

Recognizing and Sustaining the Value of Community Health Workers and Promotores

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IN BRIEF

Community health workers and promotores (CHW/Ps) can play a key role in the health care system by supporting health care organizations' efforts to care for a broad range of patients. This brief, made possible by the California Health Care Foundation, explores how this workforce is currently contributing to the health care system both in California and around the country. It highlights examples of the value that CHW/Ps provide and how their work is financed, as well as emerging opportunities to scale and sustain that work within California. This topic has particular relevance to the Medi-Cal Healthier California for All initiative, formerly known as California Advancing and Innovating Medi-Cal (CalAIM), a multi-year delivery system and payment reform initiative designed to improve the quality of life and health outcomes of the state's Medicaid population. A future brief will examine the California context in greater depth, including existing and emerging policy options to support CHW/Ps. Although both briefs view this issue through a California lens, the insights are applicable to any state seeking to strengthen its health care workforce.

As health care stakeholders across the nation seek to improve patient outcomes in cost-effective ways, much attention has turned toward the time that patients spend outside the health care setting and the role that individuals with lived experience can potentially play to support their needs.¹ Community-based organizations, health care systems, and payers are increasingly supporting staff whose most powerful credentials are their own personal knowledge and experiences. These workers have a variety of titles, including *community health worker*, *promotora*, *health navigator*, *health coach*, and *community outreach worker*, among others, but the common threads that link them are their close ties to the communities where they both live and work, and the experiences that they share with the people they serve. By leveraging their personal experiences and ties to their communities, this workforce is recognized for its unique ability to forge trusting relationships. As such, they can be an invaluable resource for engaging a wide range of populations and forging a critical connection between health care systems and their communities.

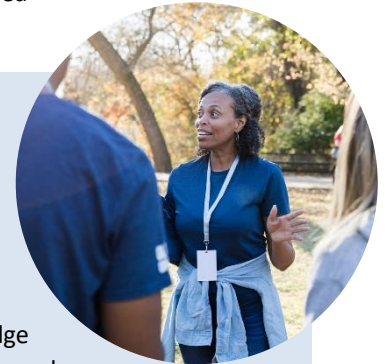
This brief broadly examines the roles this workforce — referred to in this paper as “community health workers and promotores” (CHW/Ps) — plays, and the value these individuals add to organizations that employ and/or partner with them. It also provides examples of how CHW/Ps are currently funded throughout the country, and highlights opportunities for sustaining their roles at both national and California-specific levels. A second brief will focus on the California context for this work and will detail how CHW/P efforts can be further supported within the state's evolving policy landscape. Though many of the financing concepts in this brief can extend to behavioral health peers, it is important to note that this brief does not specifically examine the role of behavioral

health peers, a related but distinct workforce, as they are the subject of separate California-based policy efforts.²

Defining Community Health Workers and Promotores

The American Public Health Association defines a community health worker (CHW) 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.”³

“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.⁴



Incorporating CHWs and Promotores into the Workforce

CHW/Ps have been part of the health care landscape since the 1950s.⁵ In 1970, the American Public Health Association recognized the workforce and formed a formal professional group to promote their use.⁶ To date, however, there are no national-level training, certification, or licensure requirements for this workforce, although some states have sought to standardize training and certification requirements to facilitate reimbursement or ease the pathway to employment.⁷ The CHW/P role draws on capabilities that are not always readily captured in a resume, such as familiarity with and connections to a community, lived experience, creativity and flexibility, and a commitment to service. Given this, emerging best practices for recruiting and retaining this workforce focus on identifying candidates with skills like empathy, open communication, and active listening abilities.⁸ CHW/Ps are employed by a wide range of entities, including community-based organizations, health care systems, Medicaid managed care plans (MCPs⁹), and government agencies. While CHW/Ps may physically conduct some of their work within traditional health care spaces, they often work in community-based settings. Their versatility extends to the roles they play, which can include:



Care team members engaging in care coordination with health care providers



Navigators helping clients navigate complex health and social service systems



Screening and health education providers/coaches collecting and providing health information to consumers



Outreach and enrollment facilitators linking clients to services that are available to them



Organizers advocating for their clients, supporting self-directed change, and promoting community development



Preventive services providers drawing on life experiences to support communities in maintaining individuals' health¹⁰

The defining feature of this workforce is their shared lived experience with the patients they serve, such as individuals experiencing homelessness, patients with substance use disorders, individuals with chronic conditions (e.g., diabetes), residents of specific geographic areas, and Spanish-speaking communities (particularly for promotores). For example, Philadelphia's **Puentes de Salud**, a nonprofit organization that promotes the health and wellness of the city's immigrant population, has established a multidisciplinary, community-based collaborative that brings together health care and social service providers to improve the lives of Latinx individuals.¹¹ Since 2007, Puentes de Salud has employed promotores to connect individuals to needed services, including chronic disease prevention, prenatal care, and obesity and nutrition.¹² The promotores also play key roles in several programs targeting specific conditions, including diabetes and heart disease. Another model that draws upon CHW/Ps' shared experience is the **Transitions Clinic Network (TCN)**, which employs CHWs who have been involved with the criminal justice system to connect with other formerly incarcerated individuals reentering society and link them to primary care. An evaluation of the TCN program, which has been replicated across the country in a multitude of settings, found fewer emergency department and inpatient visits among engaged patients, and posited that interventions such as those employed by the organization could contribute to promoting health equity given the racial disparities in America's justice-involved population.¹³

As the examples above show, CHW/Ps can be effective with a variety of patient populations as well as in diverse geographic settings. CHW/Ps can provide a valuable link between underserved communities and the hospitals and clinics located within them. Their deep familiarity of social networks and community resources — which may be less familiar to health care professionals — can bridge the cultural and socio-economic gaps between clinical professionals and the communities they serve. In urban settings, they can use their knowledge to help patients navigate complex networks of providers in dense geographic areas. In rural areas, CHW/Ps can alleviate health care workforce shortages and use their positions within tight-knit, but sometimes insular, rural communities to strengthen patient engagement with the rural health care system. CHW/Ps can also act as liaisons to social structures that play large roles in rural areas, such as churches and Native American tribal organizations. In Montana, for example, a state that has one of the highest percentages of veterans in the country, **Mountain Pacific Quality Health**, a quality improvement organization for several western states, employed veterans as CHW/Ps to engage with other returned veterans living in their state.¹⁴ The veteran CHWs, who were able to relate to this population through their shared experience of military service, were equipped with tablets to connect their patients to needed services over the large distances covered by the program.

Evidence of Impact

CHW/Ps have been shown to add significant value to the health care organizations that work with them on a variety of different levels. These include:

- **Improved health outcomes.** An assessment published by the Centers for Disease Control examined the evidence base for CHW/P interventions and concluded that improved health-related outcomes, such as chronic disease management, particularly for groups experiencing racial health disparities, can be attributed to various types of CHW/P programs, including: provision of chronic disease care services by CHW/Ps; inclusion of CHW/Ps into team-based care

models; and support for CHW/P services from state Medicaid agencies.¹⁵ Additionally, recent work in Philadelphia suggests that efforts of CHW/Ps not only improve the health of community members, but also that of CHW/Ps who have experienced trauma themselves.¹⁶

- **Promoting health and economic equity.** The CHW/P role is uniquely focused on advancing health equity since it advocates for the needs of patients who are often marginalized and for whom health care systems may be challenging to access due to socio-economic, cultural, or linguistic barriers. Additionally, CHW/Ps represent communities that are often not reflected in the professional health care workforce, and therefore their professional presence within a health care organization may help colleagues and organizational cultures be more attuned to the unique experiences of these communities. CHW/Ps programs can also address equity within underserved communities by providing employment opportunities and professional growth within the health care sector.
- **Financial return on investment (ROI).** Since CHW/Ps are typically a lower-cost workforce than licensed health care professionals, several studies have demonstrated the financial value of these non-traditional health workers, including:
 - CHW/Ps in the **Salud y Vida** program in South Texas, run by **MHP Salud**, provide health education efforts focusing on diabetes management. An evaluation of the program's 12-month diabetes self-management course showed improvements in participating patients' hemoglobin A1c levels while achieving a nearly 10 percent ROI from improved disease management.¹⁷
 - In New Mexico, **Molina Healthcare's** Medicaid managed care organization contracts with a community-based organization and the state university to use CHWs to identify individuals with complex medical and social needs in the community and connect them to needed resources. The program saved an estimated \$2 million in health care costs in one year across 448 patients, suggesting close to a 4:1 ROI.¹⁸
- **Improved patient engagement.** CHW/Ps can promote patient engagement with the health care system by helping patients overcome geographic, cultural, and linguistic barriers to connecting with providers. Evaluations of **IMPACT**, a CHW model developed by the Penn Center for Community Health Workers, have linked CHW/P interventions to increased primary care utilization, higher patient activation scores, and better reported communication with health care providers.¹⁹

Financing the CHW/P Workforce

Despite the extensive use of CHW/Ps in various health care settings for decades, as non-traditional health workers, CHW/Ps have not generally been part of the health care payment system in a formal or consistent way. The health care financing system still primarily focuses on reimbursing licensed providers who deliver discrete services to patients. CHW/Ps' unlicensed status, along with their more fluid and holistic functions, do not easily fit into that framework. Many health care organizations recognize the value of CHW/Ps, however, and are working to fund this workforce. As it currently stands, there is a patchwork of Medicaid funding options for CHW/Ps around the country:

- **Medicaid Managed Care** - The Centers for Medicare & Medicaid Services' (CMS) Medicaid managed care regulations authorize the use of CHW/Ps for services covered by MCPs, such as health education, navigation, and care coordination.²⁰ In a 2017 survey of Medicaid MCPs by the Kaiser Family Foundation, 67 percent of responding MCPs indicated that they used CHWs to address members' social determinants of health.²¹ Examples of this approach include:
 - **Minnesota's** model Medicaid MCP contract authorizes payment for services provided by CHW/Ps;²² **Michigan's** model Medicaid MCP contract goes further to include language requiring MCPs to design and implement CHW/P interventions to address beneficiaries' social determinants of health.²³
 - **Oregon's Coordinated Care Organizations (CCO)** use a variety of strategies to support CHW/Ps for their covered populations. For example, **Columbia Gorge CCO** has developed a strategy based on the Pathways Community HUB model — an approach that provides outcomes-based payments to community-based organizations and providers who deliver services to beneficiaries.²⁴ Organizations working with Columbia Gorge CCO are employing CHW/Ps to connect patients to needed services. Additionally, **CareOregon**, an MCP that supports CCOs in Northwest Oregon, employs CHW/Ps and embeds them within provider practices to provide additional care coordination services.
- **Medicaid State Plan Amendments (SPA)** - States may develop these agreements with CMS to alter how their Medicaid programs are run in order to provide different services, implement innovative payment methodologies, or extend coverage to new groups of beneficiaries. Some SPAs expand the authority for CHW/Ps to provide services, and several are particularly relevant to CHW/Ps' efforts in California, including:
 - **Health Homes** - As authorized under Section 1945 of the Social Security Act, California's health home SPA supports care coordination for Medicaid beneficiaries with complex health needs, and includes an option to include CHW/Ps as part of the health home care team.²⁵ The state's Health Home Program (HHP) leverages the experience of MCPs, which serve as the health home lead entities and work closely with community-based care management entities (CB-CMEs), local community-based health providers who provide frontline HHP services. Several HHP MCPs have used CHW/Ps in their health home model, either at the CB-CME and/or plan levels, such as Inland Empire Health Plan, which utilizes them in both fashions.
(see case study, next page).

Community Health Workers in Medi-Cal Health Homes: Inland Empire Health Plan

In 2016, in anticipation of the Medi-Cal Health Home Program (HHP), Inland Empire Health Plan (IEHP) implemented a pilot to test its care management approach. The Behavioral Health Integration and Complex Care Initiative (BHICCI) established a complex care team including CHWs to provide comprehensive care management to high-cost members with chronic conditions across health systems and providers in Riverside and San Bernardino counties. The initiative demonstrated CHWs' value, setting the stage for how IEHP would launch its health home program in January 2019.

CHWs in Action

In the BHICCI pilot, CHWs spent 70 percent of their time in the field with members, serving as the care team's "eyes and ears." Based on its BHICCI experience, IEHP structured the health home care team to include a registered nurse care manager, a behavioral health care manager, a care coordinator, and a CHW. There are currently 50 teams across IEHP's coverage area, which includes 7,200 members.

While state health home guidance described CHWs as a "recommended but not required" part of the care team, IEHP leadership mandated that CHWs be included on every health home community-based care management entity (CB-CME) care team.²⁶ Based on its BHICCI and HHP experience, IEHP describes CHWs as part of the care team that connects with the member in their community to enhance their shared care plan goals.

Funding CHWs

Medi-Cal's HHP funding comes from a combination of county, state, and federal resources. The state pays MCPs a monthly rate based on three tiers of intensity of member needs and health home service requirements. Plans contract with each CB-CME to pay an agreed-upon PMPM to serve as the complex care team.

Keys to Success

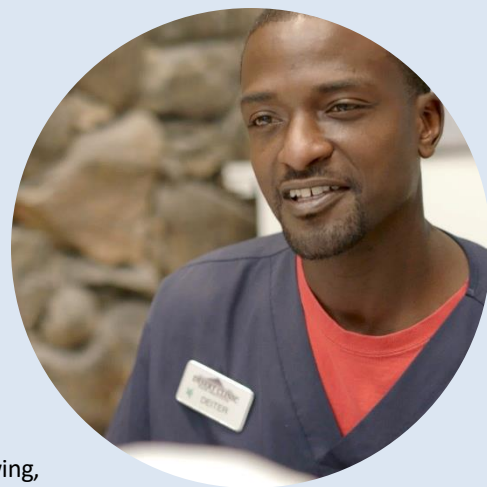
Early on, IEHP met with Heidi Behforouz, a national CHW expert who agreed that San Manuel Gateway College- Loma Linda University offered the best curriculum to train CHWs in

integrated complex care. The curriculum covers complex care topics such as motivational interviewing, trauma-informed care, medication review, assessment, and linking to community resources. The training is an apprenticeship-like program where potential new CHWs receive nine weeks of training funded by IEHP in addition to a salary equivalent to what staff would receive upon hiring. This allows the right candidates "with lived experience" to be hired by the plan. IEHP credits this training approach to their success in recruiting, hiring, and ultimately retaining capable CHWs.

Another key to the success of IEHP's CHWs is the decision to position them to work with hospital discharge staff. The health plan recognizes that members who were recently hospitalized are often more motivated to engage in care, meaning that CHWs can play a critical role in transitions of care. CHWs visit members during a hospital admission and follow up with them after discharge to coordinate care. Recent data shows that IEHP's health home eligible members who received a CHW visit in the hospital have a 38 percent engagement rate, which is significantly higher than the plan's traditional telephonic outreach.

Next Steps

IEHP's experience under the HHP has demonstrated that CHW's lived experiences and ability to connect with members has been critical to the overall success of the care team. The plan is now keeping an eye toward future potential opportunities through Medi-Cal Healthier California for All to continue using this valuable workforce.



- **Preventive Services** – A 2013 Center for Medicaid and CHIP Services informational bulletin clarified regulations authorizing preventive services provided by a CHW/P as a Medicaid-covered service, as long as the state submits a state plan amendment to authorize the reimbursement, and the services delivered are “recommended by a licensed professional.”²⁷ Minnesota, Indiana, and South Dakota have followed suit and have approved SPAs that allow for direct reimbursement for CHW/Ps providing preventive services.²⁸
- **Targeted Case Management (TCM)** – Per a SPA authorized by sections 1905(a) and 1915(g) of the Social Security Act, California has a Targeted Case Management program that allows “local governmental agencies” (which can be counties or cities) to enter into contracts with DHCS to provide additional care coordination services to certain target populations.²⁹ The Alameda County Health Services Agency, a local governmental agency, contracts with a community clinic to provide its TCM services through a Transitions Clinic Network program that employs CHW/Ps.³⁰
- **Section 1115 Demonstration Waivers** – Several states have received Delivery System Reform Incentive Payment (DSRIP) (and similar) resources and used them to fund CHW/Ps programs. For example, Massachusetts’ \$1.8 billion DSRIP demonstration waiver covers extensive infrastructure investment including development of workforce development initiatives to train more CHW/Ps. Many health care providers participating in Massachusetts’ Medicaid accountable care organization invested DSRIP incentive funds to hire CHW/Ps.³¹ In California, the Whole Person Care (WPC) pilots are funded through the state’s 1115 demonstration waiver and a majority of participating agencies and organizations are supporting CHW/P efforts (see “*Challenges and Opportunities in California to Support Community Health Workers*” on page 8 for more detail).
- **Grant Funding** – Funding from charitable organizations or government agencies accounts for a substantial portion of CHW/P programs. Organizations can use grant funding to support CHW/Ps’ work and it can be a critical mechanism for establishing programs, building infrastructure, and ramping up organizational capacity. However, it is also by nature transitory and not generally considered a “sustainable” source of revenue.

Challenges and Opportunities in California to Support Community Health Workers

California is currently engaged in numerous health care reforms, including many that focus on addressing Medi-Cal beneficiaries' health-related social needs. The section 2703 HHP provides funding through Medicaid MCPs to provide care coordination for designated populations, and CHW/Ps are noted in Medi-Cal guidance documents as an encouraged provider type. Similarly, the WPC pilots, funded through the Medi-Cal 2020 1115 demonstration waiver, provide funding for collaboration between county-based health care stakeholders and their partners to coordinate care coordination efforts for complex populations. Numerous WPC pilots have employed CHW/Ps to improve care coordination for their patients. Additionally, MCPs throughout the state have implemented programs to improve care for vulnerable Californians that rely on CHW/Ps, such as the Intensive Outpatient Care Program used by Partnership Health Plan, that are contributing to the environment of innovation and improvement.³²

Although CHW/Ps have been part of the health care system for decades, developing sustainable and supportive policies and effectively integrating them into the health care system can be challenging. Considerations for doing so include:

- **Population-focused decisions** – It is not atypical for CHW/P efforts to be tied to programs that are expected to pay for themselves and where no new money is attached (e.g., WPC). In these circumstances, funding is often connected to the workforce's ability to generate a positive ROI or to reduce aggregate costs. While there is evidence that CHW/Ps can generate an ROI in many settings, this funding strategy may limit CHW/P programming to only those populations for which evaluations have demonstrated a positive ROI, and potentially ignore populations that may not have traditionally received (but could benefit from) services. When developing CHW/P programs and funding mechanisms, policymakers should consider whether their primary goal is: (1) saving money, and therefore services should focus only on populations with a known ROI; or (2) reducing disparities, and therefore they should use an approach that allows the workforce to reach a broader population.
- **Recognizing existing resources** – CHW/Ps have been part of the health care landscape both nationally and in California for decades, employed by payers, providers, and community-based organizations. As policymakers consider ways to support CHW/P work in California, they should consider how best to build on this established foundation of organizations and knowledge. Doing so can help ensure that new programs to support CHW/P work complement existing relationships and institutions. Fully understanding the current CHW/P landscape in the state can also inform how payers and providers build CHW/P programs or tap established resources.
- **CHW/P as a career path** – The CHW/P position is often seen as “entry level,” and organizations may not have considered future professional development pathways for individuals in these roles. In order to support a committed CHW/P workforce, organizations can develop career trajectories within the CHW/P pipeline. Entities such as the Los Angeles County Department of Health Services have established a ladder with multiple CHW/P levels of responsibility to address this need and help ensure that this workforce is not “promoted out” of its critical role (*see case study, next page*).



Investing in Community Health Workers: Los Angeles County Department of Health Services

The Los Angeles County Department of Health Services (DHS), an integrated system of providers, clinics, and hospitals, has invested in CHWs to engage distinct patient populations. They hired CHWs for a series of pilot programs, beginning in 2015 with the Care Connections Program, a primary-care embedded care management program for DHS' most vulnerable patients. When the Whole Person Care (WPC) pilot began a year later, DHS further expanded use of CHWs to coordinate health, behavioral health, and social services for LA County's most vulnerable Medi-Cal beneficiaries, who are high risk, frequent users of hospitals and emergency departments.

CHWs in Action

In DHS' Care Connections Program, CHWs are part of multidisciplinary complex care teams that include a primary care provider, nurse care manager, and others such as a social worker, medical case worker, and pharmacist. In addition to coming from the communities that they serve, many of the CHWs also have personal health care experiences similar to their patients that helps inform their approach to work. The CHWs are embedded in primary care settings, and serve as the care team's extension into the community as they work to increase patients' self-management skills, link them to resources, and help to facilitate care coordination.

More recently, DHS incorporated CHWs into its WPC program, which serves targeted Medi-Cal beneficiary populations including homeless high-risk, re-entry high-risk, mental health high-risk, substance use disorder high risk, perinatal high-risk and medically high-risk. In DHS' WPC model, the CHW role includes outreach, engagement, assessment, peer support, accompaniment to appointments, and other care coordination activities. The CHW works with the patient's primary care team, as well as hospital case management for transitions and community organizations for referrals. The WPC program is housed in Regional Coordinating Centers across LA County, which serve as the home offices for most of the CHWs, who spend much of their time in the community. Across both the Care Connections and WPC programs, DHS staffs over 200 CHWs who each serve between 10 and 35 patients.

DHS' hiring process includes: (1) traditional interviews to identify a candidate's approachability and lived experiences; and

(2) discussion of case scenarios to help DHS learn about an interviewee's aptitude, ability to receive and respond to feedback, and capacity for empathy. WPC CHWs are not required to have a specific certification, but receive intensive training from DHS across more than 20 core curricula topics such as: social determinants of health, motivational interviewing, using DHS assessment and care planning resources, homelessness, incarceration, mental health and substance use disorder, safety, self-care, leadership and advocacy skill-building.

Funding CHWs

DHS funds CHWs through various sources including local county funds (Care Connections Program) and Medi-Cal 1115 waiver funding (WPC program). Through WPC, the county receives a per member per month (PMPM) payment for each target population based on the array of bundled services provided by the WPC care team. Many DHS CHWs are county employees and others are subcontracted through community-based organizations.

Keys to Success

According to Dr. Clemens Hong, LA County WPC Director, integrating CHWs into the workforce has generated broad cross-stakeholder value. For CHWs, it has created jobs, provided opportunities for success within some of the region's most vulnerable, marginalized communities, and offered a work environment where their lived experience is valued. In return, the CHWs play a critical role in supporting the county's ability to engage individuals in care. Experience has shown that the most effective way to engage DHS' target populations is to use someone who reflects their lived experience, speaks their language, and comes from their neighborhood — a role that CHWs are uniquely positioned to provide.

DHS recognizes the importance of investing in training, support, and supervision infrastructure for CHWs. Dr. Hong emphasized that investing in capacity building helps expand the CHW role from solely outreach and engagement to activities such as medication review and hospital-to-home care transitions to further the potential for successful outcomes.

- **Cultural differences** – The health care setting is typically highly formalized, with a strong focus on academic credentials and higher education, while CHW/Ps’ value is based on using lived experience and community status to reach and relate to individuals who have not traditionally been well-served by the health care system. It is valuable for states, MCPs, and health care systems to consider how to strike a balance between these two cultures to successfully integrate the CHW/P role into existing programs. This process might include, for example, determining how and where formal credentialing processes may be useful (if at all), creating robust structures for onboarding and supporting CHW/Ps once hired, and helping licensed providers understand the value the workforce brings to the health care setting.

California is currently undertaking a multi-year Medi-Cal reform effort under Medi-Cal Healthier California for All, an initiative designed to improve quality of life and health outcomes for Medicaid beneficiaries through broad delivery system, program, and payment reform. The Medi-Cal Healthier California for All proposal builds on lessons from previous pilot programs across the state such as WPC and HHP, and advances broad delivery system reforms for Californians. Under these reforms, MCPs across the state have new opportunities to integrate CHW/Ps into their transition plans. The proposal outlines a number of new initiatives under which CHW/Ps may be a valuable source of support, including:³³

- **Population Health Management** – The state will require MCPs to develop a patient-centered population health strategy that meets the following core objectives:
 - Providing preventive and wellness services;
 - Identifying member risks and needs;
 - Managing transitions across delivery systems or settings; and
 - Identifying social determinants of health and reducing health disparities or inequities.
- **Enhanced Care Management** – The state is considering a new, statewide, enhanced care management benefit to address the clinical and non-clinical needs of high-need Medi-Cal beneficiaries, particularly individuals currently enrolled in WPC and HHP. This interdisciplinary approach 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 Efforts** – The CMS managed care regulations authorize MCPs to deliver “in-lieu-of services,” defined as cost-effective alternatives to covered services that improve the health of beneficiaries and are approved by the state Medicaid authority. California is developing guidance for Medi-Cal to implement a robust in-lieu-of services program, with potential alternative interventions identified through Medi-Cal Healthier California for All. Several of the potential options offer opportunities for CHW/Ps to add value, particularly around supportive housing efforts, including: housing transition services; housing tenancy and sustaining services; and housing navigation services.

Conclusion

For decades, CHW/Ps have served as a valuable resource for health care organizations and are deservedly now being recognized as a key component for building meaningful and trusting relationships between patients and health care systems. Through their strong community connections and lived experience, CHW/Ps can connect health care systems to the communities they serve in a variety of ways, improving the health of community members and promoting greater racial and cultural equity. Their deep community ties can facilitate the health system's efforts to address not only patients' health-related social needs, but also the social determinants of their health that exist at the community level. As demonstrated by an increasing number of studies as well as examples of Inland Empire Health Plan (page 6) and Los Angeles County Department of Health Services (page 9) included in this brief, CHW/Ps can effectively improve health outcomes for patients when thoughtfully integrated into health care systems' efforts.

As the recognition of the importance of CHW/Ps has expanded, so too have mechanisms for sustaining this critical workforce. MCPs have identified opportunities in their regulatory authority to invest in the CHW/P workforce, helping to integrate CHW/Ps with providers and develop programs targeted to improve health outcomes. States, too, have recognized the important role that CHW/Ps can play and are investing funds from Medicaid demonstration waivers and SPAs to support workforce development and directly fund CHW/P work. As awareness of CHW/Ps' value increases, providers, payers, and states will be able to build on early efforts to sustain CHW/P investments on a larger scale.

Throughout the nation, CHW/Ps — employed by providers, payers, and state and local government — are effectively engaging patients and helping to coordinate their care and improve the health of their communities. As California evolves its patient-centered Medicaid focus through Medi-Cal Healthier California for All, stakeholders across the state will have unique opportunities to leverage CHW/Ps to achieve many of the initiative's important goals.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center committed to improving health care quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

- ¹ S. Kangovi and D.A. Asch. “The Community Health Worker Boom,” *New England Journal of Medicine Catalyst*. August 29, 2018. Available at: <https://catalyst.nejm.org/community-health-workers-boom/>.
- ² Sen. Bill 10, 2019-2020 Reg. Sess. September 11, 2019. Available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=2019202005B10&firstNav=tracking.
- ³ American Public Health Association. *Community Health Workers*. Available at: <https://www.apha.org/apha-communities/member-sections/community-health-workers>.
- ⁴ Centers for Disease Control and Prevention. *Promotores de Salud/Community Health Workers*. Available at: <https://www.cdc.gov/minorityhealth/promotores/index.html>.
- ⁵ MHP Salud. *History of Community Health Workers (CHWs) In America*. Available at: <https://mhpsalud.org/programs/who-are-promotoresas-chws/the-chw-landscape/>.
- ⁶ American Public Health Association. *Who We Are: CHW Section History*. Available at: <https://www.apha.org/apha-communities/member-sections/community-health-workers/who-we-are>.
- ⁷ National Academy for State Health Policy. *State Community Health Worker Models*. Last accessed: December 16, 2019. Available at: <https://nashp.org/state-community-health-worker-models/>.
- ⁸ J. Lloyd and C. Thomas-Henkel. *Integrating Community Health Workers into Complex Care Teams: Key Considerations*. Center for Health Care Strategies. May 2017. Available at: <https://www.chcs.org/resource/integrating-community-health-workers-complex-care-teams-key-considerations/>.
- ⁹ States across the country frequently use the terms managed care plan (MCP) and managed care organization (MCO) to refer to health plans serving the Medicaid population. This paper uses MCP, which is the term used in California’s Medi-Cal program.
- ¹⁰ See Health Resources and Service Administration, Bureau of Health Professions. (2007). *Community Health Worker National Workforce Study*. U.S. Department of Health and Human Services. Available at: <https://bhwh.hrsa.gov/sites/default/files/bhwh/nchwa/projections/communityhealthworkforce.pdf>.
- ¹¹ Latinx is a gender-neutral neologism, sometimes used instead of Latino or Latina to refer to people of Latin American cultural or racial identity in the United States. For more information, see <https://en.wikipedia.org/wiki/Latinx>.
- ¹² Puentes de Salud. *Promotora Program*. Last accessed December 16, 2019. Available at: <http://www.puentesdesalud.org/services/wellness-education/>.
- ¹³ S. Shavit; J.A. Aminawung; N. Birnbaum; S. Greenberg; T. Berthold; A. Fishman; S.H. Busch; and E.A. Wang. (2017). “Transitions Clinic Network: Challenges and Lessons in Primary Care for People Released from Prison.” *Health Affairs* 36:6. 1006-1015.
- ¹⁴ N. Freundlich. (2017). *Mountain Pacific Quality Health Pilot: Closing the Gaps in Rural Complex Care*. Center for Health Care Strategies, Inc. Available at: <https://www.chcs.org/resource/mountain-pacific-quality-health-pilot-closing-gaps-rural-complex-care/>.
- ¹⁵ Centers for Disease Control and Prevention. *Policy Evidence Assessment Report: Community Health Worker Policy Components*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2014. Available at: https://www.cdc.gov/dhdsp/pubs/docs/chw_evidence_assessment_report.pdf.
- ¹⁶ M. Butler. *Healing Hurt People: Helping Victims of Violence Heal from Their Trauma and Become Community Peer Health Workers*. City Wide, November 1, 2019. Available at: <https://citywidestories.com/2019/11/01/healing-hurt-people-helping-victims-of-violence-heal-from-their-trauma-and-become-community-peer-health-workers/>.
- ¹⁷ MHP Salud, “Community Health Workers and Return on Investment.” Accessed on 12/1/2019. Available at: <https://mhpsalud.org/programs/community-health-workers-roi/>.
- ¹⁸ D. Johnson; P. Saavedra; E. Sun; A. Stageman; D. Grovet; C. Alfero; C. Maynes; B. Skipper; W. Powell; and A. Kaufman. (2011). “Community Health Workers and Medicaid Managed Care in New Mexico.” *Journal of Community Health*, 37:563-571. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3343233/pdf/10900_2011_Article_9484.pdf.
- ¹⁹ S. Kangovi; N. Mitra; D. Grande; M.L. White; S. McCollum; J. Sellman; R.P. Shannon; and J.A. Long. (2014). “Patient-Centered Community Health Worker Intervention to Improve Posthospital Outcomes: A Randomized Clinical Trial.” *JAMA Internal Medicine*, 174(4): 535-543. Available at <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1828743>.
- ²⁰ Several sections of the Medicaid managed care regulations authorize Medicaid managed care organizations (MMCOs) to provide certain services that CHW/Ps may provide, such as care coordination, 42 C.F.R. § 438.208(b), and coordination with community and social support services, 42 C.F.R. § 438.208(b)(2)(iv); For a fuller discussion of how MMCOs can address beneficiaries’ social determinants of health, see D.

Crumley; J. Lloyd; M. Puciarelllo; and B. Stapelfeld. *Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations*. Association for Community Affiliated Plans, December 2018. Available at: <https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf>.

²¹ R. Garfield, E. Hinton; E. Cornachione; and C. Hall. *Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans*. March 2018. Available at: <http://files.kff.org/attachment/Report-Medicaid-Managed-Care-March-Plans-and-Access-to-Care>.

²² Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare, Minnesota Managed Care Contract, Section 6.1.9. Available at: https://mn.gov/dhs/assets/2019-fc-model-contract_tcm1053-370132.pdf.

²³ Comprehensive Health Care Program, Michigan Managed Care Contract, Section X.B.3.b. Available at: https://www.michigan.gov/documents/contract_7696_7.pdf.

²⁴ M. Applegate; L. Brennan; V. Kuenkele; S. Redding; and M. Redding. *Pathways Community HUB Manual*. Agency for Healthcare Research and Quality. January 2016. Available at: <https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf>

²⁵ California Department of Health Care Services. *Medi-Cal Health Homes Program Guide*. November 1, 2019. Available at: https://www.dhcs.ca.gov/services/Documents/MCQMD/HHP%20Documents/HHP_Program_Guide_11.01.19.pdf

²⁶ Based on California's design of health homes, community-based care management entities are locally based organizations that have responsibility, in coordination with the MCP, for ensuring that members receive access to health home services.

²⁷ C. Mann. *Update on Preventive Services Initiatives*. CMCS Informational Bulletin. November 27, 2013. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-11-27-2013-prevention.pdf>.

²⁸ See Minnesota SPA: # MN 13-022. Available at: <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-13-22.pdf>. Indiana SPA: # 18-005. Available at: <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-18-005.pdf>. South Dakota SPA: # 19-0005. Available at: <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-18-005.pdf>.

²⁹ California Department of Health Care Services. Targeted Case Management. January 21, 2016. Available at: https://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/TCM/TCM_FactSheet_01212016.pdf.

³⁰ L. Hogan and T. Macdonald Mendez. *How to Pay for It: Financing Community Health Workers in Transitions Clinics*. November 2018. California Health Care Foundation. Available at: <https://pachealth.org/wp-content/uploads/2019/02/HowToPayForCommunityHealthWorker.pdf>.

³¹ J. Rosenthal. *Behavioral Health Workforce Innovation: How Massachusetts and New York Engage Community Health Workers and Peers to Address Racial and Ethnic Disparities*. National Academy for State Health Policy, November 2019. Available at: <https://nashp.org/wp-content/uploads/2019/11/Behavioral-Health-Workforce-pdf-final-11-18-2019.pdf>.

³² K. Stremikis; C. Connors; and E. Hoo. *Intensive Outpatient Care Program: A Care Model for the Medically Complex Piloted by Employers*. The Commonwealth Fund. September 26, 2017. Available at: <https://www.commonwealthfund.org/publications/case-study/2017/sep/intensive-outpatient-care-program-care-model-medically-complex>

³³ State of California – Health and Human Services Agency Department of Health Care Services. *California Advancing & Innovating Medi-Cal (CalAIM) Proposal*. October 28, 2019. Available at: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf.