CHCF

Understanding California's Community Health Worker/Promotor Workforce

A Deep Dive into CHW/P Employer Perspectives

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About the Authors

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About the Foundation

The California Health Care Foundation (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Contents

Understanding California's Community Health Worker/Promotor Workforce: The Series

Despite being a critical part of California's health workforce, there are relatively few comprehensive data on community health workers and promotores (CHW/Ps) in California. With funding from CHCF, Healthforce Center at UCSF fielded surveys of CHW/Ps, the institutions that train them, and the organizations that employ them. Interviews with employers across the state were also conducted. The survey and interview data, published in reports, paint a more complete picture of the current CHW/P workforce as well as challenges and opportunities related to training and employment. This picture can inform policy decisions as the state looks to support and expand this important workforce.

To learn more, visit www.chcf.org/chw.

Executive Summary

In California, one of the most culturally diverse states in the country, health care must bridge cultural and linguistic divides to serve all communities equitably. As trusted community members with lived experience, community health workers and *promotores* (CHW/Ps) have a long history of connecting those not well served by the traditional health care system with culturally competent health and social services.

There is increasing recognition in California that CHW/Ps are a critical part of the health care workforce. In 2019, the California Future Health Workforce Commission recommended scaling the CHW/P workforce to broaden access to preventive and social support services as well as team-based integrated primary and behavioral health care.[1]

As the CHW/P profession continues to grow and develop, it is important to understand employer perspectives on the role. Doing so provides context for industry needs and for supply and demand. Based on interviews, this report describes employers' perspectives of many facets of the profession, including training, primary roles and skills, billing, recruitment and retention, and future directions.

Summary of Key Findings

Key findings from the collected qualitative interview data include:

- CHW/P job titles varied greatly, and some organizations used more than one title.
- Job requirements were not consistent across employers, and most employers did not require CHW/P-specific training before hiring.
- There were mixed opinions about whether CHW/Ps should be certified. Some believed that certification could help define an already ill-defined role. Others believed that it could create barriers (e.g., financial, time constraints) to entering or remaining in the profession, focus on skills learned in a classroom over the passion that many described is necessary to do this work, or both.
- Most often, the primary roles of CHW/Ps included providing connections to resources or referrals, community outreach and/or engagement, and community education.
- Several employers aligned CHW/Ps core skills and competencies with the CHW Core Consensus (C3) Project, a national CHW-led effort to define CHW roles and skills.[2]
- There are new opportunities to bill for CHW/P services, including a direct option through California's State Plan Amendment and an indirect option through CalAIM (California Advancing and Innovating Medi-Cal).
  - Some interviewees commented on the potential benefits of these funding opportunities, such as improving access to preventive care, showing return on investment for the profession, and creating more demand for the role.
  - Other interviewees acknowledged potential downsides to both of these funding streams, including the potential to overmedicalize the profession and to exclude CHW/Ps who do not work in health care settings.
- The COVID-19 pandemic changed the landscape for CHW/Ps by highlighting the need and creating demand for more workers.
- Interviewees expected the number of CHW/Ps to grow and hoped to see more clearly defined career ladders and more respect for the profession.

Methods

The research team called upon known contacts for interviews and employed a snowball sampling technique to identify more interviewees. The team also reached out to unknown contacts at organizations that employ large numbers of CHW/Ps, were organization types not yet represented in the interviews, or both.

Interviews were conducted using a semistructured interview guide between November 2021 and March 2022. During two interviews, two people were interviewed at a time. Interviews lasted 45–60 minutes and were recorded and transcribed. The qualitative software analysis program Dedoose was used to code interview transcripts for key themes. The interview guide can be found in the appendix.

Interviewees and their responses, presented in the report, are separate from organizational responses to quantitative surveys that CHW/P employers responded to in 2021. The results of that survey research can be found in *Understanding California's Community Health Worker/Promotor Workforce: CHW/P Health Care Employers*.[3] The qualitative interviews included several types of organizations that employ CHW/Ps (e.g., CBOs, health plans) that were not included in the survey research, which was limited to hospitals and health clinics. Furthermore, the interview data supplement the survey results by providing a richer context and deeper insights into the opinions and perspectives of employers.

Interviewee Makeup

Twenty-nine interviews were conducted with representatives from 27 organizations. The organizations included training institutions, county public health departments, hospitals and medical centers, clinics and clinic networks, managed care health plans, hospitals and health systems, prior Whole Person Care grantees, health boards, and community-based organizations (CBOs).

Twenty-three of the interviewed organizations employed CHW/Ps, and four did not employ paid CHW/Ps at the time of their interview. The organizations that did not employ CHW/Ps were included because they either collaborated with organizations that employed CHW/Ps, had volunteer CHW/Ps on staff, or were a training institution also involved in career services, and were thus able to speak to issues regarding CHW/P employment.

Representatives from interviewed organizations held a wide variety of positions. Many were directors or managers of CHW/P programs or departments of community health / social determinants, population health, or patient engagement. Several interviewees held roles such as executive director, chief executive officer (CEO), chief medical officer, and founding member. Others' positions included outreach coordinator, senior staff analyst, and health services administrator. In addition, many interviewees (n = 11) identified as CHW/Ps and described their career journey from an individually contributing CHW/P into a managerial role. Interviewees had spent from 7 months to 30 years at their organization (average 11.4 years) and 5 months to 22 years in their role (average 6.3 years).

Findings

This section is organized according to the key themes that emerged from analysis of the interviews:

- Job titles and hiring requirements
- Primary roles, core skills/competencies, and personal attributes
- Caseloads
- Training, including certification
- Recruitment, retention, and integration barriers

- Billing for CHW/P services
- Organizational concerns about CHW/P investment
- COVID-19 impact
- Growth and future

The authors present a summary of the findings from each theme. Each of the extensive quotes from interviewees tells a narrative of that interviewee's experience with or knowledge of the CHW/P workforce, or both. These narratives provide a rich perspective and bring this important work to life.

Job Titles and Hiring Requirements

The job titles given to CHW/Ps varied greatly, and some organizations used more than one job title depending on the tasks CHW/Ps performed, the departments in which they were housed, the funding stream for the role, or some combination. Titles most often used were community health worker (*n* = 13) and *promotor/promotora* (*n* = 8). Other job titles included outreach specialist, community health advocate, health navigator, peer navigator, community health representative, community health specialist, community outreach worker, health conductor, patient engagement specialist, and community service assistant.

Among interviewed organizations, hiring requirements were not consistent. Many organizations did not have a fixed set of requirements. Organizations that did report job requirements for CHW/P work most often listed experience (*n* = 5). Several organizations (*n* = 4) also stated that care for and/or being from the community was a requirement for hiring. Other requirements included being multilingual, having taken a form of CHW/P-specific training, and having earned their high school diploma or GED. One organization required CHW/Ps to have earned a bachelor's degree.

Primary Roles, Core Skills/Competencies, and Personal Attributes

Primary Roles

The work that CHW/Ps conducted was not always consistent and could vary greatly. Largely, this was due to differences in work setting and environment, as well as the goals of their program or initiative. Many roles remained grant funded, and the goals of those grants were usually specific and targeted, meaning funding often dictated the type of work that CHW/Ps performed. Their work also varied depending on the needs of the community in which they lived and served.

Interviewees discussed the primary roles CHW/Ps played in their organizations. Although they varied, the roles most often listed as primary were providing connections to resources or referrals (*n* = 16), community outreach and/or engagement (*n* = 14), and community education (*n* = 11). Other primary roles often mentioned included connecting with a community or individual (*n* = 9), providing advocacy (*n* = 8), providing system navigation (n = 8), conducting home visits (*n* = 7), and building community capacity (*n* = 5).

Interviewees spoke to the importance of CHW/Ps' primary roles. One interviewee from a CBO, who identified as a CHW/P, explained that providing community resources and referrals to their clients is important to make sure clients' basic needs are being met, but also to provide space for them to actively engage with their health: *"As I see it with a mom that has asthma, if that house is struggling with food insecurity, with life, with so many other issues, they have social determinants, transportation barriers, the language barriers. They're really not going to listen to me when I'm trying to let them know what the difference between the inhalers are. Because they have this block on making sure that they have money to pay the rent or have money to feed their children. And so we are a resource. We*

are that link to the community resource. What we do is that the top main issues or the top resources that our community needs, if we can't provide them here, we directly reach out to them. . . . No matter what program you're in, you are a community resource for your community. And so I think empowerment and education is key."

Another interviewee from a CBO, who also identified as a CHW/P, explained that the value of home visiting lies in understanding the clients' environment and how it impacts their health: *"We do a lot of listening, and it takes a trained ear and eye of seeing. . . . One of our strengths when we're doing the home visit is that I'm hearing this but I'm seeing [that], especially in the home visits when we do our environmental health hazard. If there's roaches, if there's mold. There's a lot of shame that comes with slum housing. And so when we ask, "Do you have roaches?" they'll probably tell us no, but I'm seeing roach evidence or I'm seeing the roaches. So I think that it takes a lot of skill to break that shame and to build that trust for them — the families — to really express what they're going through."*

Skills and Competencies

Interviewees discussed the core skills and competencies, which often dovetail with primary roles, that CHW/Ps need to perform their job. Several organizations (*n* = 5) stated that their ideas about core skills and competencies aligned with those outlined in the CHW Core Consensus (C3) Project, which are:

- Communication skills
- Interpersonal and relationship-building skills
- Service coordination and navigation skills
- Capacity-building skills
- Advocacy skills
- Education and facilitation skills
- Individual and community assessment skills
- Outreach skills
- Professional skills and conduct
- Evaluation and research skills
- Knowledge base

Other skills and competencies often mentioned included providing culturally competent communication (*n* = 5), listening skills (*n* = 5), and being multilingual (*n* = 5). More skills discussed included patient engagement (*n* = 4), teaching skills (*n* = 3), and time management (*n* = 3).

"I think that cultural community competence, of understanding the nuances of that local community and neighborhoods . . . a lot of it is connecting to resources and connecting to outside supports. And being able to understand contextually what resources that the client will be open to. Because understanding that, yeah, that YMCA may only be a half a mile from their house, but if it's on the other side of that big highway, they're not going to go there because nobody in that neighborhood wants to go north of the 8. So understanding that cultural context and the historical context of a neighborhood, and the community that lives there. . . . That to me is first and foremost, is that they can understand the nuances that, if you're not from that community you would never really understand. It would take a long time to learn."

—interviewee from a collaborative initiative

Another interviewee from a hospital/health system spoke about the importance of active listening, specifically motivational interviewing, to the CHW/P role: *"Motivational interviewing is an absolute necessity. . . . A case manager . . . had a woman come out of incarceration. . . . [The woman] had multiple physical health issues and behavioral health issues. She was homeless. . . . Her only goal was to keep her pet. She got arrested and put in jail [and] . . . when she came out, they had taken her pet. My care manager . . . got her a new [pet]. . . . This woman has remained clean and sober and housed for three years now because somebody listened to what her goal was. . . . I think what we really want is somebody to ask us, 'What do you want to do?' That's where I see the* promotores *as being exceptional because they not only are able to use that motivational interviewing concept. They're able to personalize it from more of an ethnic ability than I would be."*

Personal Attributes

Although interviewees spoke about the skills and competencies they viewed as necessary to the role, interviewees stressed that softer skills truly characterize a CHW/P. They said CHW/Ps must also have other, more intangible personal attributes to make them a good fit for the work. Attributes that were most often discussed included being from the community (n = 6), being passionate (n = 6), and having lived experience (n = 3). Other attributes included being empathic/compassionate, humble, flexible, independent, kind, organized, patient, trustworthy, resilient, nonjudgmental, and having "heart."

"Community health workers are usually someone who mirrors our population that we serve. We've either been clients before or our parents have been clients before. We come from the same community. . . . We're able to connect more with our clients. We look like our clients. So they're comfortable engaging with us and telling their story. And we're that first person that they see. So it kind of opens up the door before they go meet with a case manager or whoever they're coming to see."

—interviewee from a CBO

Interviewees also shared their opinions on which personal attributes were most important to CHW/P work and why. Some attributes included passion for the work, bilingual capabilities, humility, compassion, patience, and empathy. One interviewee from a CBO spoke about how passion for CHW/P work translates to the CHW/P identity: *"The training doesn't make CHWs. The heart, the passion, and the training enhance some skills. So even the role doesn't make a CHW. So you can be a health navigator, you can be a health educator and not be a CHW. CHW is an identity versus the role. It's who you are versus what you do. Most of the people are hiring people because what you can do, know who you are. So having people that don't speak the same language, they don't live in the same community. They don't have a heart, a passion to serve others — hiring people that they are not really committed to benefit their communities, they are not authentic CHWs. They have a title because they are doing some role, but they are not CHWs. So the identity is not clear."*

"The first thing you have to have with . . . community workers, you have to have people with humility. Because if [CHW/Ps are] making [the client] feel like they're less than [the CHW/P], [the clients] completely shut down. So you need to have somebody that speaks [the client's] language. So we're

always looking for people in this area that are bilingual. You need to have people that are friendly. That create with [clients] a trust connection. Because if [the clients] don't trust you, they will go somewhere else."

—interviewee from hospital/health system

While several interviewees acknowledged the importance of intangible attributes in the CHW/P role, one interviewee from a county program also explained that hiring for these attributes was difficult due to their unquantifiable nature and because traditional hiring systems were not designed to capture these attributes: *"Based on my experience, and also just the work that we do, I definitely think that the [personal] qualities . . . are more important to be able to do this work, because with the qualities we're talking about — being compassionate, being patient, being empathetic — and while those are built into parts of the training, they're built in for you to demonstrate them, not for us to teach you. . . . When you're filling a job posting or when you are doing an interview, the hard part is, how do you measure those? We've done some work to try to build it into the interview questions, but it's . . . not something measurable that you can tell the county HR to assess."*

Caseloads

Many organizations (*n* = 10) reported that their CHW/Ps had a client caseload, which ranged from as low as 8 to as many as 50 clients. Several had a caseload range of about 25–40 clients. The number of patients in a caseload could vary depending on several factors: the activities that CHW/P performed, client complexity, CHW/P capacity, and the department in which the CHW/P worked.

One interviewee from a health plan explained that their organization chose not to use caseloads because they make it difficult to account for the varying nature of each case: *"We chose not to assign a certain amount of members to each CHW. . . . Based on my experience of working in care management, . . . the real . . . challenge for care managers and community health workers is when they have a certain caseload requirement. It's really hard to take into account the acuity, even if you have some type of standardized assessment tool, like the amount of time an individual needs support. . . . Instead . . . we assessed the quantity of work based on how many field visits a community health worker was doing in a week. . . . The idea behind that is to encourage really face-to-face interactions with the member in the community or in their home, or accompanying them to provider visits."*

Training

Although only one organization required CHW/P-specific training before being hired (detailed information about CHW/P training programs offered across California can be found in a separate report, *Understanding California's Community Health Worker/Promotor Workforce: CHW/P Training Programs*[4]), all interviewees described newly hired CHW/Ps going through training after being hired. The post-hire training varied greatly. Some organizations did all of their training in-house, some contracted with other training or education institutions, and others participated in a combination of the two.

Post-hire training lasted from two hours to 16 months, the latter of which was an apprentice program. Some programs had multiple module-style trainings specific to certain topics, but other trainings rolled everything into one. Many of the trainings also included a job-shadowing component. During the pandemic, many of the didactic parts of the trainings were converted to virtual learning, both synchronous and asynchronous.

Certification

Several interviewees opined about whether the CHW/P profession should be certified. Depending on the interviewee's interpretation, certification may mean certification of the individual worker or creating standards for training programs. Some felt that certification could yield professional benefits, such as higher pay and more respect, as well as help define the CHW/P role.

One interviewee who supported certification explained that a certification requirement would raise questions about whether professional experience could count toward that certificate in place of formal education:

> *"If there's a certification, is there an educational requirement or is it an experiential requirement? And how do we measure that? How do we hold people accountable for that, including the state that says that person is certified? So I have no problem with a program certification, but nested within that has to be a certification for the employees of the program who are going to have direct patient contact. . . . I'm not going to negate the experience that promotoras who've been in the business for 10 years and been through all kinds of educational programs and seminars with the state and others to learn how to do this work. . . . I totally believe . . . this idea that if you've been doing this work for two years, that would count for the education piece, but I still think there has to be some kind of evaluation of that knowledge."*
>
> —interviewee from a clinic

While some interviewees supported certification, or at least more standardization for CHW/P training, they also acknowledged potential downsides to certification, such as increasing cost and limiting access to enter or remain in the profession. Some interviewees explained that CBOs could play a larger role in certifying CHW/Ps, which could mitigate the issue of access to certification.

One interviewee from a collaborative initiative opined that standardizing CHW/P core training may be more beneficial to the profession than certification, although they cautioned against developing long training programs: *"[Certification] could be helpful. . . . Instead of certifying CHWs, having a more standardized approach to CHW training that we could all sort of get on board with, so that there aren't like a thousand different CHW trainings out there. . . . But also it has to have built into it the acknowledgment that the CHW job — it really means a lot of different things. And so if you're going to be a CHW working on the care team . . . there's probably like a core curriculum that everybody needs. . . . And so I think we have to get really clear on what do we mean when we say a CHW core training, versus a CHW training so somebody's ready to go work at a health care setting and be on the care team. . . . A year-long CHW curriculum, I worry that we're creating a barrier to a position for somebody."*

An interviewee from a county program who supported certification expressed a desire for multiple certified training programs options, including programs organized and led by CBOs: *"[Certification] is so aligned with what's going on right now with the CHW benefit. . . . I do agree with certifying training programs. I don't agree with having just one certified training program in the state that all community health workers have to go through. . . . And then the only other thing that we need to think about is who is it accessible to? I think often when we talk about certified training programs, it is academic institutions or it is county entities, and it excludes*

community-based organizations from being able to access, based on, for example, cost. . . . And then the other thing is, as we certified programs, and again, in those conversations around the CHW benefit, what we've been discussing is that there needs to be an opportunity for folks to complete a certified training, if they are don't already have it."

Another interviewee from a CBO who supported CHW/P certification and the role of CBOs in providing training expressed that there were more CHW programs being developed compared to *promotor* programs: *"We are trying to really bring forward and advance the expertise of community. I think that really is our essence. So when it comes to certification, there could be a certificate. We do believe in certificates, and I think that CBOs, in particular, have been training for a long time. . . . There were CBOs and* promotores *before us, and we want to honor that community expertise with a certificate program and training. There is competition now with community colleges and with universities and with for-profit agencies that are developing community health worker programs. I don't see anybody developing a* promotor *program, but they're developing community health worker programs."*

Many raised concerns that requiring certification could act as an obstacle for some who would otherwise make great CHW/Ps. One interviewee working at a CBO remarked that certification could create a barrier to hiring for roles funded by short-term grants, such as many of the COVID-19 grants that became available during the pandemic: *"[Statewide certification] would definitely be a struggle for us because it would leave a lot of people out. There's just so many layers to our community that it would just exclude so many great leaders. So I don't think state certification would be of any use to us."*

Another interviewee from a CBO who did not support certification voiced concern that certification might exclude authentic *promotores* from the profession: *"We do not support certification for* promotores. *We feel that would somehow professionalize the field to the point where community members might be left out. And we've had these conversations with universities and colleges in the past because then they want college students to get certified as* promotores. *And for us, the model is really, we want the folks that are living inequities, who probably are not going to get to go to college to be able to be* promoters. *. . . And we feel that [certification] kind of puts this added inaccessibility to being a* promotor. *When part of being a promotor is being a part of your community and caring for your community and wanting to learn, I think removing that autonomy from it with a special certification from some sort of institution would change kind of the intention of that model."*

One interviewee from a county program who supported certification did so with the qualification that it should be the employer's responsibility to provide time and space for that person to become certified: *"The certification — the burden should be on the employer. If the employer was in a position where they said, 'We have this person and we will certify them in the ways that the state expects over this period,' that would work great. Then we can continue as we are. . . . But if it's on the individual [to take] a training to qualify for the program, then it's going to shift us greatly from the people they just showed you on the flyers to people who have the means and the wherewithal to find the community college, take the courses. . . . That would just displace the people that we have because now we are required for them to have certain qualifications in order for us to consider them."*

However, another interviewee from a clinic explained why it might not be financially solvent for employers to bear the burden of paying for certification, given the constraints of short-term grants or because some CHW/Ps do not stay at the organization that paid for their training: *"I think some type*

of training is important. I think certification is a plus, but shouldn't be a requirement because even when I looked at different training models, they're eight weeks long and some grants only last eight weeks, right? . . . And many times, we don't have the time or . . . a lot of those trainings cost money. . . . So making the financial investment of putting them through a six-week intensive training only to have them bail after being [here] one year is just very financially difficult and not financially sound. Now if someone went to City College, and they got certified as a community health outreach worker separate from the organization and they put that on the resume, of course I would put them at the top of the list, and I might even give them additional pay because of that certification."

Recruitment, Retention, and Integration Barriers

Although several organizations (*n* = 6) said they experienced no recruitment or retention barriers, the authors acknowledge that many of the interviewed organizations also train CHW/Ps and thus have a direct pipeline for hiring CHW/Ps. Other interviewees spoke to barriers they experienced when recruiting and retaining CHW/Ps. Low CHW/P wages or salaries (*n* = 7), determined by organizations opposed to the people interviewed, and having sustained funding (*n* = 6) were most often cited as the biggest barriers. Additionally, some CHW/P jobs that served a formerly incarcerated population required the CHW/P to have lived experience with incarceration. However, conviction history was also sometimes a barrier to hiring those CHW/Ps due to organization-level hiring practices.

One interviewee from a clinic commented that low salaries in high cost of living areas, in addition to the lack of career ladders, created barriers to finding CHW/P talent: "*I also think that [it's] the money, right? I'm in the Bay Area — $52K [a year] is not a lot, especially if somebody's got a family. It's really hard. And then there's no real ladder. Like when people say, 'Okay, this is great. I've been a CHW for a year, what's next?,' there isn't a CHW II that makes $56 [thousand a year] or a [CHW] III that makes $62 [thousand a year]. There's no career ladder.*"

Another interviewee from a clinic explained how the pandemic changed perceptions about CHW/P salaries, which created longer-term issues after COVID-19 grants ended. "*During COVID . . . it got competitive, it got really competitive. And the salary requirements were ridiculous. So these organizations [that] would never use community health outreach workers before, the county health department, all of a sudden they got this huge influx of money and they were paying [CHWs] $30 an hour. And as a CBO, we can't pay outreach workers $30 an hour, right? So they came in and kind of gave these astronomical salaries that they got from COVID money. But we also know that all of a sudden they start letting them go, right? So, but then the outreach workers thought that they should be making $30 an hour. So just specifically during COVID this idea of how much money we should be giving them and being disassociated with the market was very difficult.*"

Another interviewee from a clinic explained that "traditional" hiring processes did not work well because of the nature of the CHW/P role. "*I think these are challenges. . . . You don't just post this on LinkedIn or whatever, or [other] job sites. You have to build those relationships with community-based organizations who would know who good candidates for the position are, who [could] get the word out through word of mouth. Our network — we know tons of people around the state through our community health workers who know people who also were formerly incarcerated, who have come out. So it's building that network, building those relationships with community-based organizations. You have to take a different approach also in the hiring, having community health workers on your*

hiring committee, people who can help assess in the hiring practices, what kind of questions are you asking? . . . And are also hiring for some of those intangible qualities, like the passion and dedication to the community."

As for integration of CHW/Ps, many (*n* = 9) stated that they experienced no difficulties. However, the authors again recognize this is likely a result of several organizations' established presence in employing CHW/Ps and/or direct pipeline for CHW/P hiring. Among organizations that did experience integration barriers, the lack of understanding of the CHW/P role among other team members was cited as the most common barrier (*n* = 5). Other cited barriers included lack of respect among other team members, language barriers, funding sustainability, and difficulties with supervision and providing mentorship.

"Some of the other barriers that we have had is even though, as an organization, we have shown the value monetarily of what they bring to the organization, the nature of community health outreach work, there's a sort of trust that has to happen. And many people in upper management and leadership are very scared about the amount of trust you have to have, to give people to do outreach work, especially if it's coming out of their own coffers. So they really wanted good tracking systems, they wanted to have GPS put on our outreach workers so they know where they're at any given time and things like that. So there's just dealing with that constant [feeling of] having to prove yourself, constantly having to say, 'Yes, we're out there. Yes, we're doing this work.'"

—interviewee from a clinic

Billing for CHW/P Services

The State Plan Amendment

At the time of the interviews, California's State Plan Amendment (SPA) #22-0001,[5] which added CHW/P services as a Medi-Cal benefit effective July 1, 2022,[6] had not been finalized. However, most interviewees were aware that it was in development and generally understood that some types of organizations could soon bill for CHW/P services in a clinical capacity. Despite having some knowledge of this billing mechanism, interviewees did not know which services would be covered or understand the mechanism for coverage under the SPA because it was still incomplete. As a result, interviewee perceptions about the SPA, including who and what it was designed to cover, did not always accurately reflect the content of the version that was approved by the Centers for Medicare & Medicaid Services on July 26, 2022.[7]

To date, SPA coverage includes preventive services delivered in individual or group settings for issues including control and prevention of chronic conditions or infectious diseases, mental health conditions and substance use disorders, perinatal health conditions, sexual and reproductive health, environmental and climate-sensitive health issues, child health and development, oral health, aging, injury, domestic violence, and violence prevention. CHW/P services can take the form of health education, health navigation, screening and assessment, as well as individual support or advocacy. Services not covered under the SPA include clinical case management or case management that requires a license; employment services; helping recipients enroll in government programs or insurance not related to improving their health as part of a care

plan; delivery of medication, medical equipment, or medical supply; and services that duplicate another covered Medi-Cal service.[8]

Throughout the interviews, many called the SPA the "CHW benefit" or the "DHCS benefit," a reference to the California Department of Health Care Services. Some organizational representatives were hopeful about what the SPA could do for the CHW/P profession. One interviewee from a health plan felt that coverage of CHW/P services would improve access to preventive care, especially among clients with low health literacy: *"There's a lot of positives. I think [about] how [the SPA] would impact our members positively. . . . There's a lot of members that have very low health literacy that are going to get preventative care. I think for that population, this can definitely strengthen that component and give them further access into the health plan."*

Another interviewee from a clinic explained that the SPA could aid in downplaying the need to demonstrate return on investment (ROI) for the profession: *"I think [the SPA] actually will help a lot because we're talking about the ROI. Before, it was preventive services and waiting five years to get something. Right now, if we actually get some type of reimbursement, first of all, many community health workers and community clinics. . . . In fact, qualified health centers would actually have access to this. . . . Having someone inside that can help [the patient] navigate all this stuff helps a lot. And especially with Medicaid and Medicare patients, I do see a lot of advantages here because it will motivate a lot of the management executives and people [to] actually [act on] ideas to actually move it forward."*

A managed care plan interviewee also expressed excitement about their organization's future participation in the SPA and Enhanced Care Management (ECM), although they acknowledged that they were unclear about how to take advantage of it, given their role as a managed care plan and the payment structure of managed care: *"The other part is whether we want to be able to also participate in [the SPA]. Absolutely yes. We would want to. . . . We felt the same way when it comes to ECM. . . . And I know different health plans have different feelings about this, but we definitely feel that there's lots of members that are lost or missed out on because they're not linked to [primary care providers]. They don't utilize systems and there's no one there to catch those. And that health plan is in the unique position to be able to actually capture them. . . . We . . . have a complex care management program, and we have lots of work that we do with community health workers. And so we would [want to participate in the SPA], but how that would look, I don't know, because health plans don't usually provide billable services to the state unless it's a special arrangement."*

Other interviewees expressed concerns that the SPA might not be inclusive of CHW/Ps who do not work in a clinical setting, and that it could contribute to overmedicalizing the profession. One respondent from a health plan described their apprehension about the possibility of the SPA reinforcing coverage of services provided only via a traditional clinic model and how it might affect the addressing of social drivers of health: *"The SPA is created to provide services that are directly referred to by a doctor or a clinical link once a person is already engaged in the system. As opposed to receiving preventative care services outside of a traditional clinic model, which I think . . . is a big part of the role of a CHW. . . . I'm also thinking that it might [encourage] folks to start going to a more set reimbursement model in this fashion. . . . in terms of formalizing this and having a reimbursement model, then you're going to have a very funded track . . . to get people to go into a certain pipeline and perhaps not take care of the social determinants piece, which is what I think we've been talking about for the last 15 years*

that we're trying to fix. And we're still using a clinical model to address a social issue."

Further, one interviewee from a health plan explained that CHW/Ps are effective because of their close ties to the community and how the SPA could contribute to overmedicalization of the role. *"I think what makes the CHW so effective is that they have that unique experience of being of and in the community and turning them into [a] medical assistant. . . . can really lose the spirit of that, especially if we overtrain them on the medical role. And so I think that would be the biggest fear I have is that as Medi-Cal takes on more or brings more CHWs more and more into the fold, that we don't dilute the wonderful work that they are already doing and overmedicalize them. But I see the need for them continuing to grow."*

Another respondent from a CBO explained that the SPA highlights differences between CHWs and *promotores*: *"It has been an education process for all policymakers also, because to them, Medi-Cal is very straightforward. But when you start looking at money and it's tied to Medi-Cal, that's really clinics. That's really clinics, plans, and hospitals. It's not community. Because they think of us under the umbrella of community health workers, they think it's okay, but we're not. Community* promotores *are distinct. They're centered in these organizations. It has taken a lot of meetings with policymakers and even other CBOs and clinics to understand the distinction so that they can help us advocate for funds being distributed to CBOs. And in the plan, it was a section in there, and that was because of a lot of advocacy on CBOs' part."*

Also, an interviewee from a health plan felt there may be challenges with connecting the SPA and components of CalAIM: *"And so, seeing even the CHW SPA, how it's such a great idea, but how does it tie in with . . . the work that's happening on ECM? And so I think that would be my concern a little bit."*

Some interviewees expressed concerns about what the SPA would require for CHW/P education, including one who feared that a requirement of formal education would create barriers to authentic CHW/Ps from entering or remaining in the profession.

> *"There's such hot controversy around [certification]. I think we really want to be careful about not putting a barrier up for people who don't have formal education and maybe having real lives. And to say you must check the boxes of a certification program — say, your local community college — I think it's really going to cut down on the numbers of people doing the work. . . . That's one of my problems with the SPA, . . . that it looks like they're headed in that direction, which I find really, really worrisome because it's going to cut out a lot of people who could be absolutely fantastic and just don't have the book learning skills or the ability to carve out time to do a certification program. And who gets to decide what the certification program is?"*
>
> —interviewee from a clinic

CalAIM

While CHW/P services can be billed through the SPA in certain cases, the cost of CHW/P services may also be partially covered through certain parts of CalAIM (California Advancing and Innovating Medi-Cal) (PDF), a Medicaid waiver designed to shift Medi-Cal to a population health approach and make the program "more equitable, coordinated, and person-centered to help people maximize their health and life trajectory."[9] CalAIM targets

California's most vulnerable residents, including unhoused people, those without enough behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations with significant clinical needs, and the growing aging population. Enhanced Care Management (ECM) and Community Supports, also known as In Lieu of Services (ILOS), are elements of CalAIM that could be used by CHW/P employers to cover CHW/P services.

One interviewee from a college that trains CHW/Ps explained that health care organizations were working to understand the individual elements of CalAIM to be able to finance CHW/P-delivered services, but also acknowledged that these organizations may not currently have the infrastructure to participate in CalAIM. Participation would require them to develop new systems: *"Some larger FQHCs already have internal systems and [are] transferring and translating that into their policies/protocols. So that is more reimbursable. They're a little more ready, and they have infrastructure to do that. I think there are other organizations that will need some assistance, and I hope that the state will provide some assistance to build infrastructure and capacity. But I think there's a lot of work and discussion to be done around the Community Services, which is the old ILOS, right? The ECM is more on the clinical side. ILOS is definitely an area that community health workers can engage in. So I think there's a lot more that needs to be discussed on how that's going to be truly distributed across health care organizations."*

One interviewee from a hospital/health system expressed that they planned to enroll their CHW/Ps in a training program so they could participate in ECM: *"I plan to put our CHWs through . . . training. Also, as we hire new ones, because I think now that ECM is focused across behavioral health in the clinics, I think it'll be really helpful for them to have the behavioral health education too."*

However, another interviewee from a clinic was more critical of ECM, stating that there is not a place for CHW/Ps in ECM unless they are to be the case manager, which could place more reliance on the SPA: *"I don't necessarily see anything with ECM that is incentivizing hiring community health workers. There's this care manager person that has a caseload tied to them. And so, unless the care manager for ECM is a community health worker, where's the incentive to add the community health worker? Because you don't get more patients tied to that community health worker with their caseload, so you're not bringing in more funding per se for patients. So then it's now relying on the SPA piece. Well, if that doesn't cover all the services, maybe it'll help fund the community health workers who are in place, but is it going to be enough for people to hire? And we've heard from the sites — they need money to do that initial hire . . . because they have to build up their caseload, and that takes time."*

CalAIM's predecessor, Whole Person Care, aimed to coordinate "health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources."[10] One interviewee from a collaborative initiative opined that Whole Person Care better aligned with CHW/P services than Medicaid because it was a more flexible program, which mapped well onto the flexible CHW/P role while also avoiding reimbursement issues for the dynamic role: *"I think the flexibility that was part of Whole Person Care allowed CHWs to give them the space to just do whatever was needed kind of thing. If going to the supermarket is really scary for you, I can take my time. I don't have to abide by the financial systems, I can still just take my time and go to the supermarket with you. And I build a relationship with you at the same time. I help you shop so I know what food you need, help you think through like healthy eating. It's something that Medicaid doesn't tend to pay for. So, yeah, that's why in the*

SPA, like I was saying, everyone's trying to fight for the maximum flexibility because Medicaid wants to say like, 'Exactly what does a CHW do?' And it's they do whatever's needed, right?"

The same interviewee also questioned how much CalAIM would impact the CHW/P profession and argued that Medi-Cal billing through the SPA would likely affect the profession more than CalAIM by creating more demand, which would hopefully lead to more recognition of CHW/Ps' value and create career ladders within the profession: *"I don't know [if the CHW role will change in the move to CalAIM]. . . . I think the bigger question is how the [SPA] will affect them. Because if people do [hire] more because there's now a reimbursement stream for this, then hopefully over time more and more people recognize the value. . . . There's also obviously this broader shift to prevention and addressing social needs and thinking more holistically about health care in general, and racial equity in particular. And CHWs can help a lot of people realize those new goals that have been there forever but now that people realize need to be addressed."*

Another interviewee from a clinic hoped that both CalAIM and the SPA would contribute to the growth of the CHW/P profession, including creating more career ladders, but acknowledged that these funding opportunities could also create a large administrative burden: "*We'd love to see [CHW/Ps] gain more skills to become supervisors as they do the work and supervise others. We . . . see that in some of our sites where people are able to move on to be supervisors. That's not always possible in many of the sites. We're hoping that with CalAIM and the SPA, people can grow the community health worker programs, but it's unclear how this is going to play out. And I worry, because sometimes things that are implemented are just impractical for sites. [One of our sites worked with] seven health plans. So for Health Homes, they had to create seven different programs to get funded. I mean, it's so onerous. And luckily they're superstars, so they made it work somehow. . . . But I think the people we work with now are committed to having community health workers [and] see the value.*"

Organizational Concerns About CHW/P Investment

Historically, most organizations have either relied on grants to pay for the CHW/P role or self-funded the role via their own revenue streams. Often, organizations stated a reluctance to self-fund, usually citing financial constraints. This has led upper management to ask others at their organization to show CHW/Ps' return on investment (ROI) to preserve the CHW/P role, as CEOs often look toward ROI for provider groups, especially those who cannot directly bill for services. However, this has drawn criticism from some CHW/P advocates, who argue that ROI need not be shown for other medical innovations.

"This is why . . . the DHCS benefit is critical. . . . There's no ROI for a community health worker. . . . I've given up on ROIs. I've been working . . . in this field long enough that ROIs are just a path people send us on. . . . They're like, 'Oh, go work on the ROI. And then maybe we'll fund you.' And it's like, nobody had to ask the ROI on the PCSK9s [a type of medication], you guys are just funding the PCSK9s. You know? Like, why did we need a new statin medicine? I don't know, just because it got developed. So ROIs are like a rabbit hole. Because nobody believes them anymore. And at the end of the day, it's all about the Medicaid agency saying, 'This is a part of the benefit

package, and you have to offer a CHW benefit.' And once DHCS does that, then we don't have to worry about ROIs anymore."

—interviewee from a collaborative initiative

Another interviewee from a clinic argued that an additional issue with showing CHW/P ROI is that CHW/P impact can be difficult to define and measure: "I *do think because everything is moving to an ROI world, and some of the work that* promotoras *do [does] not have an ROI. . . . Some of the times, it takes a while, and they do such diverse work. They work like psychologists, medical nurses, and they go back to actually just being your friend and after that nutritionist. Then it's very hard sometimes for a company to measure. Then having a certification helps prove the ROI stuff and have like a certain standard. But on the other side, the flexibility that they already have and coming from the community by the community, it's also an advantage."*

The same interviewee further described the challenges of showing ROI for CHW/Ps, explaining that doing so will take time, which could negatively affect their patients: *"Even though . . . we're improving [financial] numbers and everything else, it feels that* promotoras *and community health workers play a role. But when economical challenges arise, they're not seen as economical drivers. . . . I think that's one of the things that was playing against us. . . . With the changes in the state, it will be very detrimental for the patients that we take care of not to think of expanding and figuring out what's the next step for* promotoras *in [our organization]. But the thing is, without the guidance [from] the state . . . I cannot request more money. Because again, I end up having the ROI question. . . . In five years, I can tell you for sure that there will be [fewer] amputees, there will be [fewer] dialysis patients. There will be [fewer] patients actually smoking, less cancer, but nobody wants to wait for five years."*

COVID-19 Impact

The COVID-19 pandemic both introduced new challenges and highlighted existing issues within the US health care system, many of which CHW/Ps were well poised to improve. Several interviewees spoke about the importance of the CHW/P role during the height of the pandemic as well as the complications that the pandemic brought to the workforce.

"I think what's happening is that through COVID, especially, I think we have seen the gaps in the system even more raw than before. So people are now seeing the value of community health workers."

—interviewee from a college that trains CHW/Ps

Several other interviewees said that the COVID-19 pandemic emphasized the need, and created demand, for CHW/Ps in health care settings. They said that CHW/Ps were especially valuable during the pandemic because the role is flexible and because their establishment as trusted members of the community let them reach out and connect with folks who would otherwise be difficult to reach.

"I think COVID actually amplified the need of promotoras. Because they were flexible and they took a lot of roles that were not there before, and they have done amazing work, saving a lot of mental health patients, a lot of good stuff."

—interviewee from a clinic

Another respondent from a clinic indicated that the pandemic highlighted the visibility of and created additional funding for CHW/Ps, called community health outreach workers (CHOWs), as the profession was designed to reach the populations in high need

before, and even more so during, the pandemic: *"There's always going to be a need for CHOWs. . . . What we found, especially with COVID, is the integral importance they play in the work. . . . There was almost no funding being done for CHOWs, and all of a sudden there was tons of money looking for people to do community health outreach work because they saw that these underserved, high-risk populations are not going to access health care through the regular mediums that everybody else does. And if you truly want to drive change within these impoverished communities or these disenfranchised communities, it has to happen within those communities. . . . So once that was realized, I think you see the power and the importance of it. So I think that there has always been and will continue to be need for CHOWs and the additional integration of them into service categories and into the clinical health care system."*

One interviewee from a CBO pointed to the importance of CHW/Ps working in CBOs, who they explained had the ability to mitigate the pandemic in their communities: *"I think, during COVID, the state and folks saw the importance of community-based organizations being the trusted messengers, people that really made the difference in their communities, especially during COVID. We [CHW/Ps at a CBO] throughout the state, the ones that were out there, the ones that were there, because we were that community. We are the ones that care."*

Additionally, one interviewee from a CBO specified that CHW/Ps were able to combat misinformation and myths about the COVID-19 virus: *"I would say that we [CHW/Ps] do a lot of unlearning in the community. Misinformation and myths travel very fast in the community. And I think that we're definitely seeing that with COVID. And so we do a lot of community building, a lot of trust building in the community. I think that for us, that's definitely our strength, that we're able to go back to our community and do a lot of unlearning . . . making sure that we are up to date with the pandemic; the information changes very rapidly. And so I think that we have those skills to rapidly update and go out into the community. So it's mostly bridge building — [we're] like the bridge between information and the community."*

Another interviewee from a clinic explained that the pandemic created challenges with integrating CHW/Ps into care teams, which was noticed by other health care professionals that expressed a desire for CHW/Ps to rejoin the care team in person as soon as possible: *"I think [integrating CHW/Ps into the organization has] been really hard this last couple years because of COVID. It was a lot easier when everybody could work on site . . . we've been doing this long enough that [at] our primary care clinics, the CHWs are seen as really invaluable. It was one of the first things when we started reopening clinics with COVID was, 'When are the CHWs coming back? We need them.' The primary care docs . . . were saying, 'We want them here' because they want to hand off patients who have resource needs or they want extra support for the patient around behavioral health. . . . I think that they are valued members of the team. And the isolation over the last year and a half, almost two years of working at home has been difficult. I feel like they're not as well integrated."*

During the height of the pandemic, funding for the CHW/P role changed; there were more grants to fund more CHW/P positions, often to provide vaccination outreach specifically. Now that these grants are closing; there remains a funding issue for CHW/Ps that could be partially alleviated by the SPA.

> *"There was a huge demand during, for COVID vaccination outreach. And then that's petered off with the. . . . I mean, it's just a funding issue. Nobody knows how to fund*

CHWs. So I think when the DHCS benefit comes out and people now have a way where they can bill on the CHWs' time, it'll really change things. [There] will be much more of a demand for that workforce."

—interviewee from a collaborative initiative

Growth and Future

Many interviewees spoke to the growth they've already seen as well as the growth they hope or expect to see in the CHW/P profession within their own organizations and beyond. They said the time for growth in CHW/P employment is now due to the COVID-19 experience and the general unmet needs of the community.

"I would say [there is a growing need for more promotores] not just in our organization, but I think in other organizations. What we have seen with the pandemic has been very detrimental to our communities. Whatever inequities were there are now only accentuated with the pandemic, and we have seen the effectiveness of the promotores model. So . . . if we're going to be able to keep on our promotores, that work in the COVID program, there's a whole phase of recovery that we're looking toward, and we feel that the infrastructure we've set up should be sustained. Because the folks that we've been able to connect with throughout the pandemic rely on that trust with promotores to tell them where to go or to seek services."

—interviewee from a CBO

The same interviewee discussed the role that CHW/Ps could play in bringing health equity to every community if the profession grew: *"And I would say about almost half of the adults that we serve are uninsured. That kind of is an indicator of them also being undocumented and not having as much access to different services as other folks. So I think it's really important that* promotores *are sort of the equity factor when we talk about any community health work, because they're there, they live in the community, they have the local expertise and the trust. So I do feel that there is a need for more* promotores *if we're talking about sort of this larger health equity conversation in our communities."*

Another interviewee from a college that trains CHW/Ps remarked that the CHW/P profession could grow because there was interest and some buy-in among leadership and managers of organizations that could employ them: *"Yes, I think there will be a growing interest [in CHW/Ps]. The need I think was always there. I think there's going to be a growing interest to hire and engage CHWs to accomplish goals and objectives that in the past might have not — CHWs might have not even been a consideration to reach those goals. But I believe now leadership and middle management are a little more open and understanding and seeking information about CHWs. So as a result, I can see more job growth and opportunities for CHWs and changes in career ladder and advancement in the profession and such."*

One interviewee from a clinic expressed that more people would need to engage with the profession and that an appropriate infrastructure would need to be in place for it to continue growing: *"I think if you want to see more growth in this field, you have to be able to onboard [certain organizations]. . . . There's probably the people who were your first innovators, then you have people who were interested but maybe didn't have the funding or they had time constraints, and then you have people*

who are not really on board. And you want to get that middle group engaged and activated, but if you have too many barriers, it just may not happen. I mean, we saw that with Health Homes and Whole Person Care. People didn't necessarily do Whole Person Care because the rates were lower than Health Homes. You can set these things up in ways that just are too onerous or not viable financially."

Interviewees also opined on the future of the CHW/P profession. Some expressed the desire for CHW/Ps to continue doing what they're doing in community settings, but also that they hope to see the CHW/P role become better recognized as a profession. One interviewee from a CBO noted that CHW/Ps help with community change by bringing people together: *"We need to really get in [the] community, create awareness, participation from the community to reflect in their own issues. Finding solutions from the community, for the community. I'm facilitating this thinking to mobilize the needle. The issue of the community and change. So, if not, we are going to be having the same issues. We got to move from the individual to collective issue. I think that's the biggest step that the CHW needs to take."*

Another interviewee from a health plan emphasized the unique position of CHW/Ps to improve clients' health via methods inaccessible to other medical staff, since CHW/Ps can work in community settings: *"There needs to be more conversation, I think, with what it is that we're trying to prevent. I mean, you have your usual suspects: hypertension, diabetes, different [people] that make our community, usually over the age of 30, 40, 50, 60. A lot of times, the only way to penetrate these communities early on is by placing people in the community and the spaces that people are frequenting, and you can't do that with a doc. You're not going to spend that money with a doctor to go out and do that or a nurse or something like that. You could use a community health worker to engage at that level."*

Yet one CHW/P from a CBO explained their desire for more recognition of the work they do and the impact they have, and to be compensated accordingly: "*I hope that we are recognized for the work that we do. I think that there's more and more evidence-based programs and more data of the changes that we do in the community. So I think for us, the big picture is to be recognized as professionals and to be compensated as professionals and hopefully have a more steady source of funding for the* promotoras, *because a lot of the times we notice that the funding is gone, but the health issues are still there."*

One interviewee from a clinic commented that in addition to CHW/Ps' ability to connect with people in the community and improve clinical outcomes, they also have the potential to sustain patient engagement in primary care: *"For me, the next level for community outreach workers is really looking at not only using them for clinical outcomes and for outreach work, but really look at utilizing them for sustainability of patients in the care system. I think that a lot of people will use outreach workers to bring people in. I think that people will use them to keep them there, but we need to use outreach workers to help find people to bring them back as well."*

Discussion

The research team conducted 29 interviews with 31 people across 27 unique employers of CHW/Ps in California to better understand their perspectives on the CHW/P role, employment demand, billing opportunities, and the future of the profession. Interviewees were typically at the C-suite level or led the CHW/P department or program at their organization. Health care organizations, such as clinics and hospitals, health plans, county health departments, training institutions, and CBOs, among others, were included. Interviewees were eager to discuss their experiences with and thoughts about

the profession at their organization and as a whole. A few organizations did not respond to interview invitations. This report lacks the perspective of some large health systems in the state that may employ CHW/Ps. Also, the research team did not have the capacity to interview many organizations that did not employ CHW/Ps or any that do not plan to employ CHW/Ps. Those perspectives would be important for future planning.

The authors found, consistent with earlier studies and reports about the CHW/P profession, that there is inconsistency with and a multitude of job titles for CHW/Ps. Collectively, interviewers listed over 20 titles, some organizations citing multiple titles depending on funding, the housing department, the specific tasks they performed, or some combination. Often, CHW/P roles were specialized to work with a specific patient population (e.g., unhoused) or disease (e.g., diabetes). This lack of a consistent definition or more encompassing definition makes it difficult to track demand and supply.

In the study sample, CHW/Ps were employed either as generalists or specialists. In a specialist role, they may work with a defined population such as pregnant women, adults and children with diabetes or asthma, or other chronic conditions. They were often responsible for providing connections to resources or referrals and community outreach and/or engagement. Many organizations stated that the core skills and competencies they viewed as most important for the role aligned with skills and competencies outlined by the CHW Core Consensus (C3) Project. The C3 project is a national model developed by researchers and leaders in the CHW community. These skills and competencies are widely recognized within the CHW community, but likely need more introduction in the health system sector. However, our interviewees understood the CHW/P role. They specified the importance of CHW/Ps' ability to provide culturally competent communication, active listening (e.g., motivational interviewing), and multilingual skills. Most important, interviewees noted that CHW/Ps needed certain personal attributes, such as passion for the work and embeddedness within the community, to properly do the work.

Training and certification of CHW/Ps evoked a mixed set of responses. Nearly all interviewees did not require CHW/Ps to have formal training upon hire. Instead, organizations described CHW/Ps undergoing role-specific, and often organization-specific, trainings after they were hired. Some organizations partnered with established training institutions, while others provided all training in-house. Although the state has made recent[11] commitments[12] to train and certify more CHW/Ps, employer opinions on CHW/P certification were mixed. Some recognized the potential for certification to standardize and better define the role, but others criticized it, explaining that it would create financial and time constraint barriers for folks who might be a good fit for the CHW/P role.

When interviews were conducted, the State Plan Amendment (SPA) had not yet been approved by the Centers for Medicare & Medicaid Services, and it was unclear how CHW/Ps would fit into CalAIM. Many interviewees discussed the opportunity to bill for CHW/P services with the SPA and CalAIM. Thus, while there was knowledge of and general excitement about these funding mechanisms, some interviewees were unsure if, or how, they could actually bill for services. Furthermore, challenges await organizations who do eventually want to bill, especially those that do not already have a Medicaid billing structure in place or who rely on a global payment system. Interviewees from organizations that were not health care organizations and didn't have partnerships with health care organizations commented that they were left out of these funding opportunities and said that the SPA could lead to overmedicalization of the profession. There is a need for more follow-up on implementation of

the SPA and uptake by CHW/P employers. Funding for positions and sustainable funding remains an issue for many employers.

The COVID-19 pandemic clearly affected the CHW/P role. Interviewees said that it highlighted the need and created demand for CHW/Ps in health care settings while also exposing larger gaps in the health care systems that CHW/Ps could address. The flexibility of the role of CHW/Ps and their close ties to and trust within the community let them address the health care crisis in a way other health care professionals could not. However, now that COVID seems to be moving to an endemic versus pandemic state, many CHW/Ps employed for pandemic-specific services are no longer employed in those positions. It would be important to track that pool of temporary workers and what they are now doing.

Most interviewees felt there was a growing need for CHW/Ps at their organizations, and at other organizations, given CHW/Ps' unique ability to support underserved communities and to advance health equity. Many also hoped to see more career ladders within the profession. Interviewees saw the future of the CHW/P role continuing to expand, especially in areas such as increasing community participation in solving community needs and sustaining patient participation in their own health care.

These employer interviews yielded a rich set of data from the employer community. They identified what is working well with CHW/P employment and identified issues for further discussion and policy development.

APPENDIX A. SEMISTRUCTURED INTERVIEW GUIDE

General Questions:

1. What is your job title?
    a. How long have you been working in this role?
2. How long have you been working at your organization?
3. How large is your organization?
    a. Probes: How many counties does your org cover, how many outpatient visits occur on a monthly or yearly basis at your org., etc.
4. Does your organization currently employ CHW/Ps?
    a. If yes, go to "orgs currently employing CHW/Ps" section.
    b. If no, go to "orgs not currently employing CHW/Ps" section.
5. How long have you been working with CHW/Ps? (if yes to the above question)

Orgs Currently Employing CHW/Ps:

1. What is your role with CHW/Ps at your organization?
    a. Probes: Leader/champion that oversees implementation of a CHW/P program, CHW/P staff; work directly with CHW/Ps; indirect involvement (your staff works with CHW/Ps, you receive information from those that are working with CHW/Ps)
2. What job title(s) does your organization use for CHW/Ps?
    a. Probe: If multiple job titles, which is/are the most common?
3. How many FTE CHW/Ps does your organization employ?
    a. Probe: An estimate is okay.
4. Do you know the average wage/salary for CHW/Ps at your organization?
5. What do you feel is the primary role of a community health worker/*promotor* (in your organization)?
    a. Probes: Providing culturally appropriate information, assessments, home visits, translation/interpretation, case finding/recruitment, connecting to community-based resources, improving health outcomes of patients, etc.
    b. Add-on, if time: Working with CHW/Ps has yielded the most valuable outcomes in which areas?
6. What are the core skills and competencies of CHW/Ps?
    a. Probes: Knowledge, personal traits, experience, fluency in languages other than English, etc.
    b. Add-on, if time: What additional skills and competencies do CHW/Ps need to work in a health care organization?
7. What kind of training did CHW/Ps have before starting work at your organization?
    a. Was this sufficient?
8. How important is CHW/P individual or training program certification to your organization?
9. Does your organization anticipate billing directly for CHWs' services under the State Plan Amendment (SPA)?

10. Is there a growing need for more CHW/Ps in your organization?
    a. Probes: Do you have open CHW/P positions? Are you considering retooling existing positions to match CHW/P roles? Are you considering expanding the number of CHW/P roles that you're hiring for?
11. What were your primary barriers to hiring CHW/Ps at your organization?
12. What were your primary barriers to integrating CHW/Ps into your organization? How is the CHW/P role coordinated with other roles at your organization?
13. What future roles for CHW/Ps do you foresee at your organization?
    a. Probe: Are you planning to hire more CHWs?

Orgs Not Currently Employing CHW/Ps:

1. Do you plan to employ CHW/Ps?
   a. If yes: What do you envision as the primary role of a CHW/P (in your organization)?
   b. If no: Why not?
      i. Probes: Don't fully understand what CHW/Ps do, not sure how well they would integrate into existing organizational structure, not enough funds to support the role, not enough trained CHW/Ps ready to be hired, etc.
2. What are / would be your organizational needs for hiring CHW/Ps?
   a. Probes: Need more help in certain department, ensuring that patients keep appointments, complete tasks that are not currently getting done, etc.
3. If you are planning to hire or if you were to plan to hire CHW/Ps, how many FTE CHW/Ps do you think you would employ?
4. If you are planning to hire or if you were to plan to hire CHW/Ps, what job title would you hire them under?
5. If you are planning to hire or if you were to plan to hire CHW/Ps, what skills would be most important for them to have and why?
6. If you are planning to hire or if you were to plan to hire CHW/Ps, where would you look to hire?
   a. Probes: Training organizations/programs, repurpose existing staff, etc.
7. If you are planning to hire or if you were to plan to hire CHW/Ps, where to you plan to look for or where do you expect funding to come from?
8. If you are planning to hire or if you were to plan to hire CHW/Ps, do you already have job descriptions for the position(s)?
   a. If no: What would you need to do to develop job descriptions?
9. Are there other positions in your organization that have particular job functions that would overlap with a CHW/P?
   a. If yes: What positions are these? Which job functions overlap?

Endnotes

1. *Meeting the Demand for Health: Final Report of the California Future Health Workforce Commission*, California Future Health Workforce Commission, February 2019.
2. CHW Core Consensus Project (website).
3. Timothy Bates, Jacqueline Miller, and Susan Chapman, *Understanding California's Community Health Worker/Promotor Workforce: CHW/P Health Care Employers*, California Health Care Foundation (CHCF), March 2023.
4. Jacqueline Miller, Amy Quan, and Susan Chapman, *Understanding California's Community Health Worker/Promotor Workforce: CHW/P Training Programs*, CHCF, February 2023.
5. *State Plan Amendment (SPA) #: 22-0001* (PDF), California Dept. of Health Care Services (DHCS), July 26, 2022.
6. "Community Health Workers: DHCS Proposal to Add Community Health Workers," DHCS, July 28, 2022.
7. "Community Health Workers," DHCS.
8. *State Plan Amendment*, DHCS.
9. *California Advancing and Innovating Medi-Cal (CalAIM): High Level Summary* (PDF), DHCS.
10. "Whole Person Care Pilots," DHCS, last modified May 23, 2022.
11. *Meeting the Demand*, California Future Health Workforce Commission.
12. "The 2023-24 Budget: Health Workforce Budget Solutions," Legislative Analyst's Office, February 21, 2023.