

CHW Toolkit

REVIEW AND ANALYSIS OF TRENDS IN OTHER STATES REPORT

CHW Toolkit: Review and Analysis of Trends in Other States

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Background

Across the United States, interest is growing in the community health worker (CHW) role and its benefits in advancing health equity and the Triple Aim. State policy activity is accelerating as evidenced by efforts in Connecticut, Idaho, Kansas, Michigan, Minnesota, Missouri, North Dakota, Utah and Wisconsin, often involving the state health department, state Medicaid agency, stakeholders and CHWs. More national associations are supporting CHW policy development, notably the American Academy of Family Practice, Association for State and Territorial Health Officers (ASTHO), the National Academy for State Health Policy, and the Patient-Centered Outcomes Research Institute (PCORI) (Rush, 2015). These organizations join other leading public and private agencies such as the American Public Health Association, the Centers for Disease Control, the Institute of Medicine and the Health Resources and Services Administration along with many national funders including the Annie E. Casey Foundation, the W. K. Kellogg Foundation, the Kresge Foundation and the Robert Wood Johnson Foundation which have long recognized and supported the CHW role.

This report summarizes current developments in the CHW field, organized around five major themes including occupational definition, workforce development, state certification, sustainable financing and evaluation/metrics. Minnesota trends are highlighted under each theme.

Occupational Definition

According to the American Public Health Association,

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

The CHW role has a long history and deep roots in many communities overseas and in the U.S. where it is known by a variety of titles. As a distinct and emerging health profession, CHWs do not typically hold a license in another health field such as nursing, paramedicine or social work. They apply their shared life experience along with their training to meet the health and related social needs of underserved populations and others experiencing barriers to health care and good health.

For nearly two decades, core CHW roles and competencies, first documented in the National Community Health Advisor Study, have informed efforts to define and standardize a scope of practice for CHWs. The 1998 study identified seven roles including cultural mediation, health

education, building individual and community capacity, connecting people with services, informal counseling and social support, advocacy, and direct service (such as taking blood pressure or administering other screening exams when sufficient training and supervision is available) (Rosenthal, 1998).

In 2014, a national effort known as the CHW Core Consensus (“C3”) Project was launched to expand and update this list of core competencies to reflect new and emerging CHW roles. While not yet complete, the C3 process has identified the following key CHW roles as of January 2016:

- Cultural Mediation among Individuals, Communities, and Health and Social Service System
- Providing Culturally Appropriate Health Education and Information
- Care Coordination, Case Management, and System Navigation
- Providing Coaching and Social Support
- Advocating for Individuals and Communities
- Building Individual and Community Capacity
- Providing Direct Service
- Implementing Individual and Community Assessments
- Conducting Outreach
- Participating in Evaluation and Research

As a next step, CHW networks across the US are being asked to formally endorse and adopt the CHW roles, skills and qualities that have emerged from this comprehensive review and consensus project. Once approved and published, project organizers intend for C3 outcomes to be used to support CHW hiring, inform public policy, educate potential CHW employers, and strengthen inter-professional relations (Rosenthal, 2015).

Minnesota Trends

Over a decade ago, the statewide Health Education Industry Partnership based at Minnesota State University, Mankato developed Minnesota’s Scope of Practice for CHWs, drawing on the National Health Advisor Study. These competencies in turn informed the development of Minnesota’s model statewide standardized CHW curriculum. In 2015, Minnesota’s curriculum was selected for national review as one of seven “benchmark” documents related to educational standards or training as part of the thorough C3 review process. In 2014-2015, the Minnesota CHW Alliance (Alliance) provided review and comment on a cross-walk between Minnesota’s curriculum and the C3 Project synthesis of the benchmark documents which identified common core roles and skills as well as new and emerging roles and competencies. In 2015-2016, the Alliance took part in the national network review and endorsement process. National guidelines furnished by the C3 Project invited every state community health worker alliance or association to form a team comprised of at least three CHWs to complete a review process and furnish comments on CHW core competencies and skills that emerged from a series of large and small group meetings over the preceding year (Rosenthal 2015).

CHW scope of practice will be studied by the Minnesota Department of Health (MDH) in connection with a project funded by the Health Resources and Services Administration. In 2015, Minnesota, Pennsylvania and Arizona were selected by the National Governor's Association to participate in the Health Care Workforce Technical Assistance Program "Aligning Policy to Practice." Represented by the MDH Office of Rural Health and Primary Care, Minnesota will focus on scope of practice related to the CHW and dental therapist/advanced dental therapist roles as emerging professions.

Workforce Development

CHW education and training are key workforce development activities. Traditionally, CHWs have been trained on the job by their employers, with training content often determined in response to specific funding opportunities, often with a narrow, disease-specific focus. Until relatively recently, foundational training has been missing with the exception of a few well-established programs across the country. Most CHW training does not offer an educational pathway because it is not credit-based.

With the rise of interest in the CHW role by a wide variety of organizations including health providers, health plans, state agencies and policy groups, there is more focus on CHW educational models and content. State-level certification, described below, often includes standards and requirements for CHW education, continuing education, training programs and/or training faculty.

There are many benefits to more comprehensive, structured training for CHWs. For example, CHW education is key to certification, leading to benefits to the field and to individuals such as greater professional recognition and clarity as well as career advancement opportunities with portability of skills across worksites. Credit-based foundational programs based in post-secondary schools, such as Minnesota's model statewide curriculum, provide an educational pathway towards an associate or bachelor's degree and articulation with education for other health careers. Another advantage to standardized training is a stronger base for evaluation and research. This helps build the evidence for and credibility of the workforce. And educational standards are critical to securing sustainable funding because public and private payers seek assurance that the workforce is adequately trained to be able to competently provide covered services. While most support the value of and move towards educational standards for the profession, important issues such as cost and enrollment prerequisites related to language skills, educational level and documented status warrant attention. For example, financial aid and employer tuition benefits are ways to support the affordability of CHW education.

Workforce development raises many interrelated questions such as who pays for CHW training, where training should be provided, faculty qualifications, how much skill development is

needed prior to hiring, how do educational methods such as popular education¹ figure into CHW training and the role of higher education. A few states are experimenting with apprenticeship models (Rush, 2015). While apprenticeships are common in the trades, they are new to the health care field and it is not clear how well accepted they will be.

Minnesota Trends

Nationally recognized as a leader in CHW education, Minnesota is the first state in the nation with a statewide standardized CHW curriculum offered in higher education. Students who complete the program at one of the six post-secondary schools that currently offer the curriculum receive a certificate of completion that is recognized by the Minnesota Department of Human Services, for public program reimbursement purposes. Over 600 individuals have earned a certificate on the basis of completing a certificate program or through the time-limited grandfathering process outlined in 2007 state legislation. The curriculum was revised and expanded from 11 to 14 credits in 2010 and portions of the program were updated in 2015. It covers CHW core competencies, health promotion competencies and field competencies including a required internship. Faculty from the six schools that offer the certificate program meet monthly through the Alliance's Education Committee. The model curriculum is in use in Michigan, South Carolina and other states where organizations have purchased the program.

The Education Committee of the Minnesota CHW Alliance has noted that CHWs are often the first in their families to enter higher education (Education Committee communication, October 7, 2015). In successfully completing the certificate program, they serve as role models and guides to members of their communities on pursuing post-secondary education which can offer improved job and salary prospects. As social determinants of health, income and educational attainment are linked to better health and greater longevity. CHWs also provide greater diversity to Minnesota's health care, public health and social services workforce and create a pipeline to address primary care workforce shortages.

An educational foundation provided through the certificate program is one leg of Minnesota's "three legged stool" of CHW education. Job orientation and ongoing employer training forms the second leg and provides essential information needed to carry out specific job duties within the context of specific employer policies and settings. The third leg is continuing education, critical to all who work in the ever-changing health field, including CHWs. While there is no state requirement for CHW continuing education at this time, most CHWs and employers value professional development opportunities which are available at no or low cost through a variety of sources including Minnesota CHW Peer Network, the Minnesota CHW Alliance, Minnesota

¹ "Popular education is education as a practice (or praxis) of freedom. It is an approach to education where participants engage each other and the educator as co-learners to critically reflect on the issues in their community and then take action to change them." <http://www.practicingfreedom.org/offerings/popular-education/>

Department of Health and voluntary health associations such as the American Cancer Society and the Minnesota Network of Hospice and Palliative Care.

State Certification

Another major trend is state-level CHW certification. Certification or credentialing of CHWs has been under way for over 15 years with a flurry of recent activity in this direction. The [National Academy for State Health Policy](#) (NASHP) maintains an up-to-date national map and comprehensive listing of current states with CHW certification programs.

A scan of state-level CHW certification programs will show that there is no “one way” in terms of structure and scope. Political landscape and state orientation to occupational regulation are major drivers. Some states have tied CHW certification programs to other credentialing boards. For example, Ohio CHWs are certified under the state Board of Nursing and Florida CHWs are credentialed through the private nonprofit [Florida Certification Board](#) which manages certification programs for over 20,000 health and human professionals in the child welfare, mental health and addiction fields. States such as Massachusetts, Oregon and Rhode Island have taken a different route and established independent state-level commissions to guide the development and implementation of the CHW certification process.

State certification typically involves a written application, proof of completion of an approved training program, criminal background check, professional references, evidence of good character as well as a fee. Comparable to regulatory provisions for other certified occupations, CHW certification programs may also include:

- Approval of training programs
- Standards for trainers
- Potential tiered practice levels
- Grandfathering provisions
- Continuing education and renewal requirements
- Reciprocity with other states
- Discipline and grievance procedures
- Statewide roster.

CHW certification confers a variety of benefits to the profession and to stakeholders (Hirsch, 2015) as outlined in Table 1.

TABLE 1. BENEFITS OF CHW CERTIFICATION

Stakeholder Group	Benefits
CHWs	Opportunity to define the practice and build professional identity
	Workforce development (pay, benefits, supervision, training, career ladders)
Providers/employers	Scope of practice in relation to other workforces
	Training standards
Public/Private insurers	Scope of practice, training
	Possible prerequisite for payment

CHW certification is not without controversy. Some commentators propose CHW program accreditation including on-site surveys along the lines of the Joint Commission rather than professional credentialing in order to improve program-level implementation which is critical to strong outcomes (Kangovi, 2015). Others question the need for certification and identify potential drawbacks to the field such as erecting barriers to entry to the workforce, “over-medicalizing” or otherwise distorting CHW identity in ways that diminish its unique strengths and creating different “classes” of CHWs (ASTHO, 2016). While these concerns are understandable given the roots of the field and deserve serious consideration, they have not deterred interest in and movement towards state certification. That is likely because supporters see its advantages in building, sustaining, and advancing the field plus major pitfalls can be avoided in careful program design with responsive and participatory processes (Wilkinson, 2015 and ASTHO, 2016). There is widespread agreement that licensure is not appropriate for the CHW field—in fact, most state CHW certification programs are voluntary—and that active involvement by CHWs in any state occupational regulation effort is essential to its success.

Minnesota Trends

As a result of the successful work of many partners through the Minnesota CHW Policy Council, now known as the Minnesota CHW Alliance, our state has established key building blocks for the CHW field including:

- CHW competencies and scope of work,
- a statewide standardized curriculum offered by a network of post-secondary schools, leading to a certificate,
- Minnesota Health Care Program (Medicaid and MinnesotaCare) payment—both fee-for-service and managed care—for diagnostic-related patient self-management and education, provided one-to-one or in groups by CHW certificate holders with supervision by specific provider types. Administrative restrictions established by the Minnesota Department of Human Services include daily and monthly caps as well as group size limits.

However, the state is missing some useful components often associated with state-level certification. For example, Minnesota lacks a statewide CHW database or registry which impedes workforce development, tracking and analysis, and hiring—a helpful tool built into the community paramedic and dental therapist/advanced dental therapist fields, two other emerging professions, via state legislation. CHW continuing education is another component that Minnesota does not require as yet. In 2015, the Minnesota CHW Alliance introduced an education process with its board and partners to begin to explore the merits of CHW certification for Minnesota.

Financing Options

Around the US, sustainable financing is identified as one of the major barriers to CHW integration (NASHP, 2015). Assuring growth in the field and broader access to the many benefits that the profession provides to low income, vulnerable populations facing barriers to good health requires viable funding mechanisms. Historically, time-limited grants and contracts have been a major funding source for the CHW workforce and it is likely that philanthropic investments will continue to help underwrite program start-up, infrastructure and research and evaluation. The lack of predictable and sustainable funding streams has constrained broader adoption of CHW strategies and limited CHW job security. With the implementation of the Affordable Care Act and the growing evidence base for CHW effectiveness, there are some progressive developments in CHW financing, with a focus on the Medicaid population. For state details, visit the [National Academy for State Health Policy](#). The following overview describes major options for CHW support.

State Plan Amendments

To date, only Minnesota (statewide) and South Carolina (regional pilot) as yet have State Plan Amendment authorization by the Centers for Medicare & Medicaid Services (CMS) to provide Medicaid coverage for CHW services, specifically diagnostic-related patient self-management education, both individual and group. While coverage does not include the full scope of the role and Minnesota's lessons underscore the need for important improvements to foster broader uptake, this policy innovation continues to interest and inspire many states.

Managed Care Contracts

With the growth of Medicaid managed care contracting, states are placing priority on managed care approaches for CHW financing. Recognizing the value of CHWs to improved access, cultural competence and outcomes for disparities populations, several states now have policies to ensure that Medicaid managed care plans include CHWs in contracting arrangements. For example, effective January 1, 2016, Michigan's state Medicaid agency requires all Medicaid managed care plans in the state to maintain a ratio of at least 1 full-time CHW for every 20,000 enrollees they serve. This is the result of a series of stakeholder forums organized by the

Michigan CHW Alliance to explore various CHW payment models and implementation plans. In New Mexico, managed care plans are required to cover CHW care coordination and include CHW services in their list of Medicaid benefits. Pennsylvania requires Medicaid managed care organizations to include CHWs in care management plans to help decrease hospital admissions and readmissions as well as reduce preventable emergency room use.

While Medicare does not yet cover CHW services, Massachusetts' One Care Program for beneficiaries that qualify for both Medicare and Medicaid ("dually-eligible") does include specific services that can be provided by CHWs (MA Dept. of Public Health Office of CHWs). Notably, a 2015 CMS guide to preventing hospital readmissions among ethnically and racially diverse Medicare beneficiaries recommends investments in non-traditional team members such as CHWs as "essential" and spotlights KentuckyOne Health's Health Connections Initiative which used "hot-spotting" techniques to identify Louisville "super-utilizers" who were helped by a multi-disciplinary team that included two CHWs (Betancourt et al, 2015).

Medicaid Waivers

Most state strategies for covering CHW services are through waiver programs such as Section 1115 demonstrations with recent developments in Texas and New York. (See the [Medicaid](#) website for more on Section 1115 waivers.

Preventive Services Rule

Under a CMS rule change published in July 2013, state Medicaid agencies may pay for non-licensed providers such as CHWs to deliver approved preventive services that are recommended by a physician or other licensed practitioner. According to CMS, this change "broadens the pool of practitioners available to furnish preventive services" and "increases beneficiary access to preventive services they might not otherwise have been able to receive" (CMS, 2014). This financing option requires a state plan amendment. Kentucky, Minnesota, Wisconsin and Washington, DC are reportedly pursuing this option (Rush, 2015).

SIM Awards/Health Reform Initiatives

Major health reform initiatives underway in many states through the CMS Statewide Innovation Model awards and other health reform initiatives include policy and financial support for CHW models. Examples include Minnesota's Accountable Communities for Health, Oregon's Coordinated Care Organizations and Vermont's Blueprint for Health. Patient-centered medical homes, health care homes and behavioral health homes in some states incorporate CHWs as members of patient-centered teams. Established funding arrangements for these delivery model innovations, some with capitated, tiered approaches, can help cover CHW services such as care coordination.

Operating Budgets

Evidence-based CHW programs like IMPaCT at the University of Pennsylvania Center for CHWs have become recognized as effective approaches to managing diverse, at-risk populations whose health is impacted by poverty, low literacy, unstable and unsafe housing and other factors. By improving care transitions, reducing costly hospital admissions and readmissions and enabling clinical members of the team to work “at the top of their licenses,” these programs have been shifted from grant support to general operating support under their health system’s annual operating budget, based on their valuable results.

Community Benefit Funds and other Funding Streams

Around the U.S., some hospitals are directing their community benefit funds to support CHW programs. Findings from community health assessments may be used to identify gaps that CHWs can most effectively fill. While CHW employment is on the rise in the health care sector, it is important to remember that CHWs also work in a wide variety of community-based settings including public health, schools, social service agencies, affordable housing, and programs for the elderly. Targeted funding streams available in these systems offer potential for CHW support.

Looking ahead, prospects for sustainable CHW financing are favorable in the context of new payment reform models. According to a federal official attending a meeting of policymakers convened by the National Academy for State Health Policy, “incorporating CHWs into team-based models of care has the potential to augment CHWs’ role in emerging value-based and bundled payment models and minimize the reliance on grant funding to support CHW initiatives” (National Academy for State Health Policy, Nov 2015).

Under value-based purchasing arrangements, state and private payers will prioritize investments in programs that simultaneously manage costs and provide optimal outcomes for patients, including underserved and most at-risk populations. Well-designed CHW programs offer potential to help accountable care organizations and other providers operating under risk arrangements to achieve key cost and quality benchmarks on which reformed financing methods will be based. During the current transition from volume-based care, CHW programs will need to continue to operate under a variety of funding mechanisms and incentives while advancing health equity and the Triple Aim.

Minnesota Trends

2007 statutory authority for CHW patient education services and care coordination put Minnesota on the map as a pioneer in Medicaid coverage for the CHW role. However, this financing option proved to be ahead of its time as CHW hiring by the health care market lagged behind for a variety of reasons. With the roll-out of the Affordable Care Act, Minnesota’s health care home initiative and the state’s SIM award, CHW programs have grown in size and number. CHW strategies are promoted and funded in the state’s Accountable Communities for Health

initiative and at least two of the state's IHPs (Medicaid ACOs) employ CHWs (Nathan Marocco, Assistant Commissioner, Minnesota Department of Human Services, Fox 9 News).

Last year, meetings between the Minnesota CHW Alliance and its partners and the Minnesota Department of Human Services (DHS) to address needed modifications and expansions to current CHW payment policy led to an increase in the monthly cap on CHW patient education services. In 2016, anticipated progress on needed improvements will require the engagement of CHWs, stakeholders, MDH, and DHS.

Evaluation and Metrics

Over the past five years, the number of articles on CHWs published annually has nearly doubled and the quality of research has improved. Nearly 400 randomized controlled trials have been published since 2010 (Kangovi et al, 2015). This growing evidence base is critical to the wider adoption of CHW services in health and social services settings by identifying CHW effectiveness in advancing the Triple Aim and health equity.

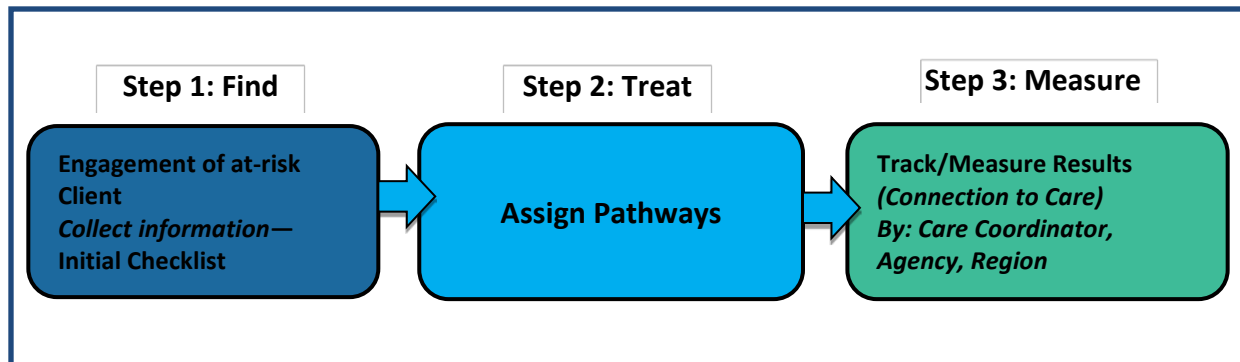
For example, according to the Centers for Disease Control and Prevention, evidence that supports the involvement of CHWs in the prevention and control of chronic disease continues to build. Results point to the role of CHW interventions in improved cancer screening rates, diabetes management, asthma outcomes and other quality indicators that are measured by the National Commission for Quality Assurance (NCQA) and its Healthcare Effectiveness Data and Information Set (HEDIS). The US Community Preventive Services Task Force has issued findings and recommendations in support of interventions that engage CHWs to prevent cardiovascular disease (CDC, 2015). A rigorous review conducted in 2013 by the Institute for Clinical and Economic Review found that “the majority of published studies shows positive impact on health outcomes and/or resource utilization relative to limited interventions or usual care” (ICER, 2013). CHW strategies have also been found to be effective in helping providers meet the US Office of Minority and Multicultural Health’s National Standards for Clinically and Linguistically Appropriate Services for Health and Health Care (CLAS).

This trend is in the right direction. Among key recommendations from a recent convening of state and federal officials is that “Improved data collection on CHWs is necessary to determine workforce size and training needs, inform payment policy and measure return on investment and impact on health care quality” (NASHP, 2015). CHW effectiveness research points to savings related to reduced emergency room use, reduced hospitalization rate, fewer hospital readmissions and reduced nursing home placements (Hostetter and Klein, 2015). A review of recent ROI studies shows an average return of 3:1 (Rush, 2016).

And while state and federal policymakers tend to share the view that CHWs are integral to health system transformation, NASHP reports tension between states’ desire for flexibility in defining CHW roles and the federal need to collect standardized data on CHW workforce to inform policy and workforce analysis (NASHP, 2015).

Among various CHW approaches, Pathways Community HUB is an evidence-based regional CHW care coordination model that has gained national recognition for its focus on at-risk populations, measurement, pay for performance, and strong results for birth outcomes (Redding, 2015) and chronic conditions. Featured by the Federal Agency on Health Care Quality and Research, the HUB model was originally piloted and evaluated in Ohio and then replicated in Michigan, New Mexico and other states. Ongoing support is provided by a variety of sources including Medicaid managed care plans such as United Health Group and Blue Cross affiliates. Figure 1 below illustrates the model.

FIGURE 1. THREE PRINCIPLES OF PATHWAYS COMMUNITY MODEL



Created by Redding, S. (2010). Score Card Pilot Results. Retrieved from the [Agency for Healthcare Research and Quality](#) 2010 conference presentations.

Minnesota Trends

Minnesota features key CHW building blocks and is home to a growing pool of CHW certificate holders. With the growing uptake of the role in clinical and community-based settings, Minnesota-based researchers are beginning to focus on the CHW field. Results are now available from a 2014-2015 Clinical and Translational Science Institute (CTSI)-funded pilot study undertaken by the University of Minnesota in partnership with the Minnesota CHW Alliance on the drivers of health care home team composition including teams that employ CHWs. And a published study by the Minneapolis Health Department reported on a comparison of results of prenatal psychosocial risk screening interviews administered by nurses and CHWs (Godecker, 2013).

While there are only a few examples of Minnesota-focused CHW research to date in the burgeoning peer-reviewed literature, many CHW employers such as Essentia Health, Ely; HealthEast Care System, St. Paul; Hennepin County Medical Center, Minneapolis; Mayo Clinic, Rochester; NorthPoint Health and Wellness, Minneapolis; and WellShare International, Minneapolis conduct and often share program evaluation that has shown positive results and

fostered stronger support for CHW services. In light of this phenomenon in our state and across the nation, the published CHW literature trails real-time CHW progress and results.

On a related front, the Twin Cities-based Medtronic Foundation has launched a major new global initiative called HealthRise that will demonstrate and evaluate the impact of frontline health workers including CHWs on chronic health conditions such as diabetes and heart disease. A comprehensive evaluation of the three Minnesota grantees will be conducted by the Institute for Health Metrics and Education at the University of Washington.

In addition, the Minnesota Department of Human Services has contracted with researchers at the State Health Access Data Assistance Center (SHADAC), which is located within the University of Minnesota's School of Public Health, to perform an evaluation of Minnesota's Accountable Health Model being implemented through the State Innovation Model (SIM) Initiative. The evaluation will document and examine the activities completed under the Emerging Professions Grant Program, the variety of approaches taken by the six grantees that received seed funding to hire and integrate a CHW into their organization, opportunities for continuous improvement, how the grant program has advanced the state's goals, and lessons learned for sustaining efforts beyond the SIM award. For more information on SHADAC's evaluation, visit the [Minnesota Department of Human Services](#) website.

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