



Five Steps to Design a Community Health Worker Program

Tools for implementing a sustainable and effective program

PUBLISHED BY

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BEST FOR

Population health and care transformation leaders

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Executive summary

Organizations in value-based contracts, particularly those taking on Medicaid risk, have a mandate to reduce acute care utilization for high- and rising-risk patients—or face financial penalties. However, at-risk patients with multiple complex clinical and social needs can be difficult to manage at scale given the limited budgets of population health departments.

A community health worker (CHW) program is one sustainable approach to supporting complex patients. As defined by the CEO of City Health Works, Manmeet Kaur, a “community health worker” is an umbrella term that means one thing: a non-clinical person hired from the community that they serve.” These lower-cost staff, often salaried by a provider organization, address social needs and support disease self-management. CHW programs offer substantial return on investment (ROI) when implemented effectively.

However, provider organizations face a number of challenges when implementing an effective CHW program:

- **Because this is a nontraditional role, no nationwide standards exist, which results in a broad range of possible models.** Care management and program leaders have trouble conceptualizing how the role can integrate with the existing care team, which can halt program development before it begins.
- **Few provider stakeholders are familiar with CHW roles or aware of their potential value.** Without clear communication of the staff’s value proposition, executive leaders will not support funding. Programs typically rely on a mix of short-term grants that ultimately peter out.
- **Program leaders rely on traditional hiring practices, which can prevent hiring the right people, effective training, and top-of-license deployment.** This contributes to high turnover rates and extraneous recruiting and training costs, threatening program ROI.
- **Programs that do not scope CHW roles carefully will lose momentum due to staff burnout.** In addition, some CHWs leave their position if they don’t see a clear path for career and salary growth. Programs with high turnover harm trusted relationships with patients; use unnecessary resources to recruit, rehire, and retrain; and are not as effective.
- **Most programs start pilots without a plan to analyze impact.** Many providers are unsure how to calculate an accurate ROI of CHW programs or communicate the ongoing value proposition with the right set of metrics.

This toolkit provides best practices and resources to help organizations anticipate these challenges and implement a sustainable CHW program.

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Five steps to design a community health worker program

1 Determine program scope

-
- Associated tools
- CHW program case study compendium
 - CHW cheat sheet

2 Secure sustainable program funding

-
- Associated tools
- Ready-to-use slides to make the case for program investment
 - Funding sources brainstorming guide

3 Source talent using nontraditional methods

-
- Associated tools
- Staffing model decision guide
 - Sample job description
 - Recruiting and hiring guidelines

4 Create a retention plan

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- Associated tools
- Sample training schedule
 - Overview of a CHW's daily role
 - Sample financial needs assessment
 - Sample career mapping process

5 Demonstrate long-term performance

-
- Associated tools
- Program metric picklist
 - Sample performance measurement dashboard
 - Calculator for the value of saved clinical time saved
 - CHW ROI estimator

Step 1

Determine program scope

There is no standard job description for a CHW. The best programs tailor their model to the specific needs of their communities. While all programs aim to address patients' social determinants of health, CHWs can also support self-management among those with chronic conditions. Leaders looking to deflect the total cost of care use CHWs to address social determinants of health. Programs designed to influence clinical outcomes, such as HbA1c levels, also use CHWs to boost chronic disease self-management.

Once leaders determine program goals, they should scope the CHW role. Key elements to consider include target patients and panel sizes, patient management timelines, service offerings, and referral strategy. While each program is unique, organizations should network with other programs when designing their model to identify which components would work best for their goals and resources.

CHWs are susceptible to “role creep” (new tasks added over time without consensus) when program leaders do not clarify the specific goals of the role. Program leaders should start by communicating the basics of the role to key stakeholders and internal leaders. To lend greater visibility to the role, detail typical credentials, average salary, and major roles and responsibilities. Then, refine and articulate a clear, in-depth understanding of the problems the CHW program will solve. Organizations use role cheat sheets for internal education and in-depth presentations to make the case for sustainable funding.

This section includes tools to help providers determine program scope:

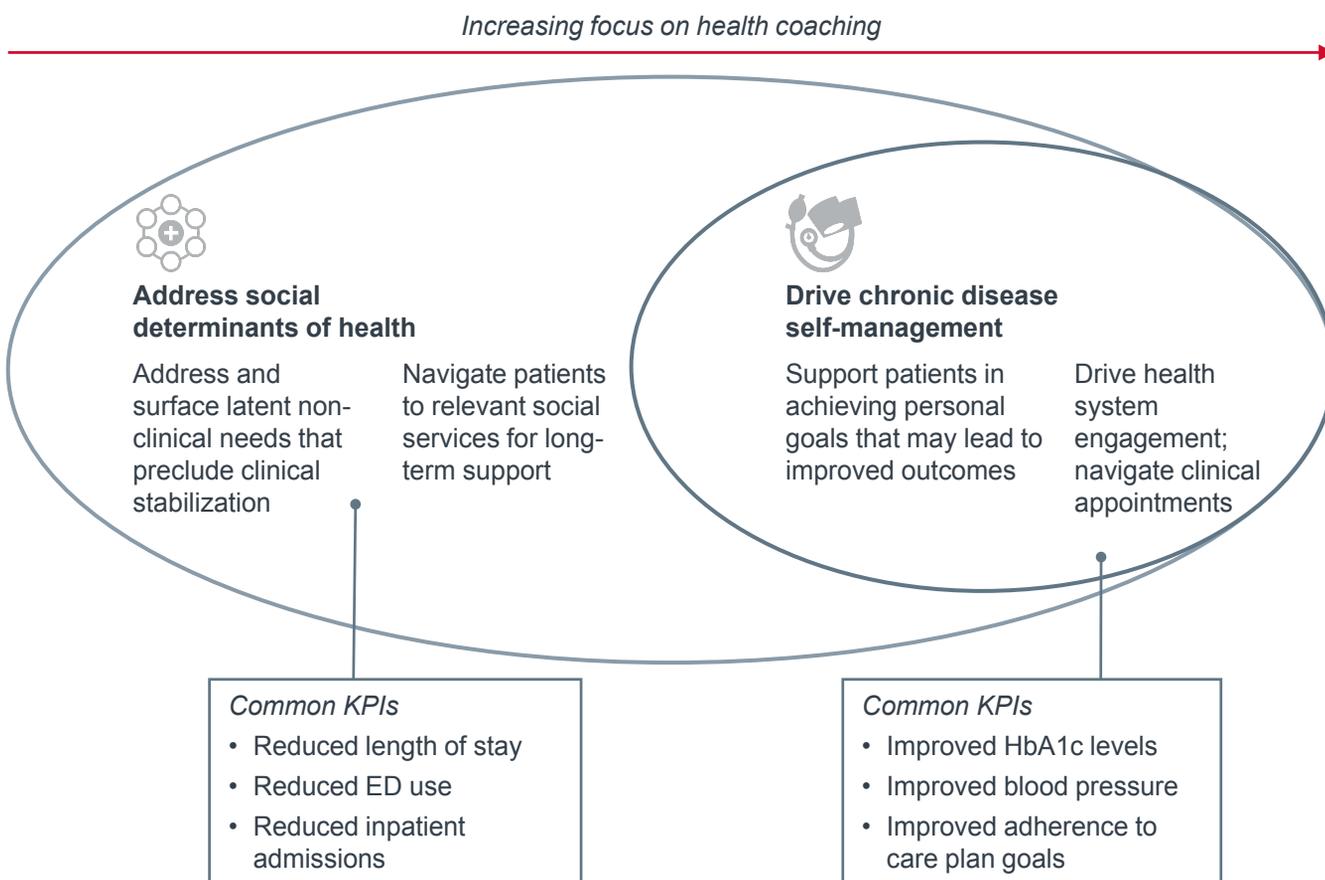
- CHW program case study compendium
- CHW role cheat sheet

Tailor CHW program to patient management goals

For populations with unmet social needs, CHWs present a lower-cost alternative to RN care managers to support at-risk patients. CHWs specialize in developing strong relationships with patients. All programs use CHWs to address patient’s social determinants of health, while a subset broaden the scope of the CHW role to drive chronic disease self-management. The biggest difference between these two goals are the key performance indicators (KPIs) CHWs will influence.

KPIs vary based on program goals. Programs focused exclusively on inflecting psychosocial needs aim to reduce total cost of care for enrolled patients, including reduced length of stay, ED use, and inpatient admissions. Programs focused on supporting chronic disease self-management aim to advance clinical outcomes, such as improved HbA1c levels, blood pressure, and care plan adherence.

Two goals of community health worker programs

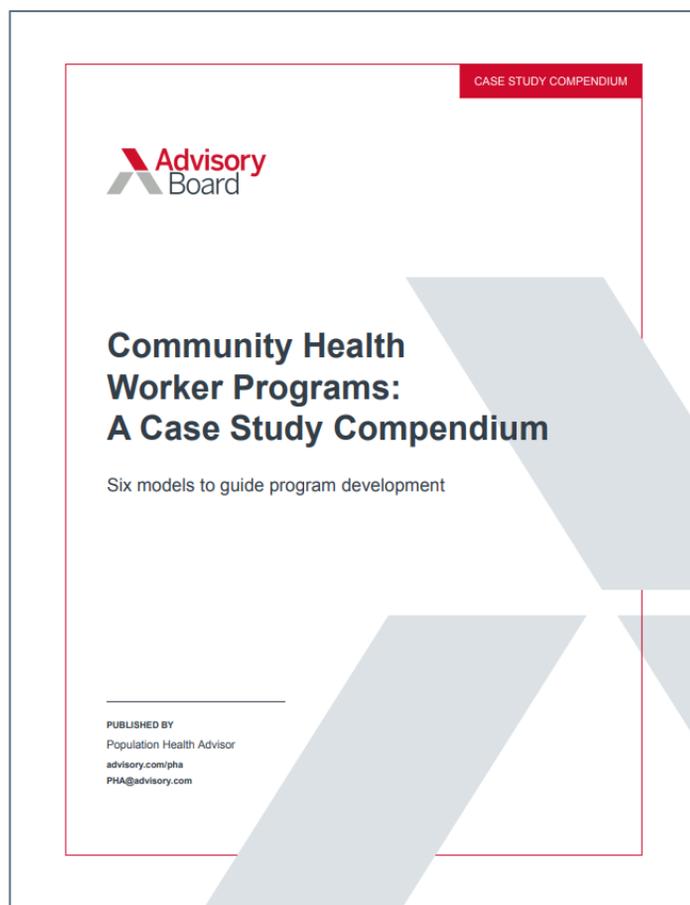


Benchmark against peers to inform program development

No two programs are alike, as organizations base programming on system strategy and resource availability. Program design varies across patient inclusion criteria, care team deployment, and the time frame for patient management. Comparing against others helps to establish program scope, including panel size, target populations, and outcome targets.

Review the successful models on the following page and in the full research report shown below to determine which components will work best for your organization and community.

Community health worker program case study compendium available online



LEARN ABOUT BEST-IN-CLASS MODELS

for CHW programs in our publication [Community Health Worker Programs: A Case Study Compendium](#) available on [advisory.com](#).

Selected community health worker programs

Review the components of the six community health worker programs listed below to understand the range of possible models.

	GOAL: ADDRESS SOCIAL NEEDS	GOAL: AID SELF-MANAGEMENT	TARGET POPULATION	PANEL SIZE PER CHW	PROGRAM OUTCOMES
Kalispell Regional Medical Center 1 FTE ¹	✓	✗	Patients with 3+ inpatient visits over 6 months	65 patients per year	Reduced inpatient visits by 57%, observation visits by 30%, and ED visits by 31%
Mercy Health System 3 FTEs	✓	✗	High-risk patients with high rates of acute utilization	25-30 patients per week	Social support from CHW and SW ² reduced ED visits by 31%, hospitalizations by 32%, and avoided \$170K in costs
NewYork-Presbyterian Hospital 49 FTEs	✓	✓	Patients with 2+ chronic conditions, 2+ ED visits, and unmet social needs	35 active patients at once	<i>Adult program:</i> 62% of patients improved HbA1c, 82% didn't readmit <i>Pediatric program:</i> reduced inpatient visits 76%, ED visits by 68%
University of Pennsylvania Health System 50 FTEs	✓	✓	Under- or uninsured patients living in high-risk service area ZIP codes	15-30 active patients at once	Measured 2:1 ROI through reduced utilization; improved access, and quality
University of New Mexico Health System 51 FTEs	✓	✓	Patients of all acuties, Medicaid beneficiaries, citizens returning from incarceration, undocumented immigrants, and children at risk for abuse	15-30 active patients at once	Measured 4:1 ROI; 83% fewer admissions
Mount Sinai Health System 6 FTEs shared across provider organizations in Harlem	✗	✓	<i>PC³ program:</i> Patients with uncontrolled conditions ⁴ <i>CHF program:</i> Inpatients with uncontrolled CHF	25-30 active patients at once	City Health Works' diabetes-specific programs led to a \$600 average PMPM drop by 10 weeks and 1.6 average HbA1c reduction at 1 year

1) Full-time equivalent.

2) Social worker.

3) Primary care.

4) Conditions include CHF, diabetes, asthma, hypertension, and depression.

Source: Population Health Advisor interviews and analysis.

Selected community health worker programs (cont.)

REFERRAL STRATEGY	PROGRAM LENGTH	CARE SETTING	HIRING MODEL	PROGRAM FUNDING
Inpatient care teams refer patient to CHW/RN dyad prior to discharge	30-90 days post-discharge	Meets patients during admission, offers home visits, attends PCP appointments	Internally hired and trained; deployed in a dyad with an RN	\$250K grant from Robert Wood Johnson Foundation across three sites
Centralized RN offering telephonic transition support refers highest-risk patients to triad of CHW, RN, SW	Six weeks post-discharge	Makes home visits, performs assessments, and connects with community resources	Internally hired and trained; deployed in a triad with an RN and an SW	Incorporated initially into hospital operations budget, then transitioned to ACO budget
Inpatient and outpatient care teams refer patients via EMR; CBO ¹ staff outreach proactively	Six months	Meets patients during admission, patient visits occur in homes and community-based organizations	Subcontracted from community partners, and internally trained; CHWs are a separate, stand-alone program	Incorporated majority of program funding into system's operational budget after successful pilots
Web-based platform uses algorithm to identify target patients	Two weeks post-discharge, four weeks post-discharge, or six months in outpatient care	Meets patients during admission or in the primary care clinic; patient visits occur in the home or community	Internally hired and trained; CHWs are a separate, stand-alone program	Pilot funds used to prove ROI, then integrated into population health and community benefit budgets
Predictive modeling identifies target patients such as high utilizers	One to six months	Offers support in the community, primary care clinics, and the ED	Internally hired and trained; CHWs are a separate, stand-alone program	Launched pilot with partner MCO ² funding; now integrated into permanent budget
Care team reviews EMR risk reports including ZIP code and diagnoses to determine outreach	Three months of active health coaching, nine months of maintenance	Meets patients in primary care clinics after care team referral or in the inpatient setting to plan for discharge	Externally hired and trained via a community partnership; CHWs are a separate, stand-alone program	DSRIP ³ funded contract with community partner, which funds a per-patient rate for CHW services

1) Community-based organization.

2) Managed care organization.

3) Delivery System Reform Incentive Payment program.

Source: Population Health Advisor interviews and analysis.

Articulate the value of community health workers

A CHW cheat sheet is helpful for disseminating internal education about the role. Use the form below to create a CHW primer for internal stakeholders.

Program design varies based on internal resources and strategy



The community health worker role at a glance

CHWs are non-clinical team members who serve as a liaison between the patient and health system. They help surface and address patients' unmet social needs and in some cases promote chronic disease self-management.

Credentials:	Most CHWs are non-licensed lay workers; while some states offer credentialing processes, many CHWs receive training from the health systems in which they serve
Target population:	Clinically and socially complex patients; often covered by Medicaid or uninsured
Panel size:	25-35 patients at once
Average salary:	\$38,370 (\$35,263-\$47,504)
Funding:	Some states offer Medicaid reimbursement for CHW services or may require that Medicaid plans provide patients with access to CHW services

Key roles and responsibilities

All programs use CHWs to address patients' social determinants of health and some broaden the role to drive chronic disease self-management. The level of focus on each priority depends on the program's goals and resources. Tasks include:

- Setting, monitoring, and supporting patient-centered goals
- Connecting patients with social services, benefits
- Performing home visits
- Providing "social prescriptions," such as accompanying patients to the bank to set up an account, to find a safe place to live, to the gym to support healthy habits, and to the grocery store to identify healthy and affordable food
- Supporting medication adherence
- Accompanying patients to clinical visits
- Communicating and coordinating with patients' clinical providers

Return on investment

When organizations carry out CHW programs effectively, providers can inflect clinical and financial outcomes. The University of Pennsylvania Health System's randomized controlled trials illustrate the impact and return on investment of primary care- and community-based programs.



Impact of the University of Pennsylvania's cross-continuum CHW programs

2:1 Program return on investment

30% Decreased multiple readmissions

69% Reduced length of stay over 6 months

Source: Kangovi S, et al., "Patient-Centered Community Health Worker Intervention to Improve Post-Hospital Outcomes: A Randomized Clinical Trial," *JAMA Internal Medicine*, 174, no. 4 (2014): 535-543; Kangovi S, et al., "Effect of Community Health Worker Support on Clinical Outcomes of Low-Income Patients Across Primary Care Facilities: A Randomized Clinical Trial," *JAMA Internal Medicine*, 178, no. 12 (2018): 1635-1643; Population Health Advisor interviews and analysis.

Step 2

Secure sustainable program funding

The concept of a CHW—a lay community member who helps patients achieve care plan goals—is not new. Permutations of the CHW role exist across the globe, with examples like the promotoras in Latin America, village health workers in India, and nutrition workers in Indonesia. However in the United States, most CHW activity occurs outside the clinical setting in the public health realm, rather than integrated into provider-based care teams. A lack of provider understanding of the role may result in unfunded programs. Without a clear path for internal funding, programs typically rely on short-term grants which are insufficient to maintain programs over time. A lack of long-term financial commitment threatens job security for CHWs, leading to elevated turnover rates and inconsistent outcomes.

Program leaders need to socialize the CHW role across key organizational stakeholders to secure long-term funding. This starts with creating a vision for how a CHW program will help meet patient's social needs and support self-management. Champions should tailor their pitch to the audience at hand, as different stakeholders, including the hospital C-suite, payers, and philanthropy, will prioritize different goals.

When key stakeholders value the tangible benefits of a CHW program, program leaders can make the case to incorporate program funding into an internal budget. However, most health system executives require clear positive outcomes before making the investment. Building the case for sustainability starts with securing pilot funding to ensure enough capital to develop program infrastructure. After proving early ROI, programs need to work with internal leaders to obtain a protected budget. Typically, programs live within the population health or community health departmental budgets.

This section includes tools to help providers secure sustainable program funding:

- Ready-to-use slides to make the case for program investment
- Funding sources brainstorming guide

Build a compelling case for investment across stakeholders

Tailor pitch to program specifics and target audience

Making the case for a CHW program isn't just a one-time presentation. The process requires heavy preparation, a well-executed pitch, and ongoing stakeholder management. Tailor your approach to stakeholder type for greater likelihood of success.

Tips for making a successful pitch

- Before**
 - Select a program champion who is well-regarded to engender trust and willingness to collaborate
 - Begin discussing benefits of CHWs prior to the pitch to engage advocates who may be involved in decision-making
- During**
 - Contextualize the conversation within the broader landscape of population health to articulate the problems that CHWs can solve
 - Clarify the role by detailing an impactful patient story and overviewing major responsibilities
 - Provide high-level operational details to demonstrate how CHWs will fit into existing workflows and infrastructure
 - Detail anticipated costs and use evidence-based estimates to determine expected ROI
 - Include non-financial outcomes such as improved quality and patient satisfaction
- After**
 - Maintain ongoing communication about program outcomes and opportunities for improvement to set the stage for ongoing investment

Tailor approach to stakeholder

-  **Hospital C-suite**
Align program with internal strategic priorities and results of community health needs assessments
-  **Payers**
Communicate how investments will benefit their members rather than overall patient population
-  **Philanthropy**
Supplement patient stories with hard ROI data, but also remember that personal stories are useful when foundations take the case to a donor market

Personalize the ready-to-use slide deck to make an effective case for investment



PREPARE FOR YOUR PRESENTATION

with our customizable, ready-to-use slide deck, [A Case for Implementing a Community Health Worker Program](#), available on advisory.com.

Source: Population Health Advisor interviews and analysis.

An intentional approach to secure budget-based funding

NYP used successful pilot to make case for permanent financial commitment



CASE
EXAMPLE

NewYork-Presbyterian Hospital

Nonprofit university hospital affiliated with Columbia and Cornell Universities • New York, NY

NewYork-Presbyterian (NYP) launched a CHW program in 2003 based solely on grant funding. Pilot funding allowed NYP sufficient time to innovate on different components and prove positive clinical and financial outcomes. Program leaders used data such as reduced length of stay to successfully make the case for the organization to incorporate the CHW program as a protected part of NYP's budget. The CHW program is now covered by community health department funds in addition to DSRIP¹ dollars.

Use pilot outcomes data to make an effective pitch for institutional funding

10 years

1

Launched CHW program with external grant funding

- Two five-year external grants allowed program leaders to test variations in programming, streamline care delivery, and create mechanisms for measuring outcomes
- Developed strong relationships with community-based organizations over time
- Engendered internal support across disciplines and identified champions, including the finance department and clinical leaders

1 year

2

Built a business plan to solicit hospital investment in programming

- Program leaders developed an in-depth business plan for the hospital to incorporate the program into a protected budget line
- Tailored presentation to priorities of finance leaders under fee-for-service by showcasing evidence that CHW care reduces length of stay

2 months

3

Presented the case to hospital leaders to adsorb program costs

- Program leaders engaged cross-discipline champions to underscore the positive financial impact of the program
- Hospital leaders reviewed the plan and incorporated funding for patients with asthma under the operations budget
- Program leaders used DSRIP funding to extend services to patients with additional chronic conditions

4

Transitioned internal funding from operations to community benefit to expand coverage to entire system

- Hospital leaders decided to move funding from the operations budget to the community health department to ensure patients with all chronic conditions across the system had CHW coverage after the end of DSRIP
- Community benefit programming allows nonprofit hospitals to continue to receive tax write-offs and improves their brand on the national stage, such as in hospital rankings

1) Delivery System Reform Incentive Payment program.

Source: NewYork-Presbyterian Hospital, New York, NY; Population Health Advisor interviews and analysis.

Solidify funding strategy at outset to plan for sustainability

Compare feasibility of the funding source with potential consequences

Use the brainstorming guide to review possible funding sources and determine a long-term strategy for program sustainability.

Brainstorming guide for building an effective funding strategy

	Funding sources 	Pros 	Cons 
Internal budget	<ul style="list-style-type: none"> Can the program file under community benefit funding? Can you estimate avoided acute care utilization as a result of the CHW program? Can you demonstrate a direct tie to other institutional strategic priorities? Does the program address needs identified in a community health assessment? 	<p>Incorporating programs into internal budgets is the best way to ensure long-term sustainability and allows providers to fully integrate CHWs into the system</p>	<p>System leaders often require a rigorous approach to determining the value of embedding program funding into operational dollars</p>
Private	<p>Have you coordinated with your organization's philanthropy department to find interested donors or foundations?</p>	<ul style="list-style-type: none"> External funding can provide the capital necessary to kick-start a new pilot program Supportive external donors can add stipulations to their grants to ensure long-term internal funding 	<p>Short-term funding doesn't ensure long-term sustainability, which leads to inefficiencies</p>
Governmental	<ul style="list-style-type: none"> Does your state allow Medicaid reimbursement for CHW services? Are you able to devote primary care funding to the role, such as PCMH¹ or CPC+²? Are you eligible to apply to demonstration programs, such as CMMI³ or DSRIP? 	<p>Organizations that secure high-profile grants inspire potential funders' trust in the program's efficacy, easing the grant application process in the future</p>	<p>Local, state, or national government funding tends to be more difficult to secure and rigid once in place</p>
Health plan	<p>Can you negotiate with payers such as managed care organizations to acquire funding for CHWs to support high-risk members (e.g., shared risk agreements, additional PMPM funding)?</p>	<p>Negotiating with health plans allows for the creation of more flexible agreements than with governmental organizations</p>	<p>Health plan negotiations require using limited leverage and may not ensure CHW support for other plans' beneficiaries</p>
Local entities	<p>Can you collaborate with community-based organizations to fund a shared FTE, such as using a community partner's space or tapping into a partner's outreach network?</p>	<p>Community partners may be incentivized to contribute resources like clinic space to meet shared objectives, off-loading some of the financial burden and strengthening care coordination</p>	<p>Community-based organizations often have tight margins and can't contribute substantial resources to additional programs</p>

1) Patient-centered medical home.
 2) Comprehensive Primary Care Plus.
 3) Center for Medicare & Medicaid Innovation.

Source: Population Health Advisor interviews and analysis.

Step 3

Source talent using nontraditional methods

CHW program efficacy hinges on recruiting and training the right talent. However, organizations that use the same hiring practices as they do for more traditional roles often fail to hire the right people, train them effectively, or use them at top-of-license. For example, program leaders report that the best candidates may not respond to job postings on a website. Applying typical recruiting practices to CHW programs may lead to high turnover rates and extraneous recruiting and training costs.

Providers have three options for staffing a CHW program: 1) hire CHWs directly, 2) share staffing ownership with partner organizations, or 3) outsource staff from external organizations. To set staffing parameters, weigh the existence of external, community resources with the potential for the greatest return on investment.

For providers staffing a program without support from external organizations, leaders should recruit applicants from the targeted community through qualitative interviews and “meet-and-greets.” Leaders should look to hire individuals who demonstrate a keen ability to build relationships.

This section includes tools to help providers source talent using nontraditional methods:

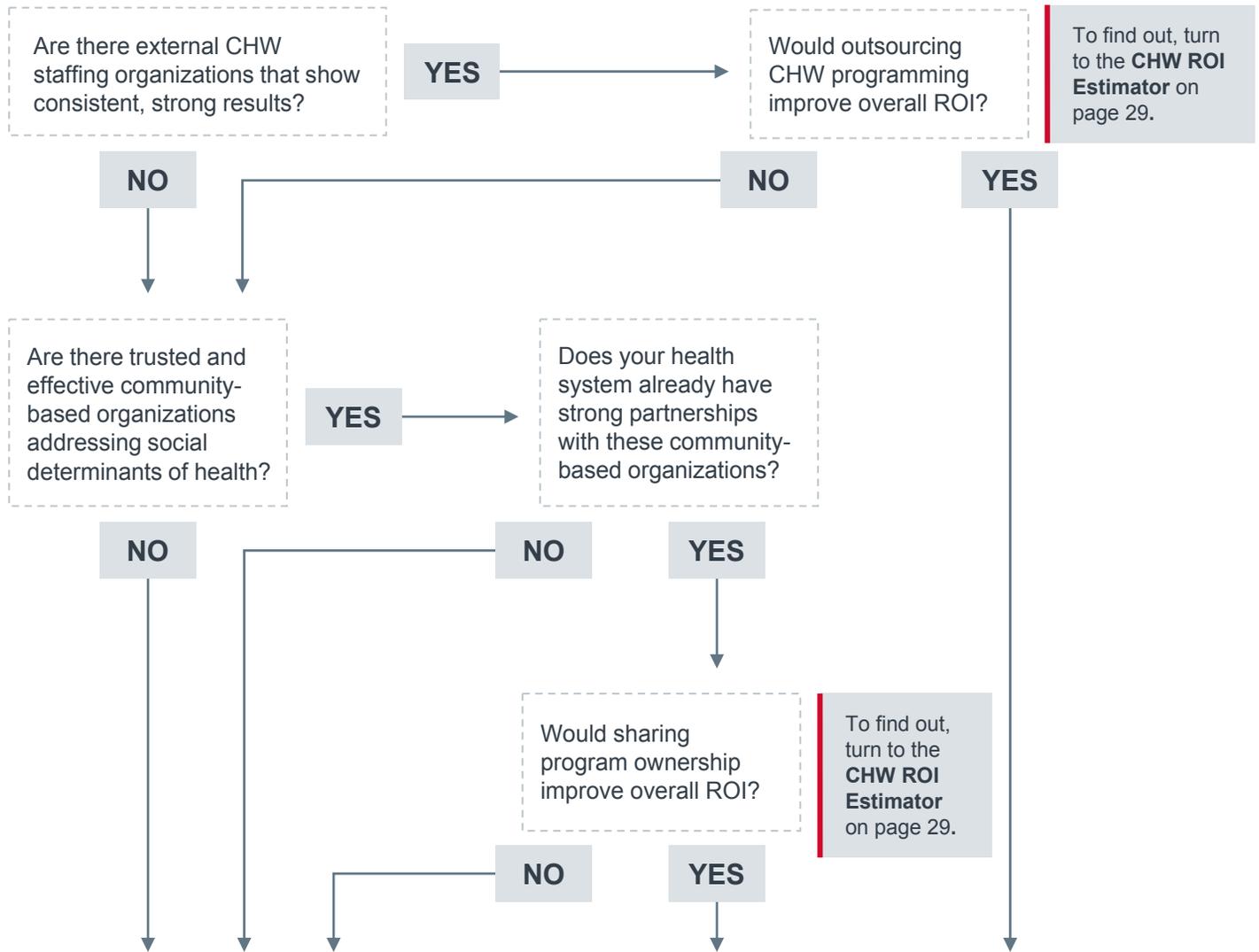
- Staffing model decision guide
- Sample job description
- Recruiting and hiring guidelines

Determine recruitment approach

Hire, share, or outsource staff based on community resources, financial viability

Use the staffing model decision guide below to assess whether CHW sourcing and management should be owned internally, shared with community partners, or outsourced to external organizations.

CHW staffing model decision guide



1

Grow and own entire program in-house

Review **The University of Pennsylvania Health System's** model in [Community Health Worker Programs: A Case Study Compendium](#) on advisory.com.

2

Share staffing ownership with partner organizations

Review **NewYork-Presbyterian Hospital's** model in [Community Health Worker Programs: A Case Study Compendium](#) on advisory.com.

3

Outsource staffing to external organizations

Review **Mount Sinai Health System's** model in [Community Health Worker Programs: A Case Study Compendium](#) on advisory.com.

Source: Population Health Advisor interviews and analysis.

Create clear job description that specifies expectations

Set internal standards for the role to ensure that staff work top-of-license

Providers that decide to hire their own CHW staff must develop a job description before recruiting for the position to communicate how CHWs will fit within care teams or departments. The best job descriptions explicitly communicate which tasks CHWs will take on to protect against “role creep” and mitigate burnout.

NYU Langone Health’s community health worker job description

COMMUNITY HEALTH WORKER

The CHW is part of an interdisciplinary team that includes, but is not limited to, medical and behavioral health providers servicing patients who suffer from complex medical and/or psychiatric comorbid conditions.

By ensuring patients remain engaged in services and programs, educated about self-care issues, and assisted with access to care, the CHW will be part of a team that improves patient health and thus quality of life.

RESPONSIBILITIES INCLUDE

- Assist patient with accessing a full range of medical, behavioral health, chemical dependency, psychosocial, and community services including referrals to self-help groups and community organizations
- Advocate for patients when barriers to care exist, including language and literacy barriers, access to transportation, problems with insurance coverage, child care problems, appointment scheduling conflicts, and more
- Assist case/care manager with coordination of patient care in the community, when the patient is hospitalized, and during transition from the hospital to the home
- Provide office and community-based support services to patients, such as escorts to medical appointments, appointment reminders, and assistance with obtaining medications from pharmacies
- Assist patients and their families with benefits, entitlements, and housing as well as any other identified needs that impact patients’ physical health and emotional well-being
- Maintain electronic records and compile statistical data in accordance with the department’s standard; complete clinical documentation within required time frames
- Assist care/case management staff in conducting pre-visit planning and hospital discharge phone outreach
- Conduct outreach efforts in the community to engage high-risk patients in case management services
- Perform other duties as assigned or volunteered in alignment with the organization’s mission, goals, and values
- Maintain caseload size established by the department and meet monthly outreach and engagement productivity requirements
- Certain openings will require foreign language skills; those determinations will be made as needed and indicated on the job posting; languages such as Spanish, Chinese, Arabic, Russian or Yiddish may be needed

MINIMUM EDUCATION

- High school diploma/GED

MINIMUM EXPERIENCE/REQUIREMENTS

- At least one year of experience in a health service related field
- Bilingual (English and Spanish)
- Computer literate

REQUIRED LICENSE, REGISTRATION, CERTIFICATION

- High school diploma/GED

PREFERRED QUALIFICATIONS

- Experience working with patients diagnosed with mental health, substance abuse, and/or chronic health conditions
- Telephone, fax machine, and photocopy skills

Tailor recruiting and hiring to surface best fits for the role

Right hires make or break the success of the intervention

Use these guidelines to streamline the hiring process by targeting recruitment, identifying key candidate qualities, determining required previous experience, and using nontraditional interview tactics.

Guidelines for finding the right candidates

Recruiting tips



- Look outside traditional recruiting mechanisms to identify candidates heavily involved in their community, including posting listings around community-based organizations and in volunteering portals
- Use geotargeting data analysis (e.g., local payer mix, community demographics, prominent diseases) and local expertise from community partners to identify target communities to serve and characteristics CHWs should embody
- Outreach to program graduates who show leadership qualities and would be able to share their own experiences of growth with patients

Key qualities and skills to prioritize



- Strong ties to the community CHWs will be serving and in-depth knowledge of existing community resources
- Similar life experiences as potential patients, including shared demographics and experience managing chronic illnesses
- Ability to speak major languages of the community
- High-caliber social, listening, and communication skills
- Empathetic and nonjudgmental
- Demonstrated leadership skills
- Assertive when advocating for patients' needs
- Ability to work with people from different cultures or those who have experienced trauma
- Ability to work independently
- Ability to form positive relationships with patients and the care team quickly

Previous experience necessary for success



- Demonstrated interest in working in a health care setting
- Involvement with local community-based organizations and social services, such as volunteering background, housing case management, and community-based mental health outreach
- High school diploma or GED

Interview tactics to determine applicant fit



- Hold group interview sessions to see how applicants interact and build relationships with peers, including whether they listen more than speak or make others feel at ease
- Role play difficult scenarios applicants could face in the role, such as a combative patient, to gauge whether they remain calm, communicative, and empathetic
- Invite applicants to shadow a CHW in the role to ensure both parties believe the position is a good fit

Source: Population Health Advisor interviews and analysis.

Step 4

Create a retention plan

There are several reasons why CHW programs can have high turnover rates:

- Lack of training to manage patients in crisis
- Insufficient management support to ensure CHWs work at top-of-license
- Difficulty managing heavy caseloads full of complex patients
- Inconsistent job stability

To provide effective care, CHWs need sufficient training, proper tools, and supportive day-to-day management. Some organizations build training programs in house, though state-run certification courses pose a good opportunity to mitigate resource needs and formalize expectations for the role. Many organizations teach CHWs how to respond in situations if they or their patients are in danger. This can include designating a main point of contact when patients experience a medical emergency and CHW safety confirmation texts to a supervisor before and after home visits.

Program leaders also develop tools to support CHWs across settings and maximize role efficiency. For example, intake assessments ease the screening process and allow for data gathering on patient demographics. These tools help CHWs work at top-of-license across care teams and ensure that they remain supported in challenging situations, reducing burnout and turnover.

Guidelines for day-to-day expectations should allow for flexibility to manage workload, protect time for administrative duties, and maintain lean patient panels. A good management team also clearly articulates pathways for career advancement.

This section includes tools to help providers create a retention plan:

- Sample training schedule
- Overview of a CHW's daily role
- Sample financial needs assessment
- Sample career mapping process

Design training to develop key skills for the position

Strong candidates more likely to succeed with robust training

To become a certified CHW in the state of New Mexico, trainees must take 100 hours of the core competency training listed below as well as a minimum of 80 hours of hands-on experience. The New Mexico Department of Health created the curriculum in collaboration with the University of New Mexico and several community colleges. The university system operates didactic training through weekly night classes over the course of six months, followed by six months of field work.

New Mexico Department of Health’s Office of Community Health Workers certification curriculum

1 The CHW profession



- Scope of practice
- History of the profession and the code of ethics
- Setting professional boundaries and practicing self-care
- Cultural humility
- Organization and professional skills

2 Communication skills



- Observation skills
- Verbal and non-verbal communication
- Active listening
- Negotiating, mediating, and resolving conflict
- Documentation protocols

3 Interpersonal skills



- Establishing trust
- Building relationships
- Demonstrating empathy and compassion

4 Health coaching



- Health promotion and disease prevention tactics
- Behavior change strategies
- Maintenance and relapse prevention

5 Service coordination skills



- Case finding and recruitment
- Navigation and linking to services
- Case management

6 Capacity-building skills



- Strengths-based approach to patient management
- Health literacy
- Community organizing
- Leadership development

7 Advocacy skills



- Speaking on behalf of individuals and organizations
- Educating health and social service systems
- Working for change in practices and policies

8 Technical teaching skills



- Adult learning principles
- Health education for individuals and groups
- Running effective meetings

9 Health outreach skills



- Opportunities for performing outreach
- Planning and conducting health outreach
- Home visits
- Safety protocols

10 Community knowledge



- Gathering community knowledge and strengths
- Identifying community needs and priorities
- Sharing results with care teams

11 Clinical support skills



- Health coaching and interpretation of test results for blood pressure, blood glucose, cholesterol, and BMI
- Identifying oxygen saturation, pulse, respiration rate, and temperature

Optional for achieving “specialist” certification, the next step in the CHW career ladder

Source: UNM Health, Albuquerque, New Mexico; Population Health Advisor interviews and analysis.

Institute processes to streamline workflow, manage workload

University of Pennsylvania's CHW daily responsibilities

No two days are the same for a CHW. Each week, CHWs may perform home visits, attend clinical appointments, and/or work with patients in the community. Day-to-day flexibility should be paired with adequate support to ensure CHWs can manage their range of responsibilities. Here's how the University of Pennsylvania's IMPaCT program streamlines their CHWs' daily workload.

★ Indicates calls that the lead CHW, Cheryl Garfield, fields from current patients, former patients, and fellow CHWs for support and advice.

Penn's IMPaCT program reserves time for clinic care and community visits

New patient intake

● **9:30 a.m. Touch base at the CHW's administrative center to plan for the day.** Cheryl starts her day by checking her list of target patients for outreach at her clinical touchdown space, Penn's Center for Community Health Workers. It's located across the street from her assigned hospital, where she heads first.

★
● **10:15 a.m. Perform outreach to target hospitalized patients for post-discharge support.** Cheryl starts outreach with patients who were flagged from IMPaCT's algorithm as eligible for programming. Cheryl determines patient viability by identifying the right point of contact on each patient's care team, including the resident, RN care manager, clinical resource coordinator, or social worker. This staff member should explain the patient's clinical status, such as if they're out for testing or when they'll be discharged.

Cheryl enrolls one patient into the CHW program, within the range of the Center's weekly goal of 1-3 new patients. She was able to get through about half of the standardized intake interview before the patient was taken for additional testing.

Lean patient panel allows for telephonic check-ins with patients and home visits

Autonomous management structure protects role integrity

Home visits

● **11:30 a.m. Check in on recently discharged patients in the community.** Grabbing her prepaid transportation pass, Cheryl heads to catch the train and then a connecting bus to conduct unscheduled pop-ins with patients she hasn't heard from or seen in a while.

Cheryl arrives at her patient Dorothy's¹ house in West Philadelphia. Dorothy's Medicaid-funded shuttle service has been unreliable, causing her to miss her dental and vision appointments. Cheryl asks Dorothy to call her the morning of her next appointment if she hasn't heard from her ride, so Cheryl can arrange an alternative.

★
★
● **1:30 p.m. Cheryl arrives at her next drop-in for her patient. Ronald¹ is a recent returning citizen from the criminal justice system and was admitted to Penn after being shot. After knocking and receiving no answer, Cheryl leaves her card to encourage him to reach out.**

Scripted assessments ease intake process and relationship building

Reserved time for administrative duties

● **2:30 p.m. Complete patient documentation in the HOMEBASE web-based platform.** Cheryl returns to the Center to write quick notes about her patient interactions of the day. Then, Cheryl meets with the Center's Chief Operating Officer to discuss their upcoming presentation at a National Association of Community Health Workers conference.

Protected time for administrative tasks allows for timely data tracking

Platform steadies panel size, streamlines patient information

1) Pseudonym.

Source: University of Pennsylvania Health System, Philadelphia, PA; Population Health Advisor interviews and analysis.

Standardize psychosocial needs assessments for CHWs

Empathy and good communication support information sharing

Standardized patient assessments prepare CHWs for each patient intake and collect patient information necessary for care. CHWs, skilled in relationship-building, use this opportunity to build trust, reduce stigma surrounding social needs, and uncover root causes of complexity.

Kalispell Regional Medical Center’s patient financial need assessment

Name: _____ Date of Birth: _____

SS#: _____ Phone: _____

Emergency Contact #1: _____

Emergency Contact #2: _____

May we contact your emergency contact if we are unable to reach you by phone? _____

What level of education do you have ? _____

Do you have Medicare? Yes _____ No _____ Coverage: _____ A _____ B _____ C _____ D _____

Do you have Medicaid? Yes _____ No _____ Coverage: _____ Waiver? _____

Are you a Veteran? Yes _____ No _____ Dates of Service: _____

Do you have Veteran’s Benefits? Yes _____ No _____ Are you the spouse of a Veteran? Yes _____ No _____

Please share general information about your current medical challenges: _____

Monthly Income	Amount	Expenses	Amount	Support System	
Wages, Tips		Rent/Mortgage		Family	
Social Security		Electricity		Friends	
SSDI/SSI		Gas		Church	
VA		Water		Neighbors	
Pension/Retirement		Garbage		Groceries	
SNAP		Groceries		Meals	
Worker’s Comp		Medical Premiums		Transportation	
Other		Prescriptions		House Cleaner	
Other		Auto Expenses		Errands	
Resources	Value	Fuel		\$ Management	
Vehicles		Clothing		Caregiver	
Home		Telephone		Socialization	
Property		Cable		Peer	
Stocks/Bonds/IRA		Internet		Support Group	
Rec Vehicles		Credit Cards		Hobby	
Other		Other		Pet	

Source: Kalispell Regional Medical Center, Kalispell, MT; Population Health Advisor interviews and analysis.

Standardize psychosocial needs assessments (cont.)

Best relationships with patients are empathetic and communicative

Kalispell Regional Medical Center's patient financial need assessment (cont.)

Physical Limitations (please check all that apply): Oxygen Wheelchair Walker Crutches Glasses
Hearing Aides Handicap Accessibility Prosthesis Pump Wounds Other _____

Technology (please check all that apply): Android iPhone Flip Phone Computer Tablet Internet

ReSource Agreement

Please sign below to indicate that you are willing to have the ReSource Team help connect you with community resources necessary to aid in your health and well-being. Your signature gives the ReSource Team authorization to talk with your financial or medical team, if necessary, to discuss your history, physical report and medication record to help create a comprehensive network of care and to connect you to appropriate resources. You have the right to revoke this authorization in writing at any time by contacting the ReSource Nurse at 406-758-1394.

Signature of ReSource Team Client: _____ Date: _____

Printed Name: _____

If legal representative, what is your relationship to the patient: _____

Ensure staff have avenues, but not requirements, for growth

Many CHWs prefer to remain frontline staff, still rewarded for performance



CASE
EXAMPLE

NewYork-Presbyterian Hospital

Nonprofit university hospital affiliated with Columbia and Cornell Universities • New York, NY

NewYork-Presbyterian (NYP) supports CHW retention by providing staff with options for salary growth and career change if preferred. CHWs can choose one of three major options for growth in NYP's program: remain in their role, explore leadership roles within the CHW program, or transition to alternative roles within the community health department.

Three common career paths support CHW growth—with or without a title change

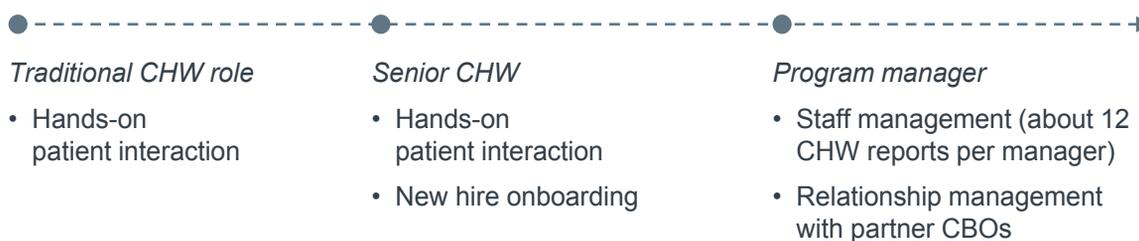
1 Remain in the CHW role in the long term

In NYP's model, CHWs are employees of partner community-based organizations (CBOs) where they are based and health system contractors. Many CHWs prefer to remain in the frontline role to continue building meaningful patient relationships. However, program leaders still must proactively support professional growth and retention by celebrating positive performance. NYP implemented:

- Annual cost-of-living increases
- Monthly CHW appreciation ceremony with a monetary gift

2 Explore leadership roles within the CHW program

Some CHWs will take natural leadership roles with their peers, including offering training and advice. Others may naturally develop positive working relationships with key points of contact at partner community-based organizations. NYP created a pipeline for natural leaders to rise to managerial roles. Each position comes with a salary raise.



3 Transition to alternate roles within the department

Some CHWs may develop an interest in exploring other health care-related roles. CHW and CBO supervisors co-lead monthly performance-based check-ins with CHWs, which can include surveying engagement and interest in department-wide opportunities as they arise. The three most common role shifts are all NYP positions with full benefits:

- *Staff assistant*: Administrative role still connected to community health
- *Program coordinator*: Located at the partner CBO sites to support CHW program manager
- *ED navigator*: Similar patient interaction as CHWs but in an acute setting vs. the community

Source: NewYork-Presbyterian Hospital, New York, NY; Population Health Advisor interviews and analysis.

Step 5

Demonstrate long-term performance

Most CHW services are not reimbursable in fee-for-service contracts except in states where CHWs are fully enrolled as Medicaid providers. Leaders often measure program ROI by estimating avoided downstream costs in both the short and long term.

In the short term, program leaders select metrics that indicate the performance of CHWs. These metrics, such as increased social service referrals and reduced primary care no-show rates, can be measured in real time and serve as a proxy for long-term outcomes. In the long term, leaders select metrics that demonstrate how CHWs lead to downstream cost avoidance.

Providers should track performance management indicators that ensure CHWs operate at full capacity. Some providers use a dashboard to manage performance in real time, communicating expectations to staff at the outset, and intervening when CHWs need support.

Providers use two ways to measure the ROI of CHWs in the long term. Some program leaders communicate ROI as the monetary value of time saved when CHWs complete tasks instead of clinical staff. Other program leaders value ROI based on cost savings achieved through avoided utilization.

This section includes tools to help providers demonstrate long-term performance:

- Program metric picklist
- Sample performance measurement dashboard
- Calculator for the value of clinical time saved
- CHW ROI estimator

Define success for program in the short and long term

Metrics should map to articulated program goals and indicate ROI

Select a mix of short- and long-term metrics at the outset to measure progress to stated goals, including reduced unnecessary utilization and improved quality scores. Process metrics offer early indications of progress, while outcome metrics are most compelling to funders and internal leaders.

Community health worker metrics picklist

Short-term	Long-term
Volume (e.g., number of patients served, number of patient interactions)	Staff turnover rate (e.g., longevity in the role)
Change in clinical measures (e.g., HbA1c level, blood pressure, body mass index)	Reduced utilization (e.g., ED use, inpatient admission, length of stay, 30-day readmissions)
Improved health literacy (e.g., understand how to take medications)	Estimated cost avoidance
Reduced no-show rates	Change in HCAHPS ¹ quality scores
Volume of social service referrals	Impact on community health priorities (e.g., reduced health disparities)
Patient- and caregiver-reported satisfaction (e.g., would refer program to a friend, enrollment and retention rates)	
Provider-reported satisfaction (e.g., off-loaded responsibilities)	

1) Hospital Consumer Assessment of Healthcare Providers and Systems.

Source: Population Health Advisor interviews and analysis.

Measure performance in real time to track progress to ROI

Penn uses platform to track improvement in patient health, cost, and satisfaction



CASE
EXAMPLE

University of Pennsylvania Health System
Six-hospital health system • Philadelphia, PA

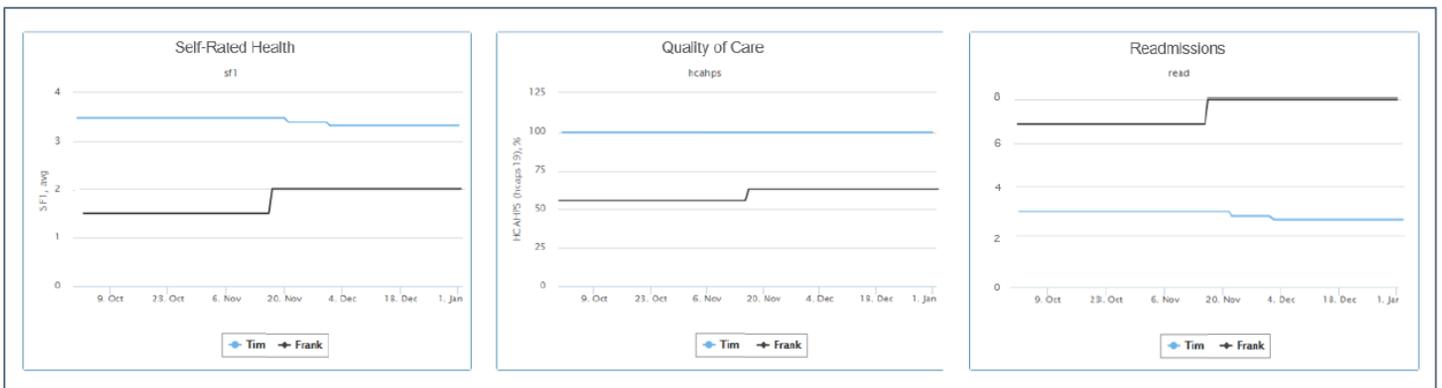
The University of Pennsylvania Health System (Penn) employs CHWs across the inpatient and ambulatory care setting under an independent management structure. The evidence-based program, IMPaCT, uses an internal algorithm integrated in a web-based platform, HOMEBASE, to identify target patients. CHWs track patient interactions and progress to predetermined benchmarks, such as percentage of patient-centered goals resolved or percentage of patients connected with a PCP within two weeks post-discharge. Leaders determine benchmarks based on performance measured during Penn’s clinical trials and include three major areas: care experience, care cost, and patient health. High performance factors into promotions along IMPaCT’s CHW Career Path Program.

Penn program managers use HOMEBASE platform to review staff performance

Summary for active patients													Summary for inactive patients												
9 patients (in past 12 months)													12 patients (in past 12 months)												
56% roadmaps complete													92% roadmaps complete												
88% of patients got discharge meds													100% of patients got discharge meds												
33% of patients had CHW present at discharge													33% of patients had CHW present at discharge												
44% of patients completed PCP appt													75% of patients completed PCP appt												
33% of patients completed PCP appt within 2 weeks													8% of patients completed PCP appt within 2 weeks												
0 readmission rate													0 readmission rate												

Study ID	Name	Start Date	Discharge or Rehab Date	Latest Review	Roadmaps Resolved	D/C Document	CHW at D/C	Meds Filled	Calendar received	Appt Complete	D/C till Appt	30d Readmissions
3801	Sally Stewart	8-30-18	9-3-18	9-6-18	33% (1/3)							1
3682	Reggie Brenner	8-17-18	8-23-18	9-5-18	50% (1/2)							7
1324	Felicia Storm	8-9-18	8-16-18	8-30-18	100% (2/2)							4

Leaders compare CHWs across three domains of patient improvement



Source: University of Pennsylvania Health System, Philadelphia, PA; Population Health Advisor interviews and analysis.

Measure value of clinical time saved with CHWs

Off-loading social support allows clinical staff to operate AT top-of-license

One way to communicate the financial impact of CHWs is to measure the value of time savings when CHWs off-load tasks from more expensive clinical FTEs, such as physicians and RNs. Survey target clinical staff to uncover average number of hours spent on addressing patients' non-clinical needs per week. Multiply the value by number of work weeks to obtain total hours spent per year. Then, multiple the yearly value with the staff type's average hourly rate. To determine hourly rate, multiply the number of work weeks per year by typical weekly hours. Then, divide average salary by that number. Repeat the process for all staff types performing tasks that could be off-loaded to CHWs to determine total savings opportunity.

Sample calculation of value of time saved when introducing CHWs into the care team

Staff member	Hours spent on non-clinical needs per week	Hours spent on non-clinical needs per year ¹	Salary	Hourly rate ¹	Value of time spent on non-clinical needs
	A	$A \times 50 = B$	\$X	$\$X / 2,000 = Y$	$B \times Y$
PCP	2	$2 \times 50 = 100$	\$243,864	$\$243,864 / 2,000 = \122	$100 \times \$122 = \$12,200$
RN	4	$4 \times 50 = 200$	\$81,000	$\$81,000 / 2,000 = \41	$200 \times \$41 = \$8,200$
SUM					\$20,400

Staffing-specific metrics picklist

Process	Outcome
<ul style="list-style-type: none"> Total number of non-clinical issues referred to CHWs from clinical team members Percentage of high-risk patients with an identified non-clinical need 	<ul style="list-style-type: none"> Number of non-clinical issues resolved by CHWs Estimated time savings of clinical staff



ESTIMATE VALUE OF CLINICAL TIME SAVED
 when using CHWs top-of-license with our [Non-clinical Care Team Member ROI Calculator](#) available on advisory.com.

1) Assumes 50 working weeks, 40 hours a week.

Source: "The highest- and lowest-paid doctors, in 5 charts," *The Daily Briefing*, Advisory Board; "What nurses are paid—and how salaries vary, mapped," *The Daily Briefing*, Advisory Board; Population Health Advisor interviews and analysis.

Capture cost avoidance due to reduced utilization

Positive ROI can help make the case for ongoing program support

The industry standard across risk-based contracts for measuring an intervention's impact is to track changes in an attributed population's per member per month (PMPM) spend. Many initiatives, including CHW programs, can take time to implement and realize a return. Use our **Community Health Worker ROI Estimator** tool below to determine the ROI of a CHW program by comparing estimated cost avoidance with intervention costs.

Fill in the following input categories to calculate program ROI: patient volumes, staffing costs, non-staffing costs, fixed up-front costs, acute utilization cost avoidance, clinical staff time savings, and increased cost of preventive care. Sourced averages are listed when possible, though organizations should enter internal data for a more accurate estimate.

Community health worker ROI estimator sample usage

Inputs	Sources	
Patient volumes		
Eligible patients based on target population (e.g., high-risk post-discharge)	500	
Percent of target population expected to enroll	50%	External source estimate for super-utilizer program.
Total intervention population	250	
Annual staffing costs		
Number of enrolled patients per CHW	30	PHA interviews and analysis ratio estimate.
Number of CHW FTEs required for enrolled patients	8.33	
Base salary per CHW	\$ 38,370	National average.
Benefits as percent of annual salary	30%	Program comparison overview.
Transportation vouchers per CHW	\$ 1,700	Program comparison overview.
Number of CHWs per manager	4	PHA interviews and analysis.
Manager FTEs required for hired CHWs	2.08	
Manager FTE salary	\$ 60,000	External source estimate.
Benefits as percent of annual salary	30%	Program comparison overview.
Annual rate of salary and benefits growth	3%	PHA interviews and analysis.
Total year staffing costs	\$ 272,594	

CHW program inputs	Year			
Volumes	0	1	2	3
Enrolled patient volume		250	300	360
Costs				
Staffing costs		\$272,594	\$280,772	\$289,195
Non-staffing costs		\$13,700	\$13,700	\$13,700
Fixed up-front costs	\$20,365	N/A	N/A	N/A
Primary care costs		\$0	\$0	\$0
Total costs	\$20,365	\$286,294	\$294,472	\$302,895
Savings and revenue				
Acute care utilization cost avoidance	\$	767,497	\$ 920,996	\$ 1,105,195
Clinical staff time savings	\$	18,264	\$ 18,264	\$ 18,264
Total savings	\$	785,761	\$ 939,260	\$ 1,123,459
Savings estimate	\$ (20,365)	\$ 499,467	\$ 644,788	\$ 820,564
	<i>Total</i>	\$ 1,944,454		
Return on investment		2.74	3.19	3.71
	<i>Overall</i>	3.71		

 **SEE HOW YOUR PROGRAM MEASURES UP**
by inputting your data in the [Community Health Worker ROI Estimator](#) available on advisory.com.

Advisors to our work

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