Community Health Worker Model for Care Coordination

A Promising Practice for Frontier Communities

A report by the National Center for Frontier Communities prepared in consultation with the Frontier and Rural Expert Panel.

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As health care costs continue to skyrocket and states embark on Medicaid expansion as a result of health care reform legislation, the Centers for Medicare and Medicaid Services (CMS), state governments and others are looking for promising practices to improve health outcomes while containing health care costs. One promising practice is care coordination services, with growing evidence as an effective and efficient model to achieve desired health care outcomes, lower health care costs and improve patient health care experiences.

An increasing number of states and organizations, including several states with significant frontier areas, are looking at how community health workers (CHWs) can be utilized to carry out care coordination services. As the fields of care coordination and CHWs move towards more formalization there is great opportunity to further define the role of CHWs as care coordinators. These changes are currently taking place within an environment where integration of health care services and systems, provision of more and low/no cost preventive services and addressing social determinants of health are high on the agendas of federal and state governments. This paper takes an extensive look at the CHW care coordination model, how this model is applied in several frontier states and emerging issues relating to workforce development, regulation, funding and policy.

Information is presented regarding the background and evolution of both the CHW and care coordination models. An overview of policy, regulatory, financing and workforce development issues are discussed with examples on how these models are emerging in six frontier states: Alaska, Montana, Minnesota, New Mexico, Oregon and Texas.

Conclusions

Conclusions regarding the future development of the community health worker model for care coordination are as follows:

- There is no consensus among states and organizations on the core functions and scope of practice for CHWs.
- Five states have established CHW training systems and credentialing regulations based on state endorsed CHW core functions and scope of practice. At least six rural/frontier states are in the process of formalizing CHW workforce development
- There is growing interest among rural and frontier states to define and develop the care coordination function of CHWs.
- There is no standard definition for care coordination. Care coordination functions, roles and responsibilities of all team members need further clarification and integration.
- CHW-specific roles and functions are not widely recognized as falling within the realm of traditional, clinical care coordination. Within the general CHW core competencies, scope and functions care coordination needs to be clearly defined.
- The Affordable Care Act and other policies provide a promising and positive environment for the development and implementation of CHWs in care coordination models.

- A limited number of states provide Medicaid/ Medicare reimbursement if CHWs work under supervision of a licensed provider. Most CHW programs depend on grant or state funding.
- Some Medicaid/Medicare MCOs contract for care coordination functions, including services performed by CHWs.

1 Introduction

The distribution of health care spending in the United States is highly disproportionate, with half of US health care dollars spent on only five percent of the population.[1] Chronic conditions consume a high proportion of health care services, and if left uncontrolled, are expensive to treat and a major driver of increased health care spending.[2] As health care costs continue to skyrocket and states embark on Medicaid expansion as a result of health care reform legislation, the Centers for Medicaid and Medicare Services (CMS), state governments and others are looking for promising practices to improve health outcomes while containing health care costs.

Care coordination delivers health benefits to those with multiple needs by assisting individuals in identifying health goals, supporting healthy decisions and coordinating services and providers to meet those goals.[3] There is mounting research that indicates care coordination services result in improvements in health, costs, patient experience (including increased engagement in preventive care), increased self-management, higher self-reported health status, and decreases in individuals' health care costs. [add citation] As a result, there is a growing interest in care coordination as an effective and efficient model to achieve desired health care outcomes and greater equity among populations with the highest health disparities.

States with a significant number of frontier communities, such as Alaska, Arizona, New Mexico, Oregon and Minnesota, have come to rely on community health workers (CHWs) as key members of the health delivery system. Published scopes of service for CHWs show that certain functions—such as health education and chronic disease management--fall within the realm of "care coordination". A growing number of states and organizations are looking at how CHWs can be utilized to carry out care coordination services. As the fields of care coordination and community health workers move towards more formalization there is great opportunity to further define the role of CHWs as care coordinators. These changes are currently taking place within an environment where integration of health care services and systems, provision of more and low/no cost preventive services and addressing social determinants of health are high on the agendas of federal and state governments. This paper examines the CHW care coordination model, how this model is applied in several frontier states and emerging issues relating to workforce development, regulation, funding and policy.

2 Background

2.1 Community Health Workers (CHWs)

CHWs are known by a variety of names, including community health worker, community health advisor, outreach worker, community health representative (CHR), promotora/ promotores de salud (health promoter/promoters), patient navigator, peer counselor, lay health advisor, peer health advisor, and peer leader. There is currently no standard or nationally recognized definition of CHWs. Typically, CHWs are lay members of communities who work either for pay or as volunteers in association with the local health care system. They generally share ethnicity, language, socioeconomic status, and life experiences with the people of the communities or neighborhoods they serve.

In the 2011 document *Community Health Workers Evidence-Based Models Toolbox* published by the U.S. Department of Health and Human Services, Health Resources and Services Administration-Office of Rural Health Policy, CHWs are defined using the 2007 CHW National Workforce Study definition:

"Community health workers (CHWs) are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, Promotoras, outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening." (HRSA Community Health Workers National Workforce Study, 2007).

In a 2011 policy brief published by the Centers for Disease Control and Prevention titled, Addressing Chronic Disease through CHWs: A Policy and Systems-Level Approach,[4] the CDC defined CHWs using the American Public Health Association's definition[5]:

"A Community Health Worker (CHW) 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 CHW to serve 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.

"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."

In 2009, the U.S. Department of Labor Bureau of Labor Statistics created a Standard Occupational Classification (SOC) with a distinct occupation code for CHWs (code # 21-1094). The U.S. Department of Labor definition of the CHW is:[6]

"Assist individuals and communities to adopt healthy behaviors. Conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs. Excludes "Health Educators" (21-1091)."

2.1.1 Roles and Settings for CHWs

The existing literature shows a wide diversity of roles and responsibilities for CHWs. Published programs require that CHWs provide various functions, including health education, chronic disease management, community advocacy, outreach and enrollment. The role of the CHW is often impacted by the community conditions of the target population with which they work and can include primary health, behavioral health (e.g. mental health, substance abuse, domestic violence, etc.) and human services (e.g. homeless and migrant populations). For example, if the CHW program is designed to support individuals with chronic health conditions such as hypertension or diabetes, the CHW may function more as a health educator or care coordinator. If, however, the program is designed to improve community access to health services the CHW may provide more outreach, enrollment, patient navigator and community advocacy functions.

Entities most likely to employ CHWs in the United States include: 1) primary care clinics, 2) community non-profit social service agencies, 3) public health offices, and 4) university-based

programs. Under clinic-based services, the functions performed by the CHW can take place within the clinic, in the community or in the patient's home. The range of roles provided by clinic-based CHWs may include community outreach, advocacy, insurance enrollment, health education, care coordination, etc. In some cases the CHW is a recognized member of the treatment team. The advantage to the clinic setting is that CHWs have easy access to patients and providers. More and more clinical settings have electronic medical records where the CHW can monitor patient registries to identify high-risk patients or track patient activity such as referrals, preventive care appointments and medication.

CHWs operating in community non-profit social service organizations or public health offices take on a variety of different roles and functions depending on the needs of the community. In these settings the CHW's role may involve more community advocacy and outreach, especially to uninsured or high-risk populations who may not have access to necessary services.

The role of a CHW in the community often depends on the sector in which they work (social services, health clinic, public health, etc.), the services they provide to patients/clients (advocacy, outreach, education, clinical support services), and the skills and competencies required for the position (communication, cultural competence, training, professional experiences, education). The field is continuously affirming core competencies and roles for CHWs as it grows and develops.

The role of CHWs in coordinating care is high on the national healthcare, human services and health equity agenda and many states are taking note. The *Community Health Workers Evidence-Based Models Toolbox*[6] grouped CHW roles into the six categories, including "care coordinator/manager" and "member of the care delivery team". In the course of building a system for CHW workforce development states must define core competencies and roles; the states of New Mexico, Oregon, New York, Montana and Minnesota all include provisions for CHW direct service and/or some aspect of care coordination.

2.1.2 Defining Care Coordination

The less healthy the patient, the more likely he/she is to have multiple diagnoses, multiple doctors and multiple medications, which increases the need for care coordination. The population living with chronic conditions is steadily increasing. In 2000, 125 million people were living with at least one chronic illness; this number is expected to grow to 157 million by 2020. By 2030, half the population will have one or more chronic conditions. Currently, half of all people with chronic conditions have multiple chronic conditions.[7]

Care coordination in itself is a complex function involving communication and coordination at various levels and within various domains. There is no one standard definition for care coordination; however, the term often includes disease management, case management and transitional care, among others.[8] The primary setting for delivery of care coordination services may include physician offices, disease management organizations, inpatient, skilled/specialty clinics, and acute and long-term care. Services can also be either community-based or home-based. Providers of care coordination services vary greatly within and among organizations and may include physicians (e.g. provider-to-provider communication within primary care practice, between primary care and specialists, among other clinical team providers, etc.), nurses, social workers, therapists, discharge planners, CHWs, patient navigators, etc.

The National Quality Forum, (NQF) is a nationally recognized non-profit organization contracted by the U.S. Department of Health and Human Services to recommend goals and key measures for priorities in the National Quality Strategy. One of the six priorities is "promoting

effective communication and coordination of care". NQF has undertaken several projects to provide guidance and measurement of care coordination, including a 2006 project that yielded an endorsed definition and framework for care coordination. NQF has defined care coordination as a "function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites that are met over time." The framework for examining and understanding care coordination identified five key domains: healthcare "home"; proactive plan of care and follow-up; communication; information systems; and transitions or handoffs. A project completed in 2010 endorsed 25 care coordination practices and 10 performance measures that can be found at: http://www.qualityforum.org/projects/care_coordination.aspx.

The appropriate use of CHWs needs to be clearly defined within the range of care coordination functions. Defining the scope and limits of care coordination for CHWs is evolving within both the CHW workforce development movement and within primary care organizations.

2.1.3 Care Coordination versus Case Management

There is often confusion between the overlapping services of case management and care coordination. A 2009 Commonwealth Fund publication[9] defines case management as a process that tends to be focused on a limited set of predetermined diseases or conditions and guided by potential health care cost savings. The process can include assessment, planning, implementation of services, monitoring, and subsequent reassessment. Traditionally, case management services provide services in a benefits package, often supported by a health plan or managed care organization. Individuals who receive case management typically require services likely to result in high costs and have complex medical needs.

In contrast, care coordination can be provided to any patient and includes a range of medical and social support services beyond medical case management. The goal of care coordination is to help link patients and families to services that optimize outcomes articulated in a patient-centered care plan. In addition to case management services, care coordination may also address the social, developmental, educational, and financial needs of patients and family. Care coordination often includes activities that may or may not be covered by defined benefit packages offered by managed care organizations.[9]

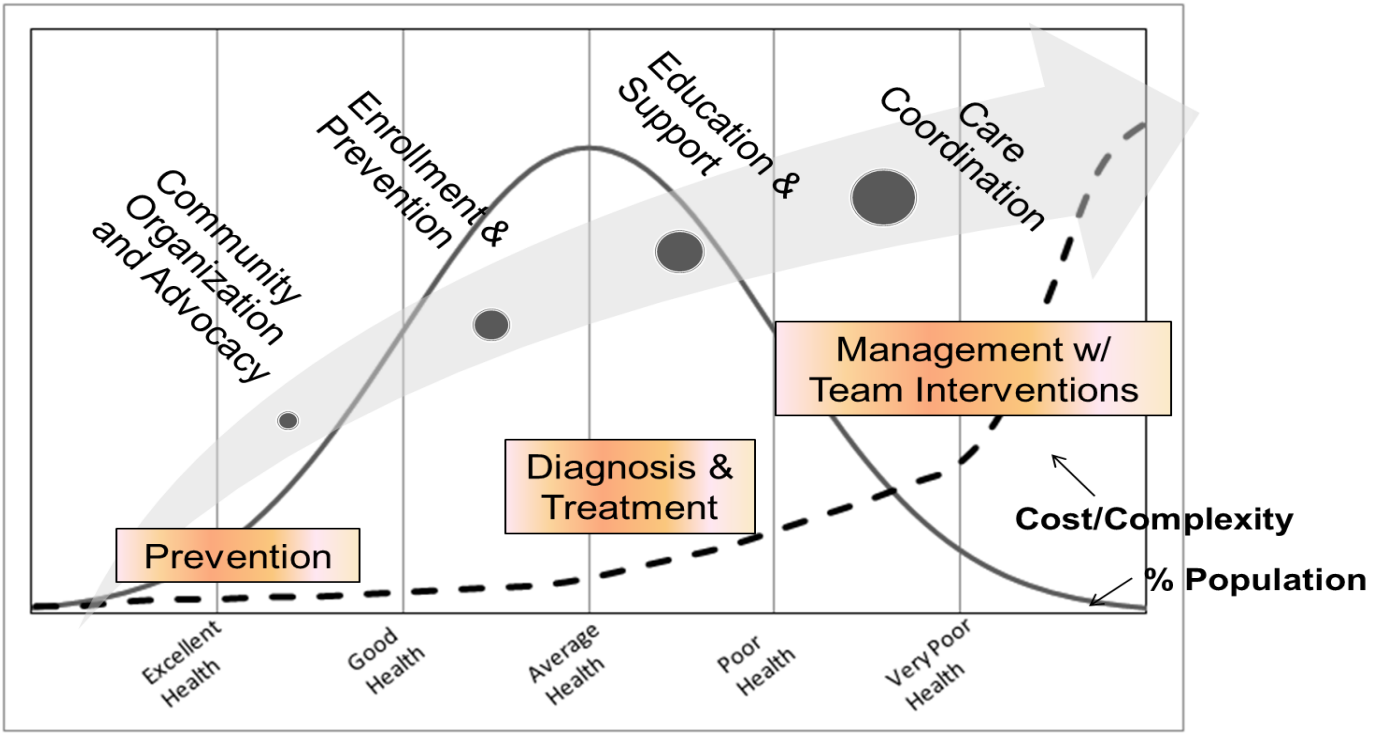
2.1.4 Community Health Worker as Care Coordinator

The focus of this paper is to address the growing interest in the use of CHWs to provide care coordination services and to identify what rural states are doing to define an appropriate scope of practice and to develop, train and supervise the CHW workforce to carry out care coordination services. As described above, care coordination is just one of several functions that can fall within the CHW scope of practice. Depending on the organization and need, a CHW may perform care coordination as their primary focus or in combination with other CHW functions.

A range of care coordination services is found in various healthcare delivery models. CHWs are being called upon more and more to engage patients and family members, to guide culturally and linguistic appropriate services, to help patients navigate the complex health care system, and for health education and chronic disease management. CHW care coordinators can be part of health care teams or operate independent of a team, often providing education or guidance in a disease specific area. Care coordination functions take place in clinic and hospital settings as well as community settings separate from the medical setting, such as a public health department, community non-profit organization and home visits. CHW care coordination will typically start with some form of case identification followed by an intervention to attempt to produce better health outcomes. CHWs and care coordination are critical parts of the health system or team especially in

high need frontier shortage areas. Figure 1 shows how functions of the CHW can vary depending on patient health status.

Figure 1: Functions of CHWs along the health continuum



Source: C. Alfero, Hidalgo Medical Services, Center for Health Innovations. 2012

3 CHW Model of Care Coordination as an Emerging Evidence-Based Practice

A recognized benefit of the role of CHWs in providing care coordination is that they are in a unique position to bridge connections between providers, patients, family members, communities and resources. The effectiveness of CHWs in promoting the use of primary and follow-up care for preventing and managing disease have been extensively documented and recognized for a variety of health care concerns, including asthma, hypertension, diabetes, cancer, immunizations, maternal and child health, nutrition, tuberculosis, and HIV and AIDS.

A policy brief on CHWs released by the Centers for Disease Control and Prevention in 2011[4] provides evidence supporting the involvement of CHWs in the prevention and control of chronic disease:

- Integrating CHWs into multidisciplinary health teams has emerged as an effective strategy for improving the control of hypertension among high-risk populations.[10,11]
- Several studies have documented the impact that CHWs have in increasing the control of hypertension among urban African American men.[8,9]
- A recent review examined the effectiveness of CHWs in providing care for hypertension and noted improvements in keeping appointments, compliance with prescribed regimens, risk reduction, blood pressure control, and related mortality.[9]

- After 2 years, African American patients with diabetes who had been randomized to an integrated care group consisting of a CHW and nurse case manager had greater declines in A1C (glycosylated hemoglobin) values, cholesterol triglycerides, and diastolic blood pressure than did a routine-care group or those led solely by CHWs or nurse case managers.[12,13]
- In reviewing 18 studies of CHWs involved in the care of patients with diabetes, Norris and colleagues found improved knowledge and lifestyle and self-management behaviors among participants as well as decreases in the use of the emergency department.[14]
- Interventions incorporating CHWs have been found to be effective for improving knowledge about cancer screening as well as screening outcomes for both cervical and breast cancer (mammography).[15] Interventions incorporating CHWs have shown improvements in asthma severity and in reduced hospitalizations.[16,17]

Further evidence of the promising role of CHWs as care coordinators appears in two Institute of Medicine reports. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2003) recommends including CHWs in multidisciplinary teams to better serve the diverse U.S. population and improve the health of underserved communities as part of a strategy for improving health care delivery, implementing secondary prevention strategies, and enhancing risk reduction.[18] The second report, *A Population-Based Policy and Systems Change Approach to Prevent and Control Hypertension* (2010), recommends that the Centers for Disease Control and Prevention (CDC) Division for Heart Disease and Stroke Prevention work with state partners to bring about policy and systems changes that will result in trained CHWs "who would be deployed in high-risk communities to help support healthy living."[19]

Finally, a recent study of care coordination services provided by CHWs to high cost Medicaid patients in New Mexico showed a substantial reduction among the CHW-intervention group compared to the non-intervention group in emergency room, in-patient, prescription, and narcotic drug utilization and cost. Total cost savings was over $2 million post intervention, compared to an estimated total program cost of $521,343.[20] This 25-month study was a partnership between Molina Healthcare of New Mexico, the University of New Mexico and Hidalgo Medical Services. Molina is now expanding the program in half the counties in NM and will implement the program in 10 states in which they operate.

4 A Promising Practice for Frontier Areas

Some of the most severe health care professional shortages are in rural and frontier areas. Almost all frontier areas are designated as Health Professional Shortage Areas (HPSAs) and are short of primary health care providers of all kinds, including medical, dental and behavioral health. As a result of expanded coverage in the Patient Portability and Affordable Care Act, primary care will be in even greater demand and access to primary care in the frontier may be even more strained. It will be critical that all licensed health professionals be used at the full capacity of the scope of their training. This will require systems change whereby providers are supported by people who can do things that the provider traditionally did themselves, such as following up on whether a patient picked up their prescription, went to the subspecialist, is compliant with diet and exercise regimes, has appropriate access to social services, etc. The CHW as care coordinator is a good candidate to provide these services, particularly in rural and frontier communities.

CHWs are well positioned to facilitate access to health care, improve health status and advance the quality of life in frontier communities by contributing to the delivery of primary and preventive care. CHWs can facilitate the connection between the patient, health services and other

community resources as well as those outside of the frontier area. CHWs are frequently members of the communities that they serve and are adept at building community capacity and ensuring the delivery of culturally competent services. Since members of frontier communities can be highly connected, CHWs have a greater opportunity to develop relationships with consumers and to serve as a liaison between the patient, providers and the community. Moreover, CHWs can serve a critical role in frontier communities when patients transition between receiving care within and outside of their home communities.

Several rural/frontier states have moved to formalize and endorse CHW programs. The evolution of the CHW systems in six frontier states is summarized below.

4.1 Alaska

4.1.1 State Infrastructure and Policy

- The Alaska CHAP Certification Board was created in 1998 by the federal government and charged with formalizing standards and procedures for Community Health Aide, Dental Health Aide and Behavioral Health Aide training, practice and certification. The Certification Board's function is to certify training centers and individual aides at all levels of training.

4.1.2 Certification/Supervision

- CHAP certification requires completion of a state-sponsored training curriculum for employment in specific health services programs such as the Community Health Aide/Practitioner program and the Alaska Native Tribal Health Consortium.
- A required preceptorship is coordinated by the employing tribal health organization, in consultation with the training center where the CHA completed Session IV. The purpose of the preceptorship is to evaluate and strengthen the CHA's clinical skills. During the preceptorship (minimum of 30 hours), the CHA provides direct patient care for a minimum of 15 patients while being observed and evaluated by a mid-level practitioner or physician preceptor. The CHA must also complete a Critical Skills Checklist during the preceptorship.
- Of the estimated 550 CHA/Ps working throughout Alaska, the CHAP Certification Board as of March 2012 certified 351.

4.1.3 Financing System

- CHAP was initially federally funded, with formal training standards established, in 1968. Today, funding to support CHAP is generally through the Indian Health Service, the Denali Commission (a federal agency) or federal Community Health Center funding,

4.1.4 CHW Workforce Development

- The Community Health Aide Program (CHAP) in Alaska consists of a network of approximately 550 Community Health Aides/Practitioners (CHA/Ps) in over 170 rural Alaska villages. The scope of practice for CHA/Ps is defined by the guidelines of the 2010 Alaska Community Health Aide/Practitioner Manual.
- The successful completion CHA Basic Training is required to become a Community Health Practitioner (CHP) and CHA credentialed. There are four CHA Basic Training sessions, divided into three sessions of 160 hours each and one session of 120 hours. Following each session, the CHA returns to the village clinic to provide patient care (clinical hour requirement), which is included as part of Basic Training. The CHA receives field follow-up by the Coordinator Instructor or Supervisor Instructor (CI/SI), for knowledge/skill reinforcement and evaluation. The Alaska Community Health Aide/ Practitioner Manual,

2010 Edition, referred to as the CHAM, is taught and reinforced throughout all aspects of training. CHAs are expected to use it during each patient encounter throughout their career.

- Cost of the Basic Training curriculum is $200.00.
- The Basic Training curriculum is delivered through four CHA training centers so that attendance at any training center will prepare students at the competency level required of the session.

Table 1: Requirements for Alaska Community Health Aide Program (CHAP) Certification

	Session I			Session II			Session III			Session IV			
	Class	Skills	Clinic	Class	Skills	Clinic	Class	Skills	Clinic	Class	Skills	Clinic	Total
Hours per Unit per Session	57.75	59.25	26	62.25	51	31	42.75	34.75	26	57	45.75	34	527.50
Hours per Session		143.00			144.25			103.50			136.75		527.50
Orientation Time		2.00			1.00			1.00			1.00		5.00
Evaluation Time		14.00			14.00			14.00			14.00		56.00
Total Hours		159.00			159.25			118.50			151.75		588.50

Source: Community Health Aide Program Alaska, Community Health Aide Basic Training Curriculum, June 2010

4.2 Minnesota

4.2.1 State Infrastructure and Policy

- A provision for CHWs passed the Minnesota legislature in May 2007.
- To create the new CHW profession, the Healthcare Education Industry Partnership (HEIP), a project of the Minnesota State Colleges and Universities system, began working in 2003 with a coalition of rural and urban health care systems, Blue Cross and Blue Shield Foundation of Minnesota, The Robert Wood Johnson Foundation and other groups.

4.2.2 Certification/Supervision

- CHW approved services that are billable under CMS must be under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government, dentists, or a mental health professional
- As of May 2012 over 500 CHWs are certified.

4.2.3 Financing System

- Funding Partners: Blue Cross Blue Shield of Minnesota Foundation, UCare Minnesota, Health Partners, Minnesota Department of Health, Otto Bremer Foundation, Robert Wood Johnson Foundation Local Initiative Funding Partners, Fairview Health Services,

Delta Dental of Minnesota, Minnesota State Colleges and University System, Minneapolis Foundation, Randy Shaver Foundation, Susan B. Komen Foundation, Mayo Clinic.

- A State Plan Amendment was approved by Centers for Medicare and Medicaid Services in December 2007 allowing for the reimbursement of providers for services provided by CHWs if:
  - Provider is a registered Medicaid provider
  - Services are provided under medical supervision
  - CHW has completed training following a standard curriculum
  - CHW must register as a Medicaid provider and may not bill the State directly
  - CHW may be an employee OR contractor of the billing provider
- CHWs can bill Medicaid for certain services (e.g. care coordination and patient education). Billing limits apply; for example, no more than eight 30-minute units per patient per month can be billed.
- MN payment legislation included CHW care coordination but the state Medicaid agency opted to seek federal approval for diagnosis-related health education services only and to postpone care coordination payment until there could be further study and definition.

4.2.4 CHW Workforce Development

- By 2005, the HEIP had established an 11-credit CHW certificate program. In addition to being taught at five sites in Minnesota, the curriculum has also been sold to (over 30) organizations outside of Minnesota. The cost of the training manual is $400.
- Training Requirements: Core Competencies (9 credit hours or 405 contact hours[*]); Health Promotion Competencies (3 credit hours or 135 contact hours); Practice Competencies – Internship (2 credit hours or 90 contact hours). A total requirement of 630 contact hours.
- Six course components in the state's curriculum reflect entry-level Core Competencies. The six components include: (1) the CHW Role, Advocacy, and Outreach; (2) Organization and Resources (Community and Personal Strategies); (3) Teaching and Capacity Building; (4) Legal and Ethical Responsibilities, (5) Coordination, Documentation, and Reporting; and (6) Communication and Cultural Competence.
- Must complete a standard state recognized curriculum and obtain a certificate from one of the designated training institutions. 14 credit hour certificate. . Must be certified and credentialed with
- Certification fees 25 plus $100 testing fee (often paid by employers)
- An online version of Minnesota's standardized CHW curriculum is under development and will be piloted beginning the summer of 2012.

4.3 Montana

4.3.1 State Infrastructure and Policy

- In 2011, Montana received the Frontier Community Health Care Coordination Network grant. The project is a joint venture with Montana DPHHS, MHREF, Montana Office of Rural Health and the Frontier Community Health Workgroup. The goal of the project is to improve health care transitions and care coordination for Medicare beneficiaries and other residents for frontier communities.

[*] Based on 45 contact hours per credit hour.

- The model is a network approach consisting of eight frontier Community Access Hospital communities that are part of the Montana Care Coordination Network.

4.3.2 Certification/Supervision

- The eight CHW care coordinators are under the supervision of the Care Transitions Coordinator, a clinically trained registered nurse. The Care Transitions Coordinator is responsible for the assessment, planning, implementation, coordination and monitoring of options and services provided by the CHW care coordinators to meet patient medical and health care needs in the community and home settings. This position is also responsible for setting up data collection and analysis systems to evaluate effectiveness of network activities and patient health outcomes.

4.3.3 Financing System

- Frontier Community Health Care Coordination Demonstration Grant (HRSA-11-202)

4.3.4 CHW Workforce Development

- The CHW care coordinators are non-clinical paraprofessionals who focus on chronic disease management and linking a select panel of patients with services to achieve selected health outcomes and to decrease hospitalizations and emergency room visits.
- Specialized training is being developed in coordination with the Montana Office of Rural Health/State AHEC office. To inform the content of the training, a meeting was held in April 2012 with the CEOs of the Community Access Hospitals to identify core competencies and focus of practice for the CHWs. A 20-hour training was delivered in June 2012. Continuing education is being developed. The use of distance learning, such as webinars and peer learning are training methods being considered.

4.4 New Mexico

4.4.1 State Infrastructure and Policy

- In 2003 senate joint memorial 073 was passed to conduct a feasibility study to develop a CHW system.
- A state advisory council consisting of many CHWs was established to inform the development of a statewide CHW system. The advisory council reports to the NM Department of Health. Advisory council workgroups include: 1) public awareness campaign, CHW workforce assessment, establish funding and standardize competency-based training.
- The Office of CHWs was established in New Mexico Department of Health in 2008. The office is currently working on a standardized definition and curriculum for CHWs in New Mexico that includes various titles such as promotores, navigators, and Community Health Representatives (typically found in the Indian Health Service system).

4.4.2 Certification/Supervision

- Certification of CHWs will be voluntary, not required.

4.4.3 Financing System

- As of 2012, there are three Medicaid Managed Care Organizations (MCOs) in New Mexico that contract with local entities to provide care coordination services by CHWs to plan beneficiaries. These entities are reimbursed by the MCOs on a fee-for-service or capitated rate based on number of beneficiaries receiving services.

- Molina Health Care of New Mexico has used the CHW care coordination model since 2006 with positive results in patient health outcomes and cost savings. Molina has contracted with the University of New Mexico to develop a care coordination curriculum to be used in 10 additional states where Molina operates.
- The New Mexico Medicaid Assistance Division allows for reimbursement of care coordination by CHWs through contracted agreements between Medicaid Managed Care Organizations and selected providers.
- In 2009, NM applied to CMS for approved reimbursement of Community Support Workers who work under the supervision of a mental health professional to provide Comprehensive Community Support Services (CCSS) to Medicaid patients with a behavioral health diagnosis. CCSS training is a minimum of 20 hours per year.

4.4.4 CHW Workforce Development

- The Office of CHWs is in the process of developing a standardized, comprehensive training curriculum consisting of 10 core competencies. Although still in the planning stage and not finalized, state certification requirements are estimated to include approximately 100 classroom hours and 100 field experience hours.
- The State plans to establish a statewide panel or committee consisting of CHWs and other experts who will review and endorse CHW training curricula developed by other entities throughout the state. CHWs may complete any state-endorsed curricula to meet certification requirements.
- The State plans to introduce legislation in 2013 to request state funding for the development and maintenance of the state CHW training and certification system.
- Goal is to fully integrate CHWs into the health care system.
- Certification DOH/OCHW is establishing a registry of CHWs in NM to bring recognition of CHW as an emerging workforce. Identifying current
- Other key features of certifying program demonstrate competencies, offered in multiple formats, including universities or community settings; offered for minimal cost to CHWs
- Large scale systems change, including 5 areas

4.5 Oregon

4.5.1 State Infrastructure and Policy

- In 2011, the Oregon Legislature passed House Bill 3650, to inform the development of an Oregon Integrated and Coordinated Health Care Delivery System. Section 11 of HB 3650 directed the Oregon Health Authority to develop and establish with respect to community health workers and other non-regulated health care workers (a) criteria and descriptions of such individuals that may be utilized by coordinated care organizations; and (b) education and training requirements for such individuals.
- Final reports with findings and recommendations were delivered to the Legislature in January 2012.

4.5.2 Certification/Supervision

- Recommendations regarding certification made by the non-traditional health worker subcommittee of the Oregon Health Policy Board include: (a) certify training programs that include the Subcommittee's recommended required core competencies and core curriculum; (b) require statewide oversight of training programs which will include the maintenance of a registry and/or certification records, ethic violations, workforce advocacy and training for health care providers and systems on effective utilization of non-traditional

health workers; (c) develop a statewide training advisory panel to guide and support to ensure uniform statewide standards for training; (d) provide certificate of completion that will be required to enroll as a provider for reimbursement; (e) review and renew the certificate programs every three years and (f) provide incentives for coordinated care organizations to develop internal agency plans for supervision and support of non-traditional health workers. Require supervision of non-traditional health workers by licensed health care professionals, licensed behavioral health professionals and Masters level public health workers.

4.5.3 Financing System

- Currently the primary source for CHWs and other non-traditional health worker services is grant funding.
- A December 2011 report from the Oregon Healthcare Workforce Committee to the Oregon Health Policy Board recommended that the state establish and expand pilot programs to test alternative payment models such as global budgets for Coordinated Care Organizations, bundled payments for acute, post-acute care and salaried providers, and to provide opportunities for multi-payer alignment around promising models of flexible, outcomes-focused reimbursement.

4.5.4 CHW Workforce Development

- In January 2012 the non-traditional health worker subcommittee of the Oregon Health Policy Board presented recommendations for core competencies and education and training requirements for CHWs, peer wellness specialists and personal health navigators. The Subcommittee defined the scope of work under the following four roles: (1) outreach and mobilization; (2) community and cultural liaising; (3) case management, care coordination and systems navigation; and (4) health promotion and coaching. The report presents specific competencies and education and training recommendations each of these roles.[21] The exact number of hours and methods are still under discussion, however, a minimum 80 core curriculum contact hours are currently recommended with additional contact hours adequate to comer supplemental training for specific worker types, practice settings or jobs.

4.6 Texas

4.6.1 State Infrastructure and Policy

- In 1999, House Bill 1864 established the Promotor(a) Program Development Committee. In 2001, Senate Bill 1051 directed the Texas Department of State Health Services (DSHS) to develop a training and certification program for promotores or CHWs.
- 2001 SB751 required that State HHS agencies used certified CHWs.
- The Texas Health and Safety Code – Chapter 48, provides authority to the Texas Department of Health (now DSHS) to establish and operate a certification program for community health workers and in 2001 the Texas CHW Training and Certification Program was implemented which provides certification for CHWs, instructors and training programs.
- A CHW Training and Certification Advisory Committee was established which advises DSHS and the Texas Health and Human Services Commission (HHSC) related to the training and certification of persons working as CHWs. The 9 member Committee consists of 4 certified CHWs, 2 public members, 1 member with experience in adult education and training of CHWs, and 2 professionals who work with CHWs.

4.6.2 Certification/Supervision

- Texas requires certification for Promotores or Community Health Workers receiving compensation for services provided
- CHW certification is for a 2-year period with 20 hours of continuing education training per year.
- As of April 1, 2011 there are over 1300 certified Promotores or Community Health Workers located in 94 counties – all Health Service Regions (HSR) [Insert # of frontier counties with certified CHWs]

4.6.3 Financing System

- No direct reimbursement to CHWs. Texas health and human service agencies are required to use certified CHWs for outreach and education programs for medical assistance.

4.6.4 CHW Workforce Development

- Certification requires eight core competencies as identified by the National Community Health Advisory Study. Core competencies include: communication skills, interpersonal skills, service coordination skills, capacity-building skills, advocacy skills, teaching skills, organizational skills, and knowledge base. 20 hours of training is required for each of the core competency areas for a total of 160 hours.
- Certification requirements for CHWs include completion of an approved 160-hour competency-based training program certified by DSHS, OR experience consisting of at least 1000 cumulative hours of community health work services within the most recent six years. Recertification requirements include 20 contact hours of continuing education every two years including at least 10 contact hours of continuing education certified by DSHS.
- Instructor requirements include completion of a 160-hour instructor/trainer program by an approved sponsoring institution or training program certified by DSHS, OR experience consisting of at least 1000 cumulative hours of instruction provided to Promotores or CHWs within the most recent six years.
- Sponsoring Institutions/Training Programs must have Committee approved curricula based on core competencies. They must be recertified every two years.
- Texas DOH certifies CHW training programs. Currently there are 20 training programs available throughout the state. No fees are charged to CHWs to get certified.

5 Regulatory, Policy, Workforce Development and Funding Issues

5.1 Regulatory Issues

5.1.1 Standards for Community Health Workers

There is no consensus among states and organizations on the core functions and scope of practice for CHWs. A handful of states have moved forward in validating the CHW field by establishing standards and identifying specific competencies, skills and training required for certification or other type of recognition as a CHW. State training standards vary considerably with training requirements ranging from 40 hours to over 600 hours.

A challenge for states in the development of a CHW workforce is how to create a system for implementing, supervising, maintaining and enforcing CHW standards of practice. Rural states such as Minnesota, Alaska and Texas have taken a lead in developing statewide systems to track, train, supervise and certify CHWs and training providers. Other rural states such as New Mexico, Oregon and Arizona have state designated offices or committees that are working towards developing a formalized system for CHW workforce development, training and oversight.

5.1.2 Standards for Care Coordination

Several states, including Oregon, Washington and New Mexico, have mandated that Managed Care Organizations (MCOs) develop care coordination services to ensure that medical and social needs are identified and met although there is no requirement that CHWs be used in this capacity. Oftentimes care coordination requirements are in the form of an "800" number assistance line for plan members. In addition, the proposed Medicaid managed care rule implementing the Balanced Budget Act (BBA) of 1997 requires states to ensure that each MCO meets requirements related to continuity and coordination of care.[22] Despite this requirement, there is no standard definition or minimal requirements for the continuity and coordination of care. Hence, MCOs are free to determine how and to what degree care coordination will take place.

Currently, both CHW and care coordination formalized training programs focus on the skills and knowledge of recognized core competencies developed by state or organizational entities. As the CHW care coordination model becomes more popular, there is a need to develop skills and knowledge specific to the care coordination function and integrate it into existing training programs.

5.1.3 Credentialing and Supervision

In a number of communities the CHWs receive brief training, a minimum of supplies and little supervision. They often work on the periphery of health care service areas, usually at some distance from health facilities. For these reasons, it is critical that as the care coordination role for CHW is developed and formalized that there is strong management and supportive supervision through the implementation of clear reporting structures and frequent consultations between the CHWs and other health care professionals who serve as leaders of integrated health care teams. There is concern among current health care providers that the absence of a structured management and supervision system, CHWs could exceed the limits of their training and have ill-defined ownership and accountability.[23]

A major area of disagreement among CHW organizations is whether or not to establish minimum standards and required credentialing. Some argue that requiring minimum training standards takes away the "essence" of the CHW and that many CHWs may not be willing or able (due to language, money, time or other barriers) to fulfill such requirements. On the other hand, there needs to be some means of demonstrating that CHWs have the skills and competencies to perform their role and a clear understanding of their scope of practice, especially when it comes to care coordination functions that may have traditionally been performed by licensed medical staff. This line of reasoning is particularly true when the CHW is being reimbursed through Medicaid or other public funding and when integrating CHWs into the healthcare treatment team.

5.2 Policy Issues

5.2.1 Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) of 2010 include provisions relevant to CHWs that are to become effective during the next four years. Section 5313, Grants to Promote the Community Health Workforce, amends Part P of Title III of the Public Health Service Act (42 U.S.C. 280g et seq.) to authorize CDC in collaboration with the Secretary of Health and Human Services to award grants to "eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers" using evidence-based interventions to educate, guide, and provide outreach in community settings regarding health problems prevalent in medically underserved communities; effective strategies to promote positive health behaviors and discourage risky health behaviors; enrollment in health insurance; enrollment and referral to appropriate health care agencies; and maternal health and prenatal care.

The ACA states that a CHW is "an individual who promotes health or nutrition within the community in which the individual resides: a) by serving as a liaison between communities and health care agencies; b) by providing guidance and social assistance to community residents; c) by enhancing community residents' ability to effectively communicate with health care providers; d) by providing culturally and linguistically appropriate health and nutrition education; e) by advocating for individual and community health; f) by providing referral and follow-up services or otherwise coordinating; and g) by proactively identifying and enrolling eligible individuals in Federal, State, and local private or nonprofit health and human services programs." The evidence shows that CHWs are well positioned for success because they already provide many and in some cases all of these services.[24]

The ACA also created the Center for Medicare and Medicaid Innovation (CMI) with a budget of $10 billion over the course of its first ten years. The CMI mandate calls for testing several alternative models of care. The following examples encourage the use of care coordination activities to improve health outcomes and reduce unnecessary health care utilization:

- Patient Centered Medical Homes – CMS endorses the National Quality Forum certification standards for PCMH, which includes care coordination of one of six key domains.
- Test care coordination models—including Community-Based Care Transition and Independence at Home—without necessarily going through CMI.
- Establish a Medicare accountable care organization (ACO) program by January 1, 2012. Although the regulations governing the program have yet to be finalized, the basic idea is to make providers accountable for the quality and cost of care of their Medicare patients and to incentivize them by passing on a portion of the savings that accrue when the per capita expenditures of their Medicare beneficiaries are a sufficient percentage below a specified benchmark amount. (There are no penalties for failure to realize savings.)
- Establish a Medicare pilot program to evaluate the use of bundled payments to cover all the inpatient hospital and post-acute care services provided to a patient for one episode of illness. Medicare will recover payments made for unnecessary readmissions within 30 days of hospital discharge after a stay for heart attack, chronic heart failure, and pneumonia (with the list of conditions to be gradually expanded).[25]

5.2.2 National Strategy for Quality Improvement in Health Care

The National Strategy for Quality Improvement in Health Care (National Quality Strategy) is an important element of the Affordable Care Act and a roadmap for improving the delivery of health care services, patient health outcomes, and population health. The Affordable Care Act calls on the Secretary of HHS to "establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health." HHS enlisted the National Quality Forum (NQF) to recommend goals and key measures for each of the six National Quality Strategy priorities. The NQF is an independent nonprofit organization that refines and endorses standards and measures of health care quality through a national consensus based approach. In March 2011, HHS released the inaugural report to Congress establishing the National Quality Strategy's three aims of better care, healthy people/healthy communities and affordable care. To advance these aims the focus will be on six priorities:

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

The NQF has identified care coordination as one of its priority areas and has initiated projects to identify best practices and quality measures on this topic. This work presents opportunity for the CHW model to be recognized as a potential best practice in advancing the aims of the National Quality Strategy.

5.2.3 Health Equity

Although health indicators such as life expectancy, chronic disease and infant mortality have improved for most Americans, some minorities experience a disproportionate burden of preventable disease, death, and disability compared with non-minorities. The HHS Action Plan for Reducing Racial and Ethnic Health Disparities identified CHWs as one of five strategies to reduce disparities.

5.2.4 Other Policy Initiatives

Other policy initiatives that favor care coordination include: Meaningful Use - EMR Potential, Patient Centered Medical Homes, CMS Innovations Application, Partnership for Patients and Payment Reform Work.

5.3 Workforce Issues: Training Requirements, Competencies and Scope of Service

If CHWs were to take a larger state and national role in the delivery of care coordination services a major issue facing states is to define the training requirements, competencies and scope of service and supervision of CHWs. For the past two decades, these areas have been very challenging for individual states and for the CHW field in general.

Several states have moved forward in formalizing the training and scope of service of CHWs. In 1999, Texas was the first State to explore the utilization of CHWs and develop legislation to govern their activities. Texas requires CHW programs in health and human services agencies to hire State-certified CHWs when possible. In 2003, Ohio developed its first CHW certification program, and as of May 2010, three accredited CHW certification programs are available. Other States such as Minnesota, Indiana and Alaska have certification programs that authorize CHWs to conduct specific activities, such as home visits and clinical service delivery, respectively. Alaska's certification programs date back to the 1950s. While they do not require certification, North Carolina and Nevada have implemented state-level standards for training CHWs and provide training at the state level. Arizona, Oregon, Southern California, Massachusetts, and Virginia have developed curriculum and CHW programs at community colleges and the states may be moving towards certification. Other states that have non-state-mandated certification programs and/or are exploring certification and utilization of CHWs include Kentucky, New Mexico and Hawaii.

There is concern within the CHW field that credentialing or other formal practices (e.g. registration and licensing) will dilute the "essence" of CHWs--the qualities that make CHWs special--by focusing more on their skills than on their relationship with the community.[26] There are also concerns that credentialing would create barriers (such as academic requirements) keeping many community members out of the field, and artificial distinctions of status between "professional" CHWs and committed individuals doing similar work.

Other barriers to implementing formal credentialing programs include:

- Cost of developing, implementing and monitoring a formalized training system.
- Enforcement issues including lack of penalties and ambiguity about responsibility for violations.
- No link to compensation or advancement for CHWs and other workers.
- Cost in time and money to CHWs for complete required training.
- Non-support by CHWs or communities. There is a question of whether or not CHWs will pursue certification or if employers will require certification if it is not mandated by the state.
- Fears related to requirements of citizenship or resident status or background checks.

5.4 Funding, Financing and Sustainability

CHWs exist in a precarious economic environment in many places. Often CHW positions are created as a result of a federal categorical disease grant program, a federal research or demonstration grant, a state services contract or as a minimum requirement of a clinical services grant such as within the "enabling" services requirement in a Community Health Center. As non-revenue producing staff members, they are often viewed as "cost centers" or as a burden to the bottom line. Their existence is often time-framed and subject to the ebb and flow of grants and contracts. Exceptions to this may occur when CHWs are part of budgeted or legislatively sanctioned full-time equivalent positions (FTE), which may be recurring annually. In times when budgets are threatened or state funding sparse, CHWs may also be at risk in local health offices. Financial support for CHW programs is tenuous at best.

The question of sustainability for CHWs and other non-licensed care coordinators may lie in pragmatic thinking about how those positions are incorporated into the core of service provision. Do we transition from a funding perspective to a financing perspective in order to provide a stable financial environment for continuous CHW or care coordinator services? Financing implies

compensation for services rendered and the health care system is generally amenable to taking risks in service investments when payments or fees for services are involved.

There are certainly many benefits to transitioning care coordinator or other traditional CHW services to the financing environment. They include:

- Transitioning from uncertain funding streams to relatively predictable budgeted revenues and expenses which is the foundation of health care investment
- The potential ability to develop longitudinal programs based on the priorities of the patient population
- As a billable service provider, CHWs and care coordinators a more integrated part of the established health care environment. Their services are then coded, evaluable, quantifiable and included in mainstream accounting, billing and quality improvement processes. Not providing services becomes a financial burden to the organization. They are "in" the system.

There are other concerns particularly for frontier programs should CHWs and care coordinator transition to a financing environment:

- Often payments are associated with licensing and / or credentialing which may be a financial and logistical burden in frontier areas as travel for formal training, time away from family and availability of a worker pool who can do those things may be limited.
- Formalizing education in and of itself may change the value of CHW services, which has traditionally and largely relied on peer relationships for its successes.
- Fee-for-service financing schemes create a volume rather than outcome incentive. Improving health and well-being is a primary function of a care coordination services. Volume payment models have not generally served these goals well. Neither has the fee-for-service payment system ensured the sustainability of the frontier health system in general due to a lack of adequate population extant for sufficient revenues to ensure a viable service delivery system. Repeating this scenario would by all accounts serve the health system better than the individual in need of support.

Assuming that it is desirable to transition from an unstable funding perspective to an integrative financing perspective, what are the options for CHW care coordination?

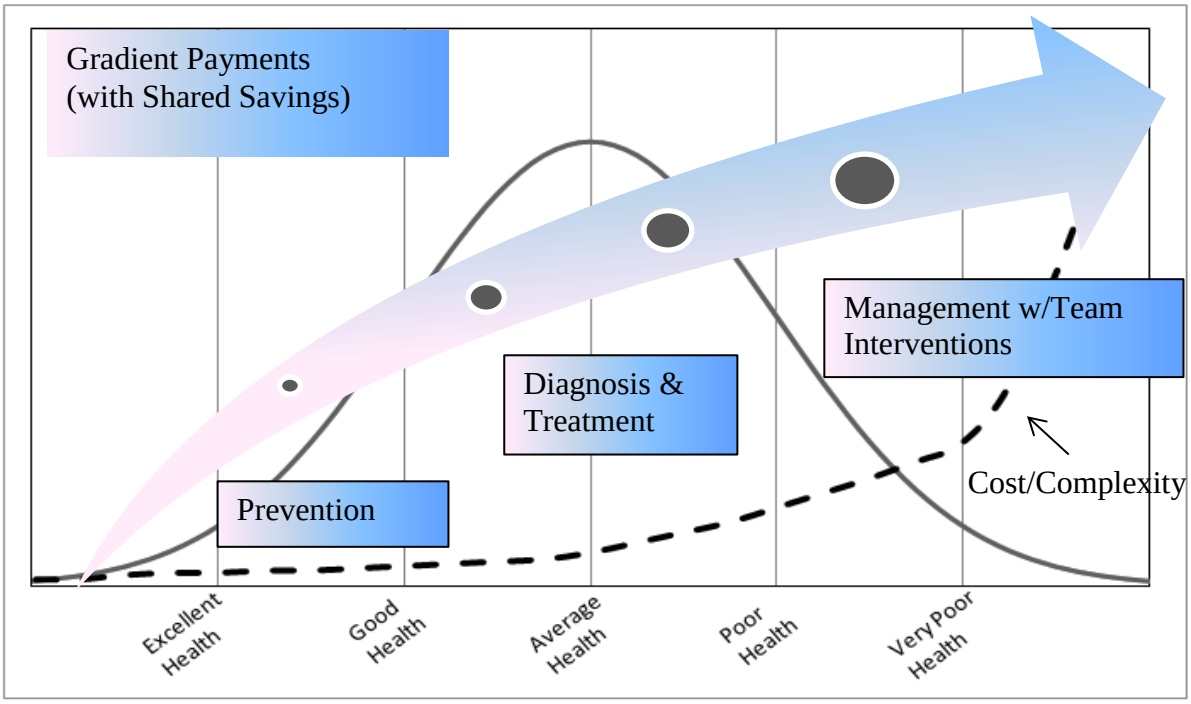
Since the concept of financing CHW care coordination services is relatively recent, there is an opportunity to design the financing system more intentionally to meet the needs of individuals in frontier communities. One concept is to have patient focused payments rather than service focused patients. Examples of patient focused payment follow:

- **Figure 2** below suggests segmenting the role of CHWs along a continuum of population needs and intervention strategies based on the health of the patient population.
    - A broad range of strategies can be financed retrospectively for improving and maintaining health, which include health promotion and prevention services for those who are healthier such as an add-on to a cost report settlement based on patient coding mix. For instance, setting benchmarks and subsequent payment add-ons for compliance with clinical preventive services goals.
    - As people become diagnosed with an illness or have progressed in an illness they require more intensive intervention culminating in care coordination.

Global payments or capitated payments can be established that include care coordination services.

- Meaningful monthly fees can be paid based on severity of patient condition or cost (Molina Financing Model)
  - Costly or very ill patients can have a higher level of monthly management payment than those who may have chronic illness but are not yet expensive
  - Conditions of Participation can include the full range of health interventions suggested
  - Incentives can be added for improving health outcomes or avoiding progression of disease, based on historical cost data and shared savings arrangements

Figure 2: Monthly Payments Based on Severity of Patient Mix



Source: **C. Alfero, Hidalgo Medical Services, Center for Health Innovations. 2012**

6 Conclusions

- There is no consensus among states and organizations on the core functions and scope of practice for CHWs.

- At least five states have formalized CHW training systems and have adopted credentialing regulations based on state endorsed CHW core functions and scope of practice. Several other states, including at least six rural/frontier states, are in the process of formalizing CHW workforce development and oversight.

- There is growing interest among rural and frontier states to define and develop the care coordination function of CHWs.

- There is no standard definition for care coordination. Care coordination functions, roles and responsibilities of all team members need further clarification and integration.

- CHW-specific roles and functions are not widely recognized as falling within the realm of traditional, clinical care coordination. Within the general CHW core competencies, scope and functions care coordination needs to be clearly defined.

- The ACA and other policies provide a promising and positive environment for the development and implementation of CHWs in care coordination models.

- A limited number of states provide Medicaid/ Medicare reimbursement if CHWs work under supervision of a licensed provider. Most CHW programs still depend on grant or state funding.

- Some Medicaid/Medicare MCOs contract for care coordination functions, including services performed by CHWs.

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