



Community Health Worker White Paper: Report and Recommendations

Introduction

The Patient Protection and Affordable Care Act (ACA) has three specific goals: improve the health of the population, lower health care costs, and provide better care for individuals. Community health workers (CHWs) can play a significant role in helping Washington State achieve all three of these goals. The intent of this paper is to trigger a deeper, cross-sector, statewide conversation about CHWs that will result in a CHW road map for the state. Below we describe the history of CHWs, their effectiveness in achieving health outcomes and cost savings, highlight what other states have done, provide considerations and insights from the field in advancing the CHW workforce, and offer practical recommendations to move forward.

Background

Community health workers (CHWs) are known by many names, including outreach workers, promotores(as) de salud, patient navigators, community health representatives, and community health advisors. Regardless of their title, CHWs are frontline workers who help individuals and communities to improve their health. The CHW model is founded on natural helping systems within communities and is based on peer-to-peer relationships rather than provider-client relationships.^{1,2} A key feature of CHWs is that they are individuals who have a relationship with and understanding of the community in which they serve, often belonging to the same culture, speaking the same language, and having similar life experiences. They “gain their core experience from local forms of knowledge.”³ As a result, they are in a unique position to engage individuals and populations that medical professionals have difficulty reaching. Around the world, CHWs have been helping their communities for more than 300 years.⁴

Definition. In the United States, the number of CHWs and CHW programs grew significantly in the 1980s, and stakeholders saw a need to create a common definition and scope of work. In 2007, the Community Health Worker National Workforce Study conducted by the U.S. Department of Health and Human Services, identified six key activities CHWs perform: (1) create more effective linkages between communities and health care systems, (2) provide health education and information, (3) assist and advocate for underserved individuals to receive appropriate services, (4) provide informal counseling, (5) directly address basic needs, and (6) build community capacity in addressing health issues.⁵ The same study also revealed that CHWs are typically hired by individual and family services (21%), social advocacy organizations (14.2%), outpatient care centers (13.3%), education programs (12.9%), other ambulatory health care services (8.4%), and physicians’ offices (5.3%).

In 2009, The American Public Health Association (APHA) adopted the following 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.⁶

This definition was submitted to the United States Department of Labor. In 2010, the Department of Labor recognized CHW as a unique standard occupation classification and defined their roles as the following:

- Assist individuals and communities to adopt healthy behaviors.
- Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health.
- May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening.
- May collect data to help identify community health needs. Excludes "Health Educators."⁷

Effectiveness. Studies have shown that CHWs produce both positive health outcomes and financial benefits. CHWs have demonstrated success in multiple arenas including: increasing enrollment in health insurance, helping individuals manage chronic conditions, improving maternal and child health, reducing infant mortality, and increasing knowledge about screening for cervical and breast cancers. CHWs have been utilized to effectively prevent and manage chronic diseases, such as diabetes, hypertension, cardiovascular disease, asthma, depression, and mental illness. The following table provides a small sample of health outcomes that have been achieved by CHWs.⁸

Table 1

	Target Population	Outcomes
Northern Manhattan Community Voices Collaborative ⁹	Low-income communities in New York City	From 2000-2005, CHWs enrolled 30,000 people in health insurance, helped 8,000 children become completely immunized, and supported 4,000 families in improving asthma management.
Vietnamese REACH for Health Initiative ¹⁰	Vietnamese American women in Santa Clara County, California	Women were assigned to two interventions: (1) lay health worker plus media-based education or (2) media-based education only. Among women who had never had a Pap test, 46% in the combined intervention obtained a test compared to 27.1% in the media-only group.
Community Diabetes Education Intervention ¹¹	Patients with diabetes	Patients who completed one year of the CHW intervention showed significant improvements in hemoglobin A1c.
Effectiveness of CHWs in the care of people with hypertension ¹²	Patients with hypertension	Significant improvements in controlling blood pressure were reported in seven of eight randomized controlled trials. Other outcomes include improvements in self-management behaviors, positive changes in health care utilization, and changes in heart mass and risk of cardiovascular disease.

Public Health – Seattle & King County ¹³	Children with asthma in low-income households	Reduced asthma symptom days and urgent health services use.
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In addition, CHWs reduce health care costs by improving access to primary care and social services and enhancing individuals’ capacity to manage their health conditions, thereby reducing costly emergency room visits and hospital admissions and readmissions.¹⁴ The following table shows examples of CHW programs and their return on investment or savings potential.¹⁵

Table 2

	Target Population	Return on Investment and/or Savings	Impact
Denver Health ¹⁶	Underserved men	\$2.28 return on investment per dollar spent, annual savings of \$95,941	Shifted inpatient and urgent care to primary care
Baltimore ¹⁷	African-American Medicaid patients with diabetes	Savings of \$1,200-\$9,300 per participant	Decreased ER visits, ER admissions, and total hospital admissions
Arkansas Community Connector Program ¹⁸	Underserved Medicaid-eligible adults	\$2.92 return on investment per dollar spent	Connected adults with unmet long-term care needs to agencies and services
Public Health – Seattle & King County ¹⁹	Children with asthma in low-income households	Savings of \$189-\$721 per participant in the high-intensity, home visit group	Reduced asthma symptom days and urgent health services use
The Langdale Company ²⁰	Employees	\$4.80 return on investment per dollar spent	Reduced employee weight, blood pressure, smoking, and cholesterol levels
Molina Health Care in New Mexico ²¹	Medicaid patients who are high consumers of health resources	Savings of \$4,564 per enrollee in a Medicaid managed care system	Reduced emergency room use, days of inpatient care, narcotic use, and other prescription drug use

The impressive health outcomes and cost savings CHWs are able to achieve are particularly important as physicians face greater demands on their time and there is growing evidence that social and cultural factors act as barriers to health care access and health status improvement. In a still largely fee-for-service world, physicians are pressured to see a high volume of patients to generate revenue, spending roughly 13 minutes with each patient.²² In that short amount of time, physicians are often unable to affect patients’ behavior change and address the barriers that may contribute to non-compliance with the care plan.²³ CHWs, on the other hand, spend more time with each patient, presenting information in a culturally-competent manner and in the language spoken by the patient.

Relationship to the Affordable Care Act. The ACA explicitly calls out CHWs as members of the health care workforce, listing them among “primary care professionals.” Furthermore, although it has not received an appropriation, the ACA authorizes the Centers for Disease Control and Prevention to award grants to “promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.”²⁴ Priority for these funds is given to geographic areas with a high percentage of residents who are eligible for insurance but are uninsured or underinsured, a high percentage of residents with chronic diseases, or a high infant mortality rate.

Through the ACA’s Medicaid expansion, Washington State expects roughly 355,000 individuals to be newly eligible for Medicaid. Additionally, 460,000 individuals will be eligible for subsidies through the Marketplace.²⁵ These individuals will not only need assistance in enrollment, but will also need help to access and appropriately utilize care. Using the ACA’s definition, CHWs can provide outreach, enrollment assistance, information and referral, culturally and linguistically appropriate and accurate health information, and care coordination. With the influx of new patients and current primary care workforce shortage, CHWs can be critical team members of patient-centered medical homes and health homes to improve outcomes. Entry into the CHW workforce may even serve as a stepping stone into other highly-demanded clinical professions.

Policy Examples from Other States

Washington State has not issued any guidelines as to CHW definition, scope of practice or work, qualifications, or how they will be reimbursed for their services. However, other states have been developing their CHW workforce for some time and have grappled with significant policy issues. Washington can look to these states to see what they have done to support and expand the CHW workforce. What follows is a brief description of CHW policy initiatives in four different states.

Massachusetts. In 2006, Massachusetts’ health reform law extended health insurance to 400,000 additional residents. Community organizations received grants for outreach and enrollment, and most organizations hired CHWs to do the job.²⁶ CHWs were successful in enrolling more than 200,000 uninsured individuals in insurance plans.²⁷ The health reform law also mandated that the Department of Public Health conduct a CHW workforce study and generate recommendations for a sustainable CHW workforce. A CHW Advisory Council was convened to carry out the study, and the Council made recommendations in four areas: (1) conduct a statewide CHW identity campaign, (2) strengthen workforce development, (3) expand financing mechanisms, and (4) establish an infrastructure to ensure implementation of recommendations.²⁸ More specifically, workforce development recommendations include developing a CHW training curriculum, establishing a CHW board of certification, and developing and implementing certification processes for CHWs and CHW trainers and training entities.²⁹ Legislation in 2010 created a CHW board of certification and meetings are currently underway to develop statewide, standardized certification criteria.³⁰

Minnesota. The Minnesota Community Health Worker Alliance, a group of stakeholders including state agencies, academic institutions, nonprofit organizations, health care professionals, and CHWs, developed a “scope of practice” and statewide standardized CHW curriculum in 2005.³¹ CHWs can become certified by completing the 14-credit certificate program.³² In 2007, the state obtained a 1115 Medicaid Waiver so state-certified CHWs could receive fee-for-service reimbursement under the state Medicaid plan.³³ CHWs can provide patient education and care coordination and must work under the supervision of a physician,

advanced-practice nurse, dentist, public health nurse, or mental health provider to receive Medicaid reimbursement.³⁴ Minnesota is the only state that explicitly pays for CHWs through Medicaid reimbursement.³⁵

Ohio. In 2003, the Ohio legislature created a statewide CHW credentialing program, which is overseen by the Board of Nursing. The curriculum includes 100 hours of didactic education and 130 hours of clinical experience, and covers four major areas: health care, community resources, communication skills, and individual and community advocacy. The Ohio Community Health Access Project (CHAP) is working to create sustainable funding for outcomes produced by CHWs.

Oregon. Oregon began efforts to integrate CHWs into primary care in 2008 with the development of a statewide CHW network. In 2011 the legislature established an integrated network of care delivery known as “coordinated care organizations” (CCO) to deliver care to medical assistance recipients using alternative payment methods, patient centered medical homes, and evidence based information. The legislation also required that beneficiaries have access to personal health navigators and qualified CHWs.³⁶ In 2013 the Center for Medicaid Services Center for Medicare and Medicaid Innovation awarded Oregon a grant to test the effects of the CCO framework and alternative payment model on health outcomes and costs. All CCOs utilize CHWs as a part of their integrated care teams. Oregon has identified performance measures to judge the program’s impact. The legislature is thinking about establishing a CHW commission to identify training and education requirements for CHWs.³⁷

Texas. In 2001, the Texas legislature required health and human service agencies to use certified CHWs for outreach and education for medical assistance recipients “to the extent possible.”³⁸ The Texas Department of Health was charged with developing and implementing a CHW training and certification program.³⁹ CHWs must be certified to receive compensation for their work. A 2011 bill required the state to study “the desirability and feasibility of employing promotores or community health workers in Texas and to explore methods of funding and reimbursement.”⁴⁰ The study produced recommendations that include exploring the feasibility of applying Medicaid reimbursement models in Texas, continuing efforts to incorporate CHWs into patient-centered medical homes and similar care management structures, and identifying opportunities to increase the use of CHWs in public health and behavioral health programs.⁴¹ As of December 2012, there were 2,100 certified CHWs in Texas.⁴²

Key issues for Washington to Consider⁴³

There is much to be learned from the other state’s efforts. Washington does not need to spend precious resources ‘reinventing the wheel.’ However, as the health care landscape is in a state of flux, what was appropriate at one time and in one context may not be applicable to Washington State.

In order to understand stakeholders’ perceptions of the CHW workforce in Washington State, we held a series of focus groups and interviews. With prepared questions on the topics of definition and scope of practice, training and credentialing, and financing, we spoke to a total of 10 CHWs (four in Seattle and six in Tacoma), six CHW supervisors, and representatives from five health plans and four health systems. Although some interviews were with people who serve the entire state, most interviewees focus on the needs of people who live in the Puget Sound area. We also held conversations with four national CHW experts in order to identify challenges other states have faced and effective solutions. Finally, we reached out to

organizations and agencies across the state to identify Washington's existing CHW workforce both inside and outside of the health care system⁴⁴.

1.) *Awareness.* In different areas of the country efforts to legitimize, define, and develop the CHW workforce have been spearheaded by a variety of stakeholders. For example, university researchers have been studying CHWs' effectiveness and making policy recommendations in the Northeast and South for over 25 years. In the Southwest CHW workforce development has been facilitated by organizations concerned with migrant populations. In Washington, the Washington Association of Community & Migrant Health Centers and the Northwest Regional Primary Care Association developed a CHW network that focused primarily on providing training, support, and peer networking for Promotores(as) de Salud affiliated with Community/Migrant Health Centers in the state. CHW interviewees expressed the need for support and recognition of their work by the public and desired some type of network or professional association that extends beyond Community/Migrant Health Centers.

The National Community Health Advisor Study revealed that CHWs are typically hired by medical service providers, individual and family services, social advocacy organizations, and education programs. However, when we contacted statewide social service and education organizations, we found that most did not know what CHWs were nor did they identify CHW-like positions within their organizations. In addition, we were unable to locate a critical mass of CHW programs or program models in Washington. However, this situation may change as health plans develop their own CHW programs or collaborate with other organizations to provide CHW services to their members.

In sum, there is no organized effort to legitimize, define, and develop the CHW workforce in Washington State.

2.) *Definition and scope of practice.* The interviewees agreed with the APHA definition and reiterated that CHWs are frontline workers who are ideally from the community they serve. They possess the same cultural and linguistic background and share similar life experiences with the people they work with. Because of these factors, they are trusted by community members. Interviewees also described the wide range of work that CHWs perform. Under the broad mission of helping people overcome barriers to care, CHWs help navigate health systems, perform outreach and education, and serve as a liaison to health professionals by offering cultural translation and relaying information back to care teams. Additionally, interviewees agreed on a general skill set that CHWs should possess. CHWs should be culturally competent, able to empower those they work with, have problem solving and people skills, and have knowledge of community resources.

While the interviewees seemed to agree on the definition, they worried that people outside of the profession do not understand the role of CHWs. One interviewee noted: "It's not well-defined. Everyone has a different idea of what it is." For that reason, one interviewee believed a national definition and description of the role was necessary. Other issues were raised by the interviewees as well. There is a perceived threat to nurses and social workers because the CHW role is not clearly defined and understood. At the same time, several interviewees noted that, if all members of the care team work at the top of these licenses, then overlap should be minimal. One doctor said that she thought CHWs were uniquely positioned to design and implement patient engagement and behavior change strategies in ways that are culturally and linguistically appropriate for the hard-to-reach populations.

Interviewees also expressed concern over what CHWs can legally do, that is, where is the line between what licensed professionals can do versus non-licensed professionals? Interviewees questioned whether CHWs must always be connected to a health care team and linked to a formal health system or whether they can address public health issues like nutrition and physical activity in the community.

3.) *Training and credentialing.* The interviewees agreed that some level of CHW training is necessary in order to prevent any accidental harm to the people CHWs work with. However, three states (i.e., Virginia, New York and Massachusetts) have officially ruled that CHWs do not need to be licensed because their duties pose minimal risk of harm to the public from unlicensed practitioners.

The interviewees indicated that core training should include confidentiality, motivational interviewing, safety, role boundaries, problem solving, and how to navigate health systems. Based on the needs of the hiring organization, further training can cover specific health topics, such as asthma or diabetes or other relevant specific topics.

Some interviewees pointed out that the Department of Health has a good introductory, statewide CHW training. This training builds upon training offered to CHWs and patient navigators in Massachusetts. It includes a two-day in-person and six-week on-line training. The skills taught include communication, organization, documentation, assessment, service coordination, cultural competence, establishing roles and boundaries, and navigating the online system. It does not thoroughly cover all of the nationally recognized CHW core competencies, but it could be expanded in order to do so. Other interviewees stated that more advanced and specialized training is needed for people who are experienced CHWs or outreach workers. Some suggested that the training could include different tracks, for example, one for CHWs who work with people who have specific diseases and one for community-based prevention.

The interviewees also cautioned against training requirements that would raise barriers to joining the CHW workforce, such as training that is cost prohibitive, time-consuming, or located far away. The issue of training for supervisors also arose, as it should be different from the training that CHWs receive and include strategies to support CHWs. To expand the workforce quickly in preparation for health care reform in 2014, it may be necessary and sufficient to create a short standardized training program for CHW's, which is then followed by continuing education and on-the-job training.

There was no consensus among interviewees regarding the need for statewide credentialing. Some felt that the issue was premature. Others believed a certificate of completion would be sufficient, but formal credentialing would become a barrier to entering the workforce. One interviewee shared the process of developing the medical interpreter profession and suggested that CHWs and other stakeholders take a similar approach. The approach involved building a scaffolding framework. First, they defined the role. This was then followed by creating a code of ethics, standards of practice, standards for training, and then finally certification.

Finally, other states have shown us that CHWs need to provide leadership in the effort to legitimize, define, and develop the CHW workforce. In states where CHWs have not provided leadership, CHWs have tended not to participate in the state certification system.⁴⁵ Interviewees also cautioned against propelling the CHW workforce into the marketplace too quickly. In order for CHWs to work in a collaborative environment with

other health care workers, extensive education must be provided to other professionals to ease perceived threats of replacement or competition.

4.) *Financing.* The interviewees agreed that whoever financially benefits from the utilization of CHWs should pay for their services. As one interviewee stated: “Sustainability is whoever is paying gets a return on investment.” However, calculating return on investment is difficult. Among a team of care providers, what portion of the success can be attributed to the CHW’s work? What outcome or performance measures should be used to fairly assess their work and value? Who is responsible and accountable for each patient or member? It is challenging to measure prevention and quantify the dollars saved by CHWs. Another problem in financing CHWs is that health plans often experience churn, i.e., members switching between plans or between Medicaid and subsidized insurance plans. This produces a lack of incentive for health plans to invest in CHWs when their work to improve health may not show savings for several years, at which point the member is enrolled with another health plan.

Some interviewees favored copying Vermont’s approach. Vermont Blueprint for Health is a statewide initiative to improve the health care system. One feature is the community care team (CCT), a multi-disciplinary care team that includes a nurse practitioner, registered nurse, social worker, dietician, behavior specialist, CHW, and a Vermont Department of Health public health specialist.⁴⁶ The CCTs coordinate care in the community and support patients with chronic disease. Since the CCTs are a shared resource, the state mandated that all three major insurers and the state Medicaid program provide funding to support them.⁴⁷ A specific amount is collected from each payer, pooled, and then distributed to the administrative entities.

Another interviewee suggested a financing model similar to the workers’ compensation system, a type of insurance that compensates employees injured in the course of their employment. In Washington State, employers and employees contribute to the Washington State Fund, which pays out workers’ compensation claims.⁴⁸ This approach would be similar to Vermont’s method of paying CHWs in that entities contribute to a pool of money. In addition to health plans, this fund could be shared by a number of health systems, community-based organizations, and/or other institutions that use CHWs.

It is critical to secure a sustainable funding mechanism if the CHW workforce is to thrive. Several sustainable funding mechanisms are feasible, including Medicaid, private insurance, and government general funds.⁴⁹ Payment models need to shift from activity and volume based billing system to an outcome and value based in order to sustain the CHW role.⁵⁰ For example, instead of fee-for-service, CHWs can be compensated through capitation, bundled payments, shared savings models, or pay-for-performance programs.

Conclusion

Historically, there are moments of seismic change. This is such a time. A radical change is taking place in our health care system. In order to meet the goals and demands of the ACA we must rethink how to carry out efficient and effective care. How can we change the health care delivery system to improve the health of the population, lower costs, and provide better care for individuals? We can make small incremental changes to address the letter of the ACA or we can broaden our vision and transform the system in a way that significantly improves the health of Washington’s citizens.

While many regions of the country have been developing their CHW workforce, to date, there have been relatively few efforts to do so in Washington State. Our interviews with people who work in King and Pierce counties indicate broad acceptance of the APHA definition of CHWs as a frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. They also agreed on the need to develop core and specialized CHW training programs. However, they cautioned against training and certification requirements that would raise barriers to joining the CHW workforce. They also agreed that a sustainable funding mechanism needs to be developed.

In Washington State, with the advent of health reform, over a half a million people will be newly insured and better able to access the health care system. This influx of people will stress the health care delivery system. CHWs are uniquely positioned help Washington State successfully respond to this challenge. CHWs have demonstrated impressive health outcomes and cost savings, particularly among low income, culturally diverse, and hard to engage populations. A large percentage of future Medicaid and Exchange enrollees will come from these groups. Per the ACA's definition, CHWs can provide outreach, enrollment assistance, information and referral, culturally and linguistically appropriate and accurate health information, and care coordination. Therefore, the state needs to develop guidelines as to CHW definition, scope of practice or work, qualifications, and reimbursement. Until we have addressed these issues, Washington will not be able to effectively develop and utilize a CHW workforce.

At the same time, there are many areas where people have more questions than answers. Most people, inside and outside of the medical establishment, do not understand the role of CHWs. There is a perceived threat to nurses and social workers because the CHW role is not clearly defined and understood. What is their scope of work? What can CHWs can legally do? Where is the line between what licensed professionals and non-licensed professionals can do? What outcome or performance measures should be used to fairly assess CHWs work and value?

Answers to these questions and others need to be answered before CHWs can significantly contribute to achieving the desired outcomes inherent in Washington State's health care reform.

Recommendations

We recommend developing a platform or vehicle to support and recognize CHWs and their work. CHWs need a network or association where they can receive support, access professional development, advocate for themselves, and powerfully contribute to broader conversations about CHWs scope of work, qualifications, and training requirements. Experience in other states indicates it is essential to have CHWs involved in these policy conversations. Otherwise, we risk developing standards based on provider-client models that may inadvertently exclude the very individuals who tend to be the most effective from becoming CHWs: individuals who are members of the community they serve, often belonging to the same culture, speaking the same language, and having similar life experiences as the people they work with.

We recommend developing, implementing and evaluating a variety of CHW programs and program model.

A variety of CHW pilot and demonstration projects need to be implemented and evaluated throughout Washington State. As the number and scope of CHW programs increases, the value of their work will become visible and, by evaluating these programs we will have a better sense of which programs are most effective with different clientele. As nurses, social workers, doctors and other professionals have experience working with CHWs, concerns about professional boundaries may dissipate. In other states, clinical staffs seek out CHWs once they have experienced how CHWs improve the delivery system and health outcomes.

The development of CHW networks and demonstration projects will build a foundation for the state to develop effective guidelines on CHWs scope of practice or work, qualifications, and reimbursement methods.

We recommend that an exploratory task force be convened to develop a CHW road map that defines the steps each key stakeholder would need to take to establish a CHW workforce for the state.

Exploratory Task Force. The task force should include key stakeholders from the public and private sectors, representing the entire state of Washington. The benefits of this approach are three fold. First, a genuine public/private partnership that supports the development of the CHW workforce could evolve from the task force. Second, creating a CHW roadmap provides a perfect opportunity for cross agency collaboration within government and cross-sector collaboration within the private sector. These collaborations could create models of ways to breakdown silos that interfere with the provision of holistic, integrated services. Finally, this cross-sector approach could create the foundation for a robust health workforce that increases opportunities to further develop and grow the traditional health professions.

Task Force Responsibilities. We recommend that the task force study the work that has been done in other states, consider the unique context of Washington State, and make recommendations on the following areas:

1. Define CHW scope of practice. It will be important for the task force to specify practice elements of the CHW roles and their associated tasks. We recommend that the task force take into account the major roles and skills identified by national CHW workforce efforts and incorporate flexibility so CHWs and employers can develop job descriptions that encompass a mix of CHW roles. It may also be helpful for the task force to confirm the mix of attributes or qualities that contribute to successful application of the scope of practice.
2. Define training standards. Multiple issues need to be addressed, including how to honor the CHW tradition, history, and peer-based model and reduce barriers to participation (i.e., cost, transportation, number of hours, limited academic skills); the core elements/content of the training and whether specialized training should be offered to address specific diseases or levels of practice; the training methodology, development and delivery; and who should provide the training. The Department of Health has a framework/platform for CHW training in place. The task force should investigate to see if this platform could be expanded to meet the needs of the state. Finally, the task force will need to make recommendations on the issue of mandatory training and certification as a pathway to reimbursement for services offered by CHWs.

3. Identify stable and sustainable financing models for CHWs. The task force should validate the business case for CHWs. Stable financing cannot be attained without a clear definition of CHWs scope of practice and training requirements. Therefore it will be important to take into account the core elements of CHWs scope of practice and training needs that must be included in all financing models, identify CHW roles that overlap with other health professions and may already be reimbursable, and make possible financing recommendations aligned with specific funding sources (i.e., Medicaid, Medicare, commercial insurance, government, health care providers, and employers).

The task force will need to be convened by either the Governor's Office , Health Care Authority or the State Legislature and will need involvement of both branches of state government for CHWs to gain the recognition needed to make a significant impact on health reform initiatives in the state.

We recommend public sector representatives include the Health Care Authority, Department of Social and Health Services, Health Care Authority, Department of Health, Commerce, Workforce Development, local health jurisdictions, and Community and Technical Colleges. We recommend private sector representatives include CHWs; health care providers; Community Health Clinics; health care payers; professional associations; funders; labor organizations; organizations advocating for the health of low-income people and communities of color; low-income housing providers; and training organizations. Finally, we recommend that CHWs be intimately involved in all aspects of the work of the task force. Some states have mandated that CHWs co-chair each work group. Other efforts have conducted focus groups across the state in order to solicit feedback from CHWs.

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