



Taking Innovation to Scale: Community Health Workers, Promotores, and the Triple Aim

*A Statewide Assessment of the Roles and
Contributions of California's Community Health Workers*

Preliminary Findings, Observations, and Recommendations

AUGUST 2013

ACKNOWLEDGEMENTS

This study was carried out by the California Health Workforce Alliance (CHWA), a statewide public-private partnership of educational institutions, health professions, employers, constituency groups, and local, state, and federal agencies. CHWA holds quarterly statewide meetings and periodic special meetings and processes to advance comprehensive, coordinated strategies to build a health workforce that effectively meets the needs of our increasingly diverse communities. CHWA operates under the fiscal auspices of the Public Health Institute, a private, nonprofit organization based in Oakland, California, that is engaged in research, technical assistance, and training programs at the state, national and international levels.

We would like to thank the Blue Shield of California Foundation (BSCF) for its insight and generous funding support for this study at a critical juncture in the federal health reform process. The study focuses on the contributions of community health workers and promotores engaged with safety net institutions, at a time when there is growing interest in prevention as a means to reduce health care costs. These workers serve as a bridge between clinical services and community-based prevention, and their contributions to the achievement of the Triple Aim objectives of reduced costs, improved patient experience, and improved population health are of particular interest as coverage expands to new enrollees in low- and moderate-income communities. Funding from BSCF for this statewide assessment is intended to inform the design of practical strategies and policies to expand CHWA's engagement with both safety net and mainstream provider organizations.

We appreciate the engagement of a Project Leadership Team with broad and in-depth expertise and experience in the engagement of community health workers and promotores. These leaders were involved all along the way, from providing early and ongoing input in the design and dissemination of an online survey instrument to the review of findings and recommendations. A list of members is included at the end of this report. We also appreciate input from the broader CHWA membership at a series of three quarterly meetings in Los Angeles and Oakland. Special sessions were held at each of the

meetings in December 2012 and March and June 2013 to seek input on study design, findings, and draft recommendations.

We are grateful for the ongoing guidance and support from Catherine Dower, JD, Associate Director of the Center for the Health Professions at the University of California, San Francisco, who served as a consultant on the project. Ms. Dower is a nationally recognized expert on the roles and contributions of community health workers, and provided invaluable support in the design of the survey instrument, the analysis and interpretation of findings, and in the development of recommendations. She also served as a member of the Project Leadership Team.

We appreciate the support of the California Primary Care Association (CPCA) in facilitating outreach to its membership of California's community health centers; these organizations were the primary focus of the study, and support from CPCA contributed to a high response rate. We are also thankful for assistance in the piloting of the survey instrument and outreach to rural safety net providers and organizations engaging promotores by Steve Barrow, Executive Director of AHEAD, and Maria Lemus, Executive Director of Vision Y Compromiso. Both also served as members of the Project Leadership Team.

Andrew Broderick, MA, MBA, Research Program Director at the Public Health Institute served as the lead researcher on the study and the lead author of this report. Staff support for outreach to survey respondents was provided by Sara Harrier, Program Administrator at the Public Health Institute. CHWA Co-Director Kevin Barnett, DrPH, MCP, served as the Principal Investigator, and provided oversight for all aspects of the study.

This preliminary report provides a brief summary of findings, observations, and recommendations from the statewide assessment, in the interest of stimulating public dialogue and input prior to the release of a more in-depth report in October 2013. The October report will include a discussion of strategies for implementing recommendations through establishing a statewide task force, envisioned for a second phase of the project.

INTRODUCTION

This brief report provides an overview of preliminary findings, observations and recommendations from the California Health Workforce Alliance's (CHWA) assessment of the current level of engagement and roles of community health workers among California's health care safety net providers,¹ and their contributions towards the achievement of the Triple Aim objectives.² Our study used the term "Community Health Worker" to refer collectively to CHWs and Promotores de Salud.³

CHWA DEFINITION OF A COMMUNITY HEALTH WORKER

CHWA's definition of a "Community Health Worker" is a person who is a trusted member of and/or who has an unusually close understanding of the community served in the delivery of health-related services through either working directly with providers or their partner organizations. This trusting relationship with the community enables CHWs to serve as a liaison between health and social services and the community to facilitate members' access to services and improve the quality and cultural competence of services delivered. CHWs build 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.

Our study builds on earlier efforts to assess the CHW field, specifically the Community Health Worker National Workforce Study⁴ (CHW/NWS) funded by the U.S. Health Resources and Services Administration. Using a broader sample than our survey, CHW/NWS estimated the number of CHWs engaged by Californian not-for-profit and for-profit organizations, such as schools, universities, clinics, hospitals, physician offices, individual-family-child services, and educational programs, was 13,000 in 2005.

This study is intended to inform dialogue and action in the public and policy arena, particularly in articulating CHW contributions to the achievement of the Triple Aim objectives and to develop practical strategies that will take their engagement to scale.⁵ In 2013, we conducted outreach with the support of our partners to 281 rural and urban health care safety net organizations. (See Figure 1) Responses were received from 125 organizations representing 685 sites, and surveys from 121 of these organizations were accepted (response rate = 43%) and are included in our analysis.

¹ Health care safety net providers are organizations that offer health care services to low-income people, including those without insurance. This includes a broad range of local non-profit organizations, government agencies, hospitals and individual providers. Our use of the term refers to a subset of the larger safety net given our sample frame and primary focus of our outreach efforts to urban and rural community health centers and clinics.

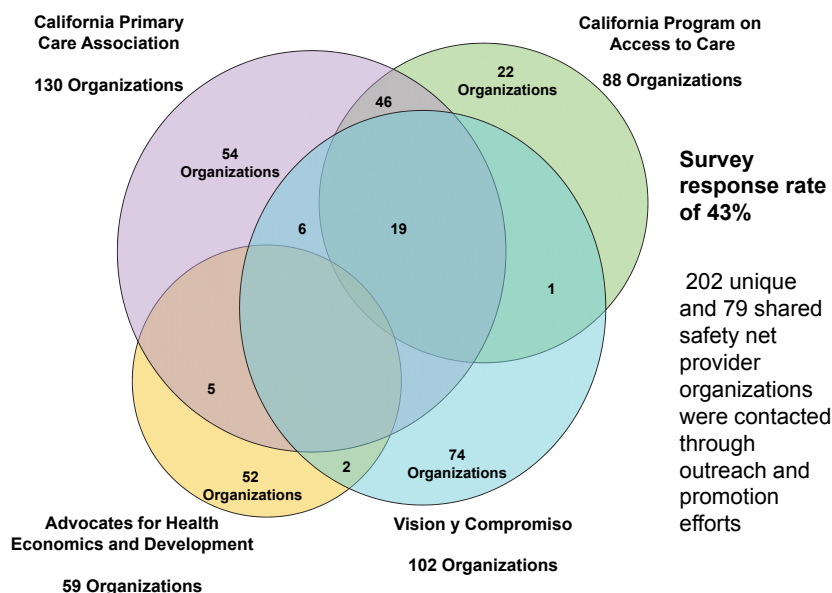
² The Institute for Healthcare Improvement's "Triple Aim" states that an optimized healthcare system achieves the following three objectives – Improving the Experience of Care; Improving the Health of Populations; and Reducing the Per Capita Costs of Health Care.

³ Our definition of CHW is consistent with those formally adopted by the Department of Labor, the Affordable Care Act, and the American Public Health Association. The use of titles different from CHW that organizations may use in referring to such persons has been captured through our survey instrument.

⁴ <http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf>

⁵ The statewide assessment includes the development of four case profiles to capture current innovations into the design of strategies that integrate the cost of CHWs into reimbursement models, address quality of care concerns, and build links between clinical care and population health improvement. The four case studies, which include two health plans and two provider organizations, will be profiled in our in-depth report in October 2013.

Figure 1: Survey Outreach Efforts



Preliminary findings present a profile of the current engagement, roles, skills, and performance of community health workers among California's health care safety net providers, and the extent to which organizations have experienced barriers to and identified actions that will promote broader engagement. A more detailed review of the findings is ongoing and, together with final recommendations that are being developed in consultation with the project leadership team and other key stakeholders in the CHW field, will be published in a final report. Core findings are summarized below:

CORE FINDINGS

- 65.3% (79/121) of surveyed organizations currently engage 1,644 CHWs in a broad range of roles and across a wide range of program areas and in diverse settings.
- Respondent organizations reported growing roles for CHWs in care coordination, particularly for chronic conditions, over the next 5 years.
- 71.8% (56/ 78) of organizations engaging CHWs collect data on the contributions of CHWs, but most focused on performance measures related to the number of screenings, health education classes, and referrals.
- Data collection related to Triple Aim objectives was reported but at limited levels, with "improve access" measures reported by 42% of organizations, followed by "improve experience of care" and "improve health of populations" (38%), and "reduce per capita cost of care" measures (21%).
- 68.4% (54/79) of providers engaging CHWs have experienced barriers with both increasing their number (46/54) and with existing workers doing more (36/50).

Preliminary observations and recommendations are presented in the following categories: Dissemination and outreach, roles and contributions, education and training, career progression, financing and reimbursement, performance measurement, professional identity, collaboration, and scaling engagement. Core recommendations are:

CORE RECOMMENDATIONS

- Disseminate broadly the findings and analysis and convene key stakeholders across the statewide health system to translate recommendations into policies that address financial and professional concerns about expanding the engagement of CHWs.
- Recognize the value of services provided by CHWs so that their work can be appropriately compensated, and develop a strategy for incremental development of capitated financing mechanisms that support the integration of CHWs into care teams.
- Provide targeted technical assistance to strengthen health centers' analytical capacity using information technology, and establish shared information systems and voluntary frameworks for real-time data sharing with hospitals to improve coordination of care.

BACKGROUND

Innovations that broaden the scope of services and links to community-based prevention, the settings in which services are delivered, and the workforce resources to deliver such services offer considerable potential to improve outcomes, reduce inefficiencies, and lower health care costs. The Triple Aim provides an overarching framework to guide organizations as they redesign structures and processes to meet the increased demand for primary care associated with expanded enrollment in the implementation of national health reform. Community health workers have demonstrated the ability to play a critically important role as a member of the primary care team, and can help to both meet the increased demand for clinical services and serve as a key resource in the implementation of broader population health improvement strategies. More detailed information is needed, however, about accomplishments to date, challenges, and opportunities to inform the design of strategies that will successfully lead to expanding the engagement of CHWs.

RESEARCH METHODOLOGY

Between January and June 2013 an online survey was disseminated to senior leadership in California's community health centers and clinics. Clinic leaders were asked to either complete the survey or supervise the submission of administrative, operational and clinical data related to the roles and contributions of CHWs. In instances where organizations operate more than one clinic, individual respondents provided inputs for all clinics affiliated with that organization.

Table 1: Respondents by Clinic Type

Clinic Type	Individual Site (n=36)	Multiple Sites (n=85)
FQHC	14	65
FQHC Look-Alike	8	7
Free Clinic	1	3
Non-FQHC Clinic	4	6
Hospital-Owned Clinic	2	9
Mobile Clinic	0	20
Other	7 *	16 **

* Other includes Rural Health Clinic, Hospital-owned Community Outreach Center, HIV Specialty Clinic, Public Health Clinic, and Wellness Center

** Other includes Adult Day Health Center, Dental Clinic, Satellite Clinic, School-based Clinic, Medical Group-owned Clinic with Specialty and Sub-Specialty, HIV Treatment Clinic, Teen Health Center, Youth Enhancement Center and WIC Clinic

The design of the CHWA survey instrument was informed by the HRSA CHW/NWS referenced previously. The Project Leadership Team helped to refine the instrument, and it was field tested with six organizations in California prior to launch. Statewide promotion and outreach for the survey was conducted in partnership with the California Primary Care Association, Vision y Compromiso, California Program on Access to Care, and Advocates for Health, Economics and Development.

PRELIMINARY FINDINGS, OBSERVATIONS AND RECOMMENDATIONS

Although there have been previous efforts to evaluate the contributions of CHWs across the nation, estimates as to the size of this workforce vary considerably. Among the most comprehensive assessments conducted to date, the CHW/NWS estimated that California had over 13,000 CHWs engaged by health employers in the public and private sectors in 2005. More recently, the occupational employment statistics released in May 2012 by the Department of Labor indicate that 5,350 CHWs were employed in California.⁶

Respondents to the 2013 CHWA survey report that 1,644 CHWs are engaged in California. This finding is lower than previous estimates reported for California's public and private health service sector. This is due to our sample frame and outreach to urban and rural community health centers and clinics, which represent a subset of the larger statewide health care safety net provider system and of the even larger health care system beyond the safety net. It is probable that a larger number of CHWs would have been reported if a broader categorization of service organizations were included.

⁶ <http://www.bls.gov/oes/current/oes211094.htm>

CHW Survey Respondent Profile

One hundred and twenty-five organizations responded to the survey. The total number of surveys accepted was 121, of which 117 were fully completed. A combined total of 668 sites were represented by the 121 respondents. Eighty-five (70.2%) of the respondent organizations operate multiple sites, representing 632 sites. Over half (62%) of the respondents were individual organizations with one site and small-sized organizations with between 2 - 4 sites.

Table 2: Respondents by Organizational Size

Number of Sites	Response Count	Response Representation
Individual (=1)	36	30%
Small (2-4)	39	32%
Medium (5-9)	23	19%
Large (10+)	23	19%
TOTAL	121	100%

CHW Engagement Profile

Approximately two-thirds (65.3%) of surveyed health care safety net providers, representing 515 sites, engage CHWs in a broad range of roles and across a broad range of program areas and in diverse settings. Of the 79 organizations that engage CHWs, a total of 1,644 CHWs were engaged in some capacity, including 799 on a full-time basis. Of these organizations, 52 (65.8%) operate clinics in urban locations. Using the California Economic Strategy Panel Regions to group reporting counties by regions, the majority of respondents, sites, and CHWs engaged were located in the Bay Area, Southern California, Southern Border, and San Joaquin Valley counties. (See Table 3)

Table 3: Respondents by Regional Classification*

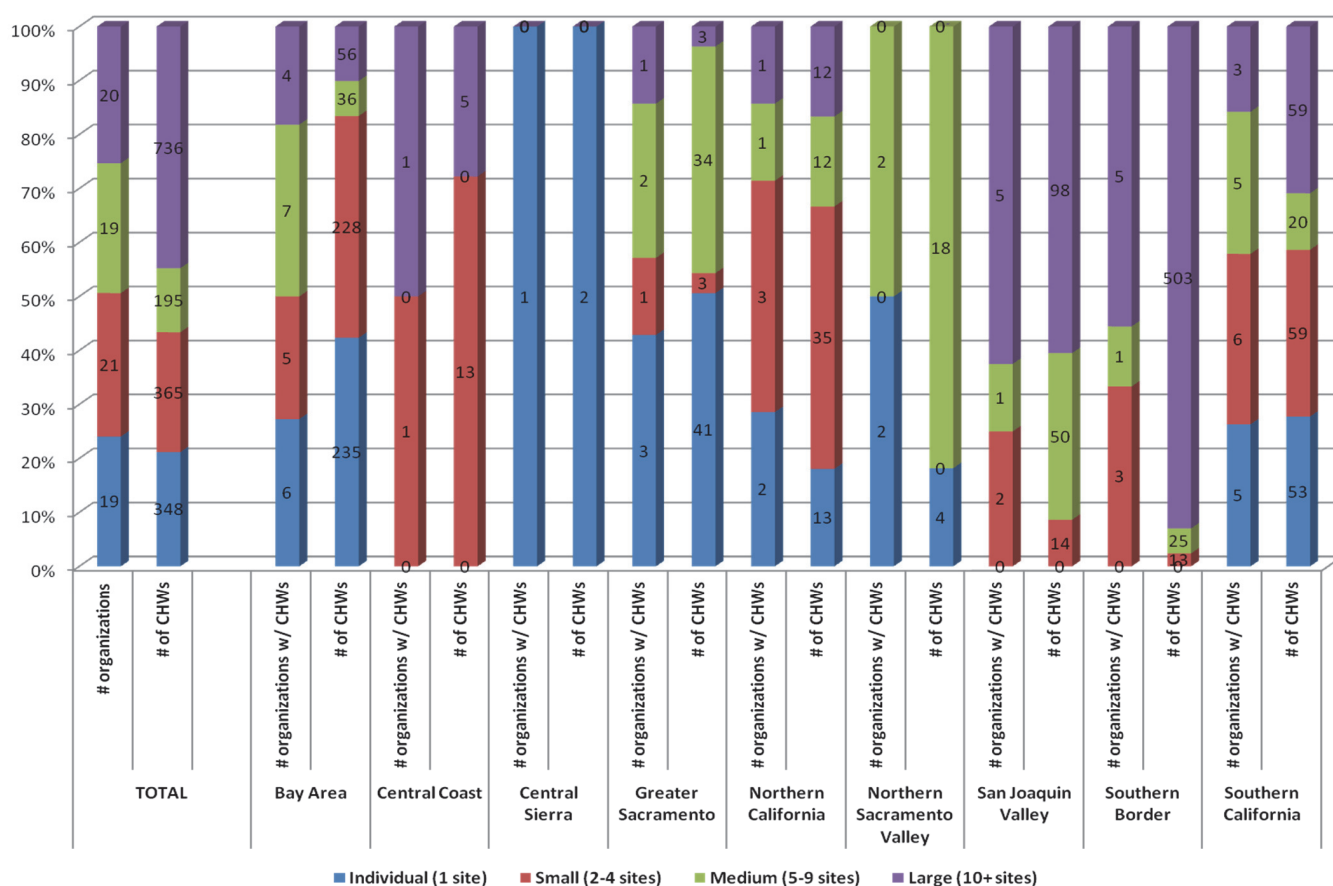
Region	Counties**	Orgs	Sites	Total CHWs	Full-Time CHWs
BAY AREA	Alameda, Contra Costa, Marin, Napa, San Benito, San Francisco, Santa Clara, Santa Cruz, Solano, Sonoma	34	181	555	149
CENTRAL COAST	Santa Barbara, San Luis Obispo, Monterey	4	30	18	6
CENTRAL SIERRA	Inyo, Tuolumne	3	29	2	2
GREATER SACRAMENTO	El Dorado, Sacramento, Sutter, Yolo, Yuba	7	32	81	33
NORTHERN CALIFORNIA	Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Siskiyou	15	37	72	64
NORTHERN SACRAMENTO	Shasta	4	12	22	22
SAN JOAQUIN VALLEY	Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare	11	126	162	125
SOUTHERN CALIFORNIA	Los Angeles, Orange, San Bernardino, Riverside, Ventura	32	134	191	134
SOUTHERN BORDER	San Diego, Imperial	11	87	541	264
TOTAL		121	668	1,644	799

* Groupings based on California Economic Strategy Panel Regions

** Counties not represented in Table 3 because there was no representation of organizations from those counties in the survey include: Bay Area (San Benito, Santa Mateo), Central Sierra (Alpine, Amador, Calaveras, Mariposa, Mono), Greater Sacramento (Placer), Northern California (Del Norte, Plumas, Sierra, Trinity), Northern Sacramento Valley (Butte, Colusa, Glenn, Tehama), San Joaquin Valley (Fresno).

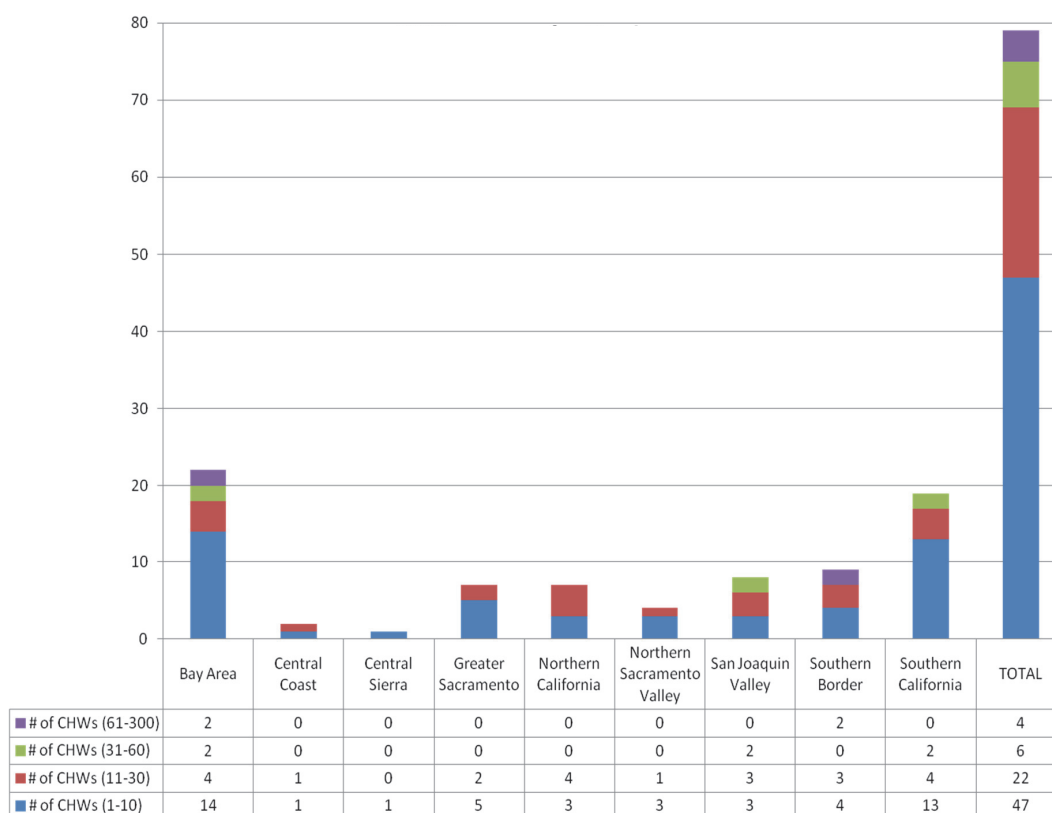
Three-quarters (75.9%) of the organizations engaging CHWs were multi-site organizations (496 sites). Of 1,296 CHWs engaged at multi-site organizations, 693 were on a full-time basis. It is important to note that when reviewing the data analyzed the number of CHWs were disproportionately distributed among surveyed organizations in the Bay Area and Southern Border areas. (See Figure 2) Of the 22 organizations in the Bay Area counties engaging 555 CHWs, two individual and one small-sized respondent reported 375 CHWs. In the Southern Border counties, one large organization reported 300 CHWs.

Figure 2: Distribution of CHWs by Organization Size and Region



Of those respondents that currently engage CHWs, 47 (59.5%) engage between 1-10 CHWs, 22 (27.8%) between 11-30 CHWs, 6 (7.6%) engage between 31-60 CHWs, and 4 (5.1%) engage more than 60. (See Figure 3)

Figure 3: Number of CHWs Engaged by Region



PRELIMINARY OBSERVATIONS AND RECOMMENDATIONS

1. Dissemination and Outreach

Observations

- There is limited understanding within the health care system of the roles that CHWs do and can play in meeting the Triple Aim and other health care goals.

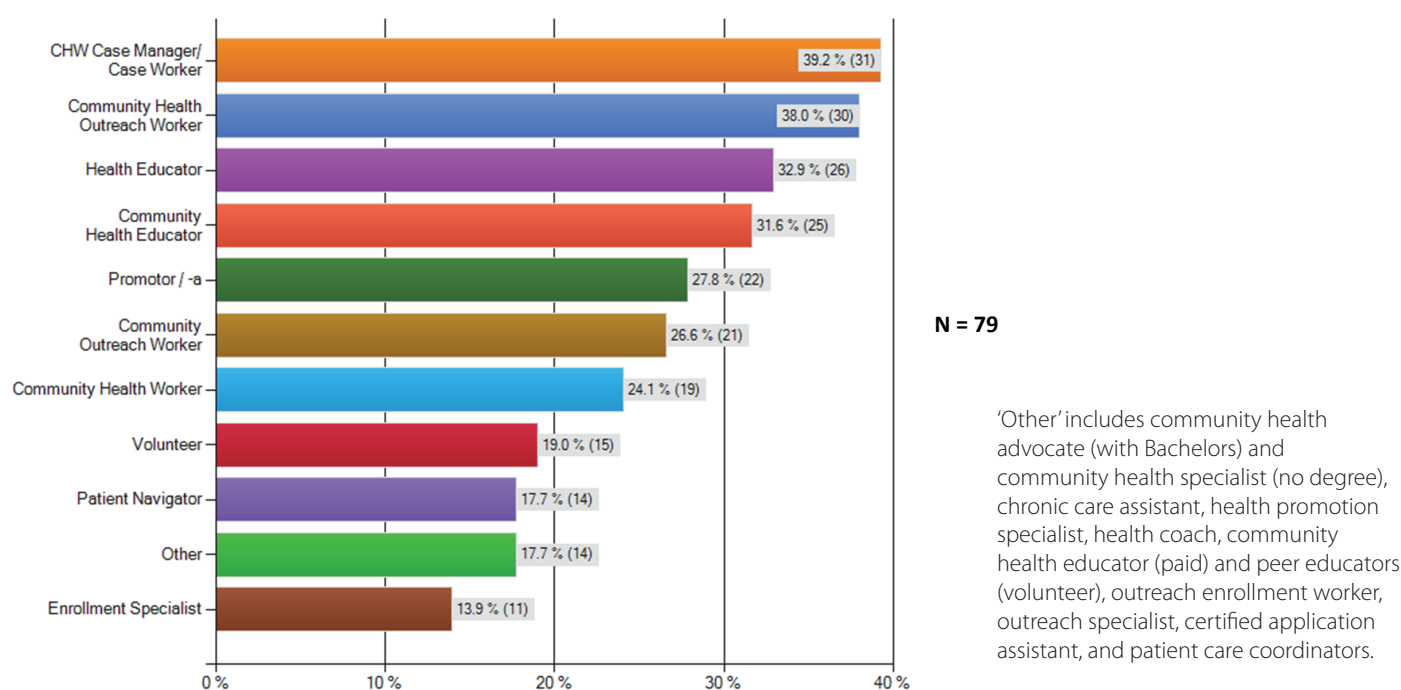
Recommendations

- Widely distribute results of this survey and examples of innovative and evidence-based practices that demonstrate the contributions that CHWs can make to meeting priority health goals.
- Convene California's health workforce stakeholders, including policy makers, clinical administrators, public health practitioners, employers, and members of the CHW workforce to formulate and advance policies that support fuller integration of CHWs into the workforce.
- Collect and consolidate CHW best practice information in a user-friendly and accessible clearinghouse.

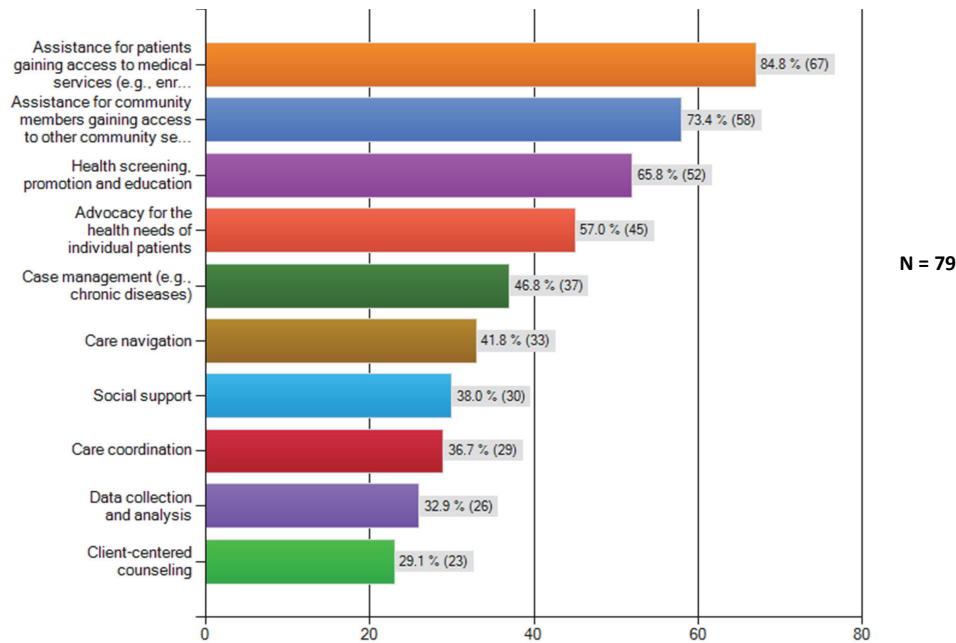
CHW Service Profile

Provider organizations use a broad range of titles to refer to persons engaged in the delivery of community health-related services. (See Figure 4) The professional titles used most frequently to refer to CHWs in California by organizations responding to the survey were “CHW Case Manager/Case Worker,” “Community Health Outreach Worker,” “Health Educator,” and “Community Health Educator.” “Promotor/-a,” “Community Outreach Worker,” and “Community Health Worker” were reported less frequently. The selection of “CHW Case Manager/Case Worker” warrants further examination as a selection bias on the part of respondents may have resulted because it was the first response choice.

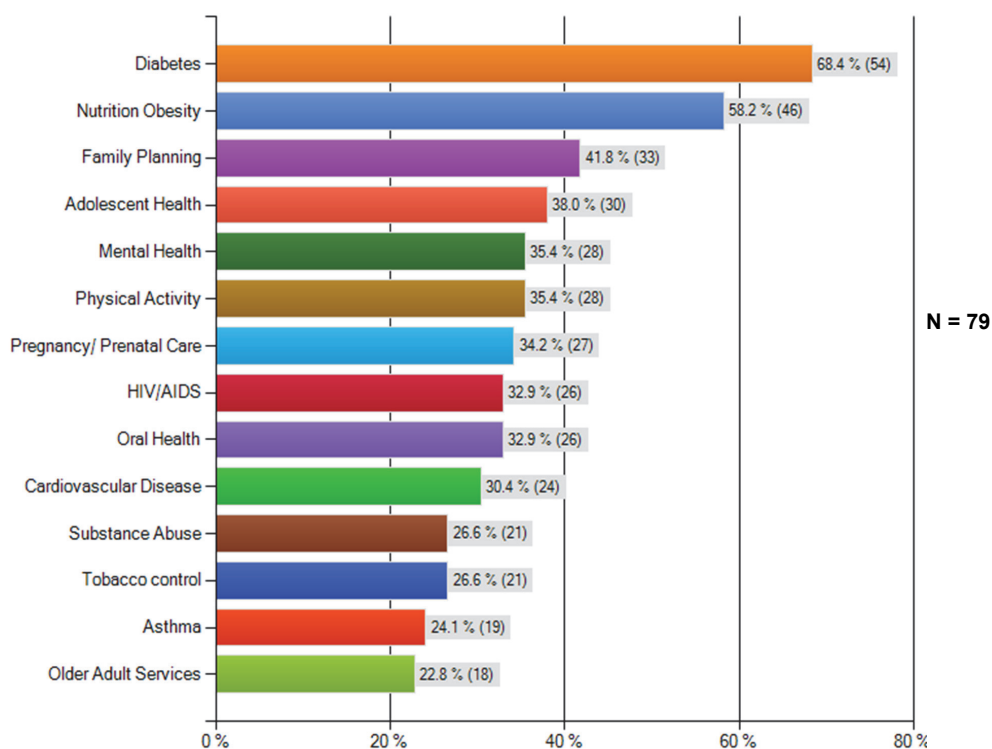
Figure 4: Professional Titles Used to Refer to CHWs



CHWs perform a wide range of operational roles. The two roles noted by more than three-quarters of 79 respondents were “providing assistance for patients with gaining access to medical services” (84.8%) and “providing assistance for community members with gaining access to other community services” (73.4%). (See Figure 5) “Health screening, promotion, and education” (65.8%) and “advocating for individual’s health needs” (57.0%) were reported as activities that CHWs perform by over half of the respondents. Possible variations may exist in the emphasis of operational roles between different types of clinics or the setting where CHWs deliver services that reflect the specific needs or priorities of the clinic organizations and/or the local communities they serve.

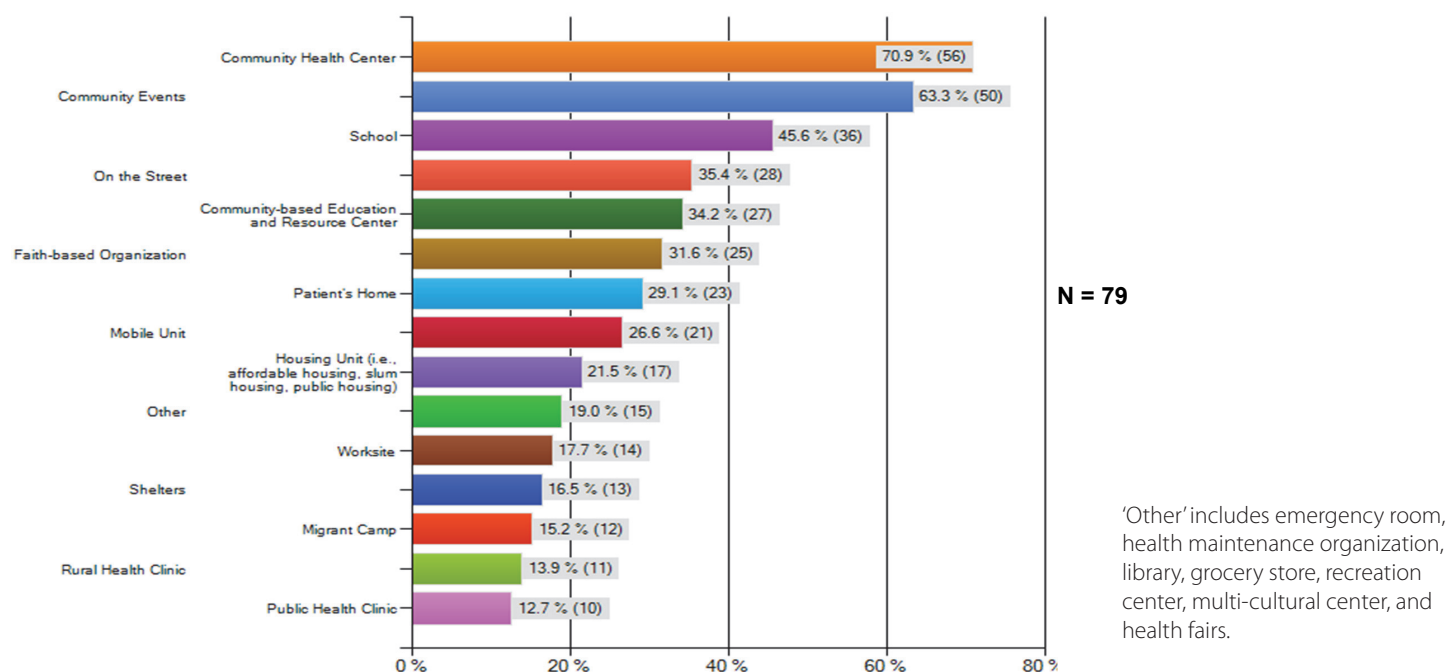
Figure 5: Operational Roles of CHWs

Respondents overwhelmingly identified “diabetes” (68.4%) and “nutrition/ obesity” (58.2%) as the leading program focus areas for CHWs, followed by “family planning” (41.8%), “adolescent health” (38%), “mental health” (35.4%), and “physical activity” (35.4%). (See Figure 6) Respondents reported a lower level of CHW engagement with pregnancy/prenatal care programs (34.2%) and programs dealing with other prevalent chronic conditions, particularly cardiovascular disease (30.4%) and asthma (24.1%).

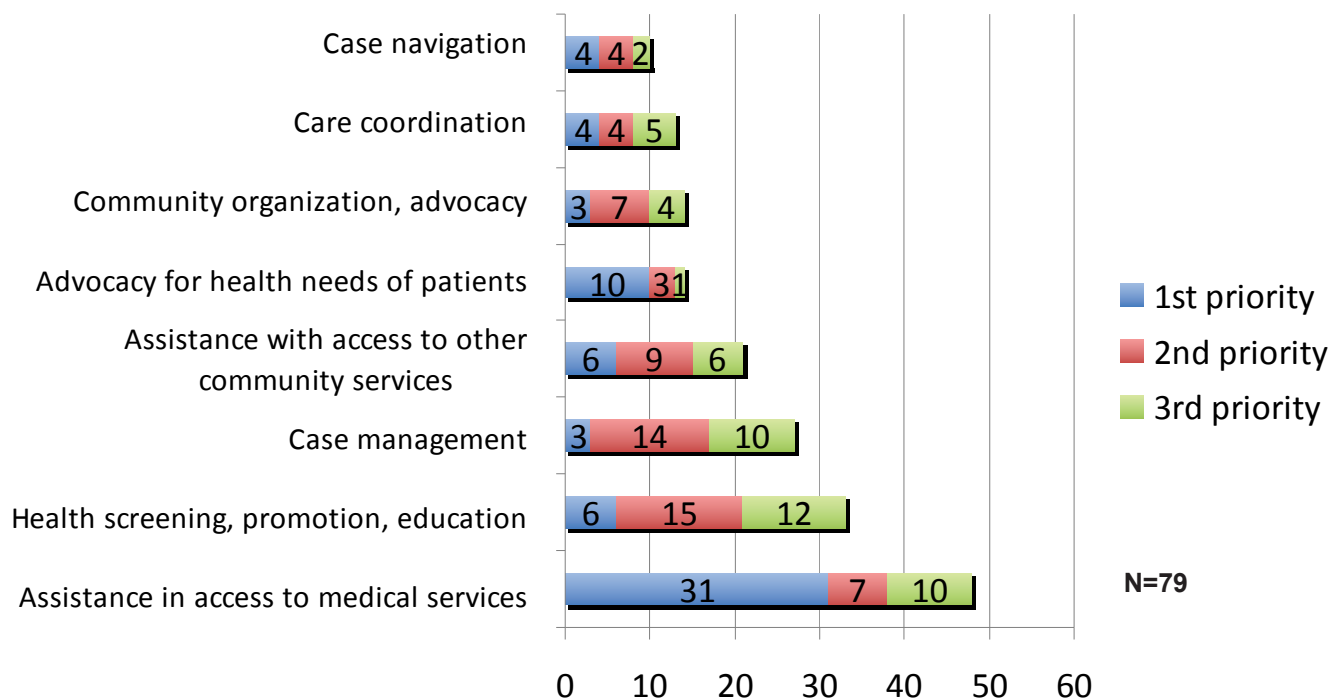
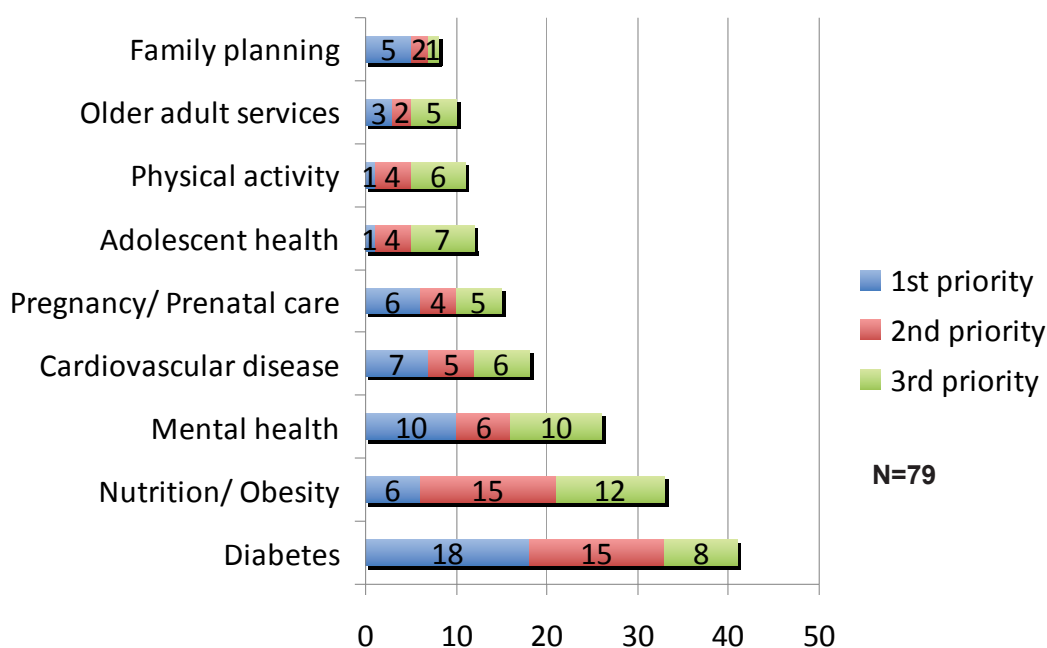
Figure 6: Program Areas of Focus for CHWs

CHWs deliver services in clinics as well as in a broad range of community-based settings. The two sites most commonly associated with the delivery of services are “community health centers” (70.9%) and “community events” (63.3%). (See Figure 7) When responses are grouped by different categories of settings, those that are a public commons, such as a community event, street, or schools, are the leading settings where CHWs deliver services.

Figure 7: Sites for Service Delivery



Organizations recognize the growing importance of the CHW role in implementing health care reforms. The care coordination role for chronic conditions will be increasingly important under reforms, and as financing mechanisms move towards global budgeting. When respondents were asked to prioritize operational roles for CHWs in the next five years, a growing interest in providing case management emerges, especially for chronic conditions. (See Figure 8) When asked to prioritize the program areas that will be the focus for CHWs in the next five years, mental health and cardiovascular disease rose relative to family planning and adolescent health. (See Figure 9)

Figure 8: Priority Ranking of Operational Roles in Next 5 Years**Figure 9: Priority Ranking of Program Areas in Next 5 Years**

PRELIMINARY OBSERVATIONS AND RECOMMENDATIONS

2. Roles and Contributions

Observations

- The broad array of titles used by employers and contractors indicates both the breadth of potential contributions and that roles tend to be defined by categorical funding sources.
- Other defined health career categories (e.g., MAs, RNs) often serve overlapping functions.
- CHWs provide a wide range of services and work in a wide range of clinical areas; these vary to some degree by location of setting and other characteristics of the clinic.

Recommendations

- Establish a competency-based framework for CHW education and training that clarifies the full range of competencies and sources of training.
- Develop a phased strategy for skill development of CHWs working in community-based primary and preventive care.
- Engage and develop CHWs as a link between public health and primary health care.

3. Financing and Reimbursement

Observations

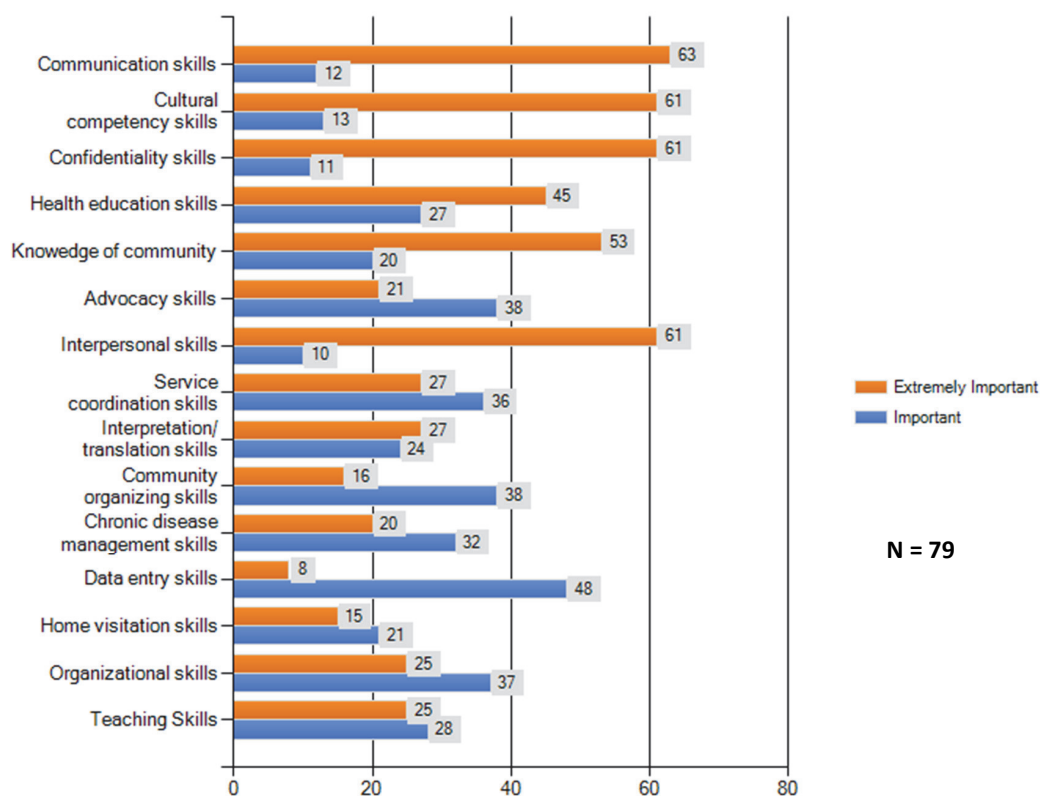
- The current focus on categorical funding streams as a primary source of funding for CHWs in private sector (and in some public sector) agencies is both unsustainable and does not support achievement of the Triple Aim objectives.

Recommendations

- Encourage and support collaborative efforts among payers, care delivery organizations, and providers to find ways to better recognize the value of services provided by CHWs so that their work can be compensated.
- Develop a strategy for incremental development of capitated financing mechanisms (e.g., with initial targeted support) that support the integration of CHWs into multidisciplinary primary care and prevention teams.
- Conduct research to promote the development of a business model framework for the return on investment in using CHWs in clinical settings.

CHW Skill Profile

“Communication” and “cultural competency” skills are extremely important requirements for safety net providers engaging CHWs. (See Figure 10) Organizations engaging CHWs consider communication combined with confidentiality, interpersonal, and cultural competency skills as “extremely important” requirements, particularly as they relate strongly to the ability to engage, create relationships, and build trust with both community and health team members. Skills related to the delivery of direct care services and organizational management processes are regarded as “important”. It is possible that organizations provide post-employment training to address skill gaps that support their ability to provide direct care, particularly as they relate to acquiring competencies that support specific programs and roles.

Figure 10: Skills Required by Organizations Engaging CHWs

PRELIMINARY OBSERVATIONS AND RECOMMENDATIONS

4. Education and Training

Observations

- As providers undergo structure and practice changes to meet an expanded need for primary care with the implementation of health reform, expanded training capacity and preparation of the CHW workforce will be critical to meet needs.

Recommendations

- Develop better alignment between CHW training and education and health care employer needs.
- Fully integrate CHWs into the clinical care team, providing incumbent and new hire CHWs with training as needed on how to work within a care team and providing other team members with training as needed on how to work as a team on patient-centered care collaboration.
- Acknowledge and integrate expected shifts in roles into education curricula, certification exams and criteria, job descriptions, and on-the-job training.
- Expand the CHW workforce supply pipeline by creating new CHW programs and expanding existing ones.

PRELIMINARY OBSERVATIONS AND RECOMMENDATIONS

5. Career Progression

Observations

- Lack of occupational identity, recognition by other health professionals, sustainable funding, and post-hire training programs prohibit CHWs from having clear career path opportunities.

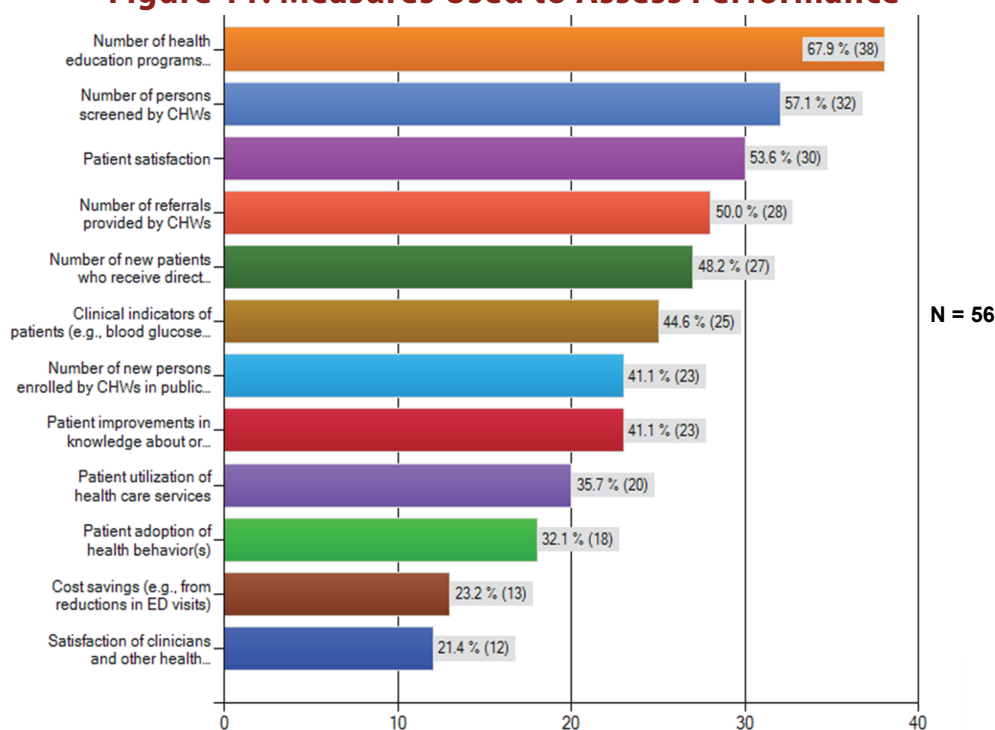
Recommendations

- Formally recognize CHWs as a professional job category and create opportunities for career advancement by establishing a standard professional description of practice and core competencies for training and certification.
- Provide career ladder and promotion opportunities for frontline workers to advance to higher positions within the CHW field, such as CHW supervisor, and into other professional disciplines, such as nursing and allied health professions.
- Explore the overlap in legal, professional, and practical scope of tasks, services, and responsibilities that CHWs share with other health professions, including medical assistants, for potential to evolve the professions.

CHW Performance Measurement Profile

A majority of organizations engaging CHWs collect data on performance and contributions, but most are not documenting their impact on specific Triple Aim objectives. (See Figure 11) Among the 77 respondents to the question of whether they collect data on the performance and contributions of CHWs, nearly three-quarters (71.4%) reported that they do. Performance measures related to assessing improved patient access to care rank highest, while those related to savings in the total cost of care rank lowest.

Figure 11: Measures Used to Assess Performance



Internal data sources are used most frequently for performance measurement. The most frequent sources of data reported by 56 organizational respondents are “administrative records” (58.9%), “client surveys” (48.2%), and “electronic health records” (37.5%). Only 10% of respondents indicated the use of electronic records only for data collection related to performance measurement. Only 15 (26.8%) organizations reported use of external data.

PRELIMINARY OBSERVATIONS AND RECOMMENDATIONS

6. Performance Measurement

Observations

- A lack of technical and analytic capacity and access to external data among community health centers impedes their ability to document return on investment and achievement of broader Triple Aim objectives.

Recommendations

- Provide targeted technical assistance to community health centers to strengthen analytical capacity through leveraging existing health information technology investments.
- Support expansion of existing health information technology capacity through investment in and integration of existing systems with mobile technology solutions.
- Explore research into the relationship between operational roles that CHWs perform and how they may contribute to improved outcomes, and the financial impacts and implications of engaging CHWs as member of staff.

7. Collaboration

Observations

- Few of the community health centers indicated access to proximal hospital utilization data that would enable them to calculate the total cost of care, and hence the contributions of CHWs to reduced preventable utilization.

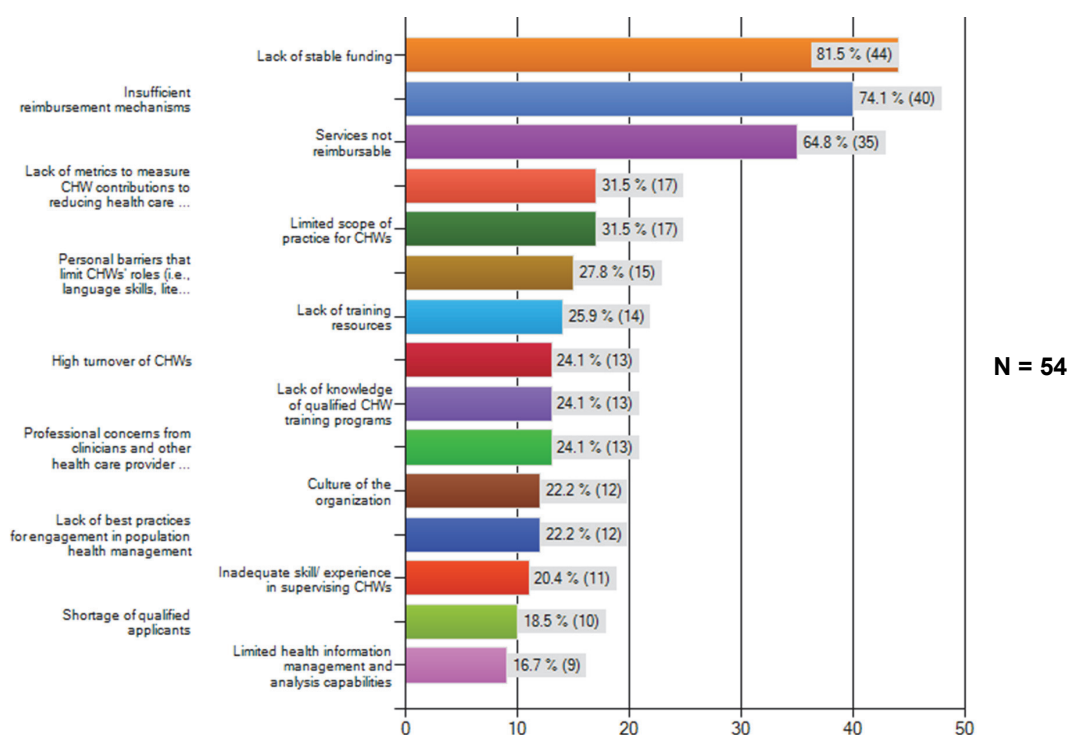
Recommendations

- Establish voluntary frameworks for real-time data sharing between hospital and community health centers on shared patient utilization that will enable continuous monitoring.
- Encourage targeted investment by hospitals in building shared health information technology capacity with community health centers to improve collaboration and coordination of care.

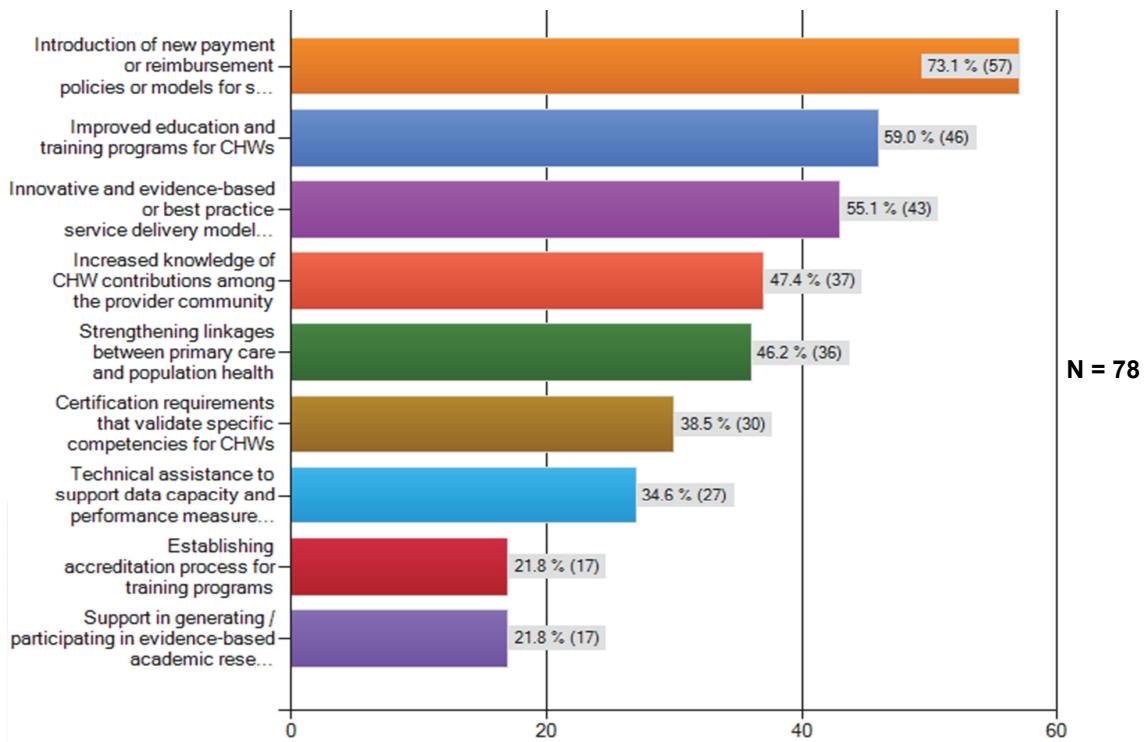
EXPANDING ENGAGEMENT: CHALLENGES AND OPPORTUNITIES

Over two-thirds (68.4%) of providers engaging CHWs cited barriers to expanding their engagement. (See Figure 12) Forty-six of those respondents (85.2%) cited barriers to increasing the number of CHWs engaged, and 36 (72.0%) cited barriers to engaging existing workers in other types of work. Respondents overwhelmingly identified issues related to funding and reimbursement as the leading barriers, followed by workforce capacity, organizational capacity, and workforce regulation barriers.

Figure 12: Specific Barriers Experienced



Priority actions that organizations identified as key to increased engagement include the "introduction of new payment or reimbursement policies," "improved education and training programs," and "innovative and evidence-based best practice service delivery models." (See Figure 13) Organizations engaging CHWs that have not experienced barriers cited improved education and training programs (66.7%) as more significant than the introduction of new reimbursement and payment policies (33.3%). For organizations not currently engaging CHWs, "certification requirements that validate specific competencies for CHWs" (48.7%) are seen as a priority action.

Figure 13: Priority Actions to Increase Engagement

PRELIMINARY OBSERVATIONS AND RECOMMENDATIONS

8. Professional Identity

Observations

- There is a lack of awareness and knowledge among members of the provider community about current innovations, CHW contributions, and delivery models that may address quality and scope of practice concerns.

Recommendations

- Support research on innovative models that pay for CHW services, lower cost, and improve care through continuous, integrated, coordinated and collaborative services.
- Improve evaluation frameworks to better capture the contributions and impacts of CHWs to community wellness and systems change.
- Continue to examine the need for state governmental regulation of CHWs. A state registration mechanism may indirectly support a census of CHW numbers and practice patterns.

PRELIMINARY OBSERVATIONS AND RECOMMENDATIONS

9. Scaling Engagement

Observations

- Lack of a clear and consistent framework for the training of CHWs impedes the development of standards that will address concerns about scope of practice, quality of care, and population health contributions.
- Tendency in the current environment to focus on near-term care needs (e.g., enrollment, chronic diseases) comes at the expense of potential broader contributions to addressing social determinants of health and population health.

Recommendations

- Develop a statewide strategy for competency-based CHW training that engages all assets, including community colleges and regional training programs, and addresses the full spectrum of competencies. Expand the supply pipeline by creating CHW programs and expanding existing ones.
- Develop a statewide strategy to build shared knowledge of the potential contributions of CHWs and align training programs with evolving employer needs. Integrate into educational curricula, certification exams, job descriptions, and on-the-job training.
- Develop a strategy to balance the work experience of CHWs with educational attainment levels.
- Develop a strategy to integrate established CHWs who are undocumented into a streamlined strategy towards legal status and citizenship.
- Fully integrate CHWs into clinical care teams, providing all team members with training as needed on how to work as a team on patient-centered collaboration.

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**Taking Innovation to Scale: Community Health Workers,
Promotores, and the Triple Aim**

*A Statewide Assessment of the Roles and
Contributions Of California's Community Health Workers*

Preliminary Findings, Observations, and Recommendations

August 2013