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EXECUTIVE SUMMARY

COMMUNITY HEALTH WORKERS:

Health System Integration, Financing Opportunities, and the Evolving Role of the Community Health Worker in a Post-Health Reform Landscape

Fitzhugh Mullan Institute for Health Workforce Equity

THE GEORGE WASHINGTON UNIVERSITY

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Background

While the term Community Health Worker (CHW) includes many different job titles and roles, as an occupational group they are generally defined as defined as public health workers that complement health care services by empowering individuals, families and the community to address the social determinants of health. Importantly, they do this in a manner that is culturally and linguistically appropriate, particularly in communities and for populations that have been historically underserved and uninsured.

The addition of CHWs to existing health care teams is increasingly viewed as one response to the value based payment policies advanced by the 2010 Accountable Care Act (ACA). Now, more than ever before, providers are thinking about how to fund CHWs; whether to form partnerships with community based organizations or to hire CHWs directly; what hiring criteria should be used and whether certification is needed; and how to supervise CHWs and evaluate their work.

The purpose of this report is to contribute to the knowledge about how CHWs work may be evolving as new employers begin to hire them, and to explore the implications of these changes for CHW management, CHW competencies and for payment policies that help enhance funding for CHWs.

Methods

We approached this task through several research strands as follows:

1) We conducted a literature review of all descriptive and evaluative studies conducted between 1980 and 2015 and developed a tabular summary of 109 studies.
2) We interviewed 21 key informants, including CHW leaders, employers and educators.
3) Using a snowball sampling approach, we constructed a database of 78 CHW programs. Data on these programs was obtained through publicly available documents, interviews and an email questionnaire.
4) We then conducted three more in-depth case studies that exemplified varied approaches to CHW integration in order to identify factors that participants believe contribute to the success of those relationships.
5) We reviewed CHW competency lists and identified areas in which new competencies might be required as part of CHW integration.
6) We explored ways in which financing of CHWs could be stabilized, particularly through Medicaid.

Part I: Review of literature 1980 – 2015

Our systematic review revealed considerable evidence from both observational and randomized designs of CHW impact. Few studies, however, compare CHW programs to a similarly priced alternative, or even to the option of no program. We also found a sharp increase in the rate of publication of new studies on CHWs during this period. The focus on Latino populations has grown, as has the interest in CHW programs focused on diabetes and obesity. There has been a decline in studies on CHWs working on women's health issues.

Part II: CHW Database

While our database is not necessarily representative of the entire nation, descriptive statistical analyses of the programs, especially when compared to descriptions presented in the HRSA 2007 report on CHWs, do suggest that the landscape has changed. Key findings and a discussion of their relevance follow.

Hospitals were the most likely organization to house CHW programs. This may be a new development and points to the rapid integration of CHWs into clinical settings. The Federal government, and especially CMMI, was the most frequent funder of programs. . The least frequent funders were health plans, suggesting the need to advance health plan commitment to CHWs. 75% of CHW programs reported delivering services in the home or in community settings, 8% in hospitals and 17% in non-hospital clinical settings such as community clinics.

Almost half the database programs required applicants to live in the community served (community membership) or to have considerable experience and understanding of that community. Eight programs (10.5%) set a minimum educational requirement of at least a high-school diploma, one required an associate's degree and another a masters or bachelor's degree. Over one-third of programs required some "other" type of training as a hiring qualification, such as becoming certified as an asthma educator or passing a program-based training course. Less than a quarter of the programs (17) had requirements for language fluency or proficiency. Only five programs require applicants to had some level of "peer status," meaning that the CHW has an understanding of the health condition faced by patients participating in the program (for example, a diabetic CHW who is working in a diabetes prevention program).

We identified four levels of integration of CHWs with health services: 1) Direct Hires, 2) Community Partnerships with formal referrals, 3) Informational Resource with no formal ties, and 4) Independent, which refers to programs with no relationship to health services. More than half the programs in the data base hired CHWs directly (41), followed by programs with no relationship with health services (Independent) (21). Only 7 programs accessed their CHWs through a Community Partnerships, and 9 engaged CHWs as an Informational Resource. Clinical providers (hospitals and clinics) and health plans were most likely to have directly hire CHWs, while Health/Social agencies, Community Based Organizations and other nonprofit entities were most likely to have no integration (Independent). Hospitals, health plans and Federally-funded programs were predominantly Direct Hires, while foundation-supported programs tended to be Independent.

Perhaps our most important finding was that programs with Direct Hire relationships were the most likely to value educational and other training criteria in hiring. To a lesser degree, they also valued community membership, but peer status was not expressly viewed as a hiring criterion for any of these programs. Conversely, programs categorized as Independent (i.e. no integration with health services) value peer status as the most important criteria in hiring, and did not expressly value education criteria.

These findings suggest several policy relevant challenges as follows:

1) **The integration challenge**: Findings suggest that Direct Hire by health services has become the most common CHW arrangement. This appears to be an important change since 2007, and is potentially positive, since it expands employment opportunities for CHWs. On the other hand, it is surprising that there are not more partnerships with Community Based Organizations (CBOs), which could represent an alternative form of integration that allow CHWs to retain greater autonomy. More research is needed to deepen our understanding of the advantages and disadvantages of different integration models. A preliminary case study comparison is presented in Part III of this report.
2) **The competency challenge:** A second issue emerges from our analysis of integration arrangements. While peer status and community membership are the most important criteria for hiring CHWs when CHWs are employed by or associated with groups outside of the health system, when they are directly hired by providers (the dominant model), education and training are more important hiring criteria. This is understandable, given that CHWs in clinical settings are working in professional teams, and required to keep written records of their work that may be audited. Nevertheless, it may also suggest that CHWs work may be changing, with new

skillsets emphasized and old ones de-emphasized. In Part IV we conduct a preliminary analyses of existing competencies, and discuss possible gaps.

3) **The funding challenge:** The Federal Government is still playing an important role in funding CHW programs, while support from health plans appears to be low. Given the spread of value-based payment reforms since 2010, the good news is that provider hiring of CHWs may continue to grow, despite the limited opportunities for direct reimbursement for their services. If this trend is confirmed, it may be considered one of the positive effects of payment reforms: not only will more CHWs be available to serve disadvantaged populations, but their work may remain outside the medicalized fee-for-service arena. Going forward, it will important to track funding sources for CHWs, and to explore options for expanding health plan support, in particular Medicaid support. In Part V we present one options for advancing Medicaid support for CHWs.

We further explore each of these areas in Parts III-V.

Part III: Case Studies of Integration

We selected three case studies from our database that represent diverse approaches to integration. We interviewed the leaders of these programs to gain insight into their model, the rationale for using a CHW workforce, and the program elements that foster communication, transfer of expertise and CHW autonomy.

1. **Direct Hire Integration**: ***IMPaCT / Penn Center for Community Health Workers.*** This model includes CHWs as team members by involving them in clinical meetings where CHWs are invited to strategize about patient care and by training supervisors on the important role of CHWs within the U. Penn system.
2. **Community Partner Integration:** ***Salud Para Todos Salud.*** In this model, community-based promotores have a partner "on the inside" who is similarly trained and understands the unique and important role of CHWs in advancing patient health. The clinical care team participated in cultural competency workshops that help to build the credibility of the CHW as an important partner. Use of a shared electronic health record is a critical element that fosters collaboration and communication between the health clinics and their community-based promotores partners.
3. **Informational Resource Integration:** ***Women- Inspired Neighborhood (WIN) Network.*** In this model CHWs educate physicians, nurses, and other health professionals on social determinants, or more specifically, the difficult circumstances patients face outside of the clinical setting. These efforts improve the capacity of the health system to address patient needs.

Despite different structural approaches to integration in these three models, it appears that successful integration may occur in each. Common elements described by participants are listed in the table below:

Common Elements of Successful CHW Integration	
Communications about Patient Care	• Established criteria for communicating with providers • CHW participation in appointments and calls between providers and patients • Attending team meetings and/or clinical rounds
Sharing of Provider Expertise	• Opportunities to strategize with health team about patient's care • Forum to share "best practices" between CHWs and other providers
Level of Autonomy	• CHWs provide tailored services for each patient • CHWs seek out new community resources for patients • CHWs have opportunities to strategize with health team about patient's care • CHWs supervised by another team member
Other Enabling Mechanisms	• Common program administration • Supervisors and other members of the care team trained on the CHW model • Program-based training for CHWs

Part IV: Analysis of Competencies

If, as our analysis suggests, integration of CHWs into health services via direct hire is advancing, and if integration holds promise for expanding the use of CHWs, then it is important to consider the new competencies CHWs may need to best integrate into health systems without jeopardizing the independence and autonomy that CHWs need to be agents of change in their communities. A clear definition of competencies helps to inform educational programs, hiring criteria, supervision and performance assessment.

Based on a content analysis of nine competency lists developed by seven states and two public health departments, we grouped competencies into four major "Modes of Impact". The purpose of these broad groups of "Modes of Impact" is to focus on the unique contributions of CHWs to health systems. The following is a summary of the competencies in these existing lists that appear to relate to these Modes of Impact.

CHWs' Current Modes of Impact	Current CHW Competencies
1. Outreach to individuals, families and communities	○ Outreach Methods and Strategies
2. Trust building with individuals, families and communities	○ Culturally Based Communication ○ Cultural Responsiveness & Mediation ○ Interpersonal Skills
3. Empowerment of individuals, families and communities	○ Teaching ○ Health coaching ○ Capacity building ○ Informal counseling ○ Community capacity building
4. Addressing Social Determinants of health for individuals, families and communities	○ Knowledge base about the community, health issues, and available services and resources ○ Community Assessment ○ Advocacy

The question for CHWs today, is what other competencies and "mode of impact" might be relevant in the new world of integration. Based on the findings from our database, interviews with 21 experts and the preliminary case studies presented in Part III, we suggest that there may be a need to conceptualize an additional "mode of impact" linked to the ability of CHWs to integrate into health

systems, while at the same time maintaining their unique occupational identity. We identified seven new competencies related to this additional model of impact.

Proposed New Mode of Impact	Proposed New Competencies
5. Ability to integrate into health systems while maintaining unique occupational identity	○ Ability to articulate unique contributions (occupational identity relating to Modes 1-4) ○ Knowledge of legal and ethical responsibilities in health systems ○ Writing and technical communication skills for documentation and reporting ○ Knowledge of health system for care coordination and system navigation services ○ Ability to work in teams ○ An ability to balance empathy for the provider with advocacy for the patient using high level negotiating, diplomacy and conflict resolution skills ○ Leadership skills – in the community & in the system as a representative of the community

Part V: Medicaid Payment Financing of CHWs

The final section of this report focuses on ways to enhance health plan funding that can be used for CHWs. We know from the literature that lack of Medicaid reimbursement for CHW services reduces patient access to CHWs. One way to increase Medicaid payment that can be used for CHWs is to create incentives for MCOs to support CHWs in conducting quality improvement (QI) activities, particularly those activities that are difficult to bill/reimburse as clinical services. The proposed minimum Medical Loss Ratio (MLR) for Medicaid MCOs, currently being reviewed by CMS, is one mechanism by which this may be achieved. CHWs, public health advocates and other stakeholders could propose that MCOs include a broad range of services offered by CHWs within QI activities, to count toward MLR requirements.