Community Health Worker program standards
A roadmap for the Commonwealth of Virginia

Final report for the Virginia Department of Health from the Penn Center for Community Health Workers

October 2021

EXECUTIVE SUMMARY

There is a growing body of evidence about the effectiveness of community health workers (CHW) in improving health outcomes, lowering health care costs and reducing health disparities. More recently, best practices are emerging about what types of program-level infrastructure help achieve these results. In light of the growing interest and investment in the CHW workforce in the state of Virginia, the Department of Health convened a 15-member advisory panel in a yearlong process to develop recommendations for program-level standards that could support high-quality CHW programs across the state. The panel ultimately recommended 14 components across 5 domains spanning hiring and compensation, training and professional development, supervision and evaluation, CHW work practice, and organizational supports and involvement in decision-making. Advisory panel members and other CHW stakeholders raised important considerations about the ability of all types of CHW-employing organizations to meet these standards, which can be explored more fully through a second phase of work focused on testing and refining the standards. Collaboration with the state Medicaid office, which is actively exploring a permanent source of CHW financing, will be critical to ensure there is a robust financing available to support organizations across all sectors to have sufficient resources to build and sustain effective CHW programs.

INTRODUCTION

Health inequity is a persistent problem all across the United States, including the Commonwealth of Virginia. Black, Brown and rural individuals are more likely to get sick and die than their white counterparts – and our country's recent reckoning with COVID-19 is only the most recent example. Inequity persists, in part, due to the tendency of our health care system to focus on treating people once they have become sick, rather than addressing the environmental, social and political conditions that often cause people to become sick in the first place. Despite tremendous advances in treatment for the deadliest diseases, health inequities by income, race, and ethnicity have persisted, and in many cases widened.[1]

Tackling these persistent health inequities requires addressing the underlying social drivers of health, and is most effective when we take a holistic approach that considers individual and community circumstances. It is further strengthened when we center and empower people who have experienced inequities – which is why there has been increasing increased capacity-building and organizational investments in the Community Health Worker (CHW) workforce across the country – and within the Commonwealth – in the past decade.

CHWS: THEIR ROLE, EVIDENCE OF THEIR EFFECTIVENES, AND CAPACITY-BUILDING IN VIRGINIA

CHWs, an umbrella term that includes Promotoras de Salud and Community Health Representatives, are a Department of Labor classified workforce that has existed in the United States for the past 80 years. Community Health Workers are not defined by a standard training or licensure, but rather by *who they are* and *what they do*. Community Health Workers are trusted individuals who share life experience with the people they serve and have firsthand knowledge of the causes and impacts of health inequity. CHWs find and meet people where they are, get to know their clients' life stories, and ask each client what *she thinks* will improve her life and health. Community health workers then provide tailored support based on these needs and preferences, which can range from battling eviction notices, organizing virtual funerals, educating expectant mothers, connecting people with high-quality primary care or advocating with policymakers for deeper systems change.

A growing body of evidence shows that CHWs support health behavior changes,[2,3] improve mental health[4] and control of chronic conditions,[2,5-7] improve patient-reported quality of care,[2] reduce hospitalizations and ED

utilization,[2,8-13] and improve health equity.[3,14] A 2019 study found that every dollar invested in a CHW intervention would return $2.47 to the average Medicaid payer.[15] This work happens across a variety of settings, including community organizations, health departments, managed care plans, mental-health centers, long-term care facilities and health systems.[16]

It is estimated there are nearly 900 CHWs currently working in Virginia[17]. The state has a robust statewide CHW association, and in recent years the state Department of Health and other key stakeholders have taken many steps to support the CHW workforce, including the formation of the Virginia CHW Workforce Development Council to promote the sustainability of CHW programs across the Commonwealth, and the creation of a certified Community Health Worker credential for individuals who meet specified training and experience requirements. In August 2021, Virginia received Coronavirus Aid, Relief, and Economic Security (CARES) funding, as part of more than $450 million in federal funding dedicated to strengthening the CHW workforce nationally. The state received more than $4.3 million, one of the largest CDC-funded awards, to expand the role and capacity of CHWs in supporting COVID-19 response and recovery in the Commonwealth and to explore innovative financing strategies to help build and sustain the CHW workforce long-term.

WHY STANDARDS?

With growing interest and investment in the CHW workforce, many states are considering optimal ways to support CHWs. Thirty-four (34) states, including Virginia, have adopted a statewide definition of CHWs, often based on the American Public Health Association definition of a CHW as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served." Nearly as many states, 33, have also recognized CHW core competencies, drawing frequently from the national CHW Core Consensus Project.[18] Additionally, many states have, or are in the process of creating, individual-level CHW trainings and certifications, including Virginia, which created a voluntary CHW certification in 2018. However, many CHWs and CHW groups have expressed concerns that such training-based certification may "weed out" natural helpers from within communities from pursuing the career path if they feel they are not good test takers or cannot afford training or certification costs. A 2020 Agency for Healthcare Research and Quality (AHRQ) study found no link between training-based CHW certification and improved patient outcomes. The AHRQ report interviewed CHWs and other stakeholders who reinforced the caution that these training-based certification programs could, in fact, discourage qualified people from becoming CHWs.[19]

As states and other stakeholders consider how to best support CHWs, the Crossing the Quality Chasm report, published by the Institute of Medicine in 2001, may provide help direction. As the report demonstrated, strong programmatic outcomes depend on the effectiveness of the systems in which they operate.[20] In recent years, best-practice guidance for CHW programs has started to emerge. Internationally, after recognizing that support for CHWs was uneven across and within countries and that best-practice examples were not consistently replicated, the World Health Organization (WHO) published evidence-based guidance on system-level supports to optimize the performance and impact of CHWs. A similar process is currently underway domestically, spearheaded by the National Committee for Quality Assurance (NCQA) and the Penn Center for Community Health Workers,[21] with a white paper on critical inputs for U.S.-based CHW programs scheduled to be released in late 2021.

Translating CHW best-practice guidance into program-level standards, which we define as a roadmap to help organizations put in place infrastructures, policies, and procedures to support high-quality care, has the potential to help achieve the goals of multiple stakeholders, including:

- Direct employers of CHWs across the state, who can use the standards develop program infrastructure to achieve better outcomes for their patients/clients
- State and commercial payers, who can incorporate the standards into conditions of participation, contract requirements or payment incentives, as well as other funders who are interested in ensuring their investments build sustainable and effective programs
- Community Health Workers, who can use the standards to advocate for working conditions most conducive to their success

APPROACH TO DEVELOPING STANDARDS FOR THE COMMONWEALTH OF VIRGINIA

To explore the value and potential approach to CHW program-level standards, the Virginia Department of Health (VDH) created an advisory panel of CHW stakeholders in May 2020. The panel included Virginia Community Health Workers, organizations that employ CHWs, and policymakers from the Departments of Health and Medical Assistance Services, along with national experts, to develop recommendations for program-level CHW standards for the Commonwealth. A list of advisory panel members is included in Appendix A.

The advisory panel met four times between June 2020 and February 2021, including a facilitated listening session with Virginia CHWs to understand their perspective on the system-level supports needed to do their best work. NCQA, a national leader in the development of quality standards and performance measures for a broad range of health care entities, provided guidance to the advisory panel regarding criteria for developing standards. NCQA's guidance included feedback that standards should be within the control of organizations and should be surveyable, in other words, standards could be effectively assessed through a participating organization's submission of documentation. NCQA also provided input on language and content of the standards, consistent with the way they develop standards for other health care entities.

After initial standards were drafted, members of the advisory panel completed a survey to provide feedback on: (a) the completeness of the draft standards (e.g. did they include the most important components for each domain), (b) the importance of each component to an effective CHW program, and (c) the feasibility of meeting each component. The survey revealed a strong consensus on the importance of 13 identified components (described below) and recommended an additional component for consideration (the 14th component, 'integration with care teams', was approved by the advisory panel in a subsequent meeting). Of the 10 advisory panel respondents, the majority ranked all components as 'very important' or 'important,' and the remainder ranked at least 75% of components as 'very important' or 'important.' Among advisory panel members whose organizations employed CHWs, 4 out of 5 members indicated that their organization could meet all components within 1 year or less. The final member agreed that their organization could meet most of the components within 1 year or less, indicating that two of these components could be completed in 1-3 years.

After the standards were revised to include feedback and input from the advisory panel survey, they were reviewed during regularly-scheduled meetings of both the Virginia CHW Association and the Virginia CHW Workforce Development Council, with opportunities for members to send written comments after the meetings.

Members of both organizations provided feedback that was incorporated into the final recommendations put forth by the advisory panel.

During the fourth and final committee meeting, the advisory panel suggested next steps for adoption of CHW program standards in the Commonwealth, including testing and refining the standards through a learning collaborative comprised of cross-sector CHW programs, discussed in more detail below.

A complete timeline of activities is included in Appendix B.

RECOMMENDED CHW PROGRAM STANDARDS

The advisory panel ultimately identified 14 components within 5 domains for CHW program standards, which are: hiring and compensation, training and professional development, supervision and evaluation, CHW work practice, and organizational supports and involvement in decision-making. A summary of the domains and components is below, with a detailed description available in Appendix C.

Recommended CHW Program Standards: Overview		
Domains	**Components**	**Description**
Hiring and compensation	CHW selection process	Organizations prioritize candidates who are from the same community and/or share life experience with the patients/clients they will support, and who demonstrate trust-building traits like empathy and strong listening skills
	Compensation	Organizations conduct or obtain a market analysis of CHW salaries and share that information with CHWs and CHW supervisors
Training and professional development	Initial CHW training	Organizations ensure that CHWs receive initial training that meets the education requirements for the Certified CHW Credential available in the Commonwealth
	CHW assessment, ongoing training, and professional development	Organizations assess CHWs on core competencies, provide ongoing training, discuss individual CHWs' career objectives, and outline a career ladder for growth within the CHW role
	Initial supervisor training	Organizations provide training to CHW supervisors on the unique identity and role of CHWs, how to provide effective and supportive oversight of CHW work, and how to use observation, performance data and community feedback to improve CHW performance
Supervision and Evaluation	CHW supervision	Organizations prioritize supervisor candidates who have previous community health, public health, or social work experience and ensure CHWs have a single (as opposed to multiple) supervisors. They also require that CHWs meet regularly with their

		supervisor to review patient/client cases and receive an annual performance evaluation
	Performance evaluation	The organization assesses CHW performance based on clearly defined benchmarks, including patient/client feedback, and shares the results of the performance assessment with CHWs
CHW work practice	CHW role	Organizations define the scope of the CHW role, including that it's holistic, person-centered, and focused on understanding and addressing patients'/clients' health-related social needs. The materials should adapt evidence-based work practices and include defined durations, processes for identifying and addressing patients' social needs, and documenting CHW work.
	Integration with care teams	Organizations outline the scope of work and responsibilities of CHWs relative to other care team members and provide guidance on communication and coordination regarding patient care and referrals
	CHW caseloads	Organizations specify appropriate caseload sizes, taking into account the CHW role, the geographic reach of CHWs, and the complexity of patient/client needs
	Emergency situations	Organizations detail how they communicate and make decisions during emergencies and provide instructions to CHWs about how to handle patient/client emergencies during and after hours
	CHW safety	Organizations have procedures to protect CHW safety, including how to track when CHWs are conducting home visits and processes for identifying and resolving concerns related to CHW safety
Organizational supports and involvement in decision-making	Professional supplies	Organizations routinely review with CHWs the equipment and supplies they need, such as a work phone, a computer with internet, a directory of local resources, and personal protective equipment (PPE) during public health emergencies, and then ensure it is available
	Involvement in organizational decision-making	Organizations actively involve CHWs in decision-making processes about their role and working conditions, including compensation, training, caseloads, work practices, equipment and supplies, as well as decision-making processes related to advancing racial and social justice and equity within the organization.

DISCUSSION AND RECOMMENDED NEXT STEPS

Across advisory panel members, there were a number of strongly endorsed concepts that were incorporated into their final recommendations. These included valuing CHWs' lived experience more than formal education, requiring completion of training that corresponds to the education requirements for the Certified CHW Credential, defining the scope of the CHW role to emphasize the non-clinical nature of their work, providing CHWs necessary supplies such as PPE during public health emergencies, and ensuring CHWs are involved in decisions that affect their work, including compensation, training, and caseloads.

When the advisory panel explored the best way to implement the 14 components they ultimately endorsed, a key consideration emerged regarding the need to ensure all organizations across the state could meet the standards. During advisory panel discussions and in meetings with the Virginia CHW Association and Workforce Development Council, four specific concerns were raised.

First, stakeholders wanted to ensure that a broad range of CHW-employing organizations (e.g., organizations of varying sizes across sectors) could consistently meet these standards. This discussion was especially salient within advisory panel discussions regarding community-based organizations that often have fewer resources than healthcare organizations. For example, although many CHWs – both members of the advisory panel and members of the Virginia CHW Association – described the importance of professional development opportunities for CHWs, other advisory panel members cautioned that smaller organizations may not be able to provide regular salary increases given their reliance on grant funding that precludes year-over-year budget increases or create a career ladder given small staff sizes. In addition, integration with healthcare teams may also be difficult for all organizations to meet in the absence of strong cross-sector partnerships between community-based and healthcare organizations.

Second, stakeholders wanted to ensure the availability of information that may be required to successfully meet the standards. As one example, the CHW compensation component specifies that organizations share a market analysis of CHW salaries once every two years. During the review of the initial standards with the Virginia CHW Workforce Development Council, one member indicated their organization wouldn't have the resources to compile such information. In response, a suggestion was made by another attendee that the Development Council itself could regularly administer a statewide employee survey to collect information on CHW salaries.

A third consideration voiced during the Virginia CHW Workforce Development Council review of the initial standards related to potential conflicts with existing human resource guidelines, particularly regarding CHW selection process, supervision and compensation. In response, a representative from NCQA reminded participants that standards are designed to be roadmaps for organizations to develop structures and processes to provide better care. Accordingly, implementation of standards needs to include time, education and resources to help organizations learn and adopt new policies and procedures.

A fourth and final consideration raised by stakeholders related to the availability of adequate funding for CHW programs. This is salient in terms of the financial resources required both to put program-level supports in place and for organizations to demonstrate that they meet program standards. Some advisory panel members were concerned about a dampening effect that CHW program standards could have on the development of new programs if standards were a requirement for funding. To address this concern, the advisory panel discussed the idea of identifying a per patient/client cost that includes the resources needed to provide the types of supports (e.g. compensation, supervision, supplies) outlined in the standards. Studies that delineate program expenses for US-based CHWs, such as a 2019 Health Affairs analysis of a clinically-trial tested CHW program,[15] may be useful resources here. This study suggested that the per client cost of six months of support from a CHW functioning in a robust program that aligns with many of the proposed standards is approximately $1,700; if funding for programs

falls short of this amount, organizations especially those with fewer baseline resources will have a hard time delivering on quality standards. The panel also stressed that funding, whether from time-limited sources such as CDC or HRSA funding or from more permanent sources like Medicaid, needed to be equally available to organizations regardless of sector. To achieve this kind of equity, Virginia can look to other state for ways this has been addressed, including requirements/incentives for managed care organizations to partner with community-based organizations in Kansas and Washington, the inclusion of community-based organizations in the health home program in Missouri, and the lead role of community-based organizations to anchor accountable care organizations in Minnesota).[22] Lessons can also be taken from contracting underway in the aging space, which offer several types of financial arrangements.[23]

To further explore how these considerations will impact the use of CHW program standards in Virginia, the advisory panel recommended convening a learning collaborative of organizations to test and refine the program standards recommended by the panel. The Commonwealth can use the information from the learning collaborative to refine the CHW program standards and develop tools to help organizations successfully meet the standards. To assist with these next steps, NCQA has provided several resources, including a structure and process for testing and refining the standards developed by the advisory panel (Appendix D) and guidance on how to evaluate if organizations meet the standards (Appendix E). We recommend the timing of any next steps with the standards be centered around the Virginia CHW Association and the Virginia CHW Workforce Development Council, closely coordinated with DMAS, which, with the Penn Center for CHWs' support, has been actively exploring options to expand Medicaid financing for CHWs in the Commonwealth.

CONCLUSION

During a yearlong process, a diverse set of CHW stakeholders in Virginia developed a set of program standards to support high-quality CHW programs across the state. As a next step, a learning collaborative should be convened to test and refine the standards, with the goal of solidifying confidence that *all* CHW-employing organizations could meet these standards. This includes ensuring the standards do not disadvantage smaller, community-based organizations; the availability of required information; time, education and resources to update existing organizational policies where needed; and adequate funding that flows across sectors. On the latter point in particular, it will be important to collaborate closely with DMAS as they explore a permanent CHW funding mechanism for Virginia. The combination of a sector-agnostic dedicated funding source for CHWs with a sufficient per patient/client cost and robust program-level standards has the potential to catalyze the growth of effective CHW programs across the state to improve health outcomes for Virginians that experience disadvantage.

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Appendix A – Advisory Panel Members

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*Left VHHA midway through the project and replaced by: Kelly Cannon, Senior Director, and Davis Gammon, Program Manager

Appendix B – Meetings

May 2020	• Assemble advisory panel
June 2020	• Convene advisory panel (meeting #1) - present concepts for system-level standards based on existing literature
July 2020	• Convene advisory panel (meeting #2) – hear from Virginia CHWs about what they need to do their best work
August 2020	• Draft standards based on discussions from first and second advisory panel meetings
September & October 2020	• Survey advisory panel members on draft standards including (a) components for each domain (b) their importance and (c) the feasibility of meeting the components of the standards
November 2020	• Convene advisory panel (meeting #3) Review findings from survey, discuss options for financing
November & December 2020	• Present draft standards to Virginia CHW Association and Virginia CHW Workforce Development Council for their feedback
January 2021	• Update standards based on advisory panel survey results and feedback from CHW Association and Development Council
February 2021	• Convene advisory panel (meeting #4) to finalize standards
April 2021	• Present final recommended standards to Virginia CHW Association and Virginia CHW Workforce Development Council

Appendix C – Proposed CHW Program Standards for the Commonwealth of Virginia

Part 1: Hiring and compensation

- CHW selection process
    - The organization has a written policy that specifies that qualifications needed for the CHW position.
        - This policy prioritizes candidates who:
            - Are from the same community/share life experience with the patients/clients they will support
            - Have previous work or volunteer experience helping others
            - Demonstrate trust-building traits like empathy and strong listening skills
            - Exhibit problem-solving skills
        - This policy does not
            - Require more than a high school diploma or GED
            - Automatically rule out individuals who have previously been incarcerated
    - The organization has a written policy for conducting interviews for CHW candidates. This process includes:
        - Currently employed CHWs (if applicable) in the interview and selection process
        - Standardized interview guides
        - Techniques (e.g. behavioral scenarios)
        - Scoring guidelines to select CHWs based on the qualifications for the position

- Compensation

    The organization conducts their own or obtains existing market analysis of CHW salaries every two years and shares that information with CHWs and CHW supervisors

Part 2: Training and professional development

- Initial CHW training
    - The organization has a written policy to ensure that CHWs have received or receive initial training that meets the education requirements for the Certified CHW Credential available in the Commonwealth. The organization can provide this training in-house or provide referrals to external trainings and cover the training costs
    - The initial training should be completed prior to CHWs beginning work with patients/clients

- CHW assessment, ongoing training and professional development
    - The organization has a process in place to assess CHWs on core competencies and includes options for verbal responses. CHWs must meet a minimum standard within 180 days on the job. Opportunities to re-assess are made available
    - The organization has a process in place for CHWs to receive training in the following areas:
        - Changes to local or state policies and services affecting CHW patients/clients
        - When roles/responsibilities and work practices at the organizational level change
        - Training based on performance feedback to help CHWs achieve or exceed acceptable performance levels
    - The organization has policies to document conversations with CHWs regarding their career objectives that includes the creation of a professional development plan
    - The organization has a policy that outlines a career ladder for growth within the CHW role. The policy

outlines responsibilities and salaries at each level, and requirements for progression.

- Initial supervisor training
    - The organization has a process in place to ensure that immediate supervisors of CHWs receive initial training. The initial training should be completed within 90 days of beginning to supervise CHWs. The organization can provide this training in-house or provide referrals to external trainings and cover the training costs
    - The organization can demonstrate that supervisor training covers the following topics:
        - The unique identity and role of CHWs
        - How to provide effective and supportive oversight of CHW work
        - How to use observation, review of performance data and incorporation of community feedback to improve CHW performance

Part 3: Supervision and evaluation

- CHW supervision
    - The organization has a written policy that specifies the qualifications needed for the CHW supervisor position, which includes candidates with previous community health, public health, or social work experience
    - The organization has a written policy on supervision that:
        - Assigns one specific person to supervise a CHW (e.g. the CHW does not report to multiple people)
        - Stipulates that supervisors meet with each CHW one-on-one on a regularly-scheduled basis to review patient cases
    - The organization has a written policy that CHW supervisors receive an annual evaluation on their performance. One component of their evaluation includes an assessment of their performance by the CHWs they supervise

- Performance evaluation
    - The organization has systems for assessing and sharing information with CHWs on their performance on an ongoing basis, which includes:
        - Clearly defined benchmarks for success and information on whether the CHWs meet those benchmarks
        - Direct feedback from patients/clients about their experience working with a CHW
        - Direct observation of CHWs' work with patients/clients
        - Providing feedback based on the performance monitoring

Part 4: CHW work practice

- CHW role
    - The organization has written materials (e.g. manuals) that define the scope of the CHW role and outline how CHWs work with patients/clients. These materials should adapt evidence-based work practices and includes processes for CHWs to:
        - Meet and get to know patients

        - Provide tailored care and support to patients based on the patients' social needs
        - Know how long to work with patients/clients
        - Graduate patients/clients from the CHW program
        - Document work with patients/clients
    - The written materials emphasize that:
        - The CHW role is holistic and person-centered
        - The CHW role emphasizes CHWs getting to know their clients/patients as people
        - The CHW role allows CHWs to provide tailored support (including but not limited to care coordination, system navigation, social support and advocacy)
        - The CHW role is focused on understanding and addressing the root causes of patients' health-related social needs

- Integration with care teams
    - The organization has a process in place to formally integrate CHWs with care teams and communicate the following:
        - What the scope of work and responsibilities of CHWs are relative to other care team members
        - How and when CHWs and other care team members should communicate and coordinate with each other to provide care and referrals

- CHW caseloads
    - The organization has a written policy for determining appropriate caseload sizes, which takes into account the CHW role, the geographic reach of the CHW and the complexity of client needs

- Emergency situations
    - The organization has written protocols for dealing with patient/client emergencies during and after hours
    - The organization has written policies for communication and decision-making during emergencies (e.g. climate emergencies, pandemics) that includes how and when CHWs will be informed of changes (e.g. chain of communication guidance) and access to emergency hotlines

- CHW safety
    - The organization has written procedures that protect CHW safety, including procedures for tracking when CHWs are conducting home visits and processes for identifying and resolving concerns related to CHW safety

Part 5: Organizational supports and involvement in decision-making

- Professional supplies
    - The organization has a written policy to routinely review with CHWs the equipment and supplies needed to perform their roles and has a process to provide the necessary equipment and supplies, such as a work phone, a computer with internet, a directory of local resources, and personal protective equipment (PPE) during public health emergencies

- Involvement in organizational decision-making
    - The organization has a mechanism for CHWs to play active roles in decision-making processes about the CHW role and working conditions, including compensation, training, caseloads, work practices, equipment and supplies
    - The organization has a mechanism for CHWs to play active roles in decision-making processes related to advancing racial and social justice and equity within the organization.

Appendix D – Testing Criteria and Evidence to Demonstrate Compliance with CHW Program Standards

Prepared by NCQA for the Virginia Department of Health

This document describes a recommended approach that the Virginia Department of Health (VDH) may take to pilot test procedures to demonstrate compliance with newly developed community health program (CHW) program standards. Once the standards are developed, the VDH may convene a learning collaborative of about 10 community-based organizations (CBOs), public health, health care organizations, and health plans that hire, contract or partner with CHWs in Virginia. These organizations would assess themselves against the standards; work to improve their performance; and share their experiences, successes and lessons learned. At the end, the VDH may produce an implementation guide to help organizations improve their ability to meet the CHW program standards in Virginia.

Key possible steps would include:

1. Form a learning collaborative to pilot test the CHW program standards in about 10 organizations that hire, contract, or partnership with CHWs.
2. Revise standards as necessary based on the pilot test.
3. Develop an implementation guide of best practices and practical tools to help organizations meet the program standards.

STEP 1: Form Learning Collaborative

The VDH would recruit and convene about 10 organizations including CBOs, public health, health care organizations, and health plans that hire, contract or partner with CHWs in Virginia. Training based on a collaborative learning model will engage all members of the learning collaborative in peer learning, thereby promoting cross fertilization of ideas and strategies that will maximize the impact of training activities. The pilot organizations would commit to sharing their best practices and challenges while working to improve their performance on the new CHW program standards.

The CHW program standards would be shared with participating pilot organizations for discussion and for use in completing a baseline self-assessment of their performance according to the program standards. After baseline self-assessment, the VDH would support the pilot organizations with implementation of improvements. For example, each organization would:

- Receive help to develop a plan and schedule for meeting standards that were self-assessed as needing work.
- Receive ongoing technical assistance to demonstrate how they meet standards.

At the conclusion of the pilot, organizations would update with their follow-up assessment to reflect progress made in implementing the standards. Feedback would be obtained using both structured and unstructured approaches to get targeted comments in key areas while allowing participating organizations to offer input in areas most relevant to them. Documents would be reviewed, and selected site visits would be made to assess the organizations' compliance. Information would be gathered on the impact of implementing the standards. These assessments would be used to make recommendations for updating their CHW programs and for further refining the program standards.

STEP 2: Revise Standards

Based on the feedback and information learned during the pilot, VDH may confer with an independent multi-stakeholder advisory panel and decide if and how the CHW program standards may need to be revised. For example, standards may need to be more descriptive and explicit, providing explanations and examples that elucidate their meaning. In addition, the difficulty and pace to meet the standards will be learned during the pilot.

VDH would need to determine how best to accommodate the standards roll-out in a variety of organizational settings and degrees of readiness, while preserving the fundamental intent and integrity of the standards. Depending on the degree of changes needed to revise the program standards, VDH would need to decide whether to extend the pilot and learning collaborative to provide additional resources to the pilot organizations and yield more information about the most effective way to implement the revised standards.

STEP 3: Develop Implementation Guide

Finally, we will seek advice on a "glide path" outlining how organizations can progress by small steps to address the essential functions. Examples of questions that will be explored include:

Based on the pilot test and learning collaborative, VDH may develop an implementation guide to provide strategies, best practices, materials, and examples that organizations can use to support their efforts to implement the standards. Answers to important questions will be explored in the guide, for example:

- What are the different ways organizations could meet a standard?
- How can organizations demonstrate that they meet each standard, and where is such documentation likely to be found?
- Which standards can rely on policies and procedures, and which standards should rely on evidence showing what the organization has actually accomplished?

The implementation guide would highlight key components of the standards and provide narrative examples of how pilot organizations have previously implemented the standards. The guide would also include examples of tools that organizations have used and other resources that may be helpful for implementation.

Appendix E – Process Document for Evaluating Proof of Standards

Prepared by NCQA for the Virginia Department of Health

An important part of evaluating proof of standards is document preparation. An organization needs to meet a standard based on what the organization can demonstrate through its documents – such as policies, program descriptions, activity reports, member materials, and other work products. The documents show what an organization does to meet the standards.

How an organization prepares those documents and presents them, along with how an organization tells its story, can make it easier for the evaluating team to confirm that an organization meets the standards. This can result in a simpler and more streamlined evaluation experience, with fewer requests from the evaluating team for clarification or additional information. The organization's objective should be to provide the evaluation team with the information necessary to accurately evaluate performance against the standards in as directed and efficient a manner as possible.

Keep in mind that the goal of the evaluating team is to confirm compliance with the requirements; therefore, the clearer it is that the intent is met; the easier it is for the evaluating team to confirm compliance on behalf of the organization. However, the organization is ultimately responsible for documenting compliance and directing the evaluating team to that documentation.

The purpose of this document is to provide guidance on preparing documents, as well as on writing compliance statements that help the evaluating team navigate the documents.

This document contains the following three sections:

1. Standards Documentation Requirement: This section describes examples of documentation and evidence that organizations must produce to meet the requirements.

2. Document Preparation: This section describes how organizations should prepare documents with suggestions on how to compile information, highlight key sections in documents, and direct evaluating team to specific information that demonstrates the organization meets a requirement.

3. Compliance Statements: This section provides an overview of what a compliance statement is and how it may assist the evaluating team in the review of an organization's documents. It also provides examples of how to compose a compliance statement.

PART 1: Standards Documentation Requirement

Organizations should review the standards to learn about the information and documentation that are required for the evaluation process. To provide additional guidance, standards include examples of documentation or evidence that the organization can use to demonstrate compliance with a standard. The examples are provided as guidance only and are not specifically required or all-inclusive. Depending on the specific standard, the types of documentation required include:

1. Documented process: Policies and procedures, process flow charts, protocols and other mechanisms that describe the actual process used by the organization.

2. Reports: Aggregated sources of evidence of action or compliance with a standard, including program evaluation management reports; key indicator reports; summary reports from member reviews; system output giving information like number of member appeals; minutes; and other documentation of actions that the organization has taken.

3. Materials: Prepared materials or content that the organization provides to its members or practitioners including written and electronic communication, information from Web sites, scripts, brochures, newsletters, and clinical guidelines.

4. Records or Files: Actual records or files that show direct evidence of action or compliance with a standard.

The standards may specify a look-back period, which is a period during which the evaluating team appraises an organization's documentation to assess performance against a requirement. Unless otherwise noted, organizations must meet the requirement throughout the look-back period.

Finally, be sure to consider all pertinent information specified in each standard during the evaluation process. For example, if the data source specifies "documented process" and the organization provides a report, full compliance is therefore not demonstrated. Likewise, if the look-back period specifies 24 months, and the organization only provides evidence of completing the activities within the last 12 months prior to the evaluation date, full compliance is not demonstrated.

PART 2: Document Preparation

The evaluating team should serve as fact finders for organizations, verifying that that the documentation presented meets the intent of the requirement. The evaluating team reviews the organization's documents to determine if they meet the standards.

The organization's obligation is to present the documentation that demonstrates compliance and to do so in a manner that facilitates review by the evaluating team. The organization is expected to:

- Provide the required documents
- Present them in an organized, readable format
- Limit documentation to the minimum necessary to demonstrate compliance
- Use available software features and tools (such as highlighting and comments) to direct the evaluating team to evidence of compliance.

If the evaluating team does not find evidence of compliance in the documents, the team will ask for clarification and provide the organization an opportunity to respond. The organization is not summarily found non-compliant without a discussion of the issues. However, when numerous documents are provided or clear evidence of compliance is not obvious to the evaluating team, the team would have the right to then go back to organizations, seek clarifying information, and request the organization be more concise in demonstrating compliance.

The onus is on the organization to demonstrate compliance, not on the evaluating team to find compliance.

What is the Best way to Prepare Documentation for the Evaluating Team?

It is important that documents are prepared in a manner for the evaluating team to efficiently review. The organizations should do the following:

- Reference the specific page number(s) and paragraph to which the organization wants to draw the evaluating team's attention.
- Designate each document as "primary" or "secondary." If the organization is considering adding more documentation, the organization should consider if the document is truly necessary to demonstrate compliance.

Organizations are strongly encouraged to make the following tools available in common software to prepare the documentation for the evaluating team:

- Highlight or underline the key text in the document to draw the evaluating team's attention to the sections that demonstrate compliance.
- Create "hyperlinks" or "bookmarks" in the document to automatically take the evaluating team to highlighted text.
- For very large documents, provide only the necessary pages. The cover page and any other pages that provide necessary dates or version tracking must be included. Organizations are encouraged to use either scanned copies or Adobe PDF, which allows an organization to extract pages from large documents while retaining the integrity of the page layout.
- Name the document in a manner that helps the evaluating team understand why it is relevant. The name should be as specific as possible.
    - Where possible, name the document according to the specific standard it supports. This may not be possible when the same document is being used for multiple standards.
    - Alternatively, use a name that conveys what the document contains or means.

Both word processing programs (such as MS Word) and Adobe PDF support these features.

How Much Documentation is Enough or Too Much?

Organizations should carefully read the information for each standard, considering the data source(s) and the look-back period.

- Each standard must have supporting documentation.
- If a standard is not applicable to the organization, the organization should supply supporting documentation or an explanation for the requirement.

Documentation that is "supplementary in nature" may make the evaluation process more complex than desired. Organizations should apply a philosophy of minimum necessary information when preparing documentation. Evaluating team should ask for and seek additional information when compliance cannot be determined in the documents presented.

PART 3: Compliance Statements

A compliance statement is an optional concise statement of "how" an organization meets the requirements of a specific standard. This statement helps the evaluating team best understand the organization's processes and documentation within the context of a specific standard.

Specify "how" the documentation supplied demonstrates compliance with the requirements of the standard. Because the organization is familiar with its own processes, it may seem apparent how documents demonstrate

compliance within the context of the standard. However, the evaluating team has limited familiarity with the organization's operational processes; and therefore, it is important to provide a foundation for how the documentation supplied meets the performance requirements of the specific standard.

Compliance statements are especially helpful when more than one document is provided. If more than one document is necessary, provide explanation on how the documents relate to each other.

- If an organization supplies numerous documents without an explanation, it is difficult for the evaluating team to synthesize how the documents together may demonstrate compliance with the standard.
- Reference the key documents that demonstrate compliance with a specific standard. Organizations should specify the document and specific pages or sections that evidence compliance.
- The statement of compliance does not have to be lengthy. It should be a concise statement of how the organization meets the specific requirements of the standards.

Are Compliance Statements Required?

The necessity of a compliance statement would vary based on the standard and on the degree to which the organization makes use of other tools (bookmarking, highlighting, and comments) to present a coherent story.

For standards that require very straightforward documentations or require just one document to demonstrate compliance, it may not be necessary for the organization to provide a compliance statement for those standards.

For standards that require several documents, organizations may use a compliance statement to provide additional background on the activities, or "tell its story," and can explain how the multiple documents relate to each other and in what order they should be reviewed.

Bookmarking, effective highlight and comments can eliminate the need for a compliance statement for many standards.

Method for Including Compliance Statements

For example:

1. Document the compliance statement in a word or PDF document and link it under the respective standard. Organizations can prepare one document for each standard, addressing all the subcomponents (if any) of a standard in that document. If this method is used, name the compliance statement file specific to the standard that it supports (e.g. "Compliance Statement for QI 1") or use a name that conveys what the document contains.