The Emerging Community Health Worker Sector: Insights from CHWs and Program Managers in the Field

A Report Prepared for the
Pacific Hospital Preservation & Development Authority

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Executive Summary

The Pacific Hospital Preservation & Development Authority (PHPDA) is chartered by the City of Seattle with stewardship of the landmark Pacific Tower and its surrounding campus in the Beacon Hill Neighborhood. PHPDA use the lease revenues from this property to fund programs in line with its mission. The PHPDA's mission is to decrease disparities in healthcare access and healthcare outcomes among King County's underserved populations. PHPDA achieves this goal by making grants to health and social service agencies that provide services and resources to a wide range of communities, with a particular emphasis on traditionally uninsured and underinsured communities of color, immigrants, linguistic minorities, and economically challenged persons.

In 2014, the PHPDA awarded over $1.3 million in community grants through their Major Grant program. Five of these awards were specific to local agencies within King County that focused on service delivery through the utilization of a community health worker (CHW) framework. In an effort to highlight the lessons learned in this first year of programming, the PHPDA hired a graduate student intern from the University of Washington School of Public Health to interview program managers and CHW staff. The goals of this report are to summarize various state-by-state adaptations of CHWs into the workforce, shed light on significant themes from the PHPDA grantee interviews, and propose key recommendations specific to the PHPDA.

Acknowledgement of the roles of community health workers (CHWs) is growing with regards to health and social service delivery in the United States. CHWs have long been working in diverse communities that often face barriers to accessing health care and social services. By identifying with the community through shared life experiences, culture, and language, CHWs greatly assist in effectively addressing community needs to improve the health outcomes of populations, and efficiently utilize resources for primary and chronic care management, including behavioral health services. Additionally, their work often spans further than a community's health care needs and includes assisting individuals with housing needs and other social services. Many states are incorporating CHWs into their workforce to increase access to health services.

Examples of states that have incorporated CHWs more sustainably into their service delivery systems but in different ways include Massachusetts, Minnesota, New Mexico, and Oregon. Massachusetts utilized two key forms of policy that advanced the employment of CHWs in the state. Minnesota is the only state in the country to have a broad range of reimbursable CHW services through Medicaid. New Mexico CHWs work under contracts with managed care organizations (MCOs) that are mandated by the state's Medicaid system. Through a State Innovation Model grant, the state of Oregon created a network of coordinated care organizations (CCOs) to include employment of CHWs. While these states provide significant examples of how the role of CHWs can be

harnessed into service delivery systems through greater funding sources, the primary funding stream for CHW programs consists of grants.

In 2013-2014, five PHPDA grantee agencies utilized CHWs in clinic or community based settings to deliver services desired by the clients they served. The agencies and general overview of the program funded by the grant are listed below:

- El Centro de la Raza: Affordable healthcare outreach and enrollment specific to Latino communities in King County.
- Harborview Medical Center: Improving management of diabetes in limited English proficient Spanish or Somali speaking patients.
- Mercy Housing Northwest: Bringing health and wellness activities to several affordable housing communities where dominant languages include Amharic, Spanish, Russian, or Vietnamese.
- Neighborcare Health: Bringing health and wellness activities to a recently redeveloped affordable housing site, Yesler Terrace, where dominant languages include Somali, Tigrinya, and Vietnamese.
- Teen Feed: Enrolling youth and young adults into health insurance and connecting them to care providers, and other services as needed.

The report describes themes that emerged through separate interviews with CHW program staff and program managers of these agencies. Prompted by a set of predetermined questions regarding the first year of the PHPDA grant, interviewees reflected on the following topics: the hiring process for CHWs, unique tasks of CHW staff, challenges and successes of the program, program related cost savings to the health care system, and future sustainable funding sources for CHWs.

Reflecting on these themes with respect to the future work of the PHPDA, there are four main recommendations to the grant agency. These recommendations can help guide the PHPDA in order to better support grantees implementing programs with CHW teams in the future.

1. Request or expect that grantees conduct an initial baseline survey of the target population served by CHWs.
2. Encourage and/or facilitate cross learning between PHPDA grantees with CHW programs through face-to-face communication (i.e. table talks or seminars).
3. Conduct follow up interviews with the five PHPDA grantees in this report to learn of progress and further experiences from these CHW based programs.
4. Be informed of decisions made from Washington State's CHW Task Force work group.

Through its grantees, the PHPDA is in an influential position to highlight the experiences of CHWs and their program managers in a field that is invaluable to bringing effective and thoughtful service delivery to underserved communities.

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After finishing the first year of my Masters in Public Health program at the University of Washington, I was given the opportunity to create this report by interviewing five grantees of the Pacific Hospital Preservation & Development Authority. These grantees were specifically chosen to interview because of their use of Community Health Workers (CHWs) in their PHPDA grant awarded program activities. Although the PHPDA grantees all served different communities, their efforts to reach and respond to the needs of community members with the help of CHW staff was truly inspiring to learn of first hand.

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Harborview Medical Center: Rose Cano, Lee-Ann Miyagawa, Salma Musa, Martine Pierre-Louis
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Neighborcare Health: Kim Do, Nuha Elkugia, Alisa Farah, Nimo Farah, Senait Gebregiorgis, Hussein Mohamed, Zoe Reese
Teen Feed: Andrew Brown, Tabitha Jensen, Genya Shimkin

Introduction

There is growing interest in the work of community health workers (CHWs) due to their increasing role in health care and social service delivery. Thus, the goals of this report are to summarize various state-by-state adaptations of CHWs into the workforce, shed light on significant themes from Pacific Hospital Preservation & Development Authority (PHPDA) grantee interviews, and propose key recommendations specific to the PHPDA.

In an effort to better understand the growing role of CHWs, the PHPDA hired a graduate student intern from the University of Washington School of Public Health to 1) conduct a literature review of how CHWs are integrated into service delivery in other states, and 2) interview program managers and CHW staff in PHPDA funded projects. Additionally, the PHPDA requested recommendations for assisting its local partners focused on implementing CHWs in agency programs.

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Background

The umbrella term "community health worker" is used to capture a variety of titles that refer to these individuals. Among other terms, CHWs are also known as outreach workers, promotores(as) de salud, patient navigators, community health representatives, and peer health promoters/educators.[1–3] Comparable positions, specifically in mental health and substance abuse service delivery, are known as mental health peer specialists and recovery coaches, respectively. Similar to their titles, CHWs' roles also vary in efforts to reach a common goal.

What is unmistakably similar in the roles of a CHW is the goal of building trust with the people they serve in order to break down systemic and perceived barriers to accessing care. Their performance is driven by their knowledge of the communities where a majority both live and work, and share the same culture, language and life experiences as their clients.[2,4] Through these attributes, CHWs have a unique ability to reach, respond to, and follow-up with underserved populations. Several examples of the influential roles of CHWs in chronic or preventative health care delivery are noted below.[2]

Program Location	Target Population	Impact, Return on Investment (ROI), and/or Savings
Arkansas Community Connector Program[5]	Underserved Medicaid-eligible adults	Connected adults with unmet long-term care needs to agencies and services $2.92 ROI per dollar spent
Molina Health Care in New Mexico[3]	Medicaid patients who are high consumers of health resources	Reduced emergency room use, days of inpatient care, narcotic use, and other prescription drug use Savings of $4,564 per enrollee in a Medicaid managed care system
Northern Manhattan Community Voices Collaborative[6]	Low-income communities in New York City	From 2000-2005, CHWs enrolled 30,000 people in health insurance, helped 8,000 children become completely immunized, and supported 4,000 families in improving asthma management
Public Health – Seattle King County[7]	Children with asthma in low-income households	Reduced asthma symptom days and urgent health services use Savings of $189-$721 per participant in the high-intensity, home visit group

Although there is not one universal, agreed-upon definition to capture the work of CHWs, there are three commonly cited definitions in public health literature:

1. In 2009, the American Public Health Association (APHA) adopted the following definition:[2,8]

   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.

2. Since 2010, the United States Department of Labor has recognized CHWs as a discrete occupation and defined their roles as follows:[2,9]

   Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement

programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs. Excludes "Health Educators."

3. The World Health Organization proposed the following definition in 2011:[10]
   Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers.

These commonly proposed definitions of a CHW give insight to the understanding of the roles and responsibilities needed for such close community interaction. Although a single definition potentially limits the understanding of CHWs' roles, states within the United States and their respective CHW programs have worked to adopt and/or create definitions to channel sustainable funding, and programming for the employment of CHWs. Furthermore, this has offered more visibility and advocacy for the importance of their position in service delivery.

Examples from other States

Even before the Patient Protection and Affordable Care Act (ACA) gave legal structure to promote CHW efforts in 2008, many states had begun to define and employ CHWs. The ACA goals are defined as the Triple Aim: improving the patient experience of care, the health of populations, and reducing the per capita cost of health care.[11,12] Under Medicaid, the ACA provides a framework for preventative health care services through CHW programming.[13]

Below are descriptions of four states that have taken multidimensional approaches in implementing CHWs into the delivery of health care. Seen together they provide an understanding of various approaches rather than suggesting that any are perfect processes to emulate. The role of CHWs in delivering social services is also critical to remember.

<u>Massachusetts</u>

Notably a long time supporter of CHWs, the state of Massachusetts and its CHWs advanced their collaborative efforts through policy change. In 2000, the Massachusetts Association of Community Health Workers (MACHW) was created to provide education, research, policy development, and advocacy to support the CHW workforce.[1] Through the efforts of this organization and its public health partners, the state implemented two key pieces of policy reform that would sustain the workforce. First, in 2006 the Massachusetts Department of Public Health was directed to carry out

a statewide study of CHWs and then develop recommendations to sustain their employment.[1,14] Significant findings of the mandated study included CHW success in helping clients with self-management of chronic illnesses, medication adherence, and navigation of the health care system. Based on this study, a second law in 2010 required the State Department of Health to develop a board certification of CHWs to advance public health goals in tandem with CHW roles.[1,14]

Massachusetts has since reserved Medicaid funding for particular CHW services and developed certification for its CHWs. The state has adopted the CHW definition created by the APHA. CHW services have largely been supported by grants, however, a Medicaid Section 1115 Demonstration Waiver allows for flexibility to test new or current approaches to financing and delivering Medicaid and Children's Health Insurance Program.[15] Through the submission of this waiver, CHW services regarding high-risk pediatric asthma and a recent project for Medicaid and Medicare, dual-eligible, adults are now supported through the state's Medicaid coverage.[16] Currently, the Massachusetts Department of Public Health is considering a Medicaid State Plan Amendment that could bring more funding opportunities for a broader range of CHW services.[16]

Certification of paid and volunteer CHWs will begin in 2015, and will consist of a paper application requiring three professional references, completion of an approved training program, 2,000 hours of relevant work experience, and a grand-fathering process open until 2018 for current CHWs with 4,000 hours of relevant work experience.[16] Approved training, comprising of 10 core competencies and 80 hours of online and in-person training, is offered by community-based organizations, Area Health Education Centers, local health departments, and the University of Massachusetts.[16]

Minnesota

In 2005, various private and public stakeholders came together to create the Minnesota Community Health Worker Alliance that would influence the first and only example of broad-range CHW services funded by Medicaid in the country. Its stakeholders included CHWs, representatives of state agencies, post secondary education institutions, state associations, non-profit organizations, payers, and the health care industry.[1] Together, members of the alliance created a "scope of practice" that includes five overarching roles: bridging the gap between communities and the health and social service systems, navigating the health and human services system, advocating for individual and community needs, providing direct services, and building individual and community capacity.[17] Through research on the return on investment from CHW efforts, the alliance advocated for policy change that led the state legislature to approve of direct hourly reimbursement of CHW services under Medicaid in 2007.[1] The next year, the Centers for Medicare and Medicaid Services (CMS) approved of a Medicaid State Plan Amendment allowing CHWs to be paid per hour under the supervision of Medicaid-approved doctors and advanced practice nurses. The approved

supervisory list has expanded since then to include dentists, public health nurses, and mental health providers.[1] The Minnesota Community Health Worker Alliance created a state-wide, standardized, 14-credit certificate program in accredited post-secondary schools for CHWs with a high school diploma or GED, at minimum. With this certificate, or at least five years of supervised experience, CHWs can qualify for Medicaid Assistance reimbursement through the supervision of approved Medicaid providers.[1,17]

New Mexico

After the passage of the ACA, New Mexico contracted with managed care organizations (MCOs), mainly Molina Health Care Inc., through the use of a Medicaid 1115 Waiver to advance the employment of CHWs and provide sustainable funding for their positions. Centennial Care, New Mexico's Medicaid program, contracts define CHWs as, "lay members of communities who work either for pay or as volunteers in association with the local health care system in Tribal, Urban, Frontier, and Rural areas and usually share ethnicity, language, socioeconomic status, and life experiences with the Members they serve. Common titles of the state's CHWs include "community health advisors, lay health advocates, promotoras, outreach educators, community health representatives, peer health promoters, and peer health educators."[18] Under these contracts, Centennial Care directs MCOs to utilize CHWs for care coordination, specifically list CHW services covered by Centennial Care's benefit package, and requires MCOs to explain the roles of CHWs in providing patient education.[18] In addition, MCOs must confirm that CHWs can provide interpretation and translation services, culturally relevant health education, help patients navigate the managed care system, connect members to community resources, and council members on health behaviors. Costs associated with CHWs such as salaries and training are covered under MCO administrative costs at capitated rates.[18]

In 2014, the governor of New Mexico signed the Community Health Worker Act in efforts to create a CHW certification. The state department of health is now creating a voluntary process and involves a background check. The process includes training and demonstration of proficiency in predetermined CHW core competencies. Current CHWs can be certified based on previous work experience. At the same time however, the New Mexico Department of Health recognizes that the overall goal is to support the CHW workforce. Thus, it will provide training, technical assistance, and promotion of career development regardless of a CHW's certification status.[19]

Oregon

After the enactment of the ACA, the state of Oregon created a statewide network of coordinated care organizations (CCOs) through a State Innovation Models grant that included the employment of CHWs. Previously, Oregon established a statewide network of CHWs in 2008. In 2011, robust payment mechanisms for CHW services through CCOs became available through an approved Medicaid Section 1115 Waiver. As locally

based organizations, CCOs serve Oregon Health Plan, Medicaid, enrollees by providing and coordinating care across primary, acute, and behavioral health care, as well as dental services.[2,20] Specifically, CCO's require that Medicaid members have support navigating the health care system, obtaining culturally and linguistically appropriate care, and connecting with social and community services.[18] Thus, certified CHWs incorporated under the supervision of a health professional are able to be reimbursed for providing these services. Although CCO's have a global fixed budget, there is no official reimbusement rate for CHWs.[2,20] The Oregon Health Authority certifies CHWs and requires 80 hours of training and 20 hours of continuing education every three years. Individuals must also be 18 years of age or older and pass a criminal background check. Grandfathering of existing CHWs for certification is possible with 3,000 hours worked in the last five years and after completing additional training.

While these states provide examples of greater funding for CHW services, other funding streams commonly consist of grants. In 2014, the PHPDA awarded over $1.3 million in community grants through their Major Grant program. Five of these awards were specific to local agencies within Seattle, King County that focused on service delivery through the utilization of CHWs. The remainder of this report details key interview themes from these agencies' experiences after the first year of the grant award.

PHPDA Grantees Utilizing CHWs

During the PHPDA's 2014-2015 funding cycle, five local agencies were awarded grants to implement new programs that incorporated CHWs as frontline workers. A majority of the grantees had similar program offerings through direct CHW services, but had different approaches tailored to their respective communities. Additionally, all grantees used different titles for their CHWs based on their roles. Below is an overview of the PHPDA funded programs at these agencies:

1. *El Centro de la Raza – Affordable Healthcare Outreach and Enrollment*
   El Centro de la Raza is committed to serving Latino communities in King County through numerous health, education, and social service programs that span all age groups. The organization hired a Spanish and English speaking individual who received certification as an In-Person Assister (IPA) through King County. Through this training, the IPA worked to enroll Latino families and individuals into health insurance plans.
2. *Harborview Medical Center – Improving Limited English Proficient (LEP) Patients' Management of Diabetes*
   The medical center has two main missions: to provide exemplary patient care and to serve as a teaching institution in the University of Washington system, Through the PHPDA grant, the HMC Interpreter Services Department brought together a team of doctors, nurses, nutritionists, and CHWs. The team helped

Spanish and Somali speaking patients with uncontrolled diabetes improve disease management and health outcomes. Specifically, two hospital CHWs known as Bicultural-Bilingual Navigator Educator Coaches (BNECs), recruited, enrolled, and provided education and follow-up services to participating patients. Additionally, the Spanish and Somali speaking BNECs were able to educate providers on a patient's specific culture and how that corresponded to patient's understanding of health and diabetes management. Each BNEC received education regarding diabetes and care management through the hospital and materials from the American Diabetes Association before enrolling participants.

3. *Mercy Housing Northwest – Bringing Health Home*
   Dedicated to nurturing healthy housing communities, the agency focused on engaging low-income housing residents in King County to enroll in health insurance plans, access primary health care providers, and provide health and wellness activities. Through the PHPDA grant, three Community Health Promoters (CHPs) and one CHP lead worked to involve residents, especially those from communities of color and recent immigrants, of seven affordable housing sites in these activities. Four of these housing communities were owned by partner agencies and had no history of on-site service delivery. Each CHP was fluent in Amharic, Russian, Spanish, or Vietnamese, which represented the major language groups of these communities. All CHPs completed the Washington State Department of Health online CHW training before engaging residents in program events.
4. *Neighborcare Health – Seattle Community Health Project*
   Focused on the ACA's Triple Aim and on improving the health of diverse communities, the PHPDA grant allowed Neighborcare to engage residents of the Yesler Terrace housing community in five activities: health insurance enrollment, community gardening, walking groups, and community health conversations. Yesler Terrace houses thousands of culturally and linguistically diverse residents, many of whom are living below the poverty level. The grant enabled a team of four bilingual CHWs, a bilingual Community Program Manager, and a multilingual Eligibility Specialist to facilitate various activities desired by the Somali, Tigrinya, and Vietnamese-speaking residents to improve their overall health. CHWs received the state's online training before beginning program activities.
5. *Teen Feed - Youth Access to Care (YAC)*
   In response to the needs of homeless youth and young adults, Teen Feed provides supportive youth coordination through street outreach and meal services. With the PHPDA grant, three YAC staff focused their time on outreach to and enrollment of clients into health insurance for those in the University District and greater Settle area. Additionally, YAC staff coached clients to advocate for their health needs, assisted in finding and attending primary care provider and dental service appointments, and followed-up with conversations of client experiences afterwards. YAC staff also received the state's online training before assisting their community.

Key Response Themes

Many themes emerged through separate interviews with CHW program staff and program managers. Prompted by a set of predetermined questions regarding the first year of the PHPDA grant, interviewees reflected on the following topics: the hiring process of CHW individuals, unique tasks of CHW staff, challenges and successes of the program, program related cost savings to the health care system, and future sustainable funding sources. These response themes are further described below.

Hiring Process

Each of the five agencies' program managers desired similar characteristics in a CHW. Managers sought individuals with strong communication and problem solving abilities to enable a dynamic learning environment between CHW staff and managers. Program managers wanted to help clients receive the best and most appropriate services, and specifically learn the best ways to do this through CHWs. Additionally, program managers wanted individuals who could facilitate partnerships with outside agencies while, at the same time, work with multiple individuals from the communities they serve. Due to the nature of these positions, agencies decided that CHWs must be from communities they serve, share similar life experiences, language, and culture.

During the first year of the PHPDA grant, it was clear that program managers utilized multiple resources to find CHW staff. Job listings and recruitment of CHWs relied on a variety of sources including: other community-based organizations serving similar language groups, Craigslist, Seattle-King and Pierce County health departments, faith communities, direct referrals from Amharic, Russian, Somali, Spanish, Tigrinya, and Vietnamese-speaking community figures and/or internal agency staff. The CHW program manager's knowledge and ability to navigate various channels was necessary to find high quality CHW candidates.

Unique CHW Tasks

CHWs performed significant tasks in efforts to assist the people they served. Some of these tasks were not explicit to their program's scope, but inevitably surfaced because of the direct relationship with clients and their lives. For example:

- El Centro de la Raza – Enrollment Navigator/IPA
  While working to enroll Latino clients into health insurance plans, the Enrollment Navigator realized that many clients were not eligible for Washington Apple Health, the state's Medicaid program, because of their undocumented status or less than five years residency in the state. In effort to further assist these clients, the Enrollment Navigator developed familiarity with and linked clients to temporary and long-term free services within the county. These included free clinics, vision and dental services, and health fairs.

- Harborview Medical Center – BNECs
  Although members of a clinic based team, the two BNECs went grocery shopping with patients and family members who were responsible for meal preparation. They visited their patients' home, observing their meal preparation habits in order to better understand how to make culturally appropriate and practical recommendations on how clients could manage their diabetes. With the help of hospital nutritionists and the primary care team, BNECs further explained blood sugar testing practices and medication adherence that crossed cultural and linguistic barriers between the provider and patient. In one instance, a BNEC extended their role to help secure housing for a patient with limited English proficiency.
- Mercy Housing Northwest – CHPs
  The team of four CHPs connected a variety of health and wellness providers with residents in each housing community. These opportunities made health resources more accessible to residents on a regular monthly basis. Examples included culturally appropriate physical activities, health screenings, and health promotion and nutritional workshops, including trips to local farmers markets.
- Neighborcare Health – CHWs and Eligibility Specialist
  The CHW team worked at Yesler Terrace, a Seattle Housing Authority (SHA) site that is currently being redeveloped. For this redevelopment to take place, Yesler Terrace residents were uprooted from their homes and given the option to move temporarily to other public housing communities. In the past year, returning and new residents moved into the newly built space. CHWs established desirable, healthful activities and became knowledgeable of social services within the community to assist limited English proficient speakers settle into the area. On several different occasions, CHWs interpreted important housing documents related to the residents' relocation, and worked with the Eligibility Specialist to attain the best health insurance plan for dual eligible adults.
- Teen Feed – YAC staff
  With a focus on homeless youth and young adults, YAC staff took their work to day centers, overnight shelters, or public spaces at those times of day when youth were most likely to congregate. In what often took more than one conversation, YAC staff talked about making health a priority and the importance of health insurance to eventually enroll clients.

<u>Program Challenges and Successes</u>

Given each program's goals under the PHPDA grant, program managers and/or CHW staff brought up common challenges and successes within the first year. Additionally, as each of the agencies move into a second year of the PHPDA grant, some agencies expressed challenges that they continue to face in moving forward.

Outreach, Trust, and Community Capacity Building

For a variety of reasons, engaging and building trust with the community was a challenge in the first year of the grant cycle for most programs. Although it was not necessarily difficult for CHWs to identify eligible community members, especially for those working in affordable housing areas, it took time for community members to "buy-into" and participate in program activities. Door-to-door visits in apartment complexes were arduous because residents seemed to be unwilling to open their doors given that they could not see who was on the other side of it. Both program managers and CHWs expressed that doing home-visits was not accepted at first because their clients did not trust CHW staff.

CHWs working with clients without stable housing also faced difficulties creating rapport. Clients without stable housing who were couch-surfing or staying at friend's homes found home-visits uncomfortable in a place that was not their own. Furthermore, follow-up meetings were challenging to schedule because clients had competing priorities, making it difficult for CHWs to find clients without a stable address. Regardless, all of the CHWs worked tirelessly to identify ways to build a connection between communities with whom they personally identified. CHWs from all programs were later trusted to enter homes or found more comfortable ways of meeting outside traditional health care spaces by using offices spaces through coffee shops and public libraries.

Even if people were wary at first, CHWs consistent efforts eventually earned the respect of community members that, in turn, influenced the larger community. Their facilitation of discussions around why clients did not or could not participate in activities, and what CHWs/agencies could do to ensure future participation resulted in greater community member engagement. Of note, CHW efforts impacted community capacity to engage in more healthful activities at one of the Mercy Housing Northwest housing communities. Eight female residents decided to become health advocates for their community and completed the state's CHW training program after participating in the Bringing Health Home program.

Additionally, many CHWs from the five agencies noted that communication pathways through natural social networks or agency partners became stronger. As a result, a message could be sent from a single CHW to several people who then communicated it to a handful of community members who delivered the message to the rest of the community. As seen by the BNECs at Harborview Medical Center, friends of currently participating patients are inquiring and seeking to participate in the grant-funded program. For all grantees in the first year of the PHPDA grant, these trusted ties will be invaluable as they move into the second year of the grant cycle.

At the same time, a significant challenge area relevant to community engagement was expressed by the CHWs at Neighborcare Health and MHNW program managers. It has continually been a challenge to involve and unite with the Somali

speaking communities that they serve. Neighborcare Health CHWs thought that this could partly be due to the fact that there is a large generation gap between the older members of the community and the younger, more numerous, members. Thus, creating and sustaining culturally and generationally engaging activities was difficult in the first year of the program. In the second year of the grant cycle, both these agencies will strive to find culturally appropriate ways that involve the full spectrum of Somali speaking communities.

Enrollment and Navigation

The greatest challenge with enrollment into health insurance plans was the fact that not all CHWs could assist to the same degree. The Washington State Health Benefit Exchange certified In-Person Assisters (IPAs), also known as Eligibility Specialists, only if there was an existing partnership between the agency and Public Health – Seattle & King County. One grantee, El Centro de la Raza, created this partnership within the first year of the grant while other grantees brought in a certified specialist from the state's network through funding from the grant. Because IPAs had access to a client's application, it enabled them to more easily enroll clients into Qualified Health Plans online. Specifically, once clients turned in an application and were made eligible, IPAs explained insurance terms such as deductibles, premiums, and out-of-pocket costs. They then helped clients navigate available Qualified Health Plans that provided appropriate coverage at an affordable price. Still, not all grantee programs had the capacity to have their CHWs become certified IPAs.

CHWs without the opportunity for this training or a full-time, in house specialist helped clients in other ways. Specifically, they worked to enroll clients by physically being present during the phone call to ensure the call was made, completed, and translation assistance was provided. Additionally, CHWs found culturally competent primary care providers to whom clients would feel comfortable connecting with on an ongoing basis. Specific to Teen Feed, this was a memorable success as they serve many homeless and LGBTQ young people who had concerns about less compassionate and culturally competent health care providers. However, YAC staff had previously come to know of providers who could be most approachable by clients, and assisted their own clients to ask questions that helped communicate their health concerns and needs. Overall, CHWs from programs that focused on enrollment and navigation provided the time, space, and knowledge to successfully find ways to assist clients seeking health insurance and primary care providers.

Access to Health & Wellness Opportunities and Other Social Services

Program managers and CHW staff agreed that the services their programs offered under the PHPDA grant would not have been possible without external partnerships. Often facilitated by CHWs, these partnerships were ultimately successful in providing activities such as: health screenings, health care insurance enrollment,

primary, dental, and maternal and child health care services, meals, transportation, physical and outdoor activities, after-school youth tutoring, as well as education regarding diabetes prevention and management, tobacco cessation, nutrition, and healthier cooking. Many of these partnered activities were offered more than once in ways that were linguistically and culturally engaging to community members because of CHW and program manager vetting. Additionally, from these partnerships, CHWs could regularly refer clients to specific service locations that also referred new clients back to agencies. For example, clients going to El Centro de la Raza wanting a subsidized public transit, ORCA card, or filing income taxes brought similar documents as needed for enrollment into health insurance. Thus, the IPA at the organization was able to reach more clients by working along side the Seattle Department of Transportation representative in the office and United Way of King County on-site tax preparers, who also referred new clients to the IPA.

Still, CHWs from several agencies were quick to identify certain needs that were a continual challenge to address for clients in the first year of the PHPDA grant. Specifically, external partnerships with vision, mental health, and/or daily childcare service providers were difficult for CHWs at El Centro de la Raza and Neighborcare to obtain at an affordable price, a convenient time and location, and with timely service delivery. Additionally, accessing affordable, fresh produce at farmers markets or from fresh produce vendors was a challenge for many clients. CHWs from Mercy Housing Northwest found this especially difficult considering they taught nutrition classes or healthy cooking workshops and their clients, mostly low-income earners, could not make sustainable changes because the markets around them did not provide these fresh foods at an affordable price. CHWs acknowledge that these will be continual challenges moving into the second year of the PHPDA grant cycle.

Cost Savings and Sustainable Funding for CHWs

Questions regarding knowledge of cost savings were only asked to program managers. None of the programs had engaged in an evaluation process of exact cost savings or return on investment per participant that could be linked to a direct correlation of CHW services within the first year of the PHPDA grant. One program manager expressed that whatever the exact dollar amount being saved might be, the fact that enrolling young adults earlier on could potentially save a lifetime's worth of healthcare costs in emergency care services. Another program manager also explained that perhaps an immediate cost savings might not be possible. Rather, a spike in health care costs prompted by more efficient prescribing of appropriate medication, and disease care management resources should be expected. Then later, this efficiency could lead to long-term cost savings to the health care system. Given that this was the first year of the PHPDA grant with particular focus on engaging community members and providing tailored services to clients' needs and interests, this question could be worth asking in the second year of the grant cycle.

Additionally, program managers pointed to various possible funding sources for CHW roles to be more visibly and sustainably permanent to the overall healthcare system. Some responded that it would be beneficial to employ CHWs in hospital teams, or for the state's Medicaid program to reimburse CHW services in clinical and community based practices. Compared to the traditional doctor, patient, dentist, and therapist model, one program manager from a clinical perspective suggested that switching to a payment model which allows for goal-oriented care would bring sustainability to CHWs and other personnel that could help focus on the whole person in community settings. Thus a refined focus on better care, population health, and lower costs (i.e. the Triple Aim) could be made possible through an outcome based payment model. It was clear that program managers wanted CHWs as long-term collaborators and employees, and hoped for systemic change to create those pathways.

Recommendations to the PHPDA

Below are four recommendations to the PHPDA to better support grantees implementing programs with CHW teams:

1. Request or expect that grantees conduct an initial baseline survey of the target population served by CHWs.
2. Encourage and/or facilitate cross learning between PHPDA grantees with CHW programs through face-to-face communication (i.e. table talks or seminars).
3. Conduct follow up interviews with the five PHPDA grantees in this report to learn of progress and further experiences from these CHW based programs.
4. Be informed of decisions made from Washington State's CHW Task Force work group.

With consideration to the key interviewee response themes in this report, the intention of these recommendations is to create more efficient learning and problems solving of community members' needs. Additionally, in regards to the often fragmented systems of health, social, and housing services there is a great opportunity for these grantee agencies to collaborate with each other to clarify and connect these systems to better assist the communities they wish to serve. In doing so, these agencies can share their experience and knowledge to collectively find ways to bridge gaps between available resources and underserved community members. Not only can this cultivate partnerships between PHPDA grantee agencies, but also with the external, community-based organizations that grantees also work with. Ultimately, this could lead to more interconnectivity between the existing service systems and community members.

Furthermore, it would be advantageous for PHPDA and the greater audience reading this report to describe the progress of these same agencies awarded the PHPDA Major Grant before the three-year grant cycle ends in 2017. Lastly, as Washington State works to create a definition, specific training opportunities, and

financing structures for CHWs in our state, the PHPDA should be aware of the decisions to come in 2016 that may guide their further support of grantees incorporating CHWs in their program activities. All of these recommendations have the potential to help the PHPDA learn with grantees employing CHWs to support diverse communities.

Recommendations to other Sectors

More can be recommended to the greater audience working to establish CHWs directly into service delivery given the current work being done in Washington State. It would be beneficial to have larger communication platforms, such as regional conferences, for CHWs and program managers to share program findings, and lessons learned from their community. As there are community based organizations and clinical teams employing CHWs, it would be beneficial to facilitate more crosstalk between these programs not only to share information, but also bridge gaps between services in engaging ways for community members. Additionally, advances are needed in developing and disseminating evaluation methods to reflect the return on investment due to the direct role of CHWs in community-based settings. Programs with CHWs that are not incorporated in clinical teams often focus on upstream care for community members. Although their role is influential in these settings, the direct correlation between CHW services and outcomes within the community are not sufficiently being measured. These trends can bring more knowledge and evidence of the direct benefit of CHWs bringing preventative service care delivery to community settings.

Conclusion

Through its grantees, the PHPDA is in an influential position to highlight the experiences of CHWs and their program managers in the field. Because of this direct access to knowledge, gaining input from grantees implementing CHWs in service activities can build a deeper understanding of CHWs' complementary and necessary role as service providers with program managers in clinic and community based settings. Furthermore, this can benefit the greater body of literature about CHWs for a wider audience to access. Ultimately, this information is invaluable because it can lead to more effective and thoughtful service delivery to underserved communities.

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