

Community Health Workers in Illinois - A Value-Driven Solution for Population Health

*Report and Recommendations from the
Illinois Community Health Worker Advisory Board*



January 5, 2016

Community Health Workers in Illinois - A Value-Driven Solution for Population Health

*Report and Recommendations from the
Illinois Community Health Worker Advisory Board*

January 5, 2016

As a breastfeeding peer counselor, I survey lactating moms regarding employers and businesses that make it easy to breastfeed. I found that many moms were not planning to breastfeed or only planning to do it for a few weeks before they returned to school. The only places to pump on campus were in open areas, locker rooms, bathrooms, and distant locations from their classes.

I communicated these concerns to faculty at Joliet Junior College. Eager to ensure students had a comfortable and quality learning environment, the College's leadership transformed an old broom closet into the school's first lactation room. This was even before lactation rooms were mandated by law. A few years later, when the College underwent renovations, a lactation room was included in the blue prints for the new building. The oldest public community college in the U.S. was one of the first to offer a lactation room to students and faculty. As a result, Joliet Junior College received the World Breastfeeding Week "Breastfeeding is Smart Business Award". I am very happy and proud that I was able to put these efforts into motion.

**Janel Hughes-Jones, IBCLC, CHW
Breastfeeding Peer Counselor
Will County**

I have been a community health worker (CHW) with Mano a Mano for four years now. The reason why I do this work is because I like to help people. As a CHW, I conduct classes on the prevention and management of chronic conditions such as Diabetes Type 2. I have come across many people who have this condition and they are unaware of their risk factors, let alone how to manage their condition effectively.

One of the many experiences that stood out for me was when I worked with a female client having a difficult time controlling her diabetes while she also was experiencing marital issues. Her husband was not very supportive in helping her manage her condition. After attending my series of ten classes, she learned how to self manage her diabetes better. She achieved her goals of losing weight and reducing her A1c level. This made her feel very accomplished and she had an improved self-esteem. As a result, she felt empowered enough to seek services to help her with her marital issues. I referred her to Mano a Mano's Family Bridges program. This is why I continue to do this work.

**Doris Torres, CHW
Mano a Mano Family Resource Center
Round Lake Park, IL**

COPYRIGHTS

“Community Health Workers in Illinois - A Value-Driven Solution for Population Health: Report and Recommendations from the Illinois Community Health Worker Advisory Board”

This report was produced by the Illinois Community Health Worker Advisory Board. The opinions, findings, conclusions, and recommendations expressed in this report are those of the authors and editors. These views do not necessarily reflect the views or represent the official policies of the organizations contributing to the development of this report and recommendations.

General permission to reproduce and/or republish all or part of the content in this report is provided, given that the content is reproduced unaltered and clear reference is made to this publication. Electronic copies of this report are available online at www.dph.illinois.gov.

LEADERSHIP-ILLINOIS COMMUNITY HEALTH WORKER ADVISORY BOARD

BOARD MEMBERS

Leticia Boughton Price (CHW)
Chicago CHW Local Network
Co-Chair

Mary Ann Abate
Rosecrance Health Network

Monica Dillon
Loyola University School of Nursing

Geraldine Hardy (CHW)
Southern Illinois Healthcare Foundation

Estela Lazo (CHW)
County of Will

Molly Martin, MD
University of Illinois Hospital and Health
Sciences System / Mile Square Health Center

Tamela Milan (CHW)
Access Community Health

Jeffery J. Waddy
South Suburban College

Melissa Gutierrez Kapheim
Sinai Urban Health Institute
Co-Chair

Teresa Berumen (CHW)
Enlace Chicago

Christopher Garcia (CHW)
Champaign County Health Care Consumers

Janel Hughes-Jones (CHW)
County of Will

Hong Liu
Midwest Asian Health Association

Lizette Martinez (CHW)
Alivio Medical Center

Amy Sagen
University of Illinois Hospital and
Health Sciences System

WORKGROUPS - LEADERSHIP

Core Competencies and Roles
Leticia Boughton Price, CHW
Molly A. Martin, MD

Training & Certification
Venoncia M. Baté-Ambrus,
CHW/Community Psychologist
Melissa Gutierrez Kapheim
Christine Lopez,
Rosalind Franklin University
Tamela Milan, CHW
Jeffery J. Waddy

Financing & Reimbursement
Amy Sagen
Charles Williams,
Norwegian American Hospital

Workforce Development
Venoncia M. Baté-Ambrus,
CHW/Community Psychologist
Teresa Berumen, CHW
Lizette Martinez, CHW

REPORT – PREPARED BY:

Mary Ann Abate
Juana Ballesteros,
Illinois Department of Public Health
Teresa Berumen, CHW
Leticia Boughton Price, CHW
Jamie Campbell,
Sinai Urban Health Institute
Melissa Gutierrez Kapheim
Janel Hughes-Jones, CHW
Bijou Hunt,
Sinai Urban Health Institute
Molly A. Martin, MD
Erica Martinez,
Health & Medicine Policy Research Group
Daniel Rabbit, Heartland Alliance
Amy Sagen

EX-OFFICIO MEMBERS REPRESENTING STATE AGENCIES NAMED IN STATUTE:

Illinois Community College Board
Amanda Corso, Director for Career & Technical Education

Illinois Department of Children and Family Services
Jerrilyn Pearson-Minor, Chief of Nursing Services

Illinois Department of Commerce and Economic Opportunity
Julio Rodriguez, Deputy Director, Office of Employment & Training

Illinois Department of Employment Security
Lisbeth Leanos, Director's Liaison

Illinois Department of Financial and Professional Regulation
Michele L. Bromberg, Nursing Coordinator

Illinois Department of Healthcare and Family Services
Bridgett Stone, Special Assistant for Business Practices

Illinois Department of Human Services
Grace Hong Duffin, Senior Policy Advisor

Illinois Department of Public Health
Juana Ballesteros, Manager Community Public Health Outreach

Illinois Department on Aging
John K. Holton, Director

TABLE OF CONTENTS

I.	MESSAGES FROM THE CO-CHAIRS.....	7
II.	EXECUTIVE SUMMARY.....	9
III.	INTRODUCTION/BACKGROUND.....	14
	A. Need for HB5412.....	16
	B. Who are CHWs? What do CHWs do?.....	17
	C. Financial Sense for CHWs	18
	D. Development of Recommendations for Illinois' CHWs.....	20
IV.	RECOMMENDATIONS	22
	A. Core Competencies and Roles.....	23
	B. Training and Certification	26
	C. Financing and Reimbursement.....	30
	D. Workforce Development.....	39
	E. Raising Awareness.....	44
V.	NEXT STEPS/IMPLICATIONS.....	46
VI.	CITATIONS.....	49
VII.	APPENDICES.....	54
	A. Appendix A - Authorizing Legislation	55
	B. Appendix B – Work Group Members.....	59
	C. Appendix C - CHW Roles, Skills and Titles.....	64
	D. Appendix D – Endorsements.....	68
	E. Appendix E - Medicaid/Core Competencies Crosswalk.....	71

MESSAGES FROM THE ADVISORY BOARD CO-CHAIRS

Community health workers (CHWs) are many things to many people, but in Illinois we have laid a foundation to establish a unified definition, set of core competencies, and list of appropriate skills. I like to call CHWs “social determinants of health agents,” because they often address many issues that affect a person’s health in a holistic way. Joining the Chicago CHW Local Network as a Steering Committee member in 2010 put me in a position to work with other CHWs and advocates to obtain state recognition for CHWs in Illinois. After years of meetings, surveys, focus groups, forums, and presentations, CHW legislation was proposed and signed into law in 2014. Public Act 098-0796 identified a standard definition for CHWs, listed core competencies and skills, and created the Illinois CHW Advisory Board.

Since January 2015, the Illinois CHW Advisory Board has worked on developing recommendations to support, grow, and sustain the CHW workforce in Illinois. Through dedication, determination, and diligence we present our recommendations. We encourage you to read them and consider your role in helping to support, grow, and sustain the CHW workforce in Illinois. I want to thank Representative Robyn Gabel, as the chief sponsor for HB 5412; she continues to prove her long-time leadership and advocacy for quality health care. I also want to acknowledge my fellow board members, CHWs, advocates, stakeholders, and supporters for all your hard work and commitment. You all are true champions. There is more work to do and I hope I can count on your support as we all work on a common goal, to improve the health and wellness of Illinois residents.

Leticia Boughton Price, BA
Network Coordinator
Chicago Local CHW Network

The Illinois Community Health Worker Advisory Board, created through HB 5412, was charged with developing recommendations to guide the Community Health Worker (CHW) workforce, CHW employers, and government agencies on how best to ensure the future success of the CHW profession and the potential impact CHWs can have on improving the lives of Illinoisans.

Supported by the Illinois Department of Public Health, under the support and guidance of Juana Ballesteros, Manager, Community Public Health Outreach, the 15-member IL CHW Advisory Board convened monthly meetings throughout 2015, ultimately developing the recommendations found in this report. The sheer number of persons participating in various workgroups throughout the year, the number of attendees at the eight state-wide listening sessions, and the continued support from CHWs and CHW advocates from various health and human service sectors shows the excitement and interest in this unique and emerging profession.

By supporting the continued development of the CHW profession, the State of Illinois has a real opportunity to create new jobs and expand education and training opportunities in communities with great need for such opportunities. In addition, the work of CHWs, backed by scientific studies, has been shown to improve the health and wellness of vulnerable communities and save health care costs, most often accrued by Medicaid and Medicare.

Over the past ten years through my work at Sinai Urban Health Institute (SUHI), Sinai Health System, I have had the privilege of working alongside CHWs. I have seen firsthand the improvements they have made in the lives of their fellow community members. I have watched CHWs grow professionally, continue their own education, take steps to improve their own health, and be an example to future generations. Through SUHI's vigorous research, we have demonstrated improvements in health and costs savings to Illinois Medicaid of our various CHW-led health interventions. During this time, where both nationally and in Illinois, we are struggling to curb health care costs and also improve the health of the population, it is an ideal opportunity for our State to be a leader in supporting the work of the CHW profession. The IL CHW Advisory Board looks forward to continuing this important work.

A special note of thanks to the Illinois Department of Public Health for hosting our meetings and the countless hours put into this work by board members and volunteers across the State of Illinois.

Melissa Gutierrez Kapheim, MS
Epidemiologist
Manager, System Integration and Outreach
Sinai Urban Health Institute

COMMUNITY HEALTH WORKERS IN ILLINOIS - A VALUE-DRIVEN SOLUTION FOR POPULATION HEALTH

EXECUTIVE SUMMARY



EXECUTIVE SUMMARY

More than 8 million Americans now have health insurance as a result of the Affordable Care Act (ACA). Insurance coverage is a means to an end: the aim is for the newly insured to use their coverage to access primary care and preventive services, as well as manage chronic illnesses to prevent future, costly complications.

Community Health Workers (CHWs) can contribute to this vision. A growing body of research demonstrates that CHWs improve health outcomes, especially among vulnerable, low-income populations. This finding is especially true when CHWs are incorporated into disease prevention programs and chronic disease management, for diseases like diabetes, asthma, hypertension, and depression.

As states continue to implement the ACA, there are multiple opportunities to expand the role of CHWs into our health care and public health systems. Section 5313 of the ACA identifies CHWs as health professionals and members of multi-disciplinary teams that can improve the delivery and quality of health care.

Illinois, like many other states, lacks some of the underlying policies, systems, and infrastructure to integrate CHWs effectively into the health care and social services systems. This report recommends that Illinois develop a strong supportive infrastructure to ensure the sustainability of this vital workforce and to strengthen the depth and breadth of its impact.

Toward this end, the Illinois Community Health Worker Advisory Board has developed recommendations for standards and policies around five key areas: (1) core competencies and roles; (2) training and certification; (3) financing and reimbursement; (4) workforce development; and (5) raising awareness.

1. CORE COMPETENCIES AND ROLES

In this report, “roles” are intended to inform job descriptions. “Skills” are intended to inform trainings, as they are the proficiencies acquired or developed through training or experience that allow one to complete tasks that contribute to fulfilling a larger function or “role”. We include a list of “qualities” that is intended to inform the selection of CHWs. These are inherent attributes that contribute toward the attainment of “skills” and serve to inform employers seeking successful CHWs.

Roles for CHWs

1. Community engagement and advocacy
2. System navigation
3. Participatory research
4. Public health concepts and approaches / Integration
5. Coordination of services
6. Education
7. Social-emotional support
8. Community/Cultural liaison

Skills for CHWs

1. Communication skills
2. Interpersonal skills
3. Coordination/Navigation skills
4. Capacity-building skills
5. Advocacy skills
6. Education and facilitation skills
7. Assessment skills
8. Engagement skills
9. Professional skills
10. Public health skills

Qualities of CHWs

1. Team player
2. Empathetic/compassionate
3. Relatable/shared life experience
4. Good communicator
5. Active listener
6. Trustworthy
7. Emotional intelligence
8. Committed
9. Good at testimony/story telling
10. Mature
11. Nonjudgmental
12. Passionate
13. Proactive, solutions-oriented
14. Reliable
15. Personable, friendly
16. Resourceful
17. Patient
18. Creative
19. Flexible
20. Global thinker/interdisciplinary/connector
21. Leadership

2. TRAINING AND CERTIFICATION

These recommendations focus on a certification and a certification renewal process for CHWs in Illinois. They also highlight the importance of developing a system of approval and accreditation for curricula and trainings leading to certification. Recommendations for this section are broken up into three main categories: (1) CHW Training; (2) CHW Certification; and (3) Creation of an Illinois CHW Regulatory Board.

CHW Training

1. There should be academic and community-based training opportunities for CHWs that lead to mastery of the CHW profession and facilitate career pathways.
2. Certified training programs should incorporate adult learning theories into the non-academic and academic curricula to reflect the approved core competencies for CHWs.
3. There should be multi-tiered training opportunities based on the needs of the communities CHWs serve and the demands of their workplace.

CHW Certification

4. Formal certification in the State of Illinois should *not* be mandatory.
5. Work-based/fieldwork experience should be embedded in CHW trainings and curricula and should be part of the certification requirement.
6. We recommend adopting a method of grandfathering to create requirements for experience-based certification.

Creation of an Illinois CHW Regulatory Board

7. The Governor should create, within the Illinois Department of Public Health (IDPH), a Community Health Worker Certification Board.
8. The CHW Certification Board should have balanced representation from the CHW workforce, CHW employers, CHW training and educational organizations, and other engaged stakeholders.

3. FINANCING AND REIMBURSEMENT

These recommendations identify reimbursement options and pathways through which secure funding for CHWs may be obtained. The Advisory Board explored financing in both the public and private sector.

1. We recommend that the Illinois Department of Healthcare and Family Services (HFS) amend contracts with managed care entities (MCE) to allow MCEs to hire CHWs or subcontract with community-based organizations that employ CHWs.
2. We recommend that HFS file a state plan amendment (SPA) in order for CHW services to be reimbursed by Medicaid.
3. We recommend that MCEs that contract with hospitals should encourage hospitals to establish and deploy CHW programs in support of patients upon discharge.
4. We recommend that Hospitals and FQHCs employ CHWs to assist with mandated activities such as community health needs assessments and community benefits.
5. We recommend that home visiting programs hire CHWs. Health care providers, the state and third-party payers should partner with and provide incentives for home visiting programs to hire CHWs.

4. WORKFORCE DEVELOPMENT

These recommendations focus on career pathways in the CHW profession and other professional areas as well as integration of CHWs into health care delivery teams, social services organizations, and government and community organizations.

1. Develop a tiered career ladder for CHWs to achieve upward mobility/occupational advancement, if desired, within the profession.
2. The Illinois Department of Employment Security (IDES) should incorporate CHW data into CHW employment statistics to identify trends and needs and to make projections.
3. CHWs should have a basic understanding of behavioral and mental health issues.

4. For CHWs who plan to or are working in the field of behavioral and mental health we recommend that training in this area should utilize best or promising practice guidelines for peer competencies in behavioral health from state and national experts.
5. Agencies that integrate CHWs into health care delivery teams, social services organizations, and government and community organizations should apply integrated and collaborative approaches in its efforts.
6. CHWs should be integrated into medical homes.

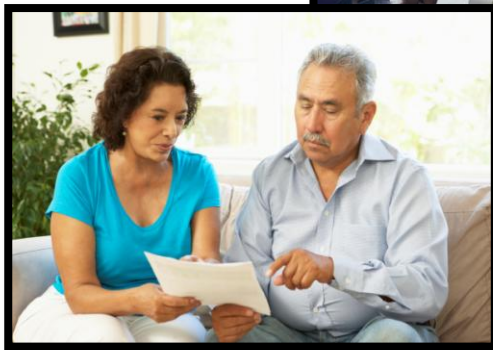
5. RAISING AWARENESS

Based on the above recommendations, it is important to raise awareness about CHWs, their contributions, and the impact they have on communities, specifically, raising awareness in the three main areas below.

1. State and local government agencies should adopt the “community health worker” term and the definition of a “community health worker” as set forth in Public Act 98-0796.
2. Develop and implement an educational campaign about CHWs targeted at CHWs, employers of CHWs, funders, policy makers, local health departments, and individuals receiving CHW services.
3. Encourage private and public funders of CHWs to use the term “community health worker” when releasing funding opportunities involving community outreach and engagement, health education and promotion, and assisting community members with health and social service systems navigation.

COMMUNITY HEALTH WORKERS IN ILLINOIS - A VALUE-DRIVEN SOLUTION FOR POPULATION HEALTH

INTRODUCTION/BACKGROUND



INTRODUCTION/BACKGROUND

Mr. Cartagena had fond memories of working and regretted that his early onset Alzheimer's made it impossible to continue. His disability income made him ineligible for Medicaid. No longer able to drive and without employment, he found himself uninsured and with little hope of finding affordable primary care. That was until, thanks to his daughter, he arrived at an Access to Care enrollment event. Thanks to the outreach work conducted by Access to Care's community health workers (CHWs), Mr. Cartagena became aware that his Alzheimer's medications were covered by the Access to Care formulary. In addition, the CHWs also referred Mr. Cartagena to local linguistically and culturally relevant services to assist him in managing his Alzheimer's. Mr. Cartagena was elated. We do not always know the profound impact outreach efforts will have on potential clients, but on that day, we knew!

**Venoncia M. Baté-Ambrus,
CHW/Community Psychologist**

The Affordable Care Act (ACA) was signed into law in March of 2010 with goals to expand coverage, reduce health care costs, and improve the delivery of health care to all Americans. Every state is considering different approaches to implementing the ACA for their population, including strategies for the future of the essential health care workforce. The ACA and states nationwide have recognized the workforce opportunities for Community Health Workers (CHWs) as part of an integrated health care and public health system. This is especially important as our health system moves away from volume-based to value-based care.

In order for Illinois to continue to advance the CHW workforce successfully, the Illinois CHW Advisory Board has developed a report with recommendations as a foundation for future policy changes and legislation.

The report and recommendations represent research, analysis, and discussions of issues that affect CHWs and stakeholders. The report and recommendations have been developed through a statewide process led by the Illinois CHW Advisory Board, a board comprised of majority CHWs, clinical professionals, academic leaders, and policy researchers. Additionally, stakeholders and community members were actively engaged in the process. These recommendations have been created to guide state leadership, community-based organizations, health care systems, and others who strive to improve the health and wellness of communities. These recommendations address how Illinois might best create an infrastructure that addresses sustainable funding mechanisms for the work performed by CHWs and a way to formalize the workforce. All of this is presented with the aim of decreasing health care costs through sustainable approaches.

A. NEED FOR HB5412

Nationally, with the passage of the federal Affordable Care Act (ACA), there is increased attention on reducing health disparities in low-income and minority communities. The ACA formally recognizes the role of CHWs in Section 5313 and offers various opportunities to expand the role of CHWs. Meanwhile, Illinois needed legislation for Community Health Workers (CHWs) because the state did not recognize the CHW profession or systematically support the CHW model. Illinois lacked a standard definition and common roles for CHWs. Additionally, there has been limited funding for CHW services and no coordination of professional development activities for CHWs. Further, there wasn't a clear career pathway for CHWs. The Legislation, HB5412, would codify the American Public Health Association (APHA) definition and create needed infrastructure to integrate the CHW model in Illinois.

HB5412 was designed to establish the necessary core competencies, skills, and knowledge of an effective CHW. The legislation recognized CHWs under state law as key components of the health care delivery system and created the Illinois CHW Advisory Board, an infrastructure to conduct research, provide expertise, and create recommendations to integrate the CHW model in Illinois. The CHW Advisory Board envisioned a CHW model that would be led by CHWs and integrates CHWs into health systems. CHWs work to improve health and social outcomes by building individual and community capacity for health knowledge and self-sufficiency through outreach, community education, informal counseling, social support, and advocacy. CHWs can hold integral roles in health, social, and faith based care delivery systems.

Recognizing CHWs under state law provides a large, diverse group of frontline workers with a professional identity. HB5412 started a legislative process that promoted the belief that CHWs must become a more integral and necessary part of any health care delivery model. The CHW Advisory Board purports that future legislation will allow Illinois to take advantage of the opportunities afforded by the ACA to establish and expand the role of CHWs as an invaluable part the solution in a better health care system.

B. WHO ARE CHWs? WHAT DO CHWs DO?

The work I do is not just my “job” but my passion. People are dying in our community because of a lack of knowledge about asthma. I currently work in an asthma program for adults living on the Westside of Chicago. Those who frequent the emergency room for their asthma are referred to the program. I visit their homes and educate them on asthma self-management.

Ensuring that patients are following proper medication techniques is one way to improve asthma management. Another way is to improve the participant’s living environment by reducing asthma triggers. For example, a client of mine knew how to administer her asthma medications correctly but did not know about mold and how it affects asthma. The home had leaking issues that caused the carpet to remain moist and grow mold. This was covered by an area rug, believing this would resolve the issue. It merely hid it. Once inside the home, I was able to assess the situation. Following my recommendations, the carpet was removed and the client immediately noticed improvement in her asthma symptoms.

I feel blessed and honored to do what I do every day, I make a difference.

Kim Artis, CHW
Sinai Urban Health Institute
Chicago, IL

As a result of the signing of HB5412, Illinois adopted the American Public Health Association definition of a community health worker (CHW).¹

“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. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.”

CHWs are known by many titles in many different countries (see Appendix C). They have been a part of health promotion and disease prevention efforts in United States communities for decades. CHWs are seen as agents of change and may act as advocates for the community.² They come from the communities they serve and reflect that diversity. Most importantly, CHWs must respond to local societal and cultural norms and customs to ensure community acceptance and ownership.³ The CHW model is supported by multiple theoretical models. Consistent with Social Ecological Theory, role models from the community, such as CHWs, can enhance behavior change interventions.⁴ One-on-one CHW interventions, typically done in the

home, are guided by Social Cognitive Theory which purports that behavior is shaped and maintained by consequences, particularly by immediate feedback from both objective sources (such as observation of self-management behaviors in the home) and an individual's social network (beliefs and traditions of family and friends).^{5, 6}

CHW programs aim to address the needs of underserved populations by training community members to be educators and advocates for their neighborhoods.⁷⁻⁹ The basic rationale for this approach is that CHWs live in the same communities and have a similar base of knowledge and experiences.^{8, 9} CHWs utilize a model that empowers community members to identify their own needs and implement their own solutions with support from health or social service providers. This leads to improved community and personal self-efficacy.¹⁰⁻¹³ CHWs seek to improve the health of communities by promoting healthy lifestyles, collaborating in awareness campaigns, participating in research, and providing social support, informal counseling, and health education. They can play a role in increasing access to and coverage of health services in near and remote areas to improve health outcomes.³

See Appendix C for a list of CHW roles, skills, titles and qualities, as recommended by the Core Competencies and Roles Work Group.

C. FINANCIAL SENSE FOR CHWS

Several community health worker (CHW) interventions in areas such as asthma care,¹⁴⁻¹⁷ diabetes management,¹⁸⁻²⁰ and cancer screening²¹ demonstrate ability to improve health, while achieving cost-savings.

CHWs make key contributions that enable health care systems to achieve the Triple Aim (improved patient care, improved population health, and reduced healthcare costs). CHWs are proven effective in enhancing health care service delivery through more efficient patient-centered care. CHWs reduce health care costs in a number of ways, including:

- Complementing clinical services as members of an integrated care team
- Connecting individuals with a primary health care home for preventive services
- Reducing unnecessary emergency room visits through care coordination and system navigation²²

The Affordable Care Act (ACA) is helping to integrate the CHW role further within the health care system. The ACA promotes new models of care delivery and financing which may lead to opportunities for CHWs to become financially sustainable partners within health care systems.²³ Studies have demonstrated that CHW utilization can provide cost-savings and return on investment (ROI) for various patient populations. For example, the health plan Molina Healthcare in New Mexico implemented a one-year pilot program targeting high-risk patients with multiple health conditions. CHWs worked as a team with social workers assisting

15 Molina members to utilize the plan's services and benefits more effectively. Over a six-month period, the intervention demonstrated a cost savings of \$7,676.^{22, 33} Other examples of cost-savings and ROI with CHW utilization can be found in Table 1 below.

Table 1. Select CHW Intervention Cost Data

	Target Population	CHW Intervention	Outcome Data
Mount Sinai Hospital, Chicago	AA children with uncontrolled asthma on Chicago's Westside	Self-management education and support, home visits, trigger reduction, connect to primary care physician (PCP)	\$5.58 saved per dollar spent; ¹⁵ Reductions in urgent health care utilization (75%)
Bronx Lebanon Hospital, NY; a patient-centered medical home	Diverse NY patient population; English, French, Spanish and South Asian languages	Care management and supportive services (e.g. home visiting, system navigation)	2:1 ROI ²⁹
Tri-County Rural Health Network Community Connector Program, Arkansas	3 counties in the Mississippi Delta with a large low-income, minority rural population	Navigation from potential nursing home care to alternative home and community-based care	\$2.6 million savings to AR Medicaid over 3 years. ³⁰
Community Health Worker Outreach Program, Baltimore, MD	AA Medicaid patients with diabetes	Outreach, self-management support, system navigation to primary/ specialty care, health insurance enrollment	Cost-savings of \$80,000 to \$90,000 per CHW per year; ¹⁹ Reduction in ED visits (40%), ER and hospital admissions (33%)
Lakewood Hospital, Cleveland Clinic Health System, Ohio	Uninsured or low-income population	Discharge planning, connect to follow-up appointments with PCP at low-cost clinics or FQHCs	Saved over \$150,000 in just six months; ³² Reduced 30-day Medicare hospital readmissions and non-emergent self-pay ED visits
Denver Health, Colorado	Underserved men	Outreach, connect with PCP, establish medical home, system navigation, case management	2.28:1 ROI; ³¹ Increased primary and specialty care, decreased urgent care, inpatient, and outpatient behavioral health utilization
The King County Asthma Program, Seattle, Washington	Children with uncontrolled asthma covered by Medicaid	Self-management education, home visits, service coordination	1.9 ROI; ¹⁷ Significant improvement in symptom-free days, caregiver quality of life and urgent health care utilization
The Langdale Company, Valdosta, GA	Employees	System navigation, wellness coaching	\$4.80 per dollar spent; ³⁴ Reduced blood pressure, smoking and cholesterol levels, increased exercise and weight loss

D. DEVELOPMENT OF THE BOARD'S RECOMMENDATIONS FOR ILLINOIS' CHWS

In Illinois, several efforts, led by both CHWs and multi-sector stakeholders, were the impetus for introducing and passing CHW legislation. These stakeholders leveraged strengths, capacities, and the will of partners to garner support for the landmark bill, HB5412. Their efforts led to Representative Robyn Gabel sponsoring and introducing the bill in February 2014. HB5412 was successfully signed into legislation on July 31, 2014; it is the first official recognition of the CHW profession in Illinois. HB5412, also referred to as the “Community Health Worker Advisory Board Act,” can be found in Appendix A. A full description of Illinois’ journey to legislation, specifically from 2009-2014, was published in the July-September 2015 edition of the *Journal of Ambulatory Care*.³⁵

Several of the article’s authors support a strong and sustainable infrastructure for Illinois’s CHWs. These same individuals lent their leadership and expertise to the development of the Board’s recommendations.

The Community Health Worker Advisory Board Act called for the Director of the Illinois Department of Public Health (IDPH) to appoint a 15-member board. IDPH put out a call requesting submission of applications for consideration of Board appointment; more than 70 applications were submitted.

The diverse 15-member board, made up of eight CHWs from across the state, along with relevant health and policy experts, was charged with considering the core competencies of a CHW necessary for expanding health and wellness in diverse communities, and reducing health disparities. The Board was also charged with developing recommendations on a certification process for CHWs as well as reimbursement and pathways for secure funding.

Co-chaired by CHW Leticia Boughton Price, Network Coordinator for the Chicago CHW Local Network, and Melissa Gutierrez Kapheim, Epidemiologist with the Sinai Urban Health Institute (SUHI), the Board first convened on January 5, 2015 and organized into four Work Groups (Core Competencies and Roles; Training and Certification; Financing and Reimbursement; and Workforce Development). Over 12 months, through thorough research and analysis, the Board and more than 70 stakeholders (see Appendix B) worked diligently to produce a set of robust recommendations exceeding the requirements set by the legislation. Juana Ballesteros, IDPH Manager for Community Public Health Outreach and Jamie Campbell, Program Manager at SUHI provided support for the Board's administrative and research needs.

All meetings followed the Illinois Open Meetings Act to ensure an accountable and transparent process. Moreover, once drafted, the recommendations were presented to a larger audience of stakeholders for public input via eight listening sessions: four in English, two in Spanish, and two bilingual (Spanish/English). Four were held in Chicago and one was held in each of the following counties: Lake, St. Clair, Winnebago, and Will. The Board developed an online survey to provide an opportunity for feedback by stakeholders unable to attend the live sessions. In total, 190 individuals provided feedback on the recommendations through the listening sessions (125) and online survey (65).

The recommendations provide not only guidance for potential new legislation but innovative concepts and frameworks for multiple stakeholder groups including health care providers, payers, training organizations, foundations, and private sector employers. The intention of these recommendations has always been to create sustainable approaches to support and advance the CHW workforce and ensure the stability of this significant component of health care.

COMMUNITY HEALTH WORKERS IN ILLINOIS - A VALUE DRIVEN SOLUTION FOR POPULATION HEALTH

RECOMMENDATIONS



RECOMMENDATIONS

CORE COMPETENCIES AND ROLES WORK GROUP

The Core Competencies and Roles Work Group developed the set of standards that outline the roles CHWs perform and the competencies required for those roles. This Work Group had the benefit of a significant existing body of policy and literature for their review. Specifically, these recommendations are aligned with those from the National Community Health Worker Common Core Project,³⁶ the National Community Health Advisory Study,⁹ New York,^{37, 38} Massachusetts,³⁹ and Oregon.⁴⁰

Process Leadership

Leticia Boughton Price, Coordinator of the Chicago CHW Local Network and Molly A. Martin, MD, Associate Professor of Pediatrics with the University of Illinois at Chicago, co-chaired this work group. All work group members provided subject matter expertise. The Illinois Department of Public Health provided administrative, research, and coordination support.

Work Group Statistics

- 3 work group meetings
- Engaged 18 stakeholders
- Representation
 - 5 CHWs
 - Policy experts, health care administrators and providers, local and state government agencies, social services, federally qualified health centers, health care training and delivery institutions, and advocacy organizations

The Work Group met in person on January 22, January 29, and February 19 of 2015 to draft these recommendations and presented their summary to the full Illinois CHW Advisory Board on March 2, 2015 for review. The Work Group incorporated the edits of the Board and other work groups over the next three months.

For the purposes of these recommendations, “roles” are intended to inform job descriptions. “Skills” are intended to inform trainings, as they are the proficiencies acquired or developed to fulfill a larger function or “role”. Because connection to the community served and related experience is a source of CHW expertise, we include a list of “qualities” which are intended to inform the selection of CHWs. These are inherent attributes that contribute toward the attainment of “skills” and serve to inform employers seeking successful CHWs.

These recommendations should be seen as an all-inclusive list of roles and skills which CHWs may be expected to fulfill. However, the exact mix of these roles and skills will vary. CHWs should not be expected to have all of the recommended qualities and skills, nor should they

perform all of the recommended roles. This structure is also intended to provide opportunities for career development pathways, in a tiered system, where CHWs can attain specialized skills in certain roles and areas such as diabetes, behavioral health, asthma, etc., while others remain generalists. See the Workforce Development recommendations for details on this tiered structure.

The following eight roles and ten skills represent the range of roles and skills our board recommends be adopted any agency designing or implementing CHW-related programs. This includes the State of Illinois for the purposes of developing and maintaining a state training and certification system, payers in the private and public arenas, researchers, service organizations, and local governmental systems. Additional detailed descriptions of the roles and skills recommendations are found in Appendix C. We also recommend adoption of a specific list of QUALITIES. Appendix C also contains a list of titles frequently applied to CHWs because “Community Health Worker” is an umbrella term. The list of titles provided is not an exhaustive list and new titles may arise with time. All of these ROLES, SKILLS, QUALITIES, and TITLES are expected to evolve as the healthcare system and workforce change.

Recommendation #1: We recommend adoption of eight ROLES for CHWs.

1. Community Engagement and Advocacy
2. System Navigation
3. Participatory Research
4. Public Health Concepts and Approaches/Integration
5. Coordination of Services
6. Education
7. Social-emotional Support
8. Community/Cultural Liaison

Recommendation #2: We recommend adoption of ten SKILLS for CHWs.

1. Communication Skills
2. Interpersonal Skills
3. Coordination/Navigation Skills
4. Capacity-Building Skills
5. Advocacy Skills
6. Education and Facilitation Skills
7. Assessment Skills
8. Engagement Skills
9. Professional Skills
10. Public Health Skills

Recommendation #3: We recommend adoption of a list of QUALITIES for CHWs.

1. Team player
2. Empathetic/compassionate
3. Relatable/shared life experience
4. Good communicator
5. Active listener
6. Trustworthy
7. Emotional intelligence
8. Committed
9. Good at testimony/story telling
10. Mature
11. Nonjudgmental
12. Passionate
13. Proactive, solutions-oriented
14. Reliable
15. Personable, friendly
16. Resourceful
17. Patient
18. Creative
19. Flexible
20. Global thinker/interdisciplinary/connector
21. Leadership

RECOMMENDATIONS

TRAINING AND CERTIFICATION WORK GROUP

Greater integration of CHWs into health and social service delivery teams has led to an increased interest in standardizing training and credentialing the workforce, particularly as it pertains to advancing the recognition of the CHW profession and instituting/regulating reimbursements for CHW services. In developing its recommendations, the Training and Certification Work Group drew from existing literature, lessons learned from other states that have statewide CHW training and certification processes, and the experience and research conducted by CHW-affiliated organizations in Illinois. The Training and Certification Work Group was charged with:

- Considering the strengths and weaknesses of: a multi-tiered education or training system, statewide certification, non-certification degree-based levels of certification, and the requirements for experience-based certification
- Making recommendations regarding the initial certification process, as well as a renewal process for community health workers
- Making recommendations on a system of approval and accreditation for curriculum and training
- Making recommendations for a proposed curriculum for community health workers that would ensure that the content, methodology, development, and delivery of any proposed program is appropriately based on cultural, geographic, and other specialty needs and also reflects relevant responsibilities for community health workers

The lack of training standards has been viewed as a barrier to the growth of the CHW profession.⁴¹ Currently in Illinois, the CHW field largely depends on employer-provided on-the-job training, and without standardization, the length and scope of training varies a great deal from employer to employer. Establishing training standards would help advance the field by ensuring that CHWs have access to adequate, robust training opportunities to prepare them for their complex and wide-ranging roles and guarantees employers that a CHW possesses basic qualifications.⁴¹ Standardized training would enable the CHW position to be transferrable between different jobs and employers.⁴² It is our hope that the establishment of CHW training and certification standards would bring greater recognition for and acceptance of the vital roles that CHWs play in healthcare and beyond.

According to the Association of State and Territorial Health Officials (ASTHO),⁴³ as of October 2015, Oregon, Minnesota, New Mexico, Texas, Ohio, and Massachusetts have laws or regulations establishing CHW certification standards. Several other states have pending legislation (Florida, North Dakota) or are in the process of establishing certification/training program requirements (Illinois, Maryland, Rhode Island). Indiana, Nevada, Nebraska, New York,

Mississippi, South Carolina, and Washington have developed state-led CHW certification/training programs without the passage of state legislation.

Recognizing that CHWs may be trained in multiple institutions and contexts, the work group aimed to develop recommendations that would advance the CHW workforce and support the Core Competencies and Roles set forth by the IL CHW Advisory Board, while addressing the need for adult learning practices and flexibility in curriculum. To oversee the continued development of these recommendations and to develop the requirements of both CHW training programs and CHW certification fully, we are recommending that the IL CHW Advisory Board continue its work, under the guidance of and housed within IDPH.

Process Leadership

Tamela Milan, CHW with Access Community Health and Jeffery J. Waddy, Dean of Health Professions and Sciences at South Suburban College, co-chaired this work group. This work group divided itself into 4 subcommittees. Subcommittees were led by: Venoncia M. Baté-Ambrus, CHW/ Community Psychologist, Melissa Gutierrez Kapheim of the Sinai Urban Health Institute, Christine Lopez of Rosalind Franklin University of Medicine and Science, and Jeffery J. Waddy. Gail Hirsch, Director of the Office of CHWs with the Massachusetts Department of Public Health and Durrell Fox (CHW) with the New England AIDS Education and Training Center at Massachusetts Association of CHWs, provided subject matter expertise. IDPH provided administrative support.

Work Group Statistics

- 4 subcommittees
- 13 work group meetings
- Engaged 26 stakeholders
- Representation
 - 6 CHWs
 - Policy experts, health care administrators, health care providers, federally qualified health centers, academic research institutions, community colleges, state and federal government agencies, advocacy organizations, social services, and community-based organizations

TRAINING AND CERTIFICATION RECOMMENDATIONS

These recommendations focus on a certification and a certification renewal process for CHWs in Illinois. They also highlight the importance of developing a system of approval and accreditation for curricula and trainings leading to certification.

Recommendations for this section are broken up into three main categories.

1. CHW Training
2. CHW Certification
3. Creation of an Illinois CHW Regulatory Board

CHW Training

1. There should be academic and community-based training opportunities that lead to the mastery of the CHW profession and facilitates career mobility.
 - a. For academic-based training programs, the State of Illinois should collaborate with the Illinois Community College Board (ICCB) and the Illinois Board of Higher Education (IBHE) to adopt a process that certifies academic-based training programs which students can attend to obtain individual CHW certification.
2. Certified training programs should incorporate adult learning theories into non-academic and academic curricula. Certified training programs should reflect the approved core competencies and roles for CHWs set forth and approved by the IL CHW Advisory Board.
3. There should be multi-tiered training opportunities based on the needs of the communities CHWs serve and the demands of their workplace.
 - a. Multi-tiered training opportunities should build off trainings on core competencies and roles.
 - b. CHWs may need to undergo additional trainings e.g., asthma, diabetes, maternal child health, and behavioral/mental health. Such additional, focused trainings should follow evidence-based best practices/guidelines in the content of their trainings.
 - c. Furthermore, multi-tiered approaches should provide opportunities that build on each other and prepare CHWs for career pathways both within the CHW profession and within allied professions.

CHW Certification

4. Formal certification in the State of Illinois should *not* be mandatory.
 - a. The need for certified versus non-certified CHWs should be at the discretion of employers and based on the needs of their organization and the communities they serve.
 - b. The certification application should be accessible.
 - c. Once certified, CHWs will have to undergo a renewal process to keep their certification in good standing.
5. Work-based/fieldwork experience should be embedded in CHW trainings and curricula and should be part of the certification requirement.

6. We recommend adopting a method of grandfathering to create requirements for experience-based certification.

Creation of an Illinois CHW Regulatory Board

7. The Governor should create, within IDPH, a Community Health Worker Certification Board. The CHW Certification Board should be the regulatory body that develops and has oversight of CHW certification (initial and renewal) for both individuals and training programs. At least one full-time professional should be assigned to staff the IL CHW Certification Board, with additional administrative support available as needed.
 - a. The Illinois CHW Certification Board should be responsible for the process of certifying candidates, regardless of the training setting (academic or non-academic).
 - b. The IL CHW Certification Board should maintain a registry and/or certification records for individually certified CHWs
 - c. The Illinois CHW Certification Board should propose a certification process for and be authorized to approve trainings from community-based organizations and academic institutions (in conjunction with the ICCB and IBHE).
 - d. The Illinois CHW Certification Board should base training approval on competencies, best practices, and affordability.
 - e. All training programs (both academic and non-academic) that are deemed certifiable by the Illinois CHW Certification Board should go through a renewal process, which will be determined by the Certification Board once established.
8. The CHW Certification Board should have balanced representation from the CHW workforce, CHW employers, CHW training and educational organizations, and other engaged stakeholders.
 - a. The members should be drawn from and/or appointed in consultation with the Illinois CHW Advisory Board.
 - b. Potential CHW Certification Board members should apply for the Board and will be appointed by the Director of IDPH.
 - c. The IL CHW Certification Board should advocate for and promote the CHW profession to ensure effective utilization of CHWs.

RECOMMENDATIONS

FINANCING AND REIMBURSEMENT WORK GROUP

The charge of the Financing and Reimbursement Work Group was to:

1. Provide findings on ROI literature for the CHW model
2. Communicate the business case and ROI for CHW model
3. Provide recommendations for best practices for reimbursement options and pathways through which secure funding for CHWs may be obtained
4. Determine where financing in both the public and private sector should be explored, e.g., this could include providing financial incentives for programs to integrate CHWs and payment guidelines for CHWs services
5. Provide recommendations on how third-party payers, Medicaid, and Medicare can pursue ROI as well as reimbursement mechanisms for CHW services.

Process Leadership

Amy Sagen, Assistant Director for Health Policy and Strategy with the University of Illinois Hospital and Health Sciences System, and Charles H. Williams Director for Medical Affairs and Performance Improvement with Norwegian American Hospital, co-chaired this work group. Erica Martinez of Health and Medicine Policy Research Group (HMPRG) and Robin Zweifel of Panacea Healthcare Solutions, Inc. provided subject matter expertise. HMPRG and IDPH provided administrative, research, and coordination support.

Work Group Statistics

- 12 work group meetings
- Engaged 18 stakeholders
- Representation
 - 2 CHWs
 - Policy experts, health care administrators and providers, research institutions, state agencies, health insurance providers, and advocacy organizations

Why do we need recommendations around financing and reimbursement?

Funding for CHWs in Illinois has historically been sporadic and inconsistent. There is no requirement for the Illinois' Medicaid program to reimburse providers who employ CHWs, and CHWs cannot be certified as a Medicaid provider. There have been pockets of funding from providers who internally fund (i.e. include funding for CHWs in their budgets) CHWs, but the funding has been unsustainable. Community- and faith-based organizations often rely on grants or foundations to help finance CHW interventions, but this funding is short-term or tied to pilot projects. When the grant or project concludes CHWs become unemployed because the organization lacks internal funding to pay their salaries.

Elsewhere in this report we provide an explanation on the ROI CHWs can provide for payers and providers. CHWs have demonstrated their value to health care organizations, and as health care systems transition to value-based care, CHWs can be key contributors in the integrated health care delivery system. In examining the ROI of CHWs, it is also important to recognize the role CHWs play in the expansion of the health care workforce. There is precedent for this - there are other health care professionals who perform similar roles and demonstrate similar competencies as CHWs. These professions have been recognized by the broader health and human service system, and are paid for their work. For example, in Illinois, Medicaid reimburses services provided by certified recovery support specialists (CRSS) who provide mental health and substance abuse support to their peers.⁴⁴ CRSS' are able to bill as mental health professionals under Medicaid Rule 132. Finally, other states have taken steps to require payers to compensate CHWs and CHW employers. Additional details surrounding Medicaid reimbursement are discussed below.

Process

Over the course of the year, the financing and reimbursement committee met bi-weekly. The majority of the conversations focused around how to obtain reimbursement from Medicaid and Medicaid managed care payers to pay for CHW services. In effort not to "recreate the wheel," the committee conducted a literature review to identify how other states have approached the funding and reimbursement question. The committee also has incorporated findings from research already conducted in Illinois into our recommendations. We reviewed summaries of state funding and reimbursement mechanisms that were written by groups such as the UIC-SPH Mid-America Regional Public Health Leadership Institute, Health and Medicine Policy Research Group and the CHW Local Network. Finally, we discussed that establishing more stable funding mechanisms for CHWs should not create barriers or prohibit CHWs who chose to perform their work as volunteers from doing so.

Recommendation #1

We recommend that the Illinois Department of Healthcare and Family Services (HFS) amend contracts with managed care entities (MCE) to allow MCEs to hire CHWs or subcontract with community-based organizations that employ CHWs.

- a. CHWs should be permitted to perform care coordination services for low risk enrollees.
- b. CHWs are integral direct service providers and should participate as members of the interdisciplinary care team.

The majority of Medicaid enrollees statewide are required to enroll in a managed care entity (MCE). MCEs are entities that assume risk for the patient population they cover, i.e. HFS pays MCEs for their enrollees, but the MCEs are not required to only reimburse Medicaid approved providers or services. Currently, CHWs are not recognized as approved Medicaid providers. MCEs can choose to reimburse CHWs, or subcontract with organizations who employ CHWs, but a limited number have done so. HFS can facilitate this practice by amending MCE contracts to allow managed care organization (MCOs) to utilize CHWs as members of interdisciplinary care teams or as care coordinators. There is precedent for this as the language used for this recommendation mirrors one made in Massachusetts in the 2009, "Community Health Workers in Massachusetts: Improving Health Care and Public Health; Report of the Massachusetts Department of Public Health Community Health Worker Advisory Council."²²

Current Medicaid contracts do not allow MCOs to "count" CHWs towards required care coordination ratios. For example, the HFS contract with MCOs for seniors and persons with disabilities requires that care coordination services provided to enrollees are delivered by licensed clinical social workers (LCSWs) or registered nurses (RNs). This limits the MCOs' ability to utilize non-clinical personnel, i.e., CHWs, to perform care coordination services for enrollees. Medicaid managed care plans contracting with CHW employers in other states are not so limited. For example, in May 2005, Molina Healthcare of New Mexico (MHNM) partnered with the state of New Mexico Medical Assistance Division and Community Access to Resources and Education in New Mexico (CARE NM) in a contract to utilize CHWs for Molina members.³³ Molina hired CHWs from CARE NM to provide support to Molina enrollees who were frequent emergency department utilizers, and billing codes were established to reimburse CHWs. Some of the services the CHWs provided included: culturally sensitive health education and advocacy, facilitation of appointment-keeping, provision of information on available community resources, and education around concepts of prevention and chronic disease management.³³

The report will share the recommendations around core competencies and roles the Board has identified for CHWs in Illinois. The competencies related to education and coordination of services includes job duties or roles that are effectively care coordination. As shown in

Appendix E system navigation includes duties such as connecting patients to resources, a main duty of care coordinators. Another one of the competencies is education, and the duties include providing culturally appropriate health education.

Recommendation #2

We recommend that HFS file a state plan amendment (SPA) in order for CHWs services to be reimbursed by Medicaid.

- a. Exercise ACA option available for states of the delivery of preventive services by non-clinical providers
- b. Work with HFS to develop Medicaid fee for service billing codes for home visiting and clinical interactions with non-MCE Medicaid recipients for CHW activities and/or other preventive services, as recommended by the United States Preventive Services Task Force USPSTF:
 - a. health education;
 - b. system navigation/care coordination; and
 - c. referrals and follow-up for social/community resources
- c. Identification of activities/preventive services that are potentially reimbursable under the Medicaid program can also inform the same or similar services CHWs could be compensated for via Medicare and private payers

One of the main activities of the committee was to create a crosswalk of the identified competencies for CHWs in Illinois. We wanted to see if the services or duties CHWs were providing in other states (and being compensated for providing) were the same as the duties we are proposing in Illinois. We paid special attention to instances where there were Medicaid billing codes approved for services CHWs provide, and to services that CHWs could provide that similar health care workers were already providing (and being reimbursed by Medicaid). We believe this work can serve as a foundation for HFS and other state agencies to begin to identify Medicaid fee-for-service billings codes for services CHWs can perform and either bill for directly or work with other healthcare professionals to receive compensation. Our findings are displayed in Appendix E.

In November of 2013, Centers for Medicare and Medicaid Services (CMS) made a significant change to the scope of providers for the Medicaid population. The CMS provision of preventive services indicates that preventive services can be “recommended by a physician or other licensed practitioner ...” rather than having the preventive services “provided by a physician other licensed practitioners...”⁴⁵ A State Plan Amendment (SPA) for the state of Illinois describing the nature and scope of the changes for the Medicaid program would be required. If the SPA is approved by CMS, Illinois would be eligible to claim Federal matching funds.

The recommendation is for HFS to submit a SPA to CMS to amend the agreement between Illinois and the Federal government to include CHWs as practitioners under Medicaid and CHIP. The SPA would require a summary of practitioner qualifications for practitioners who are not physicians or licensed practitioners.⁴⁵ CMS acknowledges the opportunity of expanding the scope of providers to enhance preventive services “as another tool for states to leverage in ensuring robust provision of services designed to assist beneficiaries in maintaining a healthy lifestyle and avoiding unnecessary health care costs.”⁴⁵

A national assessment led by the National Academy for State Health Policy on state financing for CHWs found that a number of states including Washington, DC, Kentucky, Massachusetts, and South Carolina are pursuing or exploring the option of a SPA.⁴⁶ Oregon was already approved for a SPA that explicitly included CHWs in the description of providers who could provide some services; however, only certified CHWs would be reimbursed. Limiting financing opportunities for only certified CHWs is not supported by the Illinois CHW Advisory Board. It is the responsibility of the State of Illinois to support a sustainable integration of CHWs into health care teams to ensure we have the capacity to provide the necessary primary care and preventive services for Illinoisans. Taking advantage of the provision would positively benefit the state’s health transformation initiatives. The SPA recommendation introduces financial opportunities from the ACA through the Federal Medical Assistance Percentage (FMAP) and the Essential Health Benefits requirements. The provision would be an investment in our growing health care workforce by allowing health professionals to work to the top of their credentials, increasing the capacity and effectiveness of providing preventive services.

As described, there is precedence for Illinois to pursue a SPA in order to obtain fee-for-service reimbursement for CHWs. This is important especially in areas of the state where Medicaid clients are not enrolled in Medicaid managed care plans.

CHW Services and Funding/Reimbursement Structures by State*

State	Service/Benefit CHW provides	Funding/Reimbursement Structure
Alaska	<ul style="list-style-type: none"> Includes face-to-face and telemedicine 	<ul style="list-style-type: none"> Direct reimbursement by Medicaid and through fee-for-service billing arrangements Funding also provided via Indian Health Services <ul style="list-style-type: none"> Reimbursement is ~85% of physician fee schedule for some services, but 100% for services like EPSDT screening Physician supervision is required for reimbursement
Minnesota	<ul style="list-style-type: none"> CHWs may bill for patient education and care coordination services (face-to-face) through fee-for-service 	<ul style="list-style-type: none"> 30 minute units; limit 4 units/day; no more than 8 units/month Must be supervised by clinical professional
Missouri	<ul style="list-style-type: none"> Authorized for Medicaid funding, to provide general education 	<ul style="list-style-type: none"> No specific billing code
Oregon	<ul style="list-style-type: none"> Only certified CHWs 	<ul style="list-style-type: none"> State Plan Amendment (SPA) created Patient-Centered Primary Care Homes (PCPCHs) explicitly includes CHWs in description of providers for four of the six core Health Home services
South Carolina	<ul style="list-style-type: none"> Two authorized Medicaid codes for reimbursement of CHW patient education; clinical supervisor must submit CHW service codes to receive reimbursement 	<ul style="list-style-type: none"> Individual Patient education: face-to-face, \$20 per patient for up to 2 hours/day and no more than 4 hours/month Group education: face-to-face, \$6.00 per patient with max of 5 patients in a group for no more than 1 hour/day and 4 hours/month Managed care plans reimburse for CHW services

Sources: National Association for State Health Policy, *Integrating Community Health Worker Models into Evolving State Health Care System*;⁴⁷ The New England Comparative Effectiveness Public Advisory Council, *An Action Guide on Community Health Workers: Guidance for Health Insurers*;⁴⁸ State Reform: *State Community Health Worker Models*⁴⁹

*Several states (AR, ME, NM, NY, WA, WV) are in various stages of pursuing funding for CHWs via 1115 Medicaid waivers, State Innovation Model programs and Medicaid Health Homes. These are federal funding options provided to state Medicaid programs.

Recommendation #3

We recommend that Medicaid managed care entities (MCEs) that contract with hospitals should encourage hospitals to establish and deploy CHW programs in support of patients upon discharge from the hospital to help the patients manage their health in the community.

Unnecessary hospital readmissions are a sign of a fragmented health care system. Upon discharge, many patients are confused about discharge instructions and follow-up care.⁵⁰ Hospitals are well-positioned to develop post-hospitalization systems of care that reach beyond a hospital's four walls.

Medicare spends \$17.8 billion a year on hospital readmissions. Nearly one in five Medicare patients returns to the hospital within a month of discharge. As a result, the ACA created Medicare's Hospital Readmission Reduction Program (Section 3025). Started in October 1, 2012, Medicare's Hospital Readmission Reduction Program imposes penalties, by reducing payments, to Inpatient Prospective Payment System hospitals with excess readmissions.⁵¹ CHWs have been found to be a practical and effective approach for reducing hospitalizations and readmission.

For example, Temple University Health System utilizes CHWs to assist high-risk Medicaid patients with care transitions to reduce hospital readmissions. Another example is New York Methodist Hospital, who, while looking to reduce its high rates of preventable hospital readmissions, conducted a study on patients with congestive heart failure. Half of the 137 enrolled patients received standard care and half received a CHW intervention consisting of follow-up calls and post-discharge support and education. Only 7% of patients who participated in the CHW intervention were readmitted within 30 days, compared to 19% in the control group. By addressing behavioral and socioeconomic factors of disease and disease management, CHWs are controlling readmissions, especially among high-risk populations.⁵²

Recommendation #4

We recommend that Hospitals and FQHCs employ CHWs to assist with mandated activities such as community health needs assessments and community benefits.

As nonprofit institutions, hospitals and FQHCs have important fiduciary obligations to provide benefits to their communities corresponding with their tax-exempt status. Providing Community Benefits is an important component of a hospital and FQHC's charitable activity.

In order to identify which Community Benefits a hospital or FQHC should provide, the entity must first conduct a community health needs assessment. A thorough assessment involves the

comprehensive review of unmet health needs of the community by analyzing community input, public health data, and an inventory of local community assets.⁵³

Community input should be gathered from a broad array of community members. Since the goal of the needs assessment is to identify unmet health needs of community members, it is important that hospitals and FQHCs make every effort to make community members feel comfortable providing feedback about their needs. As trusted members of the community, CHWs can facilitate the recruitment of other community members to gather information about unmet health needs. This is especially true in hard-to-reach, disadvantaged populations.

The needs identified through the community health needs assessment will inform the Community Benefits Plan. The Plan will address how the needs of the target population will be addressed.⁵³ CHWs can and should be involved in the design, implementation, and evaluation of programs that address the community health needs. This will increase the likelihood of successful programs that are truly meeting the needs of the local community. Examples of such Community Benefits programs that CHWs have effectively conducted include:

- Outreach health education to disadvantaged populations;
- Free health screenings services to disadvantaged populations;
- Domestic violence and/or child abuse and neglect prevention services.

Recommendation #5

We recommend that home visiting programs hire CHWs.

- a. The state should provide incentives to home visiting programs for hiring CHWs, e.g., preferential rating of public contract applications, demonstration project funding, etc., in all public agency contracting.
- b. Third party payers (Medicaid, Medicare, commercial health plans) should partner with home visiting programs who hire CHWs.
- c. Home visiting programs that hire CHWs should follow the recommendations put forth by the Health Connections Work Group of the Home Visiting Task Force.⁵⁴
- d. Healthcare providers (clinics, hospitals) should be encouraged to partner with home visiting programs or incorporate a home visiting program in their organization.

Home visitors offer intensive home visiting services to families from the prenatal period to age 5 in the context of program models considered evidence-based by Home Visiting Evidence of Effectiveness.⁵⁵

Home visiting programs are recognized as a preventative public health strategy. They are also an integral component of a continuum of early childhood services beginning in the prenatal stage. Home visiting programs improve the developmental trajectory of all children,

particularly those who are most at risk for poor health, educational, economic and social outcomes. Evidence-based home visiting models address physiological, social, psychological, economic, family, and other factors that influence children's health and development. Voluntary home visiting programs have been shown to be effective in supporting families and children experiencing these risks because they reach families where they live and tailor services to meet their individual needs. They are particularly important for reaching families with very young children, who often are not seen in more formal settings, such as preschool.⁵⁶

Home visiting is a potential way to serve families who may otherwise be difficult to engage in supportive services. Existing rigorous research indicates that home visiting has the potential for positive results among high-risk families, particularly on health care usage and child development.⁵⁷

The unique role of CHWs as culturally competent mediators (health brokers) between providers of health services and the members of diverse communities, as well as CHWs' effectiveness in promoting the use of primary and follow-up care for preventing and managing disease, have been extensively documented and recognized for a variety of health care concerns, including maternal and child health.

Health care providers must be educated on home visiting programs and their benefits. In addition, they should be encouraged to develop a streamlined information exchange system for referrals and follow up between home visiting programs and health care providers.

RECOMMENDATIONS

WORKFORCE DEVELOPMENT WORK GROUP

The Workforce Development Work Group was charged with making recommendations for career pathways in both the CHW profession and other health-related professional areas. It was important to recommend how to integrate CHWs into health care delivery teams, social services organizations, government agencies, faith-based and community organizations. Additionally, the workgroup was tasked with advising the Illinois Department of Employment Security (IDES) on job descriptions, titles, and salary ranges for CHWs, and ensure IDES is tracking pertinent CHW data/statistics.

Process Leadership

Venoncia M. Baté-Ambrus, CHW/Community Psychologist, Teresa Berumen, CHW with Enlace Chicago, and Lizette Martinez, CHW/Care Coordinator with Alivio Medical Center, led this work group. This work group divided itself into 3 subcommittees. All work group members as well as Kiara Bemby, ASPIN, and Lisbeth Leanos, Illinois Department of Employment Security provided subject matter expertise. IDPH provided administrative, research and coordination support.

Work Group Statistics

- 12 work group and subcommittee meetings
- Engaged 30 stakeholders
- Representation
 - 7 CHWs
 - Policy experts, health care administrators and providers, local and state government agencies, social services, federally qualified health centers, advocacy organizations, academic entities, and faith-based institutions

The CHW model is well-suited for community outreach, out-patient supports, community-based care coordination programs, and can also be implemented in settings like emergency departments. CHWs can operate within or between: health care delivery systems, public health departments, first responder entities (police, fire), faith-based communities, schools, and nonprofit organizations.

CHW Cultivation and Expansion

For the purpose of these recommendations, the Workforce Development Work Group intended to advise employers and CHWs on strategies and practices utilized to cultivate and expand the CHW employee pool. These strategies and practices should include professional enrichment, on-the-job training, and opportunities for advancement within the CHW profession via tiered levels (generalist, specialist, and trainer/supervisor). Cross-training and pathways to allied professions may also be a part of workforce development. Monetary and non-monetary rewards for paid and volunteer (unpaid) CHWs are important facets. Flextime - especially for CHWs who work non-traditional hours, job sharing, fringe benefits, and tuition reimbursement - are also incentives for CHWs. CHW work is creative, flexible, meaningful, and stems from a strong motivation and commitment to improve the holistic health (mental, physical, social, economic, safety) of communities. These recommendations should also be considered for the unique contribution that CHWs bring and desire for sustainable employment. CHW salary range is contingent upon years of practice, education, bilingualism (if pertinent to the community being served), and level or tier. CHW specialist, trainers, and supervisors should earn more than generalist. However, regardless of these criteria, it is imperative that CHWs earn a living wage that affords a healthy quality of life for themselves and their families. CHWs want to be respected on par with other team members.

Interdisciplinary Teams

CHWs have a unique role on interdisciplinary teams because of their situated-knowledge and cultural insight. The situated knowledge compliments the clinical/credentialed knowledge of other members of the interdisciplinary team and provides important insights into the patient's strengths, challenges, access to resources, and ability and readiness to comply with providers' orders. Clear role distinctions between CHWs and other team members must be established from the onset and CHWs should not be asked to perform tasks beyond their scope of skills. These recommendations also align with the qualities and skills recommended by the Core Competency and Roles Work Group.^{58, 59}

CHW Supervision

The unique nature of CHW work necessitates a supervisor who is familiar with the target community, its strength, challenges, and needs. This supervisor, who may be a senior CHW, should believe in and support the role of a CHW by employing creative strategies for effectively working in the target community. This may entail working a non-traditional schedule and/or working in a non-traditional setting in order to serve clients where they are. The unique ability of CHWs to be flexible in their schedule/setting results in increased client and provider satisfaction, improved population health and reduced cost associated with unnecessary, duplicative or belated care. CHWs would benefit from coaching and mentoring and require engaged, supportive supervision.⁵⁸⁻⁶⁰

CHW Recruitment

CHWs should be recruited through community contacts and networks. For example, trusted community leaders and advocates are good sources for referrals. Job openings should be posted at community centers, faith-based organizations, local businesses, schools, and other locations frequented by community members. Employment selection should be based on the individual's community integration, lived experience and previous work with the targeted population.⁵⁸⁻⁶⁰ For desirable qualities in a CHW also refer to the recommendations from the Core Competencies and Roles Work Group.

CHW Training

There are multiple platforms for CHW training including web-based, community college, and internal training based on the mission and goals of the organization or specific issue of concern. Training methodologies for CHWs are best when they are interactive, build on the situated-knowledge and lived experiences of the CHW, and include a combination of didactic approaches and role-playing exercises.⁶¹ The most important credential that CHWs bring to their position is the motivation to improve their communities and the situated knowledge or lived experience to affect positive individual and community change.

CHWs are cost effective for the organizations that employ them.^{35, 62} CHWs want employers to invest in them by providing opportunities and professional growth and advancement. An example includes tiered occupational levels: entry level/generalist, advanced specialist, and trainer and/or supervisor levels. CHWs seek continued professional education opportunities to address emerging needs and trends with certificates of completion. In addition, employers can also invest in CHWs by providing tuition reimbursement for CHWs pursuing academic degrees to enhance their work and explore pathways.

Recommendations

These recommendations focus on career pathways in the CHW profession and other professional areas as well as integration of CHWs into health care delivery teams, social services organizations, and government and community organizations.

1. Develop a tiered career ladder for CHWs to achieve upward mobility/occupational advancement.
 - a. Tiers should include: CHW generalists, CHW specialists (may require additional education and/or training in specific topics), CHW trainers, and CHW supervisors. (See Training and Certification Recommendation #5-Training for more details on this multi-tiered structure.)
 - b. Foster career pathways for CHWs seeking to transition to other professions through opportunities at community colleges, universities, vocational training programs, and community-based organizations.

2. The Illinois Department of Employment Security (IDES) should incorporate CHW data into CHW employment statistics to identify trends and needs, and make projections. The IDES tracks relevant CHW employment data which includes a comprehensive review of Standard Occupational Codes, Definitions, Titles, and Salaries for CHWs and other job designations CHWs may work in.
3. CHWs should have a basic understanding of behavioral and mental health. Behavioral/mental health issues have been found to be confounding factors to poor management of chronic illnesses such as diabetes, hypertension, etc. For example, the Mental Health First Aid course offers a basic understanding of behavioral and mental health conditions and is geared towards non-clinicians and non-behavioral health professionals. (See Training and Certification Recommendation #3 for more details.)
4. For CHWs who plan to or are working specifically in the field of behavioral and mental health, we recommend the following:
 - a. Cross-training or dual certification (e.g. certified recovery support specialist credential) for CHWs with lived experience in substance abuse or mental illness. (See Core Competency and Roles; Recommendation #3 for a list of qualities for CHWs.)
 - b. CHW trainings in this area should utilize best or promising practice guidelines for peer competencies in behavioral health (mental health and substance abuse) from state and national experts (e.g. Illinois Certified Recovery Support Specialists [CRSS], Substance Abuse and Mental Health Services Administration [SAMHSA] staff, and professionals involved in Screening, Brief Intervention and Referral to Treatment [SBIRT] and Trauma Informed Care).⁶³
5. Agencies that integrate CHWs into health care delivery teams, social services organizations, and government and community organizations should:
 - a. Apply integrated and collaborative approaches in efforts to meet the Triple Aim (improve the quality of patient care, improve population health, and reduce health care costs per capita).²⁹
 - b. Clearly and continuously articulate CHW roles, tasks, and competencies to staff and external partners to mitigate any inter-professional mistrust or tension which may arise.
 - c. Provide clear and adequate supervision for CHWs; supervision that is flexible and conveys understanding of the unique nature of CHW work.
 - d. Hire CHWs based on community integration, previous work with the target population, and lived experience.^{58, 59}
6. CHWs should be integrated into medical homes.^{29, 62}
 - a. CHWs should be the link between the patient and the medical home.
 - b. CHWs may require additional certificates or trainings, beyond basic CHW certification, based on the needs of the medical home.
 - c. CHWs should have supportive supervisors who are knowledgeable about the CHW model and communities being served.
 - d. Communication with all members of the health care team is important. Regular team meetings to monitor the quality of the program and provide CHWs with the necessary resources to be successful are imperative. CHW supervisors should communicate with medical staff and providers about CHWs, their skills, and value to

the health care system. For team-based health care delivery to be successful, CHWs should have frequent and direct communication with medical professionals and allied staff. Such communication can also include informal meetings and documenting in patient chart and electronic medical records with appropriate training.

RECOMMENDATIONS

RAISING AWARENESS

A nationally standardized CHW definition does not exist, posing challenges to the understanding and recognition of CHWs within the health and human services system. Raising awareness around their unique and wide-ranging abilities will not only enhance service delivery, but will also increase job and career advancement opportunities for CHWs. Thus, raising awareness ultimately will not only improve population health, but will also enhance workforce development efforts.

In order to ensure the successful implementation of the above recommendations, the Illinois Community Health Worker Advisory Board also recommends awareness-raising activities. It is imperative that such activities be wide-reaching among health and human service providers, recipients of such services, policy makers, CHW employers, and the CHW workforce itself. In addition, training organizations/academic institutions which provide CHW training should adopt the use of the term “community health worker” when developing and implementing programs. Furthermore, the role of CHWs should be incorporated into the content of training and education curricula for health care and human service professionals. This will ensure future providers are aware of the value and unique role of CHWs and will facilitate the successful integration of CHWs into health and social services systems.

The successful integration of CHWs into our evolving patient-centered, multi-disciplinary health and human services system requires policy makers and stakeholders to support the recommendations of the Illinois Community Health Worker Advisory Board.

Toward this end, the Illinois Community Health Worker Advisory Board recommends the following awareness-raising activities:

1. State and local government agencies should adopt the “community health worker” term and the definition of a “community health worker” as set forth in Public Act 098-0796.
 - a. The adoption of the CHW term will provide ongoing opportunities for accurate data collection for the State when tracking workforce size and contributions towards the elimination of health disparities.
 - b. Utilization of the CHW term throughout the health and human services system is an essential first step.
2. Develop and implement an educational campaign about CHWs targeted at CHWs, employers of CHWs, training/academic programs, funders, policy makers, local health departments, and individuals receiving CHW services.
3. Encourage private and public funders of CHWs to use the term “community health worker” when releasing funding opportunities involving community outreach and

engagement, health education and promotion, and health and social service systems navigation.

- a. In using the term “community health worker,” employers of CHWs will widely adopt and use the term as well.

COMMUNITY HEALTH WORKERS IN ILLINOIS - A VALUE-DRIVEN SOLUTION FOR POPULATION HEALTH

NEXT STEPS/IMPLICATIONS



NEXT STEPS/IMPLICATIONS

Heartland Health Outreach (HHO) has long recognized the value of CHWs, having integrated such professionals into our health care teams since 1995. They have proved invaluable for a health care clinic that predominantly serves those experiencing homelessness. Supporting and educating those in such precarious circumstances is challenging, but CHWs have the ideal skills and backgrounds to surmount such challenges. There will always be barriers to improving the health of the population HHO serves, but some of those barriers can be successfully addressed through CHWs. We have the improved health and health care decision-making to prove it.

Ed Stellan
Interim Executive Director
Heartland Health Outreach

A year long process of stakeholder engagement, research, analysis, and feedback has created robust recommendations to guide the CHW workforce in the State of Illinois. These recommendations are intended to provide a foundation for policy changes and future legislation to ensure the CHW model in Illinois is successfully integrated into the health care and public health system. The CHW profession and CHW model is being implemented nationwide, with at least 41 states using CHWs.⁴⁶ It is critical for the State of Illinois to support the further development and expansion of the CHW profession.

Subsequently to this report and set recommendations, there needs to be a request for the continuation of the Illinois CHW Advisory Board (the Board) supported by the Illinois Department of Public Health (IDPH). The Board with the staff support and guidance of IDPH has met extensively this year in preparation of the report; however, a collaborative effort with responsible leadership must continue in order to successfully implement the recommendations proposed. The Board was created to represent the state of Illinois; being led by a majority of CHWs with the support of clinical, academic, business, and community members. Recently recognizing the CHW profession in Illinois, it is critical to include CHWs in every step of the development and implementation of the CHW model, including policy changes.

Toward this end, some of the recommendations would best be implemented via legislative action. The recommendations to adopt roles, competencies and qualities would best be implemented with a legislative amendment to Public Act 098-0796 – IL CHW Advisory Board Act (The Act). The Act has a section considering core competencies and this would be an amendment to the law to incorporate the roles, competencies, and qualities to be an effective

CHW considered essential by the Board. The best time frame to introduce the amendments would be in the next year to be the foundation for the CHW professional recognition.

Sustainable funding pathways are essential for the advancement of the CHW model in Illinois. The Finance and Reimbursement recommendations do not require introducing immediate legislation through the Illinois General Assembly but are recommendations to encourage different health care agencies and organizations, such as Managed Care Entities (MCEs), hospitals, health centers, home visiting programs, and community-based organizations (CBOs) to use CHWs to provide services. Two recommendations would need action and leadership from the Illinois Department of Healthcare and Family Services (HFS). Specifically, this would be a contract policy change between HFS and MCEs and this would require the submission of a State Plan Amendment by HFS to the Centers for Medicare and Medicaid Services.

These recommendations are not only designed for state government and state agencies but may also be used by stakeholders and advocates. This report serves to guide their efforts and advocacy.

CITATIONS

1. Community Health Worker Section. *American Public Health Association*. Available at: <http://www.apha.org/apha-communities/member-sections/community-health-workers>. Accessed December 2, 2015.
2. Migrant Clinicians Network Webinar, ¿Qué es Salud Publica?(What is Public Health). Available at: http://www.migrantclinician.org/toolsource/resource/webinar_que_es_salud_publica.html
3. Lehmann U, Sanders D. *Community Health Workers: What Do We Know About Them?* Geneva, Switzerland: World Health Organization. 2007.
4. Clark NM, Zimmerman BJ. A social cognitive view of self-regulated learning about health. *Health Educ Behav*. Oct 2014;41(5):485-491.
5. Postma J, Karr C, Kieckhefer G. Community health workers and environmental interventions for children with asthma: a systematic review. *J Asthma*. Aug 2009;46(6):564-576.
6. Bandura A. Self-efficacy: toward a unifying theory of behavioral change. *Psychol Rev*. Mar 1977;84(2):191-215.
7. U.S. Health Resources and Services Administration. Health Resources and Services Administration Bureau of Health Professions. *Community Health Workers National Workforce Study*. Rockville, MD: 2007.
8. Swider SM. Outcome effectiveness of community health workers: an integrative literature review. *Public Health Nurs*. Jan-Feb 2002;19(1):11-20.
9. Rosenthal EL, Wiggins N, Brownstein JN, et al. *The final report of the national community health advisor study: Weaving the future*. Baltimore, MD: Annie E. Casey Foundation; 1998.
10. Witmer A, Seifer SD, Finocchio L, Leslie J, O'Neil EH. Community health workers: integral members of the health care work force. *Am J Public Health*. Aug 1995;85(8 Pt 1):1055-1058.
11. Perez LM, Martinez J. Community health workers: social justice and policy advocates for community health and well-being. *Am J Public Health*. Jan 2008;98(1):11-14.
12. Berman PA, Gwatkin DR, Burger SE. Community-based health workers: head start or false start towards health for all? *Soc Sci Med*. 1987;25(5):443-459.
13. Community health workers – A leadership brief on preventive health programs. *Center for Policy Alternatives*, November 1998.
14. Karnick P, Margellos-Anast H, Seals G, Whitman S, Aljadeff G, Johnson D. The pediatric asthma intervention: a comprehensive cost-effective approach to asthma management in a disadvantaged inner-city community. *J Asthma*. Jan-Feb 2007;44(1):39-44.
15. Margellos-Anast H, Gutierrez MA, Whitman S. Improving asthma management among African-American children via a community health worker model: findings from a Chicago-based pilot intervention. *J Asthma*. May 2012;49(4):380-389.
16. Krieger JW, Takaro TK, Song L, Weaver M. The Seattle-King County Healthy Homes Project: a randomized, controlled trial of a community health worker intervention to decrease exposure to indoor asthma triggers. *Am J Public Health*. Apr 2005;95(4):652-659.

17. Campbell JD, Brooks M, Hosokawa P, Robinson J, Song L, Krieger J. Community Health Worker Home Visits for Medicaid-Enrolled Children With Asthma: Effects on Asthma Outcomes and Costs. *Am J Public Health*. Aug 13 2015:e1-e7.
18. Brown HS, Wilson KJ, Pagan JA, *et al*. Cost-effectiveness analysis of a community health worker intervention for low-income Hispanic adults with diabetes. *Prev Chronic Dis*. 2012;9:E140.
19. 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*. Winter 2003;13(1):22-27.
20. Fisher EB, Boothroyd RI, Coufal MM, *et al*. Peer support for self-management of diabetes improved outcomes in international settings. *Health Aff (Millwood)*. Jan 2012;31(1):130-139.
21. Scoggins JF, Ramsey SD, Jackson JC, Taylor VM. Cost effectiveness of a program to promote screening for cervical cancer in the Vietnamese-American population. *Asian Pac J Cancer Prev*. 2010;11(3):717-722.
22. 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.
23. Shah MK, Heisler M, Davis MM. Community health workers and the Patient Protection and Affordable Care Act: an opportunity for a research, advocacy, and policy agenda. *J Health Care Poor Underserved*. Feb 2014;25(1):17-24.
24. Enard KR, Ganelin DM. Reducing preventable emergency department utilization and costs by using community health workers as patient navigators. *J Healthc Manag*. Nov-Dec 2013;58(6):412-427; discussion 428.
25. Burns ME, Galbraith AA, Ross-Degnan D, Balaban RB. Feasibility and evaluation of a pilot community health worker intervention to reduce hospital readmissions. *Int J Qual Health Care*. Aug 2014;26(4):358-365.
26. Balaban RB, Galbraith AA, Burns ME, Vialle-Valentin CE, Larochelle MR, Ross-Degnan D. A Patient Navigator Intervention to Reduce Hospital Readmissions among High-Risk Safety-Net Patients: A Randomized Controlled Trial. *J Gen Intern Med*. Jul 2015;30(7):907-915.
27. Kangovi S, Grande D, Carter T, *et al*. The use of participatory action research to design a patient-centered community health worker care transitions intervention. *Healthc (Amst)*. Jul 2014;2(2):136-144.
28. Kangovi S, Long JA, Emanuel E. Community Health Workers Combat Readmission. *Arch Intern Med*. Nov 5 2012:1-2.
29. Findley S, Matos S, Hicks A, Chang J, Reich D. Community health worker integration into the health care team accomplishes the triple aim in a patient-centered medical home: a Bronx tale. *J Ambul Care Manage*. Jan-Mar 2014;37(1):82-91.
30. Felix HC, Mays GP, Stewart MK, Cottoms N, Olson M. The Care Span: Medicaid savings resulted when community health workers matched those with needs to home and community care. *Health Aff (Millwood)*. Jul 2011;30(7):1366-1374.
31. Whitley EM, Everhart RM, Wright RA. Measuring return on investment of outreach by community health workers. *J Health Care Poor Underserved*. Feb 2006;17(1 Suppl):6-15.

32. Navigator reduces readmissions, inappropriate ED visits. *Hosp Case Manag.* Dec 2014;22(12):166, 171.
33. Johnson D, Saavedra P, Sun E, *et al.* Community Health Workers and Medicaid Managed Care in New Mexico. *J Community Health.* Sep 28, 2011.
34. Miller A. Georgia firm's blueprint for taming health costs. Available at: <http://www.georgiahealthnews.com/2011/07/programs-improve-valdosta-firm%E2%80%99s-financial-health/>. Accessed December 21, 2015.
35. Bate-Ambrus VM, Castillo A, Martinez E, *et al.* Many Ingredients, One Sublime Dish: The Recipe for the Passage of Illinois HB5412 Into Law. *J Ambul Care Manage.* Jul-Sep 2015;38(3):236-243.
36. UT Project on CHW Policy and Practice, National AHEC Organization, & APHA CHW Section. The Working Report of the Community Health Worker Core Consensus (C3) Project: Building Consensus in the CHW Field on CHW Roles, Skills, and Qualities. In press – 2015.
37. Findley S, Matos S, Hicks A, Campbell A, Moore A, Diaz D. Building a Consensus on Community Health Workers' Scope of Practice: Lessons From New York. *Am J Public Health.* 2012;102(10):1981-7.
38. Matos S, Findley S, Hicks A, Legendre Y, Canto L. Paving a Path to Advance the Community Health Worker Workforce in New York State: A New Summary Report and Recommendations. Available at <http://nyshealthfoundation.org/uploads/resources/paving-path-advance-community-health-worker-october-2011.pdf>. Accessed December 28, 2015.
39. Community Health Workers: Promoting a Vital Workforce. *Massachusetts Health and Human Services*; 2015. Available at <http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/prevention-and-wellness/comm-health-wkrs/>. Accessed December 28, 2015.
40. Angus L, Cheney C, Clark S, Gilmer R, Wang E. The Role of Non-Traditional Health Workers in Oregon's Health Care systems. *Oregon Health Authority*;2006. Available at: <http://www.oregon.gov/oha/oei/Documents/nthw-report-120106.pdf>
41. Support for community health worker to increase health access and to reduce health inequalities. Washington (DC): American Public Health Association; 2009.
42. Alvillar M, Quinlan J, Rush CH, Dudley DJ. Recommendations for developing and sustaining community health workers. *J Health Care Poor Underserved.* Aug 2011;22(3):745-750.
43. Community Health Workers Training/Certification Standards. Association of State and Territorial Health Officials; 2015. Available at: <http://www.astho.org>. Accessed December 28, 2015.
44. Certified Recovery Support Specialist: FAQ. *Illinois Mental Health Collaborative.* Available at: http://www.illinoismentalhealthcollaborative.com/consumers/crss/CRSS_FAQ.pdf. Accessed December 28, 2015.
45. Mann C. Update on Preventive Services Initiatives. *Department of Health & Human Services, Centers for Medicare & Medicaid Services*; 2013.
46. State Community Health Worker Models. *National Academy of State Health Policy.* Available at: <http://www.nashp.org/state-community-health-worker-models/>. Accessed December 29, 2015.
47. Hirsch G, Armijo K, Gayheart A. (Speakers). Webinar: *Integrating Community Health Worker Models into Evolving State Health Care System.* National Academy for State Health Policy. Available at:

- <http://www.nashp.org/integrating-community-health-worker-models-evolving-state-health-care-systems/>. Accessed December 29, 2015.
48. The New England Comparative Effectiveness Public Advisory Council: An Action Guide on Community Health Workers: Guidance for Health Insurers. *The Institute for Clinical and Economic Review*. Available at: http://cepac.icer-review.org/wp-content/uploads/2011/04/Action-Guide-for-Health-Insurers_09-05-131.pdf. Accessed December 29, 2015.
 49. State Community Health Worker Models. Available at: <https://www.statereform.org/state-community-health-worker-models>. Accessed December 29, 2015.
 50. Ness D, Kramer W. Reducing Hospital Readmissions: It's About Improving Patient Care. Health Affairs Blog. Available at: <http://healthaffairs.org/blog/2013/08/16/reducing-hospital-readmissions-its-about-improving-patient-care/>. Accessed December 29, 2015.
 51. Peers for Progress. Opportunities for Peer Support in the ACA Issue Brief. Available at: http://peersforprogress.org/wpcontent/uploads/2013/03/20130313_peer_support_and_the_affordable_care_act_3713.pdf. Accessed December 29, 2015.
 52. Kangovi S, Nandita Mitra N, Grande D, *et al*. Patient-Centered Community HealthWorker Intervention to Improve Posthospital Outcomes A Randomized Clinical Trial. *JAMA Intern Med*. 2014.
 53. The Attorney General's Community Benefits Guidelines for Non Profit Hospitals. . Available at: <http://www.mass.gov/ago/docs/healthcare/hospital-guidelines.pdf>. Accessed December 29, 2015.
 54. Recommendations to the Governor's Office of the State of Illinois for improving coordination between home visiting programs and health systems. Available at: http://www.illinois.gov/gov/OECD/Documents/HVTF_MIECHVP/Health%20Connections/FINAL%20HVTF%20HC%20WG%20%20recommendations%2023%20Feb%202015.pdf. Accessed December 28, 2015.
 55. Home Visiting Evidence of Effectiveness: Model Reports. *U.S. Department of Health & Human Services, Administration for Children & Families*. Available at: <http://homvee.acf.hhs.gov/programs.aspx>. Accessed December 29, 2015.
 56. Supplee L, Terry Adirim T. Evidence-based home visiting to enhance child health and child development and to support families. *CYF News*. Available at: <http://www.apa.org/pi/families/resources/newsletter/2012/07/home-visiting.aspx>. Accessed December 28, 2015.
 57. Avellar SA, Supplee LH. Effectiveness of home visiting in improving child health and reducing child maltreatment. *Pediatrics*. Nov 2013;132 Suppl 2:S90-99.
 58. Baté-Ambrus VM. Kindred Spirits: CHWs and Community Psychologists a Call For Mutual Support. . *The Community Psychologist*. 2014;47:6-8.
 59. Reiff R, Riessman F. The Indigenous nonprofessional: A Strategy of change in community action and community mental health programs. *Community Mental Health J. Monograph*.1965;1:1-32.
 60. Gutierrez Kapheim M, Campbell J. *Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings*. Chicago, IL: Sinai Urban Health Institute; 2014.
 61. Wiggins, N; Johnson D; Avila M; *et al*. Using popular education for community empowerment: perspectives of Community Health Workers in the Poder es Salud/Power for Health program. *Critical Public Health*. 2009;19(1):11–22.

62. Rush CH. Return on investment from employment of community health workers. *J Ambul Care Manage.* Apr 2012;35(2):133-137.
63. Wennerstrom A, Vannoy SD, 3rd, Allen CE, *et al.* Community-based participatory development of a community health worker mental health outreach role to extend collaborative care in post-Katrina New Orleans. *Ethn Dis.* Summer 2011;21(3 Suppl 1):S1-45-51.

APPENDICES

Appendix A - Authorizing Legislation

Appendix B - Work Group Members

Appendix C - CHW Roles, Skills and Titles

Appendix D - Endorsements

Appendix E - Medicaid/Core Competencies Crosswalk

APPENDIX A – AUTHORIZING LEGISLATION

Public Act 098-0796

HB5412 Enrolled

LRB098 19365 RPM 54518 b

AN ACT concerning public health.

**Be it enacted by the People of the State of Illinois,
represented in the General Assembly:**

Section 1. Short title. This Act may be cited as the Community Health Worker Advisory Board Act.

Section 5. Definitions. In this Act:

"Board" means the Community Health Worker Advisory Board.

"Community health worker" means a frontline public health worker who is a trusted member or has an unusually close understanding of the community served. This trusting relationship enables the community health worker to serve as a liaison, link, and intermediary between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities, including outreach, community education, informal counseling, social support, and advocacy. Nothing in this definition shall be construed to authorize a community health worker to provide direct care or treatment to any person or to perform any act or service for which a license issued by a professional licensing board is required.

"Department" means the Department of Public Health.

Section 10. Advisory Board.

(a) There is created the Advisory Board on Community Health Workers. The Board shall consist of 15 members appointed by the Director of Public Health. The Director shall make the appointments to the Board within 90 days after the effective date of this Act. The members of the Board shall represent different racial and ethnic backgrounds and have the qualifications as follows:

- (1) four members who currently serve as community health workers in Cook County, one of whom shall have served as a health insurance marketplace navigator;

(2) two members who currently serve as community health workers in DuPage, Kane, Lake, or Will County;

(3) one member who currently serves as a community health worker in Bond, Calhoun, Clinton, Jersey, Macoupin, Madison, Monroe, Montgomery, Randolph, St. Clair, or Washington County;

(4) one member who currently serves as a community health worker in any other county in the State;

(5) one member who is a physician licensed to practice medicine in Illinois;

(6) one member who is a licensed nurse or advanced practice nurse;

(7) one member who is a licensed social worker, counselor, or psychologist;

(8) one member who currently employs community health workers;

(9) one member who is a health policy advisor with experience in health workforce policy;

(10) one member who is a public health professional with experience with community health policy; and

(11) one representative of a community college, university, or educational institution that provides training to community health workers.

(b) In addition, the following persons or their designees shall serve as ex officio, non-voting members of the Board: the Executive Director of the Illinois Community College Board, the Director of Children and Family Services, the Director of Aging, the Director of Public Health, the Director of Employment Security, the Director of Commerce and Economic Opportunity, the Secretary of Financial and Professional Regulation, the Director of Healthcare and Family Services, and the Secretary of Human Services.

(c) The voting members of the Board shall select a chairperson from the voting members of the Board. The Board shall consult with additional experts as needed. Members of the Board shall serve without compensation. The Department shall provide administrative and staff support to the Board. The meetings of the Board are subject to the provisions of the Open Meetings Act.

(d) The Board shall consider the core competencies of a community health worker, including skills and areas of knowledge that are essential to bringing about expanded health and wellness in diverse communities and reducing health

disparities. As relating to members of communities and health teams, the core competencies for effective community health workers may include, but are not limited to:

- (1) outreach methods and strategies;
- (2) client and community assessment;
- (3) effective community-based and participatory methods, including research;
- (4) culturally competent communication and care;
- (5) health education for behavior change;
- (6) support, advocacy, and health system navigation for clients;
- (7) application of public health concepts and approaches;
- (8) individual and community capacity building and mobilization; and
- (9) writing, oral, technical, and communication skills.

Section 15. Report.

(a) The Board shall develop a report with its recommendations regarding the certification process of community health workers. The report shall be completed no later than 12 months after the first meeting of the Board. The report shall be submitted to all members and ex officio members of the Board, the Governor, the President of the Senate, the Minority Leader of the Senate, the Speaker of the House of Representatives, and the Minority Leader of the House of Representatives. The Department shall publish the report on its Internet website.

(b) The report shall at a minimum include the following:

- (1) a summary of research regarding the best practices, curriculum, and training programs for designing a certification program in this State for community health workers, including a consideration of a multi-tiered education or training system, statewide certification, non-certification degree-based levels of certification, and the requirements for experience-based certification;
- (2) recommendations regarding certification and a renewal process for community health workers, and a system of approval and accreditation for curriculum and training;
- (3) recommendations for a proposed curriculum for community health workers that ensures the content, methodology, development, and delivery of any proposed

program is appropriately based on cultural, geographic, and other specialty needs and also reflects relevant responsibilities for community health workers; and

(4) recommendations for best practices for reimbursement options and pathways through which secure funding for community health workers may be obtained.

(c) The Board shall advise the Department, the Governor, and the General Assembly on all matters that impact the effective work of community health workers.

Section 99. Effective date. This Act takes effect upon becoming law.

Effective Date: 7/31/2014

APPENDIX B – WORK GROUP MEMBERS

Members of the various work groups included CHWs as well as policy experts, healthcare administrators, and healthcare providers. The institutions represented included social service agencies, community-based organizations, health care providers, policy and advocacy organizations, state agencies, academic institutions, health plans, and faith-based institutions.

CORE COMPETENCIES AND ROLES WORKGROUP	
Leticia Boughton Price, CHW, Co-Chair	Chicago CHW Local Network
Molly Martin, MD, Co-Chair	U of IL Hospital and Health Sciences Systems/Mile Square Medical Center
Mary Ann Abate	Rosecrance Health Network
Juana Ballesteros	IL Dept of Public Health
Teresa Berumen, CHW	Enlace Chicago
Michele Bromberg	IL Dept of Financing and Professional Regulations
Meg Cooch	Illinois State Alliance of YMCAs
Monica Dillon	Loyola University School of Nursing
TaLana Hughes	Sickle Cell Disease Assoc of IL
Janel Hughes-Jones, CHW	County of Will
Hong Liu	Midwest Asian Health Association
Erica Martinez	Health and Medicine Policy Research Group
Lizette Martinez, CHW	Alivio Medical Center
Tamela Milan, CHW	Access Community Health
Jerrilyn Pearson	IL Dept of Children and Family Services
Pam Robbins	American Nurses Association-IL
Amy Sagen	U of IL Hospital and Health Sciences System
Karriem Watson	Mile Square Health Center

FINANCING AND REIMBURSEMENT WORKGROUP	
Amy Sagen, Chair	U of IL Hospital and Health Sciences System
Charles Williams, Co-Chair	Norwegian American Hospital
Leticia Boughton, CHW	Chicago CHW Local Network
Meg Cooch	Illinois YMCA
Debra Day	Aetna
Monica Dillon	Loyola University School of Nursing
Melissa Gutierrez	Sinai Urban Health Institute
Tricia J. Johnson	Rush University Medical Center
Michael Jones	IL Dept of Healthcare and Family Services
Janel Hughes-Jones, CHW	County of Will
Erica Martinez	Health and Medicine Policy Research Group
Mathew O'Brien, MD	Northwestern Medicine
Andrea Palmer	IL Dept of Public Health
Enrique Salgado	WellCare
Crystal Stevens	UCAN
Bridget Stone	IL Dept of Healthcare and Family Services
Susan Swider	Rush University Medical Center

WORKFORCE DEVELOPMENT WORKGROUP	
Venoncia M. Baté-Ambrus, CHW, Co-Chair	Community Psychologist
Teresa Berumen, CHW, Co-Chair	Enlace Chicago
Lizette Martinez, CHW, Co-Chair	Alivio Medical Center
Simone Alexander	Enlace Chicago
Luz Avila	Alivio Medical Center
Juana Ballesteros	IL Department of Public Health
Kiara Bemby	ASPIN
Daniel Block	Chicago State University
Leticia Boughton Price, CHW	Chicago CHW Local Network
Salvador Cerna	Get Covered Illinois
Anne Clancy	American Dental Association
Edwin B Fisher	Peers for Progress
Chris Garcia, CHW	Champaign County Health Care Consumers
Wandy Hernandez, CHW	Health Connect One
Lisbeth Leonos	IL Dept of Employment Security
Nanette Larson	IL Dept of Human Services
Hong Liu	Midwest Asian Health Association
Molly Martin, MD	U of IL Hospital and Health Sciences System / Mile Square Medical Center
Manuela McDonough	National Council of La Raza
Anna Meyer	Taller de Jose
Tamela Milan, CHW	Access Community Health
Julie Miyamasu	Medical Home Network ACO
Bertha Morin, CHW	Mujeres Latinas en Accion
Natalie Pacheco	Get Covered Illinois
Eric Rhodes	Presence Health
Julio Rodriguez	IL Dept of Commerce and Economic Opportunity
Amy Sagen	U of IL Hospital and Health Sciences System
Martin Schreiber	Presence Health
Alessandra Stevens	Mujeres Latinas en Accion
Jeffery J. Waddy	South Suburban College

TRAINING AND CERTIFICATION WORKGROUP	
Tamela Milan, CHW, Co-Chair	Access Community Health
Jeffery J. Waddy, Co-Chair	South Suburban College

Training & Certification Subcommittee 1:	
Melissa Gutierrez Kapheim, subcommittee chair	Sinai Urban Health Institute
Venoncia M. Baté-Ambrus, CHW	Community Psychologist
Teresa Berumen, CHW	Enlace Chicago
Leticia Boughton Price, CHW	Chicago CHW Local Network
Monica Dillion	Loyola University School of Nursing
Chris Garcia, CHW	Champaign County Health Care Consumers
Jessica Hayes	Illinois Certification Board, Inc.
Mildred Hunter	U.S. Dept of Health and Human Services, Region V
Lisbeth Leanos	IL Dept of Employment Security
Hong Liu	Midwest Asian Health Association
Christine Lopez	Rosalind Franklin University of Medicine and Science
Tamela Milan, CHW	Access Community Health
Jeffery J. Waddy	South Suburban College

Training & Certification Subcommittee 2:	
Jeffery J. Waddy, subcommittee chair	South Suburban College
Leticia Boughton Price, CHW	Chicago CHW Local Network
Kenneth Campbell	Malcolm X College
Monica Dillon	Loyola University School of Nursing
Melissa Gutierrez	Sinai Urban Health Institute
Geraldine Hardy, CHW	Southern Illinois Healthcare Foundation
Jessica Hayes	Illinois Certification Board, Inc.
Iris Kimbrough	Prairie State College
Tamela Milan, CHW	Access Community Health
Natalie Pacheco	Get Covered Illinois
Steve Rothschild, MD	Rush University Medical Center
Roy Walker	Malcolm X College

Training & Certification Subcommittee 3:	
Christine Lopez, subcommittee chair	Rosalind Franklin University of Medicine and Science
Teresa Berumen, CHW	Enlace Chicago
Kenneth Campbell	Malcolm X College
Monica Dillon	Loyola University School of Nursing
Mildred Hunter	U.S.Dept of Health and Human Services, Region V
Tamela Milan, CHW	Access Community Health
Kathryn Nelson	DuPage Federation on Human Services Reform
Jessica Ramsey	Sinai Urban Health Institute
Roy Walker	Malcolm X College

Training & Certification Subcommittee 4:	
Venoncia M. Baté-Ambrus, CHW, subcommittee chair	Community Psychologist
Mary Ann Abate	Rosecrance Health Network
Teresa Berumen, CHW	Enlace Chicago
Jeffrey Coady	SAMHSA
Monica Dillon	Loyola University School of Nursing
Denise Elsbree	Edward Hospital
Christine Lopez	Rosalind Franklin University of Medicine and Science
Tamela Milan, CHW	Access Community Health
Jessica Ramsey	Sinai Urban Health Institute
Steve Rothschild, MD	Rush University Medical Center
Jeffery J. Waddy	South Suburban College

APPENDIX C – CHW ROLES, SKILLS & TITLES

ROLES

- 1. Community Engagement and Advocacy**
 - a. Recruit
 - b. Participate in community assessment of risk and resources
 - c. Participate in environmental and safety assessments
 - d. Participate in community mobilization
 - e. Connecting and engagement
 - f. Community organizing
 - g. Community advocacy
 - h. Engage in leadership
- 2. System Navigation**
 - a. Connect people to health services, insurance, and community resources
 - b. Serve as patient/client advocate: assist patients/clients in advocating for themselves
- 3. Participatory Research**
 - a. Participate in determination of community research agendas
 - b. Critique (from community perspective) proposed research topics and methods
 - c. Identify priority research issues
 - d. Engage stakeholders in research
 - e. Participate in implementation of research
 - f. Participate in research dissemination
- 4. Public Health Concepts and Approaches/Integration**
 - a. Go to where patients/clients are: home, community, clinic, all
 - b. Participate in health promotion
 - c. Participate in community assessment
 - d. Target social/cultural determinants of health
 - e. Conduct cultural mediation among individuals, communities, and systems
 - f. Conduct and support program and service evaluations
- 5. Coordination of Services**
 - a. Provide resources and risk assessment of individuals
 - b. Participate in goal setting, action planning
 - c. Assist clients with basic needs (food, shelter)
 - d. Help clients understand service and care plans
 - e. Facilitate/assist with care plans and services
- 6. Education**
 - a. Promote health literacy: individual and community level
 - b. Provide culturally appropriate, evidence-based health education and information promoting self-management
- 7. Social-emotional Support**
 - a. Conduct behavioral health risk assessment
 - b. Assist with empowerment
 - c. Provide mentoring

- d. Provide supportive counselling and stress management
 - e. Provide leadership
- 8. Community/Cultural Liaison**
- a. Advocate for clients
 - b. Communicate with others

SKILLS

1. Communication Skills

- Ability to listen
- Ability to use language confidently and appropriately
- Ability to document work
- Ability to communicate with empathy
- Ability to use effective, purposeful, and relevant communication
- Ability to speak the language of the community being served

2. Interpersonal Skills

- Ability to provide informal counseling and social support
- Ability to conduct self-management coaching
- Ability to use interviewing techniques (e.g. motivational interviewing)
- Ability to work as a team member
- Ability to manage conflict
- Ability to practice cultural humility

3. Coordination/Navigation Skills

- Ability to identify and access resources
- Ability to coordinate services and care
- Ability to make appropriate referrals
- Ability to facilitate development of action plans and goals
- Ability to provide follow up

4. Capacity-Building Skills

- Ability to increase individual and community empowerment (identify own problems, strengths, resources)
- Ability to build connections and coalitions
- Ability to conduct community organizing
- Ability to lead others

5. Advocacy Skills

- Ability to speak up for individuals and communities
- Ability to withstand external and internal pressures
- Ability to overcome barriers
- Ability to contribute to policy development and advocacy efforts

6. Education and Facilitation Skills

- Ability to use empowering and learner-centered teaching strategies

- Ability to use appropriate and effective educational techniques
- Ability to plan and conduct educational group sessions
- Ability to find and share requested information
- Ability to respond to questions about a variety of topics

7. Assessment Skills

- Ability to participate in individual and community assessment
- Ability to identify crisis situations

8. Engagement Skills

- Ability to conduct case-finding, recruitment, and follow-up
- Ability to prepare and disseminate materials

9. Professional Skills

- Ability to set goals and follow a work plan
- Ability to develop an action plan
- Ability to prioritize
- Ability to manage time
- Ability to work in community and/or clinical settings
- Ability to observe ethical and legal standards
- Ability to set boundaries and practice self-care
- Ability to implement crisis intervention techniques when needed
- Ability to use a computer, email, and mobile phone

10. Public Health Skills

- Knowledge about pertinent health (physical, mental, behavioral) issues
- Knowledge about the U.S. health and social services systems
- Knowledge about social determinants of health
- Knowledge about critical thinking and problem solving techniques

TITLES

Hundreds of titles exist for CHWs. This is not an exhaustive list. Also note that specialty areas usually have more specific titles.

Case Manager
Coach
Community Advocate
Community Care Coordinator
Community Engagement Specialist
Community Health Advisor
Community Health Advocate
Community Health Aide
Community Health Educator
Community Health Promoter
Community Health Representative
Community Health Worker
Community Organizer
Community Worker
Compañero en Salud
Family Health Advocate
Health Worker
Helper/Supporter

Home Visitor/Support Worker
Lay Health Advisor
Lay Health Educator
Outreach Specialist
Outreach Worker
Parent Educator
Parent Support Partner
Patient Advocate
Patient Educator
Patient Navigator
Peer Counselor
Peer Health Advisory
Peer Leader
Peer Support Specialist
Peer/Teen Educator
Promotor(a) de Salud
Public Health Aide
Researcher

APPENDIX D – ENDORSEMENTS

National Support for Community Health Workers

From the CHW Network of New York City

American Public Health Association (APHA)

APHA has had a CHW Special Primary Interest Group for over 20 years. In 2009 APHA recognized this group by accepting them as the CHW Section. In 2009, APHA also issued a policy statement titled "Support for Community Health Workers to Increase Health Access and to Reduce Inequities" (Policy Number 2009-1). The CHW Section also published a national CHW definition as follows:

A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

Centers for Disease Control and Prevention (CDC)

The CDC has provided leadership in documenting and acknowledging the role of CHWs. CDC's Division of Diabetes Translation report, titled *Community Health Workers/Promotores de Salud: Critical Connections in Communities* stated, "Across the scope of CDC's diabetes programs, many ties link communities to health care systems through which runs a common thread—including and honoring the advocacy and teaching skills of community members in the role of CHWs."

U.S. Department of Labor (DOL)

In its publication of the 2010 Standard Occupation Classification revisions for the Department of Labor, the Executive Office of the President included a unique occupational classification for Community Health Workers (#21-1094), which was used in the 2010 census.

Health Resources and Services Administration (HRSA)

HRSA has a history of supporting the role of CHWs. HRSA funded the Community Health Workers National Workforce Study, a comprehensive national study of the CHW workforce released in 2007, and funds a national Patient Navigator program. HRSA mandates that all of its Area Health Education Centers use CHWs for outreach to community members.

Institute of Medicine (IOM)

In its 2002 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, IOM recognized that CHWs, "offer promise as a community-based resource to increase racial and ethnic minorities' access to health care and to serve as a liaison between healthcare providers and the communities they serve." The report also asserts that CHWs are effective as, "a strategy for improving care delivery, implementing secondary prevention strategies, and enhancing risk reduction" and recommends integrating trained CHWs into multidisciplinary health care teams. In its 2010 report, *A Population-Based Policy and Systems Change Approach to Prevent and Control Hypertension*, the IOM recommends the CDC Division for Heart Disease and Stroke Prevention (DHDS) should explore ways to make increased use of community health workers.

National Heart, Lung and Blood Institute (NHLBI)

In its Hypertension Awareness and Control Programs, NHLBI recommends a strategy of training and using CHWs: 1) as trainers of others; 2) to educate community members; and 3) to work as a member of a health care team to help improve adherence to clinical and educational recommendations.

United States Congress

The newly enacted Patient Protection and Affordable Care Law defines CHWs as members of the "Health Care Workforce" and lists CHWs as "Health Professionals." In addition, the law determines that funds granted under sec. 399V, subsection (a) shall be used to support CHWs to provide outreach, promote positive health behaviors, support enrollment in health insurance, identify and enroll underserved populations to appropriate health care agencies and community-based programs, and provide home visitation services regarding maternal health and prenatal care. Funding for the use of CHWs in underserved communities through the CDC also was included. The use of CHWs has been promoted by numerous other state and national agencies and organizations, including Aetna, the American Association of Diabetes Educators, American Diabetes Association, American Heart Association, American Hospital Association, American Medical Association, American Nurses Association, National Coalition of Ethnic Minority Nursing Organizations, National Conference of State Legislatures, and New York State Department of Health.

Endorsement for Recommendations of the Illinois Community Health Worker Advisory Board

Aetna Better Health of Illinois
Age Options
Alivio Medical Center
Chicago Community Health Worker Local Network
Chicago Department of Public Health
DuPage County Health Department
DuPage Federation on Human Services Reform
Enlace Chicago
EverThrive Illinois
Healthcare Consortium of Illinois
HealthConnect One
Health & Medicine Policy Research Group
Illinois Coalition for Immigrant and Refugee Rights
Illinois Community College Board
Illinois Critical Access Hospital Network
Illinois Hospital Association
Illinois Partners for Human Services
Illinois State Alliance of YMCAs
Mano a Mano Family Resource Center
Northwestern University Center for Community Health
Norwegian American Hospital
Rush University College of Nursing
Rush University Medical Center
Sinai Health System
Society for Community Research and Action
State Representative Robyn Gabel (18th District)
United Way of Metropolitan Chicago and United Way of Illinois
VNA Foundation

APPENDIX E – MEDICAID/CORE COMPETENCIES CROSSWALK COMMUNITY HEALTH WORKER FINANCE & REIMBURSEMENT

COMPETENCY	JOB DUTIES	REIMBURSABLE SERVICE	SOURCE/NOTES
1. Community Engagement and Advocacy	a) Recruit b) Participate in community assessment of risk and resources c) Participate in environmental and safety assessments d) Participate in community mobilization e) Connecting and engagement f) Community organizing g) Community advocacy h) Engage in leadership	<ul style="list-style-type: none"> • Conducting CHNAs (b, e) • Care coordination (e) • Preventative services 	<ul style="list-style-type: none"> • 7.A/D; 1.C: USPSTF A and B Recommendations US Preventive Services Task Force • 1.b;4.C: FQHC/Hospitals- Community Needs Assessment: Recommend CHW presence on the advisory board
2. System Navigation	a) Connect to health and community resources b) Serve as patient/client advocate: assist patients/clients advocate for themselves	<ul style="list-style-type: none"> • Care coordination • Administrative costs? 	<ul style="list-style-type: none"> • 2; 5: Administrative Support Services- Washington Healthy Home example (p13 Harvard Report)
3. Participatory Research	a) Participate in determination of community research agendas b) Identify priority research issues c) Engage stakeholders in research d) Participate in implementation of research e) Participate in research dissemination	<ul style="list-style-type: none"> • From Universities and possibly CBOs 	

COMPETENCY	JOB DUTIES	REIMBURSABLE SERVICE	SOURCE/NOTES
4. Public Health Concepts and Approaches/Integration	a) Go to where patients/clients are: home, community, clinic, all b) Participate in health promotion c) Participate in community assessment d) Target social/cultural determinants of health e) Conduct cultural mediation among individuals, communities, and systems	<ul style="list-style-type: none"> • Home visiting • Medicaid health home option • Indian Health Services (d,e) • CHNAs for FQHCs (c) 	
5. Coordination of Services	a) Provide resources and risk assessment of individuals b) Participate in goal setting, action planning c) Assist clients with basic needs (food, shelter) d) Help clients understand service and care plans e) Facilitate/assist with care plans and services	<ul style="list-style-type: none"> • Care coordination (all) • ICG regs (all) • Administrative costs (c, e) 	<ul style="list-style-type: none"> • 5.B/C: Community Mental Health Services Reimbursement Guide: ICG Application Assistant; Vocational Assessment; Community Support (Residential) • CRSS- certified recovery specialists; peer to peer model • 2; 5: Administrative Support Services- Washington Healthy Home example (p13 Harvard Report)
6. Education	a) Promote health literacy: individual and community level b) Provide culturally appropriate evidence-based health education and information	<ul style="list-style-type: none"> • Administrative costs 	<ul style="list-style-type: none"> • MN and SC approved Medicaid codes for education

COMPETENCY	JOB DUTIES	REIMBURSABLE SERVICE	SOURCE/NOTES
<p>7. Social-emotional support</p>	<p>a) Conduct behavioral health risk assessment b) Assist with empowerment c) Provide mentoring d) Provide supportive counseling e) Provide leadership</p>	<ul style="list-style-type: none"> • Preventive services (a,d) • Care coordination • ICG • CRSS • Vocational 	<ul style="list-style-type: none"> • 7.A/D; 1.C: USPSTF A and B Recommendations US Preventive Services Task Force <ul style="list-style-type: none"> ○ States must provide a state plan amendment, including the reimbursement methodology • 7.a: School Based Services- Initial Healthy Infant – Reevaluation of healthy adolescents (CPT Codes 99381-99394) • For ICG and CRSS look at Medicaid 1915 waivers
<p>8. Community/Cultural liaison</p>	<p>a) Advocate for clients b) Communicate with others</p>		