



Training and Supporting Community Health Workers and Promotores: Lessons for California and Other States

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Executive Summary

States increasingly recognize the value of community health workers/promotores (CHW/Ps) for reaching underserved populations and the need to support this workforce with professional development opportunities. There is, however, currently no single, nationally recognized standard for CHW/P training, and many organizations and states have developed different approaches. Whether training is undertaken by the state, an educational institution, or a private entity, it is important to identify organizations and trainers that specialize in training CHW/Ps. Further, states can also facilitate certification of CHW/Ps.

Following are considerations for enhancing professional recognition of CHW/Ps through training and/or certification, drawn from approaches undertaken by states across the country.

Balance training and experience – Any effort to support CHW/P training programs should consider the balance between requiring in-class training and experience on the job. In California, for example, many existing successful training programs include a practical focus allowing CHW/Ps to learn on the job from experienced coworkers. Interviewees stressed that the job itself is complex, and the creativity and flexibility required to do it is not always well-suited to be learned in a classroom. Additionally, no amount of role-playing exercises in controlled settings can adequately expose a candidate to the types of situations in which CHW/Ps find themselves, and an extended on-the-job period allows individuals to determine whether they are suited for the position.

Accessibility for all – CHW/Ps not only serve underserved communities, but often come from and live in these communities. Training programs should ensure that community members are not excluded through excessively high fees or time commitments. A number of interviewees emphasized that practical portions of training ought to be compensated financially. Examples of free CHW/P trainings, such as programs led by City College of San Francisco and the Washington State Department of Health, illustrate how statewide training efforts could be coordinated with accessibility in mind.

Train employers – The CHW/P's role in the health care system is still new to many organizations, and employers can be trained to let CHW/Ps work to the top of their capabilities. The state can identify employers ready to integrate CHW/Ps into their teams or provide technical assistance and professional development for employers that wish to employ CHW/Ps.

Ensure involvement of people with shared life experiences – Individuals such as undocumented, non-English speakers and formerly incarcerated individuals can contribute valuable lived experiences, but often encounter barriers to employment as a CHW/P. In California, for example, nearly one in 10 residents is an undocumented immigrant, and they often live in underserved communities in need of CHW/P services and are also potential candidates for CHW/P roles. Certain requirements for CHW/P training, however, such as enrollment in an institute for higher education for which undocumented individuals may not be able to secure financial aid,

can exclude members of that community. In states like California where promotores play a key role in supporting the provision of health care services, policy supports for training should be careful not to create barriers to participation for undocumented individuals.

Nothing about us without us – It is critical to involve CHW/Ps in state policymaking processes. Many issues involved in developing policy to support CHW/Ps feature tensions between competing interests. Inclusion of CHW/Ps in a meaningful way can ensure that policy decisions adequately support them. States can require participation of CHW/Ps on governing boards of organizations that employ them, or partner with state CHW/P associations to develop certification standards.

Build or “buy” – Different approaches to enhancing professional recognition of CHW/Ps require different resources. For example, Texas’ health services agency is heavily involved in its CHW/P training and certification approach, while other states, like South Carolina, rely on trusted CHW/P-focused organizations or coalitions to manage state CHW/P infrastructures. Partnering with CHW/P associations — which can act as a trusted “neutral table” — can be a valuable tool for reducing the reliance on state budgets, while ensuring the CHW/P voice in the policymaking process.

Learn from others’ efforts, but tailor to specific state needs – Early adopters of CHW/P programs and policies often have lessons to share, either informally or through a structured evaluation, that can inform other states. What has worked well in one state, however, may not be ideal or practical for another. Given the importance of tailoring approaches to specific state realities, states may want to consider not only what others have done with CHW/P professional recognition, but also how effective the approaches have been. It may be useful for states to build in an evaluation of the structure(s) they decide to pursue to inform quality improvement efforts. Ultimately, the path that a state takes should be based on the specific needs driving the CHW/P professional recognition conversation across the state.

Define the workforce broadly – The CHW/P workforce is diverse, with many individuals in this position not employed by organizations that are part of a larger health care system. In some cases, for example, community-based organizations employ CHW/Ps (although they may not use CHW/P titles). Thus, any effort to enhance statewide systems for CHW/Ps that focuses solely on health care payers and providers risks not recognizing the important roles that CHW/Ps play outside of the health care sector. It is important to support both CHW/Ps in new programs, including partnerships between the health care system and others that employ CHW/Ps, as well as those in existing CHW/P-type roles.

Considerations for California in Supporting the CHW/P Workforce

California has an opportunity to expand support for the CHW/P workforce by: (1) leveraging the work done in its existing Medi-Cal (the state's Medicaid program) initiatives that rely on multidisciplinary care teams such as the [Health Home Program \(HHP\)](#) and [Whole Person Care \(WPC\)](#) pilots; (2) developing evidence-based recommendations for [CalAIM](#); and (3) recognizing the contributions that CHW/Ps can make to the efforts to address the COVID-19 outbreak. As the policymaking process moves forward, below are key CHW/P workforce considerations for California policymakers:

- **Include CHW/Ps in the policy development process.** CHW/Ps are valuable to the health care system for their unique perspective as members of the communities they serve. The perspectives of CHW/Ps are also valuable to policymakers as they consider how best to support CHW/Ps in their work. CHW/Ps know their work better than anyone, and understand the complexity of what they do. Involving CHW/Ps in policymaking conversations will strengthen these efforts and ensure that CHW/Ps' voice is included in decision-making.
- **Revisit the recommendations of the California Future Health Workforce Commission in light of COVID-19.** The valuable work done by the [Commission](#) is still relevant; however, the prioritization may need to be revisited based on new health workforce needs arising from the pandemic response. For example, it may be valuable to assess where CHW/Ps can be useful based on new population health needs that have emerged due to the pandemic.
- **Consider the CDC PEAR report's "BEST" policy recommendations.** The CDC released a [Policy Evidence Assessment Report \(PEAR\)](#) on policies that can support the efficacy of CHW/Ps. The report's recommendations for CHW/P professional recognition are evidence-based. Any policy efforts to support CHW/Ps should consider what work the PEAR report identified as having strong evidence of positive outcomes and use it as a guidepost for policy development. There are many other contributions that CHW/Ps make to the communities in which they live that have not been formally studied or evaluated, but the PEAR report shows which elements offer demonstrated success for training, credentialing, and otherwise supporting CHW/Ps.
- **Use the extended timeline to further explore integrating CHW/Ps into Medi-Cal programs.** As COVID-19 has drawn the state's attention to those struggling with the disease and social distancing requirements, Medi-Cal has a valuable opportunity to: (1) further incorporate CHW/P workforce into its vision for Enhanced Care Management and In Lieu-of-Services to address Medi-Cal beneficiary needs, CHW/P strengths, and state budget constraints; and (2) explore ways to further integrate CHW/Ps in existing complex care management vehicles, including HHP and WPC.

- **Seek balance as the state develops policies to strengthen the workforce.** For training and certification, policymakers should be careful not to create a structure that stifles the creativity inherent in CHW/Ps' work. Standardization can empower CHW/Ps, and those aspects should be promoted. However, care must be taken not to impede the workforce at what they do best, constrain their capacity, or exclude those who lack resources to participate in formal training, or who are doing valuable work outside of the health care system, or under other job titles.

The considerations outlined above can contribute to decision-making around state policies and programs with the overarching goal of advancing the CHW/P profession in California and beyond.

DEFINING COMMUNITY HEALTH WORKERS AND PROMOTORES

Community health worker (CHW) is defined by the American Public Health Association as “a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.”¹

Promotores are a subset of community health workers who serve Spanish-speaking communities, are frequently women, and are characterized as lay health workers with the ability to provide culturally appropriate services informed by their lived experience.²

A Note on Terms: Throughout this paper, we refer to CHW/Ps, but it is not limited to those workers whose job title is “community health worker” or “promotore.” There are dozens of job titles beyond these that encompass community health work, including “health navigator,” “health coach,” “community outreach worker,” and many others. For this report, the term CHW/P is used as a catch-all term to refer to the broad range of individuals doing community health work, regardless of their specific job title.



Introduction

Community health workers and promotores (CHW/Ps) — members of the community who connect patients to needed health-related and social services in a culturally competent manner — are increasingly recognized as valuable contributors to the health care system. As part of a multidisciplinary health care team, these individuals help patients access the resources they need, identify culturally competent care, and better connect hospitals and other health care providers to the communities they serve, functioning as a bridge between patients and providers. In addition, CHW/Ps' lived experiences and connections to the communities they serve allows them to connect and build trust with patients in ways that traditional health care team members are often unable to. Recognizing the value of CHW/Ps, many states are developing policies to promote their employment and deployment.

California, like many states, is seeking to strengthen its health care workforce. In 2019, the California Future Health Workforce Commission released an action plan for building an adequate workforce to meet the health care needs of its growing, aging, and increasingly diverse population.³ The report identified key strategies for achieving its vision: (1) increase opportunities for all Californians to advance in the health professions; (2) expand education and training; and (3) strengthen the capacity, effectiveness, well-being, and retention of the health workforce. Among the top 10 priorities, the action plan included a recommendation focusing on CHW/Ps:

“Scale the engagement of community health workers, promotores, and peer providers through certification, training, and reimbursement, broadening access to prevention and social support services in communities across the state.”⁴

To help California stakeholders act on the above recommendation, this report explores considerations for strengthening and formalizing the role of the CHW/P workforce. Based on interviews with experts in California and lessons from other states across the country, the report explores: (a) CHW/Ps' roles and functions; (b) strategies for employing CHW/Ps; (c) training considerations; and (d) opportunities to enhance professional recognition of CHW/Ps. While the report focuses on the California context, lessons on training, supporting, and sustaining the valuable role of CHW/Ps can inform states across the country.

Community Health Workers and Promotores' Roles and Functions

CHW/Ps are a distinct profession that provide unique contributions within the health care sector. They are not just connectors between established elements of the health care sector such as hospitals or clinics and the communities they serve. The CHW/P brings a unique capacity to the health care system — the ability to better understand and meet the needs of individuals within the community, which adds value beyond simply enhancing the services provided by traditional providers.

CHW/Ps can positively impact health equity across the communities in which they work in a variety of ways.⁵ Because they are often members of the communities they serve, CHW/Ps typically have a deep understanding of the factors that impact residents' health, what makes their communities resilient, and the challenges they face. This understanding makes them uniquely capable to address issues in a culturally responsive way, and to establish trusting relationships with community members. In California, for example, given the socioeconomic and cultural diversity, there are many communities that can benefit from proactive and engaged outreach from partners with whom trusting relationships are established. For example, the state's high percentage of migrant workers underscores a need for multilingual, community-based individuals to serve as CHW/Ps who understand the needs and priorities of those they serve and who can connect them to necessary resources in a culturally responsive way.

CHW/Ps use their skills strategically based on the needs and geography of a given community. In urban settings, they can help patients navigate complex networks of providers in dense geographic areas. In rural areas, CHW/Ps can augment the health care team capabilities in areas with health care workforce shortages and strengthen patient engagement with rural health care systems. Across both settings, CHW/Ps can also serve as liaisons to critical social structures, including community gathering spots such as churches and hair salons. The “many hats” that CHW/Ps wear is a critical part of what makes them a valuable component of communities they serve and to health care teams.

CHW/P Core Roles

The Community Health Worker Core Consensus Project (C3 Project), a national initiative housed at the University of Texas-Houston Institute for Health Policy, is working with experts across the country to build national standards regarding CHW/P's scope of practice and raise awareness of their important role.

In 2016, the C3 Project produced a foundational framework for entities developing CHW/P policies and standards.⁶ The C3 framework report, which is broadly accepted in the CHW/P community, identifies 10 CHW/P roles:



Supporting cultural mediation among individuals, communities, and systems



Building individual and community capacity



Providing culturally appropriate health education and information



Providing direct service



Supporting care coordination, case management, and system navigation



Implementing individual and community assessments



Providing coaching and social support



Conducting outreach



Advocating for individuals and communities



Participating in evaluation and research

A study conducted by the California Health Workforce Alliance (CHWA), a statewide public-private partnership, surveyed California-based clinics and community health centers to identify CHW/P roles. Respondents indicated that the most common roles performed by CHW/Ps in the state include: (1) supporting patients with gaining access to medical and community services; (2) health screening, promotion, and education; and (3) advocating for patient's health needs.⁷ These roles broadly align with those outlined by the C3 Project.

CHW/P roles vary by employer and by the setting where services are delivered. CHW/P services are also tailored to specific populations and/or communities. Given this high degree of variation, the functions highlighted in the C3 report and CHWA represent a range of possible responsibilities and not a checklist of requirements since tailoring is a necessity for any particular CHW/P role.

TRAINING FOR PROMOTORES: PROVIDING SERVICIO DEL CORAZÓN (SERVICE FROM THE HEART)

Promotores are known for their unique capacity to serve their community, advocate for others, and bridge cultural, socioeconomic, and linguistic barriers to connect individuals to necessary resources and health care providers. California-based Visión y Compromiso is a leader in training, leadership development and capacity building of promotores. Nearly 20 years ago, it established the Network of Promotores and Community Health Workers to support promotores. The network currently represents over 4,000 promotores statewide.



In 2015, Visión y Compromiso released a report highlighting findings from focus groups with promotores that covered a variety of topics, including training.⁸ The focus group participants agreed that central tenets of training should recognize that promotores: (1) have heart (corazón); (2) share their personal experiences; and (3) value service to the community. They also noted the value of training in promoting peer support opportunities among promotores, valuable skills, access to resources, and the confidence necessary to do their work.

Based on focus group feedback, Visión y Compromiso developed the following training recommendations:

- Develop standards, core competencies and uniform training curricula relevant to the training needs of promotores' in urban, rural, and resource-limited communities;
- Create training, continuing education, and professional development pathways for promotores that build individual and community capacity;
- Provide training and technical assistance to build the capacity of organizations to integrate promotores into their workforce teams and implement the promotore model;
- Improve employment inequities and benefits for promotores; and
- Increase local and statewide capacity to evaluate and report outcomes linked to the promotores model.

Maria Lemus, executive director of Visión y Compromiso, believes in the importance of establishing core competencies and providing training and emphasizes that core competencies should be developed by the communities that promotores come from. “We think promotores are really suited for and best integrated into a model that gives support, training, and skills that we need to be able to work with our own community in the way that we know is best,” she said.

The Value of the CHW/P Workforce

CHW/Ps have been employed around the country for decades to connect communities to necessary health care services and to improve care for the members of those communities. Substantial evidence is available, both nationally and internationally, on the impact that CHW/P interventions can have on the health of patients and communities.

Formal Evaluations and Studies

The majority of national studies evaluating CHW/P efforts have focused on impacts on utilization, chronic disease management, and individuals' understanding of their health. The studies have broadly shown that CHW/P interventions can improve outcomes in a variety of settings, and that CHW/Ps' work can support cost-effective use of health care resources. Examples include:

- **University of New Mexico - Molina Health.**⁹ In 2011, researchers evaluated a program in New Mexico funded by Molina Healthcare New Mexico (MHNM), a Medicaid managed care organization. The University of New Mexico employed CHW/Ps and billed MHNM for the CHW/Ps' services, which included health care navigation, care management, and increasing access to health care for patients with complex medical and social needs. The evaluation focused on several utilization metrics and total cost of care, and compared patients who received services from the CHW/Ps to a cohort that did not. The total cost of care of the 448 patients who received services from the CHW/Ps was approximately \$2 million less than costs for the cohort not receiving their services, at a programmatic cost of around \$500,000. The lower costs were driven by reductions in health care utilization.
- **IMPACT.** The IMPACT model, developed by the Penn Center for Community Health Workers, is a CHW approach that has been adopted by numerous organizations across the country. The Penn Center has conducted formal evaluations of the model, including two randomized control trials that demonstrate its positive effect on reducing both hospital admission and readmission rates¹⁰ and patients' ability to more effectively manage their chronic diseases.¹¹
- **National Heart, Lung, and Blood Institute (NHLBI).** Within the National Institutes of Health, the NHLBI implemented the Community Health Worker Health Disparities Initiative,¹² which developed programs for CHW/Ps to deliver health education to racial and ethnic minority and underserved communities. The community-based participatory approach involved CHW/Ps in the development of the health education curricula, and the program evaluation. The evaluation examined changes in heart health knowledge, self-reported behaviors, and clinical measures in the communities served. It found that over the course of the intervention, self-reported behaviors and knowledge improved, and risks associated with hypertension and diabetes decreased for participants.¹³

- **Academic Research.** In 2016, a national meta-analysis examining CHW/P-related outcomes around the country revealed that CHW/P interventions can be cost-effective for chronic disease management services delivered to vulnerable populations.¹⁴ The analysis identified numerous studies indicating health improvements, including: increases in cancer screening rates; positive changes in mammogram uptake; and reduction in risk for cardiovascular disease. In particular, the analysis identified eight studies that reported cost savings for CHW/P interventions related to chronic disease management and cancer screening.

These findings, along with many others, support the integration of CHW/Ps into a variety of health care activities and teams both for their uniquely effective skill set and because they support cost-effective interventions.

Using the Evidence Base to Integrate CHW/Ps

In 2014, the Centers for Disease Control and Prevention's (CDC) National Center for Chronic Disease Prevention and Health Promotion released a Policy Evidence Assessment Report (PEAR) on policies that can support the efficacy of CHW/Ps.¹⁵ The PEAR identified potential programmatic and policy supports for CHW/Ps and assessed the evidence for the supports' impact.

The eight elements of successful CHW/P programs that received the report's highest ranking of "best"¹⁶ and that are associated with better outcomes such as improved access to care and improved chronic disease management, particularly for groups experiencing health disparities, are summarized below:

- Support CHW/Ps in providing chronic disease care services;
- Offer specialty area CHW/P certification;
- Include CHW/Ps in team-based care model;
- Offer core competency certification for CHW/Ps;
- Ensure that CHW/Ps are supervised by health care professionals;
- Standardize core CHW/P training curriculum;
- Provide Medicaid payment for CHW/P services; and
- Include CHW/Ps in developing certification requirements.

The CDC PEAR report illustrates a substantial body of evidence supporting the involvement of CHW/Ps in the health care sector as well as effective opportunities to support their work. The report's findings, specifically those focusing on the value of core competency-based training and certification and the inclusion of CHW/Ps in designing the policies related to this workforce, can help guide policymakers who are seeking to potentially integrate and expand this workforce.

Employing Community Health Workers and Promotores

Similar to other states in the country, in California, CHW/Ps are employed by a variety of organizations, including but not limited to public health agencies, clinics, Medicaid managed care plans (MCPs), community-based organizations (CBOs), and increasingly, hospitals and health systems. New roles and funding streams are being piloted that leverage the expertise of CHW/Ps through the state's Whole Person Care program (WPC), a pilot program designed to improve care for Medi-Cal beneficiaries through the coordination of health, behavioral health, social services, and the Health Home Program (HHP), which provides enhanced care management for individuals with complex medical needs and chronic conditions.

Public health agencies have long hired CHW/Ps to support education, health promotion, and prevention with specific populations. This may include activities such as promoting improvements in chronic condition management or conducting home visits. Public health agencies typically hire CHW/Ps as employees or as contractors through CBOs who directly employ the CHW/Ps. Funding most often comes from federal grant programs such as the CDC 1815 program, which provides funding to all 50 states to improve the health of Americans through the prevention and management of diabetes, heart disease, and stroke.

Many MCPs integrate CHW/Ps into care teams in a variety of roles, including to help support high-cost members in better managing their conditions, meet their care plan goals, and connect them to community resources. These CHW/Ps may also work with hospital discharge staff to support care transitions. Funding mechanisms typically include general operations or administrative budgets, and limited Medicaid dollars for specific populations and services. For MCPs participating in California's HHP, CHW/Ps may be employed by the MCP or by affiliated community-based care management entities (CBCMEs) partnering with the plan.

CBOs employ CHW/Ps to serve in a range of roles, including to promote health education, train patients in self-help, and connect residents to needed services and community resources. They generally fund this work by pooling resources such as grants, foundation funding, Medicaid reimbursement, or serving as a vendor to other entities. CBOs may act as a "home base" for CHW/Ps, enabling them to serve as contractors to multiple other organizations while maintaining consistent employment with the CBO. CBOs often serve as CBCMEs in California's HHP.

Community health centers and clinics hire CHW/Ps for a variety of roles, including to provide culturally responsive community-based services or helping individuals gain access to care, better manage their health conditions, or empower them to reduce risk-taking behavior. Community health centers often use administrative funds or grant dollars as their primary funding source for this workforce.

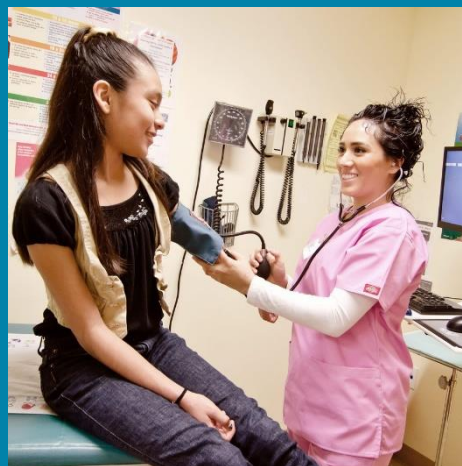
COMMUNITY HEALTH CENTER NETWORK

Community Health Center Network (CHCN) is a non-profit administrative support organization that provides business administrative support for community health centers that care for underserved communities in California's East Bay. The eight CHCN health centers serve more than 130,000 people at over 90 care locations.

In 2013, CHCN began Care Neighborhood, an intensive case management program to support high-risk, high-needs patients in connecting with local community resources and prevent unnecessary hospitalizations by addressing health-related social needs. It hired CHWs to lead this work with patients and demonstrated a 43 percent reduction in hospitalizations early on, enabling them to expand the program and further invest in CHWs.

CHCN's positive experience with CHWs through the Care Neighborhood program informed its thinking about two new initiatives in Alameda County. CHCN is a partner in Alameda County Care Connect, the local WPC initiative, and helps to provide care management to patients with the highest medical, behavioral health, social and housing needs. CHCN also began to work with their two health plans, Anthem Blue Cross and Alameda Alliance, to develop the county's HHP, which focuses on care coordination for individuals with certain behavioral health diagnoses or qualifying chronic conditions. CHCN hired CHWs with local connections to help provide care management in both initiatives. What started out as a test of a new workforce model with four CHWs has grown to 20 CHWs across eight community health centers. The CHWs are employed directly by the health centers, but receive supports such as training from CHCN.

When asked about the key criteria that they look for in hiring new CHWs, Laura Miller, MD, chief medical officer for CHCN, said "The wisdom we have gathered on what makes for a good CHW team member is their ability to be kind, having lived experience and resilience, the ability to speak multiple languages, attention to detail, and creative problem solving."



Enhancing Professional Recognition of Community Health Workers and Promotores: Training Considerations

Properly trained CHW/Ps are invaluable members of health care delivery organizations' care teams. As California considers how to support CHW/Ps, important conversations are emerging nationally about how states can facilitate this training. There is currently no single, nationally recognized standard for CHW/P training, and many organizations and states across the country have developed different approaches. Whether training is undertaken by the state, an educational institution, or a private entity, it is important to identify organizations and trainers that specialize in training CHW/Ps and offer the necessary resources and expertise.

Of the states that formally require CHW/P training, they have paid close attention to the types of experience and capacity of organizations to effectively conduct these trainings. Opinions vary in the field on the benefits of formalized training. While formal training of any kind is often considered helpful and necessary to establish standards, many CHW/P proponents have expressed concerns that a formalized training approach for CHW/Ps can erect a barrier for the workforce. For example, if a training program requires a significant investment of a trainee's time or money, individuals with lower incomes will likely have a harder time participating in the training due to lack of resources or the inability to leave their current job. These barriers often loom largest for those in the communities that CHW/Ps come from and serve. This barrier would not only potentially deprive communities from benefiting from CHW/Ps, but could also subsequently deprive prospective workers of the economic opportunities that are created through these roles.

The following sections explore key issues related to ensuring high-quality training for CHW/Ps, including curriculum considerations, current CHW/P training approaches in California, considerations for training employers of CHW/Ps, examples of state approaches for CHW/P training, and, finally, key lessons for CHW/P training.

Curriculum

Effective CHW/P training programs should clearly and comprehensively cover the core roles and competencies for CHW/Ps, regardless of work setting. *Together Leaning Toward the Sky*, a report published by the Community Health Worker Core Consensus (C3) Project, is a valuable resource that outlines the core CHW/P roles and competencies that should be covered in foundational trainings.¹⁷ The core competencies identified in the C3 report — the skills and qualities that a CHW/P ought to possess to fulfill their role — can help policymakers support the development of effective training approaches for CHW/Ps. The C3 report can serve as a starting point for a competency-based training curriculum, one of the evidence-based policy supports recommended by the CDC PEAR report.

CHW CORE COMPETENCIES

The Community Health Worker Common Core (C3) Project advanced consensus in the CHW field by producing recommendations on common elements of CHW core competencies.¹⁸



Communication skills



Individual and community assessment skills



Interpersonal and relationship-building skills



Outreach skills



Service coordination and navigation skills



Professional skills and conduct



Capacity building skills



Evaluation and research skills



Advocacy skills



Knowledge skills



Education and facilitation skills

Many states require certain CHW/P curricula to be used by approved trainers, or at least for the training curricula to address state recommendations for a CHW/P curriculum. Of the CHW/P trainers who were interviewed for this paper, there was general agreement that a CHW/P training curriculum should be based on the C3 core competences. There was also consensus that there must be a substantial amount of practical learning on the job site provided by experienced CHW/Ps or trained supervisors.

While core competences are necessary components of training curriculum, they are not sufficient for CHW/Ps whose work needs to be tailored to a particular issue area or population. There are a variety of ways to provide this specialized training. One interviewee, for example, recommended that CHW/Ps receive standard core competencies training and then receive specialized training “on the job,” such as dealing with individuals experiencing homelessness or management of particular chronic diseases. Others offer multiple training courses with a foundational course focusing on core competencies and additional courses looking at particular areas of specialization. The approach generally agreed-upon by interviewees is to provide foundational training for the core competencies shared by all CHW/Ps in the state, followed as necessary by specialized training provided either by the employer on the job or through a training organization.

MINNESOTA'S ORAL HEALTH CHW TRAINING

More than half of Minnesota's counties have few if any dental health professionals,¹⁹ which poses a major barrier for residents of rural and under-resourced areas to receive oral health care. To address this issue, the state integrated CHWs into its oral health care workforce. Minnesota was the first state in the nation to offer standardized CHW training through its community colleges.²⁰ The curriculum includes oral health topics such as:

- Dental anatomy
- Infection control
- Oral hygiene instruction and care
- Parent guide
- Access to dental coverage for dental care and oral health
- Use of fluoride and dental caries prevention
- Nutrition required for good oral health
- Identification of resources to promote optimal levels of oral health for patients, families, and communities

Minnesota has seen positive outcomes from oral health providers that have integrated CHWs into their teams. For example, before engaging CHWs as case managers, one Minnesota-based provider reported that only 20 percent of pediatric referrals to dental specialists resulted in actual visits. Since bringing a CHW on board, all of these referrals have been completed within six months.²¹ Through this program, CHWs also assist clients by building trust through culturally competent communication, helping them understand the treatment process, and promoting proper dental care.



Current CHW/P Training Approaches in California

There are numerous CHW/P training approaches currently in use in California, covering the spectrum from community college-based models to apprenticeships designed for particular needs, to programs with general and specialized training. Below are examples of some of these approaches:

- **Worker Education & Resource Center (WERC)**, located in Los Angeles, developed an apprenticeship model that tailors prospective CHW/Ps' education to the needs of employers. The WERC team engages with employers first and develops a training program around their needs and expectations. In one example, WERC developed a curriculum to train individuals who use wheelchairs to serve as CHW/Ps for patients with spinal cord injuries. Then they provide a three-week in-class curriculum for CHW/P trainees, followed by 2,000 hours of "on the job" training, during which the CHW/P is compensated as an employee.

- **City College of San Francisco** provides education at minimal cost to residents, and the school's CHW certificate program is the oldest continuously functioning community college CHW training program in the country. The training program, which features rigorous assessment and extensive practical training, works with employers to ensure that CHW/Ps learn receive the necessary experience. The program also uses CHW/Ps as trainers and lets trainees bring their lived experience into the classroom to help illustrate lessons. The program features a structured internship program with local employers, including employers that are chosen specifically because they provide sufficient support to supervise and integrate new CHW/Ps into their work.
- **Charles Drew University**, a private non-profit professional school in South Central Los Angeles, has established a Community Health Worker Academy to train CHW/Ps and place them in hospitals and other clinical sites around the city. The university worked with a local health system to develop the program, which will also establish a career ladder structure for CHW/Ps. The school plans to expand the program to other providers in the state. The curriculum is based on the C3 core competencies model, and the Academy is working with potential employers to develop modules focusing on specific content areas.
- **Loma Linda University** has a CHW/P training program focused on building the capacity of CHW/Ps to operate within the health care system. The curriculum is based on the roles and core competencies in the C3 report, and includes a set of “foundational” trainings, alongside specialty tracks, including clinic-based work, school-based work, and a series of continuing education courses designed in partnership with health plans. The curriculum includes instruction on how to work within a multidisciplinary team in a variety of settings including health systems, community organizations, or school systems.

Training Employers

The need for training should not necessarily be limited to CHW/Ps. Organizations that want to integrate CHW/Ps into the workforce can benefit from training their staff in order to enhance their organizational capabilities by engaging with CHW/Ps. For example, many traditional health care workers are unfamiliar with the roles that CHW/Ps can play in a health care system. Trainings that enhance their understanding of CHW/P's approach can be beneficial. Additionally, this type of training can help clarify how CHW/Ps' presence will provide an additional layer of support to patients and staff, creating opportunities for professional staff to work to the top of their license — rather than CHW/Ps being seen as encroaching on existing roles and relationships. Additional training support for employers can also focus on how to adequately provide supervisory support to CHW/Ps and how to most effectively incorporate CHW/Ps into organizational work-flows — topics that are critical to their success.

Several interviewees noted that training efforts focused on promoting a greater understanding of what CHW/Ps can do will help ensure that employers will not ask them to do things that they cannot do or have them serve in roles that do not maximize their competencies. Ensuring that

employers are trained to be able to effectively support CHW/Ps is so critical to some training programs that they will not place their graduates with employers that are not deemed ready to successfully integrate CHW/Ps into the organization.

State Approaches to CHW/P Training

There is no national consensus for how a state should support CHW/P training, and the states that have established such supports have done so in a variety of ways. State approaches are described in further detail below, and include:

- Providing training directly;
- Contracting with other organizations to provide training;
- Establishing statewide curricula;
- Certifying training providers; or
- Requiring certified training program to submit data on successful graduates.

The approach that a state takes depends on what resources already exist within its CHW/P community and how best the approach fits into the broader picture of its support for CHW/Ps. This includes the approach that the state takes to certification, since the two are interrelated, but separate considerations for states. Following are several examples of state approaches to supporting CHW/P training.

Massachusetts' Department of Public Health's Office of Community Health Workers points to 10 core competencies for the state's CHW/Ps (modeled after the C3 consensus competencies), and allows training sites to develop their own curricula. There are eight training sites across the state that are certified training providers.²² If a CHW/P receives training from a certified training provider, he or she qualifies for optional state certification through a "training" track, requiring 2,000 hours of work experience in addition to completing the training program. Conversely, the "experience" track requires 4,000 hours of work experience, but no additional formal training.

Minnesota was the first state in the country to adopt a formal CHW/P training curriculum based in higher education. The curriculum is 14 credit hours and offered at seven community colleges around the state. Prospective CHW/Ps entering into the program must have a high school diploma or GED. While the program is voluntary — CHW/Ps may be employed within Minnesota without having completed the training curriculum — organizations that employ CHW/Ps may not bill Medicaid for their services unless the CHW/P holds a certificate from one of these schools.

Michigan's Community Health Worker Alliance (MiCHWA), an independent stakeholder coalition committed to supporting CHW/Ps, developed a 126-hour certification training curriculum. The approach is accepted as the standard across the state, but there is no state requirement for certification, or for having completed the training program, in order to be hired.

Texas certifies CHW/P training programs, and requires that any program applying for certification provide at least 160 hours of training, with at least 20 hours spent on each of eight core competencies, which roughly mirror the C3 recommendations.²³ Applicants must deliver their proposed curriculum to the Texas Department of State Health Services (DSHS), which upon approval, posts the curriculum on its website for public dissemination. DSHS further certifies training programs as providing continuing education and CHW instructor training and continuing education. As of June 2020, there are 31 certified CHW instruction courses, seven of which are certified to provide distance learning.

Washington State's Department of Health offers free CHW/P training at multiple locations throughout the state. The eight-week course is based on recommendations for core competencies developed by a CHW Task Force. The state also offers free continuing education for CHW/Ps who have graduated from a training using the “core competency” curriculum. The continuing education trainings consist of specialized “Health Specific Modules” such as breast health and cancer screening, family planning, and HIV.

Key Lessons for California for CHW/P Training Structure

As California examines opportunities to support CHW/Ps, the opinions of experts and experiences of other states offer key considerations for policymakers. These lessons, however, are not strict policy prescriptions. Rather, the considerations outlined below illustrate the balancing that must be done between competing interests to craft thoughtful policies that will contribute to the strength of the workforce.

- **Balance training and experience.** Any effort to support CHW/P training programs in California should consider the balance between requiring in-class training and experience on the job. Many of the successful training programs already in place in California have extensive practical elements where CHW/Ps learn on the job from experienced coworkers. Interviewees stressed that the job itself is complex, and the creativity and flexibility required to do it is not always well-suited to be learned in a classroom. Additionally, no amount of role-playing exercises in controlled settings can adequately expose a candidate to the types of situations in which CHW/Ps find themselves, and an extended on-the-job period allows individuals to determine whether they are suited for the position.
- **Accessibility for all.** CHW/Ps not only serve underserved communities, but often come from and live in these communities, as well. This is one of the ways in which their work is so valuable. Any training program should ideally ensure that members of the community are not excluded through excessively high fees or time commitments. A number of interviewees emphasized that the training should be compensated financially. Examples of free CHW/P trainings, such as programs led by City College of San Francisco and the Washington State Department of Health, suggest how statewide training efforts could be conducted with such sensitivities in mind.

- **Train employers.** The CHW/P's role in the health care system is still new to many organizations and those employers can be trained to let CHW/Ps work to the top of their capabilities. The state can assess and identify employers that are ready to integrate CHW/Ps into their teams or provide technical assistance and professional development for employers that wish to employ CHW/Ps.
- **Ensure involvement of people with shared life experiences.** Traditionally individuals such as undocumented immigrants, non-English speakers, and formerly incarcerated individuals have valuable lived experiences but can encounter barriers to employment as a CHW/P. For example, nearly one in 10 Californians is an undocumented immigrant, and they often live in underserved communities in need of CHW/P services and are also potential candidates for CHW/P roles. Certain requirements for CHW/P training, however, can exclude members of that community, such as enrollment in an institute for higher education for which undocumented individuals may not be able to secure financial aid. With the key role that promotores play in California communities, any policy supports for training should be careful not to create barriers for undocumented individuals to participate.

Enhancing Professional Recognition of Community Health Workers and Promotores: Certification Considerations

Although CHW/Ps have been part of the health care workforce for decades, numerous barriers make it challenging for organizations to hire and integrate them into their teams. One of the biggest barriers to enhanced professional recognition for CHW/Ps is the lack of a formal definition for the position. As noted previously, the CHW/P role goes by many names. One organization's community health worker is another's "peer specialist," and yet another's "community health representative." Although they are all doing community health work, the lack of a single job title and clear definition make it more difficult for other stakeholders in the health care sector to understand CHW/Ps' potential role in their organizations. To guide state strategies to professionally recognize CHW/Ps, this section outlines formal vs. more flexible certification strategies, examples of certification approaches in states across the country, and key lessons for California for enhancing professional recognition of CHW/Ps.

Formal vs. Informal Recognition Approaches

Formal training and certification at the state or organization level can help alleviate some of that lack of clarity, making integration of CHW/Ps into organizations a simpler task. The health care system is highly formalized, with licensure requirements for nurses, physicians, and other professionals that define their scopes of practice, along with a payment system built on billing for discrete activities that they provide. Organizations can be less likely to engage with CHW/Ps in the absence of a recognition framework because of worries about accountability for CHW/Ps employed in practices, and perceived challenges about the difficulty of supervising individuals who are not part of the same professional structures. Formal recognition for CHW/Ps that includes a deep understanding of their distinct role can make it easier for CHW/Ps to work within the health care system. In order to ensure the value of certifying a training program (vs. certifying individuals which, in California, is not currently being considered), it may be useful to consider a mechanism for hiring entities to verify completion of a certified training program. For example, the CHW/P could register with the state upon completion of a certified training program or a training program might include a roster of graduates within a shared database that can be used for employer verification.

BUILDING A CAREER PATH TO SUPPORT PROFESSIONAL RECOGNITION

The position of CHW/P is sometimes seen as an “entry point” for employment in the larger health care system. It does not require a formal education as other professions, and it can serve as a valuable introduction to the system for individuals living in communities where there is less economic opportunity and where health care systems are frequently important employers. But organizations that view the position of CHW/P as merely an “entry point” can fail to offer opportunities for career advancement. Thus, CHW/Ps who excel in their work often end up getting “promoted out” of the position. This is not only detrimental to the profession, but to organizations themselves, that, while they may gain a valuable new nurse or care manager, loses one of their most effective CHW/Ps.

To avoid this, organizations can establish deliberate career paths for CHW/Ps, which can help promote professional recognition of the CHW/Ps within that organization. One notable employer, the Los Angeles County Department of Health Services, recently established a career path for their CHW/Ps. LA County is in the process of developing a full professional structure for CHW/P leaders within its ranks. The program will allow CHW/Ps to engage in supervised training and become trainers and managers. The career path will require a reclassification of the CHW/P profession in the organization, but it will allow individuals to develop and thrive professionally while still being employed as CHW/Ps.



The role of the CHW/P has not traditionally been part of the health care system, however, and there are tensions that exist between the formality of the health care system and the flexibility inherent in CHW/Ps’ work. Policymakers should be thoughtful about developing a professional identity for CHW/Ps that acknowledges these tensions:

- **Formality vs. Community.** CHW/Ps, by definition, are part of the communities they serve. The recognition that they are first and foremost community members, rather than health care system representatives, is key to their ability to bridge the two sectors. These connections are valuable to the health care system, which sometimes struggles to communicate effectively with the members of the communities that it serves. However, the more that CHW/Ps are integrated into the health care system under a defined set of certified functions, there is a risk that they can become too “medicalized” and lose some of their community credibility.

- **Formality vs. Inclusion.** A formal structure can erect administrative barriers that limit the reach of the profession into communities richest with experience. For example, training programs that charge a fee to achieve formal certification can limit the accessibility of the profession to community members who are otherwise well-suited to be a CHW/P. Additionally, formal certification processes can be difficult to navigate for individuals who may not have achieved certain education levels or who do not have proficiency in the language or languages required to participate.

Provided these tensions are navigated successfully, a formal professional identity for CHW/Ps can benefit not only the health care system and the communities that CHW/Ps serve, but CHW/Ps themselves. The larger system will have a greater understanding of the role of the CHW/P, and organizations that propose to employ them can adapt their processes to allow CHW/Ps to fill the roles in which they can excel.

State Certification Approaches

States have taken different approaches to CHW/P certification and credentialing in order to enhance the professional recognition of CHW/Ps, offering a variety of policies to support the workforce.²⁴ Certification of individual CHW/Ps is currently not widespread — only three states have required individual certification (Alaska, for Community Health Aides; Ohio; and Texas, detailed below), and a number of others offer, but do not require, individual certification (Florida, Massachusetts, Minnesota, Mississippi, New Mexico, Oregon, and Rhode Island). The remaining states are either considering developing standards, or do not currently certify individual CHW/Ps. Currently CHW/P certification, when linked to Medicaid payment, is based on state requirements (see Minnesota, detailed below). Following are examples illustrating different state approaches for structuring certification:

Massachusetts²⁵ has a formal, voluntary, certification process established for CHW/Ps, consisting of two pathways: (1) a state-certified training course alongside 2,000 hours of work experience; and (2) 4,000 hours of work experience. The structure was developed by a group of experts that included CHW/Ps themselves, with state legislation requiring the certification board include a representative from the Massachusetts Association of Community Health Workers.

In 2003, the **Minnesota**²⁶ Community Health Worker Alliance (MNCHWA) developed a formal scope of practice for the field,²⁷ and in 2005, the state initiated a formal certification program based on a standardized training program. Pursuant to state law and the state's Medicaid state plan, services of MNCHWA-certified CHW/Ps in Minnesota are reimbursable through Medicaid. While certification is not required for employment as a CHW/P, services of non-certified CHW/Ps are not reimbursable through Medicaid.

South Carolina,²⁸ since 2012, had an unofficial certification process that was based on training established by the South Carolina Technical School System. In 2017, the state began working with the South Carolina Community Health Worker Association (SCCHWA) to establish the South Carolina Community Health Worker Credentialing Council, which includes representatives from

the SCCHWA, the Community Health Worker Institute at the University of South Carolina, the state Department of Health and Human Services (which houses its Medicaid program); the state Department of Health and Environmental Control; the South Carolina Area Health Education Consortium, and Blue Cross Blue Shield of South Carolina. The Credential Council was formed to promote core competencies and training for the state.

Texas²⁹ DSHS established a CHW/P program to train individuals who wish to serve as CHW/Ps within the state. To receive certification, a prospective CHW/P must complete a DSHS-certified training program or have sufficient (at least 1,000 hours within the last three years) experience doing “community health work services.” If an applicant relies on the experience for their certification, DSHS verifies their work history with their employer(s), a step that helps the state ensure that CHW/Ps are qualified for their positions. Notably, Texas’ experience requirement began as an attempt to grandfather in CHW/Ps who had been working when the new certification requirements were enacted, but was never removed. Thus, there are two distinct avenues for certification in the state, which alleviates some of the concern with the more formal training approach to certification acting as a barrier to entry.

Washington has a robust training program for CHW/Ps funded by the State Department of Public Health, but does not certify individual CHW/Ps, highlighting that states engaged with their CHW/P workforce can choose not to certify individuals, even when they have training curriculums in place.

As these state examples show, there are a range of considerations and options around certification approaches. States may or may not develop individual certification requirements. If they do, they can conduct the work of certification within their state governments, or work with trusted third parties to manage certification. They can provide training opportunities to certify CHW/Ps, base certification on experience, or provide both options for a more flexible approach. States can structure their CHW/P certification based on the needs and resources available to them. If a state has an existing strong CHW/P alliance trusted by stakeholders, that organization could be well-positioned to manage certification. Similarly, if the state has commitment from policymakers to support CHW/Ps through legislation or regulation, it can establish offices devoted to supporting CHW/P certification. Decisions around if and how to conduct certification should be tailored to individual states’ needs. To address California’s CHW/P workforce challenges related to supply, diversity, and geographic distribution, the California Health Workforce Commission’s recommendation is to establish a formal certification process for CHW/P training programs provided by community colleges and community-based organizations.

Key Lessons for Enhancing Professional Recognition of CHW/Ps

Following is a summary of lessons from across the country and from California experts for consideration in determining how to advance professional recognition for CHW/Ps:

- **Nothing about us without us.** One of the clearest refrains mentioned by interviewees in developing this report was the importance of involving CHW/Ps in whatever policymaking process is adopted by the state. So many of the issues involved in developing policy to support CHW/Ps feature tensions between competing interests. Inclusion of CHW/Ps in a meaningful way can ensure that whatever policy decisions are made adequately support them. States can require participation of CHW/Ps on governing boards of organizations that employ them, or partner with state CHW/P associations to develop certification standards.
- **Build or “buy”.** Different approaches to enhancing professional recognition of CHW/Ps require different resources to manage. For example, Texas’ health services agency is heavily involved in its approach, while other states rely on trusted CHW/P-focused organizations or coalitions (like South Carolina) to manage state CHW/P infrastructures. Partnering with CHW/P associations — which can act as a trusted “neutral table” for stakeholders — can reduce the reliance on state budgets, while ensuring the voice of CHW/Ps in the policymaking process.
- **Learn from others’ efforts, but tailor to individual state needs.** Early adopters of programs and policies often have lessons to share, either informally or through a structured evaluation, that can inform the work in other states. That being said, what has worked well in one state may not be ideal or practical or another. Given the importance of tailoring approaches to specific state realities, California and other states may want to consider not only what others have done with CHW/P professional recognition, but also how effective the approaches have been. In that vein, it may be useful for states to build in an evaluation of the structure(s) they decide to pursue to inform ongoing quality improvement efforts and overall learnings. Ultimately, the path that a state takes should be informed by lessons in the field, but based on the specific needs and goals driving the CHW/P professional recognition conversation.
- **Define the workforce broadly.** The CHW/P workforce is diverse, with many individuals in this position not employed by organizations that are part of a larger health care system. In some cases, for example, CBOs employ CHW/Ps (although they may not use the CHW/P titles) to help improve the lives of people in their communities. Thus, any effort to enhance statewide systems for CHW/Ps that focuses solely on health care payers and providers, risks not recognizing and supporting the work done by CHW/Ps outside of the health care sector. In California and other states, it is important to find a flexible solution that both supports new programs, including partnerships between the health care system and others that employ CHW/Ps, as well as supporting those in CHW/P-type roles.

Community Health Workers and Promotores in Today's Climate: What's on the Horizon in California?

Since late February 2020, the COVID-19 pandemic has dramatically impacted the state's plans for CalAIM — a multi-year initiative designed to improve the quality of life and health outcomes of the state's Medicaid population. The following describes how California is adjusting to this evolving landscape and explores the potential for the CHW/Ps role to be amplified in the face of the pandemic.

CalAIM

In fall 2019, California released its CalAIM proposal that includes major delivery system, programmatic, and payment reforms focused on improving the quality of life and health outcomes of beneficiaries of Medi-Cal, the state's Medicaid program. The California Department of Health Care Services (DHCS) planned on implementing the first round of CalAIM initiatives in January 2021 pending approval from the Centers for Medicare & Medicaid Services (CMS). Due to COVID-19, however, DHCS sought an extension of California's existing Medi-Cal authority from CMS through December 31, 2021. DHCS intends to advance CalAIM implementation, albeit in a modified way, and seek approval for this later start date.

The CalAIM proposal builds on lessons from previous pilot programs such as WPC and HHP — which were intended to seamlessly sunset with the implementation of CalAIM and may or may not now depending on timing of the CalAIM extension — and advances broad delivery system reforms for Californians. Under these reforms, MCPs across the state will have new opportunities to integrate CHW/Ps into their programs. The initial CalAIM proposal included a number of new initiatives under which, if continued in even a modified fashion, CHW/Ps may be a valuable source of support, including:

- **Enhanced Care Management** – Through pilot initiatives such as WPC and HHP, California has identified the value of “whole person” care management. The CalAIM proposal includes the creation of a new, statewide, enhanced care management benefit to address the clinical and non-clinical needs of high-need Medi-Cal beneficiaries. The enhanced care management benefit would coordinate care for a number of subpopulations for which CHW/Ps could provide services, including: individuals with frequent hospital and emergency department admissions; individuals transitioning to the community from institutions or from incarceration; and people experiencing chronic homelessness.
- **In-Lieu-of Services** – Medicaid MCPs can be authorized to provide “in-lieu-of services,” defined as cost-effective alternatives to covered services that improve the health of beneficiaries. Through CalAIM, California seeks to implement a robust in-lieu-of services program, with a menu of potential alternative interventions. Several of the potential options offer opportunities for CHW/Ps to add value, particularly around supportive housing efforts,

including: housing transition navigation services; housing deposits; and housing tenancy and sustaining services.

- **Population Health Management** – The CalAIM proposal requires MCPs to develop a patient-centered population health strategy that describes their vision for: (1) providing preventive and wellness services; (2) identifying member risks and needs; (3) managing transitions across delivery systems or settings; and (4) identifying social determinants of health and reducing health disparities or inequities. CHW/Ps could be integrated into various aspects of an MCP’s overall population health strategy.

With the potential extension of current Medi-Cal authorities, the health care system’s engagement of CHW/Ps will likely be most prominently continued through existing mechanisms, such as WPC and HHP, until CalAIM implementation can be continued. Having more time with these established programs might help expand the ways that MCPs, CBCMEs, and health systems engage CHW/Ps going forward given the realities of COVID-19.

CHW/Ps and the COVID-19 Pandemic Response

The COVID-19 pandemic created a surge in acute and emergency care in combination with a public health mandate to shelter in place. The pandemic necessitated a shift in how to serve patients in the community and how to identify the workforce best suited to meet patients’ health and social service needs. In addition, the economic hardship created by the pandemic is not only exacerbating health and social service needs, but will likely also lead to a surge in new Medi-Cal enrollment. Due to economic downturn, the number of eligible beneficiaries in California is estimated to significantly rise over the course of the year.³⁰ Medi-Cal beneficiaries with disproportionate chronic conditions and unmet social needs are at higher risk. Further, the pandemic is disproportionately affecting racially and ethnically diverse groups due to systemic racial and health inequities. Thus, CHW/Ps may be uniquely positioned to support those affected by the current crisis. CHW/Ps have a unique skill set that can be leveraged now more than ever given their presence in these communities. As health care needs and approaches to care shift, the opportunities for CHW/P may also evolve. These include:

- **Leading the work to contain virus spread.** Efforts to contain the pandemic include building overall awareness of the disease, connecting with individuals diagnosed with COVID-19, notifying those they have come into contact with, and ensuring that communities have the resources to care for diagnosed patients as they isolate to protect others. CHW/Ps can contribute to each of these roles, particularly due to their unique ability to engage in culturally responsive ways. Skills such as asking questions, counseling on testing and quarantine procedures, and connecting contacts of patients who tested positive to necessary resources are familiar to CHW/Ps and are all critical for “bending the curve” of the infection rate. Massachusetts, for example, implemented a COVID-19 Community Tracing Collaborative,³¹ which includes case investigators, contact tracers, and resource coordinators to connect with contacts of patients testing positive for COVID-19. CHW/Ps are well suited to these roles given their existing knowledge of and relationships with local

health care and social service resources. In California, Governor Newsom called for 10,000 contact tracer jobs to be filled initially by state employees who volunteer to be temporarily reassigned to this work.³² As these workers head back to their prior responsibilities, more contact tracers will be needed in the state. CHW/Ps could be trained in these protocols and help support the contact tracing effort.

- **Navigating the longer-term impacts of the outbreak.** As states start to reopen their economies after months of restrictions that are likely valuable for slowing the progress of COVID-19, these restrictions have impacted the economic, physical, and mental health of individuals and the communities in which they live. CHW/Ps are well situated to help communities address these effects and support individuals as normal activities begin to resume. Their knowledge of the social networks in the community uniquely position them to identify individuals with the most need and navigate the landscape of social service providers that may have been changed by the outbreak and social distancing restrictions. Because of the pandemic, many people deferred care and will need more health care supports as they feel comfortable seeking care. Further, the mental health impact of the pandemic is yet to be assessed, but issues such as economic stress, depression/anxiety, and social isolation are all areas that CHW/Ps, with their strong relationship-building skills, are well-positioned to help with.
- **Expanding existing reach into vulnerable communities by using telehealth.** CHW/Ps' lived experiences and empathy uniquely qualifies them to communicate effectively and develop trust with others. Due to social distancing and stay-at-home orders, COVID-19 has resulted in a shift to telehealth for certain services. CHW/Ps' ability to maintain trusting relationships allow them to shift to a telehealth-based communication effectively and bridge the gap that can be created by physical distance. This allows them to continue working with patients on managing their chronic conditions, addressing COVID-19 prevention strategies, and connecting them to needed behavioral and social services. In April 2020, the California Health Care Foundation convened an online gathering of California CHW/P experts to collect insights on CHW/P experiences and needs related to the pandemic. Much of the discussion focused on how CHW/Ps were pivoting to virtual connections with clients, how telehealth can help maintain relationships with clients and community resources, and the provisions that are necessary to support CHW/Ps in making this transition, such as providing technical training, support, and equipment to conduct telehealth visits effectively.³³

As the potential for CHW/Ps to play new roles expand during this pandemic, it is important to consider standards that support and protect this workforce. The National Committee for Quality Assurance and the Penn Center for Community Health Workers are partnering to lead a multi-stakeholder advisory panel, including CHW/Ps, to propose evidence-informed standards for the CHW/P profession.³⁴ The intent is to develop standards to promote quality and could be used by state health departments, Medicaid, and health plans as they determine which health care-based CHW/P employers to include in their networks. CHW/Ps may be able to use the

standards to advocate for themselves and to ensure that employers are well-equipped to engage with the CHW/P workforce. The proposed standards are not intended to dictate how CHW/Ps are trained or to define a scope of practice; rather, they can be used to provide guidance for the systems in which CHW/Ps function. The standards could be used to frame the elements of a high-quality CHW/P program, such as: recruitment and retention strategies, appropriate compensation, and infrastructure to support sustainability. As states face a myriad of challenges due to COVID-19, national standards may provide a wide array of stakeholders with a common foundation on which to broaden their investment in CHW/Ps during the pandemic and beyond.

Given the impact of COVID-19 on state, local, and health care budgets,³⁵ funding availability is a critical concern to the sustainability of CHW/P integration in California. CHW/P advocates are reaching out to policymakers at all levels of government to identify opportunities to fund the valuable work of CHW/Ps. The Penn Center for Community Health Workers has called on CMS to add a broad range of CHW/P services as an optional Medicaid benefit that states could leverage through a state plan amendment or waiver, and provide increased federal matching funds to incentivize states to provide these services. The Center has made a similar request to Congress that requests funding for states to support a community-based workforce for rapid response contact tracing. It calls out CHW/Ps as one of the “few policy opportunities to stem a public health crisis, generate a return on investment for public dollars, help keep healthcare organizations afloat and put people back to work. This is one we cannot afford to miss.”³⁶

Supporting California's Next Steps

CHW/Ps have been doing valuable work in California for decades, and will continue to do so, partnering with hospitals, MCPs, and CBOs to improve the health of the communities they serve. Across the country and within California, there are numerous, successful approaches to training, credentialing, and sustainable payment for CHW/Ps. There is no single answer to the question of how best to support CHW/Ps in these ways. Indeed, the flexibility and diversity of the CHW/P workforce itself — an asset essential to its value — could be ill-served by an approach that is overly structured. Any policy development would benefit from understanding the history and current status of CHW/Ps in California and building on this existing foundation.

California has an opportunity to expand support for this workforce by leveraging the work done in its HHP and WPC pilots, developing evidence-based recommendations for the CalAIM process, and recognizing the contributions that CHW/Ps can make to the efforts to address the COVID-19 outbreak. As the policymaking process moves forward for the next iterations of Medi-Cal innovation, following are key considerations for state policymakers.

Considerations

- **Include CHW/Ps and their work in the policy development process.** CHW/Ps are valuable to the health care system for their perspective as members of the communities they serve — a perspective that the broader health care system often lacks. CHW/Ps perspective is also valuable to policymakers as they consider how best to support the work of CHW/Ps. CHW/Ps know their work better than anyone, and understand the complexity of what they do. Involving CHW/Ps in policymaking conversations will strengthen these efforts and ensure that CHW/Ps' voice is included in any decision making.
- **Revisit the recommendations of the California Future Health Workforce Commission in light of COVID-19.** The valuable work and research done by the Commission is still relevant; however, the prioritization may need to be revisited based on the new needs that will face the health care workforce as recovery efforts continue. For example, one recommendation called for the development of a California Health Service Corps, although it was not initially highlighted as one of the 10 priority actions. However, given COVID-19, this recommendation may have newly elevated potential for impact. In fact, in March 2020 Governor Newsom created the California Health Corps in preparation for increased health care needs.³⁷ As new health workforce needs arise as a result of the COVID-19 outbreak, revisiting and potentially re-prioritizing the Commission's recommendations is likely necessary. For example, it may be valuable to assess where CHW/Ps can be useful based on new population health needs that have emerged due to the pandemic. The California Health Service Corps may be a place where CHW/Ps are a natural fit.

- **Consider the CDC PEAR report’s “BEST” policy recommendations.** The CDC PEAR report’s recommendations are based on substantial evidence in the academic literature. Recent interviews with key stakeholders and subject matter experts conducted for this paper reinforced many of the points established in the PEAR report. Any policy efforts made to support CHW/Ps should consider what work the PEAR report identified as having strong evidence of positive outcomes and use it as a guidepost for policy development. There are many other contributions that CHW/Ps make to the communities in which they live that have not been formally studied or evaluated, but the PEAR report shows which elements have evidentiary support for successfully training, credentialing, and otherwise supporting CHW/Ps.
- **Use the extended timeline to further explore integrating CHW/Ps into Medi-Cal programs.** As the COVID-19 pandemic has rightfully drawn California’s attention to those struggling with the disease and the social distancing required to combat it, Medi-Cal and its MCPs have a valuable opportunity to: (1) leverage extra planning time to further incorporate CHW/P workforce in their CalAIM proposals for Enhanced Care Management and In-Lieu-of-Services with consideration for Medi-Cal beneficiary needs, CHW/P strengths, and state budget constraints; and/or (2) explore ways to further integrate CHW/Ps in existing complex care management vehicles, including HHP and WPC, in anticipation of CalAIM not moving forward with Enhanced Care Management under CalAIM.
- **Seek balance as the state develops policies that seek to strengthen the workforce.** For both training and certification, policymakers should be careful not to create a structure that stifles the necessary creativity inherent in CHW/Ps’ work. Standardization can protect and empower the CHW/Ps, and those aspects should be promoted. However, care must be taken not to impede the workforce at what they do best, constrain their full capabilities, or exclude members such as those who do not speak English, who lack the resources to participate in formal training, or who are doing valuable work outside of the health care system, or under other job titles.

In California and nationally, the role of CHW/Ps is a unique and valuable component to connecting with and delivering care to populations and communities affected by systemic barriers to care. Facilitating opportunities to integrate CHW/P into care teams is now more important than ever. Considerations around CHW/P training and certification are multi-faceted and requires additional dialogue from the diverse set of stakeholders — including, most importantly, CHW/Ps themselves — to further advance policymaking. Last but not least, as the COVID-19 pandemic creates new barriers to care and exacerbates the physical and behavioral health and social needs of vulnerable populations, as well as changes state budget and policy landscapes, the CHW/P workforce is well suited to play a critical contribution to people who are navigating an unprecedented health and economic crisis.

ENDNOTES

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