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EXECUTIVE SUMMARY

Minnesota has been at the forefront of health system reform for over a decade – the state has pursued statewide health reform to increase access to care for underserved and vulnerable populations, as well as for individuals in rural parts of the state, and improved population health by integrating health and social services and fostering cross-sector partnerships. In Minnesota’s 2008 healthcare reform legislation, it included language to support the development of primary care workforce opportunities statewide. Additionally, through multiple state and regional programs, the state has addressed access to primary care and related services issues using a team-based care model or using complementary skill sets in multidisciplinary settings.

As part of these efforts, Minnesota developed two related, but distinct, programs in response to the state’s primary care access needs. First, the community health worker (CHW) program was formed to address health and related service needs and identify outcome disparities as a function of cultural and language barriers, which have increased due to a growing refugee and migrant worker population in Minnesota’s urban centers and rural communities. In addition, persistent and preventable health inequities among low income Minnesotans, particularly among African American and American Indian communities, gave impetus to CHW field-building to address primary care access issues. Second, the community paramedicine (CP) program was created in response to the persistent shortage of primary care providers in rural Minnesota, resulting in inappropriate emergency department utilization and its associated high costs and poor clinical outcomes.

The Minnesota Department of Human Services (MDHS), who oversees the Medical Assistance (Medicaid) program, and the Minnesota Department of Health (MDH) partnered to develop and implement these policies. Both agencies worked together to draft the legislation in collaboration with external partners. During implementation, Medicaid focused on reimbursement policies, while MDH’s Office of Rural Health contributed subject matter expertise to develop the statewide CHW curriculum and other resources.

In both the CHW and CP programs, advocates and officials from the public health and Medicaid arms of Minnesota’s state government worked to:

- Establish model standardized curricula and a certificate process that is required for CHW billing.
- Enact payment legislation.
- Modify administrative rules at the state and federal levels.
- Create increased awareness through public engagement and community organizing.

Thus, Minnesota recognized the essential role of adequate professional preparation and training in these programs. This cultivation and professionalization of community-based providers has helped Minnesota strengthen its relationships with underserved and vulnerable populations, as well as local communities and providers, while providing improved communication and access to appropriate healthcare services to connect with diverse communities.
Despite these successes, these programs did face challenges in their development and implementation. As with CHW programs in other states, there was occupational sensitivity on behalf of other health professionals about the role of CHWs. Additional challenges for the CHW program included maintaining forward progress in the complex state plan amendment (SPA) process, navigating billing structures within federally qualified health centers and public health centers, and addressing barriers to CHW employment (e.g., limits on billable CHW hours, size restrictions for group education, and lack of reimbursement of care coordination services due to unclear definitions of these types of CHW services). Like the CHW program, the CP program also had to carefully define the scope of practice and worked with professional groups to avoid potential “turf wars.” MDHS and MDH have been able to address a number of these barriers, but are working to make progress on others. A key lesson learned from both initiatives was the importance of bridging the divide between public health and Medicaid to address implementation barriers (e.g., complex billing and SPA processes).

While evidence is still emerging of these programs’ outcomes, the sustainability provided through the policy tools used, notably Medicaid SPAs and statutory changes, will allow the state to fully evaluate each program over time.
## Glossary of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACO</td>
<td>Accountable Care Organization</td>
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<td>ACA</td>
<td>Affordable Care Act</td>
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<td>APHA</td>
<td>American Public Health Association</td>
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<td>ASTHO</td>
<td>The Association of State and Territorial Health Officials</td>
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<td>BCBSM Foundation</td>
<td>Blue Cross and Blue Shield of Minnesota Foundation</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<td>CHIP</td>
<td>Children's Health Insurance Program</td>
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<td>CHEC</td>
<td>Community Healthcare and Emergency Cooperative</td>
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<td>CHW</td>
<td>Community Health Worker</td>
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<tr>
<td>CP</td>
<td>Community Paramedic</td>
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<tr>
<td>ED</td>
<td>Emergency Department</td>
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<td>EMS</td>
<td>Emergency Medical Services</td>
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<td>EMT</td>
<td>Emergency Medical Technician</td>
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<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
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<tr>
<td>HCTTF</td>
<td>Health Care Transformation Task Force</td>
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<td>HEIP</td>
<td>Healthcare Education-Industry Partnership</td>
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<td>HPSAs</td>
<td>Health Professional Shortage Areas</td>
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<td>HRSA</td>
<td>Health Resources and Services Administration</td>
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<td>IHP</td>
<td>Integrated Health Partnerships</td>
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<td>IRCP</td>
<td>International Roundtable on Community Paramedicine</td>
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<td>MA</td>
<td>Medical Assistance</td>
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<tr>
<td>the Alliance</td>
<td>Minnesota Community Health Worker Alliance</td>
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<td>MDH</td>
<td>Minnesota Department of Health</td>
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<td>MDHS</td>
<td>Minnesota Department of Human Services</td>
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<td>MHCP</td>
<td>Minnesota Health Care Programs</td>
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<tr>
<td>MnSCU</td>
<td>Minnesota State Colleges and Universities System</td>
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<td>MSU</td>
<td>Minnesota State University</td>
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### Glossary of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>NFME</td>
<td>National Fund for Medical Education</td>
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<td>ORHPC</td>
<td>Office of Rural Health and Primary Care</td>
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<td>ROI</td>
<td>Return on Investment</td>
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<td>SIM</td>
<td>State Innovation Models</td>
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<td>SIM-EPLC</td>
<td>SIM Emerging Professions Learning Community</td>
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<td>SPA</td>
<td>State Plan Amendment</td>
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INTRODUCTION

Project Overview
With support from the de Beaumont Foundation, ASTHO has created a series of six case studies designed to describe successful collaborations between state public health departments and Medicaid agencies in which a state implemented an innovative policy change. For the purpose of this series, success is defined as demonstration of—or evident promise of—improvements in population health, cost savings to Medicaid, or both.

ASTHO and the de Beaumont Foundation convened a diverse expert group in May 2014 and provided essential guidance in choosing the programs featured in the series of case studies. This case study describes the innovations undertaken in Minnesota to address health inequities and access to primary care through development and support of emerging professions.

The de Beaumont Foundation
The de Beaumont Foundation believes that a strong public health system is essential. The foundation works to transform the practice of public health through strategic and engaged grant-making. Programs funded by the foundation build the capacity and stature of the public health workforce, improve public health infrastructure, and advance the distribution and relevancy of information and data in the field. Please visit www.debeaumont.org for more information.

ASTHO
ASTHO is a 501(c)(3) nonprofit membership association serving the chiefs of state and territorial health agencies and the more than 100,000 public health staff that work in those agencies. Its mission, from which its organizational strategy flows, is to transform public health within states and territories to help members dramatically improve health and wellness. ASTHO tracks, evaluates, and advises members on the impact and formation of policy—public or private—pertaining to health that may affect state or territorial health agencies’ administration and provides guidance and technical assistance to its members on improving the nation’s health. ASTHO supports its members on a wide range of topics based on their needs, including, but not limited to, ASTHO’s leadership role in promoting health equity, integrating public health and clinical medicine, responding to emergencies, and bringing voluntary national accreditation to fruition through the Public Health Accreditation Board. Please visit www.astho.org for more information.
METHODS

Interviews
The project team, consisting of Lisa Dulsky Watkins, Brian Costello, and Megan Miller, interviewed eight individuals involved in the development and implementation of Minnesota’s primary care workforce innovations in the following roles:

- Two officials from Minnesota’s Department of Human Services (Medicaid), including medical and policy leadership.
- Two program directors and a policy analyst at the Minnesota Department of Health (MDH).
- One community health worker (CHW) advocate and one CHW expert.
- One advocate for emergency medical and trauma services.
- One physician in private practice.

A project team member, Lisa Dulsky Watkins, led forty-five minute to one-hour phone interviews using identical questions from a standardized interview tool. Two additional team members served as note-takers, listening to and documenting each conversation. The interviews were recorded and, if necessary, transcribed for clarification. Data gathered from each interview was recorded into a data collection tool for analysis.

Document Review
With assistance from the interviewees and through independent research, the team collected government resources, news articles, and educational material on the case study topic. Project team members selected the most relevant documents for further review. All documents are listed in the references.
DATA MANAGEMENT

Data Synthesis
The project team developed three tools to facilitate data collection for the case studies: (1) the interview instrument, (2) the interview data collection tool, and (3) the document review data collection tool. These items are located in the appendices.

The interview instrument (see Appendix 2) included a structured set of questions designed to address the domains of interest suggested by the expert group (see Appendix 1), and focused on three primary domains: the interviewee’s interaction with the policy change, the processes by which the policy change was implemented, and the impact of the policy change. Following each interview, the two note-takers entered their notes into the interview data collection tool (see Appendix 3), which designated where content from the interview fit best into the various coding categories. Next, the two note-takers collaborated to create a consensus document for each interview. To do this, they compared summary documents and reached agreement regarding any discrepancies in their accounts of the content of the interview and categorization of the content. The primary interviewer then reviewed the consensus document. The team created a similar tool to gather information from documents reviewed for each case study (see Appendix 4). The document was double-coded by two researchers and reviewed by a third, primary researcher.

Data Analysis
The project team entered interview content and consensus data collection tool documents into NVivo 10 (QSR International, Cambridge, MA), a qualitative research software, assigning codes and reviewing the content from the interviews and documents. These codes facilitated organization and analysis for each case study in the series and the cross-case study analysis. The team used a multiple-case replication approach to examine major points of interaction between Medicaid and public health which resulted in (1) population health improvement or (2) Medicaid cost savings. Additionally, the team analyzed interview and document review data to examine points of convergence and divergence, with respect to the processes and drivers of several significant policy changes at the state and local levels.
MINNESOTA BACKGROUND

Demographics
In 2014, Minnesota had a population of nearly 5.5 million residents, with approximately 4.2 million living in urban areas concentrated in Minneapolis and St. Paul, as well as in Rochester, Duluth, St. Cloud, and Bloomington. Geographically, there are large rural areas of medically underserved communities across the state’s 80,000 square miles. Historically, Minnesota has had little ethnic or racial diversity, and in 2014, the United States Census Bureau determined Minnesota’s population to be 81.9 percent white, 5.7 percent African American, 5 percent Hispanic, 4.5 percent Asian, and 1.3 percent American Indian. The state’s demographics are changing with increasing immigrant and refugee movement that began over 20 years ago, especially into the state’s urban areas. Also, within the state, there is a rapidly aging population and high rates of poverty among its African American and American Indian communities.

Administrative Infrastructure
The Minnesota Department of Human Services (MDHS) manages the Medicaid program, Medical Assistance (MA), throughout the state. Within MDHS, the Minnesota Health Care Programs (MHCP) supports the broad umbrella of MDHS programs (e.g., MinnesotaCare, Minnesota Family Planning Program) for adults with low incomes who meet eligibility rules and may qualify for MA. MDH coordinates efforts with local public health agencies, tribal governments, and other organizations to improve the health of Minnesotans. MDH’s Office of Rural Health and Primary Care (ORHPC) tracks and analyzes the state’s healthcare workforce, including CHWs and community paramedics (CPs).

Healthcare Reform in Minnesota
Over the last decade, Minnesota has been at the forefront of state-led innovations in healthcare reform. The state managed multiple concurrent demonstrations and test programs that contributed to the primary care workforce enhancements described in this case study. An important turning point for the state occurred with the passage of the 2007 Omnibus Health and Human Services Budget Bill, which created the Governor’s Health Care Transformation Task Force (HCTTF) whose role was to “advise and assist the governor regarding activities to transform the healthcare system.” The task force was also charged with developing “a statewide action plan for transforming the healthcare system to improve affordability, quality, access, and the health status of Minnesotans.”

HCTTF, which included a multi-disciplinary group of leaders from business, healthcare, non-profit organizations, and the public sector, presented their recommendations to the Minnesota governor and the legislature in January 2008. These recommendations served as the backbone of the 2008 healthcare reform legislation.
Highlights of this legislation included:\(^{16}\)

- Increasing outreach of state healthcare programs.
- Promoting the use of “healthcare homes” (certified patient-centered medical homes) to improve care coordination.
- Establishing care coordination payments for healthcare homes from both public and private healthcare insurers.
- Developing a single statewide system of quality-based incentive payments for public and private healthcare entities.
- Requiring the assessments of healthcare cost savings compared to projected costs without reform.
- Submitting a study and report on shortage areas within the healthcare workforce.

In 2010, the Affordable Care Act (ACA) expanded health insurance coverage to previously ineligible Minnesotans.\(^{17}\) Medicaid coverage increased to 133 percent of the federal poverty level in 2013.\(^{18,19}\) In October 2011, Gov. Mark Dayton signed an executive order establishing a “Vision for Health Care Reform in Minnesota,” charging the HCTTF with developing strategies that improve the health of Minnesotans, increase access to care, reduce health disparities, and lower healthcare costs by developing payment reform initiatives that encourage preventive care and reward healthy outcomes.\(^{20,21}\)

There are other state-based programs that support the development of emerging professions more broadly. MDH and MDHS have jointly advanced the notion of accountable care organizations (ACOs), defined by the Robert Wood Johnson Foundation as “healthcare providers… organized into teams that together are responsible for the health of a given population and the costs of providing its care,” through the Minnesota Accountable Health Model.\(^{22,23}\) MDH and MDHS have been using its $45 million State Innovation Models (SIM) Initiative grant from the Centers for Medicare and Medicaid Services (CMS) to test the Minnesota Accountable Health Model. There is movement towards achieving the Triple Aim of improving the health of the population, enhancing the quality of care and patient experience, and reducing per capita healthcare costs.\(^{24,25,26}\) The Minnesota Accountable Health Model’s goal is to create “team-based, coordinated, patient-centered care that increases and facilitates access to medical care, behavioral healthcare, long-term care, and other services” for all Minnesotans.\(^{27}\)
The Integrated Health Partnerships (IHP) initiative is a joint effort by MDHS and MDH to develop, encourage, and examine novel care delivery efforts. IHPs – Medicaid ACOs – are designed to allow healthcare systems that achieve targets for cost and quality to share in cost savings. There are also 15 Accountable Communities for Health within Minnesota’s SIM framework to develop and improve coordinated healthcare, support systems, and population health within a geographic area (between traditional healthcare organizations and community-based social service and support organizations) or in a specific patient population. Finally, some SIM money funds the ORHPC-led efforts to advance the development of and monitoring of the impact of three emerging professional groups: (1) CHWs, (2) CPs, and (3) dental therapists and advanced dental therapists. These initiatives highlight these emerging professions’ ability to contribute to the team care models, which are integral to Minnesota’s Accountable Health Model.
THE PROBLEM - HEALTH DISPARITIES AND THE PRIMARY CARE WORKFORCE SHORTAGE

According to the United Health Foundation rankings in 2015, Minnesota was one of the healthiest states in the nation. Additionally, in 2014, Minnesota was ranked first in The Commonwealth Fund Scorecard on State Health Performance, which assessed state performances across 42 health indicators. The state is not, however, immune to the healthcare difficulties faced by the rest of the country, including health inequity and disparities, a shortage of primary care physicians and mid-level providers, and inappropriate use of emergency services. To address these issues, Minnesota explored potential solutions through emerging professions, and Minnesota thus expanded its primary care workforce through enhanced educational opportunities and Medicaid billing changes with legislative action as one step to address these systematic problems. In 2007, the state legislature authorized CHWs to participate in the Medicaid program, and, in 2011, authorized certification for CPs.

As noted above, the CHW and CP programs are both part of Minnesota’s multiple emerging professions programs. This case study examines the policy development, policy implementation, challenges, and outcomes of CHWs and CPs in Minnesota separately. While some aspects may be similar, this case study is not intended to compare and contrast these two programs.

Addressing Health Disparities and the Triple Aim with Community Health Workers

Although Minnesota is nationally recognized for the healthiness of its population, Minnesota’s immigrant population consistently endures worse health outcomes than other population groups in the state. Lack of access to care, poverty, language barriers, and structural racism are major contributors to the disparities in health outcomes.

Community Health Workers

Minnesota defines CHWs using the American Public Health Association’s (APHA) definition: “A 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 worker to serve as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build 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.”

Other areas of health inequity involve issues of poverty, limited education, childhood asthma, infant mortality and obesity rates, and delayed cancer diagnoses in African Americans, Hispanics, and American Indians compared to white Minnesotans.

Structural racism, as defined by MDH, is the:

“Normalization of an array of dynamics — historical, cultural, institutional, and interpersonal — that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and American Indians. Structural racism is deeply embedded in American society and is a potent factor leading to inequities in all major indicators of success and wellness. Structural racism is perpetuated when decisions are made without accounting for how they might benefit one population more than another, or when cultural knowledge, history and locally-generated approaches are excluded. When this happens, programs and policies can reinforce or compound existing race-based inequities.”

MDH believed that CHWs could address this lack of access to care in a culturally competent manner due to CHWs’ close ties to their communities. Through these ties, MDH believed that CHWs could build health literacy and self-sufficiency through targeted outreach, social supports, care coordination, health education, culturally appropriate care, and advocacy.

Multiple studies over the last 20 years have discussed the efficacy of the utilization of CHWs in addressing a lack of access to care and in preventing unnecessary healthcare costs across the nation. A 2003 study published in *Ethnicity and Diversity* focused on a CHW outreach program that served Medicaid patients with diabetes found a 40 percent reduction in emergency department (ED) visits, an average savings of $2,245 per patient per year, and improved patient quality of life. A 2006 study by researchers and staff affiliated with Denver Health found that for previously underserved patients who worked with CHWs, primary care and specialty care visits increased, and inpatient hospitalizations and urgent care use declined, resulting in a return on investment (ROI) of over two to one. Since 2010, the number of articles on CHWs published annually has nearly doubled, and nearly 400 randomized controlled trials have been published in the last five years.

A Health Resources and Services Administration (HRSA) study documents that CHW workforce development in the United States dates back to the mid-1960s. However, federal and state initiatives promoting CHW workforce development started to gain traction in the 1990s. The seminal 1998 National Community Health Advisor Study defined CHW competencies and has served as an important guide for over 17 years. In 1999, the Texas legislature passed a bill that led to the development of CHW pilot projects within its Medicaid managed care system and also to a feasibility study on standardization of training and certification. Following these efforts, Ohio passed CHW credentialing legislation in 2003. HRSA’s 2007 National CHW Workforce Study estimated a total of 85,879 CHWs nationally, with 1,920 in Minnesota. In 2010, the United States Department of Labor recognized CHWs as a standard occupation.
In Minneapolis, interest in CHWs stemmed from the recognition of an urgent need within Hennepin County Medical Center, the safety net hospital for Minnesota’s most populous county. One former hospital interpreter described a communications and facilitation need beyond providing language interpretation services. In 2002, the Blue Cross and Blue Shield of Minnesota Foundation (BCBSM Foundation) commissioned a statewide survey to evaluate the need for and utilization of CHW services. The BCBSM Foundation then held a forum for policymakers, educators, and healthcare representatives to discuss the results of the survey and the best mechanisms to advance the use of CHWs in Minnesota’s healthcare system. The BCBSM Foundation’s subsequent report the following year directed attention to the contributions of CHWs and the training challenges facing their employers.

**Addressing Primary Care Workforce Shortages with Community Paramedics**

HRSA has projected that without significant changes to the delivery system, there will be a national shortage of 20,400 primary care physicians by 2020. In Minnesota, 50.9 percent of counties were designated as primary care health professional shortage areas (HPSAs) in 2010. Rural areas are becoming disproportionately affected by this catastrophic shortage, and, in 2012, HRSA reported that nationally approximately 65 percent of primary care HPSAs are rural. A case study interviewee stated “It’s become clear that although we need more primary care in rural areas, no doctors are going out to these areas to do this work. Nurse practitioners and physician assistants weren’t available either. We needed to think outside of the box. One of the ways was to use [emergency medical services (EMS)] providers to provide this kind of care when they had downtime.”

Without ready access to primary care, patients and families face seeking services

**Community Paramedics**

CP is a new and evolving model of community-based healthcare in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources or enhance access to primary care for medically underserved populations. CP programs address specific local problems and take advantage of locally developed linkages and collaborations between and among EMS and other healthcare and social service providers.

at hospital EDs, resulting in higher costs and potentially inappropriate levels of care. A 2006 National Hospital Ambulatory Care Survey published by CDC found that, for ED patients whose triage status was known, approximately 39.4 percent could have waited at least one to two hours for care. These visits could occur at less costly alternative sites such as primary care practices, urgent care centers, or retail clinics, resulting in a cost savings of $4.4 billion annually. CPs can reduce non-emergent ED use by functioning “outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and enhance access to primary care for medically underserved populations.”

The development of CPs has been underway internationally for about 40 years. In 2003, officials in Nova Scotia, Canada implemented a CP model on two remote island communities where the population had no direct access to primary care. With the implementation of CP services that included emergency paramedic care as well as basic primary care, the island communities observed a decrease in hospital visits by 23 percent. Concurrently, policymakers in Australia, Scotland, and the United States were considering improving rural healthcare services through similar means. In 2005, the International Roundtable on Community Paramedicine (IRCP) convened its first annual conference in Nova Scotia to discuss independent efforts to expand the role or scope of paramedics to address the urgent need of increasingly elderly populations and overwhelmed rural healthcare services. Since then, these nations and others have worked to further develop CP models in rural areas. Gary Wingrove, chair of the rural EMS Issue Group for the National Rural Health Association and Government Relations and Strategist Affairs Specialist for Mayo Clinic Medical Transport in Minnesota, encouraged adapting the CP model for use in Minnesota, which advocates pursued.

The Problem - Health Disparities and the Primary Care Workforce Shortage
COMMUNITY HEALTH WORKERS - POLICY DEVELOPMENT

As Minnesota began developing its CHW policies, both advocates and policymakers recognized that “people were already doing this work.” These advocates and policymakers determined that in order for CHWs to combat the identified health inequities among vulnerable communities there needed to be standardized training for the profession, better recognition of CHWs’ importance, acknowledgement of CHWs as an emerging health profession, sustainability strategies, and peer support. With growing interest in the CHW role and its demonstrated impacts, in 2004 the BCBSM Foundation provided funding to Minnesota State University’s (MSU) Health Education Industry Partnership (HEIP). The HEIP helped develop the state’s model curriculum and major workforce development efforts, and engaged stakeholders in support of legislative and rule policy changes as described in this case study.

With funding from the BCBSM Foundation, the Wilder Research Center of the Amherst H. Wilder Foundation conducted CHW focus groups in 2003 and identified that there is a need for standardized education, peer support, and professional development among CHWs. Based on these results, the BCBSM Foundation spearheaded efforts to create a model competency-based educational program for CHWs, critical to foundational education, professional identity, and sustainable support. These efforts enabled MSU representatives from the Minnesota State College and University System (MnSCU), to visit the Community Health Worker Certificate Program at San Francisco State University to learn about their established CHW curriculum. Later that year, the BCBSM Foundation provided two-year grant funding to HEIP to develop and pilot the statewide curriculum for implementation through community colleges and other post-secondary schools in Minnesota. In 2005, HEIP received four additional years of funding through the Robert Wood Johnson Foundation Local Funding Partnership, which supported the Minnesota Community Health Worker Project and its statewide policy council.

In response to its 2003 survey and findings emphasizing the significance of establishing a CHW peer network for professional growth, the BCBSM Foundation provided a grant to the Minnesota International Health Volunteers, now WellShare International, to develop the Community Health Worker Peer Network. WellShare International organizes the Peer Network, which provides professional development opportunities through free “lunch and learn” workshops on various topics of interest to CHWs four to six times per year. In November 2007, WellShare International hosted the first statewide CHW conference with nearly 200 participants, demonstrating a groundswell of enthusiasm from a diverse group of stakeholders and participants.
Standardized education paved the way for sustainable payment strategies to support CHWs’ work. In 2005, the BCBSM Foundation contracted with the University of California-San Francisco Center for Health Professions’ National Fund for Medical Education to explore potential CHW payment models. Additionally in 2006, the BCBSM Foundation convened representatives from CHW organizations, the healthcare sector, and government agencies from around the state to discuss financing strategies. The broad-based partnership quickly expanded its focus on the development of scope of practice and a competency-based curriculum to other key and interrelated domains including sustainable funding.

The Minnesota Community Health Worker Project partners and allies mounted a successful legislative effort to gain coverage for CHW patient education and care coordination. The legislature heard testimony regarding the proposed language from CHWs and health system leaders. One advocate recalled noting a sense of increasing need and therefore urgency, stating “We needed to do something before it [health inequities] did something to us.” Financing through Medicaid reimbursement, coupled with the cost savings demonstrated with CHW ROI studies done in other states, allowed for critical and persuasive projected budget neutrality. The case was then made tangible through the attainment of a budget neutral fiscal note.

Later, the Minnesota Community Health Worker Alliance (the Alliance) was formed as an outgrowth of the work of HEIP and the Minnesota Community Health Worker Policy Council. The Alliance is a broad-based partnership of nonprofits, health providers, health plans, post-secondary schools, and public agencies committed to equitable and optimal health outcomes for all communities, and builds system and community capacity for better health through the integration of CHW strategies. Serving as a statewide catalyst, partner, resource, and expert, the Alliance focuses on:

- Building awareness of culturally-appropriate CHW services such as health equity strategies.
- Providing tools, technical assistance, and support for healthcare, public health, and social services design and delivery.
- Promoting leadership development, education, and research.
- Informing policy change.
- Supporting capacity-building.

CHWs were involved in the state advocacy efforts; meeting with key legislators to describe their role and its many impacts. Minnesota HF 1078 was passed and enacted into law in 2007, authorizing Medicaid payment for care coordination and patient education services by supervised CHWs who have either received a certificate from the MnSCU-approved curriculum or have had at least five years of supervised...
experience ("grandfathered in") working with a physician, registered nurse, or advanced practice registered nurse. Subsequent bills in 2008 (HF 3222) and 2009 (SF 1504) expanded the definition of approved supervisors to include dentists, certified public health nurses who are operating under the direct authority of an enrolled unit of government, and mental health providers. As this was a departure from the previously approved disbursement of federal Medicaid funds in Minnesota, a state plan amendment (SPA) was submitted to CMS for approval. The SPA included reimbursement only for patient education, unlike the legislation itself that authorized payment for care coordination, as well.

In late 2007, Minnesota received federal approval to reimburse services provided by CHWs. Unfortunately, however, the SPA did not include a clear definition of "care coordination," therefore lacking coverage for these services. A former official at MDHS said "We only requested coverage of health education... because there were three to four programs going through the SPA and this was the beginning of the medical home model and intensive care coordination. All of these other programs had explicit definitions of care coordination. This was not the case for the CHW legislation. ...We had to make sure that Medicaid claims were auditable. This is part of why you need to have a clearly defined definition of care coordination." The expectation on the part of MDHS was that CHW advocates would respond with a clear and meaningful definition of care coordination and pursue an additional SPA or other mechanisms that would allow Medicaid billing for care coordination. The challenge is defining and articulating the difference between the care coordination that is done within a patient education visit and care coordination done separate from patient education.

In introducing coverage for CHW patient education, MDHS opted to set a daily cap of two hours (four units) and a monthly cap of four hours (eight units) to patient education services provided by Minnesota CHW certificate holders for billing purposes. These restrictions were not based in statute and reflected concerns about repeating policies that led to a dramatic rise in claims for personal care attendant services. While the CHW and personal care attendant workforces are very different, placing caps on the new CHW service reflected MDHS’ historical concerns and lack of experience with CHWs in the workforce. The caps, along with low rates, limited payment to just one function in the broader CHW role, and CHW enrollment and billing challenges proved to place a damper on health provider uptake of CHW payment.

In January 2015, following over a year of conversations with CHW employers and prospective employers about their experience with MHCP’s payment policy and billing, the Alliance presented a set of coverage improvement recommendations. Subsequent discussions with MDHS have led to some progress and these discussions will likely continue.
COMMUNITY HEALTH WORKERS – POLICY IMPLEMENTATION

Although many health and social service providers have hired CHWs, integration of CHW services and use of the MHCP payment by Medicaid-eligible providers did not take off as quickly as expected. As of 2015, only a few CHW employers (e.g., clinics, hospitals, dental offices, local public health, and mental health providers) that offer services to Medicaid patients have billed for CHW services.\textsuperscript{118,119} This slower than expected growth could be due to health providers’ lack of familiarity with the CHW role and its benefits, along with provider enrollment issues, billing issues, and limited coverage. However, transformation developments supported by Minnesota’s SIM and CDC grants, implementation impacts of the ACA, and new forms of delivery (ACO and health home models) hold significant promise to further expand CHWs.\textsuperscript{120}

Federal approval made it possible for providers to bill Medicaid for patient education services provided by CHWs. According to a former MDHS employee, the rate that Medicaid pays CHWs is fair (nearly $20.00 per half hour) comparable to other professions, but the billing structure itself has created difficulties.\textsuperscript{121} One of the interviewees noted that the broad range of CHWs roles and responsibilities creates challenges and opportunities within the hospital system, seeing care delivery and communication improvement fitting into “many different pieces” of a hospital infrastructure.\textsuperscript{122} One interviewee acknowledged that there was no certainty about what to do after the payment legislation was in place, calling it a “first step.”\textsuperscript{123} Widespread use of MDHS CHW coverage policies have been impacted by a number of challenges that are discussed in the next section of this case study.
A summary of Minnesota’s CHW policy implementation is below.

Certificate of Completion
Minnesota does not have state CHW certification at this time. Instead, CHWs earn a certificate of completion from one of six post-secondary schools that currently offer the standardized curriculum. This certificate is recognized by MDHS for enrollment in MHCP and to bill for patient education and self-management services under clinical supervision. For more information visit the MN Provider Manual Section on CHWs.

Minnesota’s Community Health Workers Certificate Program

- Nation’s first statewide standardized competency-based CHW curriculum based in accredited post-secondary schools.
- The 14–credit curriculum leads to a certificate of completion that creates an educational pathway for students interested in a wide range of health and social services careers.
- The program is currently offered through a network of six post-secondary schools with daytime, evening, and weekend options, as well as in-person and online options, using adult learning and popular education approaches.
- CHW programs in additional schools are under development.
- The curriculum is comprised of three components: core competencies, health promotion competencies, and a required internship.
- Over 600 CHWs have either earned a certificate through the program or were grandfathered in under a time-limited period defined by statute.
- CHWs are required to have a certificate to enroll in MHCP and bill MDHS (fee-for-service Medicaid) or managed care plans for payment for CHW patient education services, individual or group specific training in order to receive Medical Assistance reimbursement.
- The program assures providers that CHWs have the appropriate education and training needed to provide CHW services.
- To be accepted in a certification program, candidates must have a high school diploma or GED.
Community Health Worker Roles

- Provide culturally appropriate health education, information, and outreach in community-based settings, such as homes, clinics, schools, shelters, local businesses, and community centers.
- Bridge the gap between communities and health or social service systems.
- Assure people have access to the coverage and services they need.
- Directly provide services such as informal counseling, social support, care coordination, and health screenings.
- Advocate for individual and community health needs.
- Job settings and responsibilities vary by job environment and can include: health, public health, social services, K-12 schools, behavioral health, oral health, housing, refugee resettlement, environmental health, faith-based organizations.

Common Community Health Worker Duties

- Assist individuals and communities to adopt healthy behaviors.
- Conduct outreach to serve hard-to-reach populations and help health organizations implement programs in the community that promote, maintain, and improve individual and community health.
- Coordinate services and help patients navigate health and social services.
- Provide information on available resources including coverage and connecting people to needed services.
- Provide culturally-appropriate coaching, patient education, social support, and informal counseling.
- Provide services such as first aid and blood pressure screening.
- Collect data to help identify community health needs.
- Support medication adherence.
- Help health teams better understand cultural beliefs and traditions related to health.

Community Health Workers - Policy Implementation

**Challenges**

In Minnesota, many of the challenges facing CHW implementation are related to the billing procedures and administrative challenges faced by providers and discussed in more detail below. Additionally, some of the other challenges are related to differences in Medicaid and public health culture, defining the roles of CHWs.

**Federally Qualified Health Centers (FQHCs):** FQHCs were some of the early adopters of CHWs, but could not separately bill for the basic patient education services provided by CHWs due to the FQHC billing structure. According to federal requirements, FQHCs receive an encounter rate for each Medicaid patient seen in their clinics; the encounter rate is a bundled payment intended to cover all services provided including CHW services. FQHCs providing CHW services did not receive an up-front higher encounter rate to cover CHW services, and it is a lengthy process to increase this rate. In addition, regulations prevent FQHCs from billing a fee-for-service rate for CHW services in circumstances where they bill using an encounter rate.

**Hospitals Absorbing the Costs:** Although hospitals have experienced difficulty billing for CHW services, they have an easier time absorbing the salaries of CHWs. Large hospitals can pay CHWs through incentive payments if they can demonstrate that hospitals realize cost savings as part of ongoing reform efforts in Minnesota. This type of financing requires more risk-taking than knowing that a profession can recoup its salary through direct billing. Some hospital systems have found that their CHW services produce a favorable ROI and other benefits, so they fund their programs out of their annual operating budget. In the course of a year, preventing several very costly hospital admissions or pre-term births can easily cover the salary and benefits of a CHW. As hospitals enter an era of accountability for readmissions, the use of CHWs may be more pertinent to their business models.

**Confusion at Public Health Centers:** Administrative guidelines established by MDHS called for Medicaid-eligible CHW employers to enroll CHW certificate holders with MDHS as non-billing providers. For the billing provider to properly bill for CHW services, the ordering supervisor’s national provider identifier must appear as the “pay-to” provider on the claim and the MDHS-issued, Minnesota-specific identification number (Unique Minnesota Provider Identifier or UMPI) given to the CHW certificate holder who delivers the service must appear under the “rendering provider” field on the claim. This mechanism created confusion at some local public health centers, which were less experienced in billing Medicaid. Although MDHS responded by conducting outreach and training to address the confusion, this has not led to an increased number of claims for CHW services.
Limit on the Number of Billable CHW Hours and Group Size for Group Education:
In implementing the statute and SPA, MDHS chose to restrict the number of hours that an entity could bill per CHW certificate holder per patient, limiting it to four 30-minute units in a 24-hour period and no more than eight units for an individual patient per month. Some potential CHW employers saw this limit as too low, and they were concerned that they would lose money if they hired CHWs. A former MDHS employee acknowledged that MDHS “did not get it right the first time,” but stated that “it is an iterative process and if there is an advocacy community pushing for change it can change. A persuasive argument can get Medicaid to tweak these billing processes. This is now just finally beginning to happen.” The interviewee postulated that perhaps CHW advocates did not fully flesh out how the business model would work and that “there has not been enough back-and-forth with the advocates following the initial legislative process. This is critical in an iterative process.”

Currently, Medicaid-eligible providers are limited to the number of units per day and per month they can bill per Medicaid recipient for diagnostic-related patient education and self-management services ordered by approved provider types and provided by CHW certificate holders who are enrolled with MHCP. Because of this, many potential CHW employers cannot financially justify bringing CHWs on board. In 2015, the Alliance and partners worked to address the cap on hours per month for education and patient self-management services including CHW-led diabetes-related group education, and an increase in group size was also proposed. As a result of this effort, which was strongly supported by MDH, MDHS raised the monthly cap to 24 units for a total of 12 hours, and has verbally agreed to increase the group size to 15 after originally being capped at eight. This success may open doors for other coverage improvements that will benefit Medicaid enrollees.

An interviewee said that “Not being able to bill for care coordination has slowed the growth of the profession [CHWs].” The interviewee added that in order to achieve an effective SPA that allows billing for care coordination services, CHW advocates need to present a clear definition of care coordination provided by a CHW and the relation of those CHW roles to other existing roles (e.g., the roles of providers associated with Minnesota Health Care Home program or Minnesota’s behavioral health home program for individuals with serious mental illness). Since the time of the original CHW legislation, other reform efforts have had clearer definitions of care coordination. Updating the CHW definition to be consistent with more recent reform efforts may be more likely to result in MDHS support for an updated SPA and result in the potential to not only bill for care coordination, but also other services such as patient advocacy and assisting a patient in getting access to care. The key is that each service needs a clear definition. In early 2016, CHW employer representatives met with MDHS with a prepared definition of CHW care coordination; however, agency officials reported that federal approval to update a SPA to add CHW care coordination as a covered Medicaid service is unlikely.
Bridging the Divide Between Public Health (MDH) and Medicaid (MDHS):
An MDH interviewee acknowledged that some of the CHW billing issues stemmed from a lack of understanding of the way that Medicaid works. Changing Medicaid billing procedures involves complex regulatory changes. Passage of the bill to allow for reimbursement was the first step, but there need to be subsequent activities to effect actual changes to billing. MDH staff and CHW advocates may not have been familiar with the complexities involved with implementation of billing procedures. When reimbursement for care coordination management was not included in Minnesota’s SPA, MDH and CHW advocates did not actively encourage MDHS to consider an additional SPA that would add the appropriate coverage. From a MDH perspective, an interviewee said “It is our problem if people are not being served.” From a MDHS perspective, another interviewee said it is the responsibility of the CHW advocates to continue to push for policy and billing protocol changes. An interviewee said “There were differences between the Medicaid [MDHS] and department of health [MDH] culture and the way that they operate.” A MDH interviewee recalled that a MDHS employee with experience at MDH counseled MDH staff on how to work with MDHS to influence change related to Medicaid billing and policy. It took several years for those involved to address the existing Medicaid policy and billing procedures, illustrating the need for better systems of leadership and discussions to understand each other’s positions and advocate for specific changes.

Clarifying the Role of CHWs: An interviewee stated that CHWs need to define their role themselves, and that “[T]he concept of CHW is so broad that it can be almost anything to anybody—dental, mental health, public health workers—they can work anywhere. In comparison to a nurse or home health aide, [CHWs] have not had that moment where they define their role and this creates difficulty. There is so much promise for the profession, but it needs to find itself.” In Minnesota and other states, broad-based partnerships including CHWs have defined the CHW scope of practice through legislation and also at the national level with the CHW Core Consensus Project, which is seeking to identify CHW core roles, competencies, and qualities. The Alliance is also focused on this work, ensuring resources are available from MDH’s emerging health professions unit.

Sequencing on Timing of the CHW SPA: A MDHS interviewee recalled that in 2009, CMS was considering a SPA to approve Minnesota’s Health Care Home under Section 2703 of the ACA. The Health Care Home SPA also involved care coordination, which was seen as a potentially redundant set of services in coordination with an updated CHW SPA for care coordination. Since the care coordination services were well defined for Heath Homes, MDHS staff opted not to request reimbursement for CHW care coordination.
Complexities of the SPA Approval Process: It is well known to state officials that the SPA authorization process is lengthy and complicated. It took nearly 18 months for CMS to grant Minnesota approval for its CHW SPA. As could be predicted when introducing a novel concept to a large governing body, there were many back-and-forth interactions that took time and communication. For example, before CMS streamlined the SPA approval process in 2010, CMS had 90 days to respond to a SPA request, and with each of their clarifying questions the 90-day time period started over.\textsuperscript{159,160,161}

Continued Dependence on Alternative Grant Funding: As discussed above, grant funding has supported CHW programs but grant funding is often unsustainable. Some health entities continue to rely on grants as an alternative to what is perceived as limited coverage and the cumbersome billing process.\textsuperscript{162} Also, for CHW employers that do not qualify as Medicaid providers, grant funding is often essential for operation. This reliance on grant funding negates the intent of the legislation, which sought to provide a sustainable financial model.\textsuperscript{163} Substituting grants, as with letting hospitals absorb costs, reduces the pressure on MDHS to modify their billing requirements, remove caps, and broaden coverage.\textsuperscript{164}

Continuing CHW Training: Minnesota CHWs learn how to advocate for their patients and navigate the healthcare system through the current MnSCU curriculum.\textsuperscript{165} CHWs frequently need additional training once on the job. This training often must be provided by employers. An MDH interviewee suggests that MDH could offer an open source curricula, which would offer more specific and focused training that could be conducted simultaneously with those enrolled in the current credentialing program or immediately following completion, proposing that a more sophisticated skillset could potentially increase the employability of CHWs.\textsuperscript{166,167}

Occupational Sensitivity: A CHW expert observed that “There has been some occupational sensitivity on the part of other health professions about the CHW role,” and added that for an emerging profession, “this is natural. Most physicians and nurses have not studied or worked alongside CHWs.”\textsuperscript{168} Interprofessional education opportunities could help prepare physicians, nurses, social workers, and other health professionals to work with CHWs and to help them better understand CHWs’ unique strengths and contributions to culturally-competent patient outreach, care, and education. In addition, qualitative research conducted by the University of Minnesota and the Alliance indicates that piloting the role in clinical settings enables clinics and other providers to gain exposure to the benefits of CHW integration—t o patients, the team, the health system, and the broader community.\textsuperscript{169}
COMMUNITY PARAMEDICS - POLICY DEVELOPMENT

Advocates developed the CP policy to get a better handle on escalating Medicaid costs, described as a budget item that was “continuing to go up with no end in sight.”

While CHW activity had its roots in addressing health inequities in minority, refugee, low income, and hard-to-reach populations, the CP program was primarily developed as a response to the inappropriate use of EMS and inadequate access to primary care in rural medically underserved areas. A physician close to the process recalled “As a result of my work in rural primary care, it’s become clear that no doctors are going out to these areas to do this work. Nurse practitioners and physician assistants weren’t available either. We needed to think outside of the box. One of the ways was to use EMS providers to provide this kind of care when they had down-time.”

As with the CHW policy development, CP advocates also initially addressed the lack of a standardized training curriculum for CPs. These advocates worked with organizations such as the IRCP and the Community Healthcare and Emergency Cooperative (CHEC) to adopt similar policies that were already in place in other parts of the United States and in other countries. There was early financial support from the administration through ORHPC, which funded a pilot program with Mdewakanton Sioux Health Services. The CHEC curriculum was used to train 10 experienced paramedics who were keenly interested in providing community-based services for non-emergency situations.

With an established CP pilot and a warm reception from elected officials, proponents, including the medical director of the pilot and members of the Minnesota Ambulance Association, advocated for legislation that would both recognize the new role of CPs and fund this provision of care. An interviewee close to the initiative identified several necessary elements for the legislative effort to be successful, including oversight and recognition by an EMS regulatory board and achievement of relevant and appropriate educational standards from an accredited institution.

There was some opposition from other healthcare providers regarding scope of practice, enough so that the legislative language was not introduced in 2010 as initially planned. Rather than moving forward without broad support, the advocates embarked on an 18-month-long process of dialogue and engagement, working closely with the College of Emergency Physicians, the Minnesota Medical Association, the Minnesota Nurses Association, the Minnesota Community Health Worker Alliance, and the Minnesota Ambulance Association. To achieve support, peer-to-peer advocacy was especially important in this time of consensus building. These professional groups worked collaboratively to provide feedback on the legislation, resulting in numerous drafts before crafting the final draft legislation that represented broad support from all parties involved.
This process was lengthy and painstaking, but was essential to the successful passage of the legislation. An interviewee said “You need to make sure that all of the stakeholders are on board before you move ahead. You need to be able to show your healthcare partners that this kind of paramedic can step up and fulfill this need, to complement the work of your healthcare partners. If you don’t, you’ll run into opposition - turf wars, and push back. All those ducks need to be in a row before you do it.” A MDH employee recalls that the development of the CP legislation relied on face-to-face structured meetings, with email and follow-up phone conversations. A physician close to the process spent time meeting with various professional associations, and found that a “peer-to-peer type advocacy” in which CP advocates “[utilized] already established relationships” proved imperative to bringing professional associations on board. Stakeholders and advocates in CP work have seen continued growth and interest in the CP model and have held public meetings. These public meetings have been well attended with representatives from Medicaid, MDHS, fire departments, health plans, and hospitals. A consultant and CP advocate claims that the meetings “help us grow and show what we are doing.”
COMMUNITY PARAMEDICS - POLICY IMPLEMENTATION

The Minnesota Legislature passed SF 119 in April 2011, designating and recognizing the certification of a new emergency medical technician—community paramedic (EMT-CP). CPs must have current certification as an EMT-P (paramedic), two years of full-time service as an EMT-P (or its part-time equivalent), and proof of completion of a CP training program from a college or university that has been approved by the board or accredited by a board-approved national accreditation organization. The law required the MDHS commissioner to consult with a work group of “emergency medical service provider representatives, physicians, public health nurses, community health workers, and local public health agencies” to determine what the law covered in terms of services and Medicaid payment rates. The law also required the MDHS commissioner to evaluate the impact of CP services on cost, quality of care, and coordination of care with healthcare home services.

The multi-disciplinary work group met three times and reached a consensus on EMT-CP services to be provided in January 2012, which was subsequently approved by the legislature. MDHS determined a rate for EMT-CP services by comparing the rates for defined services with that of similar professions and consulting with stakeholders. MDHS had multiple options for reimbursement including a flat rate for a service or a tiered rate with reimbursement based on the complexity of the patient encounter. One consultant involved with the rate determination process said that to cover costs and break-even, EMT-CPs need to bill at a rate of the equivalent of at least 50 dollars per hour. CP advocates leveraged positive relationships with MDHS staff and settled on a rate equivalent to 60 dollars per hour. Those close to the process cite this compensation rate as integral to the sustainability of the model.

The next step in the financing process was obtaining a SPA to authorize Medicaid reimbursement at the determined rate of 60 dollars per hour for these services. CMS staff responsible for assessment and approval were unfamiliar with the concept of paramedics providing traditional medical care in the home. MDHS conducted ongoing dialogue by conference call and document sharing to overcome CMS’ initial hesitation. MDHS submitted the SPA on Aug. 13, 2012, and CMS approved it on Feb. 25, 2013.

Following the Mdewakanton Sioux Health Services CP pilot program and the approved legislation, the Emergency Medical Services Regulatory Board certified 20 CPs in July 2012. In 2013, Hennepin Technical College and other Minnesota CP-training organizations decided to put forth almost $250,000 in funding from a 2012 grant through the Minnesota Job Skills Partnership program offered by the Minnesota Department of Employment and Economic Development to train an additional 100 CPs over the next three years. The original pilot program focused on training CPs for rural implementation; however, following the legislation and the SPA, interest for CPs spread to urban areas. North Memorial Hospital located near Minneapolis employed CPs in an urban setting and has seen considerable success through targeting congestive heart failure, diabetes, and mental health diagnoses.
A summary of the EMT-CP implementation as it stands, including the wide range of outpatient services delivered by EMT-CPs covered through the SPA, is below.

Community Paramedic Training

- The curriculum is 14 credits with 114 didactic hours and 196 clinical hours.
- Two sites offer the curriculum.

Community Paramedic Certification

- Emergency Medical Services Regulatory Board certifies CPs.
- Requirements: must be currently certified as a paramedic for two years of full-time service or its part-time equivalent, have successfully completed a CP education program through an accredited college or university, and practice under the supervision of an ambulance services medical director.
- CPs must complete 12 hours of continuing education in clinical topics approved by the ambulance medical director to maintain certification.
Community Paramedic Services

- Minor medical procedures
  - Minor suturing
  - Feeding tube insertion
  - Catheter replacement
  - Tracheostomy tube replacement
  - Wound care
  - Fluid replacement

- Laboratory services
  - Lab specimen collection and blood draws

- Assessments and referrals
  - Injury risk assessment including home safety and fall prevention
  - Oral health
  - Mental health
  - Ear, nose, and throat
  - Social evaluation

- Chronic disease care
  - Congestive heart failure, stroke, and hypertension
  - Diabetes care
  - Chronic obstructive pulmonary disease and asthma

- Other clinical care
  - 12-lead electrocardiograms
  - Respiratory services
  - Immunizations

- Care plan and hospital discharge follow-up

- Medication compliance and administration

Challenges

**Outreach:** Legislative outreach conducted by CP advocates has been critically important in securing broad support among members. However, it would have been more helpful for advocates to provide more education earlier in the process to enable the broad support of this legislation sooner.\(^{208}\)

**Approaching and Garnering Support from Other Payers:** Starting with Medicaid early on may provide a model for other payers to participate, although it limits the population of eligible patients to Medicaid beneficiaries. One interviewee suggested that approaching private health insurers immediately after legislation passage and implementation could have potentially brought them on board earlier.\(^{209}\)
OUTCOMES FOR COMMUNITY HEALTH WORKERS AND COMMUNITY PARAMEDICS PROGRAMS

Evaluation Methods
Minnesota is very early on in the evaluation stage of both the CHW and CP programs. The state is monitoring its progress by measuring training program access, numbers of CP and CHW trainees and hires, and public awareness. In small pilots, ROI analyses and clinical process metrics are available.

Additionally, SF 119 requires MDHS to conduct an evaluation to examine the effect of CP services on cost, quality of care, and coordination of care with healthcare home services. An employee with MDH noted that the CPs’ claims were just starting to come in as of early 2015, and the state evaluation process is still ongoing.

Access to Curricula and Training
MnSCU’s CHW certification program was the first statewide standardized competency-based CHW curriculum based in accredited post-secondary schools. Currently, six Minnesota schools offer this certification. A CHW expert notes “We have grown the network of post-secondary institutions offering the certificate program... We have had accomplishments to be proud of. We have a nationally-recognized model curriculum, included among benchmark programs and standards as part of the CHW Core Consensus Project, which also has been purchased by organizations outside of our state.”

SIM Emerging Professions Learning Community (SIM-EPLC):
In 2015, under Minnesota’s SIM grant, MDH funded Rainbow Research, the Paramedic Foundation, and the Alliance to develop the SIM-EPLC. This collaborative aims to contribute to the overall Minnesota Accountable Health Model Learning Collaborative by bringing together CHWs, CPs, their supporting healthcare teams, and stakeholders to learn from each other, share best practices, and build momentum for further collaboration and integration into Minnesota’s healthcare system. Since September 2015, SIM-EPLC members, including MVNA and North Memorial Health System, have been hosting learning community meetings to identify the distinctive and complementary roles of CPs and CHWs, as well as provide support and training to improve capacities of providers and community partners to deliver Triple Aim-quality care.

Outcomes for Community Health Workers and Community Paramedics Programs

Increases in Workforce
As of January 2015, over 600 CHWs in Minnesota completed the CHW certificate program training, and the number of CPs that have been trained and certified is expected to reach at least 150 by 2016. Medicaid billing for CPs has outpaced CHWs, which could be related to a number of factors including billing guidelines, payment levels, and policy resources. Additionally, billing disparities could be related to different integration challenges associated with the introduction of an entirely new role to most mainstream health providers and local public agencies in contrast to one that is built on an existing and well-respected clinical role.

Improved Disease Management
Determining the CHW workforce success in Minnesota can be measured in a number of ways including CHW success with disease management. One such indicator of CHW workforce success is determined by measuring the number of patients they support with diabetes management. According to a MDHS employee, a number of clinics are evaluated in part based on their outcomes with diabetes management. The best outcomes in these evaluations are community clinics that employ CHWs to provide educational services and care coordination.

Return on Investment
The lack of claims data makes it difficult for MDHS to evaluate the potential effectiveness of CHWs on the basis of the MHCP claims stream. An MDH employee said “I don’t think we’ve seen outcomes because we haven’t had a good enough implementation to see outcomes.” Evaluation of the MDH Emerging Health Professions grant program, which has funded both CHW and CP initiatives, would yield helpful insights and lessons for policymakers, providers, and the CHW and CP fields.

While the majority of Minnesota’s CHW employers do not currently bill Medicaid or managed care plans for their CHW services, many conduct evaluations of their CHW programs. For example, Hennepin County Medical Center has over 24 CHWs and HealthEast Care System has over 20 CHWs, and both providers collect evaluative data on their programs which have supported their continued growth and reflect the success of CHW interventions. Additionally, Mayo Clinic, Rochester experienced similar positive results using a co-supervisory CHW model; their Intercultural Mutual Assistance Program has since expanded in terms of hiring, site locations, and resources.
North Memorial Health Care internally examined its use of CPs, evaluating the number of inpatient visits 12 weeks prior to a patient’s first CP visit and 12 weeks after the patient’s first CP visit for 81 patients. The health system’s 2014 report showed a 48.3 percent reduction in inpatient visits after the first CP visit.\textsuperscript{224} Minnesota’s Integrated Health Partnerships initiative benefits healthcare providers who achieve certain benchmarks and reduce costs, and providers such as North Memorial Health Care share in the savings.\textsuperscript{225} North Memorial Health Care is one of six healthcare providers serving 100,000 Minnesotans that together spent $10.5 million less than projected in 2013.\textsuperscript{226} North Memorial Health Care received $800,000 from the state for successfully reducing costs, and attributes some of this cost savings to its CP program.\textsuperscript{227}

CONCLUSION

Minnesota has responded creatively to healthcare access and disparity issues through its CHW and CP workforce professional development programs. Savvy use of policy tools such as Medicaid SPAs and supporting legislation and grant programs, coupled with multi-stakeholder engagement and curriculum standardization, have brought both of these emerging professions to a new level of credibility and exposure.

Minnesota did face some challenges post-implementation particularly with CHWs. These challenges point to the need to build greater understanding of and support for CHW roles including CHW care coordination activities, addressing billing complexities, and improving coverage policies prior to launching the program. Not doing this may have contributed to the slower than anticipated utilization of CHWs given the workforce still has a relatively heterogeneous mix of recently certified and “grandfathered-in” service providers.

The Minnesota CP program, despite objections from other healthcare professional organizations, has seen both growth and increased acceptance as a viable mechanism for addressing primary care shortages, especially in rural regions of the state. Early results, although limited in scale, are encouraging, and the program is well-positioned for further expansion.

While evaluations of both programs are in the early stages of development from the standpoint of Medicaid claims data, and are currently lacking in robust data analysis, there is reason to be optimistic about their impacts on the achievement of the Triple Aim. Looking forward, under payment reform and systems transformation, CHWs and CPs are seen as integral components of models of care that achieve cost savings while improving patient outcomes. Their unique contributions will benefit Medicaid enrollees, the healthcare system, and the state Medicaid system. Greater communication and collaboration between advocates and leadership at MDH and MDHS offer the potential to accelerate CHW and CP integration in the next chapter of Minnesota’s workforce development initiatives.
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<td>Lisa Dulsky Watkins</td>
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<td>Frederick Isasi</td>
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<td>Paul Jarris*</td>
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<tr>
<td>Richard Jensen</td>
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<td>Laurel Karabatsos</td>
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<td>Sarah Linde</td>
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<td>Mike Maples</td>
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<td>Megan Miller</td>
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<td>Sharon Moffatt</td>
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### Appendix 1 - de Beaumont Medicaid-Public Health Expert Group Members

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<tr>
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<tr>
<td>Judith Monroe*</td>
<td>CDC Office of State, Tribal, Local, and Territorial Support</td>
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<tr>
<td>José Montero*</td>
<td>New Hampshire Department of Health and Human Services</td>
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<tr>
<td>Robert Morrison</td>
<td>National Association of State Alcohol and Drug Abuse Directors</td>
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<tr>
<td>Kelly Murphy</td>
<td>NGA</td>
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<tr>
<td>Karen Murphy*</td>
<td>The Centers for Medicare and Medicaid Services Center for Medicare and Medicaid Innovation</td>
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<tr>
<td>Kathleen Nolan*</td>
<td>National Association of Medicaid Directors</td>
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<tr>
<td>Catherine Patterson</td>
<td>de Beaumont Foundation</td>
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<tr>
<td>Harvey Perez*</td>
<td>Washington State Department of Health</td>
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<tr>
<td>Robert Pestronk*</td>
<td>NACCHO</td>
</tr>
<tr>
<td>Patricia Portzebowski</td>
<td>National Association for Public Health Statistics and Information Systems</td>
</tr>
<tr>
<td>John Robitscher</td>
<td>National Association of Chronic Disease Directors</td>
</tr>
<tr>
<td>Jeff Schiff</td>
<td>Minnesota Health Care Programs</td>
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<tr>
<td>Tom Schlenker*</td>
<td>San Antonio Metropolitan Health District</td>
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<tr>
<td>James Sprague*</td>
<td>de Beaumont Foundation</td>
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<tr>
<td>Deirdra Stockmann</td>
<td>The Centers for Medicare and Medicaid Services Center for Medicaid and CHIP Services</td>
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<tr>
<td>Hemi Tewarson</td>
<td>NGA</td>
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<tr>
<td>Carol Thornton</td>
<td>Pennsylvania Department of Health Safe States Alliance</td>
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<tr>
<td>Laura Tobler</td>
<td>National Conference of State Legislatures</td>
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<tr>
<td>Monica Valdes Lupi*</td>
<td>AASTHO</td>
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<tr>
<td>Rita Vandivort-Warren</td>
<td>HRSA</td>
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<tr>
<td>Kathy Vincent</td>
<td>AASTHO Consultant</td>
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<tr>
<td>Kristen Wan Rego</td>
<td>AASTHO</td>
</tr>
<tr>
<td>Amber Williams</td>
<td>Safe States Alliance</td>
</tr>
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</table>

*previously served as representative for organization on expert group
INTRODUCTION

Thank you for talking with me today. This interview is being conducted as part of a series of case studies that will reflect collaboration between Medicaid and public health that have yielded (or promise to yield) cost savings to Medicaid and/or improvements to population health. Do you have any questions at this time?

I would like to read a brief disclosure statement to you. If it sounds good, we’ll get started.

Disclosure statement: This interview will last for approximately an hour. As explained to you earlier, your participation is absolutely voluntary. You can decline to answer any question, and if you wish to discontinue your participation at any time during the interview process, please feel free to do so. With your permission, we would like to record this interview. This recording will only be used to confirm our notes, and will be deleted once the project is completed. Your identity will be confidential and any reports generated from this session will include only de-identified responses. Before verbally consenting to participate in this interview, I would like to make sure that you feel you understand the purpose of this project and have had the chance to ask any questions you’d like. If you do not have any questions, with your consent, we will begin the interview, and it will be recorded. (Consent)

In the course of this interview, we will be asking you several questions about [NAME OF POLICY CHANGE] which I’ll call “policy change” for short. The questions will include how the policy change started, how implementation happened, and what the outcomes have been.

1. What is your role in your agency, and how did you come to be aware of the policy change?

2. What was the problem the policy change sought to address?
   a. (Identify vision, mission and values)

3. In two or three sentences, could you summarize what the policy change was?

4. Thanks for the overview. As part of this case study, I’ll be trying to figure out when the various stages of the policy change occurred.
   a. Can you outline a timeline of the process?
   b. Were there any missteps identified during the implementation process you’ve described?
      i. How were they identified?
      ii. How were they overcome?
Appendix 2 - Interview Instrument

5. **What were the mechanisms of the policy change’s implementation?** The 2 areas we have already identified are engagement of partners and types of tools. If there were other mechanisms, please share them.

   a. Engagement of partners

      i. What external partners/stakeholders were engaged, and how? (Examples could include political, governmental and special interest groups, CMS, others.) Were they key to the process?

      ii. What internal partners and staff were engaged and primarily responsible? Were they co-located?

   b. Tools

      i. What methods of communication were used? Examples include face-to-face, conference calls, webinars, shared electronic files, public meetings

      ii. What kinds of policy tools were used?

1. Regulatory/statutory (State or local? Funded?)

2. CMS/Medicaid (Waiver, and what kind? State Plan Amendment? Other?)

3. Payer alignment

6. **There is commonly some kind of “course correction” over time in complex projects such as yours. Did this occur in your case?**

   a. Were the initial goals of the collaboration modified? If so, how?

   b. Were the original strategies significantly changed? If yes, describe.

7. **Evaluation**

   a. How did you measure outcomes of the policy change?

   b. Are there any outcomes attributable to that policy change?

   c. Is there funding dedicated to evaluation? If so, where does the funding come from (in-kind, etc.)?
8. **Sustainability**
   
a. Is there a mechanism in place to address sustainability?
   
i. If so, please describe. Has it been successful?

My final questions are about extrapolating from your experience with this policy change to others. I’m going to ask you to think about missteps, and how transferable you feel this policy change is to other locales.

9. **What from this process could be useful to other states or local entities considering similar approaches?**

10. **What was the impact of the type of policy vehicle on the implementation process?**

11. **In addition to the missteps identified earlier, if any, were there other things you might have done differently?**
   
a. If so, how were they identified?

b. How were these issues overcome?
### Appendix 3 - Interview Data Collection Tool

<table>
<thead>
<tr>
<th>Question number</th>
<th>Helpful hints</th>
<th>Question</th>
<th>Summary</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Take full notes here</td>
<td>Provide short summaries here, use quotation marks to indicate verbatim quotes, otherwise paraphrase.</td>
</tr>
<tr>
<td><strong>1.</strong></td>
<td></td>
<td>What is your role in your agency, and how did you come to be aware of the policy change?</td>
<td>Role</td>
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<td></td>
<td></td>
<td>Ignore role, focus on awareness</td>
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</tr>
<tr>
<td><strong>2.</strong></td>
<td></td>
<td>What was the problem the policy change sought to address?</td>
<td>Problem</td>
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<tr>
<td></td>
<td></td>
<td>Identify vision, mission, values</td>
<td></td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td></td>
<td>In two or three sentences, could you summarize what the policy change was?</td>
<td>Summarize policy change</td>
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<tr>
<td></td>
<td></td>
<td>Summarize policy change in as few distinct steps as possible</td>
<td></td>
</tr>
<tr>
<td><strong>4a.</strong></td>
<td></td>
<td>Can you outline a timeline of the process?</td>
<td>Timeline</td>
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<td></td>
<td></td>
<td>Critical. Report each step by month and year, if possible. Use numbered list</td>
<td></td>
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<tr>
<td><strong>4b.</strong></td>
<td></td>
<td>Were there any missteps identified during the implementation process you’ve described? How were they identified? How were they overcome?</td>
<td>Missteps</td>
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<tr>
<td></td>
<td></td>
<td>Separate responses into distinct misstep identification and solution (use semicolons)</td>
<td></td>
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<tr>
<td><strong>5.</strong></td>
<td></td>
<td>What were the mechanisms of the policy change’s implementation?</td>
<td>Mechanisms of Implementation</td>
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<td></td>
<td></td>
<td>The 2 areas we have already identified are engagement of partners and types of tools (below). If there were other mechanisms, please share them.</td>
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<tr>
<td>Question number</td>
<td>Helpful hints</td>
<td>Question</td>
<td>Summary</td>
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<td>5ai.</td>
<td>Use semicolons to separate distinct concepts</td>
<td>What external partners/stakeholders were engaged, and how? (Examples could include political, governmental and special interest groups, CMS, others.) Were they key to the process?</td>
<td>External engagement</td>
</tr>
<tr>
<td>5aii.</td>
<td>External to home agency (could include other governmental actors)</td>
<td>What internal partners and staff were engaged and primarily responsible? Were they co-located?</td>
<td>Internal engagement</td>
</tr>
<tr>
<td>5bi.</td>
<td>Internal to the home agency only</td>
<td>What methods of communication were used?</td>
<td>Communication methods</td>
</tr>
<tr>
<td>5bii.</td>
<td>Options include: face-to-face, conference calls, webinars, shared electronic files, public meetings</td>
<td>What kinds of policy tools were used?</td>
<td>Policy tools</td>
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<tr>
<td>6.</td>
<td></td>
<td>Did course corrections occur? Were the initial goals of the collaboration modified? If so, how? Were the original strategies significantly changed? If yes, describe</td>
<td>Course corrections</td>
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<td></td>
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<td>Modified goals, strategies, and tactics. Concise summaries</td>
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<td>7a.</td>
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<td>How did you measure outcomes of the policy change?</td>
<td>Measure outcomes/Evaluation</td>
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<td></td>
<td>Separate concrete impact measures from process measures</td>
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<tr>
<td>Question number</td>
<td>Helpful hints</td>
<td>Question</td>
<td>Summary</td>
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<td></td>
<td>Use semicolons to separate distinct concepts</td>
<td>Take full notes here</td>
<td>Provide short summaries here, use quotation marks to indicate verbatim quotes, otherwise paraphrase.</td>
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<td>7b.</td>
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<td>Are there any outcomes attributable to that policy change?</td>
<td>Attributable outcomes/Evaluation</td>
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<td>Yes/No, and what?</td>
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<td>7c.</td>
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<td>Is there funding dedicated to evaluation? If so, where does the funding come from (in-kind, etc)?</td>
<td>Funding for Evaluation</td>
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<td>Yes/No, and what kind?</td>
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<td></td>
<td>Is there a mechanism in place to address sustainability? If so, has it been successful?</td>
<td>Sustainability</td>
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<td>Yes/No, and what?</td>
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<td>9.</td>
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<td>What from this process could be useful to other states or local entities considering similar approaches?</td>
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<td>Focus on short phrases</td>
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<td>What was the impact of the type of policy vehicle on the implementation process?</td>
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<td>Make sure it’s attributable to vehicle specifically, otherwise “No Impact attributable” is OK</td>
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<td>11.</td>
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<td>In addition to the missteps identified earlier, if any, were there other things you might have done differently? If so, how were they identified? How were these issues overcome?</td>
<td>Missteps</td>
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<td></td>
<td></td>
<td>Will be combined with codes above. Separate responses into distinct misstep identification and solution</td>
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<td>Question number</td>
<td>Question</td>
<td>Summary</td>
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<td>1.</td>
<td>What was the problem the policy change sought to address?</td>
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<td>2.</td>
<td>What was the policy change?</td>
<td>Summarize policy change</td>
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<td>What was the timeline of the process?</td>
<td>Timeline</td>
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<td>What were the mechanisms of the policy change’s implementation?</td>
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<td>5.</td>
<td>What external partners/stakeholders were engaged, and how? (Examples could include political, governmental and special interest groups, CMS, others.) Were they key to the process?</td>
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<td>7.</td>
<td>What kinds of policy tools were used?</td>
<td>Policy tools</td>
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<td>8.</td>
<td>What was the impact of the type of policy vehicle on the implementation process?</td>
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<tr>
<td>9.</td>
<td>Is there a mechanism in place to address sustainability? If so, has it been successful?</td>
<td>Sustainability</td>
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<td>10.</td>
<td>How are outcomes of the policy change measured?</td>
<td>Measure outcomes/Evaluation</td>
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<td>11.</td>
<td>Are there any outcomes attributable to that policy change?</td>
<td>Attributable outcomes/Evaluation</td>
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Appendix 5: Community Health Worker Partners and Engagement

COMMUNITY HEALTH WORKER PARTNERS AND ENGAGEMENT

Federal Government

- Centers for Medicare and Medicaid Services (CMS)

National Non-Governmental Partners

- American Cancer Society
- National Fund for Medical Education at the University of California San Francisco, Center for the Health Professions
- Robert Wood Johnson Foundation
- SNG Research Corporation
- Amherst H. Wilder Foundation

State and Local Government

- Bloomington Division of Health
- Hennepin County Human Services, Minneapolis
- Hennepin County Medical Center, Minneapolis
- Minneapolis Health Department
- Minnesota Department of Health (MDH)
- Minnesota Department of Human Services (MDHS)
- Nobles County and Des Moines Valley
- Partnership4Health
- Saint Paul-Ramsey County Health Department

State, Regional, and Local Non-Governmental Partners

- Allina CoPilot Institute, Minneapolis
- American Indian Cancer Foundation, Minneapolis
- American Cancer Association, Midwest Division, Eagan
- American Diabetes Association, Minneapolis
- American Lung Association, St. Paul
- Bosnian Women’s Network
- Blue Cross and Blue Shield of Minnesota, Eagan
- Blue Cross and Blue Shield of Minnesota Foundation
- CAPI, Minneapolis
- Center for the Victims of Torture, St. Paul
Appendix 5: Community Health Worker Partners and Engagement

- CentraCare Health System, St. Cloud
- Centra Campesino
- Centre for Asians and Pacific Islanders
- Children’s Dental Services, St. Paul
- Children’s Hospital, St. Paul
- Comunidades Latinas Unidas En Servicio
- Community-University Health Care Center
- Confederation of Somali Community in Minnesota
- CLUES, St. Paul
- Community Dental Care, Maplewood
- Cultural Wellness Center, Minneapolis
- Deaf and Immigrant Center for Education, Eagan
- Delta Dental of Minnesota, Minneapolis
- Essentia Health, Ely
- Family Tree Clinic, St. Paul
- Generations Health, Duluth
- George Family Foundation Catalyst Initiative, Minneapolis
- Greater Twin Cities United Way, Minneapolis
- Halleland Habicht, PA, Minneapolis
- Health Advocates, St. Paul
- Health Equity Working Group, St. Paul
- HealthEast, St. Paul
- HealthFinders, Northfield
- HealthForce Minnesota, Winona (formerly HEIP)
- HealthPartners, Bloomington
- Healthy Northland
- HER Clinic, Minneapolis
- Indian Health Board, Minneapolis
- Institute for Clinical and Systems Integration, Bloomington
- Intercultural Mutual Assistance Association, Rochester
- Jewish Family Services, St. Paul
- Lake Superior Health Center*
- Lifetrack, St. Paul
- Mayo Clinic, Rochester
- Medica, Minnetonka
- Medtronic Philanthropy, Fridley
Appendix 5: Community Health Worker Partners and Engagement

- Minneapolis Urban League
- Minnesota Academy of Family Practice, Minneapolis
- Minnesota Area Agency on Aging
- Minnesota Chapter of the American Academy of Pediatrics, St. Paul
- Minnesota Better Birth Coalition
- Minnesota Black Nurses Association, Minneapolis
- Minnesota CHW Peer Network, Minneapolis
- Minnesota Commission on Deaf, Deaf Blind and Hard of Hearing
- Minnesota Community Measurement, Minneapolis
- Minneapolis Community and Technical College
- Minnesota Network of Hospice and Palliative Care, Minneapolis
- Minnesota Oral Health Coalition
- Minnesota Public Health Association
- Minnesota River Area Agency on Aging, Inc.
- Minnesota State College and University System, St. Paul
- Minnesota Targeted Home Visiting Coalition, St. Paul
- MN West, Marshall
- MVNA, Minneapolis
- National Alliance on Mental Illness Minnesota
- National Center for Healthy Housing
- Native American Community Clinic, Minneapolis
- Neighborhood HealthSource, Minneapolis
- Neighborhood House, St. Paul
- Nobles County Health Department, Worthington
- North Memorial Hospital, Minneapolis
- Northern Lights Mental Health Club House, Ely
- NorthPoint Health and Wellness, Minneapolis
- Normandale Community College, Bloomington
- Northwest Technical College, Bemidji
- Open Cities Health Center, St. Paul
- Open Door Health Center, Mankato
- Otto Bremer Foundation, St. Paul
- Paramedic Foundation
- Park Nicollet Medical Center, Minneapolis
- Pillsbury United Communities, Minneapolis
- Portico Healthnet, St. Paul
Appendix 5: Community Health Worker Partners and Engagement

- Rainbow Research, Minneapolis
- Ready, Set, Smile, Minneapolis
- Rochester Community and Technical College
- Sabathani Community Center, Minneapolis
- Saint Catherine University, St. Paul
- Saint Mary’s Health Clinics, St. Paul
- Saint Paul Foundation
- Saint Paul Public Schools
- Sanford Health, Bemidji
- South Central College, Mankato
- South Lake Pediatrics
- South Side Community Health Services, Minneapolis
- Stair Step Foundation, Minneapolis
- Stratis Health, Bloomington
- Summit Academy OIC, Minneapolis
- Sustainable Resource Center, Minneapolis
- Take Action Minnesota, St. Paul
- Twin Cities LISC
- Twin Cities Medical Society
- UCare
- UCare Foundation
- University of Minnesota Center for Clinical and Translational Research
- University of Minnesota Center for Public Health Outreach
- University of Minnesota School of Medicine
- University of Minnesota School of Public Health
- WellShare International, Minneapolis
- William Mitchell College of Law/Public Health Law Center
COMMUNITY PARAMEDIC PARTNERS AND ENGAGEMENT

Federal Government

- Centers for Medicare and Medicaid Services (CMS)

National and International Non-Governmental Partners

- Community Healthcare and Emergency Cooperative (CHEC)
- International Round Table on Community Paramedicine (IRCP)

State Government

- Minnesota Emergency Medical Services Regulatory Board
- Minnesota Department of Health (MDH)
  - Office of Rural Health and Primary Care (ORHP)
- Minnesota Department of Human Services (MDHS)
  - Health Services and Medical Management Division

State Non-Governmental Partners

- American College of Emergency Physicians
- Minnesota Ambulance Association
- Minnesota Community Health Worker Alliance
- Minnesota Home Care Association
- Minnesota Medical Association
- Minnesota Nurses Association

Regional and Local Partners

- Allina Ambulance
- Community paramedic course instructors
- HealthEast Care System
- Hennepin Technical College
- Local public health associations
- North Memorial Hospital
### Timeline

#### COMMUNITY HEALTH WORKERS

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>2003</td>
<td>• Wilder Research Center conducts CHW focus groups which identify peer support and professional development needs.</td>
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<td>2004</td>
<td>• The BCBSM Foundation launches initiative with HEIP to formalize and standardize CHW training.</td>
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<td>2005</td>
<td>• June: Robert Wood Johnson Foundation Local Funding Partnership grants HEIP funding for four more years.</td>
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<td>2006</td>
<td>• December: With funding from the BCBSM Foundation, NFME publishes a report discussing sustainable funding mechanisms for CHWs.</td>
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| 2007 | • May: Omnibus Health and Human Services Budget Bill passes, creating the HCTTF and expanding CHW abilities.  
• November: Minnesota International Health Volunteers hosts first CHW Conference in Minnesota.  
• December: Minnesota receives federal approval to reimburse CHW services. |
| 2009 | • May: Minnesota legislature passes bill (SF 1504) allowing mental health professionals to supervise CHWs. |
| 2010 | • March: ACA passes. |
| 2011 | • October: Governor signs executive order establishing a Vision for Health Care Reform in Minnesota. |
| 2014 | • October: Over 500 CHWs in Minnesota complete MNSCU-approved CHW programs. |
COMMUNITY PARAMEDICS

2007

• May: Omnibus Health and Human Services Budget Bill passes, creating the HCTTF and expanding CP abilities.

2008

• January: HCTTF presents plan and recommendations to Minnesota government.

• May: Health Care Reform legislation (SF 3780) to support the development of primary care workforce opportunities passes.

2010

• March: ACA passes.

2011

• April: Minnesota legislature passes law (SF 119) defining CPs and CP services covered.

• October: Governor signs executive order establishing a Vision for Health Care Reform in Minnesota.

2012

• January: Workgroup provides legislative report listing potential EMT-CP to be covered by medical assistance.

• July: Minnesota certifies 20 CPs and plans to certify 100 more by 2015.

• August: Minnesota submits SPA to authorize Medicaid reimbursement for wide range of CP outpatient services.

2013

• February: CMS approves SPA authorizing Medicaid reimbursement for CP outpatient services.

• February: CP training organizations announce use of Minnesota Department of Employment and Economic Development grant to train 100 CPs over next three years.

2014

• November: North Memorial Health Care reports a reduction of readmissions of almost 50 percent after CP intervention.