
# U.S. Community Health Worker Landscape Report

## PIH United States

***Updated July 2024***

*Photo by Scott McIntyre for PIH*

Partners In Health
UNITED STATES

# *Acknowledgement*

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This product also draws on the work of numerous organizations and individuals deeply immersed in the work of defining and supporting Community Health Workers. Their contributions are acknowledged via references throughout this resource.

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# *How to use this resource*

This resource was built over a three-year span (2021 -2024) primarily to inform NCDHHS' CHW programs during and after COVID-19. It was created with the goal of being a reference document to **describe the national CHW landscape**, **showcase best practices**, and **learn from the existing CHW evidence-base**.

Each section in this deck covers a different topic related to the CHW workforce, providing high—level background on important CHW concepts, links to materials with more detail, and applications of the information to primarily inform the NC CHW Initiative. The sections do not have to be viewed in any particular order and can be accessed directly from the links provided in the table of contents.

The information was last updated and reviewed in July 2024, and we encourage readers who wish to use the information to check for any changes in policies or practices that may have occurred since the last official review of the document.

## Key updates/additions for July 2024 deliverable:

- Slide 39: New slide listing federal block grants available to fund CHW programs
- Slide 50-51: Slide highlighting two states that allow CBOs to bill for Medicaid (AZ, SD)
- Slide 47: New slide on early observations from Medicare PFS implementation
- Slide 94-95: New slides with additional background on CHW hubs, a growing integration model
- Slide 106-107: New slides describing the CHW IMPaCT model (formerly known as Penn IMPaCT)
- Slide 131, 133-134, 138-140, 153, 156: New state slides on Alabama, Arizona, Illinois, New Hampshire, and New York

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# Commonly used abbreviations

| | | | |
|---|---|---|---|
| **ACL** | Administration of Community Living | **FQHC** | Federally Qualified Health Center |
| **ACO** | Accountable Care Organization | **HRSN** | Health-related Social Needs |
| **APM** | Alternative Payment Mechanism | **MA** | Medicare Advantage |
| **CBO** | Community-Based Organization | **MCO** | Managed Care Organization |
| **CCH** | Community Care Hub | **PFS** | Physician Fee Schedule |
| **CHC** | Community Health Center | **PPS** | Prospective Payment System |
| **CHW** | Community Health Worker | **ROI** | Return on Investment |
| **CMS** | Centers for Medicare & Medicaid Services | **SDOH** | Social Determinants of Health |
| **D-SNP** | Dual Eligible Special Needs Plan | **SPA** | State Plan Amendment |
| **FFS** | Fee-for-service | **VBP** | Value-based Payment |

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# Who is considered a community health worker (CHW)?

**The American Public Health Association CHW Section has adopted the following definition of a CHW:**

A community health worker is a **frontline public health worker** who is a **trusted** member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker 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 community health worker 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.

**CHWs are members of the community themselves, and as such, have unparalleled expertise in the health issues affecting their communities and geographies.**

https://www.apha.org/apha-communities/member-sections/community-health-workers
https://ucsdcommunityhealth.org/news/community-health-workers-training-program-aims-to-increase-access-to-health-care-services-in-underserved-neighborhoods/

# CHW titles may vary, however their function as trusted messengers and connecters define their role as a community health worker

## Partial list of titles for CHWs

- **Community Health Worker (CHW)**
- Promotor(a) de Salud
- Aunties (Hawaii)
- Birth Assistant (Doula)
- Birthing Family Support Worker
- Care Coordinator
- Community Advocate
- Community Aide
- Community Care Specialist
- Community Care Worker
- Community Coordinator
- Community Dental Health Coordinators
- Community Health Associate
- Community Follow-Up Worker
- Community Health Advocate
- Community Health Aide
- Community Health Coach
- Community Health Coordinator
- Community Health Educator (CHE)
- Community Health Navigators
- Community Health Organizer
- Community Health Outreach Worker
- Community Health Partners
- Community Health Representative (CHR)
- Community Health Specialist
- Community Liaison
- Community Navigator
- Community Organizer
- Community Outreach Navigator
- Community Outreach Worker
- Community Promoter
- Community Social Worker
- Cultural Case Manager
- Cultural Interpreter
- Cultural Mediator
- Diabetes Education Associate
- Diabetes Self-Management Support Associate
- Diabetes Educator
- Diabetes Family Support Worker
- Diabetes Navigator
- Family Advocate
- Family Planning Counselor
- Family Support Worker
- Family Advocate
- Family Health Advocate
- Family Health Promoter
- Family Outreach Worker (FOW)
- Family Support Specialist
- Family Support Worker
- Health Ambassadors
- Health Communicator
- Health Extension Workers
- Health/Nutrition Support Worker
- Health Promoter
- Health Liaison
- Health Specialist
- Health Workers
- HIV/AIDS Educator
- HIV/AIDS Family Support Worker
- HIV Peer Advocate
- Homeless Advocate
- Lay Health Advocate
- Lay Health Worker (LHW)
- Mental Health Worker
- Men's Health Specialist
- Men's Health Worker
- Navigator
- Neighborhood Health Advocate
- New Professionals
- Outreach Advocate
- Outreach Coordinator
- Outreach Educator
- Outreach Specialist
- Outreach Worker
- Patient Experts
- Patient Navigator
- Peer Advocate
- Peer Counselor
- Peer Educator
- Peer Health Educator
- Peer Support Specialist
- Peer Wellness Specialist
- Physical Activity Specialist
- Social Determinants of Health Specialists
- Street Outreach Worker
- Wellness Ambassadors
- Wellness Guide
- Women's Health Specialist
- Youth Development Specialist
- Youth Peer Counselor
- Youth Worker

https://cachw.org/job-titles

# Core roles and qualities – the C3 Project

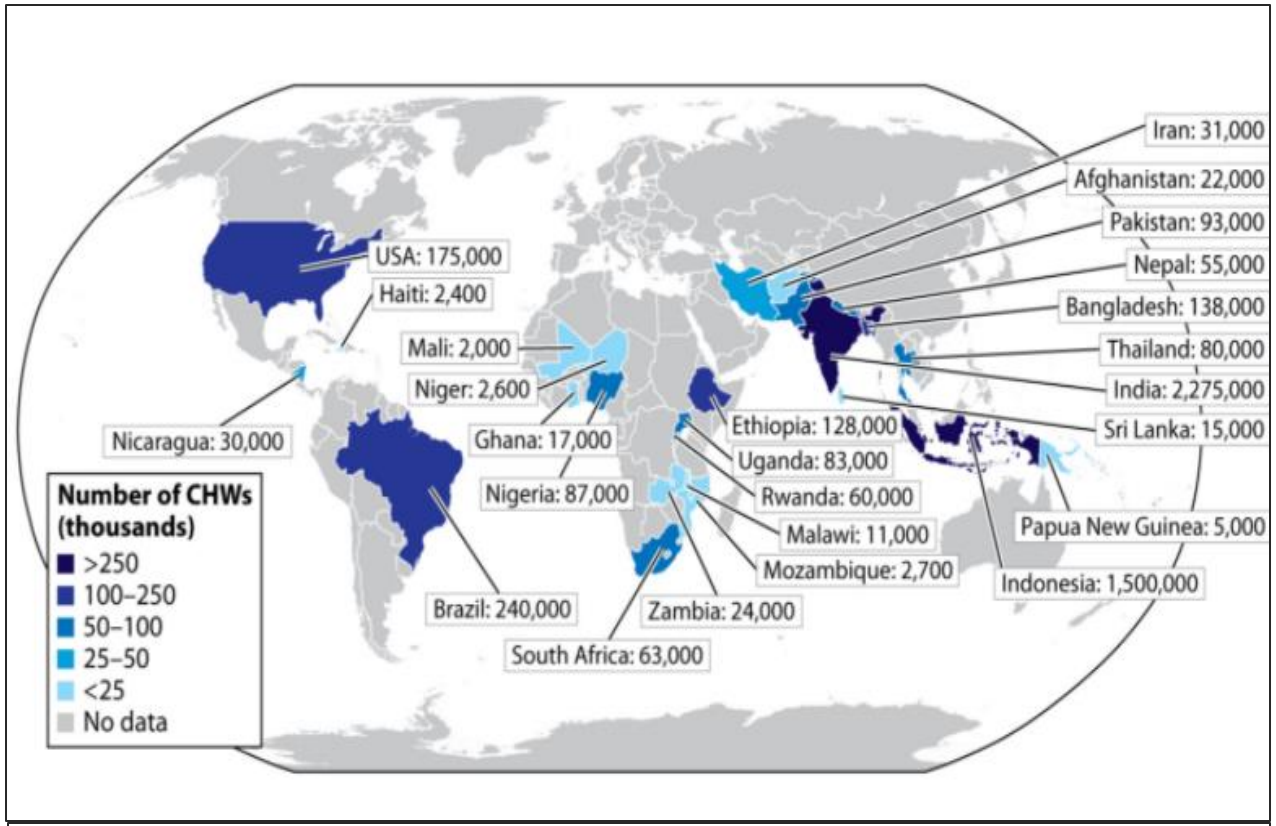
The **CHW Core Consensus (C3) Project** seeks to promote greater understanding of the full potential of CHWs within health and community development. The C3 has articulated **10 core roles (left)** and numerous **core qualities (right)** that characterize CHWs. The C3 has also identified 10 **core skills**, to be discussed in the training section of this deck.

| | |
|---|---|
| 1 | Cultural Mediation Among Individuals, Communities, and Health and Social Service Systems |
| 2 | Providing Culturally Appropriate Health Education and Information |
| 3 | Care Coordination, Case Management, and System Navigation |
| 4 | Providing Coaching and Social Support |
| 5 | Advocating for Individuals and Communities |
| 6 | Building Individual and Community Capacity |
| 7 | Providing Direct Service |
| 8 | Implementing Individual and Community Assessments |
| 9 | Conducting Outreach |
| 10 | Participating in Evaluation and Research |


https://www.c3project.org/

# CHWs significantly impact low-resource communities across the world

- Contribute **to reduction of undernutrition** by promoting of exclusive breastfeeding care (Black et al. 2008).
- Effective in **reducing mortality in children** under 5 years of age (Inst. Int. Health Progr. 2012).
- Provide **community case management** of serious childhood illness (Black et al, 2010).
- Provide interventions to **reduce neonatal mortality** (Lassi et al., 2010).
- **Reduce maternal mortality** and expand access to **family planning services** (Prost et al, 2013).
- **Prevent and reduce the spread of HIV/AIDS** (UNAIDS, 2012).
- **Prevent malaria and TB** (WHO, 2012).
- **Improve hypertension, reduce cardiovascular risk factors, increase knowledge, improvements in physiological measures and positive changes in lifestyle and self-care** were noted for diabetes, and **improve mammography screenings** (Inst. Med. 2010, Norris et al., (2006), Wells et al., (2011)).




*Perry et al. (2014) estimated the numbers and locations of CHWs from selected countries with the largest CHW programs globally.*

Click here to learn more about the need for CHWs around the world through Community Health Impact Coalition (CHIC)

# CHWs play an important part in healthcare in high-income nations

- CHWs play a significant role in increasing patient's use of preventive services such as breast and cervical cancer screening among low-income and immigrant populations (Mock et al., 2007; Junghans et al., 2023).
- CHWs are effective in the provision of culturally appropriate care, health education and advocacy (Pérez & Martinez, 2008).
- CHWs have shown to have positive effects in chronic disease management including significant impacts on diabetes care, hypertension, cardiovascular diseases, and their clinical outcomes (Gary et al., 2003).
- CHWs have increased access and utilization of primary health care services reducing hospital admissions and improving post-hospital care (McCollum et al., 2014).
- CHWs intervention can reduce need for inpatient care, refocusing on less costly primary care services, with a return on investment of $2.28 per $1 spent on CHW intervention (Javanparast et al., 2018).
- CHW programs can contribute to addressing community needs, improving social inclusion and community empowerment (Whitley et al., 2006).
- CHWs can play a significant role in pre-natal health promotion outreach, community development, and addressing social determinants of health among migrant and refugee groups (Torres et al., 2014).

# Benefits of engaging CHWs in healthcare

CHWs are a vital part of the US healthcare system. In addition to helping to reduce healthcare costs, they play a critical role in improving population health and individual patient outcomes through health education and other services.

## Local CHW Case Studies

**Baltimore |** Among Medicaid patients with diabetes who engaged with CHWs, there was an average **annual savings of $2,245 per patient per year**

**Denver |** Among health safety net users who engaged with CHWs, there was a **2.28:1 return on investment** from reduced use of urgent, inpatient care

**Hawaii |** A CHW program **reduced asthma-related per capita charges by 75%** mainly from decline in ER visits

## National CDC CHW Case Studies

**Improved hypertension control** with teams including CHWs

**Improved cancer screening knowledge** and cervical and mammography **screening outcomes**

Improved **appointment keeping**, **compliance**, risk reduction, BP control, and related **mortality**

**Better diabetes clinical measures** when cared for by a CHW and nurse case-manager group compared to CHW or nurse alone

CDC - CHW eLearning - Session 4 - Page 16 - DHDSP

Addressing Chronic Disease through Community Health Workers: A Policy and Systems-Level Approach (cdc.gov)

https://pubmed.ncbi.nlm.nih.gov/12723008/

# CHW roles in the COVID-19 response

CHWs have played important roles across all aspects of COVID-19 response - as vaccine outreach workers, navigating difficult conversations, care resource coordinators, and more - prioritizing social supports and bringing a strong understanding of community-specific healthcare challenges/barriers to their work. CHWs have:


Shared accurate and culturally relevant information on COVID-19 prevention. Distributed PPE, cleaning supplies, and other resources to prevent spread of disease.

Improved access to and uptake of COVID-19 testing - hosting testing events, providing at-home kits and education, and connecting people to testing sites.

Carried out contact tracing and case investigation to slow transmission and connect individuals to resources.

Coordinated provision of resources and services to enable safe isolation and quarantine, particularly in underserved areas or in specific communities.

Increased vaccine uptake by providing culturally-relevant COVID-19 education, supporting vaccination events, and acting as a trusted messenger to navigate challenging conversations with community members.

*See "Community Health Workers in Pandemics: Evidence and Investment Implications" Ballard, Johnson, et al*

# CHW roles in the COVID-19 response: the RADx-UP consortium

RADx® Underserved Populations (RADx-UP) is a consortium of 144 research projects studying COVID-19 testing patterns in communities across the United States, territories, and Tribal Nations. Many of the 137 RADx-UP projects embedded CHWs as key partners in their programmatic infrastructure to reduce inequities in COVID-19 testing. Through publications, the initiative was able to identify a number of ways in which CHWs were integral to Covid-19 immunization campaigns.

## Resource Allocation

- Liaisons
- Identifying Resource Needs
- Community Advisory Boards

## Payment

- Identifying assets

## Access

- Resource Navigation
- Direct resource delivery

## Communication

- Community outreach

## Data

- Data collection
- Community-based participatory research

https://radx-up.org/wp-content/uploads/2022/05/Final_radx-up_policy-paper_09may20221_508.pdf
https://radx-up.org/wp-content/uploads/2023/05/radx-up_community_health_worker_policy-paper_22may2023.pdf

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# Challenges in the field

**Access to transportation**: CHWs often travel to rural communities to provide services or conduct outreach because the populations they work with often have limited access to transportation. CHWs should be reimbursed for traveling costs.

**Safety Issues:** CHWs often deal with challenging interpersonal situations in communities and home visits, ranging from conflict management to interpersonal violence. Programs must ensure the safety of CHWs and should provide safety training to CHWs.

**Program resources:** CHWs need access to technology including mobile technology to help them accomplish their job on-the-go and in rural settings. Programs should provide resources such as wireless internet access cards, tablets, and other tools necessary to complete their tasks.

**Cultural barriers:** CHWs are often able to bridge cultural and linguistic barriers that impede positive health outcomes. All program materials should be culturally appropriate, communicating information in a way that considers the local customs, beliefs, values, and traditions of the community.

**Patient referral challenges:** CHWs often have difficulties in referring patients to healthcare providers and coordinating services with outside providers due to lack of system coordination. Steps should be taken to improve systems for coordination of care between agencies.

*Photo credit: Scott McIntyre*

# Challenges as a field

**Lack of integration with other partners:** CHW's in the community are often not connected to the rest of the public health system, including public health departments, primary care, and other less traditional health system players including social service providers.

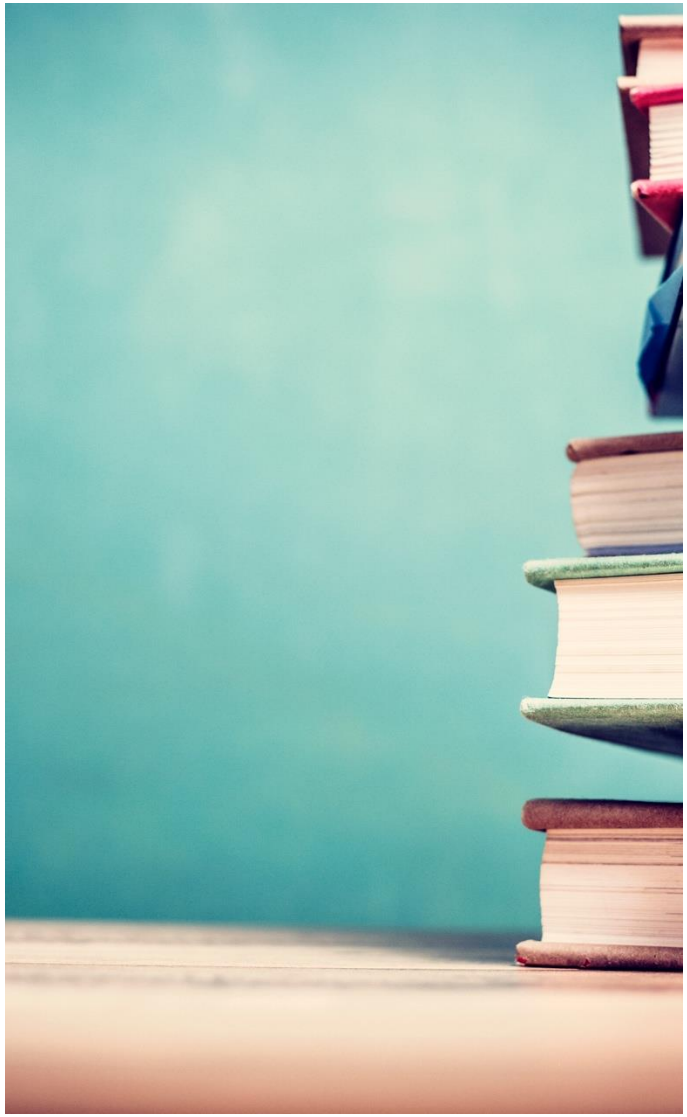
**Variable compensation (often low or none):** The compensation mechanisms for CHWs are fragmented and these positions are often time-limited, which contributes to reduced draw for new professionals and to retention challenges.

**Perceived lack of standardization:** Approaches to programming, training, and certification vary among CHWs – and while this offers flexibility for different contexts, it poses challenges for unified advocacy and public awareness.

**Unclear career advancement pathways:** "Advancement" often moves CHWs out of their role rather than into leadership positions that inform community health work, contributing to low workforce retention and a significant resources diverted to re-hiring and training.

**Funding challenges:** CHW programming is often funded by multiple grants of varying terms; funding is many times inflexible and short-term, restricting programmatic activities and staff development.

**Common threads running through these challenges include lack of awareness and value for the CHW role, as well as insufficient or inconsistent coordination with other players in the health ecosystem.**



# An emerging challenge: CHW burnout post-pandemic

US healthcare workers were already experiencing concerning levels of burnout prior to the pandemic. Now, the post-pandemic world has left nearly 76% of all frontline healthcare workers, CHWs included, exhausted and burned out.

The US Surgeon General Advisory has sounded the alarm on health worker burnout and resignation, as more than half of all US health workers suffer from at least one mental health condition.

CHWs, as they work diligently to support their clients, may struggle to support themselves. According to a 2021 self-care survey:

- Only 35% of CHWs stated can identify their *own* issues of trauma, stress, and grief and loss.
- 13% of participants rarely practice self-care and 50% practice only as needed.

***An important note on burnout***

Many aspects of burnout depend on the social and political, biological, psychological, and medical factors that cannot be fixed with self—care methods and require organizations to work across the system to create solutions. This fact is often obscured in the discourse around burnout, which puts much of the burden on the individual to use self-care for prevention. See this article for more on this perspective.

*Resources:*

- **Surgeon General's Advisory Addressing Health Worker Burnout**
- **NRC-RIM CHW Self-Care Training**
- **Self-Care for CHWs Curriculum**
- **Self-Care Action Plan**

https://nrcrim.org/sites/nrcrim.umn.edu/files/2022-05/Self%20Care%20Final%20Package%2005232022.pdf

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# State legislation best practices

**Legislation cannot singularly achieve the goal of a valued and supported CHW workforce, but many states have made great strides through bills that:**

- Create certification programs/requirements that outline career advancement pathways
- Establish standardized training curricula to provide a standard for CHW competencies.
- Offer sustainability and flexibility in funding. More financing-related best practices found on this slide.
- Include CHWs in decision-making spaces, the establishment of a CHW Advisory Body may itself be supported and shaped by legislation.
- Detail appropriate hiring criteria to ensure that CHWs are from the communities they serve.

See additional examples and information here

**State policymakers should look to include CHWs in shared decision-making processes to avoid creating unintentional barriers to entering the workforce or successfully delivering care in the community.**

Recommendations for promoting inclusion:

- **Working groups** pursuing CHW-related policies should be comprised of at least 50% self-identified CHWs such as in Illinois, Maryland, and Oregon.
- **CHW policies** should not exclude non-certified CHWs from practicing in the workforce, even as other policies encourage certification.

# State legislation support multiple aspects of CHW programming

**State law can play a key role in building effective and equitable CHW programs**, advancing policies that address multiple aspects of CHW programs to establish infrastructure, creating a shared professional identity among a valued workforce, and integrating systems to effectively meet the needs of communities.

**Infrastructure**
- CHW advisory body

**Professional Identity**
- CHW definition & scope of practice

**Workforce Development**
- CHW certification or training process
- Standard curriculum with core skills

**Financing**
- State financing and incentives for services
- Integration into team-based care

Legislative action is *not* a requirement for improvement in any of the above areas, but supportive legislation can be highly influential in obtaining buy-in and advancing programmatic goals. Legislation may require or recommend certain activities, and states vary in their approach.

https://www.networkforphl.org/wp-content/uploads/2020/01/Legal-Considerations-Community-Health-Workers.pdf
https://www.cdc.gov/dhdsp/pubs/docs/chw_state_laws.pdf

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# Education and training for CHWs

**Training is a part of any effective CHW program, regardless of whether certification is the end goal.** Training should be a continuous process that provides opportunities for updated knowledge and further skills development

- Training may be managed in house by the employer or through collaboration with external partners.
  - CHW certification bodies may partner with an outside organization to develop and administer a formal, standardized training curriculum for initial training (pre-service).
  - External organizations may include CHW associations, nonprofits, training centers, and/or institutional health education centers like community colleges.
- Some programs require a certain number of continuing education (CE) credits over a given time or offer CE for specialized care (specific conditions or advanced skills)
- **There are potential disadvantages of standardized curricula:** statewide standardization may not align with employer-specific training or lower resourced organizations may struggle to provide ongoing training or continuing education

Zack DeClerck, PIH - Malawi

NCOA: Critical Inputs for CHW Programs
NACHW: Statewide Training Approaches for Community Health Worker

# A wide variety of topics may be included in training curricula

**Topics covered by CHW training programs may differ from program to program and community to community. Topics may include:**

- Accessing healthcare and social services systems
- Practicing cultural competency
- The pathophysiology (disease processes) of different diseases
- Social determinants of health
- Translating, interpreting, and facilitating client-provider communications
- Gathering information for medical providers
- Working with clinicians
- Supporting family members and caregivers
- Delivering services as part of a medical home team
- Educating social services providers on community and population needs
- Teaching concepts of disease prevention and health promotion to patients
- Understanding how work aligns with health system goals
- Managing chronic conditions, including training on lifestyle strategies, risk factors, self-monitoring and medications
- Engaging in health prevention and promotion activities
- Home visiting
- Liability, legal, and ethical issues
- Trauma-informed care
- Stigma and community prejudices
- HIPAA and patient privacy
- Safety
- Mental health
- Motivational interviewing and public speaking
- Utilizing technology, including mobile applications and electronic health records
- Evaluation and research

https://www.ruralhealthinfo.org/toolkits/community-health-workers/4/training/curriculum

# Training curricula should focus on building core skills and competencies

In light of the considerable variation in training topics, the C3 Project has set out to promote alignment around core skills and competencies. **Many states align their training programs to the C3 standard to ensure CHWs have a well-rounded set of competencies and skills** that are applicable in a range of community health worker roles.

| C3 Core Skills | |
|---|---|
| 1 | Interpersonal and Relationship-Building Skills |
| 2 | Service Coordination and Navigation Skills |
| 3 | Capacity Building Skills |
| 4 | Advocacy Skills |
| 5 | Education and Facilitation Skills |
| 6 | Individual and Community Assessment Skills |
| 7 | Outreach Skills |
| 8 | Professional Skills and Conduct |
| 9 | Evaluation and Research Skills |
| 10 | Knowledge Base |

**Beyond simple lecture, the following approaches/ delivery methods are highly encouraged in training:**

- Popular education methods (see next slide)
- Practice time for new skills learned
- Role-play prior to interacting with patients
- Team-based exercises
- Retention and reference to training materials, such as pamphlets or manuals, 1-pagers, review cards
- Shadowing CHWs in the field
- Supervised home visits early on in training

**State CHW associations will be helpful in supporting comprehensive and ongoing training.**

https://www.c3project.org/roles-competencies

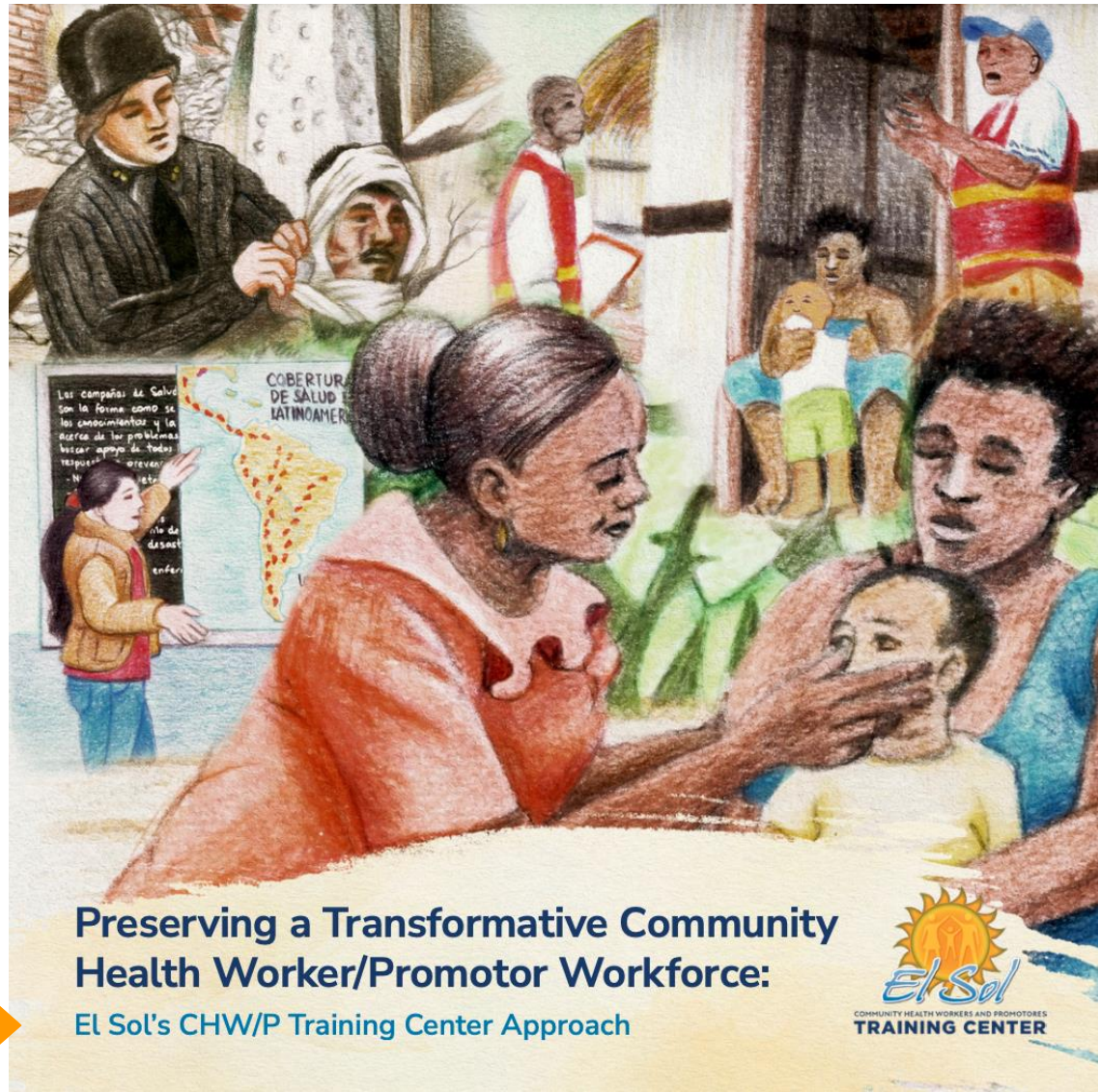
# The popular education method for training

**Best practices in CHW training follow popular education methods.**

**Popular education is a learning style that encourages participation, cooperative study, and action**. It is characterized by the belief that all people have a right to knowledge, and that education can be a collective process where students can teach and teachers facilitate exchange of information.

Popular education allows for bidirectional learning between the trainers and the students and acknowledges the role of both theory and lived experiences in learning.

Read more about one organization's approach to training CHWs using popular education methods (El Sol)



# CHW certification

Certification can be used to describe occupational standards for CHWs. Some organizations may use the terms "credentialing" and "certification" interchangeably, but credentialing may also include licensure, registration, and permit issuance – none of which are typically required of CHWs.

## General Characteristics of CHW Certification

May be **state-operated** through legislation **or privately operated** through a credentialing board, such as a CHW association or medical board.

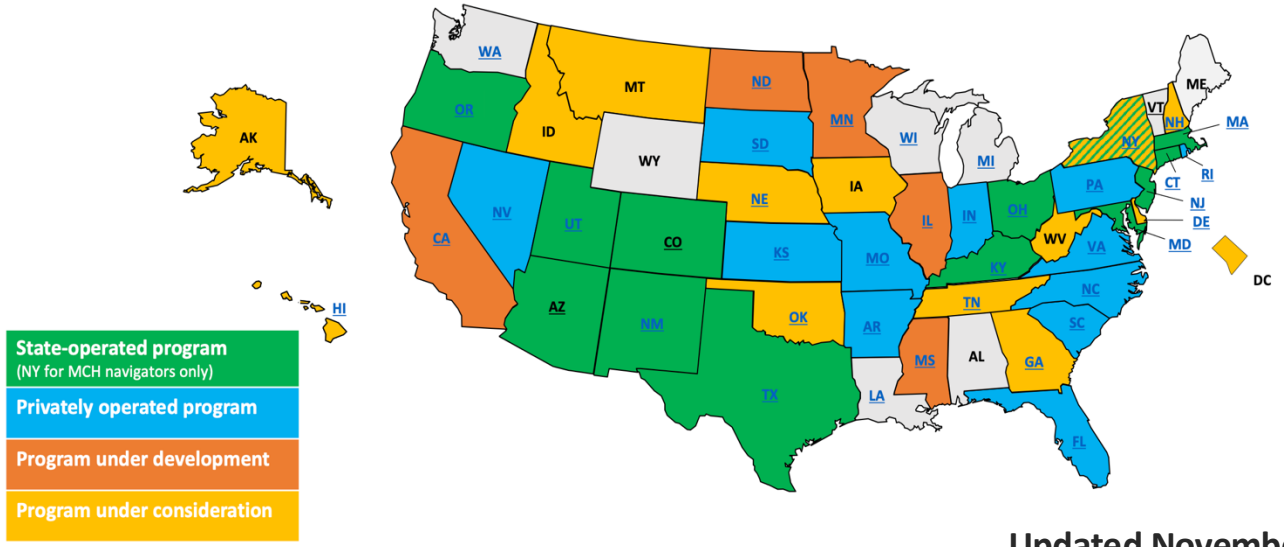
May be **voluntary or mandatory** at the state level. It may also be mandatory for employment by particular employers, or for reimbursement of services by particular funding streams (e.g. some Medicaid plans)

Is typically obtained on the basis of **formalized training** (described in detail in later sections) and experience. Equitable and responsive certification programs may offer a legacy or "grandparenting" track to acknowledge the value of **lived experience and acquired expertise** of people who have been working as CHWs before certification programs were introduced.

# CHW certification approaches vary by state

CHW certification varies widely throughout the United States. **States may have different approaches to certification in terms of how, and under what authority and regulating body, to finance, train, certify, and regulate the workforce**.

## Ever-Changing Picture: State Approaches to CHW Certification




**Updated November 2023**

***ASTHO***

**43 states** are moving toward or have already established a certification process for CHWs.

Certification may occur through a **state-operated certification process** (e.g., through a state health department), or a **privately operated certification process** (e.g., through a private certifying board).

Some efforts are guided by state legislative authority. These bodies may establish a board or workgroup of stakeholders to make recommendations around CHW certification and training.

*For another interactive map resource from MHP Salud, please click here*

https://www.astho.org/topic/brief/state-approaches-to-community-health-worker-certification/

Original source: ASTHO
Health Affairs

# Not all states have an official certification process. There are benefits as well as drawbacks of requiring certification for both CHWs and employers/payers

| | CHWs | Payers and Employers |
|---|---|---|
| **Anticipated Benefits** | • Higher wages.<br>• Improved working conditions.<br>• Increased respect from other professions.<br>• Wider career opportunities.<br>• Stable employment.<br>• Sustainable funding.<br>• Progress in building professional identity.<br>• Increased understanding of the field.<br>• Consistent standards for the field. | • Clear scope of practice boundaries.<br>• Consistent, reliable qualifications among CHWs.<br>• Simplified recruitment and selection, and a more fluid job market.<br>• Reduced on-the-job training costs.<br>• A clearer rationale for integrating CHWs into care teams.<br>• Reduced dependence on short-term funding. |
| **Assumed Negative Impact** | • New barriers to entry.<br>• Creation of a "class" system among CHWs.<br>• Making CHW practice more clinical and less connected to the community.<br>• Regulations, restrictions, or changes to what CHWs are allowed to do.<br>• Employing people without strong connections to the community.<br>• Further marginalization of volunteer CHWs. | • Pressure to increase wages.<br>• New regulations and restrictions on their organizations.<br>• Increased overall training costs.<br>• CHWs losing touch with the community, thereby becoming less effective overall. |

**Some states, (e.g. Wisconsin, Louisiana), in consultation with CHWs in their jurisdiction, have chosen not to create a certification program**

# Best practices in developing a certification process

To maximize benefits and minimize possible harm to both CHWs and employers, **certification initiatives should promote equity and ensure responsiveness to CHW needs, and CHW leadership should be at the forefront of both the certification development process and the implementation plan.**

## A responsive and equitable approach to certification:

- **Involves a diverse set of stakeholders, including community members,** in the development to help legitimize the resultant certification (e.g., CHWs, potential employers, hospital associations, community health centers, state Medicaid, medical providers, and community-based organizations)
- **Is steered by an advisory body or certification council**/board that oversees processes, reviews applications, and lays out requirements for recertification and advancement; **this board should include substantial representation from the CHW workforce**
- **Allows for multiple paths to entry** through legacy/grandparenting processes
- **Is accessible**, through a user-friendly application process without exorbitant fees, barriers around educational attainment, language, citizenship status, criminal background,
- **Only requires trainings that are appropriate for the scope of work and accessible** (in terms of geography, $, language, timings, etc.)

# There is a broad range of activity around CHW certification in the US

### State-Operated Program, Certification Required

**Texas**

- The Texas Department of State Health Services (DSHS) established the CHW program, in accordance with Health and Safety Code Chapter 48, to operate a program designed to train and educate persons who act as promotores or CHWs.
- Certification is required for any promotora or CHW receiving compensation for providing services.

### State-Operated Program, Certification Voluntary

**Massachusetts**

- The Board of Certification of CHWs has the authority to grant voluntary certification to individual CHWs and to approve CHW Core Competency Training Programs.
- Certification regulations also require approved training programs to include a CHW co-trainer or trainer in at least 40% of instructional hours, which provides an advancement opportunity for CHWs.

### Privately Operated Program, Certification Voluntary

**Florida**

- Certification is recommended, but not required. Recommendation varies from payer to payer - certification is voluntary in Florida.
- The state currently has no policy on supervision.
- Florida is examining stackable credentials that will allow CHWs to progress on a career path and to enhance the prospect of sustainability and provide them with opportunities for livable wages.

### No Certification Programs; Training Options

**New York**

- New York State currently does not have certification for CHWs, but there are training programs available which provide a certificate of completion.
- The New York State Department of Labor supports CHWs entering the workforce through an apprenticeship program.
- Many employers require a training certificate before or during the initial 6 months of employment.

See NASHP for detailed information on certification of CHWs by state.

**Table of Contents**

# Financing CHW programs and services

**The funding landscape for CHWs in the US reflects the fragmented approach to healthcare in the country.**

Most states use a combination of sources to pay for CHW programs, with CHW services paid for by the government or public funding streams, individual payment, or via grant funding to employers.

Funding is often...

...**short-term**

...**subject to funder-led decisions**

...**targeted to very specific goals or issues**.

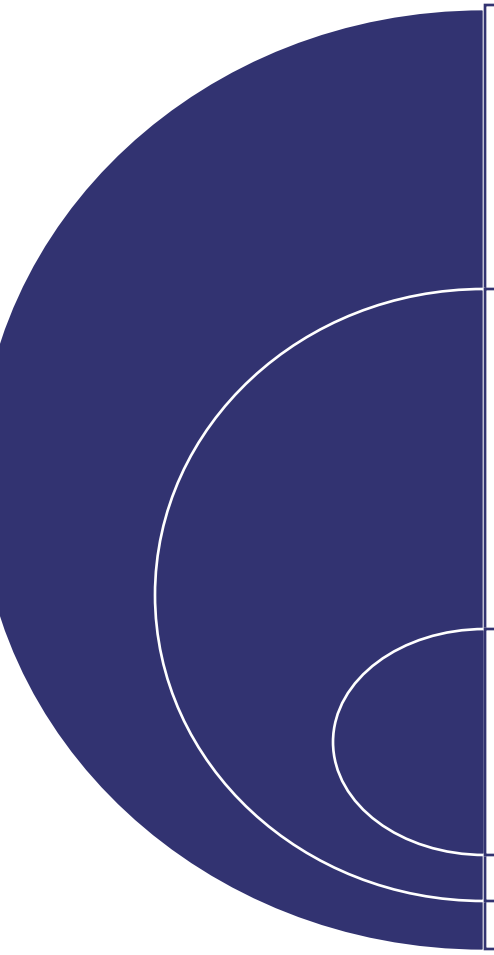
**This reality keeps CHWs in siloes and limits incentives for policy change.** Loss of project funding → lay-offs or disinvestment in community programming → continual need for reinvestment in the workforce.

As noted by the National Association of Community Health Workers, sustainable approaches to funding are *not* through project-specific grants and contracts, but via "ongoing revenue streams that explicitly provide for or 'cover' CHW services" or by "incorporating CHWs into ongoing budgeting within the employer's overall revenue picture." NACHW 2020

**This section will review key financing mechanisms for consideration by program stakeholders seeking to establish a long-term financing strategy.**

# A snapshot of the complexity: sources of funding for CHW positions

**Even with positive returns, there is no one funding stream that comprehensively covers CHWs. Below is a non-exhaustive list of funding sources that could be explored for CHW financing**

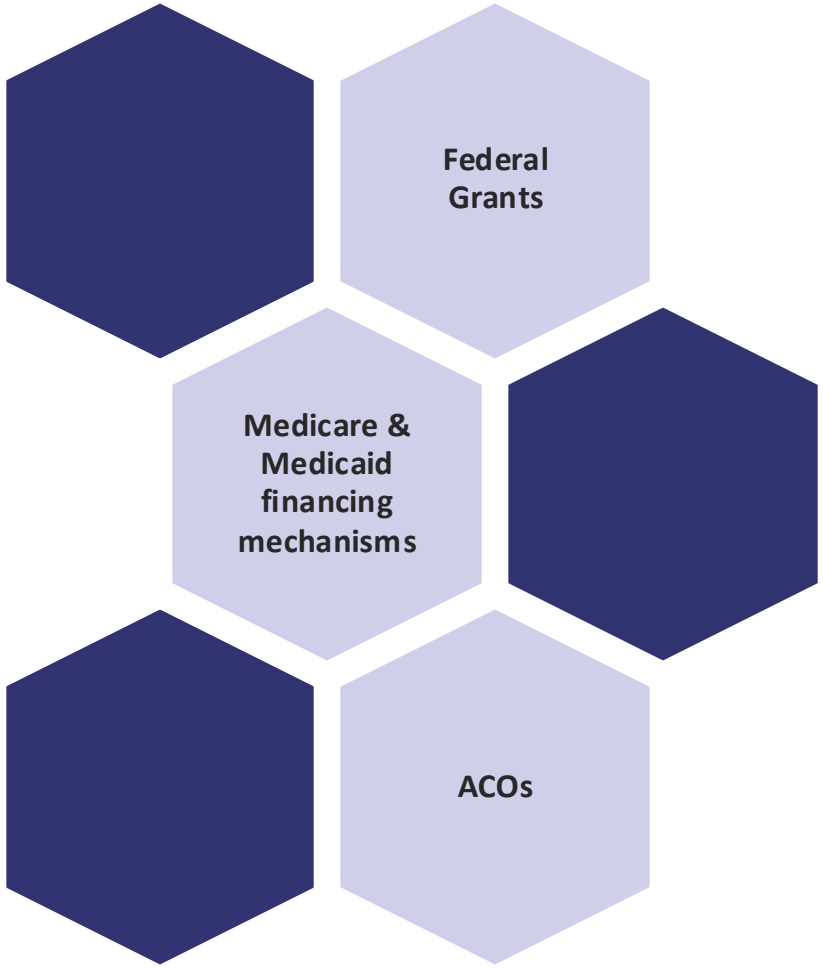


| | |
|---|---|
| **Federal Funding** | • Medicare<br>• Block grant programs (CDBG from HUD, CSBG, SSBG from ACF)<br>• CHWs as a class of providers under major public insurance programs<br>• Preparedness and disaster response |
| **State Funding** | • Medicaid, Children's Health Insurance Program (CHIP) - *primarily state-run but joint federal & state program*<br>• Mandates or incentives to state-funded provider<br>• State mandates or incentives to include CHWs in major, ongoing categorical programs<br>• Direct state appropriation |
| **Local/Regional/ Individual Employers Funding** | • Direct employment or contracting for CHW services by payers or intermediaries<br>• Private commercial insurers |
| | |
| | |

# Key concepts in CHW financing

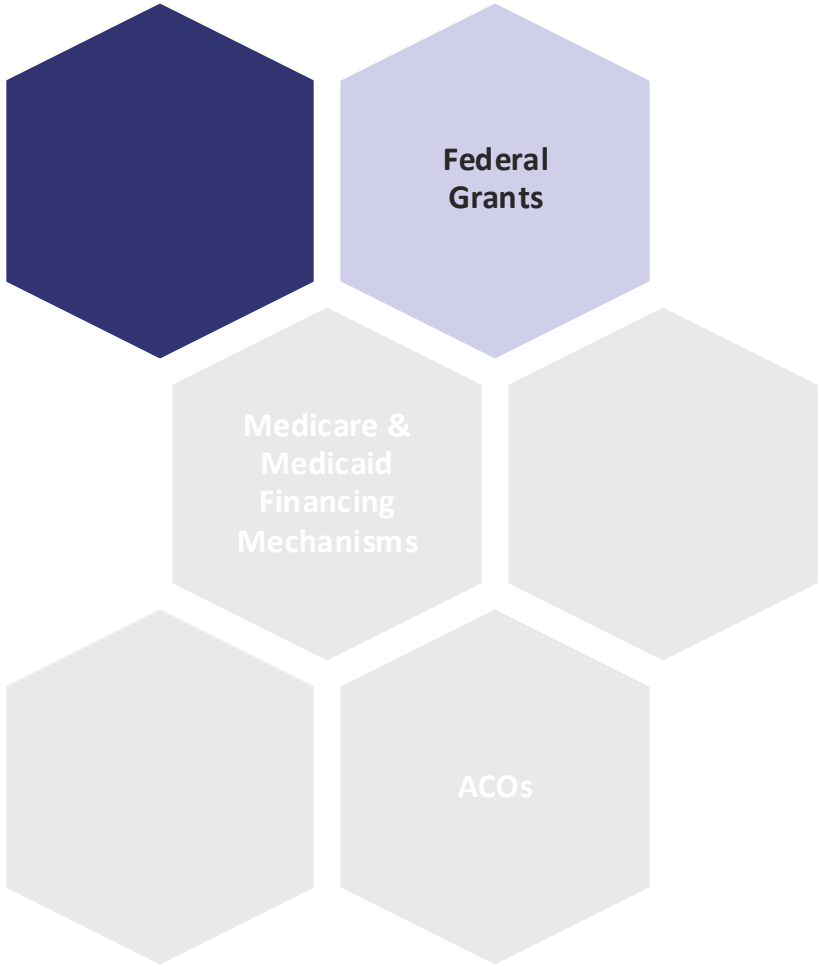
Each of the funding sources in the previous slide come with benefits, trade-offs, and complexities. It is critical to understand the basic processes and mechanisms behind each financing source in order to identify and create new opportunities for CHW financing

Given the recent spotlight on community health in state and federal programs, the following slides will give more details and resources related to **federal grants**, **Medicare and Medicaid financing mechanisms**, and **Medicare and Medicaid ACOs**.



# Key concepts in CHW financing

*Federal Grants*



# CMS recommendation of Federal Block Grants that can include CHWs

**Different organizations are eligible for a variety of federal grants to fund CHW programs. Below is a non-exhaustive list of discretionary grants that may be opportunities for CHW funding.**

## HRSA

- Black Lung Clinics Program
- Health Center Program
- Behavioral Health Workforce Education and Training (BHWET) Program for Professionals Mental and Behavioral Health Education and Training Grants
- National Organizations of State and Local Officials: Health Legislation and Governance
- Rural Health Research and Policy Programs Centers
- Ryan White HIV/AIDS Program
- Special Projects of National Significance (SPNS) Program
- Telehealth Programs

## CDC

- Supported Activities: Prioritizing High Impact HIV Prevention
- Colorectal Cancer Control Program (CRCCP) Organized Approaches to Increase
- Viral Hepatitis Networking, Capacity Building, and Training Prevention and Control

## OTHER

- Community Programs to Improve Minority Health Grant Program *OMH*
- Community Services Block Grant (CSBG) *ACF*
- National Institute of Nursing Research (NINR) *NIH*
- Opioid Affected Youth Initiative *OJP*
- Opioid STR (State Targeted Response to the Opioid Crisis) *SAMHSA*
- Section 223 Demonstration Program for Certified Community Behavioral Health Clinics (CCBHC) *SAMHSA*
- Indian Health Service, Health Information Management (HIM) Development Program *IHS*

https://www.cms.gov/files/document/community-health-worker.pdf

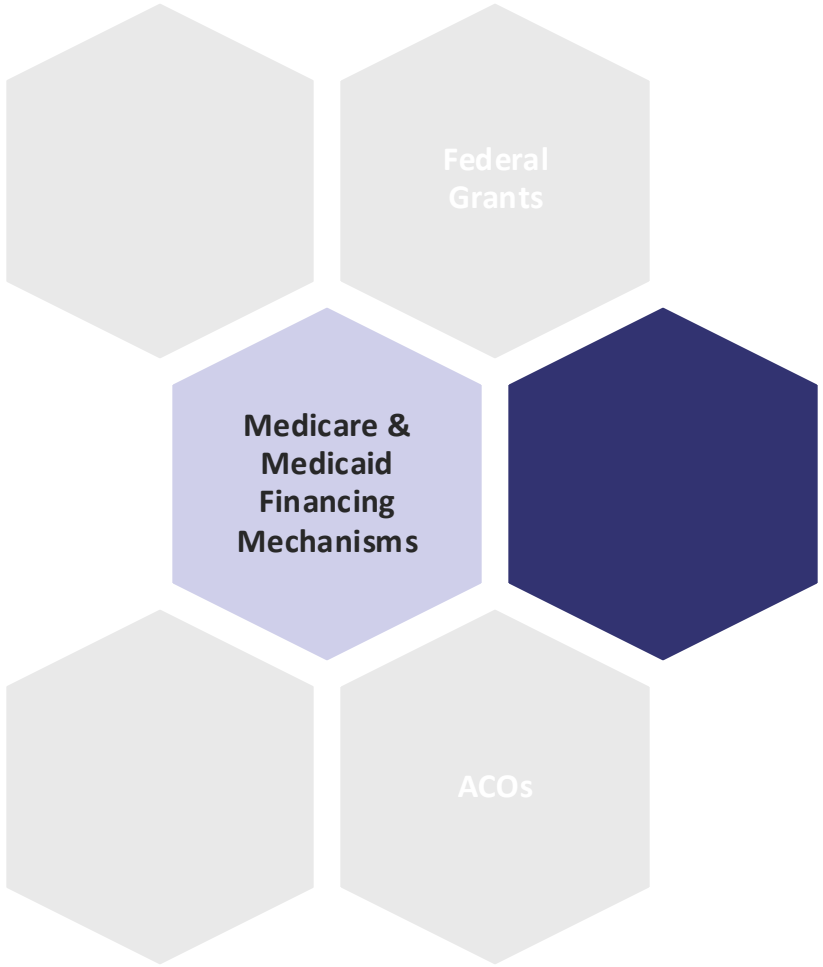
# There are also opportunities for CHW inclusion in federal health care reforms

## Below are a few federal health care reforms supporting CHWs integration into health care systems.

- **National Health Care Workforce Commission (§5101)**—includes CHWs as primary care professionals
- **Grants to Promote the Community Health Workforce (§5313)**
  - CDC grants to promote positive health behaviors and outcomes in medically underserved communities
  - Center for Medicare and Medicaid Innovation (CMMI)
- **Area Health Education Centers (§5403)**—CHWs added to mandate for interdisciplinary training
- **Hospital Readmission Reduction (§3025)**—high potential for CHW role; see MA example
- **Patient-Centered Medical Homes (§3502)**—CHWs as part of "community health teams"
- **Patient Navigator Program (§3509)**—HRSA heavily favors employing CHWs
- **Maternal, Infant, and Early Childhood Home Visiting Programs (§2951)**—via grants to states, varies by county

# Key concepts in CHW financing

*Medicare and Medicaid Financing Mechanisms*



# Selected CHW financing opportunities through Medicare

**Medicare is a federal program under the Center for Medicaid and Medicare Services that serves anyone age 65 and older, and a portion of people under 65 with certain disabilities or conditions.**

Medicare payment is traditionally provided through fee-for-service reimbursements but has more recently steered towards value-based models.

Until 2024, there had not been reimbursement codes assigned to CHW activities. Instead, Medicare providers could use APMs, such as bundled payment and risk-based contracts to get reimbursed for CHW activities.

**In, however, CMS published the 2024 Medicare Physician Fee Schedule Final Rule that has newly established codes to include reimbursement for CHWs and CHW activities related to SDOH services. See the CMS press release here. More information provided on this slide.**

## Financing Opportunities for CHWs Through Medicare

**Dual-Eligible Special Needs Plans (D-SNPs)**

Dual eligibility programs may include CHWs as part of their care teams

**Bundled Payment**

Fixed payments for all clinically related services for one healthcare event or diagnosis can be designed to include CHWs

**Fee-For-Service Reimbursement**

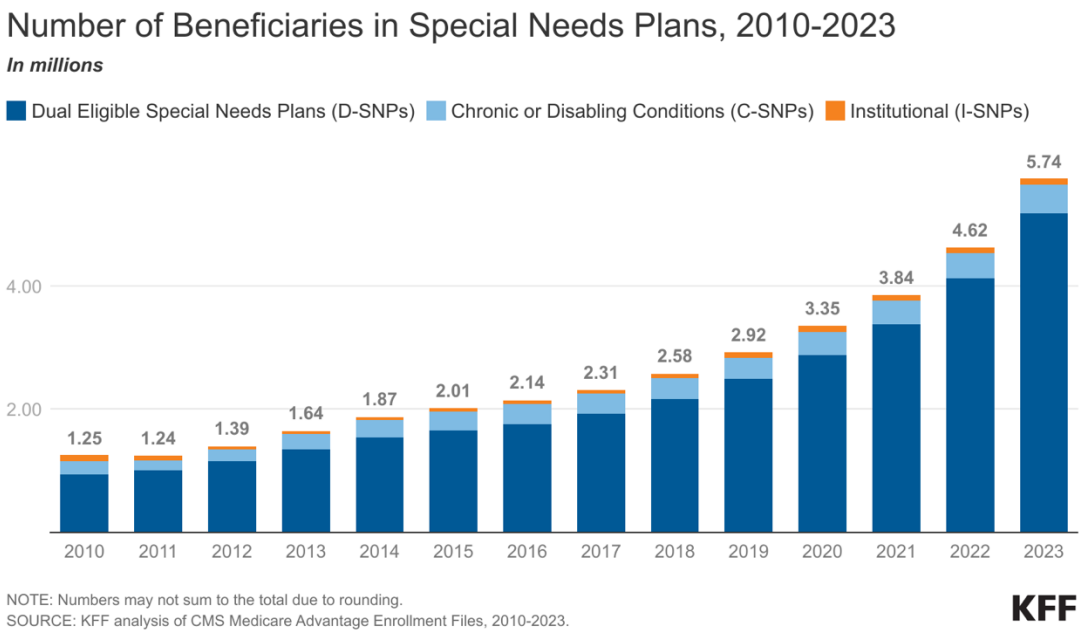
New Medicare ruling has provided reimbursement codes for SDOH-related services

https://familiesusa.org/wp-content/uploads/2019/09/HE_HST_Community_Health_Workers_Brief_v4.pdf

# Medicare: Dual Eligible Special Needs Plans (D-SNPs)

Dual-eligible Medicaid and Medicare individuals may qualify for expanded services through **dual-eligible special needs plans (D-SNPs),** administered through Medicare Advantage. Given the increased resource needs for this population and ultimate goals of integrated care, CHWs may also be ideally placed to deliver care under these plans.

- 89% of Special Needs Plan (SNP) enrollees are in plans for beneficiaries dually enrolled in both Medicare and Medicaid (D-SNPs); in 2020, 2.9 million people were enrolled in D-SNPs.
- In the current setup, dual eligibility programs may include CHWs as part of their care team and finance them with either unrestricted funds, administrative budgets, or Medicaid/Medicare reimbursement.
- California and Massachusetts have dual-eligibility programs that mention CHWs as a distinct part of the care team, however there is minimal available documentation on how CHWs are paid. More information can be found here.




KFF

https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/#
https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans

# Background on Medicare Advantage (MA)

If you have Original Medicare, the government pays for you Medicare benefits.

Some people replace their Original Medicare with Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," in which private companies are approved by Medicare and can have different offerings

This is different than a Medicare Supplement Insurance (Medigap) policy.

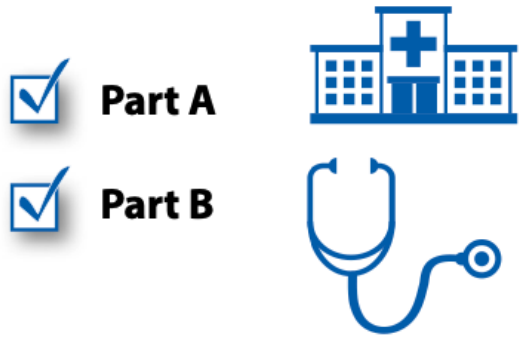
In 2022, A Request for Information was put out by CMS regarding Medicare Advantage Plan. See NACHW's comment here

## Requirements and Payment

You must have Medicare Parts A and B and live in the plan's service area to be eligible to join. People with permanent kidney failure generally can't join a Medicare Advantage Plan.

In addition to your Part B premium, you usually pay one monthly premium for the services included in a Medicare Advantage Plan. Each Medicare Advantage Plan has different premiums and costs for services, so it is important to compare plans in your area and understand plan costs and benefits before you join.

## Medicare Advantage Plans Benefits




https://www.medicare.gov/sites/default/files/2018-07/11474.pdf

# MA plans generally include benefits for SDOH and non-clinical services, presenting more opportunities for CHW employment and financing

| A non-exhaustive list of Special Supplement Benefits that may be provided by Medicare Advantage plans |
|---|
| Meals (beyond limited basis) |
| Transportation for Non-Medical Needs |
| Food and Produce |
| Pest Control |
| Social Needs Benefits |
| Indoor Air Quality Equipment and Services |
| Structural Home Modifications |
| General Supports for Living |
| Services Supporting Self-Direction |

## Payment for Services through Medicare Advantage

**CBOs**

- Can contract with MA to provide supportive services to enrolled managed care members through special supplemental benefits or regular supplemental benefits
- Contract with an enrolled Medicare health provider for FFS reimbursement for "*incident to*."

**Clinical Practices/Hospitals**

- Can contract with MA to become a network provider and bills directly for *incident to.*
- Contract with CHWs to provide supportive services to enrolled managed care members through regular or special supplemental benefits.

https://www.marc.org/aging-health/community-health-workers/chw-toolkit

# 2024 Medicare Physician Fee Schedule (PFS) Final Rule

**In 2024, CMS added CHWs to the annual Medicare guidance for the first time. The 2024 Medicare Physician Fee Schedule (PFS) Final Rule went into effect January 1, 2024.**

- Includes Medicare payment for services **performed by CHWs** and adds those services to the telehealth services list
- Includes **navigation services** as a paid service
- Allows CHWs working at **CBOs** to be included in payment rule
- Adds **SDOH screens** as a paid service with CHI services to be billed monthly or as medically necessary following evaluation/management visit
- **Allows CHCs to bill** for a number of services without direct supervision

Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule Fact Sheet

Press Release: CMS Physician Payment Rule Advances Health Equity

CY 2024 Physician Fee Schedule Final Rule

Primer for organizations that want to implement SDOH codes **with** accompanying webinar

# Implementation of the CY 2024 Medicare Physician Fee Schedule

**With the addition of CHW services to the PFS, many health systems and CBOs and other CHW employers are developing plans to implement this rule. In preliminary conversations, PIH-US has found that organizations that have already implemented the codes have found successes and challenges in the implementation process.**

+

- The codes for CHW services are already available in medical billing systems, allowing clinics to bill immediately if they have the necessary IT infrastructure
- Many CHW services can fall within the specified codes, and the ability to add on additional increments of time is a significant strength

−

- The PFS does not include specific guidance on how providers and clinical organizations can contract with CBOs to provide CHW services
- There is a still a lack of provider awareness on the role of CHWs in connecting patients to social supports, and many CHWs are not yet aware of the opportunity to bill, leading to underutilization of codes.
- FQHCs face delays in implementing the PFS as they wait for further instructions to be published in CMS' FQHC provider manual

Source: PIH-US

# Selected CHW financing opportunities through Medicaid

Medicaid is a joint federal and state program that helps cover medical costs for people with limited income. **Each state runs its own program, which means eligibility requirements, benefits, and payment structures can vary from state to state.**

States have recently started adding CHWs to Medicaid reimbursement programs.

**As the implementation process unfolds, it will be essential to develop systems that incorporate the work of CHWs and CBOs**, who are important actors in screening and delivering SDOH services.

The next slides summarize select financing opportunities that could allow for participation and adequate compensation for CHWs and CBOs.

*See this **PIH policy brief** for more information on CHWs and Medicaid.*

## Financing Opportunities for CHWs Through Medicaid

**State Plan Amendments (SPAs)**

CHWs can receive reimbursements for a defined scope of services

**Section 1115 Medicaid Waivers**

CHWs payment can be written into short-term demonstrations using various payment structures

**Operational Budgets of MCOs and Contracts**

CHWs services can be paid for through the operational budget or through subcontracted CBOs

**Alternative Payment Mechanisms (APMs)**

Gives incentive payments to provide high-quality and cost-efficient care; can apply to a clinical condition, a care episode, or a population.

https://familiesusa.org/wp-content/uploads/2019/09/HE_HST_Community_Health_Workers_Brief_v4.pdf

# Medicaid: State Plan Amendments (SPAs) for CHW financing

The Medicaid **state plan** is the legislative agreement between a state and federal government describing how that state administers its Medicaid and CHIP programs.

State plans describe the groups of individuals to be covered, services to be provided, methodologies for reimbursement and administrative activities underway in the state.

A state plan **amendment** is a permanent change to the state plan that can then be implemented through the state Medicaid office. A state may submit an amendment to CMS to make program changes, corrections, & updates.

In terms of CHWs, states may submit to expand their list of CHW services, reimbursed on a fee-for-service basis.

**Example: Minnesota's CHW Reimbursement**

MN was the first state to allow direct reimbursement for CHW services under the state Medicaid plan, submitting an SPA in 2007. This plan allows fee-for-service reimbursement of CHW services if a CHW meets certain educational requirements. The most current version of Minnesota's SPA can be found here.

**Pros**

- Permanent/lasting change

**Cons**

- Must be approved by legislature and CMS – can be administratively burdensome

*A note on reimbursement for preventive services…*

In 2014, a rule change to the Medicaid Preventive Services Rule (42 CFR 440.130(c)) made it possible for states to submit a SPA to allow coverage of preventive services delivered by a non-licensed provider, if recommended by a licensed practitioner.

# Certain states have taken steps to include CBOs in SPAs

Many states have requirements for organizations that wish to bill for Medicaid, and most often,  one of those requirements is to have a licensed medical practitioner as part of the care team. CBOs, who employ a large portion of CHWs, do not generally have contractual relationships with medical practitioners, and therefore do not fit the eligibility criteria for Medicaid billing, blocking their ability to get reimbursed.

**A few states, such as Arizona and South Dakota, have noted this limitation and created pathways to include CBOs in their SPAs so they can also participate in CHW reimbursement.**

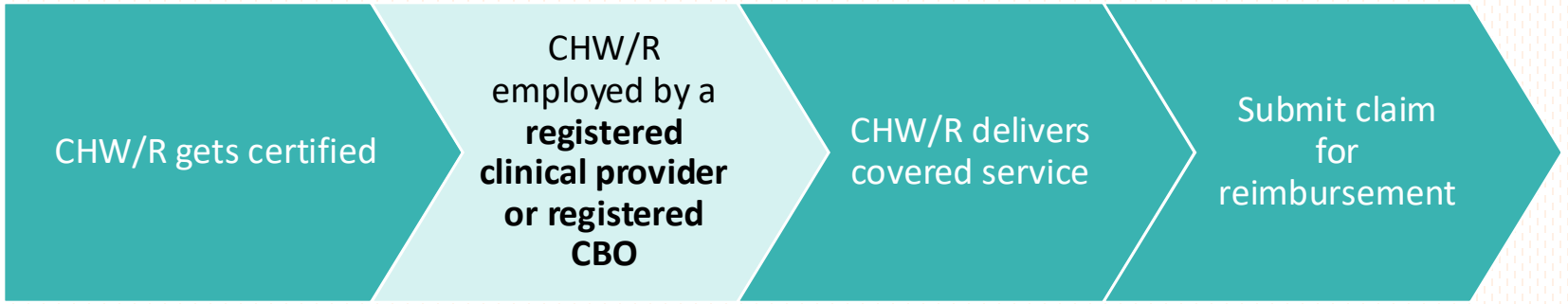
| Arizona | South Dakota |
| --- | --- |
| • In March 2024, AHCCCS created a new provider type called “CHW Organization”<br>• CBOs and tribal organizations are eligible to bill for CHW services by certified CHWs and CHRs. | • In April 2019, SD Medicaid added CHWs to the list of services a Medicaid recipient may be eligible for.<br>• A CBO can bill for CHW services after becoming a CHW Agency with SD Medicaid. |

# State example: Arizona's SPA and implementation challenges

**Arizona's SPA is noteworthy for its attempt to phase in both medical professionals and CBOs as "providers" that can reimburse for CHW education and preventative services.**

The opportunity for CBOs to submit claims is a step towards a more community-centered health system; however, in practice, the process for reimbursement may have barriers in implementation that impede CBOs from participating.

## *CHW & CHR services reimbursement process*



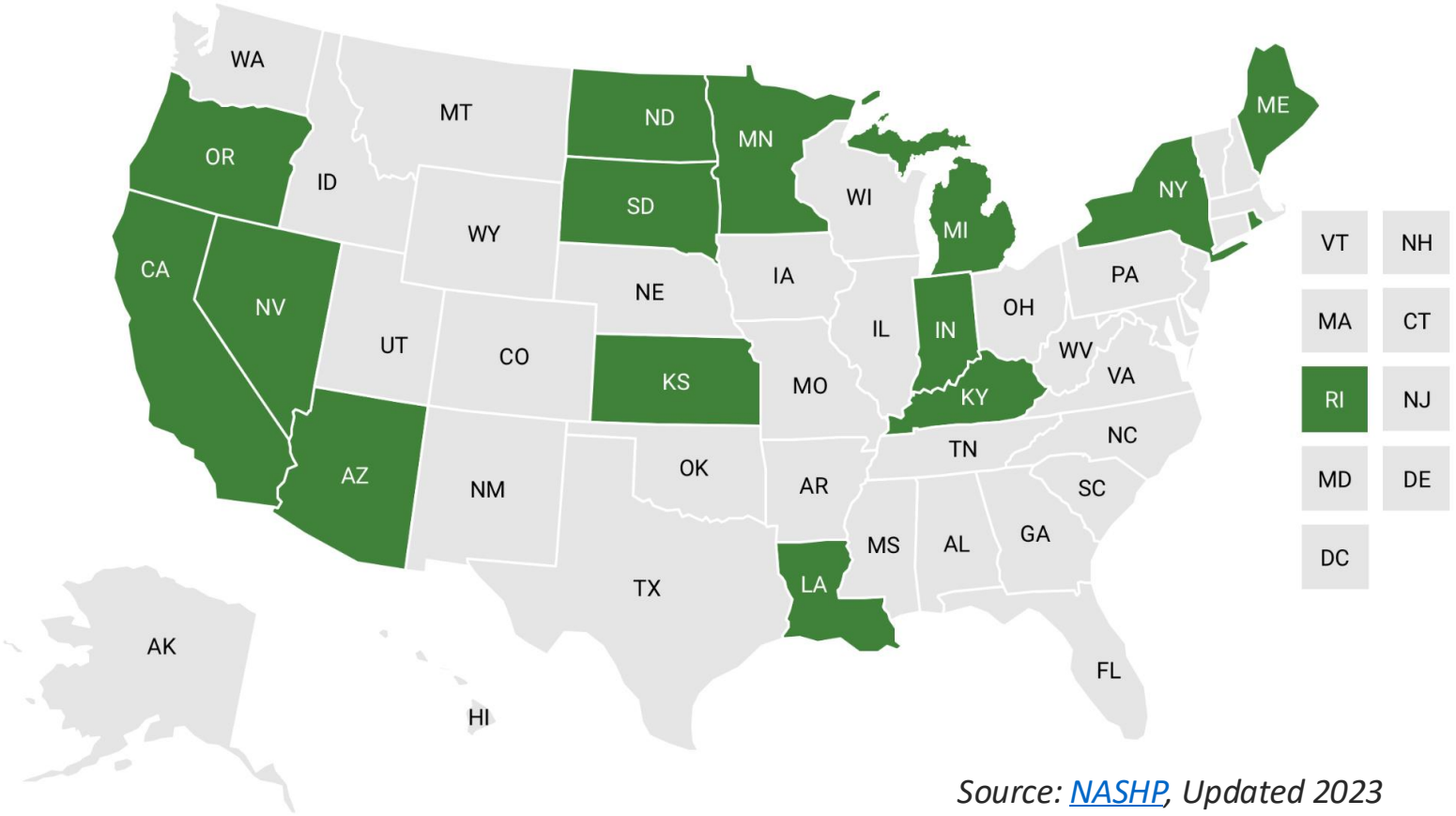

## *CBO Challenges in Implementation*

- The technology, infrastructure, and training needed for billing is complex and costly, and CBOs generally do not have the capital to build these systems
- The process for registering as a provider is time- and effort-intensive, which strains the CBO's already-limited resources
- Low reimbursement rates don't bring enough revenue for CBOs to invest in creating this infrastructure and limits their participation

https://www.azahcccs.gov/CHW; PIH-US

# CHW SPAs across the U.S.

**Map of U.S. States that currently have State Plan Amendments Authorizing Reimbursement of CHW Services**




*Source: NASHP, Updated 2023*

## Additional Resources

Primary documents for each SPA can be found here

A summary of state approaches to financing through SPAs can be found in this NASHP article

More information on CHW SPAs can be found in this Kaiser Family Foundation article

# Although most states implement their SPAs using the same CPT codes, reimbursement rates for the codes vary considerably

12 out of the 15 states with CHW financing-related SPAs have designed FFS payment methods using the three standard CPT codes that cover education and training for patient self-management (CPT 98960-2). **Although they use the same codes, the reimbursement rates vary widely- base code reimbursement rates range from $9.70 to $35.00.**

Four states have create alternate pathways to reimburse CHWs:

- Idaho and Maine have incorporated CHWs into existing SPAs administered for primary care homes
- North Dakota's SPA reimburses CHRs, specifically, using a tribal T code.
- West Virginia reimbursement is not contained in a SPA, but rather by reimbursing full care teams in a specific maternal and child health program.

| State | CPT 98960 | CPT 98961 (per person) | CPT 98962 (per person) |
|---|---|---|---|
| **Arizona** | 23.29 | 11.06 | 8.15 |
| **California** | 26.66 | 12.66 | 9.46 |
| **Indiana** | 26.56 | 12.82 | 9.42 |
| **Kansas** | 9.70 | 4.67 | 3.43 |
| **Kentucky†** | 22.53 | 19.88 | 8.03 |
| **Louisiana†** | 18.11 | 6.04 | 2.79 |
| **Minnesota** | 21.56 | 10.41 | 7.43 |
| **Michigan*** | 17.23 | 8.32 | 6.14 |
| **Nevada** | 18.34 | 8.82 | 6.44 |
| **New York** | 35.00 | 16.45 | 12.25 |
| **Oregon** | 21.44 | 10.35 | 7.61 |
| **South Dakota** | 32.43 | 16.22 | 11.35 |

*Proposed payment rates, not yet implemented

†Kentucky and Louisiana also have additional FQHC PPS reimbursement options

https://www.cthealth.org/wp-content/uploads/2024/01/CHW-Medicaid-Policies-and-Reimbursement-Approaches-by-State.pdf

https://nashp.org/state-approaches-to-community-health-worker-financing-through-medicaid-state-plan-amendments/; https://nashp.org/state-tracker/state-community-health-worker-policies/

# Medicaid: defined payment through Section 1115 waivers

**Section 1115 Waiver:** Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program.

States may use this type of waiver to test different benefit designs or new models for delivering care.

Some states have used these waivers to pay for CHWs in models that focus on specific Medicaid populations.

May use to test a design before requesting an SPA.

**Pros**

- States have significant flexibility in what they can do
- Changes are renewable

**Cons**

- Requires CMS approval
- Changes are temporary (3-5 years)
- Changes must be "budget neutral"

**Example: "Community Connectors" Demonstration in Arkansas**

CHWs conducted outreach to people receiving homebased care and referred to community services and in-home non-medical support and showed 3:1 net savings on total cost of care for participants.

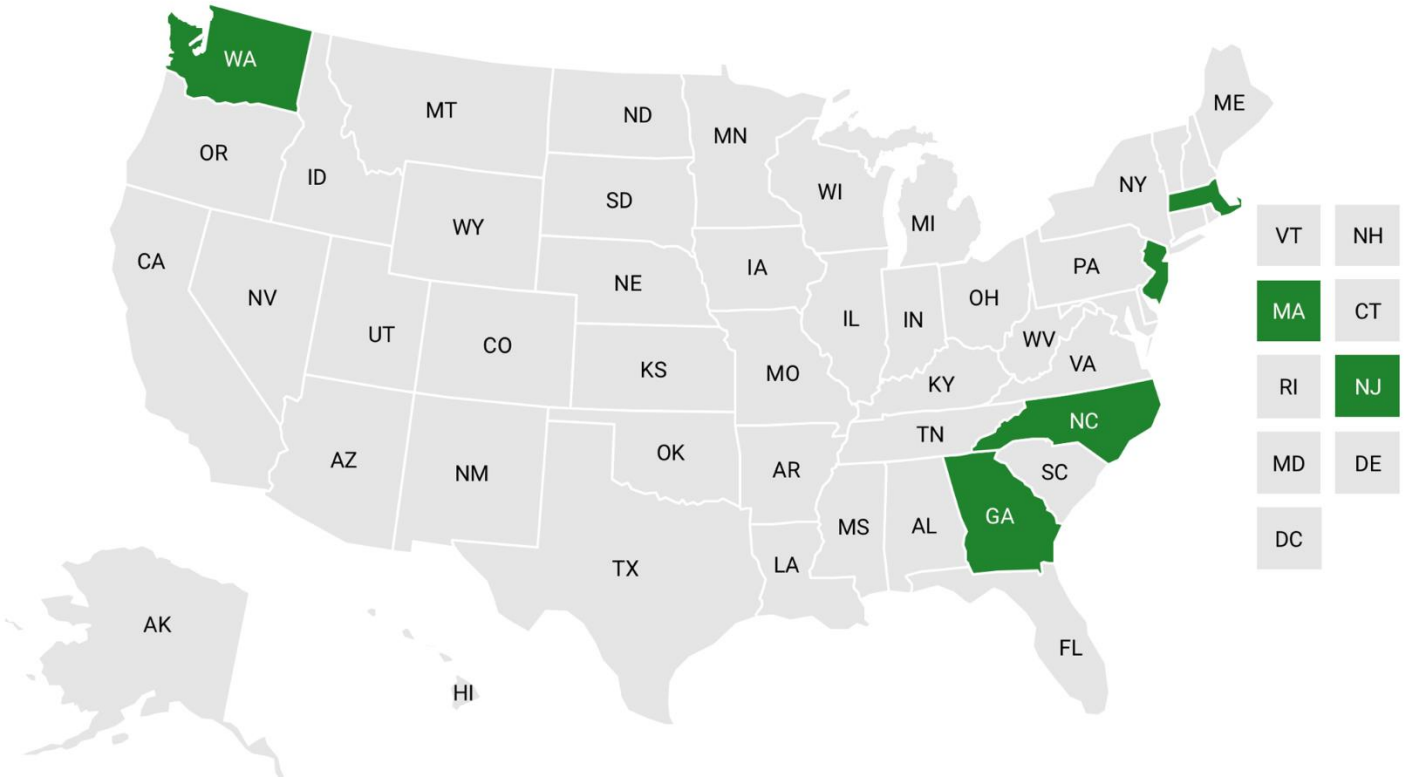
State expanded these services as part of regular Medicaid operations.

See KFF for list of list of approved Section 1115 Medicaid Waivers.

https://familiesusa.org/wp-content/uploads/2019/09/HE_HST_Community_Health_Workers_Brief_v4.pdf
https://nachw.org/wp-content/uploads/2020/10/SustainableFinancingReportOctober2020.pdf

# 1115 waivers across the U.S.

**Map of U.S. States that currently have 1115 Demonstration Waivers Authorizing Payment of CHW Services**




*Source: NASHP, Updated 2023*

**Additional Resources**

More information on 1115 waivers that include CHWs can be found here

# Special cases of Section 1115 waivers

## Delivery System Reform Incentive Payments (DSRIP)

Originated for hospital safety net care; now fund innovative health system reforms.

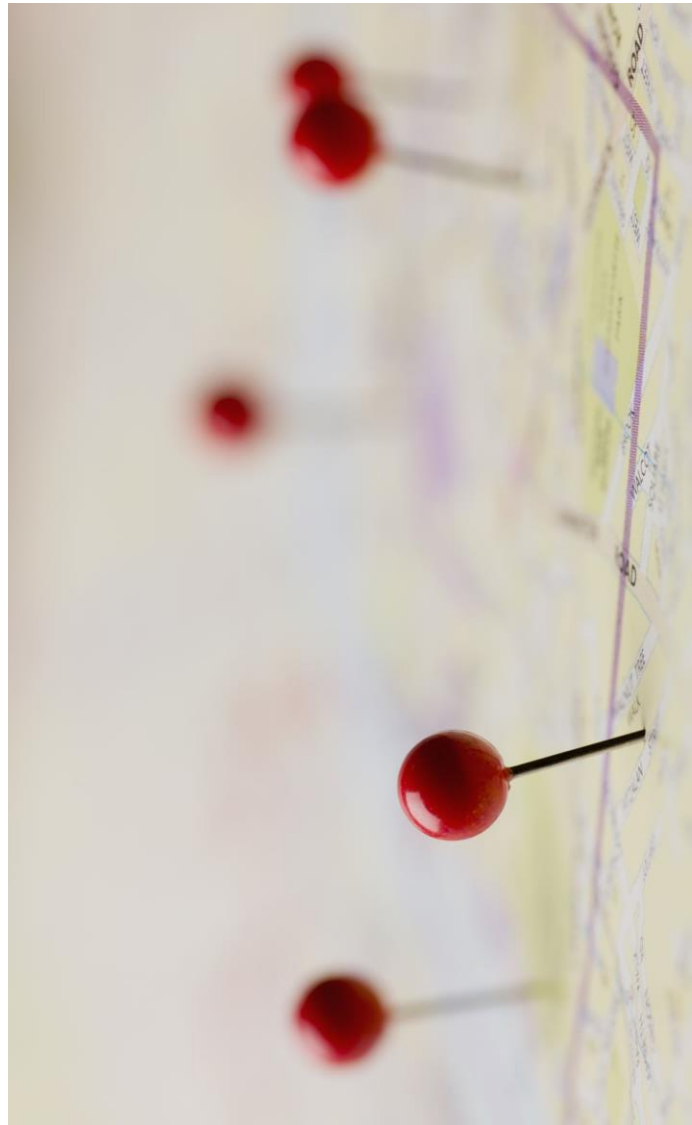
As of January 2020:

- 13 states approved for DSRIP waiver (AL, AZ, CA, MA, NH, NY, NJ, KS, NM, OR, RI, TX, and WA)
- CA, OR, RI, TX have renewed; NM, NJ, KS expired.

## Dual Eligibility through Special Needs Plans (D-SNPs)

Roughly 20% of individuals eligible for Medicare are also covered by Medicaid (usually on basis of disability) and Medicaid can be used to fill gaps for dual eligible individuals.

Support by CHWs in planning for programs serving dual eligible may be helpful. Review NY, TX, and RI dual eligible demonstration projects.



https://familiesusa.org/wp-content/uploads/2019/09/HE_HST_Community_Health_Workers_Brief_v4.pdf
https://nachw.org/wp-content/uploads/2020/10/SustainableFinancingReportOctober2020.pdf

# Medicaid: payment through Managed Care Organizations (MCOs)

Medicaid managed care delivers health benefits through contracts between state Medicaid agencies and managed care organizations (MCOs). In this arrangement, **MCOs accept a set per member per month (PMPM) payment, also known as a capitation rate, from the state Medicaid, to provide health services, and a corresponding PMPM payment is then passed down to clinical practices.**

More than 2/3 of the Medicaid population is covered by MCOs.

Services provided by MCOs can vary considerably from state to state and can include services from home visits to interpretation services. Some states require MCOs contracts to include CHW services or to directly employ CHWs and can set guidelines on if CHW core competencies need to reflect CHW certifications in their state.

### Pros

- MCOs may have more flexibility to cover services not covered by Medicaid
- States can impose requirements for services covered, staffing ratios, etc. – standardizing offerings & evaluation

### Cons

- Upfront investment in convincing MCOs to use budgets to hire CHWs and requirements for hiring may need to start simple

## More on capitation rates…

Capitation rates are based on principles of actuarial soundness, risk-adjust methods to account for enrollee health status, MCO performance incentives, and operating costs.

Appropriate capitation rates are important because they provide a financial incentive to keep out of the hospital through preventive and timely care to keep costs within the rate. If the capitation rate is insufficient or inadequately risk-adjusted, MCOs could have a financial incentive to undertreat patients or discourage enrollment of patients with more complex and expensive health needs to minimize costs.

FamilesUSA; Families USA; ASTHO.; NCSL

# MCOs and health equity: establishing financial incentives to address SDOH

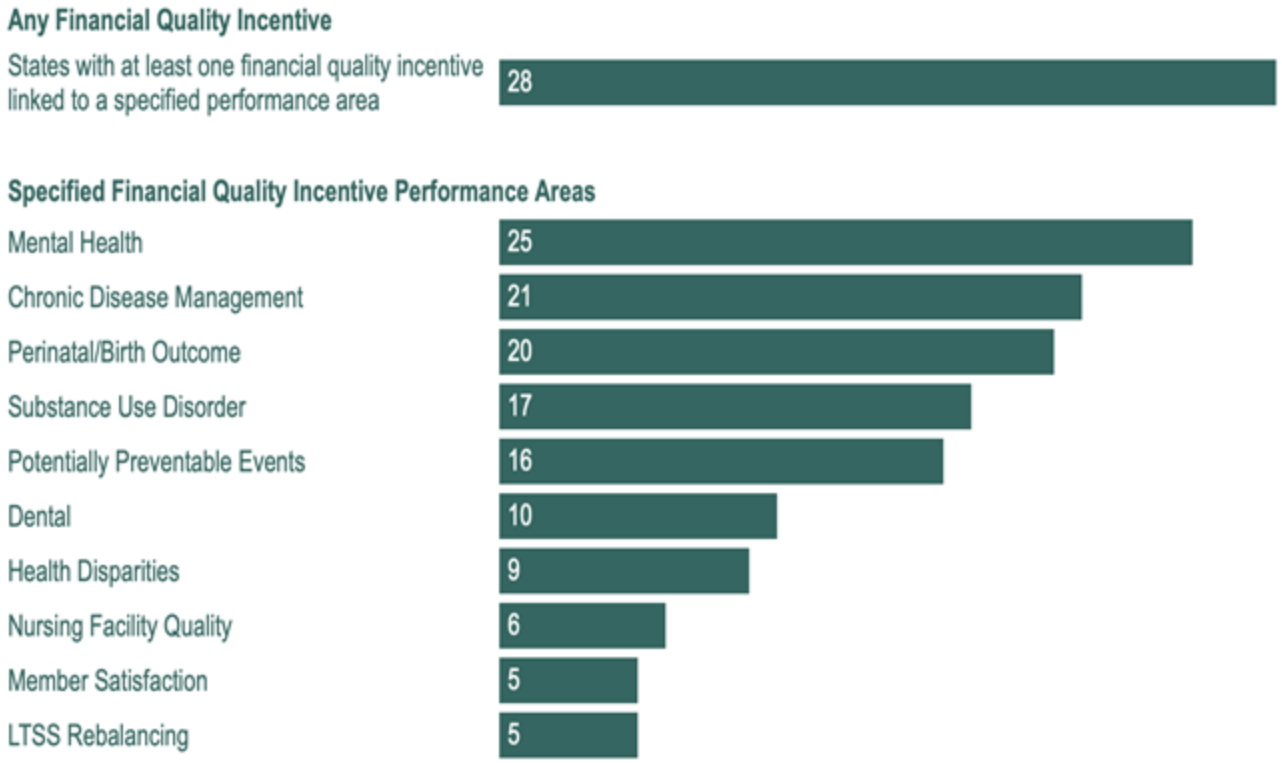
Many states have included **financial incentives** in MCO contracts to address complex conditions such as chronic disease, mental health, see right).

Given that CHWs already address many of these conditions in the community, CHWs are highly effective partners for MCOs in reaching performance goals.

**State Examples of SDOH-related Financial Incentives in MCOs**

- Washington offered incentive payments to build infrastructure for education, certification, integration of Community Health Aide Program (CHAP)-certified providers into tribal health programs
- Oregon made policy recommendations to share incentives with community partners for contributions to achieving incentive measures.
- Minnesota receives a "risk corridor calculation adjustment" for health care disparity outcomes. Points are awarded when disparity gap improves, deducted when worsens.

## Survey of State Medicaid Financial Quality Incentives (2021)




NOTE: Data are as of July 1, 2021. There were 37 responding MCO states. DE, MN, NM, and RI did not respond to the 2021 survey.
SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2021. • PNG

KFF

Adapted from https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

# MCOs and health equity: creating a low-resource payment infrastructure to allow CHWs and CBOs to participate in Medicaid

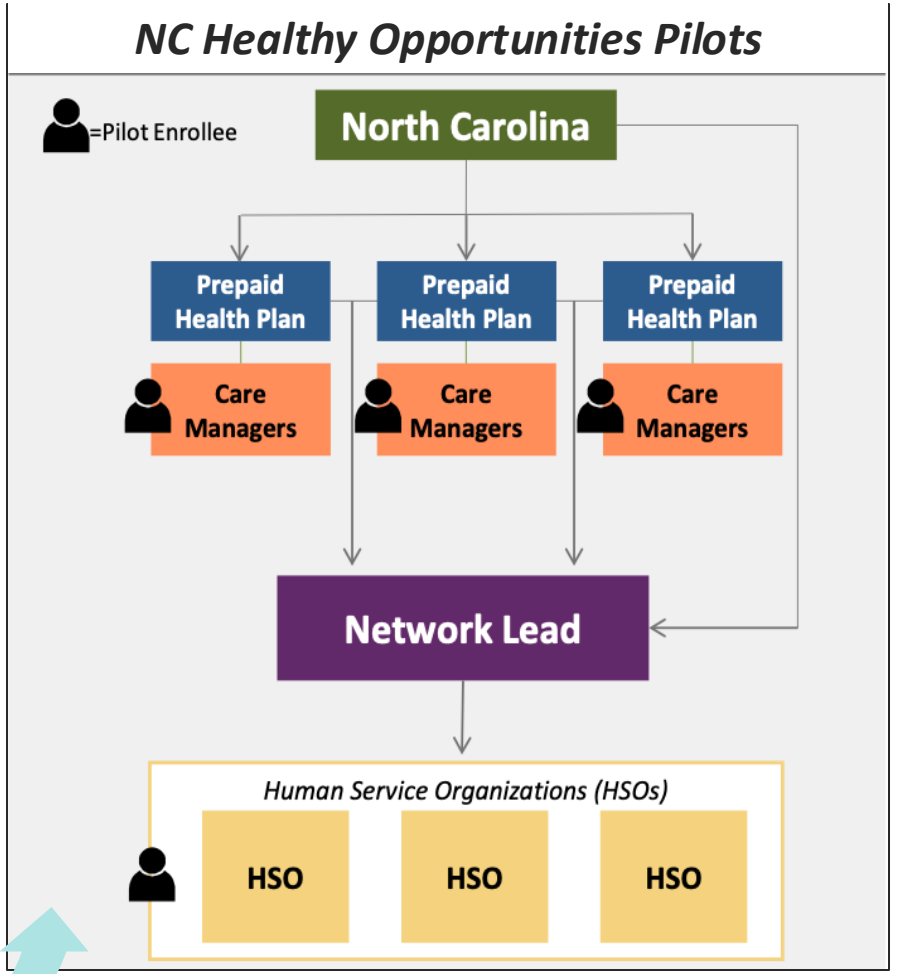
**As noted in previous slides, traditional financial infrastructures significantly impede CBO and CHW participation in health system payment models.**

→ It necessitates a large capital investment to set up and maintain the system
→ The finite terms of Medicaid contracts could deem any investment into the system obsolete after the end of contract

Fixing the system requires **acknowledging the limited resources of CBO partners and exploring ways to work *with* existing CBO systems.** Refer to this PIH-US Policy Brief for more information on approaches to including CBO in Medicaid financing structures.

**Example: North Carolina Healthy Opportunities Pilots**

The Healthy Opportunities Pilots, implemented under NC's Medicaid 1115 waiver, noted similar payment infrastructure inequities and designed a system in which Human Service Organizations (HSOs) can collect claims information from individuals using simplified, lower-tech methods, and then transferring the information to the health plan via a network lead hub entity where information is translated into a claim. In 2023, Millbank Foundation published its early lessons from implementation and in April 2024 the Cecil G. Sheps Center for Health Services Research published an interim evaluation report for CMS approval.




https://www.ncdhhs.gov/media/16512/download?attachment

# Medicaid: Alternative payment models (APMs)

State Medicaid programs are exploring many alternate payment models (APMS) to improve quality and continuity of care while reducing costs, with a particular focus on addressing the SDOH. Many of these models have the potential to incorporate CHWs as key members of the workforce.

**Patient Centered Medical Home (PCMH):** model of organizing primary care so patients receive care that is coordinated by a primary care physician, supported by information technologies for self-care management, delivered by a multi-disciplinary team of allied health professionals, and adherent to evidence-based practice guidelines.

**Medicaid Health Home:** builds on PCMH but goes further by requiring integration of physical and behavioral health services, and also extends care coordination beyond medical services to include social and community supports.

**Bundled payment**: A single payment is issued for one episode/encounter, even if multiple services and providers are involved. Provider has flexibility to spend on CH services and can improve predictability, reduce cost variation, and provide financial incentives to improve care coordination among providers and across health care settings. There are different models of administering bundled payments. It may be administratively challenging. Read more from London, 2017.

**Risk contracts:** Most often observed in Accountable Care Organizations (ACOs, which will be discussed in further detail in the context of Medicare on subsequent slides) where groups of providers come together to provide quality care. In this model, providers are at greater financial risk.

Simulations are currently underway to introduce Medicare-like ACOs into Medicaid models. The National Association of Accountable Care Organizations lists state programs that are implementing Medicaid ACOs.

https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-alternative-payment-models-in-Medicaid-MACRA.pdf
https://www.cms.gov/priorities/innovation/key-concepts/alternative-payment-models-apms

# APMs that include CHWs

Below are examples of APMS that aim to include CHWs and further incentivize practices to move towards whole-person care. As new APMs are created, ensuring substantive evaluation metrics that assess community engagement in care delivery and prioritize long-term health impacts will be crucial to moving practices and payers toward community-based care.

## Vermont

Blueprint for Health

- Using a multi-payer model to support PCMHs
- Will allow hiring of staff (such as CHWs) to support community needs and form community partnerships.

## California

- Building an APM for CHCs to deliver value-based care outside of the PPS system.
- Authorized by Senate Bill 184

## Maine

Primary Care Plus

- Provides a higher PMPM rate for comprehensive care; includes coordination, screenings, and care transition
- Practices required to do a needs assessment and develop a plan for providing CHW services, either through direct hiring or contracts/partnerships.

## Idaho

Healthy Connections

- A medical home model that offers a higher PMPM payment to "Tier 2" and "Tier 3" medical homes , in which CHWs can be employed as part of the coordination team

https://nashp.org/qa-using-an-alternative-payment-model-to-support-community-health-worker-sustainability-in-maines-primary-care-plus-program/
https://healthpolicy.duke.edu/sites/default/files/2023-05/radx-up_community_health_worker_policy-paper_22may2023.pdf
https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=14290&dbid=0&repo=PUBLIC-DOCUMENTS

# Risks associated with traditional payment mechanisms used by Medicare and Medicaid

The majority of CHWs aim to work as close to or within communities as possible, **yet traditional payment systems rely on hospital and clinic-focused billing mechanisms and can risk medicalizing CHWs in a range of ways**.

| *ASPECT OF SYSTEM* | *ASSOCIATED RISKS* |
|---|---|
| **Billing Codes**<br>The codification of clinical and non-clinical services may miss many CHWs services, or broadly group multiple CHW services under the same code | • Organizations that employ CHWs may not deliver unbillable services, significantly limiting coordinated health activities, especially in the fee-for-service models<br>• There is less flexibility in paying for multiple services if they are grouped under broad categories<br>• Narrowed CHW scope, under-utilized skillset & decreased effectiveness |
| **Payment Infrastructure**<br>The current payment infrastructure requires filing claims for reimbursable services. | • CBOs/LHDs lack resources to file claims → can't participate in insurance structures<br>• CBOs unlikely to invest in building a billing infrastructure that allows CHWs to get reimbursed, given the capital and ongoing costs → shifts CHWs into clinical settings skewing job opportunities and wages away from community organizations |
| **Limited/Traditional Evaluation**<br>Funder evaluations focus on claims, referral, and clinical data, which do not comprehensively include CHW and SDOH-related process, output, and outcome metrics. | • Evaluations may underestimate the CHW's role in achieving outcomes<br>• Can create inaccurate interpretations of CHW outcomes and impact<br>• Can devalue closed-looped referrals + impact of resource availability on outcomes |

https://familiesusa.org/wp-content/uploads/2019/09/HE_HST_Community_Health_Workers_Brief_v4.pdf
https://nachw.org/wp-content/uploads/2020/10/SustainableFinancingReportOctober2020.pdf

# PIH-US resources: CHWs and Medicaid financing policy paper and briefs

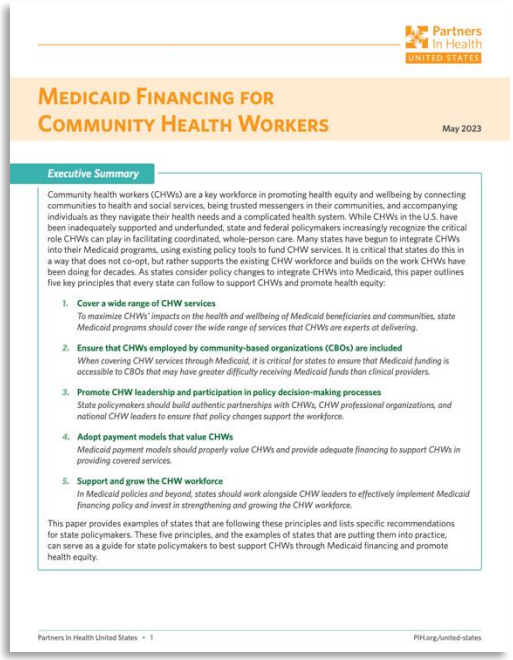
**In 2023, PIH-US published a policy paper and two briefs on CHW Medicaid Financing that focus on how state Medicaid agencies can work with organizations to incorporate CHW roles into payment systems.**

## PIH Policy Paper

[Medicaid Financing for CHWs]

## Accompanying Blog Post

[PIH Accompanying Blog Post]



Partners In Health UNITED STATES

MEDICAID FINANCING FOR COMMUNITY HEALTH WORKERS

May 2023

*Executive Summary*

Community health workers (CHWs) are a key workforce in promoting health equity and wellbeing by connecting communities to health and social services, being trusted messengers in their communities, and accompanying individuals as they navigate their health needs and a complicated health system. While CHWs in the U.S. have been inadequately supported and underfunded, state and federal policymakers increasingly recognize the critical role CHWs can play in facilitating coordinated, whole-person care. Many states have begun to integrate CHWs into their Medicaid programs, using existing policy tools to fund CHW services. It is critical that states do this in a way that does not co-opt, but rather supports the existing CHW workforce and builds on the work CHWs have been doing for decades. As states consider policy changes to integrate CHWs into Medicaid, this paper outlines five key principles that every state can follow to support CHWs and promote health equity:

1. **Cover a wide range of CHW services**
   *To maximize CHWs' impacts on the health and wellbeing of Medicaid beneficiaries and communities, state Medicaid programs should cover the wide range of services that CHWs are experts at delivering.*
2. **Ensure that CHWs employed by community-based organizations (CBOs) are included**
   *When covering CHW services through Medicaid, it is critical for states to ensure that Medicaid funding is accessible to CBOs that may have greater difficulty receiving Medicaid funds than clinical providers.*
3. **Promote CHW leadership and participation in policy decision-making processes**
   *State policymakers should build authentic partnerships with CHWs, CHW professional organizations, and national CHW leaders to ensure that policy changes support the workforce.*
4. **Adopt payment models that value CHWs**
   *Medicaid payment models should properly value CHWs and provide adequate financing to support CHWs in providing covered services.*
5. **Support and grow the CHW workforce**
   *In Medicaid policies and beyond, states should work alongside CHW leaders to effectively implement Medicaid financing policy and invest in strengthening and growing the CHW workforce.*

This paper provides examples of states that are following these principles and lists specific recommendations for state policymakers. These five principles, and the examples of states that are putting them into practice, can serve as a guide for state policymakers to best support CHWs through Medicaid financing and promote health equity.

Partners In Health United States • 1 PIH.org/united-states

## PIH Policy Briefs

- [Using Medicaid to finance CHWs based within CBOs]
- [Using Medicaid funds to support a broad scope of work for CHWs].

Using Medicaid to Fund Community Health Workers in Community-Based Organizations

Using Medicaid to Fund a Wide Range of Community Health Worker Services

Partners In Health UNITED STATES

December 2023

*Community Health Workers Promote Whole-Person Health*

*Community-Based CHWs Are Well-Situated to Serve Medicaid Beneficiaries*

*CHWs Are Well-Situated to Serve Medicaid Beneficiaries*

C3 Project Core CHW Roles

Cultural Mediation Among Individuals, Communities, and Health and Social Service Systems

Providing Culturally Appropriate Health Education and Information

Care Coordination, Case Management, and System Navigation

Providing Coaching and Social Support

Advocating for Individuals and Communities

Building Individual and Community Capacity

Providing Direct Service

Implementing Individual and Community Assessments

Conducting Outreach

Participating in Evaluation and Research

*CHWs employed by CBOs bring unique strengths that illustrate why it is so critical that Medicaid policy accommodate coverage of CHW services in community settings.*

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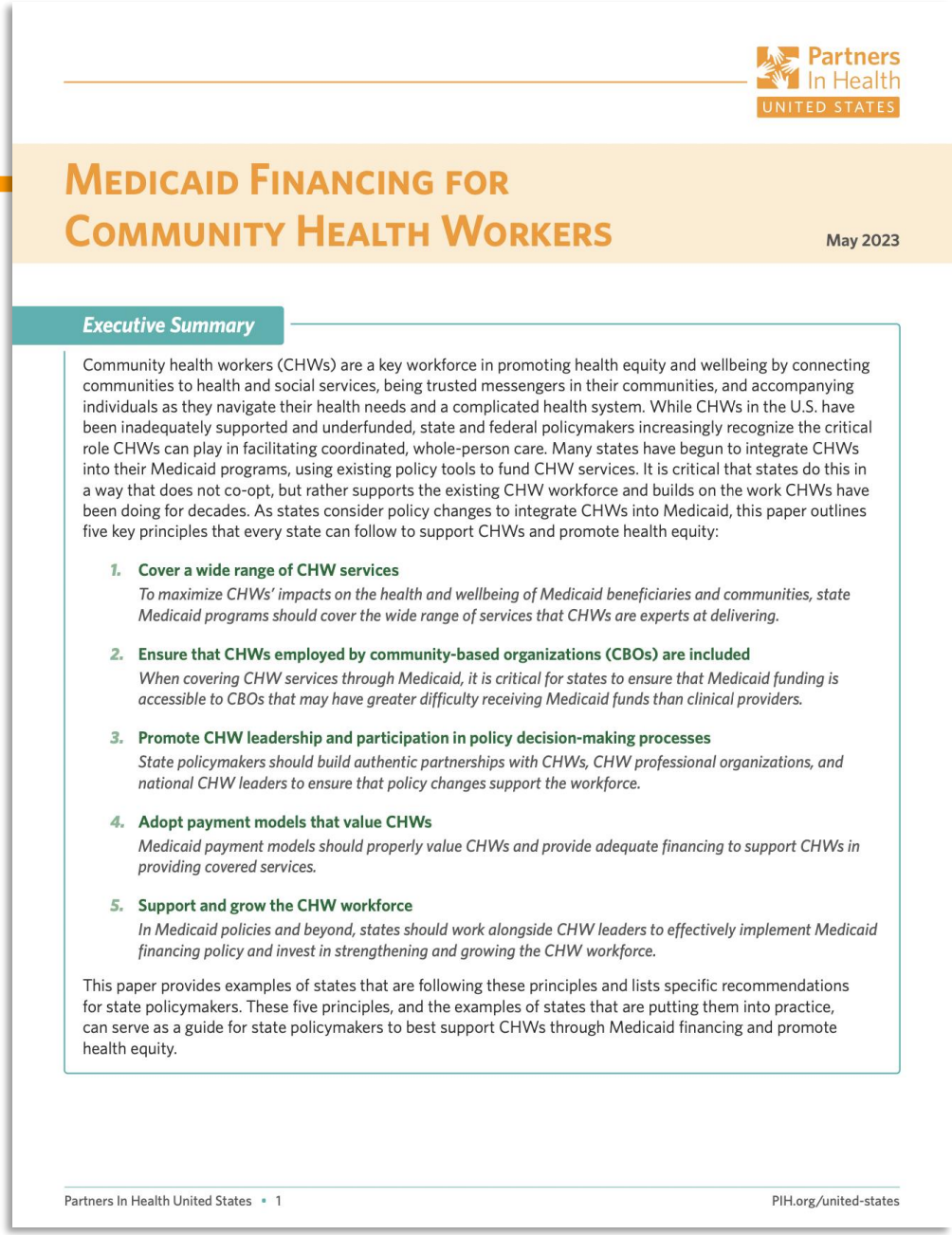
# PIH-US policy paper: Medicaid financing for CHWs

## *"Medicaid Financing for Community Health Workers"*

- Aims to actively contribute to supporting sustained investments in community health workers by recognizing their value, preserving what makes them unique and effective, and promoting community health worker leadership in policy-making processes.
- Examines best practices from states and recommends five key principles that every state can follow to fund community health workers through Medicaid and promote health equity.
- Provides key reference information for PIH-US and our partners and can be used for advocacy.
- Informed by our work with community health workers around the world and in the U.S., as well as by national partners and experts.

Link to Paper
Link to Blog Post



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# PIH-US CHW financing policy paper: recommendations for states

**The PIH policy paper discusses five principles for state Medicaid agencies to consider when trying to design CHW financing policies:**

### 1. Cover a wide range of CHW services

To maximize CHWs' impacts on the health and wellbeing of Medicaid beneficiaries and communities, state Medicaid programs should cover the wide range of services that CHWs are experts at delivering.

### 2. Ensure that CHWs employed by community-based organizations (CBOs) are included

When covering CHW services through Medicaid, it is critical for states to ensure that Medicaid funding is accessible to CBOs that may have greater difficulty receiving Medicaid funds than clinical providers

### 3. Include CHWs in policy decision making processes

State policymakers should build authentic partnerships with CHWs, CHW professional organizations, and national CHW leaders to ensure that policy changes support the workforce.

### 4. Adopt payment models that value CHWs

Medicaid payment models should properly value CHWs and provide adequate financing to support CHWs in providing covered services.

### 5. Support and grow the CHW workforce

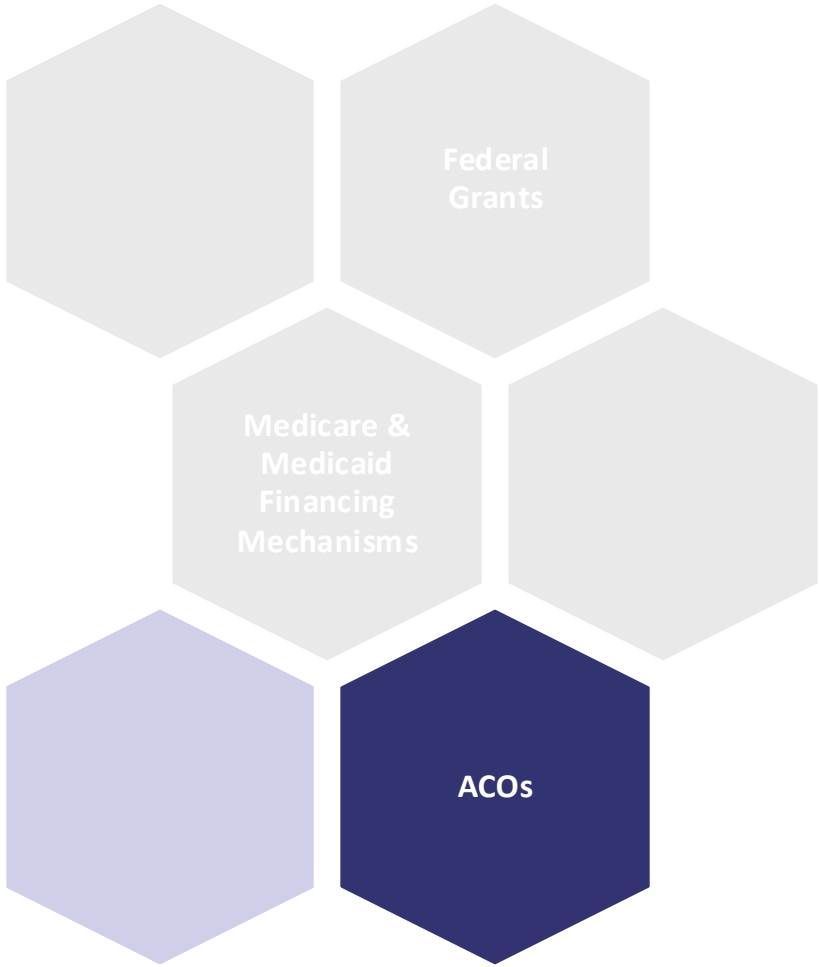
In Medicaid policies and beyond, states should work alongside CHW leaders to effectively implement Medicaid financing policy and invest in strengthening and growing the CHW workforce.

***Organization of the paper***

- → Discusses the context behind the principles
- → Describes how states can implement each principle
- → Shows two state examples for each principle
- → Gives specific policy recommendations for each principle

# Key concepts in CHW financing

*Accountable Care Organizations (ACOs)*



# Medicare *Or* Medicaid: Accountable Care Organizations (ACOs)

**Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers who voluntarily form partnerships to collaborate and share accountability for the quality and cost of care delivered to patients. Both Medicare and Medicaid can have ACOs.**

- ACOs are a natural employer of CHWs given their attention to addressing the SDOH through primary care and care coordination.
- The goal of ACOs is to simultaneously improve health and patient experiences, and to reduce per capita costs.
- ACOs must have a strong primary care foundation, and may integrate other specialists, hospitals, nursing homes, etc. to promote a high degree of care coordination.
- When an ACO succeeds in both delivering high-quality care and efficiently spending health care dollars, it shares in the savings it achieves.
- ACOs may be interested in working with Medicare *or* Medicaid, although it is primarily a Medicare model. Here are a list of states that have Medic**aid** ACO activities.

**ACOs are paid based on the risk model they commit to (upside only or upside/downside)**

## Upside Only Risk

If quality and patient satisfaction are maintained or improved and there are savings relative to the predicted costs, approximately 50 percent of the savings is paid to the ACO.

This encourages ACO participants to keep patients in good health, and if ill, to provide optimal care through a team-based approach.

## Upside and Downside Risk

Health care professionals receive shared savings for managing costs and hitting quality and satisfaction benchmarks but will also be liable for expenses that exceed the Medicare spending budget.

CMS is moving towards more ACO programs that have this two-sided risk structure.

https://www.ncmedsoc.org/wp-content/uploads/2019/02/Frequently-Asked-Questions-about-Accountable-Care-Organizations.pdf
https://files.kff.org/attachment/Evidence-Link-FAQs-Accountable-Care-Organizations

# ACOs and SDOH

**In 2022, the Institute of Accountable Care interviewed 14 ACOs on the opportunities and challenges they saw in addressing SDOH**. Of note, employing CHWs was not mentioned in their discussion, signaling a need for more education on this essential workforce.

## Findings from Institute of Accountable Care Roundtables

- Stated the importance of SDOH but have not yet figured out how to fully assess for them or how to comprehensively address them.
- Recognize the need for flexibility in how SDOH are screened, and the need for multiple access points.
- Have started to ideate on avenues for connecting, partnering, and/or referring to CBOs.
- Identified closed loop communication as an important factor in determining if SDOH needs are being met.

## Comments on Sustainability Challenges

- Identified the strengths and limitations of community partners
- Recognized importance of limiting unnecessary reporting
- Agreed on the importance of mutual decision making with partners
- Discussed their own role in helping organizations make a business case for social services by sharing their data, facilitating relationships with health plans through their well-established relationships with payers, considering funding CBOs directly, and helping organizations get hospital community benefit dollars from their affiliated hospitals.

https://www.healthaffairs.org/content/forefront/working-acos-address-social-determinants-health
https://www.institute4ac.org/sdoh-learning-collaborative/

# Medicare-like ACO programs have been implemented for Medicaid beneficiaries

Several states are leveraging State Innovation Model (SIM) awards to implement Medicaid ACO-like organizations.

| | |
|---|---|
|  **Massachusetts** | • The ACO contracts with an MCO to create a full network of care that includes primary care, specialists, behavioral health, and hospitals or the groups of primary care providers coordinate the full range of services for beneficiaries by working with a network of specialists and hospitals.<br>• Began to pay for health-related nutrition and housing supports beginning in 2020, referred to as Flexible Services.<br>• Many of the ACOs with the Medicaid program are also Medicare ACOs and many also serve privately insured patients. This effort is part of a comprehensive restructuring of MassHealth through ACOs with shared savings and mandatory but limited downside risk. |
|  **Minnesota** | • Minnesota's statewide ACO programs for Medicaid are called Integrated Health Partnerships (IHP). This program changed focus to move to accountable care processes with shared savings payment for physical, behavioral, and pharmacy care that includes quality measurement.<br>• Managed care organizations are required to work with IHPs, but the IHPs serve all Medicaid patients in the state regardless of whether they receive benefits through fee for service or managed care. |

Colorado, Connecticut, Delaware, Idaho, Iowa, Maine, New Jersey, New York, Oregon, Rhode Island, Utah, Vermont are also exploring and implementing Medicare-like ACOs for Medicaid beneficiaries.

https://naacos.memberclicks.net/medicaid-acos

# Financing options through Medicaid ACOs are similar to the options available to Medicaid MCOs

***Financing Opportunities by Employer Type***

## Health Providers, Health Practices, Community Health Centers, Hospitals

- Clinical entities can directly participate in ACOs using either operating funds or value-based payments to cover the cost of CHWs.
- They contract with other ACOs so CHWs can provide supportive services to attributed Medicare enrollees.

## Community Based Organizations

- CBOs can contract with ACO/health provider for CHWs to provide supportive services to attributed Medicare members.
- Contract with participating Medicare health providers for fee-for service reimbursement for "incident to" payments.

https://www.marc.org/sites/default/files/2022-11/CHW_Sustainability_Toolkit_FINAL_10-11-22.pdf

# Key takeaways

**There is no one-size-fits-all approach to financing CHW services. States should consider a few long-term financing strategies, striving for a braided approach that offsets the weaknesses of one source with the strengths of another.**

A braided funding approach combines multiple funding sources and reduces dependence on a single source. It also allows for the integration of resources that are not associated strictly with provision of clinical care.

- Diversifying funding sources can protect services from being cut due to inevitable budget fluctuations or restrictions from a changing portfolio of grants
- Entails navigating the requirements of multiple models, negotiating with multiple payers, and operating amidst different reporting guidelines and funding schedules

There is a large body of research and case examples related to different funding models and payment mechanisms described in this section. Future updates to this landscape report can include a deeper dive into any topic upon request.

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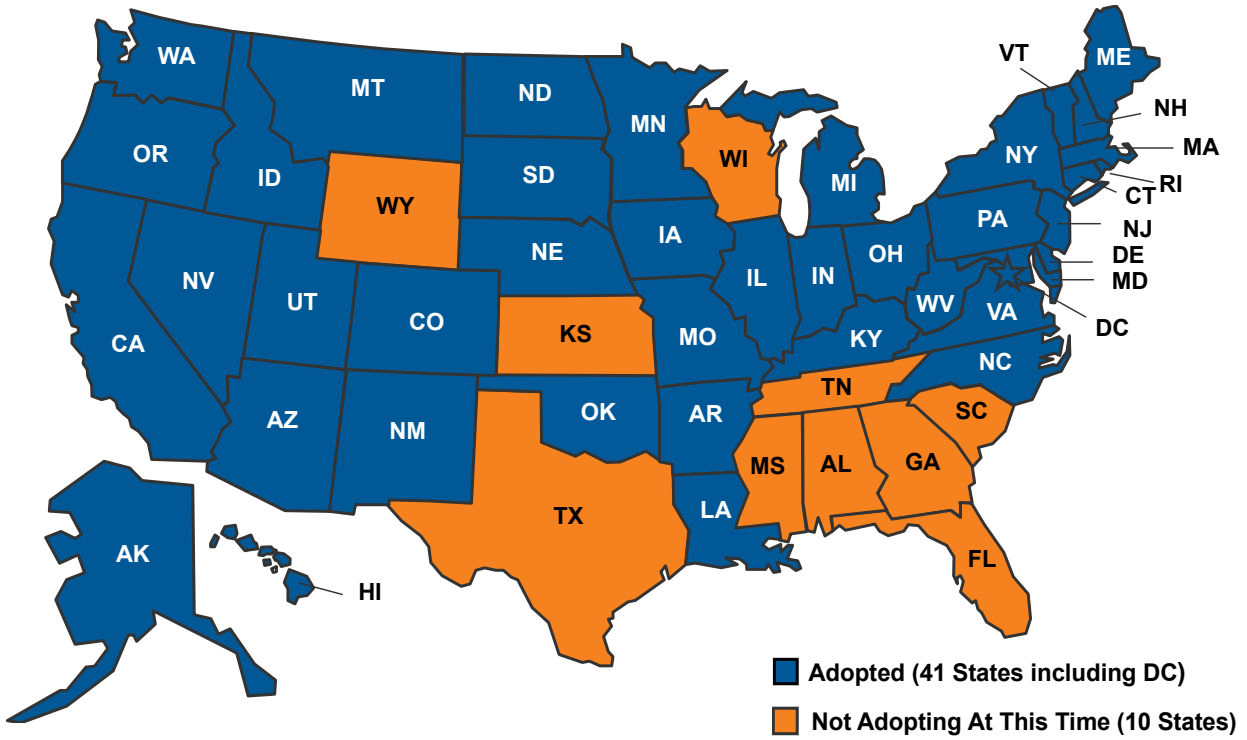
# CHWs and Medicaid expansion

Medicaid expansion through the Affordable Care Act (ACA) extends Medicaid coverage to nearly all adults with incomes up to 138% of the Federal Poverty Level ($20,120 for an individual in 2023) and provides states with an enhanced federal matching rate (FMAP) for their expansion populations.

Medicaid expansion will indubitably mean an increase in people who will need support in the Medicaid enrollment process. **CHWs are in the perfect position to effectively educate individuals on benefits, assist them through enrollment, and start their screening process**.

## Status of State Medicaid Expansion Decisions, Dec 2023




NOTES: Current status for each state is based on KFF tracking and analysis of state activity. See link below for additional state-specific notes.
SOURCE: "Status of State Medicaid Expansion Decisions," https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

# Medicaid expansion can have a significant impact on clinical diagnosis and management

## "Estimating The Potential Impact Of Insurance Expansion On Undiagnosed And Uncontrolled Chronic Conditions" – Health Affairs

The National Health and Nutrition Examination Survey examined the diagnosis and treatment of diabetes, hypercholesterolemia, and hypertension in relation to health coverage enrollment.

**Conclusions**

- Health insurance coverage was associated with higher rates of diagnosis of diabetes, hypercholesterolemia, and hypertension among nonelderly adults
- There was evidence of improved management and control of these conditions among those with coverage.

## "Early Coverage, Access, Utilization, and Health Effects Associated With the Affordable Care Act Medicaid Expansions" – Annals of Internal Medicine

A study from the University of California compared changes in health insurance coverage, access to and utilization of medical care, and health for low-income adults in states that expanded their programs and those that didn't.

**Conclusions**

- An increase in insurance rates for low-income individuals was associated with more frequent use of care and increased rates of diagnosis of diabetes and high cholesterol.

https://pubmed.ncbi.nlm.nih.gov/26355058/

https://doi.org/10.7326/M15-2234

# State Example: Michigan's enrollment assisters

Although Medicaid can significantly improve a person's health, barriers to enrollment can deter people from joining. **CHWs are perfectly positioned to be enrollment assisters, because they have the skills, trust, and connections necessary to reach newly eligible individuals** from marginalized and under-resourced communities.

## Example: Michigan Primary Care Association (MPCA) Enrollment Assisters

MPCA assessed the similarities between the activities of an enrollment assister and a CHW utilizing the Community Health Worker Core Consensus (C3) Project list of CHW core roles. **They found commonalities in all ten core CHW roles, demonstrating the potential to strengthen Medicaid expansion outreach through cross-training the CHW and enrollment assister workforces.** Several health centers in Michigan have embraced the cross-training model and employed enrollment assisters to meet the increased demand for enabling services.

MPCA provides a range of resources and assistance to support this shift in activities, including:

- **data tracking tools** that allow enrollment assisters to capture referrals and applications for services and supports beyond health coverage,
- **health coverage literacy training** for CHWs
- broad training on enabling services and **networking opportunities** for enrollment assisters and CHWs.

https://www.nachc.org/wp-content/uploads/2017/03/2017EnrollmentAssister-IssueBrief_FINAL_PUBLIC.pdf
Secondary Source: https://www.youtube.com/watch?v=TXJRvdpsNUg

# State examples: CHW roles in Medicaid enrollment

## Example: Nebraska

**Nebraska's Department of Health and Human Services provided training sessions to CHWs so they can help individuals enroll in Medicaid.**

Topics covered include:

- Eligibility criteria
- Coverage details
- How to explain why a person would want to enroll in Medicaid
- How to assist someone in enrolling in Medicaid
- How to share resources to answer questions regarding Medicaid enrollment

Nebraska does not currently have a formalized statewide infrastructure for CHWs, however they do have a CHW Consultant-Trainer program with 11 CHWs. They also distribute information to CHWs through this website.

## Example: Missouri

**Health networks in Missouri have employed CHWs to help enroll individuals in Medicaid.**

*" HCC Network operates several health clinics throughout Missouri with [CHWs] who are available by appointment to assist with questions and applications…We'll help them through the application, we'll answer any questions they have, we'll get the application to the state, and we'll continue to follow through with it until there's a decision on the application…If there's any other information or proof they need to send in, we can help them with that"*

*"A [CHW], Georgia Rodgers, was added to the NOVUS Community Health and Outreach team. She is trained in Medicaid enrollment assistance and is also a Certified Application Counselor through [CMS]. She is currently conducting Medicaid outreach in Cape Girardeau and surrounding areas, the same community that she has resided in for 39 years."*

https://dhhs.ne.gov/MCAH/CHW-Medicaid-Expansion%20Training.pdf
https://accesshealthnews.net/missouri-medicaid-expansion-is-changing-lives-for-those-aware-of-the-new-eligibility-guidelines/

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# CHW integration into Community Health Centers (CHCs) and Federally Qualified Health Centers (FQHCs)

CHCs/FQHCS are community-based clinics that provide individuals with primary and preventive care. They are optimal places for CHWs to work to connect individuals to the health system.

CHWs can have varied roles in CHCs. They can perform health screenings, give patient education, place resource referrals, arrange transportation, coordinate community outreach, follow-up after clinic visits, and enroll patients into public health and health insurance programs, among many other activities.

Integrating CHWs into these settings requires understanding roles, existing financing and payment structures, and potential opportunities to unlock funding to make CHW employment in CHCs/FQHCs attractive and sustainable.

**This section gives background information on how health centers are financed and describes potential opportunities to include CHWs in their financing systems.**

# CHCs, FQHCs, and CHC/FQHC look-alikes provide primary and preventive care to communities with underserved populations

**CHCs receive federal grant funding, but there are also CHC Program look-alikes that meet health center program requirements and receive certain HRSA benefits without receiving federal funding. The majority of CHC and CHC Look-Alikes' operating funds come from Medicaid, Medicare, private insurance, patient fees, and other resources.**

**CHCs**

- Provide set of comprehensive, high-quality primary + preventive services *regardless of patient ability to pay*
- Employ interdisciplinary teams and patient-centric approaches
- Deliver care coordination and other services that facilitate access to care
- Collaborate with other providers and programs to improve access to care and community resources
- Are community-based + patient-directed

**CHCs and "CHC Look-Alikes" can receive access to:**

- FQHC Prospective Payment System (PPS) reimbursement for services
- Discounts for pharmaceutical products
- Free vaccines for uninsured and underinsured children
- Assistance in recruitment and retention of primary care providers

CHCs receive some additional benefits and grant-funding that are not available to CHC look-alikes.

**FQHCs** are specific CHCs, CHC look-alikes, or outpatient clinics associated with tribal organizations that receive HRSA Section 330 grants, qualify for specific reimbursement under CMS, and can offer sliding scale fees.

https://bphc.hrsa.gov/about-health-centers/what-health-center
https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers

# FQHCs work within a federal payment structure called the Prospective Payment System (PPS)

Under PPS, **FQHCs are paid a predetermined rate** that encompasses reimbursement for all services provided during a single visit, adjusted annually for inflation.

+ The PPS rate structure is designed to provide **financial certainty and reduce the incentive to deliver unnecessary health care services** as can occur through fee-for-service systems.

− PPS can be **restrictive and encounter-based**. An FQHC can only receive the PPS money if certain criteria are met during the encounter.

## PPS Eligibility Criteria for Patient Encounters

1. The service is provided **within the four walls** of a clinic.
2. The service is defined as an **allowable encounter/ set of services** as defined under PPS.
3. Only **one billable service is provided to a patient per day** (with the exception that a medical visit and a dental visit can be provided on the same day).
4. The service is **rendered by a billable provider** type.

## *Medicaid MCOs and FQHCs*

MCOs have the flexibility to set their own rates for FQHC payments but must pay the FQHCs no less than they would other contracted entities for similar services. If the total payment to an FQHC is less than the PPS amount, the state must pay the difference quarterly through a reconciliation process and supplemental payment (called a wraparound payment).

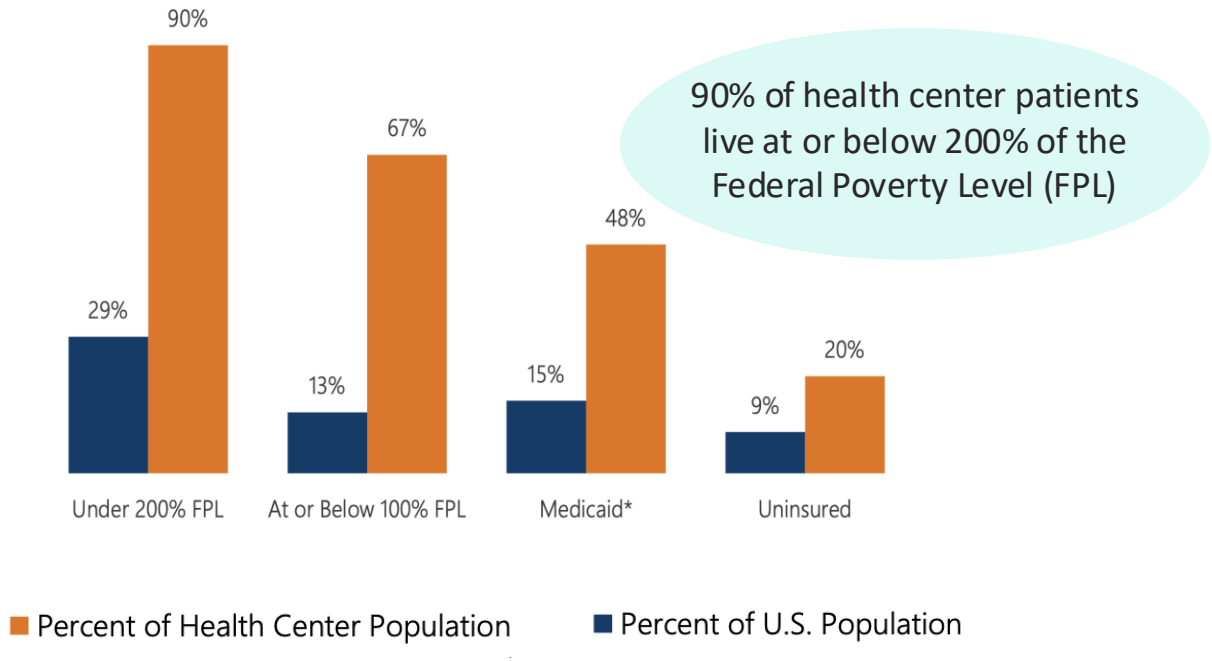
https://www.chcf.org/wp-content/uploads/2022/05/MediCalExplainedHealthCentersPaid.pdf

https://www.nachc.org/resource/community-health-center-chartbook/

# Populations served by CHCs/FQHCs largely overlap with those that work with CHWs

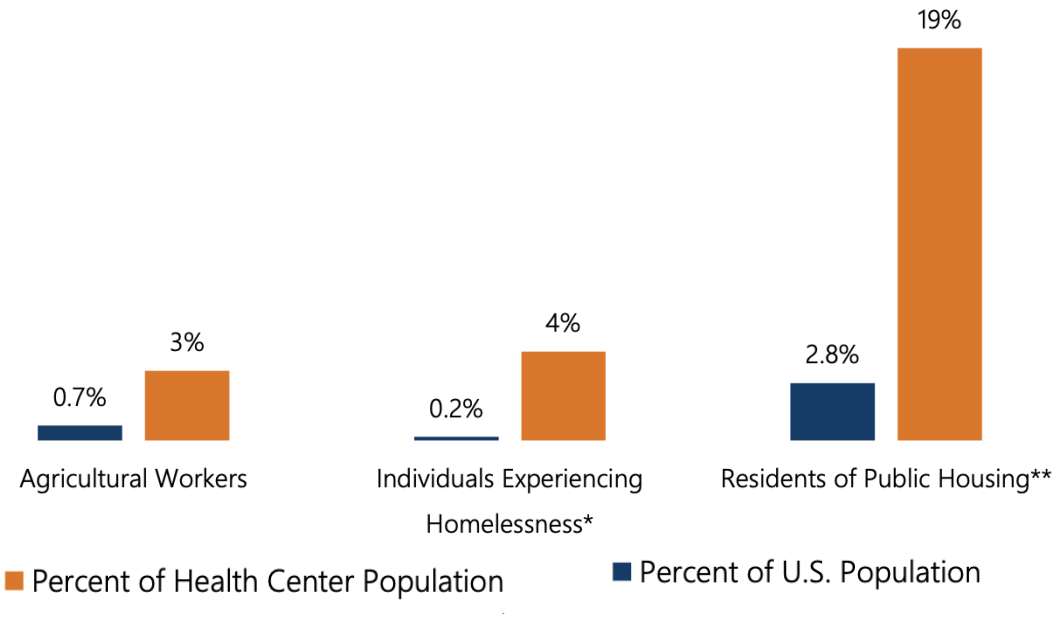
CHCs are in under-resourced areas and have a service population that largely overlaps with the communities served by CHWs. **CHWs are an optimal workforce to help bridge CHC patients to community services, or conversely, connect community members to their local CHC.**

## CHC Demographics, Income and Insurance Distribution




Note: FPL = federal poverty level, which was $12,880 per year for an individual in 2021; * Medicaid alone and not in combination with other insurance.. Sources: (1) 2021 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS. (2) U.S. Census Bureau, 2021 American Community Survey 1-Year Estimates, Tables S1701, S2704, S2701

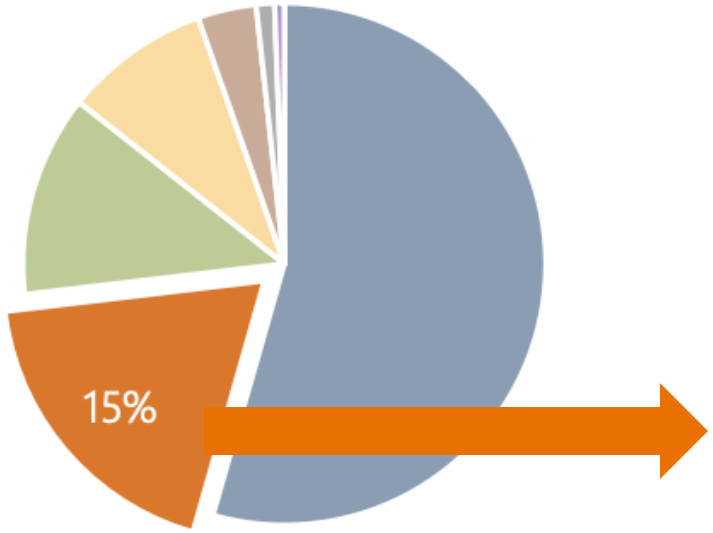
## Health Centers Serve a Disproportionate Share of Populations with Complex Needs




National data includes the total number of people receiving housing assistance, including dependents, from all relevant HUD programs. Sources: (1) 2021 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS. (2) Findings from the National Agricultural Workers Survey (NAWS). Agricultural Worker Population Estimates,. (3) U.S. Department of Housing and Urban Development. The 2022 Annual Homeless Assessment Report (AHAR) to Congress, December 2022. (4) U.S. Department of Housing and Urban Development. Assisted Housing Dataset, 2021 Based on 2010 Census

# CHWs currently make up 6% of the CHC “Enabling Services” staff

**Out of the 15% full-time staff who work on “enabling services”, 6% are currently CHWs.** Enabling services are defined as non-clinical services that do not include direct patient services that enable individuals to access health care and improve health outcomes.



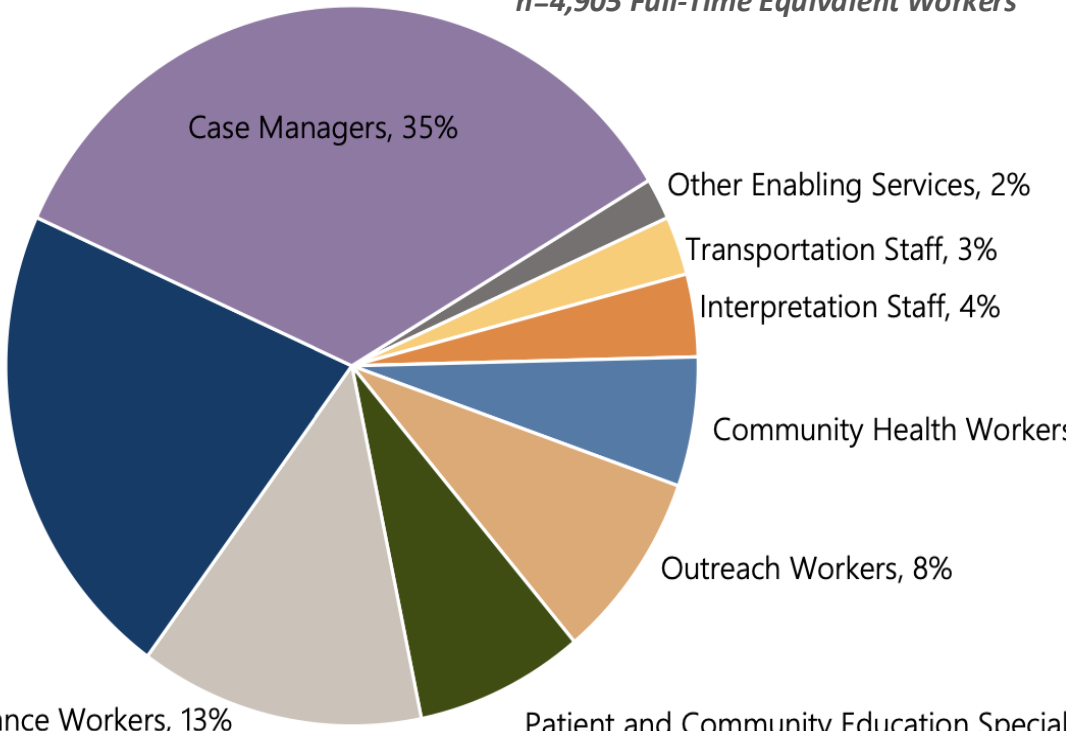

Share of Total Care Team*

*n= 32,709 Full-Time Equivalent Workers*

Source: 2021 Uniform Data System. Bureau of Primary Health Care, HRSA, DHHS.

## Health Center “Enabling Services” Staff Distribution

*n=4,905 Full-Time Equivalent Workers*

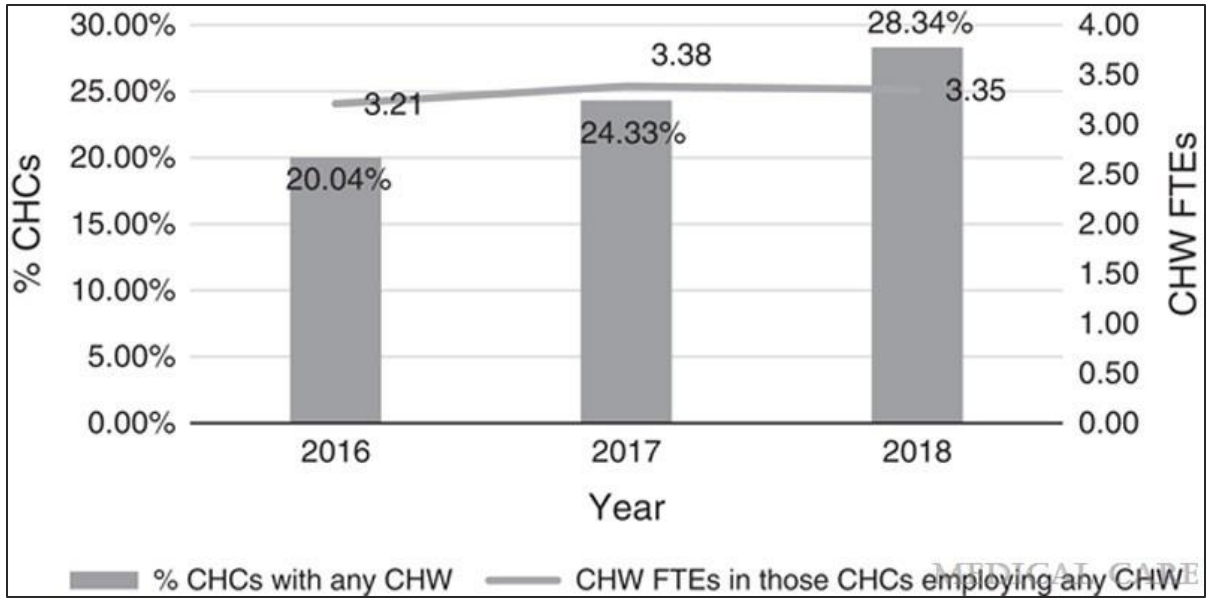



Adapted from https://www.nachc.org/resource/community-health-center-chartbook/

# An increasing proportion of CHCs are employing CHWs to work with their patients

- Data from the FQHC Uniform Data System shows that the **proportion of CHCs that reported working with CHWs increased** from 20.04% in 2016 to 28.34% in 2018 (average growth rate of 41%)
- Compared to CHCs without CHWs, since 2016, **CHCs with CHWs tended to serve more Black, Hispanic, and Medicaid patients**, as well as patients with special needs such as limited English proficiency, HIV diagnosis, and substance use disorder
- **CHCs that employed CHWs relied more on foundations/private grants**, while CHCs without CHWs rely more heavily on HRSA BPHC grants
- CHCs with CHWs tend to be in **urban areas** and in states with an approved DSRIP program

## CHWs in CHCs, 2016–2018




The percentages of CHCs with any CHW FTEs are shown for years 2016, 2017, and 2018 in the bar graph. Among the percentages of CHCs with any CHW FTEs, the actual CHW FTEs are shown in line.

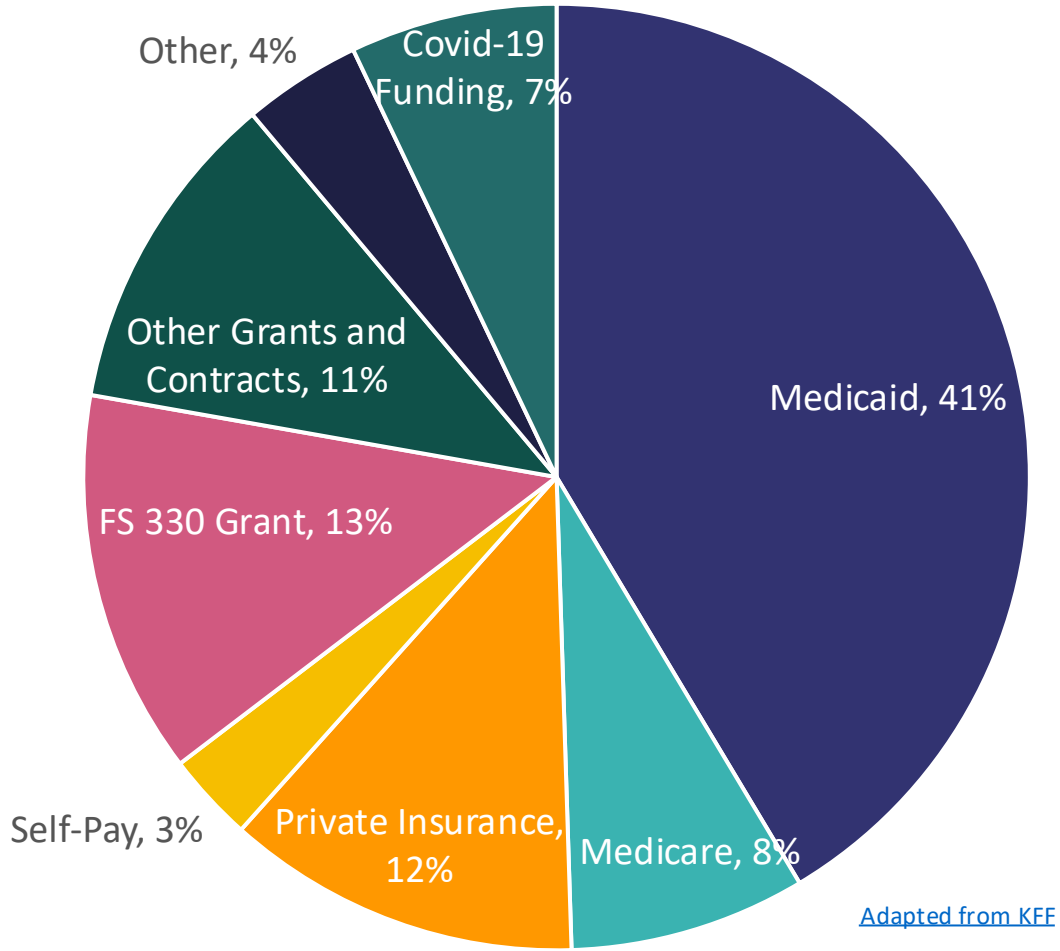
The Use of Community Health Workers in Community Health Centers

Park, Jeongyoung; Regenstein, Marsha; Chong, Nicholas; Onyilofor, Chinelo L.Medical Care59:S457-S462, October 2021.doi: 10.1097/MLR.0000000000001607

# States and FQHCs have found ways to supplement or modify the PPS to allow for more flexibility and potential funding for CHWs

- States have **some flexibility in the scope of services** considered in the PPS rate development calculation and must have a process to adjust PPS rates to reflect changes to the scope of services provided by the FQHC.
  - → HRSA 330 grants allow CHW expenses to be considered "enabling services".
  - → Some states use a higher annual inflation rate when setting PPS rates.
  - → Other states use an "enhanced" PPS rate whose supplemental payments incentivize FQHCs to provide specified services, such as case management.
- FQHCs may file a claim for both a PPS encounter and for additional Medicaid-covered services that are not included in the PPS rate.
- Some FQHCs may pay for additional or ancillary services using a different methodology. The chart on the right shows the diversity of funding sources used by FQHCs in 2021.

**CHC (Including FQHCs) Funding Sources Nationwide , 2021**




Adapted from KFF

*Does not include Look-Alikes

https://www.chcf.org/wp-content/uploads/2022/05/MediCalExplainedHealthCentersPaid.pdf

# State example: Louisiana's Medicaid SPA supports payment for CHW services through the FQHC PPS

**In 2022, Louisiana passed a SPA to support CHW reimbursement based on an alternative payment methodology (APM), allowing for reimbursement outside of the current PPS rate for CHW services provided in FQHC and rural health center (RHC) settings.**

The CHW services must be related to a specified chronic disease, documented unmet SDOH need, or pregnancy.

**LA SPA Reimbursement Eligibility Qualifications**

- CHWs must have completed a state-recognized training curriculum approved by the Louisiana CHW Workforce Coalition, or provided 3,000 hours of documented work experience as a CHW
- The supervising provider must maintain documentation of CHW qualifications
- The activities must relate to the diagnosis of one or more chronic health conditions including behavioral health, documented or suspected unmet health-related social need, or pregnancy

→ Reimbursement will be based on published salary information, including benefits, and administrative overhead.

→ One CHW salary would be approximately $42,000 based on the Bureau of Labor Statistics data.

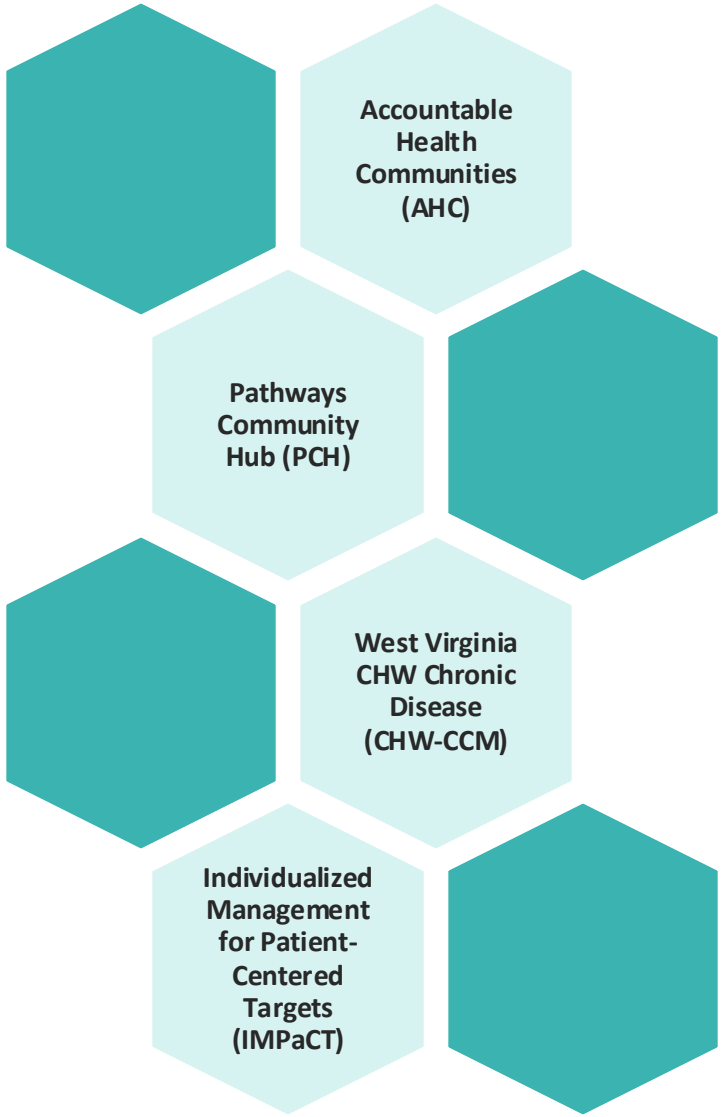
→ Individual and group services are both allowed, so there is scope to bill for group activities.

https://www.louisianahealthconnect.com/newsroom/provider-notice--community-health-workers-in-federally-qualified0.html
https://ldh.la.gov/assets/docs/MQI/MQIMeetings/Feb22/MedicaidQualGroupPresentation.pdf

# Models and frameworks of CHW integration into health systems

CHW work spans both health systems and community-based organizations. For CHWs to accompany individuals throughout their health journey, it is critical to have linkages from health systems into the community. **New frameworks and systems have been created over the last decade to integrate community and clinic- or hospital-based care**, positioning CHWs as the primary connection to care outside of a health system and emphasizing whole-person care as a primary outcome.

**Four examples of integration frameworks are listed on the right and will be further explored in the following slides.**

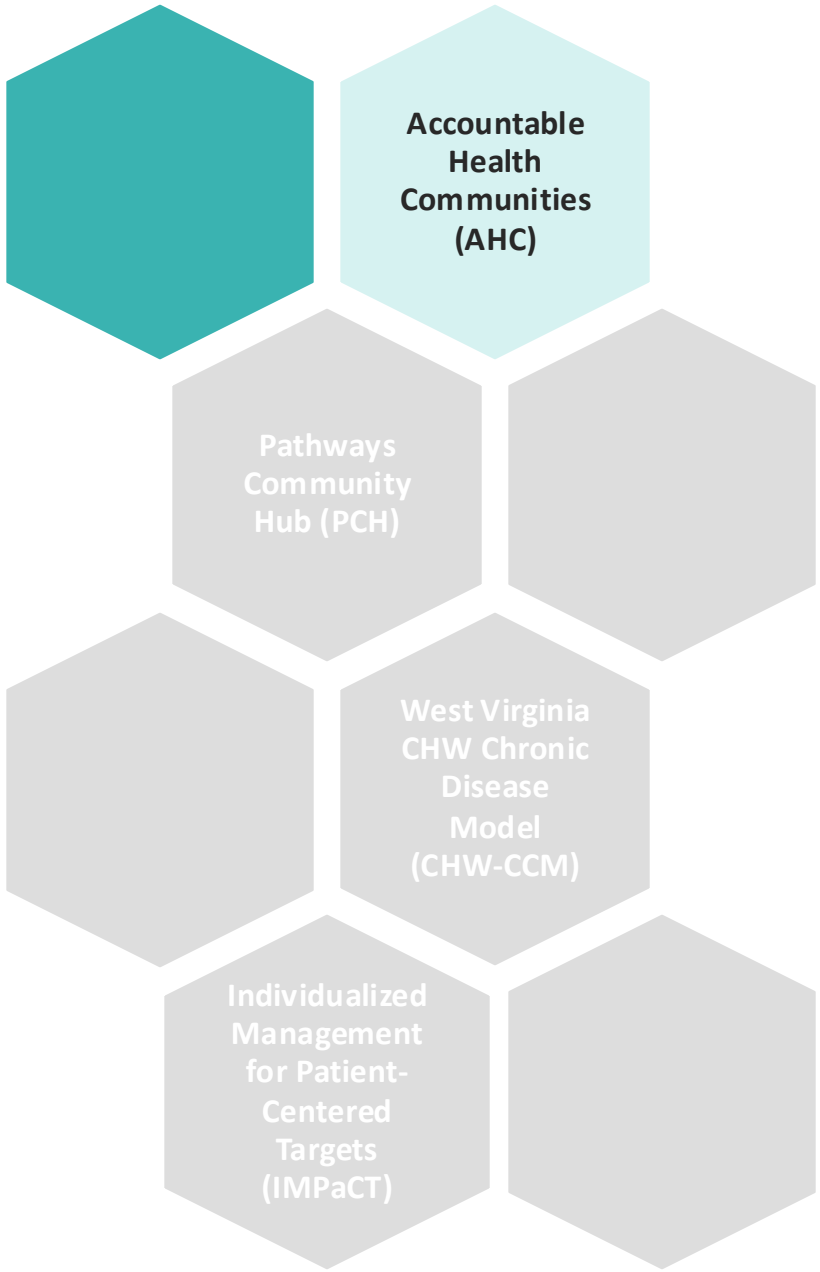


# Example 1:
# Accountable Communities for Health (ACH/AHC)

**Accountable Communities for Health or Accountable Health Communities** integrate prevention and public health with health care and SDOH to improve health outcomes, reduce costs, and provide whole-person care.

***Many states and local communities currently are or have previously implemented and tested elements of Accountable Communities for Health in their health initiatives.***

*The Funders Forum on Accountable Health has a catalog of ACH and ACH-like initiatives across the US that can be found here.*




https://www.pchi-hub.org/our-model#:~:text=A%20Pathways%20Community%20HUB%20(PCH,medical%2C%20social%2C%20and%20behavioral%20health

# AHCs are guided by 10 principles/features

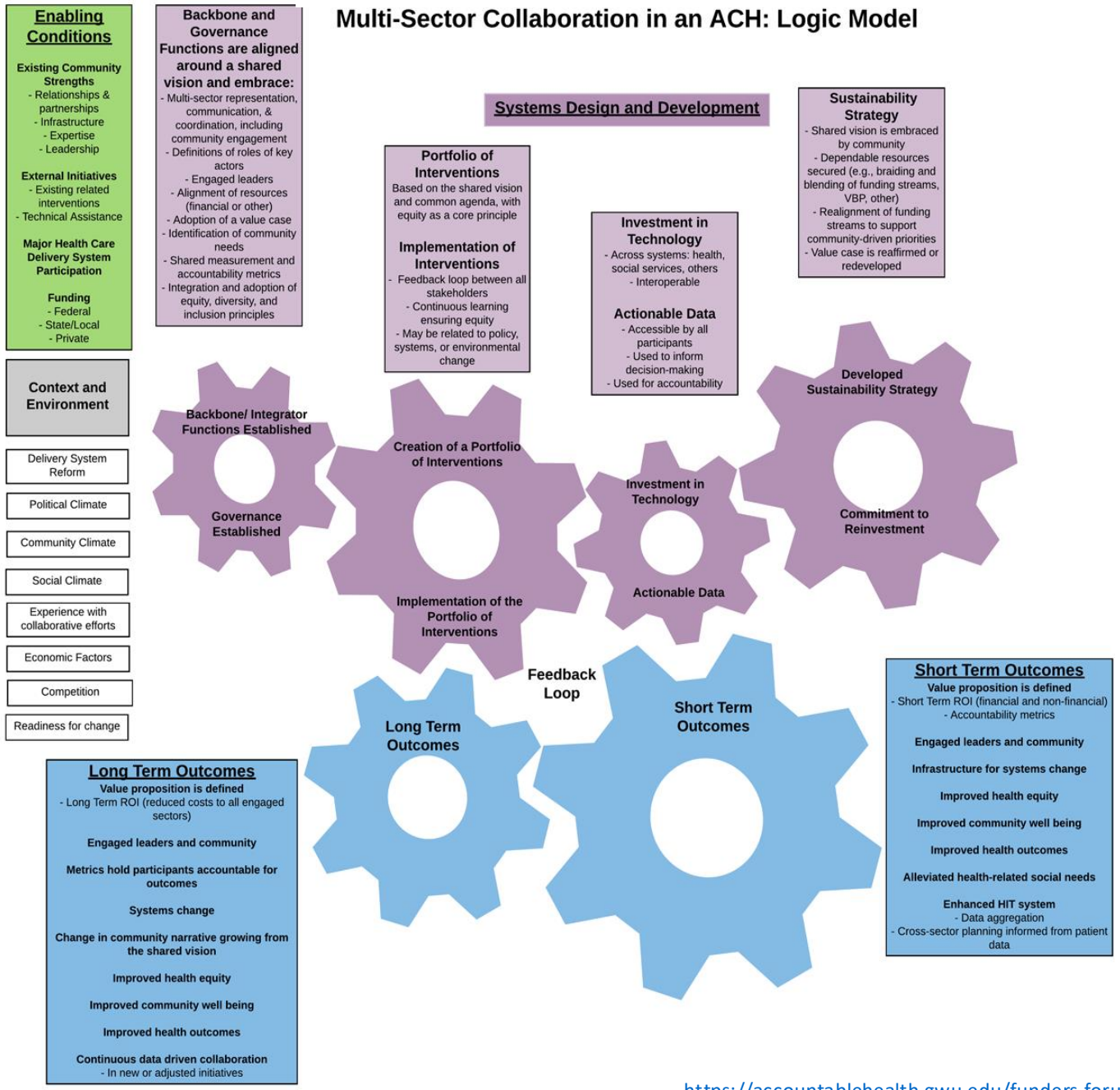
1. A **"backbone" organization** which serves as convener and integrator for a defined geographic area - may or may not serve as a fiduciary agent
2. A **governance structure** with respected community leaders, which builds on a history of collaboration in addressing the health of the community while engaging diverse consumer perspectives.
3. Effective **cross-sector alignment** among health care providers, health plans, public health, community and social services, education, business and labor.
4. An **actively engaged group of community leaders and stakeholders** to establish a shared vision, goals, and agenda, with full community engagement in decision making regarding use of resources and investment in community capacity for shared decision-making.
5. A strong **community-focus**, although may emphasize vulnerable/marginalized populations.
6. **Aligned data systems** that emphasize accessible data with accountability indicators across sectors and participants for planning, coordination of care and services across a continuum of health and social determinants, and for QI and evaluation.
7. A **business case** and return on investment defined for all sectors engaged
8. Effective **collaboration** across all participating organizations
9. Multiple funding sources for **sustainability**
10. Quality improvement and **continuous learning**

https://accountablehealth.gwu.edu/forum-analysis/principles-accountable-health#_ftn1

# Logic model for multi-sector collaboration in an AHC, The George Washington University

This logic model illustrates how the 10 principles in AHCs work together.

The gears illustrate the interconnected ways that **enabling conditions, environmental context, systems design and development, and short- and long-term outcomes interact** to drive continued learning in accountable health initiatives.




https://accountablehealth.gwu.edu/funders-forum/logic-model

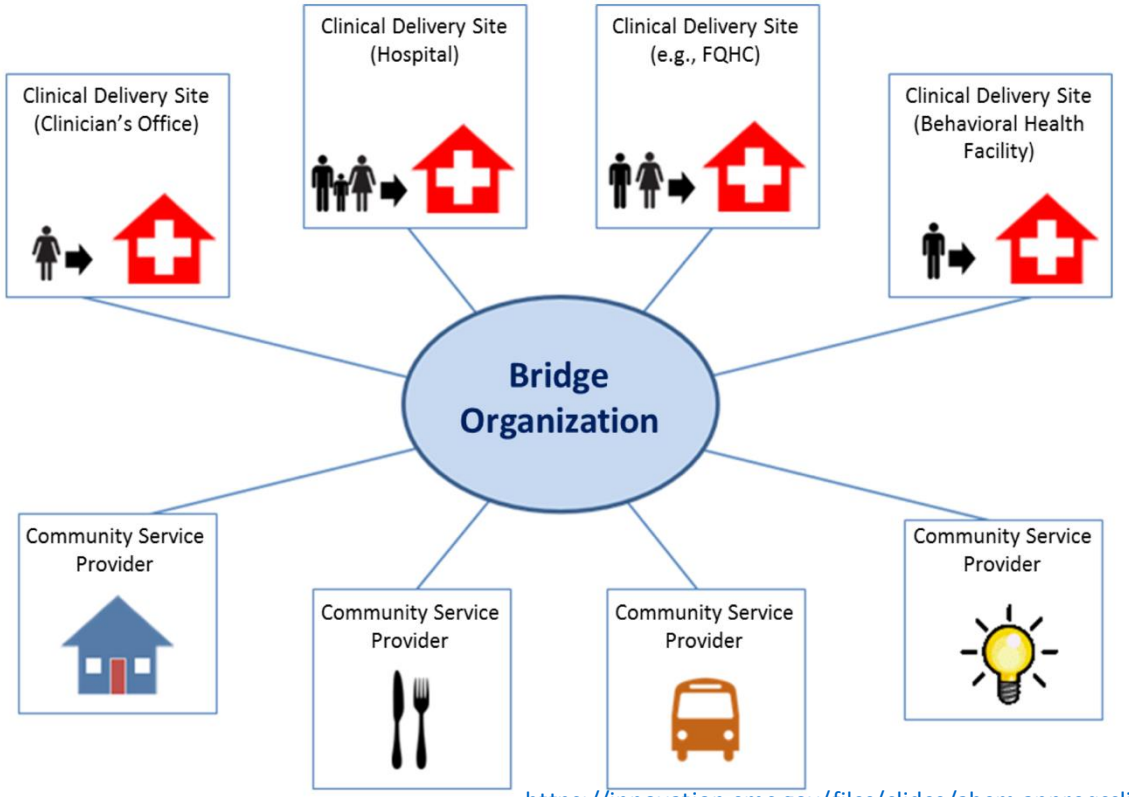
# A national study: The Center for Medicaid and Medicare Services (CMS) AHC model

**CMS funded a five-year innovation program between May 2017- April 2022 that tested whether systematically identifying and addressing health-related social needs of Medicare and Medicaid beneficiaries through AHCs would impact total health care costs and utilization.**

## Program Design

CMS funded bridge organizations to serve as "hubs", which were responsible for coordinated efforts to:

- **Identify and partner** with clinical delivery sites
- Conduct systematic health-related social needs (HRSN) **screenings and make referrals**
- **Coordinate and connect** community-dwelling beneficiaries who screen positive for certain unmet health-related social needs to community service providers that might be able to address those needs
- **Align model partners to optimize community capacity** to address health-related social needs




https://innovation.cms.gov/files/slides/ahcm-appreqsslides.pdf

https://aspe.hhs.gov/sites/default/files/documents/5b8cba1351a99e904589f67648c5832f/health-social-care-coordination.pdf

# CMS AHC additional features & innovations

**Service provision occurred along three tracks or pathways (below), each with a specific evaluation approach.**

## Track 1: Awareness

- Increase beneficiary awareness of available community services through information dissemination and referral

## Track 2: Integration

- Provide community service navigation services to assist high-risk beneficiaries with accessing services

## Track 3: Alignment

- Encourage partner alignment to ensure that community services are available and responsive to the needs of beneficiaries

## Key Innovations

- **Systematic screening** of all Medicare and Medicaid beneficiaries to identify unmet HRSN (required of all organizations)
- **Creation and maintenance of a resource inventory** of available community services and community service providers to address each of the domains included in the screening tool
- Testing the **effectiveness of referrals** to increase beneficiary awareness of community services using a rigorous mixed method evaluative approach
- Testing **the effectiveness of community services navigation** to aid beneficiaries in accessing services using a rigorous mixed-method evaluative approach
- **Partner alignment** at the community level and implementation of a quality improvement approach to address beneficiary needs

https://innovation.cms.gov/files/slides/ahcm-appreqsslides.pdf

# The role of CHWs in AHCs

- → AHC activities such as screening, navigating, and bidirectional communication, **rely on staff like CHWs** to facilitate linkage to care among health systems and community organizations.
- → To implement AHC programming, most sites used a combination of existing staff and newly hired **screening staff, including CHWs**.
- → Hiring dedicated screening staff **increased clinical site participation** by reducing burden among existing staff, but also led to **decreased awareness among** clinicians of the health-related social needs (HRSN) screening results - either because the results were not part of the health record system, or they were not reviewed by the clinicians.
- → To improve HRSN navigation, sites used warm hand-offs to pass information to clinicians after screening, **employed CHWs as navigators,** and supported beneficiaries using such techniques as motivational interviewing and trauma-informed approaches.

**Example: Rocky Mountain Health Plans, New Mexico**

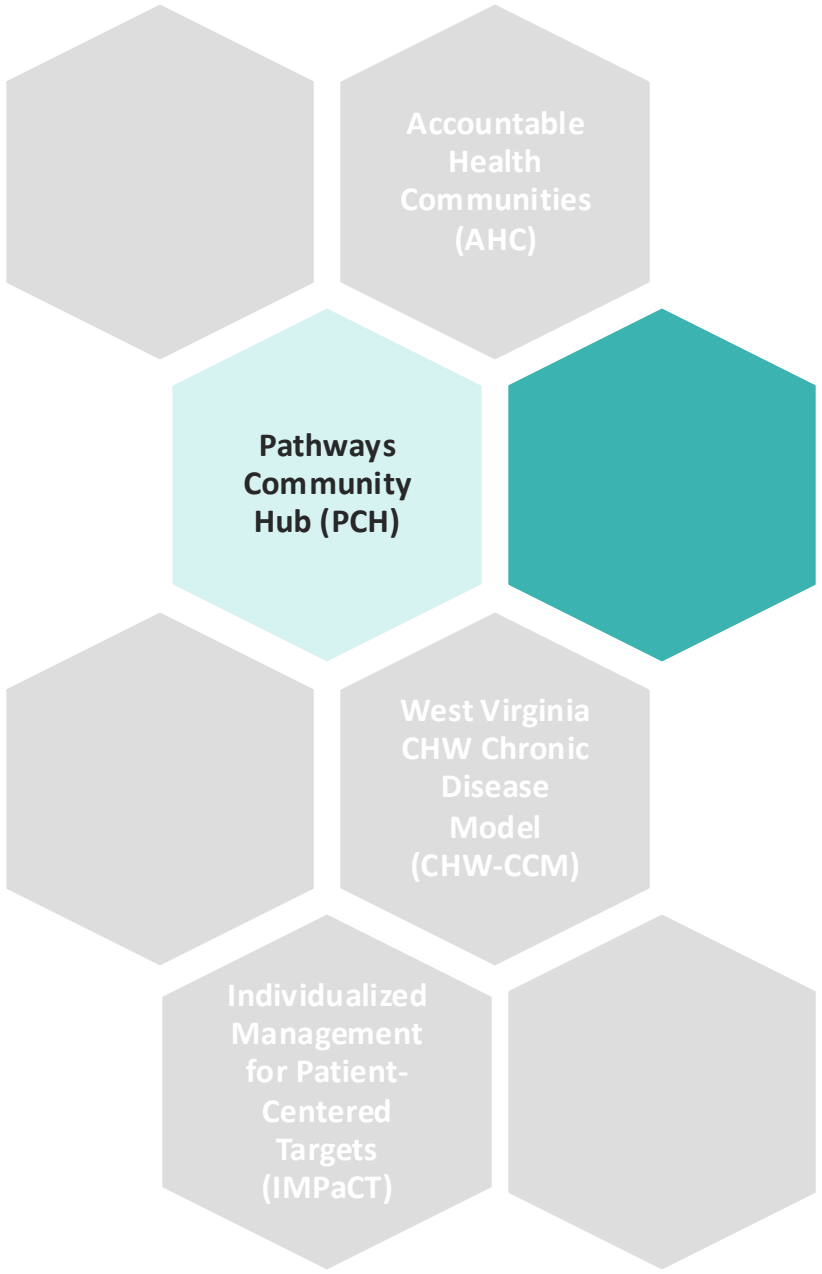
- Rocky Mountain partners with five regional organizations, known as community leads, to improve partner engagement and accountability.
- Rocky Mountain recognized that the **HRSN screening staff had needs themselves**. To support screening staff, Rocky Mountain provides gift-card incentives to staff who meet mutually agreed-upon screening goals.
- To sustain efforts to address HRSN, community leads **highlighted the importance of providing front-desk staff with training and career growth opportunities, in addition to higher pay.**

While CHWs may be valuable members of AHC teams, the usual challenges in pay, career pathways, information sharing, and data accessibility were persistent and still need to be addressed.

https://innovation.cms.gov/media/document/ahcm-casestudy-rmhp
https://www.healthaffairs.org/content/forefront/lessons-five-years-cms-accountable-health-communities-model

# Example 2:
# Pathways Community HUB (PCH)

"A **Pathways Community HUB (PCH)** is an organized, outcome focused, pay for performance **network of community-based organizations that hire and train community health workers (CHWs)** to reach out to those at greatest risk, identify risk factors and barriers, and assure connections to medical, social, and behavioral health services."




https://www.pchi-hub.org/our-model#:~:text=A%20Pathways%20Community%20HUB%20(PCH,medical%2C%20social%2C%20and%20behavioral%20health

# General background on hub models

**A “hub” is a general term for a backbone organization that can facilitate coordination between health and SDOH providers.**

They can be operated by government entities, health systems, or CBOs and create workflows that consider the unique circumstances and histories of the local environment.

Hubs vary in their governance, funding, operations, approach care coordination, the population they serve, and the nature of their interactions and relationships with other partner organizations.

Although diverse, hubs all have the common goal of combining their community partnerships and trusted relationships with administrative and technological capacity to help community members bridge their clinical health with essential social support provided by organizations in the community.

https://aspe.hhs.gov/sites/default/files/documents/5b8cba1351a99e904589f67648c5832f/health-social-care-coordination.pdf

# Key Elements of a Hub

Click here for more information on hub models

## Planning and Governance

- Establishing trust with both social service agencies and health care institutions and collaborating with multiple stakeholders across the community
- Balancing stakeholder interests, especially between social service agencies and health care institutions
- Engaging social service organizations as equal partners in decision-making and promoting balanced power dynamics

## Funding

- Managing, uneven funding distribution between health care and social services, limitations in billing for Medicare, and the necessity of blending funding from multiple sources
- Funding for longevity through mechanisms as Medicaid section 1115 demonstrations
- Champions at various government levels to foster a conducive policy environment and receive financial and administrative support for backbone organizations
- Payment mechanisms for social workers and community health workers for their role in coordination

## Data Infrastructure

- Mechanisms for transferring information across health care and social service providers, and systems to manage the challenges in sharing, accountability, and patient information across different levels of resources and data privacy constraints
- Protocols for data collection and integration to ensure robust program evaluation and consistent monitoring

## Scope and Populations Served

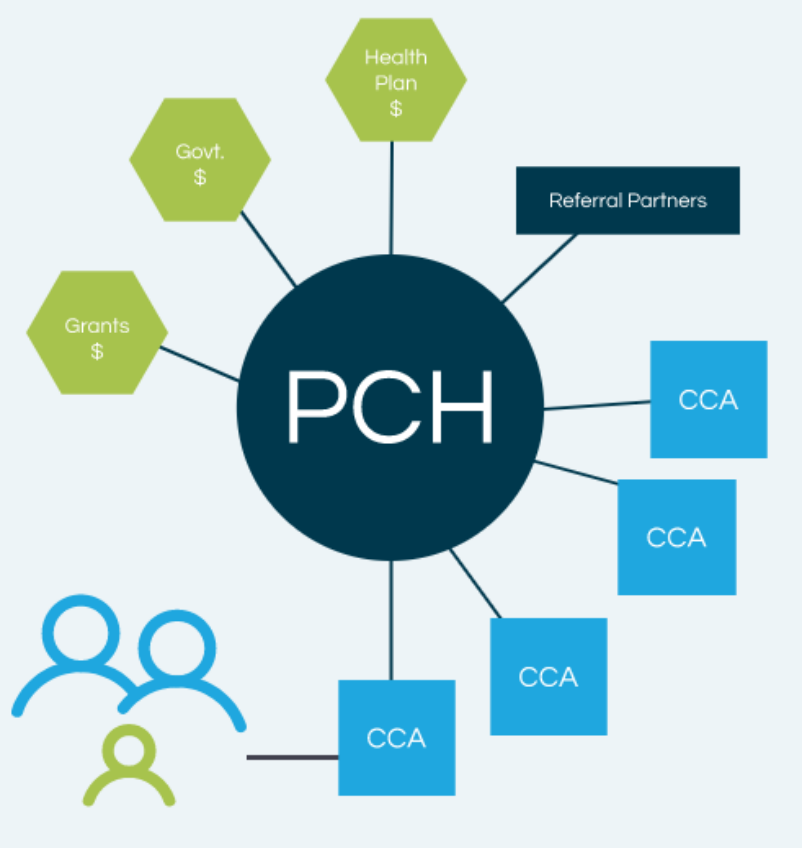
- Coordination of health services including primary care, behavioral health care, dental care, obstetric care, health education, family planning, etc.
- Coordination of social services including housing, nutrition, public assistance enrollment, substance use treatment, and interpersonal violence support
- Geographic boundaries at city, county, or regional levels, often in partnership with large health systems
- Defined populations such as high health care utilizers, older adults, pregnant individuals, veterans, and those experiencing poverty or homelessness

https://aspe.hhs.gov/sites/default/files/documents/5b8cba1351a99e904589f67648c5832f/health-social-care-coordination.pdf

# The PCHI Pathways Community Hub

**The Pathways Community Hub is a specific hub model created by the Pathways Community Hub Institute. In this model:**

- The **HUB contracts with CBOs** that hire CHWs and managers to create a service care network, also known as "**Care Coordination Agencies (CCAs)**."
- The **CCAs included in the network collect data in a standardized way**: using data collection tools, Standard Pathways, and standard reporting.
    - "Pathways" are tools used by CHWs to identify and track individually modifiable risk factors.
    - There are 21 Pathways currently certified, detailed on a subsequent slide.
- Model is **financially sustainable and unrestricted**; **multiple funding streams** enable service provision to wide range of clients and are uninhibited by funding restrictions that might otherwise make vulnerable populations ineligible for services;

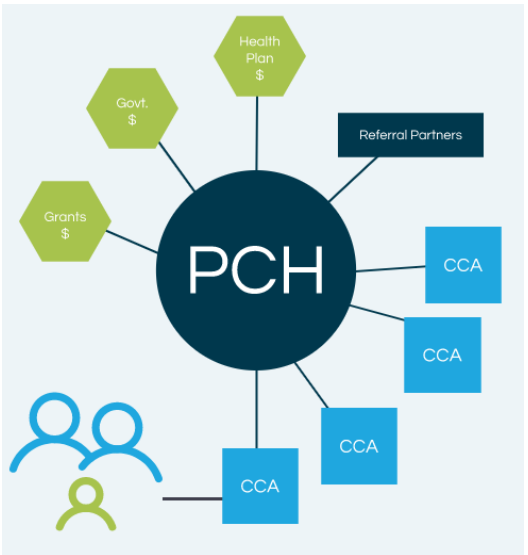



https://www.pchi-hub.org

# The PCHI Pathways Community Hub

The PCH model was developed in the early 2000s by two physicians, Drs. Mark and Sara Redding, based on their experiences working with CHWs in Alaska, where CHWs were already an embedded part of the team.

- In the first version of the model, CHWs worked with high-risk pregnant patients. However, while SDOH were being addressed individually, **care coordination and cross-communication were missing.**
- In the second iteration, the model included a HUB that coordinated care, and tracked metrics all the way from care initiation to outcome (i.e., Pathways) leading to significant improvement in outcomes.
    - In this iteration, the model included a monetary incentive for CCAs (i.e., the community health workers' employers) after the HUB clients achieve measurable, positive outcomes




***Entities using the PCH model are now required to have certification from the PCH Institute to ensure they are meeting all standards.***

https://www.pchi-hub.org/our-model.
https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05166

Redding S, Conrey E, Porter K, Paulson J, Hughes K, Redding M. Pathways community care coordination in low birth weight prevention. Matern Child Health J. 2015 Mar;19(3):643-50. doi: 10.1007/s10995-014-1554-4. PMID: 25138628; PMCID: PMC4326650

# More on the PCHI Pathways...

CHWs offer supports and services that fall into the 21 Pathways listed below. Pathways facilitate outcome-based payment and promote addressing client needs. **In the PCHI model, 50% of payments to a HUB and CCAs are tied to "closed" pathways.**

## Current Certified Pathways

- Adult Education
- Developmental Referral
- Employment
- Family Planning
- Food Security
- Health Coverage
- Housing
- Immunization Referral
- Learning
- Medical Home
- Medical Referral
- Medical Adherence
- Medical Reconciliation
- Medical Screening
- Mental Health
- Oral Health
- Postpartum
- Pregnancy
- Social Service Referral
- Substance Use
- Transportation

PCHI

**Appendix A - Pathways Community HUB Institute℠ Model**
**21 Standard Pathways**

| Pathway | Outcome |
|---|---|
| **Adult Education** | **Confirm that participant completes educational goal.**<br>___ Course/class successfully completed<br>___ Training program completed<br>___ Quarter/semester completed<br>___ Other: _____ |
| **Developmental Referral** | **Developmental evaluation completed.** |
| **Employment** | **Participant is still working 30 days from date of hire.** |

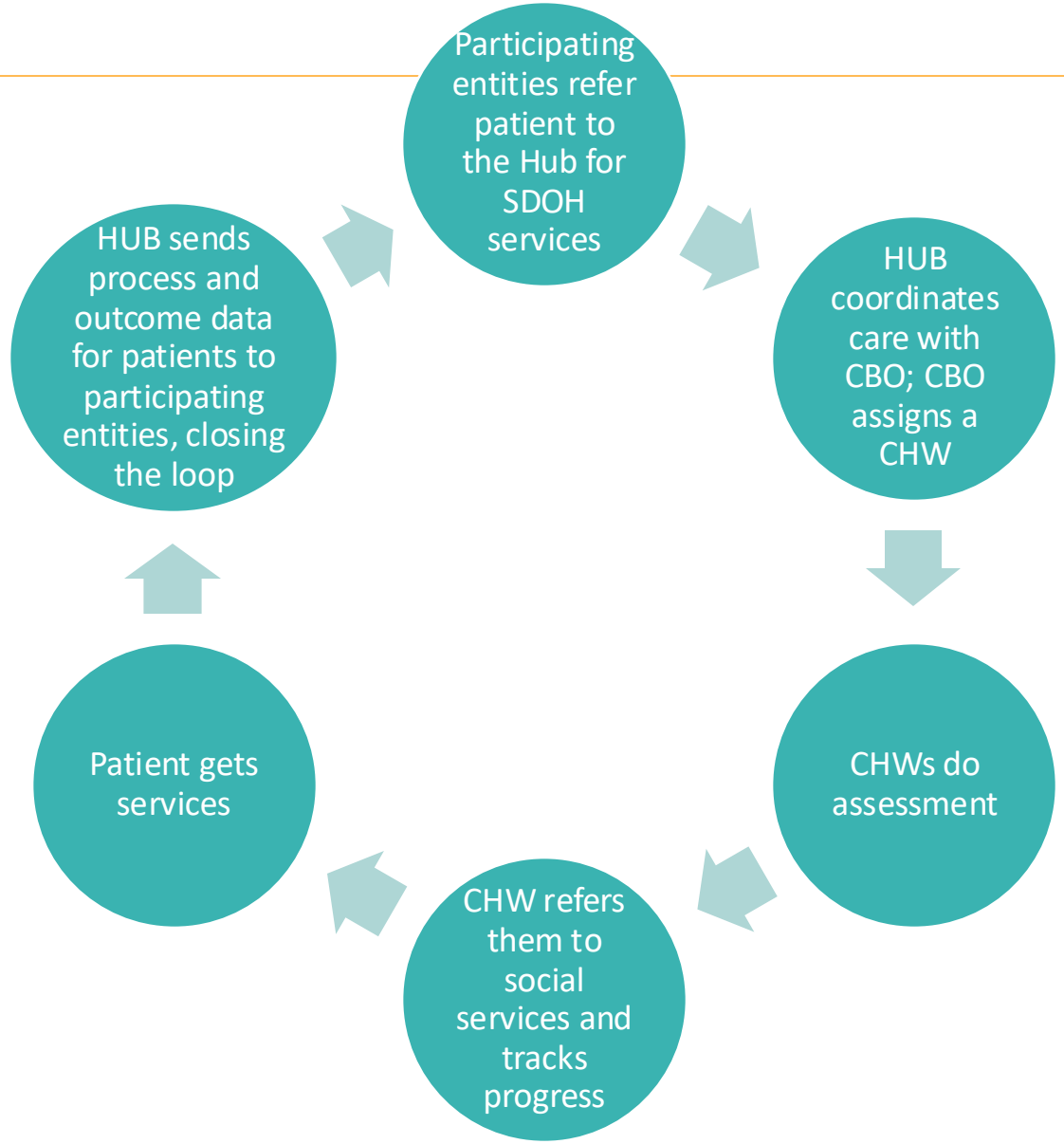
**A Pathway is "closed" when a measurable outcome, which is meaningful to the participant, is achieved.** If an outcome is not reached, then a Pathway is closed "finished incomplete," but the CHW's efforts to resolve the risk are recorded for evaluation.

https://www.pchi-hub.org/_files/ugd/2e5591_a550c6a3dbdc48898072648f23bad97b.pdf

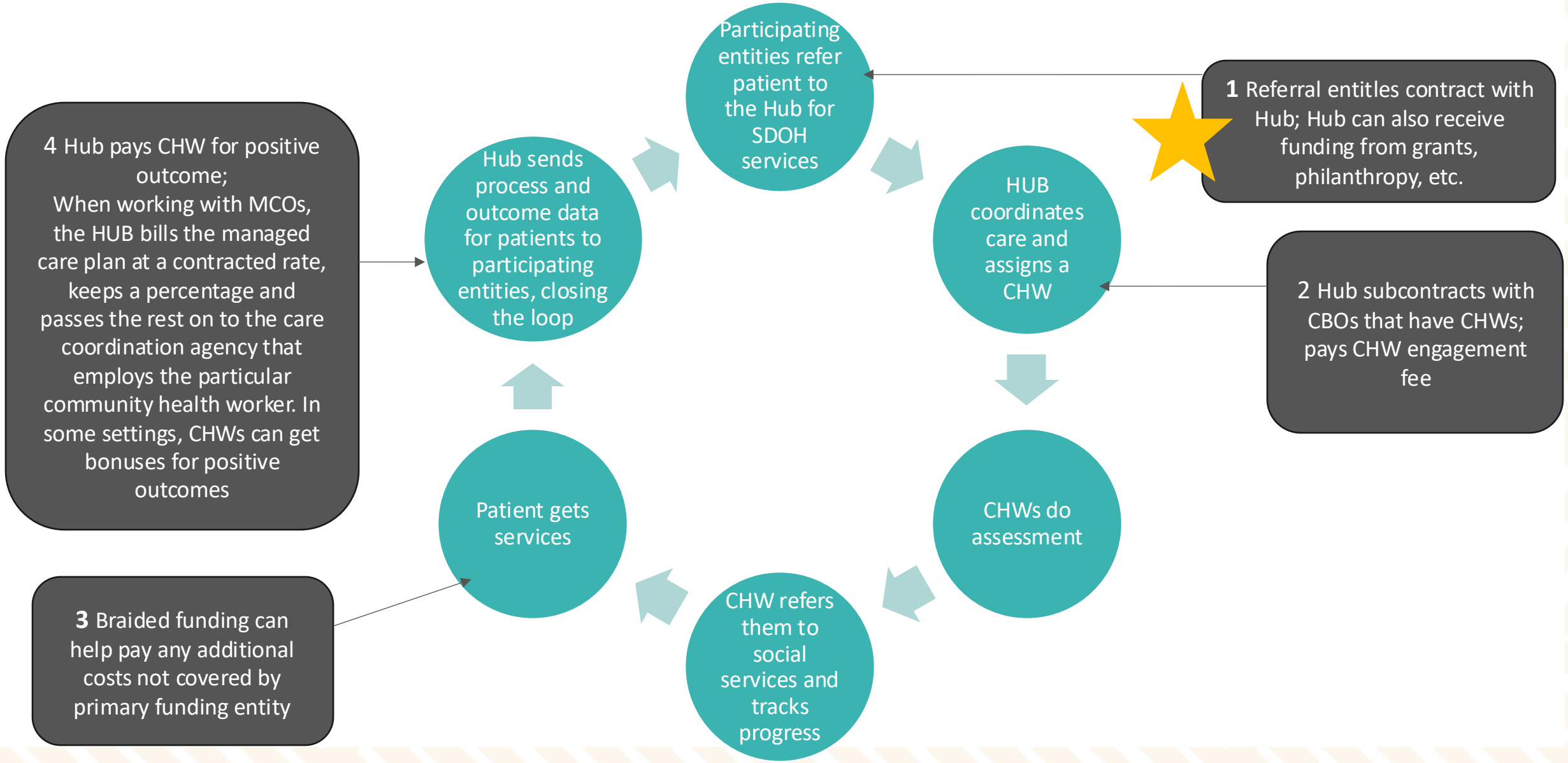
# Key benefit 1: The PCH model integrates health systems and community through a PCH HUB

**This is beneficial because it...**

1. Strategically **places coordination efforts with a CBO that is recognized and trusted by community** (i.e., casts net into community less likely to seek out medical system directly)
2. Takes the **burden of administration away** from the CBOs and PHPs
3. Offers a **neutral, centralized mechanism for care coordination** without referral bias to one organization or PHP
4. Is a regional entity, and **encourages greater regional/local investment**



# Key benefit 2: PCH relies on diverse funding streams to provide services



# Examples of states with PCHs

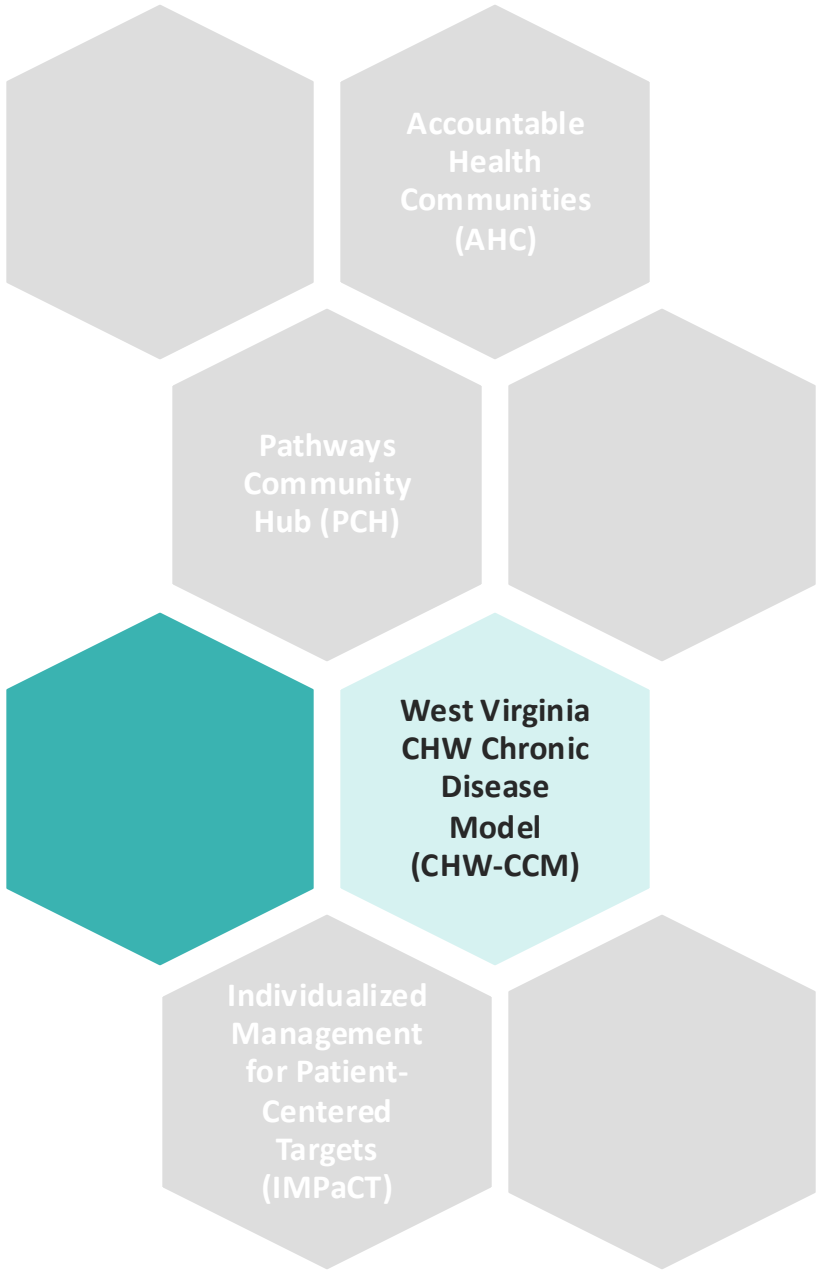
| | |
|---|---|
| **Ohio** | **California** |
| **Nevada** | **Texas** |
| **New Mexico** | **Michigan** |
| **Pennsylvania** | **Washington** |
| | **Wisconsin** |


The Administration of Community Living (ACL) has invested in a similar “hub and spoke” model called the Community Care Hub. More information on this model can be found in the CHWs and the Aging Population Section of this deck.

https://www.pchi-hub.org/hub-profiles

# Example 3:
# West Virginia CHW Chronic Care Management (CHW-CCM) Model

The **West Virginia Community Health Worker–Based Chronic Care Management (CHW-CCM) Model** was developed under a CMS Health Care Innovation Award in 2012, with the aim of improving outcomes and lowering costs for high-risk diabetes patients and has since been replicated across multiple disease processes.

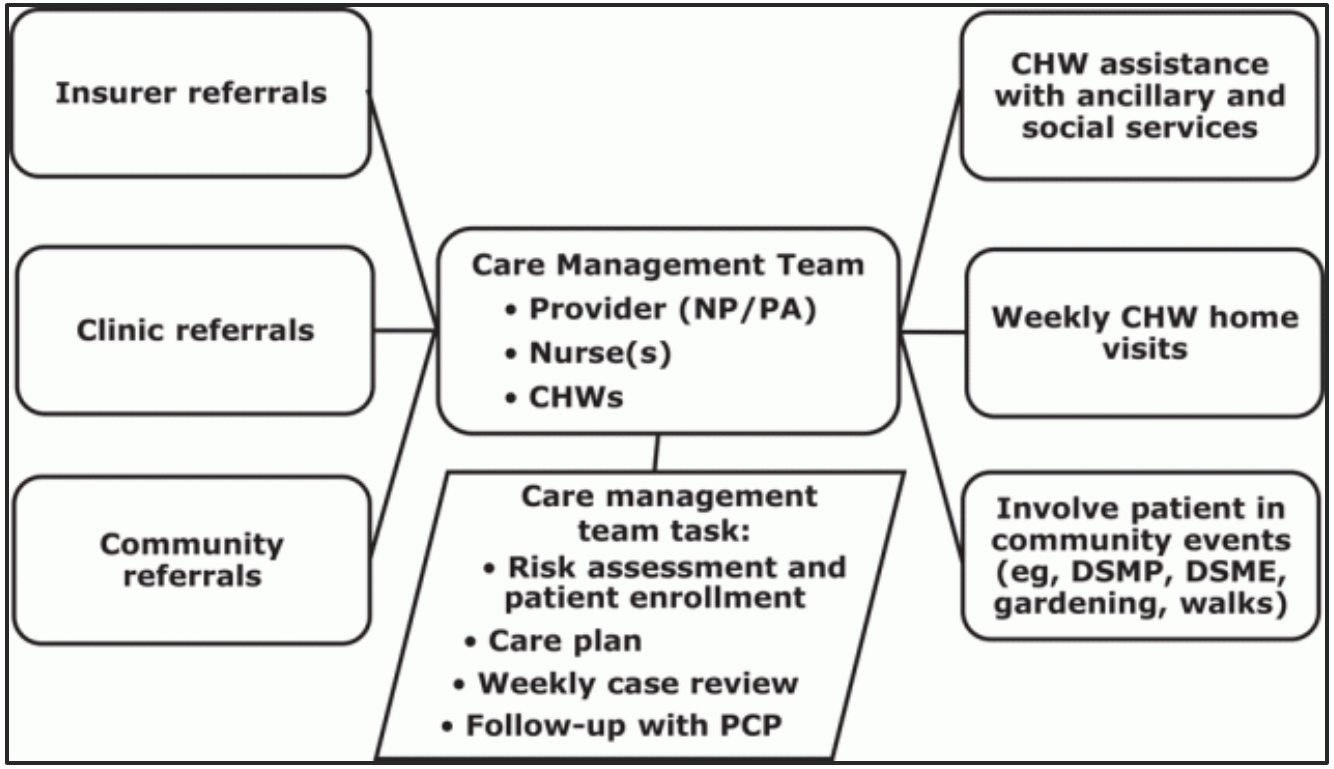



https://www.pchi-hub.org/our-model#:~:text=A%20Pathways%20Community%20HUB%20(PCH,medical%2C%20social%2C%20and%20behavioral%20health

# West Virginia's CHW Chronic Care Management Model (CHW-CCM)

**Program Details**

- Clinic enrolls high-risk patients with diabetes, heart disease, COPD
- CCM Care Management team includes a mid-level provider, a nurse, and CHWs.
- Patient enrollment through provider referrals, insurance partners who identify their high-risk members for referral, or community partners.
- The CCM team assesses patients' level of risk and enrolls eligible patients in intensive care coordination
- Once enrolled, the team works with the primary care provider to create care plans and regularly follows up with patients.




https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7021460/

# CHWs in the CCM Model

**1. CHWs receive instructions for patient care at CCM team meetings and are in regular contact with team nurse.**

- CHWs are full-time, permanent employees of the sponsoring clinics.
- Directly supervised by mid-level or nurse.

**2. CHWs arrange a time to meet with patients in homes on a weekly basis.**

- CHWs review care plan with patients, check medication adherence, review and update self-management goals, and discuss issues that affect their lives.
- The most common issues that patients bring up are social, literacy, and economic barriers to their health.

**3. As patients gain control over conditions, CHWs reduce visit frequency.**

- CHWs do not drop patients entirely. CHW interpersonal support is a strong motivator for patients to maintain control of their conditions.
- Initially a CHW's caseload is 25-30 patients. As patients gain control over conditions, the CHW reduces the frequency of home visits to 1-2x/month, taking on new patients. CHWs then ultimately have a caseload of 40 to 50 patients.
- Health insurance payers pay for continued CHW visits and receive data that demonstrate patients' continued control of their conditions, given implications for cost savings.

***A role for physician champions***

*"A factor that influenced the increase in the rate of enrollment was **the emergence of physician champions in the health centers**. Physician champions emerged as they observed how patients who had difficulties in managing their conditions would rapidly improve. This led physicians to be more assertive in identifying high-risk patients in their care and referring them to care coordination by the CHWs. Gradually, other providers in the practice would take notice…"*

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7021460/

# CCM model sustainability

**The CCM Model is funded primarily by MCOs, although start-up funding typically comes from multiple funding streams.**

## Start-up Funding

- Funding comes from national foundations, small private and family foundations, hospital conversion foundations, and government grants.
- The first health centers that adopted the model used grant funding to cover startup costs, enabling health centers to begin as soon as they were ready.
- Health centers that have committed to the model are adding CCM teams and CHWs beyond the scope of the grant funding.

## Payer Engagement

- Engaging payers from the beginning of the project was critical to success.
- Payers' familiarity with the model grew as they observed its dissemination in a 3-state region (Ohio, Kentucky West Virginia), and they ultimately saw the value of the CHWs and agreed to use their own data to make the business case.
- The program uses a fee-for-service structure and is moving towards a value-based payment model.

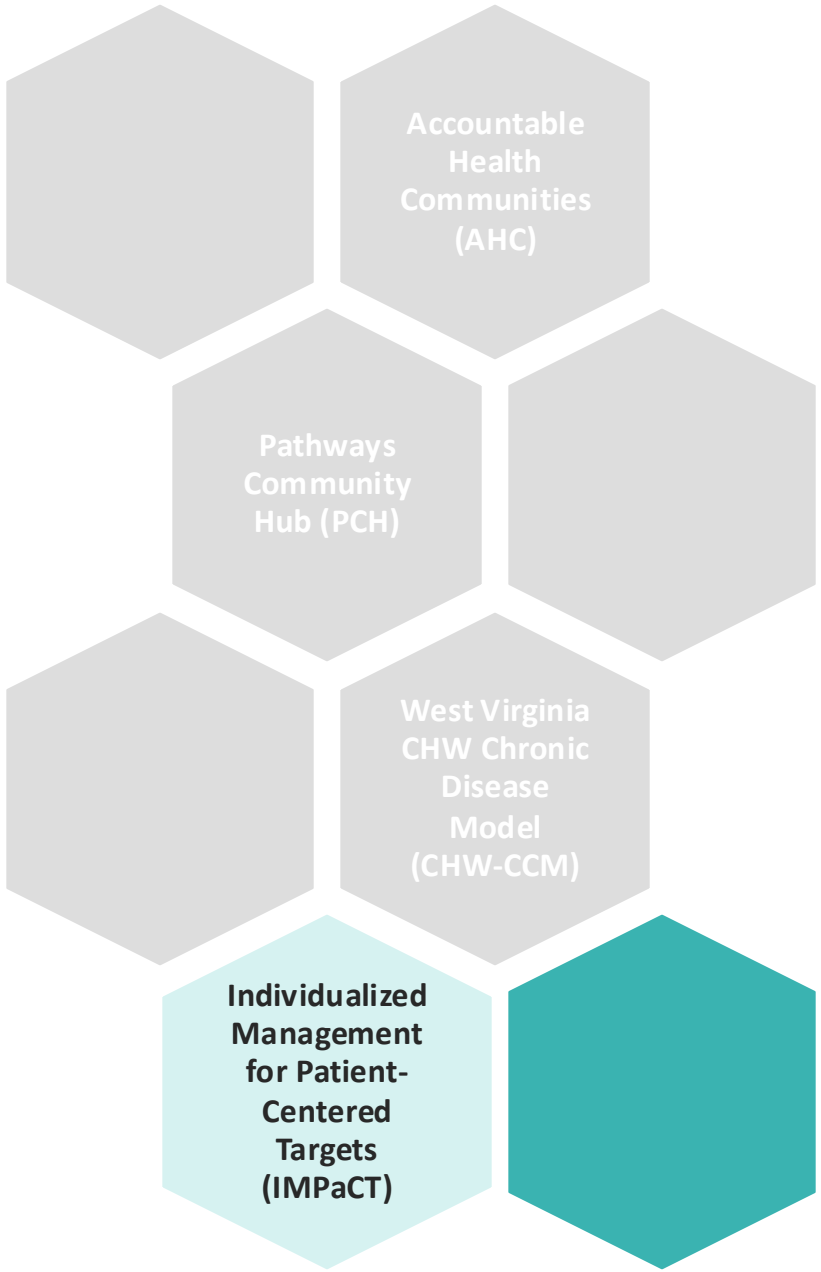
## Cost & Savings

- In an early analysis, one MCO estimated a savings of $5,000 per patient over a 4-month period.
- As savings are realized, the payers agreed to share savings with FQHCs.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7021460/

# Example 4: Individualized management for Patient-Centered Targets (IMPaCT) Model

The **Individualized Management for Patient-Centered Targets (IMPaCT) Model** is a standardized, clinical system-based model, that pairs CHWs with high-risk patients in the clinic to improve their outcomes over a period of six months. The IMPacT model has shown an ROI of $2.47 to an average Medicaid payer within the fiscal year.




https://www.pchi-hub.org/our-model#:~:text=A%20Pathways%20Community%20HUB%20(PCH,medical%2C%20social%2C%20and%20behavioral%20health

# The IMPaCT Intervention

## *Intervention*

**Goal Setting**
- Semi-structured interview with open ended social determinant screener
- Self-determined goal-setting, choosing one goal at a time

**Tailored Support**
- 6-month time frame
- Monthly in-person visits, weekly communication
- Hands-on support in coaching, tracking, advocacy, educational resources, navigation, social activities and support groups
- Inpatient assistance in discharge planning

**Connection to Long-Term Support**
- Support groups
- Community connections and social networking

**Standardized approach to**:
- Hiring (education req, behavioral interviews)
- Training (one month)
- Workflows (case load of 55 pt/yr)
- Supervision (managed by MSW with clear scope)
- Documentation (audits, assessments, performance dashboard)
- Intervention (manuals, in-person and online training, and software for documentation and reporting)

**Organizational readiness support through:**
- Key stakeholder engagement
- Centralized CHW staff with 6-CHW teams
- Coordinators responsible for enrollment and Q/A
- Program Director managing operations and budget
- Budget for CHWs to do activities with patient
- Preliminary exploration to understand context and tailor materials
- EMR privileges for CHWs

https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2707949#ioi180074r20; https://www.liebertpub.com/doi/10.1089/pop.2015.0157?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed; https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00981

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# Three types of economic evaluations used for community health

**The three most common types of economic evaluations used to describe public health programs are return on investment (ROI) studies, the cost-benefit analysis (CBA), and the cost-effective analysis (CEA). This section will focus on ROI economic evaluations, which has become an increasingly popular way to discuss the impact of CHW programs.**

## Return on Investment (ROI)

ROI ascertains the financial return of a specific dollar investment. The goal is usually to identify a tangible metric (such as hours saved), and calculate this metric into a financial return (such as dollars saved or dollars made)

$$\frac{\$\ Gained - \$\ Cost\ of\ Investment}{\$\ Cost\ of\ Investment} = ROI$$

## Cost-Benefit Analysis (CBA)

A CBA assigns a dollar value to health outcomes, including life, which is difficult to do. If the benefit-cost ratio is greater than $1, it implies that the program or intervention produces more benefit than it costs.

$$\frac{\$\ Value\ of\ all\ Benefits}{\$\ Value\ of\ all\ Costs} = CBA$$

$$\$\ Value\ of\ all\ benefits - \$\ Value\ of\ all\ costs = Net\ benefits$$

## Cost-Effective Analysis (CEA)

A CEA calculates a cost-effective ratio (CER) or incremental CER (ICER) which relates the costs of a program to a key outcome or benefit. There is only one defined effect unit that is costed for each intervention that is being compared. E.g., Cost/case prevented

$$\frac{Cost\ of\ Intervention}{Effect\ of\ Intervention} = CER$$

$$\frac{Difference\ in\ Cost\ of\ Intervention}{Difference\ in\ Effect\ of\ Intervention} = ICER$$

https://familiesusa.org/wp-content/uploads/2019/09/HE_HST_Community_Health_Workers_Brief_v4.pdf ; https://familiesusa.org/wp-content/uploads/2019/09/How-States-Can-Use-Medicaid-Managed-Care-Contracts-to-Support-CHWs_0.pdf; https://choicesproject.org/wp-content/uploads/2020/05/CHOICES_Cost-Effectiveness-vs.-Cost-Benefit.pdf; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10001534/; https://www.ajmc.com/view/the-roi-of-addressing-social-determinants-of-health

# Return on investment (ROI) studies of CHW programs

**Numerous studies have explored the impact that CHWs have on the health and well-being of historically and currently marginalized populations.**

In recent years economic studies (such as Returns On Investment studies, "ROIs") have become an increasingly popular way to show the utility and significance of investing in the community health workforce.

While many published ROIs have demonstrated the substantial impact CHW interventions can make in community health, there are both benefits and drawbacks to anchoring an intervention's value on ROI (seethis slide).

**This section will give a general overview of using ROI to describe the economic value of CHW programs, discuss the advantages and disadvantages, and provide specific ROI calculators created for CHW/public health programs.**

***A note on CHW ROIs***

*"For many countries the economics are a strong case that [still] need to be complemented…The solution is making a case that is not just economic, but also holistic to a given country's specific social context, whether that is fomenting job development, economic opportunity, rural development or women's empowerment, or making health more affordable and accessible."*

-Dr. Angela Gichaga, CEO of Financing Alliance for Health

https://www.exemplars.health/stories/economic-roi-is-not-enough

# What is ROI?

**A return on investment (ROI) analysis** is a way to calculate net financial gains (or losses), taking into account the financial resources invested as well as the amount gained through increased revenue and/or reduced costs.

The net financial return *($Gained - $Cost of Investment, numerator)* from the intervention or program describes the financial gains from implementation, which are generated by changes in quality, efficiency, and utilization of services, or in the form of financial payments.

The cost of investment (*denominator*) is the total cost of developing and operating the intervention or program.

$$\frac{\$\ Gained - \$\ Cost\ of\ Investment}{\$\ Cost\ of\ Investment} = ROI$$

***Example:***

An intervention which requires an investment of $200 and results in a $300 gain, would give an additional 50% ROI.

*($300-$200)/$200 = 50% ROI*

https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/qitoolkit/combined/f1_combo_returnoninvestment.pdf

# Example Return on investment (ROI) studies for CHWs

**Penn Center for CHWs, University of Pennsylvania Health System**

Penn Center for CHWs employed a team of CHWs and financed their salaries through their operational budget and cost savings elsewhere in the system that amounted to $2.47 per every dollar invested.

**Clinics and Organizations in South Carolina**

The Center for Applied Research and Evaluation and the Center of Community Health Alignment showed returns ranging from $0.66 to $9.72 in averted costs across four organizations and clinics in South Carolina.

https://nachw.org/wp-content/uploads/2020/10/SustainableFinancingReportOctober2020.pdf

# ROI…for whom?

In calculating ROI, or any economic analysis, **it is critical to define whose perspective defines a cost or a gain**. The perspective shapes the evaluation of the intervention or the program and determines overall ROI.

## *Perspectives on Costs*

| Cost | Perspective |
|---|---|
| Direct Medical (e.g. hospital bills) | Patients, Payors, Employers, Society |
| Direct Non-Medical (e.g. transportation, daycare) | Patients, Society |
| Indirect (e.g. lost time from work) | Patients, Employers, Society |
| Intangible (e.g. lost quality of life, pain) | Patients, Society |

## *Perspectives on Gains*

| Gain | Perspective |
|---|---|
| Direct Medical (e.g. hospital savings) | Patients, Payors, Employers, Society |
| Direct Non-Medical (e.g. Saved wages) | Patient, Society |
| Indirect (e.g. fewer sick days) | Patients, Employers, Society |
| Intangible (e.g. productivity, engagement in the community ) | Patients, Employers, Society |

**Example:** CHW workforce ROIs done by health systems may underestimate the ROI from the public health perspective, because hospitals may not perceive CHWs impact on their patients' morale and quality of life as a gain. Moreover, hospital systems may be more interested in short-term outcomes that do not always coincide with the longer-term gains achieved by CHWs. **Excluding intangible or longer-term gain of CHW programs can ultimately lead to a smaller calculated ROI that underestimates the value of CHW programs in the health and hospital system.**

https://www.cdc.gov/dhdsp/pubs/docs/cb_march2016.pdf

# Benefits and drawbacks of using ROI to address population health and SDOH

**Ultimately, there are both benefits and drawbacks to using ROI; decision-makers should ensure that ROI calculations are not used exclusively to drive programmatic choices, but treated as one input in a larger decision-making process.**

## Benefits

- ROIs for public health interventions typically show significant returns.
- Using dollar comparisons can help groups advocate for public health funding in terms of *investment and savings,* rather than *cost.*
- ROIs can improve communication and engagement between diverse stakeholders by establishing shared language and understanding of expectations or needs.
- If there is consensus on the variables going into the ROI, it can strengthen data collection systems and capture change over time.

## Drawbacks

- Comprehensive ROIs are difficult to estimate. Data systems vary in their robustness; some do not have enough data points for key variables and external influences like geographic variation can radically change the ROI calculation.
- Different studies factor different variables into ROI equations, making comparison challenging.
- ROIs readily accommodate medical costs averted by improved health (e.g. reduced hospitalizations related to asthma), but it is harder to assign dollar values to life-years saved, or intangible effects such as increased well-being or empowerment.
- Many benefits of public health interventions are realized over many years and may not factor into a funder's ROI calculation. Also, ROI can steer decision-makers towards oversimplifying decisions to fund interventions without weighing factors outside the dollar amounts used in an ROI, like equity benefits.

https://www.networkforphl.org/news-insights/lets-talk-money-barriers-and-benefits-of-investment-in-public-health/; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4929139/
http://epapers.bham.ac.uk/788/

# Potential use cases for ROI studies in CHW programming

**Fully acknowledging the benefits and drawbacks of ROI studies for CHW programs, there are some cases where estimating ROI may be beneficial if done comprehensively and equitably.**

- The **evaluation of cost savings of new interventions.** This is useful in situations where the new intervention/strategy is at least as effective as the comparison.
- To communicate an investment case for an intervention as a **tool for advocacy**.
- When considering the **macroeconomic impact** of an intervention—such as the impact on gross domestic product.
- To **maximize revenue** in a for-profit setting
- For **evaluating cross-sectoral investments** which aim to promote health and development.
- To estimate how already planned interventions will affect revenue and operating costs, to **optimize quality and financial performance**.

**When discussing ROI, it is essential to include:**

- Who receives the 'savings' or economic benefits.
- The key findings, limitations, ethical or equity considerations not captured, and how these could affect patients, policy or practice.
- The limitations of the calculation decisions made, and the methods used to value economic benefits.
- Discussion of the generalizability or transferability of results across different settings and over time, especially the variables that most significantly drive the ROI.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10471881/
https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/qitoolkit/combined/f1_combo_returnoninvestment.pdf

# CHW ROI calculator #1: health begins/SCAN Foundation

**In October 2023, Health Begins launched a newly expanded ROI calculator, created in collaboration with the Commonwealth Fund and the SCAN Foundation.**

**The calculator is based on a robust scan of the evidence-base.**

The calculator estimates the ROI of social needs interventions using pre-populated data drawn directly from national averages, benchmarks, and research.

The evidence-base used for this calculator was based on a review of 82 published studies on the impact of social services on healthcare utilization and costs.

**The calculator strives to provide fair estimates of costs accrued by CBOs.**

- Because of the time lag in published evidence, the calculator includes an inflation adjustment to better estimate current costs faced by CBOs.
- Sets a 10% administrative cost that is automatically incorporated into the reimbursement models.
- Shared savings is set at 50%.
- Ultimately, these changes means CBO costs are set to be higher, taking a more realistic approach to CBO costs.

**2 Calculator Options**

***Quick Calculator***
A quicker calculation, using prepopulated health utilization and cost data

***Legacy Deep Dive Calculator***
Manual entry of data and ability calculate multiple interventions at once

Health Begins ROI calculator

# CHW evidence used to create the Health Begins ROI calculator

**The ROI calculator measures a "care management" intervention that groups CHW programs with social worker-led models and multidisciplinary teams.**

## Reductions in Health Care Utilization and Costs Reported in Select Studies of Care Management

| Type of program | Type of evidence | Reduction in ED visits | Reduction in hospital admissions | Reduction in hospital readmissions | Reduction in hospital days | Reduction in skilled nursing admissions/days | Reduction in health care costs PMPM | Intervention cost PMPM |
|---|---|---|---|---|---|---|---|---|
| Multidisciplinary teams | S(6), M(2), P(1) | 7% to 35% (3) | 18% to 44% (4) | NS (3) | 59% (1) | 47%/52% (1) | $124 to $644 (4) | $119 to $417 (3) |
| Social worker–led models | M(2), P(2) | 37% to 89% (2) | 39% to 59% (3) | 31% to 57% (3) | N/A | N/A | N/A | N/A |
| CHWs/Navigators/Coaches | S(5), M(3), P(1) | 7% to 23% (2) | 6% to 57% (4) | 17% to 76% (3) | 8% to 34% (2) | N/A | $480 to $773 (2) | $81 to $341 (4) |

## Summary of Social Service Intervention Costs

| Type of Social Need Intervention | Unit | Number of Studies | Evidence (Unadjusted Nominal Dollars) | | | Evidence (Adjusted for Inflation to June 2023) | | |
|---|---|---|---|---|---|---|---|---|
| | | | Minimum | Median | Maximum | Minimum | Median | Maximum |
| **CARE MANAGEMENT** | | | | | | | | |
| Multidisciplinary teams** | PMPM | 4 | $119 | **$278** | $501 | $176 | **$345** | $501 |
| Community health workers or navigators | PMPM | 4 | $81 | **$134** | $341 | $129 | **$148** | $422 |

More resources on ROI can be found here.

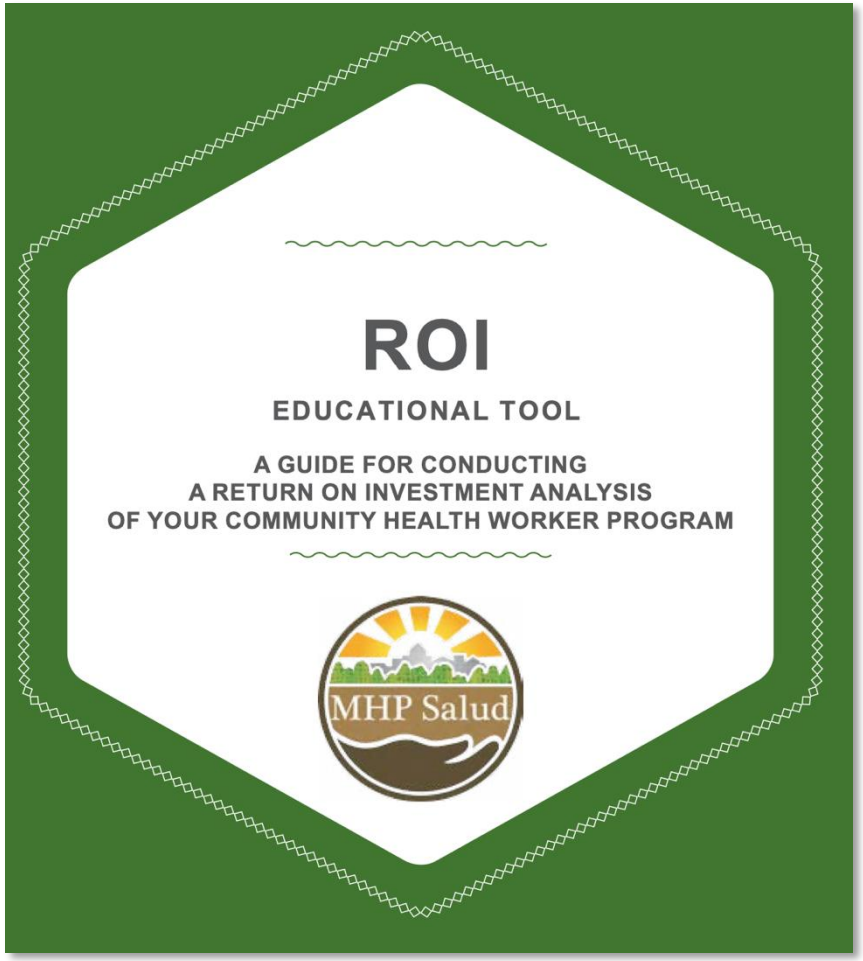
https://healthbegins.org/wp-content/uploads/2023/10/Final-Social-Service-Intervention-Costs-READY.pdf

# CHW ROI calculator #2: MHP Salud

**MHP Salud worked with various health centers to develop a process for determining CHW program ROI, culminating in a toolkit that allows CBOs to calculate the ROI of their CHW program.**

**Toolkit Components**

- Algorithm for collecting necessary data for ROI
- Data sheets to identify program outcomes
- Data sheets to create estimates with resources to help determine values
- Summary of assumptions
- Instructions on performing the ROI calculation

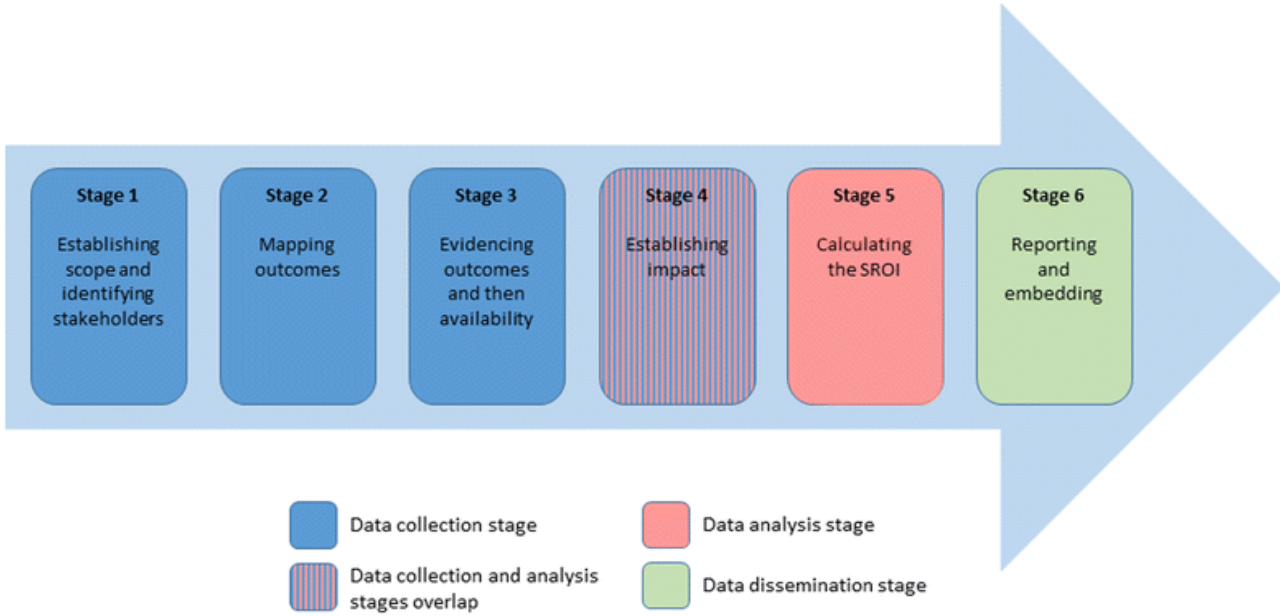



https://mhpsalud.org/portfolio-items/roi-toolkit/

# From ROI to Social ROI (SROI)

**Social ROI (SROI) is a newer framework for calculating return on investment, taking into consideration health and non-health impacts, and tries to account for potential negative effect of interventions. SROI uses dollar proxies to estimate dollar amounts for interventions that are not easily assigned monetary values.**

- SROI **considers the value produced** for multiple stakeholders in three dimensions of development: economic, social and environmental
- **Allows for the calculation of a benefits-to-costs ratio**; for example, a ratio of 2:1 means that $2 of social value is created from an investment of $1.
- Emphasizes that social value should **focus on outcomes rather than outputs**. For example, if an organization is providing diabetes education, the output of the program would be the number of education sessions, but the *outcome* is the community's increase in knowledge of diabetes management.
- **Aims to be stakeholder-specific**, calculates the SROI separately for each stakeholder and includes stakeholders in determining and valuing the outcomes.




*The SROI process engages multiple stakeholders in determining appropriate outcomes and associated monetary value proxies*

https://neweconomics.org/uploads/files/aff3779953c5b88d53_cpm6v3v71.pdf
https://doi.org/10.1186/s12889-015-1935-7

# A last note on ROIs

**PIH has compiled this list of published CHW ROI studies to be used for reference and educational purposes.**

While there are many published ROI studies on CHW work, **there are very few that have been able to reasonably tie CHW activities *directly* to longer-term outcomes** such as ED visits, changes in health status, etc.

Many of the outcomes used in ROI studies are a product of multiple factors in the system (housing, food insecurity, environmental factors, health systems access, etc.), so it is challenging to make direct comparisons between CHW's work- such as activities in behavior change, medication compliance, immunizations, etc. - with long-term systemic health changes, **and we do not recommend using any of the references as the gold standard at this time.**

**Instead, we do recommend working in partnership with local CHWs to scan the range of ROI variables and outcomes used in different studies to create a customized and mutually agreed upon calculation that considers 1) local factors and 2) proxy variables for long-term impacts that directly link to CHW activities.**

https://www.ta-community.com/media/download/635sxg/Contracting%20Spotlights_CCH%20Examples%203-30-2023.pdf

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# CHWs have the expertise and background to support the aging population

**There are an increasing number of programs across the US that are employing CHWs to support the aging population, and there are numerous studies that have shown the effectiveness of CHWs in improving chronic disease outcomes.**

## CHWs and the Aging Population

- CHWs can arrange grocery and medication delivery, assist with providing and navigating transportation, and aid in transitioning to a new living space, all of which are either proxies for falls prevention or active and healthy behaviors.
- CHWs can be effective in screening and identifying impairments in the aging population and ensure they are connected to the right health resources.
- CHW-led, multicomponent interventions that support the functional capacity of older adults with early-stage disability and frailty have been shown to improve mood and functional outcomes.

## CHWs and Chronic Disease Management

- Chronic disease Interventions by CHWs appear more effective when compared with alternatives, particularly among low-income, under-resourced, and racial and ethnic minority communities.
- CHW interventions have shown to be effective in creating a modest reduction in hemoglobin compared to usual care.
- CHWs can effectively deliver cognitive behavioral training intervention for rural patients with diabetes and chronic pain.

https://www.ncbi.nlm.nih.gov/pubmed/26890177 ;https://www.ncbi.nlm.nih.gov/pubmed/25735938 ; https://www.bettercareplaybook.org/resources/community-health-worker-interventions-older-adults-complex-health-needs-systematic-review; https://pubmed.ncbi.nlm.nih.gov/33738803/; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9957090/ https://bit.ly/2kwjrEP;

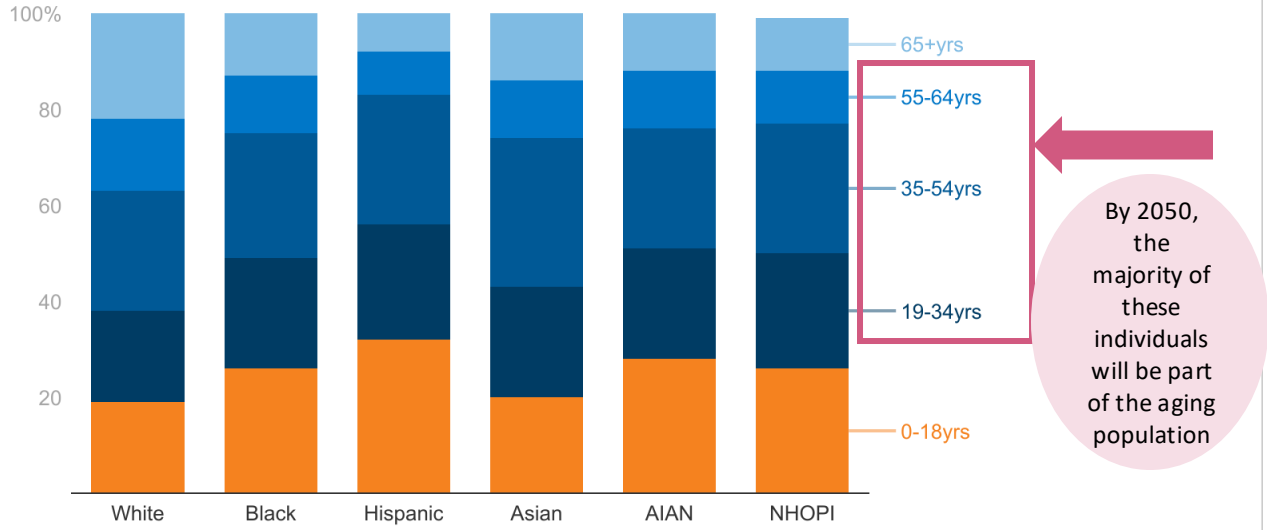
# Overview of the U.S. aging population

**America's aging population is growing, and in many parts of the country, current infrastructure is not equipped to provide the range of services needed for the increasingly diverse population of older adults.**

- **By 2050, adults over the age of 65 will make up 20 percent of the U.S. population.** Furthermore, the demographics of the aging population will reflect the increasingly diverse population of the US.
- Health systems are largely unprepared for this complexity, and **older adults suffer a disproportionate amount of harm while in the care of the health system**.
- **Older adults are disproportionately affected by chronic conditions**, such as diabetes, arthritis, and heart disease. Nearly 95% have at least one chronic condition, and nearly 80% have two or more.
- **Multiple chronic diseases account for two-thirds of all health care costs[5] and 93% of Medicare spending. Yet, less than 3% of U.S. health care dollars is spent on disease prevention to improve overall health**.

Figure 4

Age Distribution of Population by Race/Ethnicity, 2021




NOTE: Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. AIAN refers to American Indian and Alaska Native. NHOPI refers to Native Hawaiian and Other Pacific Islander. Total may not sum to 100% due to rounding.
SOURCE: KFF analysis of 2021 American Community Survey, 1-Year Estimates.

KFF

https://www.healthpolicyinstitute.pitt.edu/sites/default/files/SternCtrAddressingNeeds.pdf
https://www.ncoa.org/article/get-the-facts-on-healthy-aging
https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/

# Government-affiliated agencies focused on the aging population

**Below are federal, state, and local agencies that aim to support the growing aging population that could benefit from CHWs to help navigate their medical and SDOH concerns.**

## Administration of Community Living (ACL)

- **Federal** agency that supports the needs of the aging and disability populations, and improves access health care and long-term services

## State Unit on Aging

- **State** entity that manages coordination of state-level programs and develops and administers a multi-year state plan that advocates for and assist older residents, their families and, in many states, adults with physical disabilities.
- Functions can include certification of senior centers; planning/managing in-home services, congregate and home-delivered meals; and other aging programs.

## Area Agencies of Aging (AAA)

- **Regional or local** agencies designated by a state to address the needs and concerns of the aging population
- Primarily responsible for a geographic area, also known as a planning and service area (PSA), that is either a city, a single county, or a multi-county district.
- Coordinate and offer services that help older adults remain in their homes, such as home-delivered meals and homemaker assistance, to make independent living a viable option for individuals.

https://www.usa.gov/agencies/administration-for-community living#:~:text=The%20Administration%20for%20Community%20Living,care%20and%20long%2Dterm%20services. https://acl.gov; https://acl.gov/programs/aging-and-disability-networks/state-units-aging https://nasua.org/stateunits.php

# There are organizations and networks that are specifically aimed at addressing SDOH in aging populations

## Aging organizations and networks addressing SDOH

| | |
|---|---|
| Aging and Disability Resource Center (ADRC) | • As defined in the Older Americans Act (OAA), an ADRC is an entity, network, or consortium established and designated by a state as part of the state system of long-term care, to provide a coordinated and integrated system for older adults, people with disabilities, and their caregivers.<br>• Must have state designation. |
| Community Care Hub (CCH) | • A community-centered entity that organizes and supports a network of community-based organizations (the Community Care Network) in providing services to address health-related social needs; centralizes administrative functions and operational infrastructure, and is usually a community-based organization.<br>• Public-Private partnership administered by the ACL. |
| Community Care Network (CCN) | • A group of community-based organizations organized by a Community Care Hub to deliver services to the community.<br>• Public-Private partnership administered by the ACL. |
| Senior Centers | • Serve as a gateway to the nation's aging network connecting 1 million older adults to vital community services.<br>• Work in partnership with other community agencies and organizations and businesses to provide access to an array of opportunities for older adults to stay safe, active, and healthy.<br>• Non-profit organizations |

https://www.ta-community.com/t/p8h9cj1/adrccommunity-care-hubcommunity-care-network-comparison-chart
https://www.ncoa.org/article/get-the-facts-on-senior-centers

# A Community Care Hub (CCH) is a hub-spoke model addressing SDOH in the aging population, offering another opportunity to integrate CHWs

**CCHs are administered by the ACL, as part of its vision for coordinated person-centered care for the aging population.**

## CCHs

- Centralize administrative functions and operational infrastructure, including contracting with health care organizations, payment, referral management, service delivery fidelity and compliance, technology, information security, and data collection/reporting.
- Form trusted relationships with CBOs and healthcare organizations, and fostering cross-sector collaborations
- Engage with CBOs and the individuals they serve

## ACL Funding for CCHs

The ACL directly funds community organizations serving as hubs to coordinate access to, and delivery of, services that address SDOH through CBO partners. Health sector entities that can contract with the hub to receive SDOH services include:

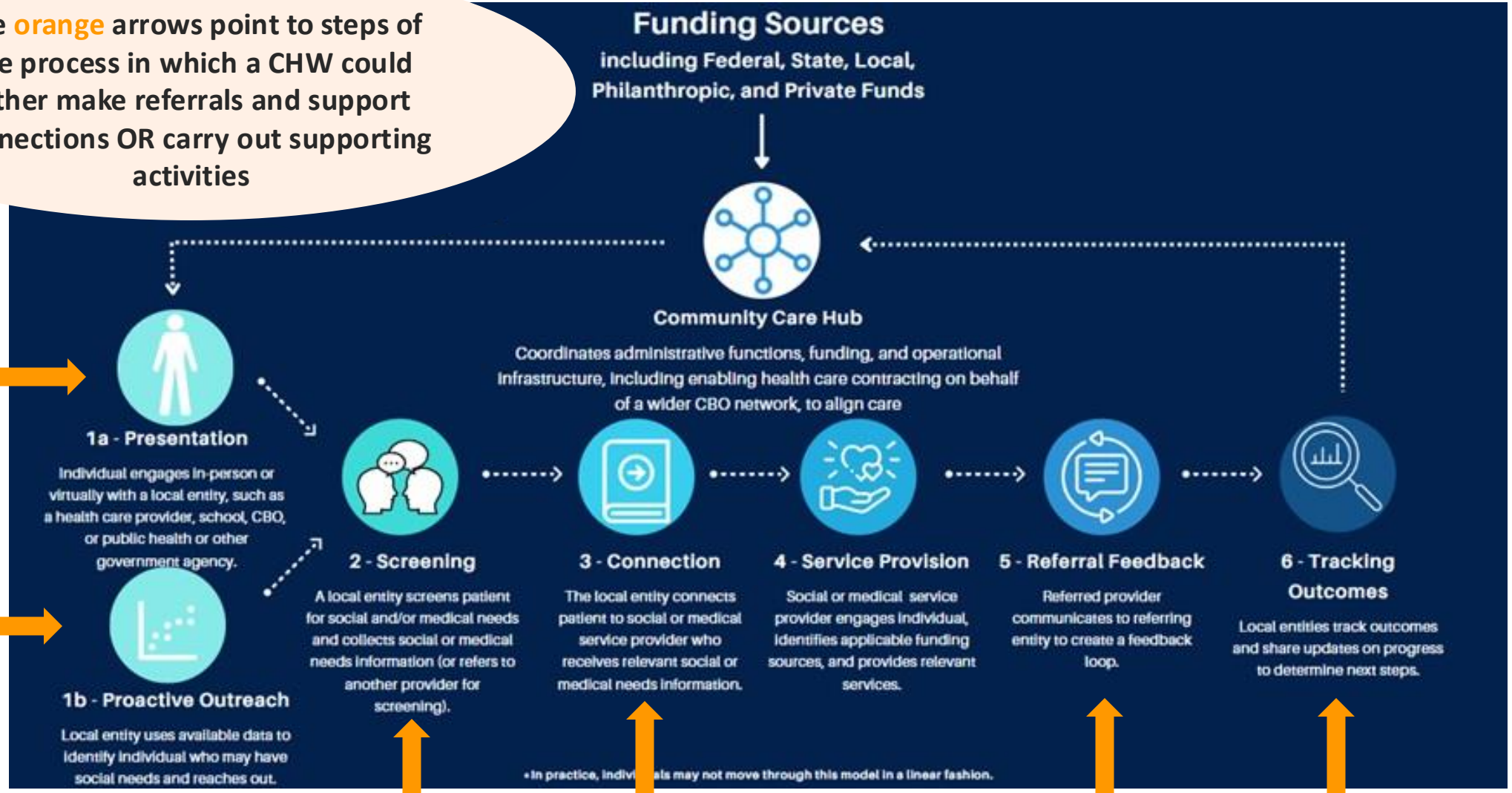
- accountable care organizations
- health plan
- managed care organizations
- hospitals
- health systems

*More information on CCHs can be found here*

https://acl.gov/news-and-events/announcements/acl-announces-selected-participants-community-care-hub-national
https://aspe.hhs.gov/sites/default/files/documents/5b8cba1351a99e904589f67648c5832f/health-social-care-coordination.pdf

# Opportunities to integrate CHWs into Community Care Hubs (CCHs)

The orange arrows point to steps of the process in which a CHW could either make referrals and support connections OR carry out supporting activities




https://www.healthaffairs.org/content/forefront/improving-health-and-well-being-through-community-care-hubs

# Example CCH: Community Care Solutions in Alabama

**Community Care Solutions (CCS) is an Alabama CCH that was formed by the Southern Alabama Regional Council on Aging (SARCOA).**

- Deploys **targeted interventions**, including a range of direct care transitions and care management services through a regional network of Area Agencies on Aging and direct service providers in each region.
- Holds a **care coordination contract with a Medicare Advantage (MA) plan** and **contracts with local hospitals and physician groups.**
- The contract with the MA plan is structured as a **capitated PMPM payment model**.
  - Risk-bearing arrangement (downside risk), with **CCS required to meet various goals to keep the full PMPM payment**.
  - As the lead entity, **CCS bears all risk on behalf of their CBO network partners**
  - **CBOs held to performance standards** on risk of exclusion from a sub-contract.

https://www.ta-community.com/media/download/635sxg/Contracting%20Spotlights_CCH%20Examples%203-30-2023.pdf

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# Introduction to state-by-state review

As previous sections have illustrated, there is immense variation among states in CHW program legislation, financing, training, and certification.

**This section provides a snapshot of selected state policy and programming related to the community health workforce.**

# Alabama

| State Legislation |
| --- |
| • None |
| **Financing** |
| • None |
| **Education, Training, and Certification** |
| • The Alabama Dept of Public Health has created a Community Health Advisors Initiative Training in August 2022.<br>• There are a few CHW training programs offered through private/nonprofit organizations (Wellness Coalition, ConnectionHealth) |


All maps in State-by-State review obtained from: https://www.nationsonline.org/oneworld/us_states_maps.htm

State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)

# Alaska

## State Legislation

- HB 209 (1993) provides Community Health Aide Program (CHAP) grants for third parties to train community health aides as Community Health Practitioners with an exam at the end of training.

## Financing

- SPA 16-0007 (2017) allows all levels of certified Community Health Aides/Practitioners (CHA/Ps) to be reimbursed for services to Medicaid beneficiaries, however they may be considered distinct from CHWs. The CHA/P program is administered by the Indian Health Service, with additional tribal, grant, or federal Community Health Center funding.

## Education, Training, and Certification

- Many CHWs in Alaska receive training through the Alaska Primary Care Association, which offers a Registered Apprenticeship Program through the U.S. Department of Labor (USDOL). Upon successful completion, CHWs receive a portable credential (Certificate of Apprenticeship) issued by the USDOL.
- Within this program, CHWs can receive specialized trainings in various topics, and pursue a Certificate in Principles of Health Coaching from the National Health Careers Association.


State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)

# Arizona

## State Legislation

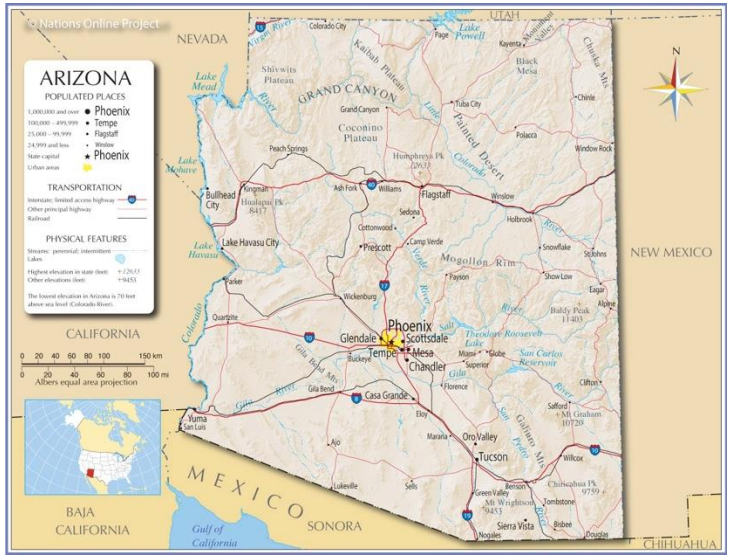
- HB2324 (2018), established a voluntary certification for CHWs, including convening of a CHW Advisory Council responsible for making recommendations to ADHS on the certification requirements and process.

## Financing

- SPA 22-0029 allows for certified CHWs and CHRs employed providers that are registered with the Arizona Health Care Cost Containment System (AHCCCS) to bill for reimbursable services, which include member education and preventive services to members with a chronic condition, at risk for a chronic condition, or with a documented barrier that is affecting the member's health.
- Indian Health Services (IHS) funds CHRs employed by Tribes in the state. CHRs that work for Tribes consist of 30 percent of the state's CHW workforce.

## Education, Training, and Certification

- The Arizona Department of Health Services (ADHS) finalized the rules for voluntary certification and launched the online application in November 2022. The Arizona Community Health Workers Association (AzCHOW), ADHS, and University of Arizona Prevention Research Center (AzPRC) partner to implement the CHW Training Program Approval process.

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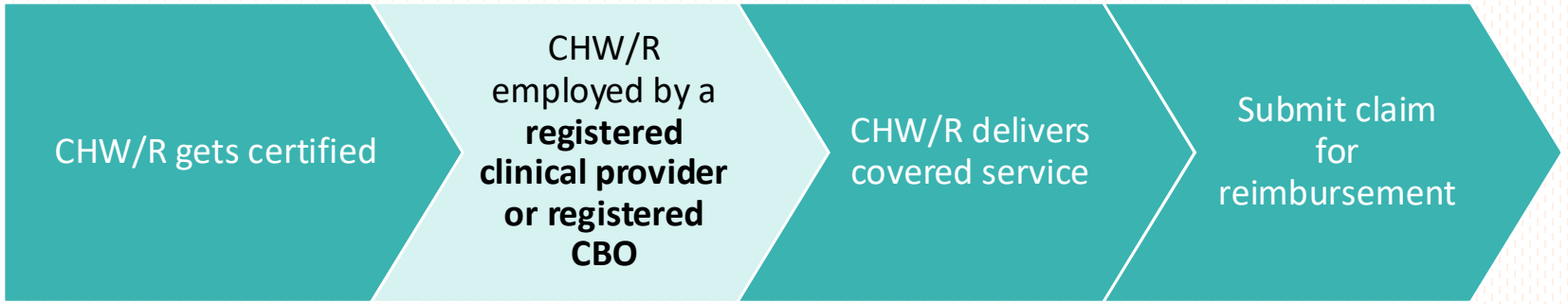
# Arizona spotlight: an innovative, inclusive SPA highlighting systemic barriers to implementation

**Arizona's SPA is noteworthy for its attempt to phase in both medical professionals and CBOs as "providers" that can reimburse for CHW education and preventative services.**

The opportunity for CBOs to submit claims is a step towards a more community-centered health system; however, in practice, the process for reimbursement may have barriers in implementation that impede CBOs from participating.

## *CHW & CHR services reimbursement process*




## *CBO challenges in implementation*

- The technology, infrastructure, and training needed for billing is complex and costly, and CBOs generally do not have the capital to build these systems
- The process for registering as a provider is time- and effort-intensive, which strains the CBO's already-limited resources
- Low reimbursement rates don't bring enough revenue for CBOs to invest in creating this infrastructure and limits their participation

https://www.azahcccs.gov/CHW; PIH-US

# California (1/2)

## State Legislation

- Section 6332 of the state's labor code contains a limited definition of CHWs.
- AB 133 (Chapter 143, Statutes of 2021) authorized DHCS to design a SPA to add CHW services as a Medi-Cal covered benefit. DHCS intends to launch CHW covered services beginning July 1, 2022
- AB 2697 (2022) requires managed care plans to reach out to providers and beneficiaries to inform them of available CHW Medi-Cal benefits , and ensures DHCS will continue working with community members, CHW/Ps, and advocates as the benefit rolls out.
- AB184 requires the Department of Health Care Access and Information develop and approve statewide requirements and curriculum for certification

## Financing

- The Department of Health Care Services (DHCS) pays managed care plans a capitated rate for CHW services.
- In July 2022, CMS approved California's SPA 22-0001, making CHW services a Medi-Cal benefit. CHW services may be billed with CPT codes 98960, 98961, or 98962. In accordance with the SPA, CHWs may be supervised by a community-based organization, local health jurisdiction, licensed provider, hospital, or clinic, as defined in 42 CFR 440.90. Managed care plans may currently contract with CBOs.
- Covered CHW services can be found in the CHW Provider Manual.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# California (2/2)

**Education, Training, and Certification**

- Through the 2022 statute, the Department of Health Care Access and Information (HCAI) was given authority to develop and implement a certificate process for CHW/P/Rs. The state, along with contracted partner R.A.C.E. for Equity, is in the process of conducting community engagement sessions and reviewing existing CHW/P/R training programs to inform and develop the certification and training process.
- Currently for reimbursement, CHW/P/Rs must demonstrate minimum qualifications via a certificate of completion or work experience, have lived experience that aligns with and provides a connection between the CHW and the community or population being served; and be supervised by a licensed provider, clinic, hospital, CBO, or Local Health Jurisdiction who is enrolled in the Medi-Cal program.


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# Connecticut

## State Legislation

- Public Act 17-74 (2017) and Public Act 19-117 (2019) established a statewide CHW definition and scope of work.
- Public Act 22-118, passed in 2022, requires the State of Connecticut Department of Social Services to establish a community action worker grant program.

## Financing

- Primary funding from grants through FQHCs, community-based organization and other organizations receiving CDC funding.
- Bill No. 991 was introduced in January 2023 that would direct the Department of Social Services to design and implement Medicaid reimbursement for CHWs.

## Education, Training, and Certification

- CHW certification began in 2020 and is obtained based on approved training by the CT Office of Health Strategy CHW Advisory Body (CHWAB) or based on hours of experience and references. CHWAB oversees requirements and continuously evaluates training programs. Membership roster here.
- Four organizations approved by CHWAB that currently provide formal training: Gateway, Housatonic Community College, the Health Education Center, and Southwestern AHEC Inc. These programs implement the CHWAB-approved core curriculum modeled after the C3 Project.


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# Illinois (1/2)

## State Legislation

- HB 5412 (2014) adopted APHA definition and created an Advisory Board within the Department of Public Health, setting requirements for membership. It prohibits CHW from performing health services that require a professional license.
- Public Act 102-0004 in 2021, creating a board with within the DPH to develop and oversee CHW certification and add CHW services as a covered Medicaid benefit with a supporting SPA implementing CHW reimbursement.
- Public Act 410 ILCS 67 passed in 2022 has been introduced to establish certification board and facilitate funding through Medicaid.

## Financing

- Medicaid does not yet reimburse CHW services in Illinois; however, there are recommended reimbursement options by its CHW Advisory Board.
- The Department of Healthcare and Family Services (Illinois Medicaid) is providing grant funding to Healthcare Transformation Collaboratives across the state to support the work of CHWs in many of these collaboratives.


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# Illinois (2/2)

**Education, Training, and Certification**

- The Community Health Worker Advisory Board Act (Public Act 098-0796) has created minimum core competencies across the state for CHWs. Additionally, the Advisory Board can consider other competencies when necessary.
- The Community Health Worker Certification and Reimbursement Act (Public Act 410 ILCS 67 (2021), directs the Illinois Department of Public Health (IDPH) to establish a certification program. Certification development is currently underway. More information on the CHW Review Board that advises on the process can be found here.
- As of 2021, training is offered through community colleges (e.g., Malcolm X College, South Suburban College) and specialized institutions (e.g., Sinai Urban Health Institute, SUHI).


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# Illinois spotlight: Illinois employer survey 2022

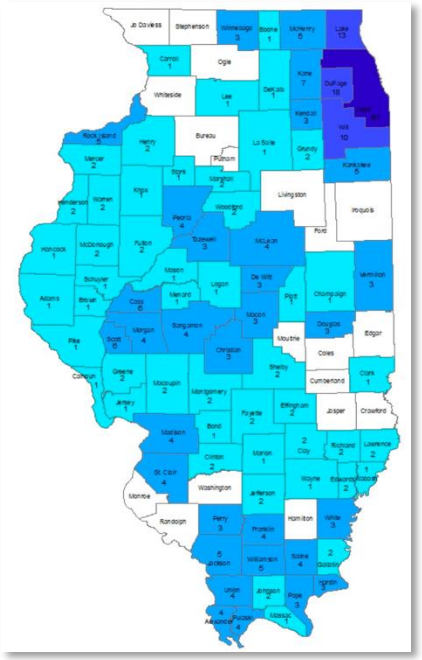
**The Illinois CHW Common Indicator Employer Survey was the first CHW survey to be conducted in the state.**

→ Created and disseminated through a collaborative effort between the Illinois Department of Public Health (IDPH), Illinois Community Health Workers Association (ILCHWA), Sinai Urban Health Institute (SUHI), Health and Medicine Policy Research Group (HMPRG), and Illinois Public Health Association (IPHA).

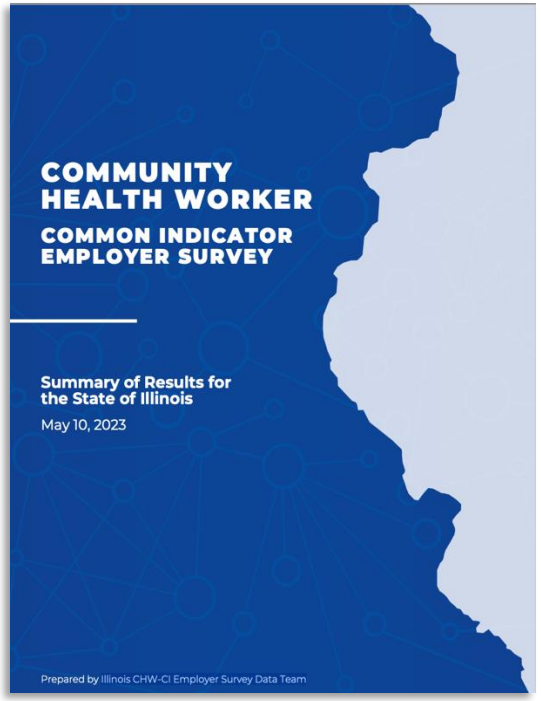
→ Surveyors noted that their original distribution list garnered 105 responses. However, using additional outreach strategies such as sending the survey out through FQHC and hospital contact lists, the team increased the number of respondents to 118. **Multiple avenues of outreach were key to increasing survey responses.**

**Key findings:**

- The average hourly rate for CHWs was $23.27 (part-time) and $22.12 (full-time).
- CHW yearly earnings ranged from $6,000 - $55,000 (part-time) and $12,000 - $87,550 (full-time). The average yearly salary was $21,186.55 (part-time) and $42,403.95 (full-time).
- 68% of employers did not have a sustainable source of funding for CHWs




**Count of CHWs Organizations by County**




https://www.sinaichicago.org/wp-content/uploads/2023/05/CHW-CI-Report-Cook-County_05.25.23_FINAL.pdf

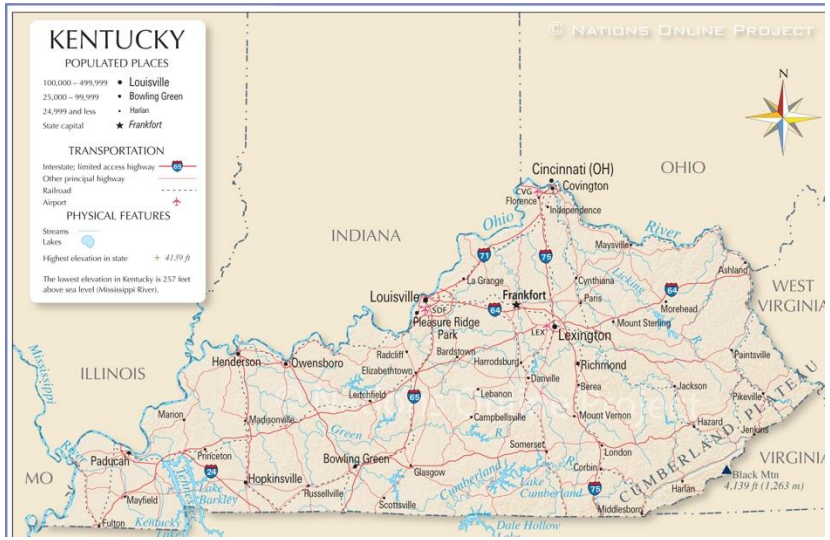
# Kentucky (1/2)

## State Legislation

- HB 525 (2022) outlines CHW definition, eligibility, certification, and continuing education and renewal, and created an opportunity for Medicaid reimbursement.
- KRS Statues 309.460, 309.462, and 309.464 (2022) outline the statutory requirements regarding CHW certification, continuing education, certification renewal and the duties of the Department for Public Health.
- Kentucky Administrative Regulation (KAR) 902 KAR 21:040 (2022) authorized the DPH to set administrative regulations for the certification of CHWs.
- KRS 205.648 and 907 KAR 3:310 (2023) address CHW Medicaid reimbursement.

## Financing

- SPA 23-0002 was passed and implemented in 2023. CHW services that can be billed include 3 CPT codes by # of individuals served and time increments.

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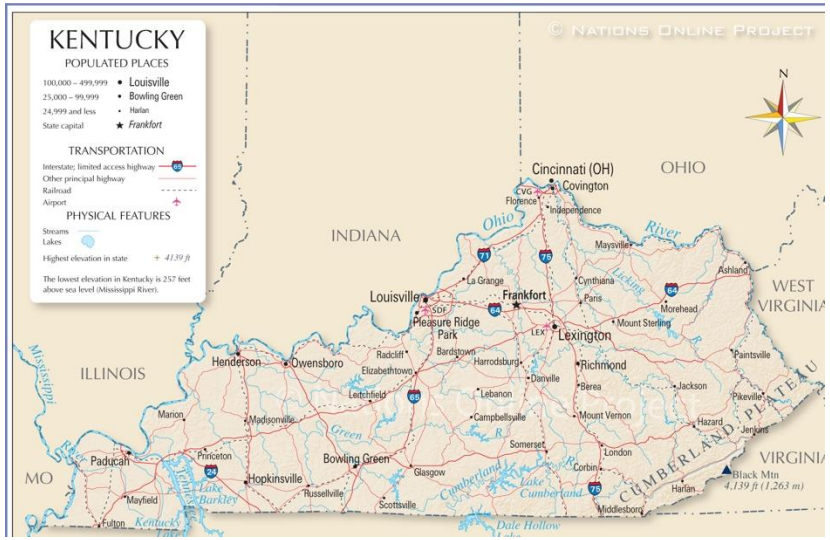
# Kentucky (2/2)

**Education, Training, and Certification**

- CHW certification from the Kentucky Office of CHWs (KOCHW) is required for Medicaid reimbursement.
- KOCHW developed the curriculum with partner organizations, which includes 40 hours of classroom-based learning and 40 hours of verifiable mentorship.
- A legacy track exists, requiring 2,500 hours of work in the past three years to qualify.
- The Kentucky Association of CHWs (KYACHW) has a certification committee that reviews the process annually
- Certified CHWs are required to earn 10 CEUs per year, five of which must come from KOCHW-approved programming. CCHWs recertify annually.




State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)
https://www.chfs.ky.gov/agencies/dph/dpqi/cdpb/CHW%20Program/CHWManual.pdf

# Kentucky spotlight (1/2): The Kentucky Office of CHWs (KOCHW)

**KOCHW, under the Kentucky Department of Public Health (KDPH), provides oversight for CHW training and certification, technical assistance for CHW organizations and partners, and communicates with KY Medicaid to inform financing policies.**

- Established in the early 2000s to support the department's own Family Health Advisors positions and other CHWs across the state
- Formed so that DPH could better advise and help carry out statewide CHW policies

**Factors underlying success of the office:**

- Collaboration between state and community actors
- Kentucky DPH champions and other influential actors who understood the importance of community presence
- Influential physicians voicing their support
- KDPH's Family Health Advisors providing early evidence of the effectiveness of the role
- Funding streams (started with an initial block grant)
- A designated CHW coordinator and staff
- Platform to hear directly from CHWs and disseminate information directly to CHWs
- A culture of collaboration
- Tenacity to continue pushing a message through setbacks and leadership changes

Source: KOCHW

# Louisiana

## State Legislation

- In 2019, through SCR 70, created the Louisiana Community Health Worker Workforce Study Committee. This committee worked on providing policy recommendations to the DOH on how best to support and expand the state's CHW program.
- HB 587 was passed June 2023, and establishes the Louisiana Community Health Worker Workforce Board within the Louisiana Department of Health.

## Financing

- LA passed a SPA in 2022 that reimburses CHW services through Medicaid MCOs.
- LA pays for CHW services through APMs; for example, there is an alternate payment methodology for adjunct services provided by rural health clinics (RHCs) for services done during evening, weekend or holiday hour. In addition, CHWs are paid outside of the PPS rate.

## Education, Training, and Certification

- In 2019, the CHW Workforce Study Committee (requiring that 50% CHW members) made recommendations including opting out of certification, and rather creating standardized trainings. It has evolved into the Louisiana CHW Workforce Coalition, which is now creating criteria and a review process for training programs.
- The Louisiana CHW Institute and Louisiana Community Health Outreach Network (LACHON) also provided CHW/supervisor training, as and public education about the roles of CHWs.


State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)

# Louisiana spotlight (1/2): CHW reimbursement through the SPA

- The SPA followed a medical model in which providers can refer out to CHW organizations
- CHWs are paid per person seen

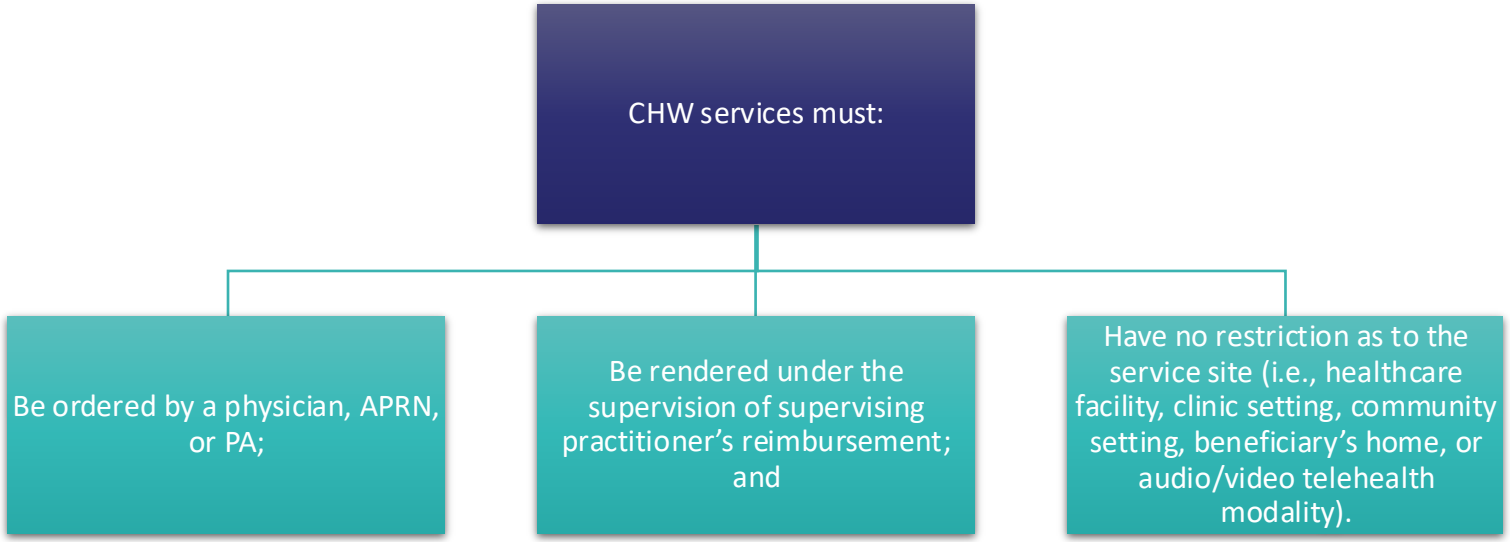
  Billable CPT Codes: (See Professional Service Fee Schedule)

  98960 – Individual CHW services

  98961 – Group CHW services

  98962 – Group CHW services
- Maximum reimbursement is two hours per day and ten hours per month per enrollee
- The physician, APRN, or PA presence in the facility is not required during the performance of the service.
- FQHCs are paid **outside** (in addition to) their prospective payment system (PPS) rate for other services.

## Reimbursement Guidelines




**CHW services were added to the MCO Manual and are mandatory for MCOs. There is no need for wraparound payment as MCOs are required to cover the CHW services.*

## Reimbursement Fees

| CPT Code | Description | Fee |
|---|---|---|
| 98960 | Education and training for patient self-management by a qualified, non-physician health care professional: 1 patient | $18.11 |
| 98961 | *As above*: 2-4 patients | $6.04 |
| 98962 | *As above:* 5-8 patients | $2.79 |

Source: Louisiana Office of Public Health Bureau of Regional and Clinical Operation

https://www.lamedicaid.com/provweb1/providermanuals/manuals/PS/PS.pdf
https://www.lamedicaid.com/provweb1/fee_schedules/FEESCHED.pdf

# Maryland

## State Legislation

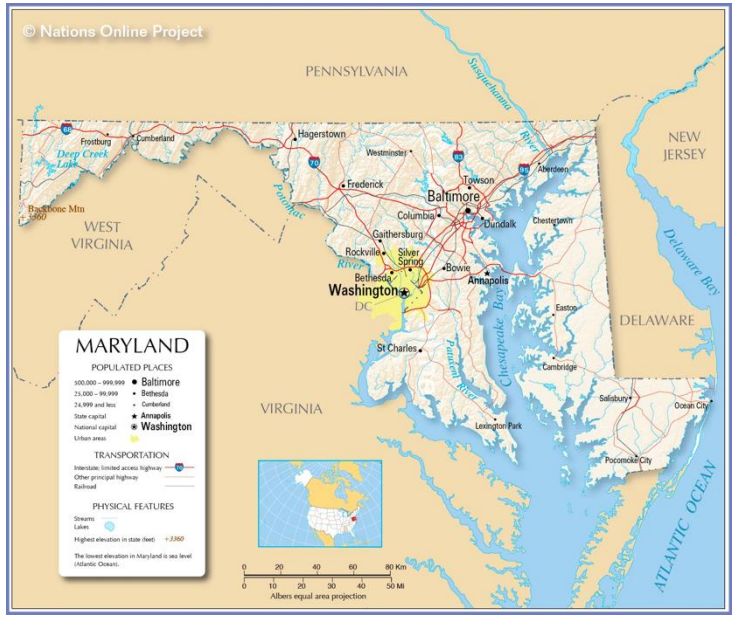
- House Bill 856 (2014) created a stakeholder workgroup to study and make recommendations regarding the Workforce Development for CHWs The Department of Health and Mental Hygiene (DHMH) and the Maryland Insurance Administration (MIA) completed the workgroup process in April 2015.
- 2018 Community Health Worker Act (Health-General 13-3701-3709) established the State CHW Advisory Committee and requires regulations be adopted for CHW certification process and to accredit CHW certification training programs.
- COMAR 10.68.01 (2019) set the requirements for an individual to be certified by Maryland Department of Health (MDH) as a certified CHW.
- COMAR 10.68.02 (2019) set the requirements for CHW certification training programs to be accredited by MDH.

## Financing

- CHWs are primarily financed using grant-related funding.

## Education, Training, Certification

- MDH serves as certifying body and requires training institutions to be accredited in order to offer training for CHW certification.
- Certification is not required




State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)
https://health.maryland.gov/pophealth/Community-Health-Workers/Pages/Certification-based-on-the-completion-of-an-Accredited-CHW-Training-Program.aspx

# Massachusetts (1/2)

## State Legislation

- Established board under MA DPH to certify CHWs (2012, see Chapter 58, Acts of 2006 Section 110; and Chapter 224, Acts of 2012. Chapter 322, Acts of 2010, 272 CMR, 2021).
- Passed law in 2007 that created a seat on the Public Health Council for a representative from the MA Association of CHWs; 2012 health reform law includes similar seat for on Prevention and Wellness Trust Fund Advisory Board.

## Financing

- CHW positions funded by grants, operating budgets, and healthcare transformation funds.
- As part of their 1115 Waiver, they are using DSRIP funding to pay ACOs to hire CHWs and has funded CHW core competency trainings .
- As part of their next 1115 waiver, the state has authority to sub-capitate primary care within ACO models, which will allow financing of team-based care for primary care services. These sub-capitation funds can be used to hire CHWs in support of the team-based care model.


Key policies:

- Certification requirements
- Training program approval policy

State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)
https://www.mass.gov/info-details/sustainability-and-health-reform

# Massachusetts (2/2)

**Education, Training, and Certification**

- CHW training is offered by community-based organizations, a local health department, a university, and community colleges.
- The Board of Certification of CHWs is within the Massachusetts DPH in the Bureau of Health Professions and Licensure. They can approve CHW training programs, requiring a CHW trainer in at least 40% of instructional hours.
- Until June 2023, two pathways to certification: work experience pathway (requires 4,000 hours of experience) or the Training + Work experience pathway.


Key policies:

- Certification requirements
- Training program approval policy

State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)
https://www.mass.gov/info-details/sustainability-and-health-reform
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# Michigan (1/2)

## State Legislation

- Public Act No. 166 (2022) budgets money for CHW services that can be delivered by way of waiver, SPA, or other avenues.

## Financing

- Michigan state 2021 Medicaid contract states that Medicaid health plans (MHPs) are required to employ CHWs at a ratio of 1:5,000 members. These CHWs may be hired by the MHP or contracted out to a community-based organization or clinical setting. MHPs are provided an incentive through the application of a ratio multiplier for meeting the contractual ratio requirement by contracting with a community-based organization or a clinic for CHW services.
- Michigan Medicaid supports several team-based care models that include CHWs, including targeted case management for recently incarcerated individuals and behavioral health peer support services.
- Medicaid SPA 23-0020 (2023) covers CHW benefits including health system navigation and resource coordination, health promotion and education, and health screening and assessment for 2 hours per day and 16 visits for per month and requires CHWs to complete a skills-based training program. CHWs will be paid on a fee-for-service basis.


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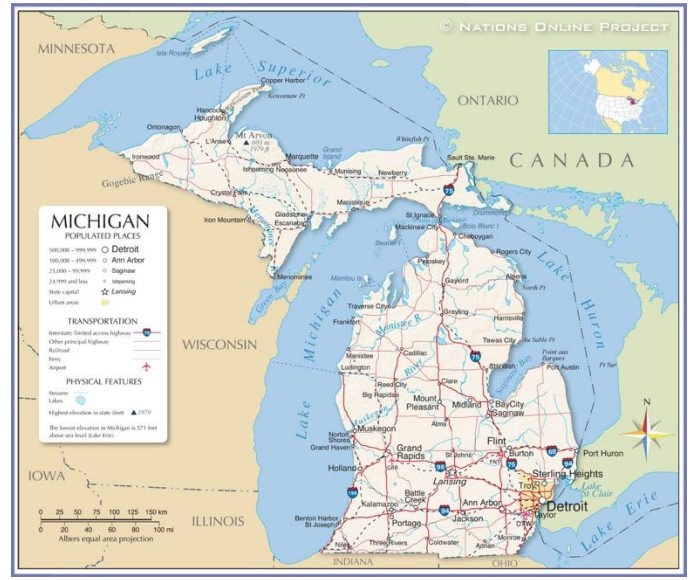
# Michigan (2/2)

**Education, Training, and Certification**

- The Michigan Community Health Work Alliance (MiCHWA) provides the CHW training, curriculum, and certification for the CHW workforce in Michigan. Certification is not currently recognized in the state legislation.
- MDHHS or Michigan Medicaid do not require a certification for reimbursement, however CHWs are required to complete a skills-based training course and continuing education training annually.

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# Minnesota

## State Legislation

- Minnesota Statutes 256B.0625, Subd. 49 (2009) allows for CHWs to partake in Medicaid and receive Medicaid reimbursements for certain services.

## Financing

- Health plans that contract with MN's Medicaid agency are required to cover diagnosis-related patient education on self-management services provided by certified CHWs working under clinical supervision.
- Minnesota's SPA reimburses for CHW patient health education.

## Education, Training, and Certification

- A state-wide standardized, competency-based educational program is recognized by MN Medicaid. It is based in accredited post-secondary schools and overseen by MN State Colleges and Universities System. The curriculum is being used by other states as well, including MI, SD, ND, OH, NJ, SC.
- Certification is not required for employment, but it is required for reimbursement for services provided to MN Health Care Program enrollees.


https://www.health.state.mn.us/facilities/ruralhealth/emerging/docs/chwreg2016c.pdf

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https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357

# Nevada

## State Legislation

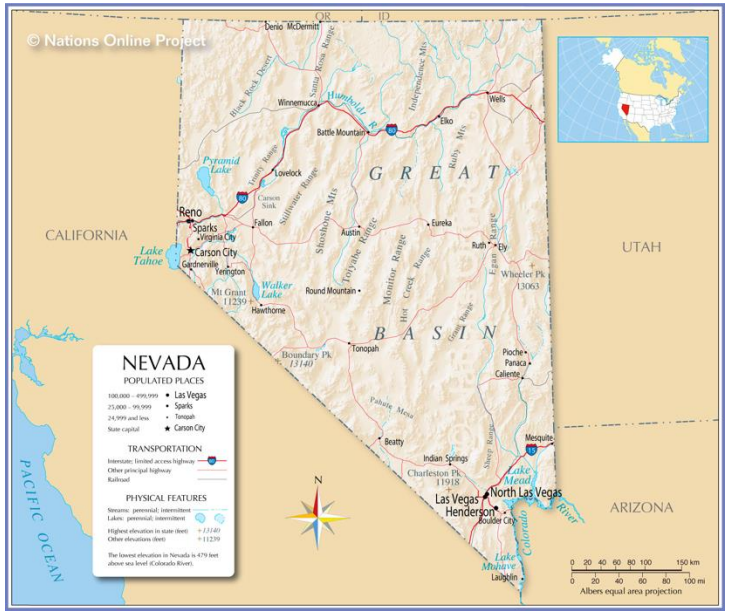
- SB 498 (2015) mandates the licensure of organizations and agencies who employ CHWs. However, the law does not provide for individual CHW certification or licensing.
- Assembly Bill 191 and Senate Bill 420 (2021) allowed NV Medicaid to cover CHW services.
- Senate Bill 117 (2023) allowed Nevada Medicaid to expand the supervision and settings allowable for CHW services.

## Financing

- SPA 21-0012 (2022) allows for the reimbursement of CHW services for health education and training for patient self-management.
- SPA 21-0013 (2022) adds CHW providers to Nevada's Alternative Benefits Plan pages.

## Education, Training, Certification

- Certification is available for all CHWs who meet the standards and training required by the Nevada Certification Board; Two tracks (CHW I and CHW II) requiring training alone vs. training and experience. The certification was developed in partnership with the NV CHW Association. Core competencies were based on competencies of the American Public Health Association (APHA), the National Community Health Association, Texas, and Massachusetts.
- Five training programs are approved by the Nevada Division of Public and Behavioral Health (DPBH).




State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)
https://nvchwa.org/get-certified/
https://nevadacertboard.org/cchw/competencies/

# New Hampshire

## State Legislation

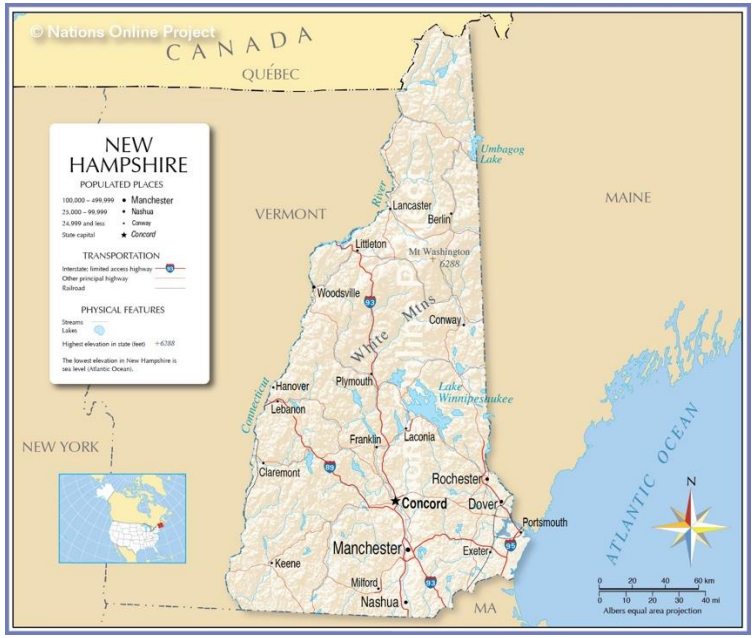
- SB 403-FN is a bill establishing state certification for CHWs. As of May 2, 2024, it has passed in both the House and the Senate.

## Financing

- None

## Education, Training, Certification

- Training through the North Country Health Consortium and Southern New Hampshire Area Health Education Center. Both organizations, in addition to the New Hampshire CHW Coalition also have curriculums for professional development.
- There is currently no CHW certification in the state




https://nashp.org/state-tracker/state-community-health-worker-policies/new-hampshire/
https://fastdemocracy.com/bill-search/nh/2024/bills/NHB00012228/#summary-menu

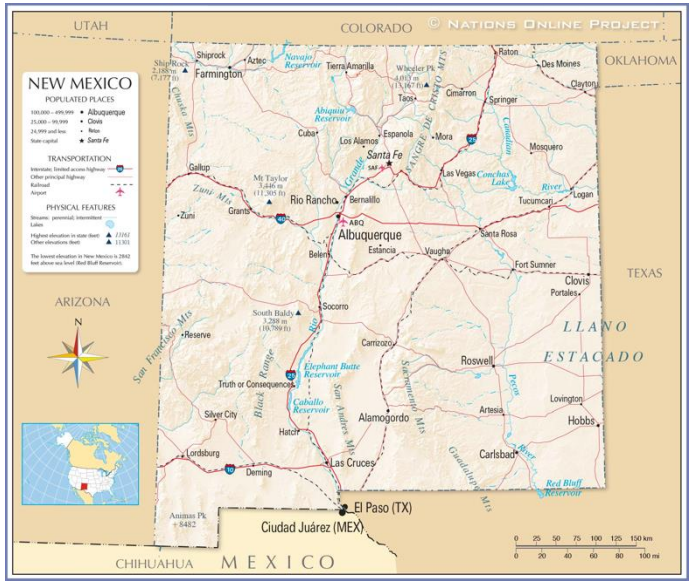
# New Mexico (1/2)

## State Legislation

- SB 58 (2015) and NMAC 7.29.5 Certification of Community Health Workers (2015) created a voluntary, statewide certification program for CHWs through the Department of Health.

## Financing

- Using a Medicaid 1115 Waiver, Centennial Care (NM Medicaid) has leveraged contracts with Medicaid MCOs to support CHWs in providing services to enrollees.
- Salaries, training, and service associated costs are billed into the MCOs' administrative costs and embedded into capitated rates paid to MCOs.
- Up to 1.5 percent of MCO capitation is at risk for performance on specified delivery system improvement targets. MCOs avoid a financial penalty if they meet all targets. In 2019, the point breakdown included 20 points each related to CHWs, telemedicine and PCMH targets, and 30 points related to MCO achievement of VBP targets.
- Currently in the process of finalizing SPA 23-0111 which will retroactively add coverage for CHW/CHR as a new reimbursable preventive service effective July 1, 2023.

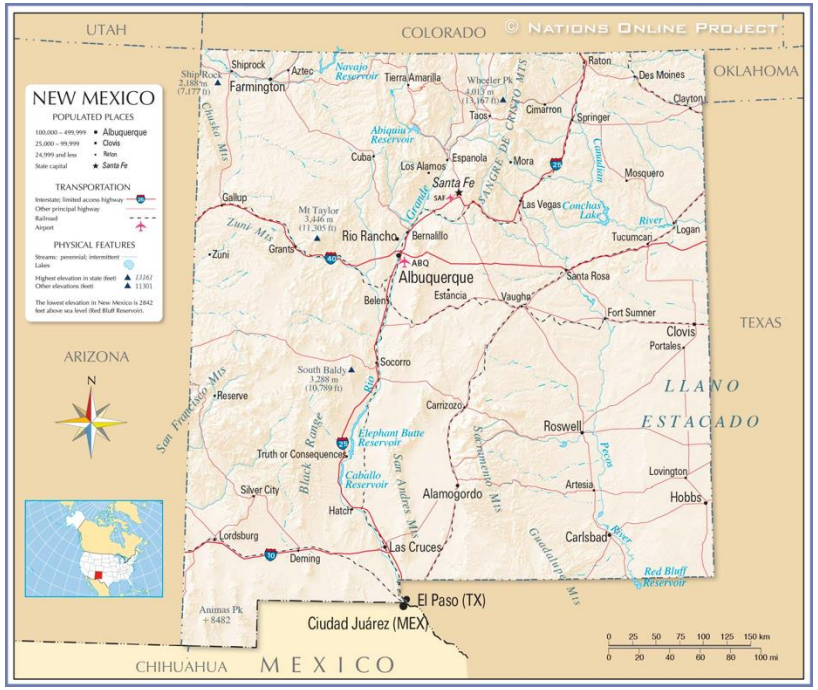



State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)
https://www.macpac.gov/wp-content/uploads/2020/03/Final-Report-on-State-Strategies-to-Promote-Value-Based-Payment-through-Medicaid-Mananged-Care-Final-Report.pdf
https://www.hsd.state.nm.us/wp-content/uploads/23-0011-CHW-CHR-NEWSPAPER-NOTICE-Final.pdf

# New Mexico (2/2)

**Education, Training, and Certification**

- The NM CHW Certification Board determines requirements for CHW state certification and serves in the advisory capacity for the NM DOH Office of CHWs, which is charged with developing a statewide training and certification process for CHWs, processing applications and issuing certificates.
- Certification requires 100 core competency training hours with an endorsed training entity approved by the NMDOH OCHW (list), including 40 hours of experiential learning approved by the agency. Legacy track is available as well.
- Two types of certification: Generalist and Specialist. Specialist certification is for CHWs who are eligible to receive specialty trainings with an approved training entity within a specialized content area if training hours of 12 or more is received consecutively.




State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)
https://www.macpac.gov/wp-content/uploads/2020/03/Final-Report-on-State-Strategies-to-Promote-Value-Based-Payment-through-Medicaid-Mananged-Care-Final-Report.pdf
https://www.hsd.state.nm.us/wp-content/uploads/23-0011-CHW-CHR-NEWSPAPER-NOTICE-Final.pdf

# New York

## State Legislation

- SPA 23-0002 (2023) allows for reimbursement for CHW services through Medicaid.

## Financing

- NY Medicaid reimburses CHWs as part of its state plan (CHW Services Policy Manual). Covered services include health advocacy, health education, and health navigation.
- State Aid to Localities allocates approximately $14 million annually with matched Medicaid funds for the PICHC Perinatal and Infant Community Health Collaboratives Initiative, which supports 26 programs that provide CHW services across the state.
- The NY Department of Health Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant funds two evidence-based home-visiting models with additional state appropriation. Some of these grant go to Healthy Families New York (HFNY) programs, where funds may be used to pay for CHWs.

## Education, Training, Certification

- New York does not have state certification
- The New York Dept of Labor lists CHW apprenticeship programs in the state and has posted guidelines for creating a hybrid apprenticeship program.
- Training programs that offer a certificate of completion are available, and many employers require this training certificate before or during the initial six months of employment.


https://nashp.org/state-tracker/state-community-health-worker-policies/new-york/

# North Carolina (1/2)

## State Legislation

- CMS approved North Carolina's Section 1115 Waiver, which allows NCDHHS to "examine the feasibility of introducing a community health worker model to assist in addressing social determinants of health."
- North Carolina Administrative Code 10A 48B.0803 states that the local health department shall ensure that program planning and implementation involve community health advocates that represent populations being served in the local health department.

## Financing

- North Carolina does not authorize Medicaid reimbursement for CHW services but does explicitly allow CHWs to be part of Medicaid managed care teams in the state via an 1115 waiver. CHWs are included as members of the care management team in both the Medicaid Standard Plan and Tailored Plan contracts. Additionally, CHWs are permitted to assist in administering Healthy Opportunities Pilot care management services.
- NCDHHS DPH received the HRSA Maternal Health Innovation (MHI) Grant in 2019, which includes CHW and doula services.


Source: NCDHHS ORH

# North Carolina (2/2)

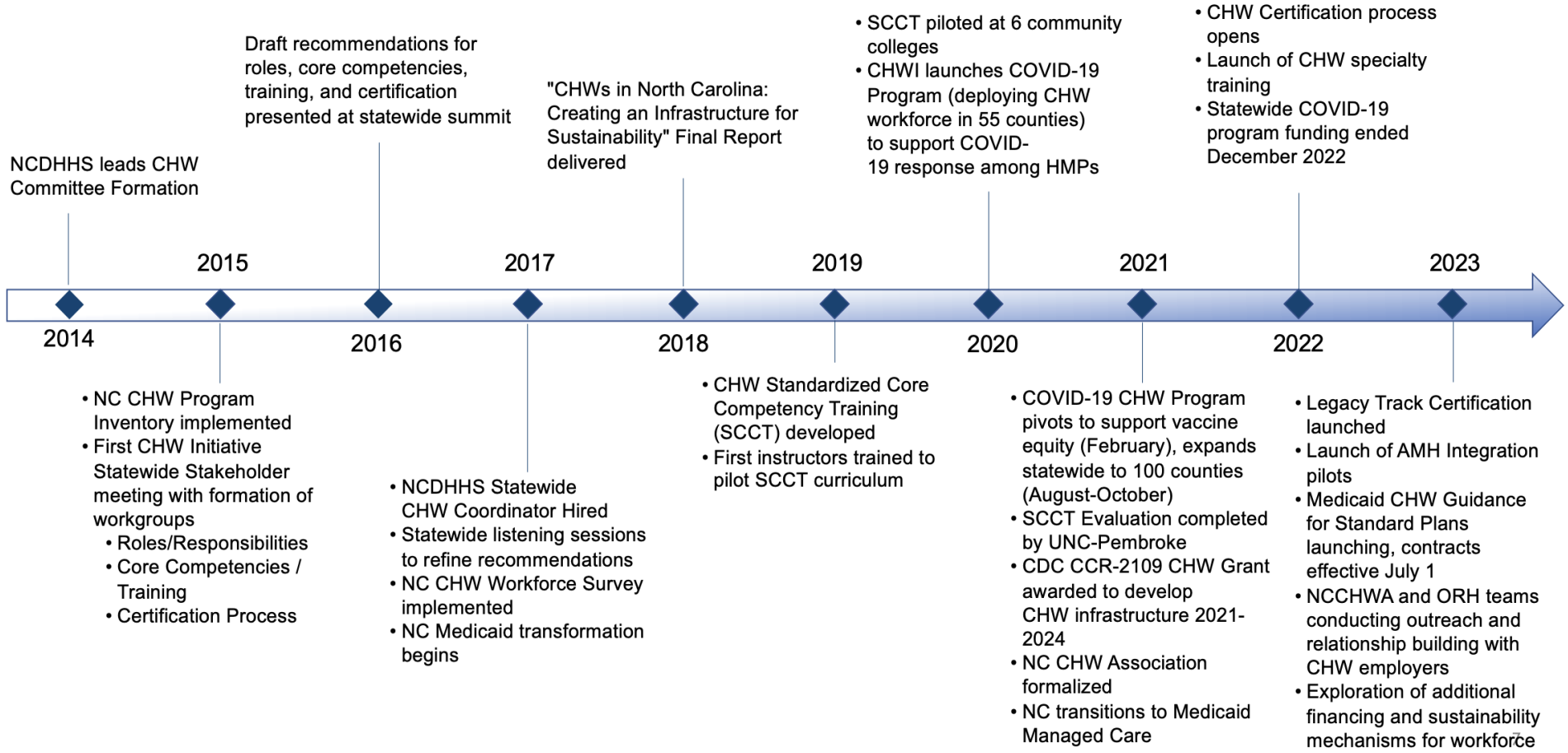
**Education, Training, Certification**

- The North Carolina Department of Health and Human Services (NCDHHS) Office of Rural Health (ORH) received CDC CCR-2109 funds to support CHW training and certification programs.
- The NC CHW Association (NCCHWA) operates a Standardized Core Competency Training (SCCT) program at community colleges across the state. The SCCT is rooted in the CHW Core Consensus (C3) Project competencies. CHWs who complete this course are eligible for certification. Additionally, NCCHWA offers a Legacy Track, which honors the lived experience of CHWs, as well as Advanced levels of certification. NC crossed the milestone of 1000 certified CHWs in 2024.
- Through the SCCT, CHWs are trained in a variety of health and social condition topics such as disease management, maternal/child health, lifestyle interventions, referrals, connections to primary care services, connections to social support services, equity, community health assessments, and more.
- NC AHEC, in partnership with NCCHWA and NCDHHS, provides a variety of optional, self-paced, free, virtual training modules for CHW training focused on specific topics and populations


Source: NCDHHS ORH

# NC spotlight (1/4):
# NCDHHS investment in a strong community health workforce

**NCDHHS has been working toward statewide infrastructure for a CHW workforce since 2014. The Office of Rural Health (ORH) invested in a CHW workforce to address inequities during the Covid-19 emergency response, and in 2021 ORH received a 3-year, 9-million-dollar CDC grant to support the creation of a statewide CHW infrastructure.**




Source: NCDHHS ORH

# NC spotlight (2/4): the Covid-19 CHW Program, a statewide CHW workforce for emergency response

**During the pandemic, NCDHHS Office of Rural Health (ORH) contracted several organizations to hire CHWs across the state.** CHWs focused on providing community-based COVID-19 education, vaccine facilitation for historically marginalized populations, and wraparound services for those impacted by COVID-19. Their work was foundational to a sustained health equity response and laid the groundwork for future community-based public health programming. All CHWs received a stipend to complete the Standard Core Competency training and receive CHW Certification.

## Major components of the COVID-19 CHW Program

**Flexible, Community-Based Workforce**
A flexible workforce trained to provide contact tracing, case investigation, testing, vaccination, and care management support for the COVID-19 response.

**Care Resource Coordination Support**
Provided access to social support resources, accurately and precisely identified gaps, and strengthened referral networks to address the social determinants of health.

**Primary Care and Behavioral Health Linkages**
Increased the number of primary care and mental health referrals made in the community and addressed barriers that prevented individuals from accessing care.

**Equity-focused Vaccine Support**
Provided valuable support via education, community vaccine events, and connections to appointments. Collaboration with initiatives ensured deeper reach and stronger response.

Source: NCDHHS ORH Community Health Workers in North Carolina Overview Deck, July 2023

# NC Spotlight (2/4): A Statewide CHW Workforce For Emergency Response, the Covid-19 CHW Program

The NCDHHS COVID-19 CHW Program put a spotlight on the **impact**, **adaptability**, and **resilience** of the community health workforce.

## Social Support Referral Impact

**Sep 2020 – Dec 2022**

**3,473,519**

**Individuals** served by CHWs

**159,978**

**Referrals** for SDOH services made by CHWs

**921,831**

**Telehealth** encounters performed by CHWs

## Vaccine Equity Impact

**Feb 2021 – Dec 2022**

**20,540**

**Vaccine education events** hosted/assisted by CHWs

**1,799,528**

Individuals present at CHW **vaccine education events**

**5,256**

**Vaccination clinics or events** assisted/planned by CHWs

**63,228**

Individuals **scheduled for a COVID-19 vaccine** with the help of CHW

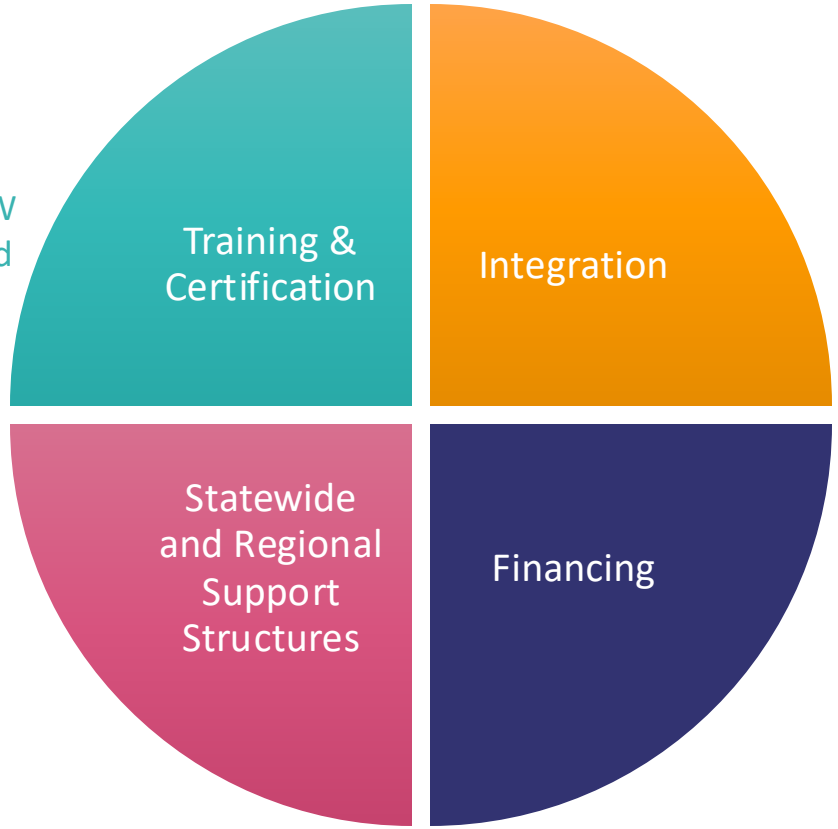
Source: NCDHHS ORH COVID-19 CHW Program Dashboard

# NC Spotlight (4/4): NC CHW Initiative and building a statewide infrastructure for CHWs

**The NC CHW Initiative is a coalition including NCDHHS Office of Rural Health (ORH), North Carolina CHW Association, and additional partners to build, integrate, and reinforce a statewide CHW infrastructure with public health and healthcare systems. This work has been partially supported by a 3-year $9 million grant (CDC CCR-2109).**

- Standardized Core Competency Training (SCCT) offered at 13 community colleges statewide, with online and bilingual Spanish/English courses available
- CHW specialty training modules launched by NC Area Health Education Center (AHEC)in 2021
- CHW certification launched in Feb 2022 by the NC CHW Association (NCCHWA), with legacy track and advanced level certification available

- NCCHWA established in 2021
- Quarterly convenings and working groups of statewide stakeholders hosted by ORH and NCCHWA
- ORH CHW Regional Coordinators, NCCHWA CHW Ambassadors, and Regional CHW Leads collaborate to support regional CHW employers and networks
- CHW employer survey across NC
- Convenings for statewide coordination of CHW data collection
- CHW-related news distribution via ORH, NCCHWA, and NC AHEC listservs




- 4 FQHC pilot programs implemented, integrating CHWs into practice operations with an evaluation component
- AHEC support for health practices on CHW integration (workgroup, coaching, learning collaborative, webinars)
- ORH, NCCHWA, and additional stakeholder participation in a health systems CHW community of practice with NC-based hospitals

- NC Medicaid (Division of Health Benefits, DHB) Medicaid strategy for integrating & financing CHWs proposed in 2023. Strategy includes CHW hiring requirements, CHW-to-enrollee ratio, and community-based CHW incentive
- Regular touchpoints with ORH, DHB, and NCCHWA to continue exploring future sustainability strategies

Source: NCDHHS ORH

# Ohio (1/2)

## State Legislation

- HB 95 (2003) was enacted and required that the Board of Nursing issue and renew CHW certificates. 2010 Ohio Administrative Code lays out additional detail.
- Section 3701.0212 of the Ohio Revised Code created a Center for CHW Excellence to be added to the 2023-2024 Ohio biennial budget with 2.5 million in appropriations each year in order to expand and strengthen the CHW workforce.

## Financing

- Ohio Administrative Code Rule Section 5167.173 requires that MCOs provide CHW or public health nurse services to Medicaid enrollees who are pregnant or capable of becoming pregnant, reside in a community served by a qualified Community HUB, and were recommended to receive CHW/public health nurse services. To meet these requirements, MCOs may directly employ CHWs or contract with CBOs that employ CHWs.
- Ohio Department of Medicaid (ODM) offers two voluntary APMs: Comprehensive Primary Care and Comprehensive Maternal Care. They provide enrolled practices with funding to support population health activities such as team-based care delivery, which can fund CHWs.


State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)
https://www.healthimpactohio.org/blog/center-for-chw-excellence-secures-funding-in-state-budget

# Ohio (2/2)

**Financing (cont.)**

- In 2018, CHW employers reported a mix of payment through reimbursement from Medicaid and payment from MCO contracts.
- ODM provides ten communities with high infant mortality and outcome disparities with biannual funding to support community-driven interventions to improve maternal and infant health. Nearly all communities use these grants to invest in additional CHW services.

**Education, Training, Certification**

- Ohio Administrative Code Rule 4723-26-02 (2020) most recently codified CHW certification requirements.
- Certification requires completion of an approved training program with 100 hours of classroom training and 130 hours of a community-based practicum.
- The Board of Nursing issues and renews certification every two years based on initial training and continuing education requirements thereafter.
- Certification is not mandatory.


State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)
https://www.healthimpactohio.org/blog/center-for-chw-excellence-secures-funding-in-state-budget

# Oregon (1/2)

## State Legislation

- HB 3650 (2011) mandated the Oregon Health Authority (OHA) to develop education and training requirement. Additionally, coordinated care organizations were authorized to provide members with access to Traditional Health Workers.
- HB 3407 (2013)established the Traditional Health Worker Commission, which supervises CHWs, Peer Support, Peer Wellness Specialists, Personal Health Navigators, and Doulas.
- HB 2024 (2015) required OHA to adopt rules and procedures for the training and certification of health workers to provide oral disease prevention services.
- OAR 950-060-0010 regulates CHW certification and provider registry enrollment, certification curriculum standards, training, and standards of professional conduct

## Financing

- SPA 12-007 (2012) and includes peer wellness specialists, personal health navigators, and doulas as “traditional health care workers” to perform services within the scope of practice of the supervising practitioner.
  SPA 11-011 (2012) included CHWs as authorized providers for four of the six health home services covered under Oregon’s health home/Patient-Centered Primary Care Homes (PCPCH
- CHWs must be certified and supervised by a health professional to qualify for Medicaid’s reimbursement. See detailed billing requirements here.


State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)

# Oregon (2/2)

**Education, Training, and Certification**

- Certification is encouraged by not required for employment; however, only certified CHWs can participate in Health Homes. After certification by OHA, can enroll in THW registry.
- CHWs can apply for certification after completing the state-approved training program or by providing documentation of experience.
- Training centers are approved through OHA's Traditional Health Worker Commission.


State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)

# Rhode Island

## State Legislation

- H 5633 (2011) established the Commission for Health Advocacy and Equity. The recommendations from the commission may include recruitment, training, and employment of CHWs.

## Financing

- SPA 21-0012 (2022), allows reimbursement for certified CHWs providing certain health-related services, with services reimbursed starting July 1, 2021.
- Rhode Island's Medicaid accountable entities (similar to ACOs) may use funds earned through the Health System Transformation Project Incentive Fund to fund CHW services.

## Education, Training, Certification

- CHW training is funded by a variety of RI state departments, private foundations and some employers. There is no standardized curriculum for CHWs, but certification requires education in specified areas.
- Certification is available for all CHWs who meet the standards by the Rhode Island Certification Board. Though it is not required otherwise, the SPA notes that services must be provided by certified CHWs or those who plan to be certified within 18 months in order to be eligible for reimbursement.


State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)

# Rhode Island spotlight (1/2): state plan amendment for CHW reimbursement

**Rhode Island's CHW SPA 21-0012 went into effect in 2021. Implementation of SPA stipulations is currently underway, and include these highlights:**

## 1905a Preventive Category

The Rhode Island CHW SPA was filed under the 1905a authority, specifically in the "preventive" category, rather than as an "other licensed provider" or "rehabilitation" category.

In this category, supervision is not required, allowing Rhode Island's CHWs to be reimbursed outside of the medical model.

## Medicaid Recipient Eligibility

Benefit eligibility requirements for CHW care included *"Beneficiary expressed need for support in health system navigation or resource coordination services."*

This allows Medicaid recipients to ask for CHW care in addition to allowing a provider to determine their need for CHW services

## Referral Requirement

Rather than having a primary care provider be the sole option for referral to CHW services, this SPA allows any "licensed practitioner of the healing arts" to issue a recommendation for CHW services and be eligible for Medicaid reimbursement.

## Collateral Services

Collateral services are "those delivered on behalf of an individual but are not delivered in that beneficiary's presence/directly to the beneficiary." This allows CHWs to bill for the time they spend coordinating, researching new support services, discussing with the care team.

## Training and Certification

Many clinical providers saw standardized training as an important aspect of setting a standard for the workforce, however, acknowledging the importance of years of lived experience, CHWs are given a grace period of 18 months of employment in order to complete certification.

RI Provider Manual

# South Carolina

## State Legislation

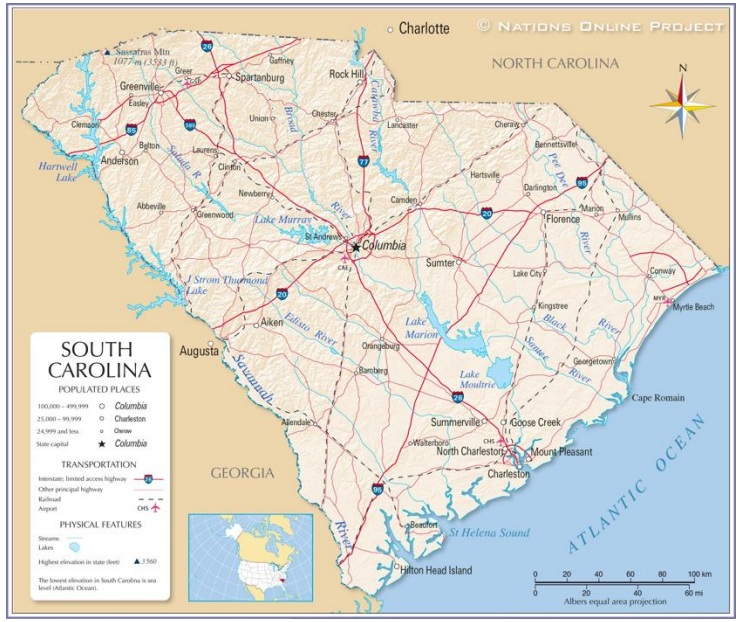
- H. 4300 (2023) appropriated funds for the SC Center for Community Health Alignment to expand the CHW programs in hospital settings.

## Financing

- The state has encouraged Medicaid managed care organizations to use CHWs, and there are some ongoing efforts to better integrate CHWs into the healthcare system.

## Education, Training, and Certification

- A certification process was established in 2012. It is administered by the South Carolina CHW Credentialing Council (SCCHWCC) and approves educational programs, including curricula, facilitators, and preceptors, to administer South Carolina's Core Competency training for CHWs.
- SCCHWCC is led by the South Carolina CHW Association and includes representation from state health officials.
- SCCHWCC revised the core competencies and the process for training CHWs in 2019.
- Certification requires 80 hours classroom, 80 hours practicum, a core competency exam, and continuing education credits. Certification needs to be renewed every two years.
- There is a tiered certification system of three levels along with a legacy track.




State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)

# South Dakota

## State Legislation

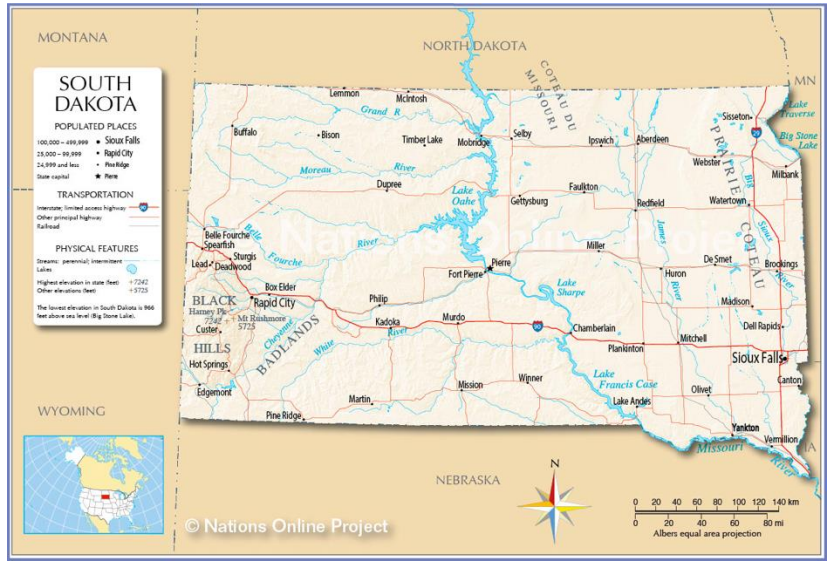
- No legislation identified.

## Financing

- SPA 19-0005 (2019) adds CHW preventive services for specific chronic diseases as a benefit under the Medicaid State Plan.
- The SPA allows for CBOs to register as CHW agencies and bill for CHW services.

## Education, Training, Certification

- The Community Health Worker Collaborative of South Dakota, in partnership with the Department of Health, administers CHW certification.
- There are separate CHW and CHR certifications. Both require 200 hours of training and 40 hours of shadowing, and cover three areas: health promotion, navigation/resource coordination, and health education. More information here.
- Training programs have to be approved by the Collaborative.
- Community Health Representatives (CHRs) are can enter through a legacy track in the CHR training program.
- CBOs must be certified for the agency to be reimbursed for services through South Dakota Medicaid.




State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)
https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Professional/Community_Health_Worker_Services.pdf

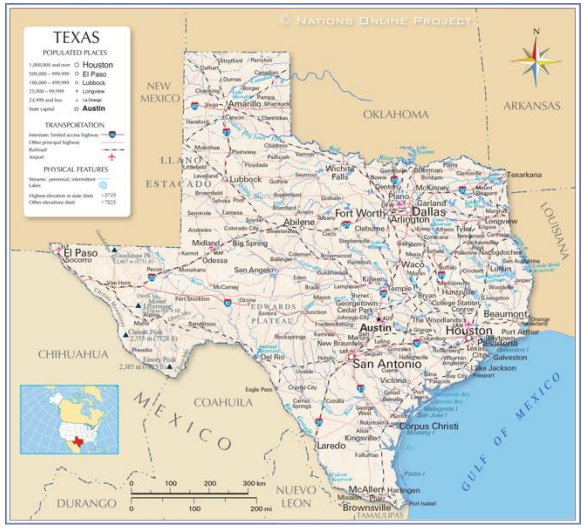
# Texas (1/2)

## State Legislation

- Texas Health and Safety Code Chapter 48 required Department of State Health Services (DSHS) to create and operate a certification for CHWs across the state.
- SB 1051 (2001) required DSHS to establish a training program to oversee certification.
- HB 2610 (2011) required DSHS to create a statewide advisory committee to provide recommendations for CHW training, funding, and employment.
- HB 113 (2023) allows Medicaid MCOs to categorize CHW expenditures as quality improvement costs.
- HB 1575 (2023) requires the Health and Human Services Commission to establish a separate provider type for a CHW who provides case management services under the Case Management for Children and Pregnant Women Program.

## Financing

- Contracted Medicaid MCOs allow CHWs-related expenses to be included in their administrative costs/quality improvement costs.

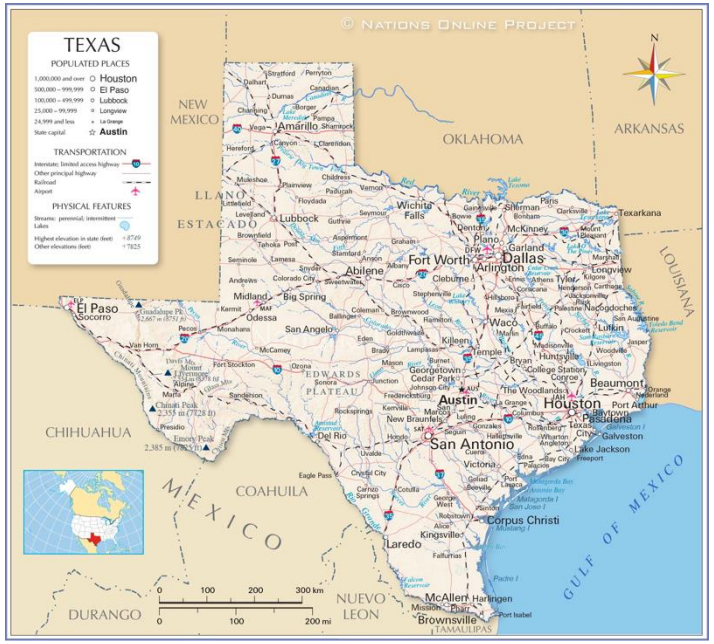



State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)

# Texas (2/2)

**Education, Training, and Certification**

- Certification is mandatory for CHWs to be compensated for services.
- DSHS oversees the Promoter/CHW Training and Certification Program for CHWs and instructors. DSHS approves programs at community colleges, AHECs, FQHCs, and CBOs to train CHWs in eight core competencies. There are two pathways to certification: experience or training. The certification is for 2 years, and there is no cost.




State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)

# Washington (1/2)

## State Legislation

- Engrossed Substitute Senate Bill 5693, Section 211 (103) (2022) appropriated $2,087,000 to the Washington State Health Care Authority (HCA), the State's Medicaid agency to establish a two-year grant program for primary care clinics to embed CHWs as part of care teams, submit legislative reports on the impacts of the grant program, and explore longer-term reimbursement in collaboration with key partners
- Engrossed Substitute Senate Bill 5187 (44) (2023) appropriated an additional $6,164,000 to maintain HCA's CHW grant through the duration of the project.

## Financing

- The State's 1115 demonstration allows CHWs to be paid as a part of Medicaid value-based payment (VBP) for justice involved pre-release services relating to screening, navigation and referral and health-related social needs services includes a category for case management, navigation, and referral, which will be used to pay for CHW services managed care an FFS populations through regional community hubs and a native hub.
- Washington's MCOs pay for CHWs though administrative costs to support case management activities through community-based CHWs who are employees of the MCO or a contracted community-based organization
- CHWs can work in health homes, which allows them to receive Medicaid funding for each patient served.


State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)

# Washington (2/2)

**Education, Training, and Certification**

- Training of CHWs occur through the Department of Health, which has established core competencies for CHWs and offers the 10-week training free of charge. Upon completion, CHWs receive a certificate of completion.
- A 2019 CHW Task Force Report provided recommendations for the development of CHW training, initiatives, and programs, including a framework, content, instructional and organizational considerations for CHW programs.
- There is no statewide certification for CHWs at this time.


State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org)

# West Virginia

## State Legislation

None

## Financing

- West Virginia does not reimburse for CHW services through its Medicaid program. However, payment is allowed (not required) via Medicaid health homes where CHWs may be part of care teams, using a fixed per member payment.
- One CHW chronic care management program (discussed in detail on the next slide) also engages insurance providers to reimburse providers for high-risk chronic disease patients

## Education, Training, and Certification

- There is no statewide certification program in WV.
- The West Virginia School of Osteopathic Medicine (WVSOM)'s Center for Rural and Community Health offers a Community Health Education Resource Person (CHERP) training program to train CHWs to work at one or more levels among Wellness, Health Promotion, or Disease Prevention & Management. Participants receive a certificate of completion.
- CHWs working in the CHW chronic care management program (next slide) receive a core training from Marshall University School of Medicine but additional training is specific to the employing health center. Most intensive training is on-the-job – supervision, team huddles, etc.


State Community Health Worker Policies – The National Academy for State Health Policy (nashp.org

# West Virginia spotlight : community health worker–based chronic care management model for patients with high health care costs

**Background**

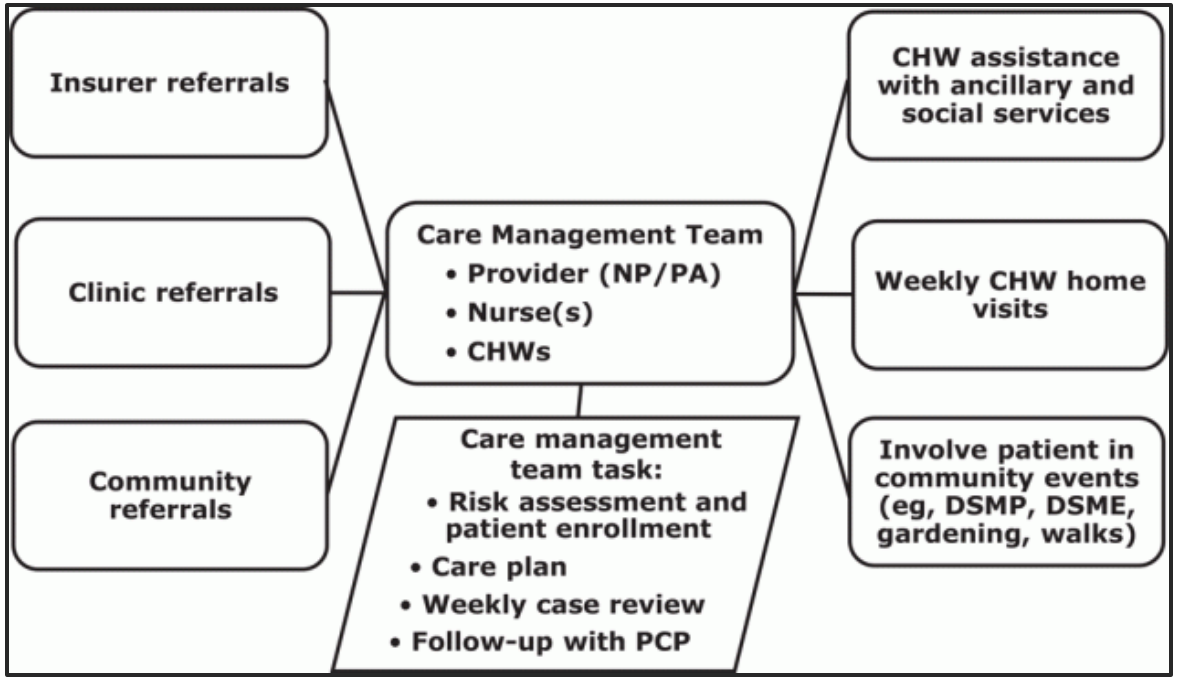
- Chronic Care Management (CCM) teams operate within clinics and serve clinic patient populations and carry out the activities indicated in the figure (right).
- Initially targeted to diabetes patients, the model has since expanded to other high-risk chronic conditions

**Financing**

- Program is financed through a mix of grant funding to support startup and shared savings arrangements with payers.
- Program leadership credit early and persistent engagement with payers as a critical aspect of sustainable financing.

**Training**

- CHWs complete a basic/core training and additional training specific to the employing health center. Most intensive training is on-the-job – supervision, team huddles, etc.




https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7021460/

# The Indian Health Services (IHS) Community Health Representative (CHR) program

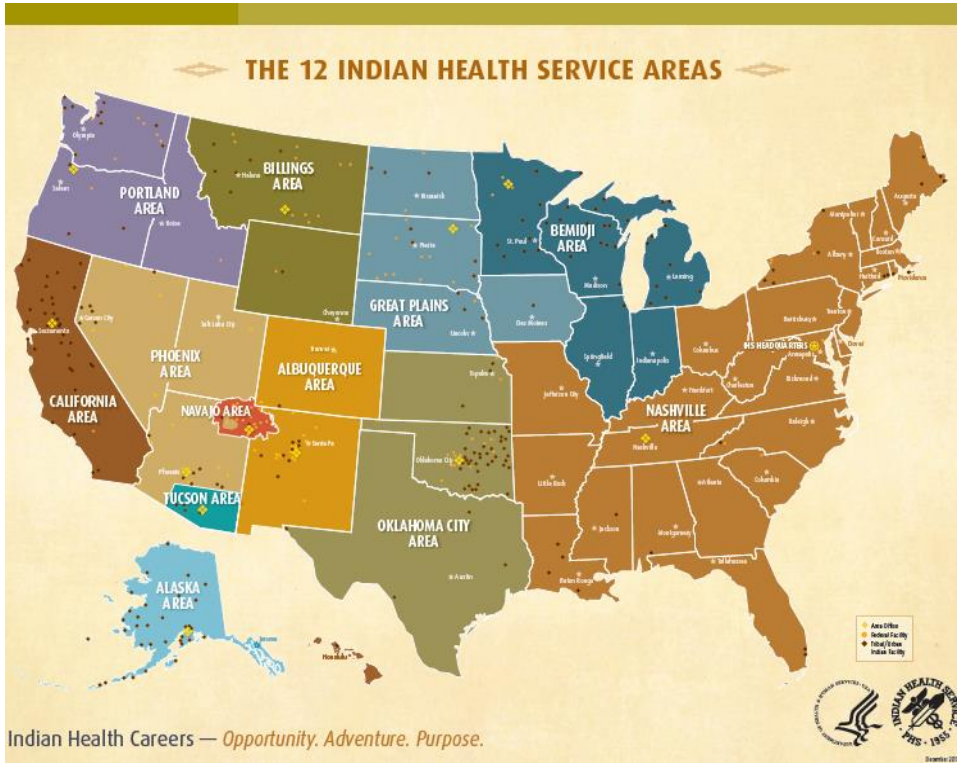
Tribal nations have a long history of utilizing CHWs. The first CHW program ever included in legislation was the CHR Program, established in 1968, under the 1921 Snyder Act (25 U.S.C. 13).

CHRs are ***"frontline public health workers who are trusted members of the community with a close understanding of the community, language, and traditions"*** (IHS).

CHR functions are tailored to the context of their community, and generally include:

- Linking between clinical setting and community to facilitate access to services and improve the quality and cultural competence of service delivery
- Increasing health knowledge of patients and communities through broad range of activities (transportation health visits, outreach, education, informal counseling, social support, and advocacy)

Currently, 1,600+ CHRs represent >250 tribes in 12 IHS areas. Although federally funded by IHS, 95% of CHR programs are directly operated by Tribes under P.L. 93-638 of the Indian Self-Determination and Education Assistance Act, as amended.




**More information about the IHS CHR Program can be found here and here.** Prominent models for CHR service delivery will be explored in next version of this report.

https://www.ihs.gov/chr/chrtraining/
https://www.ihs.gov/locations/

# Thank You

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**Appendix:**
**Evidence Deep Dive**

Systematic Reviews

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Rural Context

# Case Study - El Sol's CHW/Promotores Training Center Approach

**This case study describes how a CHW/P training center applied popular education throughout the CHW/P capacity-building process to advance and maintain the roots of the CHW/P movement.**

**This case study:**

- Highlights how a CHW/P training center incorporated long-standing guiding principles underlying the CHW/P movement.
- Aims to help stimulate reflection, dialogue and action among CHW/P organizations on how to incorporate these long-standing guiding principles into their operations, in an effort to build examples of CHW/P-centered interventions that reflect values and paradigms such as health care for all, health equity and health as a right.
- Discusses the CHW/P capacity-building process and the interrelationship between the components, to gain insight into how popular education, health equity, and community transformation principles are applied throughout the CHW/P capacity-building process.
- Provides insight that can generate more reflection, dialogue and action around the process of building organizational readiness to place and support CHWs/Ps. (See *A Guide for Organizational Readiness*)

**See here to learn more: Preserving a Transformative Community Health Worker/Promotor Workforce:** El Sol's CHW/P Training Center Approach

# Systematic Reviews

**SYSTEMATIC REVIEWS: CHW interventions show consistent promise in improving health equity, mental health, chronic disease management, and more among certain populations**

**Effects of CHW Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations**

- Interventions by CHWs appear more effective when compared with alternatives and are cost-effective for certain health conditions, particularly among low-income, underserved, and racial and ethnic minority communities.
- *Amer. Journal of Public Health, 2016, 106(4).* *https://www.ncbi.nlm.nih.gov/pubmed/26890177*

**CHW Interventions to Improve Glycemic Control in People with Diabetes**

- CHW interventions (13 RCTs) showed a modest reduction in Hemoglobin compared to usual care.
- *J. Gen. Intern. Medicine, 2015, 30(7).* *https://www.ncbi.nlm.nih.gov/pubmed/25735938*

**Mental Health Interventions with CHWs in the U.S.**

- Findings across nine studies suggest CHW-supported mental health interventions show promise, particularly given evidence of feasibility and acceptability with underserved populations.
- *J. Health Care Poor Underserved. 2018, 29(1).* *https://www.ncbi.nlm.nih.gov/pubmed/29503292*

# Randomized Trials

**RANDOMIZED CONTROL TRIALS (RCTs): Increased use of primary care, improved reported mental health, lower inpatient readmissions**

**Patient-Centered CHW Intervention to Improve Posthospital Outcomes (RCT):**

- **WHAT:** CHWs worked with low-SES hospital patients to create individualized action plans for recovery; provided tailored support for at least two weeks.
- **OUTCOMES:** Increased likelihood of obtaining primary care, greater improvements in mental health, increased patient activation, lower likelihood of multiple 30-day readmissions (40% reduced to 15.2%).

*JAMA Inter. Med, 2014, 174(4)*

**CHW Support For Disadvantaged Patients With Multiple Chronic Diseases (RCT):**

- **WHAT:** High-poverty, publicly insured patients with multiple chronic conditions worked with a CHW to achieve a disease management goal over six months.
- **OUTCOMES:** Improvements in mental health, increased support for disease self-management (63% compared to 38% control group), lower hospitalization (16% compared to 17.8% after six months, 23% compared to 32% after one year).

*ASTHO CHW Evidence Summary*

# CHW Program Successes: Return on Investment (ROI)

**Nevada CHW ROI Study**

- **WHAT:** Health Plan of Nevada (Medicaid managed care organization) hired three CHWs to work with an average of 37 patients each for 30-60 days on service referrals, transportation, patient education, accessing treatment specialists, and other services.
- **OUTCOMES: Total ROI Calculation: 1.81 ($503,384 medical/RX savings versus $278,331 program cost)**
  - Average medical costs decreased: $1,223 PMPM pre-intervention to $983 PMPM post-intervention. Prescription costs reduced from $539 PMPM to $491 PMPM.
  - Decreased number of acute admissions (-18%), readmissions (-20%), ED visits (-14%), and urgent care visits (-6%).
- *Nevada Department of Health and Human Services, May 2017.* [https://bit.ly/2sBdtDu](https://bit.ly/2sBdtDu)

**Maryland CHW Outreach Program** on Healthcare Utilization

- **WHAT:** CHWs in West Baltimore City conducted weekly home visits and phone calls to Medicaid beneficiaries with diabetes to provide education and maintain appropriate visits to primary care.
- **OUTCOMES: Savings of $2,245 per patient per year. Total savings of $262,080 across 117 patients per year**, along with improved quality of life. Driven by decrease in ED visits (-40%), hospital admissions (-33%), and Medicaid reimbursements (-27%).
- *Ethn Dis., 2003 Winter, 13(1).* [https://www.ncbi.nlm.nih.gov/pubmed/12723008](https://www.ncbi.nlm.nih.gov/pubmed/12723008)

# CHW Program Successes: Return on Investment (ROI)

**Kentucky**

- **WHAT:** Homeplace program trains CHWs with a focus on care coordination and serves low-income clients at no charge.
- **OUTCOME: ROI is $11.20 saved for every $1 invested for trainings.**
- *Rural Health Information Hub.* https://www.ruralhealthinfo.org/project-examples/785

**New Mexico**

- **WHAT:** 448 high-resource-consuming Medicaid managed care clients in 11 counties received patient education, advocacy, and social support from CHWs for six months
- **OUTCOME:** Lowered ED costs ($425,551 total), lowered inpatient costs ($$872,694 total), lower non-narcotics prescriptions ($699,129 total) and narcotics prescription ($42,091).. **Total cost differential: $2,044,465 less post-intervention compared to pre- intervention, compared to total CHW salary costs of $521,343**.
- *J. Community Health, 2011. https://bit.ly/2lFEc0Y*

**Social ROI Research Report on CHWs in Cancer Outreach and Educations across the U.S.**

- **OUTCOME:** CHWs generated **lifetime benefits of $12,348 per person** served by a CHW, or **$851,410 by every CHW that serves at least 69 individuals per year**. Compared to total direct costs (salary, benefits, administrative costs) of $41,184 per CHW per year.
- *Wilder Research, 2012. https://bit.ly/2ktAKGA*

# CHW Program Successes: Return on Investment (ROI)

**East Texas ROI from employment of CHWs in two hospitals working with ED patients**

- **OUTCOME: ROI ranging from 3:1 to more than 15:1**.
- *Rush, Carl. J Ambul Care Manage. 2012, 35(2).* *https://www.ncbi.nlm.nih.gov/pubmed/22415287*

**Denver Health Community Voices Program Piloted a CHW Outreach Program for 590 Men**

- **OUTCOME:** The **ROI of 2.28:1** was achieved through reduced service utilization and charges over 9 months. Monthly

program costs were $6,229, compared to a reduction in monthly uncompensated costs of $14,244.

- *J. Health Care Poor Underserved. 2006, 17(1 Suppl).* *https://www.ncbi.nlm.nih.gov/pubmed/16520499*

**CMMI Health Care Innovation Awards (HCIA) Meta-Analysis and Evaluators Collaborative**

- **OUTCOME:** "Of six types of innovation components... (i.e., used health IT, with CHWs, medical home intervention, focus on behavioral health, used telemedicine, workflow/process redesign intervention), only innovations with CHWs were found to **lower total costs (by $138 per beneficiary per quarter)**." Clinicians also reported spending between 30-50% less time arranging and coordinating social services and referrals.
- *CMMS, February 2018. HCIA Meta Analysis and Evaluators Collaborative.pdf*
- *https://downloads.cms.gov/files/cmmi/hcia-metaanalysisthirdannualrpt.pdf*

# CHW Program Successes: Return on Investment (ROI)

**Impact on Health Care Utilization and Costs of a Medicaid Community Health Worker Program in Detroit, 2018–2020: A Randomized Program Evaluation**

A Detroit-based study of CHWs funded through Medicaid finds that CHWs can reduce ER use and increase outpatient care among Medicaid recipients, offsetting cost savings in the short term; however, increased outpatient care among individuals who underuse such care could contribute to cost savings in the long-term

- **OUTCOME:** Those randomized to the program had fewer ED visits and more outpatient ambulatory care resource use at 12-month follow-up than beneficiaries randomized to usual care.
- Source: Michele Heisler, et al. "Impact on Health Care Utilization and Costs of a Medicaid Community Health Worker Program in Detroit, 2018–2020: A Randomized Program Evaluation", *American Journal of Public Health* 112, no. 5 (May 1, 2022): pp. 766-775. https://doi.org/10.2105/AJPH.2021.306700

**The Maryland Health Enterprise Zone Initiative Reduced Hospital Cost And Utilization In Underserved Communities, 2018**

The State of Maryland implemented the Health Enterprise Zone Initiative in 2013 to improve access to health care and health outcomes in underserved communities and reduce health care costs and avoidable hospital admissions and readmissions.

- **OUTCOME:** A reduction of 18,562 inpatient stays; increase of 40,488 ED visits in the period 2013–16.
- The net cost savings: $93.4 million
- Source: Gaskin, Vazin, et al; https://doi.org/10.1377/hlthaff.2018.0642

# CHW Program Successes: Chronic Disease Management

**Chicago CHWs Improve Asthma Management among African-American Children**

- **WHAT:** Trained CHWs from targeted communities provided individualized asthma education during three to four home visits over 6 months.
- **OUTCOME:** Asthma control was improved by 35% among adolescents working with CHWs
- *PubMed, 2012; 49(4).* *https://www.ncbi.nlm.nih.gov/pubmed/22348448*

**Maryland Study on Effects of Nurse Care Managers and CHWs on Diabetes-Related Health Complications among African Americans**

**WHAT:** Patients with diabetes were assigned to one of four care groups: 1) usual care, 2) usual care + nurse manager, 3) usual care + CHW, or 4) usual care + nurse manager + CHW.

- **OUTCOME:** Patients receiving services from both a CHW and a nurse case manager had the greatest declines in A1C (glycosylated hemoglobin) values, cholesterol triglycerides, and diastolic blood pressure.
- *Prev. Med., 2003, 37(1).* *https://www.ncbi.nlm.nih.gov/pubmed/12799126*

# CHW Program Successes: Chronic Disease Management

**Florida CHW-Led Educational Program and Service Coordination to Address Diabetes and Cardiovascular Disease**

- **WHAT:** CHWs provided community-based, behavior-changed educational programs and care coordination among under-resourced, rural, ethnically disparate populations in Gadsden County.
- **OUTCOME:** The Project H.I.G.H. saw successes in motivating participants to delay or prevent diabetes and/or cardiovascular disease, and participants reported intent to take care of their health.
- *Evaluation and Program Planning, April 2016, 55.* *https://bit.ly/2kl5Lq7*

**Outcomes at 18 Months From a Community Health Worker and Peer Leader Diabetes Self-Management Program for Latino Adults**

- **WHAT:** CHW program provided diabetes self-management education (DSME), followed by two different approaches to maintain improvements in $HbA_{1c}$ and other clinical and patient-centered outcomes over 18 months.
- **OUTCOME:** Participants in the CHW intervention at the 6-month follow-up had greater decreases in $HbA_{1c}$ and in diabetes distress, maintained $HbA_{1c}$ improvements at 12 and 18 months, had significantly fewer depressive symptoms at 18 months, had significant improvements in diabetes social support and in understanding of diabetes self-management.
- *Diabetes Care, 2018 Jul;41(7):1414-1422.* *https://doi.org/10.2337/dc17-0978*

# CHW Program Successes: Rural Context

**Texas lay health educators provided asthma or general health promotion education to elementary school children in a rural school district.**

- **OUTCOME:** Improved asthma knowledge, self-management, and self-efficacy for managing symptoms and using metered dose inhalers.
- *J. School Health, Sept. 2008, 78(9).* https://bit.ly/2k1s0r4

**North Dakota patient navigator/community health representative program aimed to reduce cancer disparities among American Indians.**

- **OUTCOME:** Individuals with cancer who received navigation services during radiation treatment had an average of 3 fewer days of treatment interruptions.
- *Cancer Control, July 2008, 15(3).* https://bit.ly/2k0kgWf

**Alabama CHWs delivered cognitive behavioral training intervention for rural patients with diabetes and chronic pain.**

- **OUTCOME:** 80% of the program participants completed the training, of whom 95% reported satisfaction.
- *Fam. Community Health, 2018, 41(3).* https://bit.ly/2kwjrEP