Santa Clara County
PUBLIC HEALTH

**Community Health Worker Program Feasibility Study**

Preliminary Findings Report

April 2026

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# Executive Summary

The 2025 Latino Health Assessment documented severe and longstanding health disparities among Latino residents of Santa Clara County, concentrated in East San José, South County, and the Cadillac-Winchester neighborhood. The assessment also highlighted the resilience and internal capacity of Latino communities and recommended expanding Community Health Worker (CHW)/Promotor services as a strategy to improve health outcomes. This report responds to that recommendation. To the extent that the Board identifies resources to direct expansion of the CHW/Promotor workforce in Santa Clara County, the Public Health Department recommends that the resulting program be designed to serve all residents identified to be at disproportionate risk for poor health outcomes in these communities, without limitation as to race or ethnicity.

This study was shaped by the CHW/Promotor workforce and the communities they serve. Promotores, community-based organization (CBO) leaders, managed care plan representatives, and County agency staff all contributed through surveys, interviews, focus groups, and advisory committees. The research team combined this community input with economic modeling and an analysis of CHW programs in five California peer counties.

**What We Heard**

Five findings emerged consistently across the community input and economic analysis.

Clinical billing through Medi-Cal covers only 6 to 9 percent of the cost of operating a CHW/Promotor program. The remaining cost requires funding from multiple sources. Programs that depend on a single grant or revenue stream are vulnerable to collapse when that source ends; one peer county lost 120 CHW positions after a single federal grant expired. A blended funding structure in which no single source exceeds 40 percent of the total budget is a structural requirement, not an administrative preference.

Individual CBOs cannot build the billing, credentialing, and quality assurance infrastructure that Medi-Cal reimbursement requires. Each CHW/Promotor generates an estimated $278,000 in healthcare costs avoided per year. Capturing those savings requires contracting with managed care plans, cybersecurity compliance, claims management, and outcome reporting that smaller organizations cannot sustain alone. The County itself likely will not have budgetary savings generated from CHW/Promotor programs to invest, but managed care plans may have modest savings. Every California county that has scaled a CHW program past 100 workers has created a coordinating entity to absorb this complexity on behalf of partner CBOs.

Compensation does not reflect the full labor of this workforce. The survey median rate of pay is $30 per hour; 64 percent of respondents say this is not a living wage. Evening, weekend, and crisis-response work routinely goes uncompensated. With only 14 percent of respondents holding full-time positions, workforce retention is a persistent challenge.

Training gaps are structural, not incidental. Existing curricula in the County collapse when grant cycles end, and the next funding cycle starts over with recruitment and retraining. The per-CHW cost model includes a $5,000 onboarding budget; sustained delivery requires investment in CBO-led training programs that cover both clinical competencies and community-identified priorities, such as intimate partner violence, disability services, and Indigenous language capacity.

Community voice in the program is not optional. The peer county analysis found four consistent success factors in programs that were scaled: blended funding, formal workforce pipelines, coalition input, and shared technology infrastructure. Stakeholders in this study identified the same priorities. The program must center the CBOs and communities it serves.

**Recommendations**

Based on these findings, this report makes seven recommendations that together secure sustainable funding and establish the program structure to deliver it.

1. Establish a community resilience hub, housed within the County's public health infrastructure and leveraging established community partnerships, to coordinate billing, credentialing, and quality assurance across partner CBOs. The hub would absorb administrative complexity so CBOs retain autonomy over programmatic and community work. The design includes a plan to scale the CHW/Promotor network over time, a blended financial structure where no single source of revenue exceeds 40 percent of the overall budget, a data-sharing system that supports cross-agency collaboration, regular public reporting, and a CBO partnership council to advise the County.

2. Preserve both clinical and community resilience pathways through dedicated funding tied to healthcare savings captured within the County's shared fiscal ecosystem, in order to increase cost-effectiveness and impact. The measured

impact of this work would evolve from service outputs in Years 1 through 2, to utilization changes in Years 1 through 3, to health and community resilience outcomes in Years 3 through 5, with an explicit minimum share of CHW time and funding dedicated to non-billable community work. The savings captured by the cost-effectiveness model come from the interaction of the two pathways. The billable clinical work produces reimbursement; the non-billable community work produces the behavioral and utilization changes that drive downstream healthcare savings. Funding one without the other erodes the fiscal return.

3. Fund training through CBO and managed care plan grants, with priority areas identified by the workforce: professional development for managers and supervisors, intimate partner violence, disability services with emphasis on children, worker compensation and rights, and Indigenous language capacity for South County. Experienced promotores begin supervised work immediately under current Department of Health Care Services (DHCS) qualification rules; new entrants receive a stipend for pre-employment training. The hub provides California Advancing and Innovating Medi-Cal (CalAIM) billing and documentation training so individual CBOs do not each have to build that capacity alone.

4. Maximize cost-effectiveness and impact by prioritizing CHW training and deployment in youth services, violence prevention, and chronic disease management across the three geographic areas, with equitable distribution reflecting local need and community capacity. Youth services include connecting families to social safety net programs, disability screenings, and mental health services in schools.

5. Build on the existing CBO landscape and protect the integrity of the CHW/Promotor role by supporting all models (cooperatives, independent, organization-based) and maintaining CBO autonomy, community input through the partnership council, and an explicit minimum for non-billable community resilience activities.

6. Ensure pay equity by establishing County labor standards as the floor for contracted CBO positions, with health coverage and benefits as a condition of County-funded contracts. The $59,000 baseline exceeds the County Living Wage Ordinance rate of $54,038 ($25.98/hr); the $62,400 survey median provides an additional benchmark. Compensation structures should also account for the evening, weekend, and crisis-response work that promotores currently perform without pay.

7. Establish a voluntary CHW-to-CHW peer network through the hub, connecting promotores across the three geographic areas for shared problem-solving and professional growth. The hub provides the infrastructure; promotores direct the content.

# Key Terms

**Community Health Worker/Promotor (CHW/Promotor)**
The compound term used throughout this report. “CHW” is the federal and state workforce classification for Medi-Cal billing; “Promotor” (feminine: promotora, plural: promotores) reflects the community-rooted model emphasizing peer connection, cultural concordance, and lived experience. The gender-inclusive form is used because partner CBOs employ both men and women in this role, though the workforce is predominantly female. See the terminology note following the study area descriptions.

**Community resilience hub**
Housed within the County’s public health infrastructure, leveraging established community partnerships, the hub would coordinate billing, credentialing, and quality assurance across partner CBOs (Recommendation 1).

**Community-Based Organization (CBO) partnership council**
A body composed of the community-based organizations served by the hub. Identifies training needs, provides operational feedback, and protects against mission drift.

**Clinical pathway**
CHW/Promotor activities reimbursable under Medi-Cal: care coordination, patient navigation, chronic disease management. Generates measurable healthcare savings.

**Community resilience pathway**
Non-billable CHW/Promotor activities: group education, leadership development, community organizing, outreach. Operates on longer timelines; value is real but not captured in cost models.

**California Advancing and Innovating Medi-Cal (CalAIM)**
A statewide initiative to transform the Medi-Cal delivery system, including Enhanced Care Management and Community Supports.

**Enhanced Care Management (ECM)**
A CalAIM benefit providing intensive care coordination for high-risk Medi-Cal members, paid as a per-member-per-month (PMPM) capitation from the managed care plan to contracted providers.

**Community Supports**
CalAIM service-based reimbursements for social interventions (housing, food, recuperative care), layerable with ECM.

**Fee-for-Service (FFS)**
A payment model in which Medi-Cal reimburses CHW services on a per-visit basis using billing codes CPT 98960, HCPCS G0019/G0022.

**National Provider Identifier (NPI)**
Required for Medi-Cal billing; the hub holds NPIs for smaller CBOs that route claims through it.

**Federally Qualified Health Center (FQHC)**
A federally designated community health center that receives federal funding and prospective cost-based reimbursement for health care services provided to vulnerable populations. FQHCs face a prospective payment system exclusion that prevents them from billing separately for CHW services (see Additional Detail in the Technical Report).

**Cooperative LLC**
A Limited Liability Corporation structured as a worker cooperative, allowing community members to participate as business owners. Six CHW/promotor cooperatives operate in East San José under this model (see The Role and History of Community Health Workers/Promotores).

**Lived experience**
In CHW practice, this refers to a worker's experience navigating the same conditions faced by the community they serve, including poverty, immigration, chronic illness, housing instability, and interactions with public systems. Research consistently finds that shared lived experience enables the trust and cultural grounding that distinguish CHW interventions from conventional case management. This is an observed characteristic of effective CHW programs across the literature, and it describes a relationship between the worker and the community rather than a demographic criterion for hiring.

**Focus population**
The focus population for the CHW/Promotor Program Feasibility Study was Latino residents in the 10 target ZIP codes. The study's focus on this population reflects documented disparities but does not preclude the implementation of a program that extends beyond it, consistent with County nondiscrimination policies.

**Disproportionate risk for poor health outcomes**
Residents who face higher-than-average rates of preventable hospitalizations, emergency department visits, chronic disease mortality, and unmet preventive care needs relative to the county average. In this study, disproportionate risk is identified through markers such as Medi-Cal eligibility or enrollment, income below the federal poverty level, presence of two or more chronic conditions, and disability status. The designation describes exposure to upstream risk factors rather than membership in any specific racial, ethnic, or demographic group.

# Introduction

## Purpose of This Report

This report presents findings from the CHW/Promotor Program Feasibility Study conducted by the Public Health Department. The study addresses four questions:

1. What does the existing CHW workforce look like in Santa Clara County?
2. What does the published evidence say about CHW program effectiveness and cost?
3. What would a CHW program cost to implement, and what economic returns could it generate?
4. What do local stakeholders and community members identify as priorities for program design?

The study also addresses a fifth question that emerged from stakeholder engagement and the evidence review: how should the program balance clinical care activities (which generate measurable cost savings) with community resilience activities (which address the structural drivers of poor health)?

Four evidence streams addressed these questions: a workforce landscape analysis, a published literature review, economic modeling (such as return on investment, budget impact, cost-effectiveness, and equity analysis), as well as stakeholder engagement (17 key informant interviews, a CHW survey, community focus groups, and advisory committees). Data sources and methodology are detailed in Study Methodology.

## Study Area

The feasibility study focuses on three geographic areas identified as priorities for CHW program expansion based on health disparities data, Medi-Cal enrollment concentration, and gaps in existing CHW infrastructure. Across all 10 ZIP codes, Medi-Cal enrollment is 25.3%, compared to 16.0% countywide; uninsurance is 5.8%, compared to 4.0%; and median household income is $126,752, compared to $159,674 (American Community Survey [ACS] 2019–2023 5-year). Within these communities, the feasibility study estimated costs and returns for Latino residents. Existing health and social service systems do not reach this population as effectively as the county average: higher rates of uninsurance, limited English proficiency, immigration-status concerns that deter participation in public programs, and fewer culturally and linguistically concordant providers all contribute to persistent disparities in health outcomes. A CHW/Promotor program addresses these barriers by fostering trust through shared language, culture, and lived experience. The cost-effective findings reflect this population's specific health characteristics, utilization patterns, and insurance mix.

The benefits of these programs, however, are not confined to the focus population. When CHWs connect residents to preventive care, enroll families in social safety net programs, and build relationships with clinics and schools, the resulting infrastructure serves all residents who face barriers to care.

- **Cadillac-Winchester** (ZIP codes 95117, 95128): A racially and economically mixed neighborhood in west San José with approximately 60,400 residents. Thirty-one percent of residents are Latino, 35% are foreign-born, and 51% speak a language other than English at home (ACS 2023 5-year). Among Latino residents, 12% are uninsured. LUNA is the only organization with a dedicated promotor/a presence, deploying workers from East San José through a county violence prevention contract.[17] Primary care infrastructure includes AACI (headquartered at 2400 Moorpark Ave), Valley Health Center Moorpark (a Santa Clara Valley Healthcare, or SCVHC, satellite), and Indian Health Center satellites. These represent anchored infrastructure, though residents also access care at facilities outside the neighborhood. Area-wide indicators: median household income $115,778–$122,647, poverty rate 9.6%, Medi-Cal enrollment 19.5%, uninsured 6.1% (ACS 2019–2023 5-year).

- **East San José** (ZIP codes 95116, 95121, 95122, 95127, 95148): Home to approximately 242,400 residents with the county's highest concentrations of Medi-Cal-eligible individuals. Forty-six percent of residents are Latino, 48% are foreign-born, and 73% speak a language other than English at home, the highest rate among the three study areas. Spanish (36% of residents 5+) and Vietnamese (19%) are the two most common non-English languages; 16% of residents speak Spanish with limited English proficiency, and 12% speak Vietnamese with limited English proficiency. Among Latino residents, 9% are uninsured. The area has a strong CBO ecosystem and a deep tradition of community organizing, including six CHW/promotor cooperatives operating as LLCs (see The Role and History of Community Health Workers/Promotores). Healthcare access points in the area are operated by organizations headquartered elsewhere; no FQHC maintains its primary site in any East San José study area ZIP code. Organizations with sites in the area include AACI, School Health Clinics of Santa Clara County, Bay Area Community Health (BACH), Indian Health Center, Comprecare, Valley Health Center East Valley, and Planned Parenthood. These clinic sites typically offer a narrower range of services than full-service health centers. ZIP codes 95116 and 95122 are on the California Department of Insurance's list of underserved ZIP codes. Area-wide indicators: median household income ranges from $83,428 (95116) to $160,729 (95148), poverty rate 8.8%, Medi-Cal enrollment 29.6%, uninsured 6.1% (ACS 2019–2023 5-year).

- **South County** (ZIP codes 95020, 95037, 95046): A region of approximately 125,800 residents encompassing Gilroy, Morgan Hill, and San Martin. Forty-eight percent of residents are Latino, 23% are foreign-born, and 40% speak a language other than English at home (primarily Spanish at 29%). Among Latino residents, 9% are

uninsured. The area has a large farmworker population and significant immigrant communities with strong mutual-aid traditions. Several CHW/Promotor organizations are locally headquartered: CARAS (Gilroy), Nueva Vida Community (Gilroy), Community Solutions (Gilroy and Morgan Hill), SC HEALS! (Gilroy/Morgan Hill), and Catholic Charities South County office (Gilroy). Healthcare infrastructure is limited relative to the northern part of the county, with residents traveling to San José or Salinas for many specialty services.[1] Area-wide indicators: median household income $134,242–$158,256, poverty rate 6.2%, Medi-Cal enrollment 20.0%, uninsured 5.3% (ACS 2019–2023 5-year).

Together, these 10 ZIP codes encompass approximately 430,800 residents.[2] Forty-four percent are Latino, 39% are foreign-born, and 60% speak a language other than English at home. Among Latino residents, 10% are uninsured, lower than state averages for Latino immigrants, reflecting California's 2024 Medi-Cal expansion to all low-income residents regardless of immigration status, but still representing approximately 18,200 individuals who may face barriers to care. Research on California immigrant communities finds that 14% of low-income immigrants avoid public programs due to immigration-status concerns, and those who do are 2.4 times more likely to delay needed medical care.[42]


*Figure 1: Santa Clara County CHW program focus areas.*[1]

## The Role and History of Community Health Workers/Promotores

Community Health Workers and Promotores (CHWs/Promotores) are trusted members of the communities they serve. They are neighbors, advocates, navigators, and healers who act as a bridge between community members and the health and social service systems meant to support them.[47] Because they share lived experience (see Key Terms), language,

[1] Primary care facilities serving South County include Gardner South County Health Center, Bay Area Community Health (BACH), Valley Health Center Gilroy, and Saint Louise Regional Hospital.

[2] Population estimates from ACS 2023 5-year data; totals vary slightly across tables due to different universes (total population vs. civilian noninstitutionalized population).

and cultural context with the people they serve, they play an essential role in connecting underserved communities to care.

The work of CHWs/Promotores is broad and multifaceted. National studies show that they are frontline public health workers whose close, trusted relationships help people access clinical care, social services, and behavioral health support.[47,48] Their responsibilities span outreach, navigation, health education, cultural bridging, advocacy, and emotional support, and these functions often appear across dozens of job titles.[49] Given how many aspects of community wellbeing they touch, the full impact of CHW/Promotor work often extends far beyond what is captured in program data.

The Promotor/a model, in particular, draws from long-standing community health traditions in Latin America and represents a powerful approach to supporting community wellbeing.[47,48] Promotores are widely recognized as culturally and linguistically well-suited to providing health education and outreach within Latino communities, and community members frequently turn to them for information, guidance, and support. This shared cultural and language background builds the trust necessary to engage individuals in their own health, especially in communities that have historically faced barriers to care. By meeting people where they are and addressing these barriers directly, the Promotor/a approach plays an important role in advancing health equity.[47,50]

Despite their critical and well-documented contributions, many regions, including Santa Clara County, have lacked comprehensive, up-to-date information about the CHW/Promotor workforce: who is doing this work locally, how many individuals fill these roles, what training they have received, how they are employed and compensated, and what challenges they face in sustaining their work. This gap in knowledge makes it difficult to design programs that reflect the realities of this workforce, allocate resources where they are most needed, develop training that builds on existing strengths, and craft policies that support long-term sustainability. Understanding the characteristics and experiences of local CHWs/Promotores is a necessary foundation for building a workforce strategy that is grounded in evidence, responsive to community needs, and capable of advancing health equity.

## Background: The Latino Health Assessment

The Board of Supervisors referral that initiated this feasibility study drew on the 2025 Latino Health Assessment (LHA) [24], which documented significant health disparities concentrated in the study's focus areas. In East San José and South County, the assessment found that "residents in these regions face some of the most severe disparities… Economic hardships, housing instability, and limited access to health care are compounded by chronic conditions such as diabetes, obesity, and heart disease" [24, p. 277]. The assessment further noted that "residents of both the East San José and South County regions bear the highest toll of health disparities as they experience less healthy neighborhood living conditions and lower life expectancy" [24, p. 277].

Specific disparities identified in South County include higher rates of opioid-drug overdose deaths and diabetes-related deaths compared to Latinos in other regions, while East San José has the highest rates of teenage births among Latino residents. The COVID-19 pandemic further deepened these disparities. Beyond health, the LHA found that "housing challenges such as overcrowding and homelessness create chronic instability in both these regions" alongside "higher rates of firearm-related injuries, violence, and youth involvement in foster care and probation systems" [24, p. 277].

The LHA's recommendations include two directives relevant to this study:

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> **LHA Recommendation: "Increase the number of patient advocates and health navigators at clinics and expand the Promotores Model to improve healthcare access" [24, p. 300].**
>
> **LHA Recommendation: Nurture and build a physical and mental health workforce with lived experience in the study's focus areas, drawn from the communities served [24, p. 280].**

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The history of CHW programs in California follows a pattern: grant funding launches a program, trains a cohort of promotores, and builds community trust over several years. When the grant cycle ends, the program contracts, trained promotores leave the field, and the next funding cycle starts over with recruitment and retraining. CalAIM's CHW billing benefit, launched in July 2022, creates a new revenue stream, but at current reimbursement rates it covers only 6–9% of per-CHW program costs. A sustained investment strategy that blends multiple funding sources is needed to break this cycle.

# Best Practices: Evidence for CHW Programs

The LHA recommended expanding the Promotores Model. Peer-reviewed evidence from randomized controlled trials and program evaluations spanning more than two decades shows that CHW programs reduce healthcare utilization and generate positive returns on investment at a macro-economic level.

## Published Return-on-Investment (ROI) Evidence

Published economic evaluations of CHW programs report returns ranging from $2.47 returned for every dollar spent (a Philadelphia Medicaid randomized trial) to $11 returned for every dollar spent (Kentucky Homeplace, rural Kentucky, over two decades).[1,2,4] These programs target populations with high baseline healthcare utilization, similar to the focus population in this study. The strongest causal evidence comes from a randomized controlled trial[1] in which six CHWs serving 330 patients saved Medicaid $1.4 million annually, returning $2.47 for every dollar invested within one fiscal year. Hospital

admissions fell by 30%. The University of New Mexico/Molina Healthcare program returned $4 for every dollar invested in a New Mexico Medicaid population.[5]

This evidence base has limitations. No California-specific return on investment study has been published. The highest return in the literature ($11 for every dollar invested) accumulated over more than two decades of operation in a rural setting.[2] Several of the highest-ROI programs operated in rural settings or with different population demographics; transferability to an urban Bay Area County is uncertain. Publication bias may also favor successful programs. Importantly, as is often true of upstream cost avoidance work, there are unlikely to be any County budgetary savings to redirect into the program at a local level.

## Healthcare Utilization Reductions

Published Randomized Controlled Trials (RCTs) report CHW-associated reductions in emergency department (ED) visits (23–51%), hospitalizations (21–50%), and 30-day readmissions (odds ratios of 0.3 to 0.44).[1,6,51,52,53,54] This study's base case assumptions are set below these published ranges, at 22%, 30%, and 23% respectively, to account for differences between research trial conditions and county-level program implementation: the ED assumption falls one point below the lowest significant RCT finding; the admission assumption uses a single-site RCT estimate [4]; and the readmission assumption falls between the strongest RCT's absolute risk reduction (17 percentage points) [1] and a pooled meta-analysis estimate (33%).[52]

These utilization reductions reflect improved access to primary and preventive care that reduces reliance on emergency settings. The strongest trial in this evidence base achieved its $2.47 return specifically by having CHWs address unmet social needs alongside clinical care, including housing instability, utility access, and food insecurity.[1] Key informants in Santa Clara County described a similar scope of practice: promotores connect residents to immigration services, energy assistance, housing resources, and public benefits in addition to healthcare navigation.[17] This broader role is consistent with evidence that health outcomes improve when upstream social determinants are addressed alongside clinical access.

A 2025 systematic review of 130 CHW cost-effectiveness studies across 380 scenarios found CHW programs cost-effective in 78–93% of scenarios, with integrated models (combining clinical and community functions) outperforming standalone clinical programs.[43] These utilization reductions form the basis for the economic models that estimate per-CHW costs, savings, and return on investment [see Findings: Economic Analysis (Clinical Pathway)]. Moreover, the experience of peer counties offers practical lessons for translating this evidence into program design.

## Lessons from Peer Counties

Analysis of CHW programs in five California counties (Los Angeles, San Diego, Alameda, Fresno, and Sacramento) identified four consistent success factors: blended funding (no single source exceeding 40%), formal workforce pipelines, coalition input, and shared

technology infrastructure. Every county that has scaled a CHW program uses CBO contracting rather than direct county employment; counties that diversified their funding portfolios weathered federal grant disruptions that destabilized less-prepared programs. Detailed county profiles, program scales, and innovation summaries are provided in the Peer County Profiles section.

The evidence and peer county experience establish that CHW programs work. The following sections present the economic case, the local workforce and stakeholder landscape, and recommendations.

# Findings: Economic Analysis (Clinical Pathway)

**What would a CHW/Promotor program cost in Santa Clara County, and what returns could it generate?** CHW programs produce value along two pathways (see Key Terms). *Clinical value* flows from one-on-one interventions (care coordination, chronic disease management, patient navigation) that reduce ED visits, hospitalizations, and readmissions. These activities are reimbursable under Medi-Cal. *Community resilience value* flows from group education, leadership development, outreach, and organizing that address the structural drivers of poor health. The detailed framework for balancing these pathways, including promotor/a role progression, funding structures, and measurement, is presented in Program Design: The Blended Model.

The economic models below quantify the clinical pathway only. Healthcare utilization data (ED visits, hospitalizations, readmissions) and established cost parameters allow rigorous measurement of clinical value; community resilience outcomes operate on longer timelines and are not captured in cost models. A measurement framework for community resilience outcomes, including collective efficacy, civic engagement, and resident-led initiatives, is described in the Program Design: The Blended Model section. The absence of a monetized community resilience analysis in this section reflects the state of measurement, not a judgment about relative importance. Programs that measure only clinical returns will, over time, narrow their focus to clinical activities; the measurement framework in Recommendation 2 is designed to prevent this.

## Scale of Need

The feasibility study focuses on Latino residents in 10 ZIP codes across Cadillac-Winchester, East San José, and South County. Latino residents in these ZIP codes face among the most severe health disparities in the county, including higher rates of chronic disease, diabetes-related deaths, and opioid overdose deaths, alongside lower access to preventive care.[24] The focus population (see Key Terms) ranges from approximately 10,500 (Latino residents with disabilities and public health coverage) to 21,000 (Latino residents with two or more chronic conditions), depending on how high-risk is defined. The per-CHW/Promotor economics are identical at any scale; program size and pace of growth are policy decisions that depend on CBO ecosystem capacity and available funding.

## Per-CHW Unit Economics

The building block of the economic model is a single CHW/Promotor. Each CHW/Promotor costs approximately $113,000 per year to employ (including salary, benefits, supervision, training, and overhead) and generates approximately $278,000 in healthcare costs avoided, producing a net benefit of approximately $165,000 per CHW/Promotor per year. Each CHW/Promotor serves 55 patients per year, with an annual program cost of about $2,050 per patient and annual healthcare savings of about $5,060 per patient. These per-CHW/Promotor figures do not change with program size at the projected scale. The detailed cost breakdown, savings derivation, and salary sensitivity analysis are in the Per-CHW Economic Detail section.

However, the total per-CHW cost of operating a program includes hub infrastructure that provides a bundle of services, including billing, credentialing, and quality assurance, estimated at $800,000–$1,200,000 per year based on peer county models. This is largely a fixed cost: at a small program (e.g., 20 CHWs), it adds approximately $50,000 per CHW; at a larger program (e.g., 150 CHWs), the per-CHW share falls to approximately $5,300–$8,000. The program therefore exhibits economies of scale on infrastructure costs. At the scales relevant to this study, the infrastructure economies dominate, and the net per-CHW cost declines as the program grows.

## Return on Investment and Cost-Effectiveness

The program generates societal returns from two perspectives. The Medi-Cal perspective counts only managed care plan savings; the healthcare system perspective counts all healthcare cost reductions, including hospital resource costs.

*Table 1: Return on investment and cost-effectiveness by perspective.*[10]

| Perspective | ROI | Annual Net/CHW | ICER |
|---|---|---|---|
| Medi-Cal Budget (conservative) | 0.64:1 | –$12,700 | $1,680/QALY |
| Healthcare (full value) | 1.78:1 | +$165,400 | –$69,775/QALY |

ROI = return on investment; ICER = incremental cost-effectiveness ratio; QALY = quality-adjusted life year. Annual Net/CHW = steady-state annual net savings per CHW/Promotor. A negative ICER (“dominant”) means the program saves money while improving health. A positive ICER below the $100,000/QALY threshold indicates cost-effectiveness. The Medi-Cal perspective counts only managed care plan savings; the healthcare perspective counts all healthcare cost reductions across the community including hospital resource costs. Per-CHW/Promotor economics do not vary with program scale. The Medi-Cal ICER of $1,680/QALY means the program improves health at low incremental cost from this perspective; the healthcare system ICER of –$69,775/QALY means the program is dominant (saves money while improving health). Full model documentation, including sensitivity analysis, is in the Technical Report.

The Medi-Cal perspective shows a per-CHW/Promotor gap of approximately $12,700 between program cost and healthcare cost avoidance. Combined CalAIM billing revenue ($7,000–$10,000 per CHW/Promotor/year) narrows but does not close this gap. The remaining shortfall is structural: it reflects the difference between what Medi-Cal reimburses and what the program costs to operate. Recommendation 1's blended funding design (no single source exceeding 40%) is the response to this gap, not an afterthought. This estimate excludes CalAIM billing revenue beyond the $7,000–$10,000 range because additional revenue depends on billing infrastructure, managed care contracting, and FQHC workarounds that do not yet exist in the county [see the revenue and funding analysis in Findings: Economic Analysis (Clinical Pathway) and in the Additional Detail in the Technical Report section].

From the broader healthcare perspective, the program returns $1.78 for every dollar invested (three-year discounted, including Year 1 ramp-up), below the published benchmark of $2.47 per dollar [1] but within the range of published CHW evaluations. The share of savings attributable to County entities depends on the payer mix of the enrolled population (Medi-Cal, uninsured, other).

From the broader healthcare perspective, the program saves money while improving health. From the Medi-Cal perspective, for every additional year of healthy life the program produces, it costs $1,680, well below the $100,000 threshold that economists consider cost-effective. Sensitivity analysis in the Technical Report tests the robustness of these findings across conservative and optimistic assumptions on utilization reductions, unit costs, and quality-adjusted life year weights.

Modeling across a wide range of assumptions shows that the program generates positive returns in nearly every scenario tested. From the narrower Medi-Cal perspective, the program breaks even roughly half the time, depending on how effectively CHWs reduce hospitalizations and emergency visits. Medi-Cal billing alone will not cover program costs. The program needs blended funding from multiple sources. There are unlikely to be any budgetary savings to the County's healthcare delivery system that could be redirected to funding these efforts.

## Revenue and Funding

Medi-Cal CHW billing and CalAIM ECM contracts typically cover less than ten percent of per-CHW cost, with the remaining amount requiring braided funding from the county general fund, grants, and interdepartmental contracts. No single source should exceed 40 percent of the total program budget, as programs relying on one stream are most vulnerable to disruption. Revenue sources and rates are detailed in the Revenue and Funding Detail section. ECM-eligible members, estimated at 4.7 to 5.5 percent of the focus population, represent a pre-funded launch cohort since SCFHP must provide ECM services that CHWs are well suited to deliver.[23,29,30] ECM and CHW fee-for-service billing are mutually exclusive for any member at a given time, though Community Supports reimbursement can be layered with ECM.[30,31]

CHW programs also complement existing County outreach infrastructure, including mobile health vans and community screenings. As managed care plans address social determinants of health under CalAIM through ECM and Community Supports, CHWs represent the local delivery infrastructure that makes these requirements operational.[4,17,29]

Detailed descriptions of each revenue stream, billing codes, rate tables, ECM enrollment data, and grant sources are provided in the Revenue and Funding Detail section. The Technical Report provides full billing analysis.

## Workforce Absorption and Scale-Up

Program growth must match the local labor market's absorptive capacity. Published CHW program evaluations and peer county experience suggest that annual expansion beyond 20% of the existing workforce strains supervision, training, and quality, a threshold confirmed by CBO directors and program managers in key informant interviews (Findings: Workforce and Stakeholder Input).[17] Interview data also indicate annual turnover of approximately 10% [17], meaning most annual additions would represent net program growth rather than replacement hiring. The workforce deployment model, which compares direct County hiring, CBO contracting, and cooperative structures, determines whether CHWs are County employees, CBO staff, or cooperative members; the absorption rate applies regardless of model.

Program costs scale linearly from the per-CHW/Promotor economics: each CHW/Promotor costs about $113,000/year in direct program costs. Hub start-up adds approximately $800,000–$1,000,000 in the first year (partial-year ramp-up), settling to $800,000–$1,200,000/year at full operations. Braided billing revenue offsets a portion of costs. Healthcare savings lag by approximately one year (savings from the first cohort materialize in the following year). Detailed year-by-year budget projections for illustrative program sizes are provided in the Technical Report.

The per-CHW/Promotor economics are favorable across all program sizes. Stakeholders across the key informant interviews identified 20% annual workforce growth as a reasonable expansion rate, provided that the funding commitment spans at least five years.[17] Program size is a policy decision; the 20% growth rate and five-year commitment horizon are the operational constraints identified by the field.

## Enrollment Strategy and Equity

The economic case above addresses whether the program is worth funding and implementing should resources become available. Equally important is whether the program reaches the people it is designed to serve. Disparity gap closure is measured by the reduction in preventable hospitalizations and ED visits relative to the county average.

Place-based programs in communities with significant immigrant populations carry two countervailing risks that directly affect whether the program reaches its intended beneficiaries.

First, if enrollment requires documentation, proof of residence, or interaction with government systems, the process itself becomes a barrier for the people the program is designed to reach. Experimental evidence on safety net enrollment demonstrates that these paperwork and eligibility burdens systematically exclude the neediest eligible people, and that proactive, in-person assistance can nearly triple participation rates among eligible non-participants.[25]

Second, any program perceived as a public service may trigger avoidance among residents in mixed-status households who fear that participation could expose family members to immigration enforcement or impact immigration processes due to evolving interpretation of the public charge rule. Research has shown that immigration enforcement reduced Medicaid participation among U.S. citizen children of noncitizens, meaning eligible residents forgo benefits when the enforcement climate is high.[26] Further evidence documented that deportation enforcement specifically reduces healthcare seeking among Hispanic adults, driven by avoidance of the healthcare system rather than loss of coverage.[27] Most directly relevant, an estimate suggests that between 108,000 and 193,000 Latino immigrants in California avoided Medicaid enrollment even after the public charge rule was reversed, demonstrating that fear creates durable barriers that persist beyond the policies that triggered them.[28]

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> **Design implication:** Research shows that 108,000–193,000 Latino immigrants in California avoided Medicaid enrollment even after the public charge rule was reversed.[28] Program intake must minimize bureaucratic touchpoints and operate through trusted community organizations to avoid deterring the residents who stand to benefit most.

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Two design features respond to these barriers. The cooperative LLC structure (see The Role and History of Community Health Workers/Promotores) addresses the workforce side by enabling participation without traditional employment eligibility requirements. On the service delivery side, operating program intake through trusted CBOs rather than County systems, as specified in Recommendation 1, reduces the institutional contact that deters participation in mixed-status households.

## Findings: Workforce and Stakeholder Input

The economic analysis quantifies costs and savings. Translating those estimates into a viable program requires understanding the workforce and stakeholder landscape: who

operates CHW programs in the focus areas, what barriers they face, and where capacity exists to absorb new positions.

## Workforce Landscape

The landscape analysis reviewed 82 organizations across three sectors (public agencies, nonprofit organizations, and FQHCs) to map the existing CHW workforce. The most concrete data comes from the public sector, where 342 CHW positions are verified through California State Controller's Office payroll records (2023–2024).[10] County government is the single largest CHW employer, accounting for 192 positions (56% of verified public sector positions), followed by K-12 school districts with 112 positions (33%). Across all three sectors, the estimated total workforce is approximately 500–650 CHWs countywide.

### *The CBO Landscape in the Focus Areas.*

The Public Health Department engaged 34 organizations through survey outreach between February and March 2026. These organizations span nine categories: 15 CBOs with active CHW/promotor programs, three FQHCs and clinics, three educational institutions, two CHW/promotor cooperatives and independent consultants, two statewide advocacy networks, and nine others (managed care, specialized populations, food/health/youth, school-based). The full organizational mapping, including names, headcounts, and service descriptions, is in the CBO Organizational Detail section.

Three findings from this mapping shape the recommendations:

*Geographic gaps*. No CHW organization is headquartered in Cadillac-Winchester; the only dedicated promotor/a presence comes from LUNA workers deployed from elsewhere. The clinical and community organizing infrastructure that East San José has built over two decades has no equivalent in Cadillac-Winchester. Cadillac-Winchester has approximately 62,000 residents and two FQHCs providing primary care, but no community-based promotor/a network rooted in the neighborhood itself (see Study Area).

*Multiple workforce models coexist*. Traditional nonprofit employment, CHW/promotor cooperative LLCs (six operating in East San José; see The Role and History of Community Health Workers/Promotores), and independent consulting all operate simultaneously. County investment infrastructure (billing hubs, supervision, procurement) must accommodate all three.

*Workforce fluidity*. These workforce counts represent a point-in-time snapshot, not a stable inventory. Workers move between organizations as grant cycles end, programs scale up and down with available funding, and some organizations have reduced or eliminated CHW positions as federal and state pandemic-era funding has expired. This fluidity is itself a central finding: any investment strategy must account for a workforce that can contract as quickly as it has expanded.

## Key Informant Interviews

The study team conducted 17 key informant interviews between December 2025 and March 2026 with stakeholders across Santa Clara County's CHW infrastructure, including CBO leaders, community college administrators, managed care plan representatives, and County program managers.[17] Six themes emerged, summarized below; these findings are integrated with survey and focus group data into five cross-cutting themes on workforce identity, compensation, training, funding, and community voice (see Findings: Workforce and Stakeholder Input).

1. **The Promotor/a-CHW distinction matters. CHWs work within clinical frameworks; promotores cover a broader spectrum including education, organizing, and advocacy. Defining CHW work solely as billable clinical activities risks excluding upstream prevention work.[17] An economic analysis of the community resilience pathway remains an important direction for future work; the measurement framework in Recommendation 2 lays the groundwork for such analysis.**

2. **Workforce pipeline and training.** Two pathways exist (San José City College, English-only, credential-bearing; community-based, Spanish-language, no credential). Neither alone meets program needs. Workforce parameters: salary expectations of $55,000 to $62,000, hiring timelines of 2 to 3 months, turnover of approximately 10%, supervision ratios of 1:6 to 1:7, and caseloads of 20 to 25 active patients.[17]

3. **Sustainability requires long-term commitment.** Non-negotiables: permanent budget line item, blended funding (no single source exceeding 40%), and community-vetted expectations before tying funding to deliverables. Planning horizon: 5 to 10 years.[17]

4. **The cooperative model.** Six CHW/promotor cooperatives operate in East San José as LLCs, allowing community members to participate as business owners. Federal employment verification guidance (USCIS M-274 Handbook) recognizes that business owners with substantial ownership interest may not require Form I-9 completion.[17]

5. **What decision-makers need to see.** Informants ranked total budget impact first, ROI second, and health outcomes tied to financial stability third.[17]

6. **Scaling risks.** The primary concern is definitional narrowing: that optimizing for Medi-Cal reimbursement would squeeze out organizing and advocacy work. Recommended annual expansion: no more than 20% of the existing workforce.[17]

## What CBOs Need to Scale

The six key informant interview (KII) themes above, read together, describe the infrastructure gaps that constrain CBO capacity to hire and retain CHWs. Four barriers emerged as the most binding constraints on ecosystem growth (Table 2).

*Table 2: Four infrastructure barriers to CBO scale-up.*[17]

| Barrier | Description | Infrastructure Need |
|---|---|---|
| Billing infrastructure | Most CBOs lack the capacity to bill Medi-Cal; FQHCs are subject to a prospective payment system exclusion (see Peer County Profiles). Identified as the single most impactful investment. | Commercial billing platform through the hub. PATH program offers up to $150K/org.[40] |
| Clinical supervision | Medi-Cal billing requires licensed provider supervision; CBOs without clinical staff cannot meet this requirement. | Shared supervision arrangement with partner FQHCs providing capacity across CBOs. |
| Training pipeline | Two pathways exist (San José City College, English-only, credential-bearing; community-based, Spanish-language, no credential) but neither alone meets program needs. | Expand both college and community-based tracks; create articulation between them. |
| Workforce stability | Grant-funded positions are inherently unstable; workers leave as funding cycles end. | Sustained blended funding model (no single source exceeding 40%). Cooperative LLC broadens eligibility (see The Role and History of Community Health Workers/Promotores). |

These four barriers represent the infrastructure gaps that a County investment could address. Closing them turns the per-CHW/Promotor economics [$113,000 cost, $278,000 savings per CHW; see Findings: Economic Analysis (Clinical Pathway)] from a theoretical model into a business case that individual CBOs can act on. Recommendation 1 proposes a community resilience hub (see Key Terms) to provide shared billing, credentialing, and quality assurance infrastructure across the CBO network (see Recommendations).

# CHW Survey and Focus Groups

## CHW/Promotor Workforce Survey

The Santa Clara County Public Health Department conducted a workforce survey to build a detailed profile of the CHW/Promotor workforce across East San José, South County, and the Cadillac-Winchester neighborhood. A total of 210 respondents from 24+ organizations completed the bilingual (English/Spanish) survey between February and March 2026. Survey findings were further enriched through a focus group with CHW/Promotor supervisors and managers, and a community discussion session in which CHWs/Promotores themselves helped interpret and contextualize the results. The survey design, eligibility criteria, recruitment procedures, and analysis methods are described in the Study Methodology section.

## Survey Findings

### *Demographics.*

Respondents are 97% Latino (n=203) and 85% Spanish-speaking (n=206). The largest age group is 40–49 (35%, n=198), followed by 50–59 (27%). Seventy-eight percent identify as promotores, 10% as CHWs, and the remainder use other titles including Family Resource Specialist, Health Ambassador, and Volunteer Parenting Coach (n=210). Detailed breakdowns of job title and language distributions are in the Separate Billing Infrastructure and Operating Model section.

### *Years of Experience.*

Respondents bring a wide range of experience to their work as CHWs/Promotores, spanning volunteer, part-time, and full-time roles over the course of their careers (n=189). More than half (56%) have been doing this work between one and five years (n=204), suggesting a workforce that is still in the early-to-mid stages of building their practice and professional identity. Fifteen percent are newer to the role, with less than one year of experience, indicating an active pipeline of emerging CHWs/Promotores entering the field. At the same time, a meaningful share of respondents bring deep, long-standing experience to this work. Fifteen percent have been serving their communities for six to ten years, 6% for eleven to fifteen years, and 8% for more than fifteen years.

Together, nearly one in three respondents has been doing this work for six or more years, representing a core of seasoned community health workers whose institutional knowledge, community relationships, and cultural wisdom are invaluable assets to any program (see tenure distribution in the Separate Billing Infrastructure and Operating Model section).

### *Geography and populations served.*

Sixty-nine percent of respondents work primarily in East San José, 35% in South County, and 18% in Cadillac-Winchester (n=199; respondents could select multiple regions).

Across all regions, 93% serve families and 69% serve immigrant populations (n=210). Regional differences are present: South County respondents report higher rates of serving people with disabilities (37% vs. 19% in East San José and 14% in Cadillac-Winchester) and rural populations (34% vs. 6% in East San José and 3% in Cadillac-Winchester). The full community distribution is in the Separate Billing Infrastructure and Operating Model section.

### *Employment and compensation.*

Employment arrangements reflect the grant-dependent funding landscape described in Findings: Workforce and Stakeholder Input. Only 14% work full-time; 26% are part-time, 24% contract, 9% per diem, and 12% are currently unemployed (n=189). Thirty-seven percent hold other jobs alongside their CHW work (n=196). Among respondents who report compensation type (n=123), 62% receive an hourly wage or salary and 30% receive stipends. The median reported hourly wage is $30 (n=76), or approximately $62,400 annualized, 13% above the fiscal model's $55,000 assumption. However, 64% of respondents say their compensation does not provide a living wage (n=109). Part-time hours, stipend-based pay, and self-reported inadequacy together describe a compensation structure that does not support a stable workforce, consistent with the workforce fluidity finding in Findings: Workforce and Stakeholder Input.

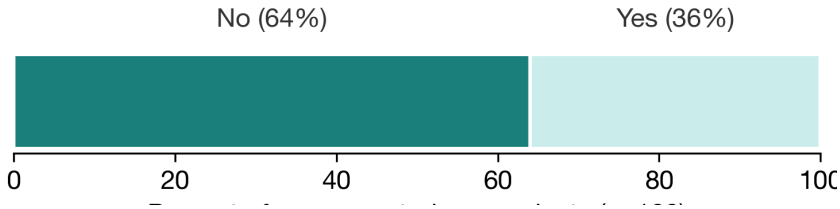


*Figure 2: Belief that compensation offers a living wage (n=109; asked only of compensated respondents).*

### *Activities and scope of practice.*

Eighty percent of respondents perform outreach and resource connection, 49% engage in advocacy, 31% in health education (n=208). Care coordination and case management account for 25%, and direct service for 9%. The low share of clinical and billable activity is consistent with the CBO ecosystem described in Findings: Workforce and Stakeholder Input: without billing infrastructure, CBOs orient their CHW workforce toward community-based rather than clinical work.

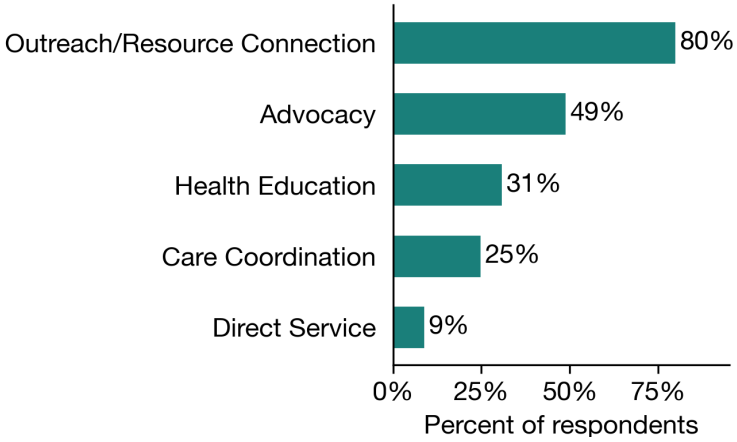


*Figure 3: Activities performed by CHWs/Promotor(a)s (n=208).*

### *Training completed and training gaps.*

The top five completed training areas are mental health (47%), education (45%), immigration (39%), housing (38%), and violence prevention (31%) (n=208). These align with the social determinants focus of the existing workforce. When asked what additional training they want, mental health again tops the list (33 respondents), followed by healthcare and health coverage (30), housing (18), immigration (16), and education and child development (14). The gap between completed and desired training in healthcare navigation is the largest of any topic, supporting Recommendation 4's emphasis on clinical training pathways.

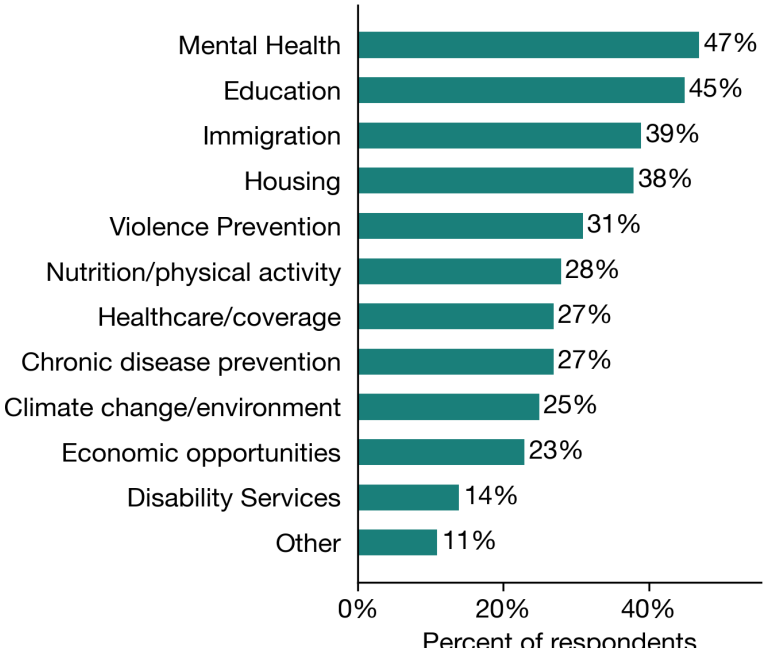


*Figure 4: Training specialty areas of survey respondents (n=208; multi-select).*

The breakdown of training needs by topic and the living wage analysis by employment type are in the Separate Billing Infrastructure and Operating Model section.

*What supports success and what gets in the way.*

Leadership support is the top success factor (47%), followed by training and professional development (35%), clear roles (30%), and access to technology (29%) (n=204). The top challenges are lack of funding (43%), pay and benefits (38%), and fear due to the political climate (31%) (n=199). The political climate finding is consistent with concerns raised in the KII cooperative model discussion (see Findings: Workforce and Stakeholder Input, Theme 4): program design in mixed-status communities must account for documentation-related barriers.

## Advisory Committee Review of Survey Findings

After the survey analysis, the CHW Advisory Committee reviewed preliminary findings and provided interpretations in four areas: role identity (the CHW-Promotor/a distinction is contested in practice; certification pathways exclude undocumented promotores), language (South County needs Mixteco and Zapoteco capacity), populations served (Cadillac-Winchester has unmet youth prevention needs amid demographic transition), and compensation (reported wages understate actual labor because they exclude uncompensated evening, weekend, and crisis-response hours). These interpretations are integrated into the cross-cutting themes below (see Findings: Workforce and Stakeholder Input).

## Supervisor Focus Group

A focus group with 11 CHW supervisors, managers, and peer leads was conducted in February 2026 with English and Spanish breakout groups. Facilitator notes were analyzed using thematic analysis. Four themes emerged: (1) lived experience as professional expertise, with cultural and linguistic concordance as the foundation of effective practice; (2) supervision and support needs, including trauma-informed supervision and peer mentorship; (3) expanding scope of practice beyond health conditions into housing, immigration, violence prevention, and disability services; and (4) community voice in program design, with participants unanimous that CHWs should be recognized as leaders, not service delivery agents. Focus group participants identified three priority recommendations: fair wages with benefits, inclusive practices that reduce bureaucratic barriers, and ongoing training with pathways to certification. These findings are integrated into Findings: Workforce and Stakeholder Input.

## Cross-Cutting Themes

Five themes emerge consistently across the key informant interviews, workforce survey, supervisor focus group, and advisory committee discussion. Each reflects convergent findings from at least three evidence streams. These themes move from foundational questions about who does this work and how it is defined, through the workforce

conditions that shape it (compensation, training, funding), to the community voice that should guide the program.

*Theme 1: The Promotor/a-CHW distinction is structural, not semantic.*

The workforce operates under two overlapping but distinct models. CHWs tend to work within clinical frameworks: patient navigation, care coordination, and Medi-Cal billing. Promotores cover a broader spectrum: education, community organizing, and systems change advocacy. Key informants drew this line explicitly. As one CBO leader stated, "Community health workers are a bit more confined and it works when you talk about medical reimbursement… promotoras cover a broader spectrum".[17] Focus group participants described lived experience and cultural concordance as the foundation of effective practice in both models.

The advisory committee added that both roles carry out many of the same functions and that several participants would have identified with more than one title. They also raised a structural concern: CHW certification training is considered inaccessible to promotores with lived experience as undocumented community members, creating a situation where those most trusted by immigrant communities are excluded from the credentialing pathways meant to recognize their contributions.

A program that defines CHW work solely as billable clinical activities risks undermining the upstream prevention and organizing work that drives longer-term community health improvement. This distinction has direct implications for how the program defines scope of practice, structures billing, and evaluates outcomes.

*Theme 2: Compensation does not reflect the full labor of this workforce.*

Across all four evidence streams, compensation ranked as the most urgent workforce need. Sixty-four percent of survey respondents reported that their compensation does not provide a living wage. The advisory committee reframed this finding: reported wages do not capture the uncompensated hours most promotores spend responding to community members in the evenings, on weekends, and during moments of crisis. Reported wages also exclude unreimbursed work-related expenses such as transportation and mobile phone use. Effective compensation is lower than the survey figures suggest.

Key informant salary expectations range from $55,000 to $62,000 annually; the survey median is $62,400. These figures are consistent across sources. Focus group participants identified fair and competitive wages with comprehensive benefits as one of their three priority recommendations.

This gap between reported wages and actual labor underscores why the economic analysis (see Findings: Economic Analysis) builds compensation estimates from full program costs rather than survey-reported hourly rates alone.

*Theme 3: Training gaps are structural and topical.*

Two training pathways exist in the County: a community college certificate program (English-only, credential-bearing) and community-based training through organizations like Somos Mayfair (Spanish-language, no formal credential). Neither pathway alone meets program needs.

The survey reveals a gap between completed and desired training. The largest gap is in healthcare navigation: respondents have training in mental health, education, immigration, and housing, but healthcare and health coverage is the second most requested topic for additional training. Focus group participants described CHW roles expanding beyond specific health conditions into housing, immigration, violence prevention, and disability services. No existing training program covers the full range of CHW activity across clinical navigation and community resilience.

Key informants identified a structural problem underlying the topical gaps. Previous waves of state and federal funding supported the development of CHW curricula at community organizations but not their sustained delivery. When grant cycles ended, training capacity contracted alongside the workforce it supported. The advisory committee added that South County has an unmet need for Mixteco and Zapoteco language capacity, currently addressed through cross-county contracting.

These findings point to three dimensions of the training gap: pathway coverage (clinical and community-based), delivery sustainability beyond individual grant cycles, and language capacity in South County.

*Theme 4: Sustainability requires long-term, blended funding.*

Grant-funded positions are inherently unstable. Workers leave as funding cycles end, and programs scale up and down with available resources. Key informants identified four non-negotiables for sustainability: a permanent budget line item, blended funding so no single source exceeds 40% of the total, community-vetted expectations before tying funding to deliverables, and protection from federal and state funding volatility through county-source primary funding. The recommended planning horizon is 5 to 10 years.

The primary concern about scaling, raised independently in both the KII and focus group, is definitional narrowing: that optimizing for Medi-Cal reimbursement would squeeze out the organizing, advocacy, and leadership development work that experienced practitioners consider essential. Key informants recommended that annual program expansion not exceed 20% of the existing workforce, allowing the labor market to absorb new positions while maintaining quality and supervision capacity.

The survey data reinforces this theme from the worker perspective. Lack of funding is the top challenge (43% of respondents), and pay and benefits rank second (38%). These are two sides of the same structural problem: program funding instability translates directly into workforce instability. The funding model, scope of practice protections, and growth rate are interconnected design decisions.

*Theme 5: Community voice must drive program design.*

All four evidence streams position community voice not as a program feature but as a condition for program legitimacy. Focus group participants were unanimous that community voice must guide program design. They recommended decision-making processes that recognize CHWs as leaders rather than service delivery agents, and inclusive funding structures that avoid mandatory documentation requirements that could exclude workers in mixed-status communities.

The survey data converges on this point. Leadership support is the top success factor identified by respondents (47%), and clear roles rank third (30%). These findings describe a workforce that succeeds with structural support and agency.

Key informants added a specific form this should take: community-vetted expectations must precede tying funding to deliverables. The advisory committee demonstrated this principle in practice: when presented with aggregate survey data showing 64% of respondents do not earn a living wage, committee members reframed the finding by adding that reported wages exclude uncompensated evening, weekend, and crisis-response hours. This reframing, which changed how the data is interpreted throughout this report, came from centering worker experience in the analytical process.

## Workforce Deployment Models

Evidence from peer counties and key informant interviews points toward contracting over direct county employment as the preferred deployment model. Every California county that has scaled a CHW program uses CBO contracting, not civil service hiring. Los Angeles deploys 900+ CHWs through 16 contracted CBOs; no California county has scaled through direct hire. Key informants identified three reasons: direct hiring draws from the same CBO workforce it would contract with (reducing rather than expanding total capacity), the county civil service process (formal examination, eligible list, classification review) averages 87 days and introduces procedural barriers that CBOs do not face, and federal employment eligibility requirements (Form I-9) limit the candidate pool in mixed-status communities. The cooperative LLC model broadens eligibility further.[17]

Advisory committee discussions reinforced this finding: the County's most effective role is as infrastructure provider (funding billing hubs, data systems, training pipelines, and procurement) rather than as direct employer. A detailed comparison of the three deployment models (direct hire, CBO contracting, cooperative LLC) and the County's six infrastructure functions is presented in the Workforce Deployment Models section.

The CBO contracting model applies to the *new* CHW/Promotor workforce created through this program. This report does not recommend replacing existing County staff with CBO-contracted CHW/Promotors. As the CHW/Promotor workforce grows, the county should assess how new and existing workforces complement each other. Workforce alignment, including scope of practice between licensed staff (public health nurses, social workers) doing ECM and home visitation and CHW/Promotors doing community outreach,

navigation, benefit enrollment, and care plan implementation, is an implementation decision involving the Public Health Department (PHD), Santa Clara Valley Healthcare (SCVH), Santa Clara Family Health Plan (SCFHP), and relevant labor stakeholders.

The workforce and stakeholder findings point to a CBO ecosystem with capacity and commitment but without the billing, supervision, and training infrastructure to scale. The 34 partner organizations mapped in this section represent the delivery network; the four barriers identified in the Findings: Workforce and Stakeholder Input section represent the infrastructure gaps that a County investment could address. The recommendations below follow from this analysis.

# Recommendations

The economic analysis, workforce survey, key informant interviews, focus groups, and peer county research all point toward the same infrastructure needs. The recommendations below respond to those findings. They incorporate input from the Fiscal Advisory Committee (managers and directors from community-based organizations and County agencies, convened March 19, 2026), the CHW/Promotor survey (210 respondents), key informant interviews (see Findings: Workforce and Stakeholder Input), and the published evidence base. The Fiscal Advisory Committee and CHW Advisory Committee were convened for this study; the CBO partnership council (see Key Terms) proposed in Recommendation 1 is the ongoing advisory body for program implementation.

A design principle runs through all seven recommendations: the clinical and community resilience pathways are not separate programs staffed by separate people. The same promotores do both, progressing from relationship building to health education to community organizing over approximately three years. What differs is how each pathway is funded, measured, and sustained. Together, these recommendations support both pathways within a single program (see Program Design; The Blended Model).

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**Recommendation 1:** Establish a community resilience hub to coordinate CHW infrastructure across CBOs, with the County as convener.

Every peer county that has scaled a CHW program beyond 100 workers uses a community resilience hub, a neutral intermediary that handles administrative functions CBOs cannot build independently. Fresno County operates the first nationally certified Pathways Community HUB in California, coordinating 7 Care Coordination Agencies and 35 CHWs under a $9.6 million CDC contract [41] (see Peer County Profiles). In Los Angeles County, the California Community Foundation and Rising Communities perform similar hub functions. In Alameda County, the Community Health Center Network anchors CHW coordination. The Penn Center for Community Health Workers (IMPaCT) scaled to 351 CHWs

across five sites using a centralized training, quality assurance, and fidelity monitoring infrastructure.

The hub would coordinate the administrative functions that individual CBOs, particularly smaller organizations, cannot sustain alone: Medi-Cal billing and claims management, credentialing and NPI enrollment, a competency framework and curriculum registry for onboarding (with training delivery through CBO and managed care plan grants per Recommendation 3), quality assurance and outcome tracking for payers, and health plan contracting. For billing specifically, the County could potentially negotiate a County-wide contract with a CHW billing and care navigation platform to provide credentialing, claims management, audit-ready documentation, and compliance support to partner CBOs.[40] Effective coordination requires staff with deep ties to the CBO ecosystem, familiarity with Medi-Cal billing and CalAIM contracting, and established relationships across the three geographic areas. Programs like the San José PEACE Partnership demonstrate how county public health infrastructure can anchor this kind of cross-community coordination while preserving CBO autonomy.

Four design principles govern hub operations: CBO autonomy over programmatic and community work, a CBO partnership council to advise the County, an operating structure determined by Administration direction, and separate billing infrastructure. These principles and their rationale are detailed in Hub Design Principles. Hub staffing (program director, finance/contract manager, program manager, quality improvement coordinator, and support staff) costs $800,000–$1,200,000 per year. Because this is largely a fixed cost, the per-CHW share decreases as the program grows: at 50 CHWs, it adds approximately $16,000–$24,000 per CHW; at 150 CHWs, approximately $5,300–$8,000.

The hub would operate through rotating in-person convenings across public and county-owned spaces in East San José, Cadillac-Winchester, and South County. This rotation serves three purposes: it distributes access equitably across the three geographic areas rather than centering one neighborhood; it is consistent with the cultural norm of face-to-face relationship building that defines promotor/a practice; and it introduces promotores to community spaces (libraries, recreation centers, county facilities) that they can then use independently for outreach, education, and organizing in their own work.

The focus population ranges from approximately 10,500 to 21,000 depending on how high-risk is defined; program scale grows as CBO capacity expands. Program intake should operate through trusted community organizations and minimize bureaucratic touchpoints to avoid deterring residents in mixed-status households.

**Funding principle: blended, sustainable financing.** Programs dependent on a single funding stream fail. The three-layer model (clinical billing, savings capture, braided external funding) is the structural response to this vulnerability, not an

administrative preference. No single funding source should exceed 40% of the total program budget. Potential sources include County general fund, Medi-Cal managed care, CalAIM CHW billing revenue, federal and state grants, and hospital community benefit funds. The third layer, "other funding," is braided external funding from multiple sources, not a single grant. Cross-county analysis shows that programs reliant on a single funding stream are most vulnerable to disruption; one peer county's loss of 120 CHW positions after a single federal grant expired is the clearest example.

**Scale-up: phased implementation.** The per-CHW economics are favorable at any scale. Stakeholders identified 20% annual workforce growth with a five-year funding commitment as the recommended expansion rate (Findings: Workforce and Stakeholder Input); the Additional Detail in the Technical Report section discusses the methodology and limitations of the baseline workforce estimate. Hub start-up costs of $800,000–$1,000,000 are incurred regardless of initial program size. The cumulative Medi-Cal budget impact is projected to turn positive by Year 3.

**Governance and accountability.** Implementation would require Administration direction designating a County lead department/agency and an operating structure for the hub. This report recommends that accountability for cross-agency data sharing and public reporting remain with the County regardless of the structure chosen.

**Cross-agency data sharing.** With Board direction, participating County agencies (Public Health Department, Social Services Agency, Probation Department) would share data through coordinated agreements. The hub should also prioritize coordination with education agencies to access the educational records and outcomes data needed to measure the full return on this investment. CHWs help residents navigate systems that span health, housing, food assistance, education, and justice. Measuring the full return on this investment requires tracking outcomes across all of these systems, not only healthcare utilization. Cross-agency data sharing lets the program document social safety net benefits that no single agency captures alone. Because this sharing may involve identifiable health information and other personally identifiable information, data sharing agreements must comply with all applicable privacy requirements, including the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and County privacy policies, with legal review preceding and during implementation.

**Regular public reporting.** The hub should publish regular reports on service takeup, program enrollment, and conversions (residents who move from crisis-driven service use to sustained preventive care and social services). These reports serve three purposes: accountability to communities, evidence for program planning, and a track record that strengthens applications for external funding.

**Recommendation 2:** Preserve both clinical and community resilience pathways through dedicated funding and an evolving measurement framework.

Key informants identified definitional narrowing (scaling only for billable clinical activities at the expense of community organizing, outreach, and leadership development) as the primary risk to program effectiveness.[17] Protecting community resilience work requires both a funding mechanism and a measurement framework, because work that is neither funded nor measured will be cut when budgets tighten.

**Preserving community resilience work.** The program should establish a minimum share of CHW time and funding dedicated to non-billable community resilience activities (group education, outreach, leadership development, community organizing). The CBO partnership council should advise on this minimum within the first six months of program operation, informed by data on billing revenue at different clinical time allocations, healthcare savings captured at each level, and which community activities would be reduced at each allocation. Two guiding principles apply. First, set the minimum before optimizing billing: clinical time should be allocated within the constraint of the minimum. Second, the minimum may adjust as the program matures and billing infrastructure develops, but budget pressure will predictably shift CHW time toward billable activities without a floor. Peer counties have identified this pattern as the primary cause of program narrowing.

**Measurement framework: three tiers.** The measurement framework must match the funding commitment. If the program dedicates a defined share of resources to community resilience, the measurement system must track community resilience outcomes with corresponding rigor. The framework operates in three tiers:

1. **Process outputs (Years 1–2):** encounters, referrals, benefit enrollment counts (CalFresh, Women, Infants, and Children [WIC], Medi-Cal). Benefit enrollment serves as a bridge measure between community outreach and system impact.
2. **Utilization efficiency (Years 1–3, ongoing):** no-show rates, ED visits for ambulatory care sensitive conditions, discharge follow-up completion, medication adherence, nurse line calls, patient portal usage. These draw on existing administrative data from County hospitals and SCFHP, requiring no new data collection infrastructure.
3. **Health and cost outcomes (Years 3–5):** hospitalizations, total cost of care, community resilience measures. Community resilience outcomes are measured through periodic surveys administered independently from the

serving CHW/Promotor; instruments and intervals are advised on by the CBO partnership council in consultation with the evaluation team.

Both clinical and community resilience streams must be maintained: programs that track only clinical metrics will, over time, allocate resources only to clinical activities, because unmeasured work is undervalued in budget decisions (Program Design: The Blended Model).

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**Recommendation 3:** Fund training through CBO and managed care plan grants, with priority areas identified by the workforce.

**The problem.** CHW training curricula already exist in Santa Clara County: Somos Mayfair operates a community-based promotor/a training program (Spanish-language), AACI and the Santa Clara Family Health Plan provide workforce development and training support, and community college certificate programs offer formal credentials.[17] Previous waves of state and federal funding supported the development of these curricula but not their sustained delivery. When grant cycles ended, training capacity contracted alongside the workforce it supported. No existing program covers the full range of CHW activity: clinical navigation and community resilience. CHWs report seeking specialized training independently to address issues they encounter in practice (intimate partner violence, ACEs, HIV, immigration-related health access) because no coordinated training covers the scope of what the work demands.[17]

**Grants to CBOs and plans, not a parallel county program.** Route the per-CHW onboarding budget ($5,000) and continuing education budget ($2,000/year) through grants to CBOs and managed care plans that already operate bilingual, community-grounded curricula. A Year 1 training needs assessment would scope the grant specifications. Routing funding through grants preserves CBO ownership of curricula and avoids the civil service and employment verification constraints that would apply if the county delivered training directly (see Hub Design Principles).

**Priority training areas.** The workforce survey, focus groups, and key informant interviews point to five priority training areas: professional development for managers and supervisors (including trauma-informed supervision), intimate partner violence, disability services (with emphasis on children), employee compensation, benefits, and worker rights, and Indigenous language capacity for South County (Mixteco, Zapoteco), currently met through cross-county contracting that should transition to locally rooted programs.

**Community input shapes the training agenda.** The CBO partnership council (Recommendation 1) identifies training needs based on what CHWs and the communities they serve are encountering. When the council identifies a gap

(intimate partner violence, for example), the county can direct a grant to the CBO best positioned to develop that module (in this case, a domestic violence services organization with CHW training experience). The module then becomes available to CHWs across the network, regardless of which CBO employs them. Training should be grounded in storytelling, lived experience, and leadership development. CHWs bring forward community wisdom that informs policy; training design should honor this by building analytical and advocacy skills alongside clinical competencies.

**Training validation under current DHCS policy. Under Medi-Cal policy, the supervising provider (the entity that submits claims for CHW services) is responsible for validating that a CHW's training covers the four core competencies (health education, health navigation, screening and assessment, advocacy) and includes field experience. DHCS does not maintain a list of approved training programs and does not require state approval of curricula.[18] Under the billing model described in Recommendations, CBOs that bill independently validate their own CHWs' training; for smaller CBOs routing claims through the hub, the hub validates. The hub maintains a competency framework and curriculum registry so that training completed at one organization is recognized across the network.**

**Trainee stipends.** Prospective CHWs are drawn from the same communities the program serves. For CHWs hired from existing promotor/a networks, California's CHW qualification rules allow them to begin supervised, billable work immediately while completing formal training concurrently; for these hires, the $5,000 onboarding budget already in the per-CHW cost model (see Findings: Economic Analysis) covers training delivered through the grant recipients described above. For prospective CHWs who lack prior experience and require a period of pre-employment training, grants should include stipend funding so that training organizations can compensate trainees during the training period. Stipends communicate that CHW/Promotor work is a professional career pathway. Stipends, as temporary streams of revenue, should be structured so as not to compromise current eligibility for means-tested programs (Medi-Cal, CalFresh, housing assistance); the training grant design should specify protections. A training needs assessment during Year 1 implementation (see Technical Report, see Limitations and Future Directions) would determine the share of new hires entering through each pathway and the resulting stipend budget.

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**Recommendation 4:** Prioritize CHW training and deployment in youth services, violence prevention, and chronic conditions.

With measurement infrastructure in place, the program can target resources where health burdens and workforce gaps are greatest. The 2025 Latino Health Assessment points to three priority areas: youth services (including violence prevention and early intervention for justice-involved youth), violence prevention (intimate partner violence, community safety), and chronic disease management (diabetes, hypertension, asthma). Promotores work with entire families, not individual clients; youth needs surface through family engagement as promotores help parents navigate school-based resources, disability services, and mental health supports. These priorities align with the training gaps the CHW workforce survey identified, where healthcare navigation was the largest unmet need.

**Equitable geographic distribution.** Distribute resources equitably across the three geographic areas. East San José and Cadillac-Winchester are densely populated urban neighborhoods; South County encompasses rural agricultural communities with farmworker populations. Equity here means allocation reflects local need and community capacity rather than a uniform formula. Youth services include connecting families to social safety net programs, disability screenings, and mental health services in schools. CHWs/Promotores can help parents navigate community and school-based resources for mental health and disability services for their children.

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**Recommendation 5:** Build on the existing CBO landscape and protect the integrity of the CHW role.

The earlier recommendations address hub infrastructure, funding, training, and deployment. The recommendations that follow address program structure. First: build on the CHW programs that communities have already created. Honor existing organizations' wisdom and experience while creating space for new models. The County's investment would strengthen what exists rather than replace it.

**Support all CHW models.** Support all CHW models: cooperatives, independent CHWs, and organization-based programs. Each model contributes differently to community health, and communities thrive when CHW structures reflect local histories, strengths, and needs.

**Protect what makes CHWs effective.** The effectiveness of CHW programs depends on shared lived experience between workers and the communities they serve (see Key Terms). As the program scales for Medi-Cal billing, three structural safeguards guard against narrowing the role to clinical tasks: CBO autonomy over programmatic work, community input through the partnership council, and a dedicated floor for non-billable community resilience activities.

**Recommendation 6:** Ensure pay equity and fair compensation that reflects the full labor of this workforce.

Training alone does not retain a workforce; compensation must match the labor. CHW/Promotor work extends into evenings, weekends, and crisis-response hours that sustain community trust but often go uncompensated. The economic analysis baseline of $59,000 represents the minimum; the survey median of $62,400 and the County Living Wage Ordinance rate of $54,038 ($25.98/hr) provide additional benchmarks.

**Compensation floor.** Benefits, including health coverage, should be a condition of County-funded contracts. A living wage is necessary for program feasibility and sustainability; across all four evidence streams, stakeholders identify compensation as the most urgent workforce need, one that affects both equity and retention.

**Recommendation 7:** Establish a voluntary CHW-to-CHW peer network through the hub.

Fair pay and benefits create the conditions for workforce stability; a peer network sustains professional growth. The hub should facilitate a peer learning network connecting CHWs across the three geographic areas. Despite the differences between South County's rural agricultural communities and the urban neighborhoods of East San José and Cadillac-Winchester, CHWs in all three areas navigate the same County systems: Medi-Cal enrollment, CalFresh, housing assistance, school services, and behavioral health referrals.

The network would create a space for shared problem-solving, resource exchange, and professional connection. Participation is voluntary and peer-driven: individual CHWs choose how and when to engage. The hub would provide infrastructure (meeting space, digital platform, coordination support) without directing content or requiring attendance. This design reflects the autonomy that CHWs and CBOs identified as a condition for program legitimacy across all four evidence streams.

The network should include both digital and in-person channels, making resources and shared experiences accessible to all CHWs regardless of geography or schedule.

The seven recommendations above define *what* the County should build. Two questions remain: how should the hub be designed, including CBO autonomy, input, and billing infrastructure (see Recommendations), and how do the clinical and community resilience pathways work in practice, including promotor/a role progression and the evolving measurement framework (see Program Design: The Blended Model)?

## Hub Design Principles

Four design principles govern the hub structure. Each responds to a specific risk identified by stakeholders, the Fiscal Advisory Committee, or peer county experience. Extended rationale, stakeholder input, and implementation details for each principle are provided in the Hub Design Principles: Extended Details section.

**CBO autonomy over programmatic and community work.** The hub coordinates billing, credentialing, and clinical infrastructure only. Community organizing, culturally specific programming, hiring and supervision of frontline CHWs, and non-billable community resilience activities remain under the full authority of each CBO, subject to contractual conditions with the County. The hub is a shared back office, not a programmatic authority.

**Participation does not require a CHW title or state certification.** The program welcomes all community workers regardless of whether they hold the CHW title, a formal credential, or state certification. A promotor/a with decades of community organizing experience and a recently certified CHW with a community college credential both participate in the same program; what differs is how their time is billed, not whether they belong.

**Community input: CBO partnership council.** The hub should be advised by a partnership council composed of the CBOs it serves. The council identifies training needs, provides a feedback loop on hub operations, protects against mission drift, and convenes to develop shared resources. Participation in council working groups is voluntary. The council's influence comes from legitimacy and funding guidance, not enforcement. Organizing documents for the partnership council, including any charter, should be developed in consultation with County Counsel.

**Separate billing infrastructure.** The CHW billing platform must operate independently from the County hospital billing system. Routing CHW billing through the County hospital system would effectively require CHWs to be County employees or County-credentialed providers, recreating the workforce constraints the hub is designed to avoid. The billing platform is a commercial CHW-specific system that the hub operates on behalf of partner CBOs. Larger organizations bill independently using the hub's platform for support; smaller CBOs and cooperatives route claims through the hub as the Medi-Cal supervising provider.

**Implementation readiness varies by function.** Billing and credentialing are contractable now through commercial platforms. Quality assurance and outcome tracking can draw on existing frameworks. Clinical supervision and health plan contracting require further

design work during implementation. A phased launch sequence is recommended: billing infrastructure first, measurement systems second, clinical contracting third.

The hub infrastructure described above enables both clinical and community resilience work. The next section details how those two pathways operate in practice: who does what, how each is funded, and how the program measures both.

# Program Design: The Blended Model

The clinical and community resilience pathways are not separate programs staffed by separate people. The same promotores do both, progressing from relationship building to health education to community organizing over approximately three years. What differs is how each pathway is funded, measured, and sustained. Three design elements structure this integration: promotor/a roles with a developmental progression, two models of care with distinct funding, and a measurement framework that evolves to capture both.

## Three Roles of a Promotor

The same promotores perform three roles, each with distinct activities and a developmental progression over time.

*Table 4: Three roles of a promotor and associated activities.*[6]

| Role | Core Activities | Stage |
|---|---|---|
| **Relationship Building** | Outreach, community needs assessment, connection to services | Year 1 |
| **Health Education** | Care navigation, chronic disease management, service coordination | Years 1–2 |
| **Community Organizing** | Leadership development, advocacy campaigns, systems change | Years 2+ |

These are not separate job descriptions. The same promotores progress through all three roles as they gain experience, trust, and skills. A new cohort of CHWs begins with relationship building and outreach; within one to two years, the same workers add health education and care navigation; by year two and beyond, experienced promotores take on community organizing and advocacy. This progression is cumulative: a promotor/a doing organizing work continues to maintain relationships and provide health education.

## Two Models of Care

The three roles map onto two models of care with fundamentally different funding structures, time horizons, and outcome pathways.

*Table 5: Two models of care: clinical and community resilience.*[7]

| Dimension | Clinical Model (Roles 1–2) | Community Resilience Model (Role 3) |
|---|---|---|
| Primary funding | Medi-Cal reimbursement | Sustained county or grant investment |
| Billable under Medi-Cal | Yes (30-minute units) | No |
| Time to measurable ROI | 2–3 years | 5–10 years |
| Outcome pathway | Fewer ED visits, hospitalizations, readmissions | Policy change, structural improvements, community power |
| Risk if pursued alone | Treats symptoms; leaves structural drivers intact | Misses near-term cost savings that build fiscal case for program |

ROI = return on investment; ED = emergency department.

Neither model alone addresses the full scope of health needs identified in the LHA. The program design recommended in this report (see Recommendations) preserves both by funding clinical activities through Medi-Cal reimbursement while sustaining community resilience work through County general fund and grant support.

## Program Timeline and Cohort Stages

Two timescales run through the budget and findings sections: *program years* and *cohort stages*.

**Program years** (Year 1 through Year 5) describe the calendar of the overall program: when positions are funded, when infrastructure is built, and when the program begins to measure impact. The five-year budget projections in the Technical Report use program years; the Findings: Economic Analysis (Clinical Pathway) section presents the per-CHW economics that underlie those projections.

**Cohort stages** describe the developmental progression of each group of CHWs hired. A cohort moves from relationship building (first year of employment) to health education (years one and two) to community organizing (year two onward) over approximately three years. Because the program scales by adding new cohorts annually, all three stages operate simultaneously by program Year 3.

The clinical model produces measurable returns (reduced ED visits and hospitalizations) once a cohort reaches the health education stage, typically after 12–18 months. The community resilience model produces visible community-level impact after a cohort has been active for five or more years. The economic projections capture the clinical timeline; the community resilience timeline is addressed in the recommendations.

*Infrastructure Build (Months 1–24).*

Before the clinical model can generate Medi-Cal revenue, a 12- to 24-month infrastructure build is required. Key components include:

- Medi-Cal provider enrollment and billing system configuration
- Referral pathways between primary care, managed care, and CHW programs
- Inter-agency data-sharing agreements for program evaluation and electronic health record integration
- Clinical supervision structures (required for Medi-Cal billing)
- CHW training and certification (per SB 184 standards)

The five-year budget [see Findings: Economic Analysis (Clinical Pathway)] accounts for these start-up costs in program Years 1–2. Programs that skip or compress this phase risk billing delays and compliance gaps, as observed in peer county implementations.[17]

## Activities and Measurement: Clinical and Community Resilience Pathways

The clinical pathway encompasses one-on-one interventions (care navigation, chronic disease management, Medi-Cal enrollment, prenatal care linkage) that generate measurable healthcare utilization changes. These activities are reimbursable under Medi-Cal and produce the cost savings quantified in Findings: Economic Analysis (Clinical Pathway). The economic models estimate cost savings from care navigation and chronic disease management, which generate the ED visit, hospitalization, and readmission reductions documented in the literature review (see Best Practices: Evidence for CHW Program).

The community resilience pathway encompasses group-level and systems-level activities (health education, rights and benefits education, community outreach, leadership development, community organizing, and social determinant navigation) that require sustained County or grant investment. In practice, existing CHW programs in the region spend most staff time on group education and community outreach rather than one-on-one clinical interactions.[17] The economic model quantifies only the one-on-one clinical pathway; the time allocation between pathways is a program design decision for the Board to make in partnership with the communities served.

Detailed activity tables with specific outputs, outcomes, and metrics for both pathways are provided in the Activities and Measurement Detail section.

## Evolving the Measurement Framework

The measurement framework for a blended CHW program develops in two phases. In Years 1–2, the program tracks primarily **output metrics**: counts of activities performed (classes held, referrals completed, enrollments processed, encounters logged). These output metrics confirm the program is operating as designed and at the intended scale.

In Years 3–5, the program transitions to **outcome metrics**: evidence that activities are producing intended changes (reduced ED visits, improved chronic disease indicators, increased benefit uptake, resident-led initiatives). These outcome metrics confirm the program is working.

The CBO partnership council advises on which outcome measures are meaningful, feasible, and culturally appropriate for the communities served. Measurement decisions made in isolation from the communities they describe risk tracking what is convenient rather than what matters. The framework develops alongside the program; it is not a fixed scorecard imposed at launch.

Setting the minimum community resilience allocation (Recommendation 2) requires data that the county is best positioned to track: billing revenue generated at different clinical time allocations, healthcare savings captured at each level, the net County investment required at each level, and which community resilience activities would be reduced or eliminated at each allocation. The CBO partnership council should participate in this decision, informed by this data, to ensure that community priorities are represented alongside fiscal analysis. The county should report these metrics at regular intervals so the allocation can be revisited as program conditions change.

The right balance between clinical and community resilience pathways is a program design decision, informed by community input and the factors discussed throughout this report: focus population size, time allocation, caseload intensity, workforce model, cohort maturity, and the measurement framework itself (see Additional Detail in the Technical Report).

**Community-level measurement: extending the evidence base.** The CHW Common Indicators Project (California Health Care Foundation) represents the current state of the art for CHW measurement in California, but explicitly excludes community-level indicators; its measures focus on individual patient outcomes (clinical, utilization, self-management). The strongest published RCT likewise measures individual-level outcomes. This program's measurement framework extends beyond both to include community-level outcomes advised on by the CBO partnership council: social cohesion, civic engagement, resident-led initiatives, and community infrastructure. Of these constructs, collective efficacy, the shared belief in a community's capacity to act toward common goals, has the most developed measurement base. The Los Angeles County Community Disaster

Resilience project identified collective efficacy, civic engagement, and community engagement as distinct, measurable dimensions of community resilience through factor analysis with 4,700 residents, with collective efficacy explaining the largest share of variance.[44] The Common Indicators Project's participant empowerment composite measures individual-level precursors to these community-level outcomes across 10 domains (including self-efficacy, sense of community, critical consciousness, and perceived control) and is already in use in California CHW programs.[46] For advocacy and policy change outcomes, no validated quantitative measures exist; the CBO partnership council will advise on process documentation drawing on advocacy evaluation methodology.[45] These outcomes require different instruments (periodic community surveys administered independently from the serving CHW/Promotor) and longer timelines. The program contributes to the evidence base for CHW/Promotor effectiveness while drawing on it.

The measurement framework tracks what the program produces. The policy environment (see Policy Context Detail) determines what the program can bill for; the Findings: Economic Analysis (Clinical Pathway) section summarizes the key billing facts.

# Limitations and Future Directions

This section addresses constraints on the current study and identifies priorities for ongoing measurement and evaluation.

## Limitations

This study was completed under a compressed timeline that shaped its design in several important ways.

**CHW/Promotor role in study design.** CHWs and promotores served as advisors to this study and provided input through surveys, focus groups, and key informant interviews. In a fully community-oriented research model, there would have been time and resources to train promotores to help develop the survey instruments and present data on their own communities and professional experiences. That level of participation would have required roughly double the time allotted for this report. Future studies of this workforce should consider a participatory model in which promotores are co-designers of the research tools, not only respondents.

**Geographic scope.** This study focused on CHWs/Promotores currently working in the three priority areas (East San José, Cadillac-Winchester, and South County). Promotores elsewhere in the County may be willing and eligible to provide services in these areas but choose not to; the barriers they face may overlap with or differ from those observed here. Future work should extend the scope County-wide.

## Measurement and Evaluation Priorities

**Youth as promotores.** This study did not explore the role of youth as promotores, which is a growing area of practice in violence prevention, mental health, and disability services. Youth-led peer health models have shown promise in other jurisdictions. A pilot evaluation of youth promotores within the program structure would generate evidence for this model and strengthen applications for violence prevention and youth development grants.

**Employment structure.** The workforce survey captured current employment status but did not explore whether respondents are the sole income earner in their household or whether they work for more than one organization simultaneously. With only 14% of survey respondents holding full-time positions, a follow-up study of employment structure would provide the data needed to design compensation standards (Recommendation 6) and to demonstrate workforce stability to funders.

**Time use and off-hours labor.** Stakeholders across all four evidence streams identified uncompensated evening, weekend, and crisis-response work as a defining feature of this workforce. A time-tracking study would quantify the scope of unpaid labor, inform the design of a structured off-hours phone service for families, and provide the cost data needed for grant budgets that include compensation reform.

# Conclusion

Each evidence stream points in the same direction: a phased CHW/Promotor program serving high-risk residents in Cadillac-Winchester, East San José, and South County is feasible. This feasibility study focused on Latino residents in these communities, and the cost-effectiveness estimates reflect the health characteristics, utilization patterns, and insurance mix of that population. This study did not estimate the economic model for other populations in these areas. As noted in the Study Area section, however, the program mechanisms that drive cost savings, including care navigation, chronic disease management, and social service referral, benefit all residents who face barriers to care. The focus population ranges from approximately 10,500 to 21,000 depending on how high-risk is defined; program growth is paced by CBO capacity rather than by population definition.

The economic models quantify the clinical pathway: the Medi-Cal perspective returns 64 cents for every dollar invested, while the broader system perspective returns $1.78 for every dollar invested. From the Medi-Cal perspective, each additional year of healthy life costs $1,680 to produce, well below the $100,000 cost-effectiveness threshold; from the healthcare perspective, the program saves money while improving health. Direct per-CHW/Promotor economics (about $113,000 cost, $278,000 savings) are stable across the projected program scale, though total program costs include hub infrastructure that exhibits economies of scale as the program grows [see Findings: Economic Analysis (Clinical Pathway)]. CBO ecosystem capacity, not the choice of focus population

definition, is the binding constraint on program growth. These returns are consistent with the published evidence base: the strongest published trial returned $2.47 for every dollar invested within one year [1], and programs with longer track records report returns of $3 to $11 per dollar.[2,3,5] This study's more conservative return reflects the Medi-Cal reimbursement rates specific to California rather than the full healthcare system costs captured in some published evaluations. Unfortunately, there are unlikely to be budgetary savings to the County health system.

The clinical pathway captures only part of the program's value. CHWs also devote time to group education, community outreach, leadership development, and organizing that addresses the structural conditions behind poor health outcomes: housing instability, food insecurity, isolation from systems, and lack of civic voice. The economic model quantifies only the clinical fraction; the community resilience pathway operates on longer timelines and requires the separate measurement framework described in the Program Design: The Blended Model section.

The policy environment creates financing pathways that did not exist five years ago, though structural barriers, particularly the FQHC billing exclusion, require workarounds that peer counties have already demonstrated. The binding constraint on program growth is CBO infrastructure, not population need. Most partner CBOs lack the administrative capacity to bill Medi-Cal independently. Every peer county that has scaled a CHW program beyond 100 workers (Los Angeles, Alameda, and others profiled in the Peer County Profiles section) operates a hub organization that coordinates billing, credentialing, and quality assurance on behalf of CBOs, while leaving community programming and CHW hiring under CBO authority. Establishing a similar hub in Santa Clara County, estimated at $800,000–$1,200,000 per year in operational costs, would unlock billing access across the ecosystem without requiring each organization to build duplicative administrative systems. Combined with an expanded training pipeline, this infrastructure investment converts the per-CHW economics from a theoretical model into a business case that individual CBOs can act on.

The central risk is definitional narrowing: optimizing for Medi-Cal billing at the expense of the community resilience work that stakeholders, peer county evidence, and the program's own logic model identify as essential to long-term health improvement. Blended funding, community input, and measurement that evolves alongside the program are the conditions that predict durability.

This report makes seven recommendations. Establish a community resilience hub to coordinate billing, credentialing, and quality assurance across the CBO ecosystem, with the County as convener, cross-agency data sharing, and regular public reporting (Recommendation 1). Preserve both clinical and community resilience pathways through dedicated funding streams and a measurement framework that evolves with community input (Recommendation 2). Fund training through CBO and managed care plan grants, with priority areas identified by the workforce (Recommendation 3). Prioritize CHW training and deployment in youth services, violence prevention, and chronic disease management

across the three geographic areas (Recommendation 4). Build on the existing CBO landscape and protect CHW role integrity (Recommendation 5). Ensure pay equity with County labor standards as the floor for contracted positions (Recommendation 6). Establish a voluntary CHW-to-CHW peer network through the hub (Recommendation 7). Together, these recommendations respond directly to the Board of Supervisors referral and the LHA's mandate to expand the Promotores Model with a workforce "represented by Latino people with lived experiences" (see Recommendations).

# Acknowledgments

## Land Acknowledgment

Santa Clara County spans Palo Alto in the north to Gilroy in the south. These lands are the ancestral and unceded territories of the Awaswas-, Chochenyo-, Mutsun-, Thámien-, and Yokut-speaking peoples. As a public agency, it is our responsibility to acknowledge the historically documented violence and injustice that occurred as local Tribal groups were forcibly displaced from these lands.

We also acknowledge and respect Indigenous Peoples of this place, including the Amah Mutsun Tribal Band and the Muwekma Ohlone Tribe of the San Francisco Bay Area, who work today to restore and protect their culture and connect to the land. As a collective, we remain committed to the visibility of this history, and we celebrate the life and health of the present-day members of these Tribes.

## County of Santa Clara Board of Supervisors

- Supervisor Sylvia Arenas, District 1
- Supervisor Betty Duong, District 2
- Supervisor Otto Lee, District 3
- Supervisor Susan Ellenberg, District 4
- Supervisor Margaret Abe-Koga, District 5

## County of Santa Clara Office of the County Executive

- James R. Williams, County Executive
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- Analilia García, Chief Equity and Inclusion Officer
- Division of Equity & Social Justice Language Access Unit

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## Community Members

This study would not have been possible without the dedication of the CHW/Promotor workforce and the community-based organizations that welcomed us, shared their experiences, and shaped this research.

More than two hundred promotores, community health workers, and their supervisors contributed their time to complete surveys, participate in focus groups, and collaborate with the research team on interpreting findings. Their willingness to candidly describe the realities of their work, compensation, and the communities they serve forms the foundation of this report.

The following organizations participated in survey outreach, key informant interviews, focus groups, or advisory committee convenings: SOMOS Mayfair, LUNA, Lazos Fuertes, Sacred Heart Community Services, Catholic Charities, CARAS, Community Solutions, Next Door Solutions, Nueva Vida Community, Amigos de Guadalupe, Madre-a-Madre, Nueva Esperanza, East San José PEACE Partnership, Latinas Contra Cancer, Community in Action Team, META (Mujeres Empresarias Tomando Acción), De Colores Community Consulting, AACI, Community Health Partnership, Indian Health Center of Silicon Valley, Santa Clara Family Health Plan, San José City College, Mission College, Foothill College, SIREN, Visión y Compromiso, Silicon Valley Independent Living Center, Parents Helping Parents, Second Harvest of Silicon Valley, Veggielution, American Heart Association, First 5 Santa Clara County, School Health Clinics of Santa Clara County, and SC HEALS!.

# Figure and Table Source Notes

1. Figure 1: Source: American Community Survey 5-Year Estimates [11]; HRSA Health Center Program data [16]; California State Controller's Office payroll records [10]. Map displays Cadillac-Winchester, East San José, and South County focus areas across 10 ZIP codes.

2. Table 7.2: Source: Economic modeling using ACS [11], HCAI [12], Medi-Cal Fee Schedule [13], and BLS [14]. Program costs include CHW salaries, benefits, supervision, training, and overhead. Healthcare savings calculated from projected reductions in ED visits, hospitalizations, and readmissions.

3. Table 1: Source: Economic modeling using ACS [11], HCAI [12], Medi-Cal Fee Schedule [13], and BLS [14]. Medi-Cal perspective uses Medi-Cal reimbursement rates; healthcare system perspective uses full resource costs. CalAIM billing revenue excluded from conservative Medi-Cal perspective. ICER from cost-effectiveness analysis over a 10-year time horizon. Dominant = saves money and improves health outcomes.

4. Table 4: Source: Conceptual framework developed from key informant interviews [17], stakeholder engagement sessions, and peer county program analysis. Role progression timeline based on observed CHW career development in peer programs.

5. Table 5: Source: Conceptual framework synthesized from key informant interviews [17], published literature [1–9], and peer county program analysis. Medi-Cal billing eligibility per DHCS CHW benefit guidelines [13]. Time-to-ROI estimates from published program evaluations [1,2,3,4,5].

6. Table 6: See table footnotes for detailed source citations.

7. Table 7: Sources: County profile documents prepared from publicly available program data, grant reports, and organizational websites. Full profiles in the Peer County Profiles section.

8. Table 10: Sources: County of Santa Clara civil service classifications; key informant interview data [17]; peer county program analysis. Compensation data for CBO and cooperative models from KII stakeholders; county classifications from official job descriptions.

9. Table 11: Sources: LA County CHWOI program documentation; San Diego Neighborhood Networks and CIE evaluations; Alameda County Care Connect reports; CalAIM PATH/CITED grant program data [23]. Specific county programs cited in text.

# Study Methodology

The feasibility question has four dimensions: workforce capacity, published evidence, economic viability, and community priorities. Each evidence stream addressed one.

## CHW/Promotor Workforce Survey Methodology

The PHD Science Branch team developed the survey instrument by integrating components from three validated instruments: the National Association of Community Health Workers (NACHW) Survey, the Stanford University Office of Community Engagement CHW Training Needs Assessment, and the Arizona Community Health Worker Statewide Survey. These instruments were adapted to ensure cultural and linguistic relevance for CHWs/Promotores working in Santa Clara County. The CHW Advisory Committee consulted on the survey's content, language, and structure. Prior to full distribution, the survey was piloted with both internal PHD staff and external community partners.

The final survey covered demographics, professional identity and role, employment and compensation, training completed and training needs, success factors, challenges, and opportunities to strengthen the workforce.

The 15–20-minute survey was created in Qualtrics and made available in both English and Spanish. All surveys were confidential, and informed consent was obtained prior to participation.

### *Eligibility Criteria.*

Respondents were required to: be 18 years of age or older; identify as a CHW, promotor/a, or representative from a CHW/Promotor-led organization; and be currently or recently (within the past 12 months) working in at least one of the three priority geographic areas serving Latinos.

### *Recruitment and Data Collection.*

The survey was distributed between February 1 and March 6, 2026 through a network of community-based organizations, health centers, and professional associations. Partner organizations hosted informal "Cafecito hours," small group sessions in which members of the research team were present to support survey completion in both English and Spanish. Eleven organizations hosted these sessions. A $75 gift card was offered to all individuals who completed the survey. A total of 210 respondents met the eligibility criteria and are included in the analysis.

### *Analysis.*

Data were cleaned, coded, and analyzed using RStudio version 2025.05.1. Descriptive statistics were used to summarize findings. Frequencies and percentages were calculated for all closed-ended survey items. For questions where respondents could select multiple responses, percentages may add up to more than 100 percent. Open-ended questions were reviewed using thematic analysis informed by the CHW Advisory Committee's interpretation of the findings.

## Study Approach

*Table 6: Study approach: Four streams of evidence.*◊[4]

| Stream | Description | Data Sources |
|---|---|---|
| Workforce Landscape[a] | Mapped the existing CHW workforce and organizational infrastructure across three sectors | Public payroll, nonprofit filings, federal registries, Public Health Department partner data, direct verification |
| Literature Review | Reviewed published evidence on CHW program effectiveness, cost, and return on investment | Peer-reviewed studies [1–9], systematic reviews, program evaluations |
| Economic Modeling[b] | Built four economic models (ROI, budget impact, cost-effectiveness, equity analysis) | Population surveys, hospitalization data, Medi-Cal fee schedules, wage data |
| Stakeholder Engagement | Gathered local knowledge and priorities through interviews, surveys, focus groups, and advisory committees | 17 KIIs [17], CHW survey, community focus groups, Fiscal and CHW Advisory Committees |

[a] State Controller payroll data [10], IRS Form 990 [15], HRSA (Health Resources and Services Administration) UDS [16]. [b] ACS (American Community Survey) [11], HCAI (Department of Health Care Access and Information) hospitalization data [12], Medi-Cal Fee Schedule [13], BLS (Bureau of Labor Statistics) [14]. ROI = return on investment; KIIs = key informant interviews.

# Peer County Profiles

The study selected five California counties that share key characteristics with Santa Clara: large Medi-Cal populations, significant Latino and immigrant communities, mixed urban-rural geography, and active CalAIM implementation. Alameda (population 1.6 million) is the closest demographic comparator; Los Angeles and San Diego offer lessons at larger scale.

*Table 7: California peer county CHW program summary.*◊[3]

| County | Scale | Key Innovation | Primary Funding |
|---|---|---|---|
| Los Angeles | 900+ CHWs | Multi-CBO contracting (CHWOI); reached 2.3M individuals | County + MCP |

| County | Scale | Key Innovation | Primary Funding |
|---|---|---|---|
| San Diego | 200+ CHWs | Community Information Exchange (26% EMS reduction) | HRSA + CalAIM |
| Alameda | 55+ CHWs | First certified CHW apprenticeship in Northern California | CalAIM ECM |
| Fresno | 120+ CHWs | PCHI-certified Pathways HUB; mobile health for farmworkers | Federal grants |
| Sacramento | varies | Social Health Information Exchange (cross-sector data) | MCP + grants |

CHW = Community Health Worker; CBO = community-based organization; CHWOI = Community Health Worker Outreach Initiative; MCP = managed care plan; EMS = emergency medical services; HRSA = Health Resources and Services Administration; CalAIM = California Advancing and Innovating Medi-Cal; ECM = Enhanced Care Management; PCHI = Pathways Community HUB Institute.

Four consistent success factors emerged across these programs:

1. **Blended funding:** No successful county relies on a single funding source. The typical mix is 25 to 40% CalAIM, 15 to 25% managed care contracts, 15 to 25% county general fund, and the remainder from grants and foundations.

2. **Formal workforce pipelines:** Counties with registered apprenticeship programs or community college partnerships (Alameda, San Diego, Sacramento) have more stable workforces.

3. **Coalition input:** Programs with cross-sector coordinating bodies (150+ partner networks, San Diego's 25+ member collaborative) demonstrate greater resilience.

4. **Technology infrastructure:** San Diego's Community Information Exchange reduced EMS calls by 26% among enrolled frequent ED users; Sacramento's Social Health Information Exchange eliminates duplicative intake.

A cautionary example: one peer county lost $11 million in federal CDC grants in March 2025, affecting 120 CHWs. Sacramento and Los Angeles face ARPA funding expiration. Counties that weathered these disruptions had diversified funding portfolios.

Detailed profiles follow. Each draws from publicly available program documentation, grant reports, and organizational websites.

## Los Angeles County

**Population:** 10 million | **Medi-Cal enrollment:** 4.2 million | **Lead agency:** LA County DPH

Los Angeles operates the largest county CHW initiative in California through the Community Health Worker Outreach Initiative (CHWOI), which contracted with 16 CBOs deploying over 900 CHWs. Between 2020 and 2023, CHWOI reached 2.3 million individuals, initially focused on COVID-19 response before transitioning to chronic disease prevention and community health.

**Key features:**

- Multi-CBO contracting model with fiscal agent structure
- CHW Son program ($17.4M over 2 years)
- L.A. Care CHW Training and Benefit Program ($1.3M investment with Loma Linda University)
- Transition from emergency response to sustainable chronic disease programming

**Lesson for Santa Clara:** The CHWOI model demonstrates how a county can deploy CHWs at scale through CBO contracting rather than direct employment, preserving community infrastructure while maintaining quality standards.

## San Diego County

**Population:** 3.3 million | **Medi-Cal enrollment:** 854,000 | **Lead agencies:** County HHSA, San Diego Wellness Collaborative

San Diego operates a coordinated CHW ecosystem with emphasis on technology infrastructure and immigrant/indigenous population services. The Neighborhood Networks hub model has served over 1,200 individuals.

**Key features:**

- Community Information Exchange, which achieved 26% reduction in EMS calls among enrolled frequent ED users
- $3M HRSA CHWAP grant (2022–2025) with UC San Diego
- Capacity-building collaborative (SDCPC: 25+ members, 200+ CHWs/promotores)
- ELEVATE program ($75M health workforce investment)

**Lesson for Santa Clara:** San Diego's Community Information Exchange demonstrates the value of cross-sector data infrastructure for CHW programs, providing measurable outcomes (26% EMS reduction) that support sustainability arguments.

## Alameda County

**Population:** 1.6 million | **Lead agency:** Alameda County Public Health Department

Alameda integrates CHW programs through public health and academic partnerships, with a focus on workforce development pathways.

**Key features:**

- Health Coach Program (founded 2014 with $200K Robert Wood Johnson Foundation [RWJF] pilot), the first certified healthcare apprenticeship in Northern California
- Health Pipeline Partnership (since 2007, 15 organizations, paid 4-month training with $1,500 monthly stipend)
- CHCN Care Neighborhood ECM (55+ CHWs, 1,000+ patients)
- Perinatal Equity Initiative (BElovedBIRTH Black infant health program)

**Lesson for Santa Clara:** Alameda's registered apprenticeship model creates a formalized career pathway for CHWs, combining community college education with paid work experience, a model replicable through partnerships with De Anza, Mission, or West Valley College.

## Fresno County

**Population:** 1.03 million | **Medi-Cal enrollment:** 52% of population | **Lead agencies:** Multiple

Fresno operates distributed CHW programs with an agricultural worker focus, including the first Pathways Community HUB Institute (PCHI)-certified Pathways HUB in California.

**Key features:**

- Rural Mobile Health Program (launched Feb 2023, $8M ARPA; 612+ events, 14,801+ patients)
- FCHIP HOPE Pathways Community HUB (25 CHWs, $12M contract, 150+ partners)
- Cross-sector partnership network (400+ stakeholders)

**Funding crisis:** Fresno lost $11M in federal CDC grants in March 2025, affecting 120+ CHWs. ARPA funding is also expiring.

**Lesson for Santa Clara:** Fresno's mobile health model is relevant for South County's agricultural communities, but the county's funding crisis illustrates the danger of single-source dependency. Santa Clara must build diversified funding from day one.

## Sacramento County

**Population:** 1.6 million | **Lead organizations:** Community HealthWorks, Wellness Without Walls

Sacramento uses its proximity to the state capital for policy engagement, with strong managed care partnerships.

**Key features:**

- Community HealthWorks: Medi-Cal navigation, ECM, Community Supports, housing, re-entry, street outreach; Pathways program housed approximately 1,000 individuals
- Sacramento Health Connect (Social Health Information Exchange launched February 2025), enabling cross-sector data integration (health, criminal justice, housing, education)
- Community college CHW training: 9-month program at Sacramento City College
- Managed care partnerships with Anthem, Health Net, Kaiser, Molina

**Lesson for Santa Clara:** Sacramento's Social Health Information Exchange demonstrates how cross-sector data integration (health, housing, justice) can support CHW effectiveness. The multi-plan managed care contracting model is directly applicable to Santa Clara's managed care landscape.

# Advisory Committee Charter Values

This section summarizes the project charter developed through the advisory committee process. The charter establishes the governance framework, scope, and implementation phases for the CHW program.

## Purpose and Background

This project fulfills Recommendation 2c in Supervisor Arenas' referral, assigned to the County of Santa Clara Public Health Department along with the Office of the County Executive and Santa Clara Valley Healthcare. In 2023, the Board of Supervisors unanimously approved a referral for a Latino Health Assessment. PHD conducted a multi-phase assessment of Indigenous and Latino residents' health, published in 2025 and presented to the Board on May 6, 2025. Of 27 recommendations identified across County departments, PHD was assigned four, including Recommendation 2c on promotoras and community health workers.

## Project Scope

**Goal:**
Implement full-scale CHW/Promotor programs in East San José and South County.

**Objective:**
Return to the Board with a comprehensive strategy for CHW program implementation, including analysis of funding streams such as Medi-Cal waivers and Cal-AIM Community Supports.

**Key Deliverables:**
Board presentation (Leg File or Off Agenda); assessment; summary report and recommendations.

## Project Team and Coordination

- **Executive Sponsor:** Angelica Diaz
- **County Coordinators:** Office of Diversity, Equity and Belonging (Analilia Garcia); Public Health Department (Rhonda McClinton-Brown)
- **Partner Agencies:** Office of the County Executive (Ky Le); Santa Clara Valley Healthcare (Michelle dela Calle)

## Implementation Phases

1. **Build the project infrastructure** (internal capacity and team formation)
2. **Build the foundation:** Establish planning principles, framework, steering committee, common language, inclusion and exclusion criteria, and topics of interest; conduct social network analysis; identify research areas
3. **Gather and analyze:** Establish research questions; develop and implement data collection and analysis plan
4. **Tell the story:** Continued data analysis; develop report outline and deliverables
5. **Real-time evaluation and quality improvement** (ongoing throughout all phases)

## Constraints

The charter notes three constraints: no additional staffing resources for the planning phase, no dedicated budget for planning, and an unknown budget for program implementation. These constraints reinforce the importance of the blended funding model described in Recommendation 1 and the phased scale-up approach that allows program growth to follow demonstrated outcomes.

# Revenue and Funding Detail

This appendix provides detailed descriptions of the six revenue categories.

*Table 8: Revenue and funding sources summary.*

| Source | Approximate Yield | Key Constraint |
|---|---|---|
| Medi-Cal CHW FFS (CPT 98960, HCPCS G0019/G0022) | $4,300–$5,000/CHW/yr | FQHCs excluded; requires billing infrastructure |
| CalAIM ECM contracts | Monthly capitation (~$300/member/month, shared across care team) | Requires MCP contract and ECM provider designation |
| CalAIM Community Supports | Service-based reimbursement (can layer with ECM) | $231M statewide allocation (FY 2025–26) |
| Federal and state grants | Variable; competitive | Subject to expiration (one peer county lost $11M/120 CHWs) |
| County general fund / cross-dept contracts | Variable | Requires permanent budget line item |
| H.R. 1 retention / Coverage Ambassadors | New stream (FY 2026–27; amount TBD) | Depends on H.R. 1 implementation timeline |

FFS = fee-for-service; FQHC = Federally Qualified Health Center; ECM = Enhanced Care Management; MCP = managed care plan.

## Medi-Cal CHW Preventive Services (Fee-for-Service)

California's Medi-Cal CHW benefit reimburses per visit: $27.54 per 30-minute unit (CPT 98960–98962), and as of April 2025, HCPCS codes G0019/G0022 reimburse at 100% of the Medicare rate for social determinants of health interventions.[13,18] Maximum billing: four 30-minute units per day for 98960; one 60-minute unit per month for G0019.[30] CBOs that employ certified CHWs can bill for individual health education, health navigation, screening and assessment, individual support and advocacy, and chronic condition self-management.[30] The county can structure its CBO contracts so that CBOs bill Medi-Cal directly or bill through the county as the enrolled provider, depending on the CBO's enrollment status.[38]

At a realistic billing volume of 3 to 4 visits per patient per 6-month engagement (adjusted for incomplete engagement: not all patients complete the full visit schedule), this generates approximately $4,300 to $5,000 per CHW per year. This pathway is limited by billing infrastructure requirements and the FQHC exclusion.

## CalAIM Enhanced Care Management (ECM) Contracts

ECM is paid as a per-member-per-month (PMPM) capitation from the managed care plan (MCP) to contracted ECM providers, and CBOs are explicitly eligible to serve as ECM lead entities or subcontractors.[23,30] The PMPM (approximately $300, though rates are set through MCP-specific negotiations) funds a multidisciplinary care team (clinical supervision, care coordination, CHW/Promotor outreach and navigation, and administrative overhead).[23,30] CHW/Promotors can deliver most of the day-to-day ECM workload: outreach and engagement, needs assessment inputs, care plan implementation, navigation, monitoring, and data collection.[19,23] The CHW/Promotor program's share of the ECM PMPM depends on the contract structure with the MCP; the full $300 does not flow directly to the CHW/Promotor program.

To deliver ECM services, CHW/Promotors must be employed by or contracted with a managed care plan (MCP)-designated ECM provider. This requires an MCP contract, credentialing, and clinical supervision. A billing platform could handle credentialing and reporting; the county could negotiate a network-level ECM arrangement with SCFHP that builds supervision into the contract design, with FQHC or clinic providers serving as supervising entities and a PMPM allocation covering supervision costs. The community resilience hub (Recommendation 1) would serve as convener, not supervisor. The specific terms (supervision ratios, compensation structure, liability allocation, and SCFHP willingness) remain to be negotiated during implementation.

Administrative data from DHCS show that Santa Clara Family Health Plan (SCFHP), the local initiative MCP covering 295,016 members, enrolled approximately 7,400 members in ECM as of 2025 Q2, a rate of 2.51% that roughly doubled over the prior year.[29] The largest pathways are homelessness (2,702 members) and LTC institutionalization risk (1,692 members).

The CHW focus population carries higher risk than the general SCFHP membership, so ECM eligibility rates are elevated. Applying risk multipliers to observed SCFHP rates, the estimated ECM-eligible share is 4.7 to 5.5%, translating to approximately 19 to 27 CHWs' worth of ECM-enrolled patients.

*ECM as a launch population.*

ECM-eligible members are a pre-funded subset of any focus population: SCFHP has a regulatory obligation to provide ECM services, and CHWs are the natural workforce to deliver them under MCP contract. ECM enrollment offers a natural early funding mechanism: CHWs serving ECM-enrolled members under contract with SCFHP would use the ECM revenue stream to partially offset program costs while building the operational track record needed to secure broader funding. Non-ECM members on the same CHW caseloads can be billed through CHW FFS codes, and as CHWs build relationships in the community, they identify additional residents who may qualify for ECM enrollment.

## CalAIM Community Supports (In Lieu of Services)

CalAIM authorizes Community Supports, which are service-based reimbursements from MCPs to contracted providers for specific social interventions such as housing transition and navigation, housing deposits, medically supportive food and meals, and recuperative care.[31,32] CBOs with CHWs can deliver these services and receive separate reimbursement from the MCP, even for members concurrently enrolled in ECM.[31] This is a distinct revenue line that CBOs providing both ECM and Community Supports can layer. The statewide Community Supports allocation is $231M for FY 2025–26.[19]

## Federal and State Grants

The county and its CBO partners can pursue competitive federal grants from CDC, HRSA, and SAMHSA. Santa Clara County has previously received CDC chronic disease prevention grants (e.g., $5.7 million in Partnerships to Improve Community Health funds) [33] and currently holds a CDC workforce and data-modernization award running through 2027.[34] HCAI has approximately $12 million in one-time CHW/Promotor/Representative workforce funds, with a funding framework developed in collaboration with a CHW advisory workgroup.[22] MCP-administered capacity grants, such as those offered by some California MCPs for CHW recruitment and training, are another grant mechanism.[35] State-level PATH ($1.85B, 2021–2026) and CITED ($580M) programs fund CHW workforce development, community-based infrastructure, and health equity initiatives.[23] California's opioid settlement funds represent an additional state funding stream for community health workforce investments.[36] Federal grant availability is subject to change, as peer county experience demonstrates.

## County General Fund and Cross-Departmental Contracts

Key informants ranked a permanent budget line item as the single most important funding element.[17] Peer counties allocate 15 to 25% of CHW program budgets from general fund. Santa Clara County has a long history of contracting with CBOs; a county grand jury report documented 155 contracts with 117 CBOs totaling over $46 million in a single fiscal year.[37] The county can fund CHW services through the Public Health Department budget and through interagency agreements with behavioral health, housing, and social services departments that share populations with CHW programs.[38] NACHW recommends building contracts based on value-based payment rather than hours worked, recognizing the added value that CBOs bring through trusted community relationships.[38]

## H.R. 1 Retention and Coverage Ambassador Work

The DHCS H.R. 1 Implementation Plan (January 2026) considers Medi-Cal enrollment retention tasks (such as supporting six-month renewals and work-reporting requirements) within scope for CHWs.[39] DHCS has indicated that additional billing guidance for these activities will follow. The governor's FY 2026 to 2027 budget includes H.R. 1 implementation funding through DHCS, and the Coverage Ambassadors program is being

expanded for H.R. 1 outreach.[39] CBOs that position CHWs for retention work could access this funding stream.

### Billing Constraints

ECM and CHW FFS billing are mutually exclusive for a given member at a given time: DHCS guidance is explicit that providers cannot bill CHW preventive-service codes for members during dates they are actively receiving ECM.[30] CHW FFS codes apply only to non-ECM members, or to members before ECM enrollment or after ECM graduation. Community Supports reimbursement, by contrast, can be layered with ECM for the same member.[31]

## Policy Context Detail

This appendix provides the full policy landscape analysis. Key billing facts are summarized in the Findings: Economic Analysis (Clinical Pathway) section.

*Table 9: Key policy facts at a glance*.

| **Policy Element** | **Status** |
|---|---|
| Medi-Cal CHW rate[a] | $27.54 per 30-minute visit (since July 2022) |
| New billing pathway for social needs[b] | 100% Medicare rate via SPA 25-0016 (April 2025) |
| Statewide uptake | Fewer than 6,000 members as of early 2025 |
| FQHC billing barrier | FQHCs excluded from CHW benefit reimbursement |
| CalAIM ECM/CS budget | $956M Enhanced Care Management (ECM) + $231M Community Supports (FY 2025 to 2026) |
| CHW certification[c] | Paused; interim qualification via training certificate or 2,000 hrs experience |

[a] CPT (Current Procedural Terminology) code 98960. [b] HCPCS (Healthcare Common Procedure Coding System) codes G0019 (individual) and G0022 (group), designated for social determinants of health (SDOH) interventions. SPA = State Plan Amendment; FQHC = Federally Qualified Health Center; CalAIM = California Advancing and Innovating Medi-Cal; ECM = Enhanced Care Management; CS = Community Supports; FY = fiscal year. [c] Senate Bill (SB) 184 (2022) directed HCAI to develop statewide CHW certification. HCAI paused the initiative in November 2023 and announced in 2024 that it would not implement a statewide certificate, redirecting $12 to $13M in remaining funds toward workforce training, organizational capacity building, immigrant community support, and future accreditation planning. CHWs currently qualify through a certificate of completion from any training program or 2,000 hours of paid or volunteer CHW experience within the prior three years.

## Federal Recognition of the CHW Role

The federal government recognizes CHWs through several mechanisms. In 2021, "community health worker" became an official Bureau of Labor Statistics (BLS) employment designation (Standard Occupational Classification [SOC] 21-1094), which estimated 60,730 CHWs employed nationally with a median annual wage of $51,030 and an 11% projected growth rate through 2034.[14] The Health Resources and Services Administration (HRSA) workforce projection models use a "high social need scenario" of 3 CHWs per 10,000 adults for communities with elevated health needs.[20]

As of 2024, 29 of 48 states allow Medicaid CHW payment through various mechanisms, with 15 states operating formal State Plan Amendments, six of which were approved in 2023 to 2024 alone.[21] California's Medi-Cal CHW benefit was approved through a State Plan Amendment with the Centers for Medicare and Medicaid Services (CMS).

## California CHW Certification

SB 184 (2022) directed HCAI to develop a statewide CHW certification program. As of November 2023, this certification program is paused indefinitely due to community input and funding considerations.[22] The 2024 Budget Act reduced HCAI's CHW workforce allocation from $280 million to approximately $12 million.[22] In the interim, California recognizes CHW qualification through two pathways: completion of an approved training program, or 2,000 hours of paid or unpaid CHW experience accrued within an 18-month window.[18]

## Medi-Cal CHW Benefit and CalAIM

California launched its Medi-Cal CHW benefit on July 1, 2022, using CPT code 98960 at a rate of $27.54 per 30-minute visit (87.5% of Medicare parity), with a maximum of four units (2 hours) per member per day and a standing recommendation of 12 units (6 hours) per member annually.[13,18]

Effective April 2025, the Department of Health Care Services (DHCS) introduced a second billing pathway through SPA 25-0016: HCPCS codes G0019 (individual) and G0022 (group), reimbursed at 100% of the Medicare rate. These codes are designated for social determinants of health (SDOH) interventions and require an initiating clinical visit within six months and a documented SDOH treatment plan. The annual standing recommendation does not apply to the G-codes.[13]

Statewide uptake has been "lower and slower than desired," with fewer than 6,000 Medi-Cal members using the CHW benefit as of early 2025.[19] A critical structural barrier affects the 50+ FQHCs in Santa Clara County: FQHCs cannot receive Prospective Payment System reimbursement for CHW services, effectively excluding the County's largest primary care providers from participating in the benefit.[18]

CalAIM (California's multi-year Medi-Cal transformation) provides alternative pathways through ECM and Community Supports. ECM allows CHWs to be designated as providers, with payment flowing through Managed Care Plans rather than fee-for-service billing, which avoids the FQHC barrier. The 2025 to 2026 state budget allocates $956 million for ECM and $231 million for Community Supports.[19]

## Additional Detail in the Technical Report

The following analyses are provided in the Technical Report, available upon request from `science.branch@phd.sccgov.org`:

- **Policy detail** (rate tables, billing analysis): Medi-Cal CHW billing codes and rates, the FQHC Prospective Payment System barrier, CalAIM covered services, ECM populations of focus, CHW qualification pathways, and billing pathway comparisons. The Findings: Economic Analysis (Clinical Pathway) section of this report summarizes the key billing facts; the Policy Context Detail section provides full detail.
- **ECM enrollment and launch population**: ECM enrollment data by pathway and the launch population analysis for Year 1 program design.
- **Workforce estimate methodology**: Data sources, known limitations (broad CHW-equivalent definition, double-counting risk, nonprofit uncertainty), reasonableness checks against BLS and HRSA benchmarks, and scaling implications. The report estimates 500–650 CHWs working across 82 organizations in the County, with 342 verified public sector positions.
- **Sensitivity and uncertainty analysis**: Probabilistic sensitivity analysis (10,000 Monte Carlo simulations), parameter ranges, and tornado diagrams. Key result: the probability of positive ROI is 47.1% from the Medi-Cal perspective and approximately 100% from the healthcare system perspective.
- **Program balance factors**: Detailed comparison showing how six design factors (focus population, time allocation, caseload intensity, workforce model, cohort maturity, measurement framework) shift the program between clinical and community resilience pathways.

## Workforce Deployment Models

From the County's perspective, two models are available for deploying CHWs: direct employment or contracting. Within contracting, the County can work with traditional CBOs or with CHW/promotor cooperatives structured as LLCs. Both are procured through County contracts; the distinction lies in organizational structure, workforce eligibility, and governance.

**Direct County Employment** hires CHWs as County staff through civil service classifications (Community Worker E07 or Public Health Assistant). This model offers stable compensation ($62K–$79K) and benefits but requires formal examination, an 87-day average hiring timeline, and federal employment eligibility verification (Form I-9).

**Contracting** funds external organizations to employ and deploy CHWs. The County sets performance expectations and reporting requirements; contracted organizations handle hiring, supervision, and day-to-day management. Two types of contracted entities operate in the focus areas:

- **CBOs** employ CHWs as staff, preserving existing community infrastructure. This is the dominant approach in California, used by Los Angeles County's CHW Outreach Initiative (16 CBOs, 900+ CHWs) and San Diego's Neighborhood Networks.
- **Promotora cooperatives (LLCs)** are member-owned organizations where promotores participate as co-owners rather than employees. Pioneered in East San José in 2017, cooperatives broaden workforce eligibility beyond what traditional employment structures permit and are self-governed, with leadership elected by members.[17]

*Table 10: Workforce deployment model comparison.*[5]

| Dimension | Direct County Employment | CBO Contracting | Cooperative LLC |
|---|---|---|---|
| Entry requirements | Community Worker (E07): 6 months CBO experience, driver's license, English literacy | Set by each organization; community knowledge and language skills typically prioritized | Set by cooperative members; lived experience and community ties prioritized |
| Compensation range | $62K–$75K (Community Worker); $66K–$79K (PH Assistant) | $55K–$62K (from KII data) | Variable; revenue shared among members |
| Federal employment eligibility | Subject to Form I-9 verification, which limits the candidate pool | Subject to Form I-9 verification | Members participate as business owners, not employees, broadening workforce eligibility |
| Supervisor pathway | Program Manager II requires BA or equivalent + 5 years experience | Determined by organization; community leadership experience accepted | Self-governed; leadership elected by cooperative members |

| Dimension | Direct County Employment | CBO Contracting | Cooperative LLC |
|---|---|---|---|
| Hiring timeline | 87 days average (civil service process with formal examination) | 2–3 months (from KII data) | Determined by cooperative |
| Effect on existing workforce | Draws from CBO-trained workforce; CBOs lose capacity they cannot easily replace | Preserves and strengthens existing CBO infrastructure | Expands total workforce by reaching candidates other models cannot |
| Medi-Cal billing | County bills directly | Requires CBO enrollment as Medi-Cal provider or use of intermediary hub | Requires LLC enrollment or intermediary hub |
| CA county precedent | Limited; most CA county CHW programs use CBO contracting | LA County CHWOI (16 CBOs, 900+ CHWs); San Diego Neighborhood Networks | East San José (six cooperatives since 2017) |

CBO = community-based organization; LLC = limited liability company; ECM = Enhanced Care Management; CHWOI = Community Health Worker Outreach Initiative; KII = key informant interview.

The comparison points toward contracting over direct employment for three reasons.

First, the County's own entry-level CHW classification (Community Worker, E07) requires six months of experience at a community-based or nonprofit organization. Direct County hiring draws from the same CBO ecosystem it would contract with. Absorbing experienced CHWs into County positions reduces CBO capacity without expanding the total workforce; the County gains what community organizations lose.

Second, County positions require federal employment eligibility verification (Form I-9), which limits the candidate pool in communities with mixed-status households. The cooperative LLC model, where members participate as business owners rather than employees, operates under different federal requirements and has expanded workforce participation in East San José since 2017.[17]

Third, every peer county program that has reached scale in California uses contracting, not direct employment. Los Angeles deploys 900+ CHWs through 16 contracted CBOs. No California county has scaled a CHW program through direct civil service hiring.

*County Role as Infrastructure Provider.*

Cross-county analysis points to a more effective county role than either hiring model: providing the infrastructure that enables contracted organizations to deliver, bill for, and sustain CHW services. Six infrastructure functions emerged from the review of peer county programs.

*Table 11: County infrastructure contributions to CHW programs.*[8]

| Function | Description | CA Precedent |
|---|---|---|
| **Medi-Cal Billing Support** | Operate or fund a Community Care Hub so small CBOs and cooperatives can bill CalAIM (ECM, Community Supports, CHW benefit) without each building independent billing infrastructure. Commercial CHW billing platforms (approximately $100 per person per month) offer turnkey credentialing, claims management, audit-ready documentation, and compliance support, reducing the infrastructure burden that limits smaller organizations from participating | San Diego Neighborhood Networks; statewide PATH/CITED grants ($580M CITED) [23] |
| **Data and Referral Systems** | Invest in Community Information Exchange and closed-loop referral platforms connecting CHWs to clinical and social services | San Diego CIE; Alameda County Care Connect |
| **Training Pipeline** | Fund community college CHW certificate programs and community-based training; support dual-language pathways | San Diego ELEVATE ($75M); SF City College apprenticeship |
| **Procurement** | Structure RFPs/RFQs that accommodate both nonprofit and LLC contracting; set quality and reporting standards | LA County CHWOI (16 CBOs, 900+ CHWs) |
| **Coordination** | Convene CBOs, managed care plans, FQHCs, and cooperatives; support shared standards without centralizing employment | Pathways HUB model (400+ stakeholders) |
| **Technical Assistance** | Provide support for National Provider Identifier (NPI) enrollment, Medi-Cal credentialing, billing compliance, and program evaluation | CalAIM PATH Technical Assistance Marketplace |

CBO = community-based organization; CalAIM = California Advancing and Innovating Medi-Cal; ECM = Enhanced Care Management; CIE = Community Information Exchange; FQHC = Federally Qualified Health Center; NPI = National Provider Identifier; RFP = request for proposals; RFQ = request for qualifications.

# Data Sources

The economic analyses in this report rely on the following data sources:

- California State Controller's Office, Government Compensation in California (2023–2024) [10]
- American Community Survey, U.S. Census Bureau [11]
- Department of Health Care Access and Information (HCAI), California Hospital Inpatient and Emergency Department Data [12]
- Medi-Cal Fee Schedule, California Department of Health Care Services [13]
- Bureau of Labor Statistics, Occupational Employment and Wage Statistics (SOC 21-1094) [14]
- IRS Form 990 filings via GuideStar, Charity Navigator, ProPublica [15]
- HRSA Health Center Program data [16]
- Key Informant Interviews (n=17), December 2025–March 2026 [17]

Published literature references [1]–[9] are listed in the References section.

# CBO Organizational Detail

The Public Health Department engaged 34 organizations through survey outreach between February and March 2026. These organizations represent a cross-section of the CHW ecosystem that a county-supported program would work through, though they do not constitute a census.

*Direct-service CBOs*. The core of the promotor/a workforce sits in community-based organizations whose primary mission is serving Latino families through a combination of health navigation, social service connection, and community organizing. In East San José, this includes SOMOS Mayfair (community organizing and promotor/a training), LUNA (a promotor/a network deploying workers across the Eastside and into Cadillac-Winchester through a county violence prevention contract [17]), Sacred Heart Community Services (a large promotor/a program serving families [17]), Catholic Charities, Next Door Solutions, and Lazos Fuertes. These organizations operate the Si Se Puede Collective and affiliated networks that form the densest CHW infrastructure in the county. In South County, CARAS, Nueva Vida Community, Community Solutions, and the South County Youth Taskforce/SC HEALS! provide promotor/a services across Gilroy and surrounding areas. Community Solutions, one of the three KII sources for this study, reported allocating approximately 50% of CHW time to group education, 40% to outreach, and 10% to one-on-

one clinical encounters [17], a distribution that illustrates how community resilience work dominates the current model.

*Clinical and billing infrastructure.* Four health organizations participated in the outreach: AACI (an FQHC and the hub for nine partner CBOs), Community Health Partnership, the Indian Health Center of Silicon Valley, and Santa Clara Family Health Plan (the county's Medi-Cal managed care plan). These organizations represent the clinical side of the CHW ecosystem: the billing relationships, supervision capacity, and credentialing infrastructure that CBOs need access to but rarely maintain independently. SCFHP's participation is particularly relevant: as the managed care plan, it controls Enhanced Care Management (ECM) contracts that could fund CHW positions through CBO partnerships (see Additional Detail in the Technical Report).

*Training pipeline.* The outreach engaged three educational institutions: San José City College (which operates the county's only formal CHW certificate program), Mission College, and Foothill College. The college pathway produces credentialed graduates but operates only in English. Community-based training through organizations like Somos Mayfair operates in Spanish and costs less, but produces no formal credential. This dual-track pipeline, and the gap between the two tracks, is discussed in the KII findings (Theme 2).

*Workforce models.* The outreach confirmed the presence of multiple employment structures operating simultaneously. Traditional nonprofit employment (Sacred Heart, Catholic Charities, Next Door Solutions) coexists with the CHW/promotor cooperative LLC model: META (Mujeres Empresarias Tomando Acción) participated in the outreach, and KII data identify six cooperatives operating in the East San José ecosystem (see The Role and History of Community Health Workers/Promotores). De Colores Community Consulting, an independent promotor/a consultant, participated across multiple cafecito events.

*Statewide and advocacy networks.* Vision y Compromiso, a statewide promotor/a network, and SIREN (an immigration rights organization) round out the ecosystem. Vision y Compromiso connects local promotor/a efforts to statewide policy advocacy and training resources. Parents Helping Parents, which organized its own independent convening for promotores without PHD assistance, illustrates both the ecosystem's capacity for self-organization and the importance of respecting existing organizational autonomy in program design.

*Table 12: Community partner organizations engaged through CHW survey outreach, February–March 2026.*

| Organization Type | Count | Organizations |
|---|---|---|
| CBOs with CHW/promotor programs | 15 | SOMOS Mayfair, LUNA, Lazos Fuertes, Sacred Heart, Catholic Charities, CARAS, Community Solutions, Next Door Solutions, Nueva Vida, Amigos de Guadalupe, Madre-a-Madre, Nueva Esperanza, East |

| Organization Type | Count | Organizations |
|---|---|---|
| | | SJ PEACE, Latinas Contra Cancer, Community in Action Team |
| Promotora cooperatives and consultants | 2+ | META (LLC); De Colores C. Consulting; six additional cooperatives per KII data |
| FQHCs and clinics | 3 | AACI, Community Health Partnership, Indian Health Center of Silicon Valley |
| Managed care plan | 1 | Santa Clara Family Health Plan |
| Education/training | 3 | San José City College, Mission College, Foothill College |
| Advocacy/statewide networks | 2 | SIREN, Vision y Compromiso |
| Specialized populations | 2 | Silicon Valley Independent Living Center, Parents Helping Parents |
| Other (food, health, youth) | 4 | Second Harvest, Veggielution, American Heart Association, First 5 SCC |
| School-based | 2 | School Health Clinics of SCC, SC HEALS! |
| **Total** | **34** | |

*Note:* Two organizations (Grail Family Health Services, Working Partnerships USA) were contacted but not pursued. CHW/promotor headcounts cited in the text (e.g., LUNA's 19 Eastside promotores, Sacred Heart's 30–40) are estimates reported by organizational contacts during outreach, not verified employment records or survey tallies. CBO = community-based organization; CHW = community health worker; FQHC = Federally Qualified Health Center; LLC = limited liability company; KII = key informant interview; SCC = Santa Clara County.

# Per-CHW Economic Detail

This appendix provides the detailed cost breakdown, savings derivation, and salary sensitivity analysis summarized in the main body.

*Table 13: Per-CHW/Promotor unit economics at steady state.*[9]

| Component | Annual Amount |
|---|---|
| Program cost per CHW/Promotor[a] | $113,000 |
| **Healthcare savings per CHW/Promotor[b]** | **$278,000** |
| Managed care plan (Medi-Cal budget) | $100,000 |
| Hospital system (full resource costs) | $178,000 |
| Net benefit per CHW/Promotor (healthcare system) | $165,400 |

| Component | Annual Amount |
|---|---|
| Patients served per CHW/Promotor per year[c] | 55 |
| Program cost per patient | $2,053 |
| Healthcare savings per patient | $5,060 |

CHW/Promotor = Community Health Worker/Promotor. Savings rounded to nearest $1,000 for readability; Technical Report Table 6.1 reports exact figures ($100,228 and $278,309).
[a] Approximate components: salary ($59,000), benefits at 35% ($20,650), supervision coordination ($19,000), training and continuing education ($2,000), infrastructure ($2,000), and administrative overhead at 10% ($10,265). Salary exceeds the County of Santa Clara Living Wage Ordinance rate ($25.98/hr, FY 2025–2026).
[b] Projected reductions in ED visits (27/CHW/year), hospitalizations (11.6/CHW/year), and readmissions (0.5/CHW/year). Managed care savings use Medi-Cal reimbursement rates; hospital system savings use full resource costs (Healthcare Cost and Utilization Project [HCUP]). The split reflects the difference between what Medi-Cal reimburses and the full cost of care that hospitals absorb. Full derivation in the Technical Report.
[c] Caseload of 55 reflects the source RCT: "six community health workers who each serve 55 patients annually" [4], with approximately 20–30 hours of direct service per patient over a 6-month intervention (derived from IMPaCT protocol and program structure).[1,4] Aligns with KII Theme 2 recommendations for optimal caseloads of 20–25 active patients at any given time.[17]

## How the $278,000 Savings Estimate Is Derived

The per-CHW healthcare savings estimate is the product of four inputs, computed for each utilization category (ED visits, hospitalizations, readmissions):

**Savings per CHW** = Caseload × Baseline utilization rate × Reduction rate × Unit cost

*Table 14: Savings model inputs and sources.*

| Input | Base case value | Source |
|---|---|---|
| Caseload | 55 patients/CHW/year | Source RCT [1] |
| Baseline ED rate | 2.23 visits/person/year | HCAI 2024 data |
| Baseline admission rate | 0.70 admissions/person/year | HCAI 2024 data |
| ED reduction | 22% | Below lowest significant RCT finding (23%) in CHW systematic review [51] |
| Admission reduction | 30% | Source RCT single-site; pooled RCT average is 21% [4,52] |
| Readmission reduction | 23% | Between Kangovi 2018 absolute RD (17pp) [1] and pooled meta-analysis (33%) [53] |

*Table 15: Unit costs and avoided utilization per CHW per year.*

| Service | Medi-Cal rate | Full resource cost | Avoided/CHW/yr |
|---|---|---|---|
| ED visit | $600 | $2,100 | 27.0 |
| Hospital admission | $7,000 | $18,500 | 11.6 |
| Readmission[a] | $6,000 | $15,000 | 0.5 |

[a] Readmission avoidance is computed conservatively from avoided admissions (11.6 × 20% readmit rate × 23% reduction = 0.5), not from all admissions.

The $278,000 total reflects both managed care plan savings ($100,000 at Medi-Cal rates) and hospital system savings ($178,000, the difference between Medi-Cal reimbursement and full resource costs). Inpatient admissions drive 77% of total savings. Ramp-up factors (50% Year 1, 75% Year 2, 100% Year 3+) reflect the time required for CHW/patient relationships to reach full effectiveness. Sensitivity analysis (Technical Report) tests robustness across conservative and optimistic assumptions for each input.

## Cost Sensitivity to Salary Assumption

*Table 16: Per-CHW/Promotor cost sensitivity to salary assumption.*

| Salary Assumption | Hourly Rate | Per-CHW Cost | System Net/CHW | System Return |
|---|---|---|---|---|
| $55,000 (reference)[a] | $26.44 | $106,975 | +$171,334 | $1.94 per $1 |
| **$59,000 (baseline)[b]** | **$28.37** | **$112,915** | **+$165,394** | **$1.78 per $1** |
| $62,400 (survey median)[c] | $30.00 | $117,964 | +$160,345 | $1.66 per $1 |

[a] Lower-bound reference; above the County Living Wage Ordinance rate ($54,038). [b] Baseline salary: above the County of Santa Clara Living Wage Ordinance rate ($25.98/hr × 2,080 hrs = $54,038, FY 2025–2026). [c] Median hourly wage reported by CHW/Promotor survey respondents (n=76, Q21).

# Activities and Measurement Detail

## Clinical Pathway: Activities, Outputs, and Outcomes

*Table 17: Clinical pathway: activities, outputs, and outcomes.*

| Activity | Output (Year 1–2) | Outcome (Year 3–5) | Metric |
|---|---|---|---|
| Care navigation | Appointments scheduled, referrals completed | Reduced ED visits, hospitalizations | ED and IP rates per 1,000 enrolled |

| Activity | Output (Year 1–2) | Outcome (Year 3–5) | Metric |
|---|---|---|---|
| Chronic disease management | Patient encounters, care plans initiated | HbA1c improvement, blood pressure control | Clinical registry data |
| Medi-Cal enrollment | Enrollments completed | Sustained coverage, reduced uninsured rate | Enrollment and disenrollment rates |
| Prenatal care linkage | Referrals to obstetric care | Timely first-trimester prenatal access | First trimester entry rate |

ED = emergency department; IP = inpatient; HbA1c = hemoglobin A1c.

## Community Resilience Pathway: Activities, Outputs, and Outcomes

*Table 18: Community resilience pathway: activities, outputs, and outcomes.*

| Activity | Output (Year 1–2) | Outcome (Year 3–5) | Metric |
|---|---|---|---|
| Group health education | Classes held, attendance, topics covered | Chronic disease knowledge, self-management behavior change | Pre/post knowledge surveys, self-reported behavior |
| Rights and benefits education | Sessions held, families reached | Reduced fear of systems, increased benefit uptake | SNAP, WIC, Medi-Cal enrollment among eligible |
| Community outreach and mobile services | Encounters, communities visited, mobile clinic days | Trust, willingness to seek care, sustained engagement | Community health survey, repeat engagement rate |
| Leadership development | Leaders trained, cafecitos hosted | Resident-led initiatives, advocacy capacity | Leaders active after 12 months, campaigns initiated |
| Community organizing | Meetings held, coalition participation | Policy changes, structural improvements | Policies influenced, coalition size, civic participation |
| Social determinant navigation | Housing, food, and energy referrals made | Housing stability, food security | Referral completion rates, 6-month follow-up status |

SNAP = Supplemental Nutrition Assistance Program; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children.

# Hub Design Principles: Extended Detail

This appendix provides extended rationale, stakeholder input, and implementation details for the four hub design principles summarized in the main body.

## CBO Autonomy over Programmatic and Community Work

The hub coordinates billing, credentialing, and clinical infrastructure only. Community organizing, culturally specific programming, hiring and supervision of frontline CHWs, and non-billable community resilience activities remain under the full authority of each CBO. This design addresses a concern raised by the Fiscal Advisory Committee: that scaling for Medi-Cal billing could displace the community organizing work that defines the promotor/a model. By absorbing billing complexity into the hub, CBOs do not have to choose between billing compliance and community work.

## Participation Does Not Require a CHW Title or State Certification

Training serves two purposes within this design: some training prepares workers for Medi-Cal billing certification (the clinical pathway), and some addresses community-identified needs that have no billing code, including intimate partner violence, disability services, ACEs, and immigration health access. Both tracks are available to all workers regardless of title. A promotor/a with decades of community organizing experience and a recently certified CHW with a community college credential both participate in the same program; what differs is how their time is billed, not whether they belong.

## CBO Partnership Council

The hub should be advised by a partnership council composed of the CBOs it serves, the CBO Working Group that the Fiscal Advisory Committee proposed in January 2026. This council serves four functions. First, it identifies training needs based on what frontline CHWs and the communities they serve are encountering: emerging health issues, gaps in the college pipeline, competencies that current training does not cover. When the council identifies a training gap, the county can direct a grant to the CBO best positioned to develop or expand a training module (Recommendation 3). CBOs with established training programs (such as Somos Mayfair's community-based promotor/a training) bring curriculum development expertise that the hub should draw on, not duplicate. Second, it provides a feedback loop on hub operations: whether the billing platform is working for smaller organizations, whether credentialing timelines are realistic, whether quality assurance requirements are creating administrative burden without improving care. Third, it protects against mission drift: if the hub begins prioritizing administrative efficiency over community responsiveness, the organizations closest to residents are positioned to flag it. Fourth, the council convenes to develop shared resources: a common framework for lived-experience qualifications, guidance for incorporating cooperative structures into grants, and organizational development support for growing CBOs. Participation in council working groups is voluntary; organizations that engage may be prioritized for capacity-

building grants. The council's influence comes from legitimacy and funding guidance, not enforcement. Baseline operational standards live in hub contracts, not council mandates. Peer counties that have sustained CHW programs beyond initial funding cycles credit ongoing CBO input as a condition of program durability.

## Separate Billing Infrastructure and Operating Model

The CHW billing platform must operate independently from the County hospital billing system. Santa Clara Valley Healthcare's billing infrastructure is designed for hospital and clinic encounters, staffed by County-credentialed providers in county employment. Routing CHW billing through this system would effectively require CHWs to be County employees or County-credentialed providers, recreating the workforce constraints the hub is designed to avoid. The billing platform recommended here is a commercial CHW-specific system that the hub operates on behalf of partner CBOs, handling credentialing, claims, and compliance through its own infrastructure.

*Billing model: shared services with a pass-through option.*

The 34 partner organizations identified in the CBO landscape section vary widely in administrative capacity. Larger organizations (FQHCs, established health nonprofits) already hold or can obtain National Provider Identifiers (NPIs) and can enroll as Medi-Cal supervising providers. These CBOs would bill independently using the hub's platform for claims management, credentialing support, and compliance documentation, but would submit claims under their own NPIs and retain full authority as supervising providers for their CHWs. Smaller CBOs and CHW/promotor cooperatives that lack billing infrastructure would route claims through the hub as the Medi-Cal supervising provider, with the hub holding the NPI and submitting claims on their behalf while the CBO retains programmatic authority over CHW hiring, supervision, and community work. This hybrid model matches the county's organizational landscape: it preserves CBO autonomy for organizations that can sustain billing independently while letting smaller organizations and cooperatives access Medi-Cal revenue regardless of administrative capacity. As smaller CBOs build billing capability over time, they can transition to independent billing, reducing their dependence on the hub's pass-through function. For CalAIM Enhanced Care Management, CBOs seeking ECM designation as MCP providers would need their own enrollment regardless of size, with the hub supporting the credentialing process.

*Hub operations outside County government.*

In every peer county model, the hub is an independently operated entity (a nonprofit, health center network, or foundation) funded by the county through a contract, not a county department or division. This is a deliberate structural choice. If the hub sits inside County government, its staff become County employees subject to civil service hiring requirements, I-9 employment verification, and county HR classifications. These constraints narrow the workforce pipeline in exactly the ways the report identifies: they exclude candidates from mixed-status households, impose credential requirements that community-trained promotores may not meet, and pull the program toward institutional

culture rather than community culture. The county's role is funder, convener, and data provider. The hub's role is operations.

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