

March 2023

breaking the cycle of intimate partner violence

Using California's Community Health Worker Initiatives to Address Intimate Partner Violence



Contents

Executive Summary	iv
I. Introduction	1
II. CHW Initiatives in California and Other States	2
A. CHW covered services and certifications	2
B. CHW services that address IPV and other HRSNs	4
III. Design Considerations for CA CHW Programs	5
A. Planning and community partner readiness.....	11
B. Service delivery models.....	14
C. Payment models	17
D. CHW recruitment and development.....	19
E. CHW training	20
F. Monitoring and tracking	24
IV. Next Steps	25
Appendix A. Research approach	28
Appendix B. CHW Initiatives in State 1115 Demonstration Waivers	29
Appendix C. CHW Training Requirements by State	33
References.....	41

Tables

1.	Recommendations for addressing IPV through Medi-Cal CHW programs	v
2.	Recommendations and strategies for addressing IPV through Medi-Cal CHW programs	6
B.1.	Summary of CHW initiatives in State 1115 Demonstration waivers	29
C.1.	State CHW training requirements and competencies	33

Exhibits

1.	California State Plan Amendment (SPA) #22-0001: Inclusion and exclusion of IPV services and certification pathways	3
2.	Healthy Opportunities Pilots: Strategies for supporting involvement of IPV service providers and other CBOs	13
3.	Pathways Community HUB Institute Model	16
4.	CHW payment in states using SPAs	17
5.	ACF: Medical advocacy and health services payment or reimbursement for FVPSA grant recipients and subrecipients	18
6.	CBO partnerships to support <i>promotores</i> training and employment	20
7.	CHW core competencies in states with SPAs and other Medicaid initiatives	22
8.	Common themes among IPV-specific CHW trainings	23

Executive Summary

Community health workers and *promotores* (CHWs) are trusted members of communities who leverage their community connections or lived experience to improve health access and outcomes. The relationships CHWs have with their communities enable them to address intimate partner violence (IPV) and other health-related social needs (HRSN) through education, connection to services, and systems navigation. To expand and sustain the CHW workforce, California amended its Medicaid state plan to add CHW services as a Medi-Cal benefit, effective July 1, 2022. On June 27, 2022, California also approved a state budget that included a health care workforce initiative to invest \$281.4 million to develop and deploy 25,000 CHWs by 2025. Currently, California is the only state that explicitly focuses on violence prevention as part of CHW services. The California Health and Human Services Agency (CalHHS) has a unique opportunity to equip the existing and expanded CHW workforce to address and prevent IPV by training CHWs on IPV and ensuring organizations employing them have infrastructure to support them.

This policy brief presents recommendations to support the participation of community partners—including IPV service providers, community health centers, CHW advocacy organizations, other community-based organizations (CBOs), and health plans—in California’s efforts to expand and sustain CHW services, particularly those that address IPV. Drawing from conversations with subject matter experts and a review of existing CHW initiatives in California and other states, the brief offers recommendations in the following areas: planning and CBO readiness, service delivery model, payment model, recruitment and development, certification and training, and monitoring and tracking (Table 1). It also provides actionable strategies for each recommendation (Table 2 in Section III), differentiating between general and IPV-specific strategies.

Table 1. Recommendations for addressing IPV through Medi-Cal CHW programs

Recommendations
Planning and community partner readiness
CalHHS should ensure that the organizations that employ CHWs understand the pervasiveness of IPV, the services needed by survivors, and the resources available in the community.
CalHHS and health plans should streamline requirements and assist CBOs in learning and implementing requirements to participate in Medicaid.
Given the power dynamics of the partnerships between CBOs and health plans, CalHHS should provide supports that facilitate CBO and CHW success.
CalHHS and health plans should fund CBOs that currently employ CHWs to build upon their current internal infrastructure to participate in the new CHW benefit and workforce initiative.
As the CHW workforce grows, CalHHS should balance growth with preserving the community philosophy of CHWs.
Service delivery model
Health plans should partner with CBOs to examine the IPV needs of the communities they serve as they explore diverse ways to include CHWs in service delivery models.
CalHHS and health plans should include CBOs that already employ CHWs to address IPV in their service delivery models.
CalHHS should provide clarity on the CHW services related to IPV that are included in the new Medi-Cal benefit and should help CBOs adapt existing service delivery models to incorporate new services.
Health plans and CBOs should integrate CHWs into care teams.
Payment model
CalHHS should ensure that Medi-Cal fee-for-service rates will adequately reimburse CHWs.
CalHHS should provide more clarity about billing for new CHW services because of potential duplication with existing Medicaid payment models.
CalHHS should help IPV service providers and other CBOs understand how billing Medicaid can work alongside existing funding sources that might have restrictions.
CHW recruitment/development
CalHHS should recognize and decrease employment requirements that can be significant barriers for CHWs' participation.
CalHHS and CBOs should develop defined career paths and other strategies to sustain the CHW workforce.
Training
In setting CHW training requirements, CalHHS should be guided by (1) CBOs that have a long history of training CHWs and (2) IPV advocacy and service organizations that can highlight the prevalence of IPV issues in communities and the need for sensitivity.
When selecting IPV-specific training curricula, HCAI should ensure they meet the needs of people who experience violence, while limiting the training burden for CHWs.
HCAI should establish trainings on the role of CHWs for supervisory and clinical staff working with CHWs.
CHW monitoring/tracking
CalHHS and health plans should adapt Medi-Cal reporting requirements for CHWs, given that the nature of their work is organic and focused on the individual.
CalHHS and health plans should partner with IPV service providers and other CBOs to protect the confidentiality of survivors in data reporting and monitoring.

I. Introduction

Community health workers and *promotores* (CHWs), trusted community members with lived experience or a close connection to the community served, have a long history of providing culturally appropriate, person-centered services and facilitating connections to such services to improve health outcomes, advance health equity, and reduce health care costs.^{1,2} Across states, a variety of professionals serve in CHW roles, including *promotores*, peer recovery specialists, birth doulas, family advocates, youth support specialists, and volunteers with interest and community connections. We will use “CHWs” in this brief to refer to these professionals. This workforce often helps address health-related social needs (HRSNs) that mitigate the effect of social determinants of health (SDOH)—social and structural factors such as the conditions where people live, work, play, and worship that affect their health and wellness.

“Community health worker” is an umbrella term and includes community health representatives, *promotores*, peers, and other workforce members who are frontline public health professionals that share life experience, trust, compassion, [and] cultural and value alignment with the communities where they live and serve.”

—National Association of Community Health Workers

Intimate partner violence (IPV) is a SDOH that has severe impacts on the physical and mental health of survivors.^{3,4} In California, 35 percent of women and 31 percent of men reported experiencing IPV in their lifetime.⁵ The intimate relationship that CHWs have with their communities is central to their effectiveness in helping people access services to address IPV and other HRSNs.

To expand and sustain this critical workforce, California became the only state to specifically extend Medicaid coverage to include CHW services related to IPV and violence prevention in 2022. California’s state plan amendment (SPA) that adds CHW services as a Medi-Cal benefit went into effect July 1, 2022.^{6,7} On June 27, 2022, California also approved a state budget that included a health care workforce initiative, which will invest \$281.4 million to develop and deploy 25,000 CHWs by 2025.^{8,9}

Blue Shield of California Foundation engaged Mathematica to research how other states have implemented CHW initiatives to address and prevent IPV, explore the readiness of California community partners to participate in these state opportunities, and identify program design considerations and supports for CHW programs. (Appendix A describes the research approach.)

This policy brief presents findings and recommendations to support the participation of community partners—including IPV service providers, community health centers, CHW

Key research questions:

- How have other state Medicaid agencies structured and funded CHW services?
- How do states employ CHWs to address IPV and other HRSNs?
- How can IPV service organizations participate in California’s efforts to expand CHW services in Medicaid? What will challenge or facilitate this participation?
- How can the California Health and Human Services Agency (CalHHS) support the CHW workforce to help address IPV?
- How can CHW training prepare CHWs to address IPV? ▲

advocacy organizations, other community-based organizations (CBOs), and health plans—in California’s efforts to further expand and sustain CHW services, particularly those that address IPV. It begins with a description of CHW initiatives in California and other states and a summary of covered CHW services and required certifications (Section II). The brief also highlights design considerations that lay ahead for CHW programs in California and provides recommendations for each of the following areas: planning and community partner readiness, service delivery model, payment model, recruitment and development, training, and monitoring and tracking (Sections III). Table 1 (in Executive Summary) summarizes our high-level recommendations. Table 2 (in section III) includes strategies for each recommendation.

II. CHW Initiatives in California and Other States

A. CHW covered services and certifications

We identified seven states in addition to California that cover CHW services for their general Medicaid populations (Indiana, Louisiana, Minnesota, Nevada, Oregon, Rhode Island, South Dakota).^{10,11,12,13,14,15,16} A [recent report](#) by the California Health Care Foundation provides detailed information on the SPAs we identified, except for Nevada.¹⁷ Other states such as Alaska, Vermont, and North Dakota cover CHW services for specific populations; a [2021 National Academy for State Health Policy resource](#) summarizes these efforts.¹⁸

Covered services

Across states, the most common covered CHW services include **health education, health promotion (including screening for HRSNs and goal setting), the navigation of community services, and care planning**. Consistent with California’s SPA, three states exclude insurance enrollment from covered services (South Dakota, Louisiana, Minnesota), whereas Louisiana also excludes transportation services.^{19,20,21,22} California is the only state that explicitly covers IPV services through a SPA and is the only state that specifies a violence prevention certification pathway.^{23,24} However, although the SPA notes IPV as an area that CHW services can address, there is some ambiguity about the extent to which violence prevention services encompass or are separate from IPV (Exhibit 1). There is also some ambiguity about the extent of training CHWs will receive to assist survivors of IPV. SPAs from other states, such as South Dakota, note that CHWs can help beneficiaries access community resources, which might be an avenue for coverage of IPV support.²⁵

CHW certification

All states with CHW-related SPAs require CHW certification or training to practice or bill Medicaid for services. Most states allow multiple vendors to provide CHW trainings, such as colleges and universities or CBOs, whereas Oregon has a state-run training program, and Minnesota allows multiple vendors to provide training using a statewide standardized curriculum.^{26,27} California offers three pathways for CHW certification (Exhibit 1). Section III.E provides more details on CHW training programs and curricula in California.

Exhibit 1. California State Plan Amendment (SPA) #22-0001: Inclusion and exclusion of IPV services and certification pathways^{28,29}

Coverage of IPV services. The SPA lists issues that CHWs can address, including but not limited to: control and prevention of chronic conditions or infectious diseases; mental health conditions and substance use disorders; perinatal health conditions; sexual and reproductive health; environmental and climate-sensitive health issues; child health and development; oral health; aging; injury; domestic violence; and violence prevention.

Violence prevention services and IPV. Although the original SPA defines violence prevention as “evidence-based, trauma-informed, and culturally responsive preventive services to beneficiaries who have been violently injured as a result of community violence,” later announcements by the state’s Department of Health Care Services (DHCS) expand the definition beyond community violence. In an updated announcement about covered CHW services, violence prevention services include services provided “for the purpose of reducing the incidence of violent injury or reinjury, trauma, and related harms and promoting trauma recovery, stabilization, and improved health outcomes.”

Certification pathways. An individual who is qualified through any of the three pathways below can provide violence prevention services. All CHWs must complete at least 6 hours of continuing education training annually.

1. CHW Certificate:

- Certificate issued by the State of California or a State designee.
- Curriculum attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social determinants of health.
- Certificate programs must include field experience as a requirement.

2. Violence Prevention Certificate:

- Certificate allows a CHW to provide CHW violence prevention services only.
- Certificates include Violence Prevention Professional (VPP) Certification issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training from the Urban Peace Institute.

3. Work Experience Pathway:

- An individual who has 2,000 hours working as a CHW in paid or volunteer positions within the previous three years can use this pathway.
 - Individual must have demonstrated skills and practical training in the areas listed under CHW Certificate pathway, as determined by their supervisor.
 - Individual may provide CHW services without a CHW Certificate for a maximum period of 18 months and must earn a CHW certificate in that period. ▲
-

B. CHW services that address IPV and other HRSNs

Addressing IPV

Currently, California is the only state that explicitly focuses on violence prevention as part of the CHW role. Across the initiatives that we reviewed, CHWs commonly screen people for HRSNs, which may include IPV services as a social need, and provide navigation support to help them access social and other community-based services. For example, CHWs might assist with accessing transportation, financial support, child care, and other resources necessary to strengthen the lives of IPV survivors and their families.

Although most Medicaid documents and available program resources do not specify whether and how CHWs should guide individuals to IPV services, **North Carolina's Healthy Opportunities Pilots** is one of the few initiatives we found that focuses on providing IPV services (see Appendix B, Table B.1). North Carolina's pilots use care management teams, made up of nurses, social workers, and community coordinators, to support navigation.³⁰ In the materials reviewed, the community coordinator role and qualifications are not defined; however, this role might be similar to that of a CHW. North Carolina's pilot program is part of the state's Medicaid Section 1115 demonstration and its transition to Medicaid managed care. Within the pilots, managed care plans pay local lead entities. These entities in turn coordinate with local human services organizations, including organizations that address interpersonal violence, to provide covered services. North Carolina intends to pay for two services on a per-member per-month basis: IPV case management for people who experience violence and violence intervention services for people who have been violent. North Carolina is currently collaborating with the North Carolina Coalition Against Domestic Violence, and other IPV-focused organizations, to determine how best to offer these IPV services through the pilots. Before implementation, the program is working toward solutions for sharing data on clients' insurance coverage and billable services, while maintaining survivors' safety and confidentiality.

Addressing HRSNs

State Medicaid programs that employ CHWs to address HRSNs use one or more of the following three service delivery models:

- Health plans employ CHWs (New Mexico, Oregon).
- Health plans contract with community-based organizations that employ CHWs (Oregon).
- Lead entities oversee the specifics of service delivery as part of collaborative partnerships. Examples include:
 - Healthy Opportunities Pilots in North Carolina
 - Accountable Communities of Health in Washington
 - Regional Health Partnerships in Texas

III. Design Considerations for CA CHW Programs

Before the goal of addressing IPV in California’s CHW Medi-Cal benefit and workforce initiative can be achieved, more must be done for planning and readiness to ensure IPV service providers and other CBOs can participate in these initiatives.³¹ Many CBOs that have worked with CHWs for years appreciate the recognition that the new Medi-Cal benefit and the workforce initiative gives to CHWs and their value. But, given the newness of both initiatives, IPV service providers and other CBOs raised many program design considerations and suggested supports to buoy participation.

Table 2 summarizes recommendations and strategies in program design areas including program planning, CHW service delivery models, payment models, staff recruitment, training, and monitoring of CHW services. The table differentiates general and IPV-specific strategies. An exploration of considerations and examples in each area follows.

Table 2. Recommendations and strategies for addressing IPV through Medi-Cal CHW programs

Recommendations	Strategies
Planning and community partner readiness	
<p>CalHHS should ensure that the organizations that employ CHWs understand the pervasiveness of IPV, the services needed by survivors, and the resources available in the community.</p>	<p>IPV-specific strategies</p> <ul style="list-style-type: none"> • CalHHS should facilitate webinars that educate organizations employing CHWs on the pervasiveness of IPV and its intersection with physical, mental, and emotional health. • CalHHS should partner with IPV service providers and advocates to educate health plans and other organizations on the service needs of survivors, which include housing and employment supports. <p>CalHHS should require health plans to connect with communities and become familiar with the organizations that offer services needed by survivors.</p>
<p>CalHHS and health plans should streamline requirements and assist CBOs in learning and implementing requirements to participate in Medicaid.</p>	<p>General strategies</p> <ul style="list-style-type: none"> • CalHHS and health plans should offer technical assistance on Medicaid basics, including claims, billing, contract components, and language. • CalHHS and health plans should consider how to simplify the claims, billing, and contracting processes for CBOs. • CalHHS and health plans should create opportunities, such as learning collaboratives, for CBOs to connect and serve as resources for one another.
<p>Given the power dynamics of the partnerships between CBOs and health plans, CalHHS should provide supports that facilitate CBO and CHW success.</p>	<p>General strategies</p> <ul style="list-style-type: none"> • CalHHS should require health plans to provide needed supports to CBOs so they can partner with them. CalHHS should ask health plans to describe their strategies for providing this support and monitor implementation of the strategies. • Health plans should consider the CBO perspective and support the setup that works best for them. This might involve establishing processes to understand the CBO’s capabilities and providing the supports needed for them participate in Medicaid. <p>IPV-specific strategies</p> <ul style="list-style-type: none"> • CalHHS and health plans should release requests for information (RFIs) rather than requests for proposals when seeking to fund IPV service providers and other CBOs. CalHHS should specifically ask for recommendations related to addressing IPV survivors’ needs. RFIs describe the goals that Medi-Cal or health plans want to achieve with a new program and invite the community, as experts in the field, to provide information and suggestions. • CalHHS and health plans should partner with trusted IPV advocacy organizations to help engage IPV service providers and build relationships.

Recommendations	Strategies
<p>CalHHS and health plans should fund CBOs that currently employ CHWs to build upon their current internal infrastructure to participate in the new CHW benefit and workforce initiative.</p>	<p>IPV-specific strategies</p> <ul style="list-style-type: none"> • CalHHS and health plans should explore funding CBOs that focus on IPV survivors and currently employ CHWs to build the infrastructure to participate in Medi-Cal and the workforce initiative. CalHHS could allocate pre-planning funds in its workforce initiative to support capacity building.
<p>As the CHW workforce grows, CalHHS should balance growth with preserving the community philosophy of CHWs.</p>	<p>General strategies</p> <ul style="list-style-type: none"> • CalHHS should partner with and elicit feedback from grassroots organizations and CBOs that have long-standing CHW experience and connection to their communities. • CalHHS should encourage training about the community philosophy of CHWs for health plans and other organizations newly joining the field. • CBOs with long-standing CHW experience should provide CHW training that includes the CHW philosophy and can be adapted to the unique needs of different communities.
Service delivery models	
<p>Health plans should partner with CBOs to examine the IPV needs of the communities they serve as they explore diverse ways to include CHWs in service delivery models.</p>	<p>IPV-specific strategies</p> <ul style="list-style-type: none"> • Health plans should communicate with all CBOs in their network that provide IPV services and fund them to develop use cases that serve as models for CHW programs to address IPV.
<p>CalHHS and health plans should include CBOs that already employ CHWs to address IPV in their service delivery models.</p>	<p>IPV-specific strategies</p> <ul style="list-style-type: none"> • Health plans should contract with IPV service organizations that already employ CHWs in the community. • CalHHS should test a pilot model that provides funding to IPV service organizations to develop into intermediary organizations that would help connect smaller CBOs with Medi-Cal.
<p>CalHHS should provide clarity on the IPV-related CHW services it includes in the new Medi-Cal benefit and should help CBOs adapt existing service delivery models to incorporate new services.</p>	<p>IPV-specific strategies</p> <ul style="list-style-type: none"> • CalHHS should provide information and technical assistance on the IPV-related CHW services it includes in the Medi-Cal benefit. • CalHHS should fund technical assistance webinars to help IPV service organizations adapt existing service delivery models and differentiate services for billing. • CalHHS should conduct focus groups to solicit input on the type of technical assistance and guidance most needed by IPV service providers and CHWs.
<p>Health plans and CBOs should integrate CHWs into care teams.</p>	<p>General strategy</p> <ul style="list-style-type: none"> • Health plans developing new programs should integrate CHWs into care teams and train staff working with them. [See training section for more detail].

Recommendations	Strategies
Payment model	
CalHHS should ensure that Medi-Cal fee-for-service rates will adequately reimburse CHWs.	<p>General strategies</p> <ul style="list-style-type: none"> • CalHHS should host conversations and listening sessions with CHW advocacy organizations, IPV advocacy and service organizations, CBOs, and health plans to discuss equitable and adequate reimbursement rates for CHWs. • CalHHS should ensure adequate funding is allocated to cover equitable payment for CHWs that is commensurate with the full range of competencies that make CHW services successful, including services in the patient’s language, culturally competent services, and lived experience.
CalHHS should provide more clarity about billing for new CHW services because of potential duplication with existing Medicaid payment models.	<p>General strategies</p> <ul style="list-style-type: none"> • CalHHS should provide technical assistance and use cases to illustrate different billing scenarios. • CalHHS should meet with existing Medicaid providers to hear concerns about renegotiating alternative payment rates and include CBOs and CHWs to brainstorm solutions to ensure fair rates.
CalHHS should help IPV service providers and other CBOs understand how billing Medicaid can work alongside existing funding sources that might have restrictions.	<p>IPV-specific strategies</p> <ul style="list-style-type: none"> • CalHHS should facilitate group discussions on how current Medi-Cal billing requirements could interact with other funding sources, particularly the Family Violence Prevention and Services Act (FVPSA) and other sources such as the California Governor’s Office of Emergency Services Sexual and Domestic Violence Prevention Program Grants. • CalHHS should develop an informational document that clearly states how Medi-Cal billing interfaces with other funding sources, particularly FVPSA. • CalHHS should disseminate documents such as the ACF informational memo to IPV service providers and other CBOs that receive funding from FVPSA and other sources.
CHW recruitment/development	
CalHHS should recognize and decrease employment requirements that can be significant barriers for CHWs’ participation.	<p>General strategies</p> <ul style="list-style-type: none"> • CalHHS should treat lived experience, including those of IPV survivors, and vocation as equivalent to formal education for CHW employment. Additional training can be provided in areas specific to their work. • CalHHS should refrain from imposing requirements such as English proficiency, which might exclude CHWs closest to the communities they serve. • CalHHS and philanthropic organizations should host discussions with CHW advocacy organizations, CBOs, and experts in employment immigration law to explore employment options for CHWs with various immigration statuses.

Recommendations	Strategies
<p>CalHHS and CBOs should develop defined career paths and other strategies to sustain the CHW workforce.</p>	<p>General strategies</p> <ul style="list-style-type: none"> • Organizations should implement strategies such as creating promotion pathways within their organization and increasing pay and stability. • CalHHS should speak with CBOs currently employing CHWs to learn about strategies for sustaining this workforce. <p>IPV-specific strategies</p> <ul style="list-style-type: none"> • CalHHS and philanthropic organizations should fund CBOs to explore innovative employment models for CHWs. This could involve CBOs partnering with organizations such as Lideres Campensinas, a non-profit organization created by and for women farmworkers, or the <i>promotore</i>-owned cooperative Mujeres Empresarias Tomando Acción. These organizations represent and serve their communities by engaging in programs for leadership development, training, violence prevention, and building healthy communities.
Training	
<p>In setting California’s CHW training requirements that will govern the Medi-Cal benefit and workforce initiative, CalHHS should be guided by (1) CBOs that have a long history of training CHWs and (2) IPV advocacy and service organizations that can highlight the prevalence of IPV issues in communities and the need for sensitivity.</p>	<p>General strategies</p> <ul style="list-style-type: none"> • California’s Department of Health Care Access and Information (HCAI) should fund existing CBOs that already provide CHW training. This would help ensure that the growing CHW workforce retains the CHW philosophy of connection to community. • HCAI should continue to elicit feedback during curriculum planning and throughout the workforce initiative. <p>IPV-specific strategies</p> <ul style="list-style-type: none"> • HCAI should engage CHWs, CBOs that employ CHWs, IPV advocacy organizations, and IPV service organizations to discuss appropriate IPV training in CHW core competencies.
<p>When selecting IPV-specific training curricula, HCAI should ensure it meets the needs of people who experience violence, while limiting the training burden for CHWs.</p>	<p>IPV-specific strategies</p> <ul style="list-style-type: none"> • HCAI, the state agency overseeing standardization of training requirements, should seek guidance from existing CBOs that employ CHWs who connect survivors to IPV services—such as East LA Women’s Center, South Bay Community Services, Community Solutions—and IPV advocacy organizations like Futures Without Violence. • HCAI, in partnership with IPV advocacy organizations and CBOs that employ CHWs, should incorporate the CUES model (Confidentiality, Universal Education, and Empowerment Support) from Futures Without Violence to prevent and respond to IPV. CUES is a short, evidence-based intervention to prevent, identify, and respond to domestic violence in health care settings.
<p>HCAI should establish trainings on the role of CHWs for supervisory and clinical staff working with CHWs.</p>	<p>General strategies</p> <ul style="list-style-type: none"> • CalHHS should seek feedback on training staff working with CHWs. • CBOs should offer trainings or other educational materials for health care providers on the role of CHWs and their value.

Recommendations	Strategies
CHW monitoring/tracking	
<p>CalHHS and health plans should adapt Medi-Cal reporting requirements for CHWs, given that the nature of their work is organic and focused on the individual.</p>	<p>General strategies</p> <ul style="list-style-type: none"> • CalHHS should host listening sessions with CBOs to inform and simplify Medi-Cal reporting requirements for CHW benefits overall. • CalHHS should develop a menu of reporting requirements that aligns with current CHW reporting practices.
<p>CalHHS and health plans should partner with IPV service providers and other CBOs to protect the confidentiality of survivors in data reporting and monitoring.</p>	<p>IPV-specific strategies</p> <ul style="list-style-type: none"> • CalHHS and health plans should host listening sessions with IPV advocacy and service organizations to (1) discuss confidentiality concerns related to reporting and monitoring for the new CHW benefit and (2) explore strategies for secure and confidential data monitoring. • CalHHS should implement strategies for secure and confidential data monitoring, in consultation with key IPV advocacy and service organizations. • CalHHS and health plans, in partnership with IPV advocacy organizations and CBOs, should fund the development of new IT solutions that address confidentiality concerns for IPV survivors.

A. Planning and community partner readiness

Given that the CHW role grew from the community and has been rooted in CBOs, California's efforts to expand the CHW workforce and their services must involve these partners. CBOs, especially those that are smaller and integral to their communities, have a system of CHWs already in place and can hire and train community members to become CHWs more easily than those that do not have a community connection. In addition, these CBOs are already a trusted partner in the community, which is essential to connecting survivors with IPV services.

Community partners discussed considerations and recommendations related to preparing CBOs to participate in the CHW Medi-Cal benefit and workforce initiative.

Recommendation: CalHHS should ensure that the organizations that employ CHWs understand the pervasiveness of IPV, the services needed by survivors, and the resources available in the community. One organization that trains CHWs on IPV emphasized the importance of understanding the intersection of IPV and other areas of health. Trauma responses affect survivors' interactions with health care services and, therefore, health outcomes. For example, a survivor may not be willing or able to provide adequate health history because of their concern about safety. To ensure CHWs can adequately address IPV:

- CalHHS should facilitate webinars that educate organizations employing CHWs on the pervasiveness of IPV and its intersection with physical, mental, and emotional health.
- CalHHS should partner with IPV service providers to educate health plans and CBOs on the range of services IPV survivors need and the organizations that provide those services.
- CalHHS should require health plans to connect with communities and become familiar with the organizations that offer services needed by survivors. For example, IPV survivors often require assistance with housing. Thus, health plans and CBOs should be working with California organizations that understand the intersection of IPV and homelessness, such as those participating in the Housing Opportunities Mean Everything (HOME) Cohort.³²

Recommendation: CalHHS and health plans should streamline requirements and assist CBOs in learning and implementing requirements to participate in Medicaid. Many IPV organizations are not Medicaid providers and are hesitant about the lengthy, administratively burdensome, and unfamiliar process of becoming one. To support CBOs:

//////
"A trusted connection is needed because so much that leads up to violence (for example, family stress) can be addressed before the violence begins, and the CHWs at these CBOs are a trusted source."

—Executive Director, CHW advocacy organization and IPV service provider

//////
"Let's think about IPV more like physical activity where its [considered] across the board as an important health topic."

—Executive, County department of public health

//////
"I just don't know the mechanics of getting involved in this [SPA] and Medi-Cal benefits generally."

—Executive Director, CHW advocacy organization and IPV service provider

- CalHHS and health plans should offer technical assistance on Medicaid basics, including claims, billing, contract components, and language. DHCS is establishing a technical assistance marketplace for CalAIM. The PATH (Providing Access and Transforming Health) Technical Assistance Marketplace provides organizations access to TA resources in various domains, including building data capacity and Medi-Cal managed care.^{33,34} However, the marketplace is primarily available to CBOs that contract with, or intend to contract with, managed care plans to provide enhanced care management or community support. Other CBOs can receive TA through the marketplace with direct DHCS approval, and DHCS should provide more clarity on its approval criteria.
- CalHHS and health plans should consider how to simplify the claims, billing, and contracting processes for CBOs.
- CalHHS and health plans could create opportunities such as learning collaboratives for CBOs to connect and serve as resources for one another.

Recommendation: Given the power dynamics of the partnerships between CBOs and health plans, CalHHS should provide supports that facilitate CBO and CHW success. One health plan said that unchecked, power dynamics could lead to a health plan or other intermediary organization steering a CBO into contract requirements that are not feasible for the CBO. To support CBOs:

- CalHHS should require health plans to provide needed supports to CBOs, such as formal referral agreements and protocols for sharing information, and access to health system leadership for regular discussions, to facilitate effective partnerships.³⁵ CalHHS should ask health plans to describe their strategies for providing this support.
- Health plans should consider the CBO perspective and support the setup that works best for them. This might involve establishing processes to understand the CBO’s capabilities and providing the supports needed for them to participate in Medicaid.
- CalHHS and health plans should release requests for information (RFIs) rather than requests for proposals when seeking to fund IPV service providers and other CBOs. CalHHS should specifically ask for recommendations related to addressing IPV survivors’ needs. RFIs describe the goals that Medi-Cal or health plans want to achieve with a new program and invite the community, as experts in the field, to provide information and suggestions. This strategy of an RFI would be particularly beneficial in communities where CalHHS and health plans do not know the primary IPV service providers and the services they provide.
- CalHHS and health plans should partner with trusted IPV advocacy organizations to help engage IPV service providers and build relationships. Although it does not specifically include CHWs in its service delivery model, North Carolina’s Healthy Opportunities Pilots^{36,37,38} offers strategies to engage and partner with IPV service providers and other CBOs (Exhibit 2).



“In the contracting process, it’s so easy for routine processes and plans to just spit out a standard contract and not realize that not every organization can actually go through that as a process or understand it.”

—Executive, Medi-Cal managed care plan

Exhibit 2. Healthy Opportunities Pilots: Strategies for supporting involvement of IPV service providers and other CBOs

- **Prioritize CBO input.** Throughout the process of designing the pilot, the North Carolina Department of Health and Human Services partnered with an IPV advocacy organization, the North Carolina Coalition Against Domestic Violence, to gather feedback from IPV service providers in the program regions. The advocacy organization used focus groups to learn about the capacity of IPV providers to participate in the pilot and has continued to meet regularly with them to provide updates and receive feedback.
 - **Build trust by working with established community leads.** IPV service providers saw and recognized the Health Opportunities network leads in the community, which helped build trust in the program. In addition, the consistent involvement of the IPV advocacy organization reassured IPV service providers that their needs and priorities were heard.
 - **Fund CBO infrastructure.** Each Healthy Opportunities network lead had capacity-building budgets that they distributed among their network CBOs. Of the \$650 million in Medicaid funding for the pilot program, \$100 million was designated to build capacity in participating CBOs.
 - **Develop IT in partnership with IPV service providers to protect survivor confidentiality.** Survivor confidentiality and safety were primary concerns for IPV service providers who wanted to participate in the pilot. The Medicaid agency and North Carolina Coalition Against Domestic Violence are working with the platform developer to create a user-friendly, one-stop shop platform that will track referrals, as well as automate and track payments, while protecting survivor confidentiality. Outside of the IPV service provider, the only platform users who can see that a survivor is receiving services are the referring case manager, the person at the health plan who receives the invoice for services, and the Healthy Opportunities network lead to troubleshoot issues with the platform and invoicing.
 - **Educate on Medicaid basics and strategize on deploying the new program next to existing programs.** A primary need among IPV service providers was information on Medicaid basics, such as billing. They also needed guidance on how to separate services funded through the pilot from existing services funded by other sources. This information allayed the concern that pilot funding would supplant existing funding and enabled IPV service providers to serve every survivor who came to them, regardless of Medicaid eligibility. ▲
-

Recommendation: CalHHS and health plans should fund CBOs that currently employ CHWs to build upon their current internal infrastructure to participate in the new CHW benefit and workforce initiative. Funds would be used to purchase new billing systems, hire specialized staff (such as finance, billing, and data staff), certify CHWs, and train them on documentation and billing. One CHW advocacy organization described the challenge of competing for new program opportunities because the organization is not as well-funded as larger organizations, even though it might be better suited to serve the local community's needs. To support CBOs:

- CalHHS and health plans should explore funding CBOs that focus on IPV survivors and currently employ CHWs to build the infrastructure to participate in Medi-Cal and the workforce initiative. CalHHS could allocate pre-planning funds to its workforce initiative to support capacity building.

Recommendation: As the CHW workforce grows, CalHHS should balance growth with preserving the community philosophy of CHWs. Multiple organizations spoke to this philosophy as being integral to CHWs' impact on clients and expressed fear that it would be lost as non-community-centered entities join the field. Organizations shared concerns that entities with the funding needed to hire CHWs might not be the entities best suited to serve the community. To retain connections to the community as the field grows:

- CalHHS should partner with and elicit feedback from grassroots organizations and CBOs that have long-standing CHW experience and connection to their communities.
- CalHHS should encourage training about the community philosophy of CHWs for health plans and other organizations newly joining the field. El Sol Community Health Workers and Promotores Training Center created an organizational readiness self-assessment tool and proposed that organizations considering integrating CHWs into new settings reflect on their readiness to embrace community transformation, which is central to the success of CHWs.³⁹
- CBOs with long-standing CHW experience should provide CHW training that includes the CHW philosophy and can be adapted to the unique needs of different communities.

B. Service delivery models

Recommendation: Health plans should partner with CBOs to examine the needs of the communities they serve as they explore diverse ways to include CHWs in service delivery models. Health plans can directly hire CHWs, contract with smaller CBOs that employ them, and sponsor CHW recruitment and training that lead to CBO employment. Understanding what model would most benefit the communities they serve requires conversations with community partners about existing needs that CHWs can address. To explore potential service delivery models for CHWs:

- Health plans should communicate with all CBOs in their network that provide IPV services and fund them to develop use cases that serve as models for CHW programs to address IPV and other HRSNs.

Recommendation: CalHHS and health plans should include CBOs that already employ CHWs to address IPV in their service delivery



“My fear is that those who haven’t had a long history of working with promotores will be the ones who have the infrastructure to apply/receive funds, yet they don’t actually understand the community and how best to serve them like the smaller grassroots CBOs do. So then this whole benefit becomes more distant from communities, and it’s not what was intended.”

—Executive Director, CHW advocacy organization and IPV service provider



“In terms of community violence, there is a lack of expertise at health plans on what the [CHW] benefit would look like specifically and how the CHW can provide the services.... As a health plan, we have a lot to learn about how we can impact this topic.”

—Executive, Medi-Cal managed care plan



“The idea of using intermediary organization[s] makes sense to me and could be a way to take advantage of the Medicaid benefits without being a provider directly or needing to make big changes to our model.”

—Executive Director, Community health center

models. One way to do this would be to directly contract with these CBOs to create pilot programs for CHWs to address IPV. However, not all CBOs have the resources or desire to be Medi-Cal providers. Another model that would enable smaller grassroots CBOs to participate in the CHW benefit would involve a lead or backbone organization serving as the intermediary to Medi-Cal. These organizations would take on the tasks of billing and reporting to Medi-Cal, serve as fiscal intermediaries for smaller CBOs, and advocate on their behalf. To encourage CBOs to explore a direct or intermediary role:

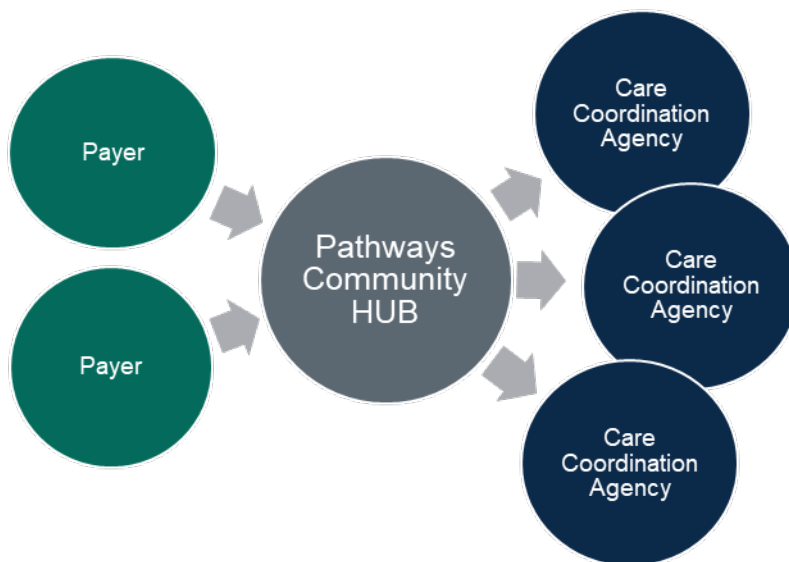
- Health plans should contract with IPV service organizations that already employ CHWs in the community.
- CalHHS should test a pilot model that funds IPV service organizations to develop into intermediary organizations that help connect smaller CBOs with Medi-Cal. Exhibit 3 describes the Pathways Community HUB Institute Model that uses intermediary entities to organize a network of CBOs that address HRSNs, family planning and behavioral health. The state of Washington has used this model to provide CHW services (see Appendix B, Table B.1). North Carolina’s Healthy Opportunities Pilots, described earlier, also uses a model with an intermediary entity to connect Medi-Cal beneficiaries to CBOs that address HRSNs, including IPV (see Appendix A, Table A.1).

Recommendation: CalHHS should provide clarity on the IPV-related CHW services it includes in the new Medi-Cal benefit and should help CBOs adapt existing service delivery models to incorporate new services. One health plan said the new CHW benefit incorporates a focus on community violence but is less clear on including a focus on IPV. In addition, CBOs said that many case managers, navigators, and peer workers funded by state and federal grants have the same skills as those listed for CHWs, and CBOs would need help adapting existing service delivery models to incorporate new CHW services. They would also need help differentiating the new CHW services from existing services, especially as this could affect grant funding (see the payment section for details).

- CalHHS should provide specific information and technical assistance on the IPV-related CHW services it includes in the Medi-Cal benefit. A DHCS announcement of Medi-Cal coverage for CHW services, updated August 19, 2022, includes a definition of violence prevention services that encompasses IPV. CalHHS should disseminate this information more widely to dispel any confusion about addressing IPV in violence prevention services.
- CalHHS should fund technical assistance webinars to help CBOs adapt existing service delivery models and differentiate services for billing. A technical assistance contractor could present examples of how CHW services could be separated so billing is feasible under Medi-Cal and other funding sources (see the payment section for details).
- CalHHS should conduct focus groups to solicit input on the type of technical assistance and guidance most needed by IPV service providers and CHWs.

Exhibit 3. Pathways Community HUB Institute Model⁴⁰

- The Pathways Community HUB Institute Model aims to leverage CHWs to transform community-based care coordination through an intermediary organization: the Pathways Community HUB.
- Payers contract with a Pathways Community HUB, which contracts with Care Coordination Agencies (CCAs) that employ CHWs. This alleviates the burden by eliminating the need for CCAs/CBOs to contract directly with payers.
- CHWs engage community members, identifying and addressing issues that align with specified pathways. Each pathway specifies billable outcomes. Pathways can include smoking cessation, pregnancy, or housing, among others.
- Pathways Community HUBs are neutral entities that do not provide direct services. They gather multiple CCAs into an organized network that provides needed services for selected pathways.
- Pathways Community HUBs provide payment to CCAs for completed outcomes and pathways, thus incentivizing CCAs to address HRSNs to achieve positive client outcomes.
- Pathways Community HUBs also track progress of clients, monitor CCA performance and community service network adequacy, and ensure quality.



Recommendation: Health plans and CBOs should integrate CHWs into care teams. A health plan that sponsored CBOs to train and then employ CHWs intentionally integrated CHWs as members of the primary care team. CHW advocacy organizations said that although CHWs have an important role in care teams because of their unique connection to the community, they are often relegated to a secondary support role under clinicians or other licensed caregivers. This oversight often occurs in environments new to CHWs. To integrate CHWs into care teams:

- Health plans developing new programs should train CHWs on clinical workflows and their role in a care team, as well as train staff working with CHWs about their value. (See the training section for more details.)

C. Payment models

Recommendation: CalHHS should ensure that Medi-Cal fee-for-service rates will adequately reimburse CHWs.

An IPV service delivery organization said that pay equity for CHWs under the new CHW benefit is essential. CBOs that currently pay CHWs an hourly rate using grant funds are concerned that the Medi-Cal fee-for-service rates would prevent them from paying CHWs a fair wage. To further explore these concerns:

- CalHHS should host conversations and listening sessions with CHW advocacy organizations, IPV advocacy and service organizations, CBOs, and health plans to discuss equitable and adequate reimbursement rates for CHWs.
- CalHHS should ensure adequate funding is allocated to cover equitable payment for CHWs that is commensurate with the full range of competencies that make CHW services successful, such as services in the patient’s language, culturally competent services, and lived experience.



“When we’ve connected with other organizations...we’ve been intentional with infusing CHWs as a member of the primary care team moving forward. They’re not a secondary need; they’re just as important. I think the depth of education on CHW services is crucial to the success of the model.”

—Director, Medi-Cal managed care plan



“It seemed to me on my first read of the benefit...that what the promotores’ hourly rate comes out to be in Medi-Cal is not equitable for the work that they’re actually doing at our agency.”

—Executive Director, IPV service organization

See Exhibit 4 for a summary of CHW payment in states using SPAs.

Exhibit 4. CHW payment in states using SPAs

Each of the eight states with CHW-related SPAs uses a fee-for-service payment model. Six states explicitly note the use of fee-for-service reimbursement in their SPAs (California, Indiana, Louisiana, Nevada, Rhode Island, South Dakota).^{6,9,10,11,13,15,16} Of these six states, four indicate that CHW services will be reimbursed based on the physician fee schedule or at a percentage of the physician fee schedule amount (California, Indiana, Nevada, South Dakota). Minnesota’s and Oregon’s SPAs do not explicitly state that CHW services will be reimbursed through fee-for-service, but this is listed elsewhere in Oregon’s state documentation and in Minnesota’s state legislation. California’s July 2022 SPA aligns with other states’ SPAs, establishing fee-for-service reimbursement based on the lowest amount between the amount billed to Medicaid, the charge to the general public, or 80 percent of the lowest maximum allowance established by Medicare’s physician fee schedule. ▲

Recommendation: CalHHS should provide more clarity about billing for new CHW services because of potential duplication with existing Medicaid payment models. Health plans and CBOs that are already participating in Medicaid value-based payment models incorporating some CHW services said they require further clarity on when a service should be included in the value-based model or the CHW

benefit. In addition, a community health center that is already a Medicaid provider said that incorporating the CHW services newly billable to Medicaid would require renegotiating the alternative payment rate it has with the state. The current per-member per-month rate incorporates all supportive services, and the center is worried that renegotiations could result in a lower rate. To offer clarity:

- CalHHS should provide technical assistance and use cases to illustrate different billing scenarios.
- CalHHS should meet with existing Medicaid providers to hear concerns about renegotiating alternative payment rates and include CBOs and CHWs to brainstorm solutions to ensure fair rates.

Recommendation: CalHHS should help IPV service providers and other CBOs understand how billing Medicaid can work alongside existing funding sources that might have restrictions. An IPV service provider said their organization receives grant funds for IPV (for example, funding under the Family Violence Prevention Services Act [FVPSA]) that restrict sharing personally identifiable information for people who receive funded services. CBOs believe these restrictions could complicate Medicaid billing because claims require some level of personally identifiable information (such as a member ID) to receive reimbursement. The Administration for Children and Families (ACF) issued an [informational memo](#) on September 19, 2022, saying that FVPSA grantees and subrecipients can receive reimbursement from Medicaid for medical advocacy and health services not funded by FVPSA grants (Exhibit 5).⁴¹ To offer clarity to CBOs:

- CalHHS should facilitate group discussions on how current Medi-Cal billing requirements could interact with other funding sources, particularly FVPSA and other sources such as the California Governor’s Office of Emergency Services Sexual and Domestic Violence Prevention Program Grants, opportunities from the Office of the Assistant Secretary for Health Office of Women’s Health, Department of Justice Office on Violence Against Women, and other federal and private funding opportunities.^{42,43,44,45}
- CalHHS should develop an informational document that clearly states how Medi-Cal billing interfaces with other funding sources, particularly FVPSA as well as other sources listed above.
- CalHHS should disseminate documents such as the ACF informational memo to IPV service providers and other CBOs that receive funding from FVPSA and other sources.

Exhibit 5. ACF: Medical advocacy and health services payment or reimbursement for FVPSA grant recipients and subrecipients⁴⁶

Per the ACF, FVPSA subrecipients that wish to receive reimbursement from a health program or third-party payer (such as Medicaid or health insurance plans) must:

- Ensure survivor confidentiality and privacy requirements are met in billing, referral, and service mechanisms
 - Refrain from charging survivors for services funded in whole or in part with FVPSA grant funds
 - Clearly separate FVPSA funding from health care reimbursements (for example, from Medicaid or health plans) to avoid co-mingling funding streams
 - Discuss scenarios with the FVPSA federal program officer and ACF grants management specialist in which subrecipients wish to receive reimbursement for medical advocacy via Medicaid, health program, or third-party payers
 - Report income received from health care sources as program income. ▲
-

D. CHW recruitment and development

Recommendation: CalHHS should recognize and decrease employment requirements that can be significant barriers for CHWs’ participation. CHWs are unique in their connection to the communities they serve and often share the same language, culture, and lived experience. CBOs often recruit former clients to become CHWs. One CHW training organization said that (1) CHWs with lived experience are more effective in and passionate about their work than those without that experience and (2) shared context and identity enables CHWs to drive change. However, employment requirements such as educational attainment, English language proficiency, and immigration status can inhibit CHWs from securing employment. Immigration status is particularly important, as some CHWs are undocumented and currently volunteer their services. To reduce employment barriers for qualified CHWs:

- CalHHS should treat lived experience, including those of IPV survivors, and vocation as equivalent to formal education for CHW employment. Additional training can be provided in areas specific to their work.
- CalHHS should refrain from imposing requirements such as English proficiency, which that might exclude CHWs closest to the communities they serve.
- CalHHS and philanthropic organizations should host discussions with CHW advocacy organizations, CBOs, and experts in employment immigration law to explore employment options for CHWs with various immigration statuses.

//////
“We do often encounter promotores who are undocumented and cannot be hired. There are ways of getting people their proper documentation through their jobs, and I’d love to see an opportunity from the government to give promotores a working document if they get a certain certification(s)... We know this can happen to people who are highly qualified to do a specific set of work. It’s tough because the undocumented promotores can be great at their jobs.”

—Director, CHW advocacy organization

Recommendation: CalHHS and CBOs should develop defined career paths and other strategies to sustain the CHW workforce. Otherwise, trained staff will move on to other positions, and CBOs will need to train additional CHWs to replace them. Several community-based organizations noted difficulty retaining CHW staff, often citing a lack of pathways for advancement. CBOs and training centers said CHWs often leave to obtain more education, work at other organizations, or pursue similar careers with more defined pathways (for example, careers as medical assistants or care coordinators). According to a survey conducted by the El Sol Community Health Workers and Promotores Training Center, 91 percent of CHWs believe the CHW field needs clearer career pathways.⁴⁷ If given the opportunity to advance professionally as a CHW, 81 percent of the survey respondents said they would prefer to advance as a CHW than move to a new field. This indicates that creating these advancement opportunities would ameliorate workforce sustainability concerns. To improve CHW retention:

- Organizations should implement strategies such as creating promotion pathways within their organization and increasing pay and stability. The El Sol Community Health Workers and Promotores Training Center posits in its report that CHWs’ ability to advance into leadership, evaluation, training and development, or advocacy and policy roles will increase the respect CHWs receive from other public health professionals, while enabling them to retain their community-centered identities.⁴⁸
- CalHHS should speak with CBOs currently employing CHWs to learn about strategies for sustaining this workforce.

- CalHHS and philanthropic organizations should fund CBOs to explore training models and innovative employment models for CHWs. For example, this could involve CBOs partnering with organizations such as Lideres Campesinas, a non-profit organization created by and for women farmworkers, and the *promotore*-owned cooperative Mujeres Empresarias Tomando Acción (META) (Exhibit 6).⁴⁹ These organizations, with members who are often *promotores* or serve in similar roles, already represent and serve their communities by engaging in programs for leadership development, training, violence prevention, and building healthy communities.

Exhibit 6. CBO partnerships to support *promotores* training and employment⁵⁰

Partnerships to train *promotores*. East LA Women’s Center is an IPV service provider that runs a *promotores* program to train CHWs who provide basic health education and support for women experiencing IPV. Lideres Campesinas is a non-profit organization created by and for women farmworkers to bring about social and economic change in their community, including in the area of domestic violence. The two organizations partnered to provide free training on how to establish a *promotores* model while advancing knowledge in the area of IPV.

Partnerships to employ *promotores*. META is a cooperative owned by women of diverse backgrounds and life experiences who serve and lead their communities as *promotores* and in other roles. The cooperative, which launched in August 2018, contracts with nonprofit organizations to work in community outreach, facilitation, and child care. META formed in partnership with SOMOS Mayfair, a nonprofit that served as an incubator for the cooperative, offering consulting services and support as the business formed. Other CBOs have considered supporting the development of similar *promotores* cooperatives.

*“Our goal is to bring in *promotores* and develop them into a co-op that could become an LLC, and then our organization could contract with the co-op and not worry about work permits because the co-op would manage it in their own business.”*

—Executive Director, CHW advocacy organization and IPV service organization

E. CHW training

Currently, California is the only state that not only specifies violence prevention services in its CHW Medi-Cal benefit but also has a separate CHW certification pathway based on violence prevention training. As stated earlier, there is some ambiguity on the extent of training CHWs will receive to support survivors of IPV. The certification pathway for violence prevention names two training certificates. One certification from the Urban Peace Academy specifies intervention training to address gang violence. The other certification for violence prevention professional training that is offered by the Health Alliance for Violence Intervention lists IPV as one session in its five-day training.⁵¹ The level of IPV training that will be required for California CHWs who use other certification pathways has not yet been determined. California has an opportunity to serve as an example for training CHWs to address IPV for other states considering expanding and sustaining their CHW workforce.

Recommendation: In setting California’s CHW training requirements that will govern the Medi-Cal benefit and the workforce initiative, CalHHS should be guided by (1) CBOs that have a long history of training CHWs and (2) IPV advocacy and service organizations that can highlight the prevalence of IPV issues in communities and the need for sensitivity.

Grassroots organizations understand the needs of the communities they serve and have expertise training CHWs to address these needs in community-centered and tailored ways. IPV advocacy and service organizations understand the prevalence of IPV issues and the range of services that survivors need.

As California’s Department of Health Care Access and Information (HCAI), within CalHHS, works to certify CHW training programs by creating a list of CHW core competencies, it must be guided by the expertise of these organizations. (See Exhibit 7 and Appendix B, Table B.1 for information on core competencies in CHW trainings in states.^{52,53,54}) To benefit from the training and IPV expertise in the state:

- HCAI should fund existing CBOs that already provide CHW training. This would help ensure that the growing CHW workforce retains the CHW philosophy of connection to the community.
- HCAI should continue to elicit feedback during curriculum planning and throughout the workforce initiative.
- HCAI should engage CHWs, CBOs that employ CHWs, IPV advocacy organizations, and IPV service organizations to discuss appropriate IPV training in CHW core competencies.

According to state representatives, HCAI will focus on program planning in Year 1 (2022–2023) of the workforce initiative, and it will engage CBOs and others committed to developing and promoting the CHW workforce to discuss core competencies and ideas for a state certification process for CHW training. HCAI will also begin planning the CHW curriculum in Year 1. In Years 2 and 3, HCAI will fund CHW training programs and innovative models of training to expand the CHW workforce.



“Universities are jumping into these trainings, but they are becoming institutionalized. The CHWs are from the community; that’s what the title is. So not everyone will embrace this community-based approach of CHWs. They are preparing community members to be integrated into the system, and that’s not the way it should be. We need to integrate the system into the community.”

—Executive Director, CHW training center

Exhibit 7. CHW core competencies in states with SPAs and other Medicaid initiatives^{55,56}

Nearly all states that have a SPA for CHW benefits outline core competencies required for CHW training curricula. Many existing CHW trainings draw on core components recommended by the Community Health Worker Core Consensus (C3) Project in 2018:

- Communication
- Interpersonal skills and relationship building
- Service coordination and navigation
- Capacity building
- Advocacy
- Education and facilitation
- Outreach
- Professional skills and conduct
- Evaluation and research
- Knowledge base

The National Association of Community Health Workers acknowledged the C3 Project as a primary guide for developing CHW core competency training and the Centers for Medicare & Medicaid Services cited it as a resource for organizations developing CHW roles. California’s and Louisiana’s trainings use the exact competencies from the C3 Project. ▲

Recommendation: When selecting IPV-specific training curricula, HCAI should ensure it meets the needs of people who experiencing violence, while limiting the training burden for CHWs.

Among CHW training organizations with IPV-specific trainings, common topics include confidentiality, peer counseling, community outreach, and linkage to services. (See Exhibit 8 for common IPV training themes.) One IPV service provider said it can be harmful to survivors to interact with CHWs who have not received adequate training on trauma, confidentiality, peer counseling, and victims’ rights. The organization suggested including these components as CHW core training. Another organization that trains CHWs recommended offering core training that at least educates CHWs on IPV so they can recognize it, address it safely, and link people to resources. Many organizations involved in training CHWs also noted that training requirements should not unduly burden CHWs. Respondents did not suggest one best practice IPV curriculum that could be added to CHW core training. To further explore setting IPV training criteria for CHWs:

“There needs to be some standardization around trauma, confidentiality, peer counseling, [and] victim rights as it can be really damaging to survivors to not have someone properly trained on these topics.”

—Executive Director, CHW advocacy organization and IPV service provider

- HCAI, the state agency overseeing standardization of training requirements, should seek guidance from existing CBOs that employ CHWs who connect survivors to IPV services—such as East LA Women’s Center, South Bay Community Services, Community Solutions—and IPV advocacy organizations like Futures Without Violence.
- HCAI, in partnership with IPV advocacy organizations and CBOs that employ CHWs, should incorporate the CUES model (Confidentiality, Universal Education, and Empowerment Support) from Futures Without Violence to prevent and respond to IPV. CUES is a short, evidence-based intervention to prevent, identify, and respond to domestic violence in health care settings.⁵⁷

Exhibit 8. Common themes among IPV-specific CHW trainings

Training development:

- Most organizations in California with IPV-specific CHW trainings developed them in-house. Some of these organizations have developed their trainings based on many years of experience serving IPV survivors and tailored them to local cultural context or to specific settings (for example, clinical or community-based).

Training duration:

- IPV-specific trainings ranged from 20-75 hours, depending on the organization and requirements for trainees.
- One organization trains both *promotores* and advocates to address IPV, in 20- and 75-hour trainings, respectively. The longer IPV advocate training aligns with requirements of the California Evidence Code for Sexual Assault Counselors, is certified by the California Office of Emergency Services, and enables advocates to provide direct IPV services. The shorter *promotores* training focuses on education about different types of violence and builds *promotores*' skills to link survivors to resources and services.
- Another organization that includes IPV in their fundamental CHW training offers two curricula lengths—an intensive track and a longer track for those working on computer and language skills as part of their CHW training.

Topics covered:

- Many IPV-specific training curricula included common topics such as:
 - Peer counseling – using CHWs' own experiences to support others
 - Community outreach – understanding the needs of and building relationships with the community, and educating community members
 - Linkages to services – knowing local IPV resources and services, assisting with connections, referrals, and navigation of services and systems
 - Confidentiality and stigma – understanding stigma surrounding IPV, the importance of maintaining privacy, and ethical and legal standards
- Some training organizations also train CHWs on specific types of violence, such as IPV, sexual violence and its effects, teen dating violence, and human trafficking. Moving beyond outreach and education in the community, some CHW training organizations also include sessions on how CHWs can affect IPV-related policy change through community mobilization.

Considerations:

- When asked about topics that should be included in any IPV-related training, many organizations highlighted confidentiality, peer counseling, and the impacts of IPV and trauma on individuals because of the sensitive nature of IPV, and the importance of maintaining relationships and trust.
 - Some organizations included personal safety in their trainings, understanding that CHWs who assist survivors may need to safeguard themselves.
 - Many organizations emphasized the need for trainings to be culturally tailored, with one noting that local domestic violence agencies “probably already have a good sense of what domestic violence in their community looks like.”
 - Some organizations also tailored trainings to employment settings. For example, trainings for clinical settings focused more on health coaching and understanding the mental, emotional, and physical health impacts of violence and trauma on individuals and their care-seeking behaviors.
-

Recommendation: HCAI should establish trainings on the role of CHWs for supervisory and clinical staff working with CHWs. CHW advocacy organizations said supervisors might not know the impacts CHWs have on clients or how to best supervise CHWs. One organization offers a training to CHW supervisors, managers, and evaluators on supervision style, programmatic planning, evaluation, and CHW philosophy. To support these trainings:

- CalHHS should seek feedback on training staff working with CHWs.
- CBOs should offer trainings or other educational materials for health care providers on the role of CHWs and their value.

F. Monitoring and tracking

Recommendation: CalHHS and health plans should adapt Medi-Cal reporting requirements for CHWs, given that the nature of their work is organic and focused on the individual. An IPV service provider said that CHWs in the field should not be concerned with tracking metrics in real time for each case and service rendered. Instead, they should focus on serving their clients and ensuring that their interactions and services are high quality and personal. One CBO said they have their *promotores* report back to a lead promotor, who is in the office and can update case data in the system on their behalf.

To ensure reporting requirements are not overly burdensome to CHWs:

- CalHHS should host listening sessions with CBOs to inform and simplify Medi-Cal reporting requirements for CHW benefits overall.
- CalHHS should develop a menu of reporting requirements that aligns with current CHW reporting practices.

Recommendation: CalHHS and health plans should partner with IPV service providers and other CBOs to protect the confidentiality of survivors in data reporting and monitoring. Health plans and CBOs said that because a member ID must be included in claims for Medi-Cal reimbursable services, reporting requirements for the new CHW benefit could put a survivor’s confidentiality and security at risk. This concern was a significant obstacle for IPV service providers interested in participating in North Carolina’s Health Opportunities Pilot. The Medicaid agency partnered with CBOs and an IT developer to create an IT platform that will support referral, coordination, and payment while addressing this concern. (See Exhibit 2 for more detail.) IPV advocates said that protection of privacy and confidentiality for survivor information must be incorporated into the design of these social service referral platforms. Futures Without Violence published a policy memo in July 2022 that describes the unique privacy concerns for IPV survivors that must be considered. The memo also lists questions that IPV service providers participating in an IT platform should consider, such as “who will be using the tool and to what end” and “how does the survivor maintain control over their health information.”⁵⁸

To protect survivors’ confidentiality:

- CalHHS and health plans can host listening sessions with IPV advocacy and service organizations to (1) discuss confidentiality concerns related to reporting and monitoring for the new CHW benefit and (2) explore strategies for secure and confidential data monitoring.

- CalHHS should implement strategies for secure and confidential data monitoring in consultation with key IPV advocacy service organizations. For example, any IT platform used to support referral, coordination and payment could designate survivors as a “sensitive” population, which would provide an additional layer of privacy protection equal to those given to people with HIV or substance use disorder.
- CalHHS and health plans, in partnership with IPV advocacy organizations and CBOs, should fund the development of new IT solutions that address confidentiality concerns for IPV survivors.

IV. Next Steps

As California implements the new CHW benefit in Medi-Cal and the CHW workforce initiative, continued discussions with community partners will be needed to further explore program design considerations and solutions. Because the nature of the CHW role is community based, CBO partners must be involved in California’s efforts to expand the CHW workforce and services to address IPV and other HRSNs. Community partners—including IPV service delivery organizations, IPV advocacy organizations, community health centers, other CBOs, CHW training centers, and health plans—raised many considerations related to program planning, CHW service delivery models, payment models, staff recruitment, training, and monitoring of CHW services. This policy brief provides recommendations in all these areas, along with important next steps for CalHHS to bolster CBO input at this stage:

- Support the planning stage for CBOs by informing and funding the development of knowledge and internal infrastructures needed to participate in the CHW benefit and CHW workforce initiative
- Instruct health plans to support CBOs via funding and technical assistance to bolster their readiness for participation
- Simplify the process for CBO participation in Medicaid
- Convene meetings with IPV service providers and other CBOs to include their expertise in planning for the CHW benefit and CHW workforce initiative
- Partner with CBOs to develop use cases that serve as models for CHW programs to address IPV and other HRSNs
- Identify and fund CBOs with experience deploying CHWs that can serve as contractual and fiscal intermediaries to Medi-Cal for small, grassroots CBOs
- Facilitate group discussions with CBOs on how current Medi-Cal billing requirements could interact with other funding sources, particularly the Family Violence Prevention and Services Act, and disseminate an informational document about those interactions
- Convene meetings of IPV service providers, IPV advocacy organizations, CHW advocacy organizations, and long-standing CHW training sites to develop consensus on the best methods for including IPV curricula in CHW training.
- Clarify IPV training curricula
- Identify issues related to confidentiality and safety that CBOs raise, and integrate solutions into the planning process.

Acknowledgements: Mathematica staff conducted the research and developed this brief, including Melanie Au, Erin LeDane, Jackie Brenner, Alyssa Bosold, Toni Abrams Weintraub, and Amanda Lechner. We appreciate Lisa James at Futures Without Violence and Lena O'Rourke at O'Rourke Health Policy Strategies for contributing their expertise and insights. Blue Shield of California Foundation funded and supported this research and issue brief.

We thank all the subject matter experts who participated in interviews and generously gave their time and expertise, including CHW advocacy organizations, IPV service providers, community health centers, other CBOs, health plans, CHW training organizations, and California state representatives.

Appendices

Appendix A. Research approach

Our policy brief aimed to answer the following research questions:

1. How have other state Medicaid agencies structured and funded CHW services in their SPAs?
2. In what ways do states employ CHWs to address HRSNs, and are there examples of CHWs addressing and preventing IPV?
3. How can IPV service organizations participate in California's efforts to expand CHW services in Medicaid? What will challenge or facilitate this participation?
4. How can the California Health and Human Services Agency (CalHHS) use its SPA to support the CHW workforce to help address IPV?
5. How can CHW training prepare CHWs to address IPV?

We gathered information to answer these research questions through a focused document review and interviews with subject matter experts. The document review included state Medicaid SPAs, 1115 demonstration waivers, managed care contracts, state Medicaid websites, and online searches for published and gray literature about Medicaid programs using CHW to address HRSNs and IPV. We extracted information on CHW services (including those related to IPV), service delivery models, certification requirements, and training. In addition, we conducted 13 interviews in fall 2022 with subject matter experts, including CHW advocacy organizations, IPV service providers, community health centers, other CBOs, health plans, CHW training organizations, and California state representatives. Nine of the organizations interviewed currently employ or contract with CHWs, and six provide direct services to survivors of IPV. We used a semi-structured interview protocol to lead discussions of up to 60 minutes. We recorded and transcribed our discussions, coded interview data, and analyzed the data to abstract high-level themes to answer our research questions.

Appendix B. CHW Initiatives in State 1115 Demonstration Waivers

Table B.1. Summary of CHW initiatives in State 1115 Demonstration waivers

State	Medicaid initiative	Summary of initiative goals and focus area	Role of CHW	Service delivery structure and partnerships
NC ^{a,b,c}	Section 1115 Demonstration Waiver (Healthy Opportunities Pilots)	Through Healthy Opportunities Pilots, beneficiaries are screened for health and social risks and referred to community services. IPV is one of the four domains of the program's interventions. Services for IPV include case management, violence intervention services, referrals to legal services, parenting support programs, home visiting services, and dyadic therapy.	Care management teams, as opposed to CHWs, screen beneficiaries for health and social risk factors , coordinate access to human services, manage care plans, and track beneficiary progress.	Health plans fund network leads to contract with human service organizations, which are paid to provide services to beneficiaries. North Carolina Department of Health and Human Services is working with the North Carolina Coalition Against Domestic Violence to launch IPV-related services within the program.
NM ^{d,e,f}	Section 1115 Demonstration Waiver (Centennial Care 2.0)	New Mexico's Centennial Care 2.0, a Section 1115 Waiver, specifies performance targets for managed care organizations to increase the use of CHWs in care coordination roles and to support members in navigating the health care delivery system.	CHWs support efforts to improve health literacy, provide translation services and culturally relevant care coordination, health education, managed care system navigation, assistance in accessing community services , counseling on health behaviors, and assistance in ensuring receipt of needed medical services.	Managed care organizations employ CHWs.

State	Medicaid initiative	Summary of initiative goals and focus area	Role of CHW	Service delivery structure and partnerships
OR ^{g,h,i}	Section 1115 Demonstration Waiver (Coordinated Care Organizations – CCOs and CCO 2.0 Contracting)	<p>Oregon's 2012 Section 1115 Demonstration Waiver renewal established CCOs and permitted global payments to CCOs, with flexibility to provide health-related services (HRS) designed to address HRSN. Oregon established that traditional health workers (which include CHWs, tribal health workers, peer, youth, and family support specialists, and birth doulas) could be covered as an HRS, under in-lieu of services, or as part of a value-based model.</p> <p>CCO 2.0, Oregon's next phase of care transformation, includes contracts with new requirements for CCOs to improve traditional health worker infrastructure. Specifically, CCOs must employ or contract with a traditional health worker liaison. The liaison must coordinate with the CCO to create a Traditional Health Worker Integration and Utilization Plan to increase the traditional health worker workforce, improve access and use of traditional health worker services, and integrate traditional health workers into care teams and service delivery.</p>	<p>Traditional health workers provide the following services: care planning, screening for HRSN and warm handoffs or referrals to social services, support with care transitions and access, home visiting, facilitation of support groups, cultural mediation and culturally appropriate health education, support with chronic disease self-management, training for new traditional health workers, and assessment and evaluation.</p> <p>Traditional health workers may take on additional roles (for example, if serving as birth doulas).</p>	<p>Oregon does not specify its service delivery model for traditional health workers but does provide guidance for CCOs to contract with community-based organizations who employ traditional health workers, as well as guidance on direct employment of traditional health workers through CCOs.</p>

State	Medicaid initiative	Summary of initiative goals and focus area	Role of CHW	Service delivery structure and partnerships
TX ⁱ	Section 1115 Demonstration Waiver (Texas Healthcare Transformation and Quality Improvement Program)	The waiver allows Texas to establish a Delivery System Reform Incentive Payment (DSRIP) program that provides incentive payments to hospitals for improvements to health, health care quality, and access for low-income populations. The DSRIP program outlines potential projects that participants can implement, which include CHWs. For example: 1) implementation of evidence-based health promotion programs that engage and employ CHWs, 2) establishing or expanding a patient care navigation program that utilizes CHWs to provide social support and culturally appropriate care to vulnerable populations, and 3) providing an intervention with CHWs to support populations with behavioral health needs.	CHWs take different roles in each suggested project, including supporting education and outreach, supporting navigation by connecting patients to appropriate care, and supporting behavioral health patients. In the care navigation program specifically, CHWs address HRSN by providing services such as arranging financial support and helping with related paperwork, coordinating transportation and child-care , and building partnerships with local community service providers.	The structure of CHW service delivery and employment is not specified. DSRIP initiatives are operated under Regional Healthcare Partnerships coordinated by a public hospital or local governmental entity that collaborates with other hospitals and providers on delivery system reform in specific geographic locations.
WA ^{k,l}	Section 1115 Demonstration Waiver (Washington Medicaid Transformation Project)	Washington's Medicaid Transformation Project supports nine Accountable Communities of Health in implementing health improvement projects to address systems capacity, health care delivery, disease prevention, and health promotion. Under the domain of health care delivery, some Accountable Communities of Health focused on community-based care coordination and used the Pathways HUB Model to support screening and navigation for HRSN using CHWs. In its Medicaid Transformation Project renewal efforts, Washington intends to build on the successes of these initial projects to create regional Community Hubs across the state that provide HRSN screening, navigation, and referral, and support payment for CHWs.	In the Pathways HUB Model, CHWs are responsible for outreach to individuals and screening to assess social, physical, and behavioral health needs . CHWs facilitate referrals to address identified needs, including to social service providers.	Accountable Communities of Health were responsible for overseeing the HUB Model. The specific structure of CHW employment is unknown and may vary.

- ^a North Carolina Department of Health and Human Services. “Healthy Opportunities Pilots: Pilot Overview and Care Management Team Roles and Responsibilities.” May 2022. <https://www.ncdhhs.gov/media/16505/download?attachment>. Accessed September 7, 2022.
- ^b North Carolina Department of Health and Human Services. “Healthy Opportunities Pilots: Standard Plan Roundtable on the Evidence Base.” May 2022. <https://www.ncdhhs.gov/media/16511/download?attachment>. Accessed September 7, 2022.
- ^c North Carolina Department of Health and Human Services. “Updated Healthy Opportunities Pilots Fee Schedule [Guidance Version].” March 2022. Available at <https://www.ncdhhs.gov/media/14071/download?attachment>. Accessed September 8, 2022.
- ^d Ruff, E., and E. Fishman. “Building Capacity for Community Health Worker Integration: Three Key Steps State Policymakers Should Take during the COVID-19 Crisis and Beyond.” Washington, DC: FamiliesUSA, July 2020.
- ^e New Mexico Human Services Department. “Centennial Care Waiver Demonstration: Section 1115 Annual Report: Demonstration Year: 4 (1/1/2017-12/31/2017).” Santa Fe, NM: New Mexico Human Services Department, April 2018.
- ^f Scrase, D. R., and N. Comeaux. “State of New Mexico Human Services Department: Draft Section 1115 Medicaid Demonstration Waiver Renewal Request to Centers for Medicare & Medicaid Services (CMS): US Department of Health and Human Services.” Santa Fe, NM: New Mexico Human Services Department, September 2022.
- ^g Oregon Health Authority. “Health-Related Services Guide for CCOs: Traditional Health Workers and Health-Related Services.” March 2022. Available at <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-Guide-THWs.pdf#:~:text=Traditional%20Health%20Worker%20s%20in%20Oregon%20THWs%20are.life%20experiences%20with%20Oregon%20Health%20Plan%20%28OHP%29%20members.%E2%80%9D>. Accessed September 5, 2022.
- ^h Traditional Health Worker Commission. “Traditional Health Worker Toolkit.” October 2019. Traditional Health Worker Commission, Oregon Health Authority. Available at <https://www.oregon.gov/oha/OEI/THW%20Documents/Traditional-Health-Worker-Toolkit-2019-Final.pdf>. Accessed September 6, 2022.
- ⁱ Oregon Health Authority. “Oregon Health Plan: Amended and Restated: Health Plan Services Contract.” January 2022. Available at <https://www.oregon.gov/oha/HSD/OHP/Documents/2022-CCO-Contract-Template.pdf>. Accessed September 5, 2022.
- ^j Centers for Medicare & Medicaid Services. “Demonstration Approval.” June 2022. Available at <https://www.medicare.gov/medicaid/section-1115-demonstrations/downloads/tx-healthcare-transformation-ca.pdf>. Accessed September 8, 2022.
- ^k Spencer, A., “Integrating Community Health Workers into State and Local Chronic Disease Prevention Efforts: Program and Financing Considerations.” Washington, DC: Academy Health, February 2018.
- ^l Washington State Health Care Authority. “About the Medicaid Transformation Project renewal.” March 2022. Available at <https://www.hca.wa.gov/assets/program/about-mtprenewal.pdf#:~:text=of%20the%20Section%201115%20Medicaid%20demonstration%20waiver%2C%20called,current%20MTP%20waiver%2C%20which%20ends%20December%2031%2C%202022>. Accessed September 7, 2022.

Appendix C. CHW Training Requirements by State

Table C.1. State CHW training requirements and competencies

State	Training requirements [^]	Training entity	Training addresses IPV*	CHW field experience as requirement of certification
CA ^a	<p>CHWs must complete at least one of the following pathways:</p> <p>A. CHW certification includes the following topics:</p> <ol style="list-style-type: none"> 1. Communication 2. Interpersonal and relationship building 3. Service coordination and navigation 4. Capacity building 5. Advocacy 6. Education and facilitation 7. Individual and community assessment 8. Professional skills and conduct 9. Outreach 10. Evaluation and research 11. Basic knowledge in public health principles and social determinants of health <p>B. Violence Prevention certification: Allows CHWs to provide violence prevention services only</p>	Multiple entities ⁺	Yes (Pathway B only)	No, but CHWs can substitute prior CHW experience for training

State	Training requirements [^]	Training entity	Training addresses IPV*	CHW field experience as requirement of certification
IN ^{b,c,d}	<p>CHWs must complete at least 45 hours of training that includes interactive learning; an internship, externship, or capstone project opportunity; and preparation for potential higher education. Topics include:</p> <ol style="list-style-type: none"> 1. Cultural mediation among individuals, communities, and health and social services systems 2. Providing coaching and social support, including motivational interviewing 3. Providing culturally appropriate health education and information including techniques for delivering health education to various audiences, basic overview of chronic diseases, trauma-informed care, and staying within Scope of Practice and how to refer when needed 4. Care coordination, case management, and system navigation including client-centered care 5. Providing direct services with an emphasis on the CHW Code of Ethics, HIPPA, confidentiality, and informed consent, and functioning within a multi-disciplinary team 6. Building individual and community capacity 7. Advocating for individuals and communities 8. Implementing individual and community assessments including stages of change and risk and harm reduction 9. Conducting outreach 10. Participating in evaluation and research 	Multiple entities ⁺	No	No, but CHWs can substitute prior CHW experience for training

State	Training requirements ^	Training entity	Training addresses IPV*	CHW field experience as requirement of certification
LA ^{e,f}	<p>CHWs must complete a state-recognized training program approved by the Louisiana Community Health Worker Workforce Coalition. Training must include the following competencies:</p> <ol style="list-style-type: none"> 1. Communication skills 2. Interpersonal and relationship building skills 3. Service coordination and navigation skills 4. Capacity building skills 5. Advocacy skills 6. Education and facilitation skills 7. Individual and community assessment skills 8. Outreach skills 9. Professional skills and conduct 10. Evaluation and research skills 11. Knowledge base 	Multiple entities ⁺	No	No, but CHWs can substitute prior CHW experience for training
MN ^{g,h}	<p>Training is required for Medicaid reimbursement. The statewide standardized curriculum includes:</p> <ol style="list-style-type: none"> 1. Roles, advocacy, and outreach 2. Organization and resources 3. Teaching and capacity building 4. Legal and ethical responsibilities 5. Coordination and documentation 6. Communication and cultural competency 7. Health promotion competencies 8. Practice competencies - internship 	Multiple entities with state-wide curriculum ⁺	No	No

State	Training requirements [^]	Training entity	Training addresses IPV*	CHW field experience as requirement of certification
NC ⁱ	<p>North Carolina’s statewide standardized training covers the following core competencies:</p> <ol style="list-style-type: none"> 1. Communication skills 2. Capacity building skills 3. Service coordination skills 4. Interpersonal skills 5. Advocacy skills 6. Personal skills and development 7. Outreach skills 8. Education and facilitation skills 9. Knowledge base 	Multiple entities with state-wide curriculum ⁺	No	No
NM ^{l,k}	<p>The New Mexico Department of Health, Office of Community Health Workers, collaborated with community-based organizations to create a standardized training. Required competencies include:</p> <ol style="list-style-type: none"> 1. The CHW profession 2. Effective communication 3. Interpersonal skills 4. Health coaching 5. Service coordination 6. Advocacy 7. Technical teaching 8. Community health outreach 9. Community knowledge and assessment 10. Clinical support skills (optional) 	Multiple entities with state-wide curriculum ⁺	No	CHW training is not mandatory, but CHWs already practicing are offered voluntary CHW certification

State	Training requirements ^	Training entity	Training addresses IPV*	CHW field experience as requirement of certification
NV ^{l,m,n}	<p>Nevada’s CHW training varies by course provider. The core competencies for CHWs in Nevada include:</p> <ol style="list-style-type: none"> 1. Advocacy skills 2. Community outreach and engagement 3. Communication skills 4. Promoting healthy lifestyles (healthy eating, active living) 5. Cultural competence and responsiveness 6. Service coordination skills 7. Individual and assessment skills 8. Health insurance basics 9. Teaching skills 10. Organization skills 11. Community capacity building 12. Professional conduct and interpersonal skills 13. Public health 	Multiple entities ⁺	No	No
OR ^o	<p>CHWs must receive their Professional Development Certification, CPR/First Aid certification, and complete a 96-hour CHW training. The training topics include, but are not limited to:</p> <ol style="list-style-type: none"> 1. Motivational interviewing 2. Communication 3. Oral and self-care 4. Nutrition <p>The SPA notes that the training curriculum focuses on outreach and mobilization, serving as a community cultural liaison, case management, care coordination and system navigation, and health promotion and coaching.</p>	State agency	No	No

State	Training requirements [^]	Training entity	Training addresses IPV*	CHW field experience as requirement of certification
RI ^{p,q}	<p>The state requires 70 hours of training/education, which can consist of seminars, workshops, college courses, etc., specific to the following domains:</p> <ol style="list-style-type: none"> 1. Engagement methods and strategies 2. Individual and community assessment 3. Culturally and linguistically appropriate responsiveness 4. Promote health and well-being 5. Care coordination and system navigation 6. Public health concepts and approaches 7. Advocacy and community capacity building 8. Safety and self-care 9. Ethical responsibilities and professional skills 	Multiple entities ⁺	No	Yes, 6 months of full-time CHW experience or 1,000 hours part-time with 50 hours of supervised work
SD ^{r,s,t}	<p>Each CHW must complete the Indian Health Service Community Health Representative basic training, or a CHW program approved by the South Dakota Board of Technical Education, the South Dakota Board of Regents, or the Department of Social Services. CHWs must complete a minimum of 6 hours of training annually thereafter.</p>	Multiple entities ⁺	No	No
TX ^{u,v,w}	<p>The Texas Department of State Health Services provides a CHW training program that covers the following competencies:</p> <ol style="list-style-type: none"> 1. Communication skills 2. Interpersonal skills 3. Service coordination skills 4. Capacity building skills 5. Advocacy skills 6. Teaching skills 7. Organizational skills 8. Knowledge base on specific health issues (including HRSN and health disparities) 	Multiple entities ⁺	Yes, Texas's 2019 CHW Training Conference included a session on domestic and family violence	No, regular renewal is required for those who are financially compensated for services

State	Training requirements [^]	Training entity	Training addresses IPV*	CHW field experience as requirement of certification
WA ^{x,y}	<p>The Washington State Department of Health offers a voluntary, free, 10-week CHW training program focusing on the following core competencies:</p> <ol style="list-style-type: none"> 1. CHW roles 2. Community outreach and engagement 3. Communication 4. HRSN and disparities 5. Organization 6. Documentation 7. Assessment 8. Service coordination 	State agency	No	CHW training is not mandatory

[^] The training requirements are high-level core components identified in state documents. Some documents contain additional details. For additional details on the components, see state documents below.

* Answers in this column are based on review of the core competencies outlined in column “training requirements.” We were unable to review the full curricula for state training programs, apart from Washington.

+ Training entities can include community-based organizations, colleges and universities, or health plans, among others.

^a Centers for Medicare & Medicaid Services. “State Plan Amendment (SPA) #: 22-0001.” July 2022. Available at <https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0001-Approval.pdf>. Accessed September 1, 2022.

^b Centers for Medicare & Medicaid Services. “State Plan Amendment (SPA) #: 18-005.” November 2018. Available at <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-18-005.pdf>. Accessed September 1, 2022.

^c Indiana Community Health Workers Association. “Education.” n.d. Available at <https://inchwa.org/education/>. Accessed September 5, 2022.

^d Indiana Community Health Workers Association. “Grandfathering.” n.d. Available at <https://inchwa.org/grandfathering/>. Accessed September 5, 2022.

^e Centers for Medicare & Medicaid Services. “State Plan Amendment (SPA) #: 22-0003.” May 2022. Available at <https://www.medicaid.gov/medicaid/spa/downloads/LA-22-0003.pdf>. Accessed September 1, 2022.

^f Rosenthal, E.L., P. Menking; and J. St. John. “The Community Health Worker Core Consensus (C3) Project: A Report of the C3 Project Phase 1 and 2, Together Leaning Toward the Sky: A National Project to Inform CHW Policy and Practice.” El Paso, TX: Texas Tech University Health Sciences Center, 2018.

^g Minnesota Department of Health “Community Health Worker (CHW).” April 2022. Available at <https://www.health.state.mn.us/facilities/ruralhealth/emerging/chw/index.html>. Accessed September 7, 2022.

^h Centers for Medicare & Medicaid Services. “State Plan Amendment (SPA) #: MN 13-02.” December 2019. Available at <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-13-22.pdf>. Accessed September 1, 2022.

ⁱ North Carolina Department of Health and Human Services. “About the NC Community Health Worker Initiative.” August 2020. Available at <https://www.ncdhhs.gov/divisions/office-rural-health/community-health-workers/about-nc-community-health-worker-initiative>. Accessed September 5, 2022.

- ^j New Mexico Department of Health. “Frequently Asked Questions about CHW Certification.” n.d. Available at <https://www.nmhealth.org/publication/view/help/1764/>. Accessed September 6, 2022.
- ^k New Mexico Department of Health. “Office of Community Health Workers.” n.d. Available at <https://www.nmhealth.org/about/phd/pchb/ochw/>. Accessed September 6, 2022.
- ^l NV Community Health Worker Association. “CHW Core Competencies.” n.d. Available at <https://www.nvchwa.org/chw-core-competencies/>. Accessed September 5, 2022.
- ^m College of Southern Nevada, Division of Workforce and Economic Development. “Community Health Worker Training.” 2022. Available at https://csn.augusoft.net/index.cfm?method=ClassInfo.ClassInformation&int_class_id=28615&int_category_id=4&int_sub_category_id=39&int_catalog_id=0. Accessed September 9, 2022.
- ⁿ Truckee Meadows Community College. “Community Health Worker Certificate – Online.” n.d. Available at https://tmcc.augusoft.net/index.cfm?method=ClassInfo.ClassInformation&int_class_id=30598&int_category_id=0&int_sub_category_id=0&int_catalog_id=0. Accessed September 9, 2022.
- ^o Oregon Department of Human Services. “Community Health Worker Certification.” n.d. Available at <https://www.oregon.gov/DHS/SENIORS-DISABILITIES/HCC/PSW-HCW/Pages/Community-Health-Worker.aspx>. Accessed September 6, 2022.
- ^p Centers for Medicare & Medicaid Services. “State Plan Amendment (SPA) #: 21-0012.” May 2022. Available at <https://www.medicaid.gov/medicaid/spa/downloads/RI-21-0012.pdf>. Accessed September 2, 2022.
- ^q Rhode Island Certification Board. “CHW Application.” August 2021. Available at https://www.ricertboard.org/sites/default/files/applications/RICB_CCHW_App_2021.pdf. Accessed September 7, 2022.
- ^r Centers for Medicare & Medicaid Services. “State Plan Amendment (SPA) #: 19- 0005.” June 2019. Available at <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/SD/SD-19-005.pdf>. Accessed September 2, 2022.
- ^s Community Health Workers Collaborative of South Dakota. “Training.” n.d. Available at <https://chwsd.org/chw-training/>. Accessed September 7, 2022.
- ^t Community Health Workers Collaborative of South Dakota. “South Dakota Community Health Worker Planning and Assessment Toolkit.” n.d. Available at https://chwsd.org/wp-content/uploads/articulate_uploads/south-dakota-community-health-worker-planning-and-assessment-toolkit-raw-FBPRhON-11/index.html. Accessed September 8, 2022.
- ^u Texas Department of Health and Human Services. “Community Health Worker or Promotor(a) Training and Certification Program.” February 2021. Available at <https://www.dshs.texas.gov/chw.aspx>. Accessed September 8, 2022.
- ^v Texas Department of Health and Human Services. “Community Health Worker (CHW) Core Competencies.” May 2017. Available at <https://www.dshs.texas.gov/chw/docs/TexasCHW-Competencies-Final.pdf>. Accessed September 8, 2022.
- ^w Bustos, C. “Office of Border Public Health Community Health Worker Training Center.” September 2019. Texas Department of Health and Human Services. Available at <https://www.dshs.texas.gov/TFBHO/TFBHO-Presentation---09-13-19---CHW-Training-Center-2019/>. Accessed September 9, 2022.
- ^x Washington State Department of Health. “Community Health Worker Training.” n.d. Available at <https://doh.wa.gov/public-health-healthcare-providers/public-health-system-resources-and-services/local-health-resources-and-tools/community-health-worker-training-program>. Accessed September 9, 2022.
- ^y Washington State Department of Health. “Community Health Worker Training Syllabus.” n.d. Available at <https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/349-044-MasterSyllabus.pdf?uid=631a401eef58a>. Accessed September 9, 2022.

References

- ¹ Centers for Disease Control and Prevention. “Community Health Worker Resources.” February 2022. Available at <https://www.cdc.gov/chronicdisease/center/community-health-worker-resources.html>. Accessed October 14, 2022.
- ² Ruff, E., E. Fishman, R. Gomez, & D. Sanchez. “Advancing Health Equity Through Community Health Workers and Peer Providers: Mounting Evidence and Policy Recommendations.” November 2019. FamiliesUSA. Available at <https://www.familiesusa.org/resources/advancing-health-equity-through-community-health-workers-and-peer-providers-mounting-evidence-and-policy-recommendations/>. Accessed October 11, 2022.
- ³ Black, M.C. “Intimate partner violence and adverse health consequences: implications for clinicians.” *Am J Lifestyle Med*, vol. 5, no. 5, 2011, pp. 428–439.
- ⁴ Coker, A.L, K. E. Davis, I. Arias, S. Desai, M. Sanderson, H.M. Brandt, et al. “Physical and mental health effects of intimate partner violence for men and women.” *Am J Prev Med*, vol. 23, no. 4, 2002, pp. 260–268.
- ⁵ Smith, S.G., J. Chen, K.C. Basile, L.K. Gilbert, M.T. Merrick, N. Patel, M. Walling, and A. Jain. “The National Intimate Partner and Sexual Violence Survey (NISVS): 2010–2012 State Report.” Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2017. Available at <https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf>
- ⁶ Centers for Medicare & Medicaid Services. “State Plan Amendment (SPA) #: 22-0001.” July 2022. Available at <https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0001-Approval.pdf>. Accessed September 1, 2022.
- ⁷ California Department of Health Care Services. “Medi-Cal Coverage of Community Health Worker (CHW) Services is Effective July 1, 2022.” Updated August 19, 2022. Available at https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_31781_01.aspx#:~:text=Effective%20July%201%2C%202022%2C%20Medi,services%20and%20asthma%20preventive%20services. Accessed January 5, 2023.
- ⁸ State of California. “Enacted Budget Summary.” June 2022. Available at <https://www.ebudget.ca.gov/2022-23/pdf/Enacted/BudgetSummary/FullBudgetSummary.pdf>. Accessed October 12, 2022.
- ⁹ California Department of Health Care Services. “Community Health Workers: DHCS Proposal to add Community Health Workers.” July 2022. Available at <https://www.dhcs.ca.gov/community-health-workers>. Accessed October 6, 2022.
- ¹⁰ Centers for Medicare & Medicaid Services. “State Plan Amendment (SPA) #: 18-005.” November 2018. Available at <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/IN/IN-18-005.pdf>. Accessed September 1, 2022.
- ¹¹ Centers for Medicare & Medicaid Services. “State Plan Amendment (SPA) #: 22-0003.” May 2022. Available at <https://www.medicaid.gov/medicaid/spa/downloads/LA-22-0003.pdf>. Accessed September 1, 2022.
- ¹² Minnesota Department of Human Services. “Community Health Worker (CHW).” July 2020. Available at https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionS_electionMethod=LatestReleased&dDocName=dhs16_140357#ep. Accessed September 12, 2022.

- ¹³ Centers for Medicare & Medicaid Services. “State Plan Amendment (SPA) #: 21-0012.” July 2022. Available at <https://www.medicaid.gov/medicaid/spa/downloads/NV-21-0012.pdf> . Accessed September 2, 2022.
- ¹⁴ Centers for Medicare & Medicaid Services. “State Plan Under Title XIX of The Social Security Act Medical Assistance Program: Oregon Health Authority: State of Oregon.” April 2022. Available at <https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/Medicaid-State-Plan.pdf>. Accessed September 1, 2022.
- ¹⁵ Centers for Medicare & Medicaid Services. “State Plan Amendment (SPA) #: 21-0012.” May 2022. Available at <https://www.medicaid.gov/medicaid/spa/downloads/RI-21-0012.pdf>. Accessed September 2, 2022.
- ¹⁶ Centers for Medicare & Medicaid Services. “State Plan Amendment (SPA) #: 19- 0005.” June 2019. Available at <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/SD/SD-19-005.pdf>. Accessed September 2, 2022.
- ¹⁷ Saleski, E. “Summary of Medicaid State Plan Amendments for Community Health Workers.” Oakland: CA, 2022. Available at <https://www.chcf.org/wp-content/uploads/2022/08/SummaryMedicaidStatePlanAmendmentsCHWs.pdf>. Accessed September 1, 2022.
- ¹⁸ National Academy for State Health Policy. “State Community Health Worker Models.” December 2020. Available at <https://www.nashp.org/state-community-health-worker-models/#tab-id-1>. Accessed September 9, 2022.
- ¹⁹ Ibid., 6.
- ²⁰ Ibid., 11.
- ²¹ Ibid., 12.
- ²² Ibid., 16.
- ²³ Ibid., 6.
- ²⁴ Ibid., 7.
- ²⁵ Ibid., 16.
- ²⁶ Ibid., 12.
- ²⁷ Ibid., 14.
- ²⁸ Ibid., 6.
- ²⁹ Ibid., 7.
- ³⁰ North Carolina Department of Health and Human Services. “Healthy Opportunities Pilots: Pilot Overview and Care Management Team Roles and Responsibilities.” May 2022. <https://www.ncdhhs.gov/media/16505/download?attachment>. Accessed September 7, 2022.
- ³¹ The term CBO refers to any organization in the community that is representative of the community and is engaged in meeting the needs of that community. The term includes but is not limited to community health centers and IPV service providers that employ CHWs.
- ³² California Partnership to End Domestic Violence. “Home Cohort: Housing Opportunities Mean Everything (HOME).” n.d. Available at <https://www.cpedv.org/home-cohort-0>. Accessed January 5, 2023.

- ³³ California Department of Health Care Services. “Technical Assistance Marketplace.” Available at <https://ca-path.com/ta-marketplace>. Accessed January 5, 2023.
- ³⁴ California Department of Health Care Services. “PATH Guidance: Technical Assistance Marketplace Initiative.” November 2022. Available at https://ca-path.com/static/media/PATH%20TA%20Marketplace%20Guidance_November%202022.f2861e4d2999e85dc403.pdf. Accessed January 5, 2023.
- ³⁵ Blue Shield of California Foundation. “Building bridges between Domestic Violence Prevention and Health Care.” n.d. Available at https://dvhealthpartnerships.org/wp-content/uploads/2018/07/DVHCP-Evaluation-Summary_BSCF.pdf. Accessed December 20, 2022.
- ³⁶ Ibid., 19.
- ³⁷ North Carolina Department of Health and Human Services. “Healthy Opportunities Pilots: Standard Plan Roundtable on the Evidence Base.” May 2022. <https://www.ncdhhs.gov/media/16511/download?attachment>. Accessed September 7, 2022.
- ³⁸ North Carolina Department of Health and Human Services. “Updated Healthy Opportunities Pilots Fee Schedule [Guidance Version].” March 2022. Available at <https://www.ncdhhs.gov/media/14071/download?attachment>. Accessed September 8, 2022.
- ³⁹ El Sol Community Health Workers and Promotores Training Center. “Preserving a Transformative Community Health Worker/Promotor Workforce: El Sol’s CHW/P Training Center Approach.” November 2022. Available at https://www.elsolnec.org/elsolchwapproach/wp-content/uploads/sites/7/2022/11/ElSol_TC_PreservingCHW_Report_final.pdf. Accessed November 11, 2022.
- ⁴⁰ Agency for Healthcare Research and Quality. “Pathways Community HUB Manual: A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes.” January 2016. Available at <https://www.ahrq.gov/innovations/hub/index.html>. Accessed January 5, 2023.
- ⁴¹ Administration for Children and Families. “Medical Advocacy and Health Care Services Payment or Reimbursement for FVPSA Grant Recipients and Subrecipients.” September 2022. Available at https://www.acf.hhs.gov/sites/default/files/documents/fysb/FINAL-ACYF-FYSB-FVPSA-ReimbursableHealthServices-IM-09-19-2022_2.pdf. Accessed January 5, 2023.
- ⁴² California Governor’s Office of Emergency Services. “CalOES Awards Over \$13 Million in Grants to Help Prevent Sexual and Domestic Violence.” Available at: <https://news.caloes.ca.gov/sexual-and-domestic-violence-grant/>. Accessed December 20, 2022.
- ⁴³ Office of the Assistant Secretary for Health, Office of Women’s Health. “Funding Opportunities.” Available at: <https://www.womenshealth.gov/about-us/work-us/funding-opportunities>. Accessed December 20, 2022.
- ⁴⁴ United States Department of Justice, Office on Violence Against Women. “How to Apply for OVW Funding.” Available at: <https://www.justice.gov/ovw/how-apply>. Accessed December 20, 2022.
- ⁴⁵ National Resource Center on Domestic Violence. “Funding Opportunities Content Topic Results.” Available at: <https://vawnet.org/materials/funding-opportunities>. Accessed December 20, 2022.
- ⁴⁶ Ibid., 28.
- ⁴⁷ El Sol Community Health Workers and Promotores Training Center. “Community Health Workers and Promotores Career Pathway Initiative.” April 2022. Available at https://www.elsolnec.org/wp-content/uploads/2022/04/el_sol_career_pathway_web.pdf. Accessed October 6, 2022.
- ⁴⁸ Ibid., 21.

- ⁴⁹ SOMOS Mayfair. “META Co-Op Launches! 17 Entrepreneurial Immigrant Women Are Proud New Business Co-Owners in East San Jose.” August 2018. Available at <https://www.somosmayfair.org/somos-blog/2018/8/28/meta-co-op-launches>. Accessed October 13, 2022.
- ⁵⁰ Ibid., 34.
- ⁵¹ The Health Alliance for Violence Intervention. “The Health Alliance for Violence Intervention (The HAVI) Violence Prevention Professional Certification Training.” Available at <https://www.thehavi.org/violence-prevention-professional-training>. Accessed January 5, 2023.
- ⁵² CHW Core Consensus Project. “About the C3 Project.” 2018. Available at <https://www.c3project.org/about>. Accessed September 27, 2022
- ⁵³ Mason, T. H., C. H. Rush, and M. K. Sugarman “Statewide Training Approaches for Community Health Workers” Boston: Massachusetts Texas Tech NACHW, 2021.
- ⁵⁴ Centers for Medicare & Medicaid Services. “On the Front Lines of health Equity: Community Health Workers.” 2021. Available at <https://www.cms.gov/files/document/community-health-worker.pdf> . Accessed September 27, 2022
- ⁵⁵ Ibid., 37.
- ⁵⁶ Ibid., 38.
- ⁵⁷ Futures Without Violence. “CUES: An Evidence-based Intervention to Address Domestic and Sexual Violence in Health Settings: shown to improve health and safety outcomes for survivors.” n.d. Available at <https://www.futureswithoutviolence.org/wp-content/uploads/CUES-graphic-Final.pdf>. Accessed October 20, 2022.
- ⁵⁸ O’Rourke, L. “Evaluating Social Service Referral Platforms: Considerations for Domestic and Sexual Violence Referrals” July 2022. Futures Without Violence. Available at <https://policy.futureswithoutviolence.org/wp-content/uploads/2022/09/Evaluating-Social-Service-Referral-Platforms-Considerations-for-Domestic-and-Sexual-Violence-Referrals-Policy-Memo.pdf>. Accessed October 17, 2022.

Mathematica Inc.

Princeton, NJ • Ann Arbor, MI • Cambridge, MA
Chicago, IL • Oakland, CA • Seattle, WA
Woodlawn, MD • Washington, DC

EDI Global, a Mathematica Company

Operating in Tanzania, Uganda, Kenya, Mozambique, and the United Kingdom

Mathematica, Progress Together, and the “spotlight M” logo are registered trademarks of Mathematica Inc.



mathematica.org [website](#)