Advancing California's Community Health Worker & *Promotor* Workforce in Medi-Cal

A Resource Guide to support Medi-Cal managed care plans and their partners in integrating community health worker and promotor *into programs that advance health equity.*

California Health Care Foundation
HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

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About the Project

In California, one of the most racially, ethnically, and culturally diverse states in the country, health care must bridge cultural and linguistic divides to serve all communities equitably. As trusted community members with lived experience, community health workers and *promotores* (CHW/Ps) have a long history of connecting those not well served by the traditional health care system with culturally congruent health and social services. Advancing this workforce will ultimately improve health outcomes for Medi-Cal members across the state and forge a path to health equity for all Californians.

A project team led by **In-Sight Associates** worked with more than 30 stakeholder organizations and CHW/Ps interested in supporting the advancement of the CHW/P workforce to better serve Medi-Cal members. The team spent a year gathering best practices to help organizations hire, train, and engage CHW/Ps throughout local health care systems. These local and national subject matter experts (see **Acknowledgements**), along with **Health Management Associates** and the **Center for Health Care Strategies**, informed the topics covered in this Resource Guide, contributed practical resources, and reviewed the compiled materials.

This stakeholder-informed Resource Guide and accompanying **online Resource Center** intend to support California's managed care plans (MCPs) and their partners to fully integrate the role and benefits of CHW/Ps into their programs.

About the Authors

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The Center for Health Care Strategies is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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Executive Summary

In California and across the country, deep disparities in health outcomes based on race, income, and immigration status exist, which the COVID-19 pandemic has exacerbated.[1] Reducing these disparities and improving health and well-being requires a person-centered focus that integrates physical and behavioral health care with services that address health-related social needs.

Community health workers and *promotores* (CHW/Ps) have a long history of providing culturally congruent, person-centered services that bridge these different systems and improving the health and well-being of the people they serve. [2] CHW/Ps perform a variety of formal roles, from supporting care transitions and referrals to encouraging and educating patients on how to take care of their own health. What makes this workforce uniquely effective is their ability to establish trusting relationships with the people they serve, grounded in shared life experience and community connections. By forging trusted relationships, CHW/Ps not only engage with individuals in health-related activities but also help to change perceptions and encourage behaviors that contribute to better health outcomes.

There is strong evidence that CHW/Ps can improve health outcomes and quality of care and reduce health care costs.[3] Across health care settings and conditions, CHW/Ps advance health equity in diverse communities because they understand the root causes of challenges that people face and can help to develop tailored approaches that are more likely to be effective.[4] CHW/P programs* show a return on investment ranging from $2.28 to $4.80 for every dollar spent on CHW/Ps for managed care plans (MCPs). [5]

In California, there are new opportunities for MCPs to support the growth of this workforce so their members can benefit from CHW/P services. The California Advancing and Innovating Medi-Cal (CalAIM) initiative creates new imperatives for MCPs to meet member needs by supporting nonclinical interventions to address health-related social needs and to reduce health inequities, including through partnerships with community-based organizations and providers.[6] MCPs can invest in CHW/P services to help achieve these goals.

Two proposals in the CalAIM initiative — enhanced care management (ECM) and in lieu of services (ILOS) — offer MCPs financial mechanisms to contract with organizations that employ CHW/Ps and innovate how care is delivered. In responding to the requirements and opportunities of these CalAIM proposals, MCPs can apply lessons from California's Health Homes Program and Whole Person Care pilots; in many of these programs, MCPs either directly employed CHW/Ps or contracted with community partners that employ CHW/Ps.

In addition to the opportunities presented by CalAIM, California is pursuing approval from the Centers for Medicare & Medicaid Services (CMS) to use federal Medicaid funds to support CHW/Ps in providing services as a

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*CHW/P programs are defined in this Resource Guide as programs and interventions that include CHW/Ps as team members. While many programs that employ CHW/Ps also employ a range of clinical and non-clinical staff, the term CHW/P program is used as a concise descriptor.

benefit for Medi-Cal members, effective January 1, 2022.[7] Through this funding, MCPs would have another opportunity to include CHW/Ps in member care.

This Resource Guide is designed to support Medi-Cal MCPs in effectively integrating this valuable workforce into their programs. Beyond, MCPs, this Resource Guide can also inform organizations that employ CHW/Ps and contract with MCPs, such as Federally Qualified Health Centers, community-based organizations, and other health and social service organizations. The Resource Guide was developed through the California Health Care Foundation's *Community Health Workers & Promotores* **in the Future of Medi-Cal** project. This project engaged stakeholders with a deep knowledge of the field to inform a series of four resource packages that support the integration of CHW/Ps into programs for Medi-Cal members. This guide synthesizes information gathered during the project and addresses the following core topics:

→ *Developing and Financing CHW/P Programs and Partnerships*: Includes information about program design, goals, financing, and partnership development between MCPs and other organizations, such as providers or community-based organizations. It outlines approaches to help MCPs and their partners establish and sustain successful contractual partnerships. It also describes financing options for CHW/P services in California and pathways for sustainability.

→ *Establishing Roles and Recruiting CHW/Ps*: Explores approaches for defining CHW/P roles within the context of interdisciplinary teams, such as care managers, clinic-based social workers, and medical assistants. Clearly defining roles can help MCPs and other stakeholders effectively incorporate the unique skills and strengths of this workforce and align various CHW/P roles with the unique needs of priority populations. This section details how MCPs and their partners can structure positions and employee supports, such as supervisory models and caseload guidelines, as well as effective recruiting and hiring strategies.

→ *Training and Supporting CHW/Ps*: Describes CHW/P training needs and approaches, including core competencies, specialized program skills, organizational practices and workflow, and ongoing professional development. It outlines multiple options for structuring training for CHW/Ps, including contracting with training organizations. It also addresses the need to help extend organizational training to additional staff, including interdisciplinary teams, CHW/P supervisors, and organizational leaders, to help all staff understand the roles of CHW/Ps.

→ *Engaging CHW/Ps in Data Collection and Program Outcome Measurement*: Highlights strategies for MCPs to incorporate the CHW/P workforce in data collection and ways to measure the impact of CHW/P programs. It outlines what data MCPs should collect to effectively resource and support CHW/P activities and what infrastructure is needed to help CHW/Ps collect data. It also describes considerations and sample measures to help guide MCPs in developing a comprehensive evaluation strategy to assess the impact of CHW/P activities.

This guide also provides practical resources to help MCPs consider the activities involved in establishing CHW/P programs and partnering with key stakeholders to effectively design and launch programs, including a **Design Checklist**, which details a high-level, step-by-step description of key activities, along with quick access to the relevant sections. It also includes curated **Resources and Tools** and **Appendices** that can be used to support program design and implementation.

Design Checklist

This design checklist provides a high-level description of the MCP activities necessary to establish a program with CHW/P services. MCPs can use this checklist to quickly find information within this Resource Guide to support program development.

STEP	RELATED RESOURCES
Developing and Financing CHW/Ps Programs and Partnerships	
✔ Assess the needs of the community and use data to determine priority populations for a CHW/P intervention	Subsection: Assess needs and determine priority populations Exhibit: Sample organizational assessment questions
✔ Identify program goals and design program scope, in partnership with CHW/Ps: - Consider needed services and program models for enhanced care management and in lieu of services	Subsection: Identify program goals and design program scope Link: Department of Health Care Services (DHCS) CalAIM website
✔ Assess whether an MCP should explore partnership with a provider or community-based organization that employs CHW/Ps: - Research potential partners - Assess their capacity for partnership - Determine the size and scale for partnership	Subsection: Partnerships between MCPs and organizations with CHW/P programs Exhibit: Sample pros and cons for partnerships
✔ Explore core contract components between MCPs and partner organizations and finalize effective contracting agreements	Subsection: Develop strong contractual partnerships Appendix: Sample contract terms
✔ Consider applying incentives as part of a financial sustainability plan	Subsection: Program financial sustainability
✔ Access resources about program design and financing	Section: Resources and tools
Establishing Roles and Recruiting CHW/Ps	
✔ Designate clear roles for CHW/Ps that meaningfully incorporate the unique strengths of this workforce and insights from CHW/Ps	Subsection: Define CHW/P roles Exhibit: Core CHW roles Appendix: CHW/Ps in CalAIM's Enhanced Care Management and In Lieu of Services
✔ Establish CHW/P supervisory models: - Identify the position that will supervise CHW/Ps - Determine CHW/P-to-supervisor ratio	Subsection: Establish CHW/P supervisory models
✔ Identify CHW/P caseloads in the context of the complexity of member needs, documentation requirements, and required travel time	Subsection: Establish appropriate CHW/P caseloads
✔ Facilitate effective integration of CHW/Ps into interdisciplinary teams: - Develop protocols and job aids to assist CHW/Ps in their work	Subsection: Develop supports for interdisciplinary team integration
✔ Develop job descriptions that clearly define CHW/P roles, tasks, competencies, and qualifications to recruit candidates who will succeed in this position	Subsection: Create job descriptions that align with CHW/P roles Exhibit: Core CHW skills
✔ Use traditional and nontraditional recruiting tools and employ interview techniques to identify candidates with strong interpersonal skills	Subsection: Use effective recruiting strategies
✔ Access resources on CHW/P roles, supervision, and recruitment, such as sample job descriptions	Section: Resources and tools

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STEP	RELATED RESOURCES
Training and Supporting CHW/Ps	
✔ Review principles and methodologies for CHW/P training, including the importance of engaging CHW/Ps in design and delivery of training	Subsection: Principles and methodologies Subsection: Engagement of CHW/Ps as co-designers and trainers
✔ Identify organization to lead training (whether an external partner or internal) for training of CHW/Ps and employer organizations	Subsection: Training implementation Appendix: Select California and national CHW/P training programs

✔ Develop training strategy and curricula for four types of CHW/P training:
   - Core competencies
   - Required program-specific specialized skills
   - Organizational processes and workflows
   - Continuing education
	Subsection: Levels of CHW/P training

✔ Establish training strategy and curriculum for the team members of CHW/Ps and for organizational leaders	Subsection: Training for organizations and supervisors
✔ Develop training strategy and curriculum for CHW/P supervisors	Subsection: Training for CHW/P supervisors
✔ Access existing examples of training frameworks and materials to inform organizational efforts	Section: Resources and tools
Engaging CHW/Ps in Data Collection and Program Outcome Measurement	
✔ Assess data goals and establish required data to support CHW/Ps in meeting member needs	Subsection: Goal setting
✔ Establish data-sharing agreements	Subsection: Shared data agreements in CHW/P programs
✔ Engage with CHW/Ps to inform data collection strategies and understand what data can support their work	Subsection: CHW/P priorities in data collection and outcome measurement
✔ Identify and develop an implementation plan for tools that can help CHW/Ps support the conducting of health and social assessments	Subsection: Tools to help CHW/Ps support health and social needs assessments
✔ Develop standardized tools, data collection methods, and platforms to connect CHW/P encounter data with members' electronic health records	Subsection: Sharing member data Subsection: Technology considerations
✔ Identify outcome measures to evaluate CHW/P activities	Subsection: Designing evaluation strategies for CHW/P activities Exhibit: Sample measures to evaluate CHW/P activities
✔ Access resources on data collection and program evaluation	Section: Resources and tools

Glossary of Terms

This glossary defines key terms used throughout this Resource Guide. It includes citations for more information as relevant.

TERM	DEFINITION
California Advancing and Innovating Medi-Cal (CalAIM) Initiative[8]	CalAIM is a multi-year initiative by the California Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of the state's population by implementing broad delivery system, program, and payment reform across the Medi-Cal program.
Community-based care management entities (CB-CMEs)[9]	CB-CMEs are a network of health care and social service providers responsible for ensuring that participants in California's Medi-Cal Health Homes Program receive all services from this program, as well as conducting outreach and engagement.
Community-based organization (CBO)[10]	CBOs include a range of organizations — such as social service agencies, nonprofit organizations, and formal and informal community groups — that often work in partnership with health care entities by providing nonclinical services that address health-related social needs.
Community-connected health workforce[11]	"Community-connected health workforce" is an umbrella term coined in this project to describe all unlicensed health professionals who either have lived experience in or are trusted members of the communities served — including those with the formal title of community health worker or *promotor*, as well as those working as recovery specialists, navigators, health coaches, and many other roles. The term is used to emphasize the shared characteristics and broad importance of this workforce across medical, behavioral, and public health settings.
Community health representative[12]	Community health representatives provide meaningful outreach, health care services, and health promotion/disease prevention services that are tailored to the distinct cultures and practices of American Indian and Alaskan Native communities.
Community health workers (CHWs)[13]	CHWs are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison, link, or 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.
Electronic Health Record (EHR)[14]	An EHR is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. While an EHR does contain the medical and treatment histories of patients, an EHR system is built to go beyond standard clinical data collected in a provider office and can be inclusive of a broader view of a patient's care.
Enhanced Care Management (ECM)[15]	ECM is a proposed benefit requirement in the CalAIM initiative to provide intensive and comprehensive care management to address the clinical and nonclinical needs of Medi-Cal beneficiaries enrolled in managed care plans who have a high need for services.

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TERM	DEFINITION
Health equity[16]	Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health, such as racism, poverty, and discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.
Health Homes Program (HHP)[17]	The Health Homes Program is a pilot that provides comprehensive care management and care coordination for Medi-Cal beneficiaries with complex medical needs and chronic conditions. The program first launched in 2019 and will be replaced by the proposed ECM benefit beginning in 2022.
Health Information Technology (HIT)[18]	HIT involves the processing, storage, and exchange of health information in an electronic environment. Widespread use of HIT within the health care industry will improve the quality of health care, prevent medical errors, reduce health care costs, increase administrative efficiencies, decrease paperwork, and expand access to affordable health care.
In Lieu of Services (ILOS)[19]	ILOS are an optional managed care plan benefit proposed in the CalAIM initiative. ILOS are flexible wrap-around services that are designed to serve as a substitute for, or to avoid, other Medi-Cal covered services such as emergency room visits, hospital or skilled nursing facility admissions, or discharge delays. Examples of ILOS include housing transition navigation services, sobering centers, and respite services.
Interdisciplinary team[20]	An interdisciplinary team includes CHW/Ps and other team members with whom the CHW/P coordinates regularly. The types of positions included on the interdisciplinary team will vary based on the setting in which the CHW/P works and the focus of the respective program.
Medi-Cal[21]	Medi-Cal is California's Medicaid program.
Peer support workers[22]	Peer support workers bring personal lived experience with substance use disorder, a mental health diagnosis, or both. Peer support workers draw upon this lived experience to "assist people with finding and following their own recovery path" and perform similar job responsibilities to community health workers in a wide range of settings.
Promotores de salud* or *promotores[23]	*Promotores* share many similarities with community health workers. They are characterized as lay health workers with the ability to provide linguistically and culturally appropriate services informed by their lived experiences in the community, and they often serve Spanish-speaking communities.
Social Determinants of Health (SDOH)[24]	SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
Whole Person Care (WPC)[25]	The Whole Person Care pilots provide coordinated and integrated medical care, behavioral health care, and social services to the Medi-Cal beneficiaries who repeatedly use multiple and often acute services and have poor health outcomes. These pilots first launched in 2017 and will be replaced by the proposed ECM benefit beginning in 2022.

Section 1: Introduction and Context

Community health workers and *promotores* (CHW/Ps) provide culturally congruent, person-centered services that support the health and well-being of the individuals they serve. In California, there are new opportunities for managed care plans (MCPs) to support the growth of this workforce so that their members can benefit from CHW/P services. The California Advancing and Innovating Medi-Cal (CalAIM) initiative creates new imperatives for MCPs to develop new strategies to meet member needs including through partnerships with community-based organizations and providers that may employ CHW/Ps.[26] MCPs can invest in CHW/P services to help achieve these goals.

This section describes the value proposition for MCPs to integrate CHW/Ps into programs that serve Medi-Cal members and provides background on the work that CHW/Ps do and the unique strengths they bring to their positions.

Background on CHW/Ps in California

Who Are Community Health Workers and *Promotores*?

According to the American Public Health Association, a community health worker is a

> "*Frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. These connections to the community are, in large part, why this workforce can effectively meet the needs of Medi-Cal members and strengthen the health care system's ability to advance health equity. This trusting relationship enables the CHW to serve as a liaison, link, or 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.*"[27]

CHW/Ps are often referred to by other titles, such as health navigators, health coaches, community outreach workers, recovery specialists, housing specialists, and family support workers.[28] There are other closely related titles of workers who conduct similar work within specific communities or health care settings. For example, *promotores de salud*, or *promotores*, share many similarities with CHWs. They are characterized as lay health workers who provide culturally congruent services informed by their lived experiences, and they often serve Spanish-speaking communities.[29] This is particularly important in California, which has a large Latinx population. In Native communities, this role is often referred to as a community health representative. Community health representatives provide meaningful outreach, health care services, and health promotion/disease prevention services that are tailored to the distinct cultures and practices of American Indian and Alaskan Native communities.[30] In behavioral health and substance use services, similar roles include behavioral health peer

support workers (referred to as peers) or recovery coaches. Peers have had personal lived experience with substance use disorder or a mental health diagnosis.

This guide uses the umbrella term of "community health workers and *promotores*," abbreviated as CHW/Ps. Regardless of the title, all CHW/Ps bring their knowledge of community resources and their own lived experience when working with patients with complex needs, such as people with serious mental illness, people experiencing homelessness, individuals who are currently or have been incarcerated, youth in foster care, and frail older adults.

CHW/Ps have been employed across public health, medical, and behavioral health settings with different job titles and in a range of roles. CHW/Ps have worked to support member engagement in chronic disease management, conduct outreach to individuals with complex needs, and facilitate improved birth outcomes, among many other diverse areas of focus. **Exhibit 1** details examples of the work that many CHW/Ps do. Here are other examples: CHW/Ps may meet with members in their homes or other community locations to discuss medical and nonmedical needs, support members in completing health risk assessments, and utilize motivational interviewing to support members in reaching their goals.

MCPs may directly hire CHW/Ps as employees, or they may contract with external partners — such as providers or CBOs — to employ CHW/Ps and manage programs that include CHW/Ps as part of interdisciplinary teams. Many CHW/Ps work for Federally Qualified Health Centers (FQHCs), public health agencies, or health plans, while others work in behavioral health settings (e.g., peer support workers). Increasingly, hospitals and health systems are exploring CHW/P interventions.[31] CHW/Ps typically work as part of an interdisciplinary team, particularly in clinical settings. Some CHW/Ps also work in community-based settings such as social service agencies. As one example, CHW/Ps with lived experience in the foster care system may work with child welfare organizations to support youth in foster care and their families. **Section 3: Establishing Roles and Recruiting CHW/Ps** details additional considerations for MCPs and their partners in understanding the potential roles of this workforce.

Exhibit 1. Examples of CHW/P Tasks

→ Meeting patients in the community

→ Encouraging patient activation and self-management

→ Teaching the importance of preventive health care

→ Building health literacy

→ Conducting health coaching

→ Developing shared care plans

→ Completing health risk screenings

→ Linking to needed community resources

→ Assisting with benefit applications

→ Helping patients to navigate housing

→ Supporting the re-entry population

→ Coordinating medication reviews

→ Enhancing care transitions

→ Accompanying patients to provider visit

> " **CHW/Ps serve as the interpreter between the community and the clinic. We build relationships with people that adds to their quality of life and, in some situations, saves lives.**
>
> *- Joe Calderon, Senior Community Health Worker*

What is the Community-Connected Health Workforce?

"Community-connected health workforce" is an umbrella term coined in this project to describe the workforce of unlicensed health professionals who either have lived experience in or the trust of the communities served — including those with the formal title of community health worker or *promotor*, as well as those working as recovery specialists, navigators, health coaches, peer support workers, and many other roles. The term is used to emphasize the shared characteristics and broad importance of this workforce across medical, behavioral, and public health settings.

Currently, many health care organizations hire unlicensed professionals who serve in similar roles performed by CHW/Ps. However, these professionals may lack direct knowledge or experience in the communities served and therefore could not be considered a community-connected health workforce or a CHW/P.

What Is the History of CHW/Ps?

CHW/Ps have been present internationally and locally throughout history.[32] Health care teams in the United States began formally including CHW/Ps in the 1950s.[33] There was greater focus on CHW/P training in the 1990s, when the City College of San Francisco established one of the first CHW/P training centers in the country.[34] Over the last 15 years, these programs have grown across California with an emphasis on incorporating CHW/Ps into interdisciplinary teams. In 2009, the Bureau of Labor Statistics created an occupational code for CHW/Ps, and the Affordable Care Act in 2010 created new funding opportunities to expand programs with CHW/P services, such as California's Health Homes Program (HHP).[35] Although there are no national training standards — and, in California, CHW/Ps are not licensed or certified — there are common competencies and responsibilities for CHW/Ps.

> **CHWs can make the relationships with the members so much more fruitful, and they do the hard work to help support members. Having CHWs as part of the interdisciplinary team shifts the focus from checking the boxes to really thinking about what we are doing to best serve our members.**
>
> *- Managed care plan representative*

How Do CHW/Ps Support Medi-Cal Members?

Medi-Cal covers 13 million Californians, with more than 80% of all members enrolled in MCPs.[36] Many MCPs integrate CHW/Ps into interdisciplinary teams in a variety of roles, such as supporting high-cost members in better managing their conditions, meeting their care plan goals, and connecting to community resources. Some MCPs have incorporated CHW/Ps into programs such as the state's HHP[37] or Whole Person Care (WPC)[38] pilots. In these programs, MCPs either directly employ CHW/Ps or contract with community partners that employ CHW/Ps.

Nineteen out of the 26 counties participating in WPC incorporated CHW/Ps in their approach.[39] As the HHP and WPC pilots transition to become statewide benefits under CalAIM's enhanced care management (ECM) benefit, MCPs can apply lessons from these programs and develop strategies to engage with the CHW/P workforce.

RELATED RESOURCE: **Whole Person Care: The Essential Role of Community Health Workers & Peers** (PDF) describes the roles of CHW/Ps in California's WPC pilots.

Advancing CHW/P Integration in Medi-Cal

A goal of the CalAIM initiative is to improve the health of California residents by supporting nonclinical interventions to address health-related social needs and reduce health inequities. Two proposals in the CalAIM initiative are particularly relevant: (1) a requirement for an ECM benefit to address clinical and nonclinical needs of individuals with complex health and social needs; and (2) authorization for MCPs to deliver in lieu of services (ILOS), which are cost-effective alternatives to covered services that improve health, such as housing navigation services. In developing plans for these services, MCPs can help to incorporate CHW/P services into member care. This guide can support MCPs and provider or community-based partners to initiate or expand effective programs that incorporate CHW/Ps and support members. **Exhibit 2** *(below)* and **Exhibit 3** *(next page)* detail ECM priority populations and optional in lieu of services.

Exhibit 2. CalAIM ECM Priority Populations[40]

→ Children or youth with complex physical, behavioral, developmental, and oral health needs (e.g., California Children's Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis)

→ Individuals experiencing homelessness or chronic homelessness or who are at risk of becoming homeless

→ People with frequent hospital admissions, short-term skilled nursing facility stays, or emergency department visits

→ Individuals at risk for institutionalization who are eligible for long-term care services or nursing facility residents who wish to transition to the community

→ People at risk of hospitalization who have co-occurring chronic health conditions and serious mental illness, substance use disorder, or serious emotional disturbance.

→ Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community

Exhibit 3. CalAIM Optional In Lieu of Services (ILOS)[41]

→ Housing Transition Navigation Services

→ Housing Deposits

→ Housing Tenancy and Sustaining Services

→ Short-term Post-Hospitalization Housing

→ Recuperative Care (Medical Respite)

→ Respite Services

→ Day Habilitation Programs

→ Nursing Facility Transition/Diversion to Assisted Living Facilities,
   such as residential care facilities for elderly and adult residential facilities

→ Community Transition Services/Nursing Facility Transition to a Home

→ Personal Care and Homemaker Services

→ Environmental Accessibility Adaptations (Home Modifications)

→ Meals/Medically Tailored Meals

→ Sobering Centers

→ Asthma Remediation

The HHP and WPC pilots offer valuable lessons to inform the launch of CalAIM and new opportunities to improve care management and health-related service provision. In these earlier models, MCPs partnered with community-based care management entities (CB-CMEs) and WPC partners to employ CHW/Ps. This guide features case examples from the HHP and WPC pilots to illustrate lessons for MCPs and their partners. In addition to the opportunities presented by CalAIM, California is pursuing approval from the Centers for Medicare & Medicaid Services (CMS) to use federal Medicaid funds to support CHW/Ps in providing services as a benefit for Medi-Cal members, effective January 1, 2022. [42] As details emerge on the type of services that CHW/Ps can provide, the structure of service provision, and how the services will be reimbursed, MCPs will have another opportunity to include CHW/Ps in providing services to members in their communities.

This Resource Guide is designed to support the integration of CHW/Ps into programs for Medi-Cal members and advance health equity, including through the CalAIM initiative. It was developed through the California Health Care Foundation's Community Health Workers & *Promotores* in the Future of Medi-Cal project and informed by stakeholders with broad knowledge of the field, including representatives of the CHW/P workforce. The guide addresses the following topics to help guide development of CHW/P program approaches:

→ Developing and Financing CHW/P Programs and Partnerships

→ Establishing Roles and Recruiting CHW/Ps

→ Training and Supporting CHW/Ps

→ Engaging CHW/Ps in Data Collection and Program Outcome Measurement

The guide also includes practical resources and tools collected in the development process and/or shared by stakeholders. The **Acknowledgments** section lists the individuals participating in this project.

Making the Case for CHW/P Integration: Impact and Opportunities

How Do CHW/Ps Impact Health Equity?

People of color, immigrants, people with low incomes, and other populations marginalized by systemic inequities experience the impacts of systemic racism, xenophobia, discrimination, and trauma, which can impact their access to health care and social supports in a variety of detrimental ways.[43] Interventions to reduce health disparities often seek to improve the quality of care and support individuals' health-related social needs such as housing, nutrition, personal safety, and transportation. MCPs and CBOs frequently struggle to successfully address these issues, due to the funding silos for health care and social services and the underfunding of social services in the United States.

CHW/Ps help to improve health outcomes among people who face unacceptable barriers to care because of their race, ethnicity, socioeconomic circumstances, or immigration status by engaging patients with open communication, trust, empathy, and empowerment. Across health care settings and conditions, CHW/Ps advance health equity in communities because they understand the root causes for challenges that members face and can partner with members to develop tailored approaches that are more likely to be effective.[44] This workforce is uniquely qualified to work with priority populations under ECM and achieve CalAIM's equity goals, including addressing racial disparities in health outcomes. There is strong evidence that including CHW/Ps on care delivery teams can advance health equity, including among patients with serious mental illness and chronic disease.[45]

As part of the communities they serve, CHW/Ps are uniquely situated to address broader racial disparities in health outcomes. They have shared experiences with patients that help them build authentic and trusting relationships, and they are familiar with community needs and strengths and can help patients navigate medical and nonmedical resources. Moreover, CHW/Ps, as members of integrated care teams, can play a critical role in addressing the range of factors that most influence health, including social determinants of health, environment, and behavior.

> " Racism is a root cause of health inequities and any effort to address this must be community-led. While health systems are not currently set up to meet the needs of our communities, working with CHW/Ps can make this change possible.
>
> *- Mayra E. Alvarez, The Children's Partnership*

A CHW/P's work with one individual often creates a ripple effect through their families, their neighbors, and their social circles. For example, perhaps a CHW/P starts working with a member who has a history of heart disease and substance use disorder. When the CHW/P visits the home, they meet the member's partner who is pregnant with their second child. The CHW/P then engages the member's partner to assess the need for prenatal care and connects them to health and social services. CHW/Ps' role in the community links MCPs to people at the neighborhood and family level, thereby addressing health inequities in a more expansive way.

CHW/P programs can also promote health equity by employing and equitably paying historically underrepresented individuals as CHW/Ps, such as people of color. CHW/Ps, who make up a culturally and linguistically diverse workforce, have been able to connect with communities of color that the health care system traditionally has had a difficult time reaching. MCPs can show they value this effort from CHW/Ps through the pay structure (competitive salaries and benefits) and opportunities to move into roles with elevated responsibility (career ladder). This can be accomplished by creating job tiers that align with higher pay and that include supervisory and leadership responsibilities. Doing so supports a health care workforce that better reflects the communities served, while also providing employment opportunities in those communities.

What Is the Evidence for CHW/Ps Improving Health Outcomes and Reducing Costs?

Research confirms the effectiveness of CHW/Ps in improving health outcomes and quality of care, reducing health care costs, and advancing health equity.[46] This research spans decades of inquiry to assess CHW/P activities, and these efforts have resulted in improvements in study design and methods of evaluation.[47] Multiple studies clearly demonstrate that CHW/Ps contribute significantly to improvements in members' access to and continuity of care; screening and other prevention activities; and adherence to treatment.[48] Managed care CHW/P programs show a return on investment for MCPs ranging from $2.28 to $4.80 for every dollar spent on CHW/Ps.[49] **Exhibit 4** summarizes this research confirming the value of CHW/P interventions, and can be used to demonstrate the evidence for the impact of CHW/P programs.

| Exhibit 4. Key Research Studies Demonstrating the Value of CHW/P Activities |
| --- |
| **Prevention** |
| → Several studies of CHW/P programs have shown significant improvements in patients' use of prevention services, such as mammography and cervical cancer screenings among immigrant women with low incomes.[50] |
| **Patient Health Outcomes and Chronic Disease Management** |
| → An evaluation by the Centers for Disease Control and Prevention (CDC) found strong evidence that integrating CHW/Ps into multidisciplinary teams improved health-related outcomes in people with chronic diseases.[51] |
| → A randomized controlled trial of the IMPaCT model led by the Penn Center for Community Health Workers demonstrated that a standardized CHW/P intervention improved chronic disease control, mental health, and quality of care.[52] |
| → CHW/Ps have had positive effects on chronic disease management and treatment adherence, including significant impacts on healthy food choices, increased physical activity, and improved clinical outcomes, such as decreased hemoglobin A1C levels among patients with diabetes.[53] |
| → In New York's childhood asthma program, over a 12-month period of care coordination, CHWs reduced asthma-related emergency room visits and hospitalization rates by more than 50%.[54] |
| **Reduced Costs or Acute Care Utilization** |
| → A meta-analysis conducted by CMS and Center for Medicare & Medicaid Innovation found that CHW/Ps lowered total costs by $138 per beneficiary per quarter. Of six innovation components evaluated (i.e., Health Information Technology, CHWs, medical home intervention, focus on behavioral health, used telemedicine, workflow/process redesign intervention), only innovations including CHWs were found to lower total costs.[55] |
| → A propensity matched study found a reduction in preventable hospitalizations and days spent re-incarcerated among members of the Transitions Clinic Network program.[56] |

(Continues on next page.)

(Continued from previous page.)

Exhibit 4. Key Research Studies Demonstrating the Value of CHW/P Activities *(continued)*
Reduced Costs or Acute Care Utilization *(continued)*
→ A study conducted by the University of New Mexico found that CHWs, as part of Medicaid managed care that provided supportive services to high resource-consuming enrollees, improved access to preventive and social services and reduced resource utilization and cost. [57]
→ A peer navigator intervention based at a large community mental health agency in California led to improved relationships with primary care providers after six months, and reduced emergency department use and improved confidence in self-care management after 12 months. [58]
→ A randomized controlled trial of a CHW-led intervention for low-income women with depression found that participating patients experienced a reduction of more than 30% in total charge amounts, as well as reduced acute care utilization. [59]
→ The IMPaCT model with a standardized CHW intervention was associated with reduced total hospital days and hospitalizations across multiple settings, including hospitals, academic primary care clinics, Veterans Affairs, and Federally Qualified Health Center primary care practices. [60]
→ In Baltimore, Black Medicaid patients with diabetes who participated in a CHW intervention had a 40% decrease in emergency department visits, a 33% decrease in emergency department admissions, a 33% decrease in total hospital admissions, and a 27% decrease in Medicaid reimbursements. [61]
ROI
→ A randomized controlled trial of the IMPaCT model featuring a standardized CHW intervention showed a ROI of $2.47 for every dollar invested by a Medicaid payer for addressing patients' social determinants of health. [62]
→ Molina Healthcare of New Mexico found that an intervention with CHWs providing patient education, advocacy, and social support to 448 patients with complex medical and social needs generated an estimated $2 million in savings over one year, suggesting close to a 4:1 ROI. [63]
→ A cohort study found an ROI of $2.36 for every dollar invested in the Community HUB model, as implemented in partnership with an Ohio health plan to reduce nonclinical barriers to care for high-risk pregnant members and their newborns through the first year of life. [64]
Patient Engagement
→ The IMPaCT model with a standardized CHW intervention led to increased patient engagement through higher patient activation scores, primary care utilization, and high-quality discharge communication with providers. [65]
Workflow and Care Coordination
→ In delivery systems that employed CHW/Ps, researchers found quantifiable impacts on workflow, with clinicians spending between 30% and 50% less time arranging and coordinating social services and referrals. [66]
Cultural Shifts in Provider Attitudes
→ An analysis found a shift in provider attitudes and increased respect for the CHW/P role. Providers noticed CHW/Ps' ability to build trust and identify and respond to patient needs, amounting not only to many providers becoming champions for CHW/Ps, but to a widespread cultural shift within some organizations. [67]
Advancing Health Equity
→ A report by Families USA analyzed nine Patient-Centered Outcomes Research Institute studies of CHW/Ps and found that across health care settings and conditions, CHW/Ps advanced health equity in diverse communities by empowering members to increase their self-efficacy and building trust in the health care system. [68]

MCP Opportunities to Integrate Health and Social Sectors

MCPs are well positioned to facilitate integration between health and social sectors, including through ECM and ILOS services. Because CHW/Ps serve as a bridge between the health care system, social service agencies, and CBOs for members with complex health and social needs, they are critical members of the community-connected health workforce who will help achieve health and social service integration.

As MCPs explore the potential roles of CHW/Ps in integrated care delivery systems and innovations, one framework that may be valuable is the "5As" developed by the National Academies of Sciences, Engineering, and Medicine (**Exhibit 5**). These five activities, known as the 5As, reflect health care system activities that strengthen social care integration.[69] Notably, CHW/P programs play a role in each of the five identified categories:
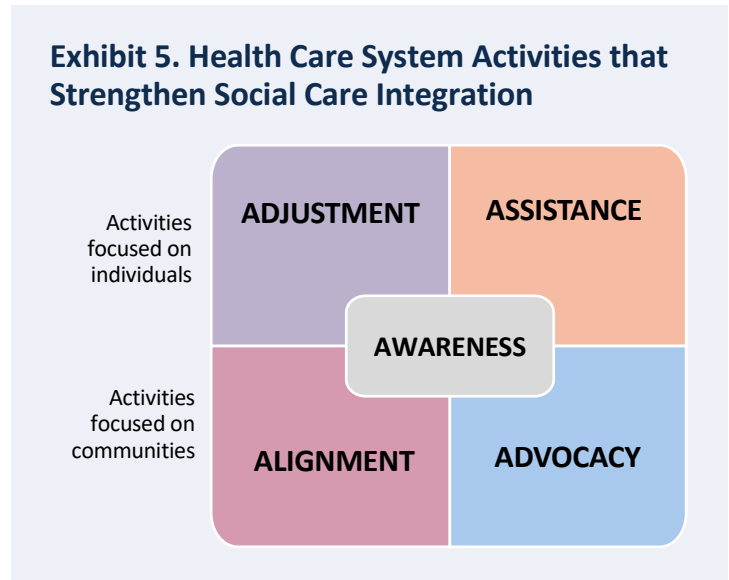
→ *Adjustment* and *assistance* focus on improving care delivery provided specifically to individual members, such as CHW/Ps providing direct assistance to members.

→ *Alignment* and *advocacy* relate to roles the health care sector can play in influencing and investing in social resources, such as by advocating for investments in programs that train and employ CHW/Ps.

→ All delivery and community-level activities are informed by efforts that increase *awareness* of individual or community-level socioeconomic risks and assets, as CHW/Ps can provide individual and community-level data to MCPs.[70]

Exhibit 5. Health Care System Activities that Strengthen Social Care Integration

CHW/Ps not only engage with members in specific health activities through their work, but they also help to change perceptions, attitudes, and behaviors that contribute to better health outcomes.

> " It's important to remember that while the data is out there, the personal connection with somebody — that's what makes it. That's where you are able to see the full story.
>
> *- California CHW/P*

Section 2: Developing and Financing CHW/P Programs and Partnerships

Managed care plans (MCPs) that are seeking to improve care for Medi-Cal members can incorporate CHW/Ps into programs, either by directly employing CHW/Ps or by contracting with partner organizations such as providers and CBOs that employ CHW/Ps. CHW/Ps can help identify member health and social needs and connect members with medical, behavioral health, and social services to address their needs. CHW/Ps are especially well positioned to support MCP goals related to enhanced care management (ECM) and in lieu of services (ILOS) benefits, due to state requirements that MCPs engage with community-based providers and the unique strengths that CHW/Ps bring in serving people with complex health and social needs.

This section explores important considerations for developing and financing new CHW/P programs or refining existing programs to incorporate CHW/Ps. Topics covered include assessing member needs and designing program goals, identifying ECM and ILOS roles in coverage and financing for CHW/Ps, contracting with partner organizations to serve Medi-Cal members, and developing financially sustainable programs and partnerships.

Background

CHW/Ps provide a critical opportunity to advance the goals of CalAIM and provide vital connections to the community. CHW/Ps support the health care system by developing strong and trusting relationships with patients in their communities. As CHW/Ps take on expanded roles in health care delivery, it is critical to preserve the unique strengths of CHW/Ps and ensure that the role does not become overly medicalized. Developing thoughtful partnerships across stakeholders with a role in the CHW/P workforce — including CHW/Ps themselves, CBOs, MCPs, government partners, community colleges, providers, training programs, patients, and others — is critical to expansion and long-term sustainability of the CHW/P role.

In states across the country, there are a variety of different Medicaid funding mechanisms that health plans and their partners use to fund services delivered by CHW/Ps. Federal and foundation grant funding have been some of the most common funding for CHW/Ps, but these sources do not provide a sustainable approach for financing this workforce. Medicaid reimbursement provides an opportunity to grow and sustain CHW/P programs and services. Examples of Medicaid payment include: (1) fee-for-service (as implemented by Minnesota, Indiana, and California under behavioral health contracts); (2) 1115 waiver authority (Oregon and New Mexico); (3) state plan amendments (Maine, Michigan, Missouri, New York, and North Dakota); (4) managed care organization contracts (administrative funding and capitated rates), including North Carolina; and (5) preventive services.[71] Many states fund CHW/P services in Medicaid through a combination of those approaches.

The implementation of CalAIM, specifically through ECM and ILOS benefits, creates new opportunities to incorporate CHW/Ps within community and health care settings and engage CHW/Ps to support Medi-Cal members with enhanced coordination of social and medical needs and culturally competent and appropriate care.[72] MCPs can directly hire CHW/Ps or contract with external partners to manage CHW/P programs. When MCPs are partnering with external organizations, it is important to understand that each partner has different funding models, cultures, and processes. Simultaneously, MCPs and their contracted partners will need to align financing strategies to best achieve program goals while supporting and strengthening the CHW/P workforce.

While Medi-Cal MCPs have been able to pay for CHW/Ps through pilot program funding as described earlier, the capitation payments currently paid to the Medi-Cal MCPs do not include CHW/Ps as recognized providers. This omission significantly impacts the ability to directly contract and pay CHW/Ps. In California's approved budget for FY 2021-2022, CHWs have been added to the class of skilled and trained individuals who can provide clinically appropriate Medi-Cal covered benefits and services effective January 1, 2022.[73] If this revision is approved and implemented, it may increase the options for building CHW/Ps directly into MCP networks and increase the ability to pay partners for services provided by CHW/Ps. Further, MCPs have received draft rates for ECM service provision, which are adjusted upward for plans that provide ILOS.

> " **The MCP has a role not just in assessing, but building capacity in their provider networks to employ CHW/Ps in the workforce. CalAIM incentive dollars for investments in care management capabilities, including investing in building CHW/P capacity and the recognition of CHW as a Medi-Cal provider type, are steps toward supporting MCPs' CHW capacity building efforts.**
>
> *- Jessica Finney, Central Coast Alliance for Health (MCP)*

Although MCPs have not yet been funded to include CHW/Ps as health care providers, they are now and will continue to be able to pay for many CHW/P provided services using administrative funds. MCPs receive funding to deliver non-benefit services, such as care coordination and navigation. MCP contracts, however, limit the percentage of total capitation that MCPs can spend on administrative services, so it may be in their interest to pay for CHW/P services as covered health care services or benefit expenses (sometimes referred to as "medical loss"). Use of administrative funds to pay for non-medical services requires less oversight than treating CHW/Ps as Medicaid health care providers.

Recent examples from California can inform MCP efforts to incorporate CHW/P programs as part of ECM and ILOS benefits. There are many successful examples of CHW/P integration within the WPC pilots and HHP. In the WPC program, nearly all pilot sites used CHWs and/or peers in their program and reported that CHWs and/or peers played a critical role in the success of their intervention.[74]

California proposed the "PATH" (Providing Access and Transforming Health) initiative in the CalAIM Section 1115 Demonstration.[75] This initiative would support the transition from WPC pilots to ECM and ILOS by providing capacity-building funding. Examples of PATH initiative funding include bridge funding for transitioning services from the WPC pilots to ECM and ILOS, and funding to strengthen CBO data-sharing infrastructure.[76] PATH resources would be targeted to support providers and CBOs, such as those that manage CHW/P programs, in communities that have been historically under-resourced.

Through CalAIM, the Department of Health Care Services (DHCS) has required MCPs to provide services in the community to better address the needs of Medi-Cal members. MCPs can do this by partnering with CBOs to provide ECM and ILOS, including those that employ CHW/Ps. While not a requirement from DHCS to the Medi-Cal MCPs, MCPs can consider developing risk-based financial incentive structures within their CBO or provider care management contracts that promote integration of CHW/Ps to improve outcomes and reduce costs related to

unnecessary care. As one example, the Pathways Community HUB model includes outcomes-based payments to providers and CBOs that deliver CHW/P services.[77] This model has been implemented in multiple states across the country. Further detail about Pathways Community HUB can be found in **a spotlight on the model**. MCPs and their provider and CBO partners will need to develop appropriate contract language to ensure clear definitions for their respective roles.

> **RELATED RESOURCE**: To learn more about payment models for incorporating community health worker services, explore the **Community Health Worker Payment Model Guide** (PDF) developed by the Oregon Community Health Workers Association.

Key Implementation Approaches

As MCPs look to incorporate CHW/Ps into program approaches, they will need to first understand their priority populations, identify program goals, and determine needed services. Next, MCPs can assess potential partners that employ CHW/Ps, develop strong partnerships and strategies to incorporate CHW/Ps, and implement financing approaches that grow and sustain this workforce. This section explores three related topics:

1. Program Design and Development

2. Partnerships Between MCPs and CHW/P Programs

3. Program Financial Sustainability

1. Program Design and Development

Assess Needs and Determine Priority Populations

The health needs of a community or a priority population should drive the development and scope of CHW/P programs. For example, MCPs interested in more effectively addressing chronic conditions, health-related social needs, and preventable acute care utilization, or in focusing on the needs of high-risk patients and/or historically under-resourced communities, may look to increase CHW/P engagement with their members. As MCPs develop goals for CHW/P programs, they should carefully balance input from health care leaders and community members to establish a shared set of principles and program goals. Conducting a community health needs assessment or community focus groups can help identify these needs. **Exhibit 6** *(next page)* includes questions for MCPs to consider when exploring whether members may benefit from a program with CHW/Ps.

Exhibit 6. Organizational Assessment Questions

→ Does your organization experience lack of trust and barriers to patient engagement, especially among members who have more complex health care needs?

→ Do your organization's clinical indicators and feedback from frontline staff demonstrate that you may need to improve your approach to meeting the needs of historically underserved populations?

→ Would your members, or a subset of your members, benefit from supports such as

  - Accompaniment to medical appointments
  - Assistance using telehealth technology to access care
  - Access to the appropriate resources to address their social needs
  - Relationships that uncover barriers that may prevent members from realizing health goals
  - Choice of cultural and linguistic preferences when accessing health care

→ Does your organization have difficulties linking to community-based organizations to address the social needs of your members?

→ Have you assessed member health disparities to identify populations that might benefit from a CHW/P program?

→ Does your organization struggle to engage members who have behavioral health needs, are experiencing homelessness, or are "hard to find"?

→ Does your organization underserve specific demographics or geographic areas due to cultural and linguistic barriers?

Next, MCPs can evaluate data indicators across different systems that point to broader social needs, frequent hospital admissions, and behavioral health data. This quantitative and qualitative data will help identify what populations may benefit most from CHW/P services as well as from broader approaches to ECM and ILOS. Each ECM priority population will require specific expertise. **Exhibit 2**, CalAIM ECM Priority Populations, and **Exhibit 3**, CalAIM Optional ILOS, in Section 1 of this guide, detail more information about these programs.

As MCPs examine data to better understand priority populations, they should consider existing provider networks and partnerships with CBOs to fill identified service gaps. ILOS are optional for both the Medi-Cal MCP and the member and must offset less clinically appropriate and more expensive services, including hospitalization or skilled nursing facilities.[78] Some examples of these services include recuperative care (medical respite), housing deposits, and meals/medically tailored meals.[79] The community-connected health workforce, including CHW/Ps, is uniquely qualified in reaching patients who qualify for ECM, building meaningful relationships, and providing ILOS services. As one example, members of this workforce with lived experience of substance use disorders could work in sobering centers.

When determining the needs of priority populations, the care management team, including CHW/Ps, can use ILOS paired with ECM services to meet pressing needs that impact health and help members avoid potential hospitalizations. For example, people who are formerly incarcerated (a priority population for ECM) are 10 times more likely to experience homelessness than the general population.[80] Providing housing connected with services for formerly incarcerated people with complex health care needs can ensure a safe environment and facilitate connections to needed primary and behavioral health care services. ILOS services, including housing transition navigation services, housing deposits, and housing tenancy and sustaining services (among others), can be critical for this population.

> **It's vital for some members to have someone available to check in with them during their transitions of care, to schedule follow-up appointments, to fill medications, and to make sure there is food and transportation set up once they are home.**
>
> *- Francis Julian Montgomery, Health Navigator*

Identify Program Goals and Design Program Scope

As organizations develop and refine CHW/P programs, they will need to identify the concrete goals they wish to achieve. CHW/P programs are designed to achieve different goals and outcomes with distinct populations. For example, programs may aim to address health-related social needs, decrease missed appointments, increase use of preventive care, provide nutrition and physical activity coaching, strengthen community engagement, or improve patient activation among prioritized populations. By identifying program goals and measurable outcomes upfront and then matching program roles and responsibilities to the outcomes, MCPs and their partners can develop a specific description of CHW/P roles and expectations that increases the likelihood of success. More information about these roles can be found in **Section 3: Establishing Roles and Recruiting CHW/Ps**.

MCPs should set CHW/P program goals with an eye toward outcomes, using the following guiding questions:

→ How will your organization measure patient activation or trust?

→ How does your organization document and measure health-related social needs?

→ What screening measures would you use to identify the needs of populations served, and who would administer these?

→ What are the intended outcomes?

→ How would your organization measure success?

→ How would the program demonstrate return on investment?

→ How will CHW/Ps be involved in identifying needed program or system improvements?

Once an MCP clarifies program goals, they can tailor a program to meet these needs by considering who is best positioned to serve the population and in what setting (e.g., community or clinic). Then MCPs can establish the responsibilities of the interdisciplinary team and clearly identify specific items to be addressed by the CHW/P position. When determining the size and scope of a CHW/P program, it is helpful to consider the following:

→ Program goals

→ Size of the priority population and the appropriate CHW/P caseload

→ Health disparities and social care needs of the population

→ Cultural and linguistic needs of the population

→ Capacity of the population to engage with technology and telehealth

→ Geographic service area, including considerations for travel time and available transportation

→ Data infrastructure, including electronic documentation tools and data exchange capabilities[81]

> **Measures of engagement are really important from the perspective of MCPs, and CHW/Ps can really improve the engagement of our members. Because if members are not engaged, they're not going to get the services, and MCPs are never going to be able to demonstrate ROI.**
>
> *- Cynthia Carmona, L.A. Care, about their Health Homes Program*

When considering potential care management partners and CHW/P programs, MCPs should evaluate their own priorities, including quality improvement, member engagement in services, broader population health goals, and cost containment.[82] MCPs can look at how CHW/Ps can help address key goals related to engagement, population health, quality improvement, racial equity, or cost containment. For example, if children in foster care (an ECM priority population) are not attending well visits, CHW/Ps can engage children and families and address barriers to care. Since CHW/Ps often live in the same neighborhood and share similar experiences with members, they are skilled in connecting with parents and families and supporting them to navigate health and social service resources and to complete well visits.

RELATED RESOURCE: The toolkit **Building a Community Health Worker Program: The Key to Better Care, Better Outcomes, & Lower Costs** (PDF) is designed to support administrative and clinical leaders in implementing successful and sustainable CHW programs.

2. Partnerships Between MCPs and Organizations with CHW/P Programs

Designing and implementing a CHW/P program often requires MCPs to collaborate with multiple partners. In seeking ways to support CHW/Ps, MCPs can identify opportunities to leverage the skills and assets of external organizations such as providers, health systems, CBOs, and state and county authorities. Successful partnerships between MCPs and programs with CHW/P services should be mutually beneficial and based on a shared understanding of program goals, priority populations, and appreciation of the value of CHW/Ps and their role within the broad interdisciplinary team. Each stage of the partnership engagement and contracting process should reflect these principles.

For MCPs to meet the goals of CalAIM implementation, they will likely need to expand their contracting to include organizations with experience employing CHWs who extend medical, mental health, and substance use services into the community. There will be a tremendous need to partner with community stakeholders to effectively support care that integrates medical, mental health, and substance use services along with relevant social services.

Assess Partnership Opportunities

One key program design decision is whether MCPs will hire CHW/Ps directly or contract with another organization to employ CHW/Ps. **Exhibit 7** *(next page)* outlines examples of pros and cons for MCPs as they consider whether to hire CHW/Ps directly at the plan level or to contract with another organization to hire, support, and manage this workforce.

Exhibit 7. Pros and Cons for MCPs Hiring CHW/Ps Directly vs. Contracting with Another Organization to Hire

MCP Hires Directly	MCP Contracts Out
PROS	**PROS**
→ MCPs can develop more direct understanding and appreciation for the value of the CHW/P workforce because of working with them directly.	→ MCPs can place CHW/P resources closer to the communities they are serving. This supports the CalAIM ECM requirement that members receive services where they want, including home or the community.
→ MCPs can build internal care management services that include the role of CHW/Ps.	→ MCPs can rely on the strong, existing expertise of partner organizations to hire, support, and supervise CHW/Ps.
→ MCPs can better control staffing ratios by engaging with CHW/Ps across all their members eligible for these services.	→ MCPs can leverage the strengths of community-based providers and organizations with a history of integrating CHW/Ps into their workforce, who may have a better sense of appropriate roles and responsibilities.
→ MCPs can achieve better integration of CHW/Ps within their interdisciplinary teams.	→ Community-based providers and organizations are often trusted members of a community and have strong connections to the community. MCP members can benefit from these existing connections, which can be hard for MCPs to build from scratch.
→ MCPs can incorporate CHW/Ps into overall operational costs, which may be a more sustainable payment model than that for a contracted CBO or provider.	→ Community-based providers and organizations can support MCPs in finding culturally specific programs, organizations, and services.
→ CHW/Ps will experience limited barriers around data sharing.	→ CBOs often have more direct access to other social supports that they can connect members to.
CONS	**CONS**
→ MCPs may not already have the supervisory structure or organizational culture necessary to support a CHW/P in being successful.	→ Low-volume providers may not have adequate panel size to support the organizational capacity building and training required for programs with CHW/P services.
→ MCPs may be limited in reaching populations with distrust of health care systems.	→ Lack of infrastructure at some CBOs impedes contracting, reporting, and payment.
→ MCPs may risk overmedicalizing the CHW/P role, and potentially disconnecting the role from the community they seek to serve.	→ Data-sharing barriers may be more prevalent.

If MCPs decide to partner with an external organization that employs CHW/Ps, they should consider which organizations are best suited as partners, based on the program goals and expertise and community connections of the respective partner organization. For example, MCPs looking to develop a comprehensive approach to engage the ECM priority population of individuals with frequent hospital admissions and significant health-related social needs should look to CBOs and providers that employ CHW/Ps and bring extensive experience engaging this population. These programs have a unique capacity to build trusting relationships and provide access to services that respond to the most pressing needs of members. A community-connected health workforce is not only able to skillfully engage these priority populations but also is familiar with and physically present in these members' specific neighborhoods, enabling them to connect to the right resources and types of care. Similarly, for the ECM priority population of "individuals at risk for institutionalization who are eligible for long-term care services or nursing facility residents who wish to transition to community,"[83] CHW/Ps can play a key role in navigating resources, connecting with family members, and addressing cultural preference to keep people aging in place at home.

Below are suggested steps for MCPs to research and assess in engaging potential CHW/P program partners.

- ☑ **Conduct a crosswalk or assessment of the potential priority populations, needed services, existing partnerships, and allowable financing arrangements**. Assessment activities should focus on CalAIM requirements and MCP strategic priorities. This assessment can allow a plan to determine what providers and partners are already engaged, what additional partners and services are needed, and how to best structure reimbursement and financing for these services.

- ☑ **Research and engage partners based on MCP needs, eligible populations, and required expertise**. Trusted community partners, members, and providers can provide a good start in helping MCPs to identify potential partners. While potential CHW/P program options may depend on MCP coverage area and location, it can be helpful to engage several partner options to consider unique expertise. CBOs that have expertise in specific priority populations (e.g., people with behavioral health needs) may be interested in expanding their workforce models to include CHW/Ps. Other CBOs and providers might already use CHW/Ps or peer support workers. Other MCPs, health systems, training organizations, and affinity groups can provide information on potential CHW/P programs in their region. MCPs can also look to partner organizations and consumer advisory boards to guide partnership ideas and better understand community-specific health needs.

- ☑ **Assess the expertise and outcomes of available CHW/P programs**. MCPs should examine the staffing, program model, population expertise, and specific value that organizations bring to a potential partnership, as well as program outcomes and provider and CBO success in providing connections to resources for specific priority populations. Considerations related to initial CHW/P hiring and ongoing training, staffing, supervision, and broader structure should also inform a potential partnership.

- ☑ **Determine financial controls, billing, and contract capacity**. MCPs should evaluate the financial controls, organizational structure, and compliance records before engaging with a contracted partner. These considerations may lead MCPs to connect with larger CBOs that have a more robust financial foundation or a designated attorney on staff. Some smaller CBOs may be the right service partner for MCP priority populations but may lack the ability to contract directly with an MCP or bill and receive payments.[84] One way to mitigate this challenge is to develop subcontracting arrangements with this potential partner and

have other CBOs act as fiscal agents. MCPs may need to adjust their current contracting approaches to address this need. MCPs can play an important role in supporting partners who are new to integrating CHW/Ps and contracting for services more generally. MCPs can help partners in identifying opportunities for ROI, investing in provider capacity, and supporting needed infrastructure to be successful.

☑ **Determine the size and scale of the contracting arrangement**. As MCPs pursue a potential contractual arrangement with partners to incorporate CHW/Ps, it is helpful to consider the scale of the partnership in relationship to overall program goals. MCPs that are new to incorporating CHW/Ps in contracted services may benefit from starting small with a targeted goal of expansion over time. This approach can help MCPs adjust, learn, and scale depending on eligible populations and care management team interventions. Upfront conversations related to capacity, referrals, standards, and caseload expectations can help clarify a shared understanding among MCP and CHW/P program partners and set expectations for the volume of work that an organization may get from the MCP under the arrangement.

☑ **Determine capacity to incorporate CHW/Ps successfully into MCP and partner workflows**. While determining appropriate partners, it is important to lay the groundwork for approaches to program design and implementation. Common challenges that can be assessed within the contracting stage include workflow changes, workflow arrangements between partners, and key point people at the MCP and partner organizations who can address workflow challenges.

Develop Strong Contractual Partnerships

When MCPs decide to partner with external organizations that employ CHW/Ps, they will need to develop contract agreements that support sustainable and effective programs. Additionally, they will need to establish strong communication around aligned goals and protocols. As MCPs explore how to incorporate CHW/Ps into care delivery programs, MCPs, providers, and CBOs must consider equitable roles for each partner at each stage in partnership development. Examples of equity considerations related to partnership development include: (1) determining an appropriate partner to serve priority populations; (2) involving CHW/P staff and leadership in designing the program; (3) supporting flexibilities in contracting and considerations for CHW/P program infrastructure to attract effective CBO partners; and (4) working with CHW/P programs, CBOs, and other partners to ensure appropriate funding for training, infrastructure, fair compensation, and career pathways.

MCP partnership and contracting arrangements must include specific costs. First, funding for yearly salary, benefits, and supervision costs is essential to bringing CHW/Ps onboard and can be considered within capitated costs. Many MCPs have experience contracting or building their own programs under Health Homes and Whole Person Care pilots. Inland Empire Health Plan, for example, funded annual salaries of CHW/Ps within their own CHW/P program for the Health Homes Program. Second, there are other additional direct and indirect upfront costs to consider in calculating funding requirements, including training and data infrastructure costs. Successful Health Home pilots invested in upfront costs before program launch, recognizing that many programs with CHW/Ps needed to hire and increase their capacity before implementation.

As MCPs develop contracts to engage CHW/Ps, they can consider training needs, data infrastructure, and appropriate caseloads based on the ECM priority populations and ILOS options and how these benefit and financing models can help support the incorporation of CHW/Ps into the care delivery system. Training and data infrastructure costs are critical investments to address in contractual agreements and program design. MCPs should consider the various degrees of readiness of clinics and hospitals in incorporating CHW/Ps into their

multidisciplinary teams. Inland Empire Health Plan found that some smaller practices took a longer period to recognize the full value and services that CHW/Ps can provide patients. One strategy that was important for Inland Empire Health Plan to maximize success was bringing providers and clinic staff into the training process alongside CHW/Ps.

One key element to address in contracts may be caseloads. The appropriate caseloads of patients to CHW/Ps vary widely in the context of the team composition, experience of staff, and needs of the patient population. California stakeholders involved in this project have reported caseload sizes ranging from 10 to 35 patients assigned to community-based CHW/Ps.[85]

It is important for MCPs to work in partnership with provider and CBO partners to ensure that contracting and programmatic agreements eliminate potential barriers for CHW/Ps in doing their work. MCP and CHW/P programs may experience challenges in developing partnerships based on their differences in legal support, data infrastructure, and financial stability. Understanding these potential limitations and providing flexibility can help to support successful partnerships.

RELATED RESOURCE: **Appendix A** of this Resource Guide includes sample contract terms for MCPs to use with partners that employ CHW/Ps. Plans and partners can use this list as a starting point in conversations to discuss pros and cons, track decisions, and outline specifics for the agreement.

In pursuing contracting arrangements, it is important to develop a clear and shared understanding of the roles, responsibilities, and expectations of CHW/Ps. Successful programs with CHW/Ps require a common understanding across all stakeholders — including leadership and clinical partners — of each partner's role on the care team.[86] These concepts are detailed further in **Section 3: Establishing Roles and Recruiting CHW/Ps**. Finally, it is important to establish realistic expectations for program outcomes at multiple points in time, and to understand that new programs will likely require significant time to demonstrate an impact on health and cost outcomes. MCPs and their partners should expect to refine their CHW/P program models over time based on strategic goals and outcomes.

3. Program Financial Sustainability

One way that MCPs can promote financial sustainability is to adopt alternative payment models that support enhanced care delivery and improved outcomes. These payment models would reward quality among partners and address the direct and indirect cost of CHW/P programs. For example, capitated rates with quality incentives can encourage the coordination between physical health, behavioral health, and social needs for patients. CHW/Ps are uniquely able to coordinate these disparate services within their own communities and connect people to appropriate services that address social needs.

Under CalAIM, DHCS is proposing a variety of funding changes and alternative payment models to promote the use and expansion of CHW/Ps.

→ **MCP incentives linked to quality and performance improvements**. These payments could potentially support pilot integration of CHW/Ps for specific priority areas, populations, or quality improvement goals that involve ECM and ILOS.[87] Incentives can be passed down to CHW/P programs and staff who are meeting these quality targets. This funding can support critical investments in the workforce, including ensuring fair pay, sufficient supports and training, and career pathways. Incentive payments have been valuable in other states to support CHW/P training and certification activities.

→ **Shared savings and incentive methodologies that will involve MCP and other stakeholder engagement**. Shared savings models can be a mechanism to reward partner organizations in achieving benchmarks and quality goals. One way that MCPs can use shared savings models is to pay for potential career pathways and opportunities for CHW/P advancement. Global payment models can also support investments in CHW/P training. Since retention of a high-quality workforce is a significant challenge for CHW/P programs, it would be valuable to enable MCPs to use these financing methods to increase retention and build provider capacity.

SPOTLIGHT ON CHW/P MODEL
The Pathways HUB model

The Pathways HUB model is a nationally replicated model that supports a network of CBOs, providers, and other agencies. Community health workers enroll patients into the HUB. MCPs base incentive payments to community health workers on the achievement of specific quality measures. A Pathways HUB model focused on reducing nonclinical barriers to care for high-risk pregnant members and their newborns, as implemented in partnership with a health plan, produced an average 236% return on investment.[88]

A cohort study found an ROI of $2.36 for every dollar invested in the Community HUB model, as implemented in partnership with an Ohio health plan to reduce nonclinical barriers to care for high-risk pregnant members and their newborns through the first year of life.

CHW/P programs likely need resources and financial support for data, technology, and legal infrastructure to meet the requirements of plans around data collection, reporting, and even contract negotiation and implementation. Under the CalAIM incentive funding, DHCS will use $1.5 billion incentive funding available over three years for eligible MCP partner organizations to support capacity building for the implementation of ECM and ILOS, which specifically includes investments in delivery system infrastructure development and workforce capacity.[89] MCPs will submit gap-filling plans, and DHCS will determine how to appropriately allocate the funding across the state within three priority areas:

1. **Infrastructure development**: Core MCP, ECM, and ILOS provider health information technology (HIT) and data exchange infrastructure for the delivery of ECM and ILOS, as well as infrastructure required for Medi-Cal billing.

2. **ECM capacity**: ECM workforce training, technical assistance, workflow development, operational requirements, and oversight capacity.

3. **ILOS uptake and capacity**: ILOS training, technical assistance, workflow development, operational requirements, take-up, and oversight.

Given the infrastructure and capacity variation across counties that have either participated in WPC/HHP and those that have not, counties with less infrastructure will potentially receive a higher proportion of the incentive payment dollars.[90] Additionally, the amount of potential incentive payment funding within a county will also be increased based on the proportion of enrollees who are members of the ECM focus populations to ensure capacity to provide sufficient access to ECM in those counties.

Common Challenges and Ingredients for Success

Developing sustainable CHW/P programs and partnerships between MCPs and organizations with a CHW/P workforce requires an understanding of the different expertise, culture, goals, and challenges of each partner. While these differences can result in common barriers, partners can implement solutions to overcome these challenges with deliberate flexibility and planning.

Funding Differences

Many CHW/P programs — particularly CBOs and behavioral health programs — extensively rely on grant funding or other time-limited funding streams, and often need to braid public and private funding steams to operate successfully. Despite the lack of consistent funding, CHW/Ps play a critical role in addressing complex health care challenges, including population health and the reduction of racial disparities in care. MCPs and CHW/P programs looking to develop successful partnerships and overcome these funding challenges will need to account for these differences in requirements, funding, and capacity within the contracting and implementation process. While grant funding can be helpful in filling gaps, it will not sustain ongoing program operations.

Infrastructure Needs

Data Infrastructure and Technology

Many CBOs and CHW/P programs have different types of care management systems to manage projects as well as client data and lack needed data infrastructure and technology.[91] It is important for MCPs and CHW/P programs pursuing a potential partnership to discuss needs related to data capabilities, data protection, and specific data elements. One potential pathway for CBOs and CHW/P partners to view population data is through read-only access of patient information, which provides data that is useful but has built-in sharing restrictions. **Section 5: Engaging CHW/Ps in Data Collection and Program Outcome Measurement** includes additional considerations specifically on this topic. MCPs should work with partners to determine data capabilities and compatibility with electronic health record (EHR) systems. Incentive dollars could be used to create an interface to EHR systems or upgrade an EHR system to create compatibility, all of which is critical to tracking outcomes, quality reporting, and billing.

MCPs will need to demonstrate flexibility and recalibrate expectations around data capacity.[92] Considerations should also be given to technology investments that can promote care coordination and data exchange, including iPads, tablets, and computers. One best practice among the Health Homes pilots was ensuring effective ramp-up costs for CBOs to make necessary investments in technology and data before program launch.[93] MCPs should work with CBO partners to better understand what investments are needed to effectively incorporate CHW/Ps and support these investments where possible. The flow of data and security protocols should be outlined in contracting, training, and shared workflows and policies.

Legal Infrastructure

MCPs and CBOs have different abilities to review, draft, and execute a contract. CBOs and CHW/P programs may not have an attorney on staff or may have an attorney only on a limited basis. This can pose a challenge as having adequate legal support on both sides can help ensure clarity in roles and expectations and that the terms of agreements are mutually beneficial, which can support longer-term partnerships. One potential solution may be for an external organization to provide pro bono legal support to CBOs for Medicaid contract review.

Section 3: Establishing Roles and Recruiting CHW/Ps

CHW/Ps perform a wide range of responsibilities within provider organizations, managed care plans, and community-based organizations. For programs that integrate CHW/Ps into the workforce, creating clear guidelines for CHW/P roles helps foster an environment where CHW/Ps can thrive. Clearly establishing CHW/P roles can also help people who work with CHW/Ps better understand their contributions.

This section explores how MCPs and their contracted partners can effectively define CHW/P roles, develop position structure and supports, and recruit strong CHW/P candidates who are able to build trusting relationships with the communities they serve.

Background

CHW/Ps serve a range of roles within health care systems and in communities. The Community Health Worker Core Consensus Project (C3 Project) produced a framework to support the development of CHW/P policies and standards.[94] Informed by CHW/P associations and networks across the country, the C3 Project identified 10 core roles for CHW/Ps, such as care coordination, case management, and systems navigation, as well as advocacy for individuals and communities. Across these roles, CHW/Ps' work often focuses on addressing health-related social needs and acting as a bridge between the community and health care and social service systems. CHW/Ps also help foster trusted relationships, which are essential to helping people get the care they need that reflects their preferences.

Each organization typically develops a unique scope of work for their employed CHW/Ps, which includes all the tasks that CHW/Ps perform within a specific program. The mix of tasks varies based on the program goals, needs of patients served, and needs of the employing organization (see examples in **Exhibit 1**).

As MCPs look to design and implement CHW/P programs, they will need to identify the relevant scope of work and competencies for CHW/Ps. *Competencies* are the skills and qualities that a CHW/P can achieve. *Skills* are abilities to do something well based on knowledge, practice, and aptitude, and *qualities* are personal characteristics or traits such as patience and compassion.[95]

While individuals working across different health settings (medical, behavioral, and public health) may share common roles within their organizations, the siloed nature of these settings has led to the use of various titles. Unlicensed professionals who are part of the community-connected health workforce also perform roles such as case management, member engagement, health coaching, health care and housing navigation, employment services, and outreach. These professionals, however, are typically behavioral health and social service providers and often do not use the job title of community health worker or *promotor*.

Key Implementation Approaches

This section describes core activities for MCPs to consider in building or expanding the CHW/P workforce in programs for Medi-Cal enrollees. These activities include defining CHW/P roles, developing CHW/P position structure and supports, and recruiting CHW/Ps.

> **My biggest lesson related to care teams staffing from our Health Homes experience is to really think about greater role definition, especially differentiating between the care coordinator and CHW roles and responsibilities.**
>
> *- Managed care plan representative*

Define CHW/P Roles

CHW/Ps are most effective when they are supported to play a wide range of roles, which allows them to build individual and community capacity for greater health and well-being. MCPs and their partners will need to designate clear roles for CHW/Ps and should communicate the scope of these roles to CHW/P candidates and staff at all levels of the organization. CHW/P roles will depend on the needs of the prioritized population, intended goals of the program, and roles of other interdisciplinary team members. Organizations can identify the competencies and responsibilities required to successfully fulfill the job description. To provide input on potential CHW/P roles, MCPs can engage a diverse array of staff, including organizational leadership, CHW/Ps within their organizations, CHW/Ps who are employed at external organizations, and staff who will work with CHW/Ps (e.g., social workers, nurses, primary care providers, substance use disorder counselors, and others).

Clear identification of CHW/P roles maximizes the unique strengths of this workforce and prevents duplication with other positions. It is very difficult for MCPs to incorporate the CHW/P workforce into programs without a precise understanding of CHW/Ps' roles and skills. Identifying CHW/P roles — and communicating what those roles are across organizational staff and leaders — can prevent CHW/Ps from becoming, as Cheryl Garfield and Shreya Kangovi at the Penn Center for Community Health Workers described, "just another cog in the clinical wheel: scheduling appointments, pinging patients to take their meds, or even performing menial tasks. CHWs can do so much more."[96] Absent a clear definition of the CHW/P role, it may become overmedicalized, which does not allow for the dynamic and person-centered work that CHW/Ps can effectively manage. MCPs and their partners should ensure that CHW/Ps are equal and integral parts of their larger team so they can perform roles at the top of their capacity.

As previously mentioned, the C3 Project identified core CHW roles and competencies that reflect the breadth of work undertaken by CHW/Ps across diverse medical, behavioral, and public health settings (see **Exhibit 8**).[98] The California Healthcare Workforce Alliance reported that the most common roles performed by CHW/Ps in California-based clinics and health centers include (1) supporting patients with gaining access to medical and community services; (2) health screening, promotion, and education; and (3) advocating for patient health needs.[99] MCPs may also employ CHW/Ps in similarly related roles such as care coordinators, but these individuals may spend more time connecting via phone than out in the community given their organizational structure.

MCPs should design requirements around team composition and roles to best address the needs of prioritized populations. CHW/Ps are well-suited to perform various roles to fulfill ECM core requirements, including care coordination, health education and promotion, and patient navigation. MCPs may also employ CHW/Ps to lead community engagement work. For example, health plans struggling with member engagement and integrating member voice into operations can employ CHW/Ps to liaise with member advisors and support their participation in quality improvement projects or communications reviews. These types of efforts, with a CHW/P serving as a hub for member engagement, can supplement other MCP initiatives such as member advisory groups. Since program impact is heavily dependent on the degree to which individuals participate in the program, a CHW/P's trust-building skills are extremely valuable in connecting with and effectively engaging with people who meet program criteria.

One of the most important roles of CHW/Ps is to increase patient confidence in the services or program to support their well-being. Because many people may have experienced repeated traumatic experiences, including discriminatory behavior from service providers, they may be afraid of going to the doctor or seeking out support. CHW/Ps engage with patients in a nonjudgmental and culturally attuned manner that builds trust.

Another potential role for CHW/Ps is helping patients transition upon discharge from medical or psychiatric hospitals. By coordinating with hospital discharge planning, MCPs can determine the roles for CHW/Ps in supporting care transitions. Staffing the CHW/P to work either within the hospital or to connect with patients before they are released can start the relationship building that is important for CHW/Ps' success in patient engagement (see the Savas Health spotlight below). Other potential CHW/P tasks — such as navigating housing, routinely revisiting the care plan, and supporting members in attending follow-up appointments — are often integral activities that are tracked, measured, and reported as key program outcomes. CHW/Ps may also play key roles in crisis response teams that provide community-based alternatives to justice involvement.

Exhibit 8. Core CHW Roles[97]

→ Cultural Mediation Among Individuals, Communities, and Health and Social Service Systems

→ Providing Culturally Appropriate Health Education and Information

→ Care Coordination, Case Management, and System Navigation

→ Providing Coaching and Social Support

→ Advocating for Individuals and Communities

→ Building Individual and Community Capacity

→ Providing Direct Service

→ Implementing Individual and Community Assessments

→ Conducting Outreach

→ Participating in Evaluation and Research

" **At the clinic, we sometimes run into the issue where the new staff believe that *promotoras* are volunteers who pass out flyers or assist in translation. I explain to them that the *promotoras* go through rigorous comprehensive training; we're not there just to give out flyers. The new staff should ask us what is a *promotora*? That way they can see what we need; our folks are capable of taking information down, referring patients or community members to services, advocacy, and much more.**

- Sandra Rodriguez, Tiburcio Vasquez Health Center

SPOTLIGHT ON EXPERT INSIGHTS ON CHW/P ROLES
Savas Health in Riverside County

Deiter Crawford, a CHW at Savas Health (formerly Desert Clinic Pain Institute) in Riverside County for the Medi-Cal Health Homes Program, has worked in both community-based and clinical settings as a CHW for over a decade. He noted that one of the most important roles that CHW/Ps play is that of a liaison. In the community, the CHW/P can listen to residents and advocate for them across the broader health care system, such as working with government agencies to change policies. In the clinical setting, CHW/Ps build rapport with both patients and the medical team by taking the time to listen and help individuals, and then relaying information back to the team.

In his experience, one of the biggest challenges is educating others about what the CHW/P brings to the team. Although CHW/Ps have a responsibility in educating others, it is also helpful when supervisors clearly translate CHW/P roles and expectations for others within the organization who are collaborating with the CHW/P. Mr. Crawford shared that it is important to emphasize lived experience when hiring CHW/Ps. "I grew up living in and going through some of the same situations that our patients may be going through. It's hard to talk to a patient about homelessness or food resources without this firsthand knowledge. The strength of the CHW/P is in our lived experiences."

Develop CHW/P Position Structure and Supports

Once CHW/P roles have been established, MCPs can design the structure of the role, which includes establishing supervisory models, determining case workloads, and developing supports for interdisciplinary team integration.

Establish CHW/P Supervisory Models

Developing a supervisory framework that leverages the strengths of CHW/Ps is critically important to the success of CHW/P programs. Poor supervision of CHW/Ps can result in low morale and poor productivity; strategies for effective supervision include coaching and peer-to-peer support.[100] Effective CHW/P supervisors can help champion and integrate CHW/Ps within interdisciplinary teams, which can lead to improved productivity and workflow across the whole team.[101]

CHW/P supervisors may or may not have clinical training, with background as nurse care coordinators, clinic managers, or program managers with Master of Public Health or Master of Social Work degrees. Additionally, some organizations employ senior CHW/Ps to provide mentorship and support or direct supervision to CHW/Ps. Factors affecting the ratio of CHW/Ps to supervisors will include the number of CHW/Ps employed, activities implemented by CHW/Ps, and roles and responsibilities of existing staff. The American Hospital Association, for example, recommends a CHW/P-to-supervisor ratio of 6:1.[102] The IMPaCT Model, developed at the Penn Center for CHWs in Philadelphia, creates teams of six CHWs and two senior CHWs who are managed by one full-time manager (typically a social worker) and one half-time coordinator.[103] Organizations seeking to establish models of CHW/P supervision may look to SAMHSA recommendations for peer support supervisors, which define the educative, administrative, and supportive roles of this position.[104]

"Supportive supervision," an approach for CHW/P supervision, focuses on observations, problem solving, collaborative reviews, and training and education.[105] Some characteristics of supportive supervision for CHW/Ps include technical and psychosocial supports and a trauma-informed approach, which recognizes that CHW/Ps may experience many of the same challenges they help patients to address.[106] Supervisors should provide consistent monitoring and coaching, prioritize CHW/P safety, and lead individual CHW/P performance assessment. As CHW/Ps frequently spend much of their time in the field, supervisors will need to be comfortable managing employees who are not based inside the four walls of the workplace.

Establish Appropriate CHW/P Caseloads

When assessing the number of members assigned to each CHW/P, employers should consider the complexity of member health and social needs, the number of program focus areas, available tools to assist CHW/Ps in their work, documentation requirements, and the distance and time needed for travel between clients.[107] Many programs prioritize a low CHW/P-to-member ratio, which creates more flexibility for meaningful member engagement and education and reduces burnout. These ratios may also vary within a program, especially if certain CHW/Ps focus on high-intensity areas that require additional time, such as securing housing. As one example, Los Angeles County Department of Health Services employs over 200 CHWs, who each have a caseload of between 10 to 35 individuals. Medi-Cal members who are prioritized for this program include people with high levels of risk related to homelessness, re-entry status for formerly incarcerated individuals, and physical and behavioral health conditions.

Develop Supports for Interdisciplinary Team Integration

CHW/Ps generally sit outside the traditional health care delivery system and will need support integrating into a multidisciplinary team. It is important to have both leadership involvement and clinical/provider support at the MCP, CBO, and provider level for integration of CHW/Ps into health care delivery systems. MCPs will need to closely engage staff at all levels to integrate CHW/Ps into their workforce structure, requiring a focus on capacity building and careful planning. First, it is critical to develop a communication plan or strategy during initial program planning to keep internal and external stakeholders informed regarding program goals, build organizational buy-in, and communicate the value and lessons from the CHW/P program.

MCPs and their partners can pursue strategies for successful integration. MCPs and CBOs in successful Health Homes pilots co-designed program goals and met regularly to troubleshoot challenges and address barriers.[108] Leaders from the Riverside County Public Health (RCPH) health system emphasized the importance of continual communication with all levels of staff about the CHW program and the benefits of CHWs in their practices.[109] Additionally, RCPH had to address challenges in program launch such as space requirements for additional staff, information technology issues, and purchasing delays. It is important to have regular and open lines of communication, anticipate potential challenges, and develop workflows and systems to address these challenges. Additional guidance on effective organizational training to facilitate integration of CHW/Ps is described further in **Section 4** of this guide.

Successful integration of CHW/Ps also requires the leadership and buy-in of executives and clinical staff, as well as the capacity to measure success and make changes by continuously tracking and measuring operational effectiveness and outcomes. One effective strategy may be to identify how program outcomes meet the specific priorities of MCP leadership. In one example from a California MCP participating in the Health Homes Program, leadership were focused on increasing Health Homes enrollment and thus increasing revenue. Leaders from the CHW/P program were able to demonstrate CHW/P contributions toward increased rates of program enrollment.

> **❝ Health care is usually this vertical hierarchy — you've got the doctors, nurses, and all the additional staff. We throw it on its side and make it horizontal. The nurse is equal to the care coordinator is equal to the community health worker is equal to the behavioral health care manager…they all have a voice and are expected to speak and advocate and share their expertise.**
>
> *- Catherine Knox, Inland Empire Health Plan*

CHW/P programs should develop clear protocols and job aids to support CHW/Ps to be effective in their work. Examples include:[110]

→ A needs assessment

→ Individual care plans

→ Risk screening protocols including for health-related social needs

→ Tracking tools to document intervention and support patient monitoring

→ Interdisciplinary team meetings

→ Data-collection tools to track outcomes

→ Electronic health record authorization

Tools such as assessments, checklists, flowcharts, member educational materials, and interview and data-collection forms can help CHW/Ps to organize their work and maximize their productivity.[111] Examples include templates for medication reviews, plans of care, activity logs, personal emergency visits, and supervisory visits. Programs will also need to clearly identify protocols and pathways for CHW/Ps to understand when an issue should be escalated to other team members.

> **Since I know about substance abuse and homelessness, the leadership put their egos to the side and say things to me like, 'Okay, you know this stuff. I am a doctor, but I don't know that,' or 'I am an OB-GYN, but I don't know much about substance abuse.' That's been really helpful with my team being open-minded and taking suggestions from me as a CHW.**

- Deiter Crawford, Community Health Worker

Establish Strategies to Recruit and Retain CHW/Ps

MCPs and their partners that have not previously employed CHW/Ps will often need to use new strategies for employee recruitment and selection when hiring for these positions. Identifying and hiring the right candidates who can build trusted relationships with members is critically important for the success of this position.

Create Job Descriptions that Align with CHW/P Roles

MCPs looking to hire CHW/Ps may benefit from tailored recruiting strategies to reach talented individuals. Employers should develop job descriptions that clearly define (1) CHW/P roles and specific tasks, both independent and within the team and employer organization; and (2) CHW/P competencies and qualifications, including interpersonal traits, technical skills, language requirements, and educational requirements if applicable. Successful CHW/Ps often possess personal qualities such as empathy, resourcefulness, creativity, and familiarity with the communities served. [112] Job descriptions should emphasize desired candidate attributes to help reach a broad base of candidates who would excel in the position.

Employers should ensure that the skills required for a CHW/P position align with the experience and educational background qualifications listed in the description. Many CHW/P job descriptions cite the importance of lived experience. Employers should define the specific nature of lived experience that is most relevant for the given program and position and state this within the qualifications. Including this information, however, may be difficult from a legal or human resources perspective. Of note, 'lived experience' should not be equated with 'inexperience.' CHW/Ps have valuable knowledge and skills gained through life experience, which should be reflected in an appropriate salary scale. MCP employers should consider that this salary scale and pay rate is a commensurate with others in the health care workforce to demonstrate the value of CHW/Ps.

Exhibit 9. Core CHW Skills[113]

→ Communication
→ Interpersonal and relationship building
→ Service coordination and navigation
→ Capacity building
→ Advocacy
→ Education and facilitation
→ Individual and community assessment
→ Outreach
→ Professional conduct
→ Evaluation and research
→ Knowledge base

In addition to describing core CHW/P roles, the C3 Project identified a set of 11 core CHW/P skills along with best practices for assessing these skills during recruitment and in ongoing training (see **Exhibit 9**).[114] These skills should guide organizational efforts related to role definition, recruitment, and training. The skills and qualities of CHW/Ps enable them to successfully achieve their roles and elevates the impact of the entire interdisciplinary team.

RELATED RESOURCE: There are a range of **sample job descriptions** for CHW/P roles available in the Resources and Tools section of this guide.

Use Effective Recruiting Strategies

Both traditional and nontraditional recruiting tools may support health plans and their partners in recruiting high-quality candidates. Although employer websites may be valuable, other methods to reach candidates who are trusted in their communities may include the following:

→ Conducting outreach to CHW associations

→ Posting flyers at community locations such as CBOs, recreational centers, houses of worship, high schools and community colleges, and local businesses

→ Conducting outreach to health clinics, community organizations, and community leaders

→ Hosting large group recruiting sessions in community settings

→ Advertising in radio, community, and ethnic media, and at social and sporting events

As CHW/P work depends on effective one-on-one interactions, the interview process should be designed to identify candidates with strong interpersonal traits. Supervisors can use direct questions, as well as role-playing and problem-solving scenarios, that can provide a more nuanced understanding of applicants' qualities. Clear assessment criteria to support the hiring process will help leadership make informed choices about hiring and identify potential training needs for newly hired CHW/Ps. Organizations might consider including CHW/Ps on hiring panels to help identify strong candidates.

Establish Competitive Salaries

Effective CHW/P programs also develop a salary scale that considers market rates, level of education, lived experience, and skills and have opportunities for full-time positions with salary increases over time. Employees in other positions, such as care coordinators, may be strong candidates for the CHW/P position, and salary flexibility may be a cost-effective strategy to recruit employees with the right skills and experience.

The low rate of pay and short-term funding streams are significant challenges for the recruitment and retention of the CHW/P workforce. In a California stakeholder forum, CHW/Ps noted that improved salaries and compensation, sufficient support through strong supervision, and clear pathways for growth are key needs.[115] MCPs can work with providers, CBOs, and CHW/Ps to ensure that salaries and benefits are aligned with living wages and comparable to local standards (e.g., consider salaries within public health departments and clinics that are doing comparable work). As one example, Inland Empire Health Plan has had success with strong staff retention of community health workers that work in clinic and community settings. A key strategy for retaining this workforce has been ensuring competitive salaries and continuous funding.

Common Challenges and Ingredients for Success

MCPs and their partners often experience challenges related to defining CHW/P roles and recruiting CHW/Ps. Some of these challenges are described below, along with potential considerations for how organizations can navigate these barriers.

Creating Flexibility within a Structured Framework

When defining CHW/P roles, employers will need to balance more prescribed responsibilities versus creating the flexibility for CHW/Ps to do what they know best. Developing trust with members, as forged by shared life experience, is critical to CHW/Ps' success. Narrowly defining their roles and activities to focus on more clinical tasks "dilutes the very strength for which they were hired."[116] For example, instead of solely addressing the members' presenting symptom or condition, CHW/Ps can identify and address members' health-related social needs to help curb chronic physical and behavioral health issues.

Considering Human Resources and Policy Constraints

Employers must balance developing job qualifications that do not create barriers for talented potential CHW/Ps along with internal human resources considerations. For example, certain minimum qualifications related to employment history or language, technical, or other skills may restrict individuals from applying who would bring valuable skills in connecting with members and the community. Additionally, some people with lived experience may be well positioned to work with prioritized groups (such as those fluent in certain languages, from particular geographic areas, or with specific disease conditions) in the community. As MCPs prioritize hiring CHW/Ps with lived experience, human resource staff need to recognize that many Medi-Cal members and their communities are

impacted by mass incarceration — and a criminal record should not be a barrier to employment. Similarly, the hiring process in local county government organizations may require steps that preclude hiring people otherwise well-suited for a CHW/P job. One solution some health care entities have used is to contract with CBOs for CHW/P programs to avoid the constraints that large health care systems have related to these challenges. MCPs will need to champion policy changes and provide guidance to decrease the barriers to hiring individuals to perform the role of a CHW/P.

Integrating a New Role into Interdisciplinary Teams

Challenges exist around incorporating a new team member role into an existing interdisciplinary team with already defined roles and responsibilities. The task of reexamining and redistributing job duties can be arduous and sometimes contentious given "turf issues" related to interdisciplinary team roles. Further, any new program — such as CalAIM's ECM program — will likely not provide detailed requirements on key infrastructure such as roles, scope of work, and supervision requirements, nor provide a standardized mechanism to evaluate program effectiveness and return on investment of CHW/Ps. MCPs should engage all program partners, including CHW/Ps, to carefully define program requirements and roles.

MCPs should thoughtfully design any requirements around team composition and roles to best address the needs of prioritized populations. For example, a team intended to focus on youth in foster care and their families would likely benefit from a different composition and duties than a team focusing on frail older adults.

> **" I feel as though CHWs do not get the credit that we deserve. We talk to doctors and nurses and connect to the plans and housing authorities all day, all while also communicating with our patients. The medical field may not realize how much we do to assist individuals.**
>
> *- California CHW/P*

SPOTLIGHT ON HEALTH HOMES PROGRAM AND WHOLE PERSON CARE

Inland Empire Health Plan and Los Angeles Department of Health Services

Inland Empire Health Plan (IEHP) hires CHWs both directly and through contracts with providers. The health plan understands that members who were recently hospitalized are often more motivated to engage in care and that CHWs can play a critical role in care transitions. Consequently, IEHP CHWs coordinate directly with the assigned care team to visit members during their hospitalization and post-discharge and to enroll new eligible members who receive a visit in the hospital. IEHP's health homes-eligible members who receive a CHW visit in the hospital have a 38%engagement rate, which is significantly higher than the plan's traditional telephonic outreach.[117] By defining the CHW role to support care transitions, IEHP can increase connections with members.

Los Angeles Department of Health Services (LADHS) incorporates CHWs into its Whole Person Care program, which serves eligible Medi-Cal member 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 this 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 with hospital case management for transitions and community organizations for referrals. LADHS employs more than 200 CHWs who each serve anywhere from 10 to 35 patients. LADHS worked with human resources to identify ideal CHW candidates through a process that includes (1) traditional interviews to identify a candidate's specific motivation for the program and position, awareness of the challenges faced by the priority populations, and experiences working with community members from the priority population; and (2) discussion of case scenarios to help LADHS learn about an interviewee's ability to build trust, receive and respond to feedback, and communicate with empathy.

Section 4: Training and Supporting CHW/Ps

Training for CHW/Ps, along with training for supervisors, colleagues, and organizational leaders that work with CHW/Ps, will help advance the goals of their respective organizations and programs. CHW/Ps often work within interdisciplinary teams that include different positions and departments. Effective training for CHW/Ps and their colleagues ensures that the entire interdisciplinary team — including but not limited to CHW/Ps — can perform to the top of their capabilities. MCPs should collaborate with CHW/Ps and community-based entities that will provide services to their members to design their training approach.

This section explores how MCPs and their partners can develop effective training approaches, including training for CHW/Ps, their supervisors, their colleagues, and other key staff in their organizations.

Background

CHW/Ps come to their jobs with variation in their lived experiences, formal and informal training, and areas of passion. Training can support CHW/Ps in preparing for their roles and can help organizational staff integrate CHW/Ps into their workflows, which will set up CHW/Ps for success. Achieving the goals that organizations set for their programs — such as improved health outcomes, coordination of high-quality services, delivery of person-centered care, and advancement of health equity — requires a robust training approach for CHW/Ps and the staff who work with them. Effective CHW/P training will prepare individuals for both a specific position and potential future work across organizations and within diverse settings.

Each employing organization will need to establish a training approach that enhances the capacity of CHW/P programs to meet the identified needs of the community and provides the tools for these programs to thrive in the context of the overall organization. Historically, most CHW/Ps received on-the-job training through mentorship by other CHW/Ps.[118] While this hands-on mentorship continues to be a critical part of the CHW/P training process, the scope of training programs has been significantly expanded to prepare this workforce for a range of different responsibilities within initiatives with diverse and complex goals.

CHW/P training programs vary in length, scope and focus of content, and pedagogy.[119] Training approaches for CHW/Ps are often designed and implemented by different entities: (1) academic institutions, such as community colleges; (2) employers of CHW/Ps such as MCPs as well as public health, medical, and behavioral health organizations; (3) CBOs that support CHW/Ps; and (4) states and counties that develop CHW/P training programs, which can be tied to certification requirements. Some training programs run by academic or other organizations offer certificate programs or provide academic credit and career advancement opportunities through formal education. These programs are usually completed within two semesters and involve a field placement. While some individuals may choose to enter training programs at educational institutions before securing an offer of employment, most CHW/Ps first participate in training through their employer.

CHW/P employers such as MCPs and their contracted partners sometimes use external entities like academic or community-based entities for initial training, and then conduct custom and ongoing training through their own organization. Employing organizations generally conduct organizational onboarding training and develop targeted continuing education opportunities, including on-the-job training, to improve certain skills and capacities and enhance CHW/P standards of practice. MCPs looking to support the CHW/P workforce may pursue regional collaborations with either other plans within a region or with a group of contracted partner organizations that employ CHW/Ps to develop shared training requirements and infrastructure. These collaborations can create efficiencies for employing organizations as well as for CHW/Ps who would be starting in a new position.

RELATED RESOURCES: **Appendix B** provides an overview of CHW/P training programs in California and select national programs. The **Resources and Tools** section also includes information about curricula and standards from other states that may be useful for California stakeholders, as well as other training resources that may be useful to organizations employing and training CHW/Ps.

Health Equity and CHW/P Training

Through their own life experiences, CHW/Ps bring an important cultural context to their work that enables them to build trusting relationships with members. Since CHW/Ps are often from communities that are most likely to experience inequities, it is important that training programs are designed to ensure accessibility and reduce potential cost, language, and geographic barriers as possible. Additionally, CHW/Ps and community-based partners should collaborate in developing a culturally responsive curriculum and leading trainings to ensure that the training reflects the needs of CHW/Ps and the context of the communities that they serve. Finally, training programs should also prepare organizational leaders as well as supervisors and colleagues of CHW/Ps to support this diverse workforce.

RELATED RESOURCE: **Preparing Community Health Workers for Their Role as Agents of Social Change: Experience of the Community Capacitation Center** (PDF) shares lessons on how to prepare CHW/Ps for their role in advancing health equity.

❝ **CHW/Ps with lived experience come with a passion that rarely can be matched, along with an understanding that only lived experience can bring to the table. This understanding builds relationships that keep people in care, while networking and building social capital and resources help address the social determinants of our community.**

- Joe Calderon, Senior Community Health Worker

Certification of CHW/P Training Programs

While many states require CHW/Ps to become certified through an approved training program and some develop state certification training programs, California has not established a single standardized curriculum for training CHW/Ps or their employers. California does not certify any training programs, run state training programs, require certification, or provide licensure of CHW/Ps. Notably, the California Future of Health Workforce Commission recommended creating a statewide certification process for CHW/P training, and expanding and standardizing training programs to support the growth of this workforce, as the lack of consistency in training programs has limited workforce growth in the state.[120] As part of these recommendations, the Commission proposed a funding expansion to support CHW/P training participation, such as through scholarships or loan repayment, and is developing best practices for employer-based training. If California decides to require participation in a certified training program in the future, employers of CHW/Ps may benefit from thorough documentation of their training curricula and staff participating in training.

Key Implementation Approaches

Training Overview for CHW/Ps

Training programs for CHW/Ps range from a few hours of training to certificate programs at community colleges or other academic institutions that last one year or more. CHW/P training should ideally include multiple levels of training that are distinct but interrelated (see **Levels of CHW/P Training**), including:

1. Training for core CHW/P competencies
2. Training for specialized programs, including specific populations
3. Training on organizational practices and workflows
4. Ongoing professional development

As California MCPs develop or refine programs to include CHW/Ps as part of CalAIM initiatives, they can pursue multiple pathways for training CHW/Ps. Broadly, these options include direct development and administration of training, an agreement with an external training organization to develop and administer training, or a hybrid approach that divides training responsibilities.

Regardless of what organization is administering the training, MCPs should help develop the training approach that will support a successful program and workforce. Standard components for training include (1) design training curricula, with the active engagement of CHW/Ps, based on educational principles and methodologies; (2) establish learning objectives and topics across each level of training; and (3) design training structure to support participants' access to training, such as duration, modality, frequency, languages offered, and costs.

> ❝ **A key question is: *Why train CHWs/Ps? What is the value? Why make the investment?* It's not just about health equity. There are expectations and drivers in our organizational systems that require that *both* CHWs and supervisors/organizations get trained.**
>
> *- Lily Lee, Loma Linda University San Manuel Gateway College*

Principles and Methodologies

CHW/Ps bring a deep knowledge of the community to their position that is based on shared lived experience, and training principles and methodologies should amplify this knowledge. Popular education methodology, which builds on the experiential knowledge of CHW/Ps and has rich historical roots, is considered a best practice in CHW/P training.[121] Elements of popular education include (1) drawing out and centering the existing knowledge of participants; (2) connecting participants' personal experiences with their broader social context; and (3) supporting participants in collectively taking action.[122] The methods of these trainings emphasize participation of CHW/Ps as active leaders in their own learning process and support participants in building knowledge together through active learning methods such as experience sharing, role playing, and collective brainstorming and problem solving.

Participatory training methods that draw on popular education can support CHW/Ps in deepening their understanding of how their individual lived experiences connect with their roles in serving communities. The California organization *Visión y Compromiso* characterizes effective *promotor* training programs as those with curricula that emphasize self-discovery and empowerment, building off popular education methodology and core competencies. A *promotor* quoted in a *Visión y Compromiso* report noted: "I brought my own roots, the training added to what I already had and helped me identify as a *promotor*."[123] Notably, popular education-based CHW/P training programs have been shown to increase participant empowerment, self-esteem, leadership, and community participation.[124] This type of training approach can be especially valuable for preparing CHW/Ps to advocate for themselves and their communities, which aligns with the broader goal of advancing health equity. In addition, this approach helps enhance the skills that CHW/Ps contribute as opposed to erasing these skills in an overmedicalized model.

> ❝ **The training has to be reflective of the CHW's experience and what they need and the community they want to help.**
>
> *- California CHW/P*

Engagement of CHW/Ps as Co-Designers and Trainers

CHW/Ps should be fully engaged at every step of training design, implementation, and evaluation. When CHW/Ps serve in leadership roles in the design of training programs, they can identify learning objectives and training topics that are the most relevant to other CHW/Ps. CHW/Ps can also use popular education methods to design these sessions. Effective training programs often engage experienced CHW/Ps as facilitators of training modules, as CHW/P facilitators can be strong teachers for incoming CHW/Ps. Through this practice, organizations can create professional development opportunities for current CHW/Ps.

> ❝ **I would hire a CHW/P who is able to communicate with the patients, community, or people they are helping. They should have good communication skills, such as motivational interviewing, active listening skills, and not jumping into 'fixing people.'**
>
> *- Nubia Armenta, Community Health Specialist*

SPOTLIGHT ON CHW/P ENGAGEMENT IN TRAINING

El Sol Neighborhood Educational Center in San Bernardino

The El Sol CHW/P Training Center in the Inland Empire region engages CHW/Ps in the development of training materials, delivery, practice, and evaluation, to ensure relevance during the transformative learning process. The center has led trainings for many CHW/Ps and has developed over 200 training modules. These modules are mapped against CHW/P core and subcore competencies, including specialized skills.

CHW/P feedback from evaluations is incorporated into future curriculum development, and CHW/P facilitators review past trainings and provide updates based on current needs, emerging best practices, or new evidence.

Levels of CHW/P Training

1. Training for Core CHW/P Competencies

The first level of training for CHW/Ps focuses on understanding CHW/P positions, developing and strengthening core CHW/P competencies, and preparing people to lead in their communities. As discussed earlier in this guide, the Community Health Worker Core Consensus Project (C3 Project) developed a single set of CHW/P roles and competencies.[125] While CHW/P positions can vary widely, the core skills listed in **Exhibit 9** reflect common skills across many CHW/P positions. The C3 Project developed this list, which is widely accepted across the field. Many individuals in the community-connected health workforce across different settings, including within medical, public health, behavioral health, and CBO employers, share these core competencies.

Learning objectives for this first level of training should be mapped to core competencies, while also focusing on preparing training participants to perform at the top of their practice rather than presuming a very limited scope. For example, CHW/P roles can include coaching, home visiting, case management, and group facilitation. Core competency training can address related skills to support CHW/Ps in working at their full scope of practice across settings. Employers should identify the areas of knowledge, skills, and abilities that will support CHW/Ps' effectiveness within their roles and ensure that trainings address each of these areas.

Some of the key topics common to CHW/P training programs include the following:

→ The history of CHW/Ps
→ Social determinants of health and the factors that affect how people engage in health care
→ Core CHW/P roles and competencies, such as capacity building, outreach, advocacy, assessment, and service coordination
→ Core skills for a community-connected health workforce such as communication, organization, and data collection and documentation
→ Key principles to support CHW/Ps in their work with communities, such as cultural humility, person-centered care, identification of implicit bias, healthy boundaries, self-care, trauma-informed practice, personal safety, and de-escalation tools for conflict resolution
→ Practical applications of CHW/P work and navigation of common challenges, such as through case studies, to identify opportunities to address gaps in care and barriers to health

When asked what training topics are most essential, many California CHW/Ps and program leaders who work closely with CHW/Ps named motivational interviewing, which supports people in making behavior changes through empathetic communication. Motivational interviewing techniques can help CHW/Ps assess member readiness to make changes, and CHW/Ps are well positioned to draw on their shared life experience to understand the challenges faced by members and to support members' navigation of services and adoption of healthier behaviors. Training should also address other CHW/P skills such as treatment planning, learning research techniques, understanding specific chronic conditions, using technology and social media platforms, mapping community-based resources, advocating for their clients, and using member data to help impact better outcomes.

CHW/Ps may participate in this core competency training in different ways, and this training varies widely in duration and scope. CHW/P training programs offered through an academic institution are often longer and broader in scope, while trainings offered through an employer tend to focus on competencies more relevant to the scope of work at the employing organization. One recommended practice is for incoming CHW/Ps to complete assessments to identify their knowledge, skills, and confidence across key competencies, and self-identify areas for needed training and ongoing professional development.

> **" CHW/Ps need to be able to communicate — to be compassionate, attentive to detail, and able to identify resources that the client needs based on subtle cues that the client shares.**
>
> *- Adriana Chung, Community Engagement Manager*

2. Training for Specialized Programs

The next level of training concentrates on specific program focus areas, with learning objectives and topics tailored to the skills required for distinct program and population needs. MCPs will likely emphasize training modules focused on foundational knowledge about Medi-Cal and CalAIM, as well as on knowledge areas and required skills to provide services under the ECM and ILOS benefits.

For CalAIM, trainings should focus on the needs of populations prioritized for ECM or on specific requirements of MCPs related to ECM and ILOS. As an example of a population-focused training, CHW/Ps working with youth in foster care and their families will benefit from training on strategies to support these populations and relevant local resources. The training can emphasize specific requirements for connecting with hard-to-reach members and conducting in-person outreach, contributing to and supporting a person-centered care plan, and working with members to identify and build on their resiliencies and potential family or community supports. Training should focus on CHW/P roles and responsibilities as they relate to the six core services components for ECM:

→ Comprehensive assessment and care management
→ Enhanced coordination of care
→ Health promotion
→ Comprehensive transitional care
→ Member and family supports
→ Coordination of and referral to community and social support services

RELATED RESOURCES: Required elements for CalAIM ECM and ILOS can be found in the **Model of Care Template** (PDF). **Appendix C**, CHW/Ps in CalAIM's Enhanced Care Management and In Lieu of Services, is a model of care crosswalk that maps core service components to CHW/P roles.

CHW/Ps have had a growing presence as part of behavioral health teams and in working across primary care and specialty behavioral health settings with individuals with behavioral health needs.[126] Specialized curricula to prepare CHW/Ps to support integrated physical–behavioral health care in primary care settings may include topics such as an overview of behavioral health conditions, use of screening tools, skills for collaborating with behavioral health clinicians, training in activity planning (an evidence-based treatment of depression), and strategies to combat stigma.[127] For CHW/Ps working in behavioral health settings, training in topics related to chronic physical health conditions would support their participation in integrated delivery of care. The position of a peer support worker is related to a CHW/P, and both are part of a community-connected health workforce who shares lived experience with members. Peer providers provide direct support to individuals undertaking mental health or substance use disorder recovery, bringing their personal experience of recovery to their work with members.[128] California enacted legislation in 2020 to establish statewide certification for peer support workers, and DHCS will create the curriculum and core competencies for certification by July 2022.[129] As this peer training is developed, some elements of those curricula may be relevant for CHW/Ps and could inform state efforts to create a pathway toward state certification of CHW/P training programs.

As CalAIM will likely lead to an increase in MCP contracts with a wider range of providers — including but not limited to CBOs, behavioral health providers, and safety-net medical providers — it is important to note that people who are part of the community-connected health workforce and are employed by these newly contracted organizations may or may not identify as CHW/Ps. These individuals have received varying levels of training and preparation. As these employers move into CalAIM contracting, MCPs will likely expect the providers to offer more structured training.

> " **CHW/Ps should already know or be eager to learn about community resources and have experience networking with other agencies. You have to be someone who can adapt to the populations you work with — comfortable doing the handholding and coaching.**
>
> *- Elma Prieto, Community Health Worker*

3. Training on Organizational Processes and Workflows

The third level of training focuses on supporting CHW/Ps to be effective within the policies and protocols of their employing organization and any contracted partners. At this level, CHW/Ps can receive training on topics such as

→ The roles of the interdisciplinary team within their organizations, including communications protocols to share information about members

→ A broad overview of managed care operations and policies, including an overview of how members receive care and how this care is paid for

→ The landscape for referrals for needed services

→ Services provided by the organization and its partners, particularly MCP programs and available member supports

→ Workflows between individuals

→ Technologies used, and organizational data-collection requirements

→ Organizational safety protocols and reporting dangerous behaviors, especially as they relate to home visits

→ Relevant policies and protocols, including HIPAA compliance

Employing organizations will often directly provide this training since it is specific to the role and setting. Training can be supported through on-the-job mentorship by existing CHW/Ps to support new CHW/Ps in understanding best practices through practical experience. For example, building relationships with community organizations is a skill best acquired by observing how other CHW/Ps establish these connections to support the diversity of client needs that can arise. While training on organizational processes will usually be conducted at the beginning of employment, refresher training will be necessary when organizational practices are adjusted. When CHW/Ps are employed by a community-based entity that contracts with a MCP, it is important for the MCP and CBO to closely collaborate to ensure that CHW/Ps are fully trained on all necessary managed care requirements and language. MCPs will need to thoughtfully support their partners, as these components may be unfamiliar for community-based entities.

Case Examples in CHW/P Training Approaches

→ **The Transitions Clinic Network (TCN)** is a capacity-building organization that trains health systems and CHWs with a history of incarceration to care for chronically ill individuals recently released from incarceration. Health systems that have implemented the TCN model of care employ CHWs who assist with care management, health system and social service navigation, and chronic disease self-management support and serve as cultural interpreters between patients and other members of their care teams. Health systems implementing the TCN model hire CHW/Ps who already have received some amount of core competency training or who have significant related work or volunteer experience, and then TCN provides additional training specific to the program. Because core competency training can vary widely, TCN created a training self-assessment based on the C3 core competencies for CHW/Ps to assess their confidence around key skills, which helps to avoid duplication of training for CHW/Ps who switch positions. TCN's senior CHWs lead a 12-week online curriculum for CHW/Ps, plus ongoing biweekly professional development sessions. TCN uses a tool to assess CHW/P integration over the course of a year.

→ **Telecare Corporation** is a behavioral health organization that hires and prepares unlicensed professionals to participate in multidisciplinary programs that support people living with behavioral health challenges, including persistent mental illness and substance use. The organization employs more than 1,500 unlicensed professionals in California who work across 49 roles, contributing to member engagement, care planning and coordination, housing stabilization, and health care navigation. Telecare prepares new employees through training, shadowing, and supervision. New employees in its community-based programs engage in about 70 hours of training (online, with supplemental in-person skills practice), staggered over the first year of employment. This training includes 11 hours on chronic disease, two hours on co-occurring conditions and recovery, and five hours on stage-matched interventions and motivational interviewing strategies. In addition, the organization provides opportunities for additional training and advancement, including a program leadership position that does not require licensure.

→ **PATH (People Assisting the Homeless)** is a leading homeless services provider in California that employs a robust, unlicensed professional workforce to serve 26,000 individuals annually. Staff roles span the organization's breadth of person-centered services such as street outreach, case management, housing navigation, and employment services. The organization hires individuals with varying years of experience, as needed for each role, and has created core competency trainings to ensure a standard of care for their served population. Upon hire and annually throughout their employment, all staff receive training in subjects that help build or reinforce a base of knowledge in homelessness, systems, evidence-based practices programs, and more (e.g., Homelessness 101, Homeless Management Information System training, and Mental Health First Aid). Training delivery includes in-person and virtual instruction by other staff members. The program also uses Relias, a training platform that manages curricula for PATH's licensed and unlicensed staff, and is managed by a designated training specialist.

→ **Homeless Health Care Los Angeles (HHCLA)** employs an array of unlicensed professionals, including those with lived experience of homelessness, substance use, sex work, and incarceration. HHCLA's training and education department has also contracted with the county of Los Angeles and local CBOs to provide training and technical assistance for community health workers and other unlicensed professionals within the homeless services sector. HHCLA offers its internal workforce, as well as homeless services staff throughout LA County, a three-tiered curriculum designed to assist staff at various skill levels: (1) care coordination and systems navigation (for entry-level and newly hired staff); (2) applied care coordination and systems navigation (for mid-level direct service staff); and (3) supervisory training for homeless services providers (for supervisory staff). Trainings at each successive staffing level sequentially build the skills most appropriate for tending to the unique needs of a diverse homeless community. Each curriculum constitutes 35 hours of training offered over the course of five days and covers a comprehensive set of topics including landscapes of homelessness, evidence-based practices, cultural equity, and core functions of case management. Staff promoted to the supervisory level receive additional training on leading people, managing work, developing self and others, and effective practices for individual and group supervision.

4. Continuing Education and Professional Development

Finally, employers must provide ongoing professional development opportunities and supplemental trainings to ensure CHW/P skill and competence development, respond to emerging issues or changes affecting workflows, and support CHW/Ps' growth in their positions and commitment to their organizations. CHW/Ps can collaborate with supervisors to identify trainings of interest for ongoing education. Employers can also solicit CHW/P input during ongoing professional development opportunities to invite CHW/P ideas for continuous quality improvement, or feedback on proposed workflow changes.

CHW/Ps work in environments that can rapidly change due to factors such as public health emergencies and new laws and regulations. When emerging best practices for CHW/Ps evolve quickly to address changes in the landscape, professional development can support CHW/Ps and their organizations in adapting to these changes. For example, CHW/P professional development during the COVID-19 pandemic supported CHW/Ps in quickly responding to the rapid scaling up of virtual visits. This included learning new technologies to provide up-to-date information about the pandemic and member health concerns, as well as skills on building relationships in an online environment and maximizing use of the video platform Zoom. The pandemic also elevated the importance of self-care for staff. Like other essential workers, CHW/Ps have been suffering from stress related to both work and their personal lives, pointing to the need for wellness resources and training.

Additionally, periodic refresher trainings can reinforce learning objectives from prior trainings, create opportunities for CHW/Ps to practice skills and receive in-depth feedback, and provide knowledge on topics related to new program activities. For example, an organization embarking on community-based participatory research projects could provide trainings to CHW/Ps on research skills to support their engagement in this work.

Ongoing education and professional development can be coordinated either by employers or through trainings led by external organizations. Partnering with organizations that focus on training and supporting CHW/Ps may help support the sustainability of this workforce and can potentially help strengthen connections between CHW/Ps across programs and employers.

> **In order to ensure that *promotores* are kept up-to-date, we continue to have trainings on health-related issues, so they can relay the message to the community.**
>
> *- Sandra Rodriguez, Tiburcio Vasquez Health Center*

Training Structure

The CHW/P training structure — including duration, format, and facilitators — should be designed to effectively address the specific learning objectives for core competency and specialized training sessions. Most programs include a dedicated period of training for foundational skills, followed by regular ongoing education in the form of professional development. Employer organizations are well positioned, for example, to train CHW/Ps on understanding their client populations, interdisciplinary team workflows, data documentation protocols, and employer policies. Some employers partner with an outside organization to manage the initial training, but then provide supplemental training that is tailored to the specific CHW/P program and organizational context, as detailed in the spotlight on MCP approaches *(next page)*.

SPOTLIGHT ON MCP APPROACHES

L.A. Care and Inland Empire Health Plan

L.A. Care collaborated with partners in the community to train CHW/Ps for their Health Homes Program and Whole Person Care pilot as well as for other MCP initiatives. The Loma Linda University San Manuel Gateway College CHW/P Academy ("CHW/*Promotores* Academy") prepared a customized training regimen for both CHW/Ps and supervisors. L.A. Care sponsored an intensive training including foundations, behavioral health and clinic-based competencies, and continuing education for CHW/Ps and the Academy's Organizational Readiness Trainings for supervisors and MCP leadership. L.A. Care worked collaboratively with the CHW/*Promotores* Academy and structured the training frequency, length, and approach to best fit their needs.

Inland Empire Health Plan also partnered with the CHW/*Promotores* Academy, which entailed paying for a nine-week intensive training for CHWs and providing start-up funding to community-based care management entities to pay CHWs full salaries while attending the training. The training contract with the CHW/*Promotores* Academy includes ongoing continuing education training for all employed CHWs, and Organizational Readiness Training to support supervisors and organizational staff in integrating CHW/Ps into this MCP. Through this partnership, more than 120 CHWs have been trained for the Health Homes Program and other Inland Empire Health Plan community programs.

Training can provide a supportive environment to CHW/Ps as they train with others who have or will have similar day-to-day experiences, or with organizational colleagues who may have different positions. The different mediums for training may include formal instruction in a classroom, virtual education, and one-on-one experiential mentoring, with many training programs involving a combination of these mediums. Regardless of the medium, training for CHW/Ps should be highly interactive and use adult learning theory principles to encourage active learner involvement.[130] Learning collaboratives can also support CHW/Ps from one or multiple organizations to come together to network, share best practices, and identify opportunities for collaboration. In the classroom, trainings should include real-life examples and case studies drawn from member stories to help CHW/Ps understand clinical outcomes and how they can best support their clients. Moving outside the classroom, training programs can include practicum experiences that allow CHW/Ps to shadow experienced CHW/Ps. These experiences should allow for frequent feedback from experienced CHW/Ps, which will provide valuable support to help new CHW/Ps understand how to address real-life challenges.

Training for Organizations and Supervisors

To ensure that CHW/Ps are effectively supported, organizational training must extend beyond CHW/Ps and include interdisciplinary teams, CHW/P supervisors, and leadership. Research has demonstrated that training CHW/Ps is necessary but not sufficient for integration of CHW/Ps into health care settings.[131] Implementing team-based care models — where clinicians and frontline workers such as CHW/Ps share responsibility for care — requires new capacities among leadership and all staff to support this practice transformation.[132] Ongoing training and coaching can support organizations to effectively hire, support, and integrate CHW/Ps. Organizational training should ideally take place before the hiring process, so that managers, department leads, and interdisciplinary team members fully understand core CHW/P competencies, their strengths in working in communities, and best practices in

CHW/P integration and support. Participants in these trainings will likely develop a greater understanding of what barriers may cause challenges for CHW/P programs — and can adjust their workflows and identify solutions.

Organizational Readiness for Introduction of CHW/Ps

Before launching new programs, employers need to assess their readiness and identify areas to be addressed in training. Organizational readiness for CHW/P programs includes developing the structures, supports, and workflows to integrate CHW/Ps, as well as identifying training needs for employer organizations and leadership.

For organizations that have not historically hired or worked with CHW/Ps, they will need to undergo systems transformation work to effectively incorporate CHW/Ps into the organizational structure and collaborate with existing staff. In particular, MCPs will need to assess their cultural and organizational norms and evaluate whether specific practices — such as employee performance management — need to be adapted to ensure optimal integration and impact of CHW/Ps. Factors that impact CHW/P integration include organizational capacity, support for CHW/Ps, clarity of roles, and clinical workflow.[133] Existing staff may be unclear about the contributions that CHW/Ps make to the quality of care and how they fit into existing staffing models, or anxious that CHW/Ps will perform duties that are outside of their scope.[134] To support effective CHW/P integration, the CHW/*Promotores Academy* offers an Organizational Readiness Training to supervisors, organizational leadership, and team members who work with CHW/Ps. This training is customized around the needs of each organization and includes background on CHW/Ps and their value, guidance on integration and maximizing CHW/P competencies, resources to support role delineation, and evaluation and assessment of CHW/P integration.

Learning Objectives and Topics

The learning objectives for CHW/P organizational trainings will help establish a strong foundation for CHW/P integration. One learning objective is to understand the historical role of CHW/Ps as members of communities with lived experience and agents of change. This context helps ensure that organizational staff view CHW/Ps as true partners in work with individual members and in thinking about community-level interventions to address social determinants of health. When staff learn about the role and importance of CHW/Ps who come from the communities served, organizational leaders who are responsible for hiring policies may have a stronger motivation to address barriers to hiring candidates who may not pass traditional background checks.

All staff should also gain a deep understanding of the work that CHW/Ps will do within a specific program — as well as what the CHW/P role does not entail. If the role is not fully understood by all staff and leadership at the outset of a program, CHW/Ps will likely be underutilized — such as by being inappropriately asked to perform clerical tasks — or will not be empowered to perform across all their capacities. Trainings for organizational staff and leadership should cover core topics such as the following:

→ The history of CHW/Ps and the broad value of this workforce, including demonstrated outcomes from CHW/P interventions

→ General competencies and roles of CHW/Ps, including how their roles relate to other clinical and nonclinical staff

→ The roles of CHW/Ps within the specific organization or program, as well as prioritized populations and measures for success

→ Strategies for integration of CHW/Ps within programs and across teams

→ Key principles such as anti-racism, health equity, and implicit bias

Training Structure and Facilitation

Organizations should consider the value of broad participation in CHW/P trainings by organizational staff. The full interdisciplinary team engaging with CHW/Ps should participate, and organizational leaders should be encouraged to participate in some portion of this training as well. Other recommended practices include (1) engaging CHW/Ps in the development of the training and as presenters to ensure that the voices and skills of CHW/Ps are elevated; (2) training all staff working with CHW/Ps on the importance of creating a safe environment, including through a trauma-informed approach and empathetic listening; and (3) aligning training with comprehensive changes in workflows and processes so that CHW/Ps can work to the top of their capabilities. For example, organizations should consider how to adapt information technology infrastructure so CHW/Ps can easily enter data while in the field and ensure that all staff are trained on CHW/P protocols for data entry. Developing these workflow changes requires significant attention within an organization and may include creating a task force to develop a comprehensive approach to support necessary changes.

Training staff across multiple levels of an employer organization on the role of the CHW/P will help create buy-in, which is critically important for developing an effective interdisciplinary team. In-depth descriptions of the specific responsibilities of CHW/Ps — and the members that they will engage — will also bring clarity for other staff in understanding this role. As CHW/Ps often spend most of their time in the field, organizational staff will rely on this initial training to illuminate the day-to-day work undertaken by CHW/Ps. Clear expectations on CHW/P work, with examples to outline the specific roles that different staff will have and the value that they add to the interdisciplinary team, will help create more effective workflows and higher levels of coordination. For example, trainings designed for interdisciplinary team members can include practical topics such as how to facilitate a team huddle (a very short team meeting to communicate how to support individual members) to engage and elevate CHW/P voices. California's Health Homes Programs and Whole Person Care pilots both found that huddles and weekly case reviews inclusive of CHW/Ps provide opportunities for informal training and development across all positions.

Organizations may draw on different structures for training. For example, one California MCP has interdisciplinary team members, supervisors, and leadership sit in on specified modules of an external CHW/P training program run by an external training institution. Other approaches include sending a few interdisciplinary team members to participate in a longer and more extensive CHW/P training curriculum. Regardless of the training approach, leaders should ensure that staff across different roles have protected time to better understand CHW/P roles, practices, and integration solutions. For organizations that may be unfamiliar with CHW/Ps, strategies such as shadowing CHW/Ps on the job, watching videos of CHW/Ps, or hearing CHW/P speakers and their colleagues from more established programs present on their day-to-day work may bring these concepts to life and lift up the voices of CHW/Ps.

Training for CHW/P Supervisors

Supervisors should participate in training that addresses the unique roles, backgrounds, and care settings of CHW/Ps. While supervision can be narrowly defined as oversight, "supportive supervision" is an effective approach for managing CHW/Ps. Supportive supervision can include observations, problem solving, collaborative reviews, and training and education.[135] Training in trauma-informed supervision and strength-based supervision may prepare supervisors to effectively support this workforce and respond to challenges such as stress and burnout. Supervisors of CHW/Ps may or may not have clinical training, and some may be CHW/Ps who provide mentorship and support or direct supervision. Regardless of credentials or level of experience, CHW/P supervisors should also

participate in some portion of the CHW/P training sessions, as well as organization-level training. Because supervisors will be responsible for managing CHW/Ps and supporting integration onto interdisciplinary teams, their training on CHW/P roles and workflows must be comprehensive. Additionally, CHW/P supervisors will benefit from ongoing performance reviews and professional development to grow their management skills and support CHW/Ps in responding to changing environments and workflows.

In the experience of one CHW/P member of the stakeholder group, having supervisors shadow or "walk in the shoes" of CHW/Ps is the best way to understand and appreciate the CHW/P role. For example, a CHW/P manager in a Whole Person Care pilot directly worked with a caseload of clients to understand her staff's experiences and needs, which helped the manager to understand that each member has unique individual needs, and that CHW/Ps should be matched with members they are best equipped to serve. Building this nuanced understand of the role will strengthen the ability of supervisors to effectively support CHW/Ps.

CHW/Ps should also have access to leadership and managerial training for advancement into CHW/P supervisor roles. As one CHW/P member of the stakeholder group noted, it is important that the community sees themselves reflected not only among CHW/Ps but also among CHW/P managers. Training will support the development of a pipeline for CHW/Ps to advance into positions of leadership. As CHW/Ps advance to leadership positions, one promising practice is to develop a learning community of CHW/P supervisors to foster continuous learning and continue to support peer-to-peer learning opportunities.

> **It's important for staff to understand that CHWs spend most [of their] time out in communities. Staff may think that if we're not in the building, we aren't working, but that is not the case.**
>
> *- California CHW/P*

Training Implementation

Organizations that employ CHW/Ps can either directly develop and administer each level of training for CHW/Ps and other organizational staff, or they can contract with external entities to lead these trainings. Different approaches may work better for the diverse types of training for CHW/Ps and for CHW/P organizational staff and supervisors. While some states such as Maine and Washington directly provide standardized statewide training, in California each CHW/P employer is responsible for training administration.

> **CHW training must include on-the-job training, and there are different entities that can provide this training, from community-based organizations to CHW entities to universities. MCPs need to be involved in the training of CHWs, whether by leading it or partnering with the other organizations.**
>
> *- Lakshmi Dhanvanthari, Health Plan of San Joaquin*

Considerations for Partnering with External Training Organizations

MCPs may hire an external training organization to develop and administer trainings on core competencies and specific program or population characteristics. This could include partnering with an academic institution or CBO with expertise preparing CHW/Ps, providers, or health care organizations such as ECM and ILOS providers. By contracting out key components of the training or including training responsibilities in an existing contract, MCPs may be able to leverage the knowledge of other organizations that are better prepared or more experienced with providing CHW/P training. Several MCPs that pursued this strategy in their Health Homes Programs by contracting with an academic institution described that this approach was very successful. One MCP noted that "CB-CMEs and their CHWs seem to be very satisfied with the course and experience." This option to contract out may provide a faster way for some MCPs to set up a CHW/P training program.

It is important for MCPs to carefully examine and evaluate the training curriculum of any potential training partners, as these curricula may vary. MCPs should work closely with the training organization, their ECM and ILOS providers, and CHW/Ps to ensure alignment of partners' training curricula with overall program goals. Training partners may also be able to develop and lead training of other organizational staff while supporting an employer organization to do system transformation work for CHW/P integration.

Considerations for MCPs and Contracted Partners to Directly Provide Training

As MCPs consider hiring CHW/Ps at the plan or contracted partner level to support CalAIM programs, one option is to extend some of their existing, generalizable training to CHW/Ps working within these programs. MCPs often have robust internal training programs to support plan staff on a range of topics including care management, data systems, human resources issues, and cultural competency. Some of these trainings may be applicable to CHW/Ps. However, given the importance of training that is specific to the CHW/P to support this workforce, MCPs should carefully consider whether they have the internal knowledge and capacity to develop CHW/P core competency trainings. MCPs will likely play a larger role in developing and administering onboarding training on relevant systems, workflows, and protocols.

Alternatively, a CBO or FQHC that employs CHW/Ps and contracts with an MCP may have strong internal expertise and experience in developing and facilitating CHW/P training, as well as the infrastructure to lead standardized curricula for a newly hired CHW/P workforce. In this scenario, the MCP should closely evaluate the curricula for CHW/Ps, supervisors, and program leaders to ensure alignment with broader goals. MCPs could support employers in providing additional training, potentially through grants, to build new trainings or to lead regional training on organizational readiness related to ECM/ILOS. Training led by employers can help support cross-training of employees and improve staff understanding of different programs. For example, a nurse, administrator, and CHW/P may all take the same course on crisis de-escalation. Employer-delivered training can also help to ensure that employment opportunities are available to all people who complete programs.

The MCP may consider providing a subset of the training for CHW/Ps and delegating more specialized training to the contracted partner organizations. For example, CHW/Ps from multiple CB-CMEs or Whole Person Care pilot partners attended MCP trainings on topics such as motivational interviewing or shared assessment tools. Then, individual partners provided additional training on certain conditions or populations such as diabetes or people experiencing homelessness that incorporated the expertise of the contracted partner.

In either scenario, the organization leading the training should incorporate the perspectives and expertise of staff with experience in CHW/P program development and implementation, curriculum development, and adult

learning and popular education methodologies. As needed, this internal team can identify and subcontract with consultants to be trainers and lead evaluation of trainings.

Another option is for MCPs to partner together to provide regional trainings. While there would need to be agreement across participating plans as to the curriculum, modality, and instructors, there could be a benefit to CHW/Ps who would receive consistent training across MCPs that they work with, and a potential cost benefit to MCPs for pooling resources.

Across these different approaches to training administration, MCPs can strengthen the capacity of their contracted ECM and ILOS providers. A contracted provider may not have capacity to organize or provide training, and an MCP can develop and coordinate that training on behalf of providers. MCPs can also include ample financial resources in their contracts for partners to establish and deliver a training program and provide guidelines to partners around training frequency, content, and assessment, as well as to support professional development or other types of supplemental trainings. MCPs can streamline contracting processes to enable faster, flexible, and sustainable contractual partnerships with CHW/P training organizations and community-based organizations.

Common Challenges and Ingredients for Success

Challenges related to training CHW/Ps, CHW/P supervisors, and interdisciplinary teams — such as not having enough time, resources, and organizational commitment — are not dissimilar to general barriers related to training in the health care field and beyond. This section explores the unique barriers and potential solutions related to structuring effective CHW/P training programs.

Establishing CHW/P Training Programs

MCPs may have a short timeline in standing up new CHW/P interventions, as well as limited expertise in developing and facilitating trainings for CHW/Ps. MCPs should build in as much time as possible for developing partnerships with communities, and prioritize comprehensive training programs for both organizational staff and for CHW/Ps. Training must begin before the program starts to first lay the groundwork for organizational integration of CHW/Ps and then to adequately prepare CHW/Ps and interdisciplinary teams that include CHW/Ps. As organizations plan out their training schedule in the dynamic context of hiring staff, developing workflows, and strengthening community relationships, they may want to consider sequencing the training to include a core training before CHW/Ps begin to work in the field, followed by ongoing training that takes place while on the job. Partnering with established training organizations can support MCPs in addressing this barrier, as can an early focus on strengthening community relationships to dynamically inform program design and training.

Addressing Training Costs

MCPs must view training as an investment — both up front and continuously — to adequately set CHW/P programs up for success. This workforce has been historically underfunded, and MCPs should recognize the value of comprehensive training to support their goals. MCPs looking to understand the value proposition in the context of ECM and ILOS as well as other programs may be interested in exploring research showing the positive return on investment from CHW/P interventions, as detailed in **Exhibit 1**. The ability to invest appropriately must also be passed along to MCP-contracted partners that may employ CHW/Ps such as CBOs, providers and health care organizations, and training partners. Incentives for individual CHW/Ps and MCP-contracted partners, such as paying CHW/Ps to participate in professional development, can also improve the success of a CHW/P program by supporting skill development and, ultimately, improving CHW/P retention.

Making Training Accessible for CHW/Ps

CHW/P training needs to be accessible for people with diverse backgrounds and lived experience, and MCPs and their contracted partners should ensure that CHW/Ps from all socioeconomic backgrounds can participate in training. Measures of accessibility include cost of training participation for an individual, training frequency, training location and time of day offered, and languages in which the training is available. Paying CHW/Ps to participate in training will help support access to training. Use of web-based trainings (both synchronous and asynchronous) can be one solution for this barrier, as individuals can participate at the times that they prefer. Web-based trainings can also facilitate tracking of participants, as well as participant evaluation and identification of topics for further attention in training. In designing training approaches, organizations should carefully consider the sequencing of synchronous and asynchronous trainings to ensure that the benefits of group learning are not lost.

Mitigating Staff Turnover

When CHW/Ps leave their positions, there is a discontinuity in services and disruption in relationships with members. Employers will need to quickly recruit, hire, and train new replacements, but turnover can lead to a position being empty for weeks or months until the position is filled and support to the community is resumed. Multiple strategies can help to both reduce staff turnover and equip employers of CHW/Ps to provide training if staff leave their positions. First, ensuring that the right CHW/Ps are hired for programmatic and organizational fit can reduce turnover. CHW/P feedback, particularly about workflows and the work environment, should be regularly invited and gathered so that there can be continuous quality improvement. Employers should conduct exit interviews to understand (and address) factors that contribute to turnover. Additionally, organizations can facilitate greater peer support to newly hired CHW/Ps by hiring CHW/Ps in pairs or groups. Robust professional development opportunities and ongoing training will also foster workforce retention. Other important strategies to support the sustainability of this workforce, such as through competitive and fair compensation, are addressed in **Section 2** of this guide, *Developing and Financing CHW/P Programs and Partnerships.*

As MCPs and their contracted partners cannot anticipate when a staffing turnover will occur, training should begin as soon as new CHW/Ps are hired and be ongoing. One option to make this type of education more feasible is to train experienced CHW/Ps in providing ongoing training in between formal training sessions. Another solution is to train multiple CHW/Ps on specialized skills, rather than creating silos where different CHW/Ps have distinct specialties within a team. For example, rather than having one CHW/P handle all members with a specific need, employers can cross-train CHW/Ps to ensure that multiple staff have the skills needed to serve this population.

Section 5: Engaging CHW/Ps in Data Collection and Program Outcome Measurement

CHW/Ps are a critical component of the community-connected health workforce who can help achieve health and social service integration as envisioned under CalAIM. They serve as a bridge between the health care system, social service agencies, and CBOs for members with complex health and social needs. CHW/Ps ability to effectively connect these different systems, however, requires strategic understanding and use of data and digital tools.

This section explores CHW/P roles in data collection and information sharing between MCPs, health systems, and CBOs. It also highlights strategies for MCPs to include the CHW/P workforce in data collection and reviews considerations for measuring the impact of CHW/P programs.

Background

CHW/Ps can play a valuable role in collecting data, transferring information between health and social service systems, and informing MCPs, FQHCs, hospital systems, and the state about community needs. CHW/Ps can also provide the most up-to-date information on elements such as member housing status, contact information, and any immediate or emergent health risks. Whether CHW/Ps coordinate care as part of an interdisciplinary primary care team in an office-based setting or engage community members in the field, they are well positioned to collect this type of information.

CHW/Ps collect individual and population health data as well as social determinants of health data. Before specific strategies for CHW/Ps to participate in data collection as well as for program evaluation are identified, it is important to understand these different types of data and how they are relevant for improving health outcomes and the delivery of care.

Social determinants of health (SDOH) are the conditions in which people are born, grow, live, work, and age.[136] Social, environmental, and behavioral factors have a bigger impact on health outcomes than medical interventions or genetics combined.[137] It is important for health care entities to document SDOH in the communities they serve to understand how to better serve people with complex health and social needs. Data collection on SDOH factors can help health care entities identify the root causes of poor health in the community and direct resources and interventions to address health-related social needs. In addition to helping to address SDOH by navigating complex health and social services programs, CHW/Ps can collect SDOH data for use by MCPs, CBOs, and other health and social service organizations. For example, CHWs employed by Transitions Clinic Network programs use a mobile app to collect data on members' health-related social needs. The tool allows them to make updates in real time, regardless of whether they are in the field or in the clinic, and provides the care team with accurate contact information or a person's immediate need for food or housing resources.

Data Considerations for Health Equity

Data collection and stratification are key to advancing health equity, as they allow MCPs to identify disparities and collaborate with CHW/Ps to design approaches to address health inequities. CHW/Ps, with their lived experience and understanding of the communities they serve, play a vital role in collecting data on social needs, access to transportation, sense of safety, and other information that might otherwise exacerbate barriers to achieving well-being. CHW/Ps, who are well positioned to establish member trust, can help explain the reasons for collecting sensitive information and address concerns about privacy and data sharing.

Expert Insight on CHW/P Role in Data Collection: Transitions Clinic Network

At the age of 23, Joe Calderon started serving a life sentence. After nearly 20 years incarcerated, he knew he wanted to meaningfully give back to his native San Francisco community upon his release. He currently works as a senior CHW and trainer at the Transitions Clinic Network, a national organization dedicated to improving health and re-entry outcomes for those returning to the community from incarceration. His lived experience allows him to deeply connect to his clients who find it challenging to re-enter society. His clients look up to him as a role model and trust him as a resource as he also navigated similar challenges.
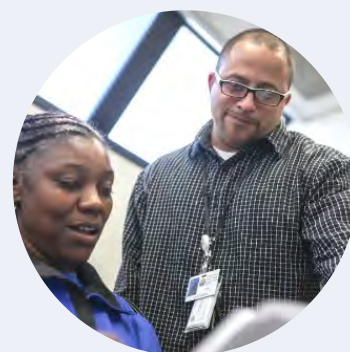
Given the re-entry community's negative experiences with unjust institutions, collecting individual's data is often a challenge. Joe understands the nuances of this and emphasizes hiring those with lived experience is the key to building trust with populations that have been most marginalized by systems of oppression. He elaborates: "One question that could be liberating for one, could be disrespectful to another. When you're asking about the social determinants of health, some people are prideful — they might not want to tell you they're hungry at night. When we think about using community health workers to collect this social health data, we must do so correctly by hiring people from the community they serve. They'll understand how to walk on that rice paper, make it happen, and get the data most useful for the health system and MCPs."

Key Implementation Approaches

Contracted providers, health delivery systems, MCPs, and CHW/Ps will need to develop roles, responsibilities, and infrastructure to support successful data collection, exchange, and evaluation. This section can help guide MCPs and their partners to ensure that CHW/P programs use data effectively to support health and social care integration and evaluate the effectiveness of these CHW/P activities. This section explores the following broad categories: (1) initial data considerations for CHW/P program design; (2) infrastructure and supports to help CHW/Ps collect data; and (3) strategies and metrics to evaluate CHW/P activities.

Initial Data Considerations for CHW/P Program Design

CHW/P programs will need to collect and exchange data to (1) address members' health and social needs; (2) share data with other partner organizations; and (3) evaluate the effectiveness of CHW/P activities. With these broad goals in mind, there are key considerations for MCPs to address in designing data strategies for CHW/P interventions. Following is a discussion of key factors to guide CHW/P data strategies, including setting initial data-collection goals, identifying shared goals for CHW/P programs, determining the information that CHW/Ps need to support members effectively, and recognizing CHW/P priorities in data collection and outcome measurement.

Goal Setting

Whether MCPs design their own CHW/P intervention, contract directly with CHW/Ps, or partner with CBOs or other social service entities, they will need to establish what data are required for effective CHW/P activities. Key questions to guide this assessment include:

→ What is the goal in collecting data?

→ What is the best method of data collection to meet that goal?

→ What data are most important to support care coordination?

→ How can data flow bidirectionally from CHW/P programs to providers and MCPs?

→ How can health information technology (HIT) or electronic health record (EHR) systems facilitate effective data sharing from the health care setting back to the MCPs?

→ How can MCPs and CBOs partner with CHW/Ps as they work to obtain the necessary authorizations and consents, as required by CalAIM?

CHW/P outreach with historically under-resourced communities and people who are disconnected from health care systems can provide MCPs with information that may not be collected otherwise. For example, if MCPs aim to engage members, then they may prioritize that CHW/Ps collect accurate demographic information such as current address and phone number, age, race/ethnicity, gender, income, employment and housing status, and internet access.

In addition to supporting MCPs' delivery of ECM and ILOS, data collected by CHW/Ps may help MCPs refine their strategies to improve overall population health, which CalAIM will require as of January 2022. For example, data collected by CHW/Ps employed by MCPs in Oregon helped the plans increase access to priority populations previously disengaged from services.[138] From an evaluation perspective, CHW/Ps' involvement in data collection and analysis can also help them learn what works in their interventions and support opportunities for program growth and development.

> " **When CHW/Ps feel empowered to inform what data are being collected, help map data-collection protocols, and lend their expertise in member-screening processes, not only do they experience better job satisfaction, but such input from them leads to systems that better serve members.**
>
> *- Deiter Crawford, Community Health Worker*

Information CHW/Ps Require to Meet Member Needs

CHW/Ps and care teams are committed to improving member health and social needs by focusing on member-centered goals. MCPs and organizations that employ CHW/Ps should collaborate on the scope of data collection to ensure that the right information is shared and available to meet member needs. If too little information is made available, then the care team may miss out on CHW/P insights and feedback. If too much information is shared, there is a risk of "information overload" whereby CHW/Ps spend valuable time sifting through paperwork or multiple digital apps.

Shared Data Agreements in CHW/P Programs

MCPs will benefit by establishing data-sharing agreements with CHW/P programs who collect data in the field. For CHW/Ps embedded in a primary care setting, health care delivery entities such as primary care providers and health systems will need to consider how to share data between entities and with the MCP. To support CHW/Ps, providers should not only authorize "read-only" access to EHRs but also give CHW/Ps time in their day to record SDOH and other social needs data into EHRs. With this information and access to these tools, CHW/Ps can accelerate care coordination, highlight potential red flags, and inform care delivery.

CHW/P Priorities in Data Collection and Outcome Measurement

Understanding CHW/P experiences in collecting data from members can help guide MCP strategies around data collection and evaluation. As part of the activities to inform this Resource Guide, a group of CHW/Ps met in February 2021 to share insights on collecting member data. The following synthesizes the participating CHW/Ps' perspectives on important types of data for CHW/Ps to collect and have available to support their work with members:

→ **Member health assessments and identified health goals.** CHW/Ps value and prioritize member-centered goals. Results from health assessments, care planning with providers, or patient surveys help shape a full picture when CHW/Ps begin their outreach and engagement with members. At the same time, CHW/Ps want to balance information gathering with their primary tasks of building trust and establishing good relationships.

→ **Demographic and health information about the member's community.** CHW/Ps often have strong community ties and are from the communities that they serve, and MCPs have access to sophisticated and highly informative data sets on the health of a given community. MCPs can contribute to CHW/P effectiveness by using this data to help focus on what type of interventions a CHW/P may want to offer their members in that community. At the same time, a CHW/P's reflection on community-level health needs can provide a feedback loop to the MCP to revise program design or goals.

→ **Member health care history.** CHW/Ps want to know what has been tried in the past and what worked or did not work with members regarding their care. CHW/Ps rely on MCPs and providers to share this information and other relevant claims/diagnosis-level information to support their work. From a CHW/P perspective, some members require high-touch relationship building that can be addressed during the data-collection process. For example, when working with an individual with behavioral health needs, a CHW/P may ask questions about behavioral health risk factors and medications as well as the member's acute care history. This helps CHW/Ps learn background context while creating space for a member to share their story, and they may learn about factors that cause a member to use the emergency department instead of going to a primary care provider. The CHW/P can use that historical information to

educate the member on appropriate emergency department use and can then assess the member's readiness for change.

→ **Member access to resources.** CHW/Ps are often well positioned to refer members to resources and help them navigate health and social sectors. Infrastructure that supports data exchange can capture the dozens of ways CHW/Ps support members' access to and use of services through documentation of "closed-loop referrals." Closed-loop referrals ensure that information is sent back to the CHW/P and other organizations once the member connects with the referral.

> " **CHWs could be really helpful to collect data as part of the assessment. There are a lot of questions that are uncomfortable — and can feel judgmental if not coming from a trusted partner— so there is a real benefit to identifying and integrating CHWs into the assessment process.**
>
> *- Managed care plan representative*

Infrastructure and Supports to Help CHW/Ps Collect Data

To successfully incorporate CHW/Ps within health and social service delivery, MCPs, providers, and health systems need to build infrastructure that equips CHW/Ps to collect and analyze data, track improvements, and participate in the design of the intervention. CHW/Ps also need the appropriate tools and training to do this work. This preparation will support CHW/Ps' full participation on the care team, better job satisfaction, and more effective systems to best serve members.[139] MCPs can start by assessing if there is sufficient technology and resources to enable successful data collection and information sharing where CHW/Ps are employed. Further, seamless data exchange across statewide health and social sectors will require significant infrastructure to support data collection and integration. Following are considerations to guide the development of necessary data infrastructure supports.

Ensure that Data-Collection Supports CHW/Ps Integration in Programs and Workflows

To support and elevate the CHW/P role, MCPs, CBOs, and health care delivery systems will need to determine how to embed CHW/Ps into regular program infrastructure and workflows. MCPs and contracted providers will need to define and establish key data-collection features of CHW/P programs, and CHW/Ps should participate in these discussions. Data-collection supports include:

→ Well-defined roles and responsibilities for data collection across all positions

→ Infrastructure, technology, and tools to carry out effective data collection across settings, as well as data-sharing agreements

→ Data-collection standards, processes, and workflows for CHW/Ps

These investments in establishing a shared understanding and infrastructure for data collection are essential for creating an integrated, seamless experience for members. Such investments will create a more effective system to share data among health and social service providers and give MCPs the population data required to effectively manage patient populations.

Tools to Help CHW/Ps Support Health and Social Needs Assessments

CHW/Ps can help to engage with hard-to-reach members to complete health assessments needed by MCPs, including individual health risk assessments, social needs screenings, and culturally responsive developmental screenings. Through established, trusting relationships, members may provide more accurate data to CHW/Ps than they would for clinicians. Regardless of the tool used, screening tools provide population data that can help meet MCP requirements for health risk assessment completion, inform CHW/P activities, population health programs, targeted community investments, new collaborations, and planning with payers and the state. Further, it is important for MCPs to collect Z-codes[140] so SDOH assessments can be used as part of risk adjustment and, ultimately, rate setting. Many SDOH screening tools "crosswalk" to Z-codes that are important for documentation.

CHW/Ps can employ a host of tools and screenings to assess health-related social needs.[141] For example, the Patient Health Questionnaire-Anxiety and Depression Scale screening combines the PHQ-9 and Generalized Anxiety Disorders surveys into a depression and anxiety screening tool.[142] The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) screens for a range of social risk factors including income and housing instability;[143] the two-item food insecurity screen assesses families at risk of food insecurity and hunger;[144] and the Hurt, Insult, Threaten, and Scream instrument screens for interpersonal violence.[145] The Centers for Medicare & Medicaid Services also developed a comprehensive Accountable Health Communities Screening Tool, which adapts questions from other screenings into one tool.[146]

MCPs should understand if the CHW/P program tracks referrals to food assistance, housing, or other social services and the extent to which it has a process to document when members have received the referred services. This demonstrates the closed-loop referral process, which is an important component of the technology infrastructure, tools, and platforms needed to integrate social care into the health care delivery system. CHW/P programs will have varying levels of technology infrastructure, applications, and resources to contribute to meaningful data exchange. Additionally, because CHW/Ps go into the community and into people's homes, they may encounter weak internet connections that may deter them from collecting data on a phone or tablet application and should have a plan to collect encounter data on paper.

RELATED RESOURCES: The Resources and Tools section of this guide includes links to available **behavioral health and SDOH screening tools**.

Sharing Member Data

Because building trust is a critical component of the CHW/P-member relationship, CHW/Ps should be familiar with how the information they are collecting will be used by the member's care team. If a CHW/P is employed by an MCP or CBO, there are different considerations to maintain trust between CHW/Ps and those they serve. MCPs, CBOs, and other entities will need to ensure that privacy policies and protocols are in place and clearly understood by CHW/Ps so that they can, in turn, clearly communicate that to members.

CHW/P programs will also need to balance building rapport with members with the need for assessments and data collection and be mindful that building and maintaining trust is a priority for CHW/Ps. CHW/Ps will need to be transparent with members about the need for sensitive data collection and describe how, why, and to what extent the information will be shared. MCPs and CBOs should consider creating a feedback loop for CHW/Ps to share members' questions and concerns about collected data and routinely support the program team in culturally appropriate approaches to collecting data from diverse communities.

Technology Considerations

As health care systems adapt to the changing dynamics of health and social service delivery and the ongoing need to integrate both sectors, several important questions arise, including what kind of technology infrastructure is needed to facilitate such integration. The HIT and health information exchange infrastructure in California, as in most states, relies on a patchwork of disconnected systems and platforms, which impede meaningful, real-time data exchange between health entities and among health and social sectors.

Important efforts are underway in California to help state and regional stakeholders address the regulatory, policy, and technical challenges to establish seamless data transfer between health and social sectors.[147] There are important considerations for MCPs to weigh in integrating a CHW/P workforce into their health information technology infrastructure. At a minimum, MCPs should use standardized tools and data-collection methods, as well as platforms, to connect CHW/P encounter data with members' EHRs.

Despite the tremendous challenges of seamless and meaningful integration of health and social data, there are promising signs of innovations that will achieve these goals. The IMPaCT model's use of HOMEBASE and the Pathways HUB model are two examples of technologies that support CHW/P data collection while integrating health and social service data (see sidebar below).[148]

Models and Technologies to Support CHW/P Data Collection and Integration

The Pathway Community HUB Model. One approach that integrates health and social sectors in hubs across the country is the Pathways Community HUB 2.0 Model, which helps communities work together to support their vulnerable populations. This model is used by MCPs to standardize quality measures and outcomes for CHWs related to risk mitigation across clinical and social categories. The HUB acts as a community care coordination system focused on reducing modifiable risk factors for high-risk individuals and populations by engaging a community-connected health workforce, including CHW/Ps, to link members to needed health and social services. These critical member connections to community services are achieved through closed-loop referrals and streamlined data collection, communication, and information exchange.

IMPaCT Model. The Penn Center for Community Health Workers is a national center of excellence focused on advancing health equity through effective, sustainable community health worker programs. This center developed IMPaCT, a standardized, scalable model to implement CHW/P activities across the country. The IMPaCT model uses HOMEBASE, a secure, cloud-based platform for CHW workflow and evaluation. This technology integrates with EHRs to pull real-time patient data such as hospital admissions. It also provides patient updates to other members of the care team and allows CHW/Ps to document patient interactions in an easy-to-use format. HOMEBASE includes automated reports that allow supervisors and directors to track triple aim metrics such as chronic disease control, patient satisfaction, and hospital admissions. Reports also include CHW caseload, frequency of contact, and achievement of patient-centered goals.[149]

Training on Data Collection

Before program implementation, MCPs should work with CHW/Ps to identify the knowledge, skills, and abilities that would enable CHW/Ps to be successful at data collection and reporting. Through a series of CHW/P stakeholder convenings and interviews for this Resource Guide, CHW/Ps expressed the need for adequate training and support in their data-collection efforts while balancing any requirements for lengthy screenings with the other important roles they play in establishing trust and building relationships with members. The CHW/P workforce has a varied skill set for data collection. **Section 4: Training and Supporting CHW/Ps** details more information on training approaches.

Designing Evaluation Strategies for CHW/P Activities

Designing an evaluation strategy is an important component of initial program design. After identifying the priority population and conducting a needs assessment, an MCP will need to identify which quantitative and qualitative measures to use to demonstrate the program is meeting individual member needs or population health goals. In addition, evaluation data can track both the level of engagement from individual members and priority population access to services and overall health and wellness. This section outlines considerations for qualitative and quantitative data to evaluate CHW/P interventions and CHW/Ps role in quality improvement.

Using Quantitative Measures to Evaluate CHW/P Activities

Metrics established before the launch of a program and adapted over time enable plans and providers to measure quality, evaluate the program, and identify and close gaps in care. For example, CHW/Ps are experts in engaging members into primary care. Measuring member engagement is a good marker to determine greater access to services and opportunities to address health equity. Examples of outcome measures to evaluate CHW/P activities, as seen in **Exhibit 10**, include member engagement, completion of closed-loop referrals, and supervisor feedback.

Exhibit 10. Sample Measures to Evaluate CHW/P Activities[150]	
Category	**Measures**
Health-Related Services	→ Number of members enrolled → Number of members served → Number of appointments made and % of appointments kept (no-show rate) → Number of CHW visits
Referrals	→ Number from primary care providers → Number from hospital/discharge → Number from hospital/ED → Number to CBOs → Number to social service agencies
Education and Support	→ Number of group sessions → Number of individual sessions → Percent member completion rate in educational series on diet, smoking, exercise, etc. → Behavioral health assessment and support → Screening for alcohol use and counseling

(Continues on next page.)

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Exhibit 10. Sample Measures to Evaluate CHW/P Activities *(continued)*	
Category	**Measures**
Satisfaction	→ Member satisfaction surveys
	→ Documentation of member-centered goals
	→ Willingness to recommend family or friends
Clinical Indicators and Population Health	→ Blood glucose levels
	→ Blood pressure
	→ Body mass index
	→ Increase in post-hospital primary care
	→ Screening for depression and follow-up
Utilization and Cost	→ Decreased ED visits
	→ Decreased admissions
	→ Decreased readmissions
	→ Total cost per member of the population served

Collecting Anecdotal Data to Evaluate CHW/P Activities

The principle of "no stories without data, and no data without stories" is well-suited when evaluating CHW/P activities.[151] CHW/P program success largely depends on CHW/Ps' ability to establish and maintain trusting relationships with members of the community. Through their ground-level, patient-focused work, CHW/Ps amass extensive qualitative data, including changes in a member's self-reported health status, employment, housing, involvement with the justice system, or health conditions. These changes in status can be shared with team members to inform treatment and also shared with plan leadership. Members' stories can often illuminate the value of a CHW/P program and help inform the decision to invest in these programs. MCPs can use a variety of strategies to capture qualitative data, including surveys, interviews, and focus groups to collect anecdotal information and stories. Collecting data on CHW/P activities and measuring the impact of the program is also about refining the CHW/P model to ensure that the model adapts and evolves.

CHW/P Value in Achieving Better Quality Metrics

CHW/Ps can assist MCPs in improving quality metrics. Plans can identify what measures will be used to track population health outcomes (and if they expect providers to track population health) and what measures they expect providers to use to track individual health outcomes. One programmatic best practice is to create a treat-to-target model that looks for improvements within the population and at the individual level.[152] Anticipated targets are set, and if they are not reached, the provider adjusts the intervention (for example, more education for staff on specific conditions or changing the type of treatment). The MCP can also ask providers to adjust how they are delivering services. If there are no population-level improvements, CHW/Ps can be part of a treat-to-target approach as part of a larger team. On a systems level, CHW/Ps can provide MCPs and other entities with valuable data to analyze community health trends.

Establishing Evaluation Metrics for CHW/P Programs

Conducting an evaluation to measure the impact of CHW/P programs can help improve quality of care. While currently there are no standard clinical quality measures specific to CHW/P activities, there are promising models across the country. The Pathways HUB model standardizes quality measures and outcomes for CHWs related to risk mitigation across clinical and social categories.[153] Transitions Clinic Network (TCN), which uses a CHW/P-based model of care, uses a fidelity tool to evaluate clinics that have successfully implemented the model of care to assure the clinics are following the evidence-based model and have similar outcomes.

Evidence-Based Model of Care

The Transitions Clinic Network (TCN) is a program that supports health systems in implementing an evidence-based model of care for people with chronic conditions returning to the community from incarceration. All TCN partner clinics employ CHWs with histories of incarceration as an integral part of the primary care team, and CHWs deliver enhanced care management. TCN completed multiple studies of their model, including a comparison of programs that include CHW services to those that do not.[154] Individuals coming out of incarceration who participated in this model and received CHW services experienced decreased ED visits and preventable hospitalizations, shorter hospital stays, and fewer technical violations for parole and probation as well as days re-incarcerated. A randomized controlled trial found a 51%reduction in emergency department visits for members of the TCN program.

RELATED RESOURCES: The Resources and Tools section of this guide includes links to **program evaluation and ROI estimator tools**.

These emerging tools and a growing interest in developing standard CHW/P quality metrics will help states, health systems, payers, providers, and CBOs measure the impact of CHW/P programs, not only at the health care system or member levels, but at the community level.[155] Bringing partners with similar goals together to collectively address member needs and standardize screening tools, assessments, and performance metrics may support even more evidence of CHW/P efficacy. Special focus should be on collaborating with technology partners with a demonstrated track record in incorporating SDOH data and referral platforms to design approaches that achieve program goals.

> **It's important to remember that while the data is out there, the personal connection with somebody – that's what makes it. That's where you are able to see the full story.**
>
> *- California CHW/P*

CHW Common Indicators Project

Based on the need to develop a common set of criteria to measure CHW/P activities, the Michigan CHW Alliance (MiCHWA) created a common set of evaluation indicators to understand the unique contributions of CHWs to successful program outcomes and their added value to health care and human services systems. This initial goal led MiCHWA to combine efforts with Oregon and other states to establish the national CHW Common Indicators Project.[156]

The goal of the CHW Common Indicators Project is to develop and adopt — through a collaborative process — a core set of common process and outcome constructs and indicators for CHW/P activities. Ancillary goals include raising awareness of CHW/P interventions and functions, promoting sustainable funding models, maintaining CHW/P involvement in the measurement process, and growing grassroots CHW/P programs. See the **Resources and Tools** section for information about the project's early findings.

Common Challenges and Ingredients for Success

Insufficient Health Information Exchange

There are longstanding and systemic challenges in health and social sectors such as privacy, HIT and health information exchange infrastructure investment, and data interoperability, which are not specific to the inclusion of the CHW/P workforce. Manatt Health Strategies developed the *CalAIM Data Exchange Roadmap*, which describes seven use cases that define information system requirements and data-sharing activities that are necessary to effectively support ECM and ILOS.[157] Many ECM and ILOS partners including providers, human service agencies, county agencies, CBOs, and MCPs do not have information technology capabilities needed to support cross-sector data exchange. There are additional challenges in regions where the data needs to go from a CBO to different provider organizations, to the MCP, and then to the state. This level of data exchange will require not only state and federal regulatory changes but all stakeholders to participate in a coordinated effort, as outlined in the *Data Exchange Roadmap*.

Following are key considerations gleaned from the *Data Exchange Roadmap* in the context of CHW/P activities:

→ **There is a widespread need for data standards, data-sharing specifications, and technology infrastructure,** especially for housing, justice, and other social sector data. CHW/Ps are involved in each of these domains and can inform the standards and practices needed to build an integrated system.

→ **There are major challenges of interoperability and data sharing** between health care and social care because of a lack of infrastructure and data-collecting and data-sharing standards among organizations.

→ **There is a risk of increasing health disparities** by "exacerbating the digital divide and by codifying bias within health systems."[158]

→ **There are no agreed-upon best practices for data sharing** to integrate social care with health care.

While fully integrated, interoperable data systems are the goal, MCPs need to identify what works for them and their partners to (1) report to the state, (2) identify and share key data to support the program, and (3) simplify the effort at the provider and care team level when possible. As MCPs implement ECM and ILOS, they have an opportunity to reflect on previous data-reporting efforts and identify opportunities to improve and streamline the data-sharing workflow. Further, MCPs can consider the roles that different components of a community-connected health workforce team, specifically CHW/Ps, can play to enhance both data collection and sharing.

Varying Data Infrastructure Across CBOs

CBOs, which provide a diverse range of medical and mental health care, substance use treatment, and/or social services, significantly vary in their technical infrastructure and data-collecting capabilities. Many CBOs are unfamiliar with health system information platforms and use a different rubric to evaluate their programs. It is important for MCPs to support community partners and stakeholders to assess their data collection and information exchange capabilities and leverage resources to address the gaps in infrastructure, tools, and platforms. Seamless data transfer between health and social sectors, including CBOs, will require new investments and resources. Few CBOs can interface with various health system technology infrastructure, products, and tools. There will need to be deliberate considerations about how to create new opportunities for CBO and health sector collaboration on data exchange.

Lack of Standard SDOH Data-Collection Measures

While numerous SDOH measurement resources exist, a systematic analysis of the strategies used to assess SDOH found wide variation in the SDOH categories used and no consensus on a standard set of indicators.[159] Because ECM and ILOS services prioritize the social and behavioral needs of members, it is important for stakeholders to engage in a process to standardize data-collection and SDOH measures.

MCPs have expressed the need to standardize SDOH data collection to produce data sets they can use. In thinking about prioritized populations in ECM, one plan leader described the need to match potentially eligible members to the right providers and programs: "The more information MCPs have about their members [such as SDOH information] and the more successful we are in getting that data and using it to match members to the right program, the better likelihood that members will agree to engage in the program and services."[160] The integrated care team, and CHW/P in particular, is a key component in assessing members' needs. The team should possess the tools and training to ensure a clear understanding of this aspect of member care along with standard screening tools and methods of data collection on health-related social needs.

Concerns Around Privacy and Consent

There are significant considerations concerning data integration and information sharing and the underlying patchwork of federal and state laws governing privacy. Integrated care and the need for data exchange among MCPs, providers, and social service agencies will require a state effort to update privacy and consent laws and regulations. Many CBOs and social service organizations involved in data sharing will need training on informed consent for individual member interactions and larger data-sharing agreements that support bidirectional flow of information. For example, 42 C.F.R. Part 2 protects patient information regarding health records as it pertains to substance use disorder. Under this rule, patient information cannot be exchanged without patient consent except in limited circumstances.[161] Therefore, there are specific challenges integrating health and social sectors with respect to the specific federal regulations governing the treatment of substance use disorder.

Existing Federal and State Privacy Regulations

Physical health information exchange is subject to HIPAA, which addresses disclosures of protected health information between "covered entities" that include health care providers and payers.[162]

Federal rules including 42 C.F.R. Part 2 and state rules including the California Health & Safety Code 11845.5 regulate certain forms of behavioral health data with narrower allowances for data sharing that require more rigorous patient consent.[163]

Homeless Management Information Systems data is subject to the Housing 2004 HMIS Data and Technical Standards, which permits disclosure of data only among housing agencies.[164]

Per findings from the Manatt Health Strategies *CalAIM Data Exchange Roadmap*, a range of stakeholders — MCPs, CBOs, health and social entities, justice-related entities, and policymakers — will need to work together to overhaul privacy and consent requirements within the context of ECM and ILOS to transition to integrated health and social care.[165]

Lack of Standardized Evaluation Measures for CHW/P Activities

While there has been tremendous progress documenting the numerous positive outcomes of CHW/P interventions, the lack of standardized measures to assess these activities has made it challenging to aggregate data across health care entities, systems, and regions. The Patient-Centered Outcomes Research Institute indicates that "despite evidence of CHWs' effectiveness, three factors impede widespread engagement of CHWs in clinical care and research: (1) a lack of understanding of CHWs' unique contributions to clinical care, (2) a lack of common indicators to measure the effectiveness of programs with a CHW workforce, and (3) inconsistent involvement of CHWs in all phases of research."[166] In addition, because CHW/Ps perform multiple roles in tandem — educator, health coach, and system liaison — it is challenging to disaggregate these roles and evaluate just one component of this complex and multidimensional position.

While measuring the impact of CHW/P programs is important, it is crucial to make the distinction between health system performance and community health performance. While it is imperative for health and social systems to become fully integrated, community health indicators have tremendous value to health systems. Leading community health indicators include access to health services; clinical preventive services; environmental quality; family and child health; mental health; nutrition, physical activity, and obesity; oral health; and reproductive and sexual health.[167] CHW/Ps can play an important role in collecting data on community health factors to inform program design and investment.

Further, while health systems are designed to understand the direct value of interventions through things such as improved screening rates or reduced emergency department utilization, MCPs and other entities may pay less attention to the indirect value of improved community health. While these indirect social benefits — including improved well-being of community members — are difficult to isolate and measure, these considerations should be acknowledged by MCPs and other health entities. The Common Indicators project provides a set of measures that could help MCPs standardize their programs.[168]

Section 6: Resources and Tools

This section contains practical resources and tools provided by project contributors or collected from subject matter experts in the field and across other states. This section contains links to publicly available resources as well as sample documents that provide practical examples to inform other programs. Please cite materials appropriately if you use these tools.

Developing and Financing CHW/P Programs and Partnerships

CHW/P Program Design and Development

RESOURCE TITLE	BRIEF DESCRIPTION
Community Health Worker (CHW) Toolkit: A Guide for Employers (PDF)	This toolkit, from the Minnesota Department of Health, is designed to provide employers and prospective employers with practical guidance for organizational and practice integration of CHWs, as well as how to understand the education and competencies of CHWs.
Managing Community Health Worker Contracts	This resource, created by two researchers from the Harvard Business School, highlights the importance of contract design in the development of the CHW workforce.
Coordinated Care Organizations (CCO 2.0) Contract 2020–2024 Traditional Health Worker Section (PDF)	This document is a contract from the Oregon Health Authority for health systems interested in partnering with CBOs.
Diffusion of Community Health Workers Within Medicaid Managed Care: A Strategy to Address Social Determinants of Health	This case study, published in *Health Affairs*, delves into how New Mexico Medicaid implemented a CHW/P program for their managed care members.
Including Community Health Workers (CHWs) in Health Care Settings: A Checklist for Public Health Practitioners (PDF)	This checklist, produced by the CDC, presents a general framework for public health practitioners to lead or assist in including CHWs and integrating the CHW scope of practice in health care settings.
Asian Health Services: Innovative Services	This resource, from the Asian Health Services (AHS), offers recommendations to coordinate with AHS for the recruitment of CHWs and offers tips for CHWs to engage with Asian American clients.
Integrating the *Promotores* Model to Strengthen Community Partnerships (PDF)	This issue brief, by the Center for the Study of Social Policy, is meant to provide organizations with a deeper understanding of the *Promotor* Model — including its purpose, history, and contributions to community capacity-building efforts.
Recognizing and Sustaining the Value of Community Health Workers and Promotores (PDF)	This brief, by the Center for Health Care Strategies, 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.
Building a Community Health Worker Program: The Key to Better Care, Better Outcomes, & Lower Costs (PDF)	This toolkit, developed by the American Hospital Association and the National Urban League, is intended to help administrative and clinical leaders across the United States implement successful and sustainable CHW programs.

CHW/P Program Design and Development *(continued)*

RESOURCE TITLE	BRIEF DESCRIPTION
Rural Health Information Hub: CHW Toolkit	This resource, supported by the US Department of Health and Human Services, describes the role of CHWs in a rural setting.
State Community Health Worker Models	This map, produced by the National Academy for State Health Policy, highlights state activity to integrate CHWs into evolving health care systems in key areas such as financing; education and training; certification; and state definitions, roles, and scope of practice.
Integrating Community Health Workers into Primary Care Practice: CHWs and Health Care for the Homeless	This toolkit, supported by the US Department of Health and Human Services, discusses the roles of CHWs for members experiencing homelessness, includes hiring, training, and integration tips.
Addressing Social Determinants of Health through Community Health Workers: A Call to Action (PDF)	This list, created by the Hispanic Health Council and its expert policy research panel, contains 20 recommendations in seven broad CHW policy categories.
Traditional Health Worker Toolkit (PDF)	This tool from the Oregon Health Authority's Office of Equity and Inclusion details the scope of practice and benefits of different roles under the traditional health workforce, which includes CHW/Ps. It also describes best and promising practices for coordinated care organizations and health systems interested in integrating this workforce.
Readiness Assessment Tool to Secure Financing for Community Health Workers (PDF)	This Readiness Assessment Tool, developed by the CDC, will allow chronic disease programs and their partners to assess current initiatives for securing financing for CHWs in their state and identify sustainability strengths and challenges.

Payment and Financing Examples from Other States

RESOURCE TITLE	BRIEF DESCRIPTION
Community Health Worker Payment Model Guide (PDF)	This report developed by the Oregon Community Health Workers Association is a guide of payment models for integrating and utilizing community health worker services.
Sustainable Financing Models for Community Health Worker Services in Connecticut: Translating Science into Practice (PDF)	This report created by the Connecticut Health Foundation demonstrates how payer or provider organizations can apply findings from published peer-reviewed studies to develop evidence-based, cost-effective CHW interventions in their own organizations.
Community Health Workers in Delivery and Payment Transformation: How New Delivery and Payment Models Can Incentivize and Support the Use of CHWs (PDF)	This case study by Families USA highlights how health system transformation initiatives implemented in Vermont and Oregon aligned with the value that CHWs provide and can incentivize CHW integration.
Community Health Worker Financing Webinar	This recorded webinar from the CDC covers topics such as community clinical linkages, CHWs' financing approaches, Medicaid and CHW financing opportunities, and the New Mexico story for financing CHWs.
How States Can Fund Community Health Workers through Medicaid to Improve People's Health, Decrease Costs, and Reduce Disparities (PDF)	This brief, produced by Families USA, discusses key questions regarding sustainable funding for the integration of CHW/Ps through Medicaid reimbursement for states that want to start or expand such programs.
CHW: Billing and Reimbursement	This resource, from the Minnesota Department of Health, outlines how CHWs are reimbursed through the state's Medicaid program.
Community Health Worker Documentation and Billing Work Flow in an Electronic Health Record: Lessons Learned (PDF)	This resource, from Hennepin Healthcare in Minnesota, outlines CHW documentation and billing workflows.
South Dakota Medicaid Billing and Policy Manual: Community Health Worker (PDF)	This resource from South Dakota Medicaid outlines the CHW covered and noncovered services as well as billing codes.
Sustainable Financing Models for Community Health Worker Services in Maine (PDF)	UMass Medical School health policy experts have developed sustainable financing models for the state of Maine to support four CHW interventions that focus on patients with the greatest, and most costly, health care needs.

Establishing Roles and Recruiting CHW/Ps

Case Studies of CHW/P Programs and Roles from California

RESOURCE TITLE	BRIEF DESCRIPTION
Whole Person Care Improves Care Coordination for Many Californians (PDF)	These findings, from the University of California Los Angeles Center for Health Policy Research, highlight opportunities and challenges in implementing a cross-sector care coordination program for patients with complex health and social needs.
AltaMed Health Services: The Evolution of our Community Health Worker Program (PDF)	This presentation demonstrates the measures of community health worker success both for process and outcome measures at AltaMed.
Supporting the Integration of Community Health Workers in Whole Person Care Pilots (PDF)	This resource, developed by the Healthforce Center at University of California San Francisco, showcases lessons from counties that employed CHWs through WPC.
Whole Person Care: The Essential Role of Community Health Workers & Peers (PDF)	This resource, created by California Association of Public Hospitals and Health Systems and California Health Care Safety Net Institute, summarizes the essential role that CHW/Ps play in the success of WPC pilots. Hiring and workforce development are discussed on slides 10–39.
Utilization of Community Health Workers in Emerging Care Coordination Models in California (PDF)	This resource brief, developed by the Healthforce Center at University of California San Francisco, discusses barriers and recommendations to better utilize CHW/Ps in various care settings in California.
Integrating the Promotores Model to Strengthen Community Partnerships (PDF)	This issue brief, produced by the Center for the Study of Social Policy, is meant to provide community leaders and their partner organizations with a deeper understanding of the *Promotor* Model, based on lessons learned from Los Angeles.
Integrating Enabling Services Staff into Health Center Care Teams (PDF)	This resource features the Community Health Center Network's work in integrating "enabling services" staff — which include CHW/Ps — into care teams, care management plans, and COVID-19 response teams.
Health Homes Year One Implementation Report 2019 (PDF)	This report details Inland Empire Health Plan's experience implementing a Health Homes Program and their success in training and integrating a CHW/P into the care team, entitled a "community-based care management entity."
CHW Role Competencies and Training Passport for CommunityConnect (PDF)	This resource, used for CommunityConnect in Contra Costa County, outlines the role competencies for CHWs and details the schedule for their training program.

Case Studies of CHW/P Programs and Roles from Other States

RESOURCE TITLE	BRIEF DESCRIPTION
How New Mexico's Community Health Workers Are Helping to Meet Patients' Needs	This case study, published by The Commonwealth Fund, describes the many ways CHWs have been integrated into health services in New Mexico to promote health and tackle social challenges including unemployment and criminal recidivism.
Community Health Worker Employment and Supervision in Ohio (PDF)	This fact sheet, from the Ohio CHW Statewide Assessment, explains the roles and competencies for CHWs in Ohio.
Integrating Community Health Workers in Ohio's Health Care Teams (PDF)	This report, produced by Universal Health Care Action Network Ohio, provides an overview of CHWs in Ohio and offers examples of other states that have adopted innovative strategies around scope of practice, training, and sustainable financing.
Community Health Workers in Vermont (PDF)	This brief, produced by the Community Health Workers of Vermont, summarizes data from a May 2020 survey of CHWs and supervisors from across Vermont to collect information about the roles, scope of work, skills, and training of the CHW workforce in the state.

Resources on CHW/P Supervision and Supports

RESOURCE TITLE	BRIEF DESCRIPTION
Community Health Worker Assessment Toolkit: A Framework for Assessing Skills Proficiency and Fostering Professional Development (PDF)	This report, developed by Community Health Worker Core Consensus Project, helps CHW employers (supervisors and program managers) and CHWs in assessing their skills both during the hiring process and on the job.
Rubric for Assessing Community Health Workers Providing Direct Client Services (PDF)	This rubric was developed by City College of San Francisco's Community Health Worker Certificate Program to assess CHW performance.
Supervision of Community Health Workers (PDF)	This excerpt from "Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guide" — developed by United States Agency for International Development — discusses key strategies for implementing CHW supervision systems.
Integrating Community Health Workers in Ohio's Health Care Teams (PDF)	This report, produced by Universal Health Care Action Network Ohio, provides an overview of CHWs in Ohio and offers examples of other states that have adopted innovative strategies around scope of practice, training, and sustainable financing.
Developing Sustainable Community Health Worker Career Paths	This is issue brief from the Penn Center for Community Health Workers shared key findings from a participatory action research framework about community health workers' perspectives on job satisfaction and career advancement and inform the design of a career development program.
Supervision Strategies and Community Health Worker Effectiveness in Health Care Settings	This paper from subject matter experts highlights tips for supervisors to effectively use CHWs in health care settings.

Job Descriptions and Salary Information

RESOURCE TITLE	BRIEF DESCRIPTION
Community Health Worker Payment Model Guide (PDF)	This is a resource that provides additional considerations for salaries and sustainable funding mechanisms for CHW/Ps.
The University of New Mexico: CHW Position Classification Description	This is a job description for CHWs working in both clinical and community-based settings.
Tiburcio Vasquez Health Center: Promotora (PDF)	This is a job description for a *promotora* position.
Contra Costa County: Community Health Worker I	This is a job posting with a salary range for an entry-level community health worker.
Contra Costa County: Community Health Worker II (PDF)	This is a job posting with a salary range for a mid-level community health worker.
Contra Costa County: Mental Health Community Support Worker I	This is a job description for an entry-level CHW in a behavioral health setting.
Homeless Health Care Los Angeles: Care Coordinator Case Manager (PDF)	This is a job description for a care coordinator case manager, whose role is similar to a CHW.
Riverside County: Community Service Assistant (PDF)	This is a job description for a community service assistant — a CHW in Riverside County.
Riverside Health: Health Coach Job Description (PDF)	This is a job description for a health coach — a CHW with a college education at Riverside Health.
Telecare Corporation Summary of Unlicensed Workforce in California (PDF)	This document is a compendium of all positions and job descriptions for the unlicensed workforce in California.

Training and Supporting CHW/Ps

Examples of Training Frameworks and Materials for CHW/Ps

RESOURCE TITLE	BRIEF DESCRIPTION
Basic Description of CHW Program (PDF)	This resource, from the Worker Education and Resource Center, offers a high-level outline of its CHW Core Competency Program.
Preparing Community Health Workers for Their Role as Agents of Social Change: Experience of the Community Capacitation Center (PDF)	This resource describes how the Community Capacitation Center in Oregon uses a combination of content, methodology, and values to prepare CHWs to make an optimal contribution to health. Recommendations are provided for CHW training programs and policymakers.
C3 Project: Community Health Worker Assessment Toolkit (PDF)	This toolkit created by the CHW Core Consensus Project (C3 Project) summarizes guiding principles for assessing CHW skill proficiencies, and includes a rubric for assessing CHW performance, self-assessment tools for CHWs and supervisors, and a sample orientation checklist.
C3 Project: CHW Roles and Competencies Review Checklist (PDF)	This checklist, designed to be used for personal, programmatic, and policy review, can help organizations assess how CHW roles and skills can be mapped to CHW training.
Centers for Disease Control and Prevention: A Community Health Worker Training Resource for Preventing Heart Disease and Stroke (PDF)	This extensive resource is intended to be used as a training manual for CHWs on heart disease and stroke, and a reference and resource for CHWs, such as tip sheets.
Community Health Center Network: Care Neighborhood CHW Training Checklist (PDF)	The Training Checklist lists training that CHCN provides for CHWs focused on organizational orientation and continuing topics. This training can take place during interdisciplinary team meetings, training and lecture opportunities, shadowing other CHCN team members, outside training opportunities, and on-the-job experiential learning.
Contra Costa Health Services: New Staff Training Checklist Contra Costa Health Services: Case Manager Training Passport (PDF)	These resources, used for CommunityConnect in Contra Costa County, outline required onboarding trainings for newly hired staff, as well as trainings that experienced CHWs lead for newly hired CHWs.
Foundations for Community Health Workers, 2nd Edition (available for purchase at online book retailers) Training Guide: Foundations for Community Health Workers	This widely used textbook has been adopted by many states as their official training curriculum and recognized as a best practice model by the C3 Project. The companion training guide provides step-by-step lesson plans for CHW trainers and teachers, including activities and assessments. Video resources for this textbook and training guide can be found at the YouTube channel.
The Kennedy CHC Community Health Worker Orientation Toolkit	This resource is a standardized training playbook for organizational orientation training with templates, activities, and work scenarios. The toolkit includes policies and procedures; assessments, documentation, and data-collection standards; job descriptions; standards for communicating with patients, coworkers, and partner agencies; and basic education guidelines.
Community Capacitation Center, Multnomah County Health Department: An Introduction to Popular Education (PDF)	This booklet is designed to be used during a workshop on popular education and includes guidance for planning trainings using popular education and *dinámicas*/movement building activities for popular education.
Santa Clara County: Care Team Assessment Tool (PDF)	This care team assessment tool is used to identify whether CHW/Ps are meeting standards for competencies.

Examples of Training Frameworks and Materials for CHW/Ps *(continued)*

RESOURCE TITLE	BRIEF DESCRIPTION
Telecare: Training Unlicensed Professionals (PDF)	This table from Telecare shows one-time training provided for unlicensed professionals, including as part of the new hire orientation. Required annual training is not included in the table.
Whole Person Care: The Essential Role of Community Health Workers & Peers (PDF)	This presentation, hosted by the California Association of Public Hospitals and Health Systems and California Health Care Safety Net Institute, discusses training and capacity building on slides 42–68 with presentations from Whole Person Care Ventura and Whole Person Care Los Angeles.
CHW Role Competencies and Training Passport for CommunityConnect (PDF)	This resource, used for CommunityConnect in Contra Costa County, outlines competencies for CHWs and details the schedule for their training program.

Examples of Training Frameworks and Materials for Organizations and Supervisors

RESOURCE TITLE	BRIEF DESCRIPTION
Supervisory Skills for Working with CHWs Outline (PDF)	This outline, produced by Community Resources, LLC and the Center for Health Impact, describes the most recent components of a training for CHW/P supervisors.
Supervision Strategies and Community Health Worker Effectiveness in Health Care Settings	This article explores supportive supervision for CHW/Ps in practice, which can inform training of supervisors.
Workforce Readiness Training: A Comprehensive Training Model That Equips Community Health Workers to Work at the Top of Their Practice and Profession	This paper details the framework, learning environment, pedagogical format, results, lessons learned, and testimonials of the comprehensive training model, "Community Health Workers/Promotores Academy," at San Manuel Gateway College, Loma Linda University in California.

Training Toolkits and Reports

RESOURCE TITLE	BRIEF DESCRIPTION
Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings (PDF)	This resource, created by the Sinai Urban Health Institute, summarizes evidence related to CHW training, supervision, and integration into health systems and provides recommendations for health care organizations.
Camden Coalition COACH Model for Complex Care (PDF)	This toolkit created by the Camden Coalition is a training manual for COACH, a set of techniques and tools used by a health care team as part of a short-term, intensive care management intervention.
Key Workforce Priorities for the Community Transformation Model (PDF)	This report by *Visión y Compromiso* explores findings related to the *promotor* model as a model for community transformation, with recommendations focused on training, curricula, and professional development for *promotores*.
Meaningful Roles for Peer Providers in Integrated Healthcare: A Guide (PDF)	This toolkit provides information for how integrated care settings can hire, train, integrate, and retain peer workers in multidisciplinary teams.
Supporting the Integration of Community Health Workers into Health Care Teams in California (PDF)	Utilizing a Theory of Change framework, this report connects intervention and support opportunities across the spectrum of policy, care delivery and workforce development to drive collective action toward integrating this complex and critically important role into health care teams in California.

Training and Certification Resources from Other States

RESOURCE TITLE	BRIEF DESCRIPTION
Missouri Community Health Worker Curriculum Overview	This resource describes the core competencies and associated abilities covered in CHW certification training programs in Missouri.
New Jersey Basic Standard Curriculum for Community Health Workers Summary of Learning Objectives	This resource summarizes the learning objectives for the New Jersey basic standard curriculum for CHWs.
Oregon Curriculum Standards for Community Health Workers, Peer Wellness Specialists, Personal Health Navigators, and Peer Support Specialists Certification	This resource outlines requirements for core curriculum topics for state approved training programs for CHWs, Peer Wellness Specialists, Personal Health Navigators, and Peer Support Workers.
Texas A&M Center for Community Health Development: Core Competency Curriculum Outline (PDF)	This resource outlines the competencies and topics covered in a 160-hour certification training offered by the Center for Community Health Development's CHW Training Center at Texas A&M.
Washington State CHW Training Program Master Syllabus (PDF) Washington State CHW Training Program Course Objectives (PDF) Washington State CHW Training Program Participant Manual (PDF)	These resources are based in Washington State's core competency training program, which is offered online quarterly.

CHW/P Roles in Data Collection and Outcomes Measurement

Designing Programs that Engage CHW/Ps to Collect Data

RESOURCE TITLE	BRIEF DESCRIPTION
CalAIM Data Exchange Roadmap	This webinar provides an overview of the roadmap to the ECM benefit and ILOS under the CalAIM initiative.
Integrating Community Health Workers on Quality Improvement Teams: Lessons from the Field (PDF)	This Health Leads report demonstrates how to equip CHWs with the tools to collect and analyze data, design, and track improvements, and ensure stronger integration into care teams.
Community Resource Referral Platforms: A Guide for Health Care Organizations (PDF)	This report, developed by Social Interventions Research and Evaluation Network (SIREN) researchers, is a guide for safety-net health care providers regarding the current landscape of these community resource referral technology platforms.
CHW Common Indicators Project: Proposed Indicators for Priority Constructs (PDF)	This draft list, developed by the Common Indicators project, is a set of evaluation indicators and measures to understand the unique contributions of CHW/Ps to successful program outcomes.
CHW Common Indicators Project: Full List of Recommended Constructs with Definitions (PDF)	This draft list, developed by the Common Indicators project, includes a list of process and outcome constructs along with definitions for programs to use to evaluate CHW/Ps.
Addressing Health-Related Social Needs among Medicaid Beneficiaries: Mapping Cross-Sector Partnership Roles (PDF)	This framework was developed by the Center for Health Care Strategies to support managed care organizations, health care providers, and community partners in mapping potential cross-sector partnership roles for addressing health-related social needs based on the relative strengths of each partner.
The Health Leads Social Health Data Toolkit (PDF)	This toolkit is designed for a range of health care teams seeking to effectively collect and apply social health program data, including steps to develop a social needs program and tips for tackling common screening challenges.
Riverside Health Items to Check for Outpatient Clinic Outreach Staff (PDF)	This document from Riverside Health provides measures for CHW/Ps to check on a patient's chart before a phone call or office visit, which includes items such as advanced directives, immunization status, and medication lists.

Behavioral Health and SDOH Screening Tools

RESOURCE TITLE	BRIEF DESCRIPTION
Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool (PDF)	This paper from Center for Medicare & Medicaid Services describes the considerations and processes that shaped the screening tool, including the component questions.
Place-Based Interventions Utilizing Community Health Workers (PDF)	This presentation from Desert Healthcare District and Foundation shows how CHWs can be useful in assessing and identifying community needs and priorities.
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences	The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PREPARE) screens for a range of social risk factors including income and housing instability.
Hunger Vital Sign Screening Tool (PDF)	This tool assesses food insecurity and hunger.
Hurt, Insult, Threaten, and Scream (HITS) Tool (PDF)	The HITS instrument screens for interpersonal violence.
Patient Health Questionnaire-Anxiety and Depression Scale (PDF)	The Patient Health Questionnaire-Anxiety and Depression Scale screening combines the PHQ-9 and Generalized Anxiety Disorders surveys into a depression and anxiety screening tool.

Program Evaluation and ROI Estimator Tools

RESOURCE TITLE	BRIEF DESCRIPTION
Rubric for Evaluating Agency Support for CHWs (PDF)	This is a draft rubric for assessing how well organizations support the success of CHW employees developed by the City College of San Francisco.
Building a Community Health Worker Program: The Key to Better Care, Better Outcomes, & Lower Costs (PDF)	This toolkit, developed by the American Health Association and the National Urban League, is intended to help administrative and clinical leaders across the United States evaluate programs with CHWs.
Community Health Worker Impact Estimator Tools: Asthma and Diabetes	These interactive Community Health Worker Impact Estimator Tools, developed by Families USA, are customizable and will provide estimates on a wide range of budget, quality, and impact measures, including return on investment and social impact.
ROI Educational Tool	This toolkit, developed by MHP Salud, was designed to calculate the ROI of a CHW/P intervention.

Appendix A: Model Contract Terms

The following includes a list of potential contract terms for MCPs to use with partners (CBOs, counties, and other organizations that employ CHW/Ps). Plans and partners can use this list as a starting point in conversations to discuss pros and cons, track decisions, and further flesh out specifics for the agreement.

CONTRACT SECTION	CONTRACT ELEMENTS

1. SCOPE OF SERVICES	**Defining Services**
	
	→ Outreach, including number of attempts and whether outreach was successful in reaching member, and type of attempt that will count, for example, mail, phone, in-person, connection through another provider
	
	→ SDOH screening and any other assessments, including whether assessments will include pre- and post-service assessment to obtain baseline data, and identifying barriers to accessing health care services
	
	→ Linkages to physical health care, behavioral health care, and social services, including follow-up to determine if referral/linkage was successful in terms of being screened and/or whether it resulted in provision of additional services or interventions addressing SDOH
	
	→ Maintenance of up-to-date CBO referral sources by checking against success of existing referrals and linkages and/or use of a community utility that is a resource to all community resources (e.g., UniteUs)
	
	→ Care coordination/care management
	
	→ Health care promotion and disease prevention activities
	
	→ Linguistic and culturally appropriate services for LEP populations
	
	→ Building capacity and/or advocating for individuals and communities
	
	→ Arranging transportation for members to service providers or other referrals
	
	→ Participation on interdisciplinary teams for assessment and person-centered planning
	
	Defining Populations
	
	→ Options developed under "enhanced care management" as defined by DHCS' California Advancing and Innovating Medi-Cal (CalAIM) proposal:
	
	  • Children or youth with complex physical, behavioral, developmental, and oral health needs
	
	  • Individuals experiencing homelessness or chronic homelessness or who are at risk of homelessness
	
	  • People with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits
	
	  • Nursing facility residents who want to transition to the community
	
	  • Individuals at risk of hospitalization with serious mental illness (SMI) or substance use disorder (SUD) with co-occurring chronic health conditions, or children with serious emotional disturbance (SED)
	
	  • Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community

CONTRACT SECTION	CONTRACT ELEMENTS
1. SCOPE OF SERVICES *(continued)*	→ Options developed under "in lieu of services" as defined by CalAIM proposal, which may or may not be focused on specific populations: • Housing transition navigation services • Filling other gaps to address social determinants of health, such as linkages to community transitions, personal care and homemaker services, home modifications, meals, sobering centers, and asthma remediation → Geography → Age range, if applicable → Limits on caseloads and cumulative numbers of patients if applicable, and whether there will be waiting lists → Prioritization of populations or needs, if applicable based on MCP priorities **Providing Training and Supervision** → Certification → Approval of job descriptions → Training expectations → Supervision expectations → Evaluation and feedback
2. MEASURING AND IMPROVING OUTCOMES	**Selecting Measures** → Inputs • Successful engagement • Intake data • Completion of assessments • Referrals • Participating in interdisciplinary care meetings and adding interventions to person-centered plan → Outputs and Outcomes • Health education services • Improvements demonstrated from self-reporting • Health-related services about appointments made • Closed-loop referrals to CBOs that result in services • Interventions that successfully address SDOH, such as housing, food support, other remediations • Transportation assistance to visit health care or other social service providers

CONTRACT SECTION	CONTRACT ELEMENTS

2. MEASURING AND IMPROVING OUTCOMES *(continued)*	**Choosing How to Measure**
	→ Quantitative
	  • Individual level
	    - Addressing individual SDOH gaps
	    - Overcoming barriers to accessing health care services, including linkage to a patient-centered primary care home
	    - Housing retention
	    - Improving health outcomes, such as avoidable ER visits, hospitalizations, and rehospitalizations, or other clinical indicators such as medication adherence, improvements in A1C
	    - Improved behavioral health outcomes, including self-reported health, adherence to behavioral health appointments
	  • Population level that addresses health disparities and closes gaps (e.g., if disparities exist between racial groups on preventive health screens, did CHW interventions close gaps?)
	→ Qualitative
	  • Member satisfaction surveys, interviews, and focus groups
	  • Surveys and interviews of health care providers and care coordinators
	
	Setting Goals
	→ At individual level
	→ By percentages on inputs
	→ By percentages on outcomes
	→ As improvement targets for making progress toward closing an identified gap
	→ Will plans work on quantifying data into dollars saved or cost-avoidance (e.g., reducing unnecessary care through improvement in care for ambulatory care-sensitive conditions or other AHRQ quality indicators, or dollars leveraged in services that are provided or linked)?
	
	Defining Data to Track Measures
	→ Data that will live with CHWs and be shared with plans
	→ Data that will live with CHWs and be shared with providers
	→ Data that will live with plans and be shared with CHW providers

3. PAYMENT REQUIREMENTS	**Determining Payment Amounts and Methodology**
	→ Flat rates per referral, per member per month or for longer time periods
	→ Flat rates adjusted by population cohort (which will require definition)
	→ Value-based performance
	  • Identification of value metrics
	  • Identification of financial risks, rewards, or shared savings
	  • Determine if cost information will be exchanged
	  • Incentive structure, if applicable
	  • Funding for start-up/infrastructure development

CONTRACT SECTION	CONTRACT ELEMENTS
3. PAYMENT REQUIREMENTS *(continued)*	**Establishing Frequency of Invoicing and Payments** → Responsibility for generating claims or invoices → Type and frequency of documentation required → Whether CBOs must use customer relationship management tool → Other underlying requirements for data collection and reporting to support payments, such as number of interactions or referrals for services → Decide if payment will be dependent on reaching "milestones"— for example, upfront funding with payments made on cadence related to contract performance → Decide if payment will be based on achieving outcomes

4. COMMUNICATIONS BETWEEN PLAN AND CBO	**Making Referrals**
	→ Determine how referrals will be taken, for example, by phone, email, and/or portals, warm or cold transfers
	→ Determine frequency of referrals (e.g., daily, monthly list, etc.)
	→ Determine how receipt of referrals will be confirmed
	→ Availability of staff to take referrals and setting expectations around warm/cold transfers, and timing of follow-up and contacts
	→ Linguistic and cultural capacity
	
	Implementing Regular and Ongoing MCP and CHW/P Communications
	→ Regular check-ins and data review
	→ Interdisciplinary team communications and meetings
	→ Care manager interface including generating care plan, sharing care plans, prior authorizations if relevant (such as for transportation), coordination of services
	→ Process for troubleshooting with named persons as contacts on both sides
	  • Emergent issues
	  • Problems in process related to referrals and/or data
	  • Financial risk issues
	
	Sharing Data
	→ Determine how CBO will share data with plan
	→ Determine if CBO and/or plan will use visual tracking tools, such as dashboards and other graphic organizers
	→ Determine how data will be shared with health care providers and/or care managers and by whom
	→ Determine if/how plan will share data with CBO
	→ Determine if/how providers and/or care managers will share data with CBO
	
	Securing Consent and Ensuring Privacy
	→ Documentation of member consent for participation and for data sharing
	→ HIPAA compliance

Created by Michele Melden, Health Management Associates for purposes of the CHCF *CHW/Ps in the Future of Medi-Cal Project*

Appendix B: Select California and National CHW/P Training Programs

NAME	BRIEF DESCRIPTION	LOCATION
CHW/P Certificate Training Programs at Academic Institutions		
Berkeley City College: Bridge to Community Health Work Certificate	Offers a non-credit certificate for students who plan to pursue a career as a CHW	Berkeley
Cabrillo College: CHW Certificate Program	Offers a CHW certificate program that can be completed in two semesters	Santa Cruz County
City College of San Francisco: CHW Certificate Program	Offers a CHW certificate program that can be completed in two semesters, and trains students to work in the fields of public health, health care, and social services	San Francisco
Pacific Clinics Training Institute: Health Navigator Certification Training Program (Peer Health Navigation)	Offers a certification program for the behavioral health workforce to train on skills and tools to link consumers of behavioral health services to critical services in the physical health care system	Pasadena
Loma Linda University San Manuel Gateway College: Community Health Workers/Promotores Academy	Offers CHW/P training certificate programs in foundations of CHW practice with a comprehensive behavioral health component, and specialty clinic-based and school-based training programs, and continuing education	San Bernardino
Sacramento City College Los Rios: Community Health Care Worker Certificate	Offers a CHW certificate program	Sacramento
Mission College: Community Health Worker Certificate	Offers a CHW Associate Degree program	Santa Clara
Castro Valley Adult and Career Education	This training organization provides a community health worker program with a health navigator focus	Castro Valley
Training Organizations that Develop and Lead Employer-Sponsored Trainings		
Charles Drew University: Community Health Worker Academy	Partners with hospitals and clinical sites around L.A. to develop curricula, and train and place CHWs in clinical settings	Los Angeles County
El Sol CHW/P Training Center	Develops customized curricula and facilitates trainings for CHW/Ps employed at health care organizations, and provides technical assistance on training and implementation for CHW/P programs	Statewide and national
Loma Linda University San Manuel Gateway College: Community Health Workers/Promotores Academy	Develops and delivers employer-sponsored competency-based trainings including (1) Foundations of CHW Practice with Behavioral Health, (2) CHW/P continuing education, and (3) Organizational Readiness Trainings for supervisors and leadership	Statewide and national

(Continues on next page.)

NAME	BRIEF DESCRIPTION	LOCATION
Training Organizations that Develop and Lead Employer-Sponsored Trainings *(continued)*		
Transitions Clinic Network	Trains health systems to implement programs with CHWs to improve health outcomes of communities impacted by the criminal justice system, and simultaneously trains CHWs and health care teams and provides technical assistance on program implementation	Statewide and national
Visión y Compromiso	Develops and facilitates: (1) core skills, advanced, and diverse specialized training in Spanish and English for *promotores* and CHWs, (2) employer-sponsored training for cities, counties, and other partners, (3) supervisor and organizational readiness training, and (4) cultural humility training, among other offerings	Statewide and national
Worker Education and Resource Center	Develops CHW/P trainings using an apprenticeship model, with trainings tailored to employers' needs	Los Angeles
National Training Programs		
IMPaCT (Penn Center for Community Health Workers)	Employers that adopt this model receive access to in-person trainings, an interactive online learning library, and manuals for all CHW/Ps, supervisors, and directors	National
MHP Salud	Offers CHW training, CHW supervisor and manager training, and training for professions working with CHWs	National
National Council for Behavioral Health	Offers a 1-day behavioral health training for groups of CHWs focused on expanding skills and expertise to support people with physical and behavioral health disorders	National
Pathways Community HUB Institute	In this model, emerging community HUBs can receive technical assistance including CHW training services, as HUBs move toward certification in this model	National
Talance, Inc., CHWTraining	CHW training includes training subscriptions within the tracks of core skills, chronic diseases, and healthy living, as well as consulting and custom training curricula	National

Appendix C: CHW/Ps in Enhanced Care Management and In Lieu of Services: A Model of Care Resource

Purpose

This document was developed as a resource for managed care plans completing the CalAIM Model of Care Template. The chart that follows indicates the potential role that CHW/Ps contracted via established local organizations can play in the enhanced care management (ECM) core services and in lieu of services (ILOS).

This document provides insight into:

→ How CHW/Ps can support outcomes, produce data, and build relationships necessary for program delivery and reporting

→ How CHW/P services align with billable encounters

Audiences

Appropriate audiences for this resource include:

→ Managed care plans (MCPs)

→ Community-based organizations (CBOs) and primary care and behavioral health providers incorporating a CHW/P into their ECM care team or ILOS services

→ CHW/P training entities

Development

This resource was produced by Heidi Arthur, Laura Collins, Lauren Ohata, and Nayely Chavez (Health Management Associates) and informed by Shannon Mong (In-Sight Associates) for the California Health Care Foundation (CHCF) *Community Health Workers &* Promotores *in the Future of Medi-Cal* project This material was based on the Draft CalAIM Model of Care Template, which was released for public comment in June 2021. It has been reviewed by members of the project's Stakeholder Group who provided input on the needs of the CHW workforce in California and MCP needs related to CHW/P integration.

Chart Structure

For each core ECM service component, the chart identifies the key function(s) involved, the function a CHW/P could perform, the specific potential CHW/P role and responsibilities, and whether such capacity must be present when the CHW/P is hired or can be developed via training and supervision. ECM/ILOS functions will not be the sole function of a CHW/P, but will instead be conducted by a team, with a lead CM who can be supported by a CHW. In some cases, the lead CM could be a CHW/P.

As part of their role in ECM Core Services, CHW/Ps can facilitate identifying member eligibility for and connection to ILOS, for those MCPs planning to implement ILOS. The chart details how that role can be integrated into the CHW/P's role for ECM, just as CHW/Ps can support identifying member eligibility for and connection to other local community-based services.

Identified functions are not intended to be prescriptive or comprehensive, as the CHW/P role, tasks, activities, and scope will necessarily vary by member, contracting entity (i.e., primary care providers, behavioral health providers, community-based organizations, or counties), and team composition — as well as CHW/P skill, experience, and certifications (e.g., more experienced CHW/Ps know how to address more of these functions).

ECM Core Service: Outreach

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Requirements for conducting outreach primarily through in-person contact.*	Community-based outreach	• Prioritize in-person contact where the member lives, seeks care, or is accessible. • Conduct home visits to support engagement in care management.	• Comfort and skill conducting home visits.	✔	✔
Use of other modalities for outreach, including how and under what circumstances teleconferencing and telehealth may be used to supplement in-person contact; number of required attempts.*	Engagement	• Explore the member's preferences for communication and leverage multiple options, as necessary, to retain contact and liaise on behalf of the care manager and care team. • Use the following modalities, as appropriate, if in-person modalities are unsuccessful or to reflect a member's stated contact preferences: (a) mail; (b) email; (c) text; (d) telephone; (e) video conferencing; or (f) other protected communication tools, such as member portal.	• Ability to ensure that a minimum number of required outreach attempts is made to engage and then maintain member engagement. • Able to manage multiple member relationships via multiple simultaneous communication channels to orient and enroll members in ECM.	✔	✔
Prioritization of those with the most immediate needs.*	Risk screening	• Build rapport with the member and gather information, as necessary for risk screening and stratification. Conduct risk screening and interpret the results.	• Able to utilize and to interpret standardized screening tools. • Able to review the member's chart. • Ability to identify needed documents, data, and assessments. • Able to check in with the supervisor and team regarding clinical gaps and priorities.		✔
Approach to outreach to members who are experiencing homelessness or with whom it may otherwise be challenging to make contact.*	Outreach to those who are homeless or hard to find	• Utilize personal knowledge of the specified member population and knowledge of local community and geographic area to actively seek, find, and engage members who might otherwise be hard to find.	• Proactive and self-directed. • Creative and flexible. • Familiarity with the population of focus and local community, including the people, places, and programs where the identified population is likely to be found and where engagement opportunities are supported.	✔	✔

* Activity related to ILOS.

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Requirements for culturally and linguistically appropriate communication.*	Culturally competent communication	• Communicate with the identified populations for which each ECM provider is responsible, in their preferred language, utilizing strategies that reflect the member's values, attitudes, and beliefs. • Engage with the member and their family in the language and style that the member prefers, serving as a cultural broker for the care manager and care team, on the member's behalf, when necessary.	• Person is culturally and geographically connected to a traditionally underserved population with complex needs. • Person is able to linguistically respond to the member and the member's caregiver/family.	✔	✔
Real-time or frequent information sharing between the MCP and ECM Providers, to ensure that the MCP can assess members for other programs if they cannot be reached or decline ECM.*	Documentation of outreach attempts	• Track and document outreach efforts to ensure that contractual time frames are honored. • Provide timely reporting when members cannot be found, engaged, or choose not to enroll in ECM. • Facilitate engagement in alternate services, as indicated, when members choose not to enroll in ECM.	• Self-directed and able to organize and plan activities as necessary to effectively manage time, meet targets, and ensure thorough documentation and follow-up. • Able to seek guidance from supervisor and care team, as needed.	✔	✔
How the MCP will facilitate information sharing between ECM providers and the MCP in a way that meets local, state, and federal privacy and security rules and regulations.*	Confidentiality protection	• Able to understand and comply with state and federal member protections related to confidentiality and information sharing. • Able to communicate with the member about state and federal confidentiality protections.	• Knowledge of HIPAA rules and regulations, including member rights and responsibility and procedures for reporting HIPAA violations.		✔

* Activity related to ILOS.

ECM Core Service: Comprehensive Assessment and Care Management Plan

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Identify necessary clinical and nonclinical resources that may be needed to appropriately assess member health status and gaps in care.	Risks, needs and strengths assessment	• The following activities are provided either directly or in support of the ECM: • Utilize standardized tools and instruments to assess holistic risks and needs. • Make initial referrals as necessary to completely assess member needs.	• Ability to engage members in the manner that works for each person to complete risk assessment. • Knowledge of local system of care and resources available to conduct rapid assessments.	✔	✔
Developing a comprehensive, individualized, and person-centered care plan by working with the member to assess risks, needs, goals, and preferences and collaborating with the member as part of the ECM process that leverages input from multidisciplinary care team members, support networks, and caregivers, as appropriate.	Goal setting and prioritizing	• Support member in identifying strengths and needs and in setting priorities for achievable short- and long-term goals. • Identify and obtain contact information for the family members, peers, friends, caregivers, and providers who the member wishes to include in care planning. • Obtain contact information and support outreach to schedule care team meeting with member.	• Ability to establish and build Member trust and willingness to participate in goal setting and care planning.	✔	✔
Incorporating into the member's care management plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, substance use disorder (SUD), long term services & supports (LTSS), oral health, palliative care, necessary community-based and social services, and housing.	Care team identification, convening, and facilitation	• Utilize motivational interviewing and other evidence-based approaches to support members in achieving their goals.	• Person-centered care planning skills, motivational Interviewing skills, and other evidence-based approaches, such as problem-solving treatment and behavioral activation. • Skills based on harm reduction principles.		✔
Ensuring the member is reassessed at a frequency appropriate for the member's individual progress or changes in needs and/or as identified in the care management plan.	Individualized care plan development	• Support member to participate in the care team as needed, including providing transportation, translation assistance, and encouraging member partnership regarding needs and preferences.	• Flexible and creative problem-solving to support member engagement in their care plan (e.g., obtaining a cell phone or data card from the MCP; assisting in setting up teleconferencing, downloading required application, assisting with first-time use).	✔	✔
Ensuring the care management plan is reviewed, maintained, and updated under appropriate clinical oversight.	Re-assessment and care plan updates	• Sustained engagement with members to rapidly intervene when status changes or updates are otherwise necessary. • Documentation and care plan development.	• Documentation skills and capacity to provide routine check-in contacts in person or via member preferred method.		✔

ECM Core Service: Enhanced Coordination of Care

Activity related to ILOS.

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Organizing patient care activities, as laid out in the care management plan, sharing information with those involved as part of the member's multidisciplinary care team, and implementing activities identified in the member's care management plan.	Guide care plan implementation	• Based on CHW experience, the CHW may act as the lead care manager or as a care management extender. • CHW coordinates with the member, caregivers, and providers/programs as necessary to ensure the care plan is implemented based on member priorities and goals.	• Ability to build rapport with members to ensure that members' voices are both heard and documented with regard to their priorities and needs toward achievement of the members' goals.		✔
Maintaining regular contact with all providers who are identified as being a part of the member's multidisciplinary care team, whose input is necessary for successful implementation of member goals and needs.*	Coordinate care team communication	• Outreach, when necessary, to the member and to providers to confirm access, resolve barriers, and facilitate seamless attention to integrated and trauma-informed care. • Expedited, seamless closed-loop referrals to treatment and services. • Routine documentation in a shared care plan used by all members of the ECM team.	• Capacity to communicate effectively with a range of professional providers.	✔	✔
Ensuring care is continuous and integrated among all service providers and referring to and following up with primary care/physical and developmental health, mental health, SUD treatment, community-based LTSS, oral health, palliative care, trauma-informed care, necessary community-based and social services, ILOS, and housing, as needed.*	Coordinate access to care	• Support lead care manager by facilitating the member's access to the clinical and community services necessary to implement the member's care plan. Communicate with the member and the member's providers to ensure that comprehensive whole person needs are identified and addressed.	• Meet with members in their home or other preferred location to identify and discuss medical and nonmedical needs, progress with recommended behavior changes, access to care, and referral follow-up.		✔

* Activity related to ILOS.

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Providing support to engage members in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to member engagement in treatment.*	Support for treatment adherence, including compliance with medication and attendance at appointments	• Know and represent the member's perspective and priorities to ensure that care planning is realistic and responsive to each member's individual circumstances. • Leverage home-based access to the member to monitor and improve treatment compliance and medication adherence. • Identify member's prescriptions and over-the-counter medications. Review the member's understanding of use and administration of medication or medical devices. • Conduct medication reviews to inform reconciliations. • Arrange transportation to fill prescriptions. • Conduct visits to check in with the member and report back to the care team about progress in the ECM program. • Work with members to identify and document their personal network of supports and program participation, should members need to be located in the future.	• Capacity to conduct and/or participate in root cause analysis to identify "barriers below the surface." • Capacity to provide interventions that reflect the principles of harm reduction.		✔
Communicating the member's needs and preferences timely to the member's multidisciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care.*	Member advocacy	• Review appointments and support scheduling and rescheduling. • Identify barriers to treatment adherence and/or high-risk behaviors for the member and the care team to consider care plan adjustments, when necessary.	• Capacity to communicate with members and maintain trust and rapport.	✔	✔
		• When needed, accompany members to clinic visits. May also support visits virtually, as appropriate.	• Capacity to support members to attend appointments.	✔	✔

* Activity related to ILOS.

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PRE-REQUISITE	VIA TRAINING/ SUPERVISION
Ensuring regular contact with the member and their family member(s), guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.	Ongoing engagement	• Engage with the member using the motivational interviewing approach. • Provide trauma-informed, harm-reduction, and other evidence-based interventions when necessary to promote Member wellness. • Collaborate with Members in making necessary adjustments to their Care Plan. • Engage Members with regard to medical and behavioral health crisis prevention plans (e.g., the wellness and recovery action plan, or WRAP) to obtain members' treatment preferences and preferred contacts that can be utilized as a crisis prevention or stabilization tool.	• Knowledge and skilled in the motivational interviewing, harm reduction, and trauma-informed care approaches.		✔
			• Sustain ongoing engagement with the member, the care team, and the care manager, as indicated to support member goal achievement.	✔	✔

Activity related to ILOS.

ECM Core Service: Health Promotion

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Working with members to identify and build on successes and potential family and/or support networks.	Identify opportunities for health within member's current or potential network	• Health promotion and self-management training for member, integrating support from family and community resources as indicated. • Assist with linkage to social supports.	• Knowledge of and ability to liaise with local health and wellness resources to make referrals and engage in follow-up related to member health conditions, including physical and mental health promotion.		✔
Providing services to encourage and support members to make lifestyle choices based on healthy behavior, with the goal of supporting members' ability to successfully monitor and manage their health.	Health education and coaching	• Distribute health promotion materials. • Provide one-on-one education. • Conduct group classes.	• Reinforce and encourage healthy behaviors. • Provide motivational interviewing skills and health coaching skills.		✔
Supporting members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.	Support for self-management to achieve wellness goals	• Provide consistent follow-up regarding member-identified goals. • Offer coaching and social support to enhance motivation. • Model, role play, and practice member-directed engagement in care, including activities such as scheduling appointments and assessing member status to inform health behavior change efforts, care plan updates, and treatment decisions.	• Motivational interviewing skills; health coaching skills; care coordination skills; specific health promotion interventions in areas such as, but not limited to, healthful eating, physical activity, alcohol and drug abuse prevention, breastfeeding, asthma management, and prevention and management of cardiovascular disease, type 2 diabetes, and overweight/obesity.		✔

Activity related to ILOS.

ECM Core Service: Comprehensive Transitional Care

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PRE-REQUISITE	VIA TRAINING/ SUPERVISION
Strategies to reduce avoidable member admissions and re-admissions across all members receiving ECM.	Inpatient admission/ re-admission prevention	• Support members and their care teams to identify risks to their stability in the community.	• Lived experience or prior experience supporting transitions to the community.	✔	
		• Ensure that each member's care plan includes member-developed strategies and strategies, identified by the member, to prevent avoidable admissions and build member capacity to become self-sufficient: • organizational skills (medication lists, appointment planning, PCP and specialists contact information). • Assess and support member understanding of discharge orders and follow-up plans.	• Ability to engage members within hospitals, facilities, and institutions; support care planning for community (re)integration.		✔
For members who are experiencing or are likely to experience a care transition: (a) Developing and regularly updating a transition plan for the member; (b) Evaluating a member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges; (c) Tracking each member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members; (d) Coordinating medication review/ reconciliation; and (e) Providing adherence support and referral to appropriate services.	Transition planning	• Work with members who are transitioning from inpatient or institutional settings to community-based care to develop transition plans that include support to access social services and attend health care appointments. • Support members to participate with inpatient treatment staff on the transition plan. • Provide advocacy on behalf of the member with health care professionals.	• Capacity to engage member in discussion of (1) treatment plan, including medications, (2) medication adherence, and (3) health literacy.		✔
	Support for treatment adherence, including medication review and reconciliation	• Monitor treatment adherence (including medication) and identify necessary adjustments to the transition plan based on the member's adherence with treatment, including medication reconciliation. • Arrange transportation as needed and communicate with member and care team to facilitate care coordinated visits.	• Ability to coordinate access to transportation.		✔

Activity related to ILOS.

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PRE-REQUISITE	VIA TRAINING/ SUPERVISION
Technologies, tools, and services that can be deployed and used to provide real-time alerts that notify ECM and care team members about care transitions (acute and subacute care facilities, ED, residential treatment facilities, incarceration, etc.) and other critical health and social determinant status changes (e.g., housing and employment).	Use technology, tools, and targeted interventions to support successful community integration and avoid re-admission	• Leverage technology to monitor risks to member's stability in the community and promote effective care delivery.	• Ability to use technology or learn interventions necessary to support member wellness.		✔

Activity related to ILOS.

ECM Core Service: Member and Family Supports

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Documenting a member's chosen caregiver(s) or family/support person.	Identifying family support	• Engage the member in identifying family supports, including caregivers, "chosen kin," and peer supports.	• Capacity to engage members in identifying available support.	✔	✔
Including activities that ensure the member and chosen family/support persons, including guardians and caregivers, are knowledgeable about the member's condition(s) with the overall goal of improving the member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, state, and local privacy and confidentiality laws.	Family engagement	• Engage member and family in discussion of member health needs and goals. • Utilize health materials to inform family members about the member's health conditions and the role they can play to support the member. • Engage member in developing strategies that leverage caregiver and family support to assist them in achieving care plan goals.	• Capacity to engage family supports in member care, identifying strategies that promote adherence, health promotion, and wellness.	✔	✔
Ensuring the member's ECM lead care manager serves as the primary point of contact for the member and chosen family/support persons.	ECM single point of contact	• Communicate with family and member regarding ECM primary care manager and care team roles. Facilitate communication as indicated based on role.	• Streamlined communication via lead care manager, in person, via email, text, and phone and other virtual communication as indicated.		✔
Identifying supports needed for members and chosen family/support persons to manage members' conditions and assist them in accessing needed support services.	Connection to wellness supports	• Engage member and family to identify assistance necessary to support member goals.	• Knowledge of available health supports and resources, including ILOS.		✔
Providing for appropriate education of the member, family members, guardians, and caregivers on care instructions for the member.	Health education	• Utilize health materials to inform members and their families about members' health conditions.	• Knowledge of resources, including care team members, and ability to coordinate and communicate effectively with informants and members.		✔
Ensuring that the member has a copy of care plan and information about how to request updates.	Sharing the care plan and updates with member	• Provide care plan to member, including updates.	• Ability to appropriately transmit electronically or in hard copy the member's care plan.		✔

Activity related to ILOS.

ECM Core Service: Coordination of and Referral to Community and Support Services

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Determining appropriate services to meet the needs of members, including services that address social determinants of health needs, including housing, and services that are offered by the MCP as ILOS.*	SDOH service planning; ILOS screening and eligibility assessment	• Support members to identify their full array of needs. • Ability to identify and support members who have low literacy and numeracy skills. • Make closed-loop referrals to local human service system to support members in addressing their SDOH needs including but not limited to housing, food, personal safety, transportation, childcare, energy assistance, education, income assistance, education, etc. • Ensure that each member who is authorized to receive a particular ILOS is appropriately outreached and oriented about the service. • Coordinate with members and their families to facilitate the members' agreement to the receipt of that ILOS and authorization for the data sharing and reporting necessary to support members' successful engagement and appropriate utilization of the ILOS service.	• Understanding of SDOH needs, knowledge of local resources, and ILOS services. • Capacity to initiate conversations about the member's needs, including issues related to food and housing security and personal safety that may require initial trust building. • Capacity to provide warm handoffs to local service providers, including ILOS provider(s). • Capacity to track and manage closed-loop referrals. • Skills related to supporting the member, member's family, and the member's care team to access needed services and ILOS.	✔	✔
Coordinating and referring members to available community resources and following up with members to ensure services were rendered (i.e., "closed-loop referrals").*	Closed-loop referrals	• Provide warm handoffs for members to identified individuals locally able to address the SDOH needs. • Open, track, and manage referrals for community and support services. • Follow-up as necessary to ensure that the need has been met. • Ensure that members know how to use the available resources to benefit from those services.	• Knowledge of and personal connections to local resources. • Capacity to support efficient planning to target priority needs. • Able to utilize tools and processes to close referral loops and track services.	✔	✔

Activity related to ILOS.

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