health Workers within California's State Innovation Model". July 2013

[2] "Taking Innovation to Scale: Community Health Workers, Promotores, and the Tripe Aim." The California Health Workforce Alliance. December 2013

definitions and focused on two, in particular: one developed by the American Public Health Association (APHA) and one that was advanced by the California Health Workforce Alliance (CHWA),[3] which was, in turn, based on the APHA definition. Table 1 provides those definitions, as well as three others from prominent agencies for comparison.

Table 1. Definitions of CHWs

Org.	Definition
APHA	A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/ social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.
CHWA	A person who is a trusted member of and/ or who has an unusually close understanding of the community served in the delivery of health-related services through either working directly with providers or their partner organizations. This trusting relationship with the community enables CHWs to serve as a liaison between health and social services and the community to facilitate members' access to services and improve the quality and cultural competence of services delivered. 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.
World Health Organiza-tion	Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional worker (WHO Study Group 1989)". CHWs are men and women chosen by the community, and trained to deal with the health problems of individuals and the community, and to work in close relationship with the health services. They should have had a level of primary education that enables to read, write and do simple mathematical calculations (WHO 1990).
Health Resources and Services Adminis-tration	Community health workers (CHWs) are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, Promotoras, outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening.
Centers for Disease Control and Prevention	Community health workers—also known as community health advocates, lay health educators, community health representatives, peer health promoters, community health outreach workers, and in Spanish, promotores de salud—are 'community members who work almost exclusively in community settings. They serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate health care.

[3] Ibid.

Although the APHA and CHWA definitions are very similar, two key differences were discussed. The first one concerned the use of the term "public health" worker. Work Group members noted that not all CHWs work in public health organizations and felt that the term might be too limiting. Second, some Work Group members observed that the APHA definition didn't reference care-related roles. The Work Group decided that in order to be as inclusive as possible with regard to who CHWs are, as well as what roles they play, the APHA definition was modified as follows:

> *A Community Health Worker is a frontline health worker who is a trusted member of and/or has an unusually close understanding of the community served. The 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 through care coordination, screening, and other care support activities. A CHW also improves population health and 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.*

III. Roles and Functions of CHWs

The Work Group next discussed the range of roles and functions of CHWs, particularly as they potentially relate to the Innovation Plan. Functions and roles refer to what CHWs do and the type of activities that CHWs carry out. In contrast, as will be described in Section V, core competencies refer to the skills, knowledge, and attributes of CHWs, which enable them to perform the various roles.

Because there is no clear scope of practice for CHWs, the Work Group identified major functions and roles of CHWs, displayed in Table 1. The major functions or categories of activities exist along a continuum from administrative to care support. Because cultural competency undergirds virtually everything a CHW does, it is shown as cross-cutting throughout the matrix. The five functions are:

- Administrative
- Education
- Advocacy and organizing

- Linking and navigating
- Care support and prevention

Within each of these functions, Work Group members identified a variety of roles that CHWs perform. It should be noted that Work Group members expressed a range of opinions about some of these roles. For example, there was not consensus about the degree to which CHWs are or should be engaged in care support, management or coordination, particularly as it concerns the provision of actual clinical services, such as measuring blood pressure. Moreover, other roles were identified, such as health coaching, that were specific to individual organizations. Finally, it's important to emphasize that individual CHWs would not be expected to perform all of the roles and functions, but rather a subset depending on the particular needs of the organization and how the position fits with other staff. Therefore, these tables should be viewed as an illustrative menu—and not an exhaustive list—of potential roles.

The Work Group agreed that many of the roles identified are general roles that CHWs play, while others are specific to each of the Innovation Plan initiatives. Therefore, two tables were created:

- Table 2 shows the continuum of general functions and common roles performed by CHWs
- Table 3 identifies potential Innovation Plan initiative-*specific* roles. Again, these are examples and are not intended to constitute an exhaustive list.

Table 2. Menu of CHW Functions and Roles

CONTINUUM OF POTENTIAL CHW FUNCTIONS AND ROLES

FUNCTIONS Performed by CHWs				
Administrative	**Education**	**Advocacy & Organizing**	**Linking & Navigating**	**Care Support & Prev.**
Cultural competency/culturally responsive services				
Enrollment assistance in health and human services programs	Provide health education and promotion on disease prevention	Advocate with health system on behalf of individuals and communities	Connect residents with community resources	Provide first aid services and health screenings, such as blood pressure
Collect data related to community health needs	Conduct outreach to community members	Promote change in support of community health goals	Enhance residents' ability to access providers	Provide feedback to medical care team about individual patient circumstances and experiences
Documentation, such as collect and enter data in EHRs	Provide social supports and counseling for healthy behaviors; coach on problem solving	Engage community members in building advocacy skills	Serve as liaison between communities, health, and social services agencies and provide "warm handoffs"	Assist with care coordination/care management support as member of a health care team (eg, "warm hand-off")
Translation (however, not medical translation)	Disseminate education resources to support health promotion	Assess and ensure patient's ability to meet basic needs (food, water, electricity, shelter, etc.)	Refer residents to appropriate services	Provide client-centered counseling and peer support (mental/behavioral health)
Assist with health-related transportation and other barriers to access	Educate medical and social service providers about community needs	Provide feedback to medical care providers about how to increase quality and patient satisfaction.		Assist patients with developing their own care management plans and priorities; assist with care regimen compliance
Assist with scheduling appointments; accompany patient on visits; follow up calls and reminders	Educate community members on how to use insurance and basic health care rights; assist with health literacy	Provide feedback to medical care providers about socioeconomic and cultural dynamics of the community		Conduct home visits and provide feedback to medical team

CHW ROLES

Table 3. Examples of potential Innovation Plan Initiative-*specific* roles for CHWs

	Initiative Goals	CHW Roles
Maternity Care	▪ Reduce the growing number C-sections and early elective deliveries, which have notable racial variation ▪ Encourage hospitals to report appropriate and timely data ▪ Develop a process for identifying outlier hospitals	▪ **Administrative**: Conduct maternity tours to explain hospital policies and practices; intake and discharge surveys to collect data to help improve service delivery and evaluate risk factors for preterm and C/S deliveries; community research to develop ways to help women prevent unwanted or unplanned high risk pregnancies ▪ **Education**: Conduct outreach to places such as day care centers, churches, etc; individual and group education for women on prenatal care, nutrition during pregnancy, tobacco cessation, home delivery options, midwifery; encourage women to attend child birth/breast feeding classes; become a certified instructor of March of Dimes' prenatal care classes; family planning and breast feeding education. ▪ **Advocacy and Organizing**: Advocate for hospitals to offer VBACs (requires 24 hour in-house anesthesia services); advocate for offering community-based services. ▪ **Linking and Navigating**: Connect women to alternative birthing services; connect women to child care needs for other children to enable her to attend prenatal appts.; facilitate access to a breast pump or related equipment ▪ **Care Support and Prevention**: Screen for signs of abusive relationships or other adverse living conditions and referrals, where necessary; conduct f/u calls and/or home visits following discharge to see how new moms are doing, remind them of well-baby visits, monitor nutrition, etc.; function as a lactation peer counselor
Health Homes for Patients with Complex Needs	▪ Widely implement health homes for patients with complex needs to better coordinate care ▪ Expand the use of team-based care to include frontline workers	▪ **Administrative:** Assist with overall care coordination, scheduling, care management, etc. ▪ **Education**: Provide group classes (in clinic and community settings) and individual counseling regarding chronic disease self-management programs; become a certified facilitator in various self management and peer-led groups; educate patients about appropriate utilization of emergency room use; health promotion ▪ **Advocacy and Organizing**: Advocate for community and environmental changes to support healthy behaviors ▪ **Linking and Navigating**: Referrals to community and social supports; assist with transitions between inpatient, outpatient and home care; assist with care coordination ▪ **Care Support and Prevention**: Home visits to monitor treatment adherence, monitor blood pressure and other key indicators, such as glucose levels; review discharge plan, if hospitalized,

	Initiative Goals	CHW Roles
Palliative Care	▪ Incorporate palliative care services in health homes for patients with complex needs to bring in greater alignment patient preferences and care delivery for end-of-life care ▪ Expand the palliative care workforce	▪ **Education**: Educate and discuss advance directive with patients and in community; educate patients about hospice and palliative care and various care options; pain management education; guided meditation and other relaxation techniques ▪ **Advocacy and Organizing**: Provide feedback to medical care providers about population perspective on palliative care (e.g., myths, fears) and how to address it; advocate for individual patient wishes with medical providers ▪ **Linking and Navigating**: Referrals to community resources regarding financial planning and resources and other social services; facilitate access to home care equipment; help patients find culturally appropriate supportive care ▪ **Care Support and Prevention:** Assist patients in developing care goals, especially regarding end-of-life; respite and other care and support for family provider
Accountable Communities for Health	▪ Develop pilot programs that advance population health through multi-sectoral collaboratives ▪ Implement and link a set of clinical and community interventions to address a target chronic condition with significant health disparities	▪ **Administrative**: Help identify "hotspotter" patients and geographies; data collection to inform team about specific community health issues and concerns, such as homelessness, substance use, etc.; home assessments related to asthma, diabetes, etc. to remove triggers ▪ **Education**: Outreach to community members with or at risk of targeted condition and enroll them in programs; conduct group classes for target patient populations regarding wellness, healthy behaviors, chronic disease management, SUD or mental health support groups, etc.; collaborate with other community based prevention programs including schools, Ys, parks and recreation departments, community action plans (e.g. asthma), etc. ▪ **Advocacy and Organizing**: Assess and ensure patients/residents' ability to meet basic needs (food, water, electricity, shelter, etc.); advocate for community, worksite, and environmental changes to support healthy behaviors. ▪ **Care Support and Prevention**: Help develop self care management plan and reinforce goals of care, medication reconciliation, wellness activities, prevention strategies; assess and relay wellbeing to medical teams.

IV. Employment Settings and Financing Models

Work Group members represented a range of employment settings, and their organizations utilize several different financing mechanisms. These brief cases provide concrete examples of the different approaches that can be taken with regard to employment and financing, roles, training and supervision.

Community Clinic: La Clínica de la Raza

- Employment & Financing: The clinic employs approximately 25 paid CHWs. Supervisors and Managers are salaried while CHWs are paid hourly. CHWs are primarily grant funded, which results in some programs only being available in certain counties or clinics. There are also 60-90 Promotores active in the clinic. They are mostly volunteer but also receive varied types of stipends.
- Role: CHWs perform a range of information, education, navigation, referral and support roles for an array of programs, including youth, HIV, oral health, among others.
- Training: The clinic developed its own Promotore curriculum that includes 10 classes, after which Promotores can receive additional training on health specific issues. In addition, eleven CHWs are trained and certified to provide outreach and enrollment assistance for Covered California and Medi-Cal expansion. There are two levels of Community Health Educator job categories: CHE I and CHE II, which requires a bachelor's degree.

Hospital and Health System:
California Hospital Medical Center (Dignity Health)

- Employment & Financing: The majority of CHWs at CHMC Health are full-time employees and receive the same benefits packages as other hospital employees. Many are grant funded and others are paid out of general operations. They often are initially hired following a paid internship.
- Role: CHWs/Promotores are typically involved in outreach and enrollment for health insurance, but are increasingly working with patients with chronic diseases, including diabetes and asthma. They have been found to be much more successful in getting patients to change health behaviors than more traditionally trained professionals.
- Training: Promotores usually come with some type of core competency training obtained through Planned Parenthood or Esperanza Community Housing. The hospital provides specialized training on health care and insurance related issues, and CHWs also receive training through the Stanford Chronic Disease Self-Management program.

Health Plan: Inland Empire Health Plan

- Employment & Financing: CHWs are hired as full-time, fully benefitted employees under a new enrollment position called a health navigator. They are funded out of general operations and with grants.
- Role: CHWs conduct outreach with the providers in their area and help connect members with their primary care providers. They also target individuals with high ER utilization and complex needs.
- Training: The plan contracts with Latino Health Access to train CHWs on core competencies, followed by internal training on the health care system and plan. Currently the program has one supervisor for 15 health navigators, although a second supervisor is needed.

Community-Based CHW Organization: Visión y Compromiso

- Employment & Financing: Visión y Compromiso employs more than 70 promotores and CHWs as both full-time and part-time staff across California. Most of these positions are grant-funded. In addition, as a statewide Network, Visión y Compromiso represents over 4,000 promotores and CHWs, who work as full-time salaried staff, independent contractors, part-time staff with no benefits, volunteers, and community workers who receive stipends, gift cards or mileage reimbursement for their community work.
- Role: Promotores and CHWs perform a wide variety of roles in diverse community settings (e.g. clinics, hospitals, schools, housing developments, non-profit organizations, family resource centers) as health educators, advocates, enrollment assistors, navigators, and organizers in their communities; their activities may also include advocacy, social support, information and referrals.
- Training: Visión y Compromiso's formative training programs such as *Latin@ Saludable, Familia Saludable* build the skills and core competencies of promotores and CHWs. These trainings are linguistically and culturally responsive, incorporate popular education and adult learning methodologies, and reflect regional priorities. Additional trainings increase the leadership and advocacy skills and build local capacity in mental health, chronic disease prevention and self-care, health insurance literacy, reproductive justice, maternal and child health, and more. Visión y Compromiso also engages employers and other workforce partners to increase understanding of the promotor model and support full integration of promotores and CHWs into healthcare and other employer-sponsored teams.

A. Employment Settings and Mechanisms

The above descriptions demonstrate that CHWs can work in many different settings and organizations to perform the various functions and roles outlined in the previous section. Most Work Group members who hire CHWs indicate that CHWs are full-salaried employees with benefits. However, some CHWs may work as volunteers, while others may receive stipends, which was historically used more frequently. Several organizations use combinations of these methods – volunteer, stipends, and employed staff.

Work Group members discussed some of the strengths and challenges of hiring CHWS in the various employment settings and through different hiring mechanism. For example, health plans, health systems, and other providers can either hire CHWs directly or can contract with a community-based organization (CBO) to provide and supervise the CHW. Providers that directly hire CHWs do so, in part, because they believe they can more efficiently integrate them in their care teams, share data and information, and directly supervise them.

Alternatively, some Work Group members believe that the CBO-as-broker model holds promise for being best able to keep the values of community front and center. However, some CHWs who participated in the Forums expressed some level of difficulty accessing and providing data on the clients when they didn't work directly for the providers.

In general, irrespective of setting and approach, a key challenge for policymakers, CHWs and their employers is the need to balance the goal of integrating CHWs into the care team without compromising CHWs' ability to maintain the community connection and perspective. CHWs will need to develop the skill and capability of working in multiple environments and bridging the needs of the care management team with the community. CHWs trained in the promotor model, for example, will likely need to expand their skill set to be able to function as part of the medical team while preserving the integrity of the promotor model.

Innovative models for employing and deploying CHWs are emerging to address this and other challenges. For example, the Community Health Access Project in Mansfield,

Ohio, includes a community hub that works with various agencies and organizations to implement, track, and manage CHW services delivered through protocols, or pathways to address different conditions.[4] The hub functions as a single locus of responsibility that facilitates coordination among the various clinical providers and other service entities.

The University of Pennsylvania Medical Center has developed a hybrid model in which Penn Medicine, the university-based medical school and health system, created the Penn Center for Community Health Workers (http://chw.upenn.edu/). The Center hires, trains and deploys CHWs to work with patients who are in the hospital as well as physician-referred patients who are high risk. But the supervision and training is managed by the Center, which also serves a support system for the CHWs.

Kaiser Permanente in Oregon is supporting a Community Care Organization (a regional entity that manages Medicaid and integrates all health care providers in a given geography) to develop a model in which it contracts with culturally appropriate CBOs as a way to tap CHWs already working in the community with the various target populations.

B. Financing and reimbursement

Sustainable financing was identified as the single biggest obstacle for scaling the utilization of CHWs. Currently, organizations that employ CHWs pay for them through a combination of funding sources, with the most common financing mechanism being grants. However grants are generally time-limited and support specific programs and, therefore, don't provide for the development of a sustainable workforce. Some health care organizations report paying for CHWs out of their general operations budget or through fees. Global budgeting, which is increasingly being used, holds promise for enabling health systems to hire and pay for CHWs.

Effective January 1, 2014, the Centers for Medicare and Medicaid Services (CMS) will now allow states to reimburse for preventive services "*recommended* by a physician or other licensed practitioner…within the scope of their practice under State law." Previously, states could only cover preventive services that were *provided* by a licensed practitioner.

[4] Eyster, Lauren and Randall R. Bovbjerg. "Promising Approaches to Integrating Community Health Workers into Health Systems: Four Case Studies". Urban Institute. December 2013

Examples of services by non-licensed providers that could potentially be reimbursable (some of which are currently covered in Medicaid managed care or other plans) include:[5]

- Care coordination and educational counseling
- Home visiting
- Group health education (potentially reimbursable as long as Medicaid enrollees have some one-on-one interaction with the counselor)
- Community health worker services, such as asthma education to Medicaid enrollees
- Lactation consultation
- Developmental screening done by trained consultants in child care centers
- YMCA diabetes prevention program
- Science-informed parenting education

States wishing to implement this option must submit a State Plan Amendment describing: what services will be covered; who will provide them and "any required education, training, experience, credentialing or registration" of these providers;[6] the state's process for qualifying providers; and the reimbursement methodology.

The rule has the potential for providing stable ongoing financing of CHWs by enabling Medi-Cal reimbursement for preventive services. However, it's important to recognize that many activities that CHWs perform may fall outside of the specific definition of preventive services under Medicaid. Another consideration with regard to the Medicaid rule is that states must specify the provider as well as the training or credentialing requirements of these providers in the state plan amendment. As will be described below, California does not yet have any state standards regarding training, certification or credentialing.

Currently, some managed care plans in California hire CHWs and other non-licensed practitioners, and they do so through a variety of funding mechanisms. Some depend on outside grants while others pay for CHWs from their general operations or administrative budgets, which may be limiting. Nevertheless, even without the Medicaid rule change, other states have taken steps to encourage their health plans to use CHWs. For example,

[5] Trust for America's Health and Nemours. "Medicaid Reimbursement for Community-Based Prevention." http://www.astho.org/Community-Health-Workers/Medicaid-Reimbursement-for-Community-Based-Prevention/

[6] CMCS Informational Bulletin. Nov. 27, 2013 http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf

New Mexico's Medicaid Managed Care Policy Manual is explicit that costs associated with CHWs can be considered administrative costs for purposes of rate setting and are included in the capitated rates.[7]

Texas is proposing to use its "section 1115" Medicaid waiver to enable reimbursement for CHWs.[8] As the state is moving almost all Medicaid recipients into managed care and restructuring its hospital payment system, it is revising managed care contracts to include new language related to CHWs. Specifically, the state is seeking to have these contracts include a definition of the CHW role in order to allow the managed care plan to bill certain CHW services as service costs rather than administrative costs. Although the state will not increase the capitation rate it pays, this change would allow managed care plans greater flexibility in deploying CHWs, because employment of CHWs will not adversely affect the medical loss ratio[9] that is regulated by the ACA.

Another innovative approach was implemented by Vermont as part of its Blueprint for Health. It utilizes a multi-disciplinary approach to care through a Community Health Team, many of which have hired CHWs to assist the care team by helping patients to identify their needs, connect to services, and schedule physician appointments. The Community Health Teams are financed, in part, through an assessment on insurers. For further information on other states' efforts, see "An Action Guide on Community Health Workers: Guidance for Health Insurers" cited in the Resource Guide.

California is investigating various options for expanding use of CHWs. It already allows certain types of preventive services—Screening, Brief Intervention and Referral to Treatment (SBIRT) for Alcohol Abuse and Rehabilitative Mental Health Services—to be provided by non-licensed health workers who are under the supervision of licensed providers. In addition, California's Section 1115 Medicaid Waiver proposal, Medi-Cal 2020, is proposing to provide incentives to managed care plans to support non-physician

[7] Witgert, K., et al.

[8] Eyster and Bovbjerg

[9] The medical loss ratio (MLR) refers to the proportion of an insurers revenues spent on clinical services and quality improvement, as compared to administrative costs, marketing, overhead and profits. The ACA set a minimum MLR of at least 80 or 85 percent. By allowing CHWs to count as a clinical expense, a managed care plan can hire more CHWs without adding to its administrative costs.

community providers, including CHWs, to be part of the care team[10]. In addition, the state's concept paper "Health Homes for Patients with Complex Needs"[11] requires CHWs to be included in the care teams.

V. Core Competencies and Training

Building from its discussion related to CHW roles and functions, Work Group members discussed core competencies and training. In general, the Work Group believes there are a set of core competencies that are applicable in all work settings. In addition to those competencies, each job requires specific employer-related skills. But the basic foundation must first be in place. In 1998, one of the earliest comprehensive studies of CHWs (called Community Health Advisors or CHAs in the report) was conducted, based on data collected directly from CHAs. The 1998 report identified eight categories of core competencies, which have generally stood the test of time.[12] They are: communication skills, interpersonal skills, knowledge base, service-coordination skills, capacity building skills, advocacy skills, teaching skills, and organizational skills.

Table 4 groups these core competencies into three broad categories: Core qualities and skills, Innovation Plan Initiative-specific skills, and work-setting skills. Moreover, core qualities and skills can be divided into personal qualities and skills.

[10] http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/FinalDraftMediCal2020WaiverRenewal.pdf

[11] California Concept Paper Version 2.0, released April 10, 2015. http://www.dhcs.ca.gov/provgovpart/Documents/HHP%20CP%202.0%20-%20DHCS%20Final%20Draft%20Version%20-%202015-04-10%20(14)Final.pdf

[12] Rosenthal, E. L., "A Summary of the National Community Health Advisor Study". The University of Arizona. 1998. http://crh.arizona.edu/sites/crh.arizona.edu/files/pdf/publications/CAHsummaryALL.pdf

Table 4. Categories of CHW Core Competencies

CHW Core Competencies		
Core CHW Qualities & Skills	**Innovation Plan Initiative-specific skills**	**Work-setting related skills**
Personal Qualities ▪ Cultural connection/ relationship to the community ▪ Empathy, compassion ▪ Interpersonal relationship building ▪ Motivational ▪ Leadership ▪ Flexible and problem solving ability ***Skills*** ▪ Listening skills ▪ Communication skills ▪ Service coordination skills ▪ Training/ability to teach ▪ Facilitation ▪ Health promotion/ education ▪ Advocacy skills ▪ Research skills ▪ Knowledge base ▪ Health coaching	***1. Maternity Initiative—Ex:*** ▪ Knowledge of prenatal care ***2. Health Homes for Patients with Complex Needs—Ex***: ▪ Knowledge of particular disease or condition ▪ Relevant care support & coordination skills ▪ Knowledge of community resources ***3. Palliative Care—Ex:*** ▪ Knowledge of end-of-life issues ▪ Comfortable working with end-of-life issues ▪ Knowledge of community's cultural perspectives on end-of-life ***4. Accountable Communities for Health—Ex***: ▪ Knowledge of community resources	▪ Organizational skills ▪ Computer skills ▪ Data entry skills for electronic health record

Work Group members, as well as CHWs/Promotores who attended the forums, repeatedly stressed the importance of personal attributes that are necessary to be a CHW/P. As many have expressed, "*not everyone can be a CHW.*" Work Group members and other national experts describe the importance of a person being nonjudgmental and empathetic with emotional intelligence; moreover, the person must be able to work independently, have initiative, and be a creative problem-solver. One expert noted the need for tenacity in the health care setting to be able to "stand up to physicians."[13] This was confirmed by CHWs who participated in the Forums; they expressed the challenge of

[13] NEHI Conference. October 20, 2014.

physicians valuing their knowledge of the patients gained through hours of interaction with them. Finally, a 2013 survey of California safety net providers found that skills related to communication, confidentiality, and community standing were the three most important skills.[14]

Currently, California does not require any type of state credential or certificate with defined training elements. Nevertheless, different types of training programs in the state have emerged—in a variety of academic, community, and health-care based settings. Several of these programs were developed and run by Work Group members.

The Community College of San Francisco (CCSF) offers a CHW Certificate Program, which is the longest continuous certification program in the nation, having begun in 1992. The program is 20 college units, and it can be completed in two semesters. In 2011, two new certification programs were added. One program focuses on youth health workers, while the second focuses on post-prison health workers. Formerly incarcerated individuals have potential for becoming effective CHWs and being able to work with many hard-to-reach populations. CCSF designed a track specifically to enable them to enter this workforce.

CCSF focuses on core competencies for working directly with individual clients and families. The program includes topics such as: cultural humility, how to conduct an initial interview with client, how to provide client centered counseling, case management services, and health education. Students are also trained on how to work at the community level and how to facilitate social or support groups.

Visión y Compromiso's training curriculum builds the skills and core competencies associated with the roles and activities of CHWs and promotores community work in a variety of settings. The training covers skills such as: communication and facilitation skills, listening, time management, outreach, presentation development, public speaking, navigation, resource referrals, data collection, as well as advocacy, leadership and additional topics based on CHWs' personal and professional interests and community concerns (e.g., mental health, ACA and health insurance literacy, disabilities). Employers

[14] "Taking Innovation to Scale: Community Health Workers, Promotores, and the Triple Aim." The California Health Workforce Alliance. December 2013

are then expected to provide CHWs with specific training in order to meet the needs of their particular positions. Other long-standing community-based training programs for CHWs and promotores are provided by Latino Health Access and Esperanza Housing.

Work Group members from Inland Empire Health Plan, California Hospital Medical Center, and La Clínica de la Raza have developed their own training curricula to enable CHWs to learn about their organizations, health insurance, and other topics related to the specific roles CHWs play in their organizations.

Work Group members also identified Latino Health Access' training program as a partner and source of CHWs, as it provides individuals with a good foundation of core competencies and skills.[15] In addition, the Work Group learned about the CA4Health program, which worked with 14 Community Transformation Grant sites across the state and provided training for CHWs on the Stanford Chronic Disease Self-Management;[16] Community Health Workers were then able to lead workshops and improve connections between clinics and healthier environments in those counties.

Although there is not an exhaustive inventory of all training programs in California, Visión y Compromiso recently completed a survey of 65 agencies in California actively involved in training promotores and community health workers.[17] The survey findings, which address the type of training curricula used, health education topics, professional skills topics, and training needs, among other issues, could help inform the further development of training programs throughout the state.

Table 3 identifies CHW specific roles for each Innovation Plan initiative—many of which will necessitate some level of training. Providers and health plans that participate in any of the four initiatives–or the initiative itself—will need to provide sufficient training to CHWs tailored to a given initiative. For example, CHWs could play a particularly helpful role with individuals dealing with end of life issues and in need of palliative care. There are strong cultural aspects associated with the end of life, yet most CHWs have little

[15] http://www.latinohealthaccess.org/the-promotora-model/

[16] http://www.ca4health.org/why-ca4health/fact-sheet/. See also short video produced by CA4Health. http://www.phi.org/news-events/716/public-health-institute-expands-dialogue-on-community-health-workers-with-new-releases

[17] "A Survey of Promotores Training Programs in California". Visión y Compromiso September 2014

experience with it and would be in need of specific training. As a first step, CHWs who have been trained in coordinated care and are working within a health home and who have an interest in working in end of life care should be identified. Appropriate training in palliative care will need to be developed for this workforce.

VI. Readiness of Providers

Many providers and health plans have reported successful experiences utilizing CHWs. However, most providers have not previously worked with CHWs and will need to undertake some level of preparation and planning to achieve a level of readiness for incorporating CHWs into their practice. This readiness, particularly as it applies to health homes for patients with complex needs, also relates to the broader effort regarding team-based care. Since CHWs often function as part of a care coordination team, the degree to which a team-based care approach has been adopted by the health system or provider will impact its readiness to incorporate CHWs.[18]

Key issues that providers will need to address include:

- Obtaining buy-in and commitment from the organization's leadership to include CHWs as part of the care team. Work Group members emphasized the commitment by the CEO of the organization, in particular, as being critical to successful implementation.
- Developing an understanding of the role of social determinants of health in health outcomes. CHWs participating at the Forums emphasized the importance of the health systems they work with becoming more aware of these issues. One innovative training example is being conducted at the Penn Center for CHWs, which is located within a health system attached to the medical school. Medical students are now shadowing CHWs for a month as part of the Impact Teaching Service to

[18] For further discussion about team-based care design considerations with regard to CHWs, see "Community Health Workers in California: Sharpening Our Focus on Strategies to Expand Engagement". http://www.phi.org/uploads/application/files/2rapr38zarzdgvycgqnizf7o8ftv03ie3mdnioede1ou6s1cv3.pdf

learn the roles of CHWs, as well as to better understand the types of life challenges being faced by their patients.[19]

- Developing clear guidelines on CHW roles and responsibilities. Participants at the Forums stressed the importance of clarity in roles and responsibilities to manage expectations, prevent duplication of effort, and minimize potential conflict with other members of the care team. This is particularly important if the CHW will perform any clinically-related services, such as medication management.
- Educating physicians, nurses and other health professionals about the added value of CHWs to help allay concerns about a CHW's role within the care team.
- Identifying and training supervisors who understand CHWs and can help integrate them with the care team. Because CHWs do most of their work in the field with patients and/or community members, CHWs believe that supervisors need to understand that aspect of the CHW role, be flexible in terms of CHWs' work schedules, and provide mentoring.
- Developing appropriate training to enable CHWs to learn about the organization and their particular role. IEHP, for example, provides extensive training for new hires.

VII. Balancing Needs

During the course of the Work Group deliberations, as well as at the Forums with CHWs, several different needs and priorities emerged among CHWs, providers and others. As health care providers and managed care organizations move forward with including CHWs in their respective workforce, it will be important to be mindful of and navigate these different perspectives.

- Clinical care activities. As mentioned at the outset, some CHWs are concerned that carrying out direct services, such as blood pressure or cholesterol monitoring, can detract from the CHW's connection to the community. Moreover, CHWs value their role in taking a "whole person" approach to their clients/patients as well as in

[19] NEHI Conference

addressing root causes of chronic disease. When CHWs operate as part of a care team, they will need to sort out how to balance the role of CHWs as an extension of the provider with their role as an advocate for the patient/community member. Similarly, CHWs described the challenge of addressing disease-specific conditions as part of a particular program when the client's needs are much broader, such as food insecurity. These issues are integral to defining CHW roles and responsibilities. For example, should a CHW's diabetes-related work also address the range of factors contributing to the patient's overall ill health, even if they are not specific to diabetes?

- Professionalization. Work Group members acknowledged that as the health care system seeks mechanisms for sustainable financing of CHWs, there will be increased pressure to standardize training and certification, leading to questions about professionalization of the workforce—for example, if CHWs are defined as a profession, should there be a career ladder? If so, what steps should be taken to ensure that professionalization doesn't ultimately create distance from the community and conflict with "heart"? Alan Weil, editor of Health Affairs, recently wrote a column regarding the future of CHWs in which he identified two paths forward for CHWs: A professional, specialized workforce and a workforce serving the community. Although they can be seen as mutually exclusive pathways, he advocates for combining the two. That approach depends on an "explicit commitment to community health."[20]

  A related issue concerns the potential standardization of training requirements and identification of core competencies. Many Work Group members emphasized the importance of CHWs' experience as critical to their effectiveness. Concerns were raised that training which focuses primarily on learned skills, which can be more easily tested, may discount community knowledge and experience, as well as personal attributes, which are more difficult to assess. It will be important to figure out how to evaluate these "intangible" qualities of CHWs as well as the tangible skills and knowledge.

[20] Weil, Alan. "What is the Future for Community Health Workers?" Health Affairs. *Once In A Weil Blog* Post. November 25, 2014

- Certification and/or credentialing. Work Group members recognized the importance of standardization of training and education programs in order for CHWs to become a reimbursable health workforce. Nevertheless, there were a range of opinions about who should develop the standards and how they would be implemented. Many states are beginning to address issues of certification and/or credentialing. Particularly as Medicaid and other payers are exploring reimbursement, quality assurance has become an important component.

  To date, states that have moved forward have adopted a certification system, which is voluntary and "signals to employers and payers that the CHW is qualified to perform certain tasks" as contrasted with credentialing and licensure, which is mandatory for being able to practice.[21]

  Texas was the first state to require a state certification, although many believe that the process may too cumbersome.[22] Other states, such as Oregon and Ohio have developed state level standards. In Oregon, there are three pathways to state certification, which is voluntary. Minnesota and New Mexico, among others, have non-mandated certification programs, while Illinois recently passed legislation establishing an advisory board to review this issue. Massachusetts enacted a law regarding certification and created a board to develop the specific standards. CHWs were very involved in the development of the legislation. For a more thorough review of state actions on certification and credentialing, please see reports by the Institute for Clinical and Economic Review and Harvard Law School cited in the Resource Guide.

- Data collection. At the Forums, CHWs spoke about several challenges associated with data collection: having access to medical records of patients (especially if the CHW works for a CBO and not the provider directly), as well as recording the data. One issue revolved around collecting data during home visits with patients. As building trust is

[21] Miller, P., Bates, T., and Katzen, A. "Community Health Worker Credentialing: State Approaches." Center for Health Law and Policy Innovation. Harvard Law School. June 16, 2014

[22] Eyster and Bovbjerg

critical to doing their jobs, some found that writing notes during the visits could undermine that trust, whereas others found that they could adapt.

VIII. Next Steps

At the conclusion of the Work Group, members strongly suggested that some type of advisory group to the state continue. Although progress was made on many issues, much more work is needed to address unresolved issues, and the Work Group encouraged that momentum created through this process be maintained. In addition, the Work Group identified several next steps that can help facilitate the inclusion and integration of CHWs within the Innovation Plan's initiatives. These initiatives offer providers, payers, health plans, and CHWs with opportunities to experiment with different models and approaches. These efforts, along with other suggested activities below, can help advance the development of best practices and policies and the spread of CHWs as a critical component of the health workforce.

A. Innovation Plan-Specific Activities

1. **Outreach and education for health plans and providers**

   Because many health care providers may not have had experience with CHWs, materials that can be used for outreach and education for providers should be developed. These materials should convey the current research and data about the value of CHWs, as well as help providers plan for incorporating CHWs into their practice.

2. **Implementation**

   a. *Readiness*. Providers and managed care organizations who are interested in hiring CHWs will require some preparation and planning; health homes, in particular, which

will be implementing team based care, should incorporate several key CHW-related questions, into their planning processes, including[23]:

- What role will CHWs play and what are their responsibilities?
- How will CHWs be supervised?
- How will CHWs relate to or integrate with the care team?
- How will CHWs be paid?
- What core competencies will drive hiring and how will CHWs be recruited?
- What training will be provided?
- How will data on clients collected by CHWs be handled and what is the analytic capacity of a given provider or plan to use it?

- *Technical assistance*. Technical assistance for providers should be considered to help them assess organizational readiness, including cultural considerations, for employing CHWs. CHWs represent a new type of resource and services, and health care providers—both direct care personnel and administrative staff—will likely need assistance with integrating this role on the team.
- *Data collection*. Much of the data collected by CHWs is qualitative. Very often, there is no place on the EHR (or paper) record to input the data; consequently, the data are not as highly valued as clinical data. Although EHRs are still in the process of being implemented, consideration should be given to how qualitative data collected by CHWs, including data related to the social determinants of health, can be incorporated into the EHRs. That information is critical to being able to address the care plans of patients, especially those with complex conditions. Hennepin Health in Minnesota has created a separate section of the EHR in which CHWs enter their data.[24]

[23] See for example, Findley, S. et al. "Community Health Worker Integration into the Health Care Team Accomplishes the Triple Aim in a Patient-Centered Medical Home: A Bronx Tale" Journal of Ambulatory Care Manage. Vole 35:1. 2014

[24] Kristen Godfrey Walters, Hennepin County Medical Center, NEHI Conference. October 20, 2014

3. Evaluation

Research is now emerging that demonstrates a Return on Investment, in some cases, of utilizing CHWs. Nevertheless, a more robust business case is needed, based on experiences in California. Consideration should be given to how best to collect data that could help inform the business case. One Work Group member also suggested developing a more expansive and inclusive Return on Investment approach that would include value to community.

4. Training for CHWs

As described previously, although CHWs can receive training on core competencies through a variety of programs (CCSF, Visión y Compromiso, Latino Health Access, Esperanza Housing, etc.) they will likely need specialized training associated with specific Innovation Plan initiatives, such as health homes for patients with complex needs or palliative care, or to work in other new areas for CHWs. Development of training materials to help providers and health plans should be explored.

B. Advancing the Field Activities

5. Core competencies, standardization and training

As California heath systems and health plans expand the use of CHWs, more training opportunities will be required to fill the need. Moreover, as health providers seek reimbursement from government and private payers, greater clarity about, including potentially standardization of, roles and competencies will be important.

Therefore, the Work Group believes that a state-led engagement process with payers, providers, plans, as well as the active involvement of CHWs, is needed to explore the following questions:

- Should California require some type of certification or credential? If so, who should confer it—e.g., the state, community based organizations, educational institutions, or some combination?

- Should training programs be certified and what should the standards be? Should all training programs (e.g., community-based as well as higher education) that meet the standards be eligible for certification?
- For individual certification, should there be a state exam or should certification by an approved training program be sufficient? Are there other approaches?
- Should core competencies focus narrowly on health care systems which would ultimately be paying for CHWs, or broadly at the range of roles and sectors in which CHWs may work?

Relatedly, one Work Group member suggested that an apprenticeship model may offer a mechanism for CHWs to be trained that provides a pathway to employment.[25] A registered apprenticeship is an industry-driven training strategy that takes unskilled or semi-skilled workers to a fully skilled level, and provides a structured method of training that provides paid employment. Such a model is being developed with the Department of Labor in east Texas, which provides for didactic training on the eight core competencies, on-the-job learning, and employer-specific skills based training. Further exploration is needed to assess the applicability of this model in California.

6. Policy and financing

As state level policy regarding CHWs is considered, the Work Group recommends that policymakers be mindful of the wide variety of titles and definitions associated with CHWs, and focus to the greatest degree possible on the characteristics of CHWs, including personal attributes and skills, and the roles they play. As described previously, states now have the option for reimbursing non-licensed practitioners for preventive services. The Work Group believes that reimbursement must be provided to CHWs in order for providers and plans to be willing to hire CHWs. Grant funding is not a sustainable approach. DHCS should review reimbursement policies, as well as

[25] Erdmann, K. and Hargrove, L. "Approaches for Successful Implementation of a Community Health Worker-Registered Apprenticeship Program". US Department of Labor, Office of Apprenticeship, and East Texas Area Health Education Center webinar.

contracting mechanisms, to identify a range of strategies that could encourage plans and providers to hire and be able to pay for CHWs.

7. Emergent issues

Two other related issues arose during the Work Group deliberations, as well as by the CHWs who participated at the forums, which were outside the scope of the Work Group's charge, but, nevertheless, will be important to examine.

- *Career ladder*. Key issues include: what types of opportunities might exist for CHWs within a health care organization? What additional training might be required?
- *HIPAA constraints and data sharing*. Further investigation is needed to clarify any HIPAA barriers to data sharing, particular for CHWs that are community, rather than provider-based.

IX. Conclusion

There is growing national attention and momentum for the potential role CHWs can play in the health care system.[26] Because of the inclusion of CHW activities in several State Innovation Model and Health Care Innovation Awards projects, the Centers for Medicare and Medicaid Innovation convened a virtual learning collaborative to share experiences and lessons learned. Several national conferences have also recently been held, such as the recent Network for Excellence in Health Innovation conference on October 20, 2014 in Washington D.C., and increasing numbers of states are exploring models of care, certification, and financing approaches to support the expansion of training and integration of CHWs. The Innovation Plan provides California a meaningful opportunity to develop a range of approaches that fit the state's health care dynamics and markets, as well as its

[26] See for example, Katzen, A. and Morgan, M. "Affordable Care Act Opportunities for Community Health Workers: How Medicaid Preventive Services, Medicaid Health Homes, and State Innovation Models are Including Community Health Workers". May 2014. http://www.chlpi.org/wp-content/uploads/2013/12/ACA-Opportunities-for-CHWsFINAL-8-12.pdf

long history with CHWs, to enhance, extend and sustain CHWs as a critical component of improving health of California's diverse populations.

Appendix 1: Summary of CHW Forums

Purpose of Forums

- *Validate discussions that the Work Group has held to date (e.g. functions/roles, employment settings and models)*
- *Obtain input on CHW perspectives regarding payment, functions and roles, core competencies and other issues*

- A total of about 50 CHWs participated in the two forums on July 18th (Los Angeles) and August 5th (Oakland, Fresno)
- Drawn from Work Group participants' organizations and contacts, with a focus on CHWs doing work related to the CalSIM Initiatives
- Racially, ethnically and gender diverse
- CHW participants worked in a variety of organizations and settings (e.g. clinic, hospital, health plan, CBO, CHW organization, independent) and played a variety of roles from frontline worker to supervisor; experiences and perspectives varied, in part, depending on the organization/setting and role.
- Geographic representation: Riverside, Los Angeles, Fresno, Oakland, San Francisco, Sonoma Counties

Roles of CHWS:

1. a) What do you find most fulfilling or rewarding about your job?

- Making a difference
- Helping community members/clients improve their health
- Helping community members/clients become empowered, not feel alone
- "Helping families make change"

b) What aspect of your job do you consider to be the most important in terms of improving the health of the people you work with?

- Building trusting relationships with clients is key and takes time/long-term engagement
- Outreach – going where the clients/community members are
- Home visits (although some CHWs weren't allowed to conduct home visits because of liability issues)
- Bring the perspective of the client and advocate for the client to the clinic or health provider
- Work/advocate for the client NOT the health system or other providers

2. What role do you play in collecting data that is used to manage the care of patients?

- CHWs *ARE* the data source for many non profit agencies.

- Collect qualitative data (e.g., social determinants of health), based on interactions with clients, which complements quantitative data; but CHWs often don't have a way to capture, link and transmit information
- Facilitate data sharing, but can be difficult to obtain data from physicians/clinics if don't directly work for them
- CHWs have to balance the need to chart and document (e.g., "if it's not documented, it didn't happen") with the need to engage clients and build trust; eye contact is critical and too much documentation in front of the client can undermine trust.
    - CHWs spoke of charting in the car after the client visit
- Bridging medical and recovery models (mental health)
- Intake assessments

3. How do or could CHWs best link the health care system with community-based programs (CBOs)?

- Connect organizations with community resources
- Develop relationships with other agencies/CBOs to learn about community resources/networking
- Peer to peer learning
- Provide transport, accompaniment to clients with other services to ensure the connection is made

4. Are there additional roles that you could or would like to perform that you believe could improve people's health?

- Yes, with training and a career ladder for opportunity
- Yes, if wisdom and experience is valued
- Meet with patients after a physician/nurse visit to explain and develop a follow up plan
- Training other health professionals in the clinic/community on how to work with the Latino community (or other cultures)
- Do basic medical tests (but differences of opinions about this)
- Work with school districts on health promotion/education

Skills, training and supervision of CHWs:

5. What do you think are the most important qualities or skills that are needed for CHWs to work in the clinical setting?

- Understanding of the community/population
- Communication skills
- Computer skills (from a clinic supervisor) to be able to input data into the chart, use EHR
- Independent research on issues/questions people may ask about a particular condition
- Being able to build relationships and partnerships with organizations and providers
- Cultural competency

- Critical thinking
- Conflict resolution
- Motivational
- Flexibility and creativity (especially when there are space constraints)

6. What are the most important qualities and characteristics that you think are needed among provider organizations to best take advantage of what CHWs have to offer?

- Clear understanding of what everyone's role is, what a CHW does, and how the CHW fits into the team (if they are part of a health care team).
    - Even with clear scope of practice, different clinics do it differently
- Understanding and buy-in for CHW's role
- Valuing experience and skills (as much as credentials)
- Career ladder for CHWs
- Be willing to invest in training and education of CHWs
- Integrate and include CHWs into care teams
- Flexibility and creativity (especially when there are space constraints)
- Communicative and transparent

7. What type of trainings would most help you do your job?

- Office skills, if part of a clinic
- Computer/data collection/data entry
- Specific disease conditions/end-of-life, if work in palliative care
- Presentation and outreach skills
- HIPAA
- Ethics

8. What type or level of supervision do you find most helpful?

- Mentoring
- Supervisors who "get" what CHWs do and advocate for CHWs
- Transparency
- Flexibility to enable CHWs to work in the field during non-traditional hours
- Supervisors do observations so understand what CHWs do

Appendix 2: Work Group Roster

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Appendix 3: Meeting schedule and topics

March 28, 2014
- Kick Off In-Person Meeting
- Identification of Key Topics

May 9, 2014
- Briefing on CA4Health's Advisory Committee Meeting on Community Health Workers
- Definition of CHW
- Identifying roles and functions

June 13, 2014
- Refining roles and functions matrix
- Employment settings and mechanisms of employing and deploying CHWs

July 18 and August 5, 2014
- Forums in Los Angeles, Oakland and Fresno

August 15, 2014
- Debrief on Forums
- Reimbursement and financing

September 12, 2014
- Core Competencies
- Training

November 7, 2014

Final In-Person Meeting to Review Draft Report

Appendix 4: Resource Guide

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13. Miller, P., Bates, T., and Katzen, A. "Community Health Worker Credentialing: State Approaches." Center for Health Law and Policy Innovation. Harvard Law School. June 16, 2014. http://www.chlpi.org/wp-content/uploads/2014/06/CHW-Credentialing-Paper.pdf