

# Community Health Worker Policy Initiative - Public Health Seattle-King County

## Final Report of Findings Under Contract PREV2635

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### Summary

This report provides context and some potential directions for several interrelated initiatives by Public Health Seattle & King County (PHSKC) involving Community Health Workers (CHWs). It is based on review of documents and informal interviews with local stakeholders and resource contacts around the country. The report is organized in the following sections:

1. **The present opportunity:** a brief environmental scan from a national perspective highlighting trends and recent findings which suggest the time is ripe for actions to formalize and integrate CHW roles in public health and the health care “safety net” in Western Washington.
2. **CHWs in local health departments:** a review of practices in selected metropolitan health departments around CHWs, with commentary on the key issue of the creation of a job category for CHWs.
3. An overview of the **major elements of policy** which must be addressed in order to standardize and integrate the CHW occupation in public sector organizations, including an array of sustainable financing options.
4. A summary of four **recommended short-term strategies for action** by PHSKC to initiate longer-term change in the employment of CHWs.

### 1. The present opportunity

Progress in the growth and understanding of CHWs over the past 20 years has been dramatic, although much remains to be done. The current federal Administration has signaled repeatedly their desire to do more for and with CHWs, but other current trends also make this an opportune time for advancing the CHW workforce. Discussed in this section are (a) aspects of the current health care crisis in which CHWs can be part of the solution; (b) recent trends in development of an evidence base for CHW impact and cost-effectiveness; (c) specific provisions in the Affordable Care Act which present opportunities for CHW involvement; and (d) other specific federal actions and programs indicative of interest in CHWs.

### **1.a. The crisis in health care**

Health care reform is a response to a dysfunctional system with costs spiraling out of control. A key element of reform is structural and payment changes to emphasize outcomes, quality and prevention, shifting away from a poorly managed system of payments for units of service to one which pays for results, encouraging creative collaborations to use resources efficiently and effectively. Much of the attention is naturally on the largest public programs, Medicaid and Medicare, which are the largest payers for care and which also serve populations with distinctive challenges in access and utilization of care.

Crucial to the new structures are an ability to reach and communicate with underserved and “hard to reach” populations and (1) improve the quality of information flow between patient and provider, (2) increase health literacy and patient capacity to adhere to treatment and improvements in health-related behaviors, and (3) reach communities with “upstream” efforts to prevent a number of chronic conditions which have reached epidemic proportions. Decision makers are coming to recognize the futility of asking clinicians to take on these tasks; as a case in point, physicians themselves are recognizing the importance of, and their own impotence in addressing, social determinants of health. According to a 2011 survey of physicians, 9 out of 10 said that unmet social needs are directly leading to poor health, yet they feel unable or unequipped to address them.<sup>1</sup>

### **1.b. The growing body of evidence on CHW effectiveness**

Historically, CHW studies have been built around very specific interventions on specific health conditions using a clinical research model, which holds the randomized controlled trial as the pinnacle of credibility. Unfortunately, the unique roles and working style of the CHW do not lend themselves to such research methods. Based on clinical research standards, most systematic reviews of the literature have found results only “suggestive” of CHW effectiveness. The narrow focus and variable methods used in these studies mean that data cannot be compared or pooled across them. Nonetheless, policymakers and other stakeholders increasingly appear to accept a stipulation that CHWs can produce important results, often where other professionals or approaches have failed. Also, until very recently there were almost no studies of *cost-effectiveness* or *return on investment* for CHWs.<sup>2</sup>

This report was not expected to include a review of literature on CHW effectiveness. But the authors have included in current and previous materials documentation on five recent models

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<sup>1</sup> Sarasohn-Kahn J. The Social Determinants of Health: US Doctors Feel Unable to Close the Gap and Deliver Quality Care. Blog post on [www.careandcost.com](http://www.careandcost.com), January 11, 2012. Brian Klepper (ed.) Downloaded from <http://www.careandcost.com/2012/01/11/the-social-determinants-of-health-us-doctors-feel-unable-to-close-the-gap-and-deliver-quality-care/>

<sup>2</sup> Health Resources and Services Administration (HRSA). The CHW National Workforce Study. Bureau of Health Professions, March 2007.

which have documented net financial return on investment (ROI) of about 3:1 or better. Some of these are described under financing models later in this report.

- The Pathways model, originally for improving birth outcomes in high-risk neighborhoods
- Molina Health Care: “high utilizer” care coordination approach for a Medicaid managed care organization
- Langdale Industries, Georgia: “high utilizer” care coordination approach for self-insured employee health benefits plan
- Texas hospitals reducing emergency department costs for uncompensated care
- Arkansas “Community Connectors” in home- and community-based long term care

### **1.c. Opportunities for CHWs in the Affordable Care Act (ACA)**

**National Health Care Workforce Commission (§5101).** The Commission’s mandate is to create strategies to deal with the demand for health care professionals as a consequence of reform. Legislative language includes CHWs as “primary care professionals,” and a CHW was named as one of the 15 members of the Commission.

**Grants to Promote the Community Health Workforce (§5313).** This section authorizes CDC to award grants to employ CHWs for health promotion purposes with an emphasis on women’s and children’s health. No appropriation has been made for this program – it is not part of the Prevention and Public Health Fund, although the Administration might be able to manipulate it to allocate funds for this program. Again, it would be for more short-term projects and would not constitute a long-term source of support.

**Area Health Education Centers (§5403).** Some AHECs are more attuned to CHWs than others; many are exclusively focused on traditional university-based health professions education. The ACA added CHWs to the AHECs’ mandate to conduct “interdisciplinary training,” so AHECs in Washington theoretically could be enlisted as allies in a CHW policy initiative or specific local projects. The authors have considerable experience working with AHECs in other states.

The remaining ACA sections below do not actually mention CHWs, but the authors believe there is compelling logic to introducing CHW roles in their implementation. Apparently some CMS officials do as well: see PowerPoint excerpt provided earlier, from a presentation delivered at the national Unity Conference, a gathering largely of CHWs, in 2010 by Dr. Paul McGann, then Deputy Director of the CMS Office of Clinical Standards and Quality.

**Hospital Readmission Reduction (§3025).** The authors believe there is strong potential for CHW role in meeting standards for readmission rates discussed in this section. Reducing readmissions will likely require greater assurance that the patient and family understand provider discharge instructions, and CHWs can conduct routine follow-up visits to assure that the patient is taking prescriptions appropriately and keeping follow-up appointments with providers.

**Patient-Centered Medical Homes (§3502).** There appears to be a natural role for CHWs as part of “Community Health Teams.” PCMHs are discussed further below. The authors have contacts in several other FQHCs who are making CHWs a central part of their PCMH design.

**Patient Navigator Program (§3509).** The ACA reauthorized this program, and grants were awarded in August 2010. As noted earlier, neither the original bill nor the ACA mention CHWs in this context. However, HRSA, in the language of its funding announcement, made it clear that they favor employing CHWs as Navigators. The announcement stated at one point that if a proposal suggested employing another type of professional that choice would have to be justified. There appear to have been no moves to authorize another round of funding for this program.

**Maternal, Infant, and Early Childhood Home Visiting Programs (§2951).** This section provided for grants to the States, which were awarded fairly quickly after passage of the ACA. CHWs were not mentioned, but at least one State (Delaware) has chosen an innovative CHW model for use of these funds. The State awarded four contracts to healthcare institutions and CBOs in June 2012 to work in selected Census tracts with key indicators of health problems. CHWs called “Health Ambassadors” will work with residents of these neighborhoods to identify the residents’ top priority health issues and develop strategies to address them. This is a relatively unique approach stressing the capacity-building and advocacy roles of the CHW.<sup>3</sup>

**Center for Medicare and Medicaid Innovation (§3021).** CMMI has not overtly stated their interest in CHWs, but the recent Innovation Challenge experience suggests that they are indeed interested. Descriptions of a number of grants include mention of CHWs, including projects for a local behavioral health safety net provider in San Antonio, Texas and a national project with Health Care for the Homeless. Anecdotal reports suggest that in conference calls with prospective applicants, a number of questions touched on CHWs and CMMI clearly indicated they were interested in proposals that could demonstrate the cost saving potential of CHWs.

**Outreach for Health Insurance Exchanges (§1311).** Implementation will require an outreach and enrollment effort. The experience of Massachusetts with its state-mandated coverage expansion Outreach and Enrollment grants demonstrated the potential impact CHWs can have in improving access to care.

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<sup>3</sup> [http://bidcondocs.delaware.gov/HSS/HSS\\_12008Ambassadors\\_RFP.pdf](http://bidcondocs.delaware.gov/HSS/HSS_12008Ambassadors_RFP.pdf)

#### **1.d. Other Current Federal Initiatives**

- CDC CHW policy e-learning series: “Promoting Policy and Systems Change to Expand Employment of CHWs” is a six-module self-paced PowerPoint with narration, available online at [http://www.cdc.gov/dhdsp/pubs/chw\\_elearning.htm](http://www.cdc.gov/dhdsp/pubs/chw_elearning.htm)
- Office of Women’s Health CHW leadership training, the “Women’s Health Leadership Institute,” rolled out in five federal regions in 2012 and received very positive evaluations from local participants in Region X.
- Department of Labor recognition of the CHW as an “apprenticeable trade:” a proposal submitted by East Texas AHEC was approved in 2010 allowing CHW training programs to apply for apprenticeship status (discussed in more detail later in this report).
- HHS Office of Minority Health Promotora/CHW initiative: a federal working group and a 15 member Steering Committee of Promotores are working on initiatives to raise awareness and recognition of CHWs and create a federal resource portal emphasizing training.
- HHS working group on CHWs: led by the Office of Health Reform in the Secretary’s Office, a high-level working group that has commissioned a scan of HHS investments and other initiatives in CHWs by the Assistant Secretary for Planning and Evaluation, to be presented by the end of 2012, with a view toward a more strategic approach to the CHW workforce.
- HUD CHW Initiatives: HUD has quietly implemented a series of demonstrations with CHWs in subsidized housing, with support evident from top Department officials.
- CMS Innovation Challenge: a number of grants were awarded with specific focus on CHWs, including a national project serving the homeless and several sites working on reducing inappropriate use of hospital emergency departments. Privately CMS staff have indicated their interest in more evidence of cost savings by employing CHWs.

## **2. CHWs in Local Health Departments**

Having highlighted important events and trends at the national level involving CHWs, we now turn to the local level to provide context and a basis of comparison for the situation in Seattle-King County. PHSKC is not alone in their investigation of the application of CHW capabilities to local public health activity. We note with interest the following general observations: (a) the local health departments interviewed vary widely in their practices involving CHWs; (b) we were unable to identify any published formal studies on the utilization of CHWs in LHDs;

(c) most of the individuals interviewed expressed interest in formal research and/or collaboration on this topic.

## **2.a. Comparing Seattle-King County Organization of CHWs with Other Local Health Departments**

Some preliminary notes were provided in the initial findings report in September from contacts with Chicago, Benton and Multnomah Counties in Oregon, and San Francisco. Additional interviews were conducted with these and several other cities based on questions raised by PHSKC in November. A grid summarizing responses appears on the following pages. We believe further investigation in this area would be fruitful, and would suggest discussion of joint publication and/or program activity with NACCHO in 2013.

We can make a few generalizations here concerning these local health departments' inclusion of CHWs as part of their planning for health reform.

- Leadership in health departments interviewed are including CHWs in planning for addressing disparities and for linking prevention to emerging forms of health service delivery.
- Health departments that oversee primary care clinics (Multnomah County, San Francisco) are increasing the number of CHW-like positions to integrate care across prevention, behavioral health, and primary care services.
- All health departments are moving toward more centralized planning for how to employ and train CHWs as part of their programs.
- Only San Antonio is investing significantly in CHW initiatives that emphasize primary prevention and social determinants at a neighborhood level.
- Of these cities only the Boston Public Health Commission is marketing CHW staff services and technical assistance to health plans and MCOs.
- Health departments interviewed all use at least one civil service job classification loosely associated with the CHW concept to employ community members without higher education degrees for entry-level positions.

Questions	Baltimore City	Boston Public Health Commission (city health department)	Portland-Multnomah County	City and County of San Francisco
<b>Definition of CHW?</b>	Yes	Yes.	Yes--health dept's capacitation center has a definition & now the state has a definition in statute (in the document). "A trusted community member who participates in capacitation so they can promote health in their own communities."  (Farquar & Wiggins 2005)	DK
<b>Titles specific to CHW? Coordinated program or division based?</b>	<p>-Titles vary. Lead Program -- Community Health Investigators ( civil service classification)</p> <p>-Titles Community Health Worker and Outreach Worker used in health promotion division programs &amp; contractors.</p> <p><b>-Still investigating whether there is an additional distinct civil service classification.</b></p> <p>-To date appears no coordinated CHW program.</p>	<p>-Vary. Public Health Advocate 1,2 (civil service classification) captures many CHW staff.</p> <p>-Program Coordinator 1 provides additional promotion possibilities for CHWs.</p>	<p>-Community Health Specialist 1 &amp; 2</p> <p>-Not coordinated CHW program, but reviewing possibility of formalizing such a program</p>	<p>-Health Worker 1,2,3,4 classification (civil service)</p> <p>-Health Worker (HW) classification facilitates planning for Division heads, as well as for training needs</p>

Questions	Baltimore City	Boston Public Health Commission (city health department)	Portland-Multnomah County	City and County of San Francisco
<p><b>Kinds of jobs/titles for CHWs at department and #s of staff</b></p>	<p>-Titles vary. Most ‘outreach workers’ or ‘community health workers’ are in Health Promotion, Disease Prevention Division. -Main type of work for CHWs is community outreach and education, in following types of programs: -Ryan White HIV/AIDS outreach, STD’s, MCH, Disparities and cardiovascular disease prevention, Lead (4 Public Health Investigators—home education, assessment, care coordination, case management), asthma program - <b>Would need to request numbers on CHW staff from Human Resources</b></p>	<p>-Count not exact but for recent state public health survey estimated city health dept employed 240 CHWs. -Very large (maybe inflated) number in Homeless Programs—150 ‘Counselors (informal) -CHWs and outreach in many programs, and the health department provides many direct services -Child health, Healthy Baby, Healthy Child, substance abuse, asthma, Community Health Initiative, homeless programs</p>	<p>-Approximately 35 CHS’s throughout health department staff -CHS’s in primary care clinics, school based health centers, HIV/AIDS community program, directly observed therapy TB</p>	<p>-Community Health Program Div: 12-15 HWs in primary care clinics; ? # HWs working as Behavioral Assistants to Social Workers in Behavioral Health Clinics; 30 in hospital-based Interpretation Program; -HW staff in primary care clinics are panel managers -HWs also staff centralized interpretation services based on hospital, serving all primary care clinics -Anticipated CHW interns from SF City College program to do community outreach and awareness with CTG</p>
<p><b>Health Department have contractors who hire CHWs?</b></p>	<p>-Yes. Deliberate strategy to minimize staff commitments is to fund CBOs and a FQHC who hire CHWs under non-civil service titles. -Appears most ‘outreach workers’ and ‘community health workers’ are employees of vendor/contractor CBO’s and a FQHC.</p>	<p>-Yes, though the department itself does unusual amount of direct service delivery itself.</p>	<p>- Yes, though job titles vary. Healthy Start early childhood services programs; HIV community program, and also Dept of County Human Services contracts a lot with culturally specific CBO's -- likely dozens of CHW-like positions. So--using the CHW term 'broadly' these are all CHWs (e.g. often not 'from the community').</p>	<p>-Yes. Some 250 contractors/vendor organizations, many of whom hire CHWs under a variety of titles -There is no count</p>

Questions	Baltimore City	Boston Public Health Commission (city health department)	Portland-Multnomah County	City and County of San Francisco
<b>CHW Training?</b> <b>What is offered?</b> <b>Who provides?</b> <b>Who pays?</b>	-Health department no longer has CHW training center. -FQHC connected to the health department adapted HUD CHW training manual and provides competency training for CHWs working in disease prevention and for CHWs working with vendor organizations.	-Health department is home to Community Health Education Center (CHEC), oldest and among most respected CHW training centers in country. -Core competency training of 25 hrs, plus additional 25 hrs of community health. -Additional trainings offered	-An 80-hour CHW basic curriculum, approved for academic credit by the Oregon State Board of Education. -M. Co Hlth Dept Capacitation Center offers CHW core competency and other training	-Long standing relationship with San Francisco City College CHW program -Completion of the program substitutes for six months of experience in meeting city hiring criteria -Community Transformation Grant will facilitate internships in health department for program students
<b>Does health department contract CHW services to MCO's, other health providers?</b>	-No.	-Just beginning to do this in asthma program. Contracted CHWs to work with Neighborhood Health Plan 2012.	-Currently not contracting CHW services out; -Looking at maybe contracting with CBO's for CHW services in future, in MCH programs	DK
<b>Does health department provide technical assistance re CHWs to health plans, providers?</b>  <b>Who pays for it?</b>	-Do not provide technical assistance, but developing a computer-based training with a variety of stakeholders with current grant funding.	-Yes. To date through Boston Asthma Home Visit Collaborative, convened by the department. -To date grant funded, but strategy is to market to health plans and providers.	-Yes and no. -Community Capacitation Center offers assistance on hiring, training, policies related to CHWs. -training to date has been offered to CBOs and service organizations, not health plans or providers.	DK

Questions	Baltimore City	Boston Public Health Commission (city health department)	Portland-Multnomah County	City and County of San Francisco
<b>How do CHWs figure in your planning re health and payment reform?</b>	<p>-Commissioner has strong interest in CHWs, for such new programs as promoting wellness programs with employers and others.</p> <p>- Seeking funding for Assistor positions as part of the ACA.</p>	<p>-CHWs are part of the department’s strategy to build connections between primary and specialty health care and public, population health.</p> <p>-Marketing the asthma home visiting model and teams is one of the initial efforts to make these linkages by the department.</p>	<p>-Oregon HB3650 highlighted role of CHW &amp; other ‘non -traditional’ health workers (peer educator, patient navigator)</p> <p>-Oregon received Medicaid waiver to pay for CHW services in 2012</p> <p>-Multnomah County HD (MCHD) planning CHW employment as part of ACOs in 9 integrated clinical care primary health clinics</p> <p>-Various MCHD units are assessing potential for CHW employment or contracting</p>	<p>-Increasingly centralized planning in the Community Health Program Division- Health Workers envisioned as part of integrating behavioral and primary health clinics;</p> <p>-Health Workers included in primary care and behavioral health teams to allow nurses and social workers to ‘work at top of license’</p> <p>-The hope is that with future payment reform HW will be covered as part of value added care</p>
<b>State Certification of CHWs?</b>	<p>-Some talk of this.</p>	<p>-State health department housed CHW Board of Certification established by legislature in 2010. Certification is voluntary.</p>	<p>-State certification likely to happen in future— recommendations from state health department Office of Equity &amp; Inclusion committee on “non-traditional health workers” are to certify training programs, not individuals, and grandparent experienced CHWs</p>	<p>-Certification is not currently part of the discussion at the city health department</p>
<b>CHW Association?</b>	<p>Not aware of one.</p>	<p>Massachusetts Association of Community Health Workers (MACHW).</p>	<p>-Oregon CHW Association growing rapidly</p> <p>-fiscal agent is Oregon Latino Health Coalition</p>	<p>DK</p>

Questions	Chicago	San Antonio
<b>Definition of CHW?</b>	None; noted as a challenge	No
<b>Titles specific to CHW? Coordinated program or division based?</b>	<b>“Public health aide” most common but many exist. Each program is independently organized.</b>	CHW and Promotora most common, dictated by funding source
<b>Kinds of jobs/titles for CHWs at department and #s of staff</b>	Numbers unknown, “probably hundreds.” <b>Positions also exist in other City departments, such as Dept. of Family &amp; Support Services</b>	Numbers unknown, department has multiple prevention initiatives
<b>Health Department have contractors who hire CHWs?</b>	Only for HIV, to interviewee’s knowledge	No. Most programs are operated directly by the Department.
<b>CHW Training? What is offered? Who provides? Who pays?</b>	No centralized program. Department has historically trained its own workers.	Varies by program. Pool of trained CHWs exists due to State certification and availability of certified training program at local community college.
<b>Does health department contract CHW services to MCO’s, other health providers?</b>	No	No. Clinical care services divested in last few years to county hospital district.

Questions	Chicago	San Antonio
<b>Does health department provide technical assistance re CHWs to health plans, providers?</b>	No	No
<b>How do CHWs figure in your planning re health and payment reform?</b>	<b>Interface with State – just starting; see important role in insurance exchanges for “patient assistor” which should be CHW, unclear with Department’s role will be</b>	Department is largely peripheral to reform planning. Only clinical services are in communicable diseases: immunizations, HIV testing and referral, and TB clinic. New department director is strong advocate for CHW roles.
<b>State Certification of CHWs?</b>	Dept. is very involved in planning for this. Participated in regional forum 1/25/13; have taken no official position but supportive of the process.	Required for paid CHW positions since 2001.
<b>CHW Association?</b>	Local only. Department supports, appears to be fairly strong, offering trainings and leadership on credentialing process. Department is <b>helping with networking, sharing info resources</b>	Local association exists, 300+ members but not very active.

## **2.b. Best Practice Models for CHW Program Organization and Administration**

Our understanding of PHSKC is that CHWs are scattered throughout the department's divisions and programs. Each set of workers answers to the hierarchy of their divisions and departments. There is no shared occupational category for positions that could be characterized as "CHW-like" jobs; nor is there an occupational category called "community health worker." In addition, the health department funds "CHW-like" workers in CBO's and partner organizations through various contracts.

Based on our research and experience this is a very common decentralized system of employing CHWs in local health departments. One exception is in Oregon's Benton County Health Department. In that department a staff person was charged four years ago with developing a "health navigator" program to serve as a link between the clinical and community work of the health department. In that health department navigators are viewed as CHWs. Not all of the CHWs throughout the department are in the same program. However, a cadre of navigator positions constitutes an autonomous or pooled staff that can be called on by any program in the agency to help with clients/patients. A chart of Benton County's "continuum" of CHW roles was provided in September.

One very exciting new program is just getting started in 2013 in San Antonio's Metropolitan Health District (SAMHD), a City department which also serves unincorporated areas of surrounding Bexar County. Using funding from a new Medicaid 1115 waiver (\$1.7 million per year for four years), SAMHD will deploy CHWs in one East Side neighborhood essentially as community organizers, applying principles of "asset-based community development" to address a broad range of determinants of health. This waiver has created 20 substate regions which have developed plans for managing uncompensated care and initiatives to improve care and outcomes through "delivery system reform incentive payments" (DSRIP).<sup>4</sup>

Other health departments report that the changing policy and financing environment is contributing to plans or early efforts to assess the number and types of community health worker employees across different departments, just as PHSKC is doing. Some are also including assessments of CHW positions among partners and other community organizations.

One area where other health departments have taken a different approach from PHSKC, however, is in the area of job classifications and CHW positions. A number of departments have a job classification that corresponds to what respondents we spoke with think of as CHW jobs.

The authors have collected numerous examples of CHW job descriptions and position announcements from local governments, most of which are very limited in detail. We have noted that a number of health departments have published a series of different job announcements with different duties, all using the same position title, suggesting that they

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<sup>4</sup> See <http://www.tha.org/HealthCareProviders/Issues/FinanceandReimburse098F/MedicaidBBBFWaiver/index.asp>

consider “CHW” to be a larger category of worker. A series of samples were provided with the initial findings report in September, including a proposed generic position description for the state of New Jersey, and an example of a policy manual for CHW positions which goes beyond a basic position description.

## **2.c. Pros and Cons of Creating a CHW Occupational Category within Health Departments**

A number of health departments have a job classification that is for CHW kinds of staff. The occupational categories have different labels across city departments, but all of them bear an intuitive relationship to the work with which CHWs are associated. They were all created prior to the national diffusion of the umbrella term “CHW.” These occupational titles cross different departments within the same agency. They are not necessarily the same name as the job titles and descriptions that are written within those occupational labels, however.

- In San Francisco’s city health department, there are four levels of Health Worker occupational categories and positions.
- In Boston’s public health department there are two levels of Public Health Advocate categories and positions.
- In the Benton County, Oregon health department the job classification is called Health Promotion Specialists 1 and 2. Recent efforts to systematize CHW positions under a shared job title within these classifications have led to changes in job titles for CHW positions across departments to be called Health Navigators.
- In the Multnomah County, Oregon health department there are two levels of Community Health Specialist.
- In the Chicago health department, CHWs occupational category is Public Health Aide, which supplements the functions of public health nurses.

**Pros:** Brief interviews with a staff person from each of these health departments indicate that one advantage of having these cross departmental occupational categories/classifications is the ease with which one can write a job description that works for a CHW kind of position or hire. The requirements for the level 1 positions do not include college degrees, and in some cases, do not include a high school degree. There is sufficient flexibility in writing job descriptions that respondents said it was relatively easy to hire the kinds of people needed by a program to fulfill a CHW role.

It seemed evident from these interviews that having such a category allowed staff to track and count the range of CHWs across programs. In Benton County Oregon there remain challenges of

changing job titles for existing CHW staff to bring all of them under one share title of Health Navigator. Still, the respondent argued, it was a matter of having the titles catch up with the system and with time and education. She thinks the effort has helped all staff understand what the distinctive contributions of CHWs are for all of their programs. This approach also has the advantage of providing a beginning career ladder for CHWs.

**Cons:** The cons that we perceive confront departments such as Seattle King County and others as they consider whether or how to make the CHW roles, occupational categories and jobs consistent across departments have to do with the challenges inherent in altering civil service categories. The other challenge that all departments describe struggling with concerns what to do with the multiplicity of terms that are emerging for work that CHWs do or can do. The most common current difficulty comes with the relationship between CHWs and the Patient Navigator term.

### **3. Elements of Necessary Policy Change**

If PHSKC and/or other stakeholders are to pursue policies and practices to regularize and recognize the occupation of CHW, it is important to note that the policy environment surrounding this field is complex and interconnected. This complexity exists regardless whether it is a local government or any other entity that is pursuing policy change.

PHSKC staff are familiar with the framing of policy arenas as laid out in APHA Policy Statement 2009-1 and a subsequent Health Affairs paper (Rosenthal et al., 2010). These are **occupational regulation and standardization, sustainable financing of CHW positions and workforce development.**

CHWs and their policy advocate allies have learned that it is most effective to work on all three of these policy fronts simultaneously, given their interconnectedness.<sup>5</sup> For example, as funding streams for public health change in the context of state budget cuts and health care reform, the importance of clarifying the nature of the field that is now widely referred to as ‘community health workers’ has become evident. The need for some kind of common understanding of the CHW workforce when approaching payers, providers or legislators has become clear.

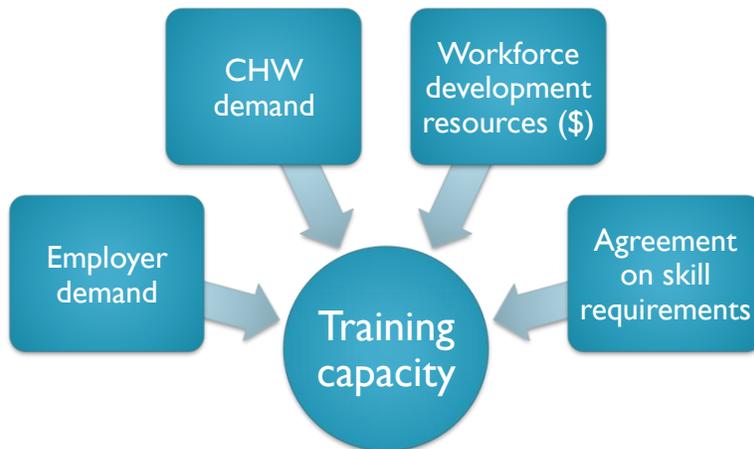
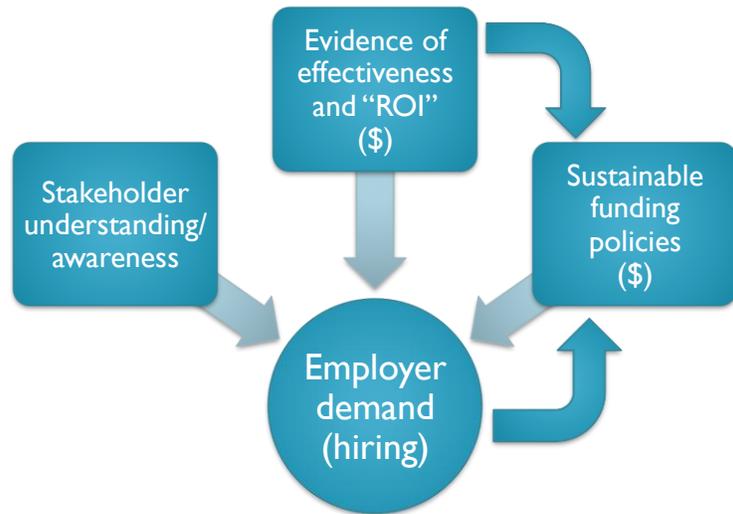
Likewise, in order to take advantage of new funding streams for prevention—whether in community and public health settings or in clinical organizations—Medicaid and health payers who serve Medicaid patients require training standards for staff who can be covered. Aside from the understandable concern that health payers express about “wanting to know who or what we are paying for,” the issue of “commonly recognized” or “state recognized standards’ for training and preparation for an occupation is for them a regulatory concern. Health plans and providers as

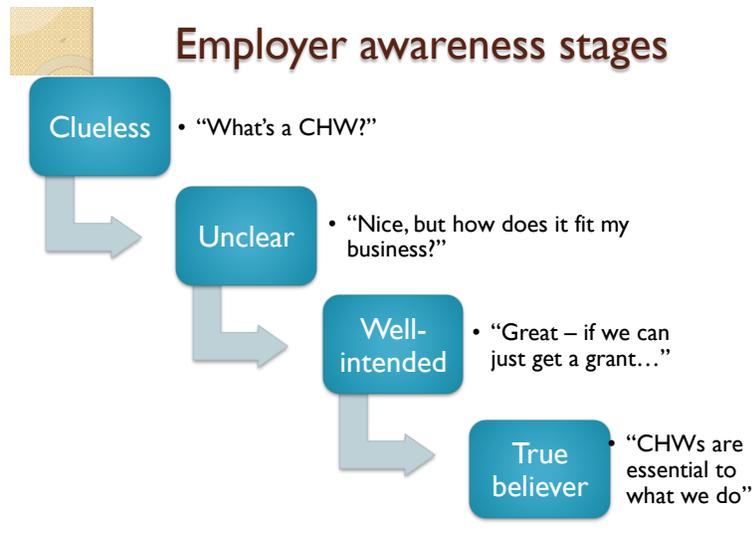
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<sup>5</sup> Rosenthal, E.L. et al. Community health workers: part of the solution. Health Affairs. 2010; 29 (No 7): 1338-1342.

well are reviewed by professional certification organizations; assuring that organizations and personnel they fund have met such standards affects their own credibility and possibly liabilities.

The graphics below may be useful in presenting relationships among policies to department leaders and other stakeholders:





In this section we will summarize key elements of each of these policy arenas. Because in many ways the question of sustainable financing of CHW positions is the most complex and politically challenging, we have devoted considerable space to current thinking on promising financing models which may be applicable in the Seattle-King County region.

In view of the sometimes daunting complexity and the wide array of policy options, we proceed from this wide-ranging discussion to section 4, on page 38, in which we present four potential short-term strategies which, in our opinion, present the greatest opportunities for establishment of momentum and a sense of progress in moving the field forward.

### 3.a. Occupational Recognition and Standardization

#### 3.a.(1) CHW Definitions, Occupational Recognition and Standardization

The authors have learned from experience in policy campaigns in Texas, Massachusetts and other states that defining the parameters of a field to policy and health finance professionals means determining a core of knowledge and skills that any worker claiming to be a CHW must have mastered, as well as arriving at a common understanding of a *scope of practice* for the occupation.

This does not mean that there cannot be variation in the kinds of work or jobs or job titles this kind of person pursues. There are many examples of other professions, e.g., nursing, where the range of tasks and skills within the defined profession can be quite wide. Still, the concept or idea of what a “nurse” is or does in general allows for sufficient shared understanding for all kinds of funders, health plans, health planners, and other professionals as well as clients and patients to discuss. This is what is needed to clearly convey what we all know is the CHW contribution to improving individual, family, or community health.

The challenges of capturing this diverse, often generalist and necessarily flexible kind of work and workforce are familiar to everyone who is engaged in expanding the opportunities these workers offer to reduce health disparities and strengthen health systems for all. Fortunately, many CHWs, together with other health professionals and other colleagues, have worked hard at creating definitions, core competencies, and professional ethics. We believe the examples below address the understandable concerns (which the authors both share) about constraining or distorting the unique strengths of this workforce.

### **3.a.(1)(a) Widely recognized CHW definitions**

There are two widely recognized definitions, and both have the advantage of having been created via national dialogues led by community health workers themselves. These are the APHA definition, adopted by the CHW Section of APHA<sup>6</sup>, and the other is the federal Department of Labor standard Occupational Classification [21-1094].<sup>7</sup> The current definition in the SOC manual does not bear close scrutiny, because it is a “placeholder,” pending adoption of a more complete definition based on input from the field, which should be in place in 2013.

We are aware that PHSKC has drafted a definition based on the APHA definition. We thought it might be useful to add two others here for your review. The definition adopted by the Massachusetts Department of Public Health has the advantage of having been phrased in functional terms.

**A Community Health Worker (CHW)** is a public health outreach professional who applies his or her unique understanding of the experience, language and/or culture of the populations he or she serves in order to carry out one or more of the following roles:

- Providing culturally appropriate health education, information and outreach in community-based settings, such as homes, schools, clinics, shelters, local businesses, and community centers;
- Bridging/culturally mediating between individuals, communities and health and human services, including actively building individual and community capacity;
- Assuring that people access the services they need;
- Providing direct services, such as informal counseling, social support, care coordination and health screenings; and
- Advocating for individual and community needs.

CHWs are distinguished from other health professionals because they:

<sup>6</sup> The APHA definition can be found at: <http://www.apha.org/membergroups/sections/aphasections/chw/>

<sup>7</sup> The Occupational Classification definition can be found at <http://www.bls.gov/soc/2010/soc211094.htm>

- Are hired primarily for their understanding of the populations and communities they serve;
- Conduct outreach a significant portion of the time in one or more of the categories above; and
- Have experience in providing services in community settings.”

Note that the term “outreach” is not standardized nationally. Some authors and other stakeholders regard “outreach” as anything done outside of the clinical or institutional setting, i.e., “out” in the community, which might include, say, home visiting. One present author (Rush) prefers a more narrow definition, in which “outreach” is population-based activity intended to “reach” and educate individuals and families. In some cases this means assisting community members on a short-term basis through enrollment or referral. But the maintenance of ongoing relationships in care coordination or chronic disease management, which may involve regular contact through home visits and other contacts “out” in the community is not “outreach” under this narrower definition.

The language in the State of Texas CHW definition has evolved from its original wording. As amended in 2010, it now reads,

Promotor(a)" or "Community Health Worker"--A person who, with or without compensation, is a liaison and provides cultural mediation between health care and social services, and the community. A promotor(a) or community health worker: is a trusted member, and has a close understanding of, the ethnicity, language, socio-economic status, and life experiences of the community served. A promotor(a) or community health worker assists people to gain access to needed services and builds individual, community, and system capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, patient navigation and follow-up, community health education and information, informal counseling, social support, advocacy, and participation in clinical research. (Texas Health and Safety Code, Chapter 48, Section 48.001(7))

### **3.a.(1)(b) What is distinctive about CHWs?**

The following points are common elements to most definitions and their underlying assumptions. These points may be useful in helping others understand the nature of the CHW workforce and the differences between CHWs and other health-related occupations:

- They generally do not provide clinical care
- They generally do not hold another professional license
- Their expertise is based on *shared culture and life experience* with the people served
- They rely on *relationships and trust* more than on clinical expertise
- They relate to community members *as peers rather than purely as clients*

- They can achieve certain results that other professionals can't (or won't)

Key to this understanding is the recognition and validation of a distinct form of *expertise* in CHWs. Clinicians and administrators looking at health-related occupations tend to rely on the extent of clinical training to define and classify the occupation. While some exposure to clinical content is important, the CHWs contribution needs to be viewed in the context of a distinctive scope of practice and a distinct set of core competencies (see below).<sup>8</sup>

### **3.a.(1)(c) CHWs and Patient Navigators (PNs)**

The authors recommend dealing early and directly with the ongoing confusion of definitions between CHW and PNs. The term “Patient Navigator” was coined by Dr. Harold Freeman at Harlem Hospital in the early 1990s, and it has been brought to the forefront by the Patient Navigator Act (2005) and its reauthorization in the Affordable Care Act (2009). PNs are most often associated with cancer diagnosis and treatment, but they have proven to be effective in other chronic conditions.

It is not productive to gloss over this issue by concluding that CHWs are the same as PN or that they are “just different.” The authors suggest Washington stakeholders adopt a stance that patient navigation is a role or function, and not a distinct occupation, considering the following distinctions:

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

Note the similarity to qualities of CHWs in the following statements from documents co-authored by Dr. Freeman:

The most important role of [the PN] is to assure that any woman with a suspicious finding will receive timely diagnosis and treatment. The Navigator accomplishes this most effectively through one-on-one contact with the patient ... to eliminate barriers ... the [PN] should [be]: culturally attuned to the ... community being served, able to communicate, sensitive and compassionate... very knowledgeable of the environment and system ... highly connected and allied with critical decision makers within the system, especial the financial decision makers.

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<sup>8</sup> Gilkey MB, Garcia C, Rush C. *Professionalization and the experience-based expert: Strengthening partnerships between health educators and community health workers*. Health Promotion Practice, March 2011 (12.2) pp. 178-182.

Note: No particular level of formal education is required.<sup>9</sup>

“[Navigators are selected largely on the basis of being] dedicated people from the community [that are] sensitive to and can communicate with the population served.”<sup>10</sup>

### **3.a.(2) CHW Scope of Practice**

Unfortunately, the definition of a scope of practice for CHWs has lagged behind other developments. To date only New York<sup>11</sup> and Minnesota<sup>12</sup> have attempted to promulgate scopes of practice, and both would probably be considered “sketchy” compared to similar definitions for other professions. It could be argued that clear communication with providers, payers and other health professions cannot be achieved in the long run without a CHW scope of practice. The New York policy initiative applied a rigorous “functional job analysis” technique which produced a richly detailed picture of what CHWs actually (or potentially) do (draft document provided in September). An early attempt at definition in the San Francisco Bay Area in the 1990s found clear distinctions in roles and skill sets between what they termed the “Clinical CHW” and the “Community Health Outreach Worker.”

### **3.a.(3) Competency-based standards and training**

The point has been made elsewhere, but it bears repeating: the lack of common standards and qualifications is likely to remain a significant barrier to sustainability of CHW services and broader acceptance of the legitimacy of CHWs by providers, payers and other stakeholders.

#### **3.a.(3)(a) CHW Core Competencies**

National consensus is crystalizing around some version of the CHW Core Competencies first defined in the National Community Health Advisor Study (Rosenthal et al., 1998). The Core Competency Areas include:

- Communication skills
- Interpersonal skills
- Informing/instructing (teaching) skills

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<sup>9</sup> Freeman HP et al. Breast Health Patient Navigator Resource Kit. Healthcare Association of New York State, September 2002.

<sup>10</sup> Vargas RB, Ryan GW, Jackson CA, Rodriguez R, Freeman HP. Characteristics of the Original Patient Navigation Programs to Reduce Disparities in the Diagnosis and Treatment of Breast Cancer. Cancer May 2008 (113:2) 426-433

<sup>11</sup> [http://www.chwnetwork.org/clientFiles/nycchw/media/chw\\_initiative2011report.pdf](http://www.chwnetwork.org/clientFiles/nycchw/media/chw_initiative2011report.pdf) (pp. 6-9)

<sup>12</sup> <http://mnchwalliance.org/scope.asp>

- Capacity-building skills
- Organizational skills
- Advocacy skills
- Service coordination/referral skills
- Substantive knowledge base

The policy initiatives in Texas, Ohio, New York, New Jersey and Massachusetts have all adopted some variation on these themes. A good example might be the elaboration proposed by New Jersey AHEC in 2008 (this document was provided to PHSKC earlier). More background documents are available if this direction is pursued further.

Core Competencies further form the basis for CHW credentialing (see next section) and for standardized training (or training standards) required to obtain such credentials.

### **3.a.(3)(b) Credentialing**

Both authors have been in policy discussions with state officials and health plans (in several states) that serve people with subsidized insurance about the possibilities of covering CHW services. In addition to requiring a definition of the occupation or profession of CHW, health plans universally stress the importance of having recognized standards of skills and qualifications, potentially extending to standards of training and credentialing. They do not appear prescriptive about what kind of credentialing, or who issues the credentials so long as it is officially accepted as a standard by the State. All three states that have passed CHW credentialing legislation have based the certification in statewide organizations or agencies with clear relevance and legitimacy in the health field.<sup>13</sup> For a brief summary of the essentials of credentialing and the Texas and Ohio systems, please see the document provided earlier, “Basics of CHW Credentialing.”

The long-standing debate among CHWs, their colleagues and allies about the pros and cons of credentialing continues. Both authors have been in the thick of such discussions, in the case of Rush for 15 years. One clear pattern is that **licensure is out of the question for CHWs**. There are forces in the culture of health care that may push for such an approach. However, three states (Massachusetts, New York and Virginia) have made formal determinations that licensure is not applicable because the unlicensed practice of CHW activities do not pose a significant risk of harm to the public. Of the other options for credentialing, *certification* has emerged as the most logical choice.

**Texas and Ohio.** Certification was offered beginning in 2002 in Texas and in 2003 in Ohio. At present there are over 2,000 Certified CHWs in Texas, while there are only a few hundred in Ohio. Basic features of these two programs are somewhat similar, but there are important differences:

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<sup>13</sup> In Texas it is the State Department of Health Office of Title V and Family Health. In Massachusetts it is in the state health department Division of Professions and Licensure. In Ohio it is in the state Board of Nursing.

Texas	Ohio
Housed in state health department	Housed in Board of Nursing
Does not specify CHW duties	Allows for performance of certain delegated nursing tasks under supervision
Requires certification of training instructors (and training programs)	Any licensed health professional can deliver training
Most training providers are not in higher education institutions	All training programs are college-based
Core Competencies are emphasized	Training standards include more clinical content
No application fee; no SSN or citizenship status required	Requires all three
“Grandfathering” made permanent in 2010 as an option for attaining certification	“Grandfathering” repealed in 2006
	Established “quality of care” standards for CHW services

In the authors’ experience a *responsive* certification system should include the following features:

- Offer multiple paths to entry, including based on experience (“grandfathering”)
- Required education should be available in familiar, accessible settings (including distance learning)
- Teach required courses using appropriate methods (adult/popular education)
- Offer easy access to CEUs
- Respect volunteer CHWs! Avoid making certification a status distinction

**The Massachusetts CHW Board of Certification.** This state can serve as a national model of CHW engagement and leadership in policy change related to their evolving field. Massachusetts has been debating, then undergoing, health reform for over a decade. The Massachusetts Association of Community Health Workers (MACHW) leadership and membership decided it was preferable to create their own definition and form of credentialing rather than have others determine it for them.

MACHW leadership, in collaboration with the Massachusetts Department of Public Health, drafted the legislation that created a CHW Board of Certification located at the Department. This draft reflected months of discussion with CHWs at forums organized by MACHW in six regions

of the state. It was this version that ultimately passed both houses of the state legislature, thanks to MACHW's statewide networks and a strong coalition of allies, including the MDPH.

The legislation passed in 2010 and the Board first officially convened in July of 2012. The legislation was designed to minimize barriers to credentialing community leaders and others who may not have extensive formal education but are suited for the work. The goal was to assure that the field retains its orientation and connection to underserved communities.

First, the certification will be voluntary. Secondly, the make-up of the Board itself was specified to include at least four CHWs nominated by MACHW (out eleven total members) and representatives from several identified public health organizations with extensive experience working with CHWs. A list of required core competencies together with a slightly revised MDPH definition are contained in the legislative language. The standards, rules and procedures will be developed by the Board.<sup>14</sup>

### **3.a.(3)(c) Training of CHW supervisors**

We have gathered substantial anecdotal evidence in Seattle and elsewhere that supervisors of CHW are often unprepared for the unusual demands of managing a CHW workforce. Incomplete understanding of CHW roles and characteristics can lead to disappointing results, or at least failure to realize the full benefits of employing CHWs. A recent paper highlights this (Duthie et al., 2012). We are involved in preparation of a follow-on paper for the Journal of Nursing Education and Practice, and in creating a supervisor skills workshop series with the Outreach Worker Training Institute in Massachusetts. We suggest that attention be paid to supervisory skills in the longer-term development of training capacity in Washington.

### **3.b. Financing options**

The shifts in financing opportunities for public health and related work, including clinical aspects of prevention (e.g. screenings, secondary prevention such as chronic disease self-management), insurance outreach and enrollment are ongoing. The following options are not exhaustive; they provide an initial overview of the most salient possibilities at this historical moment. Those of most interest to Seattle King County (including other ideas) can be explored separately. We begin with the admittedly limited innovations that focus strictly on funding community based primary or other prevention work traditional to public health. From there we focus on the range of new opportunities for local health departments to join with health care and other community organizations to create a holistic health system as part of health reform.

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<sup>14</sup> The law's language can be found here: <http://www.malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter322>

The grim reality is that, other than the authorization of Medicaid reimbursement for CHWs as providers in Minnesota, selected Medicaid waivers and pending changes in Texas Medicaid managed care (all topics that have been discussed earlier), there have been no state-initiated financing innovations for CHW sustainability actually *implemented* to our knowledge.

We have organized this section into the following categories:

1. Recent reviews of CHW financing options
2. What seems to be of interest to providers and payers?
3. Inclusion of CHWs in state standards for Patient-Centered Medical Home (PCMH) teams and partners
4. Health Homes
5. CMS Medicaid waivers
6. Medicaid managed care: CHWs paid for under Medicaid administrative costs versus as “services”
7. Payment reform or related legislation to establish a prevention and wellness trust fund
8. Contracting Prevention, Chronic Disease Management and Related Techniques to Medicaid Managed Care Health Plans or to Providers

### **3.b.(1) Recent reviews of CHW financing options**

There have been at least five recent summaries of systematic approaches to the question of financing CHW services: one by the National Fund for Medical Education (NFME) in 2006, one by the Massachusetts Department of Public Health in 2009, a third by the CHW Initiative led by the New York State Health Foundation (2011), an earlier (2007) very limited study by the Georgetown Law Center, and a policy brief by the National Health Care for the Homeless Council (2011). The first four are summarized below, and the fifth may be accessed on the Web.<sup>15</sup> These reviews have made some contribution to understanding of basic questions in this area, but none actually grappled with the details of individual funding models.

**NFME study (2006).** The study found that CHW services were funded through four funding streams, described below; it recommended future models delivering funding through Medicare pilot programs; state, federal, and community block grants; and direct payment by consumers. The authors concluded that in the absence of such sources of financing, CHW work could not be sustained.

The funding streams identified in the NFME study are:

- **Government agencies and private sector charitable foundations** (typically as short-term grants)

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<sup>15</sup> <http://www.nhchc.org/2011/10/community-health-worker-policy-brief-financing-administration/>

- **Government general funds:** dedicated line items in budgets to fund CHW positions, services, and programs. This is most common in county hospitals and health departments.
- **Hospitals, Managed Care Organizations, and employers.** This funding stream includes private organizations like hospitals and health plans that employ CHWs directly or contract with CBOs or clinics for CHW services.
- **Public Insurance (Medicaid, Medicare, and State Children's Health Insurance Programs)** in four categories:
  - a. Medicaid Managed Care: health plans in most states may employ CHWs directly or contract for CHW services.
  - b. Medicaid Section 1115 Waiver: payment per unit of service or as part of a bundled payment arrangement.
  - c. Administrative costs: outreach, education or care coordination may be considered administrative.
  - d. Direct reimbursement: CHW services recognized categorically as billable, under existing payment arrangements.

**MDPH study (2009).** Four categories of funding models were identified: public and commercial insurance, public and private sector operating budgets, public grants and contracts, and private foundation grants. For each option, legal, financial, operational and political feasibility was considered. MassHealth, the Massachusetts Medicaid program, has chosen to pay for CHW services under administrative match. MassHealth can also directly employ CHWs or contract with an institution that employs CHWs to provide services to the Medicaid recipient. The report concludes that:

- It is very important to identify sustainable financing for CHW positions, and reduce reliance on short term grants.
- Direct reimbursement for CHW services may restrict the scope of CHWs' activities, limiting their flexibility to meet patients' non-medical needs.
- The study's Advisory Council decided not to recommend direct reimbursement for CHWs services at the time of the report.
- Common qualifications or skill standards for CHWs should be a prerequisite for any changes in any financing policies.

**New York study (2011).** This study made only general recommendations, but did encourage the following:

- Incorporating CHWs into "health care teams"

- Integrating CHWs into PCMHs and Accountable Care Organizations (ACOs), noting that Level 3 PCMHs can receive incentive payments of up to \$21 per member per month from third party payers (including Medicaid)
- Providing incentive payments to Medicaid managed care organizations (MCOs) to support payment for CHW services
- Creating a Resource-Based Relative Value Scale (RBRVS) formula for CHW services as part of payment guidelines for health plans
- Creating an education program on CHWs to raise awareness among providers and other stakeholders

**Georgetown Law Center (2007).** The Harrison Institute for Public Law published a review of CHW financing options under Medicaid, which contained eight program examples in four areas: direct reimbursement, waivers, managed care organizations and administrative costs.

### **3.b.(2) What seems to be of interest to providers and payers?**

The pattern of activity seems to be grouped in a few areas of innovation:

- “Hot-spotters” models – reducing costs by improving care for high utilizers; Increasingly possible with improvements in IT. Also a major “in-win” saving money by improving care rather than reducing benefits or limiting eligibility
- Building on a solid evidence base for CHW effectiveness in traditional areas: e.g., chronic disease management, maternal and child health (birth outcomes); cancer screening and navigation
- Patient-centered medical homes (PCMHs) and Health Homes
- Care transitions and reducing readmissions – a variation on “hot-spotters,” mainly building on CHW success in redirecting high utilizers of EDs

#### **“Hot-spotters” program examples**

- Molina Health Care

Molina is a managed care organization (MCO) operating under Medicaid in 12 states, including Washington. Their CHW program in New Mexico pays a monthly fee to selected provider networks for care coordination for members identified as “high utilizers” using measures such as ED use and prescription drug costs. The program began in 2004 and is now implemented in most of New Mexico (33 counties). Providers receive a care management fee of over \$300 per member per month (PMPM). Molina reports a sustained ROI of at least 3:1 based on reduced total cost of care for these members. Molina’s corporate

office has directed the implementation of this model in all states where it has a Medicaid contract.

- Langdale Industries, Georgia

A wood products company with about 800 employees, Langdale provides self-insured health plan to its employees. The company has created a program of care coordination and health coaching for the top five percent of “high-utilizer” employees based upon their diagnosis and medications for chronic disease or a record of high cost claims. Langdale contracted with an independent nonprofit organization, the Lowndes County Partnership for Health (LCPFH), to employ an individual who works in this capacity as essentially a CHW. This individual works as a member of a team with the Medical Management nurses, case managers, and doctors, meets face to face with patients, attends doctor’s appointments and helps to engage patients in the process. Langdale has seen a net ROI of about 3:1 from cost savings. Langdale is beginning a formal case study on implementation of a similar program with Johnson & Johnson Corporation and Emory University.

- Texas hospitals and uncompensated care

Several Texas hospitals have retained CHWs under their core budgets after the end of a state-funded project involving CHWs in children’s emergency departments (EDs), assisting families to access more appropriate sources of non-emergency care. Two of the larger Houston-based systems have had responsibility for hundreds of millions of dollars in uncompensated care, and have found that the *net* internal ROI from similar CHW interventions is consistently at least 2.5:1 from reduced total cost of care, easily justifying financing the CHW positions from core budgets.

### **3.b.(3) Inclusion of CHWs in state standards for Patient-Centered Medical Home (PCMH) teams and partners**

We are aware that PHSKC staff are in regular communication with and have already influenced such language for Health Homes in Washington state. The following strategies are offered as techniques for or examples of the CHW role/workforce as part of care teams, including care coordination systems. Heightened attention to patients with one or more chronic conditions or risks, and recognition of how essential it is to connect patients to social and other support services coincide with a growing evidence base for CHW contributions. In many cases, the federal government (and some state foundations) funds demonstration projects that assist state agencies to develop new delivery and payment systems that then are sustained by state enabling legislation.

**3.b.(3)(a) Making the case for community health workers' relevance to PCMH accreditation standards.** One of the authors (Rush) has reviewed the standards of the National Committee for Quality Assurance (NCQA), which is a common standard that many states are using to score provider applicants to qualify for Patient Centered Medical Home (PCMH) accreditation. He has focused on performance “factors” (or indicators) under Elements of the medical home to which community health workers can be argued to contribute<sup>16</sup>. In each area the PCMH is scored from 0 to 100 percent based on how many performance “factors” are present under each “Element.”

Area 1: Enhance Access and Continuity

Element F: culturally and linguistically appropriate services (CLAS) - this focuses exclusively on language services, and as such the Study Team believe it deserves further refinement. Even though CHWs should not be pulled in as interpreters or translators without appropriate training, this is an area where we think they can contribute value.

Element G: the practice team - CHWs can add depth of understanding of the patient/family situation

Area 2: Managing the Patient Population

Element A: patient information; assuring the team has a complete picture, and patient/family are being candid

Element C: patient assessment

Element D: population management; this area emphasizes prevention in the patients for whom the PCMH is responsible

Area 3: Managing care

Element A: patient reminders

Element C: care management (care plan and follow-up)

Element D: medication management (reconciling and recording)

Area 4: Self-care support and community resources

Element A: self-care support

Element B: referrals to community resources

Area 5: Tracking and coordinating care

Element A: lab test follow-up

Element B: referral follow-up

Element C: coordination and care transition

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<sup>16</sup> 2011 NCQA PCMH Guidelines are available at [https://inetshop01.pub.ncqa.org/Publications/deptCate.asp?dept\\_id=2&cateID=300&sortOrder=796&mscssid=#300796](https://inetshop01.pub.ncqa.org/Publications/deptCate.asp?dept_id=2&cateID=300&sortOrder=796&mscssid=#300796)

A recent study for the RWJF Aligning Forces for Quality initiative, “Advancing Primary Care: Opportunities to Support Care Delivery Redesign in Practices Serving Medicaid and Racially and Ethnically Diverse Patients” shows that the *top two* “areas of opportunity” for improvement of primary care for Medicaid patients are “Community Orientation” and “First Contact: Access,” both areas in which a plausible case can be made for the value of CHWs.<sup>17</sup> Local health departments are logical participants in such innovations.

**3.b.(3)(b) Oregon’s Patient-Centered Primary Care Program (PCPCP)** sets standards distinct from the NCQA medical home standards. Multiple criteria in the PCPCP assessment could be met by primary care practices that are connected to chronic disease self-management teams or other outreach that include CHWs (for example the home visiting asthma team) (See Appendix G). Additionally, the **Oregon legislature specified that Accountable Care Organizations** (Coordinated Care Organizations in that state) must **indicate how they will employ ‘non-traditional health workers’** and provides incentives for them to do so. These include community health workers as well as patient navigators.

**3.b.(3)(c) Vermont** passed their health reform in 2006 and subsequently participated in a CMS demonstration initiative (Multi-payer Advanced Primary Care Practice Demonstration) that led to the creation of the **Blueprint for Health** plan. Subsequent enabling legislation has required statewide implementation of the delivery model.

The hallmark of this model is the requirement that medical homes be supported by **community health teams**, and in addition to the RN leader, members of these teams can include community health workers. The teams are linked to medical homes and can be based in separate non-profits. There are **public health specialists as part of these teams, and these teams are viewed as a “crucial link between primary care and community based prevention of chronic disease.”**<sup>18</sup>

There are financial incentives for primary care practices to engage with the community care teams, depending on their score on the NCQA medical home standards. The **community health teams** are seen as core to the model, and **multiple health payers pay into a pool of funds to support the teams.**

### **3.b.(4) Health Homes**

The authors defer to the PHSKC staff who are leading a system reform effort including creation of Health Homes. It is encouraging to see that CHW roles are being considered. Below are some preliminary findings from a more detailed assessment of potential CHW roles in New York

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<sup>17</sup> <http://www.rwjf.org/files/research/6027.advancingprimarycare.qs.080912.pdf>

<sup>18</sup> Bielaszka-DuVernay, C. Vermont’s blueprint for medical homes, community health teams, and better health at lower cost. Health Affairs. 2011;30 (No 3): 383-386.

which may be helpful to this discussion. **(Please note this information is excerpted from an unpublished draft report, so it should not be disseminated outside the Department.)**

A preliminary report<sup>19</sup> by the Center for Health Care Strategies (CHCS) on New York State's Chronic Illness Demonstration Project Learning Collaborative (CIDP), a pilot aimed at improving health outcomes and reducing costs among chronically-ill Medicaid beneficiaries, provides important lessons on what is needed to meet the needs of high-cost/high-risk populations. Although CIDP is still being evaluated, CHCS revealed some of the critical program design elements that contributed to success among the six CIDP teams. The table below lists those critical success factors and identifies related CHW roles that align with those factors.

<b>CRITICAL SUCCESS FACTORS</b>	<b>RELATED CHW ROLES</b>
High-touch interdisciplinary teams that are highly accessible	The central purpose of CHWs is to provide high-touch support and coordination. CHWs are accessible both in the clinical care setting and in community settings.
Dedicated housing coordinator	CHWs coordinate access to social services, including housing.
Dedicated staff with social service expertise	CHWs coordinate access to social services and are often the primary source of information on social services that are available in the community and among care providers.
Inclusion of peers in the staffing model	CHWs are trained peer health workers.
Client-centered service delivery model	CHWs are trained to provide support for the “whole person” and deliver services that are tailored to meet the full range of needs of each individual patient.
Partnerships with community-based organizations	The role of CHWs is to develop and maintain partnerships with community-based organizations that have access to and/or provide services to the designated patients.
Ability to coordinate medical and behavioral health care as well as social services	CHWs coordinate access to social services, including behavioral health and social services, including assisting with scheduling appointments, preparing for visits, escorting patients to appointments, interpretation, and navigation through

<sup>19</sup> Lessons for Health Homes Identified Through the Chronic Illness Demonstration Project Learning Collaborative. Center for Health Care Strategies.

[http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/02-24-2012\\_cidp\\_lessons\\_learned\\_CIDP.pdf](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/02-24-2012_cidp_lessons_learned_CIDP.pdf). Accessed June 22, 2012.

multiple complex systems.
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While other team members may also serve these roles, a CHW’s role as a peer of the patient makes the CHW a valuable member of an interdisciplinary Health Home team. Because they share or have a deep understanding of the cultural and social contexts in which patients live as well as the knowledge of how to navigate complex care and service systems, CHWs can often more readily build bridges among patients, medical providers, and service providers.

### **Paying for CHWs in a Health Home**

Health Homes will be paid for services Per Member Per Month (PMPM) basis. There are two Health Home rate codes: one for outreach and engagement and one for active care management. Because Health Homes will be paid a capitated payment, they have the flexibility to develop care teams that include non-medical staff such as CHWs. In addition to improving outcomes, having CHWs included in care teams and assuming roles that they are most equipped to do and do not require a health professional license can improve the cost-effectiveness of Health Homes. It also frees up clinical staff to focus on those roles that are specific to their professional license.

The outreach and engagement PMPM, which will be available for three months, seeks to overcome challenges that other efforts to address complex patients have faced, namely locating, enrolling, and engaging patients. Health Homes must conduct *active* outreach. Active outreach is more than sending letters and making phone calls, which are often not effective for many of these patients, particularly those with housing instability. If needed to find and engage the patient, Health Homes must be able to conduct outreach at other care delivery sites, in community settings, and at patients’ homes. The PMPM payment allows Health Homes to have CHWs conduct this type outreach and engagement, which is precisely what CHWs are trained and best suited to do.

### **3.b.(5) CMS Medicaid waivers**

Health and payment reform are well underway all over the nation, and Washington state is no exception. However, we are constantly reminded by providers and payers in Massachusetts—which has been engaged in this since health reform legislation was passed in 2006—that new forms of payment may not be fully in effect for several years, and waivers are **still a relevant strategy**.

Many states have used the 1115 waiver mechanism to demonstrate the cost-effectiveness of alternative service delivery approaches under Medicaid. New York State’s “CHW Program” (prenatal care coordination) is funded by Medicaid under an 1115 waiver. CHWs provide outreach, education, referral and follow-up, case management, advocacy and home visiting

services to women who are at highest risk for poor birth outcomes, particularly low-birth weight and infant mortality in 23 current program sites across the state.<sup>20</sup>

**3.b.(5)(a) California’s Family PACT program** involves CHWs in family planning education and counseling. The program was begun under an 1115 waiver, but was made a permanent part of the Medi-Cal program in 2012 through a Medicaid State Plan Amendment. This was justified on the basis of cost savings to Medicaid for labor and delivery from reductions in unplanned pregnancies. Indiana’s Prenatal Care Coordination program was started under a Medicaid waiver although it is no longer part of Medicaid (as of fiscal year 2012).

This is particularly important as the Medicaid expansion (for states that accept it) has to take place by 2014 (or sooner if a state requests it). **Oregon just received such a waiver**, although our respondent said this happened so recently it is still not clear how this will work. Likewise, policy recommendations in 2011 by the National Health Care for the Homeless Council<sup>21</sup> include this strategy.

**3.b.(5)(b) Massachusetts Medicaid (MassHealth) has received a waiver that supports a state legislatively mandated ‘bundled payment pilot’** for an asthma intervention that includes CHWs. The pilot will help to build cost savings evidence as well as help MassHealth and health plans to iron out mechanisms for alternative forms of payment to providers. This legislation was the result of a Boston Children’s Hospital study which established cost savings in their pediatric asthma intervention. The study and cost savings were widely publicized in Boston at a key moment in a legislative session and caught their attention.

**3.b.(5)(c)** CMS has approved an 1115 waiver for **Texas Medicaid** to expand Medicaid managed care to the entire state, and also to experiment with new approaches to delivering care and preventive services. The waiver reserves a substantial amount of funds to reimburse hospitals that provide a substantial amount of uncompensated care, as well as to increase hospitals’ effective Medicaid rates to their cost of delivering services. This essentially replaces the former “upper payment limit” (UPL) system.) In addition, a comparable amount of funds are available to hospitals, public mental health providers, physicians affiliated with medical schools and local health departments to fund **Delivery System Reform Incentive Payment (DSRIP) projects**. Most of these funds will be allocated to regional “anchors” (generally county hospitals).

Each of 20 regions will develop a regional health plan incorporating four types of DSRIP projects: infrastructure development, program innovation and redesign, quality improvements,

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<sup>20</sup> Source: NYDOH web site: [http://www.health.ny.gov/community/pregnancy/health\\_care/prenatal/community\\_health\\_worker/](http://www.health.ny.gov/community/pregnancy/health_care/prenatal/community_health_worker/) - accessed July 1, 2012

<sup>21</sup> National Health Care for the Homeless Council. *Community Health Workers: Financing & Administration: Policy Brief*. August 2011. Nashville, TN. Available at [www.nhchc.org](http://www.nhchc.org)

and population based improvements. Matching payment will be applied for after improvements have been documented. CHWs could play a role in any of the four types of DSRIP projects.

In the case of the San Antonio (Bexar County) region, the LHD (San Antonio Metropolitan Health District) will operate one DSRIP project called “Neighbors Engaged in Health.” In this project, CHWs will organize community residents in neighborhood-designed population health initiatives, which may involve education for behavior change, advocacy or program development.

### **3.b.(6) Medicaid managed care: CHWs paid for under Medicaid administrative costs versus as “services”**

Medicaid administrative charges have been used to pay for CHW services for many years. However, both the State and the Medicaid MCOs with whom the State contracts are bound by an upper limit on administrative charges. The authors believe this has acted as a disincentive to employment of CHWs under Medicaid. It appears that there has been an underlying assumption that payment for CHW activities can *not* be charged as service costs because (a) CHWs do not provide clinical care and (b) CHWs are not listed as a type of provider in the Social Security Act.

Minnesota’s State Plan Amendment (2008), adding CHW services as billable by providers, was approved by CMS in less than two months, so federal policy appears to be encouraging of such changes. If Washington Medicaid, as is the case in Texas, has allowed payment for CHWs via administrative costs only, then it is important to discuss with Medicaid officials what it would take to establish payment for at least certain CHW activities as “services” costs.

The Texas Health and Human Services Commission (HHSC) is discussing such change with the state’s health plans. Texas officials now say they intend to amend the Medicaid Uniform Managed Care Contract effective March 2013. A definition of CHW/Promotora will be added, and language clarifying that CHWs can be used in support of health plan activities will be included. HHSC will further clarify for the plans what kind of CHW-related activities can be classified as a “service” versus “administration.” The use of CHWs by health plans will not be mandated; plans can opt to employ them using existing capitation rates. HHSC does not plan to provide an increase in capitation payment amounts to account for the hiring of CHWs, making these changes cost-neutral for the state.

In addition to specifying eligible CHW activities, such a change likely will also require decisions about whether charges will be eligible for direct employment of CHWs by the health plans, by providers who may bill the health plans, or by third-party contractors, which could include CBOs. This change also has wider implications for state regulation of health insurers generally, who are subject to limitations on administrative costs under medical loss ratio (MLR rules).

### **3.b.(7) Payment reform or related legislation to establish a prevention and wellness trust fund**

Just as in the Affordable Care Act at the federal level, it is possible for states to establish a mechanism to assure a sustainable funding stream for community-based prevention. To date, the only state that has accomplished this (as far as we know) is Massachusetts. Chapter 24 of the Laws of 2012, Section 2G, was passed by the legislature and signed by the Governor in July 2012. The Prevention and Wellness Trust was funded at \$60 million earmarked over the next four years and will be paid for by a tax on insurers and an assessment on some larger hospitals. The money goes to the state Department of Public Health to be dispersed in grants.<sup>22</sup>

### **3.b.(8) Local Health Departments can contract for prevention, chronic disease management and related techniques to Medicaid Managed Care health plans or to providers**

There is a role for local health departments in providing CHW and related services as contractors with providers and health plans. This strategy is an extension of those described above. Terry Mason has been conducting a needs assessment for the Asthma Prevention and Control Program at Massachusetts DPH. She has seen evidence that providers are interested in engaging community outreach and home visits as part of asthma and other chronic disease emergency department and hospitalization reduction efforts. However, many providers, health plans, and medical directors in Accountable Care Organizations know little about how to integrate such teams, including community health workers, into their practices.

**The Boston Public Health Commission** (the city health department) has developed expertise in a pediatric asthma intervention, similar to that in SKCHD and has begun to contract community health worker staff to one of the health plans. Their goal is to contract for a larger package of services, including supportive supervision for the CHWs.

**The Prevention, Care and Treatment program (PACT)**, a collaboration between Brigham and Women's Hospital in **Boston** and the non-profit Partners In Health, developed a model of working with challenging HIV patients that centrally involves CHWs. They have expanded this program to include self-management assistance for people with multiple chronic diseases. **They contract their services to assist health plans and providers with hiring CHWs, training, supervising CHWs as part of similar intervention models.**

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<sup>22</sup> Can be found at <http://www.malegislature.gov/Bills/187/Senate/S02400>

### **3.c. Workforce development and training opportunities**

CHWs - paid or volunteer - have generally been recruited and hired first by programs and employers and then trained. The link to communities who they will serve is a primary hiring criteria, which dictates this approach to hiring. In addition, there have been insufficient jobs or job security in the field to motivate training without having a position, and the pay has generally been too low for a train first-hire later approach.

All of these factors persist, although the availability of positions and better pay levels are likely to increase. CHW training is available in a variety of settings within and across states. Some, such as Minnesota, have a state recognized core competency training that is available through state colleges. Others, including Texas and Massachusetts, have established training centers primarily in community-based organizations, to enhance access for community members who may feel less comfortable in academic settings. Until recently in Massachusetts core competency training was offered free to CHWs and their employers because they were subsidized with public funding. The pressures of cutbacks are moving these centers in the direction of charging for the trainings.

Below we offer several policy strategies that can help to promote employers' support for CHW training and to encourage new sources of sustainable financing for this training. Further discussion is needed regarding the State Department of Health standard training program and their plans for implementation. The most practical approach for PHSKC may be to influence the evolution of this program over time rather than to create an alternative training structure.

Based on the findings in this section, we have made some specific recommendations, including strategic actions in Section 5 of this report.

#### **3.c.(1) Best practices in college-supported CHW education**

The authors recommend guidelines from the CHW National Education Collaborative ([www.chw-nec.org](http://www.chw-nec.org)), a four-year project funded by the U. S. Department of Education through the University of Arizona. Discussion of its "key considerations" is recommended and can be pursued further.

**3.c.(2) Apprenticeship programs**—On-the-job training, supplemented by classroom trainings, is a very appropriate model for the CHW field. Occupations must be approved by the federal government's Department of Labor as apprenticeship-able. **The East Texas Coastal Area Health Education Center (AHEC) near Galveston** saw that policy changes in Texas health care (including a Medicaid waiver) would create a demand for CHWs. They decided that by

offering an apprenticeship program with funding from the federal recovery and reinvestment act (ARRA) they could increase employer interest in hiring and training CHWs. The funding would also make offering the training feasible for certified training centers.<sup>23</sup>

The pilot showed that most employers have kept the CHWs on staff after the funding that helped them pay for their first year's salary. Employers, too, agreed to pay for the training, a cost of about \$1,000. The advantage—the AHEC argued—was that the employer could hire the person that was right for their program (connected to the target populations), and that they would have an employee who was working while they were also being trained.

The AHEC proposal was approved by the Employment and Training Administration (ETA) in October 2010, so the CHW occupation/profession is now apprenticeable in any state. There are some steps to go through with state Departments of Labor, but the status is in place. Leslie Hargrove, director of the AHEC and the program said in an interview she thinks that this option will become more appealing with health reform. “Organizations are being pushed to improve outcomes but reduce costs and CHWs lend themselves to that. You can bring them into the health care team . . . Plus there is a shortage of nurses and nurses are expensive.”<sup>24</sup>

### **3.c.(3) Additional Ideas for Sustainable Funding for CHW Training**

The following ideas for ways to sustainably fund training—whether it is core competency or more specialized (asthma, diabetes)—come from interviews Terry Mason conducted with CHW training centers in Massachusetts, as well as with health plans and CHW asthma nurse supervisors. These interviews were part of a needs assessment she is preparing for the Asthma Prevention and Control Program at the Massachusetts DPH.

- Providers/employers must recognize the importance of training for their CHW workforce and pay for it.
- Health plans, including Medicaid Managed Care organizations, may be willing to fund CHW training once the improvements in higher quality and lowered costs for health care become evident as a result of CHW inclusion in care and prevention teams.
- As part of their grantee contracts, public health departments and other public and private funders could mandate that a proportion of the grant be applied toward core competency and other training of CHWs.

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<sup>23</sup> In Texas, as will soon be the case in Massachusetts as well, CHW training entities, as well as individual CHWs, are certified.

<sup>24</sup> Terry Mason interview with Leslie Hargrove, Executive Director, East Texas AHEC, June 26, 2012. Ms Hargrove described the core requirements of the Training Program Standard developed and registered with USDOL Office of Apprenticeship: 1) Progressive Wage (tied to training); 2) Certain number of On the Job Learning hours (performance based) and 4) 144 hrs per year of RTL (knowledge based).

- Health departments and other providers could advocate for a systematic funding stream toward CHW core competency training via funding from hospitals for community benefits or other similar programs.
- Health departments and other stakeholders should continue to promote the need for funding streams for CHW core competency and other training with national government and private funding sources.

#### **4. Recommended short-term strategies and action steps**

The preceding sections describe a very complex environment in which to initiate change. In order to avoid "analysis paralysis" we conclude this report by offering for short-term strategies which PHSKC may choose to pursue in order to begin the policy change process. The strategies were selected for their practicality, building on current strengths within PHSKC, taking advantage of existing supportive relationships with other stakeholders, and their connection to two important areas of policy. For each recommended strategy, we provide a sketch of long and short-term goals and objectives and some suggested action steps.

##### **4.a. Asthma model sustainability strategy**

**Long term goal:** Seattle King County Healthy Homes model of home-based support for asthma self-care will become integrated with health and/or medical homes statewide; and there will be Medicaid and other publicly subsidized health care coverage for CHW services and, potentially, for supervision meetings.

**Short term objective:** Provisions for CHW roles in asthma management and care coordination in ongoing payment and care coordination structures with Molina Health Care's Medicaid operations in King County. This effort can help leverage arrangements with other MMC providers and payers in King County .

##### **Action steps:**

- (1) Review Terry Mason's report for the MDPH Asthma Prevention and Control Program to think through issues such as what organizational bases for CHW employees and structural relation to health homes for the asthma team are most feasible locally, and to assess related infrastructure needs for supporting CHWs as part of these teams.
- (2) Create a plan for asthma care management as a component of Health Homes model, and covered by Medicaid Managed Care Plans, incorporating lessons learned from ongoing conversations with Molina Health Care and with colleagues in Massachusetts pursuing similar goals.

- (3) Ask Health Reform Planning Team to form a subcommittee to review this plan.
- (4) Convene a meeting with additional Medicaid MCOs to discuss their response to such a plan, including other issues and steps that will influence their decision to cover CHWs.
- (5) Based on findings from these conversations and meetings, develop a revised plan for building institutional integration and financial coverage for the Healthy Homes asthma and general chronic disease management interventions, including CHW services and potentially supervision meetings, in a feasible number of King County based MMCO's.

#### **4.b. Partnership with Pierce County and multiple current CTG projects**

Dialogue between PHSKC and the Tacoma Pierce County Health Department regarding overlapping goals and strategies for their distinct Community Transformation Grants (CTG) provides a timely opportunity to advance collaboration on CHW-related policies and practices. The Pierce County Health Department CTG pulled together five health coalitions in the county and also includes a role for PHSKC. Among the coalitions is the Cross Cultural Collaboration, which is coordinating the contribution of CHWs to the county-wide prevention initiative(s). The idea is for CHWs working in very high risk communities suffering disparities to be considered “community experts” and to assure that community perspectives and members are involved in decisions and practices of prevention campaigns. They are providing capacity-building for the other prevention collaboratives around social determinants of health and equity issues. The work is preparing CHWs to engage with policy and policy makers across a broad spectrum of services and health-related issues

At the same time, Seattle King County has recently received an even larger CTG, and reportedly the state health department has received one also.

Tacoma-Pierce County and CHEF are engaged with the Washington state health department (WDOH) and also aim to engage Seattle King County as a partner, bringing to the table CHWs through an emerging CHW network. The goal is to discuss training needs and curricula planning, as well as related topics. Presumably one of these topics will be how they can mutually support the formation of a CHW network.

**Long term goal:** Uniform practices across CTG projects in CHW position design, training requirements, data collection and creating sustainability strategies. Success with this limited goal can be used as an *example* in pursuing similar agreements.

**Short term objective:** Convene a collaborative among CTG project partners to share ideas and goals and to decide how to leverage resources to achieve shared goals regarding workforce development, positions, and sustainability of CHWs, including a CHW-led network.

**Action steps:**

- (1) Organize face to face meeting of project directors.
- (2) Compare and analyze CHW employment plans, and create proposal to align practices across projects.
- (3) PHSKC and Tacoma Pierce County Health Departments review results of comparison and determine next steps for progress in aligning practices. Include state health department grantee staff to determine relevant and feasible practices for local health departments statewide.
- (4) Negotiate as necessary with upper management of grantee agencies and CDC project officers.
- (5) Include or pursue separate discussion of additional cooperative strategies to advance CHWs and the role of prevention in health reform as part of an emerging collaboration across Pierce and King Counties' local health departments, the state, and/or other stakeholders.

**4.c. CHW network organizing**

**Long term goal:** sustainable, staffed statewide CHW network with active leadership engaged in policy and career development, *including all other elements of this strategic plan*

**Short term objective:** regular meetings of a Western Washington regional network (King, Pierce, Snohomish Counties) with significant active CHW participation and leadership

**Action steps:**

- (1) Convene meeting of staff contacts and current identified CHW leaders with PHSKC, WACMHC, Pierce County, Migrant Health Promotion, NWRPCA to discuss strategy.
- (2) Review implications of professional association for organized labor and employer community.
- (3) Obtain advice and counsel from successful CHW network in Oregon, California, New York, Massachusetts. National CHW leader Durrell Fox will be speaking at the CHEF March conference (described below), providing an opportunity to engage him in discussions with stakeholders.
- (4) Invite all CHWs in Pierce and King Counties to an organizing meeting in Tacoma (it has

been suggested that CHWs from Pierce County are less likely to come to a meeting in Seattle).

- (5) Investigate relevance for varied CHWs in King County, Washington state of attending Western Forum on Migrant and Community Health in San Francisco, Feb. 20-22, 2013. Promote awareness of the conference among appropriate organizations to assure attendance by a Washington state delegation.
- (6) Utilize the upcoming (March 25, 2013) CHEF-convened conference “Coalescing for Change: Health Promotion and Preventive Care in Times of Health Reform” to raise awareness among CHWs and initiate conversations among them concerning the importance of an active CHW network.
- (7) Building on the momentum created at Coalescing for Change conference, engage CHWs in significant roles for planning and organizing a statewide CHW conference in late 2013. Pursue funding for the conference, perhaps pooling funds from multiple CTG grants, if appropriate.

#### **4.d. Training and certification**

##### **Long term goals:**

- (1) Common CHW training standards accepted across the State.
- (2) Agreement among stakeholders concerning a process of certification of skill attainment which satisfies needs and conditions expressed by CHWs, employers and payers.
- (3) Creation of state CHW workforce development plan.

##### **Short term objectives:**

- (1) Key stakeholders agree to collaborate on definition of common training standards.
- (2) Key stakeholders agree on the appropriate entity to convene a working group to develop a certification process proposal and the individuals and organizations who should be at the table.
- (3) State government engages in the working group process and participates meaningfully.

##### **Action steps:**

- (1) Create collaboration with PHSKC, Tacoma-Pierce County Health Department, CHEF, Washington DOH, and CHWs together with the emerging CHW Network.

- (2) Obtain financial support as needed to staff a working group on certification.
- (3) Secure agreement from WDOH to expand and modify their curriculum to meet agreed standards.
  - a) Working Group and other stakeholders review the finding of Lee Rosenthal comparison of core competencies and training curricula from other states and settings.
  - b) Determine next steps, including possibility of doing task analysis.
  - c) Consider work of other states further along in this process, including New York, Massachusetts.
- (4) Negotiate process for State recognition and support of standards and credentialing (e.g., as condition for Medicaid payment for CHW services).
- (5) Consider workforce development implications in stakeholder group, including:
  - a) the concept of multiple levels of qualification, e.g., basic pre-hire, full and advanced, standard and specialization certifications
  - b) processes for validation of skills based on prior experience
  - c) recruitment and hiring standards based on key attributes of successful CHWs, such as a definition of “community membership”
  - d) the option of certifying employing organizations and/or supervisors as well as CHWs
  - e) whether a working knowledge of English will be required for certification, a significant issue worth careful attention
  - f) short and long term financial support for training
  - g) career pathways for CHWs both within the CHW field and into related fields

**4.e. Leverage possible Molina Health Care role**

**Long term goal:** increased buy-in from providers and other payers for sustainable CHW roles and payment structures resulting from Molina’s investment in their high-utilizer care coordination strategy.

**Short term objectives:**

- (1) Molina’s implementation is visible and attracts interest from providers and payers.

- (2) Elements of Molina high-utilizer strategy are integrated into Health Reform Planning Team longer-term thinking.
- (3) Molina joins in advocacy with the State on issues of training and certification.
- (4) Molina's initiative shows significant results in a relative short period of time.

**Action steps:**

- (1) Continue conversations initiated by PHSKC with Molina in Washington state regarding coverage for CHWs in asthma and other chronic disease management teams. Assist Molina in making necessary connections with providers, and within PHSKC to complete their implementation process.
- (2) Invite Molina executives to participate in other strategic elements of the CHW initiative.