



Community Health Workers in the Wake of Health Care Reform: Considerations for State and Federal Policymakers

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Introduction

As states and the nation transform their health systems, many policymakers are turning to community health workers (CHWs) to tackle some of the most challenging aspects of health improvement, such as facilitating care coordination, enhancing access to community-based services, mitigating the impacts of the social determinants of health, reducing health disparities, and containing costs. In light of the many emerging CHW models nationwide, state and federal policymakers need information and evidence to guide their decisions on CHW roles, recruitment and retention, training, credentialing, and financing. Greater alignment on strategies for defining and financing CHWs would help state and federal policymakers generate and share the information necessary to guide the most effective engagement of CHWs in a transforming health care system.

This brief captures key themes that emerged during an October 2015 meeting of state and federal leaders convened by the National Academy for State Health Policy (NASHP) with the support of The Commonwealth Fund. The goal of the meeting was to identify areas in which state and federal policy can align around the use of CHWs in transforming health systems to achieve better care, lower costs, and improved population health. A number of promising strategies and areas of agreement emerged from the October 2015 discussion between state and federal officials.



According to 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, and acts as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.*

* <https://www.apha.org/apha-communities/member-sections/community-health-workers>

- Policymakers see potential for CHWs to help states reduce health disparities because of their close relationship to and understanding of often-underserved communities.
- Improved data collection on CHWs is necessary to determine workforce size and training needs, inform policy on payment, and measure return on investment and impact on health care quality.
- As states test and implement different models to transform their health care systems in different environments, they value the flexibility to establish their own training requirements, roles, and funding arrangements for CHWs to meet their specific needs.
- State and federal policymakers can align their efforts to jointly build an evidence base to guide policy on the use and financing of CHWs.

State Snapshot

CHWs in Michigan's Transforming Health System*

CHWs participate in Michigan's transformation initiatives in one of three ways:

- Working in a clinic setting as part of a care team. Michigan emphasizes the team-based nature of CHW work, and sees CHWs as working closely with other members of the care team to ensure patients receive the quality care they need. In a clinic setting, CHWs help with referrals to additional resources and can help patients and families follow through with getting needed support.
- Working in the community as part of a Pathways Community Hub model. In this model, funded by a CMS Health Care Innovation Award, a local agency in each of three participating counties is designated as a Pathways Community Hub and tasked with connecting at-risk people with chronic conditions to CHWs. The CHWs then work with a nurse and social worker to facilitate access to needed health and social services.
- Working through an insurer or health plan. Michigan Medicaid incorporated a CHW staffing ratio into its managed care contract, requiring one CHW for every 20,000 beneficiaries. Some MCOs fulfill this requirement by hiring their own CHWs, while others contract for CHWs.

* http://www.michigan.gov/documents/mdch/Michigan_Blueprint_APPENDICES_FINAL_DRAFT_454500_7.pdf;
http://www.nashp.org/webinars/medical-home-neighborhoods/Callaghan_Slides.pdf;
<https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Michigan.html>;
<https://innovations.ahrq.gov/guide/QuickstartGuide/overview>.

Defining the Roles of Community Health Workers

The work of CHWs is wide-ranging and multi-faceted.¹ In some models, CHWs work with providers as part of care teams, performing post-care follow-ups and safety checks, referring individual patients to community services and resources, and bridging linguistic and cultural gaps between patients and clinic-based health care providers.

In other models, CHWs may take on more population health-oriented roles in the community, supporting public policies that promote health, or providing community health education. Health plans also employ CHWs to fill a variety of roles. Given the abundance of possible roles, policymakers strive to craft policies that enable CHWs to most effectively meet the needs of their communities as the health system transforms.

Policymakers see potential for CHWs to help reduce health disparities. As trusted members of the communities they serve, CHWs can provide health education and support that is culturally and linguistically appropriate. A CDC report describes the “unique role of CHWs as culturally competent mediators ... between providers of health services and the members of diverse communities.”² Many states look to CHWs to reduce disparities by helping communities overcome gaps in knowledge, literacy, trust, and health care access.

Despite near-consensus on this role for CHWs, state and federal policymakers could benefit from greater communication about and understanding of one another's cross-agency efforts to enlist CHWs in reducing health disparities.

- One federal official suggested using the U. S. Office of Minority Health (OMH)'s Federal Interagency Health Equity Team (FIHET) to help align CHW health equity efforts.³ The FIHET, which provides leadership for the OMH National Partnership for Action to End Health Disparities,⁴ convenes leaders across federal agencies and departments to address health disparities.

- A state official said that her agency can learn from the cross-agency work done by federal agencies, and believes states would benefit if federal officials were to offer convening opportunities to states.

State Snapshot

Vermont Blueprint for Health:* CHWs in Community Health Teams

CHW are part of Vermont's health transformation model. Vermont engages CHWs as members of Community Health Teams, which are local, multi-disciplinary teams that integrate primary and preventive care with social and economic support services. Community Health Teams partner with health care and social service organizations to support a primary care practice. As part of Community Health Teams, CHWs work alongside other professionals--such as mental health and substance abuse clinicians, social workers, and nutrition specialists--to help patients access the comprehensive services they need.

* <http://blueprintforhealth.vermont.gov>

- A federal official recommended that states consider using the independent, non-governmental Regional Health Equity Councils⁵ operating in each of the 10 HHS regions to advance their CHW initiatives. Some regional HHS offices already support convening around CHW issues.

In many states, CHWs are considered essential members of evolving team-based care approaches to improving the efficiency and effectiveness of transforming health systems.

Team-based care is widely recognized as critical to achieving the Triple Aim, and many see CHWs as important members of care teams who can help all members work to the highest level of their education and licensure.⁶ In many states, CHWs work alongside clinical providers to integrate and coordinate patient care in a culturally and linguistically appropriate manner. Some states believe that CHWs can help further transformation efforts aimed at making care more efficient and person-centered by connecting patients to a wide range of services and assisting with follow-up after a clinical visit. The Massachusetts Department of Public Health writes, "CHWs, as part of integrated care teams, contribute to cost-effective services that advance the Triple Aim."⁷

- Incorporating CHWs into team-based models of care has the potential to augment CHWs' role in emerging value-based and bundled payment models and minimize the reliance on grant funding to support CHW initiatives, according to one federal official.

Tension exists between states' desire for flexibility in defining CHW roles and the federal need to collect standardized data on CHW workforce to inform policy and workforce investments.

While states value the flexibility to define the roles of CHWs to meet the needs of their particular communities, that flexibility may be a barrier to collecting important data on the work of CHWs. The uniform Standard Occupational Code (SOC) classification for CHWs could help federal officials collect data and evaluate their effectiveness, as well as influence federal spending on workforce training. The U. S. Bureau of Labor Statistics updates SOCs once every ten years, and is currently working on a revision for the CHW SOC.⁸

- A federal official explained that a single occupational classification can encompass many different jobs and roles. For example, Promotores de Salud, community health educators, the Indian Health Service’s Community Health Representatives and others could all fall under the umbrella of the CHW occupation.

However, states’ desire for flexibility could complicate the potential for a uniform occupational definition to catalyze federal training funds and data collection. For example, some states do not use the title “Community Health Worker,” and do not want to regulate or standardize the roles CHWs play. Flexibility and guidance on CHW roles can both be helpful, said one state official who acknowledged the value of national efforts, such as the Community Health Worker Core Consensus (C3) Project, to build consensus around central CHW roles and skills.⁹

Determining the activities and competencies that set CHWs apart from other members of the health care workforce may also help policymakers define their roles and scope of practice. For example, nurses in some states expressed concern that CHWs would take away nursing jobs if scope of practice for CHWs were not clearly defined, or overlapped with nursing duties. Some policymakers believed that delegating some non-clinical tasks to CHWs could help nurses to practice at the top of their licensure.

- Confusion about CHWs’ roles and skills may be a barrier to their utilization, according to a federal official. If providers and program administrators struggle to understand how CHWs differ from other non-licensed health workers, they may be less likely to engage CHWs in initiatives that may otherwise have benefitted from CHW involvement.

Policymakers can align efforts to gather evidence on the impact of different CHW models on outcomes.

State and federal policymakers seek convenient, centralized access to comprehensive evidence on the effectiveness of CHW interventions. Although state demonstrations provide opportunities to develop evidence and collect data, the lack of a centralized source for evidence means that policymakers struggle to base their CHW initiatives on evidence-based best practices. While at least one federal agency currently gathers evidence on CHW effectiveness in condition-specific prevention programs, it is interested in identifying evidence on the effectiveness of CHWs as part of a comprehensive team.

Key Policy Implications

CHW Roles

- State and federal policymakers increasingly look to CHWs to increase health equity in transforming health care systems.
- Policymakers would benefit from greater communication about and understanding of one another’s cross-agency efforts to enlist CHWs in reducing health disparities and incorporate CHWs into state demonstration programs.
- Tension exists between states’ desire for flexibility in defining CHW roles and the federal need for a uniform definition to catalyze training funds and data collection.

State Snapshot

Massachusetts CHW Training and Certification

In order to advance the skills of the CHW workforce, the Massachusetts Department of Public Health (MDPH) has supported the establishment of CHW training centers throughout the state.*At the training centers, CHWs can build proficiency in the 10 core competencies identified by the MDPH Board of Certification of Community Health Workers. The Board is responsible for approving CHW training centers and certifying the CHWs who choose to apply for voluntary certification.

The 10 core competencies for CHWs in Massachusetts are**:

1. Outreach Methods and Strategies
2. Individual and Community Assessment
3. Effective Communication
4. Cultural Responsiveness and Mediation
5. Education to Promote Healthy Behavior Change
6. Care Coordination and System Navigation
7. Use of Public Health Concepts and Approaches
8. Advocacy and Community Capacity Building
9. Documentation
10. Professional Skills and Conduct

*For more information, see: <http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/prevention-and-wellness/comm-health-wkrs/>

**<http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/dhpl/community-health-workers/ma-board-of-certification-of-community-health-workers.html>

- Jointly developing a research agenda—possibly including common metrics—could help state and federal policymakers ensure that the evidence of what works informs future CHW initiatives.

Training and Credentialing

States value the flexibility to choose the approach to training and credentialing CHWs that works best for them. Some states require CHWs to meet certain competencies, some provide voluntary training, and some do not have statewide standards on training and credentialing.¹⁰ State and federal policymakers weighed the potential benefits of establishing training and credentialing standards against the potential challenges posed by such a system.

- In the absence of federal or aligned state standards, managed care organizations working across state lines may take the lead in establishing standardized CHW training and credentialing requirements.

Burdensome training and credentialing requirements could discourage members of underserved

communities from pursuing CHW careers, thus undermining the effectiveness of CHWs in promoting health equity.

States believe that the close relationships CHWs have with their communities benefit health transformation efforts. While state and federal policymakers acknowledge the importance of ensuring that CHWs have the skills and competencies needed to effectively serve their communities, policymakers are also concerned that requiring CHWs—many of whom are from low-income communities—to pay for their own training or credentialing would be a barrier to entry into the occupation. Similarly, a university-based training program might pose challenges to CHWs with limited English proficiency.

- A state official said that some policymakers want CHWs to be recognized as a profession, while others believe that a move toward professionalization would result in CHWs losing their sense of mission. Well-designed policy approaches could support professionalization while helping CHWs maintain their sense of mission, according to a state official.

- Hands-on apprenticeships with clearly defined learning objectives hold promise for training CHWs, according to some policymakers. While some states have been successful recruiting employers to participate in CHW apprenticeships, a federal official noted that apprenticeships depend entirely on the willingness of employers to participate and assign mentors to the CHWs. Such employer investment has historically been difficult to obtain.

The long-running Indian Health Service Community Health Representatives (CHR) program¹¹ may provide valuable lessons for state policymakers weighing the benefits and drawbacks of standardized certification and training for CHWs. The CHR training program includes opportunities for specialty training, as well as advanced training that may help CHRs work toward an Associate's degree.¹² Some states see a need for this sort of career development process for CHWs.

- One state recommended a tiered system for certification that would allow CHWs to work toward a more specialized certification in disease areas such as asthma or diabetes. However, other policymakers fear that such specialization could undermine CHWs' generalist focus on integrating and coordinating care and detract from CHWs' role as trusted members of the community.

Key Policy Implications

Training and Credentialing CHWs

- In crafting CHW training and credentialing requirements, policymakers balance the need to advance the skills of CHWs with the need to maintain their connection to underserved communities.
- Federal policy supporting a CHW career advancement process could help interested states develop CHW career trajectories.

Leveraging Funding Opportunities for CHWs

In the wake of national health care reform, states are leveraging a number of funding sources to transform their health systems—and these transformation efforts often incorporate CHWs. States fund CHWs through the State Innovation Models Initiative (SIM) and other state demonstrations, as well as through 1115 demonstrations and other funding streams. States are incorporating CHWs into care teams as part of Accountable Care Organizations (ACOs), Federally Qualified Health Centers (FQHCs), and advanced primary care initiatives, as well as training marketplace navigators as community outreach CHWs. In light of the federal guidance allowing Medicaid reimbursement of preventive services provided by CHWs (see text box on page 8), questions arise about next steps for financing CHWs through innovative payment mechanisms.

State and federal policymakers can more effectively share information about the uses of CHWs in state demonstrations such as SIM, ACOs, and health homes. Because there is currently no systematic way for federal officials to track states' financing and use of CHWs, it is difficult for policymakers to determine how they are used in state demonstration programs. It is challenging for states even to know how CHWs are being used within their own initiatives. For instance, it is a challenge for state SIM teams to be aware of and coordinate the different CHW activities within their own state with different funding sources.

- One state used SIM funding to bring together ACOs and patient-centered medical homes with local housing and public health officials to share information about their work addressing social determinants of health, including the use of CHWs.

CHWs and Community Health Needs Assessments

In some states, CHWs are funded with the community benefit funds available from charitable hospitals. As a condition of retaining their tax-exempt status, such hospitals are required to periodically conduct a community health needs assessment and develop a strategy for meeting community needs.* Some states are using this hospital funding to support CHW initiatives and determine needs that could be met by CHWs.

*See the IRS “New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act” at [https://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501\(c\)\(3\)-Hospitals-Under-the-Affordable-Care-Act](https://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act)

- State and federal policymakers could cooperate on a low-burden way for states and health plans to inform federal and state policymakers about their CHW use. One state suggested instituting a universal modifier on each claim that indicates whether or not a CHW was part of the intervention.

States that have engaged CHWs successfully as part of state demonstrations face challenges with sustaining their CHW initiatives. While CHW programs built with short-term funding may help build an evidence-based business case, they often don't have systems in place to sustain CHWs once grant funding ends. One state characterized CHW funding as starting with source funding, then moving to bridge funding, with a goal of securing permanent funding.

Determining the return on investment (ROI) for CHWs is a challenging but important priority for state and federal policymakers. While policymakers agreed that making the business case for CHWs was an important part of garnering support for CHW initiatives, they also acknowledged the challenges of determining ROI. For instance, some CHW initiatives aim to make longer-term changes in the health of populations. Such initiatives may not manifest positive health outcomes—and an accompanying reduction in costs—until years after the initiative has ended.

- Some federal population health initiatives—such as the CMMI Health Care Innovation Awards—attempt to show return on investment in three years,¹³ which is often not enough time for population health initiatives to yield substantial returns. Population health-focused CHW initiatives could benefit from a longer period over which to demonstrate ROI.

Attributing cost savings to a CHW initiative can also be challenging in states with multiple demonstrations occurring simultaneously. When many initiatives are taking place at once, it can be difficult to attribute savings to any one intervention. One state found that determining ROI for the use of CHWs among the Medicaid population was easier than finding ROI for private payers, whose enrollees tend to experience fewer disparities. Conveying to decision-makers the difference between those populations could help explain the role of CHWs in serving populations traditionally experiencing health disparities.

- At least one state shows ROI by looking at the costs avoided through CHW use. It is important to explain to decision-makers the basis on which ROI is calculated for CHW initiatives, so that they do not consider ROI solely in terms of money generated and available for other purposes.

Preventive Services Rule *

A CMS rule change allows Medicaid to reimburse for covered preventive services provided by unlicensed practitioners—such as CHWs—as long as a physician or other licensed practitioner recommends the services. States must amend their state plans in order to take advantage of the rule change, and amendments must include qualifications for non-licensed practitioners.

Formerly	Now
Preventive services provided by a physician or other licensed practitioner	Preventive services recommended by a physician or other licensed practitioner

* 78 Federal Register 42306; July 15, 2013. Available at <http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf>

State and federal policymakers could benefit from greater communication about the preventive Medicaid state plan amendments (SPA) option for financing CHWs. A CMS rule change (see text box) enabled states to amend their state Medicaid plans to allow reimbursement to CHWs for certain preventive services. While state policymakers appreciate the flexibility this SPA option gives them, state Medicaid agencies have not immediately shown great interest in using the preventive services SPA to finance their CHW initiatives. The tepid response of state officials can be attributed to several factors.

- States meeting their CHW needs through other funding sources may not believe that the burden of applying for a SPA is worth the effort. One state official said that Medicaid managed care plans were taking the lead on hiring CHWs and using them to achieve savings, so the state did not immediately need to invest the time in applying for the preventive services SPA.
- Another state used the 1115 waiver process to obtain the flexibility needed to fund its CHW initiatives.
- Some state Medicaid agencies also worry that a preventive services SPA may make them responsible for additional costs that may have been borne previously by managed care plans or other entities supporting CHW initiatives.
- The preventive services SPA may not be appropriate for the role of CHWs in a state's transforming system. This SPA covers preventive services only, not care coordination or the navigation or referral functions that CHWs often serve.

Federal flexibility has given states many opportunities to incorporate CHWs into SIM and other state demonstrations, and the preventive services SPA may help states sustain those CHW initiatives, if appropriate, once the demonstrations end. Greater communication between federal partners on the promise and limitations of the preventive services SPA could help further align federal flexibility with state needs. Cross-agency communication between state and federal partners could also help determine the most appropriate sources of funding for CHW initiatives involving services that are not traditionally reimbursed under Medicaid.

Looking Ahead

As more states incorporate CHWs into their health system reforms, state and federal partners could work together in a number of ways to more effectively and efficiently meet the goals of health systems transformation.

CHWs and the Medical Loss Ratio (MLR)

Some states were concerned that health plans using CHWs might run afoul of the Affordable Care Act's Medical Loss Ratio (MLR) requirement as a result of categorizing CHWs as administrative rather than clinical costs. The MLR requires plans to spend a specified percentage of revenue on clinical services and quality improvement, and penalizes those that spend too much on administrative costs.* However, state policymakers emphasized that the flexibility built into the MLR regulations makes this an issue that can be resolved. States seeking to involve health plans in their CHW initiatives could consider educating health plans on strategies for using CHWs in the context of the MLR.

*Information on the MLR is available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Inurance-Market-Reforms/Medical-Loss-Ratio.html>. See also the Kaiser Family Foundation's primer on MLR and Medicaid Managed Care Organizations: <http://kff.org/medicaid/fact-sheet/medicaid-mcos-and-medical-loss-ratio-mlr/>.

- State and federal policymakers can better align their efforts to jointly build an evidence base to guide policy on the use of CHWs.
- State and federal policymakers can improve data collection on CHWs. Efficient, systematic data collection efforts would help determine the size and training needs of the CHW workforce and inform policy on payment.
- Improved and sustained communication and shared learning—possibly including meetings, webinars, and educational materials—would help policymakers build an understanding of and shared evidence base for CHW engagement in health reforms.
- States and federal policymakers can improve information sharing about state engagement of CHWs in demonstration programs focused on improving health and controlling costs, such as SIM, ACOs, and health homes.

Key Policy Implications: Leveraging Funding Opportunities for CHWs

- A longer period over which to demonstrate ROI would be helpful for some CHW initiatives, particularly those with a population health focus.
- State and federal policymakers can communicate about ways Medicaid SPAs and other federal flexibility could more easily meet the needs of states and further the goals of federal policymakers.

Conclusion

In the wake of federal health reform, state and federal policymakers are advancing new models of care that reward quality, coordination, and efficiency above volume. As part of this transformation, health systems are increasingly addressing health equity and the social determinants of health, with an eye toward achieving the Triple Aim. Policymakers see great potential for CHWs to further those goals.¹⁴ Opportunities exist for state and federal partners to amplify the effectiveness of CHW programs by working collaboratively to improve cross-sector and cross-agency communication, standardize and streamline data collection, and build an evidence base for what works in CHW initiatives. By aligning their efforts, federal and state officials can maximize the potential of CHWs to meet entrenched health improvement challenges in the wake of health care reform.

End Notes

1. For more on the variety of state CHW models, see the NASHP State Reform chart, “State Community Health Worker Models” at <https://www.staterforum.org/state-community-health-worker-models>
2. http://www.cdc.gov/dhdsp/docs/chw_brief.pdf
3. <http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=36>
4. <http://minorityhealth.hhs.gov/npa/>
5. <http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=42>
6. See “Community Health Worker Integration Into the Health Care Team Accomplishes the Triple Aim in a Patient-Centered Medical Home: A Bronx Tale,” in the January-March 2014 Journal of Ambulatory Care Management, available at: <http://www.ncbi.nlm.nih.gov/pubmed/24309397>. See also the Institute for Healthcare Improvement’s May 16, 2014 blog post, “Team-Based Care: Optimizing Primary Care for Patients and Providers,” available at: <http://www.ihl.org/communities/blogs/layouts/ihl/community/blog/itemview.aspx?List=0f316db6-7f8a-430f-a63a-ed7602d1366a&ID=29>
7. <http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/achieving-the-triple-aim.pdf>
8. The SOC for CHWs is 21-1094: <http://www.bls.gov/soc/2010/soc211094.htm>
9. <http://www.chrllc.net/id12.html>
10. <https://www.staterforum.org/state-community-health-worker-models>
11. <http://www.ihs.gov/chr/index.cfm?module=mission>
12. <http://www.ihs.gov/chr/index.cfm?module=trainingArch>
13. <https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/>
14. <http://www.ihl.org/engage/initiatives/tripleaim/Pages/default.aspx>

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