

Incorporating Community Health Workers into State Health Care Systems: Options for Policymakers

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Recent efforts to improve the effectiveness and efficiency of the public and private health care systems have increased state and federal policymakers' attention on community health workers (CHWs). Although the CHW profession is not new, health care payers and providers, including Medicaid, often partner with these workers. Their goal is to help people navigate a complex health care system, receive preventive care, manage chronic illnesses, maintain healthy lifestyles and assist people in receiving the care they need in culturally and linguistically relevant ways.

The American Public Health Association defines a community health worker as:

"...a frontline public health worker who is a trusted member of and has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."

STATE COMMUNITY HEALTH WORKER PROGRAM EXAMPLES

STATE	PROGRAM	KEY FUNDING	EXAMPLE OF CHW SERVICES
Idahoⁱ	Idaho's Statewide Healthcare Innovation Plan uses CHWs for its patient-centered medical homes that deliver primary care, mainly in underserved areas.	Centers for Medicare and Medicaid Services, State Innovation Model Grant.	Provide health education and management to people in underserved areas with chronic conditions, e.g., diabetes management.
Kentuckyⁱⁱ	Kentucky Homeplace, established in 1994 and housed within the University of Kentucky Center for Excellence in Rural Health, employs CHWs in underserved and rural communities.	The Kentucky Department for Public Health contracts with the University of Kentucky Center for Rural Health. The legislature appropriates general funds for this program. ⁱⁱⁱ	Help clients to access resources to meet their health care needs such as adequate food, eyeglasses and dentures.
Montana^{iv}	Montana created a care coordination program that places CHWs within critical access hospitals to meet the diverse health care needs of a frontier state.	Frontier Community Health Care Coordination Demonstration Grant (HRSA-11-202).	Work to help elderly patients remain in their homes by evaluating their individual needs and connecting them to personalized care, e.g., physical therapy or other community resources.
Oregon^v	Oregon's Patient Centered Primary Care Home Program covers services provided by certified CHWs. CHWs must be included on health care teams in the Coordinated Care Organizations (CCOs), which aim to provide the best quality health care at affordable costs.	Medicaid State Plan Amendment	Ensure patients regularly see their health care provider and receive chronic disease management, e.g., going to an asthma patient's house to ensure they are managing their condition properly.
South Carolina^{vi}	The South Carolina Department of Health and Human Services' Health Access at the Right Time (HeART) initiative includes CHWs in primary care practices as community liaisons.	Eligible primary care physician practices receive a grant from the South Carolina Department of Health and Human Services. In addition, two billing codes are available for CHW services.	Encourage patients to follow appointment, medication and treatment schedules.

ⁱ State of Idaho, Idaho Statewide Healthcare Innovation Plan (Boise: Idaho, Dec. 20, 2013), <http://healthandwelfare.idaho.gov/Portals/0/Medical/SHIP/IdahoSHIP.pdf>.

ⁱⁱ University of Kentucky, Center for Excellence in Rural Health, About Kentucky Homeplace (Kentucky: University of Kentucky College of Medicine, 2015), <https://ruralhealth.med.uky.edu/about-kentucky-homeplace>.

ⁱⁱⁱ National Academy for State Health Policy, State Community Health Worker Model (National Academy for State Health Policy, June 5, 2015), <https://www.statereform.org/state-community-health-worker-models>.

^{iv} Montana Rural Health Initiative, Rural Care Coordination Toolkit (North Dakota: Rural Assistance Center), http://montanaruralhealthinitiative.info/wp-content/uploads/2014/03/care-coordination-toolkit_RAC.pdf.

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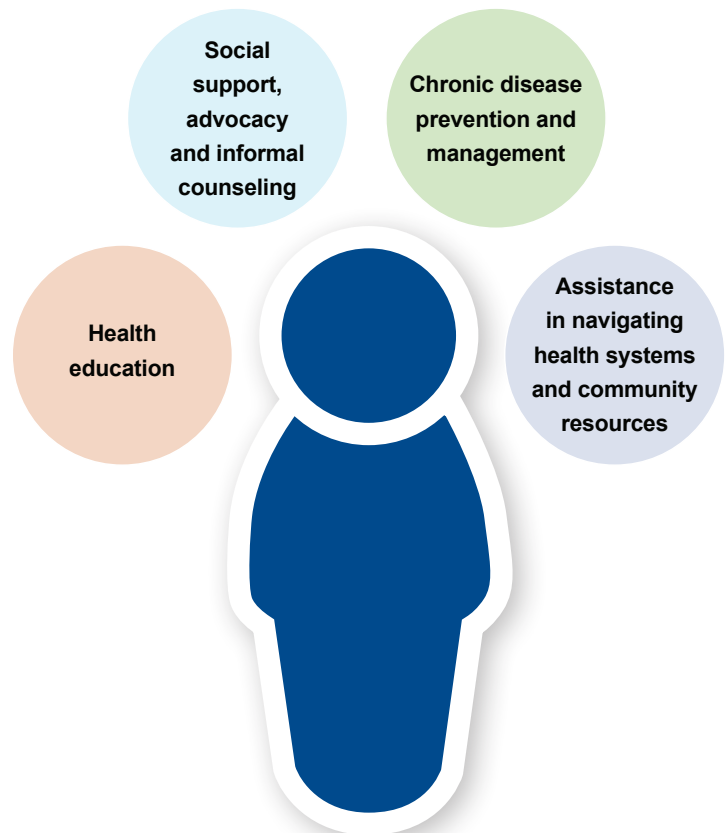
^{vi} South Carolina Department of Health and Human Services, Role of a CHW (South Carolina: Health and Human Services), <https://www.scdhhs.gov/sites/default/files/Community%20Health%20Worker%20FAQ.pdf>.

Community health workers have a long history of service in the United States and are known by many titles, such as community health advisors, lay health advocates, outreach educators, community health representatives, promotoras (or peer health promoters), and peer health educators. They have been deployed in various settings—from primary care practices and hospitals to public health departments, community locations and patient homes—and their responsibilities can cover a wide area, including health education, chronic disease prevention and management, social support and informal counseling, and assistance in navigating health systems and community resources. These types of workers are also well positioned to reach patients in rural settings, who often encounter additional challenges accessing care. Additionally, many CHWs are volunteers, contributing to their community-based, grassroots nature.

The Bureau of Labor Statistics (BLS) estimates that as of May 2014, nearly 48,000 community health workers were employed across almost all 50 states.¹ It is important to note that the estimated size of the CHW workforce tends to vary, as the BLS and other groups define this workforce and its roles and responsibilities differently. For example, in 2007, the Health Resources and Services Administration reported roughly 86,000 CHWs assisting communities across the United States. This number is substantially higher as its definition of a community health worker is much broader and includes volunteers.²

The Affordable Care Act (ACA) and the Institute of Medicine, among others, have recognized the growing role community health workers play in health care. For example, the Department of Labor created an occupation code for CHWs in 2009, the ACA enabled grants to support using these workers in underserved communities, and the Centers for Medicare and Medicaid Services (CMS) altered a rule that makes it easier to pay for CHWs' services through Medicaid. In addition, many states included community health workers as part of the workforce plan in their Health Care Innovation grants, which were funded by CMS.

EXAMPLES OF COMMUNITY HEALTH WORKER RESPONSIBILITIES



CHWs' EFFECT ON QUALITY AND COST

Community health workers' role as "health brokers"³ between communities and health care providers is widely considered to have the potential to improve quality of care while simultaneously controlling or decreasing costs. The workers' capacity to facilitate patients' self-management and access to appropriate clinical services could decrease costly and unnecessary hospitalizations, urgent care and emergency room visits, and improve quality of care. With these assumptions, CHWs have also been employed to work with "super-utilizer" patients—those who use more health services or frequently access high-cost services, such as emergency rooms.⁴ In addition, community health workers are thought to strengthen providers' understanding of communities, which could improve care by building better cultural competence and communication between providers and patients.⁵

Despite acknowledgment of these potential benefits of community health workers, only a handful of programs across the country have studied their effectiveness. For example, an Arkansas CHW program saw a nearly three-to-one return on investment of Medicaid expenditures for a program that worked with Medicaid enrollees with unmet long-term care needs, and helped beneficiaries access appropriate home- and community-based services rather than costly nursing homes.⁶ In Colorado, a Denver Health program employed CHWs to reach out to men in underserved communities to increase access to health care.⁷ Denver's program found that it saved on the cost of health care services with a return on investment of more than \$2 for every \$1 spent on the program.⁸ Some research also shows positive effects of CHWs on patients' health in some contexts and for certain diseases, such as hypertension or diabetes.⁹

While there are a handful of published studies, the true effect of CHWs on patient care and health care costs is still difficult to determine, in large part due to limitations of the research.¹⁰ For example, one review found some evidence that CHWs can positively influence patient behavior and health, but the evidence was insufficient to evaluate cost effectiveness.¹¹ In fact, very few studies have examined cost or cost effectiveness.¹² Preliminary cost effectiveness data are more frequently present within clinical service administrations that use community health workers, and these data often remain unpublished.¹³ In addition, the variety of roles, settings and populations in which CHWs serve create challenges for rigorous evaluation.¹⁴ And this diversity of contexts means that some findings may not be applicable in other health system settings.¹⁵

Overall, more research is needed to determine the effectiveness of community health workers. The Center for Medicare and Medicaid Innovation Models, which encourages the use of CHWs, requires its grant recipients to show cost savings and analysis of returns on investment.¹⁶ As states implement pilots or programs using CHWs through this funding stream, they may generate more evidence upon which other

CHWs AND HEALTH CARE TEAMS

The role of community health workers is well aligned with the goals of community care teams, primary care teams and medical homes around care coordination and access to care. CHWs' integration into primary care teams with doctors, nurses and other providers may help "magnify" the team's effects.¹⁸ According to a review by the Centers for Disease Control and Prevention, evidence suggests that including CHWs in health care teams can extend the reach of CHWs and have a positive effect on patient health.¹⁹ Integrating CHWs into multidisciplinary health care teams can be financed through mechanisms such as Medicaid, Medicare or private insurers.

In West Virginia, for example, CHWs are listed as possible members of the state's Health Home initiative care-provider teams, which are reimbursed by Medicaid through preset payments per member.²⁰ As team members, CHWs help provide services such as follow-up care after patient discharge to avoid the need for additional medical services.²¹ CHWs are similarly integrated into Vermont's Community Health Teams, whose services are paid for by Medicaid, Medicare and the state's major insurers. Vermont's Blueprint for Health, a statewide public-private partnership focused on improving health care, uses CHWs to provide a variety of services, such as attending medical appointments with patients and assisting with transportation or child care.²²

states can build. And some states, such as Massachusetts, New Mexico and South Carolina, have included studies as part of funding or support for community health workers.¹⁷



CHWs AND MEDICAID

Community health workers can be deployed to reach Medicaid beneficiaries, especially as state programs increasingly move toward a comprehensive approach that addresses patients' barriers and needs, and emphasizes preventive and coordinated care.²³

The Centers for Medicare and Medicaid Services changed a rule, as of 2014, that expanded reimbursement of preventive services and helped facilitate reimbursement for CHW services through state Medicaid programs.²⁴ State Medicaid programs are now allowed to reimburse community-based preventive services recommended by a physician or other licensed provider, and the services can be delivered by practitioners other than a physician—such as CHWs. States wishing to incorporate the flexibility under this rule must create a state plan amendment and define both CHWs and the services they provide.²⁵

Prior to the rule change, a few states funded CHWs under Medicaid through different mechanisms. Minnesota passed legislation in 2007 to become one of the first states to reimburse for

FINANCING COMMUNITY HEALTH WORKERS

Funding is one of the challenges to creating and maintaining CHW efforts in many states. CHWs are funded through a variety of federal, state, local and private dollars, including:

- Federal, state and private grants
- State and local health departments
- Medicaid
- Hospitals and clinics
- Private insurers
- Community-based organizations
- University and college research projects

Some funding is for temporary projects. In addition, a number of CHWs are volunteers. See “Sustainable Financing” section on page 9 for more information.

greater incorporation of CHWs into health care teams in areas such as prenatal care and birth outcomes.²⁹

As lawmakers examine CHW programs, prior evidence, demonstrations and legislation suggest a few key areas on which policy consideration and action could be focused.

Occupational regulation, which involves certification, licensing or other credentials for community health workers, falls under the purview of state legislatures. States may consider occupational

The map displays the following state colorings:

- Dark Blue:** WA, NV, NE, NY, IN, MS, SC
- Green:** OR, NM, TX, OH, MA
- Light Gray:** AK, HI, CA, AZ, UT, CO, WY, MT, ND, SD, MN, IA, MO, AR, LA, AL, GA, FL, NC, VA, WV, PA, NJ, CT, RI, DE, MD, DC

- Source: Association of State and Territorial Health Officials,
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regulation to create standards for the CHW profession, which has typically been very broadly defined. Credentialing requirements can include required training, skills, competencies and a standard scope of practice, which would delineate CHWs' practice abilities and limitations. Credentialing can also serve as the basis to enable reimbursement or payment for CHW services. At least five states—Massachusetts, New Mexico, Ohio, Oregon and Texas—currently have laws or regulations establishing CHW certification program requirements, and Illinois, Rhode Island and Maryland passed laws that require a work group or task force charged with determining requirements.³⁰ Other states have established processes or are working towards establishing certification processes through state agencies or other non-legislative directives. However, some CHW organizations worry that enacting uniform occupational regulations or requirements will be too restrictive for a field that has traditionally been community-driven with few barriers to entry, and may prohibit some from entering the profession.³¹

Policymakers considering occupational regulation of CHWs may explore:

- Determining if the state has existing standards for non-clinicians providing preventive care, and, if not, consider establishing qualifications.³²
- Creating a credentialing commission, task force or other work group to examine the most applicable state-specific standards.
- Developing certification programs or requirements that are based on a set of core competencies needed for CHWs across the state³³ and consider specialized certification standards for CHWs in specific programs.
- Defining a scope of practice for CHWs that allows the workers and other team members to provide care at the top of their skill set.³⁴
- Recognizing the CHW standard occupational classification, set by the Department of Labor in 2009.³⁵

Workforce Development

Similar to credentialing, decision-makers are considering the education, training and other needs to adequately develop the CHW workforce to meet



the needs of their states. Training for CHWs varies widely; it can be through formal educational institutions or learned on the job.³⁶ Standards commonly focus on skills and competencies rather than achieving specific education levels. At least six states—Indiana, Nebraska, Nevada, New York, South Carolina and Washington—have training programs, some of which are connected to certifications and were established by state agencies.³⁷ Lawmakers investigating CHW workforce issues may:

- Set state-level standards for education or training that focus on needed skills and competencies.³⁸
- Encourage the development of training programs in the health department, other state agencies or other entities.
- Develop or require specific training (e.g., disease-specific training) necessary for certain jobs.³⁹
- Allow training to be provided by clinicians, experienced CHWs or supervisors in CHW programs.⁴⁰
- Consider training for CHWs and other health care providers that helps CHWs integrate into care teams.⁴¹

- Allocate resources for CHW workforce development, including training.⁴²

Sustainable Financing

Historically, community health workers have been financed through a “patchwork of funding” with time-limited grants and numerous volunteer CHWs.⁴³ Through mechanisms including the 2014 Medicaid rule (described earlier), Medicaid demonstration projects, Medicaid managed care and the federal State Innovation Model (SIM) initiative, states are exploring sustainable financing models to develop and expand the use of CHWs by:

- Creating state policies that pave the way for direct CHW reimbursement, such as defining CHW services and eligibility to provide services.
- Encouraging state Medicaid programs to explore payment options, including managed care contracts, to support CHWs⁴⁴ or other mechanisms under the recently changed Medicaid rule.
- Considering a demonstration waiver or state plan amendment to reimburse for CHW services through Medicaid.⁴⁵
- Applying for a federal State Innovation Model grant to test and evaluate a new model that incorporates CHWs in an effort to reduce

costs and improve quality in Medicaid and Medicare.

- Working with managed care organizations and private payers to develop reimbursement models for CHWs.⁴⁶
- Examining the option to add CHWs to care teams, especially for those states considering reforms to health care payment and delivery systems that support integrated or patient-centered care.⁴⁷
- Considering reimbursement levels at wages that help maintain CHWs in the workforce.⁴⁸
- Supporting data collection or research on the cost-effectiveness of CHWs.

CONCLUSION

In efforts to reform health care delivery and payment systems — with the goal to improve quality and lower costs — many states are looking to leverage lower-cost resources such as community health workers. State decision-makers have multiple policy options to consider related to occupational regulation, workforce development and funding of CHWs. Policymakers can also support data collection and analysis to help further the research to better understand the roles and opportunities related to CHWs, and continue to inform innovative, cost-effective state health policy.

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