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Helping Leaders Advance Child Health Care Transformation

FINANCING PEDIATRIC COMMUNITY HEALTH WORKERS:

The Role of Medicaid and as Part of Primary Child Health Care and the Medical Home

Charles Bruner – October 2023 Working Paper in InCK Marks CHW Series

Introduction: Community Health Workers and Primary Child Health Care

There is increasing interest in and attention to incorporating community health workers (CHWs) into child primary health care practices as part of the medical home team, particularly for children covered under Medicaid and living in poor and underserved communities. There also is a deep and diverse body of research which shows that well-recruited and selected, trained, supported, and valued CHWs are effective in elevating child health trajectories for those they serve and rectifying racial health inequities, particularly as they relate to serving children and their families in poor and medically-underserved neighborhoods and communities. They show promise in strengthening the fabric of community for children on a population level and producing gains on that population level even beyond those they directly serve. While much of work that CHWs have done in clinical practices has been with respect to stabilizing and health maintenance for patients with special health conditions or disabilities (primarily adults), the major opportunity for CHWs with children lies in promoting healthy development, including preventing the development of future medical health conditions (see Appendix One for key resources on CHW research and evidence and Appendix Two for an annotated bibliography).

Effective reimbursement of CHWs requires that it be sufficient to provide for the full cost to the practice of employing them (or contracting for them within community-based organizations) and is based upon what makes them effective.

For children in particular, Medicaid is a key funding source for health care. CHWs can be financed under Medicaid in several ways. The Center for Medicare and Medicaid Services (CMS) has made clear that CHWs are eligible for reimbursement within state plans, as part of waivers, and as incorporated into managed care contracts and responsibilities. They can be integrated into payment systems available to Federal Qualified Health Centers. There is growing attention by states on how to do so, recognizing such financing requires particular attention to CHW's multiple roles. The following is an introduction to developing such financing, starting with describing the CHW's role in primary practice.

The Role of Community Health Workers in Primary Practice

When a child health primary care practice decides it wants CHWs as part of its practice, the practice generally envisions the CHW's role as establishing relationships with the families of the children in care and serving as the primary ongoing contact with them to identify and respond to non-clinical needs, connecting them to supports in the neighborhoods and communities they serve. The practice wants the CHWs to ensure families come for scheduled well-child visits, follow medical regimens prescribed, provide feedback to the practice, and support the practice in partnering with families and moving to equity. The practice also expects that, by having deep ties to the community, CHWs will be a bridge for the practice with the community and its institutions and support the practice in its role as a community partner.

As part of the medical home team, the role of the CHW relies heavily on relationship building and is part care coordinator, part maven, part community organizer, part advisor to the practice, part parent educator and family supporter, and part family motivator and advocate. It involves multiple, often highly individualized, actions to support and strengthen the families being served. Some of this involves direct interaction with the child and family and meets the definition of providing preventive services and supports; some involves networking and consultation and support that can be considered case management or care coordination; and some involves participation in planning in the practice and with the medical home team.

This establishes CHWs as distinct from most child health medical providers. Unlike many referrals child health practitioners make to other health professionals that involve specific expertise to address a specific medical condition, CHWs must be flexible and work from where the families are. This is not achieved solely through fifteen-minute units of service or specific service regimens and protocols (although it may be billed as such). This is not achieved solely through definitions of case management as linking families to other services (although it may be billed as such). Employing such CHWs can be a great asset to and even transform clinical practice; but it requires that CHWs be authorized and given flexibility and recognition to perform multiple roles.

How CHWs Can Be Financed for Children under Medicaid

Like other health insurance, Medicaid provides health care coverage that is specific to a covered individual and that individual's health needs. Any reimbursement for services for children covered under Medicaid must relate to the child's health and development. Medicaid, however, includes a very broad Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit for children that provides for much broader coverage of health-related services than what is provided in traditional health care for adults.

States which have moved to provide coverage for CHWs have done so in two primary ways: (1) reimbursing for the direct work CHWs do with children (and their families) as a prevention service; and/or (2) reimbursing for the care coordination work CHWs do as case management or targeted case management (often on a per-member-per-month (pmpm) payment to the practice). States also can incorporate the practice's cost of employing CHWs as part of the medical home teams within their

reimbursement for office visits (well-child/EPSDT visits) as an embedded cost for the practice to provide primary care. Whether Medicaid operates on a fee-for-service or a managed care basis, practices must receive reimbursement to enable them to fully cover their cost and maintain CHWs in their roles.

Prevention. A number of states have defined CHWs as eligible providers for prevention services that generally relate to strengthening the home environment to support healthy child development. Most states then set a reimbursement rate for billable units of that prevention service (often as fifteen-minute units of service, although it could be as a broader case rate or bundled service covering a six-month or one-year period). How they define that prevention service and to whom it applies, however, is key to how well it will apply to CHW's in performing their overall roles (see Appendix Three for a comparison of two states in this respect).

Case Management. As case management or targeted case management, states have provided pmpm payments to cover the overall work that case managers do. Members could be the entire number of children covered under Medicaid that are served by the practice or a subset of those identified with a particular concern. Although for children the latter can be limited to a diagnosed developmental delay or special health care need in the child, it also can be based on social determinants' screening of the child's environment or upon primary care clinician judgement.

Office Visit Payments. As part of the practice's overall reimbursement for office visits, the payment could incorporate some or all of the costs of CHWs who are part of the practice. Currently, however, most state payments for office visits are very low (even below those provided for Medicare) and not sufficient for practices to do more than provide basic medical care. Federally qualified health centers are particularly equipped, however, to incorporate the cost of CHWs into their reimbursement for office visits, as their rates are not set by the state or managed care providers but are based upon prospective costs, which can include CHWs. FQHCs serve twenty percent of all Medicaid children in the United States, and a much larger share of those children in low-income and medically-underserved communities.

Administration. In addition to covering CHWs as a service or as case management under the state's FFP or as part of well-child/office/EPSDT visits, Medicaid also covers, generally at a 50 percent matching rate, costs of administration. In addition to the above, some aspects of CHWs, such as training and recruitment, support to practices to incorporate CHWs, and outreach, data systems development, and evaluation, can be covered through administrative claiming. Doing so can be particularly important in expanding the use of other reimbursement options to more practices.

Calculating Reimbursement Needed to Cover and Sustain CHWs as Part of Primary Child Health Care Practice

As stated earlier, by whatever financing option or options, reimbursement under Medicaid overall must be sufficient to cover the full costs of CHW services inside clinical settings or in the community – in terms of salaries and benefits, recruitment and training and supervision costs, and equipment and resources and administrative costs. As an illustration, if the practice determines that a CHW can effectively serve 100 children and their families, and the cost of maintaining that CHW over the year is

$60,000,[1] the practice will need to receive additional Medicaid reimbursement of $600 per child per year to cover that cost (recognizing that some children and their families will require more, and some less, in the way of time and attention and therefore costs).

Financing as a preventive service. Under the ACA and federal rules, since 2014 it has been clarified that CHWs providing preventive services do not need to have a degree or credential to be eligible for reimbursement, but simply that their services be recommended by a licensed practitioner of the healing arts within their scope of practice under state law. Medicaid defines preventive care as services that prevent disease, disability, and other health conditions or their progression, prolong life, and promote physical and mental health and efficiency. For children, and young children in particular, such preventive services can include those that strengthen the safety, stability, and nurturing in the home environment that promotes the child's health. They do not need to be tied to a child's own medical condition.

To cover the overall costs of employing a CHW in a practice, if reimbursement is to come from payments for a preventive service, this would require billing on the basis of units of service or as an overall case rate. To cover that $60,000 in costs, it would mean an annual case rate of $600 per child (or $300 per six-month increment). If billed on the basis of units of service (and most states which have initiated funding for CHWs have done so under such billing and CMS is most geared toward such units), it would require an overall billing of 2000 15-minute units of service at $30 per unit during a year.[2]

Financing as case management. Increasingly, because of the flexibility it provides to practices, states are adopting pmpm payments for case management or targeted case management. These can be on a total enrollee basis (e.g. all Medicaid-covered children in the practice) or a targeted subset of those enrollees (e.g. those diagnosed with a specific special health care need or a developmental delay or identified through screening or clinician judgement as being at-risk, which can include risk due to environmental concerns, e.g. the home environment and social determinants of health). If a child-specific diagnosis of a special health care need or developmental delay, the number of children, and particularly the youngest children, who qualify is quite limited (12 to 20 percent, at most), while identifying by social or relational risk includes the majority of children on Medicaid – and those for whom CHWs can be particularly important from a preventive and developmental and community-based perspective.

If calculated for all children in the practice, using the prior assumptions, this would mean a per-member-per-month payment rate of $50 per child per month for those 100 children ($50 * 12 months * 100

[1] If the starting salary of a CHW is $18 per hour, with opportunities for advancement, the average pay would more in the order of $20.00 per hour or $41,600 per year. With 20 percent in benefits, that relates to $50,000 per year. Indirect organizational expenses (office space, training, recruitment, travel and expenses, and, in particular, supervision) at another $10,000 bring that to the $60,000 figure used here.

[2] A full-time-equivalent CHW would work approximately 2080 hours per year, with only a portion of the time in direct, billable units of service. Outreach, collateral contacts, documentation, internal staffing, travel, presentations, and other work essential to the CHW's effectiveness need to be recognized if only direct units of service receive billing. This suggests that CHWs can at most provide an average of 10 units of direct units of service each day (200 days), at the rate of $30 per unit. The rate that states currently use for such billing are more in the $10 to $15 range for a 15 minute unit of service. Billing by such units of service also requires significant documentation and paperwork, which is in addition to the actual time engaged in the direct service.

children). If for a subset of all children, the rates would have to be commensurately higher. States also have the option of differentiating the pmpm payments based upon complexity.

Financing as well-child care. When children are very young (birth to three), the child health system often is the major, if not the only, source of contact of any provider or professional in the health and human services fields with the child and family. It also is when the health system sees children most often for both well-child care and for illnesses and injury. The child health practice often is the trusted source for parents for answering questions and providing guidance on their child's health and development. The nationally-recognized standards for well-child care, *Bright Futures*, emphasize the role of well-child care in providing such guidance and support, including responding to social determinants of health. Child health practices receive most of their reimbursement for the general services they provide through well-child and other office visits.

Whether under a fee-for-service or a managed care structure, in most states practices are reimbursed in terms of office visits and their billing codes, with payments generally determined by the state. In the Affordable Care Act, such visits were temporarily raised to Medicare payment levels, but most states have since gone back to lower levels of reimbursement, something well below $100 for a fifteen-minute visit. This may enable a practice to provide essential medical surveillance, provide for vaccinations, conduct a physical examination, and do a little anticipatory guidance, but it doesn't provide for much more. If a practice sees a young person an average of four times a year, covering the additional practice cost of a community health worker (again working with one hundred children, on average), would require more than doubling that reimbursement, e.g. increasing that rate by an additional $150 per visit. States can set up differential rates of reimbursement for such visits, depending upon the scope of services provided, which could enable states to create incentives for expanding practices to include CHWs without increasing rates for those who do not.

Combining (blending and braiding) financing options. There are advantages, in terms of documentation and ease of administration, for covering the cost of CHWs through a single funding source. As the examples show, however, doing so within only one approach can involve very major increases in what currently is reimbursed. The key to the practice (or the community provider employing the CHW) is for there to be sufficient overall financing to cover the costs across the range of activities CHWs perform. States can provide options for reimbursement that include more than one of these payment options. Practices also may be able to secure funding through grants or other sources of funding (including state or community dollars, although doing so as a separate funding source does not draw down federal financial participation) to pick up any costs not assumed under Medicaid.

Key Issues to Address in Financing CHWs Through Medicaid

As states and practices move forward to incorporate CHWs into their primary child health care practice and as part of the medical home team, there are important issues to consider. These include defining the CHW practice itself, setting the qualifications for a CHW provider, and providing for an overall reimbursement that covers the cost to the practice (or community provider) in employing the CHW.

Defining CHWs in Medicaid State Plans. Defining the role and responsibility of CHWs, particularly for children, should be broad and flexible – in terms of range of services provided (including networking in

the community and family-directed supports and advocacy), patient eligibility for service (not tied to a child medical diagnosis), required skills (not restrictive of those without formal educational certifications but based upon aptitude for work and connection to community), and role in the office (not tied to specific directives from the medical provider or direct patient contact).

The National Academy for State Health Policy hosts a webpage, Community Health Worker Models,[3] that provides information on state financing of CHWs, including 15 state models doing so directly, 10 state models providing for CHWs through managed care, and 11 states having authorizing state legislation. These define the work CHWs do, who can provide CHW services, who is eligible to receive CHW services, and how these services are reimbursed. They vary substantially in the training and credentialing required to provide a Medicaid service (with greater credentialling, such as a B.A., greatly narrowing the opportunity for those who know the community best and have shared experiences to be eligible to serve). They are continuing to evolve, particularly in recognizing a much broader role for CHWs than addressing medical concerns.

Appendix Three provides a contrast between two states showing this evolution and difference. The state of Rhode Island's recently-approved Plan Amendment has a particularly broad and inclusive definition of CHWs and the actions they can perform to achieve their roles, in keeping with what makes CHWs effective in practice. Many other state plans are much more restrictive, placing specific limitations on what CHWs can do that is reimbursable, requiring their work to be tied to addressing a medical condition, and/or generally treating CHWs as directed by the health professional to conduct specific activities (see Minnesota definition, for comparison). States require different degrees of documentation, sometimes limited to a small portion of what a CHW may do to qualify for payment under Medicaid and placing particular emphasis upon providing only those services and that education that conforms with the medical practice's direction.

In addition, there are differences in the specific roles that CHWs assume when serving children and their families than when serving older, and particularly chronic care populations. The Boston Medical Center has recognized this in its different job descriptions of Community Wellness Advocates (CWAs), with those as part of its Future of Health Care Initiative serving children interspersing within the general job description specific references to working and advocating with families Appendix Four provides this description, with the job definition itself a good starting point for describing the work that CHWs will do within a medical practice. While consistent with Rhode Island's broader Plan definition of CHWs, BMC's in effect distinguishes its particular role with children.

Providing payments that cover the work CHWs do and their employment and support. Currently, the most common way to cover CHWs is through either case management and some pmpm payment or as a preventive service through specified units of service. Typically, pmpm payments for case management, however, are far from a $50 pmpm level and higher rates that approach that level often are confined to a small subset of patients with chronic and complex health conditions. Preventive services for CHWs that exist in states generally are in the $15 payment range for a fifteen-minute unit of service, far below the estimates provided earlier needed to cover the costs of maintaining CHWs in practice

[3] National Academy for State Health Policy Community Health Worker Models (2022). Retrieved at: State Community Health Worker Models - The National Academy for State Health Policy (nashp.org)

As practices and states seek to establish payment rates and qualifications for payment, it is important to do some of the types of calculations provided above and reflect, in particular, on how this looks from a business practice perspective. Providing for a true cost-based reimbursement reflective of the full investments practices need to make in employing (or practices and community-based organizations need to make in employing) them)is key to getting uptake on their use. Where foundations or other outside entities also are supporting CHWs as a strategy, they can seek to make sure that their efforts are fully leveraged by the state Medicaid system.

Opportunities for Advocates

Advocates can play key roles both at the legislative level in authorizing and providing financing for CHWs and at the administrative level in ensuring that the design, implementation, and the devil-in-the-detail in administrative rules governing payments and investments truly support CHWs.

In doing so, it is important that advocates from the community health worker field, from the child advocacy field, and from the child health financing field collaborate as much as possible in making the case for specific attention to children and to the multiple roles CHWs need to play -- and therefore the provisions that need to be incorporated in Medicaid financing of CHWs. Collectively, these different advocates and champions can help ensure that the true potential for CHWs is realized in child health care practice as well as in public health and not restricted to a narrow, medical focus or set aside as a small add-on of a possible new service rather than integral to the effectiveness of the overall practice itself.

In March, 2022, with leadership from the Washington chapter of the American Academy of Pediatrics, Washington became the first state to establish specific funding for CHWs for children and setting in motion actions to establish financing under Medicaid. The insert shows the actual text from that legislation, which could be a basis for use by other states.

Washington State Senate Bill 5693, Section 103

$2,087,000 … is provided to establish a two-year grant program for reimbursement for services to patients up to age 18 provided by community health workers in primary care clinics whose patients are significantly comprised of pediatric patients enrolled in medical assistance. … Community health workers funded under this subsection may provide outreach, informal counseling, and social supports for health-related social needs. The authority shall seek a state plan amendment or federal demonstration waiver should they determine these services are eligible for federal matching funds. ... In collaboration with key stakeholders including pediatric primary care clinics and medicaid managed care organizations, the authority shall explore longer term, sustainable reimbursement options for the integration of community health workers in primary care to address the health-related social needs of families, including approaches to incorporate federal funding.

Appendix One: The Research Base on Community Health Workers, What Makes Them Effective, and their Particular Role in Serving Children

Research on Overall CHW Effectiveness. The research on well-resourced and integrated community health workers as part of clinical practice has been described as "incontrovertible,"[4] with a deep and compelling cross-disciplinary research base.[5] The Office of Homeland Security has included CHWs on its list of critical infrastructure workers during the COVID-19 pandemic, and the Centers for Disease Control and Prevention has emphasized the importance of CHWs on improving responses to both general and specific health conditions.[6] Community health workers have demonstrated immediate health impacts in responding to patients with complex and chronic health conditions – in following medical protocols and in better maintaining patients' overall health through strengthening their resiliency,[7, 8] often with high returns-on-investment.[9, 10] CHWs have strengthened community-clinical linkages that respond to social as well as clinical determinants of health.[11] They have proved effective in helping reduce racial and ethnic health inequities.[12, 13]

Keys to CHW Effectiveness. Research also is clear, however, that for CHWs to be effective, they must be well-resourced, integrated, and truly valued by the practice – in terms of training, ongoing reflective supervision, manageable workloads, and overall support and recognition within the practice.[14] This includes recruiting and selecting them for their relational skills and giving them flexibility in building relationships to provide patient-centered and -driven responses – which is different from most medical services providing specific treatments for specific identified health conditions. One reason for the effectiveness of CHWs is their knowledge of and connection to the communities in which their families live, and this often requires substantial time in communicating and working with community partners as well as families.

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[4] Health Research Policy and Systems (2021). *Community Health Workers at the Dawn of a New Era.*
[5] InCK Marks (2021). *Building a Relational Health Workforce for Young Children.*
[6] Centers for Disease Control and Prevention. Community Health Worker Resources webpage. Public Health Professionals Gateway webpage. Retrieved at: CDC - Community Health Worker Resources - STLT Gateway
[7] Center for Health Care Strategies (2020*). Recognizing and Sustaining the Value of Community Health Workers and Promotores.*
[8] Community-Based Workforce Alliance (2021). *Advancing CHW Engagement in COVID-19 Response Strategies.*
[9] Vasan et. al. (2020). Effects of a standardized community health worker intervention on hospitalization among disadvantaged patients with multiple chronic conditions: A pooled analysis of three clinical trials. *Health Services Research.*
[10] Sangovi, et.al. (2020) Evidenced-Based Community Health Worker Program Addressed Unmet Social Needs and Generates Positive Returns on Investment. *Health Affairs.*
[11] Lohr AM, Ingram M, Nuñez AV, Reinschmidt KM, Carvajal SC. Community–clinical linkages with community health workers in the United States: a scoping review. *Health Promotion Practice.* 2018 May;19(3):349-60.Retrieved at: Community–Clinical Linkages With Community Health Workers in the United States: A Scoping Review (nachw.org)
[12] Shannon, C et. al. (2014). Community Health Workers as an Integral Strategy in the REACH U.S. Program to Eliminate Health Inequities. *Health Promotion Practices.*
[13] Hernández-Cancio, S., Houshyar, S, and Wallawander, M. (2018). "Community Health Workers: Key Partners in Improving Children's Health and Eliminating Inequities." Families USA September Issue Brief. Available at: https://familiesusa.org/wp-content/uploads/2019/09/HE_CHWs-and-Kids_Issue-Brief.pdf.
[14] Health Research Policy and Systems, op. cit. Center for Health Care Strategies, op cit., InCK Marks, op.cit., etc.

This also means supporting them in a way that does not medicalize and narrow their focus to that medical model. CHWs serve multiple roles, characterized by one research synthesis as including 12 functions (care coordination, health coaching, social support, health assessment, resource linking, case management, medication management, remote care, follow-up, administration, health education, and literacy support) across three areas of focus: clinical services, community resource connections, and health education and coaching.[15] These functions are aligned with the National Committee for Quality Improvement and the Penn Center for Community Health Workers enumeration of nine critical inputs for effective community health worker programs: recruitment and hiring, training, supervision, support, scope of work, workforce development, health and social care team integration, organizational data systems and engagement, and program stability.[16] When CHWs are supported for what they do – and not directed by the practice to focus solely on a specific medical concern – they also inform and change practices to be more responsive (including culturally and racially responsive) and effective in what they do.[17]

While most of the research on engaging CHWs in medical practices has been directed to adults and persons with special health care needs of disabilities, their impacts both on population health and racial equity are greatest in supporting children in their development through responding to social determinants of health,[18, 19] particularly young children and children in low-income and underserved communities.[20] While they come by many different names – family navigators and advocates, health realization coaches, relational care coordinators, traditional health workers, family development specialists, etc. as well as CHWs – they play a particularly important role in strengthening the safety, stability, and nurturing in the home environment, which Healthy People 2030 emphasizes as foundational to child health and well-being (see insert).[21] While important to screen, surveil, and diagnose the child for any specific health and development concerns (and respond to them), the primary factors impacting the child's health and well-being represent social determinants of health (economic, social, and relational) and where CHWs and medical homes can have the greatest impact.[22]

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[15] Hartzler, A.L., Tuzzio, L., Hsu, C. and Wagner, E.H., (2018). Roles and functions of community health workers in primary care. *The Annals of Family Medicine*, *16*(3), pp.240-245.

[16] National Committee for Quality Assurance and Penn Center for Community Health Workers (2021). *Critical Inputs for Successful Community Health Worker Programs: A White Paper.*

[17] Garfield, C and Kangovi, S (2019). Integrating community health workers into health care teams without coopting them. Health Affairs Blog, May 10, 2019. Retrieved at: Critical-Inputs-for-Successful-CHW-Programs-White-Paper-November2021.pdf (ncqa.org)https://www.healthaffairs.org/do/10.1377/forefront.20190507.746358.

[18] InCK Marks (2022). *Racial Equity Truths: Health Care Imperatives.* Webinar powerpoint with text of presentation and highlights of responses.

[19] Children's Partnership (2021). *Community Health Workers Advancing Child Health Equity.*

[20] InCK Marks. (2021) *Dismantling Racism.*

[21] Office of Disease Prevention and Health Promotion (2022). Healthy People 2030 Website. https://health.gov/healthypeople/objectives-and-data/browse-objectives/children

[22] Bethell, et. al. (2022). CAHMI work on relational risks.

Healthy People 2030 Goals for Children and their Parents and Caregivers

The Office of Disease Prevention and Health Promotion's *Healthy People 2030* sets goals for our nation's health and builds on knowledge gained over the last 4 decades in health care – with an increased focus on health equity, social determinants of health, and health literacy and a major new focus on well-being. For children, *Healthy People 2030* recognizes the primary role families play, with ecological goals that go well beyond medical care.

Goal: Improve the Health and Well-Being of Children. Childhood is a critical period of growth and development — and a child's experiences, behaviors, and health problems can have long-term impacts. Healthy People 2030 focuses on ways to directly and indirectly improve children's health, safety, and well-being. Safe, stable, and supportive relationships are critical for children's health, development, and well-being. Family-level interventions can help keep children safe and healthy.

Goal: Help parents and caregivers improve the well-being and health for their loved ones and their selves. Parents and caregivers have a major impact on the health and well-being of children and adolescents, older adults, and people with health conditions or disabilities. Healthy People 2030 focuses on ways parents and caregivers can help keep the people they care for — and themselves — healthy and safe.

Take-Away Messages on the Evidence for Community Health Workers: Success Depends on Adequate Resources and Support for Best Practice

There is compelling evidence of the value and effectiveness of well-supported community health workers serving in these capacities as part of medical homes for children. This effectiveness, however, is dependent upon those workers being:

- Selected for their skills and knowledge of the community and attributes to engage, establish trust with, and motivate and accompany the families they serve;
- Given flexibility to engage in continuous problem-solving and opportunity-identification with families, individually-tailored to the child and family's needs and hopes and in the settings where the families are comfortable;
- Provided realistic caseloads and expectations related to their work with children and families;
- Provided training and reflective supervision to meet the challenges of this work, develop additional skills, and continue in their positions;
- Provided additional training and ongoing supervision around the specific issues related to parenting and child development, when the CHW is working with children and their families; and
- Valued and with standing within the practice to ensure families receive what they need from the practice itself and CHWs avoid burnout and see career opportunity.

Appendix Two. Annotated Bibliography of Select Community Health Worker Literature

> An annotated bibliography of recent reports and research syntheses on community health workers from InCK Marks, the Center for Health Care Strategies, the Community-Based Workforce Alliance, the Children's Partnership, the Penn Center for a Community-Based Workforce, the National Committee for Quality Assurance, Families USA, the National Academy for State Health Policy, the Patient-Centered Outcomes Research Institute, the Center for the Study of Social Policy, and the American Public Health Care Association. The final bibliographic reference includes CHWs in the larger context of developing high performing medical homes for young children.

Over the past several years, the role of Community Health Workers (CHWs) in responding to health crises, improving population health, and rectifying racial inequities in health, particularly in poor and medically underserved communities has received prominent attention. In part, COVID-19 has brought to recognition how essential, but also under-resourced, the CHW workforce is. The Office of Homeland Security has included CHWs on its list of critical infrastructure workers during the COVID-19 pandemic, and the Centers for Disease Control and Prevention has emphasized the importance of CHWs on improving responses to both general and specific health conditions (asthma, cancer, cardiovascular disease, diabetes, infectious disease, injury prevention, and obesity) on its webpage devoted to CHWs.[23]

There also have been a spate of recent research summaries and analyses of the value of CHWs – which confirm, reinforce, and amplify on the essential role of CHWs in responding to health crises, improving population health, and rectifying racial inequities. While not all focus specifically on the role of CHWs in responding to children and their families, they apply to primary child health care and public health in their roles of advancing healthy child development. Below is a brief annotation of these resources. All emphasize that well-resourced and supported CHWs can and should become a core component of health systems (both health care and public health).

Zulu J, and Perry H (2021). Community health workers at the dawn of a new era. *Health Res Policy Sys* **19,** 130. https://doi.org/10.1186/s12961-021-00761-7.

> The introduction and eleven articles draw upon international research and experience to emphasize that the evidence for the value of CHWs is "incontrovertible" but dependent upon CHWs being well-financed and supported within communities. It describes the key issues that must be addressed in establishing CHWs large-scale diffusion of CHWs to meet the demand, building upon the 2014 monograph by many of the same authors, *Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guide and Case Studies for Program Managers and Policy Makers.*

Bruner C, with commentaries from Willis D, Hayes M, Bethell C, Dworkin P, Houshyar S and Gallion J, Johnson, K and Bailey, M (2021*). Building A Relational Health Workforce for Young Children: A Framework for Improving Child Well-Being*. InCK Marks Working Paper Series. No. 7. http://www.inckmarks.org/rsrcs/RelationalHealthWorkforceWP7.pdf

[23] Centers for Disease Control and Prevention. Community Health Worker Resources webpage. Public Health Professionals Gateway webpage. CDC - Community Health Worker Resources - STLT Gateway

This working paper describes the research base on child health programs and systems change efforts that incorporate relational care coordinators and/or CHWs into their practices and the demonstrated efficacy in doing so both improving population health and reducing racial inequities in health development. It summarizes the common principles or attributes of practice that make such practice effective, drawing upon not only the health care literature but the family support, service integration, child welfare, and child development literature. The commentaries by leaders in the child health field reinforce and build upon the importance of moving child health toward more integrative, preventive, promotive, and relational health care and the key role that a relational health/CHW workforce must play in doing so.

Lloyd J, Moses, K, and Davis, R (2020). *Recognizing and Sustaining the Value of Community Health Workers and Promotores.* Center for Health Care Strategies Brief for the California Health Foundation. https://www.chcs.org/media/CHCS-CHCF-CHWP-Brief_010920_FINAL.pdf

Drawing upon examples and experiences in California and around the country, this brief describes the value of CHWs as part of medical practices generally, and describes key issues and opportunities for doing so within Medicaid. Although most of the research and application of CHWs deals with adult or people with chronic diseases or disabilities, the conclusions and recommendations also align with and reinforce the other reports referenced here on resourcing, valuing, and deploying CHWs in poor and underserved communities for children and their families.

Community-Based Workforce Alliance (2021). *Advancing CHW Engagement in COVID-19 Response Strategies: A Playbook for Local Health Department Strategies in the United States.* *https://nachw.org/wp-content/uploads/2021/09/CWBA-Playbook-11421.pdf*

This playbook specifically examines the critical role CHWs have played in responding to COVID-19, drawing lessons and experiences to develop a playbook for local health departments in conceptualizing and operationalizing CHW engagement, stressing the many roles CHWs fill in this respect, including: (1) cultural mediation among individuals, communities, and health and social service systems; (2) building individual and community capacity; (3) providing culturally appropriate health education and information; (4) care coordination, case management, and system navigation; (5) advocating for individuals and communities; and (6) conducting outreach.

Barbosa, G and Alvarez M (2021) *Community Health Workers Advancing Child Health Equity.* Children's Partnership. https://childrenspartnership.org/wp-content/uploads/2021/07/TCP-Community-Health-Workers-Final-Single-Pages-1.pdf

Recognizing the racism is a public health issue, this monograph describes the core role CHWs can play in rectifying health inequities and improving population health where the overall returns-on-investment are greatest – children. Employing listening sessions as well as literature reviews, the monograph describes the value of CHWs as part of strategies to improve physical and mental health, including dental care, and provides policy recommendations for expanding CHWs as part of California's child health system.

Garfield, C and Kangovi, S (2019). Integrating community health workers into health care teams without coopting them. Health Affairs Blog, May 10, 2019. Retrieved at: https://www.healthaffairs.org/do/10.1377/forefront.20190507.746358.

This blog, from staff at the Penn Center for Community Health Workers, summarizes key factors to incorporating CHWs into medical homes, with a key emphasis upon not "medicalizing" the role of CHWs and providing them the flexibility and authority to engage in outreach, engagement, and giving voice to those they serve in the context of their communities.

National Committee for Quality Assurance and Penn Center for Community Health Workers (2021). *Critical Inputs for Successful Community Health Worker Programs: A White Paper.* *https://www.ncqa.org/wp-content/uploads/2021/11/Critical-Inputs-for-Successful-CHW-Programs-White-Paper-November2021.pdf*

Through a steering committee, listening sessions, and an environmental scan, this White Paper provides nine consensus concepts (with 27 elements in these concepts) for support CHWs. Consistently emphasized were: placing greater importance of candidates' lived experiences and trust-building traits (compared with education) in the hiring process; supervisors being promoted CHWs or having a deep understanding of the CHW role; a clearly defined CHW role; flexible and person-centered work practices and manageable caseloads to allow time for CHWs to build trust with clients/patients; incentivization through pay and career development; a welcoming environment for CHWs to foster teamwork at all levels of the organization; a strong partnership between health care and social service organizations; CHW engagement in decision-making processes; and sustainable financing for CHW programs.

Hernández-Cancio, S., Houshyar, S, and Wallawander, M. (2018). "Community Health Workers: Key Partners in Improving Children's Health and Eliminating Inequities." Families USA September Issue Brief. Available at: https://familiesusa.org/wp-content/uploads/2019/09/HE_CHWs-and-Kids_Issue-Brief.pdf.

This issue brief describes how CHWs can be key to improving child health specifically, with examples related to responding to asthma, addressing the maternal and infant health crisis, improving health insurance enrollment, and responding to lead poisoning.

Bruner C, Hayes M, Houshyar S, Johnson, and Walker-Harding, L (May 2021). Dismantling Racism: 10 Compelling Reasons for Investing in a Relational/Community Health Workforce for Young Children and Their Families. InCK Marks Initiative Discussion Brief. http://www.inckmarks.org/docs/newresources/InCKDiscussionBriefDismantingRacismMay20.pdf

This discussion brief describes the research and demographic data on: (1) the importance of prioritizing children to rectify racial inequities, (2) the value of investing in a relational health/community health worker workforce to do so, and (3) current federal opportunities to do so both within Medicaid and through new investments in a CHWs within a public health workforce.

Higgins E, Chhean E, Wilkniss S, and Tewarson H (2021). *Lessons for Advancing and Sustaining Community Health Worker Partnerships.* National Academy for State Health Policy.

https://www.nashp.org/lessons-for-advancing-and-sustaining-state-community-health-worker-partnerships/

This report provides lessons learned from responses to COVID-19 for states to build, sustain, or expand CHW partnerships. The report includes a 50-state scan of state approaches to supporting the CWH workforce and catalogues CWH Medicaid financing strategies in the states.

Medicaid and CHIP Payment Commission (April, 2022). Medicaid Coverage of Community Health Workers. Issue Brief. https://mail.google.com/mail/u/0/?tab=rm#inbox/WhctKKXXFsMRjVwSsxRQfqhTvqZxlwsQLDQfdqqqWDkTgDcsTDXqwCmqMfnSFHdxwGdTtjL?projector=1&messagePartId=0.1

This Issue Brief provides a scan of current state funding for community health workers, affirming the broad evidence for the effectiveness of CHWs and the growing interest among states in providing funding. The Brief adopts the broad definition of CHWs from the American Public Health Association, "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served," and recognizes the multiple roles they play. At the same time, the Brief emphasizes that their financing and use within Medicaid and CHIP is emerging and much of the current attention has been on specific, often medically-complex, populations.

Patient-Centered Outcomes Research Institute (2021). Research Spotlight on Community Health Workers. Fact Sheet. https://www.pcori.org/sites/default/files/PCORI-Research-Spotlight-Community-Health-Workers.pdf

This fact sheet briefly describes the work of PCORI in supporting over 75 clinical effectiveness research studies of community health workers, with an emphasis upon their role in avoiding hospitalizations for patients with chronic health conditions and enhancing care transitions and reducing disparities. While only one aspect of CHW's work, these studies have shown the potential for CHWs to better manage those conditions and provide seamless care transitions.

Rabbani R, Abdullah H, Ritchie D, Marlin K, and Wiggins N (forthcoming, 2022). *A Strategy to Address Racism and Violence in Public Health: Community Health Workers Advancing Racial Equity & Violence Prevention.* American Public Health Association Policy Statement. https://apha.org/-/media/Files/PDF/Policy/C1_2022_CHW_Strategy_Address_Racism_Violence.ashx

This policy statement expands and builds upon other American Public Health Association policy statements, focusing upon the importance of greater investments in and support for CHWs in direct action in communities to address racism and prevent violence, emphasizing that CHWs must be valued by and supported for their expertise if they are to advance racial equity at a systems level. It includes recommendations for federal action to prioritize CHWs for these roles, and the support and recognition CHWs need in doing so.

Center for the Study of Social Policy (forthcoming 2022). *Anti-racist Approaches in Health Care: Community Health Workers as Disrupters of Health Systems.*

This policy brief describes the impact of structural racism in the health care system today and the need for disruptive actions to rectify that, particularly through incorporating and then

supporting CHWs as part of health practices. This includes but extends beyond bringing experiential and community expertise as part of team-based medical homes. The brief highlights several exemplary initiatives showing the promise of doing so, and calls upon state and federal policy makers to: (1) establish sustainable financing for CHWs, (2) ensure that CHWs are valued and supported in that work within the health systems they operate, and (3) ensure that CHWs are truly integrated into the overall workforce.

Bruner, C and Johnson K (2018). *Federal Spending on Children Prenatal to Three: Developing a Public Response to Improving Developmental Trajectories and Preventing Inequities.* Center for the Study of Social Policy. Retrieved at: https://cssp.org/wp-content/uploads/2018/08/CSSP-Prenatal-to-Three.pdf

This document enumerates federal expenditures on children prenatal to three in income supports (including nutrition and housing, health care, family support, child care, and child welfare), showing that Medicaid is by far the largest single source of financing ($34 billion of the overall $84 billion), followed by the earned income tax credit ($12 billion). The document emphasizes the key role that Medicaid and child health must play in supporting healthy child development, including the use of CHWs and other relational health workers to this end.

Johnson, K and Bruner C (2018). Child and Family Policy Center. (2018) *A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health.* Child and Family Policy Center. Retrieved at: http://www.inckmarks.org/docs/pdfs_for_Medicaid_and_EPSDT_page/SourcebookMEDICAIDYOUNGCHILDRENALL.pdf

This 139-page sourcebook provides a framework for developing "high performing medical homes" that include enriched primary care during well-child visits, enhance relational care coordination, and effective provision of or referrals to preventive and development services. It provides data, research, and examples of effective practices for use in moving toward high performing medical homes, including Medicaid's role in financing them. While not specific to CHWs, CHWs can play core roles both in providing enhanced relational care coordination and themselves providing basic preventive services around strengthening the home environment and advancing the child's healthy development.

Appendix Three: A Contrast of Rhode Island Plan Amendment and Minnesota Administrative Rules for Coverage of Community Health Workers Under Medicaid

The following shows one of the most plan amendment submissions to CMS (for Rhode Island, still under review) and an earlier amendment as reflected in the state administrative code (for Minnesota). Some of the contrasts between the two are show in **bold-faced.** In effect, Rhode Island has a very inclusive model of what CHWs do. the services they provide, who they serve, and how they relate to the practice and community. Minnesota has a much narrower, medical view of the role of CHWs, based upon a patient's medical diagnosis, and provided under the supervision of and consistent with the approach of medical provider.

RHODE ISLAND CHW PLAN AMENDMENT

Community Health Worker Services Benefit: Description of the services and each of the component services:

Community Health Workers (CHW) are frontline public health professionals who often have similar cultural beliefs, chronic health conditions, disability, or life experiences as other people in the same community. As trusted leaders, they often serve as a link between their community and needed health or social services. **CHWs help to improve access to, quality of, and cultural responsiveness of service providers.** These trusting relationships enable them 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 responsiveness of service delivery. **CHWs build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as engagement, community education, social support and advocacy. CHWs hold a unique position within an often-rigid health care system in that they can be flexible and creative in responding to specific individual and community needs**. The unique strength of CHWs is their ability to develop rapport with people and other community members due to shared culture, community residence, chronic condition, disability, language, and life experiences. They are also able to enhance the cultural and linguistic appropriateness of care and help to counteract factors such as social exclusion, poverty, and marginalization. An important role of the CHW is to advocate for the socioeconomic, environmental, and political rights of individuals and their communities. CHWs often link people to needed health information and services. **CHWs address the social and environmental situations that interfere with an individual or community achieving optimal health and well-being.**

The following primary, secondary, and tertiary preventive health services are covered when performed by CHWs:

- Health Promotion and Coaching for individuals and families, including assessment and screening for health-related social needs, setting goals and creating an action plan, on-site observation of members' living situations, and providing information and/or coaching.

- Health Education and Training for groups of members on methods and measures that have been proven effective in avoiding illness and/or lessening its effects. Health Education and Training services

provided by CHWs are covered when the CHW provides the education and/or training using established training materials.

- Health Promotion and Coaching and Health Education and Training Topics may include, but are not limited to:
    - o Injury prevention
    - o Addressing family violence/interpartner violence
    - o Control of asthma
    - o Control of high blood pressure/cardiovascular disease
    - o **Control of stress**
    - o Control of sexually transmitted disease
    - o Control of toxic agents
    - o Diabetes prevention and control
    - o **Family planning**
    - o Immunizations
    - o Improvement in safety and the environmental health of housing, for example to mitigate asthma risk, risk of injury from unsafe housing, lead exposure, etc.
    - o **Improvement in nutrition**
    - **o Improvement of physical fitness**
    - o Occupational safety and health
    - o Pregnancy, infant care, and other family home visiting, including but not limited to prevention of fetal alcohol syndrome/neonatal abstinence syndrome
    - o Reduction in the misuse of alcohol or drugs
    - o Tobacco cessation
    - o Promotion of preventative screenings, such as cancer screenings

- **Health system navigation and resource coordination services**, including:
    - o Helping to engage, re-engage, or ensure patient follow-up in primary care; routine preventive care; adherence to treatment plans; and/or self-management of chronic conditions

    - o Helping a member find Medicaid providers to receive a covered service

    - o Helping a member make and keep an appointment for a Medicaid covered service

    - o Arranging transportation to a medical appointment
    - o Attending an appointment with the member for a covered medical service
    - o Helping a member find and access other relevant community resources
    - o Accompanying a member to other relevant community resources
    - o Helping a member with a telehealth appointment and/or educating a member on the use of telehealth technology

- **Care planning with a member's interdisciplinary care team as part of a team-based, person centered approach to improve members' health by meeting a member's situational health needs and health-related social needs**, including time-limited episodes of instability and ongoing secondary and tertiary prevention for members with chronic condition management needs.

- Services, including initial visits, may be delivered in a medical clinic setting or in a community setting, including but not limited to members' homes.

MINNESOTA CHW Administrative Code

Overview. A community health worker (CHW) is a trained health educator who works with Minnesota Health Care Programs (MHCP) members who may have difficulty understanding providers due to cultural or language barriers. CHWs extend the reach of providers into underserved communities, reduce health disparities, enhance provider communication, and improve health outcomes and overall quality measures. Working in conjunction with primary care providers, CHWs can bridge gaps in communication and instill lasting health knowledge.

CHW services are a diagnosis-related medical intervention, not a social service.

CHWs providing diagnosis-related patient education services to enrollees of managed care organizations (MCOs) must contact the MCOs for enrollment requirements and coverage policies.

CHW services that provide patient education for health promotion and disease management are covered if provided under the supervision of a physician, dentist, advanced practice registered nurse

Eligible Providers**. Providers must have a valid certificate from the Minnesota State Colleges and Universities (MnSCU) demonstrating that the applicant has completed an approved community health worker curriculum.** CHW providers must enroll and be screened following the MHCP provider screening requirements at the time of enrollment and once within every five years to maintain their enrollment.

Currently enrolled CHWs must inform the Department of Humans Services (DHS) of their affiliation with dentists, ARPNs, certified PHNs or mental health professionals by requesting the affiliations using the Minnesota Provider Screening and Enrollment (MPSE) Portal or by completing and faxing a signed Individual Practitioner MHCP Provider Profile Change Form (DHS-3535) (PDF).

MHCP requires CHWs to enroll so they are represented on a claim as the provider who provided the services. During the enrollment process, Provider Eligibility and Compliance will assign the CHW worker a Unique Minnesota Provider Identifier (UMPI) if the CHW does not have a National Provider Identifier (NPI).

Enrolled CHWs are considered a non-pay-to provider but must be listed on the claim as the individual who rendered the CHW services. CHWs must provide an eligible MHCP-enrolled billing provider with their UMPI or NPI, so the eligible billing provider can submit claims for their services.

Eligible Members. Medical Assistance (MA) and MinnesotaCare members are eligible to receive education services provided by a CHW.

MHCP members enrolled in the Minnesota Family Planning Program (MFPP) are not eligible to receive CHW services.

Covered Services. **MHCP will cover diagnosis-related patient education services, including diabetes prevention and pediatric obesity treatment provided by a CHW with the following criteria:**

• MHCP requires general supervision by an MHCP-enrolled physician, APRN, dentist, mental health professional, non-enrolled certified public health nurse or registered nurse working for an enrolled organization

• A physician, APRN, dentist, certified public health nurse or mental health professional must order the patient education service(s) and must order that a CHW provides the service(s)

• **The service involves teaching the patient how to self-manage his or her health or oral health effectively in conjunction with the health care team**

• The service is provided face-to-face with the member (individually or in a group) in an outpatient, home, clinic or other community setting

• **The content of the patient education plan or training program is consistent with established or recognized health or dental health care standards**. Curriculum may be modified as necessary for the clinical needs, cultural norms and health or dental literacy of the individual patients

Noncovered Services. **MHCP does not cover social services such as enrollment assistance, case management or advocacy delivered by a CHW.**

Appendix Four: Boston Medical Center Community Wellness Advocate Job Descriptions – For Serving "High Risk Populations" and for Serving Pediatric Populations in Practice of the Future Initiative

One key to recruiting and hiring Community Health Workers (CHWs) is to clearly define the distinct roles they perform with the populations they serve and how that role is integrated into the overall health practice.

The Boston Medical Center has done so in its job descriptions for Community Wellness Advocates (CWAs) – both those serving its population of high risk patients (e.g. patients with special needs or complex medical conditions, usually adults) and those serving children and their families in its "Practice of the Future" initiative (focusing upon social determinants of healthy development). BMC has developed specific job descriptions for each, recognizing that CWAs serve similar core roles but that their work with different populations requires other population-specific knowledge, skills, and engagement with community partners.

While BMC uses the term CWA, its descriptions are aligned with those developed to describe community health workers by the National Association of Community Health Workers and to emphasize their role as serving as a bridge between the health practice and the community and an advocate for the population served in securing the support that population wants.

Both job descriptions are provided here, to emphasize the different/additional roles and skills that represent work with children as compared to medically-complex adults. The first job description is for CWAs serving "high risk populations," the second for CWAs serving children and families in the Practice for the Future Initiative. Highlighted in red is common language describing the core purposes and roles of CWAs. **Bold-faced in black** are elements specific to the population served.

JOB DESCRIPTION FOR SERVING "HIGH RISK"/SPECIAL NEEDS POPULATIONS

A Community Wellness Advocate (CWA) is a trusted member of the community **who helps high risk patients maintain stable health and wellness along a continuum**, through integrating and connecting hospital, home-based, and community-based services. CWAs are responsible for providing advocacy and case management services; developing an interdisciplinary care plan based on identified patient needs; facilitating access to social service resources and other internal and external resources; monitoring the patient's progress; and problem-solving with patients to both accelerate and enhance access to concrete supports.

CWAs provide in-home or community-based one-on-one, family, and/or interdisciplinary group support to **high risk care patients** and collaborates with the Patient Care Manager, PCP, and other members of the care team to conduct needs assessments to identify and respond to barriers to the patient's health and wellness.

- Initiates face to face contact with eligible patients to describe role, explain participation benefits and begin screening process.
- Schedules and completes initial hospital, clinic, or community-based (homes, shelters, housing agencies, substance use treatment programs, etc.) visit screening, care plan, and follow up visits and phone calls for enrolled patients within specified timeframes.

- Teaches key educational messages using a variety of culturally, linguistically and educationally appropriate strategies, in a variety of settings.
- Clearly documents all activities in the patient's record and care management system.
- Participates with other staff in activities that include community outreach, presentations to community organizations, development of materials, and phone calls.
- Works with patients and providers to set goals for patient's care and provides guidance for patient to achieve those goals.
- Reinforces educational messages **regarding disease self-management** by linking clients with supportive community services and programs.
- Presents patients at case review meetings succinctly and logically.
- Consults with Patient Care Manager, primary clinical staff, behavioral health teams and / or PCP **regarding complex patient situations**, demonstrating an understanding of how to solicit and incorporate provider feedback in order to continuously develop the most optimal plan for care.
- Demonstrates the ability to function within an inter-disciplinary team (nurse care coordinators, social workers, behavioral health clinicians, physicians, resource specialists, clinical support staff, etc.), connecting the patient with resources as needed.
- Records and monitors the participants' progress toward goals within specific timeframes.
- Documents assessments and key patient updates in Epic system; documents relevant day-to-day activities and patient data.
- Prepares reports and documents as needed or requested.
- Assists patients with organizing their records, making follow-up appointments, attending follow-up appointments, and filling their prescriptions.
- Helps patients fill out applications, for example for Medical Assistance, Housing, and SNAP (Supplemental Nutrition Assistance Program).
- Provides advocacy, patient education and successful warm hand offs in accessing community-based and hospital-based programs.
- Assists patient in addressing and overcoming barriers with a range of concrete supports, including but not limited to: healthcare support services, behavioral health, financial assistance, child-care and caregiver support, housing, support with utility bills, food, financial entitlements, clothing, transportation, food pantries, violence prevention, social isolation and any other appropriate community resources.
- **Coordinates with community-based long-term services** and supports.
- Provides intensive home and community-based outreach, motivational interviewing and goal setting, resource connection and accompaniment to medical appointments as needed to help patients appropriately utilize healthcare. CWAs may visit patients in hospital and ER settings to facilitate with transitions of care.
- Establishes culturally appropriate and trusting relationships with patients and their families.
- Participates in all training activities as designated by Community Wellness Manager (CWM) and the Nurse Practitioner.
- Attends regularly scheduled supervision and other program assigned meetings.
- Develops and maintains strong relationships with the community and community resources to ensure patient access.

NOTE: The CWA will not provide hands on care or other services noted as home health services, including but not limited to: performance assessments, provision of care, treatment, or counseling; and/or monitoring of patient's health status.

EDUCATION:

HS Diploma with community experiences or Bachelor's degree
Driver's license required

EXPERIENCE:

Minimum of 2 years prior healthcare, public health, or community-based experience in community setting.

KNOWLEDGE AND SKILLS:

- Basic knowledge of healthcare system.
- Outstanding interpersonal skills of foremost importance to interact with families and patients.
- Interest in community health and outreach.
- Exceptional organizational skills; ability to multi-task and work independently and as part of a team.
- Demonstrated oral and written English communication skills.
- Fluency in Haitian Creole or Spanish preferable.
- Understanding of how language, culture and socioeconomic circumstances affect health.
- Desire to work with diverse, multi-cultural and multi-lingual populations.
- Proficiency with Microsoft Office applications (i.e. MS Word, Excel, Access, Outlook) and web browsers. Proficiency with data entry and data tracking.

JOB DESCRIPTION FOR PEDIATRIC PRACTICE FOR THE FUTURE

The Community Wellness Advocate (CWA) is a key member of the Practice of the Future innovation **team who helps promote and maintain stable health and wellness for families**, through integrating and connecting hospital, home-based, and community-based services. CWAs are responsible for providing advocacy and case management services; developing and tracking an interdisciplinary care plan based on identified patient needs; **partnering with families to establish and enact health goals**; facilitating access to and coordination among social service resources and other internal and external resources; monitoring the families' progress; and problem-solving with patients to both accelerate and enhance access to concrete supports.

CWAs provide clinic-based, in-home or community-based one-on-one, family, and/or interdisciplinary group support and collaborate with all members of the care team to conduct needs assessments to identify and respond to barriers to the families' health and wellness. As a member of an innovation team tasked with testing new and novel care delivery approaches, the specific activities of the CWA may evolve over times as the Practice of the Future model evolves.

ESSENTIAL RESPONSIBILITIES / DUTIES:

The following are key activities expected for this role:

- Functions a key member of an inter-disciplinary team (nurse, social workers, behavioral health clinicians, physicians, resource specialists, clinical support staff, etc.)
- **Provides parent coaching and support, including outreach to and engagement with families to define individual goals, promote healthy development and access to care and services**
- Schedules and completes initial hospital, clinic, or community-based (homes, shelters, housing agencies, substance use treatment programs, etc.) visit screening, care plan, and follow up visits and phone calls for enrolled patients within specified timeframes
- Assists families in addressing and overcoming barriers with a range of concrete supports, including but not limited to: healthcare support services, behavioral health, financial mobility coaching, **school-based interventions, early-intervention,** child-care and caregiver support, housing, support with utility bills, food, financial entitlements, clothing, transportation, food pantries, violence prevention, social isolation and any other appropriate community resources
- **Teaches families key educational and developmental messages** using a variety of culturally, linguistically and educationally appropriate strategies, in a variety of settings
- Clearly documents all activities in the patient's record and care management system. Records and monitors the participants' progress toward goals within specific timeframes. Documents assessments and key patient updates in Epic system; documents relevant day-to-day activities and patient data.
- Communicates plans and updates with members of the care team
- Works in partnership with the SW to comprehensively assess families' needs and strengths
- Develops and maintains strong relationships with the community and community resources to ensure patient access
- Engages in ongoing training and learning

EDUCATION:

HS Diploma preferred with knowledge of MA community services or bachelor's degree

MA Driver's License required

EXPERIENCE:

2-5 years of prior healthcare, public health, mental health, or community-based programmatic experience preferred

Bilingual, preferably in English and either Spanish or Haitian Creole

KNOWLEDGE AND SKILLS:

- Basic knowledge of healthcare system and social service landscape
- Outstanding interpersonal and communication skills
- Understanding of how language, culture and socioeconomic circumstances affect health