Healthforce Center at UCSF

Supporting the Integration of Community Health Workers into Health Care Teams in California

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Abstract / Overview
Community health workers (CHWs) and promotores de salud are playing an increasingly important role in the delivery of high quality and equitable health related services, particularly to vulnerable populations. 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.

The mission of Healthforce Center is to equip health care organizations with the workforce knowledge and leadership skills to effect positive change.

Acknowledgements

Contents

Introduction

Community health workers (CHWs) and promotores de salud are playing an increasingly important role in the delivery of high quality and equitable health related services, particularly to vulnerable populations. CHWs/promotores serve as a key linkage between community members and clinical services, serve as trusted individuals, and advocate on behalf of communities regarding issues related to social determinants of health and social justice more broadly.

On a national level, several key legislative changes have led to a growing opportunity to enhance the utilization of frontline workers, such as CHWs/promotores, to better coordinate services and supports for vulnerable communities to achieve the triple aim of better health, better care and lower costs.

The Patient Protection and Affordable Care Act of 2010 includes provisions relevant to CHWs, with a promotion of grants "to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of CHWs" using evidence-based interventions to educate, guide, and provide outreach in community settings.[1,2]

Additionally, recent changes to Medicaid through the Medicaid Preventative Services rule allows for the potential reimbursement for preventative services for non-licensed providers, such as CHWs.[3]

As the health care system embarks on the process of transitioning from fee-for-service reimbursement and volume incentivized care to value-based care, new care delivery and payment models are being implemented across care delivery settings.

Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs) are designed to enhance care coordination and management for patient populations, enhance care transitions and bridge care across clinical and community settings.

Several states - California, Minnesota, Vermont and Washington - have developed Accountable Communities for Health (ACH) models aimed at establishing clinical and community partnership strategies that integrate care delivery system transformation with community-based social services to improve health outcomes, reduce costs and impact behavioral, environmental and social determinants of health.[4]

Health care entities are taking on more financial risk and payment models are increasingly designed to incentivize outcomes and population health management through capitation, global and bundled payment models. As such, care coordination across care teams is becoming an essential component of care delivery and payment reform, especially within efforts around chronic care prevention and management for high-cost populations.

The following current and evolving state policy initiatives reflect health care delivery redesign and payment reform efforts that may incentivize and/or create opportunities for CHWs to be integrated into new models of care:

- PRIME (Public Hospital Redesign and Incentives in Medi-Cal)

- FQHC Payment Reform Pilot (APM)

- Whole Person Care Pilot

- Coordinated Care Initiative (renewed from 2013)

- Health Homes for Patients with Complex Needs

- California Accountable Communities for Health

Most of these initiatives are in the pilot stages and therefore detailed outcomes and concrete insights around payment, reimbursement and integration models for CHWs are not yet available. However, we anticipate important insights and outcomes will emerge from larger-scale initiatives incorporating and scaling up CHWs into new care delivery and payment models.

Methodology

The guiding objective for this project was to develop actionable insights into ways in which CHWs and promotores may be optimally utilized and integrated into emerging care models in California.

We designed a two-phased project intended to 1) synthesize existing literature and policy initiatives related to CHW utilization in clinical care settings and 2) provide actionable insights from existing and evolving CHW programs to enhance California's readiness to successfully integrate community health workers and promotores into the health care delivery system.

This first phase of research culminated in a research and policy brief titled Utilization of Community Health Workers in Emerging Care Coordination Models in California.

This second and final phase of the project included in-person site visits and in-depth interviews with leadership and CHWs/promotores in selected health care organizations in California who are currently integrating CHWs/promotores into health care teams.

Our site visits were designed around the following activities:

- In-depth interviews with clinical/program leadership, training/curriculum leadership and CHWs/promotores

- Observation of program-related activities such as case conferences, specialized training sessions and CHW program meetings.

Our research design was exploratory and not evaluative. Our focus was to obtain insights on drivers and barriers to successful CHW integration through a lens that looked across various health care organizational structures: FQHC, health plan, managed care organization, hospital system, medical home model and county program. The following are high-level descriptions of the six programs profiled in this study.

Community Health Center Network (CHCN)

Community Health Center Network (CHCN) is a non-profit Medi-Cal managed care organization that is dedicated to providing affordable health care to underserved communities. CHCN is comprised of eight health centers in Alameda and Contra Costa counties with more than 80 locations. With a foundation rooted in over 20 years of collaboration in health policy and advocacy work through the Alameda Health Consortium, CHCN was formed in 1996 by member health centers to participate in a rapidly expanding managed care environment. Additionally, CHCN is a designated Innovation Hub, an initiative of Center for Care Innovations with support from the California Health Care Foundation and one of four national Technology for Healthy Communities pilots.

CHCN's intensive case management program, titled Care Neighborhood, aids high-risk, high needs patients in preventing unnecessary hospitalizations by addressing the social determinants of health. CHCN applies a data-driven approach to detect patients at highest risk; community health workers are then assigned to those patients to link them to health care at clinic visits, in their homes, in the hospital, or wherever meets the needs of the patient. In building this relationship, CHWs and patients work together to create care goals. At present, CHCN employs 11 CHWs across seven health centers through their Care Neighborhood program.

Care Connections Program (CCP)

The Care Connections Program (CCP) is a community health worker-integrated, primary care-embedded care management program for Los Angeles County's (LAC's) sickest and most vulnerable patients, or about 5-10% of LAC Department of Health Services' primary care population. These patients have complex biopsychosocial needs, may be difficult to engage, and are high utilizers of care. Once targeted patients have been identified, CHWs work within multidisciplinary complex care teams to support existing PCMH nurse care managers to extend the reach of primary care team into the community. To accomplish the goals of improving care and reducing costs, CHWs enhance patients' ability to self-manage and navigate a fragmented delivery system, connect patients to available resources, and facilitate coordination as part of the PCMH.

Following the launch in 2015, CCP has met its goals to hire, train, and deploy 35 CHWs throughout five to ten primary care sites. The program scope is expanding with plans to develop a more robust PCMH-embedded CHW program and create additional CHW roles centered on transitions-of-care and the re-entry population.

Inland Empire Health Plan (IEHP)

Inland Empire Health Plan (IEHP) is a non-profit Medi-Cal and Medicare health plan that is committed to providing convenient, affordable and quality health care. Serving residents of Riverside and San Bernardino counties, IEHP was founded in 1996 and was the region's first Medi-Cal managed care plan.

IEHP's Health Navigator (HN) program includes a two-visit model comprised of home visits and follow-up phone calls. In the home, HNs educate IEHP members on prevention and disease management using iPad-enabled presentations and information tools. Additionally, HNs provide health-related assistance to a member's family and links them to the appropriate community resources to address the social determinants of health. At present, IEHP employs 11 HN's, two HN Specialists (focused on outbound follow-up), one HN Coordinator supporting the team with promotional materials, two HN Supervisors, and one HN Program Manager who oversees the HN program and staff.

IEHP is developing a broader pilot initiative that will incorporate CHWs into complex care teams within clinics focused on integrating behavioral health services into primary care. They expect to hire 18 CHWs within nine complex care teams across three health care organizations.

La Clínica de la Raza

La Clínica de la Raza is a community health center that provides primary health care and additional services to residents of Alameda, Contra Costa and Solano counties. Beginning as a single storefront in 1971, it has now grown to more than 40 locations. La Clínica delivers health care services in a culturally and linguistically appropriate manner to more effectively address the needs of the diverse population that it serves.

La Clínica has a diverse set of Health Educator, Community Health Worker, and Patient Navigator programs designed to link patients to health care. Health Educators address the social determinants of health by facilitating workshops and providing resources to help patients obtain affordable, healthy food; connect to housing, employment, and education; and encourage exercise. Additionally, some Health Educators serve the HIV positive community by acting as HIV case managers, facilitating support groups, and providing testing and outreach in various venues, such as nightclubs. The CHW program also targets the social determinants of health, but within a jail and prison re-entry context. The Patient Navigator program aims to connect emergency room visitors with insurance and other necessary services.

Transitions Clinic Network (TCN)

The Transitions Clinic Network (TCN) is a consortium of primary care clinics that aims to increase access to health care services, improve health and reduce recidivism among high-risk, chronically ill people recently released from prison. Founded by two University of California, San Francisco medical residents in 2006, TCN has implemented the Transitions Clinic model with 17 clinics in eight states and Puerto Rico, and served thousands of individuals upon their release from prison. TCN is located in communities most impacted by incarceration in order to promote successful re-integration into communities and health care delivery services.

TCN provides primary care services to recently released prisoners and their families by utilizing culturally-competent providers and community health workers with a history of incarceration. Prior history of incarceration is a unique attribute that allows CHWs to fully address the physical and behavioral health needs, as well as the social determinants of health, of this specific population. Each site has one to three CHWs who are trained in working most effectively with this population and manage an active caseload of 20-30 patients. CHWs are encouraged to spend half of their time in clinic and half of their time off-site. CHW integration within the rest of the

clinical care team (physician, MA, RN, social workers and behavioral health specialists) and community outreach are key factors to the success of the program.

Kaweah Delta Health Care District

Kaweah Delta Health Care District is the largest hospital in Tulare County as well as a certified level III Trauma Center. Originally founded in 1963, it now spans eight campuses in its health care district. Kaweah Delta offers comprehensive health care services, including but not limited to, cardiac surgery, general surgery, cancer treatment, mental health services, orthopedic surgery and a pediatric center.

Kaweah Delta utilizes CHWs to help patients manage chronic diseases such as diabetes and obesity with a focus on empowering patients. Outreach coordinators facilitate nutritional education workshops and exercise classes, all while encouraging volunteers to take on a more active role in the community by becoming "resident leaders." In addition to going on home visits, CHWs facilitate groups, plan/implement events, and attend health fairs and other presentations to conduct outreach. Within the Bridge Program, two Community Health Outreach Specialists are stationed at the Chronic Disease Management Center, while the remaining Outreach Specialists serve the rest of the district. Kaweah Delta's utilization of CHWs is centered on extending their capacity beyond treating physical and behavioral health to fully address social determinants of health. Currently, Kaweah Delta employs 12 full-time community health worker positions and two CHW-related per diem positions for a special project.

Theory of Change: Framework

To create an actionable framework to enhance utilization of CHWs in care teams in California, we developed our findings within a theory of change framework.

"Theory of Change is a rigorous yet participatory process whereby groups and project stakeholders identify the conditions they believe have to unfold for their long-term goals to be met. These conditions are modeled as outcomes, arranged graphically in a causal framework."[5]

We chose to use the Theory of Change as a framework to enhance utilization and integration of CHWs in California for several reasons. First, the workforce planning models that reflect traditional supply and demand models, education/certification, training and payment/reimbursement to address established workforce needs are limited in their capacity to fully capture the interwoven causal conditions that impact current efforts to enhance utilization of the CHW workforce in California. Second, the CHW stakeholder community is broad and diverse in terms of expertise and involvement, and we want to capture the breadth of knowledge and involvement from the CHW community. Third, although the CHW workforce is not new, current thinking about new roles and enhanced utilization is new and needs to be developed beyond existing models.

Traditional Workforce Planning Models

Traditional workforce planning models in health care center on an approach that includes the following:

• Data – Analyses of current health care workforce

• Strategy – Overarching workforce planning approach

• Planning – Approach to create pipelines to fill future workforce needs

- Evaluation – Ability to monitor effectiveness of the plan[6]

While we draw on aspects of these elements, traditional workforce planning models in health care are built on a premise that there is an *existing* role in health care organizations with corresponding data on that given workforce role that can be assessed to develop a strategy and plan to fill future workforce needs for that role.

This traditional workforce planning model cannot be directly and uniformly applied to analyses of the CHW workforce because the basic premise of the workforce planning model does not fit within current reality of the CHW workforce. Instead, any of the workforce planning efforts around CHWs must reflect the following unique factors:

- Integrating CHWs into clinical care teams requires a clinical transformation approach and not simply a supply and demand model for an existing workforce.

- A "demand" model for CHW roles in clinical care organizations is still developing within broader clinical transformation efforts; there is an emerging need to directly address social determinants of health to improve patient outcomes, but not yet a defined process to effectively integrate non-clinical CHW roles and a sustainable employment model that translates to a defined "demand" model for the role.

- The "supply" of CHWs is primarily drawn from an existing diverse workforce that is grounded in a community transformation model; here, the scope of work has traditionally been centered within communities and community-based organizations, not in clinical models of care.

Community Transformation Model

The community transformation model is understood as a "social justice model for improving individual and community health and well-being."[7] Grounded in Paulo Freire's popular education methodology, the community transformation model is built within a framework of community empowerment and social change rooted in deep community engagement and trusted relationships.

The promotor model and "lay" CHW role developed from a community transformation model. As clinical care delivery models look to incorporate these important roles into their clinical settings, an institutional shift and transformation must occur to truly integrate this *model* of care into clinical settings. This requires a more robust and appropriate workforce development framework that extends beyond traditional workforce planning models in order to acknowledge that the "supply" of CHWs comes out of a transformational model of care; it cannot simply be treated as a new health care job title that can be plugged into traditional medical models of care.

Workforce Planning Using a Theory of Change Framework

With this understanding, we grounded our analyses and actionable insights in a Theory of Change framework that more accurately captures the transformation that needs to happen across care delivery systems and across existing CHW/promotor models to successfully integrate and enhance utilization of this critical role in clinical care teams.

The Theory of Change framework allows us to create a more robust causal model that will more appropriately capture:

- The factors needed to successfully integrate CHWs into care teams across the varied conditions and CHW employer settings: community-based organizations, care delivery organizations, county initiatives and health plans.

- Interventions and actions needed to promote CHW workforce development and enhance clinical readiness to effectively and appropriately integrate the CHW role.

Enhancing the utilization of CHWs into health care teams will require equivalent attention toward building leadership readiness to leverage CHWs within care delivery settings, leveraging new payment models and building appropriate CHW workforce development strategies.

The Theory of Change model provides us with a framework to connect intervention and support opportunities across the spectrum of policy, care delivery and workforce development to yield optimal impact for this complex and critically important role.

Theory of Change Process

The Theory of Change is both a process and a product. To develop the conceptual and visual framework displayed below, we completed the following process:

- Defined the overarching long-term goal

- Conducted a "backwards mapping" process to define and connect all outcomes/preconditions necessary to ladder up to the established long-term goal

- Identified foundational "interventions" – actions – that can be leveraged to support the preconditions outlined in the framework and achieve the overall outcome

Theory of Change: Pathways to Successful CHW Integration

LONG-TERM GOAL:
Sustainable employment and integration of CHW role into health care teams

Care delivery organizations are fully primed to integrate a patient-centered non-clinical CHW role into coordinated care

CHW model of care is fully respected and established within care delivery models addressing social determinants of health

Provider and payer systems integrate CHW employment into cost of care

Leadership and Transformation training and infrastructure established for clinical leaders integrating CHW role into care delivery

Relevant business case for CHW role integration built on access, engagement, patient outcomes, and cost savings

CHW role in clinical care is established as a critical intervention at the patient level; serving as a bridge between community and clinical care to impact social determinants of health

Community-based CHWs receive training on health literacy and clinical system knowledge and utilization of clinical information systems

New payment models optimize CHW utilization

Clinical leadership has training on evidence of CHW/Promotor impact, community model, and function to address social determinants of health

Appropriate metrics developed to measure impact and ROI

Training pathways ladder between community and clinical settings, serving varied CHW-patient intervention points

Research and evaluation methodologies appropriately measure impact of CHWs across measures of clinical and social determinants of health

Community-based CHW and Promotor programs have sustained funding streams to maintain a foundational model of community action for vulnerable populations

CHW workforce pipeline is strengthened and drawn directly from local community-based CHW/Promotor organizations and advocate networks

Clinical entities demonstrate full commitment and requirements to directly address social determinants of health in care delivery models

Elevated recognition of the CHW role as a spectrum of job titles with a collective function centered on delivering person-centered care across the continuum of community through clinical settings

ACTION:
Formalized knowledge-sharing and best practices from large scale CHW integration efforts currently underway in CA

ACTION:
Formalized partnerships and collaboratives develop between clinical and CHW/Promotor community organizations

ACTION:
Streamlined training pathways link community-based organizations, health plans, and provider systems around targeted training, workforce preparation, CHW integration/readiness

We have framed the overall objective of this Theory of Change around health care transformation centered on the long-term goal of sustainable employment and integration of the community-centered community health worker role into health care teams in California.

This overarching goal is based on the following assumptions:

- The value of CHWs has been well established in the literature;

- There is an existing and growing movement toward integrating the CHW model of care into clinical care delivery models in California; and

- Current state policy initiatives and new payment models are driving both tacit and explicit support for integrating CHWs into clinical care delivery models.

We wish to underscore the fact that this goal and overall Theory of Change toward integrating CHWs into care teams is not an effort to transform *all* community health work into clinical and medical care settings. We posit that the successful integration of CHW roles into clinical care teams will require enhanced awareness and direct support for community health and community transformation models that remain centered in non-clinical, community-based settings. Moreover, successful integration of CHWs into clinical care settings will require close collaboration with CHW and promotor leadership, who are optimally positioned to serve in advisory and consultative capacities when designing CHW integration models that will traverse clinical and community settings.

Additionally, this long-term goal of sustainable CHW employment and integration is not an effort to medically "professionalize" the CHW role as a clinical role. On the contrary, the goal is to transform care delivery models in such a way that health systems have the full capacity to optimize the *existing* community health worker/community transformation model in order to:

- Improve person-centered care;

- Directly address social determinants of health and mitigate barriers to care; and

- Build sustainable employment opportunities across the entire spectrum of community health worker roles.

The following section provides detailed findings and insights for each element of the theory of change framework displayed above. The detailed findings are organized to follow the "backwards mapping" process we utilized. Therefore, each section will lead in with the previously defined "outcome" element from the framework and provide detailed insights into the defined "precondition" that must be met to achieve each outcome we have defined in this framework.

We will conclude with a section that outlines the foundational "Action" elements of theory of change framework, providing high-level recommendations and considerations for targeted actions that can serve to propel the goal of successful CHW integration into care teams forward.

Theory of Change: Detailed Findings

> **LONG-TERM GOAL:**
> Sustainable employment and integration of CHW role into health care teams

The long-term goal of sustainable employment and integration of CHWs requires three foundational and interconnected preconditions centered on:

- Care delivery system readiness;

- Full respect and commitment to establishing the CHW model of care into care delivery models; and

- Provider and payer employment models that pay for CHW roles as part of the cost of care, not a carve-out.

All three are necessary preconditions that must work in concert to achieve the overarching goal of sustainable employment and integration of CHWs that will scale across the health care delivery system.

At present, we view these preconditions as largely aspirational. There is encouraging activity and efforts that are collectively building toward these critical outcomes that we highlight in detail in the subsequent elements of this framework. Nevertheless, there is considerable work to be done in order to build the foundation to achieve these important outcomes. This Theory of Change framework will illuminate the causal mechanisms and relationships across these interwoven elements in an effort to build on existing transformation efforts and accelerate CHW integration efforts.

OUTCOME: In order to achieve the long-term goal of sustainable employment and integration of CHW role into health care teams…

PRECONDITION: Care delivery organizations must be fully primed to integrate a patient-centered, non-clinical CHW role into coordinated care models

> Care delivery organizations are fully primed to integrate a patient-centered non-clinical CHW role into coordinated care

While recognition of the value and impact of CHWs continues to grow – and CHW roles are increasingly being utilized in clinical care settings – there lacks a widespread care delivery system transformation and readiness-building effort aimed at building capacity to integrate the CHW role into coordinated care delivery models.

In many ways, this parallels the overall pace of health care delivery system reform toward true population health and complex care management. While theory and policy has embraced value-based care, person-centered care, population health, and prioritizing complex care management, the actual on-the-ground health care delivery transformation (e.g., behavior change, clinical workflow changes, health information technology/exchange, payment reform) is evolving, but at a much slower pace.

Therefore, while research, advocacy, policy, and some payment reform initiatives support utilization of community health workers as an appropriate and effective approach in health care reform efforts centered on population health and complex care management, most care delivery organizations do not have a robust infrastructure in place to easily integrate this critical community-centered role.

CHWs are not a new workforce, but integrating a non-licensed, patient-centered role that traverses clinical and community settings is new for most clinical models.

"Our health care delivery system is not mature yet in its efforts to truly 'do' population health and complex care management."

—Medical Director

We are learning from current efforts that successful integration of CHW roles requires an established infrastructure, and this requires a significant and explicit effort on the part of care delivery organizations to be fully primed to optimize this role.
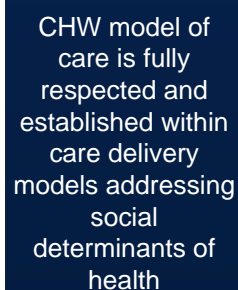
In part, this will require tangible tools and training, which is discussed in further detail below. However, truly successful integration efforts will require *culture change* within clinical care teams and care delivery organizations as a whole.

"A change in culture needs to happen with adding an extra team member and re-adjusting workflows to make sure that CHWs are integrated."

—Program Planning Leader

OUTCOME: In order to achieve the long-term goal of sustainable employment and integration of CHW role into health care teams…

PRECONDITION: The CHW model of care must be fully respected and established within care coordination models addressing social determinants of health.

> CHW model of care is fully respected and established within care delivery models addressing social determinants of health

The understanding of what a CHW does, the value they bring, and their unique working conditions across clinical and community settings must be established within care delivery systems in order to truly build, care for and sustain the CHW workforce.

At present, there is a significant lack of awareness, understanding, and respect for the CHW model of care within care delivery organizations that impacts their capacity to be fully integrated and utilized to their full potential. Full respect and establishment of the CHW role and model within care coordination models serves a mutual benefit for the CHW workforce and care delivery organizations. For many forward-leaning organizations, they are learning this as they go; even established models we spoke with and profile here in this study continue to confront growing pains as they integrate the role.

Respect and Understanding of the Role

In order to successfully operationalize the role CHWs play in care teams, it is of paramount importance that they are understood and respected as vital, professional members of the care team. From our site visits, we learned that clinical leadership and CHWs have had to navigate obstacles stemming from a lack of understanding of the value and role CHWs bring to care delivery.

"The clinic wants you to fit into a cookie cutter thing, but that's not where the job is. Not everything is easy, and not everything is written out. You have to learn how to work outside of the box."
—Community Health Worker

"In general, the clinical community often does not trust CHWs. In the beginning, there was some difficulty with this – the providers and other clinical people were guarding their patients."
—Nurse Manager

A full understanding and respect for the role requires a thorough knowledge of the historical evolution of the CHW/promotor role in community transformation models, community action and popular education.[8] This understanding should be grounded in an understanding of the precise ways in which this role and this model of care directly enhances care delivery organizations' capacity to address social determinants of health and accelerate broader efforts toward care coordination and population health management.

Supervision

CHWs cannot simply be plugged into existing care teams, but must be integrated into a supervisory and mentoring relationship with team members who are best equipped to support the unique needs of the CHW role in care delivery. Social workers are often a good fit for a supervisory role; however, clinical leaders and CHWs we spoke with are focused on developing models where there is structure and support for CHWs themselves to grow into supervisory roles.

Sustainable employment

From our site visits it was abundantly clear that those who are interested in a role as a CHW are drawn to it based on their passion and dedication to improve the health and wellbeing of their communities. Likewise, clinical leadership champions who are integrating the CHW role hold this passion and dedication; these characteristics are unique and foundational attributes that are critical requirements when hiring CHWs.

As with similar occupations that are not linked to educational attainment and are grounded in life experience over skills with commoditized economic value, community health worker wages are low. Leadership we spoke with are
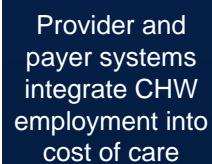
all working within their existing funding structures to increase wages of their CHWs in order to provide true living and sustainable wages.

Wages ranged considerably across the health care organizations we spoke with and those that rely on carved out, inconsistent, grant-based funding for the CHW role have much less capacity to push for higher wages relative to organizations (e.g., health plans) that are working toward integrating CHW employment into care delivery models as part of the broader cost of care.

While some CHWs/promotores have historically (and continue to) work in communities as volunteers, this does not mean that CHWs/promotores should be viewed as a predominantly "volunteer" workforce. Community health work should be understood and respected as a professional role, and the unique value and impact the role brings should carry sustainable wages with opportunities to advance into roles with increasing responsibility for those who wish to do so.

OUTCOME: In order to achieve the long-term goal of sustainable employment and integration of CHW role into health care teams…

PRECONDITION: Provider and payer systems integrate CHW employment into the cost of care.

Provider and payer systems integrate CHW employment into cost of care

To date, most CHW roles have been funded through community-based organizations and/or external grant funding. In order to achieve the overarching goal of sustainable employment and successful integration of CHWs, the CHW employment model cannot rely on external, carved-out grant funding. Turnover and inconsistent support of CHW roles can have a negative impact on the community and members served by CHW led programs.

While employment models for community health work within communities outside of clinical care settings can and should remain a viable part of the overall workforce, successfully integrating CHW roles into care delivery systems will require provider and payer systems to directly employ CHWs as part of the overall cost of care.

At present, forward-looking provider and payers are navigating employment and funding streams to integrate CHWs within clinical care organizations. Nevertheless, there was a unified sentiment across our study participants that to truly scale up a model of CHWs working within complex care teams, they must be employed by the organization to alleviate the fragmentation of CHWs that can easily occur within care teams.

"CHWs in complex care teams need to be [directly employed by the organization] just like the others in care teams. Otherwise, there is too much fragmentation."

—Senior Medical Director

OUTCOME: In order for care delivery organizations to be fully primed to integrate a patient-centered, non-clinical CHW role into coordinated care…

PRECONDITION: Leadership and transformation training tools and infrastructure is established for clinical leaders to integrate the CHW role into care delivery.

> Leadership and Transformation training and infrastructure established for clinical leaders integrating CHW role into care delivery

In order to achieve the aspirational outcome of care delivery system readiness to integrate the CHW role, targeted clinical leadership training, tools and infrastructure development must be designed and executed at the care delivery system level.

This is a critical step that many of the program leaders we spoke with are focused on in varying degrees. The medical establishment is fundamentally a hierarchical model that historically relies on defined and professionalized roles. This transformation requires training for the whole team.

Several leaders we interviewed cited a clear lack of understanding of the CHW role by nurses and other providers on the care team. This lack of understanding can have particular consequences for nurses, who may often be placed in supervisory positions over CHWs.

Transitions Clinic Network works directly with clinics to understand how the "eight-to-five, sit at your desk all day" working model that is currently embedded into most clinical systems' productivity mentality is not an appropriate model for CHWs' scope of work. In recognizing where this had directly impacted CHWs' ability to fully engage in home-visits and community outreach, their technical assistance efforts include a focus on appropriate supervision structures and awareness of the unique ways that CHWs work in and out of clinic settings.

Care Connections Program (CCP) found there was staff resistance at some sites as well as trepidation and uncertainty on the part of some PCPs, RNs, LVNs, and MAs; concerns stemmed from being held "accountable" as supervisors for non-clinically licensed CHW roles, but also from the potential disruption and additional work that could tax their already limited resources. CCP has worked toward developing a deeper understanding across teams of the ways in which CHWs are uniquely qualified to serve in their role in ways that are both complementary and distinct from RNs, MAs, and Medical Case Workers more narrowly focused clinical skills. They have found these understandings greatly improve the likelihood CHWs can be fully integrated and embraced by team members and utilized at the top of their capabilities. At the same time, this kind of innovation is an ongoing process that does involve restructuring a long-standing and prevailing hierarchical clinical model.

Amidst these challenges in care team redesign, there remains a concerted effort to develop enhanced care coordination and person-centered care delivery that directly addresses social determinants of health. While health care reform has brought about significant changes in care coordination models and cross-functional care teams that bridge clinical and social services, these models are still very much in the early stages of developing and evolving.

"When teams are not fully functional on their own, a new person with a 'murky' role presents another challenge. How do you train the team, train the CHW, and then align those trainings together?"
—Training and Curriculum Lead

Programs that are developing sustainable efforts to integrate CHWs into care teams are putting significant focus and resources into technical assistance that provides tangible tools to train clinical staff how to optimally utilize and support CHWs within care teams.

Training and infrastructure development efforts surrounding CHW integration often center on the following areas:

- Definition of CHW role/job description

- CHW skills and training

- CHW participation in the care team

- CHW supervision structure

- CHW programmatic elements (social service resources, outreach, advocacy)

Several of the site visit programs have made substantial contributions in this area.

As Transitions Clinic Network has evolved, it has developed a program toolkit designed to provide guidelines for providers looking to integrate the CHW as a member of the primary care team. In addition to addressing the basic job description, skill set, and supervision and support components of CHW implementation, the toolkit also considers other important programmatic concerns. This includes creating the infrastructure for community outreach and referral services, advocacy, clinic and direct client services, and access to technology and documentation processes.

OUTCOME: In order for care delivery organizations to be fully primed to integrate a patient-centered, non-clinical CHW role into care coordination…

PRECONDITION: A relevant business case for CHW role integration must be built on access, patient outcomes, and cost savings.

Relevant business case for CHW role integration built on access, engagement, patient outcomes, and cost savings

Developing the appropriate business case and return on investment (ROI) is a critical step in integrating CHWs into clinical care settings, yet not likely to be accomplished with a straightforward, one-size-fits-all approach. Overarching metrics that center on member/patient access to clinical and social services, clinical outcomes and cost-savings can be relevant when making the business case for integrating CHWs; however, a truly relevant business case must place value on the unique contribution that CHWs bring into clinical care models.

Therefore, a business case for integrating CHWs should reflect the fact that the CHW role itself is a transformation toward ensuring that clinical care delivery models are effectively and appropriately addressing the complex health and social needs of their members; specifically, there should be a focus on members of vulnerable populations who have historically faced barriers to appropriate and effective care.

At present, there is often a call for the CHW role to "prove" their worth in a business case analysis that no other clinical role has to bear. Many clinical leaders spoke directly to the fact that demanding an isolated ROI for CHW roles is an unrealistic standard that does not demand equivalent ROI metrics for other clinical roles.

"There is no ROI for nursing…it's a cost of doing business."
—Nurse Manager

It is critical to link the business case for integrating CHWs within overall business transformation efforts of team care and new models of care that include new roles for other team members as well.

Community Health Outreach Specialists (CHOS) at Kaweah Delta Health Care District assist patients by linking them with primary health care providers, continuous health insurance, mental health or substance abuse counseling and treatment, and various other social and medical services. The main service level goal of the Bridge Program is to assist the patients with stabilizing their lives, using an aggressive case management model and triage approach evaluating the patient's situation, prioritizing patient needs, and targeting the most pertinent patient needs first.

The CHOS position at Kaweah Health Care District was originally grant-funded. When the grant ended, there was uncertainty whether the position be able to continue within their Bridge program. However, after a financial analysis of the program, the CFO confirmed that CHOSs had saved the hospital millions of dollars through a reduction in avoidable hospital and ED admissions. Those previously grant-funded positions are now funded though the hospital

budget, and similar positions within the organization are funded through other mechanisms, such as PRIME.

A successful business case for CHW integration will be grounded in the true commitment to build a care delivery model that addresses social determinants of health and the recognition that CHWs are bringing in a new and unique "bridge" role that provides an extension to and from the community that does not systemically exist in current clinical models. Therefore, business case elements around member access, engagement, outcomes and overall cost savings should factor in the CHW role within a broader health care transformation effort. It is not the CHWs' sole responsibility to carry the burden of transforming care delivery models to manage complex care patients and reduce health disparities; however, they do provide a unique value and direct impact to these efforts that are part of broader transformation efforts. A business case should reflect the fact that the clinical organization is investing in CHWs as part of a broader investment in truly meeting the high-needs of the complex populations they serve.

"When you invest in a CHW, you invest in the community."
—Medical Director

OUTCOME: In order for the CHW model of care to be fully respected and established within care coordination models addressing social determinants of health…

PRECONDITION: The CHW role in clinical care is defined as an intervention at the patient level, serving as a bridge between community and clinical care to impact social determinants of health.

> CHW role in clinical care is established as a critical intervention at the patient level; serving as a bridge between community and clinical care to impact social determinants of health

Efforts to integrate the CHW role into clinical care must be grounded in a full understanding that the value of the CHW role comes from directly serving a community-based, person-centered function. Therefore, the CHW role and function is that of a lynchpin, a "bridge" between the community, conditions of that community, and the clinical care settings that may be physically "in" the community, but operate in a structure that is isolated from the myriad conditions of the community populations it serves.

The CHWs in clinical care settings operate as a direct intervention at the patient/member level; because their function is tied to the patient, their intervention traverses and bridges clinical and community spaces such as the home, schools, housing units and homeless shelters.

"CHWs go into the field and go into the home, develop a relationship, and become the adhesive to the care team."
—Senior Medical Director

"[CHWs] are the glue of interdisciplinary team…connects them to the patient in tangible and intangible ways."
—Director of Population Health

"The best gift the CHW brings is trust and relationship-building. Many of us come from communities that didn't take care of our health, or go to the doctor. We know the historical reasons for fear and mistrust. The CHW brings to the table trust…we are a bridge."
—Community Health Worker

This requires that managers, including human resources, have a full understanding of the CHW model of care in order to properly define the CHW role, define the scope of work, and develop relevant job descriptions. While scope of work and core competencies are important, these details should be developed within a top-down rather than a bottom-up approach that centers on a deep understanding of the model of care before defining the role.

The CHW function and scope of work requires that CHWs go where community members are – in the home, in community spaces and in various clinical settings. There must be a full understanding across clinical teams of the kind of work CHWs are engaged in (and the value of that work) when they are not in the clinic. We found that integrating CHWs into the health care team worked well when it involved most of the following activities:

- CHWs as full participants in regular clinical huddles and care team meetings.

- CHWs had regular supervision and support for their unique work demands in and out of clinic settings – safety protocols for home visits, direct mentorship, regular supervisory debriefing and tools to support burnout and emotional fatigue.

- CHWs had electronic health record (EHR) access and training, as well as the capacity to access and input patient/member information.

- CHWs had structured space and opportunity to provide direct feedback to clinical teams, and clinical teams built a structured capacity to receive and integrate direct feedback and input from CHWs.

In our visits and interviews with clinical leadership, CHW supervisors and CHWs themselves continuously reiterated that the CHW function is not simply *adding* value, but rather the role itself serves as a transformational tool that has ripple effects across the spectrum of care. The nature of the CHW role bridges a gap in health information that exists between providers' and members' lives. This directly enhances clinical providers' capacity to do their job "better."

"CHWs can hear the whole story, work on social determinants of health, and help [the member/patient] achieve what the doctor is telling them they need to do. If there is a disconnect between non-compliance and what's going on in the person's life, the CHW bridges the gap."
—Social Work Lead/CHW Supervisor

"Life experiences are key [to primary role of CHWs]. People like to be served by those that look like them. In some situations, CHWs can even train providers about community issues, especially for communities that are not well served."
—Director of Program Operations

"The goal of the CHW is to build a relationship with the patient. It is the relationship that dictates success; you don't need a formal education to do this."
—Manager of Strategic Initiatives

"There is a beauty to [CHWs] always being an outsider. When sitting in a patient's room, they make the provider more accountable, forcing a level of discussion that no other provider would have. CHWs can translate treatment recommendations to make them much more relevant and effective than any provider can."
—Medical Director

OUTCOME: In order for the CHW model of care to be fully respected and established within care coordination models addressing social determinants of health and;

OUTCOME: In order for provider and payer systems to integrate CHW employment into the cost of care…

PRECONDITION: Community-based CHWs receive training on health literacy, clinical system knowledge, and utilization of clinical information systems.

> Community-based CHWs receive training on health literacy and clinical system knowledge and utilization of clinical information systems

This is a critical component of integrating CHWs into clinical care teams that also necessitates a point of clarification from the outset.

Both clinical leadership and CHWs expressed a clear need for CHW training and resources around basic health literacy/terminology, clinical system knowledge and use of clinical information systems and technology. While this training is not central to a traditional promotor and community transformation model, it is important for CHWs working in clinical settings to have training around these skills in order to optimally navigate health systems, effectively communicate within care teams, and optimally help patients navigate clinical settings. This type of

clinical and health literacy training can also be understood as a differentiating step that delineates the clinically integrated CHW role as distinct from the community-based, community action oriented CHW/promotor role.

As we discuss in more detail below, any model that integrates CHWs should be grounded in and draw directly from an understanding of the community transformation model and insights from community leaders themselves.

While the level of proficiency may vary for CHW roles in various settings, there is an opportunity to develop this within a two-pronged approach focused on both CHW training and clinical system readiness/capacity-building:

- CHW/promotor leadership providing consultative guidance and advisory tools to help prime care delivery systems to optimally utilize the community health worker model; and

- Clinical/training entities provide CHWs with health literacy and clinical knowledge that will help them communicate and directly contribute within care teams.

We highlight the two-prong approach to underscore the fact that providing these tools is about ensuring optimal access, communication, role clarification and respect across clinical and CHW staff. Role clarification is key, as these tools are not meant to transform the CHW into a clinical role; rather, they aim to transform the care team into a holistic care delivery approach that operates as a cross-functional team consisting of clinical, social service and patient-centered/community-facing roles.

"If you are able to express yourself better, that's when doctors and nurses start paying attention and start to not care as much about the accreditation."
—Community Health Worker

While this is an important step in ensuring CHWs are optimally integrated into health care teams, it should not be viewed as the primary skill set that defines the CHW role. On the contrary, every individual interviewed echoed the point that what defines a successful CHW are largely characteristics that cannot be trained – "heart," empathy, dedication, resourcefulness, trust, communication and deep connection within the community. Possessing the "heartfelt service" that is a foundation of the community transformation model and being a part of the community served remains the cornerstone capability that any CHW must have.

Inland Empire Health Plan (IEHP) has developed a multi-pronged training approach in partnering with Latino Health Access. In addition, IEHP is structuring in-house training targeting the health care and health plan knowledge their Health Navigators need to successfully perform their role. Health Navigators first and foremost "need to come in with heart," with characteristics that cannot be taught – empathy, trust, communication, deep community connections.

As IEHP expands their program into a broader Behavioral Health Integration Complex Care Initiative, leadership anticipates training will be developed further around targeted clinical and behavioral health knowledge in addition to the fundamental training centered on communication, conflict resolution, home safety, documentation and health coaching. Additionally, they will be focusing more on developing training for clinical supervisors and care teams who do not yet have deep familiarity with the CHW/Health Navigator role.

OUTCOME: In order for provider and payer systems to integrate CHW employment into the cost of care…

PRECONDITION: New payment models optimize CHW utilization.

New payment models optimize CHW utilization

The renewal of the Medicaid 1115 waiver demonstration – Medi-Cal 2020 – has led to initiatives that individually and collectively incentivize care coordination and care management for high-need and high-utilizer populations. There are several current and developing state initiatives in California where CHW roles may be integrated within care improvement programs including:

- PRIME (Public Hospital Redesign and Incentives in Medi-Cal)

- FQHC Payment Reform Pilot (APM)

- Whole Person Care Pilot

- Coordinated Care Initiative (renewed from 2013)

- California Accountable Communities for Health (CACHI)

More detailed summaries of these initiatives can be found in our brief, "Utilization of Community Health Workers in Emerging Care Coordination Models in California."[9]

Payment reform and care delivery redesign that centers on transitioning from fee-for-service (FFS) to capitated value-based payment models and incentivizing care coordination holds promise for integrating and expanding CHW/promotor models of care as part of health care transformation toward population health management, person-centered care, cost-containment and prevention-oriented care delivery.

However, we are still in the early stages of payment reform, and payment and reimbursement for integrating CHW roles is anything but straightforward. This will continue to be a critical area of focus as successful integration of CHWs into care delivery models will require payment models and reimbursement mechanisms that can optimize utilization of CHWs in care teams and assure sustainability of the role.

"The evidence is there – [CHWs] have been doing great things in health education programs. It is time that the state notices and puts something into place for reimbursement."
—Community Outreach Coordinator

"Whole Person Care is a pathway to an ideal model and is the only way [to make an impact] because you work with the county to do something together."
—Social Work Lead/CHW Supervisor

OUTCOME: In order for leadership and transformation training tools to be established for clinical leaders integrating CHW role into care delivery…

PRECONDITION: Clinical leadership champions promote evidence of CHW/promotor impact on health, community transformation, and CHWs unique function in clinical care delivery.

Clinical leadership has training on evidence of CHW/Promotor impact, community model, and function to address social determinants of health

This is a critical step that we see gaining increased attention and focus as entities look to optimize the impact and function of CHWs into clinical care teams.

The primary driver for successfully integrating CHWs that was mentioned across our key informant interviews was leadership buy-in. A lack of adoption may not be due to outright resistance, but rather a lack of understanding of the role and the full capacity of CHWs, why they are being utilized, and how best to integrate them within care teams.

Many providers may not be fully aware that the community health worker model of care is rooted in community transformation and may not have a clear understanding of how this role can and should be integrated into care teams. Championing the CHW model of care requires clinical leaders first learn from CHWs and understand the CHW model, unique CHW capabilities, and impact that CHWs have in clinical care settings firsthand.

Clinical training and readiness to integrate new models of care should promote evidence that demonstrates CHWs' value in addition to the impact that CHWs have on patients and care teams. It is of equal importance that CHW leadership provides a visible voice alongside clinical leadership when championing the CHW model of care.

"The concept of a CHW is new to me regarding my training as a physician…I have learned so much in the shadowing process [of CHWs]; I just show up and listen. [The CHW] has rich case management experience and makes connections in the community to find what [patients] need."
—Physician Leader

"CHWs are uniquely qualified to do certain work, whereas nurses are more qualified to do clinical work – this requires management that understands that you may need fewer nurses and more CHWs. It is difficult for an establishment to do this because it's innovative and requires thinking outside the box."
—Medical Director

OUTCOME: In order for a relevant business case to CHW role integration to be built on access, engagement, patient outcomes and cost savings…

PRECONDITION: Appropriate metrics are developed to measure impact and ROI.

Appropriate metrics developed to measure impact and ROI

Within any clinical transformation effort, it will be necessary to establish appropriate metrics that allow for evaluation of clinical transformation efforts and an establishment of ROI. In order to develop the appropriate business case, it is important to identify relevant and appropriate metrics that reflect the unique contribution of the CHW role.

This is an area still in development. Several of the sites we visited are thinking critically about what metrics are truly appropriate as well as what metrics are not. One clear challenge is rooted in the fact that it is difficult (and arguably not appropriate) to try to establish isolated metrics for the impact of CHWs, as their core function is connective. They bridge member/patient care across clinic and community settings with an impact that is often diffuse.

"When you have a true team, it is difficult to attribute to which member exactly brought that saving."
—Director of Population Health

There is a growing body of literature that demonstrates evidence of the effectiveness of CHWs across metrics such as chronic illness reduction,[10] improved medication adherence, increased patient engagement,[11] community health improvement,[12] and reductions in health care costs.[13,14]

There is also a growing effort to pivot from research and evaluation toward more targeted ROI metrics and models. MHP Salud (supported by HRSA and HHS) recently released the "ROI Toolkit: A guide for conducting a return on investment analysis of your community health worker program."[15] Developing appropriate ROI metrics must formalize the importance of addressing social determinants of health and the unique contribution of CHWs into the business needs of care delivery organizations. Metrics may span the spectrum of utilization rates (ED, primary care, behavioral health), clinical outcomes, patient-centered outcomes, and patient and provider satisfaction.

OUTCOME: In order for the CHW role in clinical care to be established as a critical intervention at the patient level; serving as a bridge between community and clinical care to impact social determinants of health, and;

OUTCOME: In order for community based CHWs to receive training on health literacy, clinical system knowledge and utilization of clinical information systems…

PRECONDITION: Training pathways ladder between community and clinical settings, serving varied CHW-patient intervention points.

Training pathways ladder between community and clinical settings, serving varied CHW-patient intervention points

Training pathways for CHWs must include several factors that are unique to the CHW model of care. As we discuss throughout this framework, successful integration of CHWs into clinical care necessarily requires readiness and transformation efforts within the clinical model to optimally utilize the role. Conceptually, this requires a shift around entry into the CHW role and the training pathways for CHWs across community and clinical settings. Training pathways should reflect a lateral continuum that recognizes that the integration of CHWs into clinical care teams is about providing appropriate training from communities into clinical care settings as part of a broader effort to integrate the community health worker model *into* care delivery.

It is not about training CHWs "up" or training them "out" of community settings. Training pathways aimed at integrating CHW roles into care teams do not (and should not) prioritize educational attainment over life experience and deep connections within community settings. CHW role entry in clinical care teams and the success and impact of CHWs within clinical care settings need not be predicated on formal education or certification. Site directors echoed this theme; beyond training in core competencies, required standardized training and certification may not be the best pathway to meet the goals of enhancing CHW utilization.

"I do not see a correlation that shows that degrees lead to better outcomes or more success on the job."
—Executive Director, Workforce and Training

"Certification is not the silver bullet to demand respect [for CHWs]."
—Director of Community Outreach

There was consensus amongst clinical leadership and CHWs interviewed that there is a need to create tailored training pathways that can serve to enhance capacity and capabilities across the spectrum of community health work. CHWs whose locus of service is centered in community action and outreach should have opportunities to build their roles through trainings focused in community settings; they should also have opportunities to move laterally and integrate their existing community work capabilities into clinical care settings (if they choose) through pathways that provide them with targeted trainings necessary to integrate their work in care teams.

Transitions Clinic directly recruits and hires CHWs with a prior history of incarceration as a necessary qualification of CHWs to effectively work the targeted re-entry population. CHWs are directed to the tailored online re-entry CHW training (and/or the City College of SF post-prison health worker certificate program) to further advance their knowledge and capacity to work with formerly incarcerated individuals within the health care system. CHWs are identified and hired based on their lived experience, demonstrated commitment and passion for community work, and capacity to work in collaborative team settings. From here, training is focused on providing job-specific skill-development to enhance CHWs knowledge, skills and effectiveness to succeed in clinical settings.

There appear to be two overlapping areas that programs integrating CHWs are developing with regard to training pathways for CHWs:

- Creating parallel pathways, or "tracks," for CHWs that serve targeted areas within clinical care models.

- Developing advancement opportunities within varied tracks of CHW work.

As CHW programs continue to mature, leadership needs to explore avenues for CHW advancement that go beyond promotion to create a more robust CHW workforce capacity and impact across care delivery models. Some of the CHW "tracks" that programs leaders we interviewed are exploring include:

- CHW supervisor/mentors

- CHW evaluator/research roles

- CHW program management/administration roles

- CHW community organizing/community liaison roles

- CHW specialist roles (e.g. behavioral health, substance use)

"We want people to grow as CHWs in all levels, whether at the field level, program design/evaluation, supervisor, etc."
—Medical Director

"I feel blessed at the moment. I am a trailblazer, and I like that. I would like to have the ability to train others as well."
—Community Health Worker

OUTCOME: In order for appropriate metrics to be developed to measure and impact ROI…

PRECONDITION: Research and evaluation methodologies appropriately measure impact of CHWs across measures that reflect both clinical and social determinants of health.

> Research and evaluation methodologies appropriately measure impact of CHWs across measures of clinical and social determinants of health

In order to develop appropriate metrics and approaches to measure ROI, there is a need for more detailed consideration around what research and evaluation methodologies are most appropriate to assess the integration of CHWs into care teams.

"We have a need to build better systems of evaluation to track the success of our programs. We're thinking how to capture data of CHWs, how to track things in the EHR. If we can demonstrate impact and show data, then we can get more access to broader funding."
—Clinic Program Planner

However, for small programs that operate on ad hoc funding streams, capacity for any systematic data tracking, research, and evaluation may be minimal or non-existent. As programs broaden in scope and CHW integration is scaled up within larger initiatives, external research and evaluation partnerships may be established as a way to obtain comprehensive insights into the impact of CHWs in clinical care settings.

Robust program evaluations should emerge from upfront considerations of: intended targeted outcomes; what precisely needs to be measured/evaluated; and what are the most appropriate research methodologies (quantitative, qualitative, mixed-methods) to capture the needed data and insights.

At some point, there should be a shift from research and evaluation designed to simply "prove" whether CHWs should be utilized to research and evaluation methodologies that are grounded in clinical quality and performance improvement. From an internal clinical capacity-building standpoint, quality and performance improvement methodologies (e.g. Integrated Healthcare Institute Model for Improvement) may prove to be an appropriate strategy for clinical transformation efforts focused on successfully integrating the CHW role.

Community Health Center Network (CHCN) has developed robust analytics capabilities that can provide infrastructure, resources and guidance for smaller clinics to build this capacity and capability. CHCN has built out an internal dashboard for tracking data (to capture what a health plan would normally capture) and a patient selection algorithm based on a predictive risk model. Additionally, CHCN is making efforts to evaluate which kinds of metrics would be best used to capture certain outcomes like short-term progress, patient satisfaction, process measures, engagement measures and ER usage.

OUTCOME: In order for training pathways to ladder between community and clinical settings, serving varied CHW-patient intervention points…

PRECONDITION: Community-based CHW and promotor programs have sustained funding streams to maintain a foundational model of community action for vulnerable populations.

Community-based CHW and Promotor programs have sustained funding streams to maintain a foundational model of community action for vulnerable populations

In order to effectively develop the CHW model and training pathways within clinical care settings, there is a simultaneous need to build the sustainability of community-based CHW and promotor programs that center on CHW/promotor leaders who directly serve community health needs.

While it is encouraging to see increased payment and reimbursement opportunities for integrating CHWs into clinical care coordination models, the CHW model will be most successful when "investment" in the CHW model extends across clinical settings, the foundational community-centered CHW/Promotor organizations, and the on-the-ground community action efforts.

La Clínica de La Raza has a long history of directly addressing health disparities through their Community Health Education Department with a well-established Promotores Program that works to help community members make informed decisions about their health and develop actions to propel community change. Payment reform is indeed creating opportunities to develop a more clinically-centered CHW role, and La Clínica is developing opportunities for promotores who are interested to move into CHW roles in clinical settings.

There remains an opportunity to strengthen the relationship between existing promotores programming rooted in prevention and community health with emerging CHW roles that are integrating into clinical settings. While the roles are indeed distinct in terms of training and scope of practice, there was consensus that it could be mutually beneficial to have more collaboration and continuity. However, reliance on grant-based based funding creates a challenge to developing a sustainable and comprehensive model that supports both the vital existing Promotor community action and the evolving clinical-community CHW role in truly integrated care delivery.

OUTCOME: In order for training pathways to ladder between community and clinical settings, serving varied CHW-patient intervention points…

PRECONDITION: CHW workforce pipeline is drawn directly from local community-based CHW/Promotor organizations and advocate networks.

CHW workforce pipeline is strengthened and drawn directly from local community-based CHW/ Promotor organizations and advocate networks

Developing the CHW workforce presents a unique need and opportunity to strengthen clinical and community-based organizational relationships and partnerships to create a mutually beneficial workforce development pipeline between existing community-based organizations and clinical care organizations that are integrating the CHW role into care teams.

As clinical care entities look to develop and integrate the CHW role, working directly with organizations and community leaders can provide opportunities to engage with existing CHW/promotores (who may or may not carry these titles) to transition into clinically integrated CHW roles if they are interested in doing so.

Of equal importance, community and advocacy organizations can serve in an important advisory capacity to clinical entities working to integrate CHW models into care delivery.

"It would be nice if all of us could work together and skill share. The promotora model has more knowledge about the community, interpersonal, and family matters that [clinicians] may not be tapping into. There is room to work together…"
—Social Work Lead/CHW Supervisor

It is important to emphasize that developing a workforce "pipeline" does not mean taking CHWs/promotores out of the community and putting them into clinical settings. Rather, clinical care settings should ground their development of the CHW workforce through direct relationships with existing CHW/promotor community organizations to build, with this model, pathways into clinical care settings while supporting, strengthening, and sustaining community-based CHW organizations and advocate networks.

By strengthening a workforce pipeline between community and clinical settings, appropriate and robust training opportunities can be co-designed and co-developed that target and meet the needs across the spectrum of CHW work in clinical and community settings.

In our discussions with clinical leadership and CHWs themselves, there was a clear intention and desire to build the CHW workforce in a way that "lifts all boats" as it relates to the spectrum of clinically integrated CHWs to community-based promotoras/leaders.

"Our biggest challenge is finding a place for those in the traditional promotora model to move into the clinical model while still respecting the [traditional promotora] space."
—Executive Director, Workforce and Training

OUTCOME: In order for clinical leadership champions to be able to promote evidence of CHW/promotor impact, community model, and function to address social determinants of health, and;

OUTCOME: In order for research and evaluation methodologies to appropriately measure impact of CHWs across measures of clinical and social determinants of health…

PRECONDITION: Clinical entities demonstrate full commitment and internal requirements to directly address social determinants of health in care delivery models.

Clinical entities demonstrate full commitment and requirements to directly address social determinants of health in care delivery models

Integrating the CHW into care delivery models must be part of a larger commitment of care delivery organizations to directly address social determinants of health. This requires that care delivery organizations engage directly and partner with entities across health equity, social justice, health policy, social services, housing, transportation, faith-based and advocacy sectors to translate commitment into tangible initiatives and action with demonstrable outcomes.

Integrating primary care and public health to target social determinants of health and move toward population health management can be facilitated with a CHW workforce. Developing, championing and evaluating the impact of CHW integration role will be most successful when grounded in a broader commitment toward investing, partnering and engaging with sectors outside of primary care to create the infrastructure to address social determinants of health throughout care delivery models.

OUTCOME: In order for community-based CHW/Promotor programs to have sustained funding streams to maintain a foundational model of community action for vulnerable populations, and;

OUTCOME: In order for the CHW workforce pipeline to be strengthened and drawn directly from local community-based CHW/Promotor organizations and advocate networks…

PRECONDITION: There is elevated recognition of the CHW role as a spectrum of job titles with a collective value centered on delivering person-centered care across the continuum of community through clinical settings.

> Elevated recognition of the CHW role as a spectrum of job titles with a collective function centered on delivering person-centered care across the continuum of community through clinical settings

In order to truly elevate recognition of the CHW role and function, there must be a strong understanding of community health work as a spectrum, not a hierarchy, of work within the community to (more recently) work within clinical settings. This then involves a broad spectrum of specialized roles and job titles that fit the unique care delivery model and programs in each organization.

CHWs and promotores have what health care delivery systems often lack – a systemic way to engage with members/patients and directly support their clinical and social needs in ways that directly impact their health. Promotores and community outreach leaders have been engaged in this work for decades. Bringing in this model of community health work into more traditional clinical care models has brought a conundrum and much discussion around how to define the role of "community health worker" as a formalized job title when captured within institutional structures (such as medical models) relative to the "promotor" and lay community leader role that historically has operated more diffusely across varied community-based organizational settings.

Clinical leaders and CHWs we spoke with conceptualize the role as a spectrum that is indeed collectively providing person-centered care across a vast array of touchpoints – clinical, social service, community organization, faith-based and home. While individuals may move laterally along the continuum, generally speaking, promotores are considered to focus on community outreach, community action and the more far

upstream preventive aspects of health through deep and trusting relationships. Community health workers are understood to be trusted community members who may have been or are promotores or related community leaders; they are engaged in person-centered care that traverses both upstream health outreach and more downstream complex care management.

As care delivery models integrate CHW models into clinical care, a distinction does develop across the continuum of the role:

- CHWs engage in person-centered touchpoints across clinical and community settings

- Promotores engage in person-centered touchpoints primarily within community settings

While developing the CHW role within clinical care settings requires targeted trainings and competencies related to working within care delivery models, the success of the role is grounded in the community-centered touchpoints, trust, and relationship building capacity.

Cultural humility is not a nice-to-have, nor a skill that can be trained at scale. It is what anchors the value and impact of integrating CHWs with organic ties to their communities into clinical care.

"You can't just go to a one-hour training [on cultural competency/humility]. I feel like this is a key piece for people to understand value. If you value community members, it will be easier to understand why [CHWs] should have shared experiences, be integrated and everything else that comes along with it."
—Clinical Program Executive

"We are like the thread in the material. You don't always see it, but it's important. You are always winding and tying things together from the community to the medical field."
—Community Health Worker

Successful integration of CHWs into clinical care requires elevated recognition of this spectrum of community health work as well as a broader commitment to support the sustainability of community health programs and roles in and out of clinical settings.

Actions to Support Pathways to Successful CHW Integration

The following "actions" are recommendations for tangible steps to accelerate efforts to successfully integrate CHWs/promotores into clinical care teams. We envision these as actions that can build on existing efforts and propel the elements of this theory of change framework forward.

> ACTION:
> Formalized knowledge-sharing and best practices from large scale CHW integration efforts currently underway in CA

While there is no one-size-fits-all model for integrating, evaluating, and optimizing CHW/promotor integration into health care teams, there are lessons to be learned from successful programs and current, larger-scale initiatives that are significantly scaling up utilization and integration of CHWs into care teams.

The current literature has established an evidence-based foundation for the value and impact of CHWs and promotores in health care settings, yet there remains a need for more tactical and formalized knowledge-sharing around core components of CHW/promotor integration including (but not limited to):

- Preserving the community transformation model in clinical care delivery models

- Business case development

- Appropriate outcomes and evaluation metrics

- Tactical clinical readiness and training tools

- Role definition and training for various populations served

- CHW caseload and supervisory structures for various populations served

- Workforce support structures to ensure safety and combat burnout

> ACTION:
> Formalized partnerships and collaboratives develop between clinical and CHW/Promotor community organizations

To truly accelerate these efforts, we see a need and opportunity for more formalized partnerships and collaboration between clinical entities and CHW/promotor community organizations. CHW/promotor advocacy organizations have made great strides in educating clinical leaders about the CHW model and organic collaborations; training opportunities are emerging that bring together community-based CHW organizations and clinical care entities.[16]

Partnerships and collaboration may take various forms and could include:

- Regional collaborations between community clinics and CHW advocacy/community-based organizations centered around CHW integration within care delivery redesign and payment reform initiatives (e.g., WPC, PRIME).

- Regional or state-level technical assistance partnerships that leverage the expertise of CHW/promotor leadership and expertise of clinical leaderships successfully integrating and scaling CHW integration efforts.

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[16] As an example, see CPCA recent trainings:
https://www.cpcaevents.org/cpca/Reg/Event_Display.aspx?EventKey=1WS051617

> ACTION:
> Streamlined training pathways link community-based organizations, health plans, and provider systems around targeted training, workforce preparation, CHW integration/ readiness

Training needs around integrating CHWs/promotores are unique in the fact that training involves a multi-pronged effort that includes:

- Clinical transformation-focused training to build readiness and capacity to optimize the CHW role in care teams.

- Transitional training centered on providing a community-centered CHW/promotor workforce with training and tools to effectively transition into clinical care settings, including health literacy, clinical workflow, social determinants of health and motivational interviewing.

- Specific training around disease-specific and/or population-specific issues (e.g., behavioral health, medical high-risk, complex chronic care, homelessness, re-entry/justice-involved).

Optimizing training pathways for CHWs will require coordinated partnerships across various entities in both clinical and community settings.

Conclusion

Health care transformation centers on systemic improvement of the way patient care is delivered. To truly move the needle on health care quality and costs, attention has rightfully turned toward engaging with patients, families, and communities across a multitude of touchpoints to mitigate the clinical, social, environmental and economic factors that directly impact their health.

Integrating CHWs and promotores into more traditional clinical care models is proving to have direct impact on addressing social determinants of health, enhancing patient care, and improving access to health care and social services. Creating a sustainable community health workforce will require institutional and cultural change in health care systems as well as direct investment into community health and the existing models of care that have been actively working on-the-ground for decades to enhance the health and well-being of marginalized communities.

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