STATE OF WASHINGTON

February 25, 2016

Dear Community Health Worker Task Force:

Whether you refer to them as community health advisors or community health representatives or promotores(as) de salud, the people who take on this work possess common traits of empathy, sincerity, dedication, and a powerful commitment to uplift their neighbor and their community.

The wider health sector has come to recognize the influential role community health workers (CHWs) play within their communities and their unique ability, demonstrated by research, to engage individuals in their own health care and to support the delivery of efficient and effective health care services.

We are privileged to share with you the enclosed Community Health Worker Task Force Recommendations. These recommendations are the result of five months of intensive work by a broad-based statewide task force convened to agree on definitions, roles, tasks, skills, and attributes. Workgroups also addressed education and training as well as financial considerations for engaging the CHW work force.

This was a large task force, with some 55 members including representatives of Tribes, clinics, hospitals, educators, legislators, workforce organizations, behavioral health, health plans, professional associations and state and local agencies, as well as eighteen individuals working as CHWs. We appreciate and respect the work of each task force member, and their willingness to engage in conversations from a range of perspectives to forge working recommendations. It was our privilege to personally participate in these conversations.

The alignment between this workforce and the goals of the Healthier Washington initiative are clearer thanks to this task force. We look forward to using these recommendations to integrate CHWs into our health system transformation strategies. Look for an update this spring.

You can read more about the health sector transformation occurring under Healthier Washington at www.hca.wa.gov.hw. And we would welcome your comments at healthierwa@hca.wa.gov.

Sincerely,

Dorothy F. Teeter, MHA
Director
Health Care Authority

John Wiesman, DrPH, MPH
Secretary of Health
Department of Health

Enclosure

Community Health Worker Task Force Recommendations
Report for Healthier Washington

To Executive Sponsors:

Dorothy Teeter, Director, Health Care Authority

John Wiesman, Secretary, Department of Health

Community Health Worker Task Force Recommendations

Contents

Executive Summary

The Community Health Worker[1] (CHW) Task Force, was convened with the overarching purpose of developing policy and system change recommendations to align the Community Health Worker workforce with the work of the Healthier Washington initiative. Task force members considered the continuum of CHWs from volunteers, to CHWs employed as generalists who support the overall health and well-being of individuals and communities, to CHWs working in specialized roles as members of care coordination teams.

The Healthier Washington initiative has three main areas of action to achieve the goals of the initiative: 1) building healthier communities through a collaborative regional approach; 2) ensuring health care focuses on the whole person; and 3) improving how services are paid for. Convening the CHW task force acknowledged that based on their life experiences and role as health influencers within their communities, Community Health Workers are necessary to achieve the goals of Healthier Washington within the changing environment of health reform. This assumption is rooted in research that demonstrates CHWs can improve health outcomes and the quality of care while achieving significant cost savings, particularly when working with underserved populations.

The 55 CHW task force members represented various sectors from across the state including legislators, physical and behavioral health care delivery systems, local health jurisdictions, community-based organizations, managed care organizations, tribes, education, professional associations, labor, philanthropy, and state government. To ensure that authentic community voice and leadership was embedded into these recommendations, more than 30 percent of task force members were CHWs themselves. Throughout the process, all task force members agreed and were able to align on all of the recommendations organized in four general categories: 1) overarching guidelines & strategies; 2) definition, roles, skills and qualities (or attributes); 3) training and education; and 4) finance and sustainability considerations.

The CHW task force recommends that Washington adopt the American Public Health Association's **definition**:

> A community health worker 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 worker to serve as a liaison/link/intermediary between health/social services and the community.

To meet the goals and demands of the Triple Aim, the task force believes we must rethink how to carry out efficient and effective care with the community as the center. The task force recommends that Healthier Washington, the Accountable Communities of Health, the Practice Transformation Hub and key health reform partners use four overarching strategies to guide the development of policies related to CHWs detailed in the report.

- Describe the Community Health Worker Model as an innovative strategy for health, social service and educational systems. At the center of this model are the CHWs; whose essence is their 'heart of service' and whose passion is the health and well-being of their communities.
- Include CHWs and key leaders in all decision making forums affecting CHWs' work.
- Build the CHW model into Healthier Washington's strategic and operational plans to recommend best practices of how to integrate and support CHWs for greatest individual and system outcomes.
- Convene a group of leaders to further design and develop flexible and secure funding mechanisms, for a thriving CHW workforce

This is the time to utilize and invest in CHWs as an essential community engagement and population health strategy to support meeting the Triple Aim. The recommendations outlined in the following report provides a platform for government, policymakers and stakeholders, as well as private sector providers, payers, organizations to support a CHW workforce and integration of CHWs within the Healthier Washington initiative areas and supporting health reform efforts.

[1] Community health workers (CHWs) are known by many names, including, promotores(as) de salud, Community Health Representatives (Indian Health Services), and community health advisors. For the purpose of this report we use Community Health Workers as an umbrella term that encompasses this diverse workforce.

* The task force acknowledged that in some cultures the word unusual is not easily translated. The task force acknowledges the following synonyms to clarify what unusual means: unique/exceptional/remarkable/special/etc.

Community Health Worker[2] Task Force Recommendations

December 18, 2015

The Community Health Worker (CHW) Task Force was convened as part of the Healthier Washington initiative with the overarching purpose of developing actionable policy recommendations to align the Community Health Worker workforce with the initiative. The Healthier Washington initiative seeks to transform our health system through multiple approaches, including workforce innovation.

The initiative has three main areas of action to achieve its goals:

1) Building healthier communities through a collaborative regional approach;

2) Ensuring health care focuses on the whole person; and

3) Improving how services are paid for.

Based on their life experiences and roles as health influencers within their communities, Community Health Workers are vital to achieving the goals of Healthier Washington within the rapidly changing environment of health reform. This assumption is rooted in research, which demonstrates that CHWs can improve health outcomes and the quality of care while achieving significant cost savings, particularly when working with underserved populations. See Appendix A for supporting literature.

Task Force Process

The 55 CHW task force members represented various sectors from across the state, including legislators, representatives of physical and behavioral health care delivery systems, local health jurisdictions, community-based organizations, managed care organizations, tribes, education, professional associations, labor, philanthropy, regional support networks and state government. More than 30 percent of task force members were community health workers who span the entire CHW continuum (see Figure 1 below), from volunteers to CHWs working in a highly trained, specialized capacity. The task force met five times, from August 2015 through December 2015; three meetings of the full task force with all members and two workgroup meetings that focused on:

- CHW roles, skills and qualities (or attributes);
- Training and education;
- Finance and sustainability considerations.

For detail on the task force's membership, structure and timeline see Appendix B.

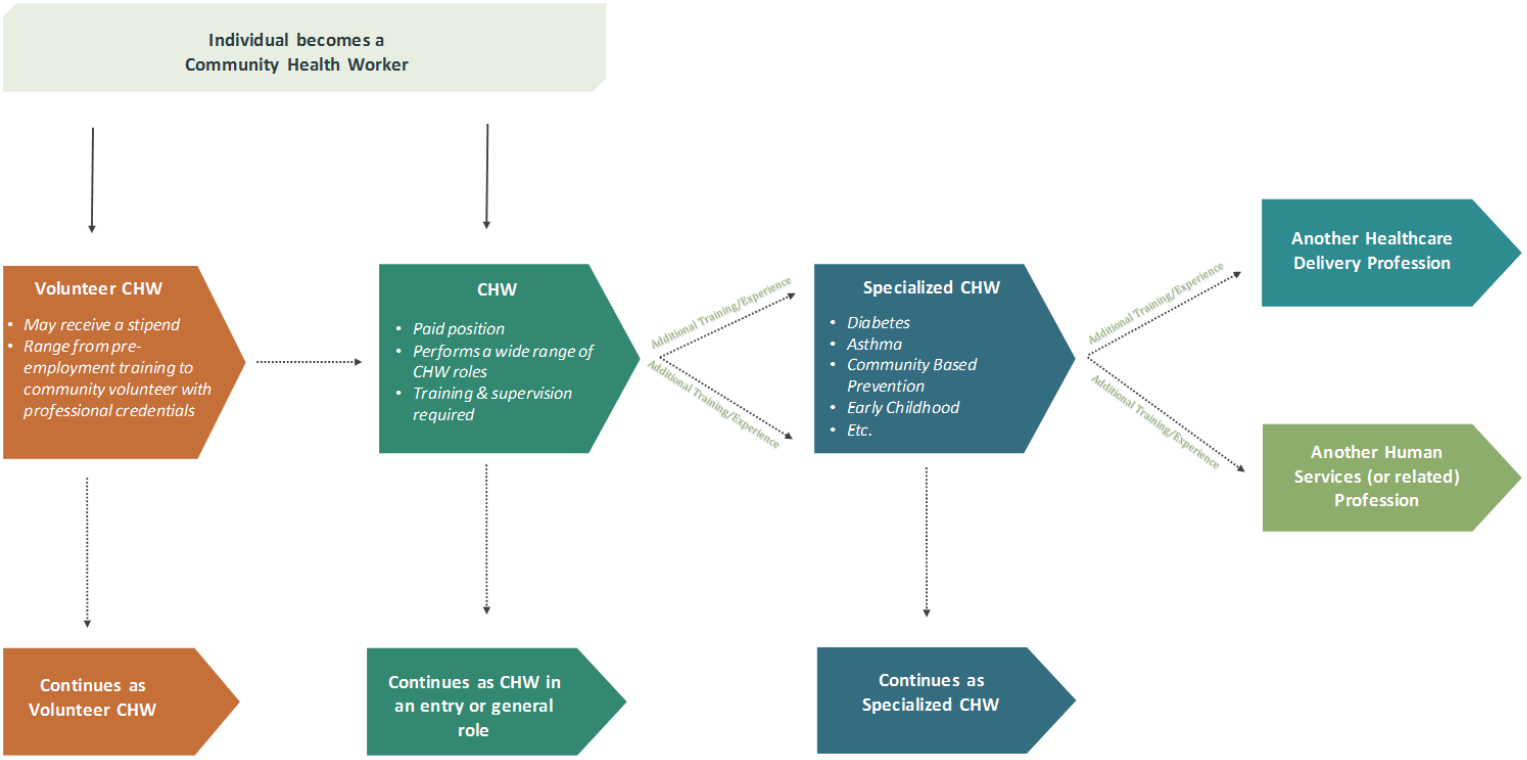
[2] Community health workers (CHWs) are known by many names, including, promotores(as) de salud, Community Health Representatives (Indian Health Services), and community health advisors. For the purpose of this report we use Community Health Workers as an umbrella term that encompasses this diverse workforce.

Recommendations

This report contains recommendations organized in four general categories: 1) overarching guidelines and strategies; 2) definition, roles, skills & qualities (or attributes); 3) training and education; and 4) finance and sustainability considerations. These recommendations came out of much thought, discussion, review and debate. **All task force members agreed and were able to align on all of the recommendations**. Consequently, the recommendations provide a platform for government, policymakers and stakeholders, as well as private sector providers, payers, and other organizations to support a CHW workforce and integration of CHWs within the Healthier Washington initiatives and other health reform efforts. The recommendations do not provide a definitive answer to complex questions such as, "What is the path to sustainable funding for CHW initiative?" Continued conversations are needed.

Task force members were asked to consider the continuum of CHWs from volunteers, to CHWs employed as generalists who support the overall health and well-being of individuals and communities, to CHWs working in specialized roles (for example, working on a care team serving patients with diabetes). Figure 1, shows the CHW Continuum and acknowledges that some CHWs may transition into other health and human service professions.

Figure 1. CHW Continuum



The task force sought to address the tension between the need for employers and decision-makers to have a clear definition and focused role for CHWs with the need to maintain flexibility that does not close options and allows CHWs to respond in culturally and linguistically appropriate ways. This is particularly true because CHWs work in multiple sectors, those that focus in individual patient care, to those concerned with population health, to those focused on community development.

At the first task force meeting August 28, members established overarching guidelines for their work and Healthier Washington's CHW work. Workgroups were asked to pursue the following guidelines when drafting recommendations on the CHWs' roles, skills, qualities, and training/education:

- Encompass the wide-ranging work of CHWs across multiple contexts
- Encompass a variety of perspectives (e.g., CHWs, employers, health plans, etc.)

- Be inclusive of work with the diverse needs of the community, such as children, youth, families, individual adults, seniors, individuals with special needs and communities
- Use plain language
- Focus on health and equity, not just healthcare (e.g. social determinants of health, human services, housing, education, etc.)

The task force also recommends that Healthier Washington, the Accountable Communities of Health the Transformation Hub and key stakeholders use three overarching strategies to guide the development of policies related to CHWs.

- Define the Community Health Worker Model as an innovative strategy for health, social service and educational systems. At the center of this model are the CHWs, whose essence is their 'heart of service' and whose passion is the health and well-being of their communities.
- Include CHWs and key leaders in all decision-making forums affecting CHWs' work.
- Build the CHW model into Healthier Washington's strategic and operational plans to recommend best practices of how to integrate and support CHWs for greatest outcomes.

Definition, Roles, Skills and Qualities. The task force recommends that Healthier Washington, the Accountable Communities of Health and partner agencies adopt the following definition, roles and skills as a guide for the work successful community health workers do.

CHW Definition. The CHW task force recommends that Washington adopt the American Public Health Association's definition of community health workers in relevant work of the Healthier Washington initiative and corresponding documentation:

> A community health worker 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 worker 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.

CHW Roles. The task force acknowledged the three unique capabilities of CHWs:

1) Relationship and trust-building with communities of color, underserved, low income populations,

2) Facilitating valuable communication between providers and patients or community members and decision-makers, and

3) Addressing the social determinants of health at the individual and community level.

The task force recommends the following roles for CHWs, recognizing that no CHWs will perform all of these roles. The purpose is to describe the broad roles community health workers may serve across multiple context and to focus on health and equity, not just health care. Ultimately, the CHWs' employer will identify which roles would be suitable to achieve their needs. The task force assumes all roles will be performed with appropriate training and supervision and CHWs will attain the certifications appropriate to the services they provide. The roles are not listed in priority order.

1. **Cultural mediation among individuals, communities, and health and social service systems.** CHWs educate individuals and communities about navigating health and social service systems and educate systems about community perspectives and cultural norms. They build health literacy and cross-cultural communication.
2. **Providing culturally appropriate health education and information.** CHWs conduct health promotion and disease prevention education in a manner that matches linguistic and cultural needs of participants or a community. They provide necessary information to understand and prevent diseases and to help people manage health conditions.
3. **Conducting outreach.** CHWs find and recruit individuals that would benefit from services. They follow-up on health and social service encounters with individuals, families, and community groups and help problem solve any barriers. They conduct home visits to provide education, assessment, and social support and present information at agency and community events
4. **Care coordination, case management, and system navigation.** CHWs participate in making referrals, care coordination and/or case management, with an emphasis on connecting individuals to their medical home/primary care provider. They connect individuals to community resources and services. As a part of this work they document and track individual and population level data and inform decision-makers and systems about community assets and challenges.

*The task force acknowledged that in some cultures the word unusual is not easily translated. The task force acknowledges the following synonyms to clarify what unusual means: unique/exceptional/ remarkable/special/etc.

5. **Providing coaching and social support.** CHWs provide support and informal coaching to individuals. They motivate and encourage people to obtain insurance coverage, care and other services when applicable, and support self-management of disease prevention and management of health conditions within the parameters set by the organization and supervisor. They also plan and/or lead support groups
6. **Advocating for individuals and communities.** CHWs advocate for individuals as well as for the basic needs and perspectives of communities. A part of this advocacy may be participating in policy advocacy.
7. **Building individual and community capacity.** CHWs build capacity of individuals to manage their health and well-being by teaching skills, expanding the individual's knowledge and supporting their empowerment to participate in individual, family, community and systems improvement. They build community capacity by strengthening a sense of community and social connection, identifying and coordinating the use of individual and community assets/strengths, defining community development pathways, strengthening and diversifying leadership, increasing participation in decision-making and training and building individual capacity with CHW peers and among groups of CHWs to improve individual and community health.
8. **Providing direct service.** CHWs provide basic screening tests (such as height and weight, blood pressure) and, with adequate supervision and training, basic services (such as first aid, diabetic foot checks).
9. **Implementing individual and community assessments.** CHWs participate in design, implementation, and interpretation of individual-level assessments (such as home environmental assessment) and community-level assessments (such as windshield survey of community assets and challenges).
10. **Participating in evaluation and research.** CHWs engage in evaluating CHW services and programs. They identify and engage research partners, and support community consent processes. They participate in evaluation and research by supporting the identification of priority issues and evaluation/research questions, development of evaluation/research design and methods, data collection and interpretation, vetting findings with the community and engaging stakeholders to take action on findings.

CHW Qualities. Research suggests a critical component of effective CHW programs and initiatives is hiring people who have the qualities or attributes that align with their roles and responsibilities. To that end the task force recommends Healthier Washington, the Accountable Communities of Health and partner agencies communicate and disseminate CHW qualities or attributes as foundational for CHWs to succeed including:

- Connected to community
- Culturally sensitive, able to work with diverse communities
- Empathic, caring, compassionate and humble
- Persistent, creative and resourceful
- Open-minded/non-judgmental
- Honest, respectful, patient, realistic
- Friendly, engaging, sociable
- Dependable, responsible, reliable

CHW Skills. The task force sought to describe the breadth of skills CHWs need to successfully perform all of the roles listed above. There is no expectation that individual CHWs have all the skills listed below. Ultimately, the organization where the CHW resides will identify which skills are appropriate and necessary to achieve their goals, with support and supervision. The skills are not listed in priority order.

1. **Communication skills:** the ability to communicate in culturally and linguistically appropriate ways, use of an interpreter when appropriate, translated materials when available, and plain and clear language; communicates in ways that engage individuals and communities, translate professional terminology and jargon into lay language, listens actively and communicates with empathy, documents work in various formats, including written, oral and electronic and identifies and uses equity language.
2. **Interpersonal and relationship building skills:** the ability to provide informal coaching and social support, cultivate relationship trust that supports self-determination, conducts self-management coaching that promotes self-advocacy and activation, uses interviewing techniques, works as a team member and understands the roles and responsibilities of all team members; manages conflict and practices openness to a variety of cultures and respects cultural and individual healing practices.
3. **Service coordination and navigation skills:** the ability to navigate and coordinate care (including identifying and accessing resources and overcoming barriers) for individuals and families in collaboration with multiple systems, appropriately connects clients to resources, without duplicating services, facilitates development of an individual or group action plan and goal attainment, and follows-up and documents care and referral outcomes.
4. **Capacity Building Skills:** the ability to help others identify and develop to their full potential, network, build community connections, and partnerships, increases individual and community empowerment by building coalitions and organizing individuals and communities and mobilizes or organizes a community around a common issue.

5. **Advocacy skills:** the ability to teach self-advocacy skills, speak up for individuals and communities, collect or use information from and with community members, be community led and driven or contribute to policy development at program, organizational, system and legislative levels; advocates for social change, bridges perspectives for policy change and support and champions social and racial equity.
6. **Education and facilitation skills:** the ability to seek out appropriate information and respond to questions about pertinent topics, plan and conduct classes and presentations for a variety of individuals and groups, use a range of appropriate and effective active learning techniques both with individuals and groups, facilitate group decision-making and discussions, and collaborate with other educators and content experts.
7. **Individual and community assessment skills:** the ability to participate in individual assessment through observation and active inquiry in order to inform conclusions or actions, provide appropriate health screening and education, participate in community assessment through observation and active inquiry to inform conclusions or actions, utilize community wisdom and voice to identify community needs and serve vulnerable individuals and provide and use information and data.
8. **Outreach skills:** the ability to build trust, organize events and conduct community outreach, recruitment and follow-up with individuals, and gather or prepare appropriate resources and materials and disseminate effectively.
9. **Professional skills and conduct:** the ability to set goals, to develop and follow a work plan, and know where to go for help, self-organize in order to balance priorities and manage time, identify and respond effectively to emergencies, use pertinent technology applicable to the setting, pursue continuing training and/or education, work safely in community and/or clinical settings, observe ethical and legal standards, follow organizational, research and/or grant policies and procedures, participate in professional development and in networking among CHW groups, set boundaries and practice self-care and work independently, while using organizational and supervisory support as appropriate.
10. **Experience and knowledge base:** including knowledge about pertinent health issues, healthy lifestyles, trauma informed care, and self-care, whole person care (integration of mental/behavioral and physical health care), basic public health principles, the needs of the community served, how health is affected by the conditions in which we live, learn, work and play, local, state, regional and national resources, systems and their cultural context and race, equity and social justice issues. CHWs also need the ability to discern reliable, evidence-based answers and to problem solve and think critically

11. **Direct service skills:** performed with appropriate training and supervision and training certifications as appropriate including the ability to conduct measurements within industry standards, administer assessments and lead self-monitoring assessments, work independently with appropriate supervision, understand and communicate the importance of preventive screenings from multiple perspectives, and understand and follow guidelines, protocols, rules and standards.
12. **Evaluation and research skills:** performed with appropriate training and supervision including the ability to synthesize information from multiple resources, prioritize and summarize information, conduct surveys and lead focus groups or interviews, and keep information confidential as appropriate.

Training and Education. The definition, roles and skills recommendations focus on the 'why' and 'what' of community health workers, while the recommendations on training and education focus on the 'how'. They provide a framework and guidelines for organizations to develop community health worker training and education programs that provide the quality assurance payers and employers require, the flexibility needed to be responsive to the concerns of diverse communities and cultures, and process that minimizes barriers that prevent people who would be excellent CHWs from being trained. The recommendations address four main issues: 1) a framework for CHW training and education that could provide quality assurance, flexibility and new opportunities; 2) what should be taught in a core training; 3) how training and education should be provided; and 4) the need to train organizations and agencies to effectively support CHWs to achieve outcomes.

The task force recommends Healthier Washington, the Accountable Communities of Health and partner agencies adopt the following training and education proposals as a guide for developing CHW training and education initiatives and programs:

Framework considerations

1. Develop Core-CHW training and education programs to prepare CHW generalists to support the health and well-being of individuals and communities including:
   a. Minimize barriers to participation by communities of color, underserved, vulnerable communities (such as cost, length of training, prior education requirements, etc.)
   b. Teach transferable skills that align with CHW roles and responsibilities.
   c. Teach skills that cross multiple roles, rather than all the skills needed to perform all roles.
   d. Design multilingual and competency based programs with materials readily available in multiple languages.
   e. Connect to other educational opportunities that allow CHWs who want to transition into other health and human service professions to get credit for his or her education and experience (e.g., stackable certificates that can be applied to a degree program).
   f. Allocate funds for the implementation of a training and education system that will enhance and increase opportunities for authentic and responsive CHW training
2. Provide additional continuing education opportunities to prepare CHWs with expertise preparing them to be successful in specific roles such as diabetes, mental health, etc.
3. Convene a workgroup to identify additional training that may be needed to successfully perform each of the recommended CHW roles so employees and employers know what additional training is needed to perform specific roles

Content considerations

1. CHW core curriculum should include technology skills, communication skills, self-care/boundaries, building individual and community capacity, cultural competency, equality/social justice, outreach and in-reach, leadership and career development, data collection and community assessment, behavioral health, physical health and oral health and the ways in which they are interrelated, system navigation (medical, social, educational and human service systems) and the heart of service (Servicio de Corazon).

Instructional considerations

1. Promote instructional practices that build on the unique lived experiences of CHWs.
2. Based on prior assessments, involve seasoned CHWs as part of instructional team in a setting that is appropriate to the community. Develop mobile instructional teams in order to serve individuals across the state.
3. Adopt a broad style of teaching that supports popular educational modalities and philosophy.
4. Deliver instruction in a method that meets learning styles and on-the-job contexts such as job shadowing, online modules and mentorship.
5. Provide fellowship and mentorship opportunities post-training.

Organizational considerations

As with any workforce component, CHW success is dependent on agencies and the ability of administrations to support CHWs across systems. Healthier Washington has an opportunity to set a clear path towards community health that has the potential to influence our state's landscape. Therefore the CHW task force recommends Healthier Washington and other key stakeholders:

1. Partner with community, agencies and CHW employers to identify the health, social service and education system changes needed to optimize community health worker outcomes within that system.
2. Provide information and training to clinic and agency board members and management teams on the role and value of CHWs, and the infrastructure needed to effectively support their work (such as how to integrate CHWs into care teams, supervision, supporting work in the community, etc.)

Finance. The goals of the Finance Considerations Workgroup were to better understand community health worker sustainability efforts and barriers across the nation, increase knowledge of current payment reform efforts in Washington, and to develop an initial list of finance strategies and opportunities to support the sustainability of a CHW workforce in Washington. The recommendations and considerations below focus on continued development of new financing strategies that move on from what is often piecemeal, patchwork, or time-limited funding that supports community health worker programs and ways to increase the knowledge and understanding of community health worker roles, skills and value. To meet the goals and demands of the Triple Aim we must rethink how to carry out efficient and effective care with the community as the center. If the CHW workforce is to thrive, it is critical to secure a sustainable funding mechanism.

The task force recommends Healthier Washington convene a workgroup of key leaders from the task force to further develop sustainability levers.

The task force recommends that Healthier Washington consider a range of financing options including, changes to Medicaid managed care contracts, hospital funding patterns, incentivize Accountable Communities of Health and behavioral health organizations, Practice Transformation HUB could prioritize CHWs as a key strategy in creating community linkages, and support the development of local, regional and statewide CHW networks and explore a Wellness Trust (Funding pool raised and set aside specifically to support prevention and wellness interventions to improve health outcomes of targeted populations. CHWs can be an authorized strategy for community engagement, prevention, and mitigation).

Sustainability. All three workgroups made recommendations to support the sustainability of a CHW workforce in Washington. The task force recommends:

1. Healthier Washington identify the health, social service and educational system changes necessary to optimize CHW best practices.
2. The Healthier Washington Practice Transformation Hub disseminate the task force's list of Community Health Worker definition, roles, skills, qualities and principles to multi-sector groups including providers, Accountable Communities of Health, social service organizations, and affiliation groups, educating them on the value a CHW workforce can provide to improve population and patient health outcomes.
3. Healthier Washington create a communication guide for providers including:
    a. CHW Education "kits" explaining role and value of CHWs for non-CHWs in the workforce; including education on how to incorporate and compensate CHWs on their teams.
    b. Disseminate CHW success stories.
    c. Create large forums for all stakeholders to see the positive outcomes of CHWs efforts.
    d. Design materials; clear talking points for non-CHWs to understand CHW role.
4. Healthier Washington explore ways to incubate, test, and evaluate CHW projects as a part of health system transformation.
5. Healthier Washington encourage statewide CHW coalition building in order to develop a system of CHWs that can support health across the multiple domains where CHWs and other peer based professionals work.

Conclusion

The task force stresses that it is imperative to continue to deepen our understanding of emerging opportunities to collectively act on our recommendations within the objectives of Healthier Washington by co-creating the answers to the following questions:

- What settings are most ready to adopt these roles, skills, etc.?
- What are the strategies Healthier Washington and the members of the CHW task force might take to adopt these in practice?
- What kind of education, training and support is needed to strengthen the ability of CHWs to perform the roles and have the skills identified?
- What actions do you think are opportunities right now that would make that action? What systems and agencies are ready for this action? What would get in the way?

This is the time to use and invest in CHWs as an essential community engagement and population health strategy to support meeting the Triple Aim, create healthier communities and construct a more sustainable health care system.

Thank You

To each and every one of the task force members who dedicated their time, energy, thought and collaborative spirit to this project. Thank you especially to the community health worker members of the task force who often had to take a day off from work in order to participate and share the wisdom of their lived experiences in this process.

Thank you also to:

- Kathy Burgoyne of Foundation for Healthy Generations, and Robbi Kay Norman of Uncommon Solutions for facilitation of the CHW task force meetings and for the writing of this report.
- Angeles Solis and Whitney Johnson of Foundation for Healthy Generations, and Megan Oczkewicz of Washington State Health Care Authority for providing staff and task force membership support.
- And thank you to University of Washington graduate students Omid Bagheri, Joy Lee, and Rachel Beck for their thoughtful contributions to and diligent support of task force meetings; and Nicole Williams also for her support in preparation, note-taking, and summarization at each of the task force meetings.

Appendices

Appendix A. Supporting Literature

American Public Health Association. Community Health Workers [Internet]. Washington, DC: American Public Health Association; 2013 [cited 2013 Apr 29]. Available from: http://www.apha.org/membergroups/sections/aphasections/chw

Anthony S, Gowler R, Hirsch G, Wilkinson G. Community health workers in Massachusetts: improving health care and public health. Boston (MA): Massachusetts Department of Public Health; 2009 Dec [cited 2013 Apr 29]. Available from: http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/legislature-report.pdf

Culica D, Walton JW, Harker K, Prezio EA. Effectiveness of a community health worker as a sole diabetes educator: comparison of CoDE with similar culturally appropriate interventions. J Health Care Poor Underserved. 2008 Nov;19(4):1076-95.

Brownstein JN, Chowdhury FM, Norris SL, Horsley T, Jack L Jr, Zhang X, et al. Effectiveness of community health workers in the care of people with hypertension. Am J Prev Med. 2007;32(5):435-47.

Brownstein JN, Hirsch GR, Rosenthal EL, Rush CH. Community health workers "101" for primary care providers and other stakeholders in health care systems. J Ambul Care Manage. 2011;34(3):210-20.

Commonwealth of Massachusetts, Health and Human Services. About the Board [Internet]. Boston (MA):

Commonwealth of Massachusetts; 2013 [cited 2013 Apr 29]. Available from: http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/dhpl/community-health-workers/about/about-the-board.html

Community Health Workers: A Review of Program Evolution, Evidence on Effectiveness and Value, and Status of Workforce Development in New England. Institute for Clinical and Economic Review, 2013.

Fedder DO, Chang RJ, Curry S, Nichols G. The effectiveness of a community health worker outreach program on healthcare utilization of west Baltimore City Medicaid patients with diabetes, with or without hypertension. Ethn Dis. 2003;13(1):22-7.

Felix HC, Mays GP, Stewart MK, Cottoms N, Olson M. Medicaid savings resulted when community health workers matched those with needs to home and community care. Health Aff (Millwood). 2011;30(7):1366-74.

Goodwin K, Tobler L. Community Health Workers: Expanding the Scope of the Health Care Delivery System. Denver (CO): National Conference of State Legislatures; 2008 Apr [cited 2013 Apr 29]. Available from: http://www.ncsl.org/print/health/chwbrief.pdf

Gottschalk A, Flocke SA. Time Spent in Face-to-Face Patient Care and Work Outside the Examination Room. Ann Fam Med. 2005;3(6):488-93.

Krieger JW, Takaro TK, Song L, Weaver M. The Seattle-King County Health Homes Project: A randomized, Controlled Trial of a Community Health Worker Intervention to Decrease Exposure to Indoor Asthma Triggers. Am J Public Health. 2005;95(4):652-59.

Jackson EJ, Parks CP. Recruitment and training issues from selected lay health advisor programs among African Americans: A 20-year perspective. Health Educ Behav. 1997 Aug;24(4):418-31.

Johnson D, Saavedra P, Sun E, Stageman A, Grovet D, Alfero C, et al. Community Health Workers and Medicaid Managed Care in New Mexico. J Community Health. 2011;37(3):563-71.

Matos S, Findley S, Hicks A, Legendre Y, Canto LD. Paving a Path to Advance the Community Health Worker Workforce in New York State: A New Summary Report and Recommendations [Internet]. New York: Community

Health Worker Network of NYC, New York State Health Foundation, Columbia University Mailman School of Public Health; 2011 [cited 2013 Apr 29]. Available from: http://nyshealthfoundation.org/uploads/resources/paving-path-advance-community-health-worker-october-2011.pdf

Martinez J, Ro M, Villa NW, Powell W, Knickman JR. Transforming the delivery of care in the post-health reform era: what role will community health workers play? Am J Public Health. 2011 Dec;101(12):e1-5.

Miller A. Georgia firm's blueprint for taming health costs. Georgia Health News. 2011.

Mock J, McPhee SJ, Nguyen T, Wong C, Doan H, Lai KQ, et al. Effective lay health worker outreach and media-based education for promoting cervical cancer screening among Vietnamese American women. Am J Public Health. 2007 Sep;97(9):1693-700.

www.OregonLaws.org, 2011

Patient Protection and Affordable Care Act of 2010. PL 111-148, sec. 5313.

Perez M, Findley SE, Mejia M, Martinez J. The impact of community health worker training and programs in New York City. J Health Care Poor Underserved. 2006 Feb;17(1 Suppl):26-43.

Rosenthal EL, Brownstein JN, Rush CH, Hirsch GR, Willaert AM, Scott JR, et al. Community health workers: part of the solution. Health Aff (Millwood). 2010 Jul;29(7):1338-42.

Texas Department of State Health Services. Community Health Workers – Rules and Legislation [Internet]. Austin (TX): Texas Department of State Health Services; 2013 [cited 2013 Apr 29]. Available from: http://www.dshs.state.tx.us/mch/chw/progrule.aspx

Texas Department of State Health Services. Community Health Workers – Promotor(a) or Community Health Worker Training and Certification Program [Internet]. Austin (TX): Texas Department of State Health Services; 2013 [cited 2013 Apr 29]. Available from: http://www.dshs.state.tx.us/mch/chw.shtm

Texas Department of State Health Services 2012 Annual Report: Promotor(a) or Community Health Worker Training and Certification Advisory Committee. Downloaded August 1, 2013 from http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589975479

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. Community Health Worker National Workforce Study. Rockville (MD): HRSA; 2007 March. Available from: http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf

U.S. Department of Labor, Bureau of Labor Statistics. 21-1094 Community Health Workers [Internet]. Washington, DC: U.S. Bureau of Labor Statistics; 2013 [cited 2013 Apr 29]. Available from: http://www.bls.gov/soc/2010/soc211094.htm

Whitley EM, Everhart RM, Wright RA. Measuring return on investment of outreach by community health workers. J Health Care Poor Underserved. 2006;17(1 Suppl):6-15.

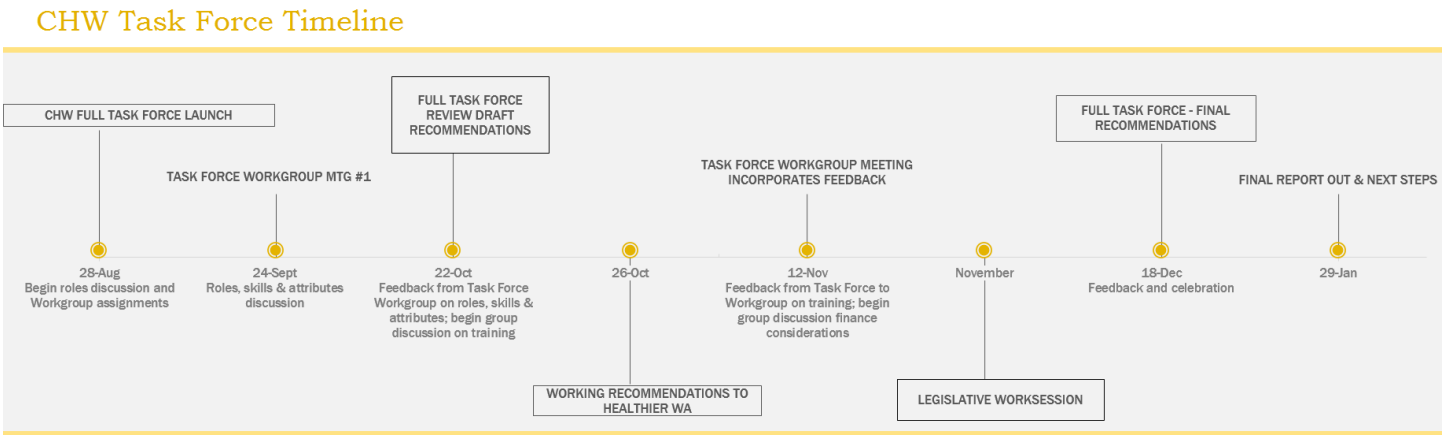
Washington State Office of the Insurance Commissioner. State of the uninsured, Health coverage in Washington state: Costs, trends and projections, 2008 to 2014. 2011 Dec 13 [cited 2013 Apr 29]. Available from: http://www.insurance.wa.gov/about-oic/commissioner-reports/documents/2011-uninsured-report.pdf

Appendix B. task force membership, structure and timeline

Task force membership, structure and timeline. The task force met five times; three full task force meetings with all membership and two meetings for specific workgroups focusing on the following issues: 1) CHW Roles, Skills and Qualities (or Attributes); 2) Training and Education; 3) Finance Considerations, see timeline figure below.

The meetings alternated between full task force membership and workgroup meetings, with each meeting building on the discussion and resolutions from the meeting before with the goal of providing opportunities for full membership review and discussion at recommendation decision points. The workgroup membership was organized to include a constant proportion of majority Community Health Workers, along with a diverse group of representatives from CHW supporting and employing agencies and institutions, and other health sector workforces. The goal of the workgroup structure was to provide time for more in-depth discussion, feedback and group thinking around the three previously identified issue groups that would inform the larger task force meeting's discussion and decision making.

Statewide community health worker task force timeline



Task force meeting structure. The meetings alternated between full task force meetings and smaller workgroups. The first full task force meeting was held on August 28, 2015, in Kent, Washington. The first workgroup, Roles and Skills, was held on September 24, 2015, also in Kent. For the third meeting (2nd full task force meeting) on October 22, 2015, many task members traveled west to Heritage University, in Toppenish, Washington. The remaining two workgroup meetings, Training and Education, and Finance, were held at the Tukwila Community Center on November 12, 2015. The full task force convened again in Kent for the final meeting on December 18, 2015. In between each meeting a great deal of time was spent reviewing, editing and drafting recommendations by workgroup members and support staff. The report condenses these iterations for this report.

Workgroup participants. Fifty-five task force members from across the state and from various sectors applied or were nominated for task force participation. Members were selected based on criteria reflecting participant knowledge and experience as a CHW or supporting CHW programs, and experience within a system crucial for CHW workforce development. The diverse, statewide membership includes legislators and representatives from communities and throughout the health sector, as well as come from business, education, physical and behavioral health care delivery systems, community-based programs, health plans, and regional support networks. More than 30 percent of the task force membership was CHWs from a variety of sectors and fulfilling a variety of roles within their agencies and organizations, including managed care organizations (MCOs), local public health jurisdictions and community organizations. A complete task force membership list is below.

Community Health Worker Task Force Members

Name	Organization
Dorothy Teeter	Health Care Authority
John Wiesman	Department of Health
Adam Taylor	Global to Local
Adena Grigsby	Healthy Living Collaborative
Amina Suchoski	United Healthcare
Anna M. Saenz	Tranquil Touch Inner Peace
Barbara Obena	Community Health Plan of Washington
Ben Danielson	Seattle Children's Hospital
Bill Rumpf	Mercy Housing
Brad Kramer	Washington State Association of Local Public Health Officials
Carlos Carreon	Cowlitz County Health and Human Services Department/ACH
Cheryl Sanders	Lummi Indian Business Council
Senator David Frockt	Washington State Senate
Dan Ferguson	Allied Health Center for Excellence
Denise Walker	The Chehalis Tribe Wellness Center
Donna Oliver	Spokane Regional Health District
Edie Higby	Community Minded Enterprises
Heidi Winston	Optum Health
Jaqueline Barton-True	Washington State Hospital Association
Jason Fitzgerald	Recovery Café
Jennifer McCausland	Washington State Nurses Association
Joleen Rodgers	The Everett Clinic
Kara Panek	Department of Social and Health Services
Kate Naeseth	Optum Health
Kathie Olson	Molina Healthcare
Kathleen Clark	Department of Health
Kathy Burgoyne	Foundation for Healthy Generations
Lani Spencer	Amerigroup
Laura Flores Cantrell	Delta Dental
Liga Mezaraups	Swedish Medical Group / Swedish Health Services
Lt. Jesus Renya	Office of Minority Health – U.S. Health and Human Services
Lupe T. Anitema	Salishan Community Health Advocate
Marcela Suarez Diaz	SeaMar Community Health Center
Mary Jo Ybarra-Vega	Quincy Community Health Center
Mary Looker	Washington Association of Community and Migrant Health Centers
Mercedes Cordova Hakim	King County Promotores Network
Michelle DiMiscio	Public Health - Seattle & King County
Molly T. Morris	Coulee Medical Center
Njambi Casten	Pierce County CHW Collaborative
Norma Owens	Coordinated Care
Orlando Gonzalez	Family Health Center
Pricilla Barnett	Passages Family Support
Rebecca Burch	Health Care Authority
Representative Joe Schmick	Washington State House of Representatives
Representative June Robinson	Washington State House of Representatives

Rhonda Medows	Providence Health Center
Seth Doyle	Northwest Regional Primary Care Association
Sharon Linn	Vancouver Housing Authority
Sophia A. Beltran	Cocoon House
Thao Tran	SEIU Training Partnership and Health Benefits Trust
Tracy Woodman	SEIU Healthcare 1199 NW Multi-Employer Training and Education Fund
Tranisha Arzah	BABES-Network, YMCA
Trina Griffin	Open Door for Multicultural Families
Veronica Sosa	Quincy Community Health Center
Vy Le	Mercy Housing

Appendix C. Meeting Materials and Supporting Documents

August 28, 2015

- Agenda
- C3 Overview

September 24, 2015

- Agenda
- CHW Bibliography
- CHW Quick Reference
- Healthier WA 1-pager
- Revised C3 Roles based on Feedback from Meeting #1

October 22, 2015

- Agenda
- Recommendations

November 12, 2015

- Agenda
- Overarching Themes from the October 22nd CHW task force meeting
- Task Force Parameters
- Department of Health's evaluation of their CHW training program
- Overview of the Indian Health Services Community Health representative program
- Financing Community Health Workers: Why and How
- National Academy for State Health Policy – State Financing of Community Health Workers (CHWs)

December 18, 2015

- Agenda
- Training and Education Recommendations
- Finance Recommendations
- Community Health Worker Definition
- Skills Recommendations
- Roles Recommendations
- Recommendations for the CHW Task Force

Appendix D. Community Health Workers letter to executive sponsors, John Wiesman and Dorothy Teeter

Esteemed State Secretary of Health John Wiesman and Director of the Health Care Authority, Dorothy Teeter,

We thank you for your leadership in convening a groundbreaking process.

As you hold this letter in your hand, wherever you are, we ask that you take a minute to honor the indigenous, upon whose land you stand. All too often, we forget to do so. In the spirit of a Community Health Worker, we intend to carry the charge of bringing often forgotten communities to the forefront.

This was our golden opportunity to show you who we are, what we do, how we do it and the passion we bring to our work as Community Health Workers. Healthier Washington is a transformative initiative, and its success is contingent upon aligning with those who live within the system's gaps. The Community Health Worker (CHW) Statewide Task Force is setting a positive and collaborative tone by ensuring community voice.

Unfortunately, much too often, processes like these are used by systems and organizations to "check a box". **As a body, we commit to making ourselves available for continued change with Healthier Washington.** This merits a face-to-face meaningful dialogue about next steps, with not just a few, but a diverse community of CHWs. This dialogue would serve to create authentic inclusion and alignment between State entities and the state's Community Health Workers. We are invested. We are interested in strategizing with you to ensure CHW voice remains an integral partner in upcoming processes across Washington State. **At the end of this letter, you will have the points of contact with whom to communicate for continued CHW alignment in the early months of 2016.**

It is indicative of the State's progress in leadership that 40% of this Task Force was composed of CHWs. When CHWs are represented, our communities are with us. We are the eyes and ears on the ground that understand the roots of disparities, provide cultural knowledge, and have a uniquely earned trust. No amount of training can replace shared lived experience.

In 2014, the American Public Health Association passed a policy statement that "urges state governments and other entities considering creating policies regarding CHW training standards and credentialing to engage in collaborative CHW-led efforts with local CHWs and/or CHW professional groups. If CHWs and other entities partner in pursuing policy development on these topics, a working group composed of at least 50% self-identified CHWs should be established (*Support for Community Health Worker Leadership in Determining Workforce Standards for Training and Credentialing*. APHA Policy Number 201414; November 18, 2014)." Thus, as the Task Force's recommendations are considered and acted upon, we urge DOH and HCA to continue to engage and

include CHWs in the decision-making process. Doing so will position the state to meet the goals of Healthier Washington.

In consideration of Healthier Washington's goals, CHWs can help the state determine how to pay for services, ensure healthcare focuses on the whole person, and mobilize communities to improve health for all populations by focusing on social determinants and health equity. **The Accountable Communities of Health and governing bodies will not meet their goals without Community Health Workers operating at the core of their model.** CHWS live at the frontlines of inequities, and therefore are critical agents for finding solutions to improve population health outcomes. We bridge gaps in prevention and integration which contribute to unnecessary health and social service costs. Ultimately, a strong CHW workforce in Washington State will strengthen our communities and care delivery systems.

Present in our state are existing and growing networks of CHWs representing a rich array of roles, communities, and cultural backgrounds. As Community Health Workers, we are accountable to our communities. As such, we ask that in the interest of transparency and alignment, CHW voices are embraced as vital in all efforts of Healthier Washington.

As CHWs, we dream of better integration of our roles within the health care system. There are many doubts about how this integration can take place; integration without compromising the unique values, and that which CHWs bring, the *heart of service*. Without better integration and acknowledgement, we run the risk that CHWs are seen as marginal, second class workers, in turn giving a lesser quality of attention to underserved communities. It is a true honor to arrive at this reflection in gratitude, because this is surely the beginning of changes that will make history in the public health of our state. It is to grant those who have creatively worked for decades with their own resources to bring an opportune voice of encouragement and mutual support to those who truly need it, a place in the continuum of care.

Finally, we are optimistic about the future of the CHW workforce, and see it as the catalyst for the improved health of our state. We collectively look forward to continued partnership and communication in every step of the way.

In the spirit of gratitude and partnership,

Signed, the CHWs,

Sophia Beltran – Snohomish County
sophia.beltran@cocoonhouse.org

Vaelupemaua Anitema Talamoni – Pierce County
vanitema@gmail.com

Tranisha Arzah – King County
tranisha@babesnetwork.org

Sharon Linn – Clark County
slinn@vhausa.com

Adena Grigsby – Clark County
adenagrigsby@gmail.com

Edie Higby – Spokane County
ediehigby@gmail.com

Michelle Di Miscio - King County
mdimiscio@yahoo.com
206.451.0537.

Marcela Suarez - Skagit/ Whatcom County
marcelasuarez@seamarchc.org
360. 926. 5708.

Orlando Gonzalez - Okanogan County
ogonzalez@myfamilyhealth.org

Vy Le – Pierce County
vle@mercyhousing.org

Njambi Casten – Pierce County
ncasten@coordinatedcarehealth.com

Molly Morris – Grant County
mmorris@cmccares.org

Trina Griffin – King County
trinaodmf@gmail.com

Anna Saenz – Yakima County
tranquiltouchinnerpeace@hotmail.com

Veronica Sosa – Grant County
vsosa@mlchc.org

Angeles Solis – Healthy Gen Staff Support
angeless@healthygen.org
509.793.6460