COMMUNITY HEALTH WORKERS: ROLES AND OPPORTUNITIES IN HEALTH CARE DELIVERY SYSTEM REFORM

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This report reviews select health services research findings on Community Health Worker (CHW) utilization that are relevant to U.S. policymakers and considers the key challenges to fully realizing the potential for CHWs to improve health care delivery.

Main Findings

- Community Health Workers (CHWs) are an emerging group of health professionals that have recently drawn increased national attention because of their potential to deliver cost-effective, high quality, and culturally competent health services within team-based care models.
- The apparent benefits of integrating CHWs into health care teams seem to depend on context. The strongest evidence of these benefits supports utilizing CHWs to deliver certain specific, high-value, preventive services – focused on reducing risk factors for cardiovascular disease and other chronic conditions – to low-income, minority, or other underserved populations.
- Despite growing interest in engaging CHWs in national delivery system reform efforts, there are several uncertainties about how to best proceed with this. Questions remain around standardizing CHW training, certification, and licensure; establishing strong economic and other evidence to support their use; and securing reimbursement for their services to ensure financial sustainability of CHW programs.

Introduction

Health care reform activities since the 2010 passage of the Affordable Care Act have resulted in significant and innovative shifts in health service delivery and reimbursement – with an overall movement towards increased value, coordination, and accountability in care. Accompanying these changes, many of the traditional roles and services of providers such as physicians, nurses, and other health care workers have expanded and evolved. In addition, some emerging, new occupations are playing an increasing role in patient-centered medical homes (PCMHs) and other team-based models for health care delivery. Although community health workers (CHWs) have
been embedded in community-based outreach programs for decades, significant national policy interest is emerging for this the occupation due to the potential ability of CHWs to improve health care access, service delivery, and care coordination, and to provide enhanced value in health care investments.²

Although there is some variability in how the U.S. Department of Labor³ and other organizations⁴ define a “Community Health Worker,” a CHW is typically a frontline public health worker who is a trusted member of, and/or has an unusually close understanding of, the community served. This trusting relationship enables the worker to serve as a link between community members and needed health and social services within their community. CHWs hold a unique position within an often rigid health care system in that they can be flexible and creative in responding to specific individual and community needs. Their focus is often on the social, rather than the medical, determinants of health – addressing the socioeconomic, cultural practices, and organizational barriers affecting wellness and access to care.⁵ CHWs are known by numerous names in their communities and in the health literature, including Promotores de Salud, Community Health Advisors, and related titles⁶,⁷,⁸ reflecting their widely variable roles and responsibilities. This variability can present a challenge for demonstrating their value through outcomes research and for attempts to standardize CHW educational pathways, certification, and reimbursement.⁹,¹⁰

This report reviews select health services research findings on CHW utilization that are relevant to U.S. policymakers and considers the key challenges to fully realizing and quantifying the potential for CHWs to improve health care delivery. Although not intended to be a comprehensive and critical analysis of the full body of research around CHWs, this paper builds on information from a number of recent reports from across the Department of Health and Human Services (HHS) – including a 2009 systematic review by the Agency for Healthcare Research and Quality (AHRQ),¹¹ a 2014 evidence assessment published by the Centers for Disease Control and Prevention (CDC),¹² a 2015 CDC policy brief on CHW interventions for chronic disease management,¹³ and a 2015 summary of findings by the CDC-supported Community Preventive Services Task Force on cardiovascular disease interventions.¹⁴ This material is supplemented with select additions from the primary health literature and reports by health policy research organizations.

Roles in health care delivery

The primary goals for deploying CHWs in health care teams are to increase access, deliver screening and preventive services, and improve system navigation, care coordination, and disease management outcomes through education and other approaches (Table 1). The unique strength of CHWs is their ability to develop rapport with patients and other community members due to shared culture, community residence, and life experiences. They are also able to enhance the cultural and linguistic appropriateness of care and help to counteract factors such as social exclusion, poverty, and marginalization.¹⁵,¹⁶ As such, and aside from the objectives for deploying them from the health system perspective, an important component of the CHW occupational identity can be to advocate for the socioeconomic, environmental, and political rights of their communities.¹⁷
The ability of CHWs to relate to patients can enable them to elicit candid information and collect more accurate clinical data than other health care workers. Additionally, their patient- and family-centered approaches can improve the comprehension of and adherence to provider instructions. Expertise in conducting outreach positions some CHWs as a resource for navigating health insurance options and successfully enrolling people in Medicaid or Marketplace plans. CHW work at the interface between health systems and the community has the potential to reduce the inappropriate use of high-cost health services, such as emergency room visits for primary care health needs and unnecessary hospital readmissions.

CHWs are most often deployed to improve outcomes in communities with high levels of health disparities or a disproportionate prevalence of chronic disease. One major goal of delivery system reform is to respond strategically to the growing national prevalence of multiple chronic conditions by improving care coordination. By 2020, 157 million people in the U.S. are anticipated to have one chronic condition and 81 million to have multiple chronic conditions. The growing national burden of chronic illness is borne to a greater extent by minority and low-income populations, who experience poorer health outcomes. For example, the likelihood that non-Hispanic black adults in the U.S. will die prematurely of cardiovascular or cerebrovascular disease is at least 50 percent greater than for non-Hispanic white adults, and infant mortality rates for non-Hispanic blacks are more than double those of non-Hispanic whites. Diabetes is more prevalent in non-Hispanic black adults, those with Hispanic ethnicity, adults with lower incomes, and those without a college education than in other segments of the population.

Such health inequities have large individual, community, and economic impacts. According to a 2009 study by the Joint Center for Political and Economic Studies, the combined additional costs

| Table 1. Major Roles for Community Health Workers in the U.S. Health System. |
| Model | Function | Examples of goals/activities |
| Lay Health Worker/ Promotora de Salud | Address social determinants of health and risk factors for chronic diseases | • screening for behavioral and other risk factors (e.g., hypertension) for chronic conditions (e.g., cardiovascular disease) • encouraging self-reporting and facilitating self-management around health behaviors (e.g., smoking cessation, exercise) • offering social support and informal counseling |
| Health Educator | Provide education services | • delivering individual or group education • encouraging adherence and compliance with treatments and medications |
| Outreach and Enrollment Agent | Increase care access | • identifying individuals and families eligible for medical services • assisting in the application for medical services |
| Team-Based Care Member | Collaboratively provide direct health services with medical professionals | • improving care coordination • providing patient support when paired with licensed health care providers (physicians, nurses) |
| Care Coordinator and Navigator | Assist in care coordination for those with complex health conditions | • monitoring and follow-up (appointment reminders, home visits) • assisting individuals and families in navigating complex medical service systems and processes |
| Community Organizer and Capacity Builder | Share social, cultural, and economic characteristics with community | • supporting community development • serving as liaisons between the community and health care systems • advocating for patients and communities, promoting community action • building community support for new activities |

Sources: Community Preventive Services Task Force (http://www.thecommunityguide.org/cvd/CHW.html); Rural Assistance Center (https://www.raonline.org/communityhealth)
to the national economy of health inequalities and premature death of minority groups in the U.S. were estimated to be total approximately $1.24 trillion from 2003–2006. This is likely due to a combination of both direct expenses from delivering health care to a sicker and more disadvantaged population and indirect costs attributed to employment-related factors and premature mortality (e.g., lower productivity, lost wages and tax revenues, leave to deal with avoidable family illnesses). Strategies that can effectively address social determinants of health and counteract health inequities experienced by vulnerable patient populations will have significant societal and economic benefits for the nation. Given their strong bonds with communities and ability to facilitate access, coordination, capacity building, and service delivery, CHWs are seen as one potential solution for achieving these aims.

**CHW Training and Credentialing**

CHWs are distinct from the other members of health care teams in that they are hired primarily for their understanding of the populations and communities they serve rather than for expertise or credentials obtained through formal health education. As such, they are traditionally trained after hiring to use their personal perspectives and experiences to link patients within their communities to services. According to one 2014 survey, up to 40 percent of all CHWs nationally may work as unpaid volunteers (Table 2). Thus CHWs differ from most other health care workers who usually have prolonged training in clinical care and formal qualifications prior to employment and who are generally paid for their services.

The extent to which CHWs are trained to perform their roles and whether or how they become certified or licensed to deliver care varies greatly from state to state, based on state and organizational licensure requirements. Several states have passed legislation identifying CHW training that could eventually be used as a prerequisite for reimbursement, while many other states are at various stages of the policy development process. For example, in Minnesota, a CHW state-standardized curriculum is offered through the postsecondary educational system. CHWs receive a certificate on completion of this curriculum that qualifies them to enroll for reimbursement under the state Medicaid program, one of only two established reimbursement models for CHWs within public insurance programs to date in which CHWs are reimbursed directly. By contrast, the state of New Mexico has no statute regarding CHWs but their Department of Health maintains a robust CHW advisory board that recommends certification standards and training, and which has disciplinary authority.

Legislative tracking of CHW training and certification requirements is performed by the Association of State and Territorial Health Officials (ASTHO). As of October 2015, ASTHO reports that:

<table>
<thead>
<tr>
<th>Table 2. Community Health Worker employment – facts and figures.</th>
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<tr>
<td><strong>Number of CHWs in the U.S., 2012</strong></td>
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<td><strong>Projected percent change in employment from 2012 to 2022</strong></td>
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<td><em>(average for all occupations is 11%)</em></td>
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<tr>
<td><strong>Paid versus volunteer</strong></td>
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<td><strong>Median pay, 2012</strong></td>
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<td><strong>States with the highest CHW employment level</strong></td>
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*Sources: Bureau of Labor Statistics (2012) and National Community Health Worker Advocacy Survey (2014)*
Six states (FL, MA, NM, OH, OR, TX) have laws or regulations which establish CHW certification program requirements.

Two states (IL, MD) have statutes creating a CHW advisory board, taskforce, or workgroup to establish certification program requirements.

Seven states (IN, MS, NE, NV, NY, SC, WA) have no laws in place but have state-led training or certification programs.

Two states (AK, MN) have established Medicaid payments for services provided by a certified CHW.

One state (FL), which already provides some CHW credentialing guidelines, has reintroduced legislation (that did not move forward in the prior legislative session) to define the duties of a CHW and establish a voluntary process by which a department-approved third-party credentialing entity may grant a credential to an eligible individual.

The remaining 33 states and the District of Columbia have not taken or introduced regulatory or legislative action around CHW education, certification requirements, or establishing Medicaid payments for CHW-provided services.

Although flexibility in responding to specific individual and community needs is considered to be a key strength of CHWs, the lack of consistent, standardized CHW educational pathways and the varying scopes of practice observed across different CHW roles are likely reasons why more universal credentialing standards have not been developed. This is a well-recognized barrier for CHWs in achieving greater respect among the other health care professions, improving their compensation and working conditions, increasing their job stability and portability, and better integrating them into the U.S. health system. In addition, as credentialing is often a critical component for insurance reimbursement, this lack of standardization may limit the potential for CHW service reimbursement by both public and private insurance plans. To this end, the focus of the Community Health Worker Core Consensus (C3) Project is to help advance consensus in the CHW field around local, state, and national training curricula and practice guidelines for the occupation. On the other hand, many CHWs have expressed concerns that standardized credentialing could create job entry barriers for the best-suited CHW candidates, such as members of diverse, low-income communities who may additionally have language barriers.

A National Profile of CHWs

In 2014, the Arizona Prevention Research Center of the University of Arizona, working through a cooperative agreement with the CDC, collected information from 1,767 CHWs from 45 states and four U.S. territories through the online National Community Health Worker Advocacy Survey. This research project examined demographic information, training, work environment, job-related roles and activities, and target populations served. The voluntary, and potentially non-representative survey was distributed online to CHWs through local, state, and national organizations and was available in three different languages (English, Spanish, and Korean).

Results of the survey showed that CHWs were more likely to be female (89 percent) with an average age of 45. The range of self-reported race and ethnicity roughly matched the composition of the communities served. The most common self-identified race was white (23 percent), and 45 percent of CHWs identified their ethnicity as Hispanic. Almost all had a high school diploma or equivalent, 13 percent had no college, approximately two-thirds reported at least some college education, and 14 percent held a graduate degree.
Paid CHWs (60 percent of the sample) tended to be full-time workers, whereas volunteers worked an average of 12 hours per week. Excluding volunteers, income varied but mostly ranged between $10-50,000 per year, and 78 percent reported having employer-sponsored health insurance. Site of employment varied greatly, with community-based sites (37 percent) the most common, followed by federally-qualified health centers (17 percent), hospitals (14 percent), local health departments (12 percent), and other clinics (10 percent). Consistent with medical literature and case studies, the survey found that most CHWs worked to deliver or promote preventive services (67 percent) although 36 percent reported working to increase access to health care services, and 24 percent reported working in areas related to mental and behavioral health. Many reported roles managing various common chronic diseases, such as cancer, cardiovascular disease, HIV infection, and diabetes.

Although known by a slightly different term, Community Health Representatives (CHRIs) have served American Indian/Alaska Native communities in a manner similar to CHWs for several decades, and are supported by HHS through Indian Health Service (IHS) funds. There are currently more than 1,700 CHRIs representing 264 tribes. The National Association of Community Health Representatives (NACHR) has representatives from twelve service areas who help to shape national policies for CHRIs and to identify and disseminate promising practices. A 2013 NACHR survey, similar to that performed by the Arizona Prevention Research Center, collected data on CHRIs, with a subsequent report describing many characteristics of the CHR workforce. The IHS provides training and technical assistance to the Indian, Tribal, and Urban Facilities who utilize CHRIs across the twelve service areas. In the IHS publication Trends in Indian Health (2014 edition), the three leading activities since 2007 for CHRIs were case management (23 percent), health education (14 percent), and patient care services (15 percent). CHRIs received over 1.7 million referrals from community contacts and providers during that period, providing about 5.7 million client contacts to address health concerns related to diabetes mellitus (15 percent), hypertension (10 percent), other health promotion/disease prevention (10 percent), heart problems (5 percent), nutrition (4 percent), dialysis (4 percent), and other health care needs.

It is notable that utilization of CHWs within health care systems has been far more extensive internationally than it has been in the United States. In many other countries, CHWs are increasingly being integrated into community-based health care systems as paid, full-time health care workers. For example, the One Million Community Health Workers Campaign is training and deploying CHWs into the health systems of sub-Saharan Africa, and as many as 600,000 CHWs in India currently provide certain primary care services, such as vaccination, and are reimbursed for their work through a fee-for-service system. In parts of Europe and in Brazil, CHWs are integrated into health care teams providing maternal and child health care, mental health services, and chronic disease management.

**Evidence on the Clinical Impact of CHWs**

In line with the far greater extent of CHW deployment seen in other countries, much of the evidence base demonstrating CHW effectiveness in improving health care outcomes has been established internationally. HHS has conducted several reviews of the literature on the achieved outcomes, cost-effectiveness, and regulation of CHWs in the United States. These literature summaries and systematic reviews, performed or supported by CDC and AHRQ, seem
to suggest that CHWs provide highly context-dependent benefits – with the greatest advantages seen when CHWs deliver certain specific preventive services to low-income, minority, or other underserved populations. The findings from these efforts are briefly summarized below.

In 2009, AHRQ commissioned the RTI International–University of North Carolina Evidence-based Practice Center to perform a systematic review of the health literature on the outcomes, costs, and cost-effectiveness of CHW interventions. This review concluded that, while large-scale evidence on CHW effectiveness in the U.S. is lacking, there are numerous smaller studies in the literature from state and local programs or that focused on specific patient populations. From the 68 identified studies, limited evidence favored CHW interventions over control groups or alternative approaches. However the clinical context of individual studies was deemed to be important, since the most encouraging findings were from interventions focusing on low-income, minority, or other underserved populations. Relatively positive outcomes were seen when CHWs facilitated delivery of certain specific preventive services (e.g., disease prevention, asthma management, cervical cancer screening with Pap smears, and mammography screening) but not others (e.g., clinical breast examination, breast self-examination, colorectal cancer screening, chronic disease management, and most maternal and child health interventions). Such studies commonly focused on specific health or cost-effectiveness outcomes related to integrating CHWs onto health care teams to help manage chronic diseases or to deliver preventive services. This review noted that the identified studies can be limited by inadequate power and a lack of rigorous research methodology. They often use non-quantitative approaches, have null findings, may be influenced by a Hawthorne effect, or are not easily comparable to each other due to differing approaches. Therefore, this review concluded that, without further research, methodological limitations make it difficult to draw definitive conclusions from the existing body of literature in order to inform policy decisions at a national level.

A CDC report in 2014 assessed and summarized the strengths and limitations of the evidence base behind a number of chronic disease policy interventions that included CHWs. From this, the CDC determined the potential for these interventions to inform future chronic disease policy decision-making (Appendix A). The greatest potential was seen for CHW deployment onto interprofessional teams under provider supervision (nurse practitioners or physicians) for interventions focused on access, patient self-management, chronic disease management, cost reduction, and improved social outcomes. This was particularly true if CHWs were assisting patient groups with significant health disparities – such as those who were low-income, uninsured, or belonging to certain racial and ethnic minority groups (e.g., African American, Asian, Filipino, Bangladeshi, Vietnamese, and Hispanic populations).

Another CDC report summarized evidence around CHW interventions designed to prevent chronic diseases, particularly those which tend to be influenced heavily by socioeconomic factors – such as hypertension, diabetes, cancer, and asthma. The clearest results were observed for patient education interventions focused on improving treatment adherence and self-management among specific patient groups based on age, race, or ethnicity. For example, there was some evidence that working with CHWs could be a cost-effective way to reduce symptoms of asthma in adolescents, for certain cancer patients to achieve more timely diagnosis and treatment, or for hypertensive patients to better adhere to medical appointments and prescribed medications.
In 2015, the CDC-supported Community Preventive Services Task Force systematically reviewed evidence from 31 research publications on prevention-focused CHW interventions targeting cardiovascular disease (CVD) risk factors, such as hypertension and dyslipidemia, in certain minority groups and underserved communities. The Task Force determined that there was strong evidence across the literature base supporting the effectiveness of integrating CHWs into team-based care models, alongside physicians and nurses, to improve patient blood pressure and cholesterol levels. Some benefits were also observed for interventions focusing on health education, insurance outreach and enrollment activities, and in increasing patient health behaviors involving diet, exercise, and tobacco cessation. Little evidence was identified for CHWs improving outcomes related to health system navigation, decreasing costs, reducing hospital length of stay or readmissions, decreasing emergency room visits, or improving mortality.

**Reimbursement**

Providing reimbursement for CHW services is an evolving and important policy area since lack of sustainable funding remains a significant challenge to the CHW occupation. The short-term grants and contracts that currently support most CHW programs potentially create unstable work prospects because funding streams are vulnerable to changes in economics, politics, and agency strategies. Reimbursement for CHW services might additionally incentivize health care systems, provider groups, and health plans to recruit, use, and retain effective CHWs to improve the quality of care delivered to their served populations. Medicaid reimbursement for CHW services is currently possible through a few different mechanisms – including leverage of the January 2014 Centers for Medicare & Medicaid Services (CMS) final rule (CMS-2334-F) on Essential Health Benefits. This rule gives states the new option to provide Medicaid reimbursement for preventive services recommended by, rather than provided directly by, a physician or other licensed practitioner. Hence, direct patient medical services can be furnished at the recommendation of a licensed provider by another health worker, such as a CHW, who may or may not be formally licensed by the state. As of November 2015, no states have completed this state plan amendment process to tap into this new reimbursement stream.

Additional Medicaid reimbursement mechanisms include capitation, direct reimbursement arrangements, waivers, and state support of administrative costs (see Appendix B for a more detailed discussion of this). Of these, capitation is likely the most promising as per-member, per-month payments to managed care health plans can be used to pay CHW salaries so long as this option is in accordance with the contract and both federal and state regulations. Through direct reimbursement arrangements with a provider, community, or tribal organization, state Medicaid offices may opt to make CHWs a billable provider. Such arrangements specify allowable reimbursement rates as well as the education, training, and certification requirements for providers. The CMS Center for Medicaid and CHIP Services (CMCS) may also match a percent of staffing and administrative expenses for state Medicaid offices and clinics to better achieve cost control, improve information technology infrastructure, and provide interpreter, outreach, and coordination services. Some of these activities may include using CHWs. State-initiated waivers, such as those allowed under Section 1115 of the Social Security Act, provide opportunities for a state Medicaid program to pilot innovative, budget-neutral demonstration projects which include CHW and other services not traditionally covered by the program. Many states are taking advantage of funding through “Delivery System Reform Incentive
Payment” (DSRIP) initiatives, a type of Section 1115 Waiver tied to performance metrics, to promote payment and system redesign which helps them achieve statewide population health goals. Complementing this, CMS launched the Medicaid Innovation Accelerator Program in 2014 with the goal of supporting states’ efforts to fast-track reforms aimed at improving health care for Medicaid beneficiaries. As opportunities such as DSRIP waivers and the Medicaid Innovation Accelerator Program help states move towards more integrated care for safety net populations across all delivery settings, this can be an impetus for states to consider incorporating CHWs into their health programs. And as new payment models continue to evolve toward capitated mechanisms for reimbursement or global payments, it is may be less important for CHWs to be reimbursable as a provider type or as someone who provides a specified service.

**Opportunities through the CMS Innovation Center**

The mission of the CMS Innovation Center is to foster health care transformation by developing and testing new models to pay for and deliver health services that can lower costs and improve care – and encouraging widespread adoption of models that achieve this. As the focus of CHW services is often to help better manage chronic disease, improve care quality and outcomes, and decrease the overall cost of care, many care models being tested within the CMS Innovation Center demonstrations seek to leverage the strengths of CHWs. These workers are included in a number of State Innovation Model strategies (in CO, CT, DE, HI, IA, IL, MD, ME, MI, MN, OH, OR, and PA – see Appendix C) and in many of the demonstration projects that have been funded under the Center’s Health Care Innovation Awards (Appendix D). It will be important to follow the outcomes of these funded initiatives to determine if CHW interventions help achieve the CMS Innovation Center’s goals, and if these health system strategies should be more widely disseminated across the nation.

**Conclusions**

Health care delivery system reform efforts are stimulating movement away from traditional, fee for service-based reimbursement towards newer payment models that focus on value, quality, care coordination, and accountability. Integrating CHWs into care teams may be one potential strategy to further facilitate this transformation. The literature suggests that CHWs may be helpful in achieving specific patient and population health goals in underserved communities with high rates of chronic disease and complex health needs. The integration of CHWs into a comprehensive care model shows some promise for improving health outcomes, particularly for interventions targeting vulnerable populations, by addressing health disparities concurrently with chronic disease prevention and management strategies. Although existing research remains limited, some evidence also suggests that using CHWs to provide health care services can be cost-effective. In addition, the patient navigation services that CHWs provide may make integration of these workers into care teams an appealing strategy for organizations and practices. Although the literature is promising overall, the variable and context-dependent outcomes seen in the U.S. to date make it difficult currently to justify broad, national policies to deploy CHWs into the health workforce and provide reimbursement for all of their services. Additional research is still needed to test and identify the most effective and economical ways that CHWs can be deployed, particularly where existing evidence is lacking or contradictory. Initiatives funded through the CMS Innovation Center may provide prototypic models for how to successfully deploy CHWs to achieve national public health aims. As promising practices for
CHW training and deployment are further identified, optimal approaches for integrating CHWs into the national health care workforce should become more evident, and CHWs may take on a more clearly defined role in health care delivery reform efforts.
### Policy Impact Potential

<table>
<thead>
<tr>
<th>Component (QuIC) Evidence Assessment method</th>
<th>Potential Impact</th>
<th>Evidence to Support Potential Impact</th>
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<tbody>
<tr>
<td>Insurance</td>
<td>Promising</td>
<td>Limited evidence suggested grants and other financial incentives to promote the CHW workforce and support its development could lead to enhanced CHW interventions, broadening of their reach, and improving health outcomes.</td>
</tr>
<tr>
<td>Reimbursement by Private insurers</td>
<td>Emerging</td>
<td>Evidence suggested some private insurers cover and reimburse CHW services, which could help support CHW interventions.</td>
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<tr>
<td>Reimbursement by Medicaid</td>
<td>Emerging</td>
<td>Evidence suggested improvements in health and health equity outcomes when Medicaid reimbursed for CHW services, and some social outcomes.</td>
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<tr>
<td>Scope of Practice</td>
<td>Best</td>
<td>CHWs practicing under provider supervision (nurse practitioner or physician) resulted in cost savings and improvement in some health outcomes.</td>
</tr>
<tr>
<td>Educational Campaigns</td>
<td>Promising</td>
<td>Two studies found that interventions were low cost and cost-effective, supporting improved health disparities, quality of care, and patient self-management.</td>
</tr>
<tr>
<td>Training and Certification</td>
<td>Promising</td>
<td>CHW interventions improve access and reduced resource utilization and costs for high-risk health care consumers in a regional Medicaid program.</td>
</tr>
<tr>
<td>Integration in Team-based Care</td>
<td>Best</td>
<td>CHWs largely provide chronic disease care services, consistent with the IOM recommendation that CHWs be integrated into teams.</td>
</tr>
<tr>
<td>Use in Chronic Disease Management</td>
<td>Potential</td>
<td>Evidence supports that CHWs largely provide chronic disease care services, consistent with the IOM recommendation that CHWs be integrated into teams.</td>
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**Conclusions Drawn**

- CHWs are effective in improving health outcomes, especially in community settings and for groups experiencing health disparities (low income, uninsured, African American, Filipino, and Hispanic populations).
- Evidence suggests that CHW interventions can improve access to and use of care, patients' understanding of their condition and self-management, and health outcomes.
- The use of CHWs in urban, rural, clinical, community, emergency department, and regional settings is supported.
- Evidence supports the use of CHWs in chronic disease management, health status, patient self-management, and social outcomes.
<table>
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<th>State Example</th>
<th>Cost (Administrative)</th>
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<tr>
<td>CHWs employed in NY to manage CHW services, and coordinate services, such as prenatal care and health education. CMCS approved a SPA for NY to support these services.</td>
<td>$72 million over three years.</td>
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### Appendix B: Opportunities for CHW Service Reimbursement through Medicaid

- CHWs can provide direct medical care, such as prenatal care and health education, within the scope of their practice.
- CHWs can provide services to Medicaid enrollees, such as prenatal care and health education, as part of their practice.
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### Other Reimbursement Opportunities

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<tr>
<th>State</th>
<th>CHW Component of Demonstration Project</th>
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<tr>
<td>Vermont</td>
<td>Vermont has developed and implemented the innovative VermontCare program, which is a model for primary care transformation. The program focuses on patient-centered care and includes community health workers. Vermont is also implementing the VermontCare Academy, which provides training and support for community health workers. The state is piloting the VermontCare model in several communities, including Rutland and Essex County. The program is designed to improve access to care, reduce costs, and improve health outcomes.</td>
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<td>Oregon</td>
<td>Oregon's Coordinated Care Model is expected to transform how health care is delivered, with a strong focus on patient-centered care and extended community health teams, including the Medicaid care coordinator. The state is expanding the care team to include community health workers, peer wellness specialists, care coordinators, and others. The model is expected to use proactive, preventative care strategies to integrate care across settings. The state is also implementing the Accountable Communities for Health (ACH) model, which is supported in part by the Center for Medicare and Medicaid Innovation (CMMI). The ACH model is expected to increase the number of community health workers and other health professionals, including physicians, nurses, and social workers. The state is also implementing the Oregon Health Plan, which is designed to improve health outcomes and reduce costs.</td>
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<tr>
<td>Minnesota</td>
<td>Minnesota is focusing on five core characteristics of successful population-based care, including team-based care coordination. Multi-disciplinary teams, including primary care providers, care coordinators, and support services providers, will collaborate to improve care planning, diagnosis, and management through transitions of care. The state is also implementing the Minnesota Collaborative Care Model, which is designed to improve access to care and reduce costs. The state is also implementing the Minnesota Care Management model, which is designed to improve care coordination and reduce costs. The state is also implementing the Minnesota Chronic Care Initiative, Support and Services at Home (SASH), which is designed to improve care coordination and reduce costs. The state is also implementing the Minnesota Medicaid Care Coordination program, which is designed to improve care coordination and reduce costs.</td>
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<tr>
<td>Massachusetts</td>
<td>Massachusetts will use a Comprehensive Primary Care Payment (CPAP) model, which is designed to improve care coordination and reduce costs. The state is also implementing the Massachusetts Medical Home Initiative, which is designed to improve care coordination and reduce costs. The state is also implementing the Massachusettssthiaaki Care Management model, which is designed to improve care coordination and reduce costs. The state is also implementing the Massachusetts Medicaid Care Coordination program, which is designed to improve care coordination and reduce costs.</td>
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<tr>
<td>Maine</td>
<td>Maine will piloting a community health worker (CHW) model designed to improve care coordination and reduce costs. The state is also implementing the MaineCare Community Health Worker (CHW) model, which is designed to improve care coordination and reduce costs. The state is also implementing the MaineCare Community Health Worker (CHW) model, which is designed to improve care coordination and reduce costs. The state is also implementing the MaineCare Community Health Worker (CHW) model, which is designed to improve care coordination and reduce costs.</td>
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<tr>
<td>Arkansas</td>
<td>Arkansas has a health workforce goal of expanding the number of community health workers and other health professionals, including physicians, nurses, and social workers. The state is also implementing the Arkansas Health Initiative, which is designed to improve care coordination and reduce costs. The state is also implementing the Arkansas Medicaid Care Coordination program, which is designed to improve care coordination and reduce costs. The state is also implementing the Arkansas Medicaid Care Coordination program, which is designed to improve care coordination and reduce costs.</td>
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**Appendix C: CMS Innovation Center – State Innovation Model Test Awards**

- Over $250 million in investments have been made in 12 states to support state-level demonstrations that are designed to improve health outcomes and reduce costs. The investments are expected to support the development and implementation of innovative models of care delivery and payment.
- The states have been selected based on their ability to demonstrate meaningful progress in improving health outcomes and reducing costs, as well as their ability to replicate their models of care delivery and payment in other states.
- The investments are expected to support the development and implementation of innovative models of care delivery and payment, including the use of data and analytics to improve care coordination, the use of innovative payment models to improve care coordination, and the use of collaborative care planning to improve care coordination.
- The states will be evaluated on their progress in improving health outcomes and reducing costs, as well as their ability to replicate their models of care delivery and payment in other states.
- The investments are expected to support the development and implementation of innovative models of care delivery and payment, including the use of data and analytics to improve care coordination, the use of innovative payment models to improve care coordination, and the use of collaborative care planning to improve care coordination.

**State Innovation Model Test Awards**

- **Round One (6 states):** AR, ME, MA, MN, OR, VT
- **Round Two (11 states):** CO, CT, DE, ID, IA, MI, NY, RI, OH, TN, WA
Tennessee

Rhode Island

Rhode Island's Community Health Worker definition is unclear and awareness of their existence and function is low among providers. The state plans to develop uniform criteria for the role of Community Health Workers, into service coordination while also supporting standards for the training and skill sets of these new professionals, such as social workers, pharmacists, community health workers, and community health emergency medical services (EMS) personnel. A policy objective is to incorporate non-traditional professions, such as massage therapists, into roles that align with the goals of the PCMH. The state also aims to review the overall licensing scheme for these professionals to ensure that they can contribute to the health workforce by adopting a team approach, PCMHs will be led by physicians, nurse practitioners, or physician assistants under the supervision of a physician.

Ohio

Ohio will align incentives, loans, and matching funds for the State Loan Repayment Program to support additional advanced practice nurse practitioners, certified nurse midwives, psychiatric nurse specialists, health service psychologists, licensed professional counselors, marriage and family therapists, and registered dental hygienists. The state will also cooperate with the State Board of Nursing for nursing licensure. Using this approach, PCMHs will be led by physicians, nurse practitioners, or physician assistants under the supervision of a physician.

New York

New York's Advanced Primary Care model will be structured to support integrated delivery systems that link with NY's model healthcare options and providers, including social workers, pharmacists, community health workers, and patient navigators. Funds will cover personnel who will be tasked with overseeing the establishment of a state certification program for community health workers and patient navigators.

Michigan

A Michigan advisory committee, including State innovation leadership, assembled in 2013 to conduct a systematic review of Michigan's Public Health Code. A primary goal was to improve care coordination and the delivery of health services to individuals with disabilities. These segments are among the most in need of specialized care coordination. Ohio will tailor PCMH and episode-based care within the primary care setting to support the needs of these high-risk populations.

Iowa

In Iowa, local public health agencies will provide resources and collaborate with the delivery system to connect the community health worker/care coordination model with the state. The state aims to align the objectives of the Iowa's PCMHs with the goals of the state's model health workforce, including social workers, pharmacists, community health workers, and patient navigators. The state will also support the expansion of value-based care in New York.

Idaho

Idaho's unique PCMHs will be led by primary care providers, including physicians, nurse practitioners, and physician assistants. The state also aims to review the overall licensing scheme for these professionals to ensure that they can contribute to the health workforce by adopting a team approach, PCMHs will be led by physicians, nurse practitioners, or physician assistants under the supervision of a physician.

Delaware

In Delaware, community health workers (CHWs) will be the primary care providers, along with other healthcare professionals, such as nurse practitioners and physician assistants. The state also aims to review the overall licensing scheme for these professionals to ensure that they can contribute to the health workforce by adopting a team approach, PCMHs will be led by physicians, nurse practitioners, or physician assistants under the supervision of a physician.

Connecticut

In Connecticut, community health workers (CHWs) will be the primary care providers, along with other healthcare professionals, such as nurse practitioners and physician assistants. The state also aims to review the overall licensing scheme for these professionals to ensure that they can contribute to the health workforce by adopting a team approach, PCMHs will be led by physicians, nurse practitioners, or physician assistants under the supervision of a physician.

Colorado

Colorado is developing standard, consistent-based criteria for community health workers and patient navigators that will support both professionals and programs. The state will also support the expansion of value-based care in New York.

New Mexico

New Mexico's Community Health Workers will be trained in patient care coordination and will work with community health emergency medical services (EMS) personnel. The state will also support the expansion of value-based care, including patient navigators and community health workers, in New York.
Patient Centered Medical Homes (PCMHs) will reward providers for addressing the social and behavioral determinants of health such as discussing environmental asthma triggers with parents, connecting tobacco users to the Tennessee Tobacco Quitline, and connecting patients to community social services. CHWs are not directly referred to in the state’s innovation plan.

Building on Washington’s broad scope and emphasis for its workforce, the state’s innovation project will specifically focus on non-traditional workforce growth for community health workers including peer support specialists. Over the duration of the project, regulatory and legislative action also will be pursued to normalize and expand the reach of telemedicine into health professional shortage areas. Finally, real-time, rapid assessment and dissemination of key health care outputs and indicators will inform workforce supply planning.
Appendix D: CMS Innovation Center – Health Care Innovation Awards

Health Care Innovation Awards Round One: Awarded Projects

The CMS Innovation Center announced the first batch of awardees for the Health Care Innovation Awards on May 8, 2012 and the second (final) batch on June 15, 2012. These organizations will implement projects that aim to deliver better health, improved care, and lower costs to people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), particularly those with the highest health care needs. Funding for these projects is for three years.

The proposed/estimated 3 Year Savings should be viewed with caution as this is based on award recipients’ initial applications, and the actual savings realized from finalized project has not yet been determined.

Source: http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Project-Profiles.html

**BEN ARCHER HEALTH CENTER**

Project Title: “A home visitation program for rural populations in Northern Dona Ana County, New Mexico”

Geographic Reach: New Mexico

Funding Amount: $1,270,845

Proposed/Estimated 3 Year Savings: $6,352,888

Using nurse health educators and community health workers to bridge the gap between patients and medical providers, aid patient navigation of the health care system, and offer services including case management, medication management, chronic disease management, preventive care, home safety assessments, and health education, thereby preventing the onset and progression of diseases and reducing complications.

**CHILDREN'S HOSPITAL AND HEALTH SYSTEM, INC.**

Project Title: “CCHP Advanced Wrap Network”

Geographic Reach: Wisconsin

Funding Amount: $2,796,255

Estimated 3 Year Savings: $2,851,266

Children’s Hospital and Health System received an award to create Care Links, which will support members of Children’s Community Health Plan (CCHP), the system’s Medicaid HMO in Southeast Wisconsin, as they navigate the health care system. Care Links will allow community health navigators to educate and empower health plan members to navigate the health care system, connect with a primary care doctor and receive preventive care and appropriate screenings. Community health navigators will offer services to individuals and families who have had two ER visits within six months. A nurse navigator will work with health plan members diagnosed with asthma who have had one ER or one inpatient stay related to asthma. Both the community navigators and the nurse navigator will reinforce the availability of urgent care and CCHP’s 24/7 nurse advice line. The goal of Care Links is to reduce avoidable ER visits, improve health outcomes (specific HEDIS measures), and reduce costs.

**COOPER UNIVERSITY HOSPITAL**

Project Title: N/A

Geographic Reach: New Jersey

Funding Amount: $2,788,457

Estimated 3 Year Savings: $6.2 million

Will train an estimated 22 health care workers, while creating an estimated 16 new jobs. These workers will include non-clinical staff, like AmeriCorps volunteers and community health workers, who will serve as part of the multidisciplinary teams to support care coordination activities.

**DUKE UNIVERSITY/SOUTH EAST DIABETES INITIATIVE**

Project Title: “From clinic to community: achieving health equity in the southern United States”

Funding Amount: $9,773,499

Estimated 3 Year Savings: $20.8 million

Uses risk algorithms (social and clinical) and geospatial software to target “hot spot” communities within 4 counties in NC, MS, and WV in need of services. The project will address care disparities through prevention, enhanced, coordinated, patient-centered team care (including home visits) provided by local care teams, and evaluation of health equity outcomes. Will implement an innovation to enhance care and improve health outcomes in underserved communities across the southern United States, highlighting disparities in care and disparities in access.

**EAU CLAIRE COOPERATIVE HEALTH CENTERS, INC.**

Project Title: “Healthy Columbia: recruiting, training, organizing, deploying, and supporting community health teams in low income area of Columbia, South Carolina”

Geographic Reach: South Carolina

Funding Amount: $2,750,398

Estimated 3 Year Savings: $2.5 million

Eau Claire will use its community health network to recruit, train, organize, deploy, and support community health workers who will work with patients to improve health outcomes and reduce costs.

**ERIE INNERSITY HOSPITAL**

Project Title: “A coordinated approach to improving patient engagement”

Funding Amount: $2,788,457

Estimated 3 Year Savings: $3.2 million

**ERRIE INNERSITY HOSPITAL AND HEALTH SYSTEM, INC.**

Project Title: N/A

Funding Amount: $2,722,786

Estimated 3 Year Savings: $2.1 million

**LENNIE Aicher Health Center**

Project Title: “A coordinated care model: spreading community health teams to low income areas of Columbia, South Carolina”

Funding Amount: $2,750,398

Estimated 3 Year Savings: $2.5 million

A coordinated care model will be developed and implemented in low-income areas of the state. The model will utilize community health workers to engage patients, improve health outcomes, and reduce costs.

**MUHAMMAD ABBASI HEALTH CENTER**

Project Title: “A coordinated care model: spreading community health teams to low income areas of Columbia, South Carolina”

Funding Amount: $2,750,398

Estimated 3 Year Savings: $2.5 million

A coordinated care model will be developed and implemented in low-income areas of the state. The model will utilize community health workers to engage patients, improve health outcomes, and reduce costs.

**MUHAMMAD ABBASI HOSPITAL**

Project Title: “A coordinated care model: spreading community health teams to low income areas of Columbia, South Carolina”

Funding Amount: $2,750,398

Estimated 3 Year Savings: $2.5 million

A coordinated care model will be developed and implemented in low-income areas of the state. The model will utilize community health workers to engage patients, improve health outcomes, and reduce costs.
**JOSLIN DIABETES CENTER, INC.**

**ASPE**

**Project Title:** Improving the health and care of low income diabetics at reduced costs for individuals with diabetes.

**Geographic Reach:** Connecticut, Massachusetts, Rhode Island, Vermont

**Funding Amount:** $4,829,955

**Year Savings:** $8.7 million

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<td>$4,829,955</td>
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**Health Resources In Action**

**Project Title:** Expanding a diabetes education program, known as “On the Road” delivered by Community Health Management coaching, and improved access to primary care.

**Geographic Reach:** Miami, Florida

**Funding Amount:** $52,600,000

**Year Savings:** $8,115,855

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**Johns Hopkins University**

**Project Title:** New England asthma innovations collaborative

**Geographic Reach:** Connecticut, Massachusetts, Rhode Island, Vermont

**Funding Amount:** $6,852,153

**Year Savings:** $4,040,657

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<td>$2,234,717</td>
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**FirstVital Health And Wellness Inc.**

**Project Title:** Improving the health and care of low income diabetics at reduced costs for individuals with diabetes.

**Geographic Reach:** Alabama, California, Connecticut, District of Columbia, Maryland, Massachusetts, New York, Puerto Rico

**Funding Amount:** $2,339,000

**Year Savings:** $9.4 million

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<td>$9.4 million</td>
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**Finity Communications Inc.**

**Project Title:** Transitions clinic network: linking high risk Medicaid patients from prison to community health centers will create an estimated 22 health care workers, including nurse transition guides, case managers, community health workers, and health behavior educators (determined through a device known as a DPN [Tinel Test], which indicates poor control). Uses technology to track risk criteria and update integrated health profiles, and to deploy targeted alerts, reminders, and care coordination, leading to reduced use of high cost health care services, including emergency room visits and hospitalizations, improved self-care management for patients with chronic conditions, a

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<th>3 Year Funding Amount</th>
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<td>$1,330,000</td>
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**Foundation For Community College Colleges**

**Project Title:** New English language immersion collaborative

**Geographic Reach:** Connecticut, Massachusetts, Rhode Island, New York, Puerto Rico

**Funding Amount:** $1,000,000

**Year Savings:** $747,962

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**Health Law Collaborative**

**Project Title:** Law for Health 2022

**Geographic Reach:** Washington, D.C.

**Funding Amount:** $1,000,000

**Year Savings:** $365,000

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<td>$365,000</td>
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<tr>
<td>Project Title</td>
<td>Funding Amount</td>
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<tr>
<td>&quot;Strengthening the state university of New Jersey (the center)&quot;</td>
<td>$3,500,000</td>
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<tr>
<td>&quot;Le Bonheur's CHAMP Program: Changing High Risk Asthma in Memphis through Partnership&quot;</td>
<td>$3,697,300</td>
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<tr>
<td>&quot;Michigan pathways to better health&quot;</td>
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<td>&quot;University of Denver hospital for children&quot;</td>
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<tr>
<td>&quot;Nevada afterbirth on point hospital for children&quot;</td>
<td>$14,347,808</td>
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<tr>
<td>&quot;Covenant health center&quot;</td>
<td>$14,145,784</td>
</tr>
<tr>
<td>&quot;Michigan pathways to better health&quot;</td>
<td>$2,896,416</td>
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The University of Chicago in partnership with Chicago Health Information Technology Regional Extension Center (CHITREC) and the Alliance of Chicago Community Health Services received an award to develop the CommunityRx system, a continuously updated electronic database of community health resources that will be linked to the Electronic Health Records of local safety net providers. In real time, the system will process patient data and print out a "HealtheRx" for the patient, including referrals to community resources relevant to the patient's condition and status. Aggregated data on patient diagnoses and referrals will be used to generate CommunityRx reports for community-based service providers to use to inform programming. The program will serve over 200,000 patients on the South Side of Chicago, most of whom are Medicare, Medicaid, and CHIP beneficiaries. The CommunityRx system will train and create new jobs for a combined total of over 200 individuals from this high-poverty, diverse community. This includes high school youth who will collect data on community health resources as part of the Urban Health Initiative’s MAPSCorps program. It will also include the creation of a new type of health worker, Community Health Information Experts (CHIEs), who will assist patients in using the HealtheRx and engage community-based service providers in meaningful use of the CommunityRx reports. The CommunityRx builds on infrastructure supported by ARRA funding from the National Institute on Aging. Anticipated outcomes include better population health, better use of appropriate services, increased compliance with care, and fewer avoidable visits to the emergency room with estimated savings of approximately $6.4 million.

University of Miami

Project Title: “Expanded activities of school health initiative”

Geographic Reach: Florida

Funding Amount: $4,097,198

Estimated 3-Year Savings: $5,620,017

Goal to improve care and access to care for children in four communities in the Miami-Dade County area who have health problems that include asthma, obesity, type II diabetes, and STDs. This intervention has resulted in an expansion of services and utility of school-based health clinics, increased collaboration with other care providers, services, and school-health stakeholders, and enhanced usage and sharing of health information technology. A team-based approach is being utilized to improve care and quality of services. This approach incorporates community health workers, nursing assistants, and dental hygienists while taking advantage of telehealth opportunities. The program will lower cost through preventive and more appropriate care and increase access to care, services, and benefits.

Children’s Home Society of Florida

Project Title: Improving child well-being through integrating care in a community

Geographic Reach: Florida

Estimated Funding Amount: $2,078,295

Will implement a medical home for students, families, teachers, and the community at the Wellness Cottage at Evans High School, which aims to reduce Emergency Department and inpatient utilization, increase sexually transmitted disease awareness, and address food insecurity and traumatic stress. Four community partners including Children’s Home Society of Florida (child welfare/behavioral health), the University of Central Florida, Orange County Public Schools and Central Florida Family Health Care will operate the Wellness Cottage, a hub for health, social, behavioral health, parental support, and after-school activities. The Central Florida Family Health Care component of the project is led by the University of Miami Health System and will provide primary care services and mental health services to children and families who visit the Wellness Cottage. The project’s team will work with community partners to implement a medical home model to improve care coordination and referral processes. The project will also focus on building community partnerships to support the Wellness Cottage and improve access to care for children and families in the community.

University of Miami

Project Title: “Expanded activities of school health initiative”

Geographic Reach: Florida

Funding Amount: $4,097,198

Estimated 3-Year Savings: $5,620,017

Health Care Innovation Awards Round Two: Awarded Projects

The CMS Innovation Center announced the first batch of prospective recipients for the Health Care Innovation Awards Round Two on May 22, 2014 and the second batch on July 9, 2014. The cumulative 39 awards are being implemented in 27 states and the District of Columbia spanning a wide range of patient populations, from children to the elderly, across the care continuum. The Health Care Innovation Awards Round Two are funding up to $1 billion in awards and evaluation to applicants across the country that test new payment and service delivery models that will deliver better care and lower costs for Medicare, Medicaid, and/or CHIP enrollees.
profession. Primary care providers will assess, diagnose, and treat common conditions, including acute and chronic diseases. Services will be provided in a variety of settings, including traditional offices, community health centers, and mobile clinics.

 Violence prevention will be integrated into all aspects of care. The clinic will collaborate with local law enforcement and community organizations to develop strategies for preventing and responding to violence. Additionally, the clinic will provide education and resources to patients and caregivers on how to identify and respond to signs of domestic violence.

 CLIFFORD W. BEERS GUIDANCE CLINIC, INC.

 Project Title: New Haven WrapAround

 Geographic Reach: Connecticut

 Estimated Funding Amount: $9,739,427

 The project will provide evidence-based, culturally appropriate integrated medical, behavioral health, and community-based services coordinated by a multidisciplinary Wraparound Team. Services include:

 1. Family engagement, recruitment, and education provided by trained community health workers in community-based settings.
 2. Multidisciplinary triage, screening, and assessment conducted by the Wraparound Team and including assessments of each family's physical, behavioral, and psychosocial risks, needs, and strengths.
 3. Family-focused care plans developed with the family, family supports, and the Wraparound Team and used to guide care and interventions.
 4. Care coordination provided by a Wraparound Team focused on coordinating the provision of appropriate care across multiple care settings, managing care transitions, reconciling and managing medications, and coordinating access to crisis support and wellness and social support services.
 5. Wellness and social support services provided at the hubs and at community-based organizations to address chronic and toxic stress (e.g., smoking cessation, parenting courses, diabetes prevention, meditation). The model focuses on high-need families, addresses medical and behavioral health care needs, integrates services across multiple health care institutions, and addresses the "chronic and toxic stress" experienced by the target population families.

 GEORGE WASHINGTON UNIVERSITY

 Project Title: PREVENTION AT HOME: A Model for Novel Use of Mobile Technologies and Integrated Care Systems to Improve HIV Prevention and Care

 While Lowering Cost

 Geographic Reach: Washington D.C.

 Estimated Funding Amount: $23,808,617

 The project will test a model that will utilize mobile technologies and optimize the prevention and care continuum (early detection, treatment adherence, retention in care, viral load suppression, decreased hospitalizations) for HIV+ individuals. The model will bring together a consortium of stakeholders including community outreach organizations, clinical care systems, a hospital, a managed care organization, the DC Department of Health, and DC Medicaid to share integrated IT systems. These systems will provide Medicaid members with the ability to receive online education, order home testing and home specimen collection for sexually transmitted infections and HIV, receive sexually transmitted infection and viral load test results, receive electronic prescriptions, and access care coordination and relinking to care. Community health workers (CHWs) will use a mobile tool to collect recruitment data, guide counseling, testing, and linkage services, and maintain a list of patients to provide care coordination who have detectable viral load, missed clinic visits, missed medication refills, emergency room visits, or hospitalizations.

 THE TRUSTEES OF COLUMBIA UNIVERSITY IN THE CITY OF NEW YORK

 Project Title: MySmileBuddy" Demonstrating the Value of Technology-Assisted Non-surgical Care Management in Young Children

 Geographic Reach: New York

 Estimated Funding Amount: $3,870,446

 The project will test a model that uses family-level, peer-counseled, and technology-assisted behavioral risk reduction strategies to divert children with early- and advanced-stage early childhood caries (ECC) from high-cost surgical dental rehabilitation (DR) to low-cost nonsurgical disease management (NSDM). Together, parents and community health workers (CHWs) will use MySmileBuddy (MSB), a mobile tablet-based health technology, to plan, implement, and monitor positive oral health behaviors, including dietary control and use of fluorides, which arrest ECC's progression.

 In the school and community, "MySmileBuddy" will provide primary care. Health risk assessments will include blood pressure, height, and weight measurements. Parent education will focus on the importance of proper oral hygiene and the benefits of early intervention. The program will also provide resources to families on how to access dental care and will coordinate referrals for necessary treatments.
References


47 Personal Communication: Mose Herne – Director of Division of Planning, Evaluation and Research, Office of Public Health Support, Indian Health Service. October 27, 2015.


69. Personal Communication. CDR Thomas Pryor, BSN, U.S. Public Health Service. Preventive and Population Health Care Models Group, Center for Medicare and Medicaid Innovation and Ellen-Marie Whelan, NP, PhD., Acting Chief Population Health Officer, Center for Medicaid and CHIP Services (CMCS) and Senior Advisor, Center for Medicare and Medicaid Innovation (CMMI) and Centers for Medicare and Medicaid Services (CMS).


78. Personal Communication. Ellen-Marie Whelan, NP, PhD., Acting Chief Population Health Officer, Center for Medicaid and CHIP Services (CMCS) and Senior Advisor, Center for Medicare and Medicaid Innovation (CMMI) and Centers for Medicare and Medicaid Services (CMS).


