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## Issue Brief

# Community Health Workers: Getting the Job Done in Healthcare Delivery

## INTRODUCTION

As U.S. healthcare providers and policy makers struggle to improve Americans’ health and to contain costs, social determinants of health are increasingly being recognized as vital drivers of population health outcomes. A recent national report, for example, found that about 60% of the variation in hospital readmission rates can be attributed to the characteristics of the community surrounding the hospital.<sup>1</sup> Additionally, those at the lower end of the socio-economic ladder experience more premature deaths, a heightened disease burden (diabetes, heart disease, and many cancers), and a disproportionate share of disabilities and mental illness.<sup>2</sup>

The Patient Protection and Affordable Care Act (ACA) and the Centers for Medicare & Medicaid Services (CMS) have created opportunities to alleviate the country’s overburdened primary care system that is currently ill-equipped to address these social determinants of health. For example, recent regulatory changes have made it possible for community health workers (CHWs) to be reimbursed for providing physician-recommended preventive services if the state submits a state plan amendment and if it is approved by CMS.<sup>3,4</sup> In addition, new federal grant initiatives are creating momentum for pursuing a community health agenda.

To explore options for increasing the role of CHWs in improving population health, the Jewish Healthcare Foundation (JHF) partnered with the Network for Excellence in Health Innovation (NEHI) to convene a day-long meeting in October 2014 focusing on CHWs (the “October CHW Summit”).<sup>5</sup> The meeting, which also received support from the Rose Community Foundation and the Association of American Medical Colleges (AAMC), had three purposes: (1) to share current models of CHW involvement, (2) to explore potential CHW roles in improving quality and reducing costs in new payment reform and healthcare delivery models, and (3) to examine how recruiting,

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training, and certification policies can support CHWs in their work and expand opportunities for the profession's advancement and growth.

One of JHF's goals in convening the October CHW Summit was to glean information and best practices from national experts to inform the development of a strategy to advance the healthcare workforce provisions of the ACA in Pennsylvania. Despite offering a number of prestigious CHW programs – Pennsylvania has not yet created a statewide policy infrastructure in support of CHWs.

This *issue brief* synthesizes the key findings from the October CHW Summit. It is intended to serve as a framing paper for a JHF-sponsored CHW Summit scheduled for April 22, 2015 in Harrisburg, PA. The goal of the April 22 Summit is to help create a Pennsylvania action plan for developing policies for training, certifying, and reimbursing CHWs, along with the metrics needed to track and measure their impact.

The *brief* begins with an overview of the history of CHWs, followed by highlights from literature on their impact. It then summarizes recent policy milestones that support the growing deployment of CHWs, fleshes out issues related to training and certification of CHWs, and offers current examples of "pioneer" CHW programs. A special section provides an in-depth look at opportunities to involve CHWs in the community-based care of frail seniors – particularly in Pennsylvania where the senior population is large and growing. The *brief* concludes with a summary of the challenges to wider integration of CHWs moving forward.

## HISTORY OF COMMUNITY HEALTH WORKERS

Community health workers serve populations that are disadvantaged in a myriad of ways around the globe. While they are formally and frequently employed abroad in less affluent regions, CHWs have been on the US landscape for generations doing outreach from settlement houses, public health clinics, neighborhood health centers, and neighborhood action organizations. They bring basic health education and prevention, monitoring, in home assistance, social supports, environmental improvements and other services to people in need. They operate under diverse titles such as *promotores de salud*, navigators,

### CHWs in the Global Community

Community health workers in developing countries are an important resource in overcoming challenges inherent in underfunded and insufficient healthcare infrastructures, as they often provide direct frontline services to underserved or rural populations in addition to health education, informal counseling, and social support.<sup>1</sup>

One leading example of the international use of CHWs is Ethiopia's Ministry of Health, which has employed CHWs that have, among other things, reduced malaria-related childhood deaths by 55% since 1990.<sup>2</sup> The *Alpine Review*<sup>3</sup> also recently highlighted examples of CHW activities in additional areas across the globe, such as:

- mothers2mothers, which has reached over 1.2M HIV-positive mothers in sub-Saharan African countries in an effort to eliminate the transmission of the virus to their babies<sup>4</sup>
- Institute of Palliative Medicine in Kerala, India, providing hospice and other forms of palliative care for those with cancer, AIDS, and other terminal illnesses<sup>5</sup>
- Jacaranda Health, offering obstetric care, safe delivery, family planning, and postnatal care at its clinic and in mobile health vans in the peri-urban areas of Nairobi, Kenya<sup>6</sup>

Other governmental and non-profit organizations deeply embrace the CHW model in their international efforts. The World Health Organization (WHO) developed a multi-year workforce strategy to ensure that "all people everywhere will have access to a skilled, motivated and supported health worker, within a robust health system."<sup>7</sup> The U.S. Peace Corps has a significant investment in both training and working side-by-side with CHWs in such diverse locales as Madagascar, Uganda, and Togo.<sup>8,9,10</sup>

Partners in Health also sustains a robust community health worker network in Haiti, Africa, and Mexico<sup>11</sup> with initiatives that have, for example, reduced or eliminated maternal death in childbirth.<sup>12</sup>

health aides, health educators, health coaches, street and outreach workers and many more.

The American Public Health Association (APHA) CHW definition<sup>6</sup> has been widely adopted. They do share some common characteristics: they are typically indigenous to the communities they serve; they operate as a liaison or intermediary between neighborhood residents and medical, health and social service agencies; they spread knowledge to encourage self-sufficiency. The CHW serves as a trusted intermediary, doing home visiting and organizing community events where appropriate, with formal care coordination and management within a medical setting usually being supervised by a physician, nurse or social worker.

The use of CHWs as a vital component of the U.S. healthcare system has been documented for decades.<sup>7</sup> Literature from the mid-1960s documents their involvement in anti-poverty initiatives, a role which evolved in later years to health promotion.<sup>8</sup> A 1998 report on CHWs (or community health advisors, as they were then called) was one of the first attempts to describe the workforce from a national perspective.<sup>9</sup>

Then, in 2007, the U.S. Department of Health and Human Services released the Community Health Worker National Workforce Study<sup>10</sup> to measure the workforce's size and characteristics, since no tracking code within the Bureau of Labor Statistics existed at that time. In 2010, the U.S. Department of Labor adopted a Standard Occupational Classification code for CHWs,<sup>11</sup> prompted by advocacy from the CHW section of the APHA, and has tracked their work since.

Currently, the Department of Labor (DOL) estimates that there are more than 45,000 CHWs nationwide,<sup>12</sup> excluding other professions that might have overlapping responsibilities (like health educators) and those who are doing CHW work but are not being tracked by the DOL. CHWs are more likely to be female and share the dominant ethnicity of the community in which they work.<sup>13</sup> More recently, successful CHW programs have engaged a broader demographic. For example, Boomers Leading Change in Health is a program that engages adults ages 50 and older as volunteers in various communities.<sup>14</sup> While CHWs assist in the care of many different health issues, most commonly they focus on helping patients manage chronic diseases, encouraging preventive health care, and ensuring healthcare access.<sup>15</sup>

## **EVIDENCE OF CHW IMPACT**

As community health workers become increasingly incorporated in healthcare teams (due in part to special project grants and progressive governmental initiatives), a growing body of evidence attesting to their impact has emerged.

Two recent studies highlight CHWs' impact. The Tri-County Rural Health Network program in Arkansas resulted in a 3:1 return-on-investment. In this program, CHWs identified Medicaid-eligible individuals who were at risk of nursing home placement and arranged for those individuals to receive home- and community-based care.<sup>16</sup> In the other study, Molina Healthcare of New Mexico used CHWs to provide support services to high resource-consuming Medicaid members. Results included a significant reduction in emergency department visits and inpatient admissions among participants, with a total savings of more than \$2 million post-intervention.<sup>17</sup> Another investigation analyzed how a CHW program out of the Penn Center for Community Health Workers (run by the University of Pennsylvania) documented improvements in primary care access, post-hospital discharge, and the quality of discharge processes, while also containing readmission rates for patients with low socioeconomic status.<sup>18</sup>

In 2009, the Agency for Healthcare Research and Quality (AHRQ) conducted a systematic review of the impact of CHW interventions, identifying the characteristics and outcomes of these programs.<sup>19</sup> A few years later, the Institute for Clinical and Economic Review (ICER) built upon AHRQ's analysis by updating the scan through 2013, examining 46 health outcome studies of "good- or fair-quality."<sup>20</sup> Overall positive findings for various conditions and preventive activities included:

- diabetes – improved HbA1c (blood sugar) levels
- asthma – reduced hospital admissions and diminished number of activity-limited days
- hypertension – increased attendance at follow-up appointments
- cardiovascular disease risk – improved systolic or diastolic blood pressure
- medical care utilization – decreased use of inappropriate emergency department visits by newly-released prisoners
- cancer screenings – better adherence for breast, cervical and colorectal cancer screenings
- childhood immunizations – increased vaccination rates

An additional 14 studies in the ICER report were evaluated to determine the economic impact of CHW projects. Of these, the majority showed CHW interventions resulted in net cost-savings,<sup>21</sup> although not every study found improvements in health outcomes relative to a control groups.

"I'm working with a patient who has uncontrolled diabetes and has been admitted [to the hospital] more than six times already. She's lacking a lot of support and feels that no one is hearing her. She calls me and I see her once or twice a week. I build a relationship with her. She's not just a patient; she's now a friend of mine. I'm the person she calls when she needs something. A lot of people look at her like she has diabetes and she's not doing what she should be doing, but she has other problems she's dealing with that I help her with."

—Jessica Valles, CHW, Camden Coalition of Healthcare Providers

## **POLICY MILESTONES**

In response to the growing body of research documenting the promise of CHWs, several policy milestones have encouraged their use in recent years. A watershed moment for the profession occurred with the passage of the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA created opportunities to include CHWs in health homes, state innovation models, and the delivery of preventive services.<sup>22</sup>

The provisions in the ACA hold the promise of "crossing the quality chasm"<sup>23</sup> between mainstream health care and community-based, public health efforts. However, hurdles remain in the key requirement that CHWs be reimbursed for delivering recommended preventive services. States must file a detailed State Plan Amendment that outlines the recommend services that will be covered and who will provide them, along with the education that will be required among these professionals and how they will be reimbursed. As of mid-2014, no state had filed such an amendment. Nevertheless, new efforts towards this end are apparent in the communications between state or regional CHW associations and state public health departments and Medicaid offices.<sup>24</sup>

This regulatory change is part of a larger shift within health care toward preventive health and wellness largely energized by the ACA. For example, value-based payments are becoming increasingly popular. In these payment arrangements, providers are required to take on some financial risk and achieve established quality metrics. The majority of payers and providers are already working with some mix of value-based payment today, and two-thirds of the market is expected to consist of these payments by 2020.<sup>25</sup> CMS aims to have 90% of their Medicare fee-for-service payments in value-based payment categories by 2018. These innovative payment models create mechanisms to incorporate CHWs within payment structures that can both improve patient outcomes and achieve cost containment goals.

In addition to the promotion of alternative payments, the ACA also established the Center for Medicare and Medicaid Innovation (CMMI) within CMS to sponsor grants for state innovation models. Many recipients of CMMI's Health Care Innovation Awards (HCIAAs) and State Innovation Model (SIM) grants have incorporated CHWs in their plans and programs for optimizing care and lowering healthcare costs.

Other noteworthy activities occurring nationally are likely to affect the CHW movement at large. Currently, 18 states have proposed or initiated policy processes for building a CHW infrastructure. An additional 12 states have established statewide working groups to begin exploring policy alternatives. Attention is focused on agreeing on occupational definitions and qualifications for CHWs, workforce development, financing strategies, and research or evaluation guidelines.<sup>26,27</sup> For example:

- **California** – CalSIM, California's State Innovation Model (SIM) design grant, was approved in April 2013 by CMMI and included exploration of the feasibility of and potential mechanisms for using CHWs across the healthcare, public health, and/or community spectra.<sup>28</sup> California is now in Stage 2 of its SIM model and is refining its design plans.<sup>29</sup>
- **Massachusetts** – Massachusetts' 2006 health reform law directed the Department of Public Health (DPH) to conduct a study on the current state of CHWs within the state and to provide recommendations for strengthening their work. The law also provided a seat for the state CHW association (MACHW) on the Public Health Council. In response to the findings from DPH's study and recommendations, the state legislature established a Board of Certification – led in part by CHWs – that is creating a state certification program and establishing training standards.<sup>30</sup>
- **New Mexico** – Project ECHO, housed at the University of New Mexico's School of Medicine, has invested in the creation of CHW training that targets culturally appropriate healthcare solutions for the state's diverse communities.<sup>31</sup> In March 2014, New Mexico's governor signed a law that makes CHWs eligible for Medicaid reimbursement if they become certified through a voluntary, statewide program.<sup>32</sup> The Department of Health is developing a process for disseminating the rules of the program to help guide next steps for implementation.<sup>33</sup>
- **Texas** – In 2001, Texas set a national precedent when the Department of State Health Services created a CHW training and certification program, which includes requirements for continuing education. Various organizations and healthcare systems in Texas have embraced the use of CHWs as one mechanism to expand their services and outreach to underserved populations.<sup>34</sup>

#### EVENT SPOTLIGHT:

#### Dr. Rishi Manchanda's Upstream Doctors

Dr. Rishi Manchanda is leading a movement in the medical field to develop a more comprehensive view of health. Through his work as a practicing physician and his involvement in health equity initiatives in the Los Angeles area, Dr. Manchanda has ignited a conversation around social determinants of health and the workforce needed to address them – one that includes community health workers. He also founded HealthBegins, an organization that offers training and technical assistance to help reform traditional healthcare processes.

In his first book, *The Upstream Doctors*, he writes: "The future of health care depends on growing and supporting more 'upstreamists'. These are the rare innovators on the front lines of health care who see that health (like sickness) is more than a chemical equation that can be balanced with pills and procedures administered within clinic walls. They see, rather, that health begins in our everyday lives, in the places where we live, work, eat and play."<sup>13</sup>

- **Oregon** – In 2013, Oregon was awarded a \$45 million SIM grant and Medicaid waiver to test the effects of its “coordinated care organizations” (CCOs) on clinical outcomes and cost savings. As an integrated care delivery system, these CCOs focus on prevention and improving health equity based on new payment models and patient-centered medical home models. Participants in the program work with health navigators or qualified CHWs. Oregon’s state legislature recently passed a bill to create a health workers commission that would set training standards for CHWs and other professionals.<sup>35</sup>

“[According to its formal definition], there are two core principles of a profession. A profession is an art that when practiced is helpful to humanity. The second parameter of a profession is that the persons who are engaged in that art govern the practice. So what we are proposing is not radical. We are actually proposing an ethical, professional posture. We are the ones we’ve been waiting for and it is our time.”

—Sergio Matos, Founder and Executive Director, Community Health Workers Network of NYC

Table I summarizes these states’ CHW policies, and more information on other state CHW initiatives can be found in the Appendix. In addition, the State Refor(u)m online network for health reform implementation maintains an overview of *State Community Health Worker Models*.<sup>36</sup> State Refor(u)m is an initiative of the National Academy for State Health Policy, and is funded by the Robert Wood Johnson Foundation.

This changing landscape suggests a future where CHWs can play a significant role in managing the health of populations and addressing social determinants of health, both of which are essential factors in determining the financial health of payers and providers, and the physical and behavioral health of patients.

Table I: State Policy Overview

	Massachusetts	Minnesota	New Mexico	Oregon	Texas
Lead State Agency(ies)	Board of Certification of CHWs, Massachusetts Office of Community Health Workers, Department of Public Health	Department of Human Services	Office of CHWs, CHW Advisory Council, Board of Certification for CHWs	Oregon Health Authority, Oregon Health Policy Board, Oregon Home Care Commission, Non-Traditional Healthcare Workforce Subcommittee	Department of State Health Services
CHW Scope of Practice	X	X	X	x	x
Benefits of Certification	Needed in order to represent oneself as a Certified CHW	Needed in order to be reimbursed through the state's Medicaid program	Needed in order to represent oneself as a Certified CHW	Only Certified CHWs are eligible for both the CCO and Patient Centered Primary Care Home (PCPCH) services.	Needed in order to receive any payments for services
Number of hours of training required for certification	80 hours plus 15 hours of continuing education every 2 years (plus MA will always required 2000 hours of relevant work experience in out training and work experience pathway)	14 credit hours of online/in class coursework plus 90 hours of supervised clinical work	In development, likely 100 hours coursework and 100 hours of field experience	80 hours of training for certification and 20 hours of continuing education every 3 years	At least 160 hours (20 hours for each of eight core competencies)
If grandfathered exception exists, how many hours of experience are required?	Yes (but only for the first three years of the certificate program), 4000 hours required	Five years of supervised experience	Certification through grandfathering for CHWs who were practicing in the state before the passage of the Community Health Workers Act will be available for a specified period	Grandfathering available to those who have worked over 3,000 hours in the past five years, and completed additional training	1,000 hours of CHW services in the previous six years
Medicaid Reimbursement?	Medicaid supports a small amount of CHW services through a §1115 waiver for high-risk pediatric asthma patients (this is	Certified CHWs are eligible to be reimbursed for certain services to individuals with Medicaid	Not reimbursement, but §1115 waiver enables Managed Care Organizations (MCOs) to bill costs associated with CHW MCO admin. fees, which are	State Plan Amendment created PCPCHs, which explicitly include CHWs as providers of 4 of the 6 core services; CHWs	CHWs were included in TX's §1115 waiver, which enables them to be reimbursed for certain services

	not operational yet, but we do have a dual eligible Medicaid-administered demonstration project (called One Care) that requires the provision of CHW to all members who request them.		included in the capitated rates	must be supervised by a health professional in order to be eligible for reimbursement	
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## TRAINING STANDARDS OF THE CHW WORKFORCE

The opportunities for increased funding sparked by the ACA have generated new energy and complexities into the conversation about the nature of what it means to be a CHW. Discussions are increasingly turning to an examination of opportunities to increase training<sup>37</sup> and enhance professional recognition<sup>38</sup> of CHWs. For some, being a CHW can serve as on-the-job training and a leverage point for entrance into the more formal healthcare professional education system. Not only would this improve the economic outlook for individual CHWs, it may translate into greater diversity within the healthcare workforce,<sup>39</sup> as well as an increase health equity.

At this time, there are no agreed upon national standards for CHW certification or credentialing.<sup>40</sup> Divergent opinions exist within the CHW community that both recognize the potential benefit to greater training, support, and professional recognition while also raising concerns that new standards could exclude the very individuals who may be best-suited to be CHWs.

Good CHW qualities are an empathetic nature and ability to understand human behavior, particularly within the communities they serve. Therefore, seeking out CHWs with these characteristics is important. Hiring and training could reinforce CHWs’ abilities in providing culturally-sensitive informal counseling, sharing appropriate health information, and building community competency to address underlying causes of health inequities. Innovative interviewing approaches contain role play and patient case studies, with subsequent training focusing on popular education<sup>41</sup> and community capacity-building techniques.

The Community Capacitation Center (CCC) in Multnomah County, Oregon provides guidance to organizations interested in improving their CHW programs. CCC helps create approaches that are in line with Chapter 3 of the National Community Health Advisor study, strengthening CHWs’ roles and skill base.

While an 80-hour basic curriculum has been approved for academic credit by the Oregon State Board of Education through Portland State University, CCC also helps develop other educational modules anywhere between 18 to 240 hours long, depending on the needs of the CHWs within each program.<sup>14</sup>

“ People frequently ask me about capacitation – it’s from the Spanish word *capacitación*, which means to build capacity. We use that in reference to training because of our belief that everyone – regardless of who we are – brings a lot of skill and capacity to any education, training, or organizing encounter.”

—Noelle Wiggins, Executive Director, CCC, Multnomah County Health Department



## PIONEERS

Many providers across the country are beginning to realize the positive impact CHWs can have on new business models of care and are incorporating them into their care planning teams. Several of these pioneers were featured in the October CHW Summit and are great examples of efforts that have utilized CHWs strengths and potential.

### *Camden Coalition of Healthcare Providers*

The Camden Coalition of Healthcare Providers (CCHP) began in 2002 as an initiative among primary care providers to find solutions to common challenges. With grant support from funders like the Robert Wood Johnson Foundation, the Coalition grew to incorporate other health professionals and partnerships with local health systems. Its comprehensive database helps identify patients who are in need of additional – and often collaborative – outreach. Its Care Management Project, for example, deploys teams of social workers, nurse practitioners, and CHWs to assist in the care of frequent utilizers of the city’s emergency rooms and hospitals.<sup>42</sup>

CCHP was one of the earliest users of “hot-spotting” to identify Camden residents with the highest utilization of healthcare services, including emergency rooms, hospitals, and physician offices. Providing care management to these patients group enabled CCHP to help patients prevent avoidable hospital visits and reduced costs by 40% to 50%.<sup>43</sup>

### *Hennepin Health*

Hennepin Health, a safety net health system, began utilizing CHWs in 2010 through its state patient-centered medical homes (PCMH) to help diverse populations navigate the healthcare system. It was initiated both through grant-funding and some accountable care organization (ACO) funding. Its PCMH has grown to include registered nurse clinical coordinators and social workers.<sup>44</sup>

### *Iora Health’s Innovative Approach to Primary Care*

Since 2010, Iora Health has been partnering with self-insured employers and unions through capitated arrangements to develop personalized care for their highest-cost beneficiaries. Iora has grown substantially over the years and serves over 8,000 patients at practices across the country today.<sup>45</sup>

Iora’s health team approach incorporates “health coaches” who, typical of CHWs, build relationships with patients and translate their complex needs to other professionals involved in their care, including a team of doctors, nurses, and social workers.<sup>46</sup> Studies have shown that Iora’s model results in a 15% decrease in patient’s costs overall<sup>47</sup> along with significant improvements in quality of care.<sup>48</sup>

“I’m a primary care physician, and about 10 years ago I got fed up with the idea of primary care, where you walk into the office and you have 38 patients booked for 7 minutes each, sometimes double-booked. And, you’re expected to take care of their problems. I had a colleague that put it pretty well; she said “every day I lose a little piece of my soul.” I went into this to try and help people, and there is just no way to help these people in this context.”

—Dr. Rushika Fernandopulle, Co-founder and CEO of Iora Health

### *Tri-County Rural Health Network*

The Arkansas-based Tri-County Rural Health Network administers a Community Connectors program that uses CHWs to identify qualified Medicaid-eligible individuals who are at risk of nursing home placement, and to arrange for those individuals to receive home- and community-based care. The three-year, three-county pilot

program resulted in a 3:1 return-on-investment<sup>49</sup> and the program is now implemented in 15 counties across the Arkansas Delta.

As a part of this program, CHWs walk through neighborhoods and talk with residents to help identify at-risk seniors. They then arrange for the delivery and installation of medical equipment and supplies (e.g., bed rails, stair lifts, and walkers), work with agencies that schedule nurses or health aides to stop by the home to check on the individual, assist in completing Medicaid-related paperwork, arrange for homemaker services as needed (e.g., shopping, laundry, light housekeeping, and light meal preparation), schedule delivery of hot meals, and contact nearby relatives to help with the resident's needs or arrange for services to ease family stress (e.g., adult day care programs). Over three years, no participants needed nursing home placement, and the program resulted in a 23.8% average reduction in Medicaid spending per participant in contrast to the comparison group.<sup>50</sup>

#### *University of Pennsylvania Health System*

The Penn Center for Community Health Worker's Individualized Management for Patient-Centered Targets (IMPACT) model was created in 2013 based on feedback from patients, caregivers and providers in the UPenn Health System.<sup>51</sup> After establishing its value through a randomized clinical trial that showed improved outcomes – including improved primary care access utilization, patient engagement and reduced readmission rates – the IMPACT model was developed and fully integrated as part of routine care within the University of Pennsylvania Health System.

Care teams consist of one manager, one half-time coordinator, and eight CHWs, two of whom are senior CHWs. The Penn Center is growing steadily and is continually conducting research on its impact.<sup>52,53</sup>

UPenn is committed to promoting collaboration within care. Over the past year, the Center has provided an IMPACT teaching service that allows fourth year medical students to shadow a CHW for a month. Jill Feldstein, director of the Penn Center for CHWs, says that “the response for medical students has been phenomenal. It's a tremendous opportunity for them, but also a great opportunity for the community health workers. Because in essence, they are put a position to educate, orient, and train future doctors.”<sup>54</sup>

### **MEETING NEEDS OF SENIORS**

The pioneers above have shown that CHWs can improve population health; lower healthcare costs by reducing emergency room visits, hospitalizations, and institutionalizations; and improve patient experience, primarily among high utilizers, but also in rural areas where access to health care is limited. In addition to the benefits urban CHWs provide to those populations, there is tremendous opportunity to use CHWs more cost-effectively to serve the elderly who are disproportionate consumers of healthcare services.

In 2010, people who were 65 years or older were hospitalized about three times as often as Americans in general.<sup>15</sup> In 2013 almost 18% of the approximately 11 million Medicare beneficiaries who were hospitalized were readmitted to the hospital within 30 days of discharge.<sup>16</sup>

In 2011, the first of more than 70 million Baby Boomers turned 65 years old. Today, more than 1 in 8 Americans are older than 65 years of age, and by 2050, the number of people in the U.S. who are 65 years or older is expected to be about 83.7 million – almost double what it was in 2012, and representing nearly 20% of the total U.S. population.<sup>55</sup> More than 20% of those over 65 will be older than 85.<sup>56</sup>

According to Medicare data, nearly 80% of those 65 and older have been diagnosed with at least one chronic disease, and 45% of people in the U.S. older than 75 years of age have four or more chronic conditions.<sup>57</sup> Even for the small percentage of seniors who do not suffer from a chronic condition, as a person ages, challenges that require assistance are increasingly common. These include limited mobility and difficulties in doing tasks like shopping, preparing meals, managing finances; following treatment plans and managing personal hygiene and dressing and feeding oneself.

CHWs may be able to help slow the rate of age-related decline in vulnerable seniors by ensuring that they have the resources they need as they age-in-place and help to navigate the healthcare system when necessary.

Two additional factors add to the attractiveness of the CHW model for seniors: (1) the majority of older Americans prefer to remain in their home and community,<sup>58,59</sup> and (2) out-of-pocket expenditures in the last five years of life leave one in four of our nation's elderly bankrupt.<sup>60</sup>

Involving CHWs in healthcare delivery is a cost-effective strategy for helping seniors prevent and manage health conditions and, ultimately, preventing unnecessary hospital and nursing home admissions and supporting family caregivers.

#### *An Opportunity for CHWs to Improve Older Adults' Health and Quality of Life in Pennsylvania*

Pennsylvania has the fifth largest percentage in the U.S. of residents who are 65 years or older,<sup>61</sup> and by 2020, more than one in four will be at least 60 years of age, making the need to improve home and community-based services (HCBS) for seniors a critical issue.

- 70% of Pennsylvanians reaching age 65 will need long-term services and supports (LTSS) for an average of three years, and 30% of Americans with chronic illnesses have indicated that they would rather die than enter a nursing home.<sup>62</sup>
- Over 65% of the State's Medicaid budget covers payments for skilled nursing care, and about 40% of the Commonwealth's Medicaid LTSS expenditures are spent on HCBS costs compared to a national percentage of 50%. Rebalancing the percent of LTSS expenditures spent on institutional LTSS compared to home and community based LTSS is not only a financial imperative, since HCBS is less expensive than institutional LTSS, but it is also an imperative to help seniors stay safely in their home and maintain independence.
- A Medicaid scorecard, "*Raising Expectations*" produced by the SCAN Foundation, The Commonwealth Fund, and AARP, reports that if Pennsylvania improved its LTSS performance to match that of the highest-ranking states, more than 15,000 Medicaid long-term care recipients would receive services in home- or community-based settings, rather than in nursing homes.
- The Pennsylvania Department of Public Welfare's review of hospital admissions for people using LTSS found that 30% of the hospitalizations were unnecessary.<sup>63</sup> At the same time, studies have estimated

The negative consequences of chronic illness are extensive. Each condition has the potential to hasten the trajectory of declining health and threatens an individual's ability to remain independent as they have increasing difficulty in performing basic tasks such as lifting objects, walking up and down steps, and other activities of daily living.

People with chronic conditions have higher rates of hospitalization and emergency room use, resulting also in repeated care transitions across home and medical settings, which themselves can be detrimental to health.

that 30% to 67% of hospitalizations among nursing facility residents could have been prevented with well-targeted interventions.

On February 27, 2015, Pennsylvania Governor Wolf announced a multi-step plan to improve access to HCBS for seniors that addresses the issue of choice, cost, and quality. The dramatic growth in the number of seniors, the opportunities in the ACA, and Governor Wolf's plan to improve access to HCBS for seniors, create an opportunity for the CHW workforce to serve as a key resource in meeting the needs of Pennsylvania's growing older population.

Broadly, the Governor's plan includes:

- Expanded access to HCBS for Pennsylvania's seniors to an additional 5,500 individuals. According to Governor Wolf, this will save the Commonwealth more than \$162.2 million in nursing home costs in the upcoming budget year.
- Phased implementation of Medicaid Managed LTSS, which fills in the gaps that currently exist in Pennsylvania's LTSS system.
- An improved Long Term Living Waiver enrollment and service plan development process enabling more timely enrollment and delivery of LTSS and thus prevention of unnecessary nursing home stays.
- An improved Department of Human Services (DHS) home modification program that more efficiently manages home modifications for qualifying seniors who can live safely in their homes with modifications. The current process sometimes makes it difficult for modifications to be made in a timely fashion, necessitating nursing home stays for seniors as they wait for modifications to be completed.
- Establishment of a Governor's Advisory Group on Participant-Delivered Home Care, directed by the Secretary of DHS, tasked with ensuring the strength of Pennsylvania's home care workforce. The Governor wants to ensure that the homecare sector is able to attract a sufficient number of competent home care workers so that seniors have the option to age at home or in a community-based setting.

Governor Wolf has stated that he recognizes the urgent need to reshape the way care is delivered to seniors. His leadership, along with compelling evidence about the impact of CHWs, provides a solid foundation for developing an action plan to create training, certification, and reimbursement policies for CHWs in the Commonwealth of Pennsylvania.

## CHALLENGES MOVING FORWARD

### *Integrating CHWs into "Mainstream" Healthcare Delivery*

As leading health systems and others begin to consider the potential role of CHWs within their organizations, many are facing challenges in integrating CHWs into already-established care teams. CHWs have not been part of most delivery systems, nor has their role been discussed in medical school curricula. Thus, medical staff's perceptions of CHWs vary considerably depending on their level of familiarity with CHWs' work.

"Cultivate new allies, new supporters. We need them to move our workforce forward. We can't do this without them. [To the supporters and allies]: We need you at the table. Get to know your CHW organizations. Share your knowledge, don't keep it to yourselves."

—Lisa Renee Holderby-Fox, CHW  
Workforce Consultant

In regard to more technical challenges of workflow integration, these systems and care teams must now devise mechanisms to record and collect data gathered by CHWs outside of traditional office visits, especially as conventional electronic health records (EHRs) and related systems are not created with CHWs' work in mind. Population health needs have not explicitly been within the purview of the delivery system, nor are EHRs structured to document social determinants of health and interventions to overcome them. Health systems will need to employ health information technology and analytic support to expand electronic record systems to aid in identifying high-risk patients who need to be connected to a CHW, and tracking patients' progress and care plans.

Leading systems are confronting these challenges by focusing efforts on building relationships and trust between CHWs and other team members, maintaining coordination among them through regularly scheduled meetings, and educating managers and leadership on how best to define and shape the CHW role within their systems.

### *Reconciling Tensions within the CHW Movement*

Perhaps one of the biggest debates among CHWs has to do with how they define themselves and the work that they do. At one end of the continuum are those who perceive strong linkages to the roots of the social movements that gave rise to the profession in the first place and concern about employing CHWs as a low-cost extension of our medical-primary care system. On the other end of the continuum, there are those who see the potential for improved professionalism of the healthcare workforce through training, certification, and reimbursement for participation as formal members of the community healthcare team. The tension between these two views is eloquently outlined in an essay by Alan Weil, who served as the closing speaker at the October CHW Summit. In it, he acknowledges the possibility of creating a hybrid model that maintains the strongest components of each: a professionalized workforce with formalized qualifications, but one that is defined by and rooted in the social, behavioral, and environmental problems of the communities that CHWs serve.<sup>64</sup>

### *Engaging Key Stakeholders*

Discussions about CHWs benefit from their inclusion. However, to uplift the vocation and pave the way for greater reimbursement for services provided, key stakeholders across the healthcare spectrum should be engaged as well (e.g., medicine, nursing, public health, social work, government, insurers, and professional associations).

## **CONCLUSION**

The United States has yet to make sufficient progress in its "health disadvantage," as chronicled in the Institute of Medicine Report of 2013, *Shorter Lives, Poorer Health*. It is almost impossible to remain complacent in the face of facts about the sad state of population health in one of the wealthiest nations with the highest per capita health expenditures. Although the U.S. has higher survival rates after age 75, and fares better relative to 16 peer countries on a number of indicators, the U.S. has higher rates of infant mortality and preterm births, drug-related deaths, injuries and homicides, obesity and diabetes, cardiovascular disease, adolescent pregnancy and sexually-transmitted diseases, chronic lung disease, HIV/AIDS, and disability.

"If you select correctly for people who are engaged and committed, they will be able to learn the skills you want them to have in order to be integrated into teams. But you will not be able to train for compassion, tolerance, and a deep understanding of the culture and language of the people they work with."

—Carol West, Executive  
Director, CHW Initiative of Sonoma  
County

While CHWs may not produce a thorough answer to what ails our population, there can be little doubt that we need to move beyond traditional primary medical practice and bring services into the community targeted to those most in need.

The mass of data confirming the utility of CHWs in addressing everything from the lifestyle and social determinants of health to health literacy, preventable hospital admissions, drug and alcohol use, medication compliance, prevention services (nutrition, exercise, and smoking cessation) and independent living is impressive. Accordingly, the JHF is organizing an invitation-only CHW Summit in Harrisburg, PA, the goal of which is to outline elements of a standardized CHW training curriculum, certification, and reimbursement mechanism to promote the use of CHWs in the Commonwealth's healthcare and social service systems.

Following the Summit, JHF will create an advisory group of experts in senior services – those involved in home- and-community based care, as well as those from the clinical healthcare sector – who will work with the Foundation to identify the factors that predict hospital and nursing home admissions for seniors, and to develop a competency-based CHW training curriculum and service delivery model focused on preventing hospitalizations and avoidable institutionalization for community-dwelling seniors. The training curriculum and service delivery model (the CHW Champions Program) will then be pilot-tested as a two-year demonstration project with select local agencies, with a longer term goal of statewide adoption.

While there may be no clear cut path to health and healthcare improvement, one thing is abundantly clear – throughout it all, CHWs should be part of the solution.

## **Appendix**

### **Expanded Summaries of Selected State CHW Policies**

Across the country, states have utilized Community Health Workers (CHWs) to varying degrees as a means of improving the health of their citizens and decreasing healthcare costs. While many have largely left CHWs unregulated, others (such as Alaska, Florida, Indiana, Massachusetts, Texas, Minnesota, New Mexico, Oregon, New York, Ohio, and Rhode Island) have elected to promulgate statutes, regulations and/or policies as a means of more clearly identifying and codifying the role of CHWs in their respective state healthcare systems. This Issue Brief provides case studies on the policy infrastructures in five such regulated states.

As demonstrated by the summaries below, there are at times significant differences that exist between states' CHW policies. One particularly notable area of distinction concerns whether (and how) to credential CHWs. Credentialing is generally seen as a means of indicating that particular CHWs have demonstrated a sufficient degree of competence so as to warrant recognition by the state. As in other fields, credentialing can take many forms including licensure (whereas only "licensed" CHWs are allowed to perform CHW functions in a given jurisdiction) and certification (which is state recognition of completion of a course of study—often through either completion of a certain number of hours of work as a CHW, or completion of a structured training program). While many states have not yet developed CHW credentialing systems, some states have installed fairly nuanced programs and several other states are in various stages of developing programs of their own. The issue of credentialing is of particular importance to CHWs since it not only provides CHWs in some states with a means of compensation (e.g. some states require certification in order to be eligible for Medicaid reimbursement for certain services) but also because of the less-tangible benefits which it confers (such as greater visibility and respect from other healthcare workers).

#### *Massachusetts*

With the passage of the Economic Opportunities Act of 1964, Massachusetts became one of the first states with a formalized CHW presence. In the 50+ years since then, Massachusetts has continued to be a leader in promoting the use of CHWs. In 2010, the state statutorily created the Board of Certification of Community Health Workers (BCCHW) at the Massachusetts Department of Public Health, which among other duties, will administer the state's CHW certification program, establish standards for CHW training programs, and investigate complaints filed against CHWs. Ten years prior to the formation of BCCHW, the Massachusetts Department of Public Health supported the creation of one of the first statewide CHW associations in the country—the Massachusetts Association of Community Health Workers (MACHW)—which advocates on behalf of CHWs across the Commonwealth. As a testament to the importance of CHWs in Massachusetts, MACHW is enabled by statute to recommend individuals to serve on both the BCCHW as well as the Massachusetts Public Health Council.

Massachusetts has been developing its certification process for a over two years and the state aims to finalize the relevant regulations sometime this year to enable the BCCHW to begin certifying both paid and volunteer CHWs. Unlike some states, Massachusetts elected not to require mandatory credentialing of all CHWs—rather certification is only required to refer to oneself as a Certified CHW. Under the current draft of the regulations, in order to gain certification, CHWs must either (1) be "grandfathered in" by having at least 4,000 documented hours of experience as a CHW or (2) complete a state-regulated CHW training curriculum and have 2,000 hours of work experience. The grandfathered exception will only exist for the first three years of the certification process, after which time all applicants will be required to complete the training (in addition to the requisite number of hours of work experience). The training program, consisting of at least 80 hours of in-person instruction or a combination and online and in-person instruction, focuses on ten core competencies including

outreach methods/strategies, culturally-based communication and care, assessment, health education, and documentation. Training is provided by a variety of third parties including community-based organizations, Area Health Education Centers (AHECs), local health departments, and a public university school of public health. Unlike in some states, Massachusetts will not require the completion of a separate practicum in order to gain certification, but it will require at least 2000 hours of documented relevant work experience. Regardless as to the means by which initial certification is obtained, under the draft regulations CHWs will need to complete 15 hours of continuing education credits every two years in order to maintain eligibility for renewal of certification.

Massachusetts, like many states, has a diverse system through which CHWs are paid or reimbursed. Like many states, Massachusetts relies primarily on governmental or philanthropic grants to pay its CHWs. Other CHWs are funded via core operating funds. In addition to such grant/operating funding, Massachusetts is establishing a MassHealth (Medicaid) reimbursement mechanism (through a §1115 waiver) for certain CHW services provided to high-risk pediatric asthma patients, and also requires the provision of CHW services for members of its dual eligible demonstration project (called One Care). Additionally, Massachusetts is also participating in a demonstration project for dual-eligible adults, a part of which involves the state use of MassHealth funds to directly employ CHWs to provide coordinated services to patients enrolled in the project.

### *Minnesota*

Minnesota has both a state agency which is charged with overseeing the training and certification of CHWs in the state – the Minnesota Department of Human Services – as well as a two statewide CHW associations – the Minnesota Community Health Worker Alliance and the Minnesota CHW Peer Network – which advocate on behalf of CHWs in the state. Minnesota also has an identified CHW scope of practice, which serves as the basis for the state-regulated, academic credit-based CHW training curriculum.

Minnesota’s state-regulated CHW certification program is fairly unique in that it is competency-based and it is specifically designed to be provided by the state’s accredited community college system. The curriculum, which was developed out of a public-private partnership, entails 14 credit hours of course work (approximately 540 contact hours) at a community college (or online from a community college), plus 90 hours of supervised clinical work. Course content includes modules on advocacy and outreach, capacity building, and health promotion related to a variety of ailments such as heart disease and stroke. Since its release back in the early 2000s, at least 16 states have decided to use Minnesota’s curriculum.

Although Minnesota does not require CHWs to complete the certification in order to practice, it does require certification (or five years of supervised CHW experience) in order to be eligible for reimbursement for any services provided to participants in the state’s health care programs (including Medical Assistance). In 2007, Minnesota obtained a §1115 Medicaid Waiver to allow state-certified CHWs to receive fee-for-service reimbursement under the state Medicaid plan. In 2008, Minnesota secured a State Plan Amendment to directly reimburse CHWs under their Medicaid program. There are billing limits however, and CHWs cannot bill the State directly (rather, payment has to go through the supervising registered provider). Furthermore, services must be “diagnosis-related” rather than “social services” to be eligible for reimbursement. Minnesota also supports CHWs through other reimbursement mechanisms as well—for example, the state passed a law that reimburses certain CHW family home visits as a means of promoting family health. Moreover, as a part of the state’s SIM grant, Minnesota is investigating the use of CHWs and other emerging health professions within interdisciplinary teams in ACOs.

### *New Mexico*



Since 2008, New Mexico has largely centralized the regulatory functions related to CHWs into a single state agency, the Office of Community Health Workers (which is housed within the New Mexico Department of Health (NMDOH)). In addition to that Office, the State also has (1) a CHW Advisory Council, established in 2003, which serves as a consultative board to the NMDOH on matters such as the development of policies concerning CHWs, as well as (2) the New Mexico Board of Certification for Community Health Workers (NMBCCHW), which provides the NMDOH with guidance on CHW training and certification and suggestions for a CHW scope of practice. Furthermore, similar to other states, New Mexico has a statewide CHW association (the New Mexico Community Health Worker Association) which serves as a resource for CHWs across the state, and additionally the Navajo Nation also has a Community Health Representative Outreach Program which represents CHWs who operate in Navajo areas within New Mexico. Both Associations and the Navajo CHR Outreach Program are members of the NM CHW Advisory Council, thus enabling them to directly engage in state policy discussions concerning CHWs.

While CHWs have a long-standing history in New Mexico, the state's policy infrastructure is currently shifting, particularly with respect to CHW certification, due to the State's 2014 passage of the Community Health Worker Act. This Act, among things, both (1) enabled the NMDOH to establish and administer a CHW certification program (including the development of training requirements to gain eligibility for certification), and (2) created the NMBCCHW. In late January 2015, the New Mexico Secretary of Health released an initial set of regulations pertaining to the Act.

Although those regulations do not clarify every issue regarding CHW certification in NM (for example, the NMBCCHW has yet to recommend what exact core competencies will be included in the certification training process), nevertheless, based on the regulations and Act itself, one can identify certain aspects of the NM CHW certification process. For example, certification will be voluntary, competency-based, and valid for two years, administered through the NMDOH (but provided by third-party providers, who must be approved by NMDOH). Furthermore, there will be two means of gaining initial/"generalist" certification – through completion of a training program or through the grandfathered exception. With respect to the former means, NMDOH will require the completion of a yet-to-be-determined training program which will include examinations for each of the core competencies (which will be determined by NMDOH based on recommendations from the NMBCCHW). With respect to the grandfathered means of gaining certification, the regulations have clarified that CHWs who have at least 2,000 hours of experience (or half-time employment/volunteering as a CHW in the five years prior to the application) are eligible for "generalist" CHW certification.

Additionally we know that, unlike many states with CHW certification, the NMDOH elected to create a tiered CHW certification system in which completion of the standard curriculum (or use of the grandfathered exception) enables a person to gain a "generalist" certification. Completion of additional education/training in "specialty areas", however, entitles a CHW to enhanced/"specialist" designations (ranging from Specialist I, for applicants who meet the requirements for a generalist plus demonstrate additional education/training in at least one specialty area, to Specialist III for applicants who meet the requirements for generalist and who demonstrate additional education/training in three or more specialty areas). The regulations provide a non-exhaustive list of such "specialty areas" – basic clinical support systems, heart health, chronic disease, behavioral health, maternal/child health, or developmental disabilities. All certifications – generalist and specialists – are valid for two years and require completion of at least 30 hours of continuing education in order to be recertified.

New Mexico currently does not provide direct Medicaid reimbursement for CHW services. CHWs are however paid under the state's §1115 Medicaid waiver (Centennial Care) for certain care coordination services provided to MCO Medicaid enrollees. In particular, the cost of CHW salaries, training, and service costs are billed as MCO administrative costs, which are embedded in the capitated rates paid to Medicaid MCOs.

## *Oregon*

Oregon handles most policy matters concerning CHWs within the Office of Equity and Inclusion, which is a program of the Oregon Health Authority. Additionally, a Traditional Health Worker (THW) Commission advises on the state policy issues regarding CHWs, peer support and peer wellness specialists, doulas, and personal health navigators. Statewide advocacy efforts are handled by the Oregon Community Health Workers Association (ORCHWA). ORCHWA is responsible for nominating 6 members of the members of the Traditional Health Worker Commission.

Oregon passed a law in 2011 that required the Oregon Health Authority to create CHW training and certification standards. To aid in the development of these training requirements, the Oregon Health Policy Board in turn created the Non-Traditional Health Worker Subcommittee (which has since become the THW Commission), which was tasked with identifying the relevant competencies and training requirements. Based on that Subcommittee's recommendations (which were subsequently adopted by the Oregon Health Authority), CHW certification is contingent upon either: (1) demonstrating 3000 hours of experience as a CHW in Oregon or (2) completing a competency-based, 80-hour CHW training curriculum. The latter is centered around a CHW scope of work designed by the Subcommittee and is provided by third parties who must have their training programs approved by the Traditional Health Worker Commission. Once certification is obtained, certified CHWs need to complete 20 hours of continuing education every three years in order to maintain their status.

Historically, the primary source of funding for CHWs in Oregon has been short-term governmental and philanthropic grants. In addition to such funding, in 2013 Oregon was awarded a \$45 million State Innovation Model (SIM) grant as well as a §1115 Medicaid waiver, which collectively enabled the state to test how Coordinated Care Organizations (CCOs) affect clinical outcomes and promote cost savings. CCOs are designed around payment reform and PCMH concepts to provide patients with an integrated care delivery system focusing on prevention and improving health equity. CHWs are involved in CCOs since Oregon's CCOs are required to offer CHW services to their members.

## *Texas*

In 2001, Texas became the first state with a state-regulated CHW certification program, which is run by the Texas Department of State Health Services (DSHS) – the primary state entity tasked with regulating CHWs. Since that time, Texas has passed additional laws which (1) require certification for CHWs who are compensated for their services and (2) require state health agencies to use certified CHWs to the greatest extent possible in health outreach and education programs for recipients of Medical Assistance (Medicaid). Unlike many states, Texas' CHWs are represented by a number of different regional CHW associations rather than a single statewide association.

The DSHS provides three distinct certification programs (for CHWs, for CHW training instructors, and for CHW training programs (which need to be certified to train CHWs and/or instructors)), based on the advice from the Texas Promotora and Community Health Worker Training and Certification Advisory Committee. At present, the state requires that CHWs complete a competency-based training program consisting of at least 160 hours of training, comprised of 20 hours of instruction in each of eight core competencies, including communication, service coordination, and health knowledge,. Alternatively, CHWs can be "grandfathered in" by demonstrating at least 1,000 hours of experience in community health work in the last six years. Texas doesn't have a standardized curriculum (rather the instructor/training programs have the flexibility to develop curriculum based on a standardized competency-based framework that meets community needs), thus creating variations between programs. Certification for CHWs, instructors, and training programs is for two years, and continuing education is required for renewal for CHWs and instructors.

Most CHWs are paid through short-term public or philanthropic grants or through core budget funding, or by local governments (such as in Fort Worth). Additionally, Texas obtained a §1115 waiver, which in effect moved almost all Medicaid recipients into managed care organizations. Under the §1115 Medicaid waiver, Texas funded projects to incentivize hospitals and other providers to transform service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness. Projects included expanding the use and integration of the CHW workforce in the Texas health care delivery system. Several of the state's Managed Care Medicaid and Children's Health Insurance Program (CHIP) health plans employ CHWs to improve access to medical homes/health homes and to decrease emergency department visits for non-acute care. MCOs include CHW-related activities as administrative costs. Maximus, the Health and Human Services Commission's (HHSC) contractor for Texas Health Steps (Children's Medicaid) enrollment broker operations, employs CHWs as outreach counselors. CHW are not funded directly through the state, rather some CHWs are reimbursed via contracts within the DSHS's Expanded Primary Health Care Program for outreach services. Moreover, Medicaid contracts with MCOs to allow for CHW reimbursement as administrative costs.

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