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Policy Considerations for Community Health Workers in an Era of Health Reform

MPH Capstone Project
Graduate Program in Public Health
Muskie School of Public Service

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INTRODUCTION

This policy brief discusses the increasing role of community health workers (CHWs) in the American health care system, as part of the overall health care reform movement that includes the Affordable Care Act. CHWs perform a critical task by bridging the gaps between the health care system and vulnerable populations in this country, bringing public health initiatives into hard-to-reach communities and helping people navigate a complicated system of care. CHWs are increasingly being deployed in hospitals and doctors' offices, especially those participating in Accountable Care Organizations (ACOs), funded in part by State Innovation Model (SIM) grants and Medicaid Health Homes and similar initiatives. These funding sources are limited, and in general the work that CHWs do in health care settings is not reimbursed by public or private insurance. CHWs also lack a unified voice to promote their value on the national stage, leaving many inside and outside the health care system uncertain as to the importance of CHWs in care settings. Finally, there is insufficient evidence to demonstrate conclusively that incorporating CHWs in health care initiatives saves money and improves outcomes.

In order to better understand how CHWs are being integrated in state health reform initiatives, including facilitating care coordination, enhancing access to community-based services, and addressing social determinants of health, the author, working in collaboration with the National Academy for State Health Policy (NASHP), developed a nation-wide scan of CHW policy activity, published online as [State Community Health Worker Models](#) in February, 2015. The CHW chart gives a comprehensive look at how states are utilizing CHWs as part of quality improvement, health care reform, and expanded models of public health.

Key policy considerations for CHWs focus in the short term on stable financing, the development of core competencies that reflect CHWs' expanding roles in the primary care system, and the creation of national CHW resource and advocacy organizations. Longer term considerations involve launching controlled research trials to demonstrate the value of CHWs in improving outcomes for patients while bringing down costs in the health care system.

BACKGROUND ON COMMUNITY HEALTH WORKERS

CHWs occupy an important but often overlooked place in the American health care system. As defined by the American Public Health Association:

A community health worker is 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 community health worker to serve as a liaison, link, or intermediary between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.¹

Across the country, CHWs serve as patient navigators, health educators, and health advocates, especially for minority populations and other vulnerable groups who, due to language and cultural barriers, a lack of health literacy, and financial constraints, have difficulty engaging with the health care system. CHWs have traditionally been involved in population health initiatives, working to improve the outcomes of communities; *promotoras de salud* in Hispanic communities and CHWs who engage the HIV positive community are some of the most often cited examples of CHWs in the United States.² In the current health care climate, CHWs are increasingly moving into more clinical settings. At the moment, however, unstable financing and insufficient familiarity with and even bias toward people who are essentially unlicensed

¹ <http://www.apha.org/apha-communities/member-sections/community-health-workers>. The APHA definition of a CHW is the basis for the definition of CHW in many states (including in state law).

² <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/413070-Integrating-Community-Health-Workers-into-a-Reformed-Health-Care-System.PDF>

paraprofessionals often limits the role community health workers can play in the formal health care system.

We are living in a time of evolution and reform within our health care system, in pursuit of the Triple Aim of improving the patient experience of care, improving the health of the population, and bringing down the overall costs. Hospitals and primary care practices are increasingly interested in population health improvement as they have come to understand that improving the health and clinical outcomes of their patients requires attention to factors, such as the social determinants of health, that fall outside of the medical care system, but that can have a profound effect on clinical outcomes and health. Good health for individuals involves, among other things, patient education, strong social supports, and ongoing help navigating a complicated system of care. Providing these components may cost more up front, but will hopefully bring down costs in the long term. Accountable Care Organizations, in particular, are looking to use population health strategies to increase their savings while improving quality of care, with a focus on managing the care of chronically ill and other challenging patients. CHWs are well-positioned to take advantage of this new emphasis on the many facets of good health and the team effort it takes to maintain it. Along with other health paraprofessionals, they are increasingly being incorporated into health care workforce development initiatives that are part of states' efforts at health care reform. This is especially true when it comes to patient centered medical homes and other similar projects that involve health teams in primary care.

As interest in CHWs has grown over the past few years, policy analysts have made a variety of recommendations that would ease CHWs' integration into the health care system. A recent discussion paper published by the Institute of Medicine's Round Table on Population Health Improvement, *Bringing Community Health Workers into the Mainstream of U.S. Health*

Care,³ makes four policy recommendations: the implementation of statewide infrastructure for CHW scope of practice, training, and certification that covers the role of CHWs in supporting team-based primary care; building the analytic capacity of safety net providers to document the value realized from CHWs; promoting sustainable financing mechanisms; and establishing an information clearinghouse to document, disseminate, and replicate innovations in the engagement of CHWs at scale. The CDC's recently updated policy brief *Addressing Chronic Disease through Community Health Workers: A Policy and Systems-Level Approach*⁴ lists four "Comprehensive Policy Components" that any state should have as it develops CHW policies. These components are: financing mechanisms for sustainable employment; workforce development; occupational regulation; standards/guidelines for publicly funded research and program evaluation on CHWs. In 2013, the Urban Institute issued a policy brief, *Integrating Community Health Workers into a Reformed Health Care System*,⁵ that made many of the same recommendations, highlighting the need for: generating and disseminating more actionable information; supporting workforce development efforts; engaging key stakeholders and thought-leaders; and building broader business cases beyond health services markets. In many ways, the concerns being addressed by policy analysts revolve around financing CHW activities, building the CHW workforce with the proper training and advocacy, and developing the data to make the business case that CHWs belong in the health care system.

BACKGROUND ON THE CHW CHART

The driving force behind the creation of CHW chart was an effort to get a closer, more comprehensive look, at how states are building CHWs into health care reform. The chart is

³ <http://www.iom.edu/global/perspectives/2015/community-health-workers.aspx>

⁴ http://www.cdc.gov/dhdsp/docs/chw_brief.pdf

⁵ <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/413070-Integrating-Community-Health-Workers-into-a-Reformed-Health-Care-System.PDF>

housed on NASHP's [State Reform website](#), which is an online network for health reform implementation. A guiding principle in the chart's construction was to use useful information in a variety of categories that state officials, CHW leadership, and policy analysts could turn to and quickly see what was happening across the country. The categories in the chart are Financing, Education, Certification, State Community Health Worker Legislation, Community Health Worker Organizations, and Community Health Worker Roles in the State. There is some overlap between the categories: both Education and Certification discuss aspects of community health worker credentialing, and core competencies wound up being listed in several categories, including Roles and Education, depending on how a state responded to the questionnaire, although the questions about core competencies were listed under Education.

The data in the chart were derived from extensive online research, and from a questionnaire sent to state CHW contacts in late 2014 and early 2015. There are currently 39 states represented, of whom 23 responded to the questionnaire or sent in information on their own. The end result is a unique compilation of data about CHWs across the country, unmatched in any other single resource that is publicly available.

POLICY RECOMMENDATIONS

The data collected for the CHW chart provide an in-depth look at CHWs around the country, and the challenges that are being encountered as they are brought into health care reform. In many ways, the information in the chart reinforces many of the policy concerns around CHWs addressed by others. As such, it became clear that the following policy considerations for CHWs need to be addressed in the short term:

- 1) The need for stable financing;

- 2) The development of core competencies that reflect CHWs expanding roles in the primary care system;
- 3) The creation of national CHW resource and advocacy organizations.

Stable financing for community health workers is key to their development as integral, not supplemental, parts of the health care system.

Even a state like Massachusetts, with its strong investments in CHWs and innovations in health care reform, relies on unstable funding such as grants to sustain their efforts. The ability to bill Medicaid directly for CHW encounters with patients is currently available only through a waiver, which South Carolina and Minnesota have done. Pennsylvania has a waiver to allow for billing by Peer Support Specialists, many of whom are CHWs. Another strategy is for states to allow the care provided by CHWs to be built into the administrative costs of a practice. For example, Mississippi allows for CHWs to be reimbursed under a “general education billing code,” while New Mexico has a waiver that allows Managed Care Organizations serving Medicaid patients to embed CHW salaries and training costs into the general administrative costs. States such as Washington have CHWs participating in Health Homes; their services are reimbursed as part of the per member per month (PMPM) payment. CHWs have been built into the State Innovation Model grants, or SIM grants, for states such as Maine and Idaho, as part of workforce development initiatives, both to create the state CHW infrastructure and to include CHWs in funding for pilot projects such as Patient Centered Medical Homes. Overall, however, this is a patchwork effort that does not provide sustainable financial support for CHWs; the money for SIM especially is finite.

A key rule change by Medicaid in January, 2014, holds promise for reimbursement of CHWs under the current fee-for-service model of the health care system. The rule allows state Medicaid programs to reimburse for services “recommended” by a licensed professional, and not

just “performed” by a licensed professional.⁶ CHWs and other medical paraprofessionals will now be allowed to bill directly for the work they do, especially health education and care coordination, if a clinician has recommended it. A Medicaid state plan amendment is still required, however, for a state to take advantage of the change. Massachusetts and South Carolina are currently planning to submit the relevant SPA, while other states appear to be watching to see what happens before following suit.

Medicare has created a potential opening to allow for reimbursement for some of the work done by CHWs in primary care settings, with the new billing code for Chronic Care Management (CCM),⁷ a service that can be provided by physicians and other practitioners to patients with two or more chronic conditions. Similar to the Medicaid rule change, CMS has provided an exemption that allows for CCM to be provided by clinic staff under the “general supervision” of a practitioner, rather than under “direct supervision,” although the practitioner is the one who will bill for the service. It is possible that this will be interpreted to allow CHWs, health educators, and other paraprofessionals to provide CCM services for the patients within a practice when appropriate, and to be reimbursed for it, even if indirectly. Once clinical care providers are able to be reimbursed by Medicare and Medicaid for the work done by their CHWs, it is possible private insurance may begin to allow it as well, providing even more stable financing to CHWs.

⁶ <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf>

⁷ <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>

It is critical that CHWs acquire the skills needed to become part of primary care, particularly team-based primary care, and that these skills are built into CHW core competencies.

Team-based primary care, under its many forms and names -- Health Homes, Patient Centered Medical Homes, Community Care Teams, etc. -- is part of many state health reform initiatives. For example, CHWs are embedded in Vermont's Community Health Teams, part of their Multi-Payer Advanced Primary Care Practice Demonstration. Similarly, a CHW pilot project in South Carolina embeds CHWs in primary care practices and allows billing for both group and individual encounters. CHWs are included as well in Michigan's SIM grant, which lists them as members of the health care team that can assist in person-centered care as part of their patient-centered medical home initiative.

As states develop core competencies and training programs for CHWs, it is worth paying attention to skill sets that are marketable to primary care. Research for the chart turned up a variety of relevant core competencies, including service and care coordination; teaching skills; informal counseling and coaching; health education for behavior change; and educating about health care systems, social service systems, insurance options and the insurance marketplace. All of these core competencies prepare CHWs to serve as navigators, peer support specialists, health educators, and other relevant positions, and to fit into PCMHs. What CHWs bring to the table, that others with similar training do not, remains their close ties to vulnerable communities, as well as the cultural competencies that many other health professionals lack.

Credentialing of CHWs is one of the areas with significant state activity, either through legislative action or through the health department. Although many CHWs, especially volunteers, will continue to be trained on the job, the movement towards certification of paid CHWs is necessary if they are to be recognized as an essential component of health care, and increasingly of primary care. Certification, core competencies, and enhanced training are helping

to turn being a CHW into an occupation. Given how heavily credentialed, licensed, and accredited the health care system is, demonstrating professionalism and recognizable credentialing to doctors and other key players is necessary for achieving greater acceptance of CHWs by the health system.

One potential downside of increased credentialing is that it could create too rigid an occupational definition for what has historically been a fairly flexible, adaptable, grass-roots oriented role, a definition which might start to move CHWs too far away from their origins in population health improvement. At the moment, the core competencies and certification requirements being implemented by states reflect CHWs' historic scope of practice, with a strong emphasis on outreach methods and strategies; advocacy, leadership, and empowerment skills; individual and community capacity building and mobilization; and culturally-based communication and care. Policymakers who are crafting state requirements for CHW training need to ensure that these topics remain at the core of what it means to be a CHW, while also adding instruction in the areas most relevant to primary care.

A related concern is that the scope of practice for CHWs not start looking too medical, and risk encroaching on the scope of practice of other health professionals, particularly nurses and CNAs. Responding to this issue, Illinois recently passed CHW legislation that prohibits them from engaging in or performing any act or service for which a license issued by a professional licensing board is required – referring to direct medical care. Other states may decide to follow this route as well. Ohio, however, is something of an outlier – CHW education and credentialing falls under the authority of the Board of Nursing, as opposed to the Board of Licensure or the Department of Health and Human Services, as seen in other states. Nurses may delegate nursing-related activities, including dispensing medication, to community health workers, as long as the

nurses are supervising them. At the moment, no other state is emulating Ohio, but if others do, it could lead to a real shift in the tasks that CHWs do within clinical settings.

There are currently no unified organizations dedicated to CHW advocacy and education, or that serve as an information clearinghouse.

Developing and researching state CHW policies brought home the fact that there is no single resource for sharing research and policy developments about CHWs. Every state that begins a policy initiative seems to be reinventing the wheel when it comes to writing a background report, doing the same literature reviews, looking at the same CHW programs, and consulting the same people, especially Carl Rush at the University of Texas and Gail Hirsch in Massachusetts' Office of Community Health Workers. Similarly, health policy organizations including NASHP, the Trust for America's Health, and the Milken Institute School of Public Health at George Washington University, are all doing research on similar aspects of CHW financing and credentialing. There is significant overlap, and no one person is aware of what everyone else is doing.

A central organization that could serve as a resource and repository of knowledge and information for states and policy analysts, and that might coordinate, or at least, share information about, research endeavors and funded projects is badly needed. There are a number of health policy organizations, such as NASHP, which might be able to take on this role. Beyond simply housing information, the organization could also track variations in approach and differences in policy implementation across the country, taking note of unique local circumstances and unexpected barriers that state community health worker initiatives face.

There is also a need for a coordinated national voice for CHWs, able to do advocacy and education while advancing their visibility. A national organization could help state CHW

associations do local advocacy, especially regarding the key issues of credentialing, financing, and scope of practice. It also could serve as a unified voice for CHWs on the national stage, giving the American Medical Association, policy makers, and other interested parties someone “official” to talk with. Although this may be somewhat inconsistent with the grass-roots origins of many CHWs, the increased professionalization of paid CHWs requires a national organization to represent them.

CONCLUSION

Right now, there is tremendous energy, enthusiasm, and policy development around CHWs and the work that they do. In the short term, education, advocacy, improved training and credentialing, and the ability to bill insurance directly for services will go a long way towards bringing CHWs into doctors’ offices, clinics, and hospitals.

In the long run, however, community health workers and their supporters will need solid evidence to demonstrate that utilizing CHWs in PCMHs and similar projects actually improves health outcomes and saves money. Making this business case will require controlled research studies that analyze what happens when CHWs are added to a health team. Does their work to help manage care bring down use of unnecessary services and ensure that people come to their appointments? Are their services as health system navigators and advocates helping patients better understand their chronic illnesses and find their way around health care settings? Are the health outcomes improving for the patients? Are real savings being achieved? There is not enough data yet to answer these questions, but in the future, evidence of savings and quality improvement will help policymakers, lawmakers, and clinicians understand the real value that CHWs can contribute to the national conversation about health.