2017

Connecticut State Innovation Model

Report of the Community Health Worker Advisory Committee

Advancing the CHW workforce one step at a time.

Approved by the Healthcare Innovation Steering Committee on February 8, 2018

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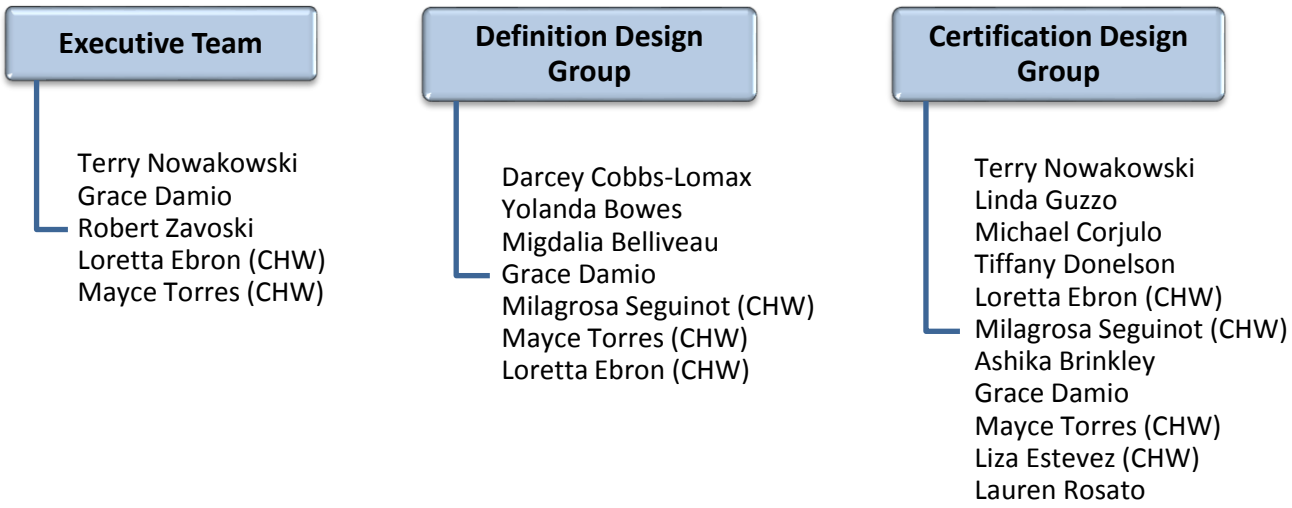

Table of Contents

Executive Summary

Community Health Workers (CHWs) have long been instrumental in addressing health needs globally. In the US, CHWs have also been recognized as critical to addressing the social determinants of health and as the key to population health. CHWs represent a broad group of healthcare workers and take on a variety of roles and names. As a diverse and relatively new workforce in Connecticut, CHWs lack a cohesive framework, definition, scope of practice, and sustainable financing mechanism. Recently, there have been attempts to standardize the CHW scope of practice and training requirements and to establish credentialing and certification programs, with the goal of enabling sustainable financing mechanisms for this vital workforce. Studies have demonstrated the importance of recognizing CHWs as a professional workforce and integrating them fully into the healthcare system.

As part of the State Innovation Model (SIM), the University of Connecticut (UConn) Health Center and Southwestern AHEC partnered with the State of Connecticut to develop a policy framework that includes a CHW definition, scope of practice, skill requirements, certification process, and options for sustainable financing. This report details the process that was undertaken to establish these recommendations.

Key Recommendations

Recommendation #1 – DEFINITION: The CHW Advisory Committee recommends adoption of the following definition for CHWs in Connecticut.

> A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of, and/or has a unique understanding of the experience, language, culture, and socioeconomic needs of the community served. A CHW serves as a liaison/intermediary between individuals, communities and health and social services to facilitate access to care, improve the quality and cultural responsiveness of service delivery, and address social determinants of health.
>
> CHWs build individual and community capacity by increasing health knowledge and self-sufficiency through a range of culturally appropriate services such as: outreach and engagement; education, coaching, and informal counseling; social support; advocacy; care coordination; basic screenings and assessments; and research and evaluation.

Recommendation #2 – SCOPE OF PRACTICE: The CHW Advisory Committee recommends adoption of the following ten roles and eleven skills to define the scope of practice for CHWs in Connecticut.

Roles

1. Cultural Mediation among Individuals, Communities, and Health and Social Service Systems
2. Providing Culturally Appropriate Health Education and Information
3. Care Coordination, Case Management, and System Navigation
4. Providing Coaching and Social Support
5. Advocating for Individuals and Communities
6. Building Individual and Community Capacity
7. Providing Direct Service
8. Implementing Individual and Community Assessments
9. Conducting Outreach
10. Participating in Evaluation and Research

Skills

1. Communication Skills
2. Interpersonal and Relationship-Building Skills
3. Service Coordination and Navigation Skills
4. Capacity Building Skills
5. Advocacy Skills
6. Education and Facilitation Skills
7. Individual and Community Assessment Skills
8. Outreach Skills
9. Professional Skills and Conduct
10. Evaluation and Research Skills
11. Knowledge Base

Recommendation #3 – CREDENTIALING/CERTIFICATION: The CHW Advisory Committee recommends that DPH establish a voluntary CHW certification program. Under this program CHWs will receive an individual two-year certification issued by DPH and be placed on a CHW registry if they complete (1) a designated "DPH approved" training program and (2) pass a standardized competency-based assessment.

A summary of the key elements of the recommendation are as follows – DPH shall:

- Designate CHW training programs as "DPH approved" based on a standardized curriculum review.
- Use the definition and scope of practice developed by the CHW Advisory Committee as the basis for developing curriculum standards; build on other training programs currently in use including the federally-funded comprehensive CHW training program used by Community Colleges.
- Establish a CHW Advisory Committee to advise DPH on development of the training program and competency assessment standards and corresponding certification procedures, with at least 50% of the seats reserved for CHWs.
- Establish a standardized competency assessment process that assesses both skills and knowledge that is reasonably accessible to individuals with language barriers and appropriately assesses cultural competency.
- Allow for grandparenting during the first two years certification is offered.
- Administer a continuing education and experience verification process.
- Establish a Certified CHW registry.

Recommendation #4 – SUSTAINABLE FINANCING: The CHW Advisory Committee recommends the following related to Primary Care Payment Models in Connecticut.

- Primary care payment reform models can provide an opportunity to sustainably finance CHWs as members of the care team.
- Primary care payment reform should include a requirement that providers incorporate Community Health Workers into their care teams.
- During the course of the Advisory Committee's work, the Centers for Medicare and Medicaid Innovation (CMMI) released a solicitation for the Comprehensive Primary Care + (CPC+) initiative, in which public and private payers were invited to participate with Medicare in a value-based primary care payment reform arrangement. Recognizing the merits of the CPC+ model and the significance of this opportunity to engage Medicare in primary care payment reform arrangement, the Committee recommended that Connecticut's payers apply. This recommendation was ultimately narrowed to include commercial payers only in light of the administration's position on Medicaid participation, which can be found in

Appendix B.

The Connecticut SIM team led this process, in collaboration with Southwestern AHEC and UConn Health Center. The process was further supported by Katharine London (Principal, Center for Health Law and Economics at the University of Massachusetts Medical School) and the Connecticut Health Foundation.

Introduction

State Innovation Model (SIM) CHW Initiative

The SIM CHW Initiative launched in 2015 when the State of Connecticut received the CMMI State Innovation Model Test grant award, a 4-year, $45 million grant. The SIM is committed to statewide healthcare reform that achieves the triple aim: Better Care, Smarter Spending, and Healthier People and Communities. Across these three categories, the SIM is also dedicated to addressing health equity and empowering consumers.

SIM's Role in Promoting CHWs
An important component of the overall SIM strategy is the promotion of CHWs along the continuum of care and the full integration of CHWs into inter-professional primary care teams. The SIM identifies team-based care as foundational to establishing a patient-centered medical home, where an individual's healthcare is coordinated in a holistic way to address his or her needs. CHWs serve as an integral part of and an extension of the healthcare team into an individual's community or home. CHWs can address cultural, linguistic, health-literacy-level, and social-determinant-based barriers that deter individuals from receiving needed healthcare services. CHWs provide health education and coaching, identify resources, assist with adherence to treatment plans, and ensure that individuals access health and social services. They also provide informal counseling and social support, advocate for individuals and communities, provide direct services (such as basic first aid), administer health screening tests, and build individual and community capacity.

The SIM recognizes the critical role CHWs play in advancing individual and population health. The promotion and integration of CHWs into the care team is a cross-cutting component of each aspect of the SIM strategy, which includes care delivery reform, payment reform, and population health planning.

Care Delivery Reform
To transform care delivery, the SIM launched the **Community and Clinical Integration Program (CCIP)**, which enables Advanced Networks and FQHCs to improve care delivery through targeted technical assistance, transformation awards, and participation in community health collaboratives. By participating in CCIP, Advanced Networks and FQHCs commit to achieve the CCIP Standards in order to:

a) Improve care for individuals with complex health needs;
b) Introduce new care processes to reduce health equity gaps; and
c) Improve access to and integration of behavioral health services.

The CCIP Standards require Advanced Networks and FQHCs to develop CHW capabilities and fully incorporate CHWs into the primary care team. Only those Advanced Networks and FQHCs participating in Person Centered

Medical Home Plus (described below) are eligible to participate in CCIP. This ensures that care delivery reform efforts and payment reform efforts are aligned to improve health outcomes.

The SIM also launched the **Advanced Medical Home (AMH) Program**, which promotes the transformation of primary care practices to become Advanced Medical Homes, an enhanced version of the team-based Patient-Centered Medical Home (PCMH) model. Through the AMH Program, practices receive technical assistance to adopt new care delivery models to improve quality, including the potential use of CHWs.

Payment Reform

Under the auspices of SIM, the primary payment reform initiative is the DSS-led **Person Centered Medical Home Plus (PCMH+) Program.** While the Department's existing Person Centered Medical Home (PCMH) initiative remains the foundation of Connecticut Medicaid care delivery transformation, PCMH+ builds on PCMH by incorporating additional requirements for care coordination, focusing upon integration of behavioral and physical health care, children with special health care needs, health equity, and competency in care for individuals with disabilities. It also represents the Department's first use of an upside-only "shared savings" approach. Participating providers that meet specified quality standards and generate savings for Medicaid will receive a portion of the savings that are achieved. PCMH+ gives local Participating Entities the flexibility to determine their best means of achieving outcomes related to identified quality measures. This will likely include use of CHWs.

Population Health Planning

The SIM is also developing a population health plan that will include piloting of Prevention Service Centers and developing a framework for Health Enhancement Communities. CHWs will play a critical role in both models, with the goal of establishing communities that are accountable for the health of their residents.

Community Health Worker Initiative

Because CHWs are essential to each area of the SIM work, the SIM Program Management Office (PMO) has an Agreement with UConn Health and Southwestern AHEC to: identify best practices for the integration of CHWs into care teams, support the technical assistance efforts through CCIP, and develop a policy framework to advance the CHW workforce across the state.

SIM CHW Advisory Committee

Under SIM, the CHW Advisory Committee was established to provide UConn Health and SW AHEC with multi-stakeholder guidance on the SIM CHW efforts. The Committee was tasked with two phases of work. The first, which is addressed within this report, was to provide recommendations on a CHW definition and scope of practice, a process for CHW certification, and mechanisms for sustainably financing CHW services. Phase two will involve advising on the development of a toolkit and technical assistance for the integration of CHWs into the healthcare system. The CHW Advisory Committee's Charter describes in detail the full charge of the Committee. It was approved by the Health Care Innovation Steering Committee (HISC), the SIM's oversight committee, on February 11, 2016.

Members of the Committee represent a broad range of CHW-stakeholder groups, including CHWs, health care providers, consumer advocates, academics, state agencies, and employers of CHWs. The names and affiliations of Committee members are detailed at the beginning of this report. The SIM PMO issued a solicitation for membership applications in late January 2016, and the HISC approved the 21 members nominated by the Personnel Subcommittee and the Consumer Advisory Board on March 10, 2016. Because one member has since resigned, there are currently 20 Committee members.

The full Committee has met 12 times, nine in person and three via webinar, including a preliminary webinar on March 29, 2016. The Committee formed two design groups: one to look in more depth at the definition (one meeting), and the other to examine in detail the issues surrounding certification (three meetings). All but one in-person meeting of both the full committee and design groups occurred at the Connecticut Behavioral Health Partnership in Rocky Hill.

In consultation with the Executive Committee, the PMO and CHW Initiative staff, along with facilitator Katharine London, developed briefing materials and an agenda before each meeting. In some cases, members were surveyed about their views on particular CHW issues and presented the results at a meeting to facilitate deliberation, consensus, and decision-making. Ms. London, a principal at the University of Massachusetts Medical School's Center for Health Law and Economics, facilitated the discussions. All meetings were open to the public, and time was always allotted for public comment. Brief summaries of each meeting are included in the Appendix. Meeting minutes, slides, and briefing materials are available on the SIM website.

Background

The Importance of CHWs

Substantial evidence confirms that intervention models involving CHWs produce improved health outcomes.[1] Rooted in the communities they serve, CHWs possess a unique understanding of how those communities function and how the local resources, environment, and culture affect health, thus enabling them to address ethnic and racial disparities in healthcare. In addition, CHWs are on the frontlines of addressing the social determinants of health[2] and are thus particularly well-positioned and equipped to connect what happens inside the clinic to what happens in neighborhoods, homes, and workplaces. By working in homes, on the street, and in clinics, they complement clinically trained healthcare teams by carrying out a broad range of responsibilities that facilitate access to services and supports and help patients achieve the goals of their care plans. By providing these services and supports, CHWs allow all members of the care team to work at the top of their licenses, increasing the efficiency and effectiveness of the care team. In short, they link the healthcare system to the community, enabling each to feedback positively on the other.[3]

"The Business Case for Community Health Workers in Connecticut," published by Southwestern AHEC in 2014, identified a CHW movement in Connecticut with a unique opportunity to improve population-based health outcomes. Extensive evidence demonstrates that intervention models that utilize CHWs result in better health outcomes across a variety of health issues by enhancing the services already offered and create cost savings and revenue enhancements. The report also confirmed that existing CHW program models[4] in Connecticut improve access to care, increase knowledge, prevent disease, and improve select health outcomes for target populations. The report identified a substantial need to educate stakeholders, inventory the existing CHW workforce, support the CHW Association of Connecticut, establish an infrastructure for CHW education and training, develop sustainable funding opportunities created through the Affordable Care Act, and establish collaborative efforts among partners to study CHW cost effectiveness.[5]

In 2012, Connecticut's Southwestern AHEC conducted a survey on CHWs and their employers to improve understanding and propel the CHW workforce in Connecticut forward. The survey report (Community Health Workers: Connecticut) was created by students at the Yale School of Public Health in collaboration with SWAHEC and was supported by the CT-RI Public Health Training Center with funding from the Health Resources Services Administration (HRSA). This survey found that CHWs in Connecticut are predominantly middle-aged minority women, which is comparable to CHWs nationwide. Both CHWs and their employers expressed a desire for more training, and CHWs also indicated a need for a standardized training program. Credentialing was considered as a formal mechanism to assist CHWs in meeting their training needs while also providing a record of their qualifications. The survey confirmed that CHWs in Connecticut are known by many job titles, which presents a

[1] CDC, "Addressing Chronic Disease Through Community Health Workers: A Policy and Systems-Level Approach," 2nd Ed., April 2015, http://www.cdc.gov/dhdsp/docs/chw_brief.pdf

[2] Phalen, J and Paradis, Rebecca. "How Community Health Workers Can Reinvent Health Care Delivery in the US," Health Affairs Blog, January 16, 2015. http://healthaffairs.org/blog/2015/01/16/how-community-health-workers-can-reinvent-health-care-delivery-in-the-us/

[3] CT AHEC et al., "The Business Case for Community Health Workers in Connecticut," Fall 2014 http://swctahec.org/wp-content/uploads/2010/08/CHW-Business-Case-2014-with-Task-Force-Final.pdf

[4] Community health workers evidence-based models toolbox. HRSA Office of Rural Health Policy. U.S. Department of Health and Human Services. Health Resources Services Administration. August 2011.

[5] CT AHEC et al., "The Business Case for Community Health Workers in Connecticut," Fall 2014 http://swctahec.org/wp-content/uploads/2010/08/CHW-Business-Case-2014-with-Task-Force-Final.pdf

barrier to their recognition as a professional workforce and seems to affect the level of payment for the work they do. Ultimately, lack of understanding of the benefit of CHWs, low pay, and unstable funding were identified as barriers to the CHW workforce in Connecticut that in turn affect job satisfaction and job security.

With the CHW workforce growing and recognition of its effectiveness at reducing health disparities by using health information to change health seeking-behaviors among underserved populations increasing, it is critical to provide robust, competency-based CHW training. Adequate and consistent training and state-wide recognition of such can lead to certification, which can boost the recognition and sustainability of what this workforce is already doing to improve health.[6] Therefore, to help achieve this goal and aid the process of integrating CHWs into the state's healthcare delivery model, the SIM CHW Initiative of Connecticut is focused on facilitating the development of an infrastructure for the CHW workforce and providing technical assistance for the integration of CHWs through CCIP.

[6] American Public Health Association, "Support for Community Health Workers to Increase Health Access and to Reduce Health Inequities," November 10, 2009, https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/09/14/19/support-for-community-health-workers-to-increase-health-access-and-to-reduce-health-inequities

Key Recommendations

A fully integrated CHW workforce will support the triple aim by improving patient care in a culturally appropriate way, reducing cost of care by improving efficiencies and allowing all team members to work at the top of their licenses, and developing healthier people and communities by linking communities to the clinical healthcare setting. Based on the substantial evidence in support of integrating CHWs fully and sustainably into the healthcare system, and given the barriers identified through numerous studies and reports, the CHW Advisory Committee developed the following recommendations to advance the CHW workforce in Connecticut.

Definition

Recommendation #1: The CHW Advisory Committee recommends adoption of the following DEFINITION for CHWs in Connecticut:

> A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of, and/or has a unique understanding of the experience, language, culture, and socioeconomic needs of the community served. A CHW serves as a liaison/intermediary between individuals, communities and health and social services to facilitate access to care, improve the quality and cultural responsiveness of service delivery, and address social determinants of health.
>
> CHWs build individual and community capacity by increasing health knowledge and self-sufficiency through a range of culturally appropriate services such as: outreach and engagement; education, coaching, and informal counseling; social support; advocacy; care coordination; basic screenings and assessments; and research and evaluation.

The CHW Definition Design Group developed a draft definition that encapsulated who CHWs are and why they are a valuable resource to address population health in the state of Connecticut. The initial discussion began on June 14th when two established CHW definitions were presented to the full Committee for consideration: 1. 2009 American Public Health Association's (APHA); and 2. 2014 CHW Association of Connecticut. Following a detailed review, Committee members felt these versions were too broad and lacked enough specificity to distinguish the role of CHWs from other public health workers, specifically how *CHWs address the social determinants of health*. The Committee members expressed a desire to review additional definitions and CHW defining information prior to drafting a definition for Connecticut. As such, a definition design group was established to complete this work separate from the monthly meetings.

A definition design group was comprised of seven committee members, three of whom were active CHWs. They convened on September 29th to review literature from six other states and one coalition: Massachusetts, Maine, Rhode Island, Texas, Florida, Minnesota, and the New England CHW Coalition. Design group members were asked challenging questions to determine if the above definitions captured the CHW roles, skills and qualities, as outlined by the CHW Core Consensus (C3) Project.[7] All members were in agreement that for CHWs to be effective in their respective roles, they must be both an integral part of the formal healthcare system and fully embedded in the community. The CHW must freely and frequently transition between these roles, seamlessly, to optimize outcomes for the patients whose needs they address. Members included more concrete examples within the definition to portray this concept, such as addressing the social determinants of health and providing care

[7] Rosenthal, E. L., Rush, H. C., & Allen, C. G. (April 2016). Understanding Scope and Competencies: A Contemporary Look at the United States Community Health Worker Field.

coordination, basic screenings, and assessments.

Only one design meeting was needed to reach consensus, and a draft definition was presented and approved by the CHW Advisory Committee for recommendation on October 20, 2016.

Scope of Practice

Recommendation #2: The CHW Advisory Committee recommends adoption of the following TEN ROLES and ELEVEN SKILLS to define the scope of practice for CHWs in Connecticut:

Roles

1. Cultural Mediation among Individuals, Communities, and Health and Social Service Systems
2. Providing Culturally Appropriate Health Education and Information
3. Care Coordination, Case Management, and System Navigation
4. Providing Coaching and Social Support
5. Advocating for Individuals and Communities
6. Building Individual and Community Capacity
7. Providing Direct Service
8. Implementing Individual and Community Assessments
9. Conducting Outreach
10. Participating in Evaluation and Research

Skills

1. Communication Skills
2. Interpersonal and Relationship-Building Skills
3. Service Coordination and Navigation Skills
4. Capacity Building Skills
5. Advocacy Skills
6. Education and Facilitation Skills
7. Individual and Community Assessment Skills
8. Outreach Skills
9. Professional Skills and Conduct
10. Evaluation and Research Skills
11. Knowledge Base

Full details of the sub-roles and sub-skills approved can be found here.

In preparation for the discussion on CHW core competencies, or roles and skills, the CHW Initiative team distributed the CHW Core Consensus (C3) Project, which details the roles, skills and qualities of CHWs nationwide. The C3 Project research team recognized the need for a current review of CHW scope of practice, but also identified an ongoing need for greater visibility of the still emerging CHW workforce in the United States. It is because of their due diligence in 2014-2015, which stemmed from the start of the National Community Health Advisor Study in 1994-1998, that the Committee was able to leverage the C3 Project Report to detail: who CHWs are, what they do, and how best to coordinate those roles and skills with others.[8]

[8] Community Health Worker Core Consensus (C3) Project: Addressing Health Equity. Texas Tech University Health Sciences Center, El Paso (lead), UT Project on CHW Policy and Practice, Mesa Public Health Associates, Community Resources, LLC. April 2016. https://sph.uth.edu/dotAsset/55d79410-46d3-4988-a0c2-94876da1e08d.pdf

In order to obtain the full Committee perspective, each CHW role and skill was organized into worksheets for review in advance of the meeting to approve, suggest revised language, or leave comments for consideration. The Committee met on July 21, 2016 to continue the discussion and review the important findings of the worksheets. Recommended changes based on the results of the worksheets and further discussion are summarized in Table 1.

Table 1. CHW Advisory Committee Recommended Changes to the C3 Roles and Skills

Roles	
Role 2.a.	Revise to include: "developmentally appropriate" to accommodate need to work with children, adolescents, adults, elderly, caregivers, and families
Role 3.	Add new: Provider relationship management in inclusion of CHW enabling cohesive communication with patients
Role 6.	Add new: Identify service gaps and make recommendations for change
Role 7.a.	Revise to include: Provide basic Mental Health and Substance Abuse screening
Skills	
Skill 1.	Add new: Negotiation skills are important in many ways including getting services when demand outstrips supply
Skill 3.	Add new: Ability to coordinate care in a way that is person-centered and leads to a better health outcome and to identify resources and overcome barriers
Skill 9.h.	Revise to include: CHWs are not mandated reporters. I believe that this piece should be revised to read "and contact Supervisor who will carry out mandated reporting requirements"
Skill 9.	Add new: Ability to work in teams if required

After careful consideration, the Committee reached consensus on minor changes to the language of the sub-roles and sub-skills of the C3 Project scope of practice, and approved the modified CT CHW roles and skills for recommendation on August 30, 2016.

Credentialing/Certification

Recommendation #3: The CHW Advisory Committee recommends that DPH establish a voluntary CHW certification program. Under this program, CHWs will receive an individual two-year certification issued by DPH and be placed on a CHW registry if they complete (1) a designated "DPH approved" training program and (2) pass a standardized competency-based assessment.

A summary of the key elements of the recommendation are as follows – DPH shall:

- Designate CHW training programs as "DPH approved" based on a standardized curriculum review.
- Use the definition and scope of practice developed by the CHW Advisory Committee as the basis for developing curriculum standards, and build on the federally-funded comprehensive CHW training program currently in use by Community Colleges.
- Establish a CHW Advisory Committee to advise DPH on development of the training program and competency assessment standards and corresponding certification procedures.
    - At least 50% of the seats on the Advisory Committee should be reserved for CHWs
    - Other multi-stakeholder representatives should include a CHW employer, higher education representative involved with a CHW training program, a commercial payer, and the CHW Association of Connecticut, in addition to relevant state agencies.
- Establish a standardized competency assessment process that assesses both skills and knowledge.
- Ensure the assessment is reasonably accessible to individuals with language barriers and appropriately assesses cultural competency.
- Ensure that the standardized competency assessment be administered by one or more DPH approved entities.
- Allow for grandparenting for the first two years.
- Assess and determine the need for a pathway to certification based on CHW experience beyond the initial two-year grandparenting period.
- Administer continuing education and experience verification process.
- Establish a Certified CHW registry listing all of the individuals who have ever received certification and the status of such certification.
- Serve as the CHW certification authority under statute.

The CHW Advisory Committee reached consensus on the Certification Recommendations during a full committee meeting on March 21, 2017.

Considerations

The discussion on certification began during the first webinar held on March 29, 2016, and continued to resurface throughout the course of this process. The CHW Symposium held on May 24th provided insight and feedback for the CHW Advisory Committee through keynote speakers and breakout sessions on CHW certification, as well as other topics. The certification highlights of this Symposium were shared with the Committee in preparation for the discussions on developing a policy framework for CHW certification. The CHW Initiative team prepared literature for review, including CHW Certification by State, and distributed a survey in advance to gain member perspectives on critical issues. The results of this survey were shared with the Executive Team and important topics for discussion were identified prior to the full Committee meeting on August 30th. The discussions continued until March 2017, and the following are highlights from those meetings as they relate to the final Committee recommendation:

The CHW Advisory Committee reached consensus regarding the potential benefits of CHW Certification. The

Committee felt that CHW Certification would clarify and standardize CHW roles and skills, standardize requirements, and foster respect for the CHW workforce, as well as improve personal and professional value of CHWs. They felt that CHW Certification would help CHW employers and potential employers understand CHW roles and skills, simplify recruitment processes, and minimize the employers' perceived risk of hiring CHWs. In addition, members believed that CHW Certification would make CHW employment more sustainable and stable, increase the chance for payer reimbursement, legitimize the profession, improve salaries, and create more job opportunities.

The CHW Advisory Committee reached consensus on a vision for an ideal CHW Certification process. The ideal CHW Certification process would: ensure individual CHWs have achieved core competencies, develop a sense of professionalism and workforce identity amongst CHWs, and empower CHWs to control their own future. It would be recognized by employers or payers, and would not prohibit experienced CHWs who are not certified from continuing their work, nor hold CHWs to unfair standards, and would not be cost-prohibitive.

The CHW Advisory Committee members reached agreement that Connecticut should pursue Certification for CHWs that is voluntary and includes a grandparenting process, as reported from the Certification Worksheet. The Committee had concerns that mandating certification may create barriers, whereas voluntary certification would help alleviate barriers, such as barriers to workforce entry and marginalization of volunteer CHWs. The Committee also felt that voluntary certification would provide opportunities and an alternative pathway for CHWs who have not received formal CHW training, but who may have years of experience working in the CHW field.

The CHW Advisory Committee members reached consensus that there should be one certifying entity and that a committee with multi-stakeholders should decide skills, training, and experience necessary for CHW Certification. The Committee felt that establishing one certifying entity would help to ensure the same standards are met across training programs, and would ensure that all Certified CHWs adhere to the same set of standards.

The CHW Advisory Committee reached consensus that the one certifying entity for CHW Certification should be the Department of Public Health (DPH), through extended discussions on this topic. The Committee observed that DPH already serves this function for most other healthcare related professions in Connecticut. They felt it was important to legitimize and create a sense of professionalism within the CHW workforce by establishing a Certification Program with the same oversight body as other healthcare professions. The Committee reviewed examples of certifying entities in other states and consulted with the DPH. DPH representatives presented and discussed with the Committee different ways professions are recognized in Connecticut. The discussion included other key topics related to certification, including what certification would look like if DPH were the certifying entity. The CHW Advisory Committee agreed it was necessary to form a Certification Design Group to look more closely at issues surrounding certification.

The CHW Certification Design Group included eleven volunteer members from the full CHW Advisory Committee. The design group convened on three occasions either in-person or by webinar on November 30, December 15, 2016, and February 7, 2017. The Design Group made recommendations that enabled the full Advisory Committee to reach consensus.

Sustainable Payment

The CHW Advisory Committee was also tasked with identifying sustainable funding mechanisms to fully integrate CHWs into the healthcare system. CHWs are currently funded largely by time-limited, program-specific

grant funding through foundations, non-profit organizations, or state funds. In some cases, healthcare organizations utilize care coordination funds to support time-limited CHW positions. The SIM goal is to identify and promote a sustainable funding mechanism for CHWs that recognizes the value CHWs add to healthcare organizations seeking to improve their care delivery efforts while reducing costs and increasing efficiency.

The Committee discussed the spectrum of existing payment models, using the framework established by the Healthcare Payment Learning and Action Network (HCPLAN) which categorizes all payment models based on how much they promote value with respect to quality and cost. The Committee recognized fee-for-service payment models as flawed for two reasons. They impose substantial administrative burdens, including coding, billing and documentation complexity. This adds to the cost of the services and limits the time that community health workers can spend with patients and in the community. Also, fee-for-service payment methods have a long history of increasing the cost of healthcare over time. This in turn makes commercial insurance less affordable for consumers and employers and it makes public programs like Medicare and Medicaid less affordable for taxpayers.

The Committee specifically focused on three types of alternative payment models: shared savings with advance payments, primary care bundles with advanced payments, and global payments. The Committee recognized that each model presents both opportunities and limitations, and developed the recommendations below to achieve a sustainable funding solution for CHWs.

Recommendation #4 – SUSTAINABLE FINANCING: The CHW Advisory Committee recommends the following related to Alternative Payment Models in Connecticut:

- Alternative payment models that provide more funding for primary care and increase the flexibility of that funding provide an opportunity to sustainably fund CHWs as members of the care team.
- Increased funding for primary care should be done as part of an alternative payment model that rewards providers for providing high quality care and effectively managing the total cost of care.
- Alternative payment models should include a requirement that providers incorporate CHWs into their care teams.

The following three models would enable sustainable financing of CHWs:

- Shared savings programs with advanced payments to support investments in expanded care team staff, including community health workers, and incentives to improve quality while reducing cost.
- Primary care bundles, when coupled with shared savings programs and advanced payments, provide even greater flexibility for care teams to use innovative ways to engage and support patients in the context of person-centered care.
- Global payments offer providers the greatest flexibility to invest in expanded care team staff and innovative ways to engage and support patients across every health care service and setting.

Note: During the course of the Advisory Committee's work, the Centers for Medicare and Medicaid Innovation (CMMI) released a solicitation for the Comprehensive Primary Care + (CPC+) initiative, in which public and private payers were invited to participate with Medicare in a value-based primary care payment reform arrangement. Recognizing the merits of the CPC+ model and the significance of this opportunity to engage Medicare in primary care payment reform arrangement, the Committee recommended that Connecticut's payers apply. This recommendation was accepted by the HISC, but ultimately narrowed to include commercial

payers only in light of the administration's position on Medicaid participation, which can be found in Appendix B.

Note: At the time when these recommendations were developed, shared savings was the most prevalent alternative payment model in use in Connecticut. Commercial payers and Medicare had adopted shared savings in some of their contracts, and Medicaid had recently piloted its first shared savings program, Patient-Centered Medical Home Plus (PCMH+) which launched January 1, 2017. The Connecticut Health Care Cabinet, established to advise the Governor on health reform implementation and chaired by Lieutenant Governor Nancy Wyman, released recommendations in early 2017 for the State to advance alternative payment models by building on PCMH+ and the State employee health plan. The Cabinet recommended a strategy to establish Consumer Care Organizations which, among other requirements, would be accountable for the total cost of care for attributed members. The recommendations within this Report align with the direction of the Cabinet's recommendations, with the understanding that given the current prevalence of alternative payment models, implementation of such recommendations may not be possible for several years.

Next Steps

The CHW Advisory Committee will continue to serve in an advisory capacity for the SIM CHW initiative by providing further recommendations on: sustainable financing mechanisms (in addition to Recommendation 4 in this Report), the development of a toolkit and resources for integrating CHWs into healthcare teams, and future SIM-supported CHW work. The development of a toolkit and resources for integrating CHWs into healthcare teams will directly align with technical assistance provided to networks participating in the Community and Clinical Integration Program and PCMH+ programs and lessons learned from these programs.

The recommendations contained in this Report are intended to be used in support of policies and legislation that aim to empower and sustain the CHW workforce in Connecticut. It is the hope of the Committee that these recommendations will provide policy-makers with a basis for determining the most effective path forward for CHWs in the State.

Appendix A. Meetings in Review

The first CHW Advisory Committee meeting took place on March 29, 2016, and meetings have been scheduled on a monthly basis. When extra work is required, design groups have been assembled to look in detail at CHW certification and the definition of a CHW.

Note: Dates link to the minutes of each meeting for further details.

March 29, 2016: **Preparatory Webinar**
SIM and CHW Initiative staff presented an overview of SIM and the Connecticut CHW landscape. CHW expert Carl Rush described the national CHW landscape.

April 19, 2016: **Meeting 1: SIM, CHW Initiative, and CHW landscape**
Content from the March 29 webinar was reviewed, and Committee members introduced themselves. Members identified some of the best possible outcomes and opportunities for the Committee, as well as the challenges to achieving or realizing them. The Committee charter was approved.

May 19, 2016: **Meeting 2: Preparation for CHW symposium (webinar)**
The Committee discussed ground rules and prepared for participation in the upcoming CHW symposium by reviewing the issues to be presented on and developing relevant questions to reflect on.

May 24, 2016: **CHW Symposium**
The CHW Initiative assisted the Hispanic Health Council with planning and hosting a symposium on CHWs at UConn Health. National experts provided perspectives on CHW program design (Joanne Calista), certification (Carl Rush), and sustainable funding (Terry Mason). Breakout sessions on the same topics included panel discussions with key stakeholders from across the state. Many members participated in the symposium, which informed the committee's subsequent deliberations.

June 14, 2016: **Meeting 3: CCIP, symposium recap, definition, roles and skills**
Mark Schaefer introduced the committee to the SIM Community and Clinical Integration Program (CCIP). Meredith Ferraro recapped the May 24 symposium. Much of the remaining discussion centered on the details of a CHW definition: whether the definitions developed by the American Public Health Association and CHW Association of Connecticut are sufficient, how to capture both CHWs' linkage and coaching dimensions, what "community" means, how/whether to refer to the social determinants of health, etc. Subsequent discussion touched on the unscheduled topic of payment systems before focusing on the CHW roles and skills (scope of practice) as recommended by the CHW Core Consensus (C3) Project. The Committee agreed that more work needed to be done on the definition through a design group.

July 21, 2016: **Meeting 4: Roles and skills, certification**
Prior to the meeting, the Committee was given a worksheet and asked to use it to comment on the C3 roles and skills. Katharine London, the facilitator, presented a summary of these comments to the Committee, which ultimately made only minor changes to the C3 document. The recommended changes can be found here. The Committee looked briefly at some of the upcoming questions about certification.

August 30, 2016: **Meeting 5: Approval of roles and skills, certification**
Changes to the C3 rolls and skills were approved. Meredith Ferraro reviewed the results of the certification breakout session from the May 24 CHW symposium and clarified the differences between a certificate,

certification, registration, and licensure. Katharine London presented the results of a poll of Committee members' views on various aspects of certification that was conducted prior to the meeting. The Committee agreed on the following basic requirements for certification:

- voluntary
- application process
- minimum number of hours of experience
- training in core competencies for those new to the field
- "grandparenting" for those with a defined amount of experience
- assessment/exam tied to roles and skills
- certification good for specified period
- continuing education hours for maintenance and renewal
- small fee

A majority of members supported having a multi-stakeholder board decide what skills, training, and experience should be required for certification. There was no consensus on what entity or kind of entity should administer certification. Concerns were raised about CHWs' community and social-determinants roles being overshadowed by their clinical roles.

September 29, 2016: **Definition Design Group**
The design group reviewed and discussed the CHW definitions from Massachusetts, Maine, Rhode Island, Texas, Florida, Minnesota, the American Public Health Association, the CHW Association of Connecticut, and the New England CHW Coalition. The group ultimately agreed on a definition, proposed by CHW Initiative staff, that took into consideration both the nine definitions that were reviewed and all of the Committee's previous discussions.

October 20, 2016: **Meeting 6: Approval of definition, certification, lessons from other states, input from DPH**
The design group's definition, along with minor changes recommended by Carl Rush, was approved. Katharine London reviewed the points of agreement on certification that were achieved at the August meeting:

- Connecticut should pursue certification for CHWs.
- Certification should be voluntary and include a "grandparenting" process.
- There should be one certifying entity.
- A multi-stakeholder board should decide skills, training, and experience.

Stanley Zazula and Maggie Litwin of the CHW Initiative presented details about the certifying entities in New Mexico, Massachusetts, Florida, Rhode Island, Oregon, and Minnesota. Chris Andresen from DPH reviewed the ways (certification, statutory recognition, etc.) through which professions can be recognized in Connecticut. Discussion covered many topics: what a certifying entity should do, disciplinary processes, codes of ethics, the need for CHWs to look like other health professionals, DPH's enforcement role, the cachet that certification from DPH would provide versus the difficulty of getting legislation passed to make it happen, how to balance the tension between the clinical and non-clinical aspects of CHWs, and SIM's neutrality on the question of certification. The Committee agreed that it was necessary to form a design group to look more closely at the issues surrounding certification.

November 17, 2016: **Meeting 7: Review of certification discussion, CCIP**
Katharine London reviewed highlights from the October discussion of certification. Jenna Lupi reviewed the elements and goals of CCIP, and Committee members provided insights into their own experiences with CHWs that might help CCIP participating entities integrate CHWs into care teams. Ms. Lupi explained that it is SIM's expectation that the combination of the Committee's work on developing a policy framework (scope of practice,

training, etc.) with CCIP's attempt to demonstrate the effectiveness of CHWs in Connecticut will lead to the identification of a sustainable funding source for CHWs and development of a vibrant and sustainable CHW workforce in the state.

November 30, 2016: **Certification Design Group 1**
Design group members were asked about their views on various aspects of certification prior to the meeting. Katharine London reviewed the basics of certification (e.g., it is not a certificate of completion) and what a responsive CHW-certification system would look like (e.g., it would include a user-friendly application process). She also recapped the points of agreement that emerged from the August discussion of certification and presented the results of the survey of the design group members' views on certification. Key concerns and issues that members raised during discussion revolved around the differential stature that certification from different entities could confer, the question of whether payers and employers would accept certification, the difficulty of changing policy once it is in law, the empowerment of CHWs to guide their own future, the fact that many parts of a certification infrastructure already exist in the form of the community college CHW-certificate programs, and the feasibility or desirability of creating a whole new certification infrastructure when one already exists at DPH. Jenna Lupi proposed the following certification model, which the design group felt addressed most of their concerns:

- Have an organization like the CHW Association of Connecticut (CHWACT) review (every two years, for example) the existing training programs in the state and approve all of those that met whatever criteria CHWACT established.
- Have DPH certify all of the training programs approved by CHWACT. This could be spelled out in legislation. Anyone who completed one of these certified trainings would be a "Certified CHW."
- Certification would be voluntary, but only those CHWs who completed a certified program could call themselves "certified."

The design group agreed that another meeting would be necessary before they could make a recommendation on certification to the full CHW Advisory Committee.

December 15, 2016: **Certification Design Group 2 (webinar)**
The purpose of the call was to take a step back and discuss the goals of the CHW initiative in general and how certification relates to those goals, assuring that all Committee members had a common baseline understanding as they prepared to reach a decision on certification. Jenna Lupi reviewed highlights from the November design group meeting and restated the certification model that she had proposed in November. She noted that achieving stature for the CHW profession and ensuring sustainable funding for their services are two overarching objectives that seem to come out of each Committee meeting. Some members thought it was necessary to know what payers think about certification before the committee could make a recommendation. Concerns were raised that the Committee was backing away from its earlier support for a more robust form of certification. Ms. Lupi affirmed SIM's support for moving beyond the status quo and developing a system in which CHWs are fully integrated and respected.

February 7, 2017: **Certification Design Group 3 (webinar)**
DPH Commissioner Raul Pino conveyed his support for recognition of CHWs through DPH and described three forms that could take: statutory recognition, certification, or licensure. He stated that whatever form it takes, it should not make CHWs into a group of second-class health workers. Jenna Lupi noted that a bill (SB-126) to define the roles and responsibilities of CHWs in Connecticut is being put forward independently of SIM. Katharine London summarized the five options that have emerged from all prior discussions:

1. DPH issues individual certification to CHWs.

2. Establish a non-governmental commission to recommend certification standards for CHWs.
3. Designate the CHW Association of Connecticut to review and approve CHW training programs that issue a CHW certificate (no individual certification).
4. Recommend not pursuing certification for CHWs (no individual certification or approval of training programs).
5. Make no recommendation at this time.

Commissioner Pino's description of certification through DPH appeared to combine elements of options 1 and 3. The design group agreed to recommend to the full Committee on February 21st that DPH grant individual certification based on completion of a DPH-approved CHW training program.

February 21, 2017: **Meeting 8: Adoption of certification recommendation**
The Committee discussed and was generally supportive of the design group's recommendation that DPH grant individual certification based on completion of a DPH-approved CHW training program and proposed the following revisions:

- The standardized assessment should take into consideration language barriers and different learning styles.
- The standardized assessment should address cultural competency.
- There should be an alternative pathway to certification that accepts experience in lieu of training.
- The CHWs on the Advisory Committee to DPH should come from a broad range of backgrounds.
- DPH should be required to seek the advice and consent of the Advisory Committee.
- Statute language should be strong enough to protect the certification system from budget cuts or less supportive DPH commissioners.

The Committee asked to see everything in writing before making a final decision.

March 2, 2017: **Meeting 9: Primary Care Payment Models (webinar)**
Jenna Lupi presented on various payment models to prepare the committee to discuss the issue on March 21, 2017.

March 21, 2017: **Meeting 10: Certification and Primary Care Payment Models**
The Committee approved the final certification recommendation after addressing issues related to length of certification and grandparenting. The group also discussed primary care payment reform models as a potential means for sustainably financing CHWs. The Committee made the following recommendations to the Steering Committee regarding sustainable financing:

- The proposed primary care payment reforms represent an opportunity to sustainably finance CHWs as members of the care team.
- Primary care payment reform should include a requirement that providers incorporate Community Health Workers into their care teams.
- Payers should apply to participate in CPC+. The administration should reconsider its position on CPC+. CHW services have been demonstrated to improve quality outcomes while containing costs. CHW models have been shown to be most effective in underserved populations, such as those enrolled in Medicaid.

June 1, 2017: **Meeting 11: APMs/Global Budgets and Endorsement of C3 Roles and Skills**
The Committee agreed that global budgets represent an opportunity for sustainably financing CHWs, but felt

that there should be an intermediate step on the path from fee-for-service to global budgets. At the request of the C3 Project, the Committee also endorsed a modified version of the C3 roles and skills.

June 28, 2017: **Meeting 12: Final Recommendation and CHW Definition in Practice**
The Committee approved its final recommendation for a CHW policy framework and approach to sustainably financing CHWs. The group also began an exercise to identify the minimum number of C3 roles that one would need to perform to be considered a CHW under CCIP.

Appendix B. State of Connecticut Administration's Position on CPC+

The Administration has carefully reviewed the Comprehensive Primary Care Plus (CPC) solicitation that has been released by CMS, and has decided that for the following reasons, Connecticut Medicaid will not submit a letter of intent:

- The Medicaid program, overall, is facing existential threats associated with proposals to radically re-structure its federal funding, both in present day and over time. The Governor has released a statement (please find attached) that details the anticipated human and fiscal impact of the proposed American Health Care Act. This arises to such a foundational set of concerns that the program must focus concerted efforts on illustrating the value of the current approach, modeling various impact scenarios, and mitigating harm to currently enrolled members.
- It is well documented that the $6 b. Connecticut Medicaid program has achieved many gains since implementation of the Affordable Care Act. In addition to increasing access through eligibility expansion, the program has successfully incorporated diverse care delivery strategies (e.g. Person Centered Medical Homes, Intensive Care Management, health homes), has improved quality indicators and care experience, and has reduced per member per month costs by 1.9% over the four years since migration away from capitated managed care arrangements.
- Under the auspices of the State Innovation Model agenda, the Department of Social Services has just launched PCMH+, a first ever upside only, shared savings initiative for Connecticut Medicaid that explicitly builds upon key planks of the Department's reform agenda - Intensive Care Management and Person Centered Medical Homes. PCMH+ seeks to enable enhanced care coordination activities - notably, behavioral health integration - through both a value-based payment approach and connections with the community-based entities that have capacity to influence social determinants of health. Under PCMH+, participating FQHCs are receiving supplemental care coordination payments that they may use consistent with their own needs and priorities, which may include hiring of community health workers. Development and implementation of PCMH+ has represented a huge lift for the Department. Considerable resources must be brought to bear in overseeing the program and assessing its impact on people and their health and care experience outcomes. Further, it is the opinion of the Administration that this initiative merits time to mature before building in additional strategies.
- The Administration, with the endorsement of the legislature, has invested significant financial and in-kind resources in Connecticut primary care practices. These include: 1) PCMH program enhanced fee-for-service payments that totaled almost $6.6 m. in CY'16; 2) PCMH program incentive and year-over-year improvement payments that totaled over $311,000 in CY'15; 3) EHR payments; and 4) in-kind multi-disciplinary practice transformation coaching through the medical Administrative Services Organization, CHNCT. Although it is conceivable that CMS would entertain conversion of a portion or all of the current payments to a bundled payment, that action would require a detailed review of whether this is in the interest of Medicaid members, careful conceptualization, stakeholder review and comment by the Medical Assistance Advisory Council, advance advisory discussion with CMS, and a formal State Plan Amendment process. Further, providers are currently in reliance on receiving these payments under the current terms, and revision may alter their continued willingness to participate. For the above stated reasons, the Department cannot focus its efforts on these actions.
- Finally, the Department is in process of rolling out other, complementary initiatives that will have direct benefit for primary care practices. Most significant among these are discussions with CMS in support of enabling specialists to directly bill for e-consults. Approval of the same will enable primary care practitioners to consult in real time. This is anticipated to help more conscientiously honor appropriate boundaries of the scope of care, reduce the need for follow-up visits, and minimize frustrating experiences with members who fail to participate in scheduled appointments.

Appendix C. Community Health Workers Titles

Abuse Counselor
Access Worker
Accompagnateurs (Partners in Health Haiti)
Acompañantes (Mexico)
Adult Case Manager
Addiction Treatment Specialist
Assistor Case Coordinator
Asthma Outreach Worker
Asthma Educator
Asthma Family Support Worker
Asthma Peer Educator
Bilingual Family Outreach Specialist
Bilingual Family Advocate
Birth Assistant (Doula)
Birth Attendant
Birthing Family Support Worker
Case Management Technician
Care Coordinator
Care Transitions Coordinator
Career Coach
Case Worker
Case Managers SNAP
Certified Application Assistant (CAA)
Certified Recovery Specialist
Close -to- Community-Providers
Community Activist
Community Advocate
Community Aide
Community Care Worker (CCW)
Community Coordinator
Community Connector (Kaiser, Molina)
Community Dental Health Coordinators (CDHC)
Community Health Associate
Community Follow-Up Worker
Community Health Adviser
Community Health Advocate
Community Health Aide
Community Health Coach
Community Health Coordinator
Community Health Educator (CHE)
Community Health Navigators
Community Health Outreach Worker (CHOW)
Community Health Partners
Community Health Promotion and Awareness Interns
Community Health Representative (CHR)
Community Health Specialist
Community Health Worker (CHW) (BLS SOC 21-1094 Community Health Workers)
Community Liaison
Community-Clinical Linkage Specialist (CCL)
Community Navigator
Community Organizer
Community Outreach Manager
Community Outreach Navigator
Community Outreach Worker
Community Social Worker
Cooperative Extension Professionals
Counselor
Cultural Case Manager
Cultural Counselor
Cultural Interpreter
Cultural Mediator
Diabetes Educator
Diabetes Family Support Worker
Diabetes Navigator
Direct Care Worker
Discharge Planner
Doula -Greek- “Women Who Serves” (Birth Assistant)
Educator
Eligibility Worker
Enrollment Worker
Family Advocate
Family Education Coordinator
Family Planning Counselor
Family Support Worker
Family Advocate
Family Health Advocate
Family Health Promoter
Family Leadership Specialist
Family Outreach Worker (FOW)
Family Support Specialist
Family Support Worker
Female Community Health Volunteers (FCHV) Nepal
Financial Counselor
Frontline Health Worker
Head Start Teacher Assistant
Health Advisor
Health Advocate
Health Agent
Health Assistant
Health Broker
Health Communicator
Health Educator
Health Extension Workers
Health Facilitator
Health/Nutrition Support Worker
Health Information Specialist
Health Insurance Counselor
Health Promoter
Health Liaison
Health Specialist
Health Workers
HIV/AIDS Educator
HIV/AIDS Family Support Worker
HIV Peer Advocate
HIV Prevention Coordinator
HIV Risk Assessment/Disclosure Counselor
HIV Service Coordinator
HIV/STD Prevention Counselor
Home Care Worker
Home Visitor
Home-Based Clinician Intake Specialist
Homeless Advocate
Independent Living Services Manager

Informal Counselor
Intake Coordinator
Intake Assistant
Interpreter
La Leche Peer Counselor (Breastfeeding support)
Lay Health Advisor (LHA)
Lady Health Worker (LHW)
Lay Health Advocate
Lay Health Worker (LHW)
Líderes para Cambio
Maternal and Child Health Case Manager
Medical Concierge
Medical Interpreter
Medical Representative
Mental Health First Aid Responder
Mental Health Worker
Men's Health Specialist
Men's Health Worker
Multicultural Health Brokers
Natural Researcher
Navigator
Neighborhood Health Advocate
New Professionals
Non Clinicians
Nutrition Adviser
Nutrition Assistant
Nutrition Educator
Nutrition Support Worker
Mental Health Aide
Outreach Advocate
Outreach Case Manager
Outreach Coordinator
Outreach Educator
Outreach Specialist
Outreach Worker
Parent Aide
Parent Liaison
Part Time Project Associates
Patient Experts
Patient Navigator
Peer Advocate
Peer Counselor
Peer Educator
Peer Health Advisor
Peer Health Educator
Peer Leader
Physical Activity Specialist
Preconception Peer Educator (Department of Minority Health)
Pre-Perinatal Health Specialists
Prevention Specialist
Program Coordinator
Promotor(a)
Promotor(a) de Salud
Promotores
Public Health Advisor
Public Health Aide
Public Service Aide
Roving Listener
SDOH Specialist
Social Determinants of Health Specialists
Social Worker Assistant
Street Outreach Worker
Team Advocate, Level I
Trabajadores Comunitarios
Trained Health Extension Workers
Village Health Workers (Malawi)
Volunteers
Volunteer Health Worker
Voluntary Health Worker
Wellness Ambassadors
Women's Health Specialist
Youth Development Specialist
Youth Worker-Program Assistant
Youth Peer Counselor
Youth Worker

*Source: Indiana CHW Association Retrieved from: http://www.cachw.org/chw-job-titles/

Appendix D. Resources

C3 Project Report

CHW Symposium Summary (Service Design)

CCIP Standards

Webinar (May 19th webinar)

CHW Certification by State (CT Health Foundation 2016)

Building Health Systems in Nepal

CHW Certification by State (CT Health Foundation 2016)

CHW Policy Brief (CT Health Foundation, 2015)

CHWs in Connecticut -Survey (Southwestern AHEC)

CHWs in Connecticut - White Paper (Heinrich Consulting for Southwestern AHEC)

Business Case for CHWs in Connecticut (2014)