

Community Health Worker Successes and Opportunities for States

BACKGROUND

The Bureau of Labor Statistics estimates that as of May 2016, nearly 48,000 community health workers (CHWs) were employed across almost all 50 states.¹ While their roles and responsibilities vary across states, CHWs often serve as a liaison between the community and the health services available within that community. Many factors contribute to an individual's overall health. Access to healthcare, knowledge of health conditions, and cultural factors can increase the health disparities gap and contribute to negative health outcomes. CHWs can improve the health status of individuals through actions such as health education, translation services, and promoting preventive services. CHWs are well recognized for improving health outcomes for conditions such as asthma, hypertension, diabetes, and HIV/AIDS.⁷ While it is evident that CHWs address significant health system barriers and community health issues, funding and financial stability remain an issue. States and CHWs must rely on a variety of funding sources such as grants or state budgets to provide health services and outreach in their communities. This issue brief gives a broad overview of how state public health departments can utilize CHWs to improve community health outcomes and generate cost-savings.

Key Lessons Learned:

- States are successfully implementing best practices and evidence-based policies to identify, control, and improve blood pressure.
- CHWs contribute to the overall advancement of the Triple Aim for health care, which includes: improved health, improved care, and reduced costs.
- Cross sector collaborations and communication will strengthen the evidence that demonstrates how CHWs generate cost savings and improve their community's overall health.

COMMUNITY HEALTH WORKER CONTRIBUTIONS

Although data on CHW cost effectiveness is scarce, there are many examples of how CHWs have contributed to the advancement of the Triple Aim for health care which includes: improved health, improved care, and reduced costs. Findings from a study on how CHWs were integrated into a patient-centered medical home in New York City show improved healthcare among clients and better services². Since incorporating CHWs into the care team, emergency department visits and hospitalizations among patients with diabetes and other chronic health problems declined significantly².

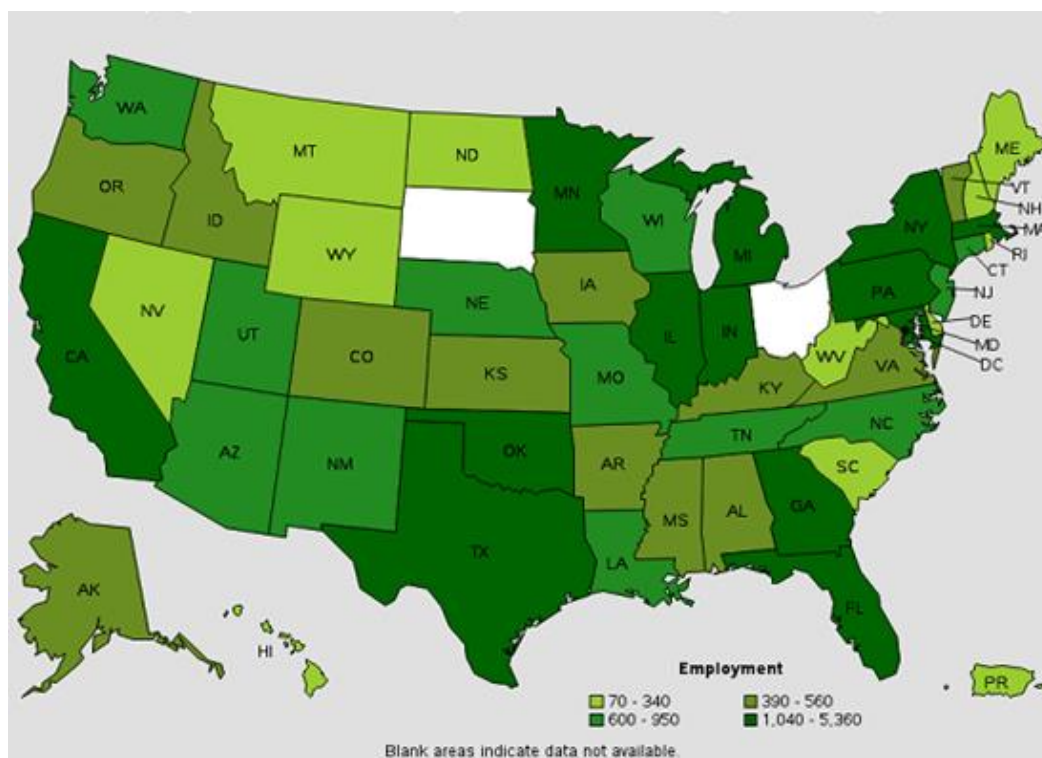
The New York study on CHWs found a generated net savings of \$1135 per patient. The return on investment was also high and showed that for every dollar invested in the CHW program, the hospital saved \$2.30. Another example of CHW cost savings was found in a cardiovascular disease intervention program in Baltimore, Maryland. In this study, participants received lifestyle and diet coaching, home-based exercise programs, home visits, and telephone reminders of appointments. The intervention led to significantly better systolic blood pressure, LDL- cholesterol, hemoglobin A1C, and patients' own perceptions of their chronic illness⁴. However, like many CHW program evaluations, cost-effectiveness data for the COACH intervention lacked.

COMMUNITY HEALTH WORKER SUCCESSES ACROSS STATES

From 2013-2016, ASTHO worked with 22 states in a learning collaborative that utilized a quality improvement process to partner across sectors including clinical, community, and public health partners to implement best practices and evidence-based policies to identify, control, and improve blood pressure. Below are brief summaries of how states involved and successfully integrated CHWs:

- **Texas:** Several local health departments engaged community health workers to promote linkages between health systems and community resources for adults with hypertension. As a result of the learning collaborative, Texas is exploring how to utilize CHWs in emergency rooms to direct patients back to primary care or other clinical outpatient settings. The Texas Department of State Health Services also operates a Promotor(a) or Community Health Worker Training and Certification Program for CHWs and instructors. Certification is for two years. The health department reviews and approves all certification, training, and continuing education programs.
- **Connecticut:** CHWs engaged with community members at risk for health inequity based on the degree of poverty and the significantly increased risk for cardiovascular disease. CHWs were able to connect individuals to clinical and self-management support. They have successfully created new tools such as patient materials about hypertension that are available in English and Spanish. Their state innovation model (SIM) includes approximately \$1 million in SIM test grant funds to support CHW workforce development.⁸
- **Michigan:** The Michigan Department of Community Health is leading a team of state and local partners in Muskegon County and Saginaw County. Muskegon County is working with primary care clinic-based care coordinators to implement best practices for assisting patients with managing high blood pressure through the engagement of CHWs. As of July 2016, they are pursuing return on investment efforts led by a representative from a local payer, HealthPlus of Michigan, a medium-sized local payer, located in Flint, Michigan. They hope to demonstrate the value of their efforts, obtain support from future financial partners, and expect the results of the ROI will also support the work of CHWs.
- **Wisconsin:** Through the ASTHO learning collaborative, five CHWs participating in the collaborative incorporated motivational interviewing approaches in their Milwaukee pilot site. CHWs received training on the American Heart Association's high blood pressure treatment algorithm, a flow chart designed to help health providers treat patients with hypertension, as well as the Check Change Control program (CCC), which focused on empowering individuals to learn about, monitor, and manage their blood pressures through a variety of resources. Each CHW committed to work with assigned participants in the CCC and Heart 360 programs and encouraged participants to attend healthy lifestyle change programs (i.e. cooking demonstrations, physical activity, and cardiovascular disease education). The baseline average blood pressure in February 2016 was 139/90, and the baseline average in May 2016 was 124/77. This shows a promising decrease in blood pressure readings over eight weeks with utilization of CHWs.

Figure 1: Employment of CHWs by State, May 2015



Source: <http://www.bls.gov/oes/current/oes211094.htm>

FINANCING OPPORTUNITIES FOR STATES

Figure 1 shows which states employ CHWs. Most states rely on public and private payment mechanisms to fund CHWs, while some CHWs are volunteers. Funding for CHWs can be difficult to secure and sustain. A lack of consistent funding leads to unstable CHW programs, which in turn creates a fragmented foundation of trust and communication in the community.⁹ In 2009, the U.S. Department of Labor recommended the creation of a Standard Occupational Classification for CHWs,¹⁰ which was also included in the 2010 provision of the ACA, including several sections that recognize the importance of CHWs to achieving ACA goals as well as opportunities for funding. In section 5403 of the ACA, Area Health Education Centers must now include CHWs in interdisciplinary training. ACA also provides funding for SIMs, which encourage ideas to transform healthcare delivery and payment. Six states were given awards and four states have included CHWs in their plans, including Arkansas, Maine, Minnesota, and Oregon.¹²

CHW financing opportunities are also available through Section 1115 of the Social Security Act, which gives the Secretary of HHS the ability to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children’s Health Insurance Program. Section 1115 waivers have been used by some states to cover the costs of CHW programs. States such as Alaska, California, and Minnesota have received waivers to consider CHWs as reimbursable professions.¹³

Figure 2: Successful CHW Funding Models

- **Minnesota:** Became one of the first states to establish a sustainable funding stream to support CHWs.¹⁶ Through their Healthcare Education-Industry Partnership, a statewide stakeholder coalition, Minnesota was able to make a financial case for CHWs by identifying ROI for the dollars spent on training and employment. In 2007, the Minnesota legislature approved reimbursement of CHW services under Medicaid. Following this, the Centers for Medicare and Medicaid Services approved a Medicaid State Plan Amendment that approved payments for CHWs.⁷
- **Texas:** A Medicaid 1115 waiver incentivizes hospitals and other providers to improve healthcare. CHWs are involved in a small number of the more than 1,300 projects and are reimbursed through this mechanism. Contract language for managed care health plans were amended to incorporate a definition of CHWs and clarified how CHW costs can be included in administrative costs.⁶
- **Maryland:** CHWs are financed primarily through grant funding, such as the Minority Outreach and Technical Assistance program grant which awards individual jurisdictions based on the proportion of minorities in the respective populations. The grant requires awardees to utilize science and data to describe and promote systems change directed toward eliminating health disparities with an emphasis on preventive health. Medicaid does not reimburse for CHWs. The workgroup on Workforce Development for Community Health Workers is tasked with making recommendations to the legislature on reimbursement and payment policies for Medicaid and private payers. CHWs are a key element of the recently submitted SIM plan.⁷

While funding from Medicaid reimbursement is a valuable opportunity for states, requirements for securing a Section 1115 waiver can be onerous since it requires detailed clinical reporting, certifications, and budget requirements. Medicaid Managed Care Organizations also provide support to CHW programs since they often use funds to finance CHW programs through employment or reimbursable benefits.¹⁴

Several states have successfully developed funding models to support CHWs. Successful payment models will be useful in attaining CHW health goals and outcomes that result in cost savings statewide. Figure 2 below shows successful CHW funding models used by states.

RESOURCES FOR ACTION

The role of CHWs depends on the organization they work for and the community that surrounds them. CHWs have different roles and responsibilities, ranging from health education, health promotion, patient advocacy, and referrals to care. There are a wealth of resources available that provide tips and guidance on how to successfully integrate and utilize CHWs into public health organizations. Figure 3 features several resources for both state health officials and CHWs. Resources focus on CHW integration efforts, best practices from successful CHW programs, and CHW financing.

Figure 3: Resources for Action

National Academy for State Health Policy: Community Health Worker (CHW) Map

Highlights state activities to integrate CHWs into evolving healthcare systems in areas such as financing, education and training, certification, and state definitions, roles, and scope of practice.

[Link >](#)

ASTHO Community Health Worker Resources

Contains resources for state health agencies on the use of non-licensed providers such as CHWs, including resources related to financing, certification and licensure, and examples of work in states to support CHWs. [Link >](#)

USAID Health Care Improvement (HCI) Project: Community Health Worker Assessment and Improvement Matrix (CHW AIM): A Toolkit for Improving Community Health Worker Programs and Services

Tool for conducting assessment and improvement for CHW practice. The toolkit examines 15 programmatic components that CHW programs should consider as important to successfully supporting CHWs. [Link >](#)

Dialogue4Health: Sustainable Financing for CHWs: Medicaid Opportunities Webinar

Features speakers from state agencies in Connecticut, Michigan, Minnesota, and Pennsylvania who provide insight into how they have approached sustainable financing levers for CHWs, such as the recent preventive service rule change (440.130), managed care contracting, and health homes.

[Link >](#)

CONCLUSION

As our healthcare landscape continues to evolve and change rapidly, CHWs are becoming more prominent in our public health workforce. It is vital that federal, state, and local stakeholders track and share best practices as CHW financing models and initiatives develop. These best practices will strengthen the data and research available on CHW cost savings and ROI. States should continue to think about which services CHWs will provide, how to integrate CHWs into their system, and available partnerships within their community. The sharing and distribution of state examples will strengthen the evidence that CHWs generate cost savings as well as improve the community's overall health.

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