CHCF

Briefing: California's Community Health Worker / Promotor and Representative (CHW/P/R) Workforce

April 28, 2023

Housekeeping

To ask a question:

- *In person*: please save your questions to ask during the Q&A part of the agenda – mics will be circulated
- *Zoom*: submit a question at any time by clicking on the Q&A icon (use the chat function for technical issues only)

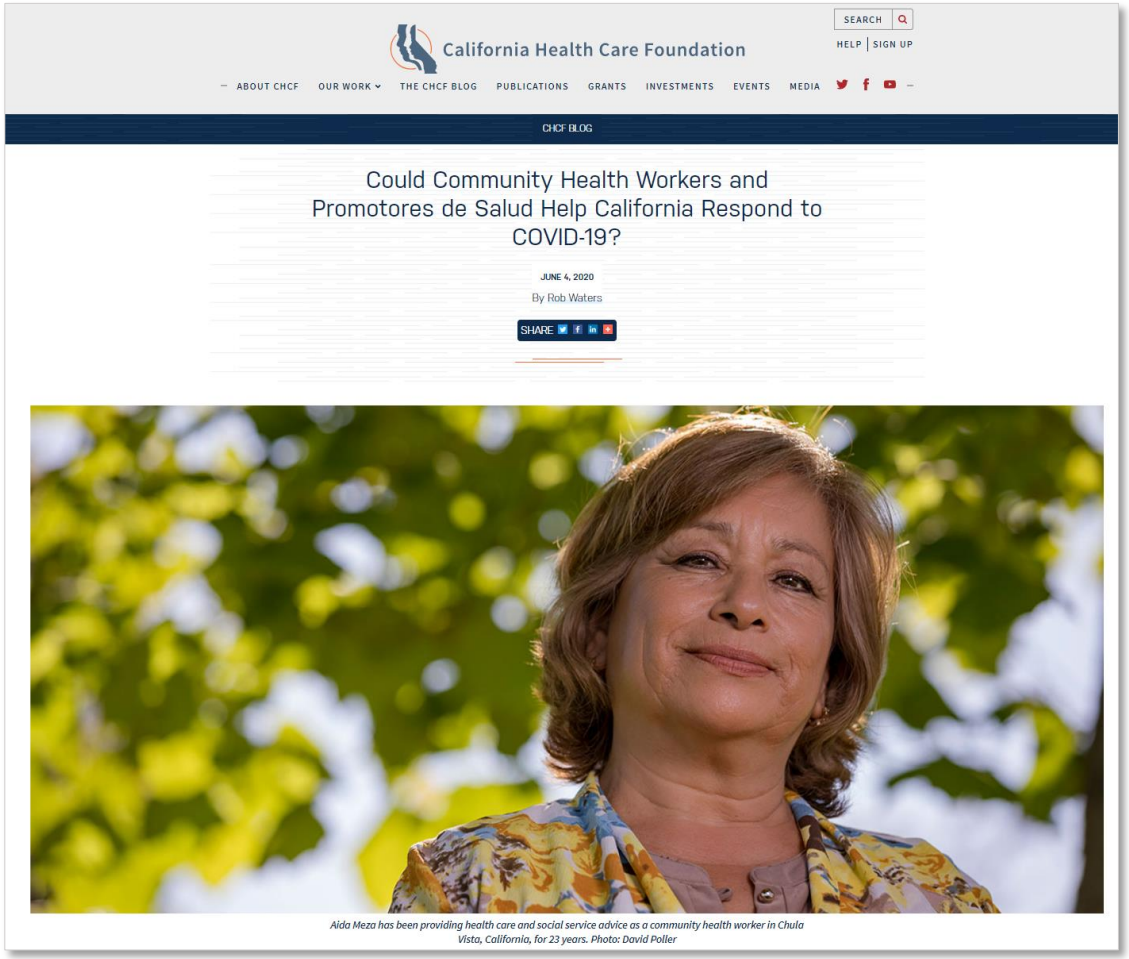
This session will be recorded:

- The recording will be available on the CHCF website next week. You will receive an email with a link once it is available.

For those of you on Zoom, we have both captioning in English and Spanish as well as translation to Spanish. Please check the Zoom chat for instructions on how to access these options.

CHW/P/Rs: Who Are They?

- Trusted members, with a close understanding, of the community served.
- Liaisons between health/social services and the community.
- Facilitate access to services and improve the quality and cultural responsiveness of service delivery.
- Increase health knowledge and self-sufficiency in communities through activities such as outreach, community education, informal counseling, social support, and advocacy.
- CHW/P/R services may include culturally appropriate health promotion and education, assistance in accessing medical and nonmedical services, translation services, care coordination, patient advocacy, home visits, and social support.



The P stands for *promotores,* trusted people who empower their peers through education and connections to health and social resources and who largely work in Latino/x and Spanish-speaking communities. The R stands for community health representatives, who do similar work in American Indian communities.

CHW/P/Rs: Why Are They Important?

Systemic Racism and Health Disparities

People of color, immigrants, people with low incomes, and other populations marginalized by systemic inequities experience the impacts of racism, xenophobia, discrimination, and trauma, which can impact their access to health care and social supports in a variety of detrimental ways.

- CHW/P/R interventions are cost-effective and can improve health outcomes, particularly when partnering with racial and ethnic minorities, low-income communities, and other communities not well-served by the health care system.[1]

CHW/P/Rs: Why Are They Important?

Shared Identity and Language

Shared identity between providers and patients can shape people's health care experiences, decisions about provider selection, and health outcomes. Language concordance between providers and patients can be an indicator of patient perceptions of quality of care and patient outcomes.[2,3,4,5]

- Latinos represent 39% of all Californians, yet make up only 7% of physicians, 8% of dentists, and 3% of pharmacists.[6]
- Based on what we know of the CHW/P/R workforce in California, the majority are Latino/x and represent other culturally diverse populations underrepresented in the state's health workforce.[7]
- CHW/P/Rs share lived experience with those they serve. They have been shown to be effective in building trust that facilitates improved health outcomes and access.[8,9]
- Other important factors of CHW/P/R success include good training, opportunities for advancement and recognition, supportive supervision, and good workplace integration.

CHW/P/Rs: Why Are They Important?

Community-Connected Health Care Systems

Medi-Cal is encouraging safety-net providers and managed care plans (MCPs) to reach out to the community with the help of CHW/P/Rs, who can engage people outside of the four walls of health care provider settings.

- CalAIM's Enhanced Care Management (ECM) and Population Health Management Program (PHMP) are requiring that Medi-Cal providers and MCPs reach out into the community in new and more proactive ways.

CHW/P/R Effectiveness

- CHW/P/R interventions are effective in a variety of areas, including care navigation; asthma, diabetes, and heart disease; mental health; post-hospital outcomes; working with publicly insured patients with chronic disease; and programs in rural settings.

- Evidence of cost-effectiveness in a variety of settings.[10]

References

1. Kim Kyounghae et al., "Effects of Community-Based Health Worker Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations: A Systematic Review," *Amer. Journal of Public Health* 106, no. 4 (Apr. 2016): e3–e28.
2. Jennifer Malat and Michelle van Ryn, "African-American Preference for Same-Race Healthcare Providers: The Role of Healthcare Discrimination," *Ethnicity & Disease* 15, no. 4 (Autumn 2005): 740–47.
3. Marla McDaniel et al., *Black and African American Adults' Perspectives on Discrimination and Unfair Judgment in Health Care*, Urban Institute, August 2021.
4. Hector M. González, William A. Vega, and Wassim Tarraf, "Health Care Quality Perceptions Among Foreign-Born Latinos and the Importance of Speaking the Same Language," *Journal of the Amer. Board of Family Medicine* 23, no. 6 (2010): 745–52.
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6. Janet Coffman, Igor Geyn, and Kristine Himmerick, *California's Primary Care Workforce: Current Supply, Characteristics, and Pipeline of Trainees*, Healthforce Center at UCSF, February 16, 2017.
7. Susan Chapman, Timothy Bates, and Jacqueline Miller, *Understanding California's Community Health Worker/Promotor Workforce: A Survey of CHW/Ps*, California Health Care Foundation, November 2022.
8. Lisa M. Boyd et al., "Features and Impact of Trust-Based Relationships Between Community Health Workers and Low-Resource Perinatal Women with Chronic Health Conditions," *Maternal and Child Health Journal* 25, no. 12 (2021): 1866–74.
9. Cristian Capotescu et al., "Community Health Workers' Critical Role in Trust Building Between the Medical System and Communities of Color," *Amer. Journal of Managed Care* 28, no. 10 (Oct. 2022): 497–99.
10. *Community Health Workers: Evidence of Their Effectiveness* (PDF), Assn. of State and Territorial Health Officials.
11. *Meeting the Demand for Health: Final Report of the California Future Health Workforce Commission*, California Future Health Workforce Commission, February 2019.
12. James G. Scott (director, Div. of Program Operations, Centers for Medicare & Medicaid Services) to Jacey Cooper (chief deputy director, Health Care Programs, California Dept. of Health Care Services), California State Plan Amendment (SPA) 22-0001 (PDF), July 26, 2022.
13. "CalAIM," California Dept. of Health Care Services.
14. "The 2022-23 Budget: Analysis of the Care Economy Workforce Development Package," Legislative Analyst's Office, March 10, 2022.
15. "Community Health Workers/Promotores/Representatives (CHW/P/R)," California Dept. of Health Care Access and Information.

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California Health Care Foundation

Understanding California's Workforce of Community Health Workers and *Promotores* (CHW/Ps)

Jacqueline Miller

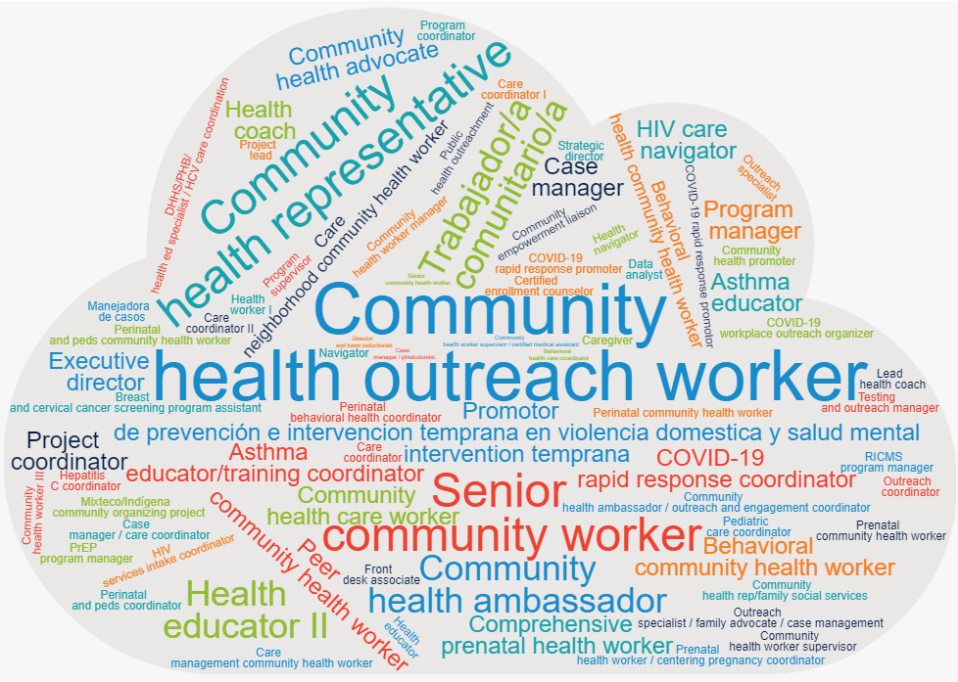
April 28, 2023

Study Details

- Focused on California only.
- Informed by an advisory group that represented seven organizations.
- Captured information about CHW/Ps working in paid and volunteer positions.
- Initially intended to measure supply and demand of CHW/Ps, but there were barriers to assessing supply.
- Comprised four main components, resulting in four reports:
  - Survey and interview data of CHW/P training/education programs: *CHW/P Training Programs*
  - Survey data of CHW/Ps working in paid or volunteer positions: *A Survey of CHW/Ps*
  - Survey data of CHW/P employers in health care settings: *CHW/P Health Care Employers*
  - Interview data of CHW/P employers in a variety of settings: *Perspectives of CHW/P Employers*

Why Is It Difficult to Measure Supply of CHW/Ps?

- The Bureau of Labor Statistics (BLS) vastly undercounts CHW/Ps.
  - The Standard Occupational Classification (SOC) code for community health workers (21-1094.00) does not capture all workers who perform CHW/P responsibilities.
  - There are some separate codes for overlapping roles (e.g., health education specialists, mental health counselors).
- There is no licensing or certification body to track the workforce.
- Many different job titles used.
  - CHW/P roles vary across organizations, funding streams, and purpose of the position (i.e., could be focused on a health condition or population).



CHW/P Demand

- Although there has always been demand for CHW/Ps, the COVID-19 pandemic highlighted need and created additional demand for these workers.

Figure 4. Employment Change Resulting from COVID-19[1]

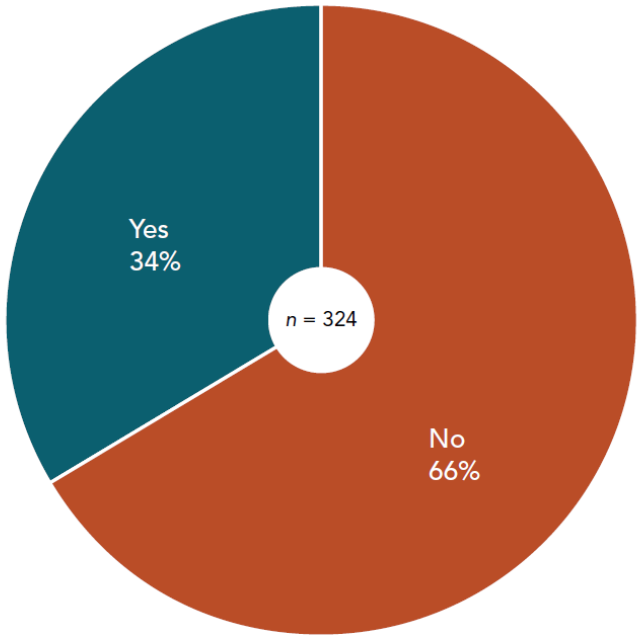
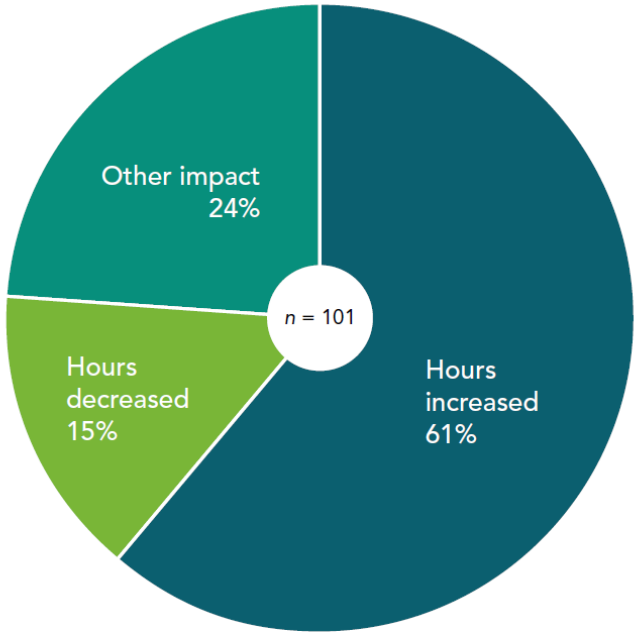


Figure 5. CHW/P Description of Employment Change from COVID-19[1]



"I think COVID actually amplified the need of promotoras. *Because they were flexible and they took [on] a lot of roles that were not there before, and they have done amazing work."*[2]

—Clinic

CHW/P Role Change During COVID

- Descriptions of “other impact” included shifting work responsibilities and taking on new roles.

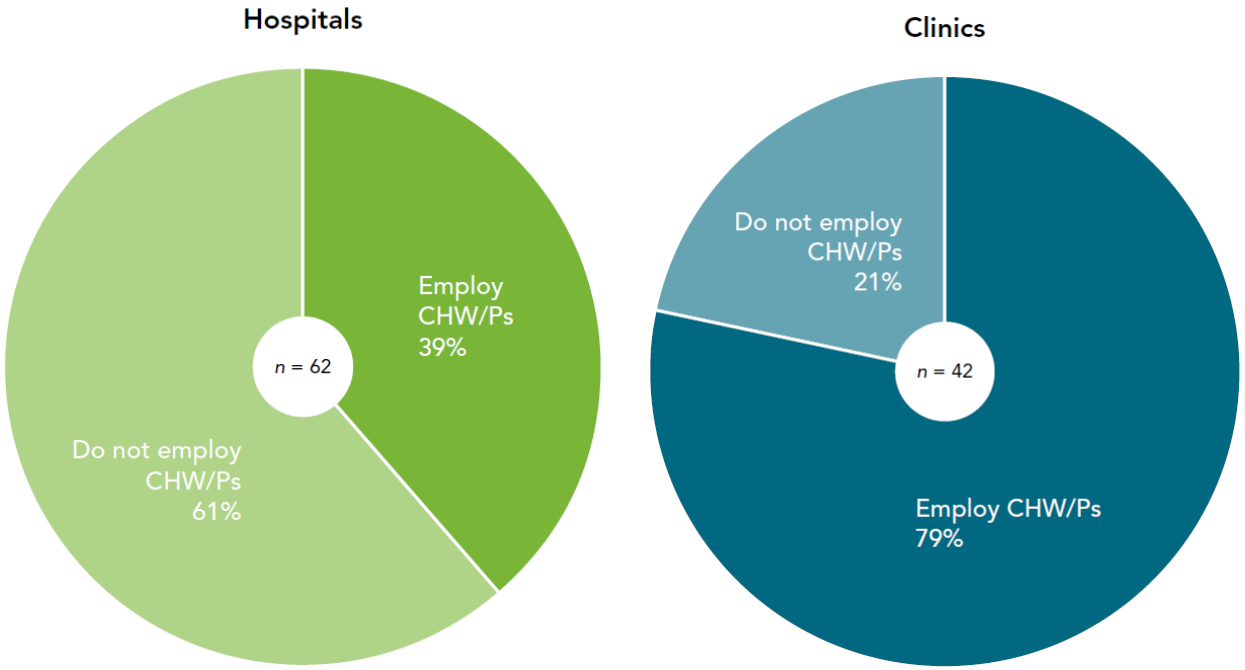
“Misinformation and myths travel very fast . . . we're definitely seeing that with COVID. And so, we do a lot of community building, a lot of trust building in the community . . . for us, that's definitely our strength, that we're able to go back to our community and do a lot of unlearning . . . making sure that we are up to date with the pandemic, the information changes very rapidly.”[2] —CBO

- Interviewees also noted other changes:
  - COVID vaccination outreach
  - More difficulty integrating the role into the clinical care team

CHW/P Employment at Hospitals and Clinics

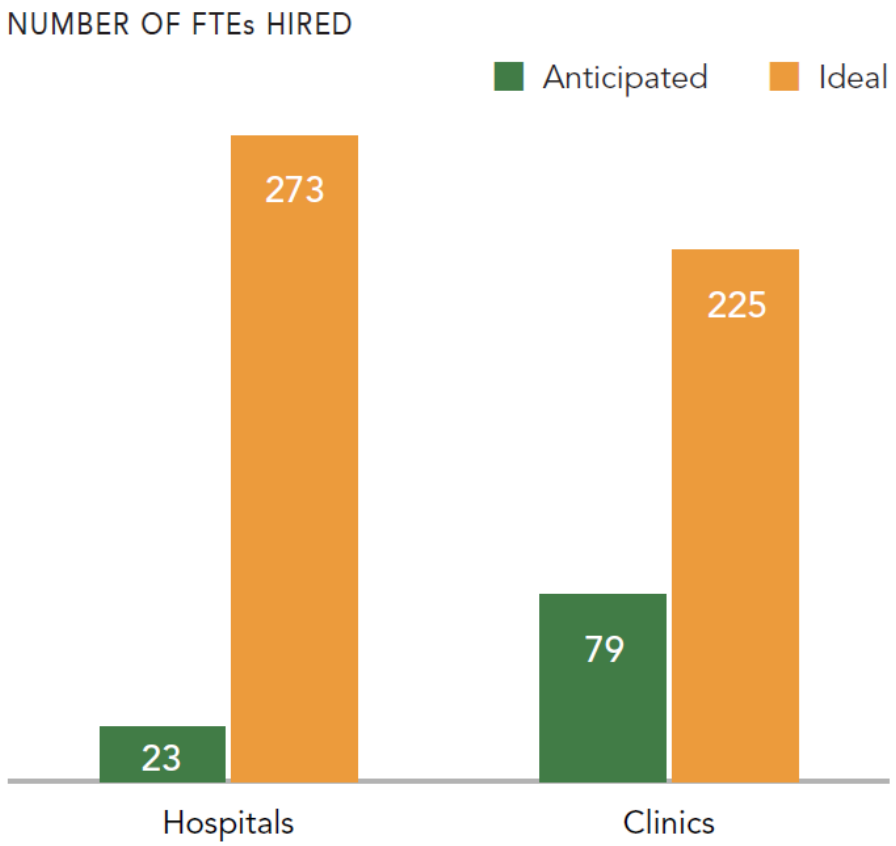
- More clinics employed CHW/Ps than hospitals.
- Hourly wages for CHW/Ps were higher in hospitals than in clinics.
  - Entry Level
    - Clinics: 70% range of $16–$20/hour
    - Hospitals: 32% range of $21–$25/hour, 32% range of $26–$30/hour
  - Senior Level
    - Clinics: 59% range of $21–$25/hour
    - Hospitals: 62% more than $30/hour
- In some instances, CHW/P wages increased during the pandemic.

Figure 1. CHW/Ps Employed, Hospitals vs. Clinics [3]



Demand for CHW/Ps by Hospitals and Clinics

Figure 9. Anticipated and Ideal Number of CHW/Ps (FTE) Hired in Next 12 Months, Hospitals and Clinics [3]

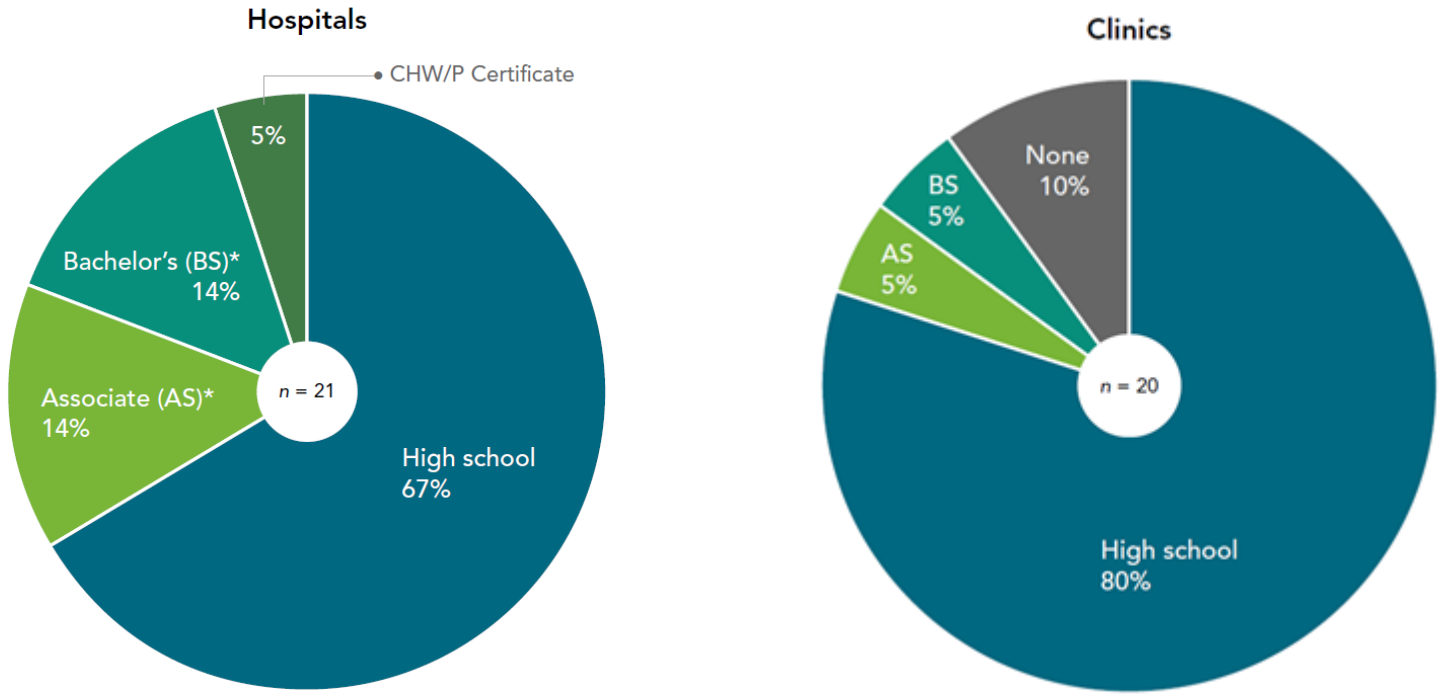


- Both hospitals and clinics wanted to hire more CHW/Ps — especially hospitals.
- Hospitals would ideally hire more than 10 times the number of CHW/Ps than currently planned.
- Clinics would ideally hire almost three times more CHW/Ps than currently planned.

CHW/P Hiring: Educational Requirements

- **Most hospital and clinic employers required that CHW/Ps have a high school education at minimum.**
- Hospitals more often required an associate or bachelor's degree, or sometimes a CHW/P training certificate, compared to clinics.

Figure 7. Minimum Educational Requirements for Entry-Level CHW/Ps, Hospitals and Clinics [3]



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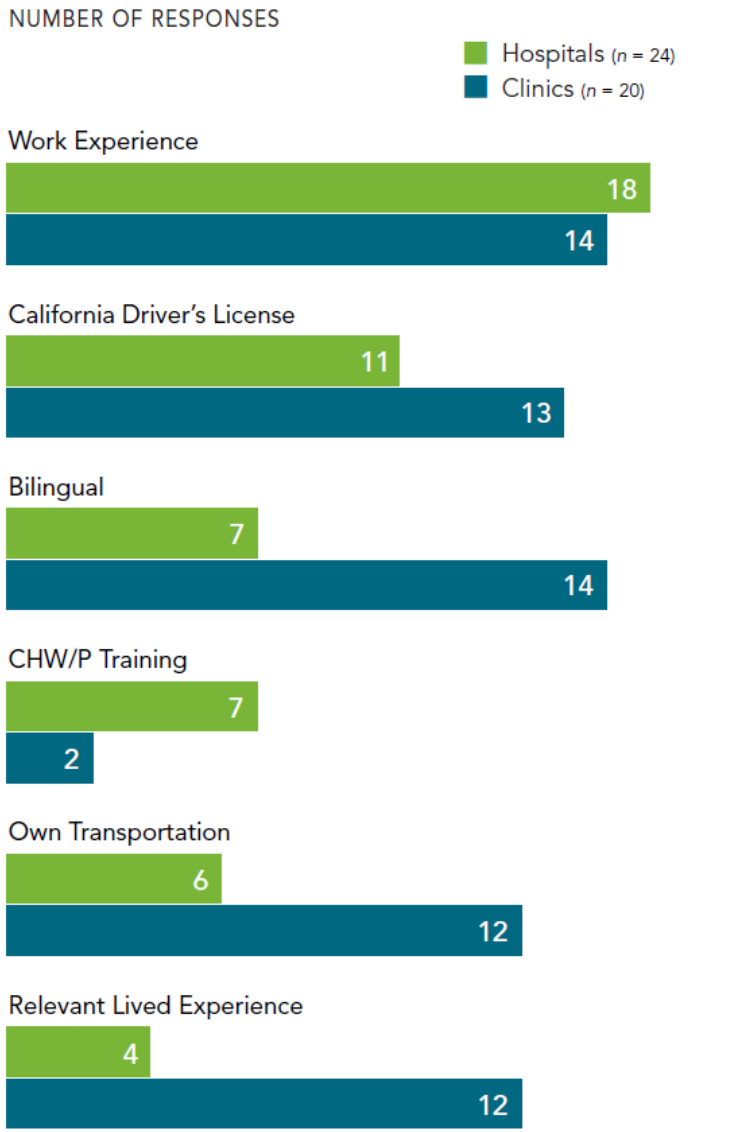
CHW/P Hiring: Job Requirements

- Job requirement most often reported for *hospitals and clinics* was work experience.
- Other requirements most important to *clinics* were being bilingual and having a California driver's license.
- Other requirements most important to *hospitals* were having a California driver's license, being bilingual, and CHW/P training.

"You don't just post this on LinkedIn or whatever, or [other] job sites. You have to take a different approach also in the hiring, having community health workers on your hiring committee . . . [and] also [hire] for some of those intangible qualities, like the passion and dedication to the community."[2]

—Clinic

Figure 8. Reported Job Requirements for Entry-Level CHW/Ps, Hospitals and Clinics[3]



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CHW/P Training Programs

- **For the state with the largest population in the country, there were relatively few opportunities for CHW/P training.**
- 25 active programs.
- Large parts of the state, such as the far north and the Central Valley, had no training programs.

Figure 1. CHW/P Training Programs in California [4]

CHW/P Training Programs and Internal Training

- A majority of active programs (18) offered general, rather than specialized, CHW/P training.
  - General: Core content that all CHW/Ps would use
  - Specialized: Specific to a chronic condition or population (e.g., diabetes, homeless)
- Most employer survey respondents and interviewees did not require new CHW/P hires to have CHW/P-specific training, but all interviewees described newly hired CHW/Ps completing training after being hired.
  - Post-hire training varied in length (two hours to 16 months) and structure (multiple module trainings vs. one overarching training).
  - Some organizations created their trainings in-house, some contracted with other training or educational institutions, and others participated in both.
  - Many post-hire training courses included a job shadow component.

Billing for CHW/P Services

State Plan Amendment (SPA) #22-0001

- Commonly referred to as the “CHW benefit” or the “DHCS benefit.”
- Became effective July 1, 2022. Provides reimbursement for some CHW/P activities, such as preventive services delivered in individual or group settings for certain issues. CHW/P services can take the form of health education, health navigation, screening and assessment, and individual support or advocacy.
- Disclaimer: at the time of interviews, the SPA was incomplete.
- Interviewees had mixed opinions about the SPA.
  - Positive: Improve access to preventive care, negate organizational need to demonstrate ROI
  - Negative: Overmedicalizes profession (excludes CHW/Ps not working in clinical settings), could require formal CHW/P education (and create barriers for some CHW/Ps)
  - Neutral: Unsure how the SPA and CalAIM (i.e., Enhanced Care Management, or ECM) would or would not tie together

Billing for CHW/P Services

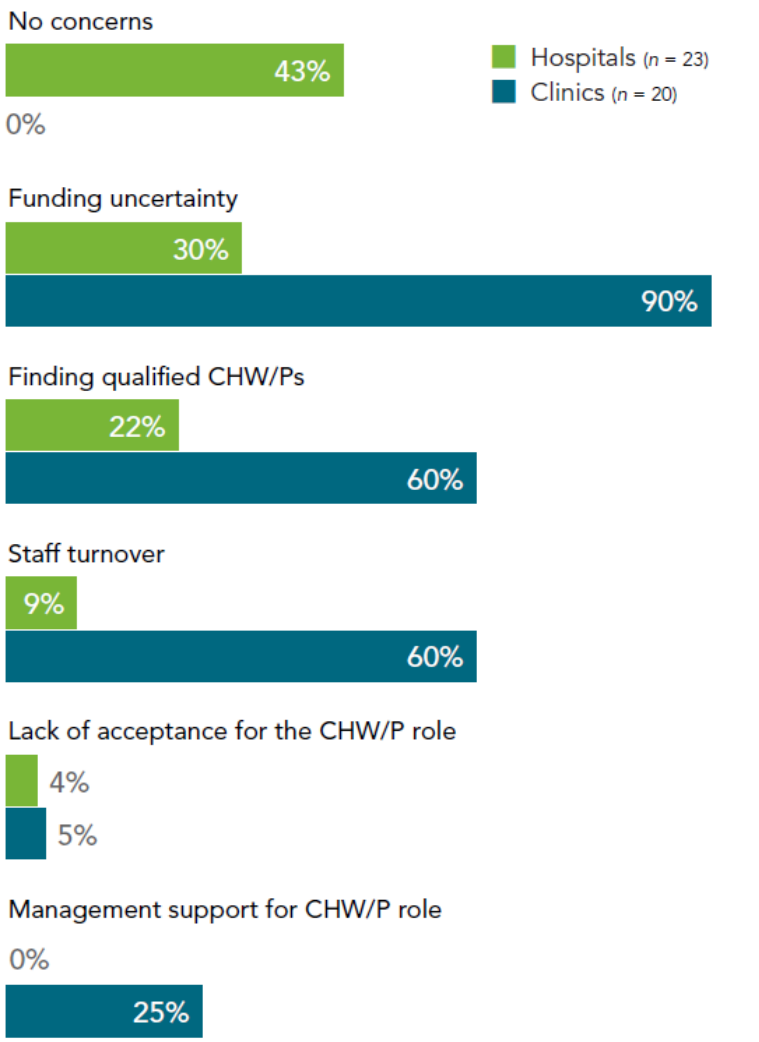
California Advancing and Innovating Medi-Cal (CalAIM)

- The cost of CHW/P services may also partially be covered through certain components of CalAIM, a Medicaid waiver designed to shift Medi-Cal to a population health approach and targets California's most vulnerable populations.
- Two components, Enhanced Care Management (ECM) and Community Supports, are of particular interest to cover some CHW/P services.
- Interviewees reported potential challenges associated with accessing CalAIM to support CHW/P work:
  - Lack of organizational infrastructure to take advantage of ECM or Community Supports
  - ECM too focused on case management / care coordination, does not incorporate other aspects of CHW/P work (i.e., lacks flexibility)
  - Might include enough funding to support existing CHW/Ps, but questioning whether there is enough funding to stimulate additional hires

CHW/P Role Sustainability

- Hospitals and clinics, but especially clinics, were concerned with funding uncertainty.
  - Other top concerns included finding qualified CHW/Ps and staff turnover, particularly for clinics.
- Almost half of hospitals indicated no concerns with sustainability, compared to zero clinics.

Figure 25. Employer Concerns About the Longevity and Sustainability of CHW/Ps, Hospitals and Clinics[3]



CHW/P Advancement and Growth

- Advancement opportunities are an important aspect of the role; they allow for growth and thus sustainability of the profession.

Figure 15. Opportunities to Advance as a CHW/P[1]

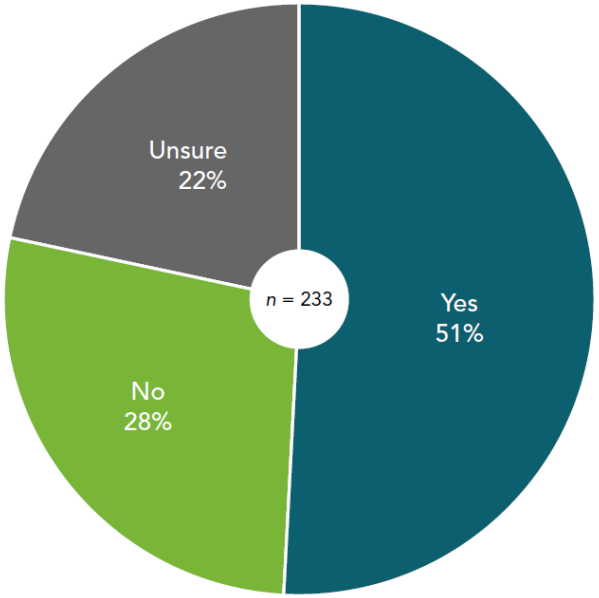
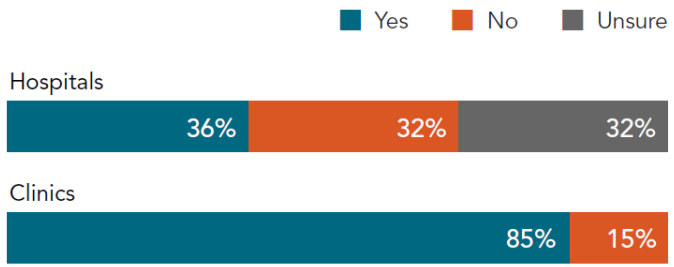


Figure 22. Advancement Opportunities for CHW/Ps, 3 Hospitals and Clinics



- Half of CHW/Ps reported they had opportunities to advance.
- More clinics than hospitals provided opportunities for advancement.

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Key Takeaways

- The COVID-19 pandemic highlighted need and created demand for more CHW/Ps.
- Employers reported ideally wanting to hire 3–10 times more CHW/Ps than currently planned.
- There were relatively few training opportunities, given the size of the state, especially in certain regions (e.g., far north, Central Valley).
- Interviewees expressed excitement about new mechanisms to bill for CHW/P services, but also some concern about implementation.
- Funding uncertainty was a top concern for hospital and clinic employers relative to CHW/P role sustainability.

Recommendations

General

- Training Programs
  - Improve access to training
    - More geographic variety
    - Subsidization/stipends
  - Better follow-up on hiring and job placement
  - More specialty training (e.g., mental health, care management, chronic conditions)?
- Employers
  - Provide higher wages
  - Offer career growth opportunities
  - Incorporate sustainable funding practices
    - De-emphasize ROI (challenging to attribute outcomes only to CHW/Ps in team-based care)
  - Increase awareness of CHW/P role and skillset
- CHW/P Data
  - California Association of Community Health Workers (CACHW) and/or National Association of Community Health Workers (NACHW) could collect data?

State

- Training
  - Fund training programs
  - Provide stipends for trainees
- Billing
  - Assist with SPA implementation
  - Ensure that CHW/Ps are a critical component of CalAIM
- CHW/P Data
  - Improve accuracy of CHW/P supply data to inform state workforce planning
    - Emphasize use of current SOC code (regardless of employee title)
  - DHCS and HCAI can work together to decide which other data are important to collect.

Chart and Quote Sources

[1] *Understanding California's Community Health Worker/Promotor Workforce: A Survey of CHW/Ps*, CHCF, November 2022.

[2] *Understanding California's Community Health Worker/Promotor Workforce: Perspectives from CHW/P Employers*, CHCF. Forthcoming.

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[4] *Understanding California's Community Health Worker/Promotor Workforce: CHW/P Training Programs*, CHCF, February 2023.

Attributions

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Thank You.

CHW/P/Rs: California's Policy Environment

- In 2019, the California Future Health Workforce Commission recommended scaling the engagement of community health workers, *promotores*, and peer providers through certification, training, and reimbursement.[11]
- In 2022, CHW/P/Rs became covered providers in Medi-Cal through an approved State Plan Amendment.[12]
- Many CHW/P/Rs are involved in the ECM program.[13]
- The 2022–23 state budget included funds to add 15,000 new CHW/P/Rs to California's workforce.[14]
- The 2022–23 state budget also directed the Department of Health Care Access and Information to initiate a certification program for CHW/P/Rs participating as Medi-Cal providers.[15]