The New England Comparative Effectiveness Public Advisory Council

An Action Guide on Community Health Workers: Guidance for Health Insurers

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Introduction

About this guide

Evidence from clinical effectiveness reviews is critical to judgments that patients, clinicians, and health insurers must make about treatment choices and coverage policies. Yet that evidence is often not translated in a way that is helpful to inform healthcare decisions. This document is a companion policy guide designed to help health insurers make use of the results from a recent report titled, "Community Health Workers: A Review of Program Evolution, Evidence on Effectiveness and Value, and Status of Workforce Development in New England" developed by the Institute for Clinical and Economic Review (ICER). This report formed the basis for the deliberations and votes of the New England Comparative Effectiveness Public Advisory Council (CEPAC) – an independent body that meets in a public, transparent forum to provide objective guidance on how information from evidence reviews can best be used by regional decision-makers to improve the quality and value of healthcare services.[1] The report pulls together the best available evidence on the effectiveness and value of community health workers (CHWs) from the published literature, findings from interviews with expert stakeholders, new survey results benchmarking the use of CHWs in New England, and public testimony.

CEPAC held its meeting on CHWs on June 28, 2013, bringing together policy experts from around the country to inform the deliberations. We have developed this action guide in order to provide a user-friendly overview of the CEPAC findings and an associated list of specific evidence-based action steps and resources that insurers can use to improve patient outcomes and the overall value of CHW services.

The information contained in this guide may be helpful for insurers in various ways. It summarizes evidence-based best practices that insurers may wish to include in contracts with provider organizations. It delineates possible quality indicators for high-quality CHW programs, and provides background on key state policy matters related to the training and certification of CHWs that health insurers may wish to influence. It also describes policy experts' experiences and perspectives on options for reimbursement. Information is provided in the following areas:

- *Certification & Training*
- *CHW Definition and Scope of Work*
- *Options for Funding*
- *Sample Request for Proposal (RFP)/ Request for Resource (RFR) language*
- *Quality Assessment*

[1] For more information on CEPAC, visit: http://cepac.icer-review.org/

Health Insurers

I. Training and Certification

Certification of CHWs is important for the standardization of training and education programs across different regions and states. Certified CHWs can achieve increased recognition from healthcare teams, provider organizations, and payers. While a certification process suggests a requirement for a uniform level of knowledge and skills, it is important for states to recognize the work history of current, experienced CHWs and to create a low cost, easily accessible road to certification to encourage ideal CHW candidates. While professional certification is not currently required in New England for CHWs, states are working toward establishing a certification process. In Massachusetts, a law was passed in 2010 creating the Board of Certification for CHWs. The Board began meeting in July 2012, and is working to create a program of certification for CHWs.

Some states outside of New England, such as Minnesota and Texas, already have certification or credentialing programs in place. In Texas, there is no application fee for certification, and the sole requirement of applicants is to complete a 160-hour CHW training program, approved by the Department of State Health Services (DSHS) or to have provided at least 1000 hours of CHW services in the last 6 years, with verification by a supervisor. In Minnesota, CHWs may provide diagnosis-related patient education services with Medicaid reimbursement if the following major requirements are met:

- Completion of an accredited CHW training program with receipt of certification
- Enrollment in the Minnesota Health Care Programs as a participating provider
- CHW supervision by an APRN, physician, certified public health nurse or dentist who is an eligible Billing Provider

Other requirements are detailed on the Minnesota Department of Human Services website (please see the following page).

In Oregon, CHWs are utilized as part of integrated care teams known as "coordinated care organizations" (CCOs) under a Center for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation award (Oregon.gov, 2013a). The state legislature is currently considering a bill to establish a health workers commission that would identify training and education requirements for CHWs and other health professionals. Established by the Oregon Health Authority, the Non-Traditional Health Worker Subcommittee has made recommendations regarding training, supervision and registration for CHWs (Angus, 2012). In December 2012, a Steering Committee began working towards implementation, along with establishment of an online registry for certified CHWs eligible for Medicaid reimbursement (Miyao, 2013). Currently in Oregon, the Home Care Commission provides training opportunities and maintains a registry of qualified Homecare Workers. After completion of 20 additional hours of core safety and skills training, Homecare Workers and Personal Support Workers receive Professional Development Recognition.

These select individuals are now eligible for free certification training as a Community Health Worker under the Oregon Health System Transformation Initiative (Oregon.gov, 2013a).

More information may be found at the links listed below.

Minnesota Department of Human Services:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357

Texas Department of State Health Services:
http://www.dshs.state.tx.us/mch/chw.shtm

Oregon Department of Human Services:
http://www.oregon.gov/dhs/spd/Pages/adv/hcc/community-health-workers.aspx

II. CHW Definition and Scope of Work

1. A Clear, Concrete Role for CHWs

Though there is no standard definition for CHWs, and states have approached in different ways how to define the scope of their practice, the most widely accepted definition for CHWs comes from the American Public Health Association:

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.

Source: American Public Health Association, 2009

Payers that reimburse CHWs have defined them in the following ways:

> **OREGON MEDICAID**: "Community health worker" means an individual who promotes health or nutrition within the community in which the individual resides, by:
> a) Serving as a liaison between communities, individuals and coordinated care organizations;
> b) Providing health or nutrition guidance and social assistance to community residents;
> c) Enhancing community residents' ability to effectively communicate with health care providers;
> d) Providing culturally and linguistically appropriate health or nutrition education;
> e) Advocating for individual and community health;

f) Conducting home visitations to monitor health needs and reinforce treatment regimens;
g) Identifying and resolving issues that create barriers to care for specific individuals;
h) Providing referral and follow-up services or otherwise coordinating health and social service options; and
i) Proactively identifying and enrolling eligible individuals in federal, state, local, private or nonprofit health and human services programs.

Source: Oregon Health Authority:
http://www.oregon.gov/oha/OHPR/HPB/Workforce/Docs/Report_NTHW_01.06.12.pdf

MINNESOTA MEDICAID: A CHW is a health worker who is a trusted member of and/or has an unusually close understanding of the community served which enables the provision of information about health issues that affect the community and link individuals with the health and social services they need to achieve wellness.

Source: Minnesota Department of Human Services, 2013:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357#P82_3449

2. Job Titles

When reimbursing CHWs, various job titles may apply, including but not limited to:

- Community Health Educator
- Enrollment Worker
- Family Advocate
- Family Planning Counselor
- Family Support Worker
- Health Advocate
- Health Educator
- HIV Peer Advocate
- Outreach Worker
- Outreach Educator
- Patient Navigator
- Peer Advocate
- Peer Leader
- Promotor(a)
- Promotor(a) de Salud
- Street Outreach Worker
- Doula

3. CHW Supervision

CHWs should be supervised by a member of the staff who has a clear understanding of their role. Health insurers who are known to reimburse CHWs require that they receive supervision in their work. This is the case in Minnesota and Oregon, where the Medicaid program in each state requires supervision from a licensed health care professional in order to receive payment. The following list includes examples of health care providers that may supervise CHWs:

- Physicians
- Certified Nurse Practitioners
- Physician Assistants
- PhD Psychologists
- PsyD Psychologists
- Licensed Clinical Social Workers
- Licensed Professional Counselors
- Dentists

4. Target Patient Populations

The scope of CHW engagement can either be structured broadly, encompassing multiple patient conditions and communities, or narrowly, where CHW services are targeted to a more focused patient population. Some states and organizations have adopted a more comprehensive approach where all patients are required to have access to care teams with CHWs without any specific requirements for eligibility. This is the case in some health systems in Vermont, where multi-disciplinary Community Health Teams are available to all patients in a given practice with no requirements in place for eligibility, referral, prior-authorization, or co-payments. In many other states in New England an incremental approach has been adopted in which CHW services are targeted to a more focused patient community. In this model health insurers may limit the target population that CHWs work with to the frail, disabled, dual eligibles, or other patient groups that are at the highest risk of expensive medical treatment. For these patient groups, successful care will very likely require outreach and assistance from health care workers who know the community and can reach these patients in a way that traditional health care teams often cannot.

III. Options for Funding

Financially sustaining CHW initiatives is one of the most significant challenges faced by organizations engaged in CHW interventions. The majority of funding remains through grants that expire and are disruptive to a program's impact. Grant funding also makes it difficult to fully integrate CHWs on care teams or expand the generalist model for CHWs. The temporary nature of grant support also makes data collection inconsistent, as programs often have to change focus or innovate to secure additional funding, making it difficult to document the long-term impact of CHWs and specific interventions.

One policy approach to creating a more sustainable model is to include a clear expectation that CHWs should be included in new care models being developed as part of large delivery system innovations. In Oregon, for example, legislative language requires that CHWs be included in the care delivered by new Coordinated Care Organizations (CCOs), the delivery system unit through which funding will flow under the state's evolving health care reform initiative. Requiring that CHWs be included by provider organizations receiving global capitation budgets is one way to provide for relatively stable funding, at least in the short term.

Short of formal requirements of this type, other creative mechanisms need to be developed. Health insurers that have explored fee-for-service payment mechanisms have confronted obstacles due to the rigid nature of the billing structure and the lack of codes for CHWs and supportive services. New mechanisms are therefore needed, but policy experts are nearly universally agreed that whatever mechanism is developed to fund CHWs in the current health care environment will need to be cost-neutral or cost-saving. This is why more robust evidence on clinical and economic outcomes is so essential to move the field forward. It is also why creative approaches to budgeting are needed, such as re-examination of entire budgets for home care services, visiting nursing, and case management, along with novel approaches to blending payment through global budgets and quality incentives from payers to provider groups. Nevertheless, policy experts believe that reimbursement through cost-neutral bundled payment by itself will not be the only answer, and that for the foreseeable future funding through additional grant opportunities and private-public partnerships will continue to serve an important role.
The table below and on the following page outlines how some state insurers have defined the scope of work of CHWs, and the funding structure they use for reimbursement.

Table 1. Current CHW Services and Associated Funding Mechanisms.

State	CHW Scope of Work/Requirements	Funding Structure
Alaska	*Covered services:* Alaska Medicaid reimburses Community Health Aides and Community Health Practitioners (CHA/P). Services may be provided at a village clinic, patient's home, or any other community location. Telemedicine services are also covered, but must be billed separately. CHA/Ps provide a wide range of services (full list of billable services is provided here), including direct services such as obtaining a patient's medical history, performing a physical examination, making an assessment, and planning care. CHA/Ps also coordinate the appointments of other visiting health care professionals who regularly visit the village to provide care, including public health nurses, dentists, and doctors. *Supervision:* CHA/Ps must be employed by a tribal organization or contracted through a tribal organization or Indian Health Service. Supervision by an enrolled Medicaid physician is required for reimbursement. *Training/Certification:* CHA/Ps must be certified through the state Community Health Aide Program Certification Board to receive payment. Additional information on training is available at: http://www.healthcareersinalaska.info/index.php/health_careers/info/community-health-aide-or-practitioner	CHA/Ps are directly reimbursed by Alaska Medicaid through fee-for-service billing arrangements. Services are typically reimbursed at 85% of the physician fee schedule, though some services, like Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings and laboratory services, receive 100% of the physician fee schedule.
Minnesota	*Covered services:* Minnesota Medicaid reimburses CHWs that provide diagnosis-related patient education services. Services must involve teaching the patient how to effectively self-manage their health in conjunction with the care team, and use a standardized curriculum consistent with established clinical guidelines or standards. The curriculum may be modified to suit the individual patient's needs, literacy, cultural norms, etc. All services must be provided in-person (individually or in a group setting) in an outpatient clinic, home, or other community setting. *Supervision:* CHWs work as part of a care team and must be supervised by specified licensed health care professionals. Services must be ordered by the licensed health professional to be reimbursed. *Training/Certification:* CHWs must have a valid certificate from the Minnesota State Colleges and Universities (MnSCU) demonstrating that the applicant has completed the approved CHW curriculum.	CHWs are reimbursable through fee-for-service by Minnesota Medicaid. CHWs are able to see anywhere from 1 – 8 patients at a time. Providers must bill in 30-minute units. Billing is limited to 4 units per 24 hours, and no more than 8 units can be billed per calendar month per recipient.

State	CHW Scope of Work/Requirements	Funding Structure
Vermont	*Covered services:* Vermont's Blueprint for Health is the state's plan to transform primary care delivery by developing patient centered medical homes that utilize a multi-disciplinary approach to care through a Community Health Team. Though each Community Health Team is flexible in terms of staffing, many delivery systems in the state have hired CHWs to assist the care team by helping patients to identify their needs, connect to services, and schedule physician appointments. CHWs with experience in health coaching also make home visits, attend physician appointments, and help patients develop their own self-management goals. *Supervision:* Supervision for Community Health Teams varies locally and depends on each individual community and practice needs. *Training and Certification:* There are no established criteria for training or certification of CHWs working as part of the Community Health Team.	State law requires that health insurers partially fund Community Health Teams. Insurers provide a total of $350,000 per each Community Health Team annually which serves a general population of 20,000 ($17,500 per year for every 1000 patients), with shares paid to a single existing administrative entity in each Health Service Area. This combined funding covers the salaries of the core team, but the specifics on how the funding is allocated is decided locally.
Oregon	*Covered Services:* Oregon received a CMS State Innovation Model Grant (SIM) to further develop its Coordinated Care Organization (CCO) model, which will focus on patient-centered and team-based care. Under this waiver, "non-traditional health workers", including CHWs, are approved as members of the healthcare team, and serve the patient in a variety of ways, including navigation, home visits, and patient referrals. *Supervision:* CHWs must be supervised by licensed health care professionals to receive reimbursement. *Training and certification:* To qualify for Medicaid reimbursement, all non-traditional health workers must be certified by the Oregon Health Authority by successfully completing an approved training program and enrolling in the state's registry of providers.	CHWs working as part of CCOs receive Medicaid reimbursement primarily through bundled or capitated payments. When CHWs are providing direct services (e.g. health promotion, care coordination, etc.) they must work under the supervision of a licensed health professional to receive reimbursement. CHWs and other non-traditional health workers involved in population management activities, including outreach, education, etc. are sometimes paid through a CCO sub-contract with a community – based organization. Doulas are reimbursed according to individual agreement achieved between a provider and CCO. Payments to providers, hospitals, or birthing centers are typically enhanced when a doula is utilized, in which case the FFS claim for delivery is billed with a modifier.

Sources:

Minnesota Department of Human Services, Provider Manual, 2013: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357#P82_3449

Dept. of Vermont Health Access, Vermont Blueprint for Health Implementation Manual, 2010: http://hcr.vermont.gov/sites/hcr/files/printforhealthimplementationmanual2010-11-17.pdf

Xerox State Healthcare LLC, Alaska Medical Assistance Provider Billing Manual, 2013: http://medicaidalaska.com/dnld/PBM_Tribal.pdf

Oregon Health Authority, Health System Transformation Update: Non-traditional Health Workers, 2013: http://www.oregon.gov/oha/amh/rule/NTHW-BriefwithRules.pdf

IV. Sample Request for Proposal (RFP)/ Request for Resource (RFR) Language

When writing an RFP or RFR, health insurers may consider requiring that CHW programs reflect the best practices identified by CEPAC as being linked by the best available evidence to improved patient outcomes. These components include:

Training:

- A training program that is at least 40 hours in length, with a focus on the development of core competencies and separate condition-specific curriculum for CHWs working in more specialized roles

Recruitment:

- CHWs should be recruited from the community they will serve, and programs should partner with community-based organizations to find appropriate candidates for CHW work

Pairing:

- CHWs have the respect of the community they serve by demonstrating an understanding of the patient's cultural and socioeconomic environment

Patient interaction:

- In-person patient interactions, either in the patient's home, outpatient clinic, or other appropriate community setting, that involve active engagement with patients to plan for future care; and
- In-person patient interaction that lasts at least 60 minutes in duration (though individual appointments may fluctuate based on individual patient needs)

Care Team Integration:

- A clear plan for integration of CHWs into the healthcare team that includes role definitions for all team members, requirements for supervision of CHWs with direct access to supervisors, and training for CHW supervisors and care team staff for how to effectively work with CHWs

Evaluation:

- Evaluations should assess CHW impact on patient health outcomes, health care utilization, and overall costs;
- Evaluations should include comparisons with relevant control or comparison groups to avoid limitation of case studies and single arm cohort studies; and
- Evaluations should incorporate patient-reported and other patient centered outcomes, and highlight whether CHWs can reduce specific gaps in care

Sample language from an RFR that encompasses some of these principles that can be easily adapted to your organization is provided on the following page (please note that this RFR is no longer active).

STATE OF MASSACHUSETTS:

RFR for Integrated Chronic Disease Management Team Utilizing Community Health Workers

"This RFR seeks to support efforts at Community Health Centers (CHCs) and Community Based Organizations (CBOs) to develop an optimal system of care that addresses chronic diseases with the input of community health workers (CHWs) as part of a team. This funding is intended to encourage a holistic approach; it will allow the chronic disease management (CDM) team to focus on the myriad of conditions and concerns that a client may experience."

Table 2. Selected Sections from the Massachusetts RFR.

Project Description	The RFR will fund two models of chronic disease management, both a community health center-based approach and a population-based approach. Community health center programs will receive $100,000 each. The funding is intended to support CHWs as part of a care team managing chronic disease; a portion of the funding may also be used to support RNs, MSWs, or other providers supervising CHWs. Population-based programs will involve patient engagement in discrete areas through door-to-door outreach, service referral, education, and home visits by CHWs. These community-based programs will be funded for up to $20,000 each. The community based programs will be expected to link, through written agreements, to local health care facilities that include community health centers.
Staffing Requirements	Background requirements for CHWs: A CHW is hired primarily for his or her understanding of the populations he or she serves and conducts outreach. Supervision requirements for CHWs: On-going support and supervision of CHWs are crucial by RNs, MSWs, or others in the program. Regular program and clinical supervision including individual and team support are necessary. CHW supervisors should have outreach experience and accompany CHWs in the field as they perform their outreach activities at least twice per year. CHW Training: All community health workers funded through this RFR are required to participate in a training determined by Massachusetts Department of Public Health. These training opportunities are rich and varied and may include but are not limited to: 1. Community Health Education Center (CHEC): http://www.bphc.org/programs/chec/chectrainings/Pages/Home.aspx 2. Outreach Worker Training Institute (OWTI) in Worcester: http://www.umassmed.edu/uploadedfiles/Message%20from%20the%20OWTI%20Director_%2008%2016%2005.pdf 3. Master trainers in the Stanford Chronic Disease Model are available from the MDPH to conduct training of trainers courses 4. A distinct course for supervisors is available to those who will supervise the CHWs 5. Patient navigator courses for more clinically-oriented CHWs and their supervisors
Project Guidelines	Programs will be expected to follow these guidelines: • Establish primary care teams that address the wide range of needs inherent in chronic disease management. These teams should also focus on the community resources available to address these needs. Linkages with community groups must reflect the understanding that chronic disease management occurs in various locations such as homes, faith institutions, supermarkets, and schools. • Provide support and education regarding self-management of chronic diseases to clients. CHWs should play a key role in delivering this service. • Intensively monitor high-risk clients. • Utilize a client identification and tracking system and in the case of CHCs, a reminder system or electronic medical record. CHWs will be expected to maintain this system. • Design and implement an evaluation system that promotes continual data collection, analysis, assessment, and quality improvement efforts.

V. Quality Assessment

The design of appropriate quality indicators may be important in contracting or in the development of quality awards or grants provided by insurers.

Areas of focus for quality assessment include the following (Mirambeau, 2012):

- Patients and Families
  - Health status
  - Access to and utilization of health services
  - Access to and utilization of community resources
  - Provision of social support
- Program performance
  - Training
  - Organization and management
  - Service delivery
  - Costs and benefits

Specific best practice indicators may include the following (Mirambeau, 2012):

Table 3. Best Practice Indicators.

CHW Activities	Process Indicators	Outcome Indicators	Impact
Improving access and appropriate use of services • Case finding/outreach • Patient reminders • Resource/referral	• # of visits • # of appointments made • # case-finding chart review • # enrolled • # patients served • # assessed/screened • # referrals made	• Changes in knowledge • Satisfaction w/CHWs • Self-management • Medication compliance • Lifestyle changes (smoking, dietary habits) • Biometrics (blood pressure, cholesterol)	• Reduced morbidity and mortality • Reduced costs • Reduction in health disparities
Risk Reduction • Health education • Informal counseling	• # of education sessions • # enrolled in education sessions • # completing program • # and type of material disseminated		

Source: Mirambeau AM. CDC Evaluation Coffee Break: evaluating community health worker programs, 2012. Available at: http://www.cdc.gov/dhdsp/pubs/docs/CB_November_2012.pdf. Adapted from Nemceck MA, Sabatier R. Public Health Nurs. 2003:20(4):260-270.

Additional examples of quality assessment or evaluation measures are provided as resources on the following page.

UNIVERSITY OF ARIZONA: The University of Arizona provides a comprehensive list of potential evaluations of CHW programs in its Community Health Worker Evaluation Tool Kit, and many may be tied to reimbursement measures. Examples include:

A. Patient Activities
    a. Number of appointments kept
    b. Number of successful referrals
    c. Patient satisfaction
B. Outcomes
    a. Appropriate healthcare service use
    b. Cost-benefit evaluation
C. Impacts
    a. Patient health status

STATE OF OREGON: As part of the Centers for Medicare and Medicaid (CMS) Innovation Award, Oregon has identified 33 performance measures against which to judge the impact of CCOs on patient health, appropriate and inappropriate resource utilization and patient satisfaction (Oregon.gov, 2013b). CHWs, as part of the integrated healthcare delivery system, are in a unique position to interact with patients and impact several listed outcomes. The full list of incentive and state measures are described below and on the following page. Many are nationally-established benchmarking measures.

Table4. Performance Measures for CCOs in Oregon.

CCO Incentive Measures ***CCOs are accountable to Oregon Health Authority (OHA)***	**State Performance Measures** ***OHA is accountable to CMS***
Alcohol or other substance misuse (SBIRT)	Alcohol or other substance misuse (SBIRT)
Follow-up after hospitalization for mental illness (NQF 0576)	Follow-up after hospitalization for mental illness (NQF 0576)
Screening for clinical depression and follow-up plan (NQF 0418)	Screening for clinical depression and follow-up plan (NQF 0418)
Follow-up care for children prescribed ADHD medications (NQF 0108)	Follow-up care for children prescribed ADHD medications (NQF 0108)
Prenatal and postpartum care: timeliness of prenatal care (NQF 1517)	Prenatal and postpartum care: timeliness of prenatal care (NQF 1517)
PC-01: Elective delivery (NQF 0469)	PC-01: Elective delivery (NQF 0469)
Ambulatory care: outpatient and ED utilization	Ambulatory care: outpatient and ED utilization
Colorectal cancer screening (HEDIS)	Colorectal cancer screening (HEDIS)
Patient-Centered Primary Care Home Enrollment	Patient-Centered Primary Care Home Enrollment
Developmental screening in the first 36 months of life (NQF 1448)	Developmental screening in the first 36 months of life (NQF 1448)
Adolescent well-care visits (NCQA)	Adolescent well-care visits (NCQA)
Controlling high blood pressure (NQF 0018)	Controlling high blood pressure (NQF 0018)
Diabetes: HbA1c poor control (NQF 0059)	Diabetes: HbA1c poor control (NQF 0059)
CAHPS adult and child composites: • Access to care • Satisfaction with care	CAHPS adult and child composites: • Access to care • Satisfaction with care

CCO Incentive Measures *CCOs are accountable to Oregon Health Authority (OHA)*	State Performance Measures *OHA is accountable to CMS*
EHR adoption (Meaningful Use 3 question composite)	EHR adoption (Meaningful Use 3 question composite)
Mental and physical health assessment within 60 days for children in DHS custody	Prenatal and postpartum care: postpartum care rate (NQF 1517)
	Plan all-cause readmission (NQF 1768)
	Well-child visits in the first 15 months of life (NQF 1392)
	Childhood immunization status (NQF 0038)
	Immunizations for adolescents (NQF 1407)
	Appropriate testing for children with pharyngitis (NQF 0002)
	Medical assistance with smoking and tobacco use cessation (CAHPS) (NQF 0027)
	Comprehensive diabetes care: LDL-C screening (NQF 0063)
	Comprehensive diabetes care: Hemoglobin A1c testing (NQF 0057)
	PQI 01: Diabetes, short term complication admission rate (NQF 0272)
	PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275)
	PQI 08: Congestive heart failure admission rate (NQF 0277)
	PQI 15: Adult asthma admission rate (NQF 0283)
	Chlamydia screening in women ages 16-24 (NQF 0033)
	Cervical cancer screening (NQF 0032)
	Child and adolescent access to primary care practitioners (NCQA)
	Provider Access Questions from the Physician Workforce Survey: • To what extent is your primary practice accepting new Medicaid/OHP patients? • Do you currently have Medicaid/OHP patients under your care? • What is the current payer mix at your primary practice?

CAHPS: Consumer Assessment of Healthcare Providers and Systems; DHS: Department of Human Services; EHR: electronic health record; LDL: low-density lipoprotein; NCQA: National Committee for Quality Assurance; NQF: National Quality Forum; OHP: Oregon Health Plan; PQI: prevention quality indicator; SBIRT: screening, brief intervention and referral to treatment

Table 5. Quality Assessment/Evaluation Electronic Resources.

The University of Arizona Rural Health Office and College of Public Health – Community Health Worker Evaluation Tool Kit	https://apps.publichealth.arizona.edu/CHWToolkit/
Oregon Health Authority	http://www.oregon.gov/oha/Pages/index.aspx
CDC – Promoting Policy and Systems Change to Expand Employment of Community Health Workers (CHWs)	http://www.cdc.gov/dhdsp/pubs/chw_elearning.htm
Rural Assistance Center – Module 6: Measuring Program Impact	http://www.raconline.org/communityhealth/chw/module6/
Global Health Workforce Alliance - Community Health Worker Assessment and Improvement Matrix (CHW AIM): A Toolkit for Improving Community Health Worker Programs and Services	http://www.who.int/workforcealliance/knowledge/toolkit/54/en/index.html

VI. Conclusion

The research on the effectiveness and value of CHWs is often narrow in scope and focused on short-term outcomes, but there is broad interest among provider organizations and many payers in moving forward to integrate CHWs into the healthcare workforce. For insurers moving in this direction there are important opportunities to apply evidence-based best practices included in this guide that have been based on the published literature, regional survey data, and expert experience. Understanding and applying this information will assist insurers in establishing high-quality CHW programs which have the potential to improve the health of patients in New England and across the nation.

Additional Resources

CDC e-learning module: Promoting Policy and Systems Change to Expand Employment of Community Health Workers (CHWs) http://www.cdc.gov/dhdsp/pubs/chw_elearning.htm	This course is designed to provide state programs and other stakeholders with basic knowledge about Community Health Workers (CHWs), such as official definitions of CHWs, workforce development, and other topic areas. In addition, the course covers how states can become engaged in policy and systems change efforts to establish sustainability for the work of CHWs, including examples of states that have proven success in this arena.
U.S. Dept. of Health and Human Services, Health Resources and Service Administration (HRSA), Office of Rural Health Policy (ORHP): CHWs Evidence-Based Models Toolbox http://www.hrsa.gov/ruralhealth/pdf/chwtoolkit.pdf	Identifies promising practice models and evidence-based practices for using CHWs in rural communities.
Rural Assistance Center: CHW Toolkit http://www.raconline.org/communityhealth/chw/	The CHWs Toolkit is designed to help rural communities evaluate opportunities for developing a community health worker program, and to provide resources and best practices developed by successful community health worker programs. Through eight modules, the toolkit offers tools and resources to develop and implement programs for using CHWs in local programs.

VII. References

1. American Public Health Association (APHA). Support for community health workers to increase health access and reduce health inequities, Policy Number 20091, 2009. Available at: http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1393. Accessed, July 2013.
2. Angus L, Cheney C, Clark S, Gilmer R, Wang E for the Non-Traditional Health Worker Subcommittee. The role of non-traditional health workers in Oregon's health care system, 2012. Available at: http://www.oregon.gov/oha/OHPR/HPB/Workforce/Docs/Report_NTHW_01.06.12.pdf. Accessed August, 2013.
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