



**foundation for
healthy generations**

Building a
Community Health
Worker (CHW)
Workforce in
Washington State

Contents

Building a Community Health Worker (CHW) Workforce in Washington State.....	3
Creating a Public/Private CHW Task Force	3
Benefits Created by Community Health Workers Across Multiple Domains	7
Workforce Development	8
Principles to Follow When Developing a CHW workforce.....	9
Work Plan.....	10
Additional Task Force Development Scoping Detail.....	11
CHW Task Force	11
CHW Network Development and Infrastructure.....	13
Community Health College and Innovation Center.....	14
Regional Health Entities.....	14
Information from Other States.....	15
Training from Other States	19

Building a Community Health Worker (CHW) Workforce in Washington State

Goal: Community Health Workers are deployed across the state to improve the health of the population, provide better care for individuals and lower health care costs.

Rationale: Developing and deploying a CHW workforce can play a significant role in helping Washington State address two of the Innovation Plan's core strategies:

- 1) Improving health overall by building healthy communities and people through prevention and early mitigation of disease throughout the life course¹ and;
- 2) Improving chronic illness care through better integration of care and social supports particularly for individuals with physical and behavioral co-morbidities²

They will do this by using the core CHWs functions to promote both community based prevention and improved chronic illness care. These functions include: (1) Create more effective linkages between communities and healthcare systems, (2) Provide health education and information, (3) Assist and advocate for underserved individuals to receive appropriate services, (4) Provide informal counseling, (5) Address basic needs, (6) Build community capacity to address health issues and (7) Assure people get the services they need.

They will work across sectors assisting people where they live, work, learn and play to improve their health while building community members capacity to form healthy communities. They will also work in medical and behavioral health organizations to assist patients to prevent and manage chronic disease.

Creating a Public/Private CHW Task Force

To effectively achieve the aims outlined above, there is a need for public and private leaders to convene as a task force for the purpose of applying diverse perspectives and experiences to examine the issues facing successful deployment of a CHW workforce across the state. Having a diverse task force will enhance the fullness of our understanding of these issues and opens opportunities for the consideration of new and better solutions. The task force shall provide: (1) recommendations on how to achieve the overall goals outlined above; (2) advise and lead prioritized policy issues that underpin the development and deployment of a CHW workforce; and (3) assist in developing the definition of a CHW, their scope of work, training standards, and financing models. This includes defining CHW qualifications that will allow Washington to take advantage of the new Center for Medicaid Services ruling allowing non-licensed providers to bill Medicaid.

¹ Enact a health in all policies approach with a focus on healthy behaviors, healthy starts for children, prevention and mitigation of adverse childhood experiences, clinical-community linkages, and social determinants of health

² Spread the adoption of the Chronic Care model and support the integration of physical and behavioral health care at the delivery level through practice transformation support, increased workforce, and linkages to community resources

In support of the Task Force there are three key vehicles to successful statewide implementation:

- 1) Statewide CHW Network:** This non-governmental Network is the backbone convener of the state's many CHW efforts. CHW networks are CHW led. The CHW Network creates a pathway for local, regional and state connectivity. It provides backbone services to loosely affiliated, grassroots, regional CHW networks and can coordinate mutually reinforcing CHW activities. The Network has the following key functions;
 - Develop CHW leadership across the state enabling the CHW collective voice to be a part of policy discussions. The regional networks link CHWs from multiple sectors at local and regional levels to promote healthy communities and improve individual health for people with chronic diseases or complex healthcare needs.
 - Identifies mutually reinforcing activities for community based prevention and system changes that can address root causes of unhealthy behavior and the circumstances that perpetuate poverty and increase risk for chronic disease.
 - Work with the Innovation Center to create the baseline information about the CHW field (e.g., ground-up information about what CHWs do, need, and want, populations served, etc.) and identify training and technical assistance needs across the state.
 - Represents CHW's on the CHW Task Force and informs the Task Force of emerging policy priorities and strategies and develops the framework for defining the CHW scope of work, training standards, and potential financing models.
- 2) Community Health College and Innovation Center:** This center becomes the statewide training and technical assistance hub. The center has the following key functions:
 - The Center creates, in partnership with the Network, the baseline information about the field (e.g., where CHWs work and in what roles, etc.).
 - The center becomes the statewide transformation "hub" that serves as a clearinghouse of CHW tools, RESOURCES, standards for training and supervision, training, and technical assistance.
 - Supports the Regional Health Entities. Across regions the Center will provide support and technical assistance to help Accountable Communities of Health or "like regional designee" to create a system to develop cadres of CHWs to address individual and populations-based community based prevention goals. It also creates a feedback loop for continuous communication between state, regional, and local partners.
- 3) Regional Health Entities:** Entities like the *Accountable Communities of Health* organizations, or like "regional designees", will develop regional CHW cadres. Each Regional Health Entity will be incentivized to create the following:
 - A cadre of CHWs that will be deployed throughout the region to promote health within local communities. The CHW cadres will be made up of a pool of CHWs that meet the needs of specific, small populations where no single agency has a large enough client base to justify hiring these CHWs directly. They will work across sectors to address state and local health priorities,

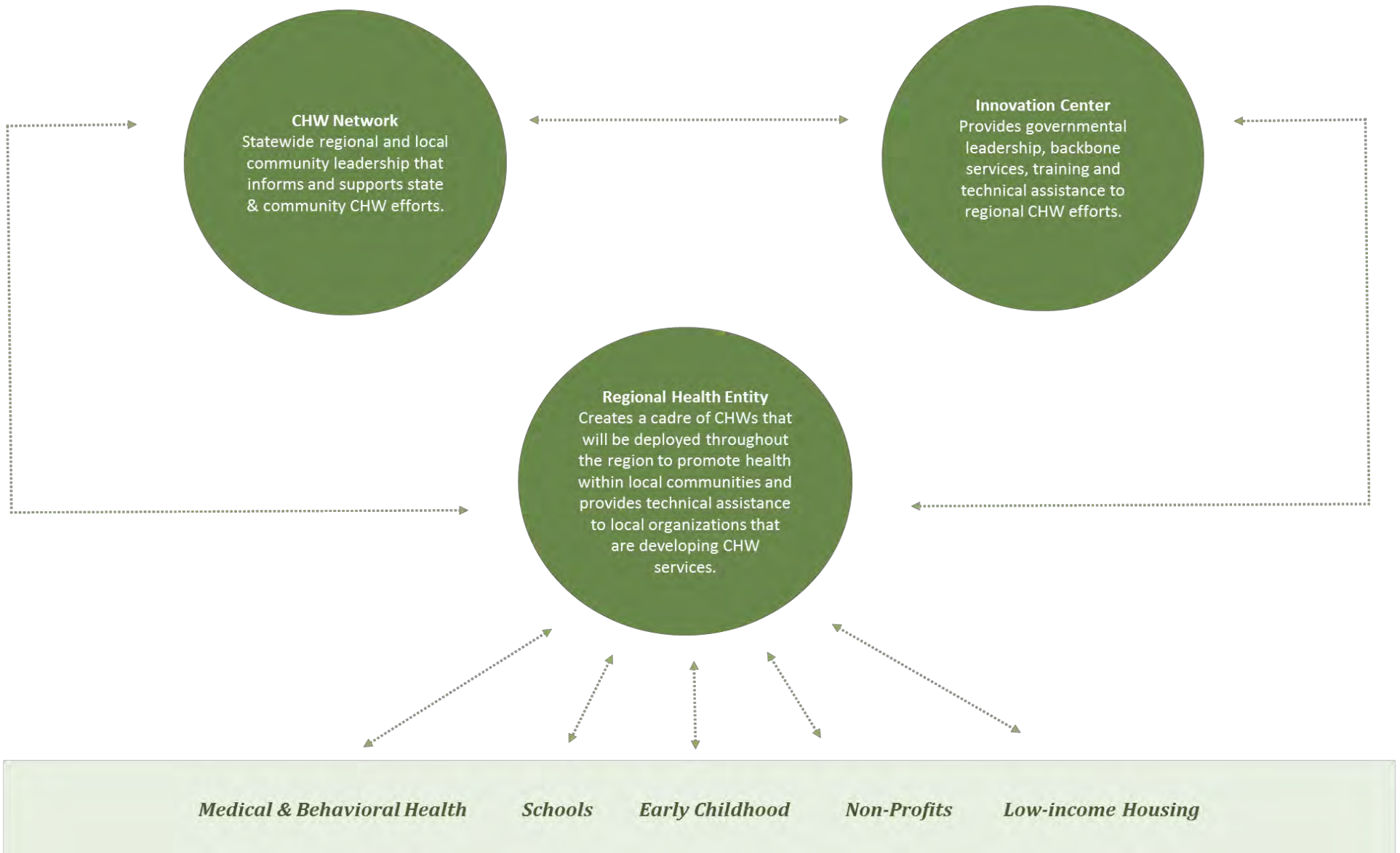
encourage resource sharing, test new funding strategies, and make sure services are responsive to the communities they serve.

- Provide technical assistance to other local organizations within the region that are developing CHWs into their workforce.

The chart below describes the relationship between the CHW Task Force, CHW Network, and the Community Health College and Innovation Center, and designated Regional Health Entities. The two-way arrows on the right depict channels that enable community members and policy makers to communicate information, ideas and challenges.

CHW Task Force

Advises & leads prioritized policy issues that underpin the development and deployment of a CHW workforce; and assists in developing the definition of a CHW, their scope of work, training standards, and financing models.



Benefits created by Community Health Workers Across Multiple Domains

This approach described above addresses five of the State’s Building blocks for transformation:

- Activate and engage individuals and families in their health and health care
- Regionalize transformation efforts
- Support Accountable Communities of Health
- Practice transformation support
- Increased workforce capability and flexibility

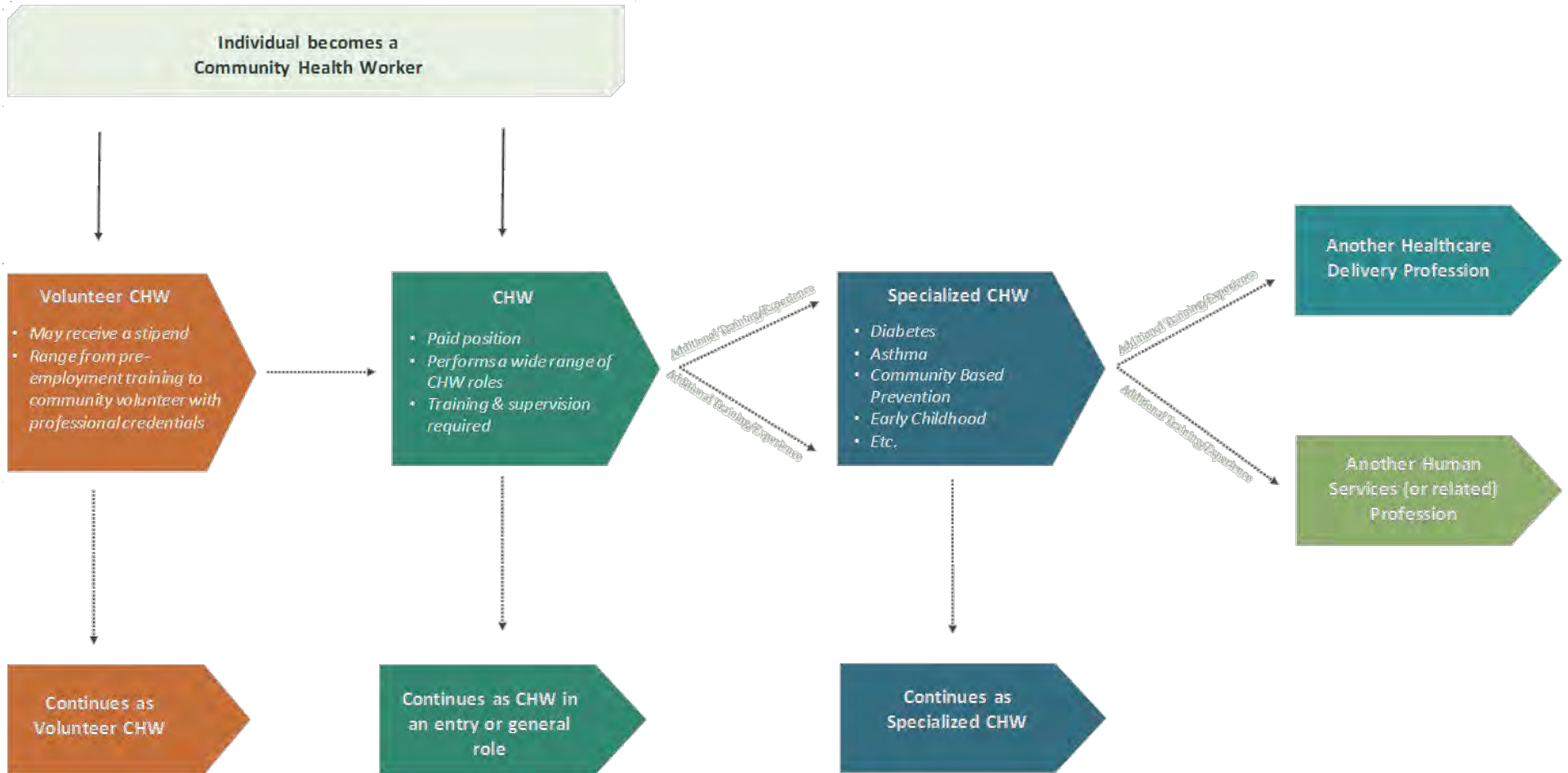
Through this model CHWs not only facilitate individual behavior change and build community capacity to address health issues, they influence system change by providing policy makers who oversee the Accountable Communities of Health with direct information, from the community and through CHWs, about the ways in which systems are, or are not, working in their community. These community based system changes can address root causes of unhealthy behavior and the circumstances that perpetuate poverty and increase risk for chronic disease.

A key feature of CHWs is that they are individuals who have a relationship with and understanding of the community in which they serve, often belonging to the same culture, speaking the same language, and having similar life experiences. Their expertise is in the community, rather than in clinical knowledge and as a result, they are in a unique position to engage individuals and populations that professionals have difficulty reaching. The table below outlines the benefits provided by CHWs.

Themselves	Family/friends/neighbors	Local community health “operating system”	Health delivery system (e.g., medical, behavioral, social service, etc.)
<ul style="list-style-type: none"> • Improve their own health • Expand employment opportunities for themselves to increase income • Personal satisfaction of fulfilling personal mission of helping others. CHWs are “natural helpers.” 	<ul style="list-style-type: none"> • Expand diffusion of useful health and human service system information • Increase appropriate use of health care delivery system • Reduce chronic disease through increased use of prevention tactics and chronic disease management • Increase social connections, reduce isolation 	<ul style="list-style-type: none"> • Create and/or strengthen social networks focused on health across multiple sectors • Get genuine reach into communities that are not congruent with mainstream culture and therefore less likely to receive accurate or useful resources • Increase community capacity to promote health 	<ul style="list-style-type: none"> • Expand workforce in ways that reinforce the value of CHWs connections to and understanding of the community and embed CHWs into multiple systems. • Create entry points into other professions (i.e., nurses, social workers, etc.) • Improve health outcomes and population health • Reduce system costs and provider frustrations

Workforce Development

Historically, well intentioned people have seen the CHW role as a stepping stone to other professions that are valued and seen as legitimate by the medical system. In this way the value of the community connections to, and understanding of, the community being served has been discounted. One reason why little attention has been paid to career development for CHWs is because there is not a sustainable funding source for CHWs' work. One area the CHW Task Force will explore is how to sustainably fund CHWs for the value they bring. At the same time, some CHWs will decide to enter other professions. The diagram below illustrates a continuum of CHW roles and a possible workforce lattice.



Principles to Follow When Developing a CHW Workforce

- Promote and support participation and leadership of CHWs in the development of policies that affect them. Equitable partnerships with CHWs - including CHWs as key decision makers in all meetings, development of documents, etc.
- Promote and support CHWs to be integrated into both medical care and community based prevention efforts, fostering the link between strategies.
- Minimize barriers to training and employment of CHWs related to language, education level, citizenship, and life experience.
- Incorporate a full range of CHW roles and competencies in the positions created.

Work Plan

Focus Area	Outcome/Deliverable	Action Steps
CHW Task Force	<ul style="list-style-type: none"> • Recommendations on policy issues that underpin the development and deployment of a CHW workforce including the definition of a CHW and their scope of work, training standards, and financing models • A framework the Innovation Center can use to develop a CHW Hub that supports a regionalized CHW system which integrates community based prevention and the Chronic Care model 	<ul style="list-style-type: none"> • Identify key stakeholders • Develop a charter for the Task Force • Invite key stakeholders to participate • Identify the key elements of a public/private governance and structure • Vision, purpose and priorities are mutually set by the partnership. This does include formal authority and structure to govern the project. Partners develop and adhere to written agreements that include but are not limited to: clear decision-making processes; transparent fiscal accountability; mutual fund development; and shared staffing & volunteers
CHW Network	<ul style="list-style-type: none"> • Baseline information about the field (e.g., where CHWs work and in what roles, ground-up information about what CHWs do, need, and want, populations served, etc.) • Increased credibility with CHWs and community members with high health needs • CHW leadership who are prepared to participate on the task force, affiliated community based organizations and to serve as trainers and leads within the CHW cadres 	<ul style="list-style-type: none"> • Hire a CHW Network Organizer/Developer • Identify and collaborate with existing, nascent CHW networks • Identify and reach out to a CHW lead in each region • Support CHW leaders to identify and reach out to other CHWs, identify needs, etc. • Provide leadership TA to CHWs to prepare them to engage in state and/or regional policy discussions
Community Health College and Innovation Center	<ul style="list-style-type: none"> • Clearinghouse of CHW training, standards for training and supervision, etc. • Diffusion of recommendations and innovation • Sustainability planning 	<ul style="list-style-type: none"> • The CHW Network Organizer/Developer should ideally manage or coordinate this work
Regional CHW Cadres	<ul style="list-style-type: none"> • Multiple test sites to evaluate the effectiveness of different CHW approaches and models of financing. • Structure for multiple sectors to develop CHWs in a variety of ways. • True community engagement 	<ul style="list-style-type: none"> • Develop CHW cadres. A pool of CHWs that can meet the needs of specific, small populations where no single agency has a large enough client base to justify hiring CHWs directly.

Additional Task Force Scoping Detail

CHW Task Force

Public and private leaders convene as a task force for the purpose of applying diverse perspectives and experiences to the examination of the issues facing successful deployment of a CHW workforce across the state. Having a diverse task force will enhance the fullness of our understanding of these issues and opens opportunities for the consideration of new and better solutions.

• Kickoff event

- Modeled after the 2014 MacColl Center Wagner Symposium, “Primary Health Extension Programs: Current Models & Future Directions,” which was held on January 31, 2014.
 - Speakers: Experts on CHWs.
 - CHWs Inclusion in the Innovation Plan.
 - Relationship to ACA – both community based prevention and clinical outcomes.
 - Effectiveness (health outcomes; ROI).
 - Policy issues. Evolution of the field. Summary of what has happened in other states, what other task forces have done and found. CHW definition, scope of work, etc.
 - Break into small groups.
 - Facilitated discussion. What does this mean for WA?
 - Groups determined beforehand. Cross-sector groups at each table that parallel the composition of the task force.
 - Questions determined beforehand. Related to CHWs in the Innovation Plan. Where we have agreement. What we need to work on.

• Task Force

- Criteria
 - 25% CHW and industry leaders from outside of the healthcare or government sectors.
 - Ethnic diversity (Latinos, African Americans, Native Americans and Asians).
 - Strong voices from the communities who will be served.
 - Represent eastern and western Washington.
- Sectors
 - CHWs and CHW supervisors (see below).
 - Medical:
 - Payers (MCOs, other insurance providers such as Regence);
 - Health Related Associations (NWRPCA, WACMHC, Hospital Association, Association of Washington Public Hospital Districts, Nurses Association, Medical Association);
 - Providers (NeighborCare, SeaMar, Yakima Valley Farmworkers Clinics, International District Health Center, Odessa Brown, Native Health a CHC in Spokane).

- **Task Force Sectors cont'd:**
 - **Community:**
 - Asian Counseling & Resource Center, Asian Pacific Cultural Center;
 - Refugee groups: Somalia Community Services Coalition, Refugee Women's Alliance, Refugee Federation Service Center, etc.;
 - Low income Housing providers (Mercy, Association of Washington Housing Authorities);
 - Poverty Advocates (Solid Ground, Poverty Action Network, Children's Alliance);
 - Community Development Organizations (i.e., White Center, Metropolitan Development Council);
 - Neighborhood House (has CHWs in low income housing);
 - Health Associations (Heart, Cancer, Lung...);
 - Open Arms Perinatal;
 - Community Mental Health with a strong peer program;
 - Area Health Education Center (Eastern and Western WA).
 - **Labor: SEIU**
 - **Government:**
 - **State:**
 - Governor's Office, Governor's Council on Health Disparities, American Indian Health Commission;
 - Legislative: Staff or legislators (e.g. Senators Becker and Keiser, and Representatives Jenkins and Robinson, and whomever went to the National Conference of Legislators);
 - State Agencies: HCA, DOH, DSHS, Workforce Development;
 - Higher Ed (Board of Community and Technical Colleges, UW (Health Promotion Research Center or Public Health), WSU (Julie Postma from Nursing has done CHW research));
 - Early Childhood (HeadStart, ECAP).
 - **Local:**
 - LHJs;
 - Human Services.
- 3 work groups: Scope of Practice; Training and certification; Finance.
- **Staffing for Task Force and Work Groups:**
Staffing for Task Force and work groups provided by the Innovation Center and CHW Network; hence staffing models the public – private nature of the task force.

CHW network development and infrastructure

The network is a non-governmental backbone convener of the state's many CHW efforts. It provides backbone services to loosely affiliated, grassroots, regional CHW networks and can coordinate mutually reinforcing CHW activities. CHW networks are CHW led. The CHW Network creates a pathway for local, regional and state connectivity.

- Contract with external agencies to develop and oversee the development of a CHW Network. If members of unorganized, relatively powerless groups such as CHWs are to participate as equal partners, leaders must emerge and be nurtured in order to avoid creating legislation/regulations that prevent many effective CHWs from participating.
 - Criteria:
 - Strong existing relationships and practical knowledge with CHWs and CHW programs.
 - Experience with statewide experience in outreach and community based health or social service type work.
 - Experience working effectively cross-culturally and cross-linguistically.
 - Experience partnering with governmental entities.
 - Responsibilities:
 - Identify and engage with CHWs and CHW programs throughout the state.
 - Nurture independent CHW leadership and organizational capacity.
 - Serve as a resource for health care providers, ACHs, CBOs, etc. to support their new or expanding CHW programs.
 - Build and maintain intentional relationships with partners and policy makers.
 - Collaborate with the Innovation Center to:
 - Support the CHW task Force and committees,
 - Gather baseline information about the field, and
 - Support ACHs or similar entities to create a cadre of CHWs that health care organizations, health insurance companies, community based organizations, schools, early childhood center and community members can refer to for access to CHW services that link people in need with CHWs based on patient demographics such as: culture, language, neighborhood residency, and health issue(s) experienced by the patient.
 - Provide technical assistance to organizations employing CHWs.
 - Secure continuing funding, braid private/public funding.

Community Health College and Innovation Center

The Innovation Center is the statewide training and technical assistance CHW Hub.

- Collaborate with the CHW Network to:
 - Support the CHW Task Force and committees,
 - Gather baseline information about the field, and
 - Support ACHs or similar entities to create a cadre of CHWs that health care organizations, health insurance companies, community based organizations, schools, early childhood center and community members can refer to for access to CHW services that link people in need with CHWs based on patient demographics such as; culture, language, neighborhood residency, and health issue(s) experienced by the patient.
- Operationalize the recommendations of the CHW Task Force and Training and Certification work group.
 - Gather and analyze CHW tools, training programs, augmented resources, etc. and identify the ways in which they meet the Task Force’s recommendations.
- Support Regional Health Entities.
 - Work with Regional Entities to develop regional CHW cadres (i.e., the number and type of CHWs needed within a region, scope of work, recruitment process, training and supervision needs, etc.).
 - Provide referrals or direct access to high quality CHW tools, training programs, augmented resources, and technical assistance providers.
 - Develop and implement a feedback loop for continuous communication between state, regional, and local partners related to CHWs.

Regional Health Entities

Entities like the *Accountable Communities of Health* organizations, or like the “regional designee”, develop regional CHW cadres and provide technical assistance to local organizations within the region that are developing CHWs into their workforce.

- Work with the Innovation Center to develop a plan for regional CHW cadres (e.g., organizational home and structure, number and type of CHWs needed within a region, scope of work, recruitment process, referral process, training and supervision needs, etc.).
- Oversee the creation of a CHW regional cadre that health care organizations, health insurance companies, community based organizations, and community members can refer to for access to CHW services that will link patients and people in need who might wish to seek medical care with CHWs based on patient demographics such as; culture, language, neighborhood residency, and health issue(s) experienced by the patient.
- Provide technical assistance to organizations implementing CHW programs and linkage to the regional cadre.

Information from Other States

Below is a summary of the paths that other states have taken, along with approximate timelines.

Massachusetts

Prior to any legislative or regulatory action:

- Nurtured independent CHW leadership and organizational capacity. If members of unorganized, relatively powerless groups such as CHWs are to participate as equal partners, leaders must emerge and be nurtured to avoid creating legislation/regulations that prevent many effective CHWs from participating. Defined CHW. CHW workforce linked to politically salient problems; otherwise [they would be] marginalized. MACHWA supported by funding from MSPHA, Boston Public Health and MA DOH. MPHA [acted as] fiscal sponsor.

May 2006. The state commissioned a **year-long** CHW workforce study which included: workforce study & employer survey; financing options; training and certification recommendations; comprehensive statewide recommendations for building a sustainable workforce.

- Advisory Council: 40 members met quarterly for 1 year. Chair Commissioner of MA Department of Public Health, MA office of Medicaid, MA Department of Labor and Workforce Development, MA Association of Community Health Workers (2 spots), Central MA AHEC, Community Partners MA League of Community Health Centers (2 spots), Lowell Community Health Center, MA Health Training Forum, Health Access Network, MA Public Health Association, MA Center for Nursing, Boston Public Health Commission, MA Association of Health Plans, Blue Cross Blue Shield, MA Medical Society, MA Hospital Association, MA Hospital Association, Center for Health Law and Economics (2 spots), Prevention and Access to Care and Treatment, Brandies University, Health Care for All, Commonwealth Connector, MA AHEC, Brightwood Health Center, New England HIV Education Consortium, Community Health Worker Initiative of Boston, Blue Cross Blue Shield Foundation, U Mass Medical School – Family Medicine and Community Health, SkillsWorks, The Boston Foundation, Dorchester House Multi Service Center, U Mass at Lowell, Neighborhood Health Plan, U Mass Medical School, U Mass College of Public and Community Services.
- 17 Department of Public Health staff
- Work groups: met frequently
 - Research: literature review. Held regional forums to gather CHW input. MACHWA put them on.
 - Survey: Contracted with a University to conduct a CHW employer survey. Described the CHW workforce.
 - Workforce training: Definition, scope of work, core competencies.
 - Finance policy.
- Results. 34 specific recommendations. Categories of recommendations include:
 - Conduct a CHW professional identity campaign to increase recognition and understanding of the CHW role.

- Strengthen Workforce Development by creating a CHW training, education and certification infrastructure. It is essential to charge an agency of government with responsibility for implementing the recommendations, doing further research, policy development, etc.
- Expand financing mechanisms. Four major funding mechanisms identified including direct provider payment to CHWs for CHW services, care team integration, revise community benefit guidelines, increase public funding categorical and contract funding for CHWs.
- Creation of a state office of CHWs to do workforce surveillance, research, coordination of training and career pathways & policy development.

Board of certification – scope of practice and certification process. CHWs help to define standards. Workforce goals: increase understanding and respect for the field and greater employment stability and equitable wages. Background research and funding was provided by foundations. Initiative led by community development, MPHA, and MACHW. Certification board located within DOH Professions Licensure. Legitimizing CHWs in statute took a 2 year legislative campaign.

State contracting policies required employers to support educational opportunities and provide supervision for CHWs.

Members of the Advisory Council/Task Force included representatives from Office of Medicaid, Department of Labor, Massachusetts Community Health Workers Network, Outreach Worker Training Institute of Central Massachusetts Area Health Education Center, Community Partners’ Health Access Network, Massachusetts Public Health Association, Massachusetts Center for Nursing, Boston Public Health Commission, Massachusetts Association of Health Plans, Blue Cross Blue Shield of Massachusetts, Massachusetts Medical Society, Massachusetts Hospital Association, Massachusetts League of Community Health Centers, and MassHealth Technical Forum.

Key Differences:

- Had 3,000 CHWs
- Massachusetts Department of Public Health was the largest funder of CHWs
- Had a strong CHW network

New York

New York has deliberately decided not to pursue a legislative strategy at this point. They decided to slow down legislative efforts when they realized the huge amount of work that needed to be done to lay the foundation for thoughtful consideration of a process to standardize the CHW workforce - including the conduct of a statewide labor market analysis and organizing CHWs regionally to inform the process. They considered it inappropriate to write regulations without understanding the labor market first.

The CHW Network of NYC, an independent professional association of CHWs, in partnership with the New York State Health Foundation and Columbia University Mailman School of Public Health, created the New York State CHW Initiative to advance the CHW workforce by establishing statewide recommendations for the employment, training, certification, and financing of CHW programs.

In 2010, the NYS CHW Initiative invited leading representatives from private, public, and non-profit sectors, including CHWs, to establish a Leadership Advisory Group (LAG) to inform the development of recommendations to advance the field of CHWs. With some 40 members, the LAG formed three work groups to develop sustainable strategies to support and advance the CHW workforce and ensure the stability of workforce. The work groups included Scope of Practice, Training and Credentialing, and Financing. Each work group was co-chaired by a CHW and one other leader. In addition, staff were assigned to each work group to support the groups' administrative and research needs. **Over the course of four months**, the work groups produced a set of recommendations for consideration by the Office of the Governor and the New York State Legislature, as well as health care providers, payers, training organizations, and private sector employers.

They conducted a statewide market analysis and original research to document the CHW scope of practice, training recommendations for content and methodology and financing recommendations. The results of that work are published in the report, "Paving a Path to Advance the CHW Workforce in NY"

www.chwnetwork.org.

Leadership members represented the following organizations: 1199 SEIU United Healthcare Workers East, American Cancer Society, Arthur Ashe Institute, Bronx-Lebanon Hospital Center; Building Bridges, Building Knowledge, Building Health Coalition; Business and Labor Coalition of New York; Columbia University Mailman School of Public Health; Community Health Worker Network of Buffalo; City University of New York (CUNY); Community Health Care; Association of New York State (CHCANYS); Community Health Foundation of Western and Central New York; Community Health Worker Association of Rochester; Community Health Worker Network of NYC; Community Healthcare Network; Community Resources, LLC; Community Service Society of New York; Community Voices, Morehouse School of Medicine; Cornell Family Development Training and Credentialing Program; Group Ministries; Health Plus; Healthcare Association of New York State (HANYS); Korean Community Services of Metropolitan New York; Little Sisters of the Assumption; Livestrong, Lance Armstrong Foundation; Manhattan-Staten Island Area Health Education Center; Nassau County Department of Health; National Council on Aging; New York City Department of Health & Mental Hygiene; New York Health Plan Association; New York Immigration Coalition; New York State Association of County Health Officials (NYSACHO); New York State Department of Health, Bureau of Community Chronic Disease Prevention; New York State Department of Health, Bureau of Women's Health Perinatal Unit; New York State Department of Health, Diabetes Prevention and Control Program; New York State Department of Health, Division of Family HealthAlliance of New York State; YMCAs, Inc.; Northeast Business Group on Health; Northern Manhattan Asthma Basics for Children; Northern Manhattan Perinatal Partnership; Northwest Buffalo Community Center; NYU Center for the Study of Asian American Health; NYU Langone Medical Center; Office of the Deputy Mayor for Health and Human Services; P2 Collaborative of Western New York; Paraprofessional Health Institute (PHI); Partnership for New York City; Ralph Lauren Center for Cancer Care and Prevention; South Central College; Teens PACT (Positive Actions and Choices for Teens); Greater New York Hospital Association; The Office of Assembly member Richard Gottfried; The University at Buffalo and United Hospital Fund

Scope of Practice Workgroup

The workgroup created four products including:

- CHW Scope of Practice: Roles and Related Tasks
- CHW Functional Task Analysis

- Preferred CHW Attributes
- CHW Scope of Practice Recommendations

Work group members represented the following organizations: Work Group Chair, Community Health Worker, Co-founder and Immediate Past Board Chair Community Health Worker Association of Rochester | Community Health Worker, Board Chair, Community Health Worker Association of Rochester | Deputy Executive Director Northern Manhattan Perinatal Partnership | Research Scientist Nassau County Department of health | CHW Program Supervisor Nassau County Department of health | Commissioner Nassau County Department of health | Health Care Coordinator New York State Department of health | Community Health Worker Northwest Buffalo Community Center | Program Director Teens PaCT (Positive actions and Choices for Teens) | Principal Community Resources, TX | Public and Professional Education Coordinator New York State Department of Health | Political Consultant | Director, Diabetes Prevention and Control Program New York State Department of Health | Senior Specialist, State and Local Campaigns

Training and Credentialing Workgroup

The Training and Credentialing work group developed the following set of recommendations which address the need for best practices and appropriate content in CHW training and appropriate certification

Members represented the following organizations: Work Group Co-chair, Community Health Worker, Group ministries | Work Group Co-chair, Co-Division Chief, University Internal Medicine/Pediatrics, the University at Buffalo | Community Health Worker, CHW Manager Bronx-Lebanon Hospital Center | University Dean for Health and Human Services City University of New York | Director of Professional Development Cornell Family Development Training and Credentialing Program | Program Manager, Livestrong Lance Armstrong Foundation | Executive Director Manhattan-Staten Island Area Health Education Center | Community Health Worker Northwest Buffalo Community Center | Program Director, Teens PACT (Positive Actions and Choices for Teens) | National Director of Curriculum and Workforce Development Paraprofessional health institute | Principal Community resources, TX | Political Consultant | Community Health Worker, Coalition Coordinator Northern Manhattan Asthma Basics for Children

Finance Workgroup

The work group sought to prepare a comprehensive set of recommendations which would address CHW financing through multiple mechanisms: Medicaid, pay-for-performance programs, commercial/private insurance, and government health care services. They also provided recommendations for the Medicaid Redesign Team concerning patient-centered medical homes, health homes, accountable care organizations, and other Medicaid innovations and demonstration projects. In addition, the group considered policy and research recommendations that are needed to support this approach to building sustainable funding for CHWs in New York.

Members of the financing committee included representatives from: Work Group Co-chair, Community Health Worker, Director Environmental Health Program, Little Sisters of the Assumption | Work Group Co-chair, Medical Director Department of Family Medicine, Bronx-Lebanon Hospital Center | CHW Program Supervisor Nassau County Department of Health | Commissioner Nassau County Department of Health | Director, Trustee and Auxiliary Initiatives Healthcare Association of New York State | Executive Director Northern Manhattan Perinatal Partnership | President & CEO National Council on Aging | Director of Government

Affairs New York Health Plan Association | Vice President, United Hospital Fund | Executive Director
Northeast Business Group on Health | Principal Community Resources, TX | Community Health Worker Buffalo
Megan Shaughnessy | Communications & Policy Coordinator YMCAs of New York State | Policy Analyst
Paraprofessional Health Institute | Political Consultant | Grants Coordinator

Important elements that led to the success of this work group:

- Conducted extensive CHW organizing in regions of our state to identify, support and recruit CHW leadership to lead our work. Conducted by the Community Health Network of NYC, Columbia University Mailman School of Public Health. Published in Journal of the American Public Health Association (Findley, Matos, Hicks, Campbell, Moore, Diaz, 2012) and Progress in Community Health Partnerships (Catalari, Findley, Matos, Rodriquez, 2008).
- Engaged top leaders from all relevant stakeholder sectors to serve as their leadership committee - including 25% CHW and industry leaders from outside of the healthcare or government sectors.
- Placed the leadership committee under CHW leadership. As the work matured and the leadership committee set up different working groups to address the three major categories, these working groups were all co-chaired by a CHW and one other stakeholder.
- Sought private funds to support our work, in order to safeguard the flexibility to conduct our work in a manner that advanced the workforce while maintaining the integrity of the work - rather than be pressured by political agendas. This was because their state Department of Health tend to be more medical in culture, values and beliefs. In addition, our DOH tends to be pretty heavy-handed in their relationships and, by default, assume an authoritative and regulatory character in their relationships (as is their legislative authority).

Training from Other States

From the CHW Network of New York City - Community Health Worker Training

Our evidence-based Community Health Worker (CHW) training program was developed in direct response to the needs of CHWs themselves, CHW employers and leaders from all relevant CHW stakeholder sectors who contributed to the publication of "Paving a Path to Advance the Community Health Worker Workforce", a landmark report that establishes workforce standards for CHW scope of practice, CHW training and credentialing and for CHW financing. The training content and methods in this curriculum were informed by market analyses conducted by the Community Health Worker Network of NYC in partnership with the Columbia University Mailman School of Public Health and published in the Journal of the American Public Health Association (Findley, Matos, Hicks, Campbell, Moore, Diaz, 2012) and in Progress in Community Health Partnerships (Catalani, Findley, Matos, Rodriguez, 2008).

This training program is designed to provide CHWs with the specific skills they need to conduct the tasks and accomplish the roles that have come to describe the CHW practice.

New and emerging professions generally attempt to establish themselves as different from existing practices by emphasizing differences with those endeavors. As a practice matures, they are generally more willing to embrace the theoretical underpinnings of existing disciplines with which they share philosophies. The CHW

practice is no different. At first most of our efforts were focused on identifying and highlighting those elements that make us different from other disciplines. As our practice matures, we are increasingly excited to recognize the disciplines which have contributed to our own practice. The CHW training program developed by the Community Health Worker Network of NYC recognizes the contributions of other disciplines to our own practice and embraces theories and practices from a number of other disciplines, including Humanistic Psychology, Compassionate Communication, Adult Learning, Popular Education, Human Development, Behavioral Change Theory, Informal Counseling and Motivational Coaching.

Research has shown that CHWs must be trained appropriately and respected by the health care system for their unique role and identity. CHWs can be effective health workers provided they are taught skills that have come to describe their practice and are supportively and educationally supervised (Hammond & Burch, 1986). Very importantly, this same research reveals that CHWs trained in irrelevant hospital settings, trained by nurses with no connection to the community or removed from community for training suffer loss of credibility in their communities and lose the very quality for which they were originally sought out. When forced to look like and sound like traditional members of the healthcare delivery system, they lose their access and the trust they enjoy in their communities.

Appropriate training of CHWs is vital to their effectiveness. This is a significant challenge for healthcare systems interested in integrating CHWs in that the dominant culture of healthcare training focuses on the acquisition of knowledge. CHWs, on the other hand, focus on empowerment and development for individuals, families and communities. Furthermore CHW training is neither pedantic in nature nor didactic in methodology. CHW education seeks to enable citizens to assume responsibility for their own and their community's health through understanding their community's health problems and the societal influences that act upon them. When one adds the cultural considerations, ethnic and religious diversity, and the adaptations needed to meet ever-changing political and societal needs, CHW education becomes a movement for social transformation. This attention to social justice is at the core of the CHW practice and must be reflected in their training.