

Community Health Worker Opportunities and the Affordable Care Act (ACA)

*Produced by Health Resources in Action of Boston
for the Maricopa County Department of Public Health*

I. Introduction:

The new environment under the ACA creates opportunities for improving population health, reducing health disparities and facilitating access to care through the development of an effective CHW workforce and integration of CHWs into new health system models.

DEFINITIONS: According to the American Public Health Association, “A CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. The trusting relationship enables the CHW to serve as a liaison/ link /intermediary between health/ social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.”

II. CHW Roles

The Institute of Medicine states that CHWs... “fill a unique space between primary care practice and public health. As members of the community, they are an integral part of the population and can advance public health initiatives by linking community members to personalized care...”

CHWs facilitate:

- Access to appropriate medical care and/or community programs
- Access to culturally competent and multi-lingual health and social services
- Adoption of healthy behaviors and

environments

- Self-management of chronic diseases
- Enrollment in appropriate public insurance programs

CHWs serve as:

- Community and patient advocates
- Providers of informal counseling and social supports
- Members of the clinical primary care team
- Advocates for policies that serve to reduce disparities
- Connectors to health and social services

III. CHWs Under the ACA

The role of CHWs has more recently become legitimized as their value to improving the efficacy of care is increasingly recognized. While there are no dedicated funding streams to support CHWs, they are explicitly acknowledged within multiple sections of the ACA (Rush, 2013) via:

- *Area Health Education Centers* (§5403)—in the reauthorized funding for AHECs, training plans must now include CHWs in interdisciplinary training. Language specifying this was included in the most recent AHEC Funding Opportunity Announcement (FOA), HRSA 12-013, which awarded 5-year planning grants from 2012-2017. One of the program requirements was to “conduct and participate in interdisciplinary training that involves physicians, physician assistants, nurse practitioners, nurse midwives, dentists, psychologists, pharmacists,

optometrists, community health workers, public and allied health professionals, or other health professionals, as practicable.” There are no currently open AHEC grants.

- *Hospital Readmission Reduction (\$3025)*— This program ends reimbursement for hospitalizations of Medicare patients deemed preventable. Hospitals are developing programs and partnerships to improve post-discharge community-based care and recovery. Connection to supports and services will be critical, which points to a high potential for CHWs to play a significant role in bridging hospital and community.
- *Patient-Centered Medical Homes (PCMH) and Community Health Teams (CHT) (\$3502)*— New primary care models emphasize the importance of a multi-disciplinary team, connection to social and other services, health promotion and chronic disease management, and cultural and linguistic access for patients. CHWs have the skills to play these roles and can be an important member of PCMHs and CHTs. Center for Medicare and Medicaid Innovation (CMMI) funding is an opportunity to partner with health systems on proposals that include CHWs as part of these structures.
- *Maternal, Infant, and Early Childhood Home Visiting Programs (MIECHV) (\$2951)* – The ACA established MIECHV and authorized grants to increase evidence-based home visiting services for “at-risk” communities. Arizona was one of 3 states awarded a competitive grant of \$9.4 million to expand its programming.
- *Hospital Community Benefits* – Community Health Needs Assessments (CHNAs) and Community Health Improvement Plans (CHIPs) (\$9007) – Non-profit hospitals are now required to conduct CHNAs every three tax years and to engage a range of stakeholders, including from the community and those with special expertise in public health. Based on this assessment, hospitals must develop a CHIP to guide the use of their Community Benefits dollars. CHWs

would be good sources of information for the CHNA – which might logically result in increased hospital support for CHW programs that target identified health challenges. CHWs can also be part of the public health department CHA or CHIP process as required by the Public Health Accreditation Board.

- *Grants to Promote the Community Health Workforce (\$5313)* – Authorized CDC in collaboration with the Secretary of HHS to award grants to “eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.” Unfortunately, funding has not yet been appropriated for these grants.

IV. Potential Roles for the Maricopa County Department of Public Health (MCDPH) to Build CHW Capacity

The main challenges for better integrating CHWs into health system activities are related to the lack of understanding by many providers, institutions, and health plans about what CHWs do and the contributions they can make to achieving the ‘triple aims’ of health reform--better quality of care, improved population health and lower costs. Additional challenges to their acceptance concern the lack of standardized training and credentialing requirements. Thus, the health care sector is generally unaware about how to integrate CHWs into their newly-reconfigured delivery and payment systems.

Below are areas of focus for MCDPH and partners to explore, with the greatest attention given to two timely issues related to current federal Requests for Proposals (RFPs): Exchange Navigator opportunities and CHWs and Bridging Public Health and Primary Care.

- **Workforce Development.** Identify career paths for CHWs and facilitate the availability of CHW trainings and continuing education opportunities. Trainings might cover both



core competencies and specialized education in such areas as chronic disease prevention and management. In addition, trainings are indicated for clinical supervisors on techniques for effectively integrating CHWs into health care teams. Health departments can directly provide these programs or assist colleges, health care organizations, workplaces or non-profit organizations in offering them, as well as establish training standards. MCDPH should become involved in the CHW Workforce Coalition and contribute to these conversations. A critical role for health departments is to assure that population health competencies and public health approaches-such as chronic disease prevention and management as well as policy and systems change skills- are included in addition to the more traditional health care access and health care-related competencies.

- **Promotion and Support.** Explore establishing an Office of Community Health Workers, at the state and/or local governmental levels, such as has been done in Minnesota and Massachusetts. Conduct assessments, assist in building a professional identity campaign through outreach, websites and reports, and define a clear “scope of practice” for both CHWs and other stakeholders, to increase public understanding and support for the profession. Support the statewide CHW Association by providing grants and technical assistance. Communicate to healthcare providers, leaders and policymakers the data about CHW efficacy and Return on Investment (ROI), such as:
 - » CHW home-based self-management and environmental interventions for children with asthma is recommended by the CDC’s Community Guide to Preventive Services, based on a review of 23 studies
 - » Arkansas saw a 24% annual reduction in Medicaid spending per participant in a CHW intervention, documented in a Health Affairs article.
 - » Christus Health in Texas used CHWs to reduce inappropriate use of the emergency room and in one region, saw a return of \$16 for every \$1 spent on CHWs, with an ROI range from 3:1-16:1.

- » In New Mexico, a CHW intervention reduced Medicaid claims and payments.
- » More examples are included in the HRiA report to MCDPH, Understanding the New Landscape for Public Health.

- **Partner with Healthcare Providers to include CHWs in New Models.** Educate health care providers about the value of CHWs and engage them in planning to integrate CHWs into new programs and models of care as they respond to increased demand for primary care to reduce preventable readmissions of Medicare patients under the ACA. See the “Bridging Public Health and Primary Care” section of this brief for more ideas.
- **Policy Development.** The ADHS is partnering with the University of Arizona to investigate the potential of credentialing or certification programs to help professionalize the occupation and increase the likelihood of insurance reimbursements for the work of CHWs. Several states, such as Texas, Massachusetts and Ohio, already have or are establishing certification programs. Advocate for public and private insurers to reimburse for CHW services in a variety of settings in the course of health reform expansion. New reimbursement mechanisms, such as global or bundled payments and pay for performance (P4P) lend themselves well to supporting CHW services. Strong policies that can demonstrate quality assurance will help pave the way. There are already national provider classifications for billing. Learn from locations where health plans are already reimbursing for some CHW services.



» Minnesota's Medicaid program is currently reimbursing for credentialed CHWs. Medicaid Managed Care Organizations (MMCOs) and some private health plans in a few other states, counties or hospitals are reimbursing for asthma home visiting services, including Medicaid to Multnomah County Health Department in Oregon, Neighborhood Health Plan to an NGO in Boston, and Blue Cross/Blue Shield and MMCO payers to Sinai Health System in Chicago.

- **Research.** Conduct program evaluations and disseminate research to further demonstrate the value and ROI of CHWs. While there is a growing body of evidence, more research is needed to understand what aspects of the work of CHWs are most effective.

V. Funding Opportunities to Promote Utilization of CHWs in the County and State Exchange Navigators

An Insurance Exchange Navigator is a specific role that will be assumed by Navigator Entities and individuals (including CHWs) to help the uninsured understand their options for selecting health insurance that is appropriate for their needs and means. Navigators are required as part of the newly configured health insurance marketplace (or exchange) under the provisions of the ACA. A current Centers for Medicare and Medicaid Services (CMS) RFP is out for Exchange Navigators for Federally-Facilitated Marketplaces and State Partnership Exchanges.

Navigator programs educate and assist residents and small employee groups with selecting qualified health plans within the Marketplace and assist with enrollment into those health plans. Massachusetts' experience indicates that there is also an important role for 'post- enrollment' support, including assistance with linking the newly insured to primary care and education about preventive and other services that are available. CHWs often play that role.

To be eligible to receive a Navigator grant, an entity must demonstrate that they have existing relationships- or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be qualified to enroll in a qualified health plan. Eligible Navigator entities include--but are not limited to-- community and consumer-focused nonprofit groups, trade and professional associations, chambers of commerce, and unions.

Navigators should specifically perform the five functions specified in the federal health reform law as follows:

- conduct public education activities to raise awareness of the availability of qualified health plans;
- distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;
- facilitate enrollment in qualified health plans;
- provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage;
- provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

The current CMS Exchange Navigator RFP is already the focus of a stakeholder group (Central Arizona ACA Coalition) in which MCDPH is a participant. MCDPH clearly has potential roles as a sub-recipient or contracted entity to support specific types of Navigator services or even be the lead coordinator for Maricopa County. In addition, MCDPH can position itself to apply for future navigation-related funding. Specific opportunities include:

- The **Health Care for the Homeless** clinic offers

a promising opportunity for Navigator and ‘post enrollment’ patient navigation funding targeted to homeless clients. The National Health Care for the Homeless Council, in a brief on CHWs, noted that “CHW programs within Health Care for the Homeless projects [are] a significant opportunity to improve health and access to care for those experiencing homelessness.”

- **MCDPH clinic staff located in Federally Qualified Health Centers** (FQHCs) may be eligible for HRSA’s supplemental \$150 million dollar outreach and enrollment funding for qualified health centers and for other initiatives as navigation needs change.
- **MCDPH could propose hiring new, or retraining and reallocating, current staff** to provide Navigator services to all MCDPH clients and/or targeted programs, populations, and communities. For example, prison and jail populations as well as newly returning veterans, are populations in need of targeted connections to insurance coverage.
- **Participate in Navigator Training.** MCDPH staff has indicated an interest in having personnel in their clinics and programs, which have direct patient contact, receive the Insurance Exchange Navigator training.

CHWs can also provide care coordination, which will be critical to new primary care models.

There are already models of integrating CHWs into new PCMH and CHT structures. Vermont’s Blueprint for Health links CHTs to medical homes. The CHT includes CHWs to provide Chronic Disease Self-Management programs (CDSM) and care coordination. This is especially valuable to enhance access to care in rural areas, and is a promising practice for MCDPH to discuss with health care partners.

MCDPH is well positioned to link CHW prevention, chronic disease and other newly covered services with primary care in FQHC’s. Conversations with state and county health department staff in Maricopa County indicate that partner health centers are strongly invested in the CHW model. Medicaid Managed Care Plans, in some states, are contracting with local health departments’ CHW program staff to provide CDSM services for MMCO members. Arizona Medicaid (AHCCCS)’s waiver to experiment with new forms of payment is an opportunity to promote this kind of model. Likewise, the newly-released (May 2013) CMMI Healthcare Innovation Challenge RFP seeks models that connect patients to community services and aim for overall health improvements for specific populations, something that CHWs and health departments can help accomplish.

VI. Bridging Public Health and Primary Care

Health system focus on the triple aim means that health care entities will be seeking ways to connect clinical services to population health improvements. MCDPH can help lead efforts to educate health care partners on the value and cost-effectiveness of integrating CHWs into their clinical teams and as a bridge to the community and prevention.

MCDPH can provide technical assistance to health care institutions on how to use CHWs effectively; identify “hot spots” of high-utilizers of care and target these neighborhoods for outreach and access to primary care; contract to provide CHW-led health education programs in community settings; and deliver proven maternal and child health, diabetes, or asthma home visiting programs using CHWs where research has demonstrated their cost effectiveness.

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