Leveraging Community Health Workers within California's State Innovation Model:

Background, Options and Considerations

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BACKGROUND

There is a long-standing history of using non-traditional health care workers in the U.S., commonly called Community Health Workers (CHWs), to provide services that complement the traditional medical and public health systems.[1] CHWs fulfill diverse roles that promote individual and community well-being, increase connectivity between the health care and public health systems and the community, and ultimately seek to improve health and reduce health care costs.

CHW programs have grown in part out of recognition that the health care system cannot meet all of the needs of patients and the community. This is particularly true with regard to the social determinants of health, which are a significant factor in health care connectivity, utilization, and outcomes for a large majority of the population. CHWs are uniquely positioned to understand and respond to the many challenges faced by patients in navigating the health care system, obtaining necessary supportive resources, and building self-efficacy and health literacy. Moreover, they can be an integral part of efforts to address the persistent health disparities in the U.S.[2]

The State Innovation Model Funding Opportunity

California's State Innovation Model (CalSIM) Design Grant was approved by the Center for Medicare and Medicaid Innovation (CMMI) at the Centers for Medicare and Medicaid Services (CMS) effective April 2013. The six-month Design Grant process in California is led by the California Health and Human Services Agency (CHHS), with the goal of producing a Statewide Health Care Innovation Plan (SCHIP). CMMI will later issue a funding opportunity announcement, ranging from $20 million and $60 million for states to apply to test and implement their SCHIP strategies. [3].

CMMI described the Design Grant process as the development of "a comprehensive approach to transforming the health system of a state, made up of 'payment and service delivery models'… that drive and reward better health, better care, and lower costs…[and] will also include a broad array of other strategies, including community-based interventions, to improve population health" [3].The Testing Grant proposals that result from the Design Grant process are expected to propose payment

reform strategies that meet these criteria, and that are likely to yield net health care cost savings within the three-year grant period.

Let's Get Healthy California Report Serves as CalSIM Foundation

The CalSIM initiative builds upon the framework, goals, and indicators outlined in the state's *Let's Get Healthy California* (LGHC) final report, released December 2012 (www.chhs.ca.gov) The report is the product of six months of deliberations from a Task Force comprised of diverse California health and health care leaders, co-chaired by CHHS Agency Secretary Diana Dooley and former CMS Administrator Don Berwick. The framework identifies six goals, three of which cover the lifespan and three of which are pathways to improving health and health care: (1) Healthy Beginnings; (2) Living Well; (3) End of Life; (4) Redesigning the Health System; (5) Creating Healthy Communities; and (6) Lowering Costs. Cutting across all six areas is Health Equity: Eliminating Disparities.

Six private sector work groups corresponding to the six LGHC goals were convened by California's Design Grant team. Each work group was tasked with developing payment and public policy recommendations relating to their respective goal, along with private sector recommendations. The recommendations are then considered by the state CalSIM team, which includes representatives from various departments and major programs. A select number of recommendations will be included in the state's final SCHIP submitted to CMMI.

Interest in Use of Community Health Workers under California's SIM

Two work groups (Work Group 2: Living Well, and Work Group 5: Creating Healthy Communities) have proposed, among other approaches, models that would use CHWs. This brief was commissioned by the CalSIM team to explore the feasibility of using CHWs, and the range of potential models for CHW placement within the health care system, public health system, and/or community.

Specifically, the goals of this policy brief are to:

1. Characterize the continuum of professions that may provide services/education aligned with the CHW model, including Promotores, patient navigators, and other titles;
2. Describe possible approaches to incorporate these professions into the primary care system or into community-based practice models, including reviewing examples from other states;
3. Describe possible financing mechanisms to support these professions; and,
4. Identify any evidence of beneficial outcomes associated with this the use of CHWs and associated professions.

Finally, this brief discusses strengths and weaknesses of the CHW models proposed by Work Groups 2 and 5, and makes recommendations for potential actions should the CalSIM team decide to adopt either or both models.

Throughout this brief, "CHW" is used as an umbrella term capturing the full continuum of professions that provide services aligned with the CHW model.

BUILDING ON SIGNIFICANT EXPERTISE IN CALIFORNIA

The content in this brief is based on a review of the literature as well as the valuable opinions and insight of a broad array of experts and advocates interviewed for this project. There is substantial experience and expertise in California and around the nation related to the CHW model. California has the opportunity to build on the work already underway around California by many leaders and innovators in the field.

The framing of the SIM Testing and Implementation grant offers a meaningful opportunity to increase use of CHWs in California. While the SIM initiative is limited to a three-year time frame, and is expected to yield savings within the grant period, CMMI's guidance also indicates that it should focus on population health improvement, community-based interventions, and reducing disparities. CHWs are a promising strategy to address these goals. The SIM initiative offers a framework to build on the substantial existing experience within the state to promote sustainability for a workforce and program model that can be carried forward beyond the SIM Testing Grant period.

THE COMMUNITY HEALTH WORKER PROFESSION

Defining the CHW Role

Recently, the U.S. Department of Labor established distinct occupational codes for CHWs and Health Educators.[4-7] Furthermore, the American Public Health Association (APHA) has established a CHW definition, which is widely used and cited as the authoritative definition:

> *"A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.*
>
> *A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy." [8]*

Specific tasks and responsibilities vary between CHW programs. A set of seven core roles for CHWs was defined in the National Community Health Advisor Study of 1998 to include:

1. Cultural mediation between communities and health and human services system.
2. Informal counseling and social support.
3. Advocating for individual and community needs.
4. Assuring people get the services they need.
5. Building individual and community capacity.
6. Providing culturally appropriate health education.
7. Providing direct services.[9]

Characteristics and Activities of CHWs

CHWs are commonly described as non-traditional health workers or lay health workers. In many cases but not always, CHWs come from the community they serve and have shared background, culture, and language with their clients which can enhance their effectiveness.[10]

The characteristics and activities of CHWs vary along several continuums:

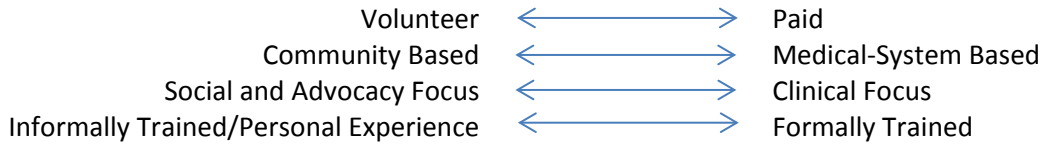

Figure adapted from: *Community Health Workers and Promotores in California[10]*

CHW Compensation

The Community Health Worker National Workforce Study (2007) estimated the total CHW population in California to be greater than 9,000 individuals, of whom 64% were paid and 36% were volunteers.[11]

It is unclear whether health care providers or community agencies should rely on volunteer-based CHW programs. Many experts argue that CHWs should be paid, to recognize the value of their role and services.[12] In addition, there are challenges associated with administering a volunteer-based model, in which it may be more difficult to build accountability and reliability among CHWs. However, there are some advocates who argue that paid CHWs may lose authenticity and trust in the community, and that a volunteer-based model is advantageous for this reason.[10] The difficultly of paying CHWs who do not have legal employment status in the U.S. is another consideration. Currently, some programs may use alternative pay models to compensate CHWs including those who are undocumented, such as via food and travel stipends.

CHW Training

CHWs must be highly knowledgeable about community resources and needs, and must also have content expertise around the specific health, behavioral, and advocacy topics on which they counsel clients.[12, 13] Employers may hire CHWs in part based on existing knowledge of the community and their personal background/experiences. Targeted on-the-job training to build knowledge and skills is ubiquitous among CHW employers, often driven by specific grant funded programs or initiatives with highly focused programming.[10] Little specific information is available about employer training practices. In surveys of CHWs, most have reported interest in receiving additional training on an ongoing basis.[14]

Few states have mandated training or certification for CHWs, but interest in this approach is growing.[1, 12] Standardized training and certification for CHWs is thought by many experts to be a promising approach that will increase perceived value of the CHW model, create consistency in the workforce, improve CHW skills and knowledge, and promote reimbursement for CHW services.[1, 12] Some experts argue for a core competency-based training model that builds a foundation of essential skills, balanced with ongoing continuing education and on-the-job training. Texas, which has established CHW

certification requirements for paid workers [12], uses a core competency approach in certifying approved training programs for CHWs [15]. There are several certificate programs for CHWs available in California and many more around the nation.[16] One of the most recognized training programs in California is based at the City College of San Francisco, which operates a two-semester certificate program for CHWs at a cost of under $300.[17]

There is some concern among experts and advocates that a state-mandated training or certification model could be harmful because it might exclude currently practicing or new CHWs who have little formal education, lack the resources to obtain training/certification, or are undocumented.[1, 10] Certification may also be perceived to decrease community trust in CHWs. In Texas's model, CHWs are certified based on *either* completion of an approved training program *or* completion of a minimum number of hours of work experience, and no questions regarding citizenship status are included in the process.[15] Experts agree that development of new training or certification requirements for CHWs should be informed by CHWs themselves.[1]

Alternatives to establishing a formal certification requirement were also suggested by experts. One option for states or other convening organizations is to develop a registry of CHWs for the purpose of workforce analysis and planning. Another, potentially complementary, option is to establish a centralized resource clearinghouse. With this approach, a state could define the CHW role and scope of practice (with input from stakeholders), share resources for quality, share sample job description templates and training materials, and centralize a list of available training programs.

Variation in Job Titles

The services provided by CHWs have been described by a wide range of titles.[10] The title "Community Health Worker" is often considered an umbrella term capturing the range of professions that fulfill these functions within the health system and community. Other frequently used titles are displayed in Table 1.

Some health care providers may have pre-conceived impressions about the potential role and utility of CHWs and related titles, which may be in part related to their understanding of the specific title used. Experts recommend using provider champions to educate traditional medical professionals about CHW roles and responsibilities. Some employers have strategically avoided describing their programs with the term CHW to avoid these connotations.

Table 1: Job Titles and their Connotations

Title	Connotations
Community Health Worker (CHW)	Commonly used as an umbrella term. When used as a specific job title: Can be based primarily within the medical system or the community. Can have varying areas of focus including social and/or health care issues.

Title	Connotations
Promotores de Salud	Primarily serving Latino/Hispanic communities. Respected community member or leader, from and living in the community being served. Generally has a community orientation rather than working within the medical system. Emphasizes human rights, social justice, and both medical and non-medical needs.
Community Health Advisor	May be used as an umbrella term. May suggest a community orientation (rather than a medical-system orientation).
Lay Health Worker/Advocate	May be used as an umbrella term. May suggest a focus on lay people who volunteer to provide health education and community assistance.
Patient Navigator	This term has been adopted under the Affordable Care Act to describe individuals who will help individuals and small businesses enroll in coverage via health benefit exchanges. Also used to describe CHWs that focus on continuity of care and assist patients during care transitions.
Patient Connector/Integrator	Common job title for CHWs that provide preventive services within the medical or community setting, often under supervision from a medical professional.
Community Outreach Worker	Traditionally used to describe CHWs in HIV-positive communities.
Outreach Worker	Common job title for CHWs that focus on application and enrollment assistance.
Peer Support Specialist/Peer Advisor	Traditionally used to describe CHWs working in the mental/behavioral health field. Often the CHW has a history of personal experience with the population/condition targeted.
(Peer) Health Educator	Focused on informal education/counseling aspects of CHW model.
Community Health Representative	Traditionally used to describe CHWs working within Native American Communities.
Case Manager	May be focused on a particular medical or behavioral health condition(s). Skills and responsibilities do not typically extend to community building and advocacy activities common in the traditional CHW role.

Differentiation from Traditional Health Professions

CHW-like roles can be filled by traditional health workers/allied health professionals, such as Medical Assistants, Social Workers, and Licensed Vocational Nurses in some settings. However, these traditional health workers are distinct from CHWs in several ways, including: (1) they are licensed and as such have a regulated title and scope of practice; (2) they are subject to training/certification requirements specific

to their role; (3) they provide clinical services in addition to any CHW-like services; and (4) they may lack the community and cultural connectivity that typically characterizes CHWs.

Experts agree that it is essential to distinguish CHW and traditional health care worker roles and titles. Role differentiation is seen as critical particularly for CHWs who work within the medical practice setting, to avoid some apprehension among traditional health workers about protecting their scope of practice. Such role clarification may also be increasingly important as payers/purchasers consider reimbursement for CHW services.[12]

Furthermore, several experts highlighted the importance of creating a career pathway for CHWs with opportunities for advancement over time, and role differentiation can help facilitate this process. While individuals may become CHWs through many pathways, and may or may not be interested in "climbing" a career ladder, developing such a pathway may attract additional CHWs to the profession and/or promote retention in the workforce.[13] One potential career pathway for CHWs is toward traditional health professions such as nursing. An alternative pathway is to formalize recognition of seniority and experience among CHWs by establishing CHW job classes that have increasing responsibilities and emphasize skills such as program planning, supervision, and advocacy at the upper levels. For example, the San Francisco Health Department uses a model with a four-tiered CHW job classification.[12, 18]

HEALTH CARE SYSTEM VERSUS COMMUNITY-BASED PRACTICE MODELS

In general, there are two main approaches to structuring CHW programs. The first locates CHWs primarily within a medical practice setting, such as a medical office, clinic, hospital, or health department; the second locates CHWs primarily within the community.[1, 10] Community-based CHWs may work in a wide range of settings such as health fairs, schools, churches or other community gathering places, and homes.[10, 13, 19] Such community-based CHWs may have explicit ties to medical practices, such as via a memorandum of understanding which establishes a regular schedule of community education sessions, or may assist clients in navigating care at their places of treatment without a formal clinic-based role.

The Community Health Worker National Workforce Study [11] identified five models of care using CHWs:

1. **Member of the Care Team**: similar to a case management model, the CHW works to complement the activities of a lead provider (e.g. physician, nurse, or social worker). The CHW is used to enhance care team's productivity by assisting with coordination and communication tasks such as making as appointment reminders and encouraging patient compliance. May include some health education and informal counseling tasks or direct services such as blood pressure screening. Some activities may be conducted in community or home-based settings.
2. **Navigator**: focuses less on clinical management and more on assistance navigating the health care system through referral support, appointment assistance and follow-up, and education about the appropriate use of services.

3. **Screening and Health Education Provider**: the CHW may be clinic or community based, and provides information and education about specific health conditions, self-care strategies, recommended treatment patterns, and goal setting. May include making home visits to assess environmental and social factors and provide or advocate for necessary supports.
4. **Outreach/Enrollment Worker**: the CHW provides community and individual assistance for application and enrollment into available services.
5. **Organizer**: the CHW is a community leader and advocate who promotes change by engaging the population in community development and leading civic engagement activities.[11]

CHWs working within the first two models (member of the care team, and navigator) are likely to be located primarily within a medical setting. Those in the third and fourth roles (screening and health education provider, and outreach/enrollment worker) may be primarily deployed in either a medical setting or the community, and are likely to bridge both settings. CHWs in the final model (organizer) are likely to be based primarily in the community.

EVIDENCE OF BENEFICIAL OUTCOMES

Evaluating the impact of CHW programs is challenging for several reasons. Some of the characteristics of CHW interventions that make demonstrating effectiveness of the CHW model challenging include:

- Some of the intended outcomes of CHW intervention, such as improved self-efficacy, are difficult to measure. Other outcomes focus on prevention, such as avoiding development of a chronic disease, posing an additional challenge in measurement.
- The benefits of many CHW interventions accrue over an extended period of time and may not be immediately measurable.
- Many programs lack data on the whole client, including data on the total cost of care. This can be exacerbated by short-term funding streams which may provide minimal support for evaluation activities and disrupt data collection.
- Programs that are targeted to high-cost or high-utilizing populations are likely to experience regression to the mean (in which costs/utilization naturally normalize toward the population average over time), which may call into question any evidence of savings.

Going forward, it is widely agreed that rigorous evaluation of CHW programs is essential.[20] There is growing evidence of the positive impact of CHW programs. A recent comprehensive report by the Institute for Clinical and Economic Review (ICER) summarizes the existing evidence to date.[20] The two areas in which beneficial outcomes have been documented relate to health care costs and health outcomes.

Health Care Costs

There are a number of examples of positive return on investment (ROI) resulting from CHW programs, both in published and unpublished accounts. However, research on cost outcomes of CHW programs is limited [12, 18], and is generally restricted to targeted clinic-based CHW programs (rather than

community-based ones) because of the difficulty of measuring total cost of care at the community level. Specific examples of evidence with regard to cost savings include:

- **Denver Health**
  Denver Health is a safety net system in Colorado. An outreach program using 12 CHWs provided health education, enrollment assistance, referrals, navigation, and care management services to underserved residents of the community.[21] An assessment of cost savings with a strong pre-post methodology documented an ROI of $2.28 to $1.00 attributed largely to decreases in inpatient utilization. This savings analysis accounted for program administration costs and for the increased use of non-acute services that occurred following the CHW intervention.[12, 21]
- **CareOregon**
  Although results are preliminary, internal data reported by CareOregon reflect a decrease in inpatient and emergency utilization for patients who had completed the intervention, and show notable downward cost trends for individual clients.[22, 23]
- **Inland Empire Health Plan**
  Although unpublished, IEHP reports that the program is cost neutral at a minimum (saves as much as the cost of implementation)while improving performance on quality metrics; it is also associated with a reduction in emergency department use among intervention families.[24]
- **New Mexico's Medicaid Managed Care Program**
  Managed care enrollees with high resource utilization in New Mexico's Medicaid program were targeted for a community-based CHW intervention including education, advocacy, and social support. A robust evaluation design documented significant decreases in emergency room and inpatient service use. The total cost differential from before to after the CHW intervention was estimated to be roughly $1.5 million (among 448 individual beneficiaries) after accounting for program implementation costs.[20, 25]

Additional evidence of cost reductions associated with CHW programs can be found. However, most experts believe that the cost effectiveness of CHW intervention requires further analysis.[12]

Health Outcomes

Evidence of the beneficial impacts of CHW interventions on health outcomes is more robust than cost-related evidence, but has also been criticized as insufficient to clearly support practice recommendations.[12] Recent literature on this topic is characterized by more rigorous research methods and is beginning to provide reliable evidence of beneficial outcomes. Most findings related to improved health behaviors and outcomes following CHW programs are derived from programs targeted to specific populations or conditions.[12, 18, 20, 26] Specific examples identified by ICER include:

- Diabetes: improved diet, reduced hemoglobin A1C.
- Children's Asthma: reduced use of urgent/emergent health care services, reduced activity limitations.

- Cancer Screening: increased rates of compliance with cervical, breast, and colonoscopy screening recommendations.
- Maternal/perinatal health: increased childhood vaccination rates, and improved maternal mental health and attendance at prenatal appointments.

The ICER report provides very comprehensive summaries of existing evidence of health outcomes for these and other disease conditions/populations.[20]

FINANCING MECHANISMS

Funding for CHW programs may come from a range of sources, including government agencies; charitable foundations; health system entities such as payers or purchasers; and private sector companies.[12] Some have also suggested that consumers could directly purchase CHW services.[12]

Nationally, the most common financing mechanism for CHW programs is through grants.[10, 12, 18] While this approach is common, it has substantial drawbacks. CHW programs that operate based on grant funds often have several sources of funding which may have varied goals, target populations, time-periods, and other stipulations.[12, 18] This can lead to time-limited employment opportunities, disjointed workforce pathways and skills/training, inconsistent availability of client services, and high administrative burden.[18] Moreover, this approach does not build a sustainable funding stream because the funder (e.g. foundation) may change funding priorities or otherwise become unable to provide ongoing support.[12]

Two alternative financing mechanisms should be considered if CHW services are included in the CalSIM Testing Grant proposal. These strategies could promote greater consistency, reliability, and sustainability than a grant-based model. They are:

- A budgetary approach
- Reimbursement to service providers for CHW services.

Budgetary Approach

In the first approach, a central organization such as a clinic consortium, purchaser, payer, or payer-coalition would establish a budget for a CHW program (Figure 1).[12] The budget could be drawn from the organization's general funds, from grants made to the organization, or from fees/contributions from payers or purchasers (such as in Vermont's Regional Community Health Teams, which are jointly funded by all insurers in the state [27]).

This organization would then act as the direct employer of the CHW workforce, or would disseminate the available budget rather than administer the CHW program internally. Several experts argued in favor of the centralized employment model (as opposed to delegating employment to specific medical/community settings where CHWs may work), because it can facilitate the peer support and supervision that are widely regarded as essential to CHW effectiveness and satisfaction. As the

employer, the central funding agency would allocate CHW services to clinic or community settings according to priorities and goals.

The alternative model in which the central organization disseminates the budget to CHW employers would continue the common grant-based model in which individual agencies would apply for a period of funding to support a specific project or program. However, establishing a grant funding stream via a central organization may overcome some pitfalls of grant-funded CHW programs, because the central organization could promote consistency and sustainability in program services, limit exposure of CHWs to the uncertainties of grant funding, and unify strategic funding priorities and administrative requirements.

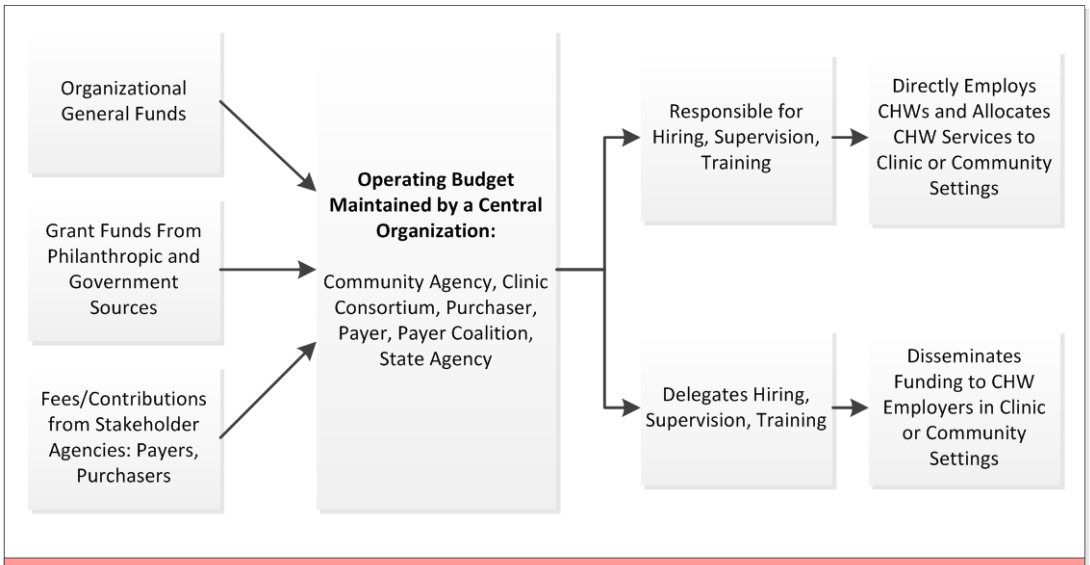

Figure 1: Budgetary Approach

A growing number of organizations have established a budget to support an internally-administered CHW program, such as CareOregon [22] and the Inland Empire Health Plan (IEHP) [28]. There are also examples of health systems and private for-profit companies that operate CHW programs funded through a budgetary approach.[12]

Case Study: CareOregon

CareOregon is a Medicaid health plan in Oregon State which administers a CHW program funded largely by a CMS Innovation Center grant combined with some organizational funds.

The health plan has been offering programs to address the needs of complex members since 2003, and currently operates a CHW program focusing on persistently high-cost members. CHWs are embedded in designated clinics that have a sufficient number of clients meeting utilization-based program targeting criteria. Target clinics are identified using claims analysis, but specific patients are recruited based on referrals from the medical team and hospital census data.

CHWs provide client advocacy, assistance with social support, self-management development, and

behavior change counseling, among other activities. The participating clinics do not receive any financial benefit as a result of the program. CHWs have a workspace at the clinic and interact with medical staff in team huddles and clinical supervision. However, a majority of their time is spent in the community meeting with clients. Each CHW is expected to have roughly 20 clients receiving weekly contact at any given time and around 60 clients over the course of the year.

Case Study: Inland Empire Health Plan

Inland Empire Health Plan (IEHP) is a non-profit health plan in San Bernardino and Riverside Counties of California. IEHP administers a CHW program funded largely by First 5 San Bernardino combined with some organizational funds.

A team of CHWs serves targeted patients within the broad IEHP membership. CHWs services are based at the central IEHP offices, rather than in specific medical practices. Patients are recruited based on utilization data and referrals from medical practices.

The CHW program is designed to address patterns of inappropriate utilization among members, such as use of the emergency room for an avoidable reason or missing essential primary care such as immunizations or well-child exams. Patients/families who enroll in the program receive a three-visit intervention over the course of 1-2 months. CHWs visit patient's homes to conduct health education, connect patients to available resources, and encourage appropriate system navigation.

Reimbursement to Service Providers

In the second approach, reimbursements made to direct service providers would support CHW efforts. This approach is more applicable to health-system based CHWs, but could be structured to accommodate community-based CHWs as well. In this approach, hiring, training, and supervision of CHWs would be delegated to the direct service providers.

In the health system, CHW services could be supported by bundled payments or other aggregated forms of payment (global fees, etc) made by insurers.[12] There are also examples of direct encounter-based billing for CHW services, such as in Minnesota's and Alaska's Medicaid programs.[12, 18] Recent federal rulemaking supports use of unlicensed providers for delivery of preventive services recommended by a physician or other licensed health care practitioner.[29, 30] In addition, CHW activities defined as administrative services under the Medicaid state plan can be reimbursed via administrative cost claiming.[12, 18]

Pursuing encounter-based reimbursement for non-administrative CHW services would likely require increased formalization of the workforce regardless of the payer(s) involved. Moreover, some argue that if the payment model makes direct encounter-based payments for CHW services (as in Michigan's Medicaid program) the nature of billing will create new pressures related to documentation, episode

frequency and duration, and qualifications of CHWs that would distance CHW services from the intended model.[12]

Community-based organizations could also potentially be reimbursed on a per-service or per-client basis by an organization such as a wellness trust. However, this might create challenges for CHW employers related to reliability of funding, and may be less desirable than the current grant-based model for disseminating funds to CHW programs in the community.

APPLYING CHW CONCEPTS TO CALIFORNIA'S SIM PROPOSAL

Two work groups (Work Group 2: Living Well, and Work Group 5: Creating Healthy Communities) have proposed, among other approaches, models that would use Community Health Workers (CHWs). The structure and focus of the two proposed CHW models are distinct, but both have potential promise for achieving goals of the LGHC Task Force and the SIM initiative.

Work Group 2: Living Well | Patient-Centered Medical Home for Medically Complex Patients

The model envisioned by Work Group 2 would place CHWs in medical practices as part of a team-based care model serving medically complex patients with a significant chronic disease burden and high medical costs. Targeting CHW services to specific individuals/populations that are actively recruited for intervention is a common approach, and may be appropriate in the setting of the SIM Testing Grant because there may be greater opportunity for short-term savings among populations with extreme health care utilization patterns.

CHWs in this model would work in concert with the medical team to address social determinants of health, assist patients in navigating the health care system, provide health education, and promote self-management and increase self-efficacy. This model of CHW work is similar to the role of a case manager, who offers a high-touch and intensive service framework to patients. Examples of similar programs include the IEHP [28] and CareOregon [22] initiatives, and the Intensive Outpatient Care Program in California [31]. The specific activities of the CHWs may vary based on the characteristics and needs of the actual targeted population. However, CHW services would expand on traditional medical services by reaching outside of the medical setting into community and home.

This model of CHW placement aligns with the Patient Centered Medical Home (PCMH) model that is broadly endorsed in the U.S. The practice standards set forth by the National Committee for Quality Assurance (NCQA) include an expectation that PCMH-designated practices provide "self-care support and community resources" to patients.[32] Many of the specific activities that might enable a practice to meet PCMH requirements [33] could be accomplished by CHWs. Moreover, others have suggested additional ways in which CHWs can support PCMH services and help to transform delivery of primary care, such as managing care transitions, providing care management, and offering individual and family support.[26, 34, 35] California could emphasize CHW as an additional resource that enhances the "medical home-ness" of a practice.

If implementing this model, the CalSIM team should consider:

- Establishing a detailed understanding of the characteristics of the target population, and the drivers of their outcomes/behavior/expenditures, so that hiring and training of CHWs can be targeted to match the identified population needs.
- Using a multi-payer framework to fund this model, to reach the broadest possible population of eligible patients and to simplify implementation for participating clinics/providers.
- Focusing CHW services in clinics/practices that already use a team-based care model, or have a demonstrated readiness to use team-based care practices. Providers with experience in a team-based setting may be better able to effectively leverage CHW services and to maximize the value of CHW time as a means to help all medical staff practice at the top of their license.

Work Group 5: Creating Healthy Communities | Patient Integrator at the Individual Level

Work Group 5 envisioned a model in which CHWs are leveraged within community settings to deliver a range of preventive programs, such as community wellness initiatives, chronic disease prevention, and programs to promote active lifestyles or healthy eating. In this approach, CHWs work within their communities to promote long-term community improvement through advocacy, education, capacity building, and networking. While CHWs would interact with the health care system by facilitating access to care for community members, being a knowledgeable source of information about community resources and programs, and communicating/advocating for community needs to providers, their primary focus would not necessarily be medical.

CHWs in this model may focus on particular populations, community/health issues, or goals, but may also act as general community leaders and advocates who are accessible and flexible to meet community needs as they arise. This model, which is not targeted in the sense that there is no set algorithm for defining eligible populations, is often thought of as exemplified by the Promotor(a) model that is well established in California.[19] [36] While services are community based and are not targeted, the programs generally have a defined structure based on a curriculum or other strategy and may be delivered over a defined period of time. Examples of programs that align with this model include the many initiatives led by Latino Health Access and the Esperanza Community Housing Healthy Homes program on topics such as diabetes self-management, breast health, mental health, and community issues such as access to green space.[12, 19, 36]

Historically, community-focused CHW programs such as the one envisioned by Work Group 5, have been funded largely by a mix of philanthropic and government grants, and have also involved a substantial amount of volunteer effort. Within the SIM initiative, California could formalize a more sustainable funding stream for CHW efforts by leveraging contributions from the medical system into a wellness trust or similar funding model. The SIM initiative could establish specific funding priorities, to align with the goals of Work Group 5. Direct service-based reimbursement may also be applicable given recent federal rulemaking allowing Medicaid reimbursement for preventive services delivered by CHWs and other non-licensed providers. [29, 30] Work Group 5 suggested that this framework be adopted and extended to other purchasers.

Prevention-focused services delivered under this model are unlikely to lead to measurable reductions in health care costs during the SIM period, because they focus on long term outcomes with benefits that will accrue over a period of years or decades. Nevertheless, there are other valuable potential outcomes based on this model, such as increasing self-efficacy, improving trust in the medical system, and promoting community awareness and engagement in health-related issues.

If implementing this model, the CalSIM team should consider:

- Engaging CHWs and advocacy groups when designing the funding model, so that it achieves the goals of building sustainability and consistency while avoiding potential unintended consequences such as distancing CHWs from the community, decreasing CHW legitimacy, or limiting the flexibility and responsiveness that is essential to the success of this model.
- Selecting funding priority areas that not only align with the SIM initiative goals, but also align with community needs. California may consider undertaking a needs assessment as an early stage of the SIM initiative to help establish an understanding of community experience and outcomes at the baseline, community-identified needs, and CHW workforce capacity.

General Considerations and Caveats

If the CalSIM team pursues the CHW model as a potential strategy to meet the goals of the LGHC task force and the SIM initiative, there are several overarching considerations -- as well as some cautions -- that should be noted.

In either of the SIM concepts proposed by Work Groups 2 and 5, California should consider:

- Involving CHWs and advocacy groups in the planning and design process.
- Engaging CHWs to explore whether standardized training requirements should be established for CHWs practicing within the model.
- Exploring feasibility of a centralized employment model for CHWs, to decrease administrative/supervisory burden, promote consistency in CHW training and standards, and provide CHW peer support.
- Designing a multi-payer and multi-stakeholder financing model that does not limit CHW services to specific groups of insured individuals.
- Incorporating a robust evaluation plan for the CHW initiative, ideally during the design phase to maximize planning and availability of necessary data.

However, the CalSIM initiative may not need to explicitly endorse or adopt the CHW model. Many providers and community organizations in California are already using CHWs, and it is likely that use of the CHW model will continue to grow even in the absence of the SIM initiative. As an alternative to directly endorsing a specific CHW model within the CalSIM Testing Grant, the CalSIM team could encourage use of CHWs by leveraging partnerships with payers and purchasers that could provide guidance to their contracted providers. For example, New Mexico has required its contracted Medicaid managed care plans to adopt CHW programs.[29]

There is substantial tension within the CHW community around many of the concepts discussed in this brief. Formalizing the role of CHWs through paid employment, health system reimbursement, and standardized training requirements are all somewhat controversial among many stakeholders. There are real concerns that such moves could reduce perceived legitimacy and challenge the allegiance of CHWs, discourage new entrants into the workforce, and drive out currently practicing CHWs. While many stakeholders and experts from a wide range of fields agree that leveraging the unique skills of CHWs can be an effective strategy in achieving the Triple Aim, there is disagreement about how best to further the growth of the CHW workforce.

CONCLUSIONS

CHWs represent a diverse workforce that can further health and wellness in the broad population or among specific subgroups of individuals, by providing services that bridge community members and community resources including medical system services. The characteristics and activities of CHWs vary considerably along several continuums, with CHWs working as paid or volunteer resources, in community or medical-system based settings, focused on social issues or medical issues, and receiving various levels of training.[10]

There is growing evidence of the effectiveness of CHWs in achieving improvements in health outcomes and reducing health care expenditures. However, most evidence is based on specific programs, often based in clinical settings and addressing a specific target population. This may be largely due to the challenges of measuring long term impacts of more general, preventive interventions.

California's SIM team should consider using CHWs in the models proposed by Work Groups 2 and 5. Both models represent innovative approaches to reduce health care disparities while addressing growth in health care costs and leading California toward the LGHC Task Force's goal of being the healthiest state in the nation by 2020. However, there are several considerations and cautions related to either approach. If the SIM team determines to pursue use of CHWs within the Testing Grant, it should begin by engaging CHWs in the planning and design of the specific program approach. It may be possible to leverage the SIM Testing Grant as a framework to support such engagement and dialog, building on the strong base of existing expertise and effort related to CHWs in California.

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